August 25, 2006

To: Interested Colleagues

Re: 1.) *Hubris*-related theories & the scientific explanation of American foreign policy; 2.) New, rapid learning systems in world politics.

Although it might be unsettling, I think it is time to add *hubris*-related ideas to IR and American foreign policy textbooks as a scientific explanation of cases in American foreign policy, including the current Iraq War. There are several classic and modern theories:[1] One clinically-based model that had a good fit across three return engagements of US interventions in Central America also seems to have a good fit with emerging evidence concerning the current Iraq War. It also predicts that Vice President Cheney's personality is a driving force in what becomes, if it is engaged, an error-prone syndrome.[2]

1.) American foreign policy and hubris-related theories.

The new *clinical* contribution to IR theory is to posit a power-drama syndrome of international behavior that, while it masquerades as hardheaded rationality/Realpolitik, is oddly-wired and actually operates as a dramatic overlay, engaging imagination and emotion rather than reason alone. For example:

1.) A bold, highly self-assured, and overconfident policy using violence for dominance and hierarchical control against lower status foreign challengers *coexists* with

2.) Extraordinary fear and an acute (domino theory) sense of vulnerability.

3.) Once engaged, the "hardball" power drama drives the policy. The policy is difficult to change by evidence (e.g., Ron Suskind, The One Percent Doctrine: Deep Inside America's Pursuit of Its Enemies Since 9/11 (NY: Simon & Schuster, 2006).)

4.) The policies run aground in foreign realities that, in retrospect, were poorly

understood and against opponents who were under-estimated. There also is a tendency for decision makers to capture their own imaginations, and to believe that American viewpoints and categories define foreign reality.

5.) An idealistic and virtuous self-image not withstanding, typically the idealism and a long-term vision of hegemonic benevolence (economic reconstruction, democracy) are under-funded, poorly planned and executed, and not sustained. Legal, ethical, and human rights constraints have a diminished place, even when this behavior becomes self-defeating. There is little genuine compassion for victims.

6.) This baseline psychological syndrome tends to repeat across hegemonic engagements with non-nuclear opponents, with little genuine learning.

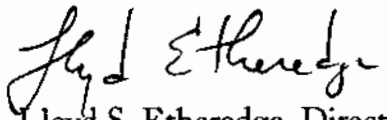
- A Reply to Senator Kay Bailey Hutchison

- Recently, Senator Kay Bailey Hutchison (R-Texas) questioned whether there are civic contributions of behavioral science.[3] Although she might not like it, *hubris*-related theories of American foreign policy are a good example of a cumulative, sophisticated, and science-based civic contribution. They raise important warnings that are not obvious to decision makers at the time. Just as, in an earlier era, social scientists raised good questions about the baseline behavior of arms races, especially the Soviet-American nuclear arms race.

2.) Rapid learning systems and world politics

An important new variable in world politics (and IR theory) - of unknown magnitude - is the still-undeveloped potential of the new, inexpensive, many-to-many, global communications and computing technologies. The political acceleration that new technologies make possible can be destructive (e.g., the 2,400+ jihadist Websites and the new, still experimental, use of terrorism as a marketing/recruitment strategy). And also (i.e., if the applications are organized) constructive: your students might be interested in the enclosed report of the new elements of a national/ international rapid learning system that is underway for

healthcare.[4]



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1. A brief discussion of the Greek use of the term for ethical analysis and to explain political behavior is: http://en.wikipedia.org/wiki/Hubris. For a review of fourteen modern psychological approaches beginning with Lasswell's 1948 model: Lloyd S. Etheredge, "Hardball Politics: A Model," Political Psychology, 1:1 (1979), pp, 3-26. Available online at www.policyscience.net.

2. Lloyd S. Etheredge, Can Governments Learn? American Foreign Policy and Central American Revolutions (NY: Pergamon Press, 1985). A further discussion of the syndrome model and specific predictions of repeating 1.) Policy characteristics; 2.) Behavior within the policy process; and 3.) Characteristic tendencies to errors of judgment and perception are included, with a copy of this memorandum, on www.policyscience.net. The full text of the 1985 study is available at www.policyscience.ws.

3. Jeffrey Mervis, "Senate Panel Chair Asks Why NSF Funds Social Sciences" in Science (May 12, 2006), p. 829.

4. Internet-based colloquia to accelerate the international creative process and respond to urgent global challenges also are part of the international rapid learning systems. See, for example, www.nyas.org and www.videocast.nih.gov. Re a UK component: Ben Hirschler, "Half a Million Britons Set for DNA Disease Quest," Reuters, August 21, 2006. Online.

Let me now proceed, formally, to integrate the argument. Like the shape of iron filings on a sheet of paper which reveals the shape and power of a magnet beneath, the strong imagination system we have surveyed produces the form, and repetition of, three vectors of blocked learning: (1) characteristic policies; (2) characteristic self-blocking behavior within the American executive branch's policy process; and (3) a characteristic syndrome of errors of judgment and perception.

Vector 1: The Form of Policy

The American government since World War II has not been empire-minded to the same degree as many other regimes in history; there are important distinctions and discriminations to be made. Nevertheless, I think we best understand American foreign policy toward leftist revolutionary challenges to governments within its (self-designated) sphere of identification and influence as expressing, in the main, the impulses and motives I have just described.

The principal American policy, in fact, is not intervention but "business as usual" inattention; any lower-status country, without power, which has not yet become a "trouble spot" is taken for granted. The depth of analysis and search in the American decision process is limited, and only when another major power which *genuinely* threatens America is involved (e.g., the Missile Crisis) is there motivation for extensive, consequential thought.

When a leftist revolutionary process begins, a standard American policy sequence (see the discussion of the 1980s in the next chapter, Table 7.2) unfolds, accompanied by agitated debate (with overdramatization) and producing an increasingly activist policy designed to restore a sense of control with respect to this growing, public challenge. Events thousands of miles distant suddenly arouse "hysteria" in American policymakers, overconfidence in their power to manage events, and a feeling of necessity to do so.[69]

I have outlined the core elements of this policy structure in Table 6.2, elements reflecting the presence of this top-down drama: overconfidence, fear, defective ethics, slightly drunken and emotion-charged talk, depersonalized and scornful hostility (regardless of the merits of the revolution), deteriorated humor, and feverish activism.

From: Lloyd S. Etheredge, Can Governments Learn? American Foreign Policy and Central American Revolutions (NY: Pergamon, 1985) pp. 158–162

Table 6.2. Hardball Politics: A Repeated System of American Foreign Policy

Main Characteristic: Inattention to lower status nations between crises.

Reaction engaged via revolutionary challenge from below

I. *Ambition and Overconfidence*
1. Escalating violence employed to preserve a dramatic role (above) of unchallenged domination and control. "Light at the end of the tunnel" faith, albeit without externally validating evidence and without a rational plan for an end game.

II. *Fear and Suspicion*
1. "Domino theory" national security threats are overdramatized.

III. *Defective Ethics*
1. Ideals poorly integrated and abandoned readily. Absence of principled restraint.
2. Depersonalization leads to "technocratic" rationality. Deaths and injuries to foreigners, especially of low status, enter rational calculations as "nothing to lose."

IV. *Emotionally Organized Thought*
1. Discussions, especially if public, will appear slightly drunken, that is, confident yet decoupled from reality, use emotion-laden symbols consistent with an imagined role of rightful American dominance, and possess only a modest ability to afford clear analysis of local realities.

V. *"Cold," Scornful Aggression*
1. Policies are designed to prevent America's "visible" (i.e., dramatically consequential) defeat—or the "visible" success of an illegitimate challenger. Rational, "coercive diplomacy" designed simply to negotiate specific changes or limits in behavior is not used.

VI. *Deteriorated Humor*
1. Absence of modesty and good humor.

VII. *Hyperactivity*
1. Activism, particularly increasing to the point of obsession as earlier policies prove ineffective and challenges grow.

Vector 2: Behavior Within the Policy Process

If we recognize the national security world to be, as I have suggested, a subculture with a highly charged sensibility of power drama, I believe we can understand more clearly a common cause of the self-blocking behavior reviewed in chapter 4.[70]

Primarily, one finds highly ambitious men, decided in the rightness of their views (to the point of overconfidence) and preferring like-minded advisers. The deepest fear of the highly ambitious is to be excluded from the inner circle at the top, and they dissemble, engage in self-censorship, and mute the emotional force of their communication upwards. Individuals have strong fear of appearing weak or tender-minded in such circles and engage in self-censorship of any reservations that might appear to reflect these traits, leading policy discussions to further bias toward the hardball sensibility.

Table 6.3. Hardball Politics: Self-Blocking Characteristics of the American Policy Process

I. *Ambition and Overconfidence*
   1. Decided world views.
   2. Too hasty preference for like-minded advisers.
   3. Majority confident of successful use of force.

II. *Fear and Suspicion*
   1. Strong fear of being excluded from access to power leads to inhibition and self-censorship, especially by subordinates.
   2. Fear of expressing "soft" views.
   3. Strong fear of press exposure.

III. *Emotionally Organized Thought*
   1. Tendency, in a top-down system, to ignore subordinates and take them for granted in planning.

IV. *Defective Ethics*
   1. Dissembling and strategic maneuvers within the policy process.
   2. Limited sense of personal responsibility for outcomes.

V. *"Cold" Aggression*
   1. Strong rejection of the "disloyal" (e.g., Bowles).
   2. Scorn of weakness (liberal idealists "lack balls").

VI. *Hyperactivity*
   1. Accompanied by exaggerated sense of the import and importance of one's work.

Vector 3: Characteristic Tendencies to Faulty Perceptions and Judgments

Finally, if we reconsider the pattern of misjudgments and misperceptions I have suggested (chapter 2), these, as well, may be seen to be expressions of the imagination system I described in the previous section: that is, to be assessments made likely as an effect of the underlying presence of a "hardball" dramatic sensibility for thinking about America's position in the world and the nature of power in international relations. I suggest the following proposition: *At each point where the policy process stopped at what was, in retrospect, a misjudgment or misperception, it did so because the stopping point was a node of the hardball dramatic sensibility.*

Table 6.4. Hardball Politics: Characteristic American Tendencies to Errors of Judgment and Perception

I. *Ambition and Overconfidence*
   1. Substantial overconfidence in success, even without evidence or a rational plan (a mystical "light at the end of the tunnel" faith).
   2. Overconfident faith in mass public support for American-defined purposes in the target country. Overconfident faith in eventual public vindication through success at home.
   3. Substantial underestimation (and scorn for the ability and learning rates of) lower status opponents.

II. *Fear and Suspicion of Opponents**
   1. Strong fear of ambitions of other rival nations (e.g., Castro, Soviets) and of America's domino vulnerabilities, worldwide, if weakness is displayed.
   2. Strong fear of vulnerability to Republicans and other aggressive domestic opponents if there is "failure" through perceived weakness.

III. *Defective Ethics*
   1. Uncritical belief in the coincidence of American policy and moral virtue.
   2. Compassion (and, to an extent, reality) disappears in a "nothing to lose from trying" obsession for success.
   3. Strategic dissembling and press manipulation to out-maneuver genuine democratic accountability.

IV. *Symbolic Involvements*
   1. Use of ambiguous phraseologies and characterizations with modest power to clarify issues and forces in local reality.
   2. Tendency to overdramatize and to capture one's own imagination. In policymaking, this leads to the self-absorbed belief that American viewpoints effectively define reality.
   3. Direct experience of sinister, malevolent forces.

V. *Hyperactivity*
   1. Unrealistic faith that a plethora of activist programs, begun "when the hour is late," will restore control.

*Note that fear is a function of the insecure self, overconfidence a function of the grandiose self. Hence the two will not, a priori, be thoughtfully integrated (as in the months before the Cuban missile crisis when the anxious search for missiles coincided with confidence they would never be introduced).

Table 6.1. From Within: The "Hardball Politics" Imagination System

Normality	*Borderline (HP)*	*Psychosis*
Integrated subjective self	Structural split into two selves (grandiose/depleted)	Complete fragmentation of subjective self
Mature self-esteem	Grandiosity/shame	Full delusional constitution of grandiose self; cold paranoid grandiosity/omnipotent persecutor
Mature self-confidence	Imperial, absolute self-confidence/hypochondria, continual worry about well-being, insecurity	Full delusional constitution of grandiose self; cold, paranoid/omnipotent persecutors and malevolent forces
Mature ambition	Compelling drive to merge with ("attain") idealized powerful offices; solipsistic claims for attention; fears of inadequacy	Full delusional constitution of grandiose self; cold paranoid grandiosity/omnipotent persecutor
Genuine love, warmth with autonomous individuals	Partial withdrawal of object libido; partial narcissistic bonding (loyalty/disloyalty)	Complete withdrawal of object libido; narcissistic bonding
Secondary process (secularized) reality testing and creative use of primary process under ego control	Partially distorting idealizing, twinship and mirror stereotypes; vague awe, primary process "religious" feelings, reified abstractions, and experiences of forces, pressures, power; habitual ambiguity and indirection; marked libidinal intrusions into speech and thought	Massive projection and transference; full deterioration of reality testing; uncontrolled intrusion of primary process, incomprehensible, illogical, fully emotionally expressive speech and thought
Mature, playful humor	Deteriorated humor	Absent
Capacity for enthusiasm	Episodes of hypomanic excitement	Auto-erotic tension state

Date: Mon, 07 Aug 2006 10:25:21 -0400
To: "Dr. Guy de The - Co-Chair, IAMP" <dethe@pasteur.fr>, "Dr. Anthony Mbewu - Co-Chair, Interacademy Medical Panel" <anthony.mbewu@mrc.ac.za>
From: Lloyd Etheredge <lloyd.etheredge@yale.edu>
Subject: IAMP & the first (US) national Rapid Learning System (for healthcare)
Cc: "Dr. Laurence Ehlers - Federation of European Academies of Medicine" <laurence.ehlers@cfwb.be>, "Ms. Muthoni Fanin - IAMP Secretariat" <iamp@twas.org>, "Dr. Ji-Sheng Han - Chinese Academy of Sciences":hanjisheng@bjmu.edu.cn, hanjisheng2005@gmail.com;, "Dr. Peter Lackmann - Academy of Medical Sciences UK":PJL1000@cam.ac.uk, m.manning@acmedsci.ac.uk;, "Dr. Jan Lindsten - Royal Swedish Academy of Sciences":jan.lindsten@cmm.ki.se, rsas@kva.se, karin@kva.se;, "Dr. Gunnar Oquist - Royal Swedish Academy of Sciences":gunnar.oquist@kva.se, diskh@kva.se;, "Dr. Dimitry Orlov - Russian Academy of Medical Sciences":orlov@ramn.ru, lumel2006@yandex.ru, "Dr. Nancy Pritchard - Australian Academy of Science" <nancy.pritchard@science.org.au>, "Dr. Kiyoshi Kurokawa - Science Council of Japan" <kurokawa@is.icc.u-tokai.ac.jp>, "Dr. Yumei WEN - Chinese Academy of Engineering":ymwen@shmu.edu.cn, lxj@cae.cn, kjc@cae.cn;, "Dr. Bob Williamson - Australian Academy of Science" <r.williamson@unimelb.edu.au>,

Dear Dr. de The and Dr. Mbewu:

The vision (discussed in the following announcement) for national rapid learning, which could become international, might be of interest to the InterAcademy Medical Panel and to institutions and individuals in your network.

with my best regards,

Lloyd Etheredge

Good news! Our first national rapid learning system (for healthcare) has started to get underway.

I'm forwarding a summary (1, below) of the design issues and implementation steps identified at the stakeholders conference in Washington. Harvey Fineberg, the new President of the Institute of Medicine, is taking the lead. Additional information and the original papers are available online at www.iom.edu/ebm. As the IOM summary notes, many national institutions are lagging and have not yet adapted to the pace which new technology makes possible.

Background

We now have 17+ million electronic health records, in standard formats in large databases (US); and also many existing and new drugs and treatments whose efficacy and side-effects can be evaluated more quickly, and which can be targeted to patients as new genome data for each patient becomes available and these data systems can be developed and collated/mined by academic and private sector researchers. [Several of the large private HMOs (e.g., Kaiser) also include social and behavioral data for selected populations to assist learning & patient feedback/empowerment about disease risk, onset, management, and treatment efficacy.] And we are just at the beginning . . .

- The vision also works internationally. It may be easier to develop in other countries with national healthcare systems that can make centralized decisions about electronic health records and large N databases w/ privacy safeguards. Identical formats across all countries are not necessary if the emerging systems are designed at the basic level to include all relevant data & allow fast and accurate translations across formats for online datamining.

Additional Developments: RWJ

You also might be interested in the grant announcement (2, below) from the Robert Wood Johnson Foundation for the development of Personal Health Information Manager software - a personal electronic health record that can (voluntarily) interface with the new US national rapid learning system. The winning designs probably will allow add-in modules for individuals with different health needs, etc. One of the background ideas is to give away the first 50 million copies to create a critical mass quickly and an open-architecture platform/market that the nonprofit and for-profit sectors can build upon. (Open architecture systems can be adapted by clinics & research projects in UDCs.) The vision also works internationally.

Building on the Healthcare Prototype?

Exciting times! This healthcare prototype also raises the question of whether there may be other policy areas where new, rapid learning (national/international) systems are possible.

Lloyd

Additional information (Item 1)

Dear Colleagues:

I am forwarding a summary of key issues identified at the recent Institute of Medicine Roundtable to develop a national (US) rapid learning healthcare system. A printed volume will not be published until next year, but the agenda book and speaker presentations are now available online at: www.iom.edu/ebm.

As we begin to think about an international rapid learning system for healthcare, identical formats across all countries are not necessary if data systems include all relevant data & allow easy translations across formats. The Index Medicus /National Library of Medicine (US) has done pioneering work on nomenclature issues.

Lloyd Etheredge

On the behalf of the IOM Roundtable on Evidence-Based Medicine, we would like to thank you for your participation in our workshop on *The Learning Healthcare System,* and to share with you an initial summary of some of the key issues and themes that emerged during workshop proceedings. Because these will help shape the foci of particular interest in the work of the Roundtable and the IOM, we would appreciate having your perspective as a participant about the key issues raised, and their priority. We would also like to take this opportunity to solicit any feedback you may have on the workshop content or conduct. Depending on the initial responses, we may develop a follow-up query instrument to solicit suggestions on priorities and strategies, but in the meantime, please send any feedback or comments directly via email to lolsen@nas.edu.

The workshop covered a wide range of topics and issues but several common themes and issues were identified by participants, including the importance of:

Adapting to the pace. The need for continuous learning and a much more dynamic approach to evidence development and application□one that takes full advantage of developing information technology□given the rate at which new interventions are developed, as well as new insights about individual variation in response to those interventions.

Culture change: The need for culture change to enable the evolution of the learning environment as a common cause of patients, providers and researchers

New clinical research paradigm: The development of a new clinical research paradigm□one that draws clinical research more closely to the experience of clinical practice, including the development of new study methodologies adapted to the practice environment, and a better sense of when RCTs are most practical and desirable.

Electronic health records: The essential application of electronic health records as a prerequisite for long-term change, if properly defined, utilized and broadly deployed.

Clinical data as a public utility: The need to see the collection of data and development of evidence as a public good, including re-assessing both issues related to ownership and to interpretations of HIPAA and other patient privacy issues that currently slow progress toward a system that constantly improves clinical insights.

Data base linkage and use: The potential for structured, large databases as new sources for evidence, including issues in fostering interoperable platforms and in the development of new means of ongoing searching of those data bases for patterns and clinical insights.

Incentives: The need to develop incentives to draw research and practice closer together, develop the needed patient records and interoperable platforms to foster more rapid learning.

Public engagement: The need for improved communication about the nature of evidence and its development, and the active roles for patients and healthcare professionals in evidence development, and dissemination.

Scientific broker: The potential utility of a credible scientific broker□to foster the shift in clinical research paradigm, the consistent and complementary use of standards of evidence, the development of consistent recommendations and to help

identify priority issues for systematic assessment.

Leadership: The need for leadership on these issues to marshal the vision, nurture the strategy, and motivate the actions necessary to create a learning healthcare system.

Agenda book materials and speaker presentations are available at: www.iom.edu/ebm. A summary of the workshop will also be available soon and a compilation of manuscripts elaborating on participant presentations will be published and available through the National Academies Press by early 2007. Thank you again, and we look forward to your continued involvement in Roundtable sponsored activities.

Sincerely,
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Additional Information (Item 2)
New RWJF Program Promotes Design of Innovative Personal Health Record Systems

The Robert Wood Johnson Foundation (RWJF) is pleased to announce **Project HealthDesign: Rethinking the Power and Potential of Personal Health Records**, a new $3.5 million national program to stimulate innovations in personal health information technology. Project HealthDesign encourages health and technology pioneers to imagine a next generation of personal health record (PHR) systems that would empower patients to better manage their health and health care.

Project HealthDesign supports the development of interoperable personal health record systems that will provide a range of flexible tools that can best support individuals' needs and preferences. Specifically, it will support up to 10 teams of technology designers – working closely with consumers – to design and test prototypes of innovative PHR applications that can be built upon a common technology platform. By enlisting the expertise and creativity of designers, patients, health professionals and informaticians to design PHR systems, the program aims to greatly expand the ways that PHRs can support patients' specific needs and medical providers' ability to provide optimal care.

RWJF is pleased to collaborate with the California HealthCare Foundation, which provided $600,000 in additional funding for *Project HealthDesign*.

The Call for Proposals (CFP), issued today, invites applicants to create consumer-focused personal health applications and test prototypes with target populations. The CFP is available at www.rwjf.org/cfp/projecthealthdesign.

Project HealthDesign will host Web Conference Calls on July 27 (2 PM EDT) and August 2 (1 PM EDT) – participation in these calls is strongly encouraged. They will provide prospective applicants the opportunity to learn more about the program and this grant competition and participate in a real-time Q&A session with RWJF and *Project HealthDesign* staff. To register for the calls, please visit www.projecthealthdesign.org.

The application deadline is Tuesday, September 19, 2006, at 2:00 PM EDT.

We encourage you to share this announcement with interested colleagues and/or to include a notice of this new program and funding opportunity on your Web site, and in relevant journals, newsletters, listservs or other publications. For additional information on *Project HealthDesign* and this funding opportunity, please visit www.projecthealthdesign.org.

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