IMPLEMENTATION OF PSRO LEGISLATION

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-THIRD CONGRESS

SECOND SESSION

MAY 8 AND 9, 1974

Part 1 of 2 Parts

ORAL TESTIMONY

U.S. GOVERNMENT PRINTING OFFICE

33-013 O WASHINGTON : 1974

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price $4.20

COMMITTEE ON FINANCE

RUSSELL B. LONG, Louisiana, *Chairman*

HERMAN E. TALMADGE, Georgia	WALLACE F. BENNETT, Utah
VANCE HARTKE, Indiana	CARL T. CURTIS, Nebraska
J. W. FULBRIGHT, Arkansas	PAUL J. FANNIN, Arizona
ABRAHAM RIBICOFF, Connecticut	CLIFFORD P. HANSEN, Wyoming
HARRY F. BYRD, Jr., Virginia	ROBERT DOLE, Kansas
GAYLORD NELSON, Wisconsin	BOB PACKWOOD, Oregon
WALTER F. MONDALE, Minnesota	WILLIAM V. ROTH, Jr., Delaware
MIKE GRAVEL, Alaska	
LLOYD BENTSEN, Texas	

MICHAEL STERN, *Staff Director*

SUBCOMMITTEE ON HEALTH

HERMAN E. TALMADGE, Georgia, *Chairman*

VANCE HARTKE, Indiana	CLIFFORD P. HANSEN, Wyoming
J. W. FULBRIGHT, Arkansas	ROBERT DOLE, Kansas
ABRAHAM RIBICOFF, Connecticut	BOB PACKWOOD, Oregon
WALTER F. MONDALE, Minnesota	WILLIAM V. ROTH, Jr., Delaware

CONTENTS

(Parts 1 and 2)

ADMINISTRATION WITNESS

PUBLIC WITNESSES

COMMUNICATIONS

APPENDIXES

APPENDIX A

APPENDIX B

SUBJECT INDEX

IMPLEMENTATION OF PSRO LEGISLATION

WEDNESDAY, MAY 8, 1974

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
OF THE COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to notice, at 10 a.m., in room 2221, Dirksen Senate Office Building, Senator Herman E. Talmadge, presiding.

Present: Senators Long (chairman of the full committee), Talmadge, Bennett, Curtis, Hansen, Dole.

OPENING STATEMENT OF SENATOR TALMADGE

Senator TALMADGE. The committee will please come to order.

Today the Subcommittee on Health begins 2 days of hearings to evaluate the status of implementation of the professional standards review organization legislation.

The professional standards review organization legislation was designed to afford practicing physicians at local levels an opportunity on a voluntary and publicly accountable basis to undertake review of the medical necessity and quality of care provided under the $25 billion medicare and medicaid programs. The intent was to substitute responsible, comprehensive, and professional review by the community of physicians in an area for the hit-or-miss review which had heretofore been provided in a less-than-effective fashion by the Government and insurance company personnel.

Effective professional review is vital to the existing medicare and medicaid programs and will be a key element in any national health insurance program. As a matter of fact, virtually all of the national health insurance proposals contain the professional standards review organization provision. Given the significance of professional standards review organization, it is important that we move promptly in implementing the statute so as to establish an effective base for public accountability which would bring changes which may be necessary at some times in the professional standards review organization program.

We have no time for stalling or dilatory tactics.

As I have said, we must establish a review of the quality of services provided under medicare and medicaid.

At the outset I want to point out these hearings are not legislative. They are oversight hearings.

I want to stress that due to the large number of public witnesses, the 10-minute rule on presentation of oral statements by any or all organizations will be strictly applied. Full texts of any witnesses' statements will be included, of course, in the printed transcript.

My distinguished colleague, the Senator from Utah, who is the ranking minority member of this committee, is here. He is the author of the professional standards review organization statute, and I yield to him.

OPENING STATEMENT OF SENATOR BENNETT

Senator BENNETT. Thank you very much, Mr. Chairman.

I am certainly pleased these hearings on professional standards review organization implementation are being held. They will provide an excellent opportunity to establish a balanced record of what the professional standards review organization is and what it is not. They will provide an opportunity to correct the multiplicity of distortions which often deliberately have been disseminated by those who often should and often do know better.

More importantly, this hearing will provide an opportunity to detail the progress to date by those many physicians and physician organizations which have been engaged in an effort to make the professional standards review organization a reality. This is an opportunity to hear from those responsible as well as perhaps some irresponsible elements of American medicine. It is an opportunity to point out that the professional standards review concept is benefiting from the active interest and supportive efforts of many of the medical special societies as well as the organizations of practitioners in the several professional standards review organization areas.

We have a long list of witnesses and I will, of course, as the father of the professional standards review organization statute, have a fair amount to say during the balance of the hearing.

Before I close, however, I should like to point out that as of the end of April more than 100 organizations of physicians have applied for professional standards review organization planning grants. At least 14 medical organizations have applied for conditional professional standards review organization operating status and an additional 17 requests for proposals to establish statewide professional standards review organization support centers have been received.

The professional standards review organization concept is rapidly on its way to becoming a reality in 46 States plus the District of Columbia and Puerto Rico, from which these applications came. This means that there are only four States in the Nation that have not been represented in the applications received to date.

I am particularly pleased that my own State of Utah, which has so often led the way, has been formally announced as the first professional standards review organization designate. In anticipation, the Utah physicians have been operating a professional standards review organization prototype for more than 1 year, and tomorrow we will hear from Dr. Allan Nelson, another key leader of Utah's effort who can share with us the actual experience of actually operating a professional standards review organization, even though it is not officially designated.

I thank you very much for this opportunity, Mr. Chairman.

Senator TALMADGE. The chairman of our full committee is with us and he has a statement.

OPENING STATEMENT OF SENATOR LONG

The CHAIRMAN. Mr. Chairman, I look forward to hearing the testimony over the next 2 days at these hearings on the implementation of the professional standards review organization program.

The issue of who will review the medical care provided under the Federal health programs and how that review will be carried out is a very important one. This committee, under the leadership of Senator Bennett, tried to work out a review mechanism which would assure that physicians, in a properly accountable fashion, would have the opportunity to perform the review, if they preferred to assume that responsibility.

We will hear over the next 2 days from a large number of medical organizations, some of whom I understand support the professional standards review organization provision and others who object to it. I would hope that with all of the testimony from these organizations on the record, all of us, physicians and legislators alike, will be in a better position to assess the implementation of this program, as well as the various alternatives.

Thank you very much.

Senator TALMADGE. Thank you.

Senator Ribicoff has a statement and an article he would like to have appear in the printed record.

[The statement of Senator Ribicoff with an attached article, follows:]

OPENING STATEMENT OF SENATOR RIBICOFF

In 1972 Congress demonstrated its concern with rising costs of health care by enacting Professional Standards Review Organizatiton legislation.

The PSRO law was designed to afford practicing physicians at local levels an opportunity, on a voluntary and publicly accountable basis, to undertake review of the medical necessity and quality of care provided under the $25 billion Medicare and Medicaid programs.

It is intended to substitute responsible, comprehensive professional review by the community of physicians in an area for the hit-or-miss review which has been provided in less than effective fashion by government and the private sector.

The federal government must take effective steps to control rising costs and utilization. This can be accomplished in a number of ways. Necessary review can be accomplished through professionalism and local control. Or it can be provided by bureaucratic fiat, mandate and arbitrariness in determining medical necessity and quality of care.

I prefer to see the review accomplished not by the bureaucracy in Washington but through local expertise as the PSRO law envisions.

Many doctors in Connecticut agree. And I am pleased that they are working to prepare for implementation of PSRO. In both Hartford and Bridgeport and Eastern Connecticut where PSRO units are being formed, physicians recognize their responsibility to review utilization and quality of care.

PSRO legislation is not federal control of doctors. Rather it is an opportunity for them to exercise their skills and expertise in making our health care system function more smoothly.

My distinguished colleague on the Finance Committee, Senator Wallace Bennett of Utah, who authored the PSRO concept, has worked tirelessly not only to pass the legislation but to see that it is implemented properly.

Senator Bennett stresses that PSROs are voluntary. Where they choose not to do so, the community of physicians in an area are not required to undertake a PSRO operation.

The legislation also provides adequate safeguards to assure that the confidentiality of the doctor-patient relationship is retained.

Today under Medicare and Medicaid norms are set—often haphazardly. This often results in retroactive denial of payment for claim. In contrast, the PSRO legislation seeks to assure that the range of norms are developed professionally by the working physicians in an area. Many doctors differ on the methods they use in treating a case. PSRO legislation recognizes this and provides the greatest possible amount of flexibility in medical practice.

In several states PSRO prototypes are in operation and have demonstrated substantial cost savings.

I hope that as the PSRO legislation is implemented, doctors around the country will work with PSROs as many are doing in Connecticut.

SOCIETY WILL ACCEPT DOCTOR PEER REVIEW

(By Ron Georgeff, Staff Reporter)

The Connecticut State Medical Society has reaffirmed an earlier decision to comply with the federally mandated Professional Standards Review Organization (PSRO) law but expressed some reservations about it.

Action by the medical group came Tuesday at the society's annual meeting at the Hartford Hilton. The delegates tabled a motion to call for repeal of the PSRO law, implying they would reconsider such a move if the law proved unworkable.

The PSRO law provides for a physicians' peer review system to monitor the quality and costs of hospital and nursing-home care for Medicare and Medicaid patients. The state is divided into four areas that must establish PSROs to carry out this review.

PSROs must be designated by the federal government by Jan. 1, 1976.

The law has generated considerable opposition among physicians in Connecticut and across the country, who feel it is government intrusion into private medicine. Supporters argue that the law is to make the medical profession publicly accountable.

The CSMS, last December, voted to lead in the implementation of the law, which decision it basically confirmed Tuesday.

The physicians, however, noted these reservations:

That the law not result in controls which would adversely affect the quality of health care and interfere with the patient-doctor relationship.

That confidentiality of patients' medical records be safeguarded.

That the cost of PSRO administration not exceed the cost of any savings through implementation.

That the American Medical Association's attempts to get amendments be supported and, if necessary, work for repeal of the law if its shortcomings are not corrected.

Dr. Sidney Cramer of Hartford, outgoing president, sounded a cautionary note in his final remarks.

"I would plead with you once more to consider the merits of moving with great deliberation . . . toward making any final, irreversible commitment to implementing PSRO in Connecticut no matter if the law remains unamended and no matter whether the regulations forthcoming prove to be professionally unacceptable."

Dr. Cramer said he supported the majority view but still urged a cautious approach.

Senator TALMADGE. Senator Dole.

OPENING STATEMENT OF SENATOR DOLE

Senator DOLE. Mr. Chairman, the practice of medicine is one of the most critical elements in determining the quality of life in any country. Without competent, effective, and accessible medical care to assure

good health, no people can fully realize their goals for achievement in the economic, social, and political arenas. No nation, however wealthy in minerals, agriculture, or other bounty, can hope to become or remain great without a foundation of basic good health for its citizens.

VARIETY OF PROGRAMS

With these points in mind, the United States has, for many years, pursued a wide variety of programs to deal with the need for improving the health standards of its citizens. And I believe we can take immense pride in the achievements which have raised the standards of health in America to the level which many take for granted today. In cooperation and partnership with the medical professions, educational institutions, industry, and business. Government has played a major role through a wide variety of programs and policies in the health field.

In the history of these programs, medicare and medicaid probably stand out as among the most ambitious, expensive, and controversial. And within these two programs, perhaps no aspect has been of greater concern to the physicians and surgeons of America than the professional standards review organizations established by Public Law 92–603.

VOTED AGAINST PROFESSIONAL STANDARDS REVIEW ORGANIZATION

As one who, in 1970 voted against professional standards review organizations legislation in the Senate, I particularly welcome these hearings by the Health Subcommittee, because it is most important that a full and detailed understanding of this program's implementation be available for study and for the information of the general public. Those of us who had doubts about the wisdom of placing further bureaucratic and administrative burdens on the medical profession have a special interest in having fresh, factual knowledge of the program's operation. And those who supported this legislation also have a responsibility for monitoring their proposal's effect, performance, and development.

CONCERN FOR HEALTH CARE

Regardless of our original positions on the program, however, I believe each member of the subcommittee has a sincere and genuine concern for seeing that the interests of patients, doctors, hospitals, and taxpayers are well served by this and other Federal health programs. And, therefore, I am hopeful that these hearings will help explain some of the questions which have arisen, clarify areas of misunderstanding and confusion, and provide a sound basis for assessing the need to enact changes, revisions, or safeguards to the present statute.

VIEWS OF KANSAS DOCTORS

To be quite candid, the PSRO concept is highly unpopular among the doctors of Kansas. When these hearings were announced, I contacted a large number of practitioners across the State to solicit their firsthand views on the program. Out of more than 100 busy doctors

who took the time to respond, only some 5 or 6 could be said to be favorable, while the remainder expressed varying degrees of doubt, reservation, and hostility toward the concept.

Perhaps some of this negative reaction can be attributed to faulty understanding, incorrect information, and perhaps just old-fashioned resistance to change. But at the same time, I also feel that these doctors' comments reflect a fundamental concern with the welfare of their patients and the individual doctor's ability to do the best job of serving the greatest number of people. And this latter point is a major concern in many of our rural counties where one or two doctors serve a population spread across many hundreds of square miles at a ratio which seriously threatens the quality of care that can be provided through their already strained resources of time and energy.

For the subcommittee's benefit, I would request that copies of a number of these letters be included in our hearing record at the conclusion of my statement as a general indication of the opinions and concerns about PSRO held by Kansas physicians in different types of practices and localities throughout the State.*

I would also note that the House of Delegates of the Kansas Medical Society yesterday adopted a resolution which generally reflects the views expressed in the letters I have received. Generally supporting the American Medical Association's position, the KMS called for constructive amendment of the PSRO statute or its repeal. At the same time, however, the delegates voted unanimously to support the Kansas Foundation for Medical Care in its efforts to develop the medical community's own system of review and accountability related to the medical necessity, quality, and appropriateness of medical services received by the people of Kansas.

CONCLUSION

So in conclusion, Mr. Chairman, I would observe that the doctors in Kansas are very much concerned about quality and economy in their practices and in the health programs of the Government. But they are also worried that their practices may become so burdened by regulation, redtape, and possibilities for harassment that they will lose much of their effectiveness as doctors.

It would be my hope and expectation that in the administration and implementation of PSRO that the Department of Health, Education, and Welfare will demonstrate a continuing sense of fairness, flexibility, and reason. And from Secretary Weinberger's testimony yesterday, I believe that spirit presently prevails at the highest levels of his department. But most importantly, I hope that those in charge of any Federal health program will never lose sight of the fact that the quality of health care for the American people has to be the underlying and prime goal of our entire system—including Government personnel, doctors, nurses, institutional administrators, and Congress.

Senator TALMADGE. Now, it is a pleasure to hear from the first witness, the Honorable Caspar W. Weinberger, Secretary of Health, Education, and Welfare.

We are honored to have you with us, Mr. Secretary.

I am informed that you must be out by 11:15, and I assure you that we will try to do so.

*See appendix G, p. 853.

STATEMENT OF HON. CASPAR W. WEINBERGER, SECRETARY OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY DR. HENRY E. SIMMONS, DEPUTY ASSISTANT SECRETARY FOR HEALTH; JAMES B. CARDWELL, COMMISSIONER, SOCIAL SECURITY ADMINISTRATION; STEPHEN KURZMAN, ASSISTANT SECRETARY FOR LEGISLATION; AND JAMES S. DWIGHT, ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE

Secretary WEINBERGER. We are honored to have the opportunity to appear before you, and we would like to have our statement, which in the interest of time I will perhaps paraphrase a bit, inserted in your record.

Senator TALMADGE. The entire statement will appear in the record, Mr. Secretary.*

Secretary WEINBERGER. Mr. Chairman, the task of implementing the PSRO legislation has been a difficult assignment. The PSRO provisions of Public Law 92-603 are complex and controversial. In the 1½ years since the enactment of the legislation we have assembled a highly capable staff which has been actively engaged in carrying out these provisions. It is a difficult job, but I am pleased to report that we're on schedule and intend to continue our implementation of the statute. And I would like to add that I believe the HEW staff has done an outstanding job, given the magnitude and complexity of the administrative assignments. Our desire has been and continues to be to carry out congressional intent in developing this important program.

I should note here that the administration believes that the successful implementation of the PSRO legislation should have the highest priority. As the members of the committee have undoubtedly noted, we have incorporated PSRO requirements into our proposal for comprehensive health insurance. In fact, the PSRO function has been included in many of the national health insurance bills pending before this committee, including the bill introduced by the chairman of this committee, S. 2513. The rationale for such requirements is clear: No national health insurance system can succeed in delivering needed health care services without built-in mechanisms to assure the effective and efficient utilization of health care facilities and resources.

And let me add here, Mr. Chairman, that we have not, as some have suggested, included PSRO requirements in our CHIP proposal simply as a cost control measure. PSRO is principally a quality assurance program. It is in no way contemplated that any PSRO requirement in existing law or in CHIP would deny needed care or quality care to any patient. The intent of PSRO, as we see it, is to promote more effective utilization of health resources. If this intent can be realized, unnecessary costs will be avoided and no one will be denied care because of unnecessary utilization of health resources by those who do not need the care. In short, PSRO is a program which will eliminate waste and maintain quality—goals which all of us can agree on. I think it is significant that the Senate committee report on this subject was intro-

*See p. 29.

duced by calling attention to the cost overruns that were contemplated in medicare and medicaid in the next few years ahead.

Implementation of the PSRO program began shortly after the passage of the enabling legislation in October 1972. The first major task to be accomplished was the designation of PSRO areas. In early 1973 the Department completed the guidelines which were then used in determining the most appropriate PSRO areas in each State.

To briefly summarize then, these guidelines emphasized that areas should not cross State or county lines; that existing review organizations and planning areas should be considered; that medical service areas should be taken into account, as well as the need for coordination with medicare and medicaid fiscal agents; and that physician populations should generally range between about 300 and 2,500. It should be emphasized that these were guidelines and not absolute criteria, and they were aimed at assisting local groups and organizations who were participating in the area designation process.

These area designation guidelines were then distributed around the country and used in meetings held by the Department with over 1,000 interested organizations in almost every State. Based upon the discussions at these meetings, the Department issued proposed designation of 182 PSRO areas on December 20, 1973. We then received over 1,700 comments from a wide variety of interested organizations and individuals and, based upon these comments, we made several changes. On March 18, 1974, we then published the final designation of 203 PSRO areas.

Many medical organizations expressed concern about the proposed area designations published in December. For example, there were some organizations in populous States which desired designation as statewide PSRO's, a designation which often appeared precluded by the terms of the statute. Wherever we could do so under the statute we authorized statewide PSRO's.

But as we had an opportunity to talk to the leaders in many of these States, it became quite clear that they were not asking to function as statewide PSRO's. What they seemed to be indicating was that they wanted the local physicians, the local regions of the States to do the medical review, to set the medical standards, and to see that the program of review worked. They thought it appropriate to establish on a statewide level some kind of an aid to those groups to help them get that job done, to give them technical and administrative support, and to do some things that can be done best from the State level. We had no difficulty with that concept at all because this is what we had been planning to do all along.

However, that is not a statewide PSRO. That is, to use the term we have devised, a statewide PSRO support center. They will be available to the PSRO's throughout the State to help them get their job done. We are now offering Federal contract funds to those State organizations to help bring the PSRO program into fruition in large States.

The publication of final area designations in March made it possible to accept applications from organizations wishing to be the PSRO for a particular area. In our discussions around the country, it became

apparent that organizations varied considerably in their stage of development. Many have been performing peer review for quite some time and would be able to qualify for conditional designation as a PSRO. Others were just getting started and were in need of assistance to help them develop the necessary PSRO organizational structure and review plans necessary to qualify for designation as a conditional PSRO.

We, therefore, decided to accept applications for two types of funding—one from organizations which qualified for conditional designation and one from organizations for planning purposes to help them meet the PSRO requirements.

The Department undertook a number of activities to explain to interested organizations how they should apply for planning, conditional, or support center funding. In mid-March we issued a PSRO manual, which contains explicit instructions on how to apply and the basic PSRO qualifications and requirements. In early April, at a Washington, D.C., meeting organized by the American Association of Foundations for Medical Care, the Department discussed with over 400 participants the basic PSRO requirements. We also discussed the manual at open public meetings with our national council and its subcommittees, as well as with the major national organizations, such as the American Medical Association, the American Hospital Association, and the Joint Commission on Accreditation of Hospitals.

One word about the manual itself. The manual contains a set of guidelines. They are not regulations. This was done purposely so that we can gather comments and modify it based upon actual operating experience. The medical care review system which is described in the manual is characterized by flexibility and encourages local decisionmaking and local innovation. Local PSRO's may, of course, recommend alternative review systems based upon their best judgment and experience and which are in compliance with the statutory requirements. With your permission, Mr. Chairman, I would like to submit the PSRO manual for the record.

Senator TALMADGE. Without objection, it will be inserted.[1]

Secretary WEINBERGER. The manual contains only 7 of the expected 17 chapters. The other 10 chapters, which will cover such areas as data requirements, evaluation, hearings and appeals, and reimbursement, will be available soon. However, we wanted to issue those sections needed to get the program started. In addition, we have traveled extensively, meeting with almost all interested groups in an effort to help them develop their PSRO's.

Mr. Chairman, it is these meetings and other conversations we have had which form the basis for my report to you that the PSRO program is moving ahead on schedule as of now.

We have received and are reviewing 131 proposals for planning contracts, for conditional PSRO designation, and for statewide PSRO support centers. In addition, we have contracted with the Pennsylvania Foundation for Medical Care to be a support center. And I am pleased to say that yesterday we published in the Federal Register the notice to the physicians of Utah our intent to designate conditonally the Utah PSRO.

---

[1] See appendix D, p. 665.

Planning contracts for potential PSRO's will be awarded to organizations to help them meet the requirements for conditional designation as a PSRO, and will help finance such activities as recruiting of physician members, designing their review plan and selecting staff. We are currently reviewing 104 proposals for planning contracts.

Organizations that are ready to conduct PSRO review of medical care will be awarded funds as conditional PSRO's. We are currently reviewing 14 proposals for conditional PSRO designation. The organizations which will be approved will have met the statutory organizational requirements such as open and voluntary membership including a substantial proportion of physicians in the PSRO area—which we set at about 25 percent. They will have open election of officers and they will rotate reviewers. As conditional PSRO's, they will have developed an appropriate review plan approved by the Department.

A third type of activity to be funded are the statewide PSRO support centers which I have already mentioned briefly. These centers are designed to capitalize upon the experience and knowledge of State professional organizations, particularly the State medical societies and foundations. We are currently reviewing 13 applications for support center funds. We expect these organizations will stimulate and support the development and operation of the PSRO program. They will be of particular help to local PSRO's in activities such as educating physicians about peer review and assisting groups to develop these organizational structures and review plans. There is no doubt that the development of local PSRO's can be significantly facilitated through the leadership, experience and support of State-level organizations.

In our implementation efforts, Mr. Chairman, we have been materially assisted by the National Professional Standards Review Council, a body authorized by Public Law 92-603. The Council has provided us with substantial advice and direction in these early, but most important days of PSRO implementation. As the PSRO's become operational, the role of the Council will expand to include those activities specified in the law.

With your permission, Mr. Chairman, I would like to submit for the record the minutes of the Council meetings.

Senator TALMADGE. Without objection, it will be inserted.*

Secretary WEINBERGER. Ernest Saward, who is chairman of the National Professional Standards Review Council, will be testifying later today about the Council's activities.

Another important implementation step relates to data gathering. The minimum data needs of Professional Standards Review Organizations have been defined and a basic data set to serve as the foundation upon which data collection activities would be based has been developed in collaboration with the American Association of Health Data Systems. We do not intend to establish new data systems which would duplicate existing systems, but rather we will build on existing systems. We believe that, in the early phases, Professional Standards Review Organizations should not be overburdened with data they are not

*See appendix C, p. 589.

prepared to use and do not yet need; nor should we encourage the hasty development of additional data systems, the need for which remains to be demonstrated.

Our implementation activities must be carried on with close communication with physicians, other health professionals and consumers. We are trying to communicate directly with the medical profession through individual physicians, through their medical associations, and through speciality societies. With your permission, I would like at this point to submit for the record copies of informational materials which we have distributed to the medical profession.

Senator TALMADGE. Without objection, it will be inserted in the record.*

Secretary WEINBERGER. I would like to note here that the W. R. Kellogg Foundation has awarded a grant of over $1 million for a study of six prototype PSRO's. This is a major, private initiative that will complement our implementation of the PSRO program. This study will develop and test alternate approaches to incorporating a greater emphasis on quality assessment and assurance in PSRO. We are working closely with the American Association of Foundations for Medical Care, the American College of Physicians, the American College of Surgeons, and the American Society of Internal Medicine who are responsible for the conduct of this study.

The current PSRO effort is fortunate to have as a base upon which to build the long history and experience of peer review activities carried out in hospitals and medical care foundations, and as Senator Bennett has mentioned that Utah was one of the pioneers in this field and California was, of course, also.

We are not, in other words, creating a wholly new peer review activity. Rather, we will be formalizing, expanding, and in some cases, improving existing review systems and assuring that physicians participate in and control the decisionmaking in medical review.

There are some basic misconceptions concerning the PSRO program which we have encountered in the course of implementing the law and I think two or three of these should be mentioned.

A major concern is that PSRO's will interfere with the physician-patient relationship and impair confidentiality of patient records. I cannot stress strongly enough that the Department shares the concern of both patients and physicians about the need for maintaining the confidential nature of data and information used by PSRO's. We believe that PSRO activities should require no change in the existing system of physician-patient relationships because local physicians, not Federal employees, will be reviewing patient records in much the same manner as they are currently doing. There are strong penalty provisions in the statute for anyone who would breach that relationship, and I am personally committed to assuring that PSRO's will not impinge on confidentiality.

As you know, I am an active member of the President's Domestic Council Committee on the Right to Privacy. The committee is currently preparing a report on needed actions to assure confidentiality in all aspects of our daily lives. The problems of confidentiality of

*See appendix F, p. 885.

health records in the existing system is one area the committee is examining. And I should note that confidentiality issues have been dealt with not only in our present medicaid and medicare programs, but also in existing private health insurance plans.

With the assistance of experts and affected organizations, the Department currently is developing guidelines and regulations which will address confidentiality in very specific terms.

These guidelines will be made available to the PSRO's, to data processors who support PSRO's, and other involved groups. Their application will be mandatory for all the PSRO's and all groups which handle data for any PSRO.

A second concern is that PSRO will lead to "cookbook medicine." This concern is based on the misconception that the norms, standards, and criteria of care developed by local physicians will be the absolute determinants of care, rather than serve as checkpoints which supplement the review process. We expect that the development of criteria which will be done locally rather than at the Federal level, will take into account the efforts of the national specialty societies and other peer review organizations in this area, but the fundamental responsibility for the establishment of norms, criteria, and standards rests with the local PSRO.

PSRO criteria will be established for classes of patients with a particular diagnosis or problem. When applied, they will screen out cases requiring more in-depth review. It is at this point that peer review really comes into play. All factors related to the particular case in question must be considered before any decision affecting payment is made. Mr. Chairman, we believe this is the opposite of "cookbook medicine."

A third concern is that PSRO represents an encroachment by the Federal Government in the practice of medicine. I need not remind the members of this committee that PSRO's will be composed exclusively of local, practicing physicians. Those physicians will form, administer, and operate the PSRO in their area. They will develop, select, and modify norms, criteria, and standards to be used in reviewing care. Only physicians can make final review determinations on care provided by other physicians. The Federal Government has no desire or authority to perform review of medical care. We agree with physicians that local practitioners are those best qualified to review care provided by their peers.

A fourth concern is that PSRO's will generate large administrative costs, wholly unjustified by any benefits. As the committee is well aware, Public Law 92–603 provides that the entire cost of administering the PSRO program is financed by the Federal Government.

We believe the cost of the program is small in comparison with the multibillion-dollar budgets of the medicaid, medicare, and maternal and child health programs which are subject to PSRO review. In addition, we believe PSRO represents an excellent example of a good investment of Federal moneys. When PSRO is fully operational, the health dollars spent for medicare, medicaid, and maternal and child health beneficiaries will be spent better and the patients will be receiving better quality care. In addition, taxpayers' dollars will be spent more effectively and with less waste of money and other resources.

A final concern which has been raised is that of the time and paperwork which will be required of physicians because of PSRO. Mr. Chairman, as we all know, most physicians already spend time performing peer review and related activities in hospitals. When hospital review is performed satisfactorily, and meets PSRO objectives, the PSRO will not duplicate it. Thus, in many cases, PSRO review will not require additional time and will not adversely affect the amount of time physicians can spend with their patients.

In addition, the PSRO review system has been designed to minimize physician paperwork. The physician's time will be concentrated on matters requiring professional medical judgment. Other staff can be used to do all the preliminary screening and handle administrative detail. Paperwork will be kept to a minimum through greater uniformity and standardization in the collection and recording of medical care data. Moreover, I want to stress that performing review is on a voluntary basis, as is membership in a PSRO. No physician will be forced to engage in PSRO review activities.

As you are well aware, PSRO is a very complex and ambitious program. We must not move so rapidly that we make unreasonable demands upon the medical care delivery system or have unrealistic expectations of what can be done in a short period of time.

Many organizations are now making legislative recommendations with respect to the PSRO program. We believe this is premature. We are studying ways in which the program might be improved. It is still too early in the development of the program to determine exactly what form those improvements should take—which aspects of the statute will work and which may require modification. We have extensively analyzed the law and some of the proposed changes. We have concluded that the law should be implemented as it was enacted, for the present.

In the coming year we will, in conjunction with our national council, undertake a major evaluation of the program. We have under consideration a large-scale assessment of the first year of the program's operating experience—possibly to be carried out by a non-Federal organization. Such an assessment would provide us with sufficient information to determine what, if any, changes should be made in either the statute or in our guidelines and regulations. We will also be sponsoring a national peer review conference this fall to examine the state of the art and to share experiences among the various PSRO's and others working in the field. The results of all of these activities will be shared with this committee.

Also, during the next year, the Department will continue to move ahead vigorously with the implementation of the program. We plan to fund PSRO's in most PSRO areas and will offer extensive technical assistance to those organizations requiring assistance.

At this point, Mr. Chairman, I would like to emphasize two factors which form much of the foundation for our implementation of the statute. The first of these is that, as the statute requires, peer review activities are to be performed by physicians and other medical professionals, not by laymen and government employees. Second, we believe that a considerable majority of the medical profession supports peer review and our implementation activities. In fact, it would have

been impossible to make the progress that we have made to date in implementing Public Law 92-603 if we did not enjoy the cooperation and support of major segments of the medical profession. This is not to pat the Department on the back. It is to say we have had as a result of our activity a very substantial amount of cooperation from the people who will have to carry virtually the full burden of this program, and that is the private physicians of this country.

For example, Dr. Robert Hunter, a member of the board of trustees of the American Medical Association, noted in an article in American Medical News:

> The real issue is whether or not our profession and our State and national organizations are going to allow themselves to be divided, threatened, and perhaps destroyed by the implementation of a law that—reduced to its basic elements—cannot be called undesirable.

The concept of peer review and our implementation of the statute have brought forth the endorsement and support of many physician organizations, including: The American College of Physicians, the American Society of Internal Medicine, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the National Housestaff Physicians Association, and the Student American Medical Association.

In addition, we are working closely with several medical specialty groups on PSRO-related activities. For example, we will be funding an activity by the American College of Radiology to help determine the efficacy of five of the most common X-ray procedures. We are also reviewing a proposed contract which would help develop standards for the appropriate use of antibiotics which involve the American College of Physicians, the American College of Surgeons, the American Academy of Pediatrics, the American Academy of Family Physicians and the Infectious Disease Society of America. We believe that the medical profession is actively involved, as it should be, and supports our efforts to implement the PSRO statute. Consequently, we are somewhat perplexed by criticism of our implementation effort which has been voiced by certain leaders of organized medicine. We believe that such criticism reflects neither the widespread professional support for peer review which we have found nor the real reaction to our implementation activity by the medical profession.

In conclusion, Mr. Chairman, I should like to stress our commitment to work with the Nation's health professionals in achieving an effective quality assurance program through PSRO's. I believe we have done a very creditable job of implementing a complex statute. We believe that a quality assurance program is necessary, not only because of the mandate of existing law, but because of the importance of such a program to any system of comprehensive health insurance.

That completes my formal statement, Mr. Chairman. I appreciate very much the opportunity to give it. I tried to abridge it a bit in the interest of time, and we will be delighted to answer any questions you may have.

With me today are James B. Cardwell, Commissioner, Social Security Administration; Stephen Kurzman, Assistant Secretary for Legislation; James S. Dwight, Administrator, Social and Rehabilita-

tion Service; and Dr. Henry E. Simmons, Deputy Assistant Secretary for Health, who is responsible for this program and who deserves a great deal of the credit to date.

Responsibility for Operation of PSRO's

Senator Talmadge. I would like to clarify the Department's understanding of the legislative intent. Who is responsible for the development of norms, parameters, and standards of care in a PSRO area?

Secretary Weinberger. The local PSRO's.

Senator Talmadge. Is it a fair statement that what the PSRO statute does is transfer functions to local doctors that formerly was delegated to the Secretary, his clerks, and insurance clerks?

Secretary Weinberger. I think that is a fair statement, yes.

Capabilities of Regional Office Personnel

Senator Talmadge. A number of prospective PSRO applicants have complained of the lack of knowledge and technical capability on the part of personnel charged with PSRO responsibilities in the regional offices. What are you doing to assure that regional office personnel are knowledgeable with respect to PSRO and capable of responding properly and promptly to legitimate inquiries?

Secretary Weinberger. Yes, Mr. Chairman, this is a very important question because we place heavy reliance and are placing increasing reliance on our regional office to deal directly with members of the public and State and local governments. This is a departmentwide effort, and it is consistent with the idea that we should have the Federal Government present in a much more capable way and visible way, able to deal with the local people. We have made an effort to strengthen regional offices generally. We have allocated 32 positions to the regional structure, and our 1975 budget will include 100 more positions to allocate to the regional directors to strengthen our capability there. We have intensive training programs at the regional office level for their staff, and we are already utilizing the staff that is there.

We certainly recognize that this is an important part of the Department's responsibilities, and we believe the steps we have taken will improve the regional office capability.

I think we have to bear in mind that PSRO is a new program and that some of the questions that can't be answered regionally can't be answered in Washington at this point, either, because we are in process of developing guidelines and regulations and the remaining chapters of our manual, as we described, but we are fully aware of the importance of a strong regional capability, and with these additional 100 positions that we are talking about, I believe we will make real progress in improving the ability of the regional office to be fully responsive.

Ad Hoc Advisory Group of Physicians to Assist PSRO

Senator Talmadge. At the conference on H.R. 1, the Department agreed to appoint an ad hoc advisory group consisting of physicians experienced in the operation of prototype review organizations, such as those in New Mexico, Georgia, Colorado, and Sacramento and San

Joaquin, Calif., to assist in the implementation in the PSRO amendment. In his letter to me of September, 13 1973, Secretary Weinberger said: "It is our intent, however, to take steps to convene such an advisory group within the next several weeks and to utilize their experience and knowledge in the implementation of the program."

When does the Department plan to carry out this program and honor its commitment in the conference?

Secretary WEINBERGER. We are honoring it, Mr. Chairman, with the intensive consultation we have had with the different groups, many or all of the ones you have mentioned. We don't have a formalized advisory committee of that kind. We do have the National Council which is provided for in the statute, and we have had a number of extensive discussions and interviews and opportunities for submission of ideas as well as conferences and meetings with these various groups.

The program, as it becomes operational, will probably have somewhat more formal arrangements that would look like this kind of group. I have to confess, frankly, that I have a desire to reduce the number of total advisory committees within the Department, which when I came exceeded 430, I believe. We are down to 370 now. Wherever we have the mechanism for proper consultation, we have tried not to form a specific formal advisory group, but we have the National Council, which is the overall group from whom you will hear this morning, and we have the consultation process that is underway and has been all through this year and last year. But as the program becomes operational, we may need to formalize these arrangements; and if so, we are fully prepared to do that.

Senator TALMADGE. I think that it was intended in the legislation, Mr. Secretary, that these doctors would be experienced in that program and could go in the respective States and tell them what to do and how to work it.

Secretary WEINBERGER. That is clearly the intent, and we will have experienced people who will be willing to go into the States and provide technical assistance and work out of the regional office. That is the intent of the statute.

Senator TALMADGE. That is what you are doing now?

Secretary WEINBERGER. Yes, sir.

Senator TALMADGE. Chairman Long.

ROLE OF THE SECRETARY OF HEW IN PSRO

The CHAIRMAN. Thank you for a fine statement, Mr. Secretary.

I believe many people who are very fearful of not only what the PSRO is, but what they conceive it might lead to, will feel more assured when they read what you said here. Under this PSRO proposal, the Secretary of HEW has the final say with regard to standards and procedures; is that correct or not?

Secretary WEINBERGER. I think ultimately the Secretary, whoever he is at any given moment, is supposed to develop and is the man responsible for the final regulations that are proposed and eventually adopted; yes, sir.

The CHAIRMAN. At a time when we would like to assure the doctors that this proposal does not in any way envisage anything other than

what you have set forth in this statement, I wonder if it might be desirable for us to simply repeal that provision whereby the Secretary has the final say and leave your function to be entirely advisory, and consultative, because of the fears that this is the beginning of State control of medical practice, I would feel a lot more secure if we ran these PSRO's the way the statute envisages because the alternative is if the doctors don't run this thing the way we have in mind that surely the Congress would insist on putting back with the Secretary power to reverse their judgment and reverse their findings. Basically it seems we are all agreed on what the purpose should be. What we are concerned about is hobgoblins that some people dream up, and in some cases something a lot more genuine, the honest fears of doctors and others that this might be the wedge whereby the Government takes charge of their profession and begins to run it for them.

I just wonder if you might be willing to go along with some proposal where, unless and until doctors abuse this approach and fail to do it the way we had hoped they would, that they would have the final say rather than you?

Secretary WEINBERGER. Well, Senator, let me comment on that this morning for just a moment.

I think to a considerable extent it depends on what we are talking about. Someone, I take it, has to have the final authority to issue regulations. I don't care much who it is, but it has to be placed somewhere. If you are talking about, however, the setting of standards and norms and criteria for the medical practice in any given area, the Secretary doesn't have anything to do with it, and this Secretary doesn't want anything to do with it.

The CHAIRMAN. Do I understand that you don't have that power now and are not seeking it and don't want it?

Secretary WEINBERGER. That is right. That is in the local PSRO's. The power to set the standards and norms and criteria is, and in my opinion, has to be in the hands of local physicians and that is one of the reasons for the area designations, because there is a difference in norms and standards in each part of each State. That is what we tried to identify and work from in making some of these area designations. The people in Washington, specifically including the Secretary, and I should add several others, should have nothing to do with that part of medical practice, and I don't want it and I don't think any change in the law is necessary to assure that, but if somebody wants to put a section in that the Secretary shall have nothing to do with the setting of standards I would endorse and welcome that. I don't think it is necessary because I think that is what the law says now.

On the other hand, if we are talking about regulations for the development of various functions of a statewide support group or regulations that will guide the Federal role that is assigned in the assistance and technical assistance in establishing PSROs, somebody has to finally promulgate those regulations and that is what I was answering, based on my understanding of the question, that the responsibility lays with the Secretary. I don't know who else can and should have it. I am not going to miss anything that is taken away. But somebody has to be the final person who promulgates the regulations in areas where there is an appropriate Federal role. There is nothing appropriate

about a Federal role in determining the standards, criteria and norms of medical practice or anything of that kind. That is something local physicians have to do.

Role of the National Advisory Council

Senator Bennett. Will the Senator yield to me for a second?

The Chairman. Yes.

Senator Bennett. There must be some kind of a mechanism when it becomes obvious that this local system is falling down and the overall evaluation is in the hands of the National Professional Standards Councils which is made up entirely of physicians. It is assumed that only in extreme cases would reference be made of unusual local standards to the National Council, but if review is necessary it is still in the hands of the medical profession.

The Chairman. I think that is a point that is not understood. I met with a large number of doctors, in fact the State Medical Society of my State 2 days ago, and they had been led to believe, and I believe that they really thought that the Secretary of HEW has the final say in matters of this sort. If this is the case where it is the accredited medical authorities, the doctors themselves who have the final say, I for the life of me don't see how they would feel so fearful of the matter as they do that if they think that a layman, the Secretary of HEW, has the final say.

You are telling me no, that authority stays with the doctors. Perhaps if they have an unusual practice then the National Advisory Council composed entirely of doctors would be in a position to call attention to a local practice that the Council thinks is a bad health procedure, but that it would still be doctors and people who believe in the private practice of medicine and support that who would make these decisions; is that correct?

Secretary Weinberger. My understanding is as I have given it to you, Senator, yes. I think the words of the statute, of course, are clear and the sustantial deviation from any actual norm of care or anything of that kind that a PSRO might adopt is certainly going to be noticed and discussed by the National Council, which is a group of physicians also, and they are going to undoubtedly make suggestions if there is something that deviates very substantially from what is established as some sort of regional norm in any individual situation. But I don't see any area in which the Secretary of Health, Education, and Welfare, at some time in the future, whether he happens to be a doctor or not, is going to be able to say that you have to treat this disease in this way in Ogden, Utah. I wouldn't want that power. If there is anything in the act that indicates that there is such power I am not aware of it and I would oppose it.

Substandard Quality Health Care

The Chairman. Well, I am aware of a situation which occurred quite a few years ago, where a person who happens to have passed on to his maker, a very fine citizen, a former head of the State medical society, and my family physician, a distant relative—went to the

hospital, he was ill, they put him in any oxygen tent. He stayed there for about a week and he finally began to get a little better. People couldn't understand why he didn't get completely well. No one thought to turn on the oxygen. He was suffering all the time. After it was all over with, his wife, having headed the State medical society auxiliary told me we must not say anything about this, we don't like the public to think that things like this happen in hospitals, and we ought to keep this kind of thing quiet because it might tend to undermine public confidence.

So I am sure that anyone to whose attention that practice, or at least that error was called would undoubtedly adopt a procedure or could be persuaded to adopt a procedure to see that it didn't happen again. Persuasion of a board at the national level would probably appeal to those doctors a lot more than if somebody said here, that is very bad, you have to change your way of doing business. I think there is a difference in making someone aware of the fact and then having them changing it to make sure it doesn't happen again rather than having even a group of highly qualified peers out of Washington telling those people you should change your way of doing business.

Secretary WEINBERGER. I could propose a regulation which would say in all appropriate instances where oxygen is indicated and there is an on-off switch the switch should be turned on, but I don't think it would improve the standard of medical care, because occasionally right now we have some regulations that aren't carried out, and I think—let me just in all seriousness, read the section from the manual that I think is designed to explain what my belief is and what I believe carries out the statute. This is section 702.2 of the manual.

> In each of its review activities the PSRO will use norms, criteria and standards which are useful in identifying possible instances of misutilization of health care services or of the delivery of care of substandard quality.

Now, I suppose there are some extreme cases where a local PSRO might say in the case of appendicitis nobody should be hospitalized. I would suspect that would be picked up surely by the statewide group or the National Advisory Council or some doctor who wanted to hospitalize a patient and might even appeal under the appeal procedures. At some point along the line the procedures which we would establish by regulations promulgated by the Secretary would be sufficient so that the aberration that this obviously would be could be caught and changed. The Secretary would promulgate regulations under this kind of standard and regulations enabling doctors to correct aberrations, but that is a very different thing than the Secretary sitting down in Washington saying 5 days' hospitalization and no more for this disease. It is that latter decision I wouldn't want to have or any Secretary to have.

Senator TALMADGE. Senator Bennett.

NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL

Senator BENNETT. Mr. Chairman, I have only three questions.

In accordance with section 1163 it was intended that the National Professional Standards Review Council would undertake arrangements with various specialty organizations for the development on a

continuing basis for recommended parameters which would then be distributed to local PSRO's as the basis for their determination of their own set of parameters. The intent was that the Council would determine the advisability of such an arrangement and the Department would then negotiate the necessary contract with the College of Surgeons.

Is the Department carrying out the legislative intent?

Secretary WEINBERGER. Yes, it is my understanding that we are. This has come up and I would be glad to have Dr. Simmons perhaps elaborate on this, but I have no information that indicates we are not. My information indicates we are.

Senator BENNETT. Dr. Simmons.

Dr. SIMMONS. We are, Senator.

Senator BENNETT. Do you propose to permit, in acordance with the legislative intent, review of out-of-institution care by those conditional PSRO's which have demonstrated their capability?

Secretary WEINBERGER. Yes, this is the ambulatory care provision and we have not required PSRO's to review such services unless they request this function.

COST SAVINGS AT THE EXPENSE OF QUALITY

Senator BENNETT. This is redundant, but I would like to get it back in the record again.

Do you know of any way in which your Department has indicated to perspective PSRO's they should concentrate on cost savings at the expense of quality?

Secretary WEINBERGER. No, sir.

MORE FLEXIBILITY SOUGHT AT HEW

Senator BENNETT. Quite a few PSRO's have contacted us concerning the apparent rigidity of the process by HEW. Are you preparing a more flexible approach?

Secretary WEINBERGER. Yes, sir, we are, and the rigidity is not in the Department of HEW. It is the Federal contract and all the procedures that flow from the activity of awarding a Federal contract. I am not prepared to say that it shouldn't be reasonably rigid in view of some of the things we have found. We have an agreement mechanism we are working on now, and when it is adopted, we will be moving toward that.

At the moment where we have contracts and activities that come within the Federal Contract Act we are staying within that and following those procedures, and they are somewhat rigid, but we are moving to a situation where we can use a more flexible kind of mechanism as we get the program operational. We will have the safeguards. But we will have some greater flexibility than the contract procedures under the Federal statute.

Senator BENNETT. Well, you are aware of the problem and you have, as I understand your answer, adopted a policy to make your system as flexible as possible.

Secretary WEINBERGER. Yes, I would anticipate we would see a greater degree of flexibility with the fiscal year that starts July 1.

Senator TALMADGE. Senator Curtis.

Senator CURTIS. Thank you, Mr. Chairman.

Is there a time limit?

Senator TALMADGE. Yes. There is 10 minutes, and I also promised the Secretary I would get him out of here in 20 minutes. I urge the Senators to be as brief as possible, and if you want to interrogate the Secretary at further length, we will ask him to come back.

Secretary WEINBERGER. Yes, sir.

SUCCESS OF PEER REVIEW BEFORE STATUTE

Senator CURTIS. I know you are a very busy man.

Mr. Secretary, in what States did peer review exist before the statute was enacted?

Secretary WEINBERGER. Well, Senator, I can tell you two and there are probably several others. I know it existed in Utah and California. I believe it existed in Colorado. Dr. Simmons, who knows much more about this than I do, can probably add a few more.

Senator BENNETT. New Mexico.

Secretary WEINBERGER. Yes.

Senator CURTIS. Did they do a good job?

Secretary WEINBERGER. Yes, I have no hesitancy in saying the one I was familiar with in California did a good job. Perhaps there is uneven quality in various parts of the country. The ones I am familiar with did a good job. I think one of the keys is full physican participation and that was characteristic of the ones that I saw.

Senator CURTIS. Some of them did a job that might be described as very good or rather outstanding; isn't that true?

Secretary WEINBERGER. I would not hesitate to say yes on that, yes, sir.

Senator CURTIS. Now, they did it without any Federal statute or whatever?

Secretary WEINBERGER. That is correct.

Senator CURTIS. Did any of those States ask for a Federal statute?

Secretary WEINBERGER. I have no knowledge on that, Senator, at all. I came to this fairly late, and I don't really know whether there was a demand for it or not.

ULTIMATE FEDERAL GOVERNMENT CONTROL OF PSRO?

Senator CURTIS. Now, my quarrel with PSRO's enactment has been consistent all the way through. I opposed it the first time it passed the Senate in 1970—in that the layman in the ultimate analysis does not provide for a continuation of peer review as had been started in many States, but rather carried long enough that if, at a later time those administering it chose to make it so, puts the ultimate control in the Government.

I was shocked when the language was first—as I recall the history of this, there was testimony or a statement made to the effect that the doctors should police their own profession. I agree with that. I think it can be done without Federal legislation. But the time that recommendation was carried out and put into print I took occasion to mark

up a copy of it and see what authority it did delegate. I have before me this committee print, and I am reading from page 29, section 1152(a), "The Secretary shall not later than January 1, 1974, establish throughout the United States appropriate areas with respect to which Professional Standards Review Organizations may be designated"—there is no responsibility directly on the medical profession to police themselves. "The Secretary shall establish."

Down a few lines later, "The Secretary determines that such organization is capable of fulfilling"—the Secretary determines.

Under that same section, six or seven lines from the bottom, "such other public, nonprofit private, or other agency or organization, which the Secretary determines, in accordance with criteria prescribed by him in regulations,"—

Will the Secretary 10 years from now be writing the regulations? He will be able to select a PSRO agency. He may select a Ralph Nader, I don't know.

Under (2) (B) on that same page, "an organization which the Secretary, upon the basis of examination and evaluation finds capable of performing"—this is not in any sense of the word an authorization for the doctors to clean up and regulate their own house. This has all the authority anyone desiring to exercise it, and I am convinced you are not desiring to exercise it, can control the practice of medicine.

On the next page under 2, "whenever the Secretary shall have entered into an agreement," and down the page, "he shall not renew such agreements"—I am not trying to pick words out of context, but to go over this rapidly to illustrate the number of places where absolute authority is given to the Secretary, and I am not talking about the present Secretary. I am talking about the future Secretaries and I am cognizant about the fact no Secretary can do these things individually. Among the things he determines, such organization meets the conditions, down near the middle of the page under (d), "Any such agreement under this part with an organization, other than an agreement established pursuant to section 1154, shall be for a term of 12 months; except that, prior to the expiration of such term such agreement may be terminated by the Secretary at such time and upon such notice as may be prescribed in the regulations as terminated by the Secretary, that such organization is not substantially complying."

Under (e), "the Secretary is authorized to waive any or all of the review, certification, or similar activities otherwise required under or pursuant to any provision of this Act where he finds, on the basis of substantial evidence of the effective performance of review and control activities by professional standards review organizations," and dropping to, "the Secretary shall, prior to entering into any such agreement with any organization for any area, inform the doctors of medicine"—I am not trying to hit them all, but over on the next page, section 1153, "any review with respect to such services which has not been designated by the Secretary as the full responsibility of such organization shall," and section 1154, "the Secretary shall initially designate an organization as a professional standards review organization for any area on a conditional basis with a view to determining the capacity of such organization to perform the duties and

functions imposed under this part on Professional Standards Review Organizations."

The Secretary has absolute authority to write regulations, to appoint, to be the ultimate arbiter in all these things. Under (b) in that section, "during any such trial period the Secretary may require a Professional Standards Review Organization to perform only such of the duties and functions required under this part"——

Senator BENNETT. Will the Senator yield?

You have used your 10 minutes and you haven't allowed the Secretary to respond.

Senator TALMADGE. That is correct.

Senator CURTIS. If I may have 10 seconds.

I am not trying to put the Secretary on the spot. I am trying to put this committee on the spot. We wrote a pattern here that clearly gives the Government of the United States authority to run the medical profession of the country.

Senator TALMADGE. Without objection on the part of any member of the committee, I will ask the Secretary to respond.

Secretary WEINBERGER. Mr. Chairman, and members of the committee, these are legitimate worries. There is no power that is given that can't be abused and that is one of the basic things that we all have to live with and try to avoid. The Chairman of the Federal Trade Commission and the FTC itself has unbelievable powers if you read the statutes over American business, staggering powers, and they have to be exercised with very considerable caution, and if they are not, quite properly they can or should be modified or taken away.

The powers that you are reading, Senator Curtis, are there. They are powers that have to go to someone. When we are talking about the allocation of Federal funds and the payment of Federal funds to groups that are formed under the statute to receive them, the powers that you have read are powers that are posted in the Secretary for the purpose of determining whether Federal funds should go to particular organizations that are applying to be PSRO's and whether or not certain organizations qualify to start receiving federal funds under these powers.

The way to avoid this kind of situation, I have to say, is not to pass a medicare-medicaid statute, because we have passed a medicare-medicaid statute under which billions of dollars of the taxpayers are paid out, and this is one of the mechanisms to assure that the quality of care of the people eligible under those statutes is high and there is not an unnecessary utilization of the services so as to require a wasteful payment of the taxpayers' dollars. Once we get into Government involvement something of this kind of review procedure is essential. We have been into this since 1965. It applies only to the payment of Federal funds for services performed under this act. Someone has to determine for the Congress, for the people, whether or not an organization that is established under a statute meets the criteria of the statute and therefore receives and should continue to receive Federal funds, and someone should determine whether or not a particular organization is performing the duties laid on them by the Congress.

It is my intent and I believe it has been my practice to administer these as carefully as we can with due regard to the intent and for

the state of the Treasury and for the requirement in the act. That is obviously what we are continuing to do. The presence of those authorities and powers to my mind simply means the Congress has embarked upon a course of activity that requires Federal activity, and when that happens someone has to be given the authority to insure that the Federal activity is in accordance with the statute and is being done and in such a way that the funds are being paid out in accordance with the intent of the Congress. That is what I understand to be the reason for lodging these particular powers in the Secretary to which you have referred.

Senator TALMADGE. Senator Dole.

KANSAS DOCTORS QUESTION PSRO

Senator DOLE. Well, I won't take my 10 minutes. I will be glad to give Senator Curtis some of that.

I was one of the 18 who unsuccessfully voted with the Senator to delete this provision.

I made an effort to determine, Mr. Secretary, and I think the views of Kansas doctors are probably represented around the country, and I think there are some very serious concerns and they have all been raised here this morning. Since I sent a letter to them and had many replies, there have been new developments in Kansas. Prior to that time I had four letters for it, and one fellow wrote two of those. In the second one he raised some questions about his first one. But in any event, and I have a great number who have questions about it,[1] all in the areas raised by the chairman and Senator Long, I think perhaps much is misunderstanding and much may depend on what happens as far as what information is developed.

CONFIDENTIALITY OF PHYSICIAN-PATIENT RELATIONSHIP

But the Sedgewick County Medical Society is very active, the largest one in the Kansas, Wichita area. The President is under the impression that the information and data collected by PSRO program as well as those involved in the program may be subpenaed and used in action in court cases; is that a correct interpretation of the law?

Secretary WEINBERGER. Not to my knowledge. There is nothing in the statute or in the way it will be administered that requires a change in the confidentiality of the existing patient-physician relationship or the record. If there is such an interpretation possible I would favor a change in the law. There is nothing required in the PSRO effort that would interfere or should interfere with the confidentiality of the patient's record and the confidentiality of the patient-physician relationship.

What we believe we are carrying out is the intent of Congress in implementing this act.

Senator DOLE. I think in reference to that there was another indication in one letter that we didn't know what we were doing in the Congress, but that is nothing unusual, so I can answer that very easily.

---

[1] See appendix F, page 835.

But I think just so we emphasize the concern that the Kansas medical profession has, in almost every letter there is a willingness on the part of the writer, but they are fearful of interference with their practice. I think you have made that clear at least three or four times, that is not the purpose, not the power you want, it is not in the law now. They are concerned about confidentiality of patients' records.

Secretary WEINBERGER. I think they are properly concerned with these things, Senator. But I believe the concern is not warranted by the way we are administering it or by the statute. There are clauses or phrases that give people particular problems. I have no objection to changing those provisions.

But it is my belief we can and are administering this law so that it does not require any interference with confidentiality, and it does not tell anybody in Washington to tell the doctor how to practice medicine.

Senator DOLE. Are you offering any amendments?

NO AMENDMENTS SEEN NECESSARY

Secretary WEINBERGER. No, sir, not at this point. We don't believe amendments are necessary, and it may be with a complicated subject of this kind when it is implemented some amendments will appear necessary. There are penalties against disclosure, as you know. Maybe they are not severe enough. At this time we don't feel we need amendments, but if somebody does, we would be glad to look at them.

But I have no hesitancy in saying it is the intention of the Department to administer this in a way that doesn't have the Department telling physicians how to practice medicine. This is a much broader concern and would certainly be emphasized in our implementation efforts.

Senator TALMADGE. Would Senator Dole yield at this point?

Senator DOLE. Yes, sir.

Senator TALMADGE. I promised the Secretary, due to another engagement——

Secretary WEINBERGER. It is a White House engagement. I have to be down there at 11:30. That is the only kind of an appointment——

Senator TALMADGE. I was about to suggest this: Senator Hansen hasn't had an opportunity to question the Secretary at all. Others might want to question him at further length. I was about to ask the Secretary to come back before the committee at his convenience and ours to respond to the committee.

Secretary WEINBERGER. Mr. Chairman, I will leave all these gentlemen hostage here to answer any questions.

Senator TALMADGE. With that understanding, you are excused at this point.

Do you desire to question his subordinates further?

Senator DOLE. If that is all right with him.

Secretary WEINBERGER. Yes.

Dr. Simmons is the man directly in charge of the execution of the program in our Department.

Thank you very much.

Utilization Review Committees and PSRO Relationship

Senator Dole. Is there any conflict between the so-called utilization review committees that many areas have and the PSRO's?

Dr. Simmons. No; in fact, that is one of the advantages of PSRO. It really builds on and incorporates that which is working effectively.

No Duplication of Efforts Seen

Senator Dole. How do you answer the argument of the doctor who says it duplicates what we are doing in one area of the State or hospital?

Dr. Simmons. That is not so.

Senator Dole. It is not so?

Dr. Simmons. No.

Senator Dole. How would that work under some PSRO plan?

Dr. Simmons. The PSRO is authorized to utilize the efforts of the existing system within hospitals that are functioning effectively. The hospital associations are already working with these to develop mechanisms. Our program melds into those and they are compatible. They have a system that is about to be created that builds to the maximum extent it can on what exists.

Estimated Cost of Implementation

Senator Dole. What is the estimated cost of the implementation of the plan? I have one letter suggesting that it is about $300,000.

Dr. Simmons. I can give you the budget figures.

Thirty-seven-million dollars the first year, and we will be going to $57 million next year, which we think will be adequate to get the PSRO effort started throughout the country. There is an estimate, on the basis of some prototype organizations of about $250,000 to $300,000 a year. It is hard to be sure, because some of the important data decisions haven't been made, and in large areas the cost may be greater, and in small areas less.

Senator Dole. Is it hoped it might be a comparable savings because of the program? Is that the primary purpose, cost containment where Federal programs are involved?

Dr. Simmons. No; I think we have to be very honest and clear on that. This program is one where you have instructed or asked the profession to take on responsibility for assuring quality care. There will be instances where the profession will find that what is going on right now is inappropriate or can be done, in effect, with less resource use. This will result in a savings of money. There will be other instances where the profession will find that good quality care will result in greater expense. Where that balance is, is very difficult to predict. What we do predict is that you can be assured that the funds the public has spent for medical care will be wisely spent for care of a reasonable quality rendered in appropriate settings.

Senator Talmadge. Senator Hansen.

PSRO's and Private Office Practice

Senator Hansen. Thank you very much, Mr. Chairman.

We have solicited suggestions from the Wyoming State Medical Society, and we have also been in touch with the director of the Wyoming-Colorado regional medical program, Dr. Nicholas, in order to be able to make a more objective evaluation of the legislation before us, and I think it might be helpful to offer, for whatever benefit it may be, some of their observations.

I get the impression that overall they feel that PSRO's appear to be workable, but that if this concept were extended into the private office practice there would be tremendous opposition from it. I think it is fair to say that as long as review is done within hospitals with medicare and medicaid patients it will not be so bad, but if and when a national insurance plan incorporates PSRO and extends it to universities he sees real problems; that is, the executive director of the Wyoming society. Dr. Nicholas of the Wyoming regional program feels that generally the more directly involved physicians have become with the program, he believes, the more resentment and criticism there is on the part of the physicians generally.

Here are some of the problems that he sees with PSRO's. Norms of care could be a problem, but if minimum standards are set this is largely mitigated by the physicians' peer review mechanism. He does not feel such standards stifle innovation and experimentation. A hospital PSRO review works well, but an extension of PSRO to office practice medical care will cause tremendous resistance by private doctors. PSRO requires a tremendous amount of bothersome paperwork and consumes about 4 hours a week of a physician's time when he is serving his rotation, which comes up once every 6 months. This is half a day a week.

I might add parenthetically, Dr. Simmons, that having served on a hospital board of trustees for a number of years, that is an extremely important point. If there is one thing that frustrates and angers a doctor, is to be saddled legislatively with a responsibility that he doesn't think really relates too much to the practice of medicine. So, anything that can be done to minimize the filing of reports and filling out of forms certainly would be a real plus, in my opinion.

Physician Endorsement of PSRO's?

Lastly, the director of the Wyoming-Colorado regional program observed that nobody wants PSRO's, but they are willing to live with it in the face of worse alternatives. I think it would be fair to say the position of the medical profession insofar as I know, and I am able to discern it in my State of Wyoming, is that having first stayed completely shy of this legislative area, and learning if they don't have any input in the legislation, doctors will have laws written for them by people who really don't know what they are doing. They have since concluded that the best thing they can do is to try to work with this legislation.

I think that in general fairly represents what I believe to be the principle of doctors with whom I have exchanged ideas. If you would comment on those points——

Dr. SIMMONS. I would be very glad to.

First of all, Wyoming is doing a very good job. Your State has applied to become a PSRO, and that may well be possible.

It isn't true that all of the profession is against PSRO. There are a number who see the benefit and are taking an active part.

Senator HANSEN. If you would yield at that point, Doctor, let me correct the impression that I certainly left with you. I didn't mean to imply that I was speaking, trying to reflect a national consensus. I will say insofar as I knew, recalling expressions from doctors I visited with personally, I don't think there was enthusiasm for PSRO's, but those with whom I did visit concluded it was far better to get in and advise and to have some input into legislation in order that it could be drafted in a manner that would reflect the professional competence and understanding that only doctors have in this area rather than to leave it up to Congress. I think doctors as well as others may be well aware of the propensity in Congress for lousing things up.

Dr. SIMMONS. The statement that you made about the resentment about it, actually I guess our experience in traveling around the country, and we have done that extensively in the past 6 months is that if anything the resentment is getting less as physicians are understanding what PSRO is. The initial resentment was against a program that never existed and never could exist under this legislation. There was a lot of confusion. If I had been as misinformed as others were, I would have been against it myself. But as you are able to enter into a dialog and sit down and say, there is a potential and say, here is how it is going to operate, and provide our experience, the reaction from physicians has been favorable. That is why Dr. Hunter said in his interview, it is hard to resent a law that in its basic components cannot be called undesirable. I think that is what you will see in the months ahead, that the profession will understand its opportunity.

Your concerns with respect to the office setting, I think, are very important. The experience of groups of physicians who are already conducting this in the private sector themselves is that it is desirable. I think you will find that the physicians will see that in PSRO too.

The program cannot direct them to go in the direction of ambulatory care. There is an advantage to seeing what is going on in the offices. But that is a judgment physicians have to make.

As far as stifling innovation, I think this program may be the first time, in fact, will be the first time we can see where we are going and see where there is change. On the paperwork, clearly, we have to cut that to the maximum extent possible, but one of the things PSRO can do is identify the kinds of care that take a lot of time that is no longer appropriate. When we find that out and change it that will free up physician time and beds.

There are substantial improvements we can make. The PSRO can make improvements by developing these standards of care to free up resources that can be used elsewhere.

Senator HANSEN. You may have misunderstood me, Doctor. What I should have read, in case I did not. was, he does not feel such standards need stifle innovation and experimentation. If I did not make that point clear I wish to do it now.

Senator TALMADGE. Thank you, gentlemen.

If Senators wish to interrogate you further we will ask you to come back.

Senator CURTIS. Mr. Chairman, may I make a request for the record?

Senator TALMADGE. Certainly.

Senator CURTIS. I ask unanimous consent that the law establishing PSRO be printed in the record and that the printer designate by using a bolder type, certain sections of it which I have marked, but that the record will show that this is my presentation and not binding on the rest of the committee.

Senator TALMADGE. Without objection, that will be done.*

Thank you very much, gentlemen.

[The prepared statement of Secretary Weinberger follows:]

STATEMENT OF CASPAR W. WEINBERGER, SECRETARY OF HEALTH, EDUCATION, AND WELFARE

Mr. Chairman and Members of the Committee, I am pleased to appear before this Committee to report on the present and planned implementation of the Professional Standards Review Organization (PSRO) legislation enacted as a part of P.L. 92-603 in October 1972.

Mr. Chairman, the task of implementing the PSRO legislation has been a difficult assignment. The PSRO provisions of P.L. 92-603 are complex and controversial. In the one and a half years since the enactment of the legislation we have assembled a highly capable staff which has been actively engaged in carrying out these provisions. It is a difficult job, but I am pleased to report that we're on schedule and intend to continue our implementation of the statute. And I would like to add that I believe the HEW staff has done an outstanding job, given the magnitude and complexity of the administrative assignments. Our desire has been and continues to be to carry out Congressional intent in developing this important program.

I should note here that the Administration believes that the successful implementation of the PSRO legislation should have the highest priority. As the Members of the Committee have undoubtedly noted, we have incorporated PSRO requirements into our proposal for comprehensive health insurance. In fact, the PSRO function has been included in many of the national health insurance bills pending before this Committee, including the bill introduced by the Chairman of this Committee, S. 2513. The rationale for such requirements is clear: No national health insurance system can succeed in delivering needed health care services without built-in mechanisms to assure the effective and efficient utilization of health care facilities and resources.

And let me add here, Mr. Chairman, that we have not, as some have suggested, included PSRO requirements in our CHIP proposal simply as a cost control measure. PSRO is principally a quality assurance program. It is in no way contemplated that any PSRO requirement in existing law or in CHIP would deny needed care or quality care to any patient. The intent of PSRO, as we see it, is to promote more effective utilization of health resources. If this intent can be realized, unnecessary costs will be avoided and no one will be denied care because of unnecessary utilization of health resources by those who do not need the care. In short, PSRO is a program which will eliminate waste and maintain quality—goals which all of us can agree one.

PSRO IMPLEMENTATION ACTIVITIES

Mr. Chairman, I would now like to turn to our implementation activities which have actively involved the physician community of this country.

Implementation of the PSRO program began shortly after the passage of the enabling legislation in October 1972. The first major task to be accomplished was the designation of PSRO areas. In early 1973, the Department completed the guidelines which were then used in determining the most appropriate PSRO areas in each State. To briefly summarize them, these guidelines emphasized that areas should not cross State or county lines; that existing review organizations and planning areas should be considered; that medical service areas should be taken into account, as well as the need for coordination with Medicare and Medicaid fiscal agents; and that physician populations should generally

*See appendix E, page 819.

range between about 300 and 2500. It should be emphasized that these were guidelines and not absolute criteria, and they were aimed at assisting local groups and organizations who were participating in the area designation process.

These area designation guidelines were then distributed around the country and used in meetings held by the Department with over one thousand interested organizations in almost every State. Based upon the discussions at these meetings, the Department issued proposed designation of 182 PSRO areas on December 20, 1973. We then received over seventeen hundred comments from a wide variety of interested organizations and individuals and, based upon these comments, we made several changes. On March 18, 1974, we then published the final designation of 203 PSRO areas.

Many medical organizations expressed concern about the proposed area designations published in December. For example, there were some organizations in populous States which desired designation as Statewide PSROs, a designation which often appeared precluded by the terms of the statute. Wherever we could do so under the statute we authorized Statewide PSROs.

But as we had an opportunity to talk to the leaders in many of these States, it became quite clear that they were not asking to function as Statewide PSROs. What they seemed to be indicating was that they wanted the local physicians, the local regions of the States to do the medical review, to set the medical standards, and to see that the program of review worked. They thought it appropriate to established on a Statewide level some kind of an aid to those groups to help them get that job done, to give them technical and administrative support, and to do some things that can be done best from the State level. We had no difficulty with that concept at all because this is what we had been planning to do all along.

However, that is not a Statewide PSRO. That is, to use the term we have devised, a Statewide PSRO Support Center. They will be available to the PSROs throughout a State to help them get their job done. We are now offering federal contract funds to those State organizations to help bring the PSRO program into fruition in large States.

The publication of final area designates in March made it possible to accept applications from organizations wishing to be the PSRO for a particular area. In our discussions around the country, it became apparent that organizations varied considerably in their stage of development. Many have been performing peer review for quite some time and would be able to qualify for designation as a conditional PSRO. Others were just getting started and were in need of assistance to help them develop the necessary PSRO organizational structure and review plans necessary to qualify for designation as a conditional PSRO.

We, therefore, decided to accept applications for two types of funding—one from organizations which qualified for conditional designation and one from organizations for planning purposes to help them meet the PSRO requirements.

The Department undertook a number of activities to explain to interested organizations how they should apply for planning, conditional or support center funding. In mid-March we issued the PSRO Manual, which contains explicit instructions on how to apply and the basic PSRO qualifications and requirements. In early April, at a Washington, D.C., meeting organized by the American Association of Foundations for Medical Care, the Department discussed with over 400 participants the basic PSRO requirements. We also discussed the Manual at open public meetings with our National Council and its subcommittees, as well as with the major national organizations, such as the American Medical Association, the American Hospital Association, and the Joint Commission on Accreditation of Hospitals.

One word about the Manual itself. The Manual contains a set of guidelines. They are not regulations. This was done purposely so that we can gather comments and modify it based upon actual operating experience. The medical care review system which is described in the Manual is characterized by flexibility and encourages local decision-making and local innovation. Local PSROs may, of course, recommend alternative review systems based upon their best judgment and experience and which are in compliance with the statutory requirements. With your permission, Mr. Chairman, I would like to submit the PSRO Manual for the record. The Manual contains only seven of the expected 17 chapters. The other 10 chapters, which will cover such areas as data requirements, evaluation, hearings and appeals, and reimbursement, will be available soon. How-

ever, we wanted to issue those sections needed to get the program started. In addition, we have travelled extensively, meeting with almost all interested groups in an effort to help them develop their PSROs.

Mr. Chairman, it is these meetings and other conversations we have had which form the basis for my report to you that the PSRO program is moving ahead on schedule.

We have received and are reviewing 131 proposals for planning contracts, for conditional PSRO designation, and for Statewide PSRO Support Centers. In addition, we have contracted with the Pennsylvania Foundation for Medical Care to be a Support Center. And I am pleased to say that yesterday we published in the *Federal Register* the notice to the physicians of Utah our intent to designate conditionally the Utah PSRO.

Planning contracts for potential PSROs will be awarded to organizations to help them meet the requirements for conditional designation as a PSRO, and will help finance such activities as recruiting of physician members, designing their review plan and selecting staff. We are currently reviewing 104 proposals for planning contracts. Organizations that are ready to conduct PSRO review of medical care will be awarded funds as conditional PSROs. We are currently reviewing 14 proposals for conditional PSRO designation. The organizations which will be approved will have met the statutory organizational requirements such as open and voluntary membership including a substantial proportion of physicians in the PSRO area—which we set at about 25 percent. They will have open election of officers and they will rotate reviewers. As conditional PSROs, they will have developed an appropriate review plan approved by the Department.

A third type of activity to be funded are the Statewide PSRO Support Centers which I have already mentioned briefly. These Centers are designed to capitalize upon the experience and knowledge of State professional organizations, particularly the State medical societies and foundations. We are currently reviewing 18 applications for Support Center funds. We expect these organizations will stimulate and support the development and operation of the PSRO program. They will be of particular help to local PSROs in activities such as educating physicians about peer review and assisting groups to develop these organizational structures and review plans. There is no doubt that the development of local PSROs can be significantly facilitated through the leadership, experience and support of State-level organizations.

In our implementation efforts, Mr. Chairman, we have been materially assisted by the National Professional Standards Review Council, a body authorized by P.L. 92-603. The Council has provided us with substantial advice and direction in these early, but most important days of PSRO implementation. As the PSROs become operational, the role of the Council will expand to include those activities specified in the law. The Council represents a vital force in our efforts to assure the success of the PSRO program. With your permission, Mr. Chairman, I would like to submit for the record the minutes of the Council meetings held over the past year.

Another important implementation step relates to data gathering. The minimum data needs of PSROs have been defined and a basic data set to serve as the foundation upon which data collection activities would be based has been developed in collaboration with the American Association of Health Data Systems. We do not intend to establish new data systems which would duplicate existing systems, but rather we will build on existing systems. We believe that, in the early phases, PSROs should not be overburdened with data they are not prepared to use and do not yet need; nor should we encourage the hasty development of additional data systems, the need for which remains to be demonstrated.

Our implementation activities must be carried on with close communication with physicians, other health professionals and consumers. We are trying to communicate directly with the medical profession through individual physicians, through their medical associations, and through specialty societies. With your permission, I would like at this point to submit for the record copies of informational materials which we have distributed to the medical profession.

I would like to note that the W. R. Kellogg Foundation has awarded a grant of over $1 million for a study of six prototype PSROs. This is a major, private initiative that will complement our implementation of the PSRO program. This study will develop and test alternate approaches to incorporating a greater emphasis on quality assessment and assurance in PSRO. We are working closely with the American Associations of Foundations for Medical Care, the American

College of Physicians, the American College of Surgeons, and the American Society of Internal Medicine who are responsible for the conduct of this study.

The current PSRO effort is fortunate to have as a base upon which to build the long history and experience of peer review activities carried out in hospitals and medical care foundations. We are not, in other words, creating a wholly new peer review activity. Rather, we will be formalizing, expanding, and in some cases, improving existing review systems and assuring that physicians participate in and control the decision-making in medical review.

BASIC MISCONCEPTIONS CONCERNING PSRO

I would now like to discuss certain misconceptions about the PSRO program which appear to me to be the ones most commonly held.

A major concern is that PSROs will interfere with the physician-patient relationship and impair confidentiality of patient records. I cannot stress strongly enough that the Department shares the concern of both patients and physicians about the need for maintaining the confidential nature of data and information used by PSROs. We believe that PSRO activities should require no change in the existing system of physician-patient relationships because local physicians, not Federal employees, will be reviewing patient records in much the same manner as they are currently doing. There are strong penalty provisions in the statute for anyone who would breach that relationship, and I am personally committed to assuring that PSROs will not impinge on confidentiality.

As you know, I am an active member of the President's Domestic Council Committee on the Right to Privacy. The Committee is currently preparing a report on needed actions to assure confidentiality in all aspects of our daily lives. The problems of confidentiality of health records in the existing system is one area the Committee is examining. And I should note that confidentiality issues have been dealt with not only in our present Medicaid and Medicare programs, but also in existing private health insurance plans.

With the assistance of experts and affected organizations, the Department currently is developing guidelines and regulations which will address confidentiality in very specific terms. These guidelines will be made available to the PSROs, to data processors who support PSROs and other involved groups. Their application will be mandatory for all the PSROs and all groups which handle data for any PSRO.

A second concern is that PSRO will lead to "cookbook medicine." This concern is based on the misconception that the norms, standards, and criteria of care developed by local physicians will be the absolute determinants of care, rather than serve as checkpoints which supplement the review process. We expect that the development of criteria which will be done locally rather than at the Federal level, will take into account the efforts of the national specialty societies and other peer review organizations in this area, but the fundamental responsibility for the establishment of norms, criteria and standards rests with the local PSRO.

PSRO criteria will be established for classes of patients with a particular diagnosis or problem. When applied, they will screen out cases requiring more in-depth review. It is at this point that peer review really comes into play. All factors related to the particular case in question must be considered before any decision affecting payment is made. Mr. Chairman, we believe this is the opposite of "cookbook medicine."

A third concern is that PSRO represents an encroachment by the Federal Government in the practice of medicine. I need not remind the Members of this Committee that PSROs will be composed exclusively of local, practicing physicians. Those physicians will form, administer and operate the PSRO in their area. They will develop, select and modify norms, criteria and standards to be used in reviewing care. Only physicians can make final review determinations on care provided by other physicians. The Federal Government has no desire or authority to perform review of medical care. We agree with physicians that local practitioners are those best qualified to review care provided by their peers.

A fourth concern is that PSROs will generate large administrative costs, wholly unjustified by any benefits. As the Committee is well aware, P.L. 92-603 provides that the entire cost of administering the PSRO program is financed by the Federal Government.

We believe the cost of the program is small in comparison with the multi-billion dollar budgets of the Medicaid, Medicare and Maternal and Child Health

programs which are subject to PSRO review. In addition, we believe PSRO represents an excellent example of a good investment of Federal moneys. When PSRO is fully operational, the health dollars spent for Medicare, Medicaid and Maternal and Child Health beneficiaries will be spent better and the patients will be recieving better quality care. In addition, taxpayers' dollars will be spent more effectively and with less waste of money and other resources.

A final concern which has been raised is that of the time and paperwork which will be required of physicians because of PSRO. Mr. Chairman, as we all know, most physicians already spend time performing peer review and related activities in hospitals. When hospital review is performed satisfactorily, and meets PSRO objectives, the PSRO will not duplicate it. Thus, in many cases, PSRO review will not require additional time and will not adversely affect the amount of time physicians can spend with their patients.

In addition, the PSRO review system has been designed to minimize physician paperwork. The physician's time will be concentrated on matters requiring professional medical judgment. Other staff can be used to do the preliminary screening and handle administrative detail. Paperwork will be kept to a minimum through greater uniformity and standardization in the collection and recording of medical care data. Moreover, I want to stress that performing review is on a voluntary basis, as is membership in a PSRO. No physician will be forced to engage in PSRO review activities.

As you are well aware, PSRO is a very complex and ambitious program. We must not move so rapidly that we make unreasonable demands upon the medical care delivery system or have unrealistic expectations of what can be done in a short period of time.

Many organizations are now making legislative recommendations with respect to the PSRO program. We believe this is premature. We are studying ways in which the program might be improved. It is still too early in the development of the program to determine exactly what form those improvements should take—which aspects of the statute will work and which may require modification. We have extensively analyzed the law and some of the proposed changes. We have concluded that the law should be implemented as it was enacted, for the present.

In the coming year we will, in conjunction with our National Council, undertake a major evaluation of the program. We have under consideration a large-scale assessment of the first year of the program's operating experience—possibly to be carried out by a non-Federal organization. Such an assessment would provide us with sufficient information to determine what, if any, changes should be made in either the statute or in our guidelines and regulations. We will also be sponsoring a National Peer Review Conference this fall to examine the state of the art and to share experiences among the various PSROs and others working in the field. The results of all of these activities will be shared with this Committee.

Also, during the next year, the Department will continue to move ahead vigorously with the implementation of the program. We plan to fund PSROs in most PSRO areas and will offer extensive technical assistance to those organizations requiring assistance.

THE MEDICAL PROFESSION'S RESPONSE TO PEER REVIEW

At this point, Mr. Chairman, I would like to emphasize two factors which form much of the foundation for our implementation of the statute. The first of these is that, as the statute requires, peer review activities are to be performed by physicians and other medical professionals, not by laymen and government employees. Second, we believe that a considerable majority of the medical profession supports peer review and our implementation activities. In fact, it would have been impossible to make the progress that we have made to date in implementing P.L. 92-603 if we did not enjoy the cooperation and support of major segments of the medical profession.

For example, Dr. Robert Hunter, a member of the Board of Trustees of the American Medical Association, noted in an article in *American Medical News:*

"The real issue is whether or not our profession and our state and national organizations are going to allow themselves to be divided, threatened, and perhaps destroyed by the implementation of a law that—reduced to its basic elements—cannot be called undesirable."

The concept of peer review and our implementation of the statute have brought forth the endorsement and support of many physician organizations, including: The American College of Physicians, the American Society of Internal Medicine, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the National Housestaff Physicians Association, and the Student American Medical Association.

In addition, we are working closely with several medical specialty groups on PSRO-related activities. For example, we will be funding an activity by the American College of Radiology to help determine the efficacy of five of the most common x-ray procedures. We are also reviewing a proposed contract which would help develop standards for the appropriate use of antibiotics which involve the American College of Physicians, the American College of Surgeons, the American Academy of Pediatrics, the American Academy of Family Physicians and the Infectious Disease Society of America. We believe that the Medical profession is actively involved, as it should be, and supports our efforts to implement the PSRO statute. Consequently, we are somewhat perplexed by criticism of our implementation effort which has been voiced by certain leaders of organized medicine. We believe that such criticism reflects neither the widespread professional support for peer review which we have found nor the real reaction to our implementation activity by the medical profession.

SUMMARY

In conclusion, Mr. Chairman, I should like to stress our commitment to work with the nation's health professionals in achieving an effective quality assurance program through PSROs. I believe that we have done a very creditable job of implementing a complex statute. We believe that a quality assurance program is necessary, not only because of the mandate of existing law, but because of the importance of such a program to any system of comprehensive health insurance.

Mr. Chairman, this concludes my prepared remarks. I will be pleased to answer any questions that you or your colleagues may have.

Senator TALMADGE. The next witness is Dr. Ernest Saward, chairman, National Professional Standards Review Council, accompanied by Raymond J. Saloom, D.O., member, National Professional Standards Review Council.

STATEMENT OF DR. ERNEST W. SAWARD, CHAIRMAN, NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL, ACCOMPANIED BY RAYMOND J. SALOOM, D.O., MEMBER, NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL

Dr. SAWARD. Mr. Chairman, I am pleased to have this opportunity to appear before you, representing the National Professional Standards Review Council. The National Council has had an interesting and active first year. When the Council met for the first time last July, the PSRO program was essentially a hypothesis. Now it is a reality. During this crucial period, the council has been active not only in the deliberations and decisions of the program, but also in direct personal communication with the health professions. Because of this unique vantage point, we welcome this chance to tell you our assessment of the PSRO program and to report to you some of our accomplishments and frustrations in this first year.

As you know, the National Professional Standards Review Council was established by mandate of the legislation. Its 11 physician members were appointed by Secretary Weinberger in June 1973.

The council's primary role is to advise the Secretary in the administration of the PSRO legislation and report to the Congress. As we

see it, this carries a twofold responsibility. The first is t oprovide advice on program implementation within the requirements and intent of the legislation and possible modifications thereof. The second is to interpret the needs and desires of both the public and the health professions and communicate this to the administration. A corresponding responsibility, which council members have unhesitatingly assumed on their own, is the interpretation of the program to interested groups and persons around the country.

I might say, as you will well imagine, this has taken a good deal of time.

It would be less than candid to tell you that the council immediately began to function effectively and productively. This first year has been one of development for us. When we began last July, the honest differences that exist in the medical profession about the PSRO legislation, were naturally and inevitably present in the council. These differences surfaced, for example, over those early decisions on area designation policy. The council itself first had to come to grips with its own opinions and determine ways that it could work effectively as a unit. Obviously, this took time, but we are past that now. The council works well together. There is always free exchange of ideas and views but there is forward movement and decisions are made. A surprising degree of consensus now exists.

During this early phase of Council existence, three subcommittees were formed: one on policy development, one on issues related to data and norms, and one on evaluation. The consultants were from a wide range of organizations, as was mentioned earlier in previous testimony.

Through these smaller groups, Council members discussed issues with the staff and with consultants and then brought back to the full Council their recommendations. While these subcommittees are not a permanent part of Council structure and later will probably give way to ad hoc groups for consideration of timely issues, they have worked well this first year.

The Council has wrestled with the major PSRO policy issues as they developed over the course of the year. Considerable progress has been made; yet it has become clear that the issues involved in this program are difficult ones. With some of the requirements of the legislation, there are no clearly known or available methodologies. However, the Council is optimistic about the development of necessary methodologies and the resolution of significant issues; and clearly, in the course of this year, the requirements and the issues have come into better focus.

For a few minutes, I would like to address some of the specific issues that the Council considered this past year and our recommendations.

One of the earliest concerns of the Council was the absence of peer review requirements for federally operated health facilities. Accordingly, the Council recommended extension of peer review to these institutions.

As I alluded earlier, area designation policy was a significant and controversial issue for the Council. In a position statement the Council expressed its desire for the administration to consider the possibility of a statewide PSRO, even in States that had greater than 2,500 phy-

sicians if that option was the choice of the physicians rather than having local area organizations. While the administration, following this legislative intent, adopted a policy of local review of care, the combination of that approach with the proposed development of the statewide PSRO support centers has been generally consistent with the Council's views.

The whole area of PSRO data, of course, is a major consideration. There are exceedingly difficult issues and the Council has agreed to adopt a specific minimal data set (the UHDDS) for use in the PSRO program. Another early facilitating action took place when the Council adopted precise definitions of the terms "norms," "criteria," "standards," and "screening." Later, the Council urged the Secretary to form a group to study and recommend a uniform coding system or, failing that, a set of compatible systems for recording and retrieving health care data.

A continuing concern of the Council has been preadmission certification or preauthorization of hospital admissions. The Council, on several occasions, has gone on record opposing such methods as costly, ineffective, and potentially discriminatory. We have recommended instead that the PSRO's be informed of effective and more acceptable concurrent review mechanisms.

The Council has spent considerable time with the subject of statewide PSRO Councils—their role, their membership and their organization. Recommendations have been made on many of these issues.

The Council has been sensitive to the concern that national norms, criteria, and standards might be imposed on PSRO's from above. Recognizing, on one hand, the valuable work being done by various organizations in the development of model criteria sets and on the other hand, the importance of local criteria development which has a better chance of being internalized by those involved—the Council has urged that all necessary assistance be given to PSRO's so that they are able to come up with criteria that are both locally acceptable and evaluatively compatible.

Evaluation of PSRO's and the program itself are of major concern to the Council. As a first step, the Council adopted a statement of goals for the National PSRO program. Work continues with the staff in developing an evaluative strategy. Development of the PSRO manual was a major activity this year for in it is contained guidelines for PSRO development and operation. The Council reviewed each of the chapters of the manual as they developed, discussed them with the staff and recommended changes both in language and in policy.

Within a short time now, several conditional PSRO's will begin operation and many other potential PSRO's will work in a planning phase toward developing themselves into effective peer review organizations. To get to this point, many of the tough policy issues have been resolved; yet many more remain.

The Council intends to have a role in the rsolution of these issues and others—as it advises the Department and Congress and interprets and conveys to it the needs of the public and the health professions.

Appropriate level of care placement of the patient and appropriate length of stay review are relatively well understood and hold large gains to be realized. The major focus of attention, however, has been the more difficult and less certain area of technical process review as

the definition of quality. Here lies the greatest professional interest and the less known methodology and consequence.

Now as the program becomes operational, the Council can begin to take on these additional responsibilities that are mandated by the legislation. Among these are assuring that PSRO's have the necessary resources to perform effectively and that they have access to information and data that can be helpful and useful to them. And as PSRO's really begin to function, one of the Council's most important functions will be to keep in touch with their successes and their problems—to evaluate their performance—and to compare their performance with each other During this next year, we will be working on the methodologies to accomplish this. The Council will have recourse to various consultants on the special issues involved.

Eventually, the Council may want to suggest some modifications in the legislation. At this point, however, we want to see the program in operation—to give it a chance to function under present requirements.

It is clear that different health enactments of Congress apply different quality assurance mechanisms. For example, end stage renal disease is given a special mechanism, and so are HMO's. It would be well for all to keep in mind that it is best to have only one currency in use at a time and surely professional standard review methods should be uniformly applicable to all programs in the 203 designated areas of our country. Special consultants can be used to qualify programs under the uniform standards.

In summary, we believe that the PSRO program is off to a good start. The program—and the council—have made considerable progress this year. We recognize the difficulties ahead, for this is a tremendously complex venture and the nature of the program inevitably invites divided opinions. We are, nevertheless, firmly committed to its goals and we feel optimistic about its success.

Dr. Raymond Saloom, a member of the council and chairman of the council's policy development subcommittee, is with me, and we will be happy to answer your questions.

Membership of the NPSRC

Senator Talmadge. Thank you, Doctor, for your statement.

Section 1163, paragraph B, creating a National Professional Standards Review Council, reads as follows:

> Members of the Council shall consist of physicians of recognized standing and distinction in the appraisal of medical practice. A majority of such members shall be physicians who have been recommended by the Secretary to serve on the Council by national organizations recognized by the Secretary as representing practicing physicians. The membership of the Council shall include physicians who have been recommended for membership on the Council by consumer groups and other health care entities.

Do all the members of your council fit that category?

Dr. Saward. Yes, sir.

NPSRC Visiting the States

Senator Talmadge. Have any of your members or you been in the respective States to work with physicians in ironing out the problems of PSRO's?

Dr. SAWARD. I personally have. Dr. Saloom is the leader of activities in Pennsylvania. My impression is most of the members of the council have been quite active with local groups and in working with this kind of program, speaking at any kinds of medical meetings around the country.

Senator TALMADGE. Thank you, Doctor.

Senator Bennett.

NPSRC AND DEVELOPMENT OF NORMS AND PARAMETERS

Senator BENNETT. Dr. Saward, precisely what is the national council preparing to do in accordance with its authority under the section the chairman referred to, to provide for development of suggested norms and parameters which local PSRO might choose to utilize or adopt?

Dr. SAWARD. We have a subcommittee on this topic and we are looking at the methodologies that are involved in trying to develop, as I said in my prepared text, first of all, a set of definitions that can be uniformly applied, and what we would like to see is that the definitions and the methodologies that come into being are uniform enough so that they can be evaluated in some way, but we are not developing the criteria for the total organizations.

I think there has already been considerable discussion of that point this morning, that those are locally derived and the opinion has been strongly represented on the council that to be effective they must be locally derived.

AVAILABILITY OF NPSRC TO THE STATES

Senator BENNETT. Are you available for consultation at the request of a local group?

Have you had any such consultations? Have any consultations with the various medical specialty societies taken place?

Dr. SAWARD. I would think again almost without exception every one of us on the National Council has made himself available for consultation. I have not taken an inventory of this but I can certainly speak for myself and some of the others. We have very definitely been involved with our local organizations and the State organizations and interacting.

Senator BENNETT. You mean as individual physicians, members of the council?

Dr. SAWARD. Generally they have requested collaboration as a member of the council.

Senator BENNETT. Do you have any comments, Dr. Saloom?

Dr. SALOOM. No, basically some member of our council has been in almost every State of the Union, at least the 203 areas. I know I have been involved in at least 10 to 15 States personally. All of our physicians on the council have been in various States.

Senator BENNETT. No further questions.

Senator TALMADGE. Senator Curtis.

Selection of NPSRC Members

Senator Curtis. Dr. Saward, you are the Chairman of the National Professional Standards Review Council?

Dr. Saward. Yes, sir.

Senator Curtis. How many members are on that council?

Dr. Saward. Eleven. At the moment there are 10 because one is deceased.

Senator Curtis. Who selected them?

Dr. Saward. My understanding is that the Secretary selected them through nominations submitted.

Senator Curtis. Who named the chairman?

Dr. Saward. The Secretary.

Senator Curtis. What is your authority?

Dr. Saward. As chairman?

Senator Curtis. No, on the council.

Dr. Saward. I believe the authority is set forth in the statute.

I don't have a copy to read back to you, but generally it is to perform the functions of advising the Secretary, the Congress, and to conduct the evaluation of the program, to make recommendations for changes in it, and to provide the development of the standards and criteria that are essential to have some uniform data and evaluative function.

Compensation of NPSRC Members

Senator Curtis. Who fixes the compensation of the members of the council?

Dr. Saward. I really don't know specifically, but I believe the statute handles that problem.

Senator Curtis. Fixed by the Secretary; is it not?

Dr. Saward. Yes.

Yes, it is in the statute also.

Senator Curtis. Yes.

Use of OPSR Staff by the NPSRC

How many full-time employees does the council have?

Dr. Saward. The council has no full-time employees per se.

The staff of the Office of Professional Standards Review serves as the staff of the council. There is a good working relationship between the two.

Senator Curtis. How much time do you anticipate the members of the council will find it necessary to give?

Dr. Saward. The council meets usually for a day and a half, approximately every 5 or 6 weeks, but as I told you, as the amount of time council members spent, that would be a very gross estimate.

We have volumes of materials to read, documents to go over, suggestions to make, other kinds of subcommittee activities to conduct, and the meeting, as I said in the statement, consumes a very great deal of time in answering questions about the nature of this act to other physicians and to the communities.

Senator Curtis. Now, what staff is it that is available to carry on your work?

Dr. SAWARD. The Office of Professional Standards Review has a staff, and the staff is available and used by the members of the council.

Senator CURTIS. Now, that is the staff at HEW?

Dr. SAWARD. The staff headed by Dr. Simmons, who spoke to you before.

Senator CURTIS. It is an HEW staff?

Dr. SAWARD. Yes.

Senator CURTIS. You have no independent staff of your own?

Dr. SAWARD. No.

Senator CURTIS. Who makes up your agenda for your meetings?

Dr. SAWARD. They are made up by consultation between the Director of the Office of Professional Standards Review and myself and whatever suggestions others who may have suggestions.

Senator CURTIS. But you are without any supporting staff other than that which you get from the Department?

Dr. SAWARD. That is right.

Senator CURTIS. Has the Secretary or the Department promulgated any regulations or instructions to you people in writing?

Dr. SAWARD. I don't recall. The Secretary spoke to the first meeting of the council and gave his views of it, but there have been no specific instructions.

Senator CURTIS. By the Secretary, I mean, the Secretary or his delegate. Have there been any instructions or regulations issued to the council?

Dr. SAWARD. No; I don't recall specific instructions to the council.

Senator CURTIS. I mean in writing?

Dr. SAWARD. No. There is a good teamwork function between the Office of Professional Standards Review and the council. This was rather slow to organize. If you would have asked me this last summer I wouldn't have been nearly so sure in my answer. But the way it has developed in the course of the year, we find teamwork has developed in the staff of the PSRO.

Senator CURTIS. You do not find yourself in disagreement with officials and employees of HEW that are assigned to help you?

Dr. SAWARD. We do air our views, and they have been aired many times, and vigorously, at the council meetings.

Senator CURTIS. Can you give an illustration of that?

Dr. SAWARD. Well, probably the subject of greatest difference of opinion that occurred between—not necessarily the council as a whole, but in some degree the council as a whole, but individuals on the council, was the subject of area designations. There was very distinct input of feeling and viewpoint on particular areas and the policy of area designation.

Senator CURTIS. Which side prevailed in that controversy?

Dr. SAWARD. I think in fact the intent of the law prevailed.

Senator CURTIS. Yes, but—that is a gratifying thing to know. I am sorry it isn't a better law.

You said there was a different point of view. I assume that was on the interpretation of the law. Whose point of view prevailed?

Dr. SAWARD. Well, actually the area designations, the specific point of view, I would say, of many on the council was there. There was by no means a single opinion of the council, that the way area designa-

tion was made, the Office of Professional Standards Review made the ultimate decision.

Senator CURTIS. The Government made it?

Dr. SAWARD. Yes, sir.

Senator CURTIS. That is all.

Senator TALMADGE. Senator Hansen.

EDUCATING PHYSICIANS TO PSRO

Senator HANSEN. Dr. Saward, in discussing the PSRO program you said that many tough policy issues have been resolved and yet many more remain. Do you envision there will be problems with physicians who do not know what the norms or standards are, and who will not know how to comply with them?

Dr. SAWARD. Senator Hansen, the greatest problem with this law and its implementation has been that the overwhelming majority of physicians either are unfamiliar with it or don't understand it, and this is going to be a continuing problem. It is a complex law. There is no way of saying to anybody, it is a simple law.

The goals to be achieved by it are also complex, but very worthwhile. The communication and understanding of how this is going to function, and again I would like to stress the understanding at the local level, how it is going to function and how the physicians are going to have it function at a local level is key to the whole intent.

We have made tremendous gains in that area already, but they are by no means enough. They have just begun, really, to get understanding. But wherever the effort has been made one wins friends to the intent of this kind of law.

Senator HANSEN. Well, drawing upon the observations you have just made, doctor, would it be advisable to appropriate a sum of money for an educational component of the PSRO legislation that would educate physicians as to what the guidelines and standards are and how they can comply with them, in your judgment?

Dr. SAWARD. I am not the person to respond on the needs of money one way or another.

Senator HANSEN. Would it be advisable in order to achieve the objective you have just mentioned?

Dr. SAWARD. The functions must go on, yes.

TARGETS FOR MODIFICATIONS IN PSRO

Senator HANSEN. You have said that you may envision modifications in the law but that you feel it best to wait until the program is in operation. At what point, based upon your present experience, would you recommend amendments to the law? Do you have in mind this year, possibly 1976, 1977, what time frame are you talking about?

Dr. SAWARD. I will say it is not beyond reason that a year from now we may see things that we don't visualize now and that we might have recommendations at that time.

Senator HANSEN. What areas so far do you feel might be considered targets for change?

Do you have any feel yet as to the particularly troublesome areas that you think might suggest where changes in the law ought to be made?

Dr. SAWARD. No, I have no concrete suggestions, but the whole subject of technical process review to attain quality is a very complex issue, quite in a theoretical sense as well as in a practical sense. There are very many other parameters of quality, outcome, consumer satisfaction and so forth and so on. These areas are not spoken to in the law. I think it is probably wise they aren't to begin with, but I think as the technology of quality assessment develops further there may be recommendations as to how more feasibly and how more effectively to come to some of these goals. There is no question we desire the goals.

Senator HANSEN. Have you had correspondence from physicians about the country and from hospitals as well which might be helpful in assessing some areas of concern that you think would be candidates for——

Dr. SAWARD. I don't think that one could be on the council very long before we had letters from fellow physicians, and we have had them coming in, and indeed, some of the suggestions, I am sure, will be helpful.

Senator HANSON. I am glad there have been no breakdowns in the mail.

Thank you, Mr. Chairman.

Senator BENNETT. Mr. Chairman, may I have another minute?

Senator TALMADGE. Senator Bennett.

RESPONSIBILITY OF SECRETARY IN DESIGNATING PSRO AREAS

Senator BENNETT. I am sorry. Senator Curtis left because his discussion with you about your participation in the development of the PSRO areas left in my mind a little bit of a feeling that he had the impression that this was part of your function. He has already read this into the record,

The Secretary shall, not later than January 1, 1974, establish throughout the United States appropriate areas with respect to which Professional Standards Review Organizations may be designated.

Is there anything in your charge which gives you responsibility in the designation of the areas?

Dr. SAWARD. We felt our responsibility was to give advice about policy in as full form as we could from what we knew was happening with physicians of the country, because we were all practicing physicians.

Senator BENNETT. But you agree in the end it is the responsibility of the Secretary to designate the areas?

Dr. SAWARD. I never thought otherwise.

Senator BENNETT. I think it is significant that they started out with 183 and ended up with 204, so obviously the Secretary took the advice of a great many physicians around the country, and I am sure he took yours, in making this readjustment which produced approximately 21 more areas than have originally been anticipated.

Dr. SALOOM. I think in all fairness too, Senator, we have to mention that the support center concept was very much on advice from the

council, that we felt that we had existing medical organizations that should be used. This was one of the recommendations that came from the council.

Senator BENNETT. You are, quote, an advisory council, and I am delighted to see you take that part of that function seriously.

RESPONSIBILITY OF SECRETARY IN REVIEWING PSRO WORK QUALITY

Earlier in the discussion while the Secretary was here the question was raised by the Chairman of the Committee, Senator Long, as to who had the power finally to review the quality of the work being done by the PSRO's, and the record very clearly says that the Secretary does not have that power, but in the event there are questions about that quality, those questions may come up to you.

Do you have that understanding?

Dr. SALOOM. Yes, sir.

Senator BENNETT. Of course, you haven't had any yet because we haven't had any areas designated. But you have the clear understanding that is part of your responsibility?

Dr. SAWARD. The way we are working, we are anticipating that function, and the fact that one of the three subcommittees we have is on evaluation is directly directed to that topic.

Senator BENNETT. I suppose it is premature to ask you to give us any kind of a reading on the approach you think you may take?

Dr. SAWARD. I think it is premature, but we have been working out to define the goals so we will have a way of measuring what it is we are evaluating.

Senator BENNETT. Let's assume that such a complaint comes and you evaluate it under your criteria and you decide that the local agency is in fact failing, do you have any power to force them to change their set of criteria?

Dr. SAWARD. We would hope at least we have the power of communication with them and give them our thoughts as practitioners.

Senator BENNETT. You have that power obviously, but do you have the power to in fact say to those groups, you must change this particular parameter?

Dr. SAWARD. Not that I know of.

Senator BENNETT. So in the end the ultimate right to set the parameters rests with the local organizations?

Dr. SAWARD. That is right.

CREDENTIALS OF MEMBERS OF THE NPSRC

Senator TALMADGE. Doctor, I have only one final question.

I have already read this language into the record. The language creating a National Professional Standards Review Council states: "Members of the Council shall consist of physicians of recognized standing and distinction in the appraisal of medical practice."

Would you please submit for the record the credentials of the Members of your Council that comply with that part of the statute?

Dr. SAWARD. Certainly.

Senator TALMADGE. Thank you, sir.

Thank you very much, Doctor. We appreciate you and your associate, Dr. Saloom, being with us and your contribution.

Senator Long.

The CHAIRMAN. Doctor, I just want to congratulate you for your statement and your dedication to the cause of good health and the health of people of this country, and your taking on of this burdensome duty.

You don't have an easy task. I appreciate your taking on this type of task and the same goes for members of your Council.

Senator TALMADGE. Thank you, gentlemen.

[The following was subsequently supplied for the record:]

ERNEST W. SAWARD, M.D.

Born: October 19, 1914—New York City.

Education: Grade School—New York City; High School—Franklin, New York; College—Colgate University, A.B. 1936; University of Rochester Medical School, M.D. 1939.

Professional Experience: House Officer, Barnes Hospital, St. Louis, Missouri, 1939–1941; President, Peter Bent Brigham Hospital, Boston, Mass., 1941–1942; Wartime, Chief of Medicine, Hanford Engineer Works (Atomic Energy Project); 1945–1970, Medical Director, The Permanente Clinic, Kaiser Foundation Hospitals and Kaiser Foundation Health Plan, Portland, Oregon; 1964–1970, Executive Committee, Community Health Foundation Medical Group, Cleveland, Ohio; and 1970–present, Professor of Social Medicine and of Medicine and Associate Dean for Extramural Affairs, University of Rochester, School of Medicine and Dentistry, Rochester, New York.

Member or Fellow: Group Health Association of America (President); National Academy of Sciences Institute of Medicine; National Academy of Sciences Panel on Health Status of the Disadvantaged; American Public Health Association; American Board of Internal Medicine; American Medical Association; American Heart Association; American College Chest Physicians; American Federation for Clinical Research; American Association for Advancement of Science; The Preventive Heart Reconditioning Foundation, Inc., Vermont (Board Member); Xerox Center for Health Care Research (Board of Trustees); and Milbank Memorial Fund (Technical Board).

Technical Adviser (1962–present): Plan de Salud para la Comunidad in Cordoba, Argentina; C.E.M.I.C., Buenos Aires, Argentina.

Project Director (1966–1970): Office of Economic Opportunity Health Project, Portland, Oregon.

Recent Publications:

Saward, E. W., "The Kaiser Foundation Medical Care Program, Oregon Region: A Close Look at a Group Health Program in Action," *Proceedings of the Eleventh Annual Group Health Institute of the Group Health Association of America*, Portland, Oregon, May, 1961, pp. 126–129.

Saward, E. W., "Use of Extra Charges," *Proceedings of the Thirteenth Annual Group Health Association of America*, Detroit, Michigan, May, 1963, pp. 180–182.

Saward, E. W., "Reactions to the West German Medical Care Program with Particular Reference to Cardiovascular Disease," *American Journal Cardiology*, Vol. 13, May, 1964, pp. 681–682.

Greenlick, M. R., Ph.D., Hurtado, A. V., M.D., and Saward, E. W., M.D., "The Objective Measurement of the Post-Hospital Needs of a Known Population," *American Journal of Public Health*, Vol 56, No. 8, August, 1966.

Greenlick, Merwyn R., Ph.D., and Saward, Ernest W., M.D., "Impact of a Reduced-Charge Drug Benefit in a Prepaid Group Practice Plan." *Public Health Reports*, Vol. 81, No. 10, October, 1966, pp. 938–940.

Saward, E. W., M.D., Blank, Janet D., B.S., and Greenlick, Merwyn R., Ph.D., "Documentation of Twenty Years of Operation and Growth of a Prepaid Group Practice Plan," *Medical Care*, Vol. VI, No. 3, May–June, 1968, pp. 231–244.

Saward, E. W., M.D., "The Relevance of Prepaid Group Practice to the Effective Delivery of Health Services," *Eighteenth Annual Group Health Association of America*, Institute Proceedings, June 18, 1968, Sault Ste. Marie, Ontario, Canada.

Greenlick, Merwyn R., Ph.D., Hurtado, Arnold V., M.D., Pope, Clyde R., Ph.D., Saward, Ernest W., M.D., and Yoshioka, Samuel S., "Identifying Determinants of Medical Care Utilization," Ninety-sixth Annual Meeting of American Public Health Association at Detroit, Michigan, November 10–15, 1968.

Colombo, Theodore J., M.P.H., Saward, Ernest W., M.D., Greenlick, Merwyn R., Ph.D., "The Integration of an OEO Health Program into a Prepaid Comprehensive Group Practice Plan." Ninety-sixth Annual Meeting of American Public Health Association at Detroit, Michigan, November 10–15, 1968.

Hurtado, Arnold V., M.D., and Saward, Ernest W., M.D., "The Organization and Utilization of Home Health and Extended Care Facility Services into a Prepaid Comprehensive Group Practice Plan," Ninety-sixth Annual Meeting of American Public Health Association at Detroit, Michigan, November 10–15, 1968.

Saward, Ernest W., "The Relevance of the Kaiser-Permanente Experience to the Health Services of the Eastern United States," *Bulletin of the New York Academy of Medicine*, Second Series, Vol. 46, No. 9, pp. 707–717, September, 1970.

Hurtado, Arnold V., M.D., Greenlick, Merwyn R., Ph.D., McCabe, Marilyn, B.A., and Saward, Ernest W., M.D., "The Utilization and Cost of Home Care and Extended Care Facility Services in a Comprehensive, Prepaid Group Practice Program," Ninety-eighth Annual Meeting of American Public Health Association, Houston, Texas, October 26–30, 1970.

Greenlick, Merwyn R., Ph.D., Freeborn, Donald K., Ph.D., Colombo, Theodore J., M.P.H., Prussin, Jeffrey A., M.A., and Saward, Ernest W., M.D., "Comparing the Use of Medical Care Services by a Medically Indigent and a General Membership Population in a Comprehensive Prepaid Group Practice Program," Ninety-eighth Annual Meeting of American Public Health Association, October 26–30, 1970.

Saward, Ernest W., M.D., "Some Values Inherent in an Organized System of Medical Care," *Proceedings of the Royal Society of Medicine Anglo-American Conference on Medical Care, London, April 5–7, 1971*, (In Press).

E. Scrivner, M.D.

Education: grade school, graduated 1920; high school, Central High School Graduated 1924; B.S. degree, Washington University 1926; M.D. degree, Washington University 1930; Surgical internship, Barnes Hospital, 1930–1931; maternity hospital, St. Louis University 1931–1932; assistant resident, Barnes & St. Louis Maternity 1932–1933; and resident gyn-ob, Barnes & St. Louis University 1933–1934.

Date of birth: January 29, 1907, St. Louis, Missouri.

Marital status: Married Ruth Shaw—January 10, 1931. Mrs. Scrivner is active in civic affairs, Woman's Auxiliary to St. Clair County Medical Society, Woman's Auxiliary to the Illinois State Medical Society, Woman's Auxiliary to the American Medical Association, President-elect 1972–73.

Two sons—Peter C., Administrative Assistant to Congressman Melvin Price, Washington, D.C. Two children; Roger M., Attorney, East St. Louis, Illinois. Two children.

TEACHING APPOINTMENTS

Assistant Clinical Professor, Dept. of Ob-Gyn, Washington University; School of Medicine, St. Louis, Missouri.

HOSPITAL STAFF APPOINTMENTS

Belleville Memorial Hospital, Belleville, Illinois; Centreville Township Hospital, East St. Louis, Illinois; Christian Welfare Hospital, East St. Louis, Illinois; St. Elizabeth Hospital, Belleville, Illinois; St. Mary Hospital, East St. Louis, Illinois; Barnes Hospital, St. Louis, Missouri; and St. Louis Maternity Hospital, St. Louis, Missouri.

MEMBERSHIP AND OFFICES IN SOCIETIES, BOARDS, AND FELLOWSHIPS

American Medical Association, Committee on Health Care of the Poor—1970–71, 1971–72, 1972–73; Illinois State Medical Society; President-elect 1972–73; Board of Trustees—Since 1963; Chairman, Board of Trustees 1970–71, 1971–72; Maternal Welfare Committee—1954–1963; Chairman 1961–62, 1962–63; Vice

Chairman 1955; Nursing Committee—Chairman 1962; Ethical Relations Committee—Chairman 1966; Perinatal Committee—Past CoChairman; Southern Illinois Medical Society—President 1962; St. Clair County Medical Society—President 1948; American Association for Maternal and Child Health, President 1967–1968; Board of Directors—Since 1962; Executive Committee—Since 1962; Illinois Association for Maternal and Child Health; President 1958; Executive Committee—Since 1960; American Cancer Society, Illinois Division; Board of Directors; Scientific Committee; 2nd Vice President 1970–71, 1971–72; American Cancer Society, District VIII (Formerly St. Clair County Chapter); Executive Committee; Illinois Obstetrical and Gynecological Society; Past President; Chairman, Legislative Committee; St. Louis Gyn Society; Fellow American College Obstetricians and Gynecologists; Diplomat in American Board of Obstetrices and Gynecology—1939; Fellow American College of Surgeons—1951; American College of Surgeons, Liaison Fellow, Commission on Cancer, District 12—Since 1968.

CIVIC ORGANIZATIONS

Belleville Area College School of Nursing; Advisory Committee to Nursing Education—Chairman; Nurse Scholarship Committee of St. Clair County—Chairman; Bi-State Regional Medical Program—Illinois Representative; ARCH Bi-State Comprehensive Health Planning—Executive Committee, Board of Directors, 1965–1972; St. Clair County Medical Society Inner City Health Programs Health Guide Program—Chairman 1969; East St. Louis Social Planning Council: Director 1971; Past Vice President; Health and Hospital Division—Chairman 4 years; Illinois Association for Mental Health—Director-at-Large 1968–1971; Mental Health Association of St. Clair County: Board of Directors; Past President; Illinois Regional Medical Program, Task Force V—1968; Illinois Department of Public Health, Advisory Hospital Council (reappointed to 6/30; Illinois Comprehensive Health Planning Advisory Council 1971–74; United Fund of Greater East St. Louis, Board of Governors 1970–73; Illinois State Trust Company—Board of Directors; and Bankers Trust Company—Board of Directors.

RAYMOND JACOB SALOOM

Born: July 1, 1930, Pennsylvania.

Married to the former Mary Jo Manno and the father of five sons.

B.S. degree, 1955, University of Pennsylvania.

D.O. degree from the Philadelphia College of Osteopathic Medicine (formerly the Philadelphia College of Osteopathy) 1960.

Interned: Bashline Osteopathic Hospital, Grove City, Pa.

Licensed: Pennsylvania, Rhode Island, Ohio.

Military Service—February, 1951–January, 1954 served in the U.S.A. Counter Intelligence as 1st Sgt. Maj., 109th CIC Detachment, Fort Meade, Md. He received competitive Reserve Commission of 2nd Lt. in military intelligence. He holds a citation for recognition of meritorious and outstandng performance of duty.

Dr. Saloom is currently president-elect, and a member of the Board of Trustees, of the Pennsylvania Osteopathic Medical Association.

ORGANIZATIONS AND OFFICES HELD

Past President and Secretary-Treasurer of the 9th Dist. Pa. Osteopathic Medical Association.

Vice President of the Pennsylvania Osteopathic Medical Association.

Chairman statewide Utilization Insurance Review Committee of the Pa. Osteo. Medical Ass'n.

Delegate to the American Osteopathic Association.

Member of the Pennsylvania Medical Society at Western Pennsylvania Steering Committee as a representative of the Pa. Osteo. Med. Ass'n.

Member of the Pa. Osteo. Med. Ass'n Committee on Ethics and Grievance.

Member of the Pa. Osteo. Med. Ass'n Committee on Medical Care Plans.

Member of the Pa. Osteo. Med. Ass'n Committee on Veterans Affairs.

Chairman of the Pa. Osteo Med. Ass'n Committee on Veterans Affairs.

Blue Shield Commissioner for Butler County.

Member of the Physicians Advisory Committee of the Western Pennsylvania Comprehensive Health Planning Agency.
Chairman utilization and audit committee for Bashline Memorial Hospital.
Member of the Executive Committee of the Bashline Memorial Hospital.
Vice Chairman—OB Dept., Bashline Mem. Hosp.
Secretary Dept. of GP, Bashline Osteo. Hosp.
American College of General Practitioners, member of their Board of Trustees.
Active member of the Philadelphia College of Osteopathic Medicine Alumni Ass'n.
Member of Syria Shrine.
Member of the New Castle Consistory.
Member of Grove City Masonic Cedar Lodge No. 800.
Member of the American Legion.
Member of the Lions Club.
Member of the Moose.
Was a delegate to the National Academy of General Practice.
Phi Sigma Gamma Fraternity—past president, vice president, secretary-treasurer and member of board of trustees.
Dr. Saloom was the first D.O. to be employed by the Civil Service Commission. On July 2, 1963, he was appointed medical officer, general medicine and surgery, for the Civil Service Commission, division of retirement and insurance.
Residence: RD2, Harrisville, Pennsylvania 16038.
Office: 301 Prairie Street, Harrisville, Pennsylvania 16038.
Hospital Staff Membership: Bashline Hospital, 516 Oakland Avenue, Grove City, Pennsylvania 16127.

ROBERT B. HUNTER, M.D.

Robert B. Hunter, M.D., of Sedro Woolley, Washington, was elected to the AMA Board of Trustees in June 1971, and re-elected to a full three-year term in June 1972.

A native of Fort McDowell, California, Doctor Hunter was born on April 10, 1919. He earned his B.S. at the University of Washington in 1939 and graduated from the University of Pennsylvania Medical School in 1943. Doctor Hunter completed his internship at Buffalo General Hospital in Buffalo, New York.

In 1944 Doctor Hunter joined the Army Medical Corps. He served in the Pacific Theater and had attained the rank of captain when he was discharged in 1946.

Having served as president of the Skagit County Medical Society and the Washington State Medical Association, Doctor Hunter was elected to serve as a Washington delegate to the AMA House of Delegates in 1964. He served in this capacity until his election to the Board of Trustees. Doctor Hunter was a member of the Council on Constitution and Bylaws from 1968 to 1971, and he has chaired two reference committees and belonged to many more.

Doctor Hunter is a member of a three-man partnership in general practice and general surgery. He belongs to the active staff of United General Hospital in Sedro Woolley, and is part of the courtesy staff of both Skagit Valley Hospital in Mt. Vernon and Island Hospital in Anacortes.

Dr. Hunter is a member of the faculty of the University of Washington School of Medicine, Department of General Practice.

He is a charter member of the American Board of General Practice, and also belongs to the Washington State Obstetrical Society and the Pan Pacific Surgical Association. Doctor Hunter was chairman of the Washington State Medical Disciplinary Board from 1964 to 1970.

Among his community activities, Doctor Hunter lists the Sedro Woolley Rotary Club, the Sedro Woolley Chamber of Commerce, the American Legion, the B.P.O.E., the Bellingham Yacht Club and the Washington Athletic Club.

Doctor Hunter's hobbies including fishing, swimming, and collecting canes and miniature owls. Doctor and Mrs. Hunter have two sons.

DONALD C. HARRINGTON, M.D.

Business Address: 445 West Acacia Street (P.O. Box 230)—Stockton, California 95201.

Birth Date: July 28, 1912, Jacksonville, Oregon.
Education: Medical School: University of Clifornia School of Medicine, San Francisco, California, M. D. Degree—June, 1938.
Internship: University of California Hospital—1938–39, San Francisco, California.
Residency: University of California Hospital—1939–41, San Francisco, California.
Past Professional Activities: California Medical Association Council; Board of Trustees—California Blue Shield; Chairman, Medical Services Commission—California Medical Asociation; Consultant, Department of Public—State of California; Member of Advisory Committee of Mental and Child Health—State of California.
Present Status: Private Practice—Obstetrics and Gynecology; Chief of Obstetrics and Gynecology—San Joaquin County Hospital; Medical Director—San Joaquin Foundation for Medical Care; President—American Association of Foundations for Medical Care; Chairman—HCSA Data Committee.
Military: Major—U.S. Army Air Corps—1942–1946.
Societies: San Joaquin County Medical Society; California Medical Association; American Medical Association; San Francisco Gynecological Association; Pacific Coast Gynecological Association; and California Academy of Medicine.
Licenses: State of California—July, 1938.
Certification: Diplomate—American Board of Obstetricians and Gynecologists; Fellow American College of Surgeons; and Fellow American College of Obstetricians and Gynecologists.

ROBERT JOHNS HAGGERTY

Born: Saranac Lake, New York, October 20, 1925.
Education: Cornell University, A.B.—1946, M.D.—1949, Phi Beta Kappa, A.O.A.
Internship: Strong Memorial Hospital, Rochester, New York, 1949–51.
Residency: Pediatrics, Childrens Hospital Medical Center, Boston—1953–55.
Medical Director, Family Health Care Program, Harvard Medical School, 1953–1964.
Professor of Pediatrics, Chairman of Department, University of Rochester School of Medicine, 1964–present.
Health Services Research Study Section, NCHSR&D—HS, Member 1964–70, Chairman 1968–70.
Member New York State Health Planning Advisory Council.
Military—Capt. U.S.A.F., 1951–53.
Markle Scholar, Academic Medicine, 1962–67.
Member: Assoc. of Medical School Pediatric Dept. Chairmen.
President of Amer. Assoc. of Poison Control Centers, 1962–64.
American Academy of Pediatrics.
American Pediatric Society.
Association of Ambulatory Pediatric Services (Chairman, 1963–64).
Association of American Medical Colleges.

MERLIN K. DUVAL, M.D., ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS

Dr. Merlin K. DuVal was nominated May 13, 1971 by President Nixon for the position of Assistant Secretary for Health and Scientific Affairs. His nomination was confirmed by the Senate on June 19, 1971, and he was sworn in July 21, 1971 by HEW Secretary Elliot L. Richardson.

As Assistant Secretary Dr. DuVal directs the activities of the Public Health Service. He provides health policy direction for and coordinates all health and health-related programs in the Department with those of other Federal agencies in addition to advising and providing technical support to international health organizations. He has major staff responsibilities in the fields of health and medicine, population dynamics, scientific affairs and international health activities.

Dr. DuVal was born in Montclair, New Jersey, October 12, 1922. After receiving his A.B. degree from Dartmouth College in 1943 and his M.D. from Cornell University Medical College in 1946 he interned in surgery during 1946–47 at New York Hospital, New York City. He then joined the Navy for two years, serving at the U.S. Naval Hospital, St. Albans, New York, and at Little Creek, Virginia. During 1949–50, he was an intern at Roosevelt Hospital in New York City and from 1950–54 served as resident in surgery at the Veterans Administration Hospital, Bronx, New York.

He became an instructor in surgery at the State University of New York School of Medicine, Brooklyn, in 1954 and Assistant Professor of Surgery a year later.

In 1957 Dr. DuVal went to the University of Oklahoma Medical Center as Associate Professor of Surgery. He was Professor of Surgery from 1961–64 and Vice Chairman of the Department of Surgery from 1960–64. He also served as Director of Development, and in 1962 became Assistant Director of the Medical Center.

In 1964, Dr. DuVal accepted an invitation to develop the new College of Medicine at the University of Arizona, as dean. He was serving in that capacity when nominated by President Nixon for the post of Assistant Secretary for Health and Scientific Affairs.

Dr. DuVal is a Fellow of the American College of Surgeons and also serves on the College's Committee on Undergraduate Education. He has served as chairman of: the Commission on Education for the Health Professions of the National Association of State Universities and Land Grant Colleges; the Task Force on Accreditation of the Liaison Committee on Medical Education; the Governor of Arizona's Steering Committee to Regional Medical Programs; and the Arizona Anatomical Board. He is a member of the American Surgical Association Committee on Governmental Relations.

He was Director of the Arizona Regional Medical Programs, and was on the board of directors of the Southwest Research Foundation, the National Foundation for Asthmatic Children (Tucson, Arizona), and the Arizona Kidney Foundation.

Dr. DuVal is a Diplomate of the American Board of Surgery and the National Board of Medical Examiners. His other memberships include: The American Medical Association, National Association of State Universities and Land Grant Colleges, Medical Society of the United States and Mexico, Society of University Surgeons, American Surgical Association, Association of American Medical Colleges, International Surgical Society, American Association for the Advancement of Science, Arizona Medical Association, Arizona Surgical Association, Pima County Medical Society, and the Tucson Surgical Society.

He is on the editorial board of the *Journal of Medical Education* and was Associate Editor of *Arizona Medicine*.

Dr. DuVal is married to the former Carol Nickerson. They have three children—David, 24; Barbara, 22; and Frederick, 16.

RUTH M. COVELL, M.D.

Date and Place of Birth: August 12, 1936; San Francisco, California.

Marital Status: Married; two children.

Education: Stanford University: B.A. with honors, 1958; University of Vienna: No degree, 1955–56; and University of Chicago: M.D. 1962.

Training: July 1962 to July 1963: Intern in Medicine, University of Chicago Hospitals and Clinics, Chicago, Illinois; July 1963 to July 1964: Resident in Medicine, University of Chicago Hospitals and Clinics, Chicago, Illinois.

Brief Chronology of Employment: April 1959 to June 1962 (intermittently): Research and training assistant, Departments of Anatomy and Surgery, University of Chicago, Chicago, Illinois.

August 1964 to June 1966: Medical Officer, Division of Medical Care Administration, USPHS, Washington, D.C. Bulk of work was on the development of policies, standards for providers of service and regulations for the Medicare Program. Also provided consultation and assistance to grant applicants in the development of programs that would qualify for community health project grant support, served on Surgeon General's committee on Radiation Practices, assisted in development of OEO training programs, etc.

June 1966 to August 1967: Medical Officer, Program Planning and Evaluation, Office of the Surgeon General, USPHS. Assisted in development of PHS program structure, goals and objectives. Acted as staff member of special program analysis group established by the Secretary to investigate the policy and program issues surrounding providing comprehensive health care for children. Assisted in drafting child health legislation. Six months spent on detail to the Secretary's office directing program analysis on the delivery of health services for the poor.

September 1967 to January 1969: Medical Officer, Office of the Assistant Secretary for Planning and Evaluation, DHEW (left at Grade 15). Senior staff assistant for program evaluation. Chairman of interagency health evaluation roundtable. Consultant to OEO on evaluation of neighborhood health centers. Provide consultation in health planning to agencies. Assistant in development of five year DHEW health plans. Initiate and coordinate special analytical studies used to make major decisions at Department and Bureau of the Budget levels.

January 1969 to present: Consultant to Health Services and Mental Health Administration and OEO (occasional).

April 1969 to present: Health Sciences Planning Officer, functioning as staff assistant to the Vice Chancellor for the Health Sciences and Dean of the School of Medicine at the University of California at San Diego, La Jolla, California; concerned with long range planning for the medical and health sciences which includes developing long range plans and projections based on current academic plans, assisting in the development of alternative and/or additional strategies and programs, assuring that capital and budgetary activities reflect such program planning, assisting in the analysis and development of resources and programs supportive to our education program; acting as Executive Secretary to the UCSD Health Sciences Planning Council, concerned with overall medical school relation to the community in service and training programs.

May 1970 to present: Lecturer, Department of Community Medicine, University of California at San Diego.

Honors: Phi Beta Kappa; Alpha Omega Alpha; and DHEW Superior Work Performance Award.

Membership:

Association of Teachers of Preventive Medicine (member, Committee on Allied Health Personnel).

American Public Health Association (APHA).

Medical Care Program Committee, APHA.

Chairman elect, Western Section—Association of American Medical Colleges Planning Group.

San Diego Planned Parenthood Medical Advisory Committee.

Citizens Health Services Advisory Committee, San Diego City Schools.

RMP-CHP Allied Health Task Force of San Diego and Imperial Counties.

Community Health Section, Comprehensive Health Planning Association of San Diego, Imperial and Riverside Counties.

Model Cities Health Project, Community Advisory Board.

Chairman, Chancellor's Affirmative Action Subcommittee on Women.

Community Advisor to the Junior League of San Diego County.

Physician's Assistant Committee, and Task Force on Determination of Needs for Education Programs in Health Sciences, Coordinating Council for Education in the Health Sciences, San Diego and Imperial Counties (prepared Physician's Assistant contract proposal).

Selected Publications, Reports, etc.

Prohaska, John V. and Collins, Ruth M., "Pseudomembranous Entercolitis", *Surgery*, October 1962.

"Health Insurance for the Aged—Conditions of Participation for Hospitals", USDHEW, USGPO, Febraury 1966 (major author)—Conditions of Participation for Independent Laboratories", USDHEW, USGPO, March 1966 (major author). Conditions of Participation for Home Health Agencies", USDHEW, USGPO, March 1966 (major author).

"Maternal and Child Health Programs", USDHEW, USGPO, October 1966 (major contributor).

"Human Investment Programs—Delivery of Health Services for the Poor", USDHEW, USGPO, December 1967 (author).

"Child Development: Summary of the Child Development Task Force Report", April 1968 (contributor).

"University of California—Planning for the Health Sciences 1970–80", Office of the President, November 1970, pp. 180 (major staff contributor).

Covell, R.M., "Impact of National Health Insurance Plans on the Consumer", pp. 62-68 in *National Health Insurance*, Eilers, R.D. and Moyerman, S.S. (eds.) Homewood, Illinois: Irwin Inc., July 1971.

Policy paper on Peer Review prepared for American Public Health Association and used by DHEW Office of Assistant Secretary for Health and Science Affairs and Commissioner of Social Security as staff document. Report presented 11-71 at annual APHA meeting.

Other: Member, UCSD Advisory Committee for the Biomedical Library; Member, Community Medicine Concentration Area Committee; Member, Community Mental Health Center Advisory Committee, PPRO, Irvine; and Member, Health Services Evaluation Panel, CCRMP.

CLEMENT R. BROWN, JR., M.D.

Date of Birth: February 27, 1928, in Washington, D.C.

Marital Status: Married, seven children.

Education: High School: St. Anthony, Washington, D.C.; College: Catholic University of America, Washington, D.C., B.A. cum laude, 1949; Medical School: Georgetown University School of Medicine, Washington, D.C., M.D., 1953; Internship: Providence Hospital, Washington, D.C., Rotating Intern, 1953-1954.

Medical Residency: 1956-1959.

First Year: Providence Hospital, Washington, D.C.

Second Year: D.C. General Hospital—Senior Resident, Georgetown University Medical Service: 8 months—pulmonary disease, 8 months—cardiology, 2 months—cardiopulmonary lab (performed and assisted with cardiac catherization daily, along with a full range of pulmonary function studies, including blood gas and work of breathing studies.) 4 months—general medical wards (medical consultant to admitting and emergency room, and psychiatry section).

Third year: Robert Packer Hospital & Guthrie Clinic, Sayre, Pennsylvania—Chief medical resident: 2 months—cardiology service; 4 months—gastroenterology service; 6 months—conducted my own service (responsible for all patients admitted through dispensary, assisted in educational program, lectured in cardiology, pulmonary physiology, vector electrocardiography.)

Fellow in Research in Medical Education: (sponsored by American Heart Association) 1964-1965, University of Illinois Medical Center, Office of Research in Medical Education, Chicago, Illinois.

Military Service: Captain, U.S. Air Force, 1954-1956; Commander, 525th USAF Infirmary, New Castle A.F.B., Wilmington, Delaware. Honorably Discharged, August, 1956.

Licensure: Illinois, Pennsylvania, Diplomate of the National Board of Medical Examiners.

Certification: American Board of Internal Medicine, November, 1964.

Academic Positions: 1971 to present—Director of Medical Education, Mercy Hospital and Medical Center, Chicago, Illinois. Supervision of education programs for internships and residencies. Involved in education program development at undergraduate, graduate and continuing education levels. Application of the Bi-Cycle Concept through quality assurance program to achieve curriculum development at all levels.

1965 to 1971: Director of Medical Education. Chestnut Hill Hospital, Philadelphia, Pennsylvania. Supervised organization, operation and evaluation of internship and residency training programs. Organized programs of continuing medical education. Chairman of Medical Audit Committee, assisting staff in defining its needs for a program of continuing medical education. Senior Attending Physician—Active Staff.

1959 to 1964: Director of Medical Education. Miami Valley Hospital, Dayton, Ohio. Supervised organization, operation and evaluation of internship and residency training programs. Organized programs for continuing medical education, including organization and operation of first two-way radio programs in continuing medical education in this part of the mid-west. Organized and conducted one of the seven pilot programs in Family Practice approved by the Council on Medical Education of the A.M.A. Member of Consulting Staff—Director of Hemodialysis Unit. Associate Director of Cardiopulmonary Laboratory.

Academic Appointment: Associate Professor of Medical Education, Center for Educational Development. University of Illinois College of Medicine.

Memberships: Asociation for Hospital Medical Education: Executive Committee, 1967-1970; Nominating Committee, Past Chairman (2 years); Teaching &

Institutes Committee, Past Chairman (8 years); Committee on Continuing Education, Past Chairman (2 years); Committee on Consultations; and AHME-RMP Liaison Committee; Society of Teachers of Family Medicine Research Committee; Illinois Regional Medical Program Task Force on Content and Standards of Care; Association of American Medical Colleges Advisory Committee on Continuing Medical Education.

Consultant Work: Association for Hospital Medical Education, faculty member in regional programs in teaching institute, February, 1963, 1965, September, 1967; chairman, Teaching & Institutes Committee—planned educational portion of all national meetings for 8 years. Greater Delaware Valley Regional Medical Program, Medical Education Consultant; HEW, Division of Regional Medical Programs, Consultant on medical education, Scientific and Technical Review Panel for CME program grant applications. National Center for Health Services Research and Development Member, Site Visit Teams & National Grant Review Panels. American Medical Association, Member Continuing Medical Education Accrediting Teams. Joint Commission on Accreditation of Hospitals, Regional Workshops. Book II Project. Hospital Utilization Project, Pittsburgh, Pennsylvania. Commission on Professional and Hospital Activities, Education consultant. Senate Subcommittee on Health (Senator Edward Kennedy and Representative William Roy, Kansas), Consultant to staff regarding HMO legislation. EMCBO (Experimental Medical Care Review Organization), Hawaii Project, Consultant. Medical Schools—Undergraduate and continuing education, Quality of Care Review for: Universities of Washington, Alabama, Colorado, Puerto Rico, Florida, Utah, Illinois, Nevada, Maryland, Connecticut, Temple, South Carolina, Vermont, Michigan, Manchester (England), Virginia, Missouri, California (at San Francisco), Southern California, Wisconsin, North Carolina.

Committees: Association of American Medical Colleges: Continuing Medical Education Committee; Longitudinal Research Study Group; American Hospital Association: Advisory Committee on Quality Assurance; Chairman, Policy and Guidelines Committee; University of Illinois, College of Medicine: Deans Committee; Committee on Educational Policy; Abraham Lincoln School of Medicine (University of Illinois): Task Force for Curriculum Development; Task Force for Curriculum Implementation; and Phase I Advisory Committee.

Senator TALMADGE. The next witness is Dr. Truman G. Schnabel, Jr., president of the American College of Physicians, accompanied by Edward C. Rosenow, Jr., executive vice president; and Calvin F. Kay, M.D., deputy executive vice president.

Thank you, gentlemen. We are delighted and honored to have you with us. You may proceed, sir.

STATEMENT OF TRUMAN G. SCHNABEL, JR., M.D., F.A.C.P., PRESIDENT, AMERICAN COLLEGE OF PHYSICIANS, ACCOMPANIED BY EDWARD C. ROSENOW, JR., M.D., F.A.C.P., EXECUTIVE VICE PRESIDENT, AND CALVIN F. KAY, M.D., F.A.C.P., DEPUTY EXECUTIVE VICE PRESIDENT

Mr. SCHNABEL. Mr. Chairman, members of the committee, I am honored to represent the American College of Physicians before your committee.

In addition to being president of the college, I am also a professor of medicine in the medical school of the University of Pennsylvania.

With me today, as you have stated, are on my right, Dr. Edward C. Rosenow, the executive vice president of the college; and Dr. Calvin F. Kay, the deputy executive vice president of the college.

In addition to the administrative and educational responsibilities that we have as officers of the college, each of us are involved in patient care. I think and I believe, or at least I hope you have in your hands an outline of some of the functions of the college relating to professional education and high quality medical care.

The interest of this college in PSRO is an appropriate and logical extension of these interests. Today I wish to present my interpretation of the position of the American College of Physicians with relation to the present and proposed implementation of the proposed PSRO legislation enacted as part of Public Law 92–603.

As a start in presenting this position, I would like to state the official position of the college which was stated in a resolution adopted by its board of regents on April 7, 1973. The resolution is as follows:

Resolved that the Board of Regents of the American College of Physicians agrees that the PSRO law provides an opportunity for the medical profession to monitor itself and thus gives the public assurance of quality care and at the same time provides a means for education of its members. The College will engage in aspects related to the PSRO law as necessary or desirable to assure the realization of College goals—education of our members and quality care.

The American College of Physicians has, at the present time, approximately 27,000 members throughout the United States and Canada. All of the members are specialists in internal medicine and its allied medical specialties, or are in training to become specialists in internal medicine. The object of the college, as stated in its constitution, is to maintain an organization of qualified physicians in the field of internal medicine and its allied specialties for the following purposes:

1. Maintaining and advancing the highest possible standards in medical education, medical practice, and research.
2. Preserving the history and perpetuating the best traditions of medicine and medical ethics, and
3. Maintaining both the dignity of internal medicine and the efficiency of its function in relation to the public welfare.

The college has a distinguished record of achievement in the field of graduate, postgraduate, and continuing medical education, and in so doing, it has contributed immeasurably to the improvement of health care through the high quality of medicine practiced by its members. It is clear now, however, that the education of physicians alone will not maintain the public welfare at the highest level. Equally important are those other purposes of the college, the efficiency of the practice of medicine, and the maintenance of standards of quality of practice and of medical research. The college must therefore concern itself with society and the economy in addition to the education of physicians if it is to fulfill its purposes. This concern of the college has led to its interest in the PSRO legislation. Such legislation should lead to physician education—and I would like to stress that—and at the same time be associated with quality care obtained at a reasonable cost. The college thus supports the concept of the evaluation of physician performance and the quality of health care in relation to costs. It believes that physicians should play a major role in such an evaluation, but it understands that the public, through the Government, must also be responsible for the support of such a vast enterprise if it is to succeed. It feels strongly that governmental control for such a law should be based in the health section of the Department of Health, Education, and Welfare.

The college believes that some flexibility in medical standards is appropriate and feels that the legislation can and must be able to recognize regional differences in the practice of medicine. The college has always been concerned and continues to be concerned with the

confidentiality of medical records. It believes that the law should be as protective as possible of the privacy of the doctor-patient relationship. Because of its belief that the PSRO law provides an opportunity for the medical profession to monitor itself for its own education and for the assurance of quality care, the college has done the following:

1. In general, been supportive of the PSRO law. It has previously objected to preadmission hospital certification. While it does not wish to suggest further amendments to the law at the present time, it reserves the right to do so if major problems develop as regional organizations begin operation.

2. It has urged its members to support the law and to take an active part in its regional implementation. Its governors have been instructed to appoint a representative of the college in the various regions throughout the country who should play an active part in the development of the professional service review organizations.

3. It has set standards of the practice of medicine of a quality type and is cooperating at the present time with the San Joaquin Foundation in the use of these standards to monitor medical care. With four other medical organizations it is responsible for the management of Private Initiative in PSRO, founded under a grant of the Kellogg Foundation to analyze the manner in which PSRO is being implemented in each of six PSRO regions, to assist in the implementation and to develop techniques for the general application to other PSRO's to help avoid the pitfalls and to encourage elsewhere those features that will make PSRO useful and effective.

4. It has supported the concept of recertification or reevaluation of its members.

5. It has sought funds to establish standards for the use of antibiotics. In this project it is working in cooperation with the American College of Surgeons, the American Academy of Pediatrics, the American Academy of Family Practice, and the Infectious Disease Society.

In summary then, the college is supportive of the PSRO legislation. The college believes that it can lead to better health care for the general public. The college has urged its membership to be supportive and to be actively involved in the implementation of the law and may, at some time, speak forth in an attempt to make the law a better one if it believes necessary, for the public good.

Senator TALMADGE. Thank you, Doctor.

COOKBOOK MEDICINE?

In your statement, you indicated that the college is establishing standards of practice of medicine of a quality type to use in monitoring. There are those who argue that any standards constitute cookbook medicine even if those standards apply only as checkpoints. What is your response to that allegation?

Mr. SCHNABEL. The setting of standards as a goal in the way that patients should be cared for—set standards should have a certain degree of flexibility in their character. I do not believe ultimately that these do lead to cookbook medicine. These, I believe on the other side of the coin, we will improve the quality of medicine that is given.

Information Dissemination and PSRO's

The Chairman. Doctor, I would like to get your suggestions as to the extent to which PSRO might be useful in advancing the national interest in health care. I am aware of situations and I am sure you are aware of many more where someone comes up with a medicine or a procedcre which would appear to be a far more effective cure for a given ailment than presently exists, and then perhaps in further research it is discovered that there are side effects or others begin to fear this might do more harm than good, so the prevailing view may then shift away from it.

What I would like to have from you is this: Where you are struggling in an area where a new medicine or a new procedure appears to be the most hopeful thing and then where subsequently it looks like further research leads to the notion it might promote cancer or something to take that approach, it might do more harm than good, how long does it take the average doctor, and I had in mind the average general practitioner in the average city in this country, to find out about the new approach and then to find if the prevailing view has shifted?

Mr. Schnabel. Senator Long, I don't know how to answer your question as to exactly how long it takes information to be disseminated to physicians throughout the country. As to the efficacy of drugs and medication and types of therapy, they have a number of publications, the Annals of American Medicine, the Journals of the American Medical Association, which are read by physicians throughout the country and I would hope through reading such journals they would be apprised of the problems as far as the various forms of therapy.

My concept of the review mechanism which is associated with PSRO is that one of its good features is that by continual review of that which is occurring within an institution within the practice of a physician that individual physician will be made aware at an earlier opportunity of such changes in thought regarding treatment and bad parts of treatment than he would in other circumstances.

In other words, I would like to stress that I think this review mechanism has a tremendous educational possibility.

The Chairman. Would it be true that although we would like to assume that most doctors stay right on top of the latest thing in their line of endeavor, that in areas particularly among general practitioners, especially where they are not specializing and trying to treat a whole scope of medicine that there are perhaps a substantial number of people who are not completely up on the latest thing to have been developed in various and sundry lines of medical treatment, and the PSRO's might help spur those people to keep up their interest in the latest developments in these areas.

Mr. Schnabel. Yes; I believe that would be true.

The Chairman. I know anybody objects to people looking over their shoulder, but in the last analysis if a fellow is sort of intent to doze on what he knows and is not constantly pressing to find what the latest developments in medical practice are, doesn't it mean in some cases a person might fail to give his patients the best medicine that we would like to hope for the patient?

Mr. Schnabel. Yes.

I would like to mention, in addition to this, that the American College of Physicians, which is primarily concerned with the education of its members, has developed what it calls a self-assessment test, which is now in its third edition, and is this year being subscribed to by some 24,000 of its members. This self-assessment test contains questions on latest forms of therapy. It also has with it references to articles so that the physician, after taking the test, receives the answer and may look up such articles as related to the questions in the text. So that this again is a mechanism that has been developed to try to enable physicians to keep up with current practices.

The CHAIRMAN. Well, I would hate to think that some poor soul would have to die just because his doctor was not aware of the fact that a new medicine had been developed which appeared to offer a cure where prior to that time nobody had anything effective.

I know that you, being at the top of your profession, would certainly hope that wouldn't happen anywhere in the country.

Mr. SCHNABEL. I certainly hope it wouldn't.

Senator TALMADGE. Senator Bennett.

Senator BENNETT. Thank you, Mr. Chairman.

Naturally, I am personally very much appreciative of your constructive support of the PSRO program.

IMPROVEMENTS IN QUALITY OF MEDICAL CARE

Assuming proper and sensitive implementation of the legislation, can you suggest to the committee some specific areas of improvement in the quality of medical care that we might reasonably expect?

Are there any specific areas that have come under your observation?

Mr. SCHNABEL. Well, I would hope, first of all, that what we would really be concerned with was outcome. In other words, hopefully people would be treated more adequately, in a better way, and perhaps in a shorter period of time.

We are concerned with other organizations relative to the use of antibiotics, and I would think with a review mechanism such as associated with the PSRO there is a method to determine how antibiotics are used throughout the organization and perhaps use them in a wiser and better method.

Senator BENNETT. Are you aware—I am sure you must be—that that was exactly the type of PSRO review system set up in New Mexico in which the medicare patients were reviewed?

Mr. SCHNABEL. Right. Also in my own State of Pennsylvania by Dr. Clem Brown at the Germantown Hospital some years ago.

FLEXIBILITY NEEDED

Senator BENNETT. You indicated the college's belief that some flexibility is appropriate and feel that the legislation must be able to recognize regional differences in the practice of medicine.

In your review of the statute and the committee report, have you found any indication that the law would require medical standards to be inflexible and regional differences could not be recognized?

Mr. SCHNABEL. No, as I read the law and as I heard Secretary Weinberger this morning, if I interpret his remarks correctly, there is the intention to have the law flexible.

Preadmission Hospital Certification

Senator Bennett. You indicated your objection to preadmission hospital certification. As to preadmission certification, the law does not require it, but it does authorize PSRO to require that on a selective basis when it determines it to be necessary, for example, selective as to a hospital or as to a practitioner, as to a certain diagnosis, do you believe that such a discretionary authority may be a necessary tool if PSROs fulfill their overall responsibility?

By this I mean, can you conceive of situations where prior approval might be reasonable and appropriate?

Mr. Schnabel. I would rather think of that part of the law as being something that would be determined as to whether it would really be implemented as the law itself is implemented throughout the country.

In other words, I would not like to have that particular part of the law enacted as the PSRO law becomes implemented.

Senator Bennett. It is my understanding that this phase of the law does not give the Secretary or the Advisory Council the right to set national conditions for preadmission, but gives the local PSRO the right to apply that requirement to a particular physician in a particular case if it finds that he may be grossly abusing his privilege.

Do you think that should be denied?

Mr. Schnabel. Well, I think these are matters that should be determined by the physicians themselves in their local area.

Senator Bennett. Under the law they will be so determined. There is nothing in the law that requires that they be set up on a national basis?

Mr. Rosenow. Could I supplement a little?

Our feeling about the preadmission is that it is an impractical thing. You have a committee of doctors who are deciding whether my patient should go in the hospital and the only person they can get information from is me. This is kind of impractical. We don't have any objection whatsoever to reviewing why I put people in the hospital on an ongoing basis, and if I turn out to be admitting them for everything nobody else is admitting them for we have got to put the axe on me.

Senator Bennett. The thing that concerns me is a doctor performing a particular type of surgery on every patient he can get into the hospital. I wonder if the PSRO shouldn't have the power to say to him, before you admit any more patients for that particular type of surgery maybe you had better let somebody else have a look.

Mr. Rosenow. Being a medical man myself, they shouldn't be abusing this.

The PSRO group would pretty soon identify that person and that would be one of the benefits of the law.

Senator Bennett. This is the one, this particular provision is in the law, that once the local PSRO has identified that kind of a situation they should be able to move in before the operation has been performed and the patient has been put through unneeded agony and financial expense.

So, may I interpret your objection to the preadmission certification idea as an objection in principle and that you would consider there might be exceptions which, on the judgment of the local PSRO, might be imposed?

Mr. Schnabel. Yes.

Senator BENNETT. That is all, Mr. Chairman.
Senator TALMADGE. Thank you very much, gentlemen.
We appreciate your contribution to our hearings.
[An attachment to Mr. Schnabel's statement follows:]

SUPPLEMENTARY OUTLINE OF PERTINENT COLLEGE FUNCTIONS

POSTGRADUATE, GRADUATE AND EDUCATIONAL ACTIVITIES OF THE COLLEGE

1. The Annals of Internal Medicine, which has a circulation of some 70,000 copies monthly.
2. The Annual Session which is attended by 5,000 to 7,000 physicians each year.
3. Regional Meetings with an attendance of between 4,000 and 6,000.
4. 40 Postgraduate Courses attended by approximately 4,000 physicians.
5. Education film strips called the Medical Skills Library.
6. The Self-Assessment test pioneered by the College now is in its third edition. This year, over 24,000 physicians have subscribed.
7. As a founding member of the American Board of Internal Medicine, on which Board it is responsible for half of the members. The American Board of Internal Medicine, through its specialty, subspecialty examinations and now the upcoming recertification examination has, and will have, a profound and salutary influence upon the quality of medical practice since its inception in 1937.
8. The College is a founding and continuing member of the Residency Review Committee, which is responsible for the surveillance and the accreditation of residency training programs in Internal Medicine throughout the country.
9. The College shares membership in many other organizations concerned with various aspects of graduate and postgraduate medical education, including the Interspecialty Council, the AMA Section on Internal Medicine, the Council of Medical Specialty Societies, and many others.

HEALTH CARE ACTIVITIES OF THE COLLEGE

1. The College has played a major role in the Joint Commission on Accreditation of Hospitals, which was founded by the American College of Physicians, the American College of Surgeons, the American Medical Association, and the American Hospital Association. These organizations continue to be represented by commissioners on the Joint Commission. The voluntary organization has as its function the accreditation of hospitals following inspection of organizational structure of facilities and personnel at all levels. As a result of these inspections there has resulted a definition of the functions of the trustees, administrators and staff of the hospital and the Commission has developed educational programs to foster the aims of high standards of hosiptal care.
2. The College has long been on record in support of medical audit and utilization review. It has participated in the organization and has continued representation on the Board of the Commission of Professional and Hospital Activities. It provides computerized analysis of the records of over 40% of the patients discharged from general hospitals in the United States, for use by hospital committees on medical audit and utilization review. Committees of the College have developed standards for the delineation of privileges of hospital staff physicians and members of the College have recently served as representatives on the newly founded Medical Liability Commission.
3. Committees of the College have been instrumental in the development of criteria and standards for medical care. These criteria and standards have been used by the San Joaquin Foundation for medical care to monitor the practice of medicine in a particular area in California. It is hoped that these standards and criteria will be generally useful for computerized analysis of claims data for definition of appropriate patterns of care of organization with programs of total prepaid medical care.

Senator TALMADGE. The next witness is Dr. Russell B. Roth, president of the American Medical Association, accompanied by Robert B. Hunter, member, board of trustees, and Edgar T. Beddingfield, vice chairman, council on legislation.

Senator BENNETT. Obviously, Mr. Chairman, we will not be through with this panel at 1 o'clock. Can we break at 12:30 and come back at 1:30?

Senator TALMADGE. Is that agreeable to you, Doctor?

Mr. ROTH. Yes.

Senator TALMADGE. Chairman Long says he regrets to miss your testimony. He has stated that he would read your testimony in detail.

So, pursuant to Senator Bennett's suggestion, we will recess at this time and come back at 1:30 p.m.

AFTERNOON SESSION

Senator TALMADGE. The committee will please come to order.

The committee is delighted to have as our next witness Dr. Russell B. Roth, president of American Medical Association, who is accompanied by Dr. Robert B. Hunter, a member of the board of trustees; and also, Dr. Edgar T. Beddingfield, Jr., vice chairman of the Council on Legislation.

We are honored to have you with us, gentlemen. You may insert your full statement in the record and then summarize it.

STATEMENT OF DR. RUSSELL B. ROTH, PRESIDENT, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY DR. ROBERT B. HUNTER, MEMBER, BOARD OF TRUSTEES, AND DR. EDGAR T. BEDDINGFIELD, JR., VICE CHAIRMAN, COUNCIL ON LEGISLATION

Dr. ROTH. Thank you, Mr. Chairman.

It is our desire to discuss with you specific concerns over Public Law 92-603, with special reference to section 249F. The intent of this provision in the law is to establish a mechanism for the evaluation of the quality of medical services, together with a determination of what federally financed programs may appropriately pay for, or decline to pay for. It would provide a medium for public accountability on the part of providers of medical services.

Clearly, evaluation of the character of medical service with respect to necessity, quality, and appropriateness depends heavily, if not exclusively, on the judgment of medical peers. The surpassingly important question which needs to be considered here is: In a program depending totally on physician understanding, physician acceptance, and physician cooperation, how are things shaping up after more than a year of preliminary organization?

It is with a very real sense of misgiving that we need to testify to the fact—the clearly demonstrable fact—that things have often gotten off to an incredibly bad start.

A significant proportion of the physician population has been estranged. We cannot be precise in numbers, but it seems evident that, as understanding of the PSRO law spreads, the resistance to it grows. State medical societies numbering 14 have formally declared as policy that they will work for repeal of PSRO. And 29 State medical societies support a policy of amendment and/or repeal. A formal court suit contesting the validity of the law has been filed, although that is not by the AMA.

It should be fully understood that all of this has happened, not because of resistance on the part of the medical profession, but in spite of the fact that the American Medical Association, for over a year, has dedicated to the success of the effort a major contribution in time and talent of experts in the field plus over $200,000 of its own funds. In other words, the best efforts of the legislators involved—the staff of the Senate Finance Committee, the staff of the PSRO administrative office in HEW, and physicians from AMA, from assorted State medical societies, and specialty medical organizations—have not succeeded in created in the profession the climate of acceptance and cooperation essential to success. The fault does not lie with the sincerity or intensity of the effort to cooperate; it lies with the basic ineptitudes of the statute.

Professional peer review has been an obligation long recognized by physicians and accepted by them. Over several decades they have worked at the task of evaluating the quality of services, adjudging medical necessity, and determining reasonable charges. Much progress has been made, but it must be remembered that where success has been achieved there has been a major factor of physician sponsorship and cooperation. A diversity of approaches has been employed. No single, generally applicable program has been devised. Experimentation funded by private sources as well as by the Federal Government continues. Much of the problem with PSRO lies in a premature leaping to conclusions without waiting for experimental results.

It has been seriously proposed that because of the bad start, it may be best to fall back, regroup, and start over again. The official AMA position is that repeal may need to be considered if amendatory patchwork is unacceptable. It should be noted, however, as Senator Bennett and the AMA have pointed out, that the problem is not limited to section 249F. Other provisions in law would constitute residual problems.

Three alternatives confront this subcommittee:

First, to leave the law as it is—try it for size and shape, and set aside the judgment of many responsible physicians that it will not work;

Second, to delete the sections of the law which propose conflicting, overlapping, and unacceptable controls (including sections such as 229, 213, and 249F), and to replace them with a well-ordered, generally agreed-upon approach which will have a better chance of working; or

Third, to amend the law in line with suggestions which are being offered in these hearings.

It is our conviction that the events of the past year—the best efforts of the AMA, of the staff of the Senate Finance Committee, of Dr. Edwards, Dr. Bauer, Dr. Simmons, and the rest—have made it apparent that the first alternative would be ill advised.

In order to deal more precisely with our AMA involvement in cooperative efforts to make the program work, I would ask Dr. Robert Hunter, chairman of our special advisory committee on PSRO, to provide information to the subcommittee.

STATEMENT OF DR. ROBERT B. HUNTER

Dr. HUNTER. Senator Talmadge, Senator Bennett, and Senator Hansen, I am Dr. Robert B. Hunter, a practicing family physician from Sedro-Woolley, Wash. I am a member of the American Medical Association's board of trustees, chairman of its Advisory Committee on PSRO, and also serve as a member of the National Professional Standards Review Council. I appreciate the opportunity to appear before you and to present what I consider some of the more significant activities of the AMA relative to professional standards review organizations (PSRO's).

Within 1 month following the enactment of the PSRO law in October 1972, the AMA house of delegates directed the association to work toward achieving a leadership position in the implementation of the PSRO program. This position was taken in an effort to insure that the law would be implemented in a manner least disruptive to the practice of good medicine, and to protect the best interests of both the public and the medical profession.

Accordingly, an Advisory Committee on PSRO was established by the AMA Board of Trustees to make recommendations concerning appropriate association involvement in PSRO implementation. The Advisory Committee membership was drawn from the medical profession, health care institutions, and other organizations with a valid interest in, and relationship to, those review activities mandated by the PSRO law. The committee includes representatives from the American Association of Foundations for Medical Care, American Dental Association, American Hospital Association, American Nursing Home Association, Blue Cross Association, Group Health Association of America, Inc., Health Insurance Association of America, National Association of Blue Shield Plans, and the National Medical Association. Other professional and health care organizations including the American Osteopathic Association have participated in committee meetings.

The Advisory Committee quickly turned to its task and held its organization meeting January 1973. Without exception, the members expressed a vital concern with the PSRO legislation and agreed that the AMA committee activities should include (1) assisting in designation of PSRO areas, (2) assisting in the development of rules and regulations concerning PSRO, (3) coordinating development of guidelines for quality medical care, (4) monitoring of prototype PSRO's, (5) initiation of mechanisms to aid in PSRO formation, (6) identify data gathering, processing and storage needs, (7) develop communication mechanisms for the public and the profession, and (8) set up a protocol for evaluation of the program. Consequently, eight consulting task forces composed of over 60 leaders and experts in their respective fields were formed to carry out these activities.

The AMA Advisory Committee has met on eight separate occasions, the most recent being on April 6, 1974. Each of the task forces has also met a number of times, and as progress has warranted, meetings have been held with the subcommittees of the National Professional Standards Review Council, and with the Office of PSR.

The breadth and scope of the work of the AMA task forces can best be indicated by highlighting just a few of their activities:

(*a*) Sponsorship of a joint meeting in May 1973, of task force representatives and counterpart staff personnel working with DHEW's task forces on PSRO to identify equivalent responsibilities and to initiate direct liaison in an effort to more effectively share PSRO information and effort.

(*b*) Conducted several briefings on PSRO implementation for State and county medical society representatives, including a May 1973 meeting here in Washington which was attended by more than 120 representatives from 39 State medical societies.

(*c*) Sponsorship of a series of eight regional conferences across the country, held between August and November 1973, and designed to present the latest information then available on PSRO. Over 100 speakers discussed various facets of PSRO and its possible impact with well over 1,000 invited individuals who attended the conference series. A representative of DHEW actively participated in at least one segment of each conference.

(*d*) Joint meetings between the AMA's task force on rules and regulations and DHEW representatives for the purpose of reviewing the task force's recommendations and the PSRO program manual prepared by OPSR, in an attempt to coordinate Federal and private efforts in the regulatory area. These important and productive meetings were held on January 10 and March 14, 1974. Additional joint meetings are anticipated.

(*e*) Preparation by the task force on structure and organization of a "Handbook" setting forth various elements which might be included in a PSRO structure such as the types of committees and appeal mechanisms necessary and the appropriate relationship of professional review programs to data systems. Sample bylaws and articles of incorporation which may be used by physicians as possible models in establishing a PSRO are also included in this document.

(*f*) Initiation by the task force on communications and education of a program to inform physicians, health care organizations and the public to all aspects of PSRO. This program has included wide distribution of an audio slide presentation describing PSRO concepts and a newsletter, entitled PSRO Report, designed to widely disseminate relevant information on PSRO.

(*g*) Formulation by the task force on data collection, processing and storage of recommendations for a PSRO minimum data set, definition of specific data elements, consideration of factors involved in patient and physician identifiers, and problems of confidentiality of medical data. On March 29, 1974, the task force reviewed its data and recommendations with representatives of DHEW and discussed differences and similarities between the task force data set and the current version of the data set being formulated by DHEW for use with medicare and medicaid programs. A similar meeting to further discuss these subjects with DHEW is scheduled for May 29, 1974.

(*h*) Initiation by the task force on guidelines of care of a program to coordinate development by national medical specialty societies of medical care criteria for diagnoses accounting for 75 percent of their respective inpatient practices. To date, 29 specialty societies have vol-

untarily joined in this development project. The task force sponsored a "how to" workshop on development of criteria in July 1973, and encouraged use of a standardized format by specialty societies participating in the project. At the AMA's request, representatives of DHEW have regularly attended meetings of the task force in an effort to ensure that the criteria development project has maximum input regarding requirements of PSRO. The task force has also held a joint meeting with the National Council's Subcommittee on Data and Norms to integrate requirements of the PSRO law into the criteria project. Further, the AMA's task force, the National Council's Subcommittee on Data and Norms and the Office of Professional Standards Review have agreed to standardized definitions for the terms "norms", "standards", "critera", and "screening" in an effort to insure that we are all speaking the same language.

I have attempted, Mr. Chairman and members of the subcommittee, to briefly highlight what I consider to be some of the constructive efforts of the American Medical Association in the implementation of the professional standards review program.

My colleague, Dr. Beddingfield, will now present to you what the AMA considers to be constructive amendments to the Professional Standards Review Organization legislation.

This is Dr. Beddingfield, Senator.

Senator TALMADGE. Proceed, Doctor.

STATEMENT OF DR. EDGAR T. BEDDINGFIELD

Dr. BEDDINGFIELD. Mr. Chairman, and members of the subcommittee, I am Dr. Edgar T. Beddingfield, Jr., a practicing family physician from Wilson, N.C.

Senator TALMADGE. I am sorry to call you down, but we have eight more witnesses to be heard today.

I do want you to know this. All testimony will be inserted in full in the record.*

Our staff will prepare a summary of all testimony, and every member of this committee will get a copy of it. And in that way your views will be known.

I will yield at this time to the Senator from Utah.

Senator BENNETT. Thank you.

I would like to begin by saying to Dr. Beddingfield again that this is not a legislative hearing. We are not considering amendments at the present time. So all we can properly do is put your amendments in the file against the time when the committee might be considering changes in the law. And we hope you understand that. We certainly have no objection to receiving the amendments. You can be sure they will be looked at carefully to see whether there is any content in them that we think will improve the law. But just on the off-chance that somebody might say amendments were offered and we would not even consider them, you should know that this is not a hearing at which amendments will be considered.

Dr. HUNTER. If you will receive them, sir.

---

*Dr. Beddingfield's prepared statement appears at p. 74.

AMA Attacks on PSRO

Senator Bennett. To begin with, I would like to make a statement, Mr. Chairman. Since I am the author of the PSRO program which has been under attack by the AMA very vigorously, in the last few months particularly, I would like to begin by saying how pleased I am by the activities that Dr. Hunter has described of the AMA Advisory Committee on PSRO. I might add that Dr. Hunter and I have appeared many times on the same program discussing the PSRO. And I have great respect for his understanding of the program.

I am fully aware that physicians such as Dr. Hunter and others like him, have spent a great deal of time working toward the implementation of the program. And I congratulate him for his activities in this respect. But I am extremely distressed by the tone and content of Dr. Roth's remarks.

In your statement, Dr. Roth, you say that "A significant proportion of the physician population has been estranged." And you go on to say that this estrangement has occurred "not because of the resistance on the part of the medical profession, but in spite of the fact that AMA has, over a year, dedicated to the success of the effort a major contribution in time and talent of experts plus over $200,000 in its own funds". And finally you say: "The fault does not lie with the sincerity or the intensity of our effort to cooperate."

Frankly, Dr. Roth, I think this is demeaning of the committee for you to come before us and broadly imply that AMA has been completely supportive of the implementation of the PSRO law. I and other members of the committee are fully aware that you and other officers of the AMA have been equally as vehement in describing to those State medical societies that are opposed to PSRO your sincere and intense effort to repeal or amend the PSRO today. It seems to me, Dr. Roth, that you reach a point where you cannot have it both ways. I do not see how you can honestly read page 2 of your statement without explaining such things as the PSRO "Deleterious Effects Kit" which I hold in my hand. This kit, and the anti-PSRO statements that you and other officers of the AMA have made, have created far more estrangement than any of Dr. Hunter's efforts to cooperate have been able to overcome.

I must say that over the past 4 years of PSRO effort one of the things that has been most disappointing to me personally has been the failure of the leaders of AMA to say the same thing regardless of which side of an issue their particular audience might be on.

I am sure you realize that PSRO was born out of PRO, which was an AMA proposal. And it seems to me you turned against PSRO when we decided that it was inappropriate to allow your constitutent State societies to administer the law. And then we moved to the concept of voluntary local organizations of practicing physicians. And I note that one of your amendments is an attempt to get that State concept back into the law.

I cannot seem to make it clear enough that the Federal Government cannot turn over to a private organization, organized for the benefit of its own members, and representing—I do not know whether it is half or slightly more than half of the practicing physicians in

the country—and able to prevent some physicians from getting membership, the operation of a law that affects all physicians. Now, it seems to me that after your California meeting, after your Disneyland meeting, you have come up with three heads. Dr. Hunter represents one head: Let us support the law and let us do what we can to make it work. And you represent another head: Let us kill it. And Dr. Beddingfield represents the third head: Let us amend it. But the end of that is, let us amend it to death, because you cannot bear to see the control of the law pass out of your hands into the hands of local physicians who are not completely under your control.

I may be wrong, but that is the way I have read my experiences when I have appeared in various groups, and have been questioned by people whose attitude has been affected by yours, and when I have tried to defend the PSRO proposal against its detractors. I think you would be perfectly happy to support the PSRO program if we amended it to turn it over to your control.

I think you should remember back to the fact that you opposed medicare. And when we overruled your opposition, two interesting things happened. The American medical profession no longer had the responsibility for charity medicine. And the Federal Government assumed in its place a burden that has now reached something like $25 billion a year. And we who are responsible for the oversight of that service have an equal responsibility to see that the service rendered is worth the $25 billion, both to the taxpayers and to the patient.

This law has been carefully worked out to leave the right to review in the hands of the physicians themselves and in the hands of the local physicians. And it was written to require that the local physicians organization apply so that nobody could say the Secretary of HEW was selecting the reviewers. We have tried every way we can to preserve the right of the local physicians to carry on their program. And I think in total, in spite of all of the work that has been done by Dr. Hunter and his committee, the total effect of your combined activities has been to use your words, estrange the doctors from PSRO. And I am glad that we have already gotten into the record this morning an indication that you have failed, because we have had more than 100 applications from local PSRO groups. And the first State supportive contract has been agreed to. And the first local PSRO group has been designated from my own State of Utah. We are on the way. And I do not think you can stop it. And I think you should get on the ball, because I think this program is going to live. And if AMA continues to kick against the bricks, it will be you and not the PSRO program, or the Finance Committee, that will suffer in the contest.

Having delivered that rather emotionally charged opinion, I would like to get down to some specific questions. I would like to ask each of the witnesses, beginning with Dr. Beddingfield, did you know the contents of this kit before it was issued?

Dr. BEDDINGFIELD. No, sir.

Senator BENNETT. Dr. Hunter, did you know the contents of this kit before it was issued?

Dr. HUNTER. No, sir.

Senator BENNETT. Dr. Roth, did you know the contents of this kit before it was issued?

Dr. ROTH. No, sir.

Senator BENNETT. In other words, the AMA is not master in its own house. Are you prepared to say that you disown it, you wish it had never been issued, that the claims and statements made in it are false and the AMA disowns it?

Dr. Beddingfield.

Dr. BEDDINGFIELD. I would not be prepared to accept that statement in total. I think there are some ill-advised contributions to it. But I think there is some potential and inflammatory language. Some of the language is certainly ill chosen. But there is a copy of the law in there, for example, and we could not disown that. And there is an analysis of the law, which is a clear objective analysis of the law. There are certain things in there which I wish had not gone out in there, yes, sir.

Senator BENNETT. Are you proud of the fact that the proposed sample speech issued to be delivered by AMA members bears the title "Exorcising the Devil"? Have we reached the point where our scientific organizations are reduced to exorcism in order to get their point over?

Dr. BEDDINGFIELD. I think that the title of the speech was ill chosen. Perhaps it was in keeping with things that are currently of interest in the world, in the Nation. But I think it was ill chosen.

Senator BENNETT. Dr. Hunter, do you think the AMA should repudiate this document?

Dr. HUNTER. I believe that the speech entitled, "Exorcising the Devil" is needlessly inflammatory. It has been withdrawn from any further issuance of the kit. However, you and I can sit here and agree that the pages of history cannot be expunged. And that speech has been delivered.

Senator BENNETT. But it still bears the imprimatur of the AMA. I am glad to hear that you are not distributing any more copies of it. But there are plenty out there.

Dr. Roth, what do you think about it? I realize that you were not in your present position when it was distributed.

Dr. ROTH. Yes, sir. I have been president since last June.

But I would like to point out, Senator, if I may in this connection, that my role is that of a responsible representative of and spokesman for my constituency, and that what I do is inevitably determined by the policy positions taken by our house of delegates, which is the supreme, really the only policy-establishing part of our organization. And because of one of their pronouncements this kit was prepared. And I would read to you from the action section of their PSRO pronouncement:

> That this House of Delegates as individual physicians and through the Board of Trustees and its Council on Legislation work to inform the public and legislators as to the potential deleterious effects of this law on the quality, confidentiality and cost of medical care.

This was a directive to us, and, therefore, the staff put this together.

I think all of us are distressed in that it has perhaps intensified an adversary atmosphere in which we should discuss the supremely important issue of the application of successful peer review, which I assure you we are as interested in, as is the committee. In fact, the techniques of peer review were invented by our profession. And I think

responsible accomplishments of a successful program is the objective of all of us. And what we are giving you is the opinion, matured after perhaps a relatively short time. In 1 year we had hoped to line up enthusiasm and cooperation and willingness of far more organizations to apply for an active role in PSRO. It has not happened, and it is going the other way at an alarming rate, sir. In the distributed text of my statement it states that 13 State medical societies have come out against PSRO for repeal. I had to change that in my oral delivery to 14, because within the last 2 days another one has gone on this route. We have a number of associations going, and this is distressing to us, as I am sure it is to the committee. Our suggestion is that you need the troops to win this war. And we are losing the troops.

Senator BENNETT. May I ask one question?

I face you with a statement in the letter of March 13 written by Dr. Howard to accompany the kit which says:

An editorial, "PSRO standard or substandard medicine," has been included for insertion in medical journals or newsletters. We have also enclosed a suggested speech which does an excellent job of pointing to the dangers of the present law.

And then it says:

We suggest local press contacts receive priority for the receipt of these releases. In this way maximum media exposure hopefully, will result and be of significant help to us in our fight against PSRO.

Now, you cannot have it both ways, Dr. Roth.

[The March 13, 1974, letter follows:]

AMERICAN MEDICAL ASSOCIATION,
Chicago, Ill., March 13, 1974.

To: AMA Delegates and Alternate Delegates; State Medical Associations; Metropolitan County Medical Societies; and National Specialty Societies.
Subject: Deleterious Effects of PSRO.

The enclosed kit details some of the deleterious effects of the PSRO law. The contents of the kit are designed for internal communication purposes within your medical society and to provide resource materials on the subject to the news media within the area served by your society.

The resource materials that deal with AMA policy on PSRO are self-explanatory. An editorial, "PSRO: Standard or Substandard Medicine", has been included for insertion in medical journals and/or newsletters. We have also included a suggested speech which does an excellent job of pointing to the dangers of the present PSRO law.

Three statements outline primary PSRO pitfalls, i.e. "Confidentiality" . . . "PSRO Norms—or Guidelines?" . . . and "Showboating and Scapegoating." They may be used internally for the membership, of course. But we suggest local press contacts receive priority for the receipt of these releases.

Each of the three statements may be retyped with the name of your society inserted as indicated in the texts. They might also be presented to local members of the media by appropriate representatives of your society. In this way, maximum media exposure hopefully will result and be of significant help to us in our fight against PSRO.

Your American Medical Association believes that it is vitally important to develop an effective informational campaign to apprise the physcian membership and the general public on the concerns that surround the PSRO program. The AMA has asked each state to survey members of Congress to determine the potential of repealing the law. At the same time, we have drafted specific amendments for presentation to Congress.

Finally, we suggest that you may wish to share the contents of this kit with each member of your state's congressional delegation.

Sincerely,

ERNEST B. HOWARD, M.D.

Dr. ROTH. No, sir. We obviously have been forced to switch. After having honorably failed in our effort to have the House language accepted rather than the Senate language in H.R. 1, we took the same route that we did after the passage of medicare when we cooperated and set up a special advisory committee which worked long and hard in the writing of the regulations. We have tried to do this here, but it has not gained acceptance. At Anaheim, as part of our deliberations in Fantasyland, we came out with a firm declaration by our house of delegates. Again, I report that the policymaking group said, the considered opinion of this house of delegates is that the best interests of the American people, our patients, would be served by repeal of the present PSRO legislation. That is reasonably loud and clear. But the board of trustees still insisted that because this might be impossible to achieve, there should be a policy position which would prevail so long as the law remains in force, and recommended a continuation to exert its leadership and to support constructive amendments, coupled with a continuation of the efforts to develop appropriate rules and regulations. And this, sir, is what we are trying to do in consonance with the dictates of our constituency.

Senator BENNETT. If the law were amended to allow your constituent State societies to become the PSRO's, and we repeal that section of the law which sets up the local agencies, would you then move to repeal the law?

Dr. ROTH. I do not happen to think this is the key issue. I think that one of the problems, and one of the major differences in thrust between our earlier PRO proposal and the modification that now stands in PSRO, that the thrust of our bill would have been to take advantage of physician development, physician enthusiasm, and physician sponsorship and cooperation in peer review in the many ways it was being developed, and to support those, to extend them and gradually to achieve a successful operation.

Now, what happened under PSRO was that the very first approach to this kind of enlistment of enthusiastic effort ran into a roadblock in the districting, where we had States that wanted to take the responsibility. Under the terms of the law they found that it was an arbitrary decision that they had to be divided up into multiple PRO's. Not all States wanted single State PSRO, as you well know, sir. There are many that are happy with the designations. There are many that are unhappy. And I am sure you know by now that at least one State has entered suit on this subject, and we have at least one more considering such action.

So here where the physician wanted to do the job on the general terms of the rest of the law's provisions, they immediately ran into a frustration and an estrangement. And I think that there are States that are now standing for repeal that would not be for repeal had they not run into this obstacle. It is one of the ineptitudes that I referred to.

Senator BENNETT. I have overstayed my time. I will come back again later.

ROLE OF DOCTORS IN PSRO

Senator TALMADGE. I supported the original PSRO legislation because I thought doctors were better qualified to monitor it themselves

than Government bureaucrats and insurance company clerks. Do you not agree with that?

Dr. ROTH. Totally, sir.

Senator TALMADGE. Are you not aware also that before the PSRO amendment was agreed to that insurance company clerks and Government bureaucrats had far greater delegations of authority than the PSRO has right now?

Dr. ROTH. Yes, sir. We have been living with that in medicare and medicaid.

Senator TALMADGE. Are you not further aware that that authority is still in the act where a Government clerk can come in your office or an insurance clerk can come in your office and get your records and look at them and virtually anything else he wants to do?

Dr. ROTH. Yes, sir. I would point out in our suggested amendments we would change that.

Senator TALMADGE. What is so objectionable about letting local doctors do in the future what Government clerks and insurance clerks have been able to do now for years?

Dr. ROTH. Actually, it would be done much better. And that is precisely our objective.

NEED FOR PSRO'S

Senator TALMADGE. On another subject, I will be very brief. In the absence of cost controls on health care, do we not need professional standards review to assure appropriate usage of costly health care services?

Dr. ROTH. Dr. Hunter, would you like to react to that?

Dr. HUNTER. Yes, sir, I would say so.

MEDICAL SOCIETY PSRO-TYPE REVIEWS

Senator TALMADGE. There have been some complaints about confidentiality and cookbook medicine and cost of review relative to saving, and so forth. The medical societies in Sacramento, Calif., New Mexico, Utah, and Colorado have been doing PSRO-type reviews for the Government. I assume that the AMA evaluated the activities of those medical organizations. What were your specific findings with respect to those operations?

Dr. HUNTER. We viewed them with interest. And we applauded their efforts. And we felt that their accomplishments were worthy of documentation.

Senator TALMADGE. I will reserve the balance of my time and yield later to the Senator from Utah if he desires.

And now Senator Hansen is recognized.

Senator HANSEN. Thank you, Mr. Chairman.

I will direct my questions to the panel, and who you feel might best respond, it would be up to your determination.

PSRO AND NATIONAL HEALTH INSURANCE

What do you envision the results to be when PSRO's are extended to all health care, including ambulatory and office care under a national health insurance program?

Dr. ROTH. That, Senator Hansen, is one of our greatest concerns. It is being widely alleged that one of the important things in connection with PSRO is to have it accomplished now, because it will be incorporated into any kind of national health insurance that may be soon enacted. And it is also envisioned, particularly as one listens to discussions about the impact of the PSRO on the prescribing habits of physicians, with regard to antibiotics, and things of that sort, that this must inevitably imply that this get carried on into office practice in the out-of-hospital setting where a substantial part of that kind of medical practice is carried on.

This falls in the general area reported on by Dr. Saward this morning, when he said methodologies of handling this kind of review simply do not exist. Virtually all of the review has been applied either to institutional care or in some limited cases, as in the New Mexico experience, to a statewide medicaid, title 19, program. And the techniques of doing quality care are fragmentary. So that we are fearful of a mandatory governmentally described program for industrywide application.

TIMING OF AMA SUGGESTED AMENDMENTS

Senator HANSEN. My second question deals with a subject that has already been discussed with some degree, more than perhaps just normal interest. But nevertheless, let me ask, Why do you say that the law needs to be amended now rather than after an initial period of implementation and experimentation?

Dr. ROTH. I would like to ask Dr. Beddingfield to reply to that, sir.

Dr. BEDDINGFIELD. Senator Hansen, many of the apprehensions and concerns that were expressed by the Secretary this morning were addressed by the amendments which I did not have time to present in my presentation. And I would hope that they would receive the careful attention of the committee.

Senator HANSEN. Dr. Beddingfield, let me say by way of partial response to your expressed hope that I certainly will be glad to consider those. That may not mean anything, but it seems to me that any organization, or any professional group, anyone who comes under the purview of a particular law, may be at some disadvantage. And it does not offend me that you might have some suggestions to make as to ways in which the law can be improved.

I am very lowdown on the totem pole, and I would not want to hold out any false hope that you might take undue encouragement from what I have said.

Dr. ROTH. May I add to this, Senator, that one of our amendments which I think is more important, is to give more time for implementation if this law is to be continued, because it seems obvious that when the law was passed in 1972, that there was a recognition on the part of the Congress that the profession was being asked to do an extraordinary job, and that they gave us 3 years. January 1, 1976, may have seemed far off at that time, but here we have spent half of it, and now the remaining 18 months seems to be a very short time, when we recognize that it was just yesterday that we got the first authorization to begin one PSRO. And so if we are to live with this, to improve it, to improve its chances to be a success, we feel that it requires more time. We have a dual purpose proposed amendment in that respect.

Development of Norms for Care

Senator Hansen. One final question. Specifically, how could the norms as designated in the law cause what you call cookbook medicine?

Dr. Roth. Senator, I think it comes from an experience in working with Federal programs, medicare, and medicaid. Cookbook medicine would occur if there are indeed for each diagnosis a set of norms, and the understanding grows among all physicians that as long as their practice conforms to these norms that fees will be paid and there will be no problem about peer review. This is what we are eternally told. It seems to me that there will be a compulsion toward doing everything that the norm authorizes; the physician will feel if he does so he is secure, he is playing according to the Federal rules, and he will be paid, there will be no problems about it, and it may even improve his legal status if anybody ever wanted to bring up any question as to the propriety of his treatment. This is certainly not in tune with the use of the judgment and the experience of the physician who certainly does not normally carry out his management of a case according to cookbook recipes. I think this is what we are talking about because it could be a major contributor to escalation of the expenses of the whole program.

Senator Hansen. I might just observe, Doctor, that judging by the experience some people have had who were engaged in what is sometimes referred to as good Samaritan acts, and have found themselves before the courts answering charges that have been made, I must say, as one who comes from that part of the country where there are not all that many people, and having seen firsthand more than one occasion where good intentions paid off very well, I am glad that everyone has not been instilled with the fear that I think you rightly anticipate could discourage some doctors from deviating from it. Because from personal observation I can say that there are a few people alive today I know of that would not have been alive if the person had been able to view the full spectrum of court action and had been made aware of the dangers of picking up somebody that is badly hurt, is unable to speak, and you do not know what is wrong with them. And thank God there are still people who are willing to take the chance and do what they believe is right, despite the fact that they could obviously find themselves in a legal situation where they would be confronted by somebody saying that they are contributing to their total paralysis or even their death.

Dr. Roth. Thank you.

Senator Hansen. Thank you.

Senator Talmadge. The Chair yields such time as he has remaining to the Senator from Utah.

Senator Bennett. I am interested in this discussion of norms because I hold in my hand again Resolution No. 56, Specifications for the Development of Norms for Care, Diagnosis, and Treatment, adopted by your clinical convention in 1972. And every one of these requirements is met as far as I can tell by the situation set up in the law.

Dr. Roth. Except one, sir.

Senator Bennett. What is that?

Dr. Roth. That is our stress—I will have it in a moment.

This is the resolution that has the three sections.

Senator Bennett. I can supply it to you if no one else can.

Dr. ROTH. I am sure we have it here. But at any rate, I am familiar with it enough to point out the single exception. And that is the stress that these be used as guides. This is the thrust of the amendment which we propose. And the specifics of the language that raise some concern are in section 1156–A of the act, which says that these norms shall be used as principal points of evaluation and review. It is interesting to us that the PSRO manual, as it has just been distributed, departs from this language too and points out that it would be more appropriate for an initial point of evaluation that is not the principal point by which the appropriateness of the treatment shall be judged. We think there is a profound difference in the actual facts of the practice of medicine between these two stages.

Senator BENNETT. I think this is an exercise in semantics. I think you will find that when you come to consider the way the norms are used as instruments and have been used by those who have actually used them, the law is quite adequate.

Dr. ROTH. We will be very happy to see that the PSRO manual makes this switch in approach. So we would interpret this action as hopefully being eventual support.

Senator BENNETT. I think the amendment is superfluous. The committee report refers to them as checkpoints, and all the way through we who have worked on the program considered them simply to be trigger points, points of comparison.

ISSUE OF CONFIDENTIALITY

I would like to move before my time runs out back to this kit. On page 10 of the speech in the kit you devote the entire page to the issue of confidentiality, and say—you end by saying:

Lest anyone think I am being melodramatic on this point, I remind you of the growing abuse of privacy by government, by industry, by credit rating bureaus, and by unwitting computers.

Based on your knowledge of millions of millions of medicare patients and their treatment, how many have complained to you that their privacy has been violated?

Dr. HUNTER. As an individual practitioner? None.

Senator BENNETT. None. How many have complained to the American Medical Society or to their constituent societies and been referred to the American Medical Society?

Dr. HUNTER. I know of none, sir.

Senator BENNETT. In other words, are you not tilting at a windmill here?

Dr. HUNTER. No, sir. We are trying to act on behalf of our patients. This is not a matter of concern to us, it is a matter of concern for our patients.

Senator BENNETT. The chairman has pointed out that the law has made it possible for clerks and bureaucrats to have access to these records for a long, long time.

Dr. HUNTER. Yes, sir. We do not approve of that either.

Senator BENNETT. And after all of this experience you cannot indicate the existence of any complaints. Now, we think we have strength-

ened the provision against the release, the unauthorized release of confidential material in the bill. But you know that no review process can operate if you can deny the reviewer access to the records he needs to study the review. This seems to me axiomatic.

So I just want to make the point that this issue of confidentiality which was blown up in your kit, has in my mind been blown up out of all proportion to the actual facts as they exist. And the facts as they exist are a pretty good measurement of the risk that exists. I do not know of any better one.

Of course, if you want to approach this problem as some people are approaching the question of nuclear power, if the ultimate situation existed and every patient's files were automatically revealed to the public—maybe that is possible under the law, but following this line of reasoning you reach the point where you cannot legislate against every conceivable situation. And I hope to develop during these hearings the fact that this concern about norms is really a red herring rather than a fundamental problem, because there is no data to support it.

I have no further questions, Mr. Chairman.

Senator TALMADGE. Thank you very much, Dr. Roth, and your associates. We appreciate the contribution you have made to our deliberations.

DEVELOPMENT OF NORMS FOR CARE

Senator BENNETT. We had a discussion during the last exchange about Resolution No. 56. And I think for the sake of the clarity of the record the resolution should appear as part of that discussion.

Senator TALMADGE. Without objection, it is so ordered.

[The resolution and Dr. Beddingfield's prepared statement, with an appendix containing the AMA's suggested amendments, follows. Hearing continues on p. 82.]

NO. 56 SPECIFICATIONS FOR DEVELOPMENT OF NORMS FOR CARE, DIAGNOSES, AND TREATMENT

HOUSE ACTION: ADOPTED

Resolved, That the American Medical Association supports the development of "norms" for medical care as stated in Public Law 92-603 calling for the establishment of "professionally developed norms of care, diagnoses and treatment, based upon typical patterns of practice in its regions," provided such "norms":

1. Have a content which:
   a. Recognizes the separate concern for cost and quality.
   b. Recognizes that medical care often deals with patient problems rather than specific diagnoses.
   c. Recognizes the frequent occurrence of multiple problems in a single patient.
   d. Recognizes the uniqueness of individual patients.
   e. Recognizes the fact of regional variations in medical care patterns, e.g., differences in availability of facilities and services.
2. Have a structure which:
   a. Is developed by organized medicine.
   b. Has major input from national and regional specialty societies.
   c. Is acceptable to the practicing physician at the regional level.
3. Are applied so as to:
   a. Be useful for assessment of professional performance.
   b. Recognize deficiencies in medical care in order to identify appropriate areas for continuing education.
   c. Assure continuing evaluation and amendment of the "norms" by the medical profession.

PREPARED STATEMENT OF DR. EDGAR T. BEDDINGFIELD, JR.

Mr. Chairman and members of the subcommittee, I am Doctor Edgar T. Beddingfield, Jr., a practicing family physician from Wilson, North Carolina.

Mr. Chairman, section 249F of P.L. 92-603 introduced into the Social Security Act an extensive program for the review of health services provided or reimbursed under the Act. The legislation is intricate, with complicated interrelationships. In some respects it sets forth broad policy statements as to the direction of the legislation, in other parts it is quite specific and detailed, while in still others it is ambiguous. It is important to note, also, that the PSRO law is an additional review mechanism which in many cases overlaps previously enacted utilization review requirements as well as similar review procedures which were mandated in other sections of P.L. 92-603. It is not surprising, then, that the law has created a great deal of confusion and misunderstanding. In an effort to resolve some of these conflicts and ambiguities, the American Medical Association has developed amendatory language which is intended to bring the program closer toward its stated goal of professional medical review. At this time I would like to describe some of the problem areas which our proposed legislation addresses.

An area of particular concern has been the nature and development of the "norms of health care services" which would be developed pursuant to Section 1156. It is unclear in the law where the responsibility lies for the development of these norms. Accordingly, the AMA in Section 4 of its proposed amendments would clearly state that criteria of health care shall be identified or developed by each Professional Standards Review Organization giving due consideration to such criteria of care identified or developed by national medical specialty organizations.

There are further conflicts within the present law regarding the application of the "norms." Section 1156 states that the norms would be used as "principal points of evaluation and review." Nevertheless, Section 1167(c) tends to institutionalize the norms of care by purporting to insulate providers and practitioners from civil liability when they adhere to the norms of care. These sections are patently contradictory, and we would anticipate that the net result would be that the norms of care would be viewed as rigid federal minimum requirements. Moreover, the provisions imposing refund penalties on providers and practitioners could also contribute to the rigidity of the norms. Patients and the profession alike are legitimately concerned with the prospect of cookbook medicine. These concerns will continue until the law is clarified. With this object, the Association has recommended that the "norms" should be guides for care and should be clearly understood to be initial points of evaluation and review. Furthermore such guides must not be substituted for the medical judgment of individual physicians in the delivery of health care services. Moreover, the Association is calling for the repeal of Section 1167(c) which seeks to give statutory recognition to the norms as providing immunity from civil suit. In our opinion that provision is not in the best interest of the public or the profession. There should be no compulsion on physicians toward strict adherence to fixed treatment norms.

Another issue of extreme importance relates to the confidentiality of information accumulated and stored by PSRO's. Section 1155(a)(4), for example, requires the development and regular review of patient profiles of care. In other words, the system would have to maintain records of all of the care provided or reimbursed on behalf of some 35 million medicare and medicaid beneficiaries and recipients. Aside from the enormous expense and questionable value of compiling and regularly reviewing this data there is a clear potential for mischief in the very existence of such exhaustive computerized records. We recognize that Section 1166 of the Social Security Act sets forth criminal penalties for the unauthorized disclosure of such information, but statutory prohibition does not assure confidentiality. The American Medical Association urges maximum protection of the public from the very real danger of invasions of privacy. The amendments which are attached to this statement provide appropriate discretionary authority in the PSRO to maintain necessary profiles, while eliminating mandatory universal patient profiles.

Confidentiality is also an essential element of candid peer review. If quality assurance programs are to be effective in promoting discussions within the medical profession and in operating as an effective means of continuing medical

education and of improving patient care, the deliberations and the records of the review committees must be held in the strictest confidence. For these reasons our amendments seek to protect these medical records from discovery in civil litigation.

Proceeding to another point, Doctor Roth has observed that several sections of the law relate to utilization review and quality assurance programs. An unfortunate fact of the last year or so is that conflicting regulatory schemes have been offered under these various and sometimes contradictory provisions. It seems clear that Congress intended for section 249F to be the principal avenue for review of services. Nonetheless, numerous bureaus and agencies have advanced utilization review procedures on the basis of tenuous authority. Intermediary Letters, including requirements for pre-admission approval, have been proposed under the aegis of Section 213. Preadmission approval systems have been proposed under the purported authority of Sections 207, 237 and 239 of P.L. 92-603. These efforts have created confusion that have tended to predetermine the structure and form of the PSRO system and they have alienated large numbers of the profession and the public. The Association therefore submits that overlapping and redundant review authorities be deleted and the amendments so provide.

Consistent with organized medicine's longstanding support of peer review as an effective method of continuing medical education, the AMA recommends that the sanctions and penalties applicable to health care providers and practitioners be made more flexible so that any such sanctions will be related to the gravity of the violation.

As written, the PSRO law (sec. 1157) requires that a violation of *any* obligation must be reported by the PSRO to the Statewide Professional Standards Review Council and forwarded to the Secretary. It is possible, therefore, that all deviations, however minor, would have to be reported to the Statewide Professional Standards Review Council as violations of the Act. We would suggest that a more responsible approach would be to permit the local PSRO to forward only those actions of the provider or practitioner where they show an inappropriate practice pattern or when such actions constitute gross and flagrant violations of the Act.

The Association has also considered the question whether federally provided institutional care (such as care provided or reimbursed through the Veteran's Administration or the Public Health Service) should be within the purview of PSRO review. It was concluded that if improved patient care is to be achieved through this program such improvements should be achieved within the federal system. Our amendment, which is in accord with the substance of a recommendation of the National Professional Standards Review Council, calls for the inclusion of VA and Public Health Service programs within the gambit of PSRO reivew.

Another of our amendments relates to the formation of organizations within the state to provide technical and other assistance to local PSROs. While we are aware that recognition is currently being given to the development of statewide PSRO Support Centers, we are of the opinion that specific authorization should be provided in the law for the creation and recognition of appropriate organizations performing such functions.

The final point that I would make in the limited time available relates to the overall implementation timetable. It is clear that Congress intended that practicing physicians develop the PSRO program. The program could be compromised beyond redemption if the medical profession were expected to meet a deadline which is unrealistic. It is evident that if the intention of the Congress is to be carried out, that is to say, if the medical profession is to be given a meaningful opportunity to establish utilization review and quality assurance programs an extension of time beyond January 1, 1976 must be granted, as the Association recommends in its amendment. Moreover, in the period of time during which fledgling PSROs are formed a study should be conducted to determine when, if ever, organizations other than professional associations should be permitted to conduct the review function.

Mr. Chairman, I have reviewed only a portion of our amendments. Attached to this statement, as Appendix A, is an itemization of all of our recommended amendments. We have also attached, as Appendix B, a draft bill containing recommended text to accomplish these changes.

We thank you for the opportunity of discussing the specifics of the AMA's proposed amendments. I realize this presentation is somewhat lengthy, but as you know this is a most complex issue which requires careful attention and study.

We will now respond to questions which this Committee may have.

Appendix A

MAY 1, 1974.

PSRO AMENDMENTS

The following is a list of amendments to the PSRO law that has been recommended by the AMA Council on Legislation and approved by the Board of Trustees. The policy recommendations set forth below are not in the form of suggested legislative language but rather reflect the substance of the amendments.

(1) The definition of "qualified organization" under Section 1152(b)(1)(A) should be expanded so that organizations, including foundations, designated by medical societies will be specifically eligible for consideration as a PSRO.

(2)(A) Authority for the Secretary to enter into PSRO contracts with groups other than professional associations, as provided in Section 1152(b)(1)(B), should be postponed from January 1, 1976, to July 1, 1978.

(B) The National Professional Standards Review Council should conduct a study to review the extent of professional participation in the implementation of the PSRO program. Such study would be completed by January 1, 1978, and thereupon presented to Congress, at which time Congress could determine whether, and under what conditions, other agencies would be allowed to serve as PSROs.

(3)(A) Section 1156 should be amended to specifically direct the respective PSROs to ascertain and develop appropriate guidelines, (referring to norms, criteria and standards) drawing upon the expertise of national, state, and county medical associations and specialty societies.

(B) The law should be amended to specifically state that such guidelines (referring to norms, criteria and standards) are to be guides only and cannot be substituted for individual professional judgment.

(4) Consistent with policy in opposition to preadmission certification of institutional care, such authority presently existing in the PSRO law should be deleted.

(5) "Regular Review" of Patient and Provider profiles should not be required to be based upon case-by-case analysis of care provided or received. Section 1155(a)(4) should be amended to allow for the review on a sample basis.

(6) Section 1160(a)(3) providing for financial penalties in lieu of termination or suspension should be repealed. A system of graduated sanctions, clearly stating the maximum applicable penalty (such as, a suspension up to 30 days for the first finding by the PSRO that the provider or practitioner has established a pattern of practice which is unacceptable) should be established.

(7) Certain reporting provisions require PSROs to submit to the Statewide Council, for forwarding to the Secretary, all determinations made by the PSRO that a practitioner or a provider has violated any obligations relating to necessity, quality or situs of care furnished (Section 1157 and 1160(b)(1)). These provisions should be amended to require the PSRO to report to the Statewide Council only when it determines that a pattern of practice requires such attention or that a provider or practitioner has grossly and flagrantly violated the obligations imposed under the Act. Such determinations should be made only after a conference with the provider or practitioner in an attempt to seek compliance, and a finding that he or it has shown an inability or lack of desire or intention to comply with the program requirements.

(8) Section 1167 should be amended to provide that the written records of Professional Standards Review Organizations, Statewide Professional Standards Review Councils, and the National Professional Standards Review Council shall not be subject to subpoena or discovery proceedings in any civil action; nor shall the identity of any member, employee, or person providing information, counsel or services be subject to subpoena or discovery proceedings; nor shall the discussion or deliberations of any such organization, council member, employee, or person by subject to subpoena or discovery proceedings in any civil action.

(9) Section 1167 (c) should be repealed. Section 1167 purports (in subsection (c)), to limit the liability of an individual furnishing items or services when

such individual has acted in compliance with the norms of care applied by a PSRO provided that he exercised due care in his conduct. This provision could have the unintended and undesirable effect of pressuring practitioners to adhere to the norms. Moreover, the provision is at best meaningless because on its face it is applicable only when the practitioner has exercised due care—the very issue at the heart of the malpractice issues.

(10) The law should be amended to state the limited functions of the "norms, criteria, and standards" developed thereunder and to define their applicability in civil cases.

(11) Section 1168, referring to the reimbursement of PSRO expenses, should be amplified so that contract applicants will have an accurate understanding as to which organization expenses will be reimbursable.

(12) The law should be amended to provide for the appeal of area designations.

(13) The law should be amended to provide for PSRO review of care delivered through all federal medical programs such as the Veterans Administration and Public Health Service.

(14) Section 1155 (b)(4) should be repealed. PSROs would be authorized under Section 1155 (b)(4) to inspect the facilities in which care is rendered or services are provided by practitioners or providers. Institutions are currently subject to inspection by the Joint Commission on Accreditation of Hospitals, and, moreover, facilities are generally subject to regulation under state and local law. It has been observed that the further requirements of onsite inspections by PSROs would be an unwarranted duplication.

(15) Section 1155 (b)(3) should be repealed. Practitioners and providers are obligated to maintain supporting documentation substantiating the necessity and quality of care provided under Medicare and Medicaid. These record-keeping requirements (Section 1160 (a)(1)(C) are duplicated by an ambiguous authorization under Section 1155 (b)(3) allowing PSROs to "examine the pertinent records" of practitioners and providers. This authority is, at best, redundant and could be the subject of abuse. It should be observed that unrestrained examinations of medical records would jeopardize their confidentiality.

(16) The role of the state medical society should be further augmented by authorizing the Secretary to enter into contracts with the state medical society, or its designated organization, to provide technical and administrative assistance to PSROs in the administration of the PSRO program. Under such contracts, the organization would be reimbursed directly by DHEW.

(17) Section 218 of P.L. 92-603, which describes circumstances under which payment may be made under Medicare for certain otherwise noncovered items and services, and under which recovery can be made from provisions and practitioners, should be repealed.

(18) Provisions of Section 27 of P.L. 92-603, relating to utilization review procedures under Medicaid should be repealed.

(19) Section 229 of P.L. 92-603, authorizing the creation of program review teams should be repealed.

Appendix B

Bill No. ------

In the (Senate) (House) of the United States

Date ------

93D CONGRESS
2d Session

Mr. ---------- of ---------- introduced the following bill: which was read twice and referred

To the ---------- Committee

A BILL To amend Part B of title XI of the Social Security Act to provide a more effective administration of Professional Standards Review of health care services, to expand the Professional Standards Review Organization activity to include review of services performed by or in federally operated health care institutions, and to protect the confidentiality of medical records

Be it enacted by the Senate and House of Representatives of the United States of America in Congress Assembled,

SECTION 1. Section 1151 of the Social Security Act is amended by inserting "(a)" after the designation "Sec. 1151." and by adding a new subsection (b) as follows:

"(b) In order to promote uniformly effective, efficient, and economical delivery of health care services of proper quality in federally-owned and operated health care institutions serving the civilian population, it is further the purpose of this

part to utilize the Professional Standards Review Organizations established under this part to apply suitable procedures of professional standards review to services provided by or in health care institutions operated by the Public Health Service and the Veterans Administration, in accordance with the provisions of Sec. 1155(h)."

SEC. 2. Section 1152 of the Social Security Act is amended—

(a) By amending subsection (a):

(1) To insert "(1)" after the designation "Sec. 1152. (a)" and delete "(1)" and "(2)" in the first sentence.

(2) To add a new subsection (a)(2), as follows:

"(2)(A) The Professional Standards Review Organization areas shall be established or revised by the Secretary after consultation with appropriate professional associations representative of doctors of medicine or osteopathy who are in active practice in the areas affected, such as, state and county medical associations and specialty societies, and the Secretary shall provide an opportunity to all interested persons residing within any state for public hearing with respect to any area within the state in which he proposes to establish or revise a Professional Standard Review Organization area. In establishing or revising any such area, the Secretary shall consider, among other things, recommendations, as provided above, of the doctors of medicine or osteopathy within a state for the establishment of a statewide Professional Standards Review Organization or multiple Professional Standards Review Organizations. An area may be established statewide or as one of multiple areas within a state irrespective of the number of physicians within such area. Where the entire state has been established as a single Professional Standards Review Organization area, the review functions shall be performed locally by local review units approved by the designated Professional Standards Review Organization. When an area designation is proposed as an appropriate area with respect to which a Professional Standards Review Organization may be designated the Secretary shall publish such proposal and allow ample opportunity for public comment and recommendation. Moreover, upon making any such area proposal, the Secretary shall release all relevant data and criteria upon which his recommended area designation is based together with a statement of his rationale for the determination.

"(B) Final determination of the Secretary in the establishment or revision of any Professional Standards Review Organization area shall be subject to review in a civil action commenced by any interested person, without regard to jurisdictional amount, within 60 days following publication of such determination in the Federal Register or within 60 days following enactment of this subsection, whichever is later. Such action shall be brought in the district court of the United States for any district in which the area in controversy is located. If it be shown to the satisfaction of the court that the Secretary has acted arbitrarily, or has not met the requirements in subparagraph (A), the court shall have the power to reverse the determination of the Secretary, to remand the matter to the Secretary for reconsideration and redetermination of the Professional Standards Review Organization area to be established, and to enter any other appropriate relief. The judgment of the court shall be final except that it shall be subject to review in the same manner as a judgment in other civil actions."

(b) By redesignating subparagraphs (A) and (B) of subsection (b)(1) as "(B)" and "(C)", and adding a new subparagraph (A) as follows:

"(A) A private non-profit organization, including a medical foundation, designated by a state medical society of any state to perform in such state the duties, functions and activities of a Professional Standards Review Organization required by or pursuant to this part,".

(c) By changing Subsection (c)(1) to read as follows:

"(c)(1) The Secretary shall not enter into any agreement under this part under which there is designated as the Professional Standards Review Organization for any area any organization other than an organization referred to in subsection (b)(1)(A) or (B) prior to July 1, 1978, nor after such date, unless, in such area, there is no organization referred to in subsection (b)(1)(A) or (B) which meets the conditions specified in subsection (b)(2). In any event, the Secretary shall not enter into any contract designating an organization or entity

referred to in section 1152(b)(1)(C) without the concurrence of the National Professional Standards Review Council."

(d) By changing "subsection (b)(1)(A)" in subsection (c)(2) and subsection (c)(2)(A) to "subsection (b)(1)(A) or (B)".

(e) By adding a new paragraph (3) to subsection (c) as follows:

"(3) The National Professional Standards Review Council shall conduct a study of the designation of professional associations as organizations in the implementation of section 1152 during the period ending June 30, 1977. The study shall provide information for the purpose of evaluating whether, and under what conditions, organizations other than professional associations shall be allowed to perform the review functions as provided in section 1152(b)(2). The study shall be submitted to the Secretary and to the Congress on or before January 1, 1978."

(f) By changing "January 1, 1976," in paragraph (f)(1) to "July 1, 1978,".

SEC. 3. Section 1155 of the Social Security Act is amended—

(a) By deleting all of subsection (a)(2) and substituting the following:

"(2) Each Professional Standards Review Organization shall have authority for arranging for the maintenance (to the extent it deems necessary or advisable for the effective performance of its duties) of profiles of care and services received and provided with respect to patients, with discretion in the organization to provide for their review on a regular, sample, or other selective basis as determined by the organization to be necessary or advisable in the performance of its duties, and to determine with respect to each health care practitioner and provider whether the care and services ordered or rendered are consistent with the citeria specified in clauses (A), (B), and (C) of paragraph (1). In all cases the organization shall utilize in such profiles, to the greatest extent practicable, methods of coding which will provide maximum confidentially as to patient identity and assure objective evaluation consistent with the purposes of this part."

(b) By deleting subsection (a)(3) and redesignating paragraphs (4), (5) and (6) as "(3)", "(4)" and "(5)", respectively.

(c) By deleting all of subsection (b) and substituting the following:

"(b) To the extent necessary or appropriate for the proper performance of its duties and functions, the Professional Standards Review Organization serving any area is authorized in accordance with regulations prescribed by the Secretary to make arrangements to utilize the services of persons who are practitioners of or specialists in the various areas of medicine (including dentistry), or other types of health care, which persons shall, to the maximum extent practicable, be individuals engaged in the practice of their profession within the area served by such organization."

(d) By adding new subsections (h), (i), (j), and (k), as follows:

"(h) Each Professional Standards Review Organization with which the Secretary enters into an agreement under this part shall also, as a part of its responsibility and authority under that agreement, assume responsibility for professional standards review of health care services furnished by or in institutions operated by the Public Health Service and the Veterans Administration in the area which it serves. In carrying out this review, the Professional Standards Review Organization shall utilize the same guides for health care services which are applied to non-federal institutions in the area, making reasonable allowance for differences in the types of patients served and the choice of sites for care available within those federal systems. To the fullest extent feasible, all sections of this part shall apply equally to federal and non-federal institutions review, except that sections 1158 and 1159 shall not be applicable.

"(i) In place of other reporting and review requirements of this part contained in sections 1158 and 1159, Professional Standards Review Organizations charged with reviewing health care provided in such federal facilities shall develop procedures whereby deficiencies shall be brought to the attention of administrators of the hospitals and other federal institutions concerned. At the end of each fiscal year, each Professional Standards Review Organization which is responsible for such review of federal institutions shall present to its Statewide Professional Standards Review Council (or to the Secretary, if no such Council exists) a report indicating the number of cases reviewed for each such institution, the number and type of medically unnecessary services provided, deficiencies in the quality of care provided, and services which could have been provided in a less costly facility with equal medical effectiveness.

"(j) Each Statewide Professional Standards Review Council which receives the reports required in subsection (i) shall review them and, if appropriate, consult with the appropriate hospital administrators, and forward such reports to the Secretary. The Council may, as it deems appropriate, indicate any improvements in effective and efficient provision of services from year to year, and offer such other comments and recommendations as it believes to be pertinent.

"(k) The Secretary, upon receiving these reports from the Statewide Professional Standards Review Councils, shall consolidate the data contained in such reports, separating data relevant to Veterans Administration and Public Health Service institutions, respectively, and shall transmit the data relevant to Veterans Administration institutions to the Administrator of Veterans Affairs. The Secretary shall also make an annual report to Congress on the results of review by professional Standards Review Organization of such federal hospitals, in which such hospitals shall be identified at least by branch of service, state, and size, and shall present appropriate statistical data concerning utilization of resources in such institution in comparison with non-federal institutions within the same Professional Standards Review Organization area together with any recommendations for appropriate changes affecting utilization of services in federal hospitals."

SEC. 4. Section 1156 of the Social Security Act is amended—

(a) By deleting the words "Norms of" in the title thereof and substituting the words "Guides for".

(b) By deleting subsection (a) and substituting the following:

"(a) Criteria of health care shall be identified or developed by each Professional Standards Review Organization, giving due consideration to such criteria of care identified or developed by national medical specialty organizations. Such criteria of care shall be used by the Professional Standards Review Organization as guides of care. Such guides, where appropriate, shall be based upon typical patterns of practice in the Professional Standards Review Organization area (including typical lengths-of-stay for institutional care by age and diagnosis) and used as initial points of evaluation and review; provided, however, such guides shall not be substituted for the medical judgment of individual physicians in the delivery of health care services. Moreover, such guides shall not, in any civil litigation, be applied as evidence of the standard of proper medical care with respect to any treatment in the absence of competent medical testimony. The National Professional Standards Review Council and the Secretary shall make available technical assistance in utilizing and applying such guides to organizations requesting such assistance."

(b) By deleting "norms" in the first sentence of subsection (b) and substituting "guides".

(c)(1) By deleting subsection (c)(1) and substituting the following new paragraph:

"(c)(1) The National Professional Standards Review Council shall provide for the distribution to each Professional Standards Review Organization and to each other Agency or person performing review functions with respect to the provision of health care services under this Act, or under other health care programs covered by this part, of appropriate materials indicating various guides being utilized in other geographical areas. Such data concerning guides shall be reviewed and revised from time to time."

(2) In subsection (c)(2), by changing "norms" to "guides", and by changing "a principal point" to "an initial point".

SEC. 5. Section 1157 of the Social Security Act is amended by deleting the first sentence in section 1157 and substituting the following:

"If, in discharging its duties and functions under this part, any Professional Standards Review Organization determines that any health care practitioner or any hospital, or other health care facility, agency, or organization violates obligations imposed by section 1160 and that a pattern of violations exists from which a finding is made by the organization that the conduct of such person or entity constitutes a substantial violation, then such organization shall report the matter to the Statewide Professional Standards Review Council for the state in which such organization is located together with the recommendations of such organization as to the action which should be taken with respect to the matter. The Professional Standards Review Organization shall make its determination only after providing to the person or entity an opportunity for conference with such organization in an attempt to gain compliance with the obligations imposed by section

1160 and making a finding that such person or entity has shown an inability or lack of desire or intention to comply with such obligations."

SEC. 6. Section 1160 of the Social Security Act is amended—

(a) By inserting in the first sentence of subsection (a)(1) after "under this Act," the first time it appears in that subsection, the following:

"or in the provision of health care services and items by or in health care institutions operated by the Public Health Service or the Veterans Administration,".

(b) By deleting "under this Act—" immediately preceding clause (A) in subsection (a)(1), and substituting:

"under this Act or under the other federal authorities to which this part is applicable—".

(c) By inserting at the end of paragraph (b)(1) the following new sentence: "*Provided, however,* That if there has been no previous imposition of sanctions resulting in termination or suspension under this section, the Secretary's action against such practitioner or provider for suspension or termination shall be limited to a suspension for not more than 30 days of the eligibility of such practitioner or provider to provide health care services on a reimbursable basis under this Act. *Provided, further,* That where sanctions are found to be appropriate with respect to a practitioner or provider acting under the federal authorities enumerated in section 1151, the organization shall forward its report, findings and recommendations to the Administrator of Veterans Affairs or the Secretary of Health, Education and Welfare, as appropriate, and the Administrator or the Secretary shall order appropriate remedial action and notify the Professional Standards Review Organization within 30 days as to the sanctions imposed and remedial actions directed hereunder."

SEC. 7. Section 1167 of the Social Security Act is amended by deleting subsection (c).

SEC. 8. (a) Section 1862(d) of the Social Security Act is repealed.

(b) Section 1866(b)(2) of the Social Security Act is amended by changing the comma at the end of clause (C) to a period, and deleting the remainder of that paragraph ending with "grossly inferior quality.".

(c) Section 1903(i) of the Social Security Act is amended by deleting paragraph (2) and redesignating paragraphs (3) and (4) as paragraphs "(2)" and "(3)".

(d) Section 506(f) of the Social Security Act is amended by deleting paragraph (2) and redesignating paragraphs (3) and (4) as paragraphs "(2)" and "(3)".

(e) Section 1157 of the Social Security Act is amended by deleting the last sentence.

SEC. 9. Section 1879 of the Social Security Act is repealed.—

SEC. 10. Section 1903(g) of the Social Security Act is amended by deleting all that follows after "utilization of such services" in paragraph (1) and precedes the last sentence of that paragraph, and substituting for such stricken material the phrase "in accordance with the requirements of this title."

SEC. 11. (a) Section 1168 of the Social Security Act is amended by deleting the word "and" at the end of subsection (b), by adding "and" at the end of subsection (c), and by adding the following new subsection:

"(d) funds from general revenues to compensate for all expenses attributable to the review and supervision of health care items and services reimbursed or provided under federal authorities other than those within the Social Security Act, such as, those enumerated in section 1151."

(b) Section 1168 is further amended by adding at the end thereof the following: "For the purposes of this part the Secretary shall reimburse organizations for their ordinary and necessary expenses incurred in the performance of their official duties and functions, including, organizational expenses, filing fees, reasonable attorneys' fees, and other expenses set out in regulations of the Secretary. Any Professional Standards Review Organization shall also recover from the Secretary, as a part of its ordinary and necessary expenses, reasonable costs incurred in the course of litigation, as well as such amounts as may be recovered against such organization in the course of any civil litigation, settlement or other resolution of a civil liability claim or other action lodged against such organization (including reasonable attorneys' fees and expenses of litigation) on the basis of its performance of its official duties and functions."

SEC. 12. Section 1166 is amended by substituting therefor the following:

"Sec. 1166. (a) Notwithstanding the provisions of 60 Stat. 238 (5 U.S.C. 552, as amended) or any other provision of law—

"(1) The written records, as well as any other data or information acquired or evidence adduced, or working papers, reports, proceedings, findings or recommendations made with respect to such data, information or evidence of the Professional Standards Review Organizations or any committees or any other agencies performing functions for the organization, of any Statewide Professional Standards Review Council, and of the National Professional Standards Review Council under this part shall be held in confidence and shall not be disclosed to any person except to the extent that may be necessary to carry out the functions and duties imposed under this part; and

"(2) The written words, as well as the date of information acquired or evidence adduced, or working papers, reports, proceedings, findings or recommendations made with respect to such data, information or evidence of the Professional Standards Review Organizations or any committees or any other agencies performing functions for the organization, of any Statewide Professional Standards Review Councils and of the National Professional Standards Review Council shall not be subject to subpoena or discovery proceedings in any civil action; nor shall the identity of any member, or employee of a Professional Standards Review Organization, of the Statewide Professional Standard Review Council and the National Professional Standards Review Council, or person providing information, counsel or services to such organization be subject to subpoena or discovery proceedings for the purpose of obtaining information relating to the written records or data or information acquired or evidence adduced or working papers, reports, proceedings, findings, or recommendations made with respect to such data, information or evidence under this part.

(b) Nothing provided in this part shall prevent the use of the information acquired under this part for research or statistical purposes. However, for such purposes, the name or identity of any patient, practitioner or provider whose records have been studied, or of any member or employee of a Professional Standards Review organization, of the Statewide Professional Standards Review Council and the National Professional Standards Review Council, or any person providing information, counsel or services to such organization shall not be disclosed.

"(c) It shall be unlawful for any person to disclose any information described in subsection (a)(1) other than for such purposes authorized in this part, and any person violating the provisions of this section shall, upon conviction, be fined not more than $1,000 and imprisoned for not more than six months, or both, together with the costs of prosecution."

SEC. 13. Section 1169 of the Social Security Act is amended as follows:

(a) By inserting in the title thereto before "Desiring to Be Designated" the words "Designated Or".

(b) By redesignating clauses (a) and (b) as subparagraphs "(1)" and "(2)".

(c) By inserting "(a)" after the designation "Sec. 1169." and adding a new subsection (b) as follows:

"(b) The Secretary is authorized to enter into a contract with any state medical society or private non-profit organization (including medical foundations) designated by a state medical society for the provision of necessary technical and other assistance in the creation and operation of local professional standards review organizations. The functions of such organization may include assistance necessary for conditional designation as a Professional Standards Review Organization, the preparation of prototype plans and operations, general administration of operational functions set forth in this part, and such other functions as the Secretary may by regulations prescribe. Organizations providing such management and technological assistance and otherwise coordinating and implementing review efforts and advising Professional Standards Review Organizations pursuant to any such agreement will be reimbursed directly by the Secretary to the amount of expenses reasonably and necessarily incurred by such organization in preparing to carry out, and in carrying out, the duties and functions required by such agreement."

Senator TALMADGE. The next witness is Dr. William Campbell Felch, president, American Society of Internal Medicine.

Dr. Felch, you may proceed for 10 minutes. And your entire statement will be inserted in the record.

STATEMENT OF DR. WILLIAM CAMPBELL FELCH, IMMEDIATE PAST PRESIDENT OF THE AMERICAN SOCIETY OF INTERNAL MEDICINE; ACCOMPANIED BY DR. GLENN MOLYNEAUX, PRESIDENT OF ASIM; DR. WILLIAM R. FELTS, TRUSTEE OF THE SOCIETY; AND WILLIAM R. RAMSEY, EXECUTIVE DIRECTOR

Dr. FELCH. Thank you, Senator Talmadge, Senator Bennett and Senator Hansen. I am Dr. William Campbell Felch. The list of witnesses says that I am the president of the American Society of Internal Medicine. Until 3 days ago I held that office. I am now the immediate past president. With me are Dr. Glenn Molyneaux, the newly-elected president of ASIM; Dr. William R. Felts, a trustee of the society; and Mr. William R. Ramsey, its executive director.

The American Society of Internal Medicine is a federation of 51 component societies of internal medicine. ASIM has a membership of over 12,000 internists, most of whom are in practice, delivering primary care or subspecialty care, or both. We have submitted a written statement which describes our credentials in detail. It also contains our position and our concerns in some detail. I will attempt to summarize these in the time available.

ASIM's current position on PSRO was clearly stated just 3 days ago, May 5, 1974, at the society's annual meeting in San Francisco. At that time ASIM's House of Delegates unanimously endorsed a report of board of trustees which, while expressing certain concerns about PSRO, ended with this sentence: "Since it is law, the American Society of Internal Medicine will assist in its orderly implementation and will seek to modify those portions of the law it finds objectionable."

In addition, our house of delegates passed resolutions instructing the board to promote review dedicated to assuring quality, to educate the membership and the public about PSRO, to seek appropriate amendments, and specifically to seek extension of time deadlines for those PSRO's which could be slow in getting started.

These position of ASIM, which, we believe to be unique for a national house of delegates structured medical organizations, represent effort at defining and deliberating the scope and purview of peer review. A detailed list of our activities in promoting peer review before and after PSRO legislation appears in our written testimony. And I will only mention here that these activities include, first, conceptual effort at defining and deliberating the scope and purview of peer review.

Second, educational efforts distributed at our membership and at larger audiences, including a peer review manual and a PSRO guidebook.

Third, research efforts, including a HEW contract to study methodology to evaluate the quality of medical care.

I would like particularly to mention our present involvement along with four other medical organizations, in a major deliberative effort called private initiative in PSRO. In this program, which will provide a neutral and objective evaluation operated in the private sector, is supported by a 5-year grant from the W. K. Kellogg Foundation in excess of $1 million. And the goal of this study is to develop,

test and evaluate the system components of PSRO at six PSRO sites. We anticipate that much useful information will come out of this project, which will eventually be helpful to all PSRO's.

I would not wish to give the impression that we in ASIM find no problems in PSRO. We have definite concerns both with the present language of the legislation and with the potential impact of future regulations. And these concerns are spelled out in detail in our written testimony. They include certain specific recommendations about certain portions of the law, including sections 1155(b)(3), 1156, 1167(c), and 1167 in *toto*.

One proposal I would like to emphasize relates to section 1156, which has to do with norms criteria and standards. Our concern is that this section as presently written could be construed as saying that only those criteria or standards established by the PSRO locally are proper procedure in the practice of medicine. So we propose consideration of the addition of the following statement:

The omission of any portion of a criterion or standard cannot be interpreted as a breach of good medical practice, and the addition of a service not included in a specific criterion or standard does not indicate that that service was inappropriate or unnecessary in the care of a specific patient.

Senator BENNETT. May I interrupt you at that point and say that we feel that that is implicit in the law. But I would be very happy to put the committee on record—put myself, that is all I will do—as being willing to write language of that sort into the law, because it certainly was never the intention of the law to prevent that kind of a situation.

Dr. FELCH. Thank you, sir.

Our broader, less specific concerns of PSRO include reference to such matters as: (1) The possibility that an individual PSRO might fail if a rigid time frame were enforced to January 1, 1976.

(2) The difficulties arising in quality assessment, if chiropractors and other substandard practitioners are included in the review process.

(3) The need for recognition of the burden of the review process, both in terms of dollar costs and of displacement of patient care time.

(4) The maldistribution of this review process. Our belief is that it should equally apply to the Veterans' Administration, the Armed Forces, and the U.S. Public Health Service hospitals.

We would especially like to direct your attention to our two major concerns: (1) That consideration of cost may overshadow the consideration of quality. We believe that administrative responsibility for the implementation of these programs must remain in the hands of health professionals at both the national and local level so that improvement in the quality of medical care remains the primary thrust of the program.

(2) Our second concern is that there could result a growing invasion of the confidentiality of the medical record because of increased involvement of third parties in a review system, particularly when there exists poorly defined authorization for the release of medical information, and at the same time an increased capability for machines to communicate identifiable information about the patient without the knowledge of the patient.

To summarize: (1) ASIM has an established record of continuing support of the peer review concept.

(2) ASIM has thus far viewed the PSRO legislation as an opportunity to implement that concept—if it is properly implemented.

(3) ASIM has concern that governmental involvement in peer review can lead to the development of bureaucratic mechanisms which could interfere with the proper conduct of peer review by the profession.

(4) ASIM has a special concern that PSRO is viewed in some quarters as a cost containment mechanism. When PSRO activity is reviewed in the future, it may well be found that dollar savings are not impressive.

(5) ASIM believes that the ultimate evaluation of the success or failure of PSRO should depend on how well it has served the purpose of upgrading the quality of care for this country's citizens.

We thank you for the opportunity to present these views, and we would be glad to answer any questions.

Senator TALMADGE. Thank you, Dr. Felch.

QUALITY OF CARE DESERVES PRECEDENCE OVER COST

In your statement, you express the concern that quality of care deserves precedence over consideration of cost. It is a statement that I entirely agree with. I think every member of this committee would also.

In your review of the Bennett amendment and the committee report language, did you find any areas where cost cutting was emphasized at the expense of the quality of care?

Dr. FELCH. No, sir, not in that amendment.

Senator TALMADGE. Thank you, sir.

Senator Bennett.

Senator BENNETT. First, let me say, Dr. Felch, that I obviously have not had a chance to study your proposed amendments. I tried to focus on them as they ran by me. Offhand, I can see no objection to any of them. I think I agree with you with respect to them. I think the legislation was intended to cover most of the problems you mentioned. And if it is just to rewrite some words to make it more clear, I see no problem with that.

PATIENTS BENEFIT FROM REDUCTIONS IN UNNECESSARY HOSPITAL CARE

I have a couple of questions. Would you not agree that most patients benefit from reductions in unnecessary prolonged hospital care in terms of avoidance of infarction or embolism, and is this not a kind of quality consideration that is important in this review process?

Dr. FELCH. Yes, sir.

Senator BENNETT. Would you not agree that the prevention of unnecessary service, surgical service, is a quality consideration that also has the positive cost side effect?

Dr. FELCH. Yes, sir.

Senator BENNETT. That is all I have.

Senator TALMADGE. Senator Hansen.

Senator HANSEN. I have no questions, Mr. Chairman.

Senator TALMADGE. Thank you very much, gentlemen, for your valuable contributions to our deliberations.

[The prepared statement of Dr. Felch follows:]

PREPARED TESTIMONY OF THE AMERICAN SOCIETY OF INTERNAL MEDICINE, PRESENTED BY DR. WILLIAM G. FELCH, PAST PRESIDENT, ASIM

SUMMARY

The position of the ASIM is to assist in the orderly implementation of PSRO and seek to modify those portions of the law it finds objectionable.

ASIM has a record of continuing support of the peer review concept including development of manuals and sample national guidelines.

ASIM has been involved in several experimental approaches to review of quality of care and has urged its members to become involved in local peer review organizations and PSROs.

The major concerns of ASIM are that considerations of cost may overshadow considerations of quality; that unequal application of the law may affect quality of care; and that confidentiality of patient information may not be adequately safeguarded.

ASIM recommends development of legislation to provide "due process guarantees," including security, accuracy, provision for change, knowledge of purpose and informed consent.

Other specific concerns are listed, relating to artificial deadline requirements, inclusion of substandard practitioners, centralization of data collection and improper use of physicians in the review mechanism, as well as detailed recommendations in Sections 1167, 1867(c), 1156 and 1155B(3).

STATEMENT

I am Dr. William Campbell Felch, Immediate Past-President of the American Society of Internal Medicine. With me are Dr. Glenn Molyneaux, the newly elected President of ASIM; Dr. William R. Felts, a Trustee of the Society; and Mr. William R. Ramsey, its Executive Director.

The American Society of Internal Medicine is a federation of 51 component societies of internal medicine. ASIM has a membership of over 12,000 internists, most of whom are in practice, delivering primary care or subspecialty care, or both.

From its inception 18 years ago, the American Society of Internal Medicine has been concerned with the overall quality of medical care and the proper utilization of the medical care delivery system.

CURRENT ASIM POSITION ON PSRO

Three days ago, on May 5, 1974, the House of Delegates of the American Society of Internal Medicine endorsed a report of ASIM's Board of Trustee's which reads as follows:

"The American Society of Internal Medicine adheres to its policy that the high quality of medical care deserves precedence over considerations of cost. Professional review by others of similar training and practice interest (Peer Review) is the most effective and most efficient way to evaluate judgments, decisions and actions related to patient care.

"PSRO (Sec. 249F, PL 92-603) appears to represent a law designed to implement an experiment in cost control and quality assurance on a nationwide basis, and perhaps was based upon inadequate pre-enactment trials, data and cost and outcome projections. Since it is law, the American Society of Internal Medicine will assist in its orderly implementation and will seek to modify those portions of the law it finds objectionable."

In addition, the House passed resolutions concerning PSRO as follows:

"*Resolved*, That the American Society of Internal Medicine continue to promote and seek to improve existing professional review procedures dedicated to assuring quality medical care for our patients, and be it further,

"*Resolved*, That the American Society of Internal Medicine continue its campaign to assure public and ASIM membership awareness of all facets of PSRO legislation, and be it further

"*Resolved*, That the American Society of Internal Medicine, through its Board of Trustees and in cooperation with other organizations, seek to amend Public Law 92-603 and, in particular, Section 249F regarding PSRO, and be it further

"*Resolved*, That ASIM seek to specifically amend Public Law 92-603, Section 249F to provide an extension of time if it should be necessary to fully develop a functioning PSRO in all localities of 50 states, Puerto Rico and District of Columbia."

PRE-PSRO ACTIVITIES

The American Society of Internal Medicine first formally declared its interest in the review of medical care in 1966 when its House of Delegates urged its membership to serve on utilization committees of their local medical societies and hospitals. Then, in rapid succession, the American Society of Internal Medicine:

By resolution instructed the ASIM to exert its leadership in the study and develop a methodology to evaluate the quality of medical care.

Endorsed in 1969 the formation of state and local peer review committees and encouraged its members to participate in the action of these committees.

Supported in September of 1970 the intent of PSRO legislation and its overall thrust in the field of peer review.

Emphasized the importance of nationwide implementation of peer review as a means of assuring the quality of medical care for all people.

Expressed to the Board of AMA its belief in the need for nationwide implementation of peer review.

Recommended to the Board of AMA the concept of a national leadership workshop conference to instruct and demonstrate the mechanisms of peer review to the physicians of the country.

Appropriated $50,000 to this end.

Jointly sponsored a national peer review conference in May of 1971.

Developed and published a manual entitled "Peer Review: Background Information on What to Do and How to Do It," describing peer review, its concepts, structure, implementation and goals, and distributed this publication to its component societies for their use in the development and implementation of local peer review committees and organizations.

Reaffirmed in April 1972 its support of peer review as a mechanism which could maintain the quality of medical care while holding the costs of such care within reasonable bounds.

Endorsed the principle that disciplinary action against a physician could best be handled by his own medical society through its peer mechanism.

Stated that disputes between a physician and third parties could best be reviewed by the medical society's peer review committee.

Supported the development of sample national guidelines for medical care and indicated that such guidelines should:

1. Have a content which:
   a. recognizes the separate concerns for cost and quality;
   b. recognizes that medical care often deals with patient problems rather than specific diagnoses;
   c. recognizes the frequent occurrence of multiple problems in a single patient;
   d. recognizes the uniqueness of individual patients;
   e. recognizes the fact of regional variation in medical care patterns, i.e., difference in availability of facilities and services;
2. Have a structure which:
   a. is developed by organized medicine;
   b. has major input from national and regional specialty societies;
   c. is acceptable to the practicing physician at a regional level;
3. Be applied so as to:
   a. be useful for assessment of professional performance;
   b. recognize deficiencies in medical care in order to identify appropriate areas for continuing education;
   c. assure continuing evaluation and amendment of the "norms" by the medical profession.

EXPERIMENTATION IN QUALITY ASSESSMENT

The American Society of Internal Medicine has also been involved in several experimental approaches to reviewing the quality of care:

In 1970, the American Society of Internal Medicine was awarded a contract by the Department of Health, Education and Welfare to develop a methodology

to assess the quality of medical care in the ambulatory setting. This study has been completed and now is a matter of public record.

The ASIM has also been an active participant with the American Academy of Pediatrics, the American Academy of Family Physicians and the American Medical Association in the development of a methodology to assess the quality of medical care during childhood and youth.

The American Society of Internal Medicine is currently involved with four other medical organizations in a major collaborative effort called Private Initiative in PSRO. This program, which will provide a neutral and objective evaluative effort operated in the private sector, is supported by a two-year grant from the W.K. Kellogg Foundation for $1,013,378. The goal of this study is to develop, test and evaluate all the elements and components of PSRO systems.

POST-PSRO ACTIVITIES OF THE AMERICAN SOCIETY OF INTERNAL MEDICINE

Since the enactment of Public Law 92–603, the American Society of Internal Medicine:

Has encouraged its members to seek representation of internists in local, state and regional groups concerned with assuring quality medical care through the implementation of Section 249F of that law.

Organized a PSRO Task Force charged with monitoring all PSRO activities.

Resolved that "The American Society of Internal Medicine should steadfastly maintain that the quality of medical care of patients must supersede all considerations of cost; that the Peer Review Committee of ASIM provide guidelines for PSRO activity in internal medicine, and that component societies be urged to actively seek appointment to local PSRO's and attempt to have ASIM guidelines accepted as the standards for internal medicine."

Established in November 1978 the Policy "that ASIM advocates peer review as proper procedure to achieve quality assurance for medical care. Section 249F of Public Law 92–603 is built upon the concept of peer review, but this law has not yet been *proven* to be a adequate administrative or legal device to assure the proper development and utilization of the peer review process. The ASIM emphasizes that partial or complete failures of individual PSRO's should not be automatically interpreted as a failure of peer review."

Reaffirmed this policy in February of 1974.

Submitted a set of sample national guidelines for medical care to the American Medical Association for use by its PSRO Task Force.

Published early in 1974 a manual entitled "PSRO: A Guide to Its Implementation Through Peer Review." Both handbook and guidelines have been made available to the profession.

Actively participated in PSRO activities with the Executive branch of government, the National Professional Standards Review Council, the American Medical Association's Task Forces and their parent Advisory Committee on PSRO.

Found that members of our federation throughout the country are involved in start-up efforts for PSRO's.

GENERAL CONCERNS OF PSRO DEVELOPMENT AND IMPLEMENTATION

The American Society of Internal Medicine has a number of broad concerns about PSRO:

That considerations of cost may overshadow considerations of quality. We believe administrative responsibility for the implementation of these programs must remain in the hands of health professionals at both a national and local level, so that improvement in the quality of medical care becomes the primary thrust of these programs.

That there could result a maldistribution of quality assessment, and therefore of quality care, because of the lack of equal application of the provisions of the law. We believe that those mechanisms of review that have been designed to assure quality and contain the cost of medical care should be applied equally in the core city as well as the VA hospital, in suburbia as well as the U.S. Public Health Service and military hospitals.

That there could result a growing invasion of the confidentiality of the medical record by increased involvement of third parties in the review system. These concerns are heightened by poorly defined authorization for the release of med-

ical information and by the increased capability of machines for communicating interrelated identifiable patient information without the knowledge of the patient. The ASIM recommends development of appropriate legislation to provide "due process guarantees" including security, accuracy, provision for change, knowledge of purpose and informed permission for use.

That a requirement to implement fully provisions of Section 249F in their final form on January 1, 1976, may lead to confusion, inefficiency, excessive cost and even possibly to the failure of individual PSRO's. We believe that Section 249F be implemented gradually, taking into consideration that various experimental models now in development and operation and the wide variation in professional expertise existing in various geographic areas of the country. We believe that intelligent and effective implementation should take priority over attempts to meet an artificial deadline that may lead to failure to fulfill the purpose of the law.

That a lowering of the total quality of health care may occur by including chiropractors and other substandard practitioners of the healing arts in federally financed programs. The inclusion of such practitioners in review efforts could distort the overall statistics by which medical practitioners of medicine and osteopathy are judged, producing an unwarranted bias in the analysis of the overall quality and cost of medical care. We believe that, if these practitioners must be included in federally financed health care programs, statistics of the quality of their practice and their utilization of the medical care delivery system should be separately identified items.

That centralization of data collection under the bureaucracy poses several potential problems, especially unwarranted intrusion on the privacy of the individual. We believe that data collection, source of data capture, points of data conversion and edit, data merging, location of data storage, information development and distribution must be the responsibility of each individual PSRO and that such data are the sole property of each PSRO. We also believe that only such data as are necessary to fulfill the purpose of the law should be made available by the local PSRO to other organizations or levels of government and this data should not have the potential for individual patient identification.

That improper utilization of physicians in the review mechanism could have an adverse influence on an already overburdened medical care delivery system. It has been estimated that it could take one physician to review every 250 physicians in this country, which extrapolated, would require 1,200 full-time physicians involved in the review process. We believe that adequate staffing and electronic data processing should be made available to the physicians involved in the review process in order to increase the efficiency of their operation.

That the substantial total administrative and review costs of PSRO programs may be included in accounting of the direct costs of medical care. We believe that administrative and review costs must be kept as separate and identifiable budget items.

That the implementing regulations dealing with variations from PSRO norms could over-emphasize punitive aspects. We believe that physician evaluative mechanisms should lead, whenever possible, to a process of continuing medical education so that the overall quality of medical care can be improved.

SPECIFIC CONCERNS WITH LANGUAGE OF PSRO LEGISLATION

In addition ot the broad concerns, ASIM has specific and detailed concerns:

That Section 1167 fails to give immunity to PSRO records in legal actions. We recommend that the written records of a Professional Standards Review Organization should be made not subject to subpoena or discovery proceedings in any civil action.

That Section 1167c, pertaining to "due care," may have the unwarranted effect of influencing certain practitoners to adhere over-zealously to norms of care developed by PSRO's rather than exercising proper clinical judgment. This may lead to over-utilization of the medical care system and can not be interpreted as being "due care." We recommend that this Section of the law be further defined so as to separate those provisions that are specifically protective of providers from those provisions that may tend to encourage certain providers of medical care to practice "cook book medicine."

That Section 1156, having to do with norms, criteria and standards, may interfere with the quality of medical care and the utilization of the health

care system by implying that only those criteria or standards established by the PSRO are proper procedures in the practice of medicine. We recommend that this Section be amended to contain the following statement:

"The omission of any portion of a criterion or standard cannot be interpreted as a breach of good medical practice and the addition of a service not included in a specific criterion or standard does not indicate that that service was inappropriate or unnecessary in the care of a specific patient."

That Section 1155B(3) makes the medical records of all patients cared for by a practitioner or provider of medical services available to examination by the PSRO without concern for the source of financing of that medical care. We recognize that a local PSRO has an obligation to examine the medical information as it pertains to the utilization of the medical care delivery system and the quality of medical care rendered to a patient whose medical care has been financed by a federal program. We recommend that this Section of the Law be amended so that the medical records of patients not involved in federally financed medical care programs will be secure from examination by PSRO's.

CONCLUSIONS

(1) ASIM has established record of continuing support of the peer review concept.

(2) ASIM has thus far viewed the PSRO legislation as an opportunity to implement that concept—if it is properly implemented.

(3) ASIM has concern that governmental involvement in peer review can lead to the development of bureaucratic mechanisms which could interfere with the proper conduct of peer review by the profession.

(4) ASIM has a special concern that PSRO is viewed in some quarters as a cost containment mechanism. When PSRO activity is reviewed in the future, it may well be found that dollar savings are not impressive.

(5) ASIM believes that the ultimate evaluation of the success or failure of PSRO should depend on how well it has served the purpose of upgrading the quality of care for this country's citizens.

Senator TALMADGE. The next witness is Dr. John C. Taylor, president of the American Osteopathic Association, accompanied by Dr. Frank McDevitt, chairman of the Committee on PSRO's.

Doctor, you may proceed, sir. Your entire statement will be inserted in the record, and you may summarize it.

STATEMENT OF DR. JOHN C. TAYLOR, PRESIDENT, AMERICAN OSTEOPATHIC ASSOCIATION; ACCOMPANIED BY DR. FRANK McDEVITT, CHAIRMAN OF THE COMMITTEE ON PSRO'S

Dr. TAYLOR. Thank you, Senator, Senator Bennett, and Senator Hansen.

Mr. Chairman and distinguished members of the committee, I am John C. Taylor, D.O., a practicing osteopathic physician from Kansas City, Mo., and I am privileged to serve as president of the American Osteopathic Association. With me is Frank McDevitt, D.O., a practicing osteopathic physician from Livonia, Mich., and who is the chairman of the American Osteopathic Association's Committee on Peer Review.

At the outset, I would like to express our gratitude for the committee's invitation to share the views of the osteopathic profession on what is perhaps the most important medical legislation adopted to date.

The osteopathic profession delivers high quality, efficient, and uninterrupted medical treatment to thousands of patients each year

through the efforts of 15,000 D.O.'s and 250 osteopathic hospitals providing 25,000 patient beds. The eight existing schools of osteopathic medicine will produce approximately 5,000 new physicians in the next 5 years.

The committee is certainly aware that there have been rumblings within the medical community regarding uncooperative intentions and petitions for repeal of the provision. While we cannot speak for every individual osteopathic physician, or every State and local osteopathic society, we can say that "the position of the American Osteopathic Association is now, as it has been since the inception of this legislation, one of support and cooperation."

We feel that the objectives of the law are commendable and we applaud the efforts of Congress directed at affording the organizations of the health professions the opportunity to review the professional activities of their peers. We are confident that physicians can successfully monitor their own performance is based upon our experience with peer review in the osteopathic profession; and our confidence that this legislation will be fully and effectively implemented is based on our belief that the greater number of physicians in this country have considered peer review to be a professional responsibility long before it became a legal obligation.

In the osteopathic profession we have had formal peer review mechanisms for 25 years, through our State and local associations, and since 1970, through resolution of our house of delegates, the American Osteopathic Association has endorsed the widest possible use of peer review mechanisms.

Accordingly, not only do we support the principle of peer review, as provided for in Public Law 92-603, we insist upon our full participation thereunder.

We are prepared and have attempted to take a position of leadership in the implementation of this law and our comments today are made in that context.

While most of the recent discontent surrounding PSRO has been precipitated by misunderstandings of the law (some of which has stemmed from willful misrepresentations by misguided individuals bent on impeding implementation of the law rather than seeing to its fair application), there are some areas of the law at the implementation stage which give rise to legitimate concern.

We would like to highlight briefly a few areas which have come to our attention and which we believe may measurably enhance the smooth implementation of professionals standards review.

We have received several complaints from State and local osteopathic associations that a given area designation does not correspond to logical or existing medical service regions. Some of these problem designations were commented on prior to the adoption of the final area designations. It can only be assumed that either physician input was disregarded in those instances where no modification was made, or that there were some overriding considerations for maintaining apparently less than optimal review areas. If the former premise prevails, it is most unfortunate; if the nonresponsiveness was predicated

on the latter then perhaps an explanation was in order, but not forthcoming.

To expand further on the point we have just raised, it is our feeling that many of the problems in the early implementation of the program have resulted from a failure on the part of the Department of Health, Education, and Welfare to promptly disseminate clear information to the practicing physician regarding his rights and responsibility under the law. In short, there has been a public relations breakdown, which has been aggravated by the antagonists we have referred to above.

The American Osteopathic Association has attempted within our means to fill the void of reliable information to our membership. However, as the committee is aware, our association represents only a fraction of the physicians subject to the law.

Looking prospectively, we would ask the committee to take any steps necessary to insure that there is no dichotomy in the administration of PSRO which will tend to establish two independent and not necessarily consistent criteria for the program's effectiveness, namely, quality assurance and cost control. The promise of the legislation was that there would be peer review and not fiscal review. Accordingly, we are unalterably opposed to the vesting of any administrative powers outside of PSRO.

In concluding, we would urge that careful scrutiny be given to any regulations adopted in order to safeguard the interests of both the recipient of health care services and the provider. Further, we would like to underscore the osteopathic profession's concern that maximum assurance of absolute confidentiality of patient records be preserved at all costs and parenthetically, according to Senator Bennett's statement today we feel much better in that respect.

Mr. Chairman, this concludes our formal remarks. Again, we would like to thank the committee for the opportunity to testify before you this morning. We will be pleased to answer any questions which the committee may have.

Senator TALMADGE. Thank you, Doctor.

DISTINCTIVE ASPECTS OF OSTEOPATHIC PRACTICES

Are you satisfied that the distinctive aspects of osteopathic practices are adequately recognized at this point in PSRO?

Dr. TAYLOR. May I refer that question to Dr. McDevitt, who is our representative on the PSRO?

Dr. MCDEVITT. Thank you, Dr. Taylor.

To this point we have been very well satisfied. The Department of HEW has been very receptive to our questioning, and have responded well. And Senator Bennett made himself personally available for questioning. And we were very appreciative of this. And to this point we feel that we are very pleased with the response that our distinctiveness lead us to.

Senator TALMADGE. Senator Bennett.

Senator BENNETT. My question dovetails with yours. Do you think that osteopathic physicians will have any unique difficulties under the present structural arrangement that has been set up to put PSRO's into operation?

Dr. McDevitt. We do have many concerns in this area. Very briefly, as you know, there are only 15,000 osteopathic physicians in the country. Some States with large osteopathic populations have minimal or a paucity of DO's or where there may be only 7 to 10. It is our position, of course, that only one osteopathic physician is a significant number. And we are concerned of the possibility that these physicians, maybe 10 to 12 in one State, may not even have any type of recognition into this PSRO structural arrangement.

So we do have these concerns. And at the present time, we are expressing these concerns to proper people in the HEW. And in the time that we have been involved it has helped.

Senator Bennett. I hope in every State you have at least two so that you have one man to review the other.

Dr. McDevitt. Senator Bennett, I might also suggest that in some of these States there could be four or five States combined together to do that very thing.

Senator Bennett. That is a possibility.

I have no further questions.

Senator Talmadge. Senator Hansen.

Senator Hansen. No questions.

Senator Talmadge. Thank you very much, gentlemen. We appreciate your contribution.

(The prepared statement, with attachment, of the American Osteopathic Association, follows:)

Testimony by the American Osteopathic Association Presented by John C. Taylor, D.O., President, and Edward P. Crowell, D.O., Executive Director

Mr. Chairman and Distinguished Members of the Committee: I am John C. Taylor, D.O., a practicing osteopathic physician from Kansas City, Missouri, and I am privileged to serve as the President of the American Osteopathic Association. With me is Edward Crowell, D.O., an osteopathic physician and Executive Director of the American Osteopathic Association.

At the outset, I would like to express our gratitude for the Committee's invitation to share the views of the osteopathic profession on what, perhaps, is the singularly most important health issue of our time.

The osteopathic profession delivers high quality, efficient and uninterrupted medical treatment to thousands of patients each year through the efforts of 15,000 D.O.'s and 250 osteopathic hospitals providing 25,000 patient beds. The eight existing schools of osteopathic medicine will produce approximately 5,000 new physicians in the next five years.

In February of this year, the Board of Trustees of the American Osteopathic Association reaffirmed the profession's support for the concept of a National Health Insurance program. This resolution, which you will find attached to the end of this statement, is substantially the same as the one adopted by the AOA House of Delegates in July 1970, and again in July 1971.

Our remarks today will be directed toward specific provisions of S. 2513 (Long-Ribicoff), S. 2970 (Administration), S. 3286 (Kennedy-Mills), and S. 444 (Medicredit) as they relate to the basic principles our association has supported in its resolution.

This association is committed to the position that health care is a basic right and that the benefits of modern medical science and of technology should be available to all citizens. We are aware that health care services are lacking in rural and inner city areas. We agree that a major effort must be made to reach out to those who have been denied health care for economic, social or geographic reasons. We would hope this would not result in and perpetuate a separate system for the poor and underprivileged.

If an optimal, or near optimal, state of health is to be reached, the national health care program must be comprehensive and include preventive, health maintenance, diagnostic and treatment, restorative and protective services. Additional

public and private financing of health care services alone will not guarantee that these will be available, acceptable and accessible to all people. We are opposed, therefore, to some proposals for National Health Insurance heretofore introduced which have addressed themselves merely to providing more public funding to meet the cost of care. This kind of health insurance plan would in no way guarantee the quality of care rendered, which is a matter of monumental importance to the osteopathic profession.

It appears that one of the major decisions Congress will have to make in drafting a National Health Insurance law is the manner in which the program will be administered. Whether the plan should be built within existing Federal agencies or under the auspices of a totally new and distinct Federal entity, and whether private insurance carriers will play an active role in the coverage offered merits careful scrutiny.

We believe that the interest of both patient and provider will be best served by refining and building upon the administrative structure which has developed under Medicare and Medicaid. We hope that the transition to Federally underwritten health care will not be disruptive to the delivery of health services or unduly complex and expensive to administer. For that reason, and because the private insurance industry has demonstrated its capability to effectively intermediate, our association would support the continued reliance on the private health insurance industry to act as the carrier for national health insurance coverage rather than building a Federal insurance bureaucracy.

While we do not have strong feelings regarding the detailed financing of a National Health Insurance plan, we support the approach of deductibles and co-insurance. Nevertheless, we are concerned that these payment provisions, as embodied in S. 2970 and S. 3286, could represent more money for health care than the majority of American families can afford, We fear that the deductible and co-insurance provisions may discourage the consumption of preventive and health maintenance services.

Our profession recognizes the convenience of the health card approach, however, we would hope that any identification system developed will not be discriminatory to the indigent.

A provision in the Administration's proposal, S. 2970, which would mandate the reimbursement rate for prescription drugs to be at the same level as that of the lowest comparable drug is of concern to us. It is our belief that only the practicing physician who has the knowledge of what he can expect from a given therapeutic agent, as used in the treatment of a given illness and with respect to various types or classes of patients should determine the drug administered. His clinical experience permits him to select the drug which will be most efficacious and best tolerated by a given patient. We understand that this provision would theoretically not preclude the physician from prescribing any drug he believed to be most appropriate, but rather "only" deny reimbursement if it was not the lowest cost drug alleged to be comparable. We believe that the practical effect of non-reimbursement will be to discourage the prescribing of *the* most efficacious drug which we insist is the patient's right.

Of paramount interest to the osteopathic physician with the advent of a universal health care plan is that the following principles must be retained: choice as to location and type of practice, input into the establishment of their fees and the method of payment for services rendered and the right to set the standards of their peers (including continuing medical education, certification, re-certification and PSRO).

While we are certain that all of the drafters of the legislation before this Committee share our concern for the protection of these basic rights, we would note that the language of S. 3286, comes closest to an articulation of our views in this regard. We further note that Senator Kennedy's bill makes specific and forceful assurance of the right of free choice of physician, which we applaud. We firmly believe that a national health care program should avoid dehumanization of health care delivery, the destruction of existing physician-patient relationships or the opportunity for the patient to discriminate among prospective providers.

Our profession shares the Committee's grave concern over the devastating effects of catastrophic illnesses or accidents, which often leave the stricken family in financial ruin. Therefore, we urge that the plan adopted by the Congress contain a provision which will protect the American family against the prohibitive costs of a medical disaster.

We believe that the provisions of the Long-Ribicoff bill, S. 2513, would most appropriately respond to this important aspect of health insurance coverage, whether enacted as a free-standing measure or as part of a broader NHI law.

We would note here that the Administration's bill has placed heavy emphasis on HMO's as an elective alternative for those covered. While we support the concept of HMO as a possibly desirable delivery method, we would enjoin caution in placing heavy reliance on them until they have proven their effectiveness through utilization in a broader sense than in the past.

With respect to the scope of benefits provided by a program of National Health Insurance, we would like to underscore our enthusiastic support for the provisions in S. 3286, S. 2970 and S. 444 relating to coverage for preventive medical services. As we have alluded to above, the osteopathic profession is convinced that the answer to the elevation of the Nation's health can only be effected through a comprehensive, systemic program of preventive medicine.

In concluding, we would be remiss in failing to observe that it seems implicit in the broader extension of health insurance that there will be a corresponding rise in the demand for health services. Accordingly, we would respectfully suggest that a part of the consideration of a national health insurance plan should be the consideration of augmented Federal support to medical education, to insure that adequate numbers of competent medical practitioners will be available.

Mr. Chairman, this concludes our formal remarks. Again, we would like to thank the Committee for this opportunity to testify before you this morning. We will be pleased to answer any questions which the Committee may have.

Resolved, That Memo H–July/71–83, as amended by the AOA Board of Trustees in February 1974, (National Health Insurance Statement) be adopted:

Whereas, the American Osteopathic Association House of Delegates in 1970 supported the concept of a Program of National Health Insurance, and

Whereas, there are several bills proposing various National Health Insurance Plans presently being considered by the United States Congress; therefore, be it

Resolved, That the American Osteopathic Association communicate with appropriate governmental bodies to insure representation in the planning stages of any Program of National Health Insurance, and be it further

Resolved, That although our Association favors a program of National Health Insurance, we refrain from endorsing specifically any of the myriad health insurance proposals now before Congress and from presuming to propose a program of our own. The expertise of this profession lies in the delivery of quality health care, not in the field of legislative drafting and advocacy. However, it is our considered opinion that in planning any Program of National Health Insurance, the following recommendations shall be incorporated:

1. To the end that the American people may enjoy the highest caliber of health care, any Program of National Health Insurance shall vest in the various health professions responsibility for establishment and enforcement of standards for continuing education of health personnel, certification of medical personnel to specialty bodies, and professional standards review; since only the health professions are best equipped to make enlightened decisions in those areas.

2. Recognizing that the pursuit of adequate health care is a human right, not merely a privilege, we believe that any Program of National Health Insurance shall assure access to comprehensive and continuous health care services of high quality for all citizens.

3. The principles of universal coverage of all necessary health services and free choice of physician and institution shall be central to any plan for National Health Insurance coverage.

4. All committees involved in planning and delivery of a Program of National Health Insurance shall have equal representation from consumers institutional providers and physicians (D.O., M.D., and related health professionals) in active practice.

5. The institution of any Program of National Health Insurance shall be accomplished, insofar as is practical, through building upon the strengths of the existing delivery system rather than inauguration of a new system which would be untested and wholly foreign to patient, physician and institutional provider.

Any Program of National Health Insurance shall include a reaffirmation of the free-enterprise system whereby a physician is free to choose his own location and type of practice,

6. Method of payment for services rendered shall be the decision of the individual provider of service. Payment for services shall be for reasonable hospital charges and for usual, customary and reasonable physician's fees. Per capita assumed risks, as in the Health Maintenance Organization (HMO) concept, could be preserved if proven effective.

7. An effective system of true peer review at the local level, to insure the highest quality of health care at reasonable cost, shall be incorporated into the program.

8. Any Program of National Health Insurance shall include an efficient and effective system of primary health care.

9. Any Program of National Health Insurance shall place major emphasis on a comprehensive program of preventive medicine, including coverage of all diagnostic, therapeutic and preventive medical services.

10. Any Program of National Health Insurance shall include a plan to offset the costs of major or catastrophic illness.

11. Any Program of National Health Insurance shall include an efficient and effective system of emergency medical services.

12. Any Program of National Health Insurance shall encourage the fullest participation of all of our country's physicians. High priority must be given to a paralleled program to assure the availability of health care manpower, and ease of entry into the health care system.

Senator TALMADGE. The next witness is Dr. Joseph F. Boyle, speaker of the California Medical Association house of delegates, accompanied by Dr. Stanley A. Moore, president.

STATEMENT OF DR. JOSEPH F. BOYLE, SPEAKER OF THE HOUSE OF DELEGATES, CALIFORNIA MEDICAL ASSOCIATION, ACCOMPANIED BY DR. STANLEY A. MOORE, PRESIDENT, AND PAUL BROWN

Dr. BOYLE. Senator Talmadge, Senator Bennett, and Senator Hansen, I am Dr. Joseph Boyle, speaker of the house of delegates of the California association. I practice internal medicine in Los Angeles, Calif.

With me is Dr. Stanley A. Moore, a radiologist from San Diego, who is president of our association. And Mr. Paul Brown of our staff.

In March of 1974, the California Medical Association house of delegates adopted three resolutions which in part state that there is a renewed dedication to voluntary peer review in California directed toward maximum assurance of quality medical care for all of our patients.

Second, that we expected concerted opposition to PSRO through every legislative and legal means available to us.

And three, that our association actively seek repeal of the PSRO law. It is important that you understand that these resolutions were not adopted in hasty emotional debate but rather they were the product of almost 1½ year of discussion all over our State involving many thousands of conscientious, sincere private practitioners in all fields of medical specialties and almost the entire spectrum of medical practice from rural communities to urban medical centers and the staffs of university teaching institutions. These resolutions accurately reflect the sentiments of the overwhelming majority of our 25,000 members. A more detailed exposition of our reasons for this is before you in our written testimony. In the time available to us, I will briefly state some of those reasons.

First, we believe that it is unecessary to implement this law to accomplish its purposes. And its implementation will destroy the effect of the existing programs.

Second, it will subject medical practice to a stultifying recommendation in time and restriction that will seriously threaten the quality of all medical care, beginning with medicare, medicaid, and federally financed child health care, but ultimately involving all patients regardless of how their care is financed.

And third, we do believe that it will seriously jeopardize the confidentiality of private medical records.

Insofar as the need for PSRO is concerned, as Senator Bennett has taught or has so aptly pointed out, all the means for utilization review already exist in other statutes. Beyond this, as many members of this comittee know, in California, as well as in other States in this country, a very effective and steadily improving system of voluntary peer review currently addresses itself on a daily basis. Literally thousands of private practitioners at the local hospital or medical societies level regularly scrutinize all phases of medical practice both for quality assurance and appropriateness of utilization. Statewide in California, these functions are regularly monitored by our association's hospital survey program. And they are now being evaluated and integrated in a coordinated program of statewide peer review.

Our hospital medical staff survey program given in 1961 is now nationally recognized as being replicated by other States and is now in its second year the combined survey of JCAH, and its approval is now recognized by the California State law as meeting quality of care requirements for licensures of all health care facilities in our State.

Since 1971, the California Medical Association Peer Review Commission has further refined with the integration of all local review functions, and does provide a scientific evaluation of both medical value to patients, differing modes of care, and appropriate levels of utilization.

Parenthetically, it should be noted that this is all voluntary; second, financed out of our own resources; and third, is available to individual patients, physicians, hospitals, and health care institutions and governmental agencies.

And fourth, is applied without distinction to member and nonmember physicians alike without bias as to whether or not they pay dues or participate in association affairs.

By contrast, PSRO mandates the destruction of this voluntary review process. There will be established in our State 28 new entities, over 200 nationally, with little or no relationship to existing medical associations, and with such sweeping authority as to destroy existing voluntary review programs.

I might point out in this that the authority as we see it vested in the PSRO legislation, does allow the Secretary to waive all review by medical society or hospital staffs, or does allow the Secretary to waive review by the CMA-JACH survey programs once PSRO is imposed.

And while it is a fact that section 1115(e)(1) seems to require that the PSRO accept the work products of existing review mechanisms, the scope of this requirement is extremely limited. In no way is it applied to preadmission certification, and in no way relates to the review and approval of long-term care for chronologic illness or the management of complex diagnostic and therapeutic management of a seriously ill patient. Moreover, sufficient broad discretion is granted the Secretary in regulations that define compliance or noncompliance

within review process as to make local autonomy of even limited peer review illusory at best. While we recognize the sincerity of Senator Bennett in the manner in which he has put this law together, he is relying on the integrity and upon the role to be played by many Secretaries in the future and in fact by a Senate Finance Committee which Senator Bennett will no longer be a member to monitor.

We note also under section 1155(a)(b) a member of a local hospital staff would not be ordinarily permitted to conduct the peer review program of that hospital. There is no question in our mind that the effect of 249F of Public Law 92-603 will be the destruction of existing review programs.

We have serious concerns with respect to the "norms of care." And although it has been labeled as untrue that there will be a national "cookbook" for the management of each diagnostic and therapeutic problem, it is exactly what section 1156 of PSRO seems to demand. While it seems that there will be professionally developed norms of care based upon typical patterns of each region, it proceeds then to say that in accordance with section 1156(c), the National Professional Standards Review Council shall provide materials indicating the regional norms to be utilized, and that the approval of the National Professional Standards Review Council of norms of care, diagnosis and treatment, shall be based on its analysis of appropriate and adequate data.

And section 1155(c)(2) says that each review organization, agency or person shall utilize the norms developed under this section as principal points of evaluation and review for any health care services which have been or are proposed to be provided. Even the loose application of these stringent requirements will without any question instantly subject the use of these norms for the application of individual physician judgment, either because of the absolute prohibition of deviation from these norms, or because of the onerous task of explaining variations for at least 50 percent of all of our patients for whom care is provided or proposed to be provided. What is euphemistically referred to as local review with regional norms in fact becomes adherence to norms that have been nationally developed. When we consider the complex variation of diagnostic and therapeutic situations that exist in a heterogenous population all over this country in the management of a simple common cold, consider the complexity of establishing standards for the management of such a diagnosis in the spectrum of potential patients afflicted: a healthy adult man or woman, working alone or working in a crowded office or in a classroom or nursery or caring for young children at home; a six-months-old infant otherwise healthy or afflicted with cystic fibrosis, allergic bronchitis or other physical or mental impairment; an adult or child with an assortment of associated chronic illnesses that run the gamut from bronchial asthma to concomitant renal dialysis or markedly impaired immuno-suppressive mechanisms associated with drugs used in renal transplant or in the treatment of extensive cancer, leukemia or a host of other disorders. Consider the expansion of this normative process to the thousands of diagnostic variations and combinations of diseases listed in compedia of diagnostic nomenclature, and you will recognize readily that the medical profession's concern about "cookbook medicine" is more than mere fantasy.

We believe that such norms would have to be so sweepingly broad as to have absolutely no effect, or be so sufficiently narrow as to be indeed restrictive and stultifying.

We believe that over a period of time medical care in this country does change, as it is evaluated in different parts of the country, and as one mode of therapy or diagnosis becomes superior, it is adopted. Modes of medical practice vary substantially all over the United States, and for good reason. Treatment and diagnostic procedures are constantly in a state of change and evaluation. As one mode of therapy acquires clear superiority it becomes adopted by practitioners generally. Practice within the constaints of "norms of care" will cause this evolutionary change and continual evaluation to cease. It will mandate mediocrity aimed at meeting the averages contained in every list that is developed. Innovations in provision of care will only be attempted by the most persistent of physicians willing to endure countless hours of time and frustration explaining to a National Professional Standards Review Council judgments that traditionally have been subject to scientific evaluation by local peer review unencumbered by norms that must be met regardless of the physician's individual competence, training, background, or experience.

We have had substantial experience with prior authorization. And we can tell you with some authority that prior authorization, one, does not contain costs; two, is denied needed care; and three, promotes continuing frustration and irritation in everyday patient management; and four, imposes unnecessary work on the physician and his office staff; and five, encourages the delay of needed care beyond the point where this can be most effectively, safely, and inexpensively provided.

Our concerns with respect to confidentiality we also believe are real. We believe that as the law requires, that there be developed individual personal patients' profiles, and that these be subject to computerization and computer analysis. And as the examination of the data contained in these patients' profiles and the invasion of physicians' offices to examine records continues, there will be a spreading, a sharing of this information regarding a specific individual patient. And yet, Senator Bennett, I have had patients of mine, particularly welfare patients, complain that their confidentiality has been invaded.

It also gives the local PSRO a rather considerable authority, but allows the Secretary to determine the degree to which this confidentiality of records must be met in order to satisfy the needs of the program.

In summary, the California Medical Association has carefully analyzed 249F of 92–603 to determine whether it can be implemented without interfering with the ability of California physicians to provide the best possible care to their patients. We have concluded that it cannot. We have concluded that this law can best be implemented by repealing it.

Senator TALMADGE. I hate to interrupt you at this point, but your entire statement will be inserted in the record, and a synopsis of it will be made available to every member of the committee.

Senator Hansen, any questions?

Majority of California Doctors Seen Opposing PSRO

Senator Hansen. I understood you to say as you began your testimony, Dr. Boyle, that perhaps the majority of the physicians in the State of California opposed PSRO. Did I hear you correctly?

Dr. Boyle. That is absolutely correct, Senator.

Senator Hansen. I have no further questions.

Senator Talmadge. Senator Curtis?

Peer Review in California

Senator Curtis. Doctor, would you distinguish, if you can, what you as a physician would consider peer review in what we have here, PSRO?

Dr. Boyle. Yes, sir. In my written testimony submitted to the committee, we do have an extensive description of peer review as it is conducted in California. Basically, what is conducted is this. At each hospital level there are review committees that regularly examine the credentials of the physicians that staff it, and regularly evaluate the quality of care being provided in that hospital, and regularly review the outcome of care in that hospital. And in California we are now developing a formalized system of a quality audit to allow this to be put in a somewhat more formal fashion and allow each individual hospital staff to develop criteria against which they will measure the performance of their members.

Senator Curtis. This is prior and apart——

Dr. Boyle. This is a continuing review process.

Senator Curtis. Prior and apart from the PSRO law?

Dr. Boyle. We have no PSRO law in California. With respect to utilization review, in the majority of hospitals where I practice, in the area where I practice, and in the majority of hospitals in the State of California now, I believe, what happens is that there is a permanent utilization review committee. The permanent utilization review committee then is augmented each month by temporary review committee members. These review committee members three times a week look at the records of patients at each nursing station or each station in the hospital to determine whether or not that patient is receiving appropriate care, whether or not he or she should receive that care outside of the hospital, and they make these recommendations to the individual physician. Should the physician believe that his patients' care is not being appropriately evaluated, he has an opportunity to either speak to the chairman of the committee or to the committee itself.

Should the committee believe that this physician regularly thwarts its intention or regularly does not follow its directions, they will review his records on a daily basis and will advise him, or her if it happens to be a woman physician, that this patient either should or should not be in the hospital, and this patient should or should not be receiving the mode of care he is receiving. This is on a continuing local basis.

In California, we have medical review commissions that perform this function. We have a State medical survey program which regularly monitors the performances of these hospitals. And now we have, as I indicated, a statewide review commission which is regularly-

submitting excess of scientific facts to our scientific board so that we can obtain an idea as to whether a mode of therapy is appropriate or not, whether it has scientific medical value or not, and what is the appropriate level of utilization of that service. This is all on a voluntary basis using criteria that local people have voluntarily adopted because these believe it is for the best interests of their patients. It is not something that they feel they must conform to that has been placed upon them. It can be changed by the pressure of the local physician.

Senator CURTIS. Now, contrasted to that, how do you characterize or describe what PSRO proposes?

FAULTS SEEN IN PSRO

Dr. BOYLE. PSRO will have to create a totally new organization which in the case of hospital care will have to require that the patient's care be reviewed on the basis of some set of norms. This set of norms must conform to whatever criteria are developed by the National Professional Standards Review Council. The council from time to time looks at these norms and sees if they vary, and may or may not approve them. But nonetheless, if there is some variance, they must be subject to approval. These norms will then be applied to the evaluation of care in this hospital. Should there be something wrong with these norms, the process of having them changed would be to go from the individual patient to the physicians who have staff membership, and then to the PSRO, and then perhaps to a State council, and then perhaps to a national council before one could really make any serious changes in these things. Otherwise one would be continually trying to meet what is written down on the page. And believe me, although it may make good sense in Washington in the chambers of the Senate Finance Committee, when it gets out into a community such as Los Angeles where there are about 14,000 different doctors and 175 different hospitals all trying to do their very best to take care of patients, it comes out in an entirely different way.

Senator CURTIS. In retrospect, it is my opinion, a personal opinion, that it is unfortunate that we didn't have more in-depth hearings. It is impossible to read somebody else's mind. But I am inclined to think that many of these who supported PSRO thought they were supporting peer review. I did not accept that. I found problems might go with the language from the start. But as I tried to illustrate this morning with the Secretary, it is my personal opinion that the language that finally ended up in the law is not only not peer review, but by the sum total of all its provisions the ultimate authority is in the Government bureaucracy, and not in the hands of the doctors.

Would you agree with that?

Dr. BOYLE. Yes, sir.

Senator CURTIS. Thank you.

Senator TALMADGE. Senator Bennett?

PSRO AND CALIFORNIA

Senator BENNETT. Doctor, you read very quickly. And I am afraid that it has been impossible for me to take in and sort out and now give you back——

Dr. BOYLE. I apologize, Senator. Ten minutes is a short time.

Senator BENNETT [continuing]. All you have said. So after I have had a chance to read what you say, I may want to get in communication with you, because I think it contains many misunderstandings of the peer review program.

I am interested in the same question Senator Hansen raised. You say the vast majority of the doctors in California are opposed to peer review. But we have had applications for peer review authorizations or organizations from nearly every area of California except Los Angeles.

Is there any significance to the fact that you live in Los Angeles?

Dr. BOYLE. First of all, Senator Bennett, I was not among those who went out and tried any kind of campaign to drum up support for repeal of PSRO. That is a movement in California that arose very, very spontaneously.

Second, I should point out to you that in Los Angeles there is 40 percent of the State population, and 40 percent of the physician population.

And third, we are aware that there are some areas of the State, many areas of the State in which there have been applications made, some of these on behalf of organizations that do truly represent practicing physicians, and some of which could not. We are aware of the fact that even in many of those areas opposition to PSRO outweighs support by a substantial majority.

I personally have been involved in discussions of PSRO all over the State of California during this last 1½ years involving, I would say, probably at a minimum three and a half or possible 4,000 different physicians. There is not anything other than a smattering of people who support the concept. There are people who have said, well, if we don't do it, then they will give it to Blue Cross, Blue Shield, or if we don't do it, God knows who will get it, so maybe we had better do it, maybe we had better be the ones to apply it. Perhaps we would be better advised to try and see if we can't make it work.

But I can assure you that in San Diego County and in San Francisco County the medical elections in both of those county societies were decided on this issue, and those who were in support of applying for a PSRO, to become a PSRO designate lost the election, and by substantial numbers, I mean like 4 and 5 to 1.

Senator BENNETT. I think California has still got a lot to learn. They are a long way from understanding the program.

QUALITY OF CARE AND PSRO

You mentioned the deletery effects of PSRO on quality of care. There are several PSRO prototypes operating in California by component organizations of CMA. Have you ever made a study of their programs, have you ever personally gone to see how they operate?

Dr. BOYLE. I have seen how a couple of these do work, Senator. And I would say, first of all, although they may be PSRO prototypes, in fact they are something quite different. What they are are local programs that have evolved out of conditions of local physicians in which the directions of those programs can be changed instantly.

Senator BENNETT. So they can be changed under the PSRO program. But the local physician control of the program is central to the idea, and it seems to me that is the point you miss.

Dr. BOYLE. Senator, I submit, 1156(c) (1) and (2) to my mind read differently.

Senator BENNETT. I realize that you are entitled to your interpretation. And I am entitled to mine. But is it fair to say that your interpretation is colored with the idea that you think PSRO should not succeed because it will replace this program you are so proud of?

Dr. BOYLE. No, Senator, I think it is based on my ability to read what the written records said. I realize that the committee report, and your intent in discussions, and in some of the statements that you have entered into the Congressional Record before the Senate, would indicate what you believe it would do. But we also have had substantial experience with what happens when a law such as this is written and regulations begin to become massaged and massaged and massaged over a period of time, as the Secretary finds it increasingly necessary to make the restrictions more stringent in order to comply with this section of the law.

Senator BENNETT. Don't you think Congress has the power, if the Secretary begins to move away from its congressional intent, to rewrite the language to bring it back?

Dr. BOYLE. They almost never do.

Senator BENNETT. In other words, to use the words of an old, old radio character that used to answer every argument that he couldn't win by saying, "Even if it was good, I still wouldn't like it." I wonder if that isn't the position you bring before us today.

Dr. BOYLE. I don't believe so, Senator.

Senator BENNETT. In exactly how many hospitals in California does your CMA staff survey system operate.

Dr. BOYLE. My impression is that at the present time they have surveyed virtually every hospital in California, and that they have in the majority of instances surveyed most of them several times. This is now by California State law a requirement for licensure. So there will be no question about the fact that this will be surveyed.

Senator BENNETT. Are you aware that the PSRO law provides that if adequate review mechanisms exist in a hospital—and I assume that you would consider your review mechanisms adequate—that the PSRO can turn over to that organization the responsibility to conduct the review in that hospital?

Dr. BOYLE. As it is written, Senator, it relates only to one brief section, and that has nothing whatsoever to do with preadministration certification or operation for long-term care, or prior authorization for care, and complex and costly diagnostic and therapeutic procedures. That applies to only one specific section of that law.

Senator BENNETT. And what section does it apply to? Does it cover 90 percent of it and not 10, 1 or 2?

Dr. BOYLE. Actually it covers to a degree what we are already doing. And that would not in any way interfere. The problems are, if it were applied in that fashion, the problems are, first of all, that the PSRO must find that the hospital is conducting basically what the PSRO would be doing, and that is to say, using its norms of care.

And secondly, that would require that the Secretary at his discretion may determine what is compliance and not compliance. We would be inclined to find that if over a period of time a PSRO had authority in a given area, that it would begin to assume greater tendency to meddle in the affairs of that individual hospital. And we think that the Secretary might find that there are regulations that could be construed to find the hospital was not complying.

Senator BENNETT. You start on the assumption that the PSRO norms are less sound and safer than the existing hospital norms in each case? That would seem to be the way you have approached the problem, that to adopt the PSRO norms would be to reduce the quality of the medical care.

Dr. BOYLE. We believe that adopting these norms and attempting to apply them in the management of individual patient care, particularly when you start talking about prior authorization, will begin to interpose the judgments of other people between the physician and his patient. We believe that it will deny the patient his right to full access to that physician's knowledge, experience, and professional judgment.

PRIOR AUTHORIZATION AND PSRO

Senator BENNETT. Can you point out to me in the bill where prior authorization is required?

Dr. BOYLE. Yes, sir.

In 1155(2) (a) and (b).

Senator BENNETT. Read it. I don't have the bill before me.

Dr. BOYLE. It says:

Each professional standard review organization shall have the authority to determine in advance any elective administration to a hospital or other health facility.

Senator BENNETT. Has the authority, but it does not say the PRSO shall require prior authorization. Were you here this morning when this was discussed?

Dr. BOYLE. I most certainly was. And I have been in California where the Secretary of one of our State commissions was given the authority to require prior authorization. And you can bet we have had that for the last 2½ years. And I can also assure you that it substantially interferes with my ability to take care of my patients.

Senator BENNETT. He is not a doctor, and here it is the doctors that would require prior authorization. And, of course, again that is California, they have big ideas of power in California which we don't have elsewhere.

Dr. BOYLE. It may or may not be physicians, Senator as you know.

PSRO MEMBERSHIP

Senator BENNETT. As I know.

Now, let's stop right there. No one except physicians and osteopaths may serve on the PSRO. Aren't you aware of that?

Dr. BOYLE. Until after January 1, 1976.

Senator BENNETT. No, from now on, under no circumstances can a nonprofessional be appointed as a PSRO, as a member of a PSRO. Have you missed that?

Dr. BOYLE. If I have missed that—it may be an organization, not a practicing physician, yes.

Senator BENNETT. What we are talking about are two different things.

Dr. BOYLE. We have plenty of physicians doing prior authorization in California that don't know anything about the practice of medicine.

Senator BENNETT. And this is the sort of thing we are trying to get away from. Under the law the Secretary must give priority to the local physicians to organize the PSRO. And only when they reject that privilege has he the power to move elsewhere. And I think you are aware of that.

Fortunately many of the PSRO areas in California have already indicated that they are going to apply. And it is going to be interesting to me to see how the leadership in those local areas will stand up against the kind of pressure that you represent here today. And I think they will stand up. And I think we are going to have 28 regional areas, regional PSRO areas in California in operation before we get through with this program.

And you mentioned the fact that I won't be here very long. I don't expect to live long enough to see the repeal of PSRO, in spite of the fact that the California Medical Association is working for it.

PRIOR APPROVAL OF CARE AND SERVICE

Senator TALMADGE. Mr. Constantine?

Mr. CONSTANTINE. Dr. Boyle, under California's medicaid program generally today, is there any requirement of prior approval of care and service by the State?

Dr. BOYLE. Yes.

Mr. CONSTANTINE. Is it extensive?

Dr. BOYLE. Oh, yes.

Mr. CONSTANTINE. Are there areas where it isn't required?

Dr. BOYLE. There are two areas, to the best of my knowledge. One is a pilot project in Fresno County where they have an on-going review process of their own. And to the best of my knowledge, the only other area is in Sacramento, where they have a certified hospital administration program.

Mr. CONSTANTINE. And who does the prior approval?

Dr. BOYLE. The prior approval is usually done by State employees.

Mr. CONSTANTINE. State employees today.

In your statement you listed three resolutions as having been passed at your convention.

Are there any other resolutions with respect to PSRO approved?

Dr. BOYLE. The three resolutions are in part contained in this. There were other parts to these same resolutions which I think we did provide you. Now, I am not really sure about it, but I think sometime back either we or Dr. Monime did send you copies of our resolution, I hope, or promised to send them.

Mr. CONSTANTINE. Wasn't it also said at your convention that each county could choose whether it would participate in PSRO?

Dr. BOYLE. I believe that is true. Of course, we cannot dictate to our counties societies what to do.

Mr. CONSTANTINE. In California did Blue Cross, Blue Shield and the State apply norms and parameters in determining if the case is reasonable for people under medicare and medicaid today? Do they measure your claims against screenings that they have established?

Dr. BOYLE. They have screens that they look at, yes.

Mr. CONSTANTINE. But those are parameters?

Dr. BOYLE. Those are just levels of service being provided through this medical policy committee.

PHYSICIAN AND PATIENT PROFILES

Mr. CONSTANTINE. Do they maintain physician and patient profiles? Do Blue Cross and Blue Shield do that?

Dr. BOYLE. To the best of my knowledge they do not maintain patient profiles. They do maintain physician payments profiles.

Mr. CONSTANTINE. Blue Shield has indicated to us that they do maintain both patient and physician profiles.

Dr. BOYLE. I am unaware of that.

VIOLATIONS OF PRIVACY

Mr. CONSTANTINE. Just so we can follow it, we had not heard, frankly, of any violations of privacy in the medicaid-medicare programs, that is, the patient complaints.

Now, that doesn't mean that it hasn't existed. And the staff has been tracking it right from the beginning of the program, because the committee has an obvious interest in legitimate privacy, that borderline between confidential and coverup.

Now, where your patients complain that their privacy was violated——

Dr. BOYLE. I am not talking about my patients, I am talking about welfare patients in medical hospitals.

Mr. CONSTANTINE. They were medical patients. Precisely how was their privacy violated? Presumably they complained to you that their privacy has been violated. What were the circumstances and what did you do about it?

Dr. BOYLE. Anything I could do about it. The information we have is from medical patients who were on medical rolls that their names became available to people in the general community.

Mr. CONSTANTINE. But that isn't a patient record.

Dr. BOYLE. They have to have the information to begin with. There have been people who have had apparently a diagnosis made known to some other third party.

Mr. CONSTANTINE. Your patients?

Dr. BOYLE. My patients. I serve, in addition to being in private practice, and in addition to serving as speaker of the house of delegates of the California Medical Asssociation, as president of the comprehensive planning council of Los Angeles County. And as a consequence we have many people who bring many stories to us. So——

Mr. CONSTANTINE. Do you act on the stories?

Dr. BOYLE. We do what can be done. We advised some of the State legislatures of our serious concern about invasion of privacy of welfare patients.

Mr. CONSTANTINE. Mr. Chairman, if you don't mind, could we ask Dr. Boyle to provide for the record the specific instances in which patient privacy has been violated, specific cases? We think it would be very helpful in perhaps changing medicaid law.

Senator TALMADGE. Will you provide that for the record, please.

Dr. BOYLE. I will do my very best to get it for you, Senator. A lot of these things are told to me in public meetings. I will try to track it down.*

Senator TALMADGE. Thank you very much, Doctor. We appreciate the contribution you have made.

[The prepared statement of Dr. Boyle follows: Hearing continues on p. 119.]

PREPARED TESTIMONY BY JOSEPH F. BOYLE, M.D., SPEAKER OF THE HOUSE OF DELEGATES, CALIFORNIA MEDICAL ASSOCIATION

Mr. Chairman and members of the subcommittee, I am Dr. Joseph F. Boyle, a privately practicing physician from Los Angeles, California. I am privileged to serve as speaker of the House of Delegates of the California Medical Association, an elected representative body which acts on behalf of over 25,000 practicing physicians in our state. Accompanying me today is Dr. Stanley A. Moore, president of the California Medical Association and a radiologist practicing in San Diego. We appreciate the opportunity to present the views of the California Medical Association with respect to the present and proposed implementation of the Professional Standards Review Organizations, Section 249–F of Public Law 92–603.

CMA RESOLUTIONS ON PSRO

At its most recent meeting, the House of Delegates of the California Medical Association adopted three resolutions:

RESOLUTION NO. 7A–74

Resolved, That the California Medical Association immediately undertake a campaign to assure public awareness of the true nature of the PSRO legislation and of the significant accomplishments and consequent public benefit derived from peer review efforts of the profession; and, be it further

Resolved, That the California Medical Association directly encourage and support in every possible way the expansion and improvement of voluntary peer review procedures dedicated to the assurance of quality medical care for all of our patients.

RESOLUTION NO. 64–74

Resolved, That the California Medical Association manifest its opposition to the PSRO legislation and to other objectionable provisions of P.L. 92–603 through legal and legislative action; and, be it further

Resolved: That the CMA Council, in consultation with legal counsel, direct an appropriate Commission to implement this course of action.

RESOLUTION NO. 7–74

Resolved, That the CMA actively seek to amend Title XI of the Social Security Act so as to repeal Section 249–F, Part B–professional Standards Review Organization; and, be it further

Resolved: That the CMA actively seek to amend all other provisions of P.L. 92–603 which impose constraints upon the exercise of professional judgment, or which interfere with the performance of peer review at the local level; and, be it further

Resolved: That the above actions be transmitted to the AMA for implementation.

These three resolutions express a strong and continuing commitment on the part of California physicians to responsible peer review for quality assurance and utilization control. They express the deep concern of our members over the

*At presstime the material requested had not been received by the Committee.

absolutely disastrous effects on patient care that they foresee will very surely and very rapidly follow upon the heels of the implementation of PSRO. They express the dedication of California doctors of medicine to pursue all legal and legislative means available to protect their patients' rights to access to all the benefits of the highest possible quality care, free of artificial impediment and restraint, and in an ethical climate in which the confidentiality of their records can be guaranteed.

These resolutions were not adopted in hurried, heated, emotional, reactionary debate. They were adopted after approximately 1½ years of careful consideration and prolonged discussion, in hospital staff meetings, meetings of county medical societies, meetings of the Council of the California Medical Association and countless special forums all over the state of California. These deliberations involved not just a few highly inflamed individuals, but many thousands of conscientious, sincere, practicing doctors spanning the entire spectrum of medical practice from small community hospitals to large metropolitan medical centers and the staffs of teaching institutions and university centers.

(We are aware that representatives from some California counties with foundations for medical care have expressed support for PSRO. You should be aware that: (1) these counties include fewer than 10 percent of California physicians; and (2) in a poll of at least one of these foundations, of those physicians who expressed an opinion on PSRO only 27 would support PSRO, while 93 desire repeal or amendment of this law.)

Our discussions of PSRO have considered all aspects of this law and all modes of response to it, including: amendment; participation in the law with the hope that its direction could be guided so as to prevent interference with medical practice; a host of similar responses; and *repeal.* As a result of these long debates, our association has concluded that Section 249–F of Public Law 92–603, PSRO, represents bad law that cannot be amended satisfactorily except by its outright repeal.

A total exposition of our reasons for this determination is impossible in the brief span allotted to us today. We will cite some of our reasons for you. We will provide a lengthier discussion should you desire it.

DELETERIOUS EFFECTS OF PSRO

Our most fundamental concern is the deleterious effect that we perceive the implementation of this law will have upon the quality of patient care. We see further in its implementation the destruction of an effective review system that has evolved over many years and which is participated in voluntarily by thousands of physicians in our state on a daily basis. And, finally, this law contains a grave threat to the confidentiality of patient records despite provisions and disclaimers to the contrary.

We are absolutely certain that Senator Wallace Bennett, the author of PSRO, was completely sincere in his intent to place review of medical practice in the hands of local professionals. It is our view, however, that PSRO was unnecessary to accomplish this purpose for two reasons. First, as Senator Bennett has pointed out to the Senate (Congressional Record of April 1, 1974), even without a PSRO law, the secretary of Health, Education and Welfare already has sufficient statutory authority to require professional review; with or without PSRO, necessary review will be accomplished. In fact, at the present time, review of medical practice *is* in the hands of local professionals in California, as well as in every other state in this country. Secondly, peer review is being accomplished on a voluntary basis without the interposition of third parties' determinations between the judgment of practicing physicians and their patients, without additional expenses to the government, the insurance industry or the paying public. Furthermore, such review is becoming increasingly effective in both quality assurance and utilization control, and it can be expected to become ever more effective in the future. And it is applied to *all* institutional care, not simply that which is being paid for under Title 18, Title 19 or Title 5 of federal law.

PEER REVIEW IN CALIFORNIA

As some members of this committee are aware, there is a very complex quality assurance program in effect throughout the state of California. It involves county medical societies, foundations, hospital medical staffs, the California Medical

Association, Insurance carriers and fiscal intermediaries. Credentials review, medical ethics, medical review, medical and surgical audit and utilization review are under a constant state of surveillance. At the local level, these activities are pursued vigorously by local physicians under rules that have been adopted voluntarily. On a statewide basis, California Medical Association's hospital medical staff survey program, begun in 1961, is an integral part of this review and audit process. It is perhaps our most widely publicized and most often emulated quality assurance activity. These surveys help assure that local review of hospital physician practices is being pursued in an effective, conscientious fashion. Under this program, trained physicians analyze the organization of a hospital's medical staff, the adequacy of its records, its medical competence, efficiency of its credentials review, its medical and surgical review, its procedures for determining medical and surgical privileges and other factors that are directly related to patient care, physician performance and the education and disciplinary practices of each hospital staff. Utilization review and medical audit are integral parts of this system and now are being integrated with programs of continuing medical education, education certification and a statewide medical audit program that is directed toward enhancing the quality of care available to individual patients in individual hospitals and toward increasing the uniformity of this quality throughout the state.

California Medical Association survey procedures are the most comprehensive and systematized of any organization in this country and are being adopted by many other states. The value of this program has been recognized by the Joint Commission on Accreditation of Hospitals and by the state of California. We are now in our second year of performing combined surveys with JCAH, and California state law now recognizes approval under the CMA medical staff survey program as meeting the quality of care requirements for relicensure of all health care facilities in our state.

In addition, we are now in the third year of operation of a statewide Peer Review Commission of the California Medical Association. Its objectives are to provide for the integration of peer review activities throughout the state; to provide advice and guidance for local peer review activities; to review local peer review functions of county medical societies, foundations and hospital staffs; to provide scientific evaluation of the appropriateness of different modes of medical care, from the standpoints of the medical value to patients of diagnostic and therapeutic procedures, and of the appropriate levels of utilization. It should be noted that although these are functions of state and county medical societies and foundations, the review process involved is now applied equally to services and the practices of both member and non-member physicians, without distinction or bias and without the requirement that a non-member physician participate in the functions of the local or state medical association or pay dues. This is financed entirely by our medical societies on a voluntary basis.

In this system, there is also extensive provision for mediation, grievance hearings and appeal available to individual patients, physicians, hospitals, insurance carriers and governmental agencies.

PSRO: VAST, NEW BUREAUCRACY

In an effort to accomplish these same purposes, PSRO will create a vast new bureaucracy totally separate from the voluntary peer review program already in place. It mandates the development in our state of 28 separate new organizations (nationally more than 200 of these) with little or no relationship to existing medical organizations and with such vast authority as to threaten the destruction of all review programs as they now exist. To replace it a complex, new, completely untested system is to be imposed—individual, personal medical care rendered to a totally heterogeneous population of sick patients is to be subjected to compulsory, computerized review, measured against data-processing-massaged "norms" of the "profiles" of the average care sought for and received by the average patient from the average doctor. Somehow, it is also envisioned that a majority of busy, local practitioners will voluntarily immerse themselves in this process.

While Section 1152(e) seems to permit the secretary of HEW to waive duplication of review and control by PSRO if effective review and control already exist, careful reading of this section clearly indicates that precisely the opposite effect is intended by this section of the law. That is to say, at the discretion of

the secretary, hospital staff review, CMA–CHA survey review, local medical society review, etc., may be waived upon the assumption of these responsibilities by the PSRO. And while Section 1155(e)(1) would appear to require that Professional Standards Review Organizations accept the work products of hospital review committees or other organizations, this requirement applies only to the provisions of Section 1155(a)(1) and is in no way applied to mandates of preadmission certification of elective admissions (Section 1155(a)(2)(A)) or of prior authorization for complex diagnostic or therapeutic procedures (Section 1155(a)(2)(B)) and the provision of services to the chronically ill, as mandated in this same section. Additionally, Section 1155(e)(2) grants the secretary broad latitude in the development of regulations which would permit even this limited acceptance of an existing local review process and leaves to his sole discretion the determination of compliance or non-compliance. Moreover, Section 1155(a)(5) clearly indicates that physicians assigned responsibility for review of hospital care "ordinarily should not be responsible for the review of care and services provided in any hospital in which those physicians have active staff privileges." Quite clearly, what the right hand giveth, the left hand taketh away.

Among the most potentially destructive provisions of PSRO are contained in Section 1156, "Norms of Health Care Services for Various Illnesses or Health Conditions." Although it is difficult for non-physicians and even for non-practicing physicians to understand, this "normative" approach to the practice of medicine in the management of individual patient problems poses severe restrictions upon each individual patient's rights. The patient is entitled to the proper assumption by a physician, of his or her own choosing, of the personal responsibility for the provision of medical care and for the full application of that physician's knowledge, skill and judgment in the provision of individualized, personal medical care.

"NORMS OF CARE—COOKBOOK MEDICINE"

Although it has been labelled as untrue that there will be a national "cookbook" for the management of each diagnostic and therapeutic problem, that is precisely what Section 1156 of PSRO demands. It states that there will be "professionally developed norms of care," etc., "based on typical patterns of practice in each region," but then proceeds with Section 1156(b) to require that such norms shall include, "*in accordance with regulations of the secretary*," "differing, but acceptable, modes of treatment and methods of organizing and delivering care . . . consistent with professionally recognized and accepted patterns of care" and of the type of facility "to be the type in which health care services . . . can be most *economically* provided." And (Section 1156(c)) the National Professional Standards Review Council *shall provide "materials indicating the regional norms to be utilized" and that "the approval of the National Professional Standards Review Council of norms of care, diagnosis and treatment shall be based on its analysis of appropriate and adequate data."* And (Section 1156(c)(2)) "each review organization, agency or person . . . shall utilize the norms developed under this section as a principal point of evaluation and review for . . . any health care services which have been or are proposed to be provided."

Even the loosest application of these stringent requirements will, without any question, instantly substitute the use of these norms for the application of individual physician judgments, either because of absolute prohibition of deviation from these norms or because of the onerous task of explaining variations for at least half of all patients for whom care is provided or proposed to be provided. What is euphemistically referred to as local review with regional norms, in fact, becomes adherence to norms that have been nationally developed. In the management of a simple common cold, consider the complexity of establishing standards for the management of such a diagnosis in the spectrum of potential patients afflicted: a healthy adult man or woman, working alone or working in a crowded office or in a classroom or nursery or caring for young children at home; a six-months-old infant otherwise healthy or afflicted with cystic fibrosis, allergic bronchitis or other physical or mental impairment; an adult or child with an assortment of associated chronic illnesses that run the gamut from bronchial asthma to concomitant renal dialysis or markedly impaired immuno-suppressive mechanisms associated with drugs used in renal transplant or in the treatment of extensive cancer, leukemia or a host of other disorders. Consider the expansion of this normative process to the thousands of diagnostic variations and combinations of diseases listed in compendia of diagnostic nomenclature, and you

will recognize readily that the medical profession's concern about "cookbook medicine" is more than mere fantasy.

Such norms would have to be so sweepingly broad as to have absolutely no effect or be sufficiently narrow as to be, indeed, restrictive and stultifying. Modes of medical practice vary substantially all over the United States, and for good reason. Treatment and diagnostic procedures are constantly in a state of change and evaluation. As one mode of therapy acquires clear superiority it becomes adopted by practitioners generally. Practice within the constraints of "norms and care" will cause this evolutionary change and continual evaluation to cease. It will mandate mediocrity aimed at meeting the *averages* contained in every list that is developed. Innovations in provision of care will only be attempted by the most persistent of physicians willing to endure countless hours of time and frustration explaining to a National Professional Standards Review Council judgments that traditionally have been subject to scientific evaluation by local peer review unencumbered by norms that must be met regardless of the physician's individual competence, training, background or experience.

And while the norms of care required under Section 1156 are intended as a cost-containment measure, we believe that their application may have an opposite effect. First, the average physician who believes that he may be prohibited from going beyond the range of diagnostic and therapeutic procedures prescribed in these lists may withhold more extensive evaluation or treatment in many instances in which either more serious and more difficult-to-manage problems may emerge or in instances in which chronic illness will develop, requiring protracted and expensive therapy that could have been prevented, had he felt freer to exercise his own judgment in each individual case. Second, since we know from long experience that "norms" or "guidelines" or "standards" very rapidly become *rules* under which everyone is expected to conform, the physician will feel compelled to utilize the entire range of diagnostic and therapeutic modalities contained within these norms so as to avoid criticism and to prevent his failing to apply some modality of care from being used as evidence of incompetence or negligence in professional liability lawsuits.

Dr. Kerr L. White, professor of medical care and hospitals at Johns Hopkins University in Baltimore, writing in The Western Journal of Medicine ("Caveats for PSRO," April 1974, copy appended), has discussed the subject of norms of care in considerable detail. One of White's statements is of particular pertinence: "The real test of a clinician is the extent to which his patients are returned to work or school, kept out of bed, relieved of functional impairment or pain and freed from the use of unnecessary or useless drugs. These are the measures that really count as far as the patients and public are concerned—and, I would add, as far as the bulk of the medical profession is concerned." This is our concern: that individual physicians be permitted to continue to exercise their individual judgments in the application of their training and experience in the management of individual patients' problems, not that physicians be made to conform to rules and regulations devised and/or approved by a committee of 11 physicians and the secretary of HEW, several thousand miles away.

PRIOR AUTHORIZATION

Several sections of 249F clearly demand prior authorization of elective admissions and diagnostic and treatment procedures. The medical profession in California has had a long experience with prior authorization under a variety of governmental programs extending back to 1955 and before. Our experience with this form of practice has demonstrated beyond question that prior authorization (1) does not contain costs; (2) denies needed care; (3) promotes continuing frustration and irritation in everyday patient management; (4) imposes unnecessary work on physician and his office staff and (5) encourages the delay of needed care beyond the point where it can be done most efficiently, safely and inexpensively, thus requiring ultimately more expensive and costly care to the detriment of many patients' health and well-being.

Some further objections of our association include:

ASSUMES PHYSICIAN ABUSE

The PSRO Manual states that admission certification "initially will be required for *all* elective admissions" (PSRO Manual Section 705.14). Exceptions will be made when physicians or specific diagnoses are clearly identified as not requiring review.

The clear implication of this requirement is that most physicians will abuse the Medicare, Medicaid, and Maternal and Child Health programs. The physicians of California believe that this type of review and control should be required only after a pattern of abuse has been established. The PSRO provisions, as now written, subject all physicians to an unusual form of "second guessing" to stop a few abusers.

AUTHORITY AND CONTROL

A physician has the legal and moral obligation to provide effective, efficient and economical care of high quality. Traditionally, he has relied upon the full measure of his training, skill and experience. He cannot rely upon a committee or governmental agency's judgment.

Through their professional associations and medical staff organizations, physicians have voluntarily accepted obligations to the public to assure that they are qualified and capable of performing the services which they undertake to provide their patients. This obligation is met through:

Reviewing the physician's credentials, including his training, experience and practice history, by the medical asociation and/or medical staff when he applies for membership.

Establishing staff privileges to perform medical and surgical procedures that are commensurate with the physician's training and experience.

Reviewing practice problems, regardless of source of complaint.

Recomending disciplinary action to licensing boards.

Examining and certifying specialty qualifications.

Assuring the best medical training possible through medical school accreditation.

Organizing continuing education for physicians through conferences and refresher courses.

This responsibility cannot—and should not—be delegated to any other body. It is highly improper, therefore, for the secretary of HEW to presume to delegate authority and responsibility for review to the hospital medical staff.

We further object to the PSRO law which bypasses existing professional organizations and puts ultimate control and authority in the hands of the secretary of HEW:

He is the primary party to all contracts for the planning and operation of local PSRO's, the state council and the statewide support centers. He is empowered to take all disciplinary actions against offending physicians. He is the final authority in appeals.

He sets regulations governing medical care without consultation with or concurrence by the National Professional Standards Review Council of physicians.

He puts into effect directives, rules and manuals without benefit of regulatory comment, thus bypassing organizations and individuals whose input is essential for the successful implementation of a law of such magnitude.

In addition, we are particularly concerned about the effect that the PSRO legislation, and specifically the implementation contemplated by Chapter VII of the PSRO Program Manual, has on physicians' attitudes toward hospital staff peer review and its educational responsibilities.

For example, the manual requires that hospitals use PSRO-developed or approved criteria. Yet the success of our medical audit program as well as the JCAH and the QAP medical audit programs is due directly to the physicians initiative in developing their own criteria for medical care evaluation in their own hospitals. It is a learning process for physicians. Their voluntary participation generates an immense amount of enthusiasm. And under these programs, physicians develop a commitment to their own set of procedures that could never exist under PSROs, which impose criteria developed *outside* the hospital setting.

CONFIDENTIALLY

Physicians in California also are concerned with the effects of PSROs on patients' right to the privacy of their personal and medical histories.

The PSRO law provides for the development of patient and provider profiles (Section 1155(a)(4) of the Law). It also requires extensive reporting to the state and national councils as well as to the secretary of HEW. And while the law demands confidentiality of patient identification with penalties for breaches of this requirement, it clearly permits the HEW secretary to determine the degree of invasion of privacy he finds necessary to implement the law.

This reporting requirement necessarily will involve the development of centralized data banks capable of reporting information to the state and national councils. Once recorded, the information is available to a greatly expanded group of individuals, including PSRO staff who have the authority to review this information. With this vast expansion in the use of confidential medical record data and with the increase in the number of persons handling this data, the potential for misappropriating confidential information will be immeasurably increased.

The law also gives the local PSRO the authority to review patients' records in physicians' offices. Heretofore, these records have been considered privileged and confidential. They should remain so.

COST

There is a complete lack of any real insight into what the administrative cost of operating PSROs will be. There have been estimates ranging from five-million to almost one-billion dollars per year. The major portion of the cost is the development of new peer review structures and new federal and state agencies. Existing systems, organizations and structures—which cost the taxpayers virtually nothing—are ignored.

While the PSRO law declares as one of its major purposes economical delivery of health care services, it is doubtful that PSROs will save money. In fact, as the law is implemented, we may very well find the reverse to be true. For example, costs are bound to increase through the ordering of a test or other service solely because it is listed in the established criteria for a specific diagnosis, even though in the professional judgment of the physician the test or service is not medically necessary. Thus, we are deeply concerned that under this law the American people will be forced to pay an exceedingly high cost for a system of peer review that will *lower* the quality of medical care in this country.

PROFESSIONAL LIABILITY

Section 1167(c), dealing with professional liability, has the appearance of giving physicians some special protection, but in no way alters anything.

Courts will continue to hold a physician responsible for using his best medical judgment, and that it will not be an adequate defense to argue reliance on criteria, norms and standards of a PSRO. Extensive case law establishes these facts beyond question. Indeed, inappropriate use of norms and standards could be used to show *negligence* on the part of the individual physician.

SUMMARY

In summary, the California Medical Association has carefully analyzed section 249F of Public Law 92-603 in an effort to determine whether this law can be implemented without interfering with the ability of California physicians to provide the best possible medical care to our patients. We have concluded that it cannot. We have attempted to evaluate Section 249F to determine whether it can be satisfactorily amended to allow for the continuation of effective local professional peer review. We have concluded that PSRO is bad law . . . that it cannot be amended except by its repeal. We believe that the application of PSRO to medicine as it is practiced in the state of California as well as elsewhere in the United States will have an extremely deleterious effect upon the quality of care available to our patients; that it will encourage a high degree of mediocrity and stifle all advances and innovations in provision of medical care; that it will deny needed care; that it will interfere with the physician's ability to freely exercise his judgment in the management of individual patients' problems; that it will deny the right of our patients to full access to their physicians' scientific training and experience; that it will seriously jeopardize the confidentiality of patients' records; that it will pose serious problems in the generation of and prosecution of professional liability lawsuits; that it will do great harm to existing peer review programs, if not ultimately destroy these programs entirely; and that it will create a vast new, costly bureaucracy to accomplish that which is absolutely unnecessary, since requirements for utilization review and quality assurance already exist in other statutes.

Our commitment to conscientious peer review with local and state surveillance by practicing physicians remains as strong as ever. We hope that the Congress

will take whatever action is necessary to see to it that these programs are not only retained but enhanced. We believe that the activities of our association warrant this support.

APPENDIX

[From the Western Journal of Medicine, April 1974]

CAVEATS FOR PSRO'S

(By Kerr L. White, M.D.,* Baltimore)

As matters stand now, it seems probable that Professional Standards Review Organizations (PSRO's) will base their assessments on specific standards of practice promulgated locally, regionally or nationally, and that these standards will serve as the basis for taking corrective, perhaps punitive, action against practitioners who fail to meet them. While most physicians would agree that our profession must strive relentlessly to improve the services we provide, and many of us believe that broader accountability is inevitable, the PSRO prescription as currently being discussed may well be a recipe for chaos. There are five assumptions underlying this scheme that should not go unexamined. These assumptions are:

1. Practitioners in the United States are distributed bimodally with respect to their clinical competence—that is, there are "good doctors" and "bad doctors" and we know how to tell them apart. It seems to be assumed further that the "good doctors" will be the ones to say which are which.
2. Medical practice is more usefully assessed in relationship to "diagnoses" and "processes" than in relationship to "performance" or "outcomes" of patient care.
3. Contemporary medicine has a substantial number of clearly defined and well-understood preventive, diagnostic and therapeutic forms of intervention for which the clinical efficacy and patient care utility have been objectively assessed by means of randomized clinical trials or other credible evidence, and we know precisely what to do for the majority of the most common health problems brought to the medical profession.
4. Health information systems now exist that will permit objective statements to be made about the adequacy of care given to a specific patient by a specific practitioner at a specific time and place.
5. Sub-optimal patient care, however defined and measured, is due more to the inadequacies of the individual practitioner than to failures in the organization of health care systems or institutions or to the inappropriate allocation of priorities and resources by society.

There are, in addition, three objectives underlying the concepts of "standards for practice," and the PSRO legislation in particular, which should be stated so that all can appreciate what is being discussed:

1. The overall costs of health care both individually and collectively should be contained, if not reduced.
2. There should be a relatively uniform, minimal level of expectation with respect to the clinical efficacy and patient utility of medical care for all citizens.
3. Equity of access, or "fair shares," should characterize the setting of priorities and the allocation of national, state and local resources for health care.

In other words, the essential problem with respect to health care policy and the setting of so-called standards of practice" is to balance costs, quality and equity. This is always the task in any effort to restructure health services.

Finally, by way of introduction, it should be understood that in talking about objective assessments and even about measurement, we mean the assignment of numbers to objects, attributes or events according to rules; we are not talking about the kind of assessment of quality embodied in the aphorism: "Mirror, mirror on the wall, who are the best clinicians of them all?" My comments, therefore, will be based on the assumption that we are concerned with improved measure-

---

*Based on remarks made at the Fall Meeting of the Institute of Medicine, National Academy of Sciences, November 15, 1973.

The author is Professor of Medical Care and Hospitals, The Johns Hopkins University, Baltimore.

Reprint requests to: K. L. White, MD, Department of Medical Care and Hospitals, The Johns Hopkins University, School of Hygiene and Public Health, 615 North Wolfe St., Baltimore, MD 21205.

ment, or even any reliable measurement, as a basis for decision-making referrable to standards, normal values, deviations and sanctions.

Now, with respect to the first assumption, namely that there is a bimodal distribution of overall clinical competence for the entire practicing profession, let me start by saying that I know of no evidence that would support this assertion. We have no idea about the shape or skew of the distribution of clinical competence; we do know something about the ability to answer examination questions and about the frequency with which some procedures, operations and treatments are employed. However, even if a bimodal distribution could be identified or even if the lowest 5 percent of practitioners on a normal distribution were classified as "bad doctors" by the "good doctors," is it desirable to place our emphasis on punishing or correcting the "bad doctors" or is it better to put the emphasis on helping the other 95 percent to improve the level of their practice? I would argue that our efforts should be put on strengthening those aspects of medicine that are good and helping those physicians who most of the time make every effort to do their best, rather than on the small number of "bad guys" who should be unfrocked because of fraud, chicanery or overt incompetence.

Most of the efforts to date with respect to evaluation of Medicare and Medicaid, and even the work of some of the Foundations for Medical Care, have been concerned with fraud and chicanery and very little with assisting the great bulk of practitioners to improve the care that they provide. If we have limited resources to devote to improving the quality of care through PSRO activities, I suggest that the emphasis be placed on information and education for the majority, not punishment for the few "rascals" and "incompetents" among us. An educational and behavioral posture toward the medical profession on the part of the profession itself rather than a punitive or even "corrective" posture seems central to attainment of the three overall objectives with which most, I think, would agree.

Surely one of the central features of any profession is its capacity to evolve and adapt in response to society's needs. If this assertion is wrong then the potential, if not the performance, of continuing education, and perhaps of medical education itself as a basis for a lifetime of learning, needs to be reexamined carefully.

The second assumption states that medical practice is more usefully assessed in relationship to "diagnoses" and "processes" than in relationship to "outcomes" of care. It is the functional result as reflected in the individual and collective capacity of patients to perform and produce after receiving medical care that counts, not what procedures or treatments are employed. A diagnosis is only a means to an end; of itself it has little discernible medical utility and no social utility. At best it is all too frequently a hypothesis that requires testing. This is particularly true at the level of primary care and frequently at the level of secondary care.

However, of much greater moment is the realization that patients do not present at the level of primary care or even at the levels of secondary and tertiary care with "diagnoses"; they present with symptoms, complaints and problems for which they seek relief. The task of medicine is to resolve the problems that are first perceived by patients as "headache," "pains in the chest," "rashes," "stomach pain," "backache," "unusual bleeding," "cough," "weakness" and "fatigue" and the hundreds of other symptoms that initiate the demand for medical care and constitute the language of disease.

If our guides or requirements for the management of specific diseases and diagnoses are based on the "process" approach and characterized by lists of prescribed procedures derived from the contemporary collective wisdom of "experts," then I think we run the serious risk of encouraging five undesirable trends:

1. *Defensive medicine.* There will be a tendency for physicians, particularly those who are less secure and in the greatest need of support and education, to carry out the full range of prescribed procedures so that they minimize the risk of "corrective" action.

2. *Cookbook medicine.* Individual clinicians will be encouraged to work by the book, to follow the authoritarian pronouncements of the "experts" and to use the Merck Manual approach for the care of patients, rather than to accept the professional risks and intellectual rewards of developing and applying their clinical knowledge and acumen in the best interests of specific patients. The cookbook approach to medicine would seem to me to be anti-intellectual and should be vigorously discouraged. It could stultify and fossilize clinical practice and stifle its evolution.

3. *Normative medicine.* The threat of sanctions will encourage all physicians to move toward the mean values or to remain within some range that reflects central tendencies. One only has to recall the conventional wisdom of the past with respect to normal deliveries, myocardial infarctions and hepatitis to realize the possible tyranny of slavish adherence to all contemporary standards.

4. *Hazardous medicine.* The greater the number of procedures carried out and the longer the patient is in hospital, the greater the risk of misadventure. The object of any clinical exercise should be to relieve the patient of his complaint or distress as rationally and rapidly as possible with the minimum number of procedures and the shortest possible institutional involvement. In at least one study, 20 percent of the patients experienced some hazardous episode and 7 percent died as a result.[1] A hospital is a very dangerous place to be if the benefits do not outweigh the risks!

5. *Inflationary medicine.* Cost containment requires that we be more selective in the procedures done, and on balance, do fewer, not more; and that we reduce hospital days used, not increase them. If "process" standards are prescribed, it seems highly probable that this will considerably increase the number of procedures and hospital days. New demands on laboratories, radiology units and record rooms are bound to exacerbate manpower shortages as well as inflate costs, and they cannot be justified in the absence of evidence that improvement in the health care or health status of the population will result.

Let me give some practical examples: By what standards do we judge a general internist in a town of 25,000 people with a 100-bed hospital when faced in his office by a 50-year-old housewife with vague intermittent upper abdominal pain and an alcoholic husband, or when faced by a 35-year-old auto mechanic with vague chest pain of two weeks' duration? Medicine at this level is still largely probabilistic, not deterministic, and the individual decisions in each case may be based on historical, behavioral, social and clinical evidence that is infintely more relevant at the first encounter with these two patients than would be a gastrointestinal x-ray survey, a gall-bladder series or an electrocardiogram. How do we assess care objectively at this level? At present we do not even know the distribution of these common problems in the populations of patients seen by physicians in different practice settings.

The real test of the clinician is the extent to which his patients are returned to work or school, kept out of bed, relieved of functional impairment or pain and freed from the use of unnecessary or useless drugs. These are the measures that really count as far as the patients and public are concerned—and, I would add, as far as the bulk of the medical profession is concerned.

The third assumption affirms that we have a substantial number of efficacious procedures that have been evaluated by randomized clinical trials or on the basis of long and wide experience, and that we have benefits which clearly outweigh any attendant risks, hazards or costs. In the latter category, I would put streptomycin for tuberculous meningitis and not vitamin B–12 for backaches.

First, it is essential to distinguish between the three functions of preventing, curing and caring. Second, we need to identify those forms of preventive, diagnostic and therapeutic intervention that are clearly beneficial and for which problems and under what conditions they are beneficial. This alone should free enormous amounts of money and resources for the caring function, much of which seems to be the indirect benefit of the placebo and Hawthorne effects. These are scientific and educational exercises for the long haul to which some segment of the medical establishment should address itself aggressively.

I doubt that any accurate account exists, but I would be very surprised if more than a quarter of all the tests, procedures and therapeutic regimens imposed on specific patients are more beneficial and useful than they are harmful or useless, and the figure may be lower. It would be important to know. The efforts to improve quality and reduce costs should be directed at educating practitioners to undertake fewer procedures of dubious value and encouraging them to improve their clinical expertise.

To stimulate discussion, let me suggest alternative ways in which the middle-aged woman and the young man described above might be treated by a physician and end up in both instances by being relieved of their symptoms. The first involves two or three visits in the course of a month or two, a wait-and-see, probabilistic approach, supported by one or two tests or x-ray studies done with the

[1] Schimmel EM: Hazards of hospitalization. Ann Intern Med 60: 100–110, 7964.

patient ambulatory, while the second involves several days in the hospital and a vast battery of diagnostic and therapeutic procedures. It might well be argued that the burden of proof is on those who would favor the latter approach to patient care as representing better care. Yet this is what we will be encouraging if we promulgate "expert" standards for managemenut of "chronic cholecystitis" and "coronary artery insufficiency"—the diagnostic labels we use to justify hospital admission and insurance coverage.

The fourth assumption asserts that we have national, regional, state and local health information systems to generate the necessary knowledge for making sensible decisions about the competence of the individual practitioner's care of his individual patients. This is not the time or place to discuss the conceptual and technical problems of health care information systems and the work that lies ahead of us in developing an adequate network of such systems in this country.[3]

A few comments are indicated in the present context, however. One possibility widely mentioned in PSRO discussions is the use of the length-of-stay standards produced by the Professional Activity Study (PAS) hospital discharge abstract system of the Commission on Professional and Hospital Activities. While the commission deserves great credit for its pioneering efforts, it should be clear that there are a number of limitations to the usefulness of PAS data. What is not fully understood is: (1) the hospitals participating in PAS volunteer to do so, on the basis of enthusiasm, interest or need, (2) they are concentrated in the 200 to 500 bed category and (3) they account for only about 25 percent of the short-term nonfederal hospitals of the country and 40 percent of their 36 million discharges annually. However, the numbers involved are much less important than the fact that the hospitals are not a statistically representative sample of all hospitals in the country and hence of all practices. It would be misleading from a statistical and logical point of view to generalize to the national experience, let alone regionally or locally from these kinds of data. It should also be understood that the validity and reliability of PAS length-of-stay standards depend upon the individual performance of the many medical record rooms who supply the basic data. Many serious reservations have been voiced about the quality of these data and in at least one recent study of a large metropolitan hospital, they were found to be totally inadequate.[3]

What is needed as the basic health information system for the description of health care currently being given, at least at the level of the hospital, is the universal application of the Uniform Hospital Discharge Data Set and the related terms, definitions and classification schemes, through decentralized hospital discharge abstract systems that measure regional patterns and reflect regional needs. There are about a dozen of these regional systems now in operation across the country (including several based on the PAS system) and the terms of the basic data set have been officially promulgated by the United States National Committee on Vital and Health Statistics and endorsed by the American Hospital Association.[4,5] These 14 "bits" of information can generate a large number of critical tables that would inform practitioners and administrators alike about the health care system of the country in the ways that Florence Nightingale advocated more than a century ago.[6]

This approach to the development of information about health care recognizes the principles of parsimony and utility in the expensive collection of data about patient care. It is more sensible to carefully collect a little information on the entire universe of patients or the population at risk than to haphazardly collect a great deal of data of uncertain validity and reliability from a limited group of patients admitted to selected volunteering hospitals. Particularly if

---

[3] Murnaghan JH: Health services information systems in the United States today. N Engl J Med 290: 603–610, 1974.

[3] Hendrickson L, Myers J: Some sources and potential consequences of errors in medical data recording. Meth Inform Med 12: 38–45, Jan 1973.

[4] Murnaghan, JH, White KY (Eds): Hospital Discharge Data: Report of the Conference on Hospital Discharge Abstract Systems. Med Care 8: Supplement 1–215, 1970 and Philadelphia, J. B. Lippincott Co., 1970.

[5] United States Department of Health, Education, and Welfare, United States National Committee on Vital and Health Statistics. Uniform Hospital Abstract: Minimum Basic Data Set. Washington, D.C., Government Printing Office, 1972 (DHEW Publication No. HSM 73–1451).

[6] Nightingale F: Hospital Statistics and Hospital Plans. London, Emily Faithfull & Co., Victoria Press, 1862.

we are to have so-called national standards or even regional and local standards, they must be based on the objective collection of credible data and the generation of useful information that describes the full range of hospital experience. If we can agree that standards should not be based on authoritarian pronouncements of experts who see a selected segment of the sick people of the country, or on "normative" rates from unrepresentative samples of patients or hospitals, then we should start with the universal recording of a prudent amount of comparable empirical data that has some chance of being analyzed and understood at national, regional, state and local levels.

We have the knowledge and expertise in this country to develop these systems and to use them effectively. Let me give some examples. It would be more informative to compare measures such as case fatality rates, lengths of stay, rates for selected diagnostic and therapeutic procedures, rates for selected complications, and mean total charges per admission (as a proxy measure of the intensity and complexity of care) among hospitals and among all hospitalized residents of counties, states, medical catchment areas, regions and the nation, than to focus on specific aberrations of physicians in specific cases. There is nearly always an explanation for clinical activities associated with individual cases when they seem unusual by some external standard. By contrast, the initial "belling of cats" is usually much easier when directed at hospitals or groups of institutions or systems than at individual physicians and their individual patients. By aggregating credible data that will describe the performance of institutions and the care received by population groups, those responsible for the distribution of health care resources and the allocation of priorities can see what and where the problems are before they attempt to identify individual practitioners as offenders in particular instances. The effect on an institution or a group of hospitals of information based on objective monitoring may be as large or even greater than the collective effect of individual sanctions, corrections or punishments directed at the physician; at least this is one possible conclusion based on an examination of one claims review system that has been carried out.[1]

It would, then, be preferable to examine small amounts of information based on universal coverage and to evolve information systems gradually than to embark on vast data collection exercises in an unsystematic fashion designed to feed computers and offend common sense.

The fifth assumption suggests that inadequacies in care are related more to "practitioner" failure than to "systems" failure. While some air crashes are undoubtedly related to pilot error, many more are related to systems failures and even here the attention given to the design of systems and the provision of redundancy far exceeds anything we have in health care. By focusing on the care given by groups of institutions like hospitals, Foundations for Medical Care or HMO's and on the care received by populations defined by geography, we bring to light systems problems and the related issues of priorities, resource allocation, health insurance arrangements, incentives and managerial competence. This has the enormous advantage of informing the public and its representatives in the legislatures and on the boards of trustees, as well as the profession itself, about the characteristics of their health care systems and their impact on the individual actions of patients and physicians.

The pressure exerted on institutions to improve the collective and individual performance of physcians and other personnel is likely to be politically more palatable and operationally simpler than pressure applied on the small fraction of aberrant physicians who are described as "bad doctors." The emphasis would be on supporting and educating the great bulk of physicians and improving the general environment in which they work rather than on harassing individuals or segregating them for special comment. This can always be added later as circumstances warrant, but it seems a poor place to start from the point of view of overall needs.

In summary, I question the present emphasis on "process" standards directed at physicians' practices that seems to characterize much of the thinking about PSRO's because:

---

[1] Buck CR Jr: Peer Review: The Impact of a System Based on Billing Claims. Baltimore, Maryland, Department of Medical Care and Hospitals, The Johns Hopkins University, (Sc D Thesis, processed) 1973.

1. Much work needs to be done to separate efficacious procedures from the rest. For only a small proportion of the problems presented by patients at the level of primary care do we know enough to set "process" standards, or even to define what currently goes on.

2. Much more needs to be done to build up population-based, problem-oriented information systems that use data parsimoniously for making useful decisions about the medical care provided by hospitals and other health care institutions for the populations they serve.

3. The use of predetermined "process" standards based on data of uncertain validity collected from unrepresentative samples would, in my judgment, be anti-intellectual, unduly rigid, and discourage clinical initiative, and would be potentially hazardous to patients and inflationary.

4. "Systems" failure may be as important or more important than "practitioner" failure if medical care is unacceptable with respect to access, quality and cost. We should focus on hospitals and systems before we focus on individual physicians and their individual patients.

5. An educational rather than a punitive approach is preferable if medicine is to maintain its professional traditions. Do we want to catch a few rascals, or do we want to improve medical care for all citizens?

Senator TALMADGE. The next witness is Dr. John M. Babich, president of the Medical Care Foundation of Sacramento, accompanied by Dr. James C. Bramham, chairman, PSRO steering committee, and Dr. James J. Schubert, medical director.

Doctor, your entire statement will be inserted in the record. And you may proceed, sir.

STATEMENT OF DR. JOHN M. BABICH, PRESIDENT OF THE MEDICAL CARE FOUNDATION OF SACRAMENTO, ACCOMPANIED BY DR. JAMES C. BRAMHAM, CHAIRMAN, PSRO STEERING COMMITTEE; AND DR. JAMES J. SCHUBERT, MEDICAL DIRECTOR

Dr. BABICH. Mr. Chairman, my name is John M. Babich. I am a practicing pediatrician in Sacramento, Calif. I serve as president of the Medical Care Foundation of Sacramento. Joining me today are Dr. James J. Schubert, a practicing orthopedic surgeon, who has also served as past president of this organization, and who is the medical director of the medical care foundation and Dr. James C. Bramham, also a practicing pediatrician and past president of both the medical society and the medical care foundation. Dr. Bramham is currently chairman of our PSRO steering committee.

As some of you will recall, we gave testimony before the Senate Finance Committee in June of 1970 relative to the formulation of the PSRO legislation. We were then and remain supportive of the concept that private practicing physicians be given the responsibility to act as medical intermediaries in their own communities. As part of our testimony, we introduced to you our certified hospital admission program (CHAP), a prospective inpatient review program developed by Sacramento area physicians.

Since our prior testimony, our CHAP program has been implemented in various forms throughout the Nation. In these few short years, we have monitored a total of 113,557 admissions. By coordinating our experimental medical review organization (EMCRO) grant with the local efforts of almost 200 practicing physicians actively involved in our peer review management program, the Medical Care

Foundation of Sacramento has had a dramatic impact upon cost containment and enhancement of health care delivery.

Two rather significant outgrowths of our activities were the development of our foundation community health plan (FCHP) a prepaid health care delivery system for title XIX residents of the Sacramento five-county area. We now have some 37,000 participants in this innovative and dedicated program. Utilizing our own foundation funds, we have also constructed and now operate the Del Paso Neighborhood Center for Health Care bringing quality medical services to an economically and medically underprivileged area. Until now, this community of 45,000 people had but one physician practicing in this large, geographically isolated area. These are but two responses by local organized medicine to our community's challenge to improve access, quality, and cost containment.

At this time, we are responding to other needs of our community; in the development of prepaid programs for medicare recipients and private groups, as well as assistance in such areas as durable medical equipment, health transportation, and health education.

The Medical Care Foundation of Sacramento has become a medical intermediary involved in health care delivery-administration, quality control, cost containment, consumer advocacy, public accountability, and the continuing enhancement of professional standards.

Mr. Chairman, the Medical Care Foundation of Sacramento continues to support Senator Wallace Bennett in the development and implementation of the professional standards review organization (PSRO) legislation. In reviewing the details of the law and the proposed guidelines for implementation of PSRO, we have some positive and constructive recommendations and suggestions. They are:

1. The PSRO law was designed to involve the private sector as medical intermediaries. HEW should not totally dominate and control PSRO. Rather, HEW should be redirected to support local autonomy and the private sector in appropriate but perhaps varying organizational structures.

2. The national council is currently being used as a sounding board and reaction panel to guidelines, rules and programs initiated by HEW. It is, at best, advisory and certainly not administrative.

We urge:

A. That the national council be given all administrative control of the PSRO program. This means that the council should have formal authority written into the law.

B. That the council report to the Secretary and act as a separate agency.

C. That the council has the authority to hire and fire its own staff and have control of its own budget.

By this we mean that the council should have its own independence.

D. That the council be expanded to allow for adequate elected representation by PSRO's.

E. That the council elect its own officers.

3. We urge the utilization of experienced individuals and organizations in the form of a special technical task force to serve the National PSRO Council. This should be a working task force and, as you

know, this was strongly urged in your committee's original report. This was agreed to in the council and is stated in the floor manager's report.

4. There are ambiguous and conflicting opinions on how the local PSROs will manage data and be funded for their operations. We urge both flexibility in the structure of PSRO organizations as well as a recognition of the funding requirements and the vital importance of data management by the local PSROs.

Our delegation to the California Medical Association supported a resolution predicated upon four specific points:

1. That the standards and criteria endorsed by the local practicing psysicians of the PSRO area be utilized.

2. That PSRO be independently operated by local organized medicine.

3. That the Secretary of Health, Education, and Welfare waive all other review mechanisms as stated in the law.

4. That implementing regulations do not operate to the detriment of the professional care of the patients.

These four points should serve as a basis for the ongoing partnership between government and medicine.

Senator TALMADGE. Thank you very much, doctor, for your contribution.

Senator Bennett?

QUALITY OF CARE AND PSRO

Senator BENNETT. Unlike the many witnesses we have had so far, you are the first witness that has experience with operating a PSRO-type review. The council's doctors in Sacramento have been doing that for several years.

Based on your experience, has professional review diminished the quality of care or enhanced it?

Dr. SCHUBERT. I am Dr. Schubert, Mr. Chairman, medical director of the foundation.

The foundation's experience during the past 4 years has been nothing but improved quality of care in our review programs. When we started our program in 1969 for a few small private groups, and then in 1970 when we began to do the professional review for the State of California in our area, we found many abuses of the use of Government programs and Government funds, and some very bad examples of just bad medicine being practiced. And we have faced these problems in our communities, and we corrected the majority of them. And we continue to move ahead. We have emphasized our program.

PATIENT CONFIDENTIALITY

Senator BENNETT. Have you encountered any problems with the violation of patient confidentiality?

Dr. SCHUBERT. We have not had any complaints from doctors or patients of a violation of the doctor-patient relationship.

Dr. BABICH. That includes both at the foundation level as well as the medical society level since we have been in business.

Forms and Parameters

Senator Bennett. Do you utilize forms and parameters as check points?

Dr. Schubert. Yes, Senator, we do.

Cookbook Medicine?

Senator Bennett. Do you think this is a cookbook medicine?

Dr. Schubert. In our community it is not cookbook medicine. The doctors make the decision, and the criteria were simply as you explained them earlier, they are simply trigger points at which we make a decision.

Elimination of Unnecessary Hospitalization

Senator Bennett. Has this review resulted in savings and moderations of costs to the medicare and medicaid programs?

Dr. Schubert. In our program we have demonstrated a saving. We have reduced the average length of stay in most of our programs, if not all of them. We have—we feel that we have eliminated unnecessary hospitalization.

Dr. Babich. I would like to point out that when Sacramento first went into this program in 1970 when we first appeared here that the State, because of a budget deficit of approximately $150 million, applied this prior authorization for all the doctors of California. However, the doctors of Sacramento were allowed to experiment with their hospital administration certification program. And that program in the first year of the practice for operations in Sacramento resulted in enough savings of hospital days to effect a saving of approximately $3 million. And if that was extrapolated for the population of Sacramento County to the rest of the State of California, it would save the entire deficit that the Governor was looking for. And if that had been extrapolated further, according to our calculation at that point, to every single patient and every hospital, it would have represented a value of $4 or $5 billion.

Physician-Review Hours

Senator Bennett. Apart from normal in-house hospital review, is there an inordinate amount of physician time recorded under your program.

Dr. Bramham. I checked on that for last month. I have the exact figures of 165 hours of physician time for a hospital program. About 80 percent of that is for medicare and medicaid patients.

Senator Bennett. How many hospitals does that cover?

Dr. Bramham. It covers 23 acute-care hospitals.

Senator Bennett. And how many physician-review hours does your program require every month on an average? Is this a good average?

Dr. Bramham. I don't think—you mean the total number of hours?

Senator Bennett. Can you give us an idea of how many physician-review hours?

Dr. Bramham. That was 160, was the total number of hours doctors spent monitoring hospital care. That doesn't include the time we

spent on outpatient review, combined doctor hours. There are some 200 doctors, 150 to 200 doctors who are always participating in the review system. And we rotate.

Senator BENNETT. So that the fear of some doctors that they would have to give up their golfing afternoon doesn't seem to be justified?

Dr. BRAMHAM. No, sir.

BENEFITS OF LOCAL REVIEW

Senator BENNETT. As a result of your doing this review under medicare and medicaid, instead of social security or the State, what specific benefits do doctors, patients, hospitals and nursing homes gain?

Dr. BRAMHAM. There are several gains. Of course, the hospitals are quite in favor of this program locally, because it assures them that they are going to be paid, because we do certification on a current basis. And we deny them on a current basis. So, they know when the authorized number of days are up. And then they can make arrangements with the patients to pay if they wish to extend further. It is a great benefit to the patients, Senator, for the patients to know this, because some of them find out months after the fact under the previous system that they have to pay for a number of days of hospital care that they did not expect.

Now, the patient knows it at the time. If they want to stay in a few more days, that is up to the patient to make that decision, or the family, and they know they are going to have to pay for it then. And they can appeal, and the doctor can appeal. And we have arranged appeals mechanisms.

Senator BENNETT. But you don't throw the patient out of the hospital and subject him to the risk of further trauma or even death because the form says that 5 days is enough?

Dr. BRAMHAM. We never discharge a patient. This is up to the attending physician.

PATIENT AND PHYSICIAN PROFILES

Senator BENNETT. Based on your experience, are patient and practitioner profiles necessary components of a successful program?

Dr. SCHUBERT. We have eight using profiles, Senator, for some time. And they start out in a very simple form, and we gradually have increased them as we find our needs there. And we have found a great deal of uses for profiles, because we can identify bad practices. One of the unfortunate things that happens is that a physician may have a patient in one hospital and readmit the patient to another hospital. By having a central profile of activity we can trace and evaluate the activity of the doctor if we have reason to.

NO STRANGE MEDICINE PRACTICED IN SACRAMENTO

Senator BENNETT. In criticizing the efforts of your prototype PSRO the president of the council of medical staffs has utilized the professional activities study profile, which claims to show that 50 percent of the patients with the diagnosis of myocardial infarction have stays of 5 days or less.

He points out that in his section of the country the stay is 3 weeks, and implies that this is strange medical practice on the part of the Sacramento doctors.

Are you losing very many patients?

Dr. BABICH. No. We may be even a little bit better than the national average. And our official length of stay for myocardial infarction in the foundation and in Sacramento is 21 days, Senator.

Senator BENNETT. I don't know where he found his figures of 5 days or less, do you?

Dr. BABICH. We would invite him to inspect our shop with an on-site visit.

Senator BENNETT. So if 21 days is 3 weeks and they say it is 3 weeks in his part of the country, then you are not practicing strange medicine in Sacramento?

Dr. BABICH. No, sir.

Senator BENNETT. No further questions.

Senator TALMADGE. Senator Curtis?

IS A NATIONAL PSRO LAW NEEDED?

Senator CURTIS. Dr. Babich, this experience that you described in Sacramento, was that conducted under this newly enacted PSRO Federal law?

Dr. BABICH. No; this first started in 1969 on the private insurance program where we go the idea. And at that time Dr. Braham was one of the four founding physicians of this concept, if you will. And we are involved in a medical as well as a physical intermediary problem of trying to get the Foundation and get involved in the health care delivery system of our community. And the only way we could do this was by trying to make the practice of medicine more efficient, and to insure quality medicine. And this is what our CHAP program does.

Senator CURTIS. I don't want to put words in your mouth, but is it fair to describe that this is a voluntary program in that area initiated and carried out by the physicians?

Dr. BABICH. Yes, sir.

Senator CURTIS. Do you need a national PSRO law to continue?

Dr. BABICH. Not in Sacramento. But I think you need it for the rest of the country.

Senator CURTIS. But you do not need it in Sacramento?

Dr. BABICH. We have it in Sacramento now. We have been practicing that since 1969.

EXCESSIVE POWER OF SECRETARY OF HEW SEEN IN PSRO

Senator CURTIS. I am impressed in your statement on item 2: "The National Council is currently being used as a sounding board and reaction panel to guidelines, rules initiated by HEW. It is at best advisory and certainly not administrative. We urge"—and then you have A, B, C, D, and E—that the national council be given all administrative control of PSRO.

Dr. BABICH. Yes, sir.

Senator CURTIS. And that the council report to the Secretary and act as a separate agency. It is your feeling now that as the law is written it is under the Secretary, subject to his control?

Dr. BABICH. Yes, sir. Could I expand on that? The average practicing physician, excluding all the people involved in health care like we are, the average doctor in his little office gets real confused by a mass of bureaucracy, and if he could understand that he was going to have doctors represent him at a high level that would solve his fear.

Senator CURTIS. And then C: "That the Council has authority to hire and fire its own staff and has control over its own budget."

They do not have it now, do they?

Dr. BABICH. No, sir; they do not have a staff, and they do not have a budget.

Senator CURTIS. And both the staff and the budget are in the hands of the bureaucracy, aren't they?

Dr. BABICH. Yes, sir.

Senator CURTIS. "That Council be expanded to allow for adequate elected representation by PSROs."

Dr. BABICH. Yes, sir; I think that every PSRO region, of which there are 10 in the United States, should be allowed to elect one, because that would be the linkage between the practicing physician in his community or his PSRO on the national level.

Senator CURTIS. At the present time the bureaucracy can select the council and name its officers and control its budget?

Dr. BABICH. This is true.

Senator CURTIS. And provide the staff. Now, do you recommend the extension of the PSRO law as it is on the books now without these amendments that you recommend be put into effect throughout the entire country?

Dr. BABICH. Yes, sir.

But I am ambivalent. I would still like these suggestions to be seriously considered by the Senate. Because if this is going to adequately work throughout the United States, it is only going to work because the doctors are participating in it. And you cannot force a doctor to do anything.

Senator CURTIS. Of course, as I understand your recommendations, A, B, C, D, and E, are a very serious criticism of the PSRO law.

Dr. BABICH. Not as such. The intent——

Senator CURTIS. Because by recommending A, that indicates that the national council doesn't have any power. B, that it is not separated from the bureaucracy. And C, that it doesn't have any staff or can't control its budget. And D, that you want it elected and that is a good idea.

The way it is, the Secretary or somebody in the bureaucracy elects them and appoints the officers. And he relates to the election of officers.

Now, I think that while I have no criticism whatever of what has been accomplished in Sacramento, that idea that the medical profession can police the medical profession—I think your recommendations A, B, C, D and E, are one of the most emphatic condemnations of the law that I have read.

Dr. BABICH. It was not my intent to condemn the law, but to present suggestions to improve the intent of the law, and that is to get good peer review and quality medicine for the people of this country, and to have an atmosphere in which doctors can practice in their own office without hindrance.

Senator CURTIS. I think everybody will buy that, peer review, and where doctors can practice in their own offices without hindrance. I

think that is true. But I think without your five amendments that can't be done.

Mr. BABICH. I think it could still be done, but I think it would be much simpler and easier to be done with the recommendations that we have from Sacramento.

Senator CURTIS. I commend you for your amendments and the candor with which they were presented. Because you have put your finger on the very thing that I emphasized in reading the law this morning. This is not peer review. This is bureaucracy review as it is written out.

Dr. BABICH. The intent of this statement that we had was not that there would be amendments, but suggestions for the Senate to consider when they do whatever they do with the law in its final form. We are not power hungry from our section of the State, and maybe we don't understand the machinations of how laws are written.

Senator CURTIS. I think you came up with a very well reasoned criticism of this law.

Thank you.

Senator TALMADGE. Senator Hansen?

Senator HANSEN. Dr. Babich, as you made these five points that Senator Curtis has just alluded to, if I recall, essentially the question was, did you not believe these were very important points that constituted changes that you felt might be effected in one manner or another with respect to the law?

Dr. BABICH. Yes, sir, that is the intent.

Senator HANSEN. I gather that you didn't propose these five points with an idea necessarily of trying to make the old PSRO law, but rather that you felt the implementation of these concepts, these ideas that you have here would make for a better law.

Dr. BABICH. There is no question about that, sir.

Senator HANSEN. I think it is important that we understand that your role here today isn't to try necessarily to see how badly you can undercut the PSRO, but rather to point out, based upon your experience and observation, and the implementation of the law, areas of deficiency that you think should be addressed. And I gather that you said whatever the Senate does with the law, or with the bill I would infer what you are suggesting here is that amendments be made to the law.

Now, as was pointed out earlier today, these hearings were not called to consider amendments, but I think, in order that we have the benefit of your professional expertise, you should not be precluded from calling attention to changes that you think would be helpful. And I gather that is what you have done here.

Am I right in assuming that?

Dr. BABICH. I hope so. It was not our intent to gut the law, or to cut it short, or to ruin it. That is why we stated on page 4 of the testimony that the Medical Care Foundation at Sacramento continues to support Senator Wallace Bennett's development and implementation of the Professional Standards Review Organization legislation. We think this is one of the finest concepts ever to come down the pike as far as medicine is concerned. It gives us the opportunity and the authority to conduct our own business affairs.

Senator HANSEN. And then having said that, you do go ahead and make some specific recommendations. And I think the colloquy speaks for itself that just took place between you and Senator Curtis as to the precise manner in which you think changes could be effected to make the law more responsive, to make it more realistic, and to permit you, given the latitude and the authority to do those things that I gather you feel your council can do better than the organizational structure spelled out in the Federal law could do.

Is that a fair statement?

Dr. BABICH. Yes, sir. We think that the law with those recommendations would be implemented in a much smoother and more rapid fashion throughout the country.

CALIFORNIA MEDICINE

Senator HANSEN. It is not my purpose to impugn the quality of medical practice in the State of California. But do you think that California measures up fairly well with respect to the other 49 States?

Dr. BABICH. Sir, I don't want to degrade the other 49 States, but I think we practice the finest brand of medicine in California anywhere in the world.

Senator HANSEN. As a practicing politician that will sell pretty well at home.

Senator TALMADGE. Senator Bennett?

FLEXIBILITY IN PSRO

Senator BENNETT. There are a couple of things I didn't cover when I was questioning you before.

In your statement—and when I get papers piled this high I lose it and can't find it again so I can't give you the page number—in your statement you indicate your feeling that there should be a variety of approaches available to the local Professional Standards Review Organization. And isn't that possible under the law?

Dr. BABICH. Yes, it is. This is the word that has been resounding through these halls for the past day, flexibility on the part of HEW to allow this to occur. We don't think any one system will be the answer to the whole United States.

Senator BENNETT. Neither do I. And that is why the law was written so that the plan must be developed at the local level and not handed down from the Secretary.

Dr. BABICH. Correct. We agree 100 percent.

Senator BENNETT. Have you applied for designation as a Professional Standards Review Organization in your area?

Dr. BABICH. Yes, sir.

Senator BENNETT. So this would indicate your faith that you can operate as successfully under the Professional Standards Review Organization system as you have been operating in preparation for it?

Dr. BABICH. There is no question about it, Senator, we probably will operate better than we are operating now.

Senator BENNETT. Also, for the record—and this was stated in your statement—you have been the recipient of an EMCRO grant from HEW.

Dr. BABICH. Yes, sir.

Senator BENNETT. So you have had the benefit of some Federal financing in the operation of your program.

Dr. BABICH. We have had quite a bit of Federal—we have had, even an HMO grant of considerable sum of money.

Senator BENNETT. Could you put into the record the total grants you have had in Federal funds to develop the program?

Dr. BABICH. My medical director takes care of the finances.

Senator BENNETT. Cost containment?

Dr. BABICH. In Chicago they are called bagmen.

Dr. SCHUBERT. We will get the number to you, Senator Bennett.

Senator BENNETT. Thank you.

That is all.

[The following information was subsequently supplied for the record:]

HMO grants—July 1971-June 30, 1972, $122,000.

HMO grants—July 1972-December 31, 1973, $190,000.

EMCRO grants—June 1971-May 1972, $133,000.

EMRCO grants—June 1972-May 1973, $150,000.

Senator TALMADGE. Thank you very much, gentlemen. We appreciate your contribution.

The next witness is Dr. William M. Lees, chairman of the board, Illinois Professional Standard Review Organization, accompanied by Mr. Howard Cook, executive director of the Chicago Hospital Council.

Your entire statement will be in the record, Doctor. And you may summarize it.

STATEMENT OF DR. WILLIAM M. LEES, CHAIRMAN OF THE BOARD OF DIRECTORS, ILLINOIS PROFESSIONAL STANDARDS REVIEW ORGANIZATION, ACCOMPANIED BY HOWARD COOK, EXECUTIVE DIRECTOR OF THE CHICAGO HOSPITAL COUNCIL

Dr. LEES. Thank you, Senator.

I am Dr. William Lees, a practicing physician in the State of Illinois, and chairman of the interim board of directors of the Professional Standards Review Organization. This opportunity to present testimony on behalf of the IPSRO is much appreciated.

In January of 1972 Illinois physicians demonstrated their commitment to peer review and public accountability by implementing through the Illinois Foundation for Medical Care the hospital administration and surveillance programs, in other words, the HASP. This program, which is the largest of its kind in the country, having already monitored over half a million cases, and supported by State and Federal funds, placed in the hands of practicing physicians the determination of medical necessity for the initiative and length of stay for medicaid and general assistance patients in Illinois.

Contrary to some opinions, Illinois physicians are not rejecting the peer review being sought under Public Law 92-603. They are, however, rejecting PSRO. And we support the amendments to this law as

proposed by the American Medical Association. Pending changes in the law, we propose to carry out those review responsibilities under a voluntary, all-patient review program through the Illinois Professional Standards Review Organization, incorporated in October of 1973.

This is the intent of this organization, whose board is composed of doctors of medicine, doctors of osteopathy, and hospital and nursing home representatives, representatives of third party insurance carriers, and medicaid State agencies, comprehensive health planning and the public, to modify and expand the HASP program and seek from the Secretary of HEW approval of their statewide program under section 237 of Public Law 92–603. We do this in full knowledge of the voluntary nature of PSRO, or section 249F.

In an address before the Illinois State Medical Society on April 3, 1974, the Honorable Caspar Weinberger stated in part:

> We recognize that the Federal Government cannot and should not be in the position of reviewing and monitoring the quality of care which physicians provide their patients. Only physicians can judge the appropriateness and quality of care. And that is what PSRO is all about. The Government is merely asking the physicians of this Nation to assure us a quality of care which meets standards set by the medical profession itself.

We can assure the Government of effective peer review in Illinois, but we submit that if PSRO is truly voluntary, and that if under section 237 a superior system is allowable, and if the goal of all this legislation is responsible, comprehensive professional review instituted by health care professionals, then the Department of HEW, instead of denying and restricting this innovative plan, should actually aid in the establishment of IPSRO. Physicians and others involved in the provision of medical care services in Illinois have so indicated their desire to perform peer review in a different, though compatible, and better way.

Dr. LEES. And Senator, if you will permit, I would like to ask Mr. Howard Cook of the Chicago Hospital Council to carry on with our testimony.

Mr. COOK. I am here today as a member of the Board of Directors of the Illinois Professional Standards Review Organization, and at the request of that board. So that is my reason for being here today.

As this committee is well aware, doctors in hospitals have been engaged in peer review for a long while through medical staff credentials committees, tissue committees, infection committees, utilization committees, and many other mechanisms. Such review is the cornerstone on which hospital standardization and hospital accreditation have been built.

And such systems of peer review are virtually unknown in other industries, professions or indeed, in government.

In Illinois we have had some experience with areawide peer review, and we make a distinction with the word "areawide," because HASP has been operational for about 2 years. We have learned a lot of things from HASP, and often the hard way.

It is on the basis of that that we have developed a set of three principles which have been used to formulate the IPSRO. And those three principles are as follows: One, the program should be applied

to all patients. If quality review, if utilization review, has any validity as a concept, it has validity for all patients and not just for those involved in Federal programs. And, therefore, the structure of the IPSRO should meet the needs of all patients, physicians, hospitals and third party payers.

As a corollary of that point, in principle No. 2, physicians, plus hospitals, third party payers, government and non-government, nursing homes, the public, and other non-physicians involved should be included in the programs development, governance, and implementation. These programs affect hospital income and hospital expense, the allocation of hospital resources, personnel and procedures. And they affect third party similarly. Therefore, all who are affected by the program should be involved in the development of the basic policies by which the program operates.

Nonphysicians will not be included in the judgment of care of specific patients or in choosing criteria for making such judgments.

And the third principle is that utilization in quality review can be best carried out at the hospital level, and controls must insure that the work is done effectively and in a timely manner.

Illinois doctors of medicine and osteopathy, hospitals, nursing homes, third party payers, and the State of Illinois have all embraced those concepts and have joined together to incorporate the IPSRO program. A board of directors has been appointed. A permanent board will soon be created, and will include representatives of the comprehensive State health planning agency and the public in addition to the State and voluntary people now serving.

IPSRO appears to meet, with little exceptions, the requirements set forth in section 249. And yet, the Congress and the Department of HEW have chosen to emphasize geography over the much more important issue of board composition.

We believe we learned from our experience with HASP some of the things that need to be changed, what makes a cost-effective as well as a health-effective program. We believe that we should not look to PSRO type of activity as a way of containing hospital costs, the reasons behind rising hospital costs are numerous, they are complex. And I believe they are well known to members of this committee. This type of review will simply not touch the major aspects of hospital costs.

Finally, I would like to close with four conclusions which we have reached.

(1) The careful study of the best ways in which to carry out utilization and quality review is needed.

(2) The best chance of achieving effective utilization/quality review which allows flexibility to effect change based on experience is through organizations such as the Illinois Professional Standards Review Organization.

(3) Sections 207, 213, 237, and 249F of Public Law 92–603 should now be amended so that a single, carefully designed, utilization and quality review monitoring program can be designed.

(4) Such amendments should allow sufficient flexibility so that an organization such as the Illinois Professional Standards Review Organization can be officially recognized and allowed to demonstrate

its ability to develop and conduct an areawide utilization and quality review monitoring program that is both cost-effective and "health-effective."

Thank you.

Senator TALMADGE. Senator Bennett.

SUGGESTED MODIFICATIONS SEEN TOO FAR REACHING

Senator BENNETT. Mr. Chairman, I am particularly puzzled at the apparent meaning of Mr. Cook's statement, which is that he wants the law modified so that it not only reviews or concerns itself with the service of the physician to his patient, but it must take in all of the aspects of health care delivery to the third party payers of the hospitals, everybody else. He says, the physicians must not review those things. You cannot ask questions about them. But you cannot operate the system unless they are all involved in setting it up. I think this would be an extension of responsibility if we were to rewrite the law to cover all of these things or to provide the rights of these supplementary or satellite operations, allow the people representing those satellite operations to impact on the fundamental problem of the relationship between the patient and the doctor and the quality of health care. This is a concept that I think is far beyond the scope of the law. And if we were to amend the law to do that, then you would say that the Federal Government should involve itself with every aspect of health care. And I do not think you really mean that. We very carefully excluded from participation in PSRO hospital administrators, consumer representatives, third party payment representatives, and others who might like to see this thing operated so that they would be protected in their particular empire against the effects of the program.

ILLINOIS AND PSRO

I hope you do not believe that IPSRO has the complete support of the physicians of Illinois. Several physician sponsored organizations have applied for designation as PSRO, including one from Chicago. Does your group oppose—will you now go out and attempt to persuade these people to drop their applications? Are you going to take active part in trying to thwart the normal operation of the program in Illinois?

Dr. LEES. I do not believe that we are going to try to thwart PSRO. The intent of peer review is well known to the physicians in Illinois. We are firmly of the opinion that we do not believe there should be two standards of care.

Senator BENNETT. But you are not answering my question.

Dr. LEES. I will answer your question, Senator. We will attempt to ask them to withdraw their application for planning grants, because we believe that we can do it in a better fashion and do it for all patients, not necessarily a double standard for the poor or for those who are old, we think all patients deserve that benefit, Senator.

Senator BENNETT. Are you saying now that under your system they get a double standard?

Dr. LEES. No, under our system all patients will be reviewed, whether they are under medicare, medicaid or what.

Senator BENNETT. There is nothing in the law that would prevent the PSRO that is set in motion or put in place to review medicare, medicaid patients, from contracting with the State of Illinois, or private insurance companies, or Blue Cross and Blue Shield, to give them the same kind of service on a fee or compensation basis. So you can continue to cover everybody in your hospital if the local PSRO wishes to extend its activities to that extent.

Dr. LEES. We are fully aware of that. And that is the reason we asked them to join us at this board level. They do not have a physician who will make the decisions. And we believe that this plan, if the intent of the law is as in the statements made not only by you, Senator Bennett, and by Dr. Edwards and Dr. Simmons, that this law is flexible, it can be innovative, and if we have something which is superior and innovative and does exactly everything that the law requires under the intent and under the rules and regulations, we hardly see why it should be resisted.

Senator BENNETT. We are back again to what I said to the AMA this morning. The basic problem is, you like the law if you control it. If you do not control it you do not like it, and you will go out to these incipient PSRO's and try to persuade them to withdraw.

For the record, I would like to read from a publication of the Illinois State Medical Society.

Write Your Congressman. Tell him you do not support the Federal Government's PSRO program. Tell him that excessive bureaucratic interference in an attempt to reduce costs will lower the quality of medical care.

Is that the kind of testimony we have been having today as to the goal and purpose of PSRO? Has it not been made clear that the responsibility is the quality of medical care and not to reduce costs?

Tell him you prefer a voluntary plan for quality assurance—superior to PSRO—now being developed for Illinois by doctors, hospitals and others. This alternate plan will protect the confidentiality of your records and assure high quality care at reasonable costs.

CONFIDENTALITY

Can you tell us how you can better protect the quality and the confidentiality of records than PSRO can?

Dr. LEES. I think we can control the quality. We have demonstrated that with the HASP program, Senator.

Senator BENNETT. I am talking about confidentiality.

Dr. LEES. As to the confidentiality of records, we believe, if the records are maintained locally rather than regionally or federally, we will have fewer fingers in the pie.

Senator BENNETT. Do you think the PSRO requires the records to be maintained regionally or federally?

Dr. LEES. This was the impression I was given by those who spoke on that law, yes.

Senator BENNETT. I think you have a thorough misunderstanding. The records will be maintained and are under the control of the local PSRO. Now, if the local PSRO decides that it is wise to use a central data bank, it is their decision, not the decision of the man who operates the central data bank.

Dr. LEES. But, Senator, we were informed by members who are supposedly knowledgeable from the regional areas of HEW that there would be a regional data bank.

Senator BENNETT. Does IPSRO maintain a central data bank?

Dr. LEES. We do, yes, sir.

Senator BENNETT. So what are you complaining about?

Dr. LEES. It is only for the State of Illinois.

Senator BENNETT. Are you aware that PSRO areas may not cross State lines?

Dr. LEES. I am aware of what it says in the guidelines, yes, sir.

Senator BENNETT. I have been sitting here trying to resist temptation. But I am going to succumb. It is always pleasant.

I have here a questionnaire which I sent out which was returned to me by an executive of an Illinois County medical society. And he has written in the margin: "Frankly, our members distrust the State society more than they do the Department of HEW. We would prefer to develop our own system."

I have no further comment.

Senator TALMADGE. Senator Long.

The CHAIRMAN. Let me ask you this. Are you aware of any patient who has complained about a violation of the confidentiality of his records?

Dr. LEES. Yes, sir, I am, in my own practice with a single patient, a patient who applied for a credit rating and he was at that time under the Department of Public Aid, and information with regard to some psychiatric consultation was made known, and on that basis he did not get his credit.

The CHAIRMAN. I wish you would make available to us if you can, on whatever basis you think appropriate, that fact, so that we can look into it.

I want to protect the confidentiality of anybody. Any proper protection of a patient, I am for. But frankly, I sometimes wonder if this was not a matter of a doctor raising this confidentiality matter for their own advantage rather than for the advantage of the patient. We lawyers have laughed about it sometimes, we say, we lawyers have got to be mighty careful, we are not like our fellow professional people in the medical profession, they can bury their mistakes, but lawyers have them on the record for years to come to contend with.

The same thing goes for politicians, even the President is finding out that confidential though you might think it is, the people are finding out about everything we do. There is no point in complaining about it. Those are the facts of life. We politicians have very little confidentiality available to us. I treasure such as we do. And I try to preserve it for the other fellow.

But I am not aware of any patient complaints except the one to which you made reference. And if that is a widespread fact of life, I would certainly want to know about it and try to do what I can about it. Now, if it is not, then, of course, I think we ought to look at it for what it is.

Dr. LEES. I am not certain, Senator, whether it is widespread. But I do know that the more fingers are in the pie, the easier it is for information to get out.

Senator BENNETT. That was obviously released from your office. Who released it?

Dr. LEES. What was released? I did not understand you. The information on this one patient?

Senator BENNETT. Yes.

Dr. LEES. It was not released. That is my own patient, and I have not released it, and I will not unless he tells me I can do so.

Senator BENNETT. I am not interested in his name, I am interested in knowing—you said that information got into a credit file. Who violated the confidentiality and released it to the credit files?

Dr. LEES. Had I known I would have pursued it relentlessly.

Senator BENNETT. Did it exist only in your office?

Dr. LEES. The information?

Senator BENNETT. Yes, sir.

Dr. LEES. No, this was prior to the time I saw the patient. I had nothing to do with it. He told me this story.

Senator BENNETT. So it could have been released by some means from the office of a previous doctor who treated him, or by some means from a public record, maybe the Department of Welfare or something of the kind?

Dr. LEES. That is possible.

Senator BENNETT. But if it was not your patient, you really cannot give us any information as to how it came to be released?

Dr. LEES. I object to that, Senator. I said it was my patient. I operated on this patient, and he told me that this occurred prior to the time he came there.

Senator BENNETT. Then, all you can give us is hearsay as to how it was released, you have just told me you cannot tell me how it was released.

Dr. LEES. Who released the information?

Senator BENNETT. Yes.

Dr. LEES. I cannot tell you, no, sir. I can only tell you what the patient told me. And that is what I base my diagnosis on also, what he tells me.

DIVERSITY APPEALING

The CHAIRMAN. Permit me to say that I find considerable appeal to your suggestion of diversity. I really think that we would be well advised to try a number of approaches to this problem, because all we really ought to be doing, as I see it, is trying to find out what is right, not who is right. It is not too important whether you in Illinois do things better than we do in Louisiana, the important thing is, what is the best approach, what is the best answer. And unless we have tried some of these things I really do not see how we are going to be able to decide.

Dr. LEES. You are saying it far better than I could. We think we have an innovative plan. If this is flexible, give us the opportunity to go down in flames in 1976, if you wish, but give us the opportunity to demonstrate to you what funds we have received from the State of Illinois, Department of Public Aid. We think we can give as good care and still save some funds for the rest of the patients.

The CHAIRMAN. Well, if you were testifying for the Louisiana Medical Society I am sure I would lead the charge for it. But I find a great deal of appeal to it, and I may support it even for the Illinois Medical Society.

Dr. LEES. Thank you. We support many things in our hospital for Louisiana also.

Senator BENNETT. This is a trade.

Senator TALMADGE. Mr. Constantine.

PERFORMANCE DATA ON HASP REQUESTED

Mr. CONSTANTINE. Could you please provide us for the record, with specific performance data on HASP over time showing the amount of money invested and the specified savings achieved, et cetera, excluding Cook County Hospital? We have been trying to get that for a couple of years now, that is, your HASP data excluding Cook County Hospital.

Dr. LEES. From whom were you trying to get this data?

Mr. CONSTANTINE. Dr. Scrivener and Mr. White.

Dr. LEES. We do have data—I do not know how easy it would be to extract the 60 percent of the patients that go to Cook County Hospital. But we do have an extensive file on a half million patients that we have seen. We will try to get you that information. But you have, I believe, been given in your office information from the Illinois Department of Public Aid, indicating the projected savings and the actual savings on this program.

Mr. CONSTANTINE. We would like to see what data you have showing your performance, that is, the achievement in reduction of days or estimated days, relative to a prior period, excluding Cook County Hospital.

Dr. LEES. We will try to get that to you. But I assure you our data, as you put it, will be no different from the data the department of public aid gave you.*

Mr. COOK. I would like to correct one thing that may be a misunderstanding, due to shortage of time I skipped through this. I did not mean to imply that the HASP program would become the IPSRO. What I meant to imply was that our experience in HASP taught us a lot of things, often the hard way. We found out many things that ought to be done. differently. And many of those are the basis upon which the IPSRO, therefore, has been operated. We are not here to say that HASP is the program we think there should be rather than the IPSRO. We think that IPSRO is an outgrowth of HASP based on experience.

IPSRO MEMBERSHIP

Mr. CONSTANTINE. Just one further question for the record. IPSRO is entirely physician run.

Dr. LEES. It is entirely physician run.

Mr. CONSTANTINE. Does your board consist entirely of physicians?

Dr. LEES. The board is not made up entirely of physicians, because

*At presstime the material requested had not been received by the Committee.

we feel that the input of those involved in health care is important to us, particularly in regard to data——

Mr. CONSTANTINE. I just want to make the distinction between a PSRO where the membership consists solely of physicians as opposed to another approach.

Dr. LEES. The PSRO must have no membership as such. I think I told you that.

Mr. CONSTANTINE. No; it has as members every licensed doctor of medicine and osteopathy.

Dr. LEES. They may be members. But the physicians are the only ones that make the decisions in the standards review situation.

Senator TALMADGE. Thank you very much, Dr. Lees and Mr. Cook, for your contribution.

[The prepared statements of Dr. Lees and Mr. Cook follow:]

PREPARED TESTIMONY OF WILLIAM M. LEES, M.D., CHAIRMAN OF THE BOARD OF DIRECTORS, ILLINOIS PROFESSIONAL STANDARDS REVIEW ORGANIZATION

Mr. Chairman: I am Dr. William Lees, a practicing physican in Illinois and Chairman of the Interim Board of Directors of the Illinois Professional Standards Review Organization. This opportunity to present testimony in behalf of the IPSRO is appreciated.

To quote Senator Talmadge (within the 3/20/74 hearing notice) and Senator Bennett (before the Senate on 4/1/74): "PSRO legislation was designed to afford practicing physicians at local levels an opportunity, on a voluntary and publicly accountable basis, to undertake review of the medical necessity and quality of care provided under the $25-billion Medicare and Medicaid programs. It was intended to substitute responsible, comprehensive professional review by the community of physicians in an area for the hit-or-miss review which has heretofore been provided in less than effective fashion by Government and insurance company personnel."

Senator Bennett continued on to state: "It is particularly important to note that all of the review responsibility and authority which a PSRO may assume is separately authorized, under non-PSRO provisions of the law, to the Department of HEW and to the carriers and intermediaries under Medicare as well as to state agencies under Medicaid . . . the absence of the PSRO statute would not leave a review vacuum. Necessary review will be accomplished with or without the PSRO provisions. What the PSRO alternative offers, however, is professionalism and local control instead of bureaucratic fiat, mandate and arbitrariness in determining medical necessity and quality of care."

The physicians of Illinois have well noted the voluntary nature of PSRO participation and the fact that it is an alternative to review by non-professionals as otherwise established by law. The physicians of Illinois further note that Section 237 of PL 92-603—and this is a part of the established law separate and apart from the PSRO provisions—we note that Section 237 allows the Secretary to permit a state agency that has demonstrated that it has a superior Title XIX review system to authorize use of that system in behalf of Title XVIII beneficiaries. It is the intent of the IPSRO to establish a superior peer review system.

We stand firm in our commitment to peer review, and to bringing about changes in the medical care delivery system where change is indicated appropriate or necessary as a result of peer review. We also remain firm in our decision to do it separately and apart from the PSRO provisions and to develop a superior review system for substitution. We feel that we have already established a sound basis toward a superior system.

The Hospital Admissions & Surveillance Program, known as HASP, the largest plan of its type, first became operational in January of 1972. The program was established, prior to any implementation of PSROs, to screen the medical necessity of Medicaid and General Assistance admissions and lengths-of-stay, and to facilitate payment by certifying those approved. The HASP has been and is being funded by state and federal funds. We question the justification of tearing down this system already funded and implemented.

HASP policy and procedure is established on a statewide basis by a state committee, with review responsibilities delegated to eight regional committees and approximately 32 local committees; each of these committees has a membership of four physicians, two hospital administrators, and one consumer member.

The Illinois Foundation of Medical Care, which administers the HASP program, also established committees which studied and developed plans to incorporate within the HASP system the review of care within long-term-care facilities, the evaluation and assurance of quality of care, and the education of hospital utilization review committees, where necessary, to assist them in attaining appropriate proficiency and participation. Each of these portions of the overall system, in various stages of development, have never been implemented, and the reason they've not been is all the federal legislation that was pending and the uncertainty of the direction in which it would take these issues.

The IFMC's two years of experience in monitoring more than 500,000 admissions under HASP has led us to the conclusion that peer review programs of this type can more readily and effectively achieve the desired goals of quality patient care and cost effectiveness if the responsible parties in health care delivery work together in a coordinated statewide effort in response to the issue involved—that is providing quality medical care based on medical necessity, as related to the socio-economic problems of a specific case. We wish to emphasize that the voluntary Illinois statewide concept incorporates within it statewide planning opportunities that, in our opinion, cannot be addressed as effectively by a multitude of individually-established PSROs in our state. We recognize that the HASP system falls short of the ultimate goal, but the necessary modifications are currently being developed by which to provide an effective all-patient review system. This system will encourage, through its flexibility, peer review by qualified institutional utilization review committees.

Now we've made our decision to move ahead as quickly as possible—we don't stand alone in our decisions.

The Illinois Professional Standards Review Organization was established in October of 1973. This new corporation is committed to professional peer review. The Board, besides having a majority membership of doctors of medicine, includes doctors of osteopathy, representatives of hospital and nursing home associations, third-party insurance carriers, the Medicaid state agency, Comprehensive Health Planning and the public. These parties are jointly assuming responsibility for modifying and expanding the HASP program to establish an all-patient review program on a statewide basis.

Although policy, procedure and appropriate standards will be formulated at the state level, local participation will be assured in the establishment of those standards. Local autonomy will be stressed and review responsibilities will be authorized to local medical review organizations whose membership will consist of physicians and doctors of osteopathy. Our plan will allow review to be performed by more specifically-local areas than those defined in the federally-proposed eight regions in Illinois.

IPSRO will also incorporate within its plan the review of care in long-term-care facilities, the assessment and assurance of quality of care, with emphasis on continuing education of physicians and hospital utilization review committees. Those programs developed by the Illinois Foundation are already being studied for modification as may be considered appropriate for the expanded plan of all-patient review.

Those involved in IPSRO are convinced that only through the coordinated effort and involvement of each of the several disciplines concerned with health care delivery, and only by implementing a total package of review for all patients, can an effective, equitable and improved health care system be accomplished in the best interests of the patients.

In an address before the Illinois State Medical Society on April 3, 1974, the Honorable Caspar Weinberger stated in part, "We recognize that the Federal Government cannot and should not be in the position of reviewing and monitoring the quality of care which physicians provide their patients. Only physicians can judge the appropriateness and quality of care. And that is what PSRO is all about. The Government is merely asking the physicians of this nation to assure us a quality of care which meets standards set by the medical profession itself."

We can assure the government of effective peer review in Illinois, but we submit that if PSRO is truly voluntary, and that if under Section 237 a superior system is allowable, and if the goal of all this legislation is responsible, comprehensive professional review instituted by health care professionals, then the Department of HEW, instead of denying and restricting this innovative plan, should actually aid in the establishment of IPSRO. Physicians and others involved in the provision of medical care services in Illinois have so indicated their desire to perform peer review in a different, though compatible, and better way.

PREPARED STATEMENT PRESENTED BY HOWARD F. COOK, EXECUTIVE DIRECTOR, CHICAGO HOSPITAL COUNCIL

Mr. Chairman, members of the subcommittee, ladies and gentlemen, I am Howard F. Cook, Executive Director of the Chicago Hospital Council. I am a member of the board of directors of the Illinois Professional Standards Review Organization and am here today in that capacity and at the request of that board.

Doctors and hospitals have been engaged in peer review for a long while now. Medical staff credential committees, tissue committees, infection committees, utilization committees, and medical audit committees are the most common mechanisms used to accomplish this work. The orderly and professional review of professional work in the hospital is the major cornerstone on which hospital standardization and hospital accreditation has been built. Such systems of peer review are virtually non-existent in other industries and professions.

Doctors and hospital administrators in Illinois have more experience with areawide peer review programs than their colleagues in other states because the Hospital Admission Surveillance Program, better known as HASP, has been operational in Illinois for over two years. HASP, as you may know, is operated by the Illinois Foundation for Medical Care under a contract with the Illinois Departments of Public Aid and Public Health. HASP deals exclusively with Medicaid patients.

One major lesson from HASP is that, in spite of the fact that we have been carrying out peer review for years, the state of the art of areawide peer review is such that we do not yet know the most cost effective way in which to carry out such review. Areawide peer review programs are expensive. They presently demand a great deal of time of physicians and hospital personnel. Their administration is expensive. We have learned that, before embarking upon a massive areawide peer review program, careful study of the cost-effectiveness of such a program is essential.

Our experience under HASP has taught us other things as well. As a result, we developed a set of principles which we believe must be included in any quality review/utilization program, if the program is to be both equitable and effective. Those principles, in highly summarized form, are:

1. The program's policies and procedures must be applied to all patients to prevent the confusion and expense inherent in operating several different programs for the various different payment classes of patients. If utilization and quality control has any validity as a concept—it has validity for all patients and should be applied to all. Its structure should meet the needs of all patients, physicians, hospitals and all third-party payers—and not just federal programs.

2. Physicians plus hospitals, third-party payers (Medicare and Medicaid, Blue Cross, and commercial insurance carriers), skilled nursing facilities, the public, and other non-physicians who will be significantly affected by the program must also be involved in the program's development, governance, and implementation. These programs affect hospital income and expense, allocation of resources, personnel and procedures; and they affect each third-party payer similarly. Therefore, all who are affected by the program's policies and procedures must be involved in the development of the basic policies and procedures by which the program operates.

The role of the non-physician cannot, however, include evaluation of whether care rendered to a specific patient is acceptable or otherwise, nor can the non-physician participants choose criteria for making such judgments.

3. Utilization and quality review can be best carried out at the hospital level and controls must insure that the work is done in an effective and timely manner.

Illinois doctors of medicine and osteopathy, hospitals, skilled nursing facilities, third-party payers, and the state of Illinois have embraced the above concepts and have joined together to incorporate the Illinois Professional Standards Review Organization. An interim board of directors has been guiding the development of IPSRO's program. A permanent board will be created and will include representatives of the Comprehensive State Health Planning Agency and the public in addition to those now serving.

IPSRO will contract with local medical review organizations to carry out evaluation of the effectiveness of hospital utilization and quality review processes, to provide assistance to hospitals and hospital medical staffs in upgrading utilization and quality review, and to impose sanctions where necessary and appropriate.

IPSRO appears to meet, with little exception, the requirements set forth in Section 249F of Public Law 92-603. Yet, the Congress and the Department of Health, Education, and Welfare have chosen to emphasize geography over the much more important issues of program concept, board composition, or organizational competence.

The organizations which support and make up IPSRO have had significant experience with HASP. We have learned, often the hard way, what works and what doesn't work. We have learned the importance of being able to measure a program's cost-effectiveness. We have learned that utilization and quality review monitoring programs can be very expensive. We have learned that HASP needs to be changed, and we believe that we know how to go about effecting such change. Finally, we have learned that such programs must be both cost-effective and "health-effective". We are working to insure that patients receive high quality care that appropriately meets their needs and is provided at the most appropriate, feasible level.

I cannot guarantee that IPSRO, or for that matter, any utilization and quality review monitoring program, will contain costs. The reasons for rising health care costs are numerous and highly complex. The costs of goods and services purchased by hospitals have risen rapidly. Hospital wages and employees benefits have had to catch up with those of industries with whom we compete in hiring workers. Hospitals provide services now which were unheard of ten years ago. Many other factors come into play. Utilization and quality review monitoring programs will have no effect on these factors. Such programs will affect only utilization and as I mentioned earlier, there is no proof that such programs are cost-effective.

The containment of health care costs and the carrying out of cost-effective utilization and quality review are extremely complex and confusing on their own. Trying to deal with such matters is difficult enough without the addition of unnecessary confusion. Yet, because Sections 207, 213, 237, and 249F of Public Law 92-603 all deal with utilization and quality review, but each does so in a different way, confusion is rampant. Rather than have one orderly, well-defined carefully phased program, we have four or more.

The preceding facts and principles lead to some basic but important conclusions:

1. Careful study of the best ways in which to carry out utilization and quality review is needed;

2. The best chance of achieving effective utilization/quality review which allows flexibility to effect change based on experience is through organizations such as the Illinois Professional Standards Review Organization;

3. Sections 207, 213, 237, and 249F of Public Law 92-603 should now be amended so that a single, carefully designed, utilization and quality review monitoring program can be designed;

4. Such amendments should allow sufficient flexibility so that an organization such as the Illinois Professional Standards Review Organization can be officially recognized and allowed to demonstrate its ability to develop and conduct an areawide utilization and quality review monitoring program that is both cost-effective and "health-effective".

Senator TALMADGE. The next witness is Dr. John Wood, president of the American Association of Foundations for Medical Care, accompanied by Dr. William F. Dowda, vice president, and Dr. Donald C. Harrington, past president.

Doctor, you may insert the full statement in the record and summarize it, sir.

STATEMENT OF DR. JOHN M. WOOD, PRESIDENT OF THE AMERICAN ASSOCIATION OF FOUNDATIONS FOR MEDICAL CARE, ACCOMPANIED BY DR. DONALD C. HARRINGTON, PAST PRESIDENT

Dr. WOOD. Mr. Chairman, I am Dr. John Wood, a pathologist practicing in Denver, and presently serving as president of the American Association of Foundations for Medical Care. Accompanying me today are Dr. Donald C. Harrington of Stockton, Calif., our immediate past president, and Dr. James Schubert of Sacramento, a director and chairman of our PSRO task force committee.

The American Association of Foundations for Medical Care recognizes and appreciates the Senate Finance Committee's deep concern for the successful implementation of the PSRO statute. Our association and its member foundations, as prototypes of the PSRO concept, have consistently supported the purposes of this legislation and we welcome any opportunity to help accomplish those objectives.

The foundations are in the forefront of medicine's effort to make medical care more efficient through sophisticated utilization and peer review practices. The foundation movement provides the cutting edge of American medicine's progress in developing the new technologies of quality evaluation.

Mr. Chairman, foundations for medical care represent a voluntary response on the part of the local medical profession in many communities throughout the land to the undeniable need for a more rational use of medical resources. And the experience of the more mature foundations demonstrates beyond any reasonable doubt that modern utilization and peer review processes bring solid benefits to both the public and the profession.

If the PSRO statute is reasonably administered with due regard to the needs and concerns of the professional people involved, we truly believe this great and necessary venture will be successful.

Foundations for medical care are as conservative as they are progressive. They build on the community's existing health care resources. They insist on comprehensive benefit patterns, so that the doctor may prescribe for each patient the precise regimen most suited to the patient's needs. They fortify the concept of "incentive reimbursement" or fee for service. They strive to enlist every physician in foundation programs and peer review activity, and thus help him to better understand to better serve the health needs of his community.

The foundations challenge the physician to resume his natural leadership in medical management and in controlling the practice of medicine.

The AAFMC has been privileged to play an active role in implementing PSRO. Our association initiated and is presently one of five national professional organizations sponsoring and directing the "private initiative in PSRO" program, funded by a $1 million grant from the W. K. Kellogg Foundation. This project will assist 6 PSRO prototypes which are now being selected from a field of more than 40 applicants. This endeavor has been coordinated with OPSR.

The AAFMC sponsored a 2-day workshop-conference on PSRO April 1–2, 1974, in Washington, D.C. The 417 registrants included 214 physicians and representatives of 119 medical societies or foundations for medical care. In this conference, representatives of prospective

PSRO's worked in shirt-sleeve sessions with the OPSR staff in criticizing the PSRO manual, exploring the qualifying process for a candidate of PSRO's, and, perhaps most important, setting up good working communications between OPSR and prospective PSRO's throughout the country.

AAFMC has established the Institute for Professional Standards which is working with major universities on the east and west coasts to set up training programs for physicians, executives, nurse coordinators, information specialists and others who will be needed in administering PSRO functions. The institute's board of regents includes representatives of numerous operating foundations, national medical specialty organizations, the Group Health Association of America, AMA and the student AMA. AAFMC members are expected to provide faculty members and sites for internships and preceptorships for this vital education effort.

As the acknowledged pioneers in peer review, the heart of the PSRO function, members and officers of the AAFMC stand ready at all times to help interpret the true significance of this statute to our profession and to help them meet the challenge that PSRO poses to medical men to function as masters in the house of medicine.

In recent months we have been pleased by the activity of OPSR and HEW and by the progress of their work as exemplified by publication of the PSRO guidelines and rapid movement toward approval of planning and conditional contracts with prospective PSRO's.

We are here today not only to support the concept of PSRO but to offer for your consideration some suggestions for amendment, which, in our opinion, will strengthen the program.

We suggest that, as proposed in the committee's report to Congress, new consideration might be given to requiring establishment of a technical task force as a mechanism that would enable OPSR to utilize on a far broader and deeper base than it has so far—the wealth of professional experience and technical expertise available in various foundations.

We suggest that the role of the national PSRO council be expanded to permit it to act as an independent agency, to control its staff and its budget; and that the council be expanded to include elected representatives of local PSRO's.

Both the law and all regulations should be carefully tested to assure that each PSRO will have total access to all medical data required to carry out its mission, while recognizing the practical need for uniform reporting to the State and national councils.

We are confident, Mr. Chairman, that if your distinguished committee continues to exercise vigilant oversight, desirable amendments will eventually be offered from various sources and will be duly considered. We appreciate the opportunity of testifying before the subcommittee on behalf of the American Association of Foundations for Medical Care. Thank you.

The CHAIRMAN. (now presiding). Senator Bennett.

Senator BENNETT. This is for Dr. Harrington.

REVIEW CRITERIA FOR A COMMON COLD

The council of medical staffs in March 1973 took one of your review criteria for the common cold. And this is the example:

Diagnosis. Acute upper respiratory infection in the absence of a complicating factor.

Visits. Either home or office, preferably office.

Number of visits. Between two and four, or one and a phone call.

Frequency of visits. Three to four days apart.

Lab and X-ray. Seldom. X-ray of chest when complications are present. WBC and differential may be indicated. Culture may be indicated.

Therapy. Analgesics, sedatives, antitussives, expectorants, antihistamines, and chemotherapy.

Duration. Seven to ten days.

Comment: Cost of treating "colds" under PSRO—$34 billion!

They arrive at that by assuming that there will be an office visit, drugs, WBC, culture insensitives, total, $41. Number of common colds in the United States, population 200 million, 4 colds per year, $41 per cold, plus one X-ray out of 610 colds, $34 billion.

Do you think this is a reasonable extrapolation from the application of your criteria and norms?

Dr. Harrington, do you want to comment on that?

Dr. HARRINGTON. Somebody just said that figures do not lie and liars do not figure. And I think this may be an example of just that. Actually, this document was developed back in about 1956. And if we had it to do all over again right now, I think we would eliminate one thing, chemotherapy, because at the present time we do not have chemotherapy unless this has been the possibility of a strep throat and a culture and this sort of thing. For the common cold we do not use chemotherapy. As far as these costs that have accumulated, they are utterly ridiculous. These criteria that we are talking about— and these are, you might say, optimum criteria—they are not critical criteria, they are criteria that are expansive criteria as to what could possibly be used for the common cold. And as I say, it was developed approximately 20 years ago.

Senator BENNETT. You cannot insist that these criteria are always there in every case and always will require this kind of treatment?

Dr. HARRINGTON. No, sir. These could be used, for instance, if a claim came through for a chest X-ray, we would probably allow the chest X-ray, because we would feel that the man thought this probably might have been bronchitis or pneumonia or something, so he tries an X-ray to check it out. However, this goes into the patient profiles, and we find that he is getting chest X-rays on every single person, that physician would be brought to task to inquire what his thoughts were.

As Dr. Shubert testified earlier, you need profiles, because what occurs on one man does not give you the answer. We are talking about criteria.

There has been a term that has been greatly misused today, particularly by your witness. And that is the term "norms." Norms are not developed. Norms are observed reality. In other words, I happen to be on the national council, as you know, I am chairman of their daily committee. There is no way that we could pass down norms to Sacramento. It is an observed performance of Sacramento, the norms.

Senator BENNETT. I am glad to have had the chance to make that statement for the record.

The CHAIRMAN. Let me ask you this. What do you estimate it would cost the country to treat the common cold the way you think your foundation would recommend it to be treated? That group estimated $34 billion. What is your estimation?

Dr. HARRINGTON. I would hate to estimate it, for the reason that I guess that many of them are treated perhaps the way it says, perhaps just one visit and a phone call, or perhaps just a phone call. We could tell you what it costs to treat a common cold.

The CHAIRMAN. You do not need to be exact. But you have got before you how this particular group—and I know these people—estimated that it would cost $34 billion to treat common colds the way your Foundation estimates they would be treated. Now, would you mind assuming that you have got $200 million, and give me off the top of your head about how many colds you would think there would be and what it would cost to treat them.

Dr. HARRINGTON. Let us not assume that the number is right. Probably the average cold in our area would be treated by perhaps one office visit, and perhaps maybe $2 to $3 worth of drugs.

Senator BENNETT. Actually, would not 90 percent of the colds never get into the doctor's office?

Dr. HARRINGTON. Most of them do not.

Senator BENNETT. If we have medicine chests full of remedies, and we have television sets that sell them to us night and day for the treatment of the common cold.

How many common colds do you see as a doctor in the course of a week?

Dr. HARRINGTON. I am a gynecologist, so I would not see too many. You can ask Dr. Wood. And do not ask Shubert, he is a bone doctor.

Are our two pediatricians still here?

Senator BENNETT. Dr. Babich, how many common colds do you see?

Dr. BABICH. In the wintertime it is about 40 percent of our practice in the office. And the average pediatrician sees somewhere between 25 and 30 patients a day.

Senator BENNETT. Do you think that is true for the adult as much as for the child?

Dr. BABICH. No, sir. They believe in the television commercials.

The CHAIRMAN. Thank you very much, gentlemen. It is good to get some of these facts before us so we can better analyze what the situation is and what we are going to do about it.

PREVENTIVE ACTIVITIES OF THE ADA

Next, we will call Dr. Sidney R. Francis, DDS, on behalf of the American Dental Association.

While you are getting yourself organized, Dr. Francis, permit me to congratulate your profession through you on the fine job that the dentists of this Nation are doing in your association in encouraging preventive activity such as fluoridation and various things of that sort, which, if they were all as successful as some of their advocates would hope, might put all of you people out of business. But it seems that they have not caused your profession to shy away from it, you have continued to urge and advocate research and activities in this area.

STATEMENT OF DR. SIDNEY R. FRANCIS, AMERICAN DENTAL ASSOCIATION, ACCOMPANIED BY DR. ERIC BISHOP, ASSISTANT DIRECTOR OF DENTAL HEALTH

Dr. FRANCIS. Thank you, sir.

Senator Long and Senator Bennett, my name is Dr. Sidney Francis from South San Francisco, Calif., where I am in general dental practice. I am accompanied by Mr. Eric Bishop, who is assistant executive director of dental health of the American Dental Association.

In the interest of time I am not going to read all the prepared statement. It has been supplied to you.

The American Dental Association has asked me to present the association's comment on part B, title XI of the Social Security Act, popularly known as the professional standards review organization plan. I am chairman of the Council on Dental Care Programs of the California Dental Association. California dentists have used the professional peer review system for several years. Peer review is, for example, an integral component of the California Dental Service, the largest dental prepayment plan in the world serving more than 2 million beneficiaries.

The American Dental Association testified before the Senate Finance Committee in February of 1972 on what is now Public Law 92–603, the Social Security Amendments of 1972. The proposal at that time to establish professional standards review organizations was a prime item in the ADA testimony. The association offered several amendments to the PSRO structure to give dentists proper representation within PSRO's and within the National and State PSRO councils and to insure that only dentists review dental procedures and services. Unfortunately, those amendments were not included in Public Law 92–603 despite the following statement of intent by the principal author of the program to our witness, Dr. James A. Catchings, in the hearings of February 7, 1972.

I might say, Mr. Chairman, that the association was and is grateful for the sensitivity Senator Bennett demonstrated at that time about the dilemma the dental profession might face if the law was written in a way that brought the dentists under the regulation without full representation. This, of course, is what has happened and we hope it can be corrected before the program comes to full implementation.

However, the only direct reference to dentistry in the entire statute is in the following parenthetical and permissive language in section 1155 (b) as follows:

> To the extent necessary or appropriate for the proper performance of its duties and functions the Professional Standards Review Organization serving any area is authorized in accordance with regulations prescribed by the Secretary to—
>
> (1) Make arrangements to utilize the services of persons who are practitioners of or specialists in the various areas of medicine (including dentistry), or other types of health care which persons shall, to the maximum extent practicable, be individuals engaged in the practice of their profession within the area served by such organization.

Thus, notwithstanding, the fact that dental services, amounting to several hundred million of Federal-State funds, are provided under

titles V, XVIII, and XIX and are subject to PSRO law, there is no "mandate" that such services be reviewed by dentists, and, in fact section 1152 does not permit a dentist to be a member of a PSRO. Nor does the law require that dentists participate in the development of "norms of care, diagnosis, and treatment based upon typical patterns of practice" or even permit the appointment of a dentist to the National Review Council.

In view of the foregoing, and the facts that:

(1) Inpatient hospital admissions for dental care are well over a million per year;

(2) Of the nearly 100,000 practicing dentists in the country, more than 15,000 regularly admit patients to hospitals;

(3) The law contemplates and permits expansion of PSRO's to ambulatory services; and

(4) All of the major pending national health insurance bills include substantial dental benefits.

The American Dental Association believes that the amendments we are suggesting should be accepted. To do otherwise is to subject a large segment of the dental profession to a highly regimented and stringent regulatory mechanism without any meaningful representation in its development and operation. This can only compound the existing complications and difficulties in attempting to meet the requirements of the program. (The amendments are included as an appendix to this statement.)

In offering these amendments, the association's principal objective is to improve the PSRO operation. The dental profession is prepared to assume the responsibility of peer review, whether that review is related to private health insurance plans or public programs like medicare and medicaid. But unless dentists are involved in the planning and administration of PSRO's a sound system for reviewing medicare and medicaid dental services will not be possible.

Again in our judgment, unless dentists have proper representation on the national and statewide professional standards review councils, the vital data and information needed to improve dental review procedures will not emerge.

Finally, unless dentists make final determinations on the quality of dental services, including dental services in hospitals as well as in private office settings, there can be no effective evaluation of dental services. It is axiomatic that dentists are the best judges of quality dental care. Review by peers furthermore is the best system yet devised to assure that medicare and medicaid patients receive high quality care—peer review by physicians of medical procedures, peer review by dentists of dental procedures. It should be emphasized too that recognition of dentistry in the beginning phases of the program is of considerable urgency particularly to those members of the profession who are specialists in oral surgery and whose practices are conducted largely in hospital settings. In this connection, the American Society of Oral Surgeons already has adopted Comprehensive Guidelines of Hospital Oral Surgery Care for Professional Standards Peer Review which I would like to file for the committee's information.

The American Dental Association has taken no position on the geographic areas encompassed by PSROs. The association does, how-

ever, see merit in the one PSRO per State concept favored by the American Medical Association. State medical and dental associations have established programs and have resources to assist in the administration of PSROs. Many state associations have conducted highly successful peer review activities for several years past. If emphasis on local determination is the goal of HEW for the PSRO program, that can be achieved by assigning the actual review functions to local groups of physicians or dentists.

The association has reviewed the PSRO amendments proposed by the American Medical Association. Several have peculiar significance to medicine. Others are of some concern to the dental profession. We have commented briefly on two of those and it is in our statement which has been submitted.

In closing, I would like to emphasize that the objective of the PSRO plan should be to provide excellent peer review of medicare and medicaid services. Dentists and their professional associations are committed to peer review as a responsible mechanism to insure that patients receive the kinds and quality of health care they deserve. Anything within the PSRO plan that deters dentists and physicians from joining wholeheartedly in the central function of PSRO's, mainly the peer review operation, should be deleted in our judgment.

On behalf of the American Dental Association, I thank the committee for the opportunity to comment on the PSRO provisions of the Social Security Act. Attached to my statement are two appendices: one is our proposed amendments to the PSRO plan, the other is the association's guidelines for peer review committees. I request that these be included in the record.

Thank you for the opportunity to appear.

The CHAIRMAN. Thank you very much for your statement, Dr. Francis.

Let me congratulate your association for the fine work that your members are doing. If it weren't for you I wouldn't have any teeth today. So, I appreciate it.

Senator BENNETT. May I comment?

The CHAIRMAN. Yes.

PHYSICIAN REVIEW OF HEALTH SPECIALISTS

Senator BENNETT. I meant what I said. And I still have that feeling. When the report was written to accompany the bill it contained this statement on page 265: "It is expected that the PSRO's will make specific arrangements with groups representing substantial numbers of dentists for a necessary review of dental services."

And I have assumed all along that no doctor would review the work of a dentist, but that the PSRO would contact in its area a responsible dentist, or if a dental review organization exists, it would contact that organization and ask them to make the review. There is a very practical reason why. We would have faced a serious problem if we had broken the line and opened the PSRO to anyone other than physicians and osteopaths.

What about the physical therapists? What about the chiropractors? All of them claim they are health specialists, and that they operate in a field, and that therefore they should be included in the review.

But on the theory that only physicians can review physicians and only dentists can review dentists, we felt in the end, maybe unwisely, that we would build our central organization out of physicians, but insist that when it was necessary to have the services of other professionals in connection with reviews, that they must make a contract with a proper representative of the service being reviewed. And we don't want a doctor reviewing a dentist's work, and we don't want a doctor reviewing a chiropractor. But we want a reputable chiropractor to review the work of his colleague if that comes into the situation.

I can understand your feelings about maybe being left out a little bit. But that is why it was done. We didn't know where to stop. Some health practitioners are way out on the edge of the service. But once you start, then pretty soon each one claims the right. I am just as important as he is, and there are as many of our group of my people as there are dentists, and therefore we must be included. That is the rationale. And I will assure you that I will go back personally to HEW to try and make sure that they will follow that out, and that their regulations and the contracts they make with PSRO's when they are organized will make sure that you have that right to review your own discipline.

Dr. BISHOP. We thank you very much. We understand these points you have raised.

And I want to say two things, if I may. One, we have met with Dr. Simmons of the staff on a couple of occasions, in fact, we sponsored a conference for State dental societies in our State. When it comes to the actual clinical review of the quality of services that are appropriate to be included, I think you are quite right, there is no question that most of these PSROs are going to make a contact with an appropriate group. And that is not a serious concern to us basically. The concern of the profession is that the PSRO itself is the place where the structure, the administration, the flavor, the tone of the entire operation is going to be set. And we understand the practical problems. Here is a profession of 100,000 members who see 90 million patients a year, or some 300 patients a year, which amounts to some $5 million of the health care bill.

So that we feel, one, we are in a slightly different position than perhaps some of the other groups to which you referred.

And then secondly, even with it we are faced still with the dilemma on the one hand that the services are regulated, but on the other hand the dentist cannot be in the structure participating, even though he can be called in and out to look at specific cases.

Senator BENNETT. That was the dilemma we faced. And we resolved it the way we thought best. Maybe it wasn't the best resolution.

Dr. BISHOP. Most respectfully we don't think so, no.

Senator BENNETT. Let's get some experience both from your side and our side, or the doctors' side, and let's see if maybe it was the right or not the right one, or whether some kind of an accommodation can be made that will satisfy both sides.

Dr. BISHOP. In the interim, Senator, in response to something you said earlier, it would be helpful—and we spoke to HEW about this—if additional contracts come in, if we make them show what specific arrangements they are going to require. And they said, we don't feel we can do it.

Senator BENNETT. Can I encourage them a little?
Dr. FRANCIS. We would certainly appreciate that.
[The prepared statement of Dr. Francis follows:]

PREPARED STATEMENT OF DR. SIDNEY R. FRANCIS REPRESENTING THE AMERICAN DENTAL ASSOCIATION

Mr. Chairman and members of the committee, I am Dr. Sidney R. Francis of South San Francisco, California, where I conduct a general dental practice. The American Dental Association has asked me to present the Association's comments on Part B, Title XI of the Social Security Act, popularly known as the Professional Standards Review Organization Plan. I am Chairman of the Council on Dental Care Programs of the California Dental Association. California dentists have used the Professional Peer Review System for several years. Peer review is, for example, an integral component of the California Dental Service, the largest dental prepayment plan in the world serving more than two million beneficiaries.

I was fortunate to have a part in the development of the Peer Review Program for California dentists because of official assignments I have had with both the California Dental Association and the California Dental Service. In truth, the perfecting of peer review as a prime means for assuring quality dental care is an avocation for me. My credentials for this appearance also include advisory assignments with other health groups such as membership on the Peer Review Commission of the California Medical Association and the Medical Policy Committee of Blue Shield.

We appreciate the opportunity to appear here today at what have been termed "oversight" hearings. We believe that is an appropriate term because it appears to us, and we hope you will agree, that a major problem of the dental profession in dealing with the P.S.R.O. program stems from a legislative oversight.

The American Dental Association testified before the Senate Finance Committee in February of 1972 on what is now Public Law 92-603, the Social Security Amendments of 1972. The proposal at that time to establish professional standards review organizations was a prime item in the ADA testimony. The Association offered several amendments to the P.S.R.O. structure to give dentists proper representation within P.S.R.O.s and within the national and state P.S.R.O. councils and to insure that only dentists review dental procedures and services. Unfortunately, those amendments were not included in P.L. 92-603 despite the following statement of intent by the principal author of the program to our witness, Dr. James A. Catchings, which I would like to quote from on the record of those hearings of February 7, 1972 at page 2418:

"Senator Bennett: Mr. Chairman, I would like to express my thanks to Dr. Catchings for his support of the principle of peer review and to assure him that the language of the bill as it is finally adopted, if any peer review is adopted, will make sure that only dentists review the work of dentists . . ."

As I indicated, Mr. Chairman, we presume it was an oversight that the assurance as quoted above was not carried over into the language of the law. In fact, the only direct reference to dentistry in the entire statute is in the following parenthetical and permissive language in Section 1155(b) as follows:

"To the extent necessary or appropriate for the proper performance of its duties and functions, the Professional Standarsd Review Organization serving any area *is authorized* in accordance with regulations prescribed by the Secretary to—

> (1) Make arrangements to utilize the services of persons who are practitioners of or specialists in the various areas of medicine (including dentistry), or other types of health care, which persons shall, to the maximum extent practicable, be individuals engaged in the practice of their profession within the area served by such organization."

Thus, notwithstanding, the fact that dental services, amounting to several hundred million of federal-state funds, are provided under Titles V, XVIII and XIX and are subject to the P.S.R.O. law, there is no "mandate" that such services be reviewed by dentists, and, in fact Section 1152 does not permit a dentist to be a member of a P.S.R.O. Nor does the law require that dentists participate in the development of "norms of care, diagnosis and treatment based upon typical patterns of practice" or even permit the appointment of a dentist to the National Review Council.

In view of the foregoing, and the facts that:

(1) Inpatient hospital admissions for dental care are well over a million per year;

(2) Of the nearly 100,000 practicing dentists in the country, more than 15,000 regularly admit patients to hospitals;

(3) The law contemplates and permits expansion of P.S.R.O.s to ambulatory services;

(4) All of the major pending national health insurance bills include substantial dental benefits and

(5) As a matter of simple equity and fairness.

The American Dental Association believes that the amendments we are suggesting should be adopted. To do otherwise is to subject a large segment of the dental profession to a highly regimented and stringent regulatory mechanism without any meaningful representation in its development and operation. This can only compound the existing complications and difficulties in attempting to meet the requirements of the program. (The amendments are included as an appendix to this statement).

In offering these amendments, the Association's principal objective is to improve the P.S.R.O. operation. The dental profession is prepared to assume the responsibility of peer review, whether that review is related to private health insurance plans or public programs like Medicare and Medicaid. But unless dentists are involved in the planning and administration of P.S.R.O.s, a sound system for reviewing Medicare and Medicaid dental services will not be possible. Again, in our judgment, unless dentists have proper representation on the national and statewide professional standards review councils, the vital data and information needed to improve dental review procedures will not emerge. Finally, unless dentists make final determinations on the quality of dental services, including dental services in hospitals as well as in private office settings, there can be no effective evaluation of dental services. It is axiomatic that dentists are the best judge of quality dental care. Review by peers furthermore is the best system yet devised to assure that Medicare and Medicaid patients receive high quality care—peer review by physicians of medical procedures, peer review by dentists of dental procedures. It should be emphasized too that recognition of dentistry in the beginning phases of the program is of considerable urgency particularly to those members of the profession who are specialists in oral surgery and whose practices are conducted largely in hospital settings. In this connection, the American Society of Oral Surgeons already has adopted Comprehensive Guidelines of Hospital Oral Surgery Care for Professional Standards Peer Review which I would like to file for the Committee's information.

The American Dental Association has taken no position on the geographic areas encompassed by P.S.R.O.s. The Association does, however, see merit in the one P.S.R.O. per state concept favored by the American Medical Association. State medical and dental associations have established programs and have resources to assist in the administration of P.S.R.O.s. Many state associations have conducted highly successful peer review activities for several years past. If emphasis on local determination is the goal of HEW for the P.S.R.O. program, that can be achieved by assigning the actual review functions to local groups of physicians or dentists.

The Association has reviewed the P.S.R.O. amendments proposed by the American Medical Association. Several have peculiar significance to medicine. Others are of some concern to the dental profession and I shall comment briefly on two of these. The AMA recommends deletion of the authority to require preadmission certification for institutional care. The American Dental Association joins in this recommendation. The Association filed a strong protest to recently proposed regulations for preadmission certification requirements mainly in connection with Medicare and Medicaid services. Those proposed regulations were withdrawn by the HEW Secretary after he received vigorous objections from representatives of hospitals and the professional groups. We believe Congress should take similar action and remove this most serious flaw in the P.S.R.O. structure. The preadmission certification concept has many objectionable features, the most unfortunate being its real threat to the benefits that Medicare and Medicaid recipients are now guaranteed. The Association also joins AMA in recommending deletion of the P.S.R.O. authority to inspect institutional health care facilities. This is an obvious duplication of a function performed by the joint commission on hospital accreditation and state and local regulatory agencies.

In closing, I would like to emphasize that the objective of the P.S.R.O. plan should be to provide excellent peer review of Medicare and Medicaid services. Dentists and their professional associations are committed to peer review as a responsible mechanism to insure that patients receive the kinds and quality of health care they deserve. Anything within the P.S.R.O. plan that deters dentists and physicians from joining wholeheartedly in the central function of P.S.R.O.s, mainly, the peer review operation, should be deleted in our judgment.

On behalf of the American Dental Association, I thank the Committee for the opportunity to comment on the P.S.R.O. provisions of the Social Security Act. Attached to my statement are two appendices: one is our proposed amendments to the P.S.R.O. plan, the other is the Association's guidelines for peer review committees. I request that these be included in the record.

A BILL To amend Part B of Title XI of the Social Security Act to expand the Professional Standards Review Organization activity to provide for the review of dental care services by dentists

Be it enacted by the Senate and House of Representatives of the United States of America in Congress Assembled that

SEC. 1. Section 1152 of the Social Security Act is amended:

(a) By inserting in subsection (b)(1)(A)(ii) the word "dentistry" after "medicine".

(b) By inserting in subsection (b)(1)(A)(iii) the words "and dentists" after "physicians".

(c) By inserting in subsection (b)(1)(A)(v) the word "dentistry" after "medicine" and the words "or dentistry" after "medical".

(d) By inserting in subsection (f)(1) the word "dentistry" after "medicine".

SEC. 2. Section 1155 of the Social Security Act is amended:

(a) By inserting in subsection (a)(5) the words "or dentists" after "physicians".

(b) By inserting in subsection (a)(6) the words "or dentist" after "physician".

(c) By inserting in the last sentence of this section the words "or dentist's family" after "family".

(d) By inserting in subsection (c) the word "dentistry" after "medicine" wherever it appears.

(e) By inserting in the first sentence of subsection (d) the words "and dentists" after "physicians".

(f) By inserting in subsection (d)(1) the words "and dentists" after "physicians".

(g) By inserting in subsection (d)(1) the words "and dentists" after "physicians".

(h) By inserting in subsection (d)(2) the words "or dentist" after "physician".

SEC. 3. Section 1156 of the Social Section Act is amended:

(a) By inserting in subsection (d)(1)(A) the words "or dentist" after "physician".

(b) By inserting in subsection (d)(1)(B) the words "or dentist" after "physician".

SEC. 4. Section 1162 of the Social Security Act is amended:

(a) By renumbering paragraph (3) paragraph (4).

(b) By adding a new paragraph (3) as follows: "(3) two dentists, one of whom shall have extensive hospital experience."

(c) By inserting in subsection (e) the words "or dentists" after "physicians".

SEC. 5. Section 1163 of the Social Security Act is amended:

(a) By striking the comma after "physicians" in subsection (a)(1) and inserting in lieu thereof "and two dentists".

(b) By inserting in subsection (b) the words "and dentists" after "physicians" wherever it appears.

SEC. 6. Section 1167 of the Social Security Act is amended by inserting the word "dentistry" after "medicine" wherever it appears.

GUIDELINES FOR PEER REVIEW COMMITTEES

The following guidelines are recommended:

1. Licensed dentists should be involved at all levels of review of the dental aspects in a dental component of a national health program, and review of the quality of professional services should be under the control of licensed dentists.

2. Dental societies should establish effective committees that have consumer representation to ensure accountability to the public. The committees should be well publicized and should provide for discourse between consumers and dentists.

3. Review in a dental component of a national health program should include review of program design and administration, quality of services rendered, fee questions, and utilization of services.

4. Continuing review of the design and administration of the dental component of a national health program should include such matters as effectiveness in meeting the dental needs of the population, patient utilization, economy in administration, effect of benefit patterns on dental health and dental practice, provision of uniform forms and procedures, efficiency of administrative requirements, accessibility of dental care, utilization of fluoridation, and effectiveness of review procedures.

5. Review of quality of dental care in a national program should include review of the quality of services performed, review of the reasonableness of procedures and whether the services were performed in accordance with professional standards.

6. Review of treatment should be performed according to professionally established guidelines through review techniques, such as screening of claims, statistical audits, random sampling of records, review of radiographs, random examination of patients, and evaluation of complaints.

7. Dental society review committees should be used in the dental component of a national health program for review of professional matters, such as review of services rendered and fee questions.

8. Channels of referral to dental review committees under a national program should be open to the program administrators, dentists, insuring agencies, and patients.

9. Appeal procedures for all participants should be provided in the review structure of a national program.

10. A dental review structure in order to be creditable, must include appropriate sanction against abuse.

11. Effective review procedures should be developed to resolve fee questions, to determine if fees are in accordance with provisions of the program, and to assess whether fees are in fact usual, customary, and reasonable when this payment method is used.

12. Effective procedures should be instituted to protect members of review committees. (This guideline was added by the House of Delegates.)

The CHAIRMAN. Next we will hear Leda R. Judd, staff director, consumer health project, National Urban Coalition, accompanied by Robert E. McGarrah, Jr., staff attorney.

STATEMENT OF ROBERT E. McGARRAH, JR., STAFF ATTORNEY, HEALTH RESEARCH GROUP, ACCOMPANIED BY LEDA R. JUDD, STAFF DIRECTOR, CONSUMER HEALTH PROJECT, NATIONAL URBAN COALITION

Mr. MCGARRAH. Mr. Chairman, members of the committee, I am Robert E. McGarrah, Jr., an attorney with the Health Research Group in Washington, D.C., a public interest organization concerned with health care delivery, food and drug safety, and occupational safety and health.

With me is Leda R. Judd, director of the National Urban Coalition—its consumer health project. Together we have begun a consumer clearinghouse on PSRO activity.

We appreciate this opportunity to present to your committee some of our concerns regarding public accountability in the PSRO program.

I would like to request that my complete statement be inserted in the record following my testimony.

The CHAIRMAN. It will be done.

Mr. MCGARRAH. Together with you, Senator Bennett, and PSRO Director Simmons, we share indignation and dismay that the AMA and others have so bitterly resisted the first Federal effort to promote a systematic local physician review program. However, if they are to have any positive impact on the quality and cost of medical care, PSRO's must become local, publicly accountable review organizations.

Although it may signify major changes to American doctors, to consumers who pay this country's annual $94 billion health care bill, PSRO today means next to nothing—or if they've heard about it at all, consumers know it as the new Federal program targeted for exorcism by the American Medical Association.

Just as they know little of PSRO, consumers know almost nothing about effective publicly accountable doctor review organizations. This hardly comes as a surprise, since all indications are that what is called "peer review" is, in fact, little more than a secret exercise in back scratching by medical societies and their wholly controlled subsidiaries, the State medical boards.

During the 5-year period from 1968–72, for example, of the 356,534 physicians in this country, only 1,033 or less than 0.3 percent were actually disciplined by State medical boards. And of these cases, a mere 382 or about 77 physicians a year actually had their licenses revoked. These sorry figures take on an even sorrier meaning when one learns that a full 48 percent of all these disciplinary actions were for drug-related offenses. Worse still, only 15 States have statutes which include professional incompetence as grounds for disciplinary action against a physician.

State medical societies have an even worse record than the State medical boards. According to Dr. Robert Derbyshire, secretary of the New Mexico Board of Medical Examiners, the AMA abandoned its State medical society disciplinary reporting system as a "waste of time." Furthermore, in 1968, the latest year for which figures are available, 33 State societies reported they took no disciplinary actions whatever.

Consumers are beginning to know that peer review is synonymous with self-protection. They are beginning to know that organized medicine does virtually nothing to protect them from becoming a statistic among the estimated 10,000 deaths resulting from 2 million unnecessary operations each year. They are beginning to know that ineffective peer review and the promotional excesses of the drug industry are responsible for billions of wasted dollars, hundreds of thousands of unnecessary hospitalizations for adverse drug reactions, and thousands of lives needlessly lost.

The annual climb in the number of malpractice actions filed is still another signal that consumers have little confidence in the secret peer

review erratically conducted by physicians in hospitals, medical societies, and State medical boards. People who fall victim, or whom suspect they may have, to doctors unaffected by medicine's self-regulation have few alternatives to a malpractice action.

To its credit, PSRO will replace an erratic nonsystem of self-protection with a systematic physician review of all the care a doctor provides his or her patient in the hospital. But how effective will the law be in reversing organized medicine's current rate of inactivity in protecting the public from incompetent practitioners? Certainly it is too much to expect consumers to believe that PSROs, which are really medical societies, will radically alter a dearth of effective medical self-regulation merely by adopting regional review standards and applying those standards to each local doctor.

The PSRO statute, unfortunately, fails to assure consumers the protections they deserve. Section 1160(b)(2) provides the only source of public information on inadequate physicians and hospitals. But the information does not become public until (1) the local PSRO finds either insubstantial compliance "in a substantial number of cases" or gross and flagrant violations;

(2) The statewide PSRO council makes its review of the local PSRO and

(3) the Secretary concurs and approves the prior reviews.

Furthermore, even if the Secretary agrees with the decisions of the local and statewide PSRO councils, he can refuse to make public the name of the offending doctor or hospital, and instead simply require the offender to either pay the Government for the unnecessary services or pay a $5,000 fine.

Consumers can look to only two other very vague PSRO provisions in their search for a measure of public accountability from PSRO: Section 1163(f) requires the National Professional Standards Review Council to submit an annual report to Congress with comparative data on the review activities of each PSRO area; and Section 1166(a)(2) provides for PSRO data disclosure, prescribed by the Secretary's regulations, "to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care". The National Council's report is unlikely to furnish consumers with adequate data on doctors or hospitals who fail to meet a local PSRO norms and standards. Nor is the National Council's report conducive to local accountability to local consumers in a PSRO area.

Whether HEW will issue regulations permitting disclosure of specific information on individual physicians and hospitals remains to be seen. Indications from the Department's response to the AMA's recent anti-PSRO barrage, however, are that HEW views physician and hospital profile data within the same confidentiality framework as patient records. HEW's response to the AMA stated that "the privacy of patients and physicians is a basic civil right and must be respected."

Confidentiality of patient records and confidentiality of physician and hospital profiles are unquestionably two separate issues. The PSRO statute treats them separately. Section 1155(a)(4) for example, requires that the collection of PSRO patient profiles shall "to the greatest extent practicable . . . provide maximum confidentiality as to patient identity". There is no mention of such a requirement with respect to

doctors and hospitals. In fact, the Secretary has discretion to divulge the names of offending doctors and hospitals. The different PSRO statutory treatment accorded to patient and provider profiles is consonant with other provisions of the Social Security Act.

Furthermore, at common law, the physician-patient relationship and the patient's right to privacy is recognized only as one which can be exercised by the patient. AMA attempts to attack the PSRO law for its threats to the physician-patient relationship should therefore be recognized for the sham that they are. What the AMA fears is clear—its fear is the vaguest hint at public accountability for physicians.

If PSRO is to convince consumers that it will be any different than the self-interest peer review they have come to expect from medical societies, it must demonstrate its effectiveness. The long and drawn out process whereby a physician or hospital is perhaps revealed to the public for improper practice and services is simply inadequate as a public accountability measure. Doctors have as much to fear under these provisions as they do under existing peer review schemes—absolutely nothing. There is simply no incentive for local PSRO reviewing physicians to be accountable to their patients when their patients are completely ignorant about the strength and effectiveness of local peer review.

The same principles that led the Senate Finance Committee to require public disclosure of survey reports on hospitals and skilled nursing facilities, logically should require that practitioner and provider profiles be disclosed to the public. The committee report on H.R. 1 found that

> * * * ready public access to timely information about the existence or absence of deficiencies * * * would help substantially in encouraging facilities to correct their deficiencies and, to at the same time, enable physicians and patients to make sound judgments about their own use of available facilities in the community. Given the necessary information, the community should be able to exert greater influence on institutions to assure that they develop and maintain higher standards of care. (emphasis added) Sen. Rep. No. 92-1230, pp. 288-289.

The committee's logic is perfectly adaptable to the PSRO program. Either by regulations pursuant to section 1166, or by amendment to the statute, the Secretary should require that each PSRO's norms, standards, and criteria, together with its practitioner and provider profiles be routinely provided to a PSRO consumer advisory group. The consumer group would be made up of local community organization members who are beneficiaries of Federal health programs. Each consumer advisory group would make contractual arrangements with a medical school or other independent medical group in its area for its own professional staff assistance to evaluate the data it received from the local PSRO.

Contracts between the PSRO consumer advisory group and the medical school would be independent of the local PSRO. Financing for the contracts could be provided by a requirement that a local PSRO turn over a fixed percentage of its annual operating revenues to the local consumer advisory group.

After professional staff analysis of the data received from the local PSRO, the consumer advisory group would then make public a re-

port on individual physicians and hospitals in its local area. The report would also include an evaluation of local PSRO performance. In this manner, consumers would be assured of accurate, independently evaluated information about the capabilities of local practitioners and providers, as well as a performance analysis of their local PSRO. The evaluated information would be public, and thereby exert a strong force for public accountability and improvement from the local PSRO.

If some system of local public disclosure of local PSRO profiles is not forthcoming, the available evidence from medical society and State medical boards indicates that consumers will be justified in concluding that the status quo of today's secret medical peer review—unnecessary surgery, extraordinary overprescribing, and incompetent practitioners—will continue. PSRO wisely requires systematic local review by local physicians. Consumers would not dispute the fact that physicians are best qualified to review other physicians' work—as long as problems of conflict of interest do not invalidate the review process.

Our proposal should not in any way be taken as the only vehicle for public accountability and consumer involvement. The PSRO effort will require significantly more consumer participation and public disclosure at the local PSRO level, as well as at the State and national council levels, than now appears to be the case. HEW's recent efforts to reduce the number of consumer members on statewide PSR councils must therefore be condemned. A statewide council's four public members should not represent special nonphysician professionals who may be in conflict of interest, nor would they represent State bureaucrats. These groups already have numerous channels of access to PSRO operations. Consumers are the public, however, and they are currently excluded from participation in any aspect of the PSRO program. To clarify public consumer involvement, the Finance Committee's Report on the 1973 Social Security Amendments (H.R. 3153) should be changed to specify that the four public positions on statewide councils be consumers.

From the Assistant Secretary for Health to the local PSRO, the program should remain a publicly accountable physician-review program. But unless PSRO profile data becomes public information, it is impossible to argue that merely by requiring systematic review of care, medical peer review will be any different than it is today. PSRO must not perpetuate poor practice, it must foster public accountability. The PSRO program must therefore:

1. Require annual public disclosure of local PSRO profiles on practitioners and providers.

2. Provide specifically designated funds to local PSRO advisory groups for independent professional analysis of profiles and overall PSRO performance.

3. Require that the four public members of statewide PSR councils truly represent the public—they must therefore be consumers of health services.

The CHAIRMAN. Senator Bennett.

Senator BENNETT. I have no questions, except to make the note that everybody is a consumer of health services.

Conflict of Interest Seen in Self-Regulation

Mr. McGarrah. Unfortunately, Senator Bennett, I think that there are certain problems of conflict of interest that are involved in professional self-regulation. And that is the concern that we have been addressing ourselves to in our efforts, concern with PSRO as well as other aspects of medical professional activities.

The Chairman. It seems to me that we might find a way to accommodate your views. I think there is a lot of merit to what you are saying here.

Mr. McGarrah. Thank you, sir.

The Chairman. And perhaps the way to do it—an alternative way to do it might be to simply provide that these profiles, doctors profiles and patient profiles, be made available to us by just eliminating the names. You don't need to know who the individual was, just say Dr. A, Dr. B, C, and D.

Mr. McGarrah. We think—it is well known that some practitioners do a large amount of unnecessary surgery. And I think it would be a good thing for consumers to know about that before they go to a physician so that they could steer away from that.

The Chairman. Have you ever read the book The Citadel?

Mr. McGarrah. No, sir.

The Chairman. It was a best seller. It was written by A. J. Cronin. I have made reference to it a time or two, so our staff has all read it. I was surprised to learn the first time I inquired that the witnesses for the American Medical Association had not read it. It was a novel written by a doctor who left medicine to be a writer and he wrote a lot of fine books. I was very much impressed by the book. And I felt that the criticisms that the doctor made in that book—written many years ago—are in large measure still true, at least to some extent.

For example, this practice of just giving a patient a bottle of something that one has no reason to assume would do him any good at all is, I fear, still going on now. They have a nice name for it. I am told it is placebo. There is one little episode in there where this doctor—this was supposed to have happened in England many years ago—this doctor had his wife running the dispensary for him, his office in his home. And he rushed in one day and said, give me a bottle of something.

We are out of it, she told him.

Well, give me a bottle of just anything—which he proceeded to go out and provide the patient with, for a fee, on the theory that none of it is going to do any good anyway, but you make a fee by providing him with some so-called medicine.

There was another event set forth in the book where a sort of society type surgeon, who was nothing but a complete incompetent butcher, performed an operation, and the patient died. That person should not have been performing a serious operation.

And I fear that even today we have a lot of people performing operations who should not be out practicing on others, they ought to let somebody do it who has the competence and does it right.

There are a number of other things pointed out in the book, practices at that time which were not good. And I fear they are still going on today.

I notice you make reference to these unnecessary operations. That is too bad. Something ought to be done about that. And I think your organization, if you persevere, will succeed in doing something about it, too.

Mr. McGARRAH. Thank you, sir.

The CHAIRMAN. As a matter of fact, since you brought the subject up, I think I will ask the College of Surgeons about that tomorrow morning.

Thank you very much.

That concludes today's hearings.

The committee will meet again at 10 o'clock tomorow morning.

[Whereupon at 4:50 p.m., the committee recessed, to reconvene at 10 a.m., Thursday, May 9, 1974.]

IMPLEMENTATION OF PROFESSIONAL STANDARDS REVIEW (PSRO) LEGISLATION

THURSDAY, MAY 9, 1974

U.S. SENATE,
SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON FINANCE,
Washington, D.C.

The subcommittee met, pursuant to recess, at 10:05 a.m., in room 2221, Dirksen Senate Office Building, Hon. Herman Talmadge presiding.

Present: Senators Talmadge, Long (chairman of the full committee), Bennett, Curtis, and Dole.

Senator TALMADGE. The subcommittee will please come to order.

I want to remind witnesses that due to the large number of witnesses the subcommittee will hear, each organization is limited to a total of 10 minutes of oral testimony.

The subcommittee will now be pleased to hear from the representatives of the American College of Surgeons; Dr. C. Rollins Hanlon, the director of the American College of Surgeons, accompanied by Dr. J. D. Martin, Jr., chairman of the Peer Review Committee, and Dr. William H. Muller, Jr., regent and chairman, Pending Legislation Committee.

Thank you very much, gentlemen. We are honored to have you with us. Your entire statement will be inserted in the record.

STATEMENT OF C. ROLLINS HANLON, M.D., DIRECTOR OF THE AMERICAN COLLEGE OF SURGEONS, ACCOMPANIED BY J. D. MARTIN, JR., M.D., CHAIRMAN, PEER REVIEW COMMITTEE; AND WILLIAM H. MULLER, JR., M.D., REGENT AND CHAIRMAN, PENDING LEGISLATION COMMITTEE

Dr. HANLON. Thank you, Mr. Chairman.

I am Dr. C. Rollins Hanlon, director of the American College of Surgeons. As indicated, on my left, accompanying me, Dr. J. D. Martin, Jr., of Atlanta, formerly professor and chairman of the Department of Surgery, Emory University School of Medicine, and currently the chairman of the Joint Peer Review Committee; and on my right, William H. Muller, Jr., professor and chairman of the Department of Surgery, University of Virginia Medical Center, Charlottesville, a member of the board of regents of the American College of Surgeons, and recently, president of the American Surgical Association.

Senator TALMADGE. The Senator from Louisiana.

The CHAIRMAN. I would like to ask, because I am going to have to leave, I would like to ask if Dr. Stewart, the president of the Louisiana Medical Society, is here: and I would like to ask, Mr. Chairman, if after the next witness we could call Dr. Stewart, because I will not be here.

Senator TALMADGE. I understand, and Dr. Stewart will be called next.

The CHAIRMAN. Thank you.

Dr. HANLON. We are appearing before your committee to demonstrate the interest of our college in peer review by virtue of its efforts to set forth surgical guidelines for screening, under the provisions of Public Law 92-603, creating professional standards review organizations. The college was the first organization to establish voluntarily a minimum standard for hospitals in order to assure the best care of the patients with a humanitarian aspect as the primary consideration. These efforts antedated but paralleled the intent of PSRO, beginning 55 years ago.

From 1919 to 1952, our college, through its board of regents and by means of dues of the fellows, financed and administered the program of hospital standardization until the technical and financial burdens of carrying this kind of program led to its being handed over to the Joint Commission on Accreditation of Hospitals—the JCAH—in 1952, in ceremonies which were attended by former U.S. Senator Lister Hill.

The JCAH included the American Medical Association, the American Hospital Association, the American College of Physicians, and the American College of Surgeons, which previously, alone, for more than 30 years, had supported this voluntary effort entirely from the dues of its fellows without any personal gain, except the improvements in the standards of patient care.

Please note that the minimum standards for our hospitals were designed to safeguard the care of every patient in the hospital by insistence on competence on the part of doctors; adequate clinical and pathological laboratory facilities to insure correct diagnosis; a thorough study and diagnosis in writing for each case; and by a monthly audit of the medical and surgical work conducted in the hospital during the preceding interval; and by prohibiting the practice of division of fees under any guise whatsoever, because the division of fees leads to the referral of patients not to the best surgeon, but to the one who is willing to rebate fees.

When this program was assessed by the board of regents in 1933, it was apparent that the average duration of patients' stay in the hospital had been greatly reduced, and that hospital mortality rates had been definitely lowered.

The hospital standards program was then supplemented by the organization of hospital tissue committees to assess the quality of care of surgical patients. This was followed by other committees, and a movement was instituted to assure that all care of all patients was placed under unified review, entitled medical audit.

These developments were made possible in the midfifties by a grant from the Kellogg Foundation to the college. The medical audit pro-

gram was turned over to the Commission on Professional and Hospital Activities in 1959. The Commission on Professional and Hospital Activities—or SPHA—is a voluntary organization in which the college still actively participates. It has grown to be the world's largest and most sophisticated institution devoted to the collection and analysis of hospital medical data.

This brief recital of the accomplishments of the college in assuring humanitarian, high quality surgical services to all patients in hospitals serves to emphasize that the college was in the vanguard of professional peer review at a time when the technology and scientific knowledge of medicine was much less advanced than at present.

The founders of the college in 1913 established strict requirements for fellowship in order to stimulate surgeons to upgrade their professional competence in the interests of improved surgical services to patients. The organization of the college by highly trained and motivated surgeons served to emphasize the compelling need for clean, safe and adequately equipped hospitals in which surgeons could perform operations following which patients could be assured an opportunity for recovery without fear of death from fire or infection due to unclean hospital surroundings.

The founders of the college understood the folly of preparing surgeons for highly skilled service to humanity without concurrent interest in the condition of hospitals where their patients were to be treated.

Mr. Chairman, I have appended a pertinent historical document supporting our statement thus far, and I respectfully request that the document be added to the printed record.[1]

Senator TALMADGE. Without objection, it will be inserted.

Dr. HANLON. Current activities related to implementation of PSRO includes surgical guidelines for screening purposes, representing a 2-year effort by fellows of the college under the able leadership of Dr. Martin, seated on my left.

A reprint of the preliminary guidelines resulting from the efforts of Dr. Martin and his committee, taken from the March issue of the college bulletin, is appended. These 12 general surgical diagnoses, according to the Commission on Professional and Hospital Activities, account for 75 percent of hospital admissions in general surgery. Many hours of deliberation and multiple meetings were held before Dr. Martin's committee, and its consultants were able to arrive at suitable guidelines for each of these 12 diagnoses.

The surgeons who participated were individuals in private practice in medium and large communities, and various professors of surgery in academic areas throughout the United States. All surgical specialties were involved in order to eliminate conflicting overlap with criteria and guidelines developed by individual specialties.

The listing of the Peer Review Committee, the consultants, and the surgical specialty representatives will be found on the inside cover of the reprint before you.

These surgical guidelines have been structured to assist surgeons in the preparation of guidelines for screening at the PSRO regional levels. Because there are so many variables, the guidelines for screen-

[1] See p. 169.

ing which have been formulated by the college are not designed to set rigid, all-encompassing standards applicable in every case. Therefore, omission or addition of specific methods of treatment by a physician in an individual case does not necessarily indicate an incorrect approach. The guidelines for screening must be related to many factors which can only be assessed by a group of peers at the level of practive.

Sixty-five chapters of the college in the United States have been notified that they may participate in the early stages of development of PSRO's, if that is the policy of the chapter. The board of regents is aware of the positive impact of knowledgeable, highly trained fellows of the college participating in the formulation of appropriate surgical guidelines which should result in improved surgical services to patients. There can be no susbtitute for surgery performed by surgeons who by virtue of education extending beyond a 1- or 2-year period of formal hospital training have attained skills and knowledge which go beyond the mere performance of surgical operations, thereby providing a proper surgical background from which to offer the public humanitarian and highly competent surgical services.

PSRO peer review processes, using the surgical guidelines for screening, may help to identify those physicians whose surgical performance falls below acceptable standards of patient care. If this result is achieved as a secondary result of PSRO, then a basic objective of the American College will have been realized: that is to say, improvement in the quality of care for the surgical patient in both diagnosis and management. Ever-increasing knowledge of its application in the care of patients will require periodic review and updating in these guidelines.

The board of regents established its Peer Review Committee as an ongoing activity of the college. It is anticipated that all surgical specialties will continue to be actively engaged in this effort. The expense of the project is becoming a significant budget item to the college.

Senator Bennett, speaking to the board of governors of the college last October, indicated his anticipation that the National PSRO Council would contract with specialty groups such as the college, which in turn, with its constituent specialty groups would prepare appropriate suggested surgical guidelines. To date, we have not been informed of any favorable response to our request for financial assistance in the formulation of these guidelines.

The college, by virtue of its historical leadership in peer review, has demonstrated for many decades its ability to take affimative action in the best interest of the patient without compulsion in the form of Federal law. I trust that the continuing vigorous efforts of the college will not be impeded by unnecessary and confusing Federal rules governing implementation of PSRO.

I feel, and I am reflecting the opinion of our board of regents when I state that the college will continue to support constructive efforts to improve surgical care in the United States and throughout the world, provided we are accorded the freedom to exercise our professional judgment unfettered by third-party intervention attempting to dictate how we shall deliver the high quality care which all patients deserve.

We have been assured by Senator Bennett that we will have this authority and responsibility.

Because of the enviable record of the college for innovative pursuit of excellence, it is natural that we should support the concept of peer review.

Mr. Chairman, we are deeply grateful for the opportunity to present this statement of the American College of Surgeons on implementation of PSRO. We will be pleased to answer questions you may direct to us.

Senator TALMADGE. Thank you very much, Doctor, for an excellent statement. And it is a personal pleasure to welcome Dr. J. D. Martin, Jr., who has an enviable reputation in my own State.

PSRO AND SURGICAL PROCEDURE

How does the college anticipate potential improvements in surgical care of patients under PSRO?

Dr. HANLON. We would feel, Mr. Chairman, that a wider spread of standard review procedures, which are now employed in many of our institutions, the wider dispersion of these procedures, such as may be expected under PSRO, might result in a broader application of these guidelines, and thereby would improve the surgical care of patients.

Senator TALMADGE. Does the college feel that a significant number of surgical procedures are performed by less than adequately trained physicians?

Dr. HANLON. It is difficult, of course, to say what a significant number of surgical procedures might be considered. However, the college feels strongly that less than adequate training for some of the surgeons who are operating in this country is a problem. By that, I mean that it is the feeling of the college that surgery should be performed, as I indicated in my initial statement, by people who are adequately trained not merely to do operations, but to perform the skilled decisionmaking processes before, and the very demanding post operative care.

Now, as to how many operations are done by people who are less than adequately trained, I may say that there are about 90,000 people in this country who are carrying out surgical operations. About one-half, or 46,000, of those individuals are certified by their respective surgical boards. The one-half constitutes some 15,000 who are in training; some 20,000 who are self-declared—and in many instances highly competent surgeons; in other instances, not so competent—and another 10,000 who do surgery as an incident to other activities, such as general practice.

It is our feeling that the care of surgical patients in this country will be enhanced significantly when essentially all surgical procedures are done by what we consider to be adequately trained surgeons.

Senator TALMADGE. Is there any justification to the charge that there are too many unnecessary surgical procedures performed in the United States?

Dr. HANLON. I think there undoubtedly, Mr. Chairman, are unnecessary operations done in this country. And unnecessary operations are those which appear to be necessary beforehand, but are subsequently shown—the removal of a normal appendix in which all of the symptoms of appendicitis have been present is shown to have been unnecessary in one sense, but actually the risk of not doing it demanded that it be done. On the other hand, a number of studies have been made in this country which show that on a close analysis of a given number of operations, some of them can be judged by peer review to have been poorly indicated or to have been inappropriate treatment. By that, I mean that surgery may have been done when medical management might have sufficed; or the surgery might have been done without adequate trial of other measures.

I would not say that this is a nonexistent problem; it is a very definite problem. The degree of it was looked into by the college 2½ years ago when we asked our fellows by questionnaire—25,000 fellows, of whom some 15,000 responded—and of those responding, 11 percent indicated that in the communities where they worked, they thought that operations on questionable indications did occur, as often, perhaps, as once a week in their area.

I hasten to say that 87 percent of those responding thought that such practices were rare or extremely uncommon.

And all of this, as you recognize, is anecdotal and impressions; but I want to reiterate that it is a problem which the college is making every effort to diminish and to stamp out by virtue of having all surgical procedures done by those who have learned not merely to do the operations, but also to understand the indications when an operation is called for.

Senator TALMADGE. Thank you, doctor.

Chairman Long?

SUPPORT FOR PSRO

The CHAIRMAN. Doctor, do I take it from your statement that you agree with the peer review legislation, subject to some additional suggestions that you make here, or am I in error about that?

Dr. HANLON. Perhaps I do not understand you, Mr. Long.

The CHAIRMAN. Do you generally agree with the peer review legislation that is on the statute books today?

Dr. HANLON. Yes. I think that the fact that we have worked so many years on this concept, and that we have, for the last 2 years, under Dr. Martin's committee, worked aggressively to develop the guidelines which are mandated by the legislation, I think gives evidence that we are both sympathetic to and working actively to implement this law.

UNNECESSARY SURGERY

The CHAIRMAN. I think you have pretty well answered the question. There was a statement made by some idealistic young people yesterday, speaking for a consumer group. They quoted from a book that I have not read—apparently written by a man named Williams, "How To Avoid Unnecessary Surgery"; published in 1971. They re-

ferred to a statistic of 10,000 deaths resulting from 2 million unnecessary operations each year.

Are you familiar with that book, or have you come across those statistics?

Dr. HANLON. I am familiar with this book and it is written under a pseudonym, so that it is difficult to speak to the author to find out what basis, if any, he has for those statistics. A frequently quoted statistic concerns a common operation, which is hysterectomy. And 15 years ago—and I believe Dr. Knowles, of the Rockefeller, has recently restated this—some 15 years ago a survey was made of a Teamsters study after some 60 hysterectomies had been done; and of those 60, 40 were perfectly justified and 20 of those 60 were thought to have possibly questionable indications.

Now, if one takes that percentage of approximately one-third and labels those—and mind you, this was done by a single reviewer without review by others—if one labels one-third of those as unnecessary and applies it to the total number of such operations done in the country, you can come up with ballpark and generally unsubstantiated figures of the magnitude that you have indicated. But I think these are extremely soft data, and I believe they should be viewed as such.

The CHAIRMAN. In other words, you think a lot of that has to do with the study made on hysterectomies where there is considerable leeway for difference of opinion between doctors as to whether the operation should or should not have been performed?

Dr. HANLON. Yes, and I think that it was pointed out in that study that a number of these operations were done in unaccredited hospitals. It does not necessarily indicate that if an operation is done in an unaccredited hospital it is a bad or unnecessary operation. On the other hand, all other things being equal, the caliber of practice in accredited hospitals tends to be higher and the indications for operation more stringently applied than in unaccredited hospitals.

The CHAIRMAN. When I was a practicing lawyer, I gained the opinion that if I was going to give advice on a good way to hire lawyers for a particular type of litigation it would be to see who lawyers hire to defend themselves. In other words, if some friend was in criminal trouble, a good way to decide who would be a good person to defend him would be to look and see who lawyers hire to defend themselves when they were prosecuted. And you would find that you probably did not go very far astray. I would think that if I wanted to have an operation performed, particularly major surgery, I might be well advised to see if I could not talk to some doctor, not about him performing the operation, but ask him who he would go to if he were to have that operation performed on him.

Do you think that would be a good way of going about deciding what doctor to hire to perform an operation?

Dr. HANLON. Yes, Mr. Chairman. I think the term for that in the medical profession is that he is a doctor's doctor.

The CHAIRMAN. Yes.

Dr. HANLON. I do not mean to say that a doctor takes care of himself, because as they say about lawyers, he then has a fool for a pa-

tient. But I believe that if you want to see a good surgeon, the surgeon who takes care of other surgeons and other physicians and their families might be assumed to be a highly reliable surgeon.

The CHAIRMAN. I am a little bit concerned about the fact that perhaps in a lot of cases people are having operations performed by general practitioners, who might not perform many operations, because he is their family doctor or they have a high regard for him, when, in many instances, it would be far more desirable if they would have that operation performed by—in the case of major surgery, particularly—a surgeon, a specialist.

What advice can you give me in that area; what we should or should not do about it?

Dr. HANLON. I think this is a highly sensitive issue. It is our feeling that all other things being equal, the better qualified a surgeon to do all of the complex aspects of an operation, the better the care of that patient will be. We recognize that highly trained surgeons are not present in every remote and small community in this country. Therefore, one has the problem of distribution; and patients would prefer, if they could, to stay in their own communities. On the other hand, if going a short distance—and in these days of rapid transportation—to a better center, often results not only in better care, but in less expensive care, because of the fact that the operation is performed more expertly, more expeditiously, and the aggregate cost to the patient, granting that he is away from his home base for a certain time, is less than if it were done in his own community somewhat less expertly.

In certain emergency situations in remote communities, we can see that some degree of operative skill applied by the person on the scene is certainly better than none at all.

The CHAIRMAN. Well, I am aware of situations where a patient died, not because the doctor did not do the best he could under the circumstances, but because those who made the decision simply did not realize that they had a better surgeon available to them who probably would have done a better job just because he specializes and does a great deal of operations and would have been more likely to have looked for perhaps the small items that the other fellow might have overlooked.

I just wonder what, if anything, we can do to move in the direction of having someone who has the best competence do the operation rather than have it fall to the person who has nothing like the expertise to do it.

Dr. HANLON. I think when the college or any other standard setting body which has been dedicated to both ethical and competent practice of the profession—when the college advocates that those who should do operations should be people of the highest competence, we are accused at times of self-serving and of being restrictive in wishing to have such surgical care delivered by our members. And I think that I would concede that that is our desire. But I concede also that that desire is pretty obviously motivated by what is in the best interest of the surgical patient.

The CHAIRMAN. Thank you very much.

Senator TALMADGE. Senator Bennett.

Senator BENNETT. I am sorry, Mr. Chairman, but I did not get here in time to hear the statement. I remember very pleasantly my visit with the members of the college, and I certainly hope that the hopes that I expressed there can be carried out; and if there is any way that I can continue to help to have them carried out, I will. I have no questions.

FEDERAL BUREAUCRACY AND PSRO

Senator TALMADGE. Senator Curtis.

Senator CURTIS. Doctor, I am very much impressed by the long record of activities of your association in the practice of medicine.

In your statement, you have the following paragraph:

> The college, by virtue of its historical leadership in peer review activities, has demonstrated for many decades its ability to take affirmative action in the best interests of patients without compulsion in the form of Federal law. I trust the continuing vigorous efforts of the college will not be impeded by unnecessary and confusing Federal rules and regulations governing implementation of PSRO.

Now all of this activity that you have described, whereby you have had peer review committees and other mechanisms to improve the practice of medicine and surgery, that has been done without any Federal law, has it not?

Dr. HANLON. It has.

Senator CURTIS. Prior to the enactment of this law, did you or your association ask for Federal legislation?

Dr. HANLON. We did not ask for it, no, sir.

Senator CURTIS. Do you know of any doctors who did?

Dr. HANLON. I am not personally aware of any who did, sir.

Senator CURTIS. The thing that disturbs me is that whatever power we delegate here is not to Secretary Weinberger or my dear friend Senator Bennett, but we are giving power to a bureaucracy that they will be operating 5, 10, 20 and so on years from now.

Is it your understanding that at the present time the national council on PSRO is chosen by the Secretary—are you familiar with that?

Dr. HANLON. I am familiar with it. It was chosen by the Secretary on the basis of nominations for suitable individuals submitted by a broad segment of the medical profession.

Senator CURTIS. But the Secretary does choose them?

Dr. HANLON. He has, in many parts of this law, substantial ultimate authority, yes, sir.

Senator CURTIS. And he names the chairman.

Dr. HANLON. He does.

Senator CURTIS. They have no staff of their own.

Dr. HANLON. I do not think that it is specified in the law how they are to implement it, no, sir.

Senator CURTIS. They testified yesterday they have no staff of their own, that is provided by HEW.

Do you feel that it is necessary that we have a Federal law for the college to continue the fine work that they have done up to now?

Dr. HANLON. I can answer that in two ways, Senator; and that is, the activities of the college and the control they exert over their fellows apply only to their fellows—and by that I mean, we have some 27,000 dues paying fellows in this country, but there are 92,000 individuals in training in organized medicine and out of it, who are carrying out operative procedures. The vast majority of those who are outside of the college are not under our rules and do not necessarily and, indeed, have no concern for our regulations and standards. And I think this represents an obvious problem when one speaks of insuring quality.

Senator CURTIS. I am not asking you to pass judgment on any who do not belong to your organization. Some of them may be very dedicated people who belong to other groups, local and otherwise, who are doing an excellent job of improving medicine. I am asking you, so far as the people you work with, do you need a Federal law to carry on the fine work you have been doing?

Dr. HANLON. I suppose that the fact that we did not advocate the passage of the law would suggest that we did not consider this as an abiding need. On the other hand, with the law on the books, we have felt it our civic and professional duty to insure, insofar as we can under that law, that the provisions of the law are implemented.

Senator CURTIS. I think that is a fair position. I do not know if there will be any vote besides mine or not to repeal this; but hypothetically, if the law were repealed, you would not stop the fine work that you have been doing for the last decade.

Dr. HANLON. No. But as I indicated in the statement, the precise way in which we may do this might be done in a way which would be less constricted and more of our own choosing than those which are mandated under the regulations of the law.

Senator CURTIS. Do you mean you might do a better job?

Dr. HANLON. No; not necessarily better, but a job which would be done strictly according to our plans and without the moral or legal suasion that is broadly applicable under the law to all those to whom it applies.

Senator CURTIS. One more question.

Later on in your statement, you seek the freedom to exercise a professional judgment unfettered by third-party intervention. Who are third parties?

Dr. HANLON. I believe that all third parties constitute in the ideal an interposition betwen what is the basic issue when a patient has a problem and comes to the physician, and if financing were not a problem, there would be no need for any third party.

Senator CURTIS. In other words, third party includes the Government?

Dr. HANLON. It does.

Senator CURTIS. That is all.

Senator TALMADGE. Senator Dole.

Senator DOLE. No questions.

Senator TALMADGE. Thank you very much, Doctor. We are honored by the contribution you have made in our deliberations.

[The following material was submitted by Dr. Hanlon:]

Minimum Standard for Hospitals

1. That physicians and surgeons privileged to practice in the hospital be organized as a definite medical staff. Such organization has nothing to do with the question as to whether the hospital is open or closed, nor need it affect the various existing types of medical staff organization. The word *staff* is here defined as the group of doctors who practice in the hospital inclusive of all groups, such as the active medical staff, the associate medical staff, and the courtesy medical staff.

2. That membership upon the medical staff be restricted to physicians and surgeons who are (a) graduates of medicine of approved medical schools, with the degree of Doctor of Medicine, in good standing, and legally licensed to practice in their respective states or provinces; (b) competent in their respective fields; and (c) worthy in character and in matters of professional ethics; that in this latter connection the practice of the division of fees, under any guise whatsoever, be prohibited.

3. That the medical staff initiate and, with the approval of the governing board of the hospital, adopt rules, regulations, and policies governing the professional work of the hospital; that these rules, regulations, and policies specifically provide (a) that medical staff meetings be held at least once each month; (b) that the medical staff review and analyze at regular intervals their clinical experience in the various departments of the hospital, such as medicine, surgery, obstetrics, and the other specialties; the medical records of patients, free and pay, to be the basis for such review and analysis.

4. That accurate and complete medical records be written for all patients and filed in an accessible manner in the hospital, a complete medical record being one which includes identification data; complaint; personal and family history; history of present illness; physical examination; special examinations, such as consultations, clinical laboratory, x-ray, and other examinations; provisional or working diagnosis; medical or surgical treatment; gross and microscopical pathological findings; progress notes; final diagnosis; condition on discharge; follow-up; and, in case of death, autopsy findings.

5. That diagnostic and therapeutic facilities under competent medical supervision be available for the study, diagnosis, and treatment of patients, these to include at least (a) a clinical laboratory providing chemical, bacteriological, serological, and pathological services; (b) an x-ray department providing radiographic and fluoroscopic services.

Taken from the Hospital Standards Manual.

This document was adopted in 1919 and represents the revisions in it through 1946.

FROM BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS, MARCH, 1974

Preliminary Report

Proposed General Surgical Guidelines for Screening

Preface

The American College of Surgeons has long subscribed to the concept of peer review and its Fellows have participated both individually and collectively in many phases of such activity.

The guidelines for screening which have been formulated by the American College of Surgeons are for the purpose of serving as models which can be helpful in the preparation of guidelines for screening at the regional level. These can be prepared together with suitable descriptions and the resulting guidelines for screening will be applicable in quality review of large numbers of cases.

Because there are so many variables, the guidelines for screening which have been formulated by the American College of Surgeons cannot set rigid, all encompassing standards applicable in every case. Therefore, the omission or addition of specific methods of treatment by a physician in an individual case does not necessarily indicate an incorrect approach. The guidelines for screening must be related to many factors which can only be assessed by a group of peers at the level of practice.

With ever increasing knowledge and its application to care of patients, these guidelines for screening will be periodically updated. Later articles in the American College of Surgeons' BULLETIN will address the difficult question of terminologic classifications, and the method of using these proposed guidelines in conjunction with various diagnostic and procedural classifications. Suggestions and criticism of these proposed guidelines are earnestly requested.

American College of Surgeons

Guidelines Worksheet

DIAGNOSIS:

Inguinal Hernia

1. Indications for Admission
   Admitted for surgery because of:
   a. Mass in groin
   b. Intestinal obstruction without palpable mass (Richter's hernia)
   c. Hydrocele, connecting, in children
   d. Definite history of hernia

2. Length of Hospital Stay (with applicable modifiers)
   usually 0 to 1 day; up to 3 days in special cases, preoperative
   usually 0 to 3 days for children; 0 to 7 days for adults, postoperative

3. Services Usually Performed or Provided
   a. History:
   b. Past History:
   c. Physical Examination: with attention to testes in scrotum of child
   d. Laboratory Tests: Required—pathology report of excised tissues in adults

Usual	As Indicated
CBC	Biochemical Profile, e. g. SMA-12
Urinalysis	Prothrombin Time
Chest X-ray (over 45)	Serology
ECG (over 45)	

   e. Special Diagnostic Procedures:

As Indicated
Sigmoidoscopy
Cystoscopy
Barium Enema
Intravenous Pyelogram
Herniogram

   f. Consultations:
      As Required
   g. Special Therapy Services:
      As Required
   h. Specific Nursing Services:
      As Indicated
   i. Medications (as indicated)
      Sedatives, Tranquilizers
      Analgesics, Narcotics
      Antibiotics (for specific indications)
      Diuretics
      Cardiac Stimulants
      Anticoagulants
      Bronchial Dilators
      Antidiabetic Agents
   j. Operations:
      Herniorrhaphy
   k. Hospital Course:
      Appropriate progress notes, with particular attention to wound healing and urinary tract function
      Postoperative complications include urinary tract infection, and rarely sepsis, hemorrhage or thromboembolism

4. Indications for Discharge
   Patient ambulatory
   Incision clean
   Absence of complications
   Availability of suitable home or other facility for care

5. Ambulatory Care
   Follow-up office visits, as required up to 30 days

MODIFIED SINCE PUBLICATION

American College of Surgeons
Guidelines Worksheet

DIAGNOSIS:
Cholecystitis and Cholelithiasis

1. Indications for Admission
   - Suspected Cholecystitis
     - Pain, nausea and vomiting
     - Recurrent gallbladder attacks
     - Fever
     - Jaundice
   - X-ray Diagnosis of Cholelithiasis
2. Length of Hospital Stay (with applicable modifiers)
   - 1 to 2 days, preoperative cholelithiasis and cholecystitis
   - 6 to 10 days, postoperative
   - 10 to 12 days, postoperative with exploration of common duct
   - 1 to 3 days, preoperative acute cholecystitis
   - 8 to 12 days, postoperative
3. Services Usually Performed or Provided
   a. History: with specific reference to biliary tract
   b. Past History:
   c. Physical Examination: with specific reference to presence or absence of upper abdominal mass or tenderness
   d. Laboratory Tests: **Required**—pathology report of excised tissue

Usual	As Indicated
CBC	Biochemical Profile, e. g. SMA-12
Urinalysis	Prothrombin Time
Chest X-ray (over 45)	Serology
ECG (over 45)	Blood Type and Cross-match
Blood Sugar	
BUN	
Serum Bilirubin	
Alkaline Phosphatase	
Serum Amylase	
SGOT	

   e. Special Diagnostic Procedures: (as indicated)
      - Cholecystogram (preoperative)
      - IV Cholangiogram (preoperative)
      - T-tube Cholangiogram (postoperative)
      - Liver Needle Biopsy
      - Retrograde Catheterization of Common Duct
   f. Consultations:
      - As Required
   g. Special Therapy Services:
      - As Required
      - Pulmonary Physiotherapy, postoperative
   h. Specific Nursing Services:
      - As Indicated
   i. Medications: (as indicated)

Sedatives, Tranquilizers	Cardiac Stimulants
Analgesics, Narcotics	Anticoagulants
Antibacterials	Bronchial Dilators
Diuretics	Antidiabetic Agents

   j. Operations:
      - Cholecystectomy, with or without operative Cholangiogram
      - Cholecystostomy
      - Choledochostomy
      - Choledochoduodenostomy
   k. Hospital Course:
      - Appropriate progress notes
      - Preoperative preparations—antibiotics (optional)
      - Postoperative important complications: hemorrhage, bile peritonitis, pancreatitis, liver function

PANCREATITIS

4. Indications for Discharge
   - Ambulatory
   - Complications under control
   - Availability of suitable home or other facility for care
5. Ambulatory Care
   - Follow-up visits up to 60 days

American College of Surgeons

Guidelines Worksheet

DIAGNOSIS:

Cholecystitis and Cholelithiasis

1. Indications for Admission
   - Suspected Cholecystitis
     - Pain, nausea and vomiting
     - Recurrent gallbladder attacks
     - Fever
     - Jaundice
   - X-ray Diagnosis of Cholelithiasis
2. Length of Hospital Stay (with applicable modifiers)
   - 1 to 2 days, preoperative cholelithiasis and cholecystitis
   - 5 to 10 days, postoperative
   - 10 to 12 days, postoperative with exploration of common duct
   - 1 to 3 days, preoperative acute cholecystitis
   - 8 to 12 days, postoperative
3. Services Usually Performed or Provided
   a. History: with specific reference to biliary tract
   b. Past History:
   c. Physical Examination: with specific reference to presence or absence of upper abdominal mass or tenderness
   d. Laboratory Tests: **Required**—pathology report of excised tissue

Usual	As Indicated
CBC	Biochemical Profile, e. g. SMA-12
Urinalysis	Prothrombin Time
Chest X-ray (over 45)	Serology
ECG (over 45)	Blood Type and Cross-match
Blood Sugar	
BUN	
Serum Bilirubin	
Alkaline Phosphatase	
Serum Amylase	
SGOT	

   e. Special Diagnostic Procedures: (as indicated)
      - Cholecystogram (preoperative)
      - IV Cholangiogram (preoperative)
      - T-tube Cholangiogram (postoperative)
      - Liver Needle Biopsy
      - Retrograde Catheterization of Common Duct
   f. Consultations:
      - As Required
   g. Special Therapy Services:
      - As Required
        - Pulmonary Physiotherapy, postoperative
   h. Specific Nursing Services:
      - As Indicated
   i. Medications: (as indicated)

Sedatives, Tranquilizers	Cardiac Stimulants
Analgesics, Narcotics	Anticoagulants
Antibacterials	Bronchial Dilators
Diuretics	Antidiabetic Agents

   j. Operations:
      - Cholecystectomy, with or without operative Cholangiogram
      - Cholecystostomy
      - Choledochostomy
      - Choledochoduodenostomy
   k. Hospital Course:
      - Appropriate progress notes
      - Preoperative preparations—antibiotics (optional)
      - Postoperative important complications: hemorrhage, bile peritonitis, pericarditis, liver function
4. Indications for Discharge
   - Ambulatory
   - Complications under control
   - Availability of suitable home or other facility for care
5. Ambulatory Care
   - Follow-up visits up to 60 days

American College of Surgeons
Guidelines Worksheet

DIAGNOSIS:

Varicose Veins

1. Indications for Admission
   - Demonstrable varices with or without symptoms admitted for operation
   - Stasis dermatitis
   - Deep or superficial phlebitis
   - Ulceration

2. Length of Hospital Stay (with applicable modifiers)
   - 0 to 1 day, preoperative
   - 3 to 5 days, postoperative, unilateral
   - 3 to 7 days, postoperative, bilateral
   - Excision of ulcer and graft—
   - 1 to 14 days, preoperative
   - 3 to 21 days, postoperative

3. Services Usually Performed or Provided
   a. History: discomfort, progressive disease, dermatitis, ulcer edema
   b. Past History: special attention to pregnancy, oral contraceptives, drug therapy, trauma
   c. Physical Examination: particular attention to demonstrable varices, incompetent short saphenous vein, incompetent communicating veins, fibrosis, pigmentation, description of peripheral pulses, edema, ulceration
   d. Laboratory Tests: Required—pathological examination of excised ulcers

Usual	As Indicated
CBC	Biochemical Profile, e. g. SMA-12
Urinalysis	Prothrombin Time
Chest X-ray (over 45)	Serology
ECG (over 45)	Cultures

   e. Special Diagnostic Procedures:

Usual	As Indicated
Vascular Lab Studies	Phlebography

   f. Consultations:
      - As Required
   g. Special Therapy Services:
      - As Required
        - Inhalation Therapy
        - Pressure Bandages or Boot
        - Elastic Supports
   h. Specific Nursing Services:
      - As Indicated
        - Special Wound Care
   i. Medications: (as indicated)

Sedatives, Tranquilizers	Anticoagulants
Analgesics, Narcotics	Antidiabetic Agents
Antibacterials (for specific conditions)	Local applications for ulcer
Diuretics	

   j. Operations:
      - Long and Short Superficial Saphenous Ligation and Stripping, Unilateral, Bilateral, etc.
      - Debridement of Stasis Ulcer
      - Excision of Leg (stasis) Ulcer, with or without Graft
      - Ligation of Incompetent Communicating Veins
      - Ligation of Femoral Vein(s)
      - Injection Therapy
   k. Hospital Course:
      - Appropriate progress notes, with particular attention to wound healing and thrombophlebitis

4. Indications for Discharge
   - Ambulatory with satisfactory wound healing
   - Availability of suitable home or other facility for care

5. Ambulatory Care
   - Follow-up office visits
   - Ligation of long, short, communicating veins—up to 14 days
   - Excision of ulcer and grafting—up to 28 days
   - Complicated—determined by specific complication
   - Phlebography, if indicated

American College of Surgeons
Guidelines Worksheet

DIAGNOSIS:

Appendicitis

1. Indications for Admission
   - Abdominal pain and tenderness
   - Previous attacks of appendicitis, for interval appendectomy

2. Length of Hospital Stay (with applicable modifiers)
   - 2 days, observation in suspected cases if unoperated
   - 3 to 7 days, unruptured
   - 7 to 14 days, ruptured

3. Services Usually Performed or Provided
   a. History: anorexia, nausea, vomiting, abdominal pain
   b. Past History: previous attacks
   c. Physical Examination: positive abdominal findings, rectal and pelvic examination findings, fever, pulse and state of hydration
   d. Laboratory Tests: Required—pathology report of excised tissues

Usual	As Indicated
CBC	Chest X-ray
Urinalysis	Abdominal X-ray
	ECG (over 45)
	Biochemical Profile, e. g. SMA-12
	Serology
	Sedimentation Rate
	Prothrombin Time

   e. Special Diagnostic Procedures:

As Indicated
Intravenous Pyelogram
Barium Enema
GI Series

   f. Consultations:
      As Required
   g. Special Therapy Services:
      As Required
   h. Specific Nursing Services:
      As Indicated
   i. Medications: (as indicated)
      Sedatives
      Analgesics, Narcotics
      IV Fluids
      Antibiotics, for specific indications
   j. Operations:
      Appendectomy
      Simple Drainage (or both)
   k. Hospital Course:
      Appropriate progress notes, with reference to wound healing, fever, and gastrointestinal function
      Important postoperative complications: sepsis, intestinal obstruction

4. Indications for Discharge
   - Ambulatory
   - Afebrile
   - No significant wound drainage
   - Availability of suitable home or other facility for care

5. Ambulatory Care
   - Follow-up visits up to 28 days

American College of Surgeons
Guidelines Worksheet

DIAGNOSIS:

Hemorrhoids (Internal and External)

1. Indications for Admission
   - Symptomatic protrusion
   - Rectal bleeding
   - Rectal pain, or
   - Combination of above, requiring hemorrhoidectomy
2. Length of Hospital Stay (with applicable modifiers)
   - 3 to 7 days postoperative
3. Services Usually Performed or Provided
   a. History: same as #1 above (bleeding, pain, prolapse)
   b. Past History:
   c. Physical Examination:
   d. Laboratory Tests: **Required**—pathology report of excised tissues

Usual	As Indicated
CBC	Biochemical Profile, e. g. SMA-12
Urinalysis	Prothrombin Time
Chest X-ray (over 45)	Serology
ECG (over 45)	

   e. Special Diagnostic Procedures: (as indicated)
      - Anoscopy (required)
      - Proctosigmoidoscopy (required)
      - Barium Enema (usual)
      - Colonoscopy (optional)
   f. Consultations:
      - As Required
   g. Special Therapy Services:
      - As Required
   h. Specific Nursing Services:
      - As Required
   i. Medications: (as indicated)
      - Sedatives, Tranquilizers
      - Analgesics, Narcotics
      - Antibacterials (for sepsis)
      - Diuretics
   j. Operations:
      - Applicable procedure for condition
   k. Hospital Course:
      - Appropriate progress notes
      - Preoperative—preparation of bowel
      - Postoperative—common complications: urinary tract infection, sepsis, hemorrhage
4. Indications for Discharge
   - Bowels moving
   - Absence of bleeding
   - Availability of suitable home or other facility for care
5. Ambulatory Care
   - Follow-up visits, as required up to 45 days

American College of Surgeons

Guidelines Worksheet

DIAGNOSIS:

Breast Mass

1. Indications for Admission
   - Single or multiple masses
   - Discharge from nipple
   - Nipple deformity
   - Pain or discomfort
   - Skin lesions
   - Elevation of skin temperature
   - Axillary adenopathy
   - Abnormal mammogram or xerogram
2. Length of Hospital Stay (with applicable modifiers)
   - 1 to 3 days, benign lesion
   - 7 to 12 days, malignant (uncomplicated postoperative course)
3. Services Usually Performed or Provided
   a. History: menstrual history, history of pregnancy, lactation, family history of cancer of breast
   b. Past History: previous breast operation, hormone therapy
   c. Physical Examination: presence, location, size and description of mass; discharge from nipple; axillary nodes location and size; evidence of skin involvement; satellite lesions
   d. Laboratory Tests: Required—pathology report of excised tissues

Usual	As Indicated
CBC	Biochemical Profile, e. g. SMA-12
Urinalysis	Prothrombin Time
Chest X-ray	Serology
ECG (over 45)	X-ray, Bones
	Bone Marrow
	Type and Cross-match (preoperative)

   e. Special Diagnostic Procedures:

Usual	As Indicated
Needle Biopsy or	Mammogram (preoperative)
Excisional Biopsy with	Cytology, Cyst Fluid (preoperative)
Microscopic Exam	Bone Scan (preoperative)
	Liver Scan (preoperative)
	Thermography/Xerography (preoperative)

   f. Consultations:
      As Required
   g. Special Therapy Services:
      As Required
      Radiation Therapy
   h. Specific Nursing Services:
      As Indicated
      Wound Care and Arm Exercises
   i. Medications: (as indicated)

Sedatives, Tranquilizers	Bronchial Dilators
Analgesics, Narcotics	Antidiabetic Agents
Antibiotics (for sepsis)	Hormone Therapy
Diuretics	Chemotherapy
Cardiac Stimulants	

   j. Operations:

Excision of Mass	Radical Mastectomy
Partial Mastectomy	Extended Radical Mastectomy
Complete Mastectomy	Ablative Therapy

   k. Hospital Course:
      Appropriate progress notes, with attention to wound including bleeding, serum accumulation, skin necrosis and sepsis
4. Indications for Discharge
   - Satisfactory postoperative progress
   - Absence of contingencies
   - Availability of suitable home or other facility for care
5. Ambulatory Care
   - Immediate follow-up office visits postoperatively, as required for 60 days
   - Postoperative radiation therapy (optional)
   - Hormone or chemotherapy (optional)
   - Reexamination from three to six months for first year, thereafter every six months

American College of Surgeons

Guidelines Worksheet

DIAGNOSIS:

Diverticular Disease of Colon

1. Indications for Admission
   - Abdominal pain, particularly in LLQ
   - Abdominal tenderness
   - Lower GI bleeding
   - Diarrhea, constipation, flatulence associated with known diverticulitis
   - Repeated attacks of diverticulitis
   - Intestinal obstructions
   - Colonic fistula (skin, bladder, vagina, etc.)
   - Fever

2. Length of Hospital Stay (with applicable modifiers)
   - 3 to 10 days, without operation
   - 0 to 7 days, with operation, preoperative
   - 7 to 21 days, with operation, after each stage

3. Services Usually Performed or Provided
   a. History: same as #1 above
   b. Past History:
   c. Physical Examination: include pelvic and rectal
   d. Laboratory Tests: Required—pathology report of excised tissue

Usual	As Indicated
CBC	Biochemical Profile, e. g. SMA-12
Urinalysis	Prothrombin Time
Chest X-ray (over 45)	Serology
ECG (over 45)	Blood Type and Cross-match
Stool Exam	

   e. Special Diagnostic Procedures:

Usual	As Indicated
Barium Enema	Colonoscopy
Sigmoidoscopy	Intravenous Pyelogram

   f. Consultations:
      - As Required
   g. Special Therapy Services:
      - As Required
        - Pulmonary Physiotherapy, postoperative
        - Stomal Therapy
   h. Specific Nursing Services:
      - As Indicated
   i. Medications: (as indicated)
      - Sedatives, Tranquilizers
      - Analgesics, Narcotics
      - Antibacterials, as indicated
        - a. for acute diverticulitis
        - b. for preoperative preparation of colon (optional)
        - c. for persistent sepsis postoperatively
      - Diuretics
      - Cardiac Stimulants
      - Anticoagulants
      - Bronchial Dilators
      - Antidiabetic Agents
   j. Operations:
      - Resection and anastomosis in 1, 2, or 3 stages
      - Colostomy
      - (and/or drainage as indicated)
   k. Hospital Course:
      - Appropriate progress notes
      - Preoperative—in elective cases, preparation of colon
      - Postoperative—common complications: sepsis, intestinal obstruction, urinary tract infection

4. Indications for Discharge
   - Normal bowel or colostomy function
   - Ambulatory
   - Wound free of sepsis
   - Free of drainage
   - Availability of suitable home or other facility for care

5. Ambulatory Care
   - Follow-up visits up to 60 days

American College of Surgeons
Guidelines Worksheet

DIAGNOSIS:

Carcinoma of Colon and Rectum

1. Indications for Admission
   - Carcinoma of the colon or rectum
   - Symptoms and signs suggesting partial or complete obstruction of the colon or rectum
   - Lower GI bleeding
   - Iron deficiency anemia suggestive of chronic blood loss from the colon
   - Abdominal, rectal, or pelvic mass of possible colon or rectal origin
   - Change in bowel habit
2. Length of Hospital Stay (with applicable modifiers)
   - 0 to 7 days, preoperative, malignant neoplasm of the colon
   - 12 to 20 days, postoperative
   - 0 to 3 days, preoperative, malignant neoplasm of the rectum
   - 10 to 21 days, postoperative
   - (this would vary with any complication or other contingency)
3. Services Usually Performed or Provided
   a. History: same as #1 above
   b. Past History:
   c. Physical Examination:
   d. Laboratory Tests: Required—pathology report of excised tissues

Usual	As Indicated
CBC	Biochemical Profile, e. g. SMA-12
Urinalysis	Prothrombin Time
Chest X-ray	Serology
ECG (over 45)	Sedimentation Rate
Stool Examination	
Blood Type and Cross-match	

   e. Special Diagnostic Procedures: (as indicated)
      - Proctosigmoidoscopy (independent procedure) with biopsy
      - Barium Enema
   f. Consultations:
      - As Required
   g. Special Therapy Services:
      - As Required
        - Pulmonary Physiotherapy, postoperative
   h. Specific Nursing Services:
      - As Indicated
        - Ostomy Specialist
   i. Medications: (as indicated)
      - Sedatives, Tranquilizers
      - Analgesics, Narcotics
      - Antibacterials
        - preoperative—antibiotic preparation of bowel (optional)
        - postoperative—as indicated
      - Diuretics
      - Cardiac Stimulants
      - Anticoagulants
      - Bronchial Dilators
      - Antidiabetic Agents
   j. Operations:
      - Applicable procedure for condition indicated
   k. Hospital Course:
      - Appropriate progress notes
      - Preoperative—preparation of colon (elective operation)
      - Postoperative—most common complications: sepsis, hemorrhage, intestinal obstruction, urinary tract sepsis
4. Indications for Discharge
   - Normal bowel and respiratory function
   - Healing wound (CA rectum)
   - Availability of suitable home or other facility for care
5. Ambulatory Care
   - Follow-up office visits up to 90 days
   - Recommendations for every 6 months thereafter

American College of Surgeons

Guidelines Worksheet

DIAGNOSIS:

Gastric and Duodenal Ulcer

1. Indications for Admission
   - Pain
   - Obstruction
   - Bleeding
   - Perforation
   - Elective Surgery

2. Length of Hospital Stay (with applicable modifiers)
   - 1 to 7 days, if no operation
   - 5 to 14 days, if operation
   - 14 days, if complications

3. Services Usually Performed or Provided
   a. History: melena, hematemesis, ulcerogenic medications, localization, character pain, relationship to food, failure to gain weight in children
   b. Past History: prior treatment for peptic ulcer
   c. Physical Examination: vital signs, if bleeding or perforation, abdominal, rectal
   d. Laboratory Tests: Required—pathology report of excised tissues

Usual	As Indicated
CBC	Biochemical Profile, e. g. SMA-12
Urinalysis	Prothrombin Time
Chest X-ray (over 45)	Serology
ECG (over 45)	Serum Amylase
Stool Guaiac	Acid Secretion Levels
Blood Type and Cross-match	Gastric Cytology
	Serum Gastrin

   e. Special Diagnostic Procedures:

Usual	As Indicated
Abdominal and Chest X-rays (perforation)	Cholecystogram
	Barium Enema
Upper GI X-ray	Gastroscopy (with biopsy)
	Sigmoidoscopy
	Arteriography (bleeding)

   f. Consultations:
      As Required
   g. Special Therapy Services:
      As Required
      Pulmonary Physiotherapy, postoperative
   h. Specific Nursing Services:
      As Indicated
   i. Medications: (as indicated)

Antacids	Special Diets
Parenteral Fluids	Antibiotics, for specific indications
Blood Products	Analgesics, Narcotics

   j. Operations:
      Closure Perforation
      Partial Gastrectomy, alone or with Vagotomy
      Total Gastrectomy
      Pyloroplasty, alone or with Vagotomy
      Gastrojejunostomy, alone or with Vagotomy
      Vagotomy, Truncal, Selective Gastric, Parietal Cell
      Remedial Gastric Procedures
   k. Hospital Course:
      Appropriate progress notes, with particular attention to wound healing, gastrointestinal function, and diet.
      Important postoperative complications: suture line perforation, stomal malfunction, hemorrhage

4. Indications for Discharge
   - Patient ambulatory
   - Eating without difficulty
   - Availability of suitable home or other facility for care

5. Ambulatory Care
   - Follow-up office visits up to 30 days

American College of Surgeons
Guidelines Worksheet

DIAGNOSIS:

Hiatal Hernia

1. Indications for Admission
   - Pain
   - Dysphagia
   - Bleeding
   - Dyspnea
   - Uncontrolled regurgitation
   - Large esophagastomatic hernias
   - Failure to gain weight in children

2. Length of Hospital Stay (with applicable modifiers)
   - 0 to 4 days, if no operation
   - 5 to 14 days, if operation
   - 14 days, if complications

3. Services Usually Performed or Provided
   a. History: special attention paid to esophagitis, obstruction, melena, reflux, GI bleeding, aspiration pneumonia
   b. Past History: special attention to previous treatment
   c. Physical Examination: special attention to weight loss, lungs, abdomen
   d. Laboratory Tests Required—pathology report of excised hernias

Usual	As Indicated
CBC	Biochemical Profile, e.g. SMA-12
Urinalysis	Determination of Gastric Acidity
Chest X-ray	
ECG (over 45)	

   e. Special Diagnostic Procedures:

Usual	As Indicated
Esophagogram	Barium Enema
Upper GI X-ray	Esophageal Motility
Esophagoscopy	Esophageal and Gastric pH
	Arid Perfusion
	Bronchoscopy and Bronchogram
	Cholecystogram

   f. Consultations:
      - As Required
   g. Special Therapy Services:
      - As Required
        - Pulmonary Physiotherapy, postoperative
   h. Specific Nursing Services:
      - As Indicated
        - Intensive Care
   i. Medications: (as indicated)
      - Antacids
      - Analgesics
      - Sedatives
      - Antibiotics (for special indications)
   j. Operations:
      - Transabdominal or Transthoracic Hiatal Hernia Repair with Anthrellax Procedure, with or without Vagotomy-Pyloroplasty
      - Incidental GI Surgery
   k. Hospital Course:
      - Appropriate progress notes, with special attention to wound healing and gastrointestinal and pulmonary function
      - Important postoperative complications: hemorrhage, perforation, obstruction, and esophagogastric function

4. Indications for Discharge
   - Normal postoperative recovery
   - Eating without difficulty
   - Patient ambulatory
   - Availability of suitable home or other facility for care

5. Ambulatory Care
   - Follow-up office visits, 30 days
   - Esophageal dilatations, if required

American College of Surgeons

Guidelines Worksheet

DIAGNOSIS:

Intestinal Obstruction

1. Indications for Admission
   - Abdominal pain
   - Vomiting
   - Distention
   - Obstipation
   - Newborn infants: failure to pass meconium in 48 hours

2. Length of Hospital Stay (with applicable modifiers)
   - 5 to 7 days, non-surgical treatment
   - 5 to 21 days, surgical treatment
   - (modified by associated medical and surgical complications)

3. Services Usually Performed or Provided
   a. History: abdominal pain, vomiting, distention
   b. Past History: previous operation or trauma; family history of congenital malformation
   c. Physical Examination: general physical exam with particular reference to abdominal distention, peristaltic activity, rectal and vaginal examination
   d. Laboratory Tests: Required—pathology report of excised tissues

Usual	As Indicated
CBC	Prothrombin Time
Urinalysis	Serology
Chest X-ray (over 45)	
ECG (over 45)	
KUB X-ray	
Blood Type and Cross-match	
Biochemical Profile	

   e. Special Diagnostic Procedures:

Usual	As Indicated
Barium Enema	Sigmoidoscopy
	Upper GI Series

   f. Consultations:
      As Required
   g. Special Therapy Services:

Usual	Optional
Fluid and Electrolyte Replacement	Pulmonary Physiotherapy
Nasogastric Suction	Transfusion
	Hyperalimentation (intravenous)

   h. Specific Nursing Services:
      As Indicated
   i. Medications: (as indicated)
      - Sedatives, Tranquilizers
      - Analgesics, Narcotics
      - Antibacterials (for specific indications)
      - Diuretics
      - Cardiac Stimulants
      - Anticoagulants
      - Bronchial Dilators
      - Antidiabetic Agents
   j. Operations:
      Applicable procedure consistent with operative findings
   k. Hospital Course:
      - Appropriate progress notes, with particular attention to abdominal findings, fluid and electrolyte balance, gastrointestinal function
      - Preoperative—preparation for surgery
      - Postoperative—most common complications: ileus, recurrent obstruction

4. Indications for Discharge
   - Satisfactory recovery from obstruction, whether operative or non-operative
   - Availability of suitable home or other facility for care

5. Ambulatory Care
   - Follow-up office visits, as needed up to 45 days

American College of Surgeons

Guidelines Worksheet

DIAGNOSIS:

Goiter

1. Indications for Admission
   - Enlargement of thyroid gland—nodular or diffuse (solitary or multiple)
   - Symptoms of hyperthyroidism, with or without enlargement of the gland
     a. dyspnea on exertion
     b. tacchycardia
     c. loss of weight, but good appetite
     d. exophthalmos
     e. more than 2 years of medical treatment in children for hyperthyroidism
2. Length of Hospital Stay (with applicable modifiers)
   - 1 to 3 days (longer if serious associated disease), preoperative
   - 0 to 2 days for needle biopsy or aspiration, postoperative
   - 4 to 6 days for operation limited to thyroid, postoperative
   - 7 to 10 days if neck dissection is also carried out, postoperative
3. Services Usually Performed or Provided
   a. History: neck pain, dyspnea, tacchycardia, swelling in neck (with duration)
   b. Past History:
   c. Physical Examination: special attention to neck, skin, pulse, blood pressure, vocal cords
   d. Laboratory Tests: Required—pathology report of excised tissue

Usual	As Indicated
CBC	Biochemical Profile, e. g. SMA-12
Urinalysis	Serology
Chest X-ray	Blood Iodine
ECG (over 45)	T_3, T_4 Evaluation or Others

   e. Special Diagnostic Procedures:

As Indicated
Radioactive Iodine Uptake
Thyroid Scan
Needle Biopsy or Aspiration
Selective Arteriography

   f. Consultations:
      As Required
   g. Special Therapy Services:
      As Required
      Cardiac or Pulmonary Physiotherapy
   h. Specific Nursing Services:
      As Indicated
   i. Medications: (as indicated)

Antithyroid Drugs	Diuretics
Iodine	Cardiac Stimulants
Sedatives, Tranquilizers	Bronchial Dilators
Analgesics, Narcotics	Thyroid Supplement

   j. Operations:
      Needle Biopsy
      Subtotal Lobectomy (unilateral)
      Subtotal Thyroidectomy (bilateral)
      Total Lobectomy (unilateral)
      Total Thyroidectomy (bilateral)
      Subtotal Thyroidectomy with Radical Neck Dissection
      Total Thyroidectomy with Radical Neck Dissection
      Total or Subtotal Thyroidectomy with Limited Neck Dissection
   k. Hospital Course:
      Appropriate progress notes, with special attention to bleeding, dyspnea, stridor, horseness and tetany
      Preoperative—euthyroid
      Postoperative—important complications: bleeding, tracheal compression, nerve paralysis
4. Indications for Discharge
   - Uncomplicated postoperative recovery
   - Ambulatory
   - Absence of dyspnea
   - Availability of suitable home or other facility for care
5. Ambulatory Care
   - Follow-up office visits, as required up to 90 days
   - X-ray therapy, when indicated
   - Radioactive iodine therapy, when indicated
   - Thyroid replacement therapy, when indicated

Director's memo

PROFESSIONAL STANDARDS REVIEW ORGANIZATION (PSRO)

It would be difficult to find a subject on which there is more talk and less comprehension than the current status of peer review. Some years ago, we published Mr. Heinz Kuehn's primer on the subject (BULLETIN 56, 54—July/August 1971), updated this two years ago (BULLETIN 57, 30—March 1972), and in the December 1973 BULLETIN we carried reports of talks by Senator Wallace Bennett, author of the PSRO legislation and by Henry E. Simmons, MD, MPH, new director of the Office of Professional Standards Review (OPSR). These latter reports were authoritative as of October 1973 when the talks were delivered at the Clinical Congress, but events haved moved swiftly since then.

At the AMA Clinical Meeting in Anaheim in December 1973, following a lively discussion in the House of Delegates, a statement emerged which seemed to modify the previous AMA posture of cooperative participation with the law while working to modify its objectionable features. A firm stand for repeal of the law was presented by highly vocal members of the House of Delegates and the resulting clamor was intensified by HEW Secretary Weinberger's announcement of incipient insistence on preadmission certification before hospital admission. Under severe pressure from various quarters, this governmental position was relaxed but the cries for modification or repeal of the law have not diminished.

In these confused and emotional circumstances, the possibility has been raised of "a College statement by the Regents". Such a statement, it is fondly hoped by some, would "provide leadership" and even affect events in Washington legislative and bureaucratic high places. This hope has no basis in the facts of past experience. The ambivalent AMA statement after its December meeting reflects the strong polarization of its federated groups toward postures of repeal of the law on the one hand or vigorous cooperation in implementation on the other. Is any useful purpose to be served by a formal College statement on the subject?

The Regents addressed this question at length in February and rejected as unfeasible and inappropriate the issuance of a position statement at this time. They have no evidence of a widespread consensus among the Fellowship concerning PSRO, nor is any likelihood of imminent legislative reversal conceded even by those who most strenuously object to the law. On the other hand, it is superfluous to urge observance of the law, when most Fellows and the College Peer Review Committee are cooperating by making vigorous efforts to establish guidelines so that widespread, formal peer review may be effected as mandated by P.L. 92-603.

Under Dr. J. D. Martin, Jr., of Atlanta, immediate past Regent of the College, a combined Peer Review Committee of Regents and Governors with specialty consultants has been developing guidelines over a period of more than two years. The results of this effort are published in this issue of the BULLETIN, reflecting multiple meetings with all surgical specialties to eliminate conflicting overlap with criteria and guidelines developed by individual specialties. An assessment of the value and usage of the proposed guidelines is made in the preface.

A consensus was reached to withhold terminologic coding from these guidelines until current problems with conflicting coding systems have been overcome. However, a preference was expressed for the *Hospital Adaptation of International Classification of Disease—Second Edition (H-ICDA-II)*. This encompasses diagnostic coding and procedural coding as well. The tentative guidelines published in this BULLETIN are to be transmitted to the AMA Task Force on Guidelines of Care under the chairmanship of Dr. Claude E. Welch, President of the College, for possible re-publication at a later time with those developed by other specialties.

Reprinted from the BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS, March 1974

American Surgery's Noblest Experiment

Carl P. Schlicke, MD, Spokane, Wash

A cliché commonly heard today is that medical care is becoming dehumanized. It is of interest that those who entertain this belief have developed a vocabulary hardly designed to decelerate such a trend, if indeed it exists. In the lexicon of the sociologist, the economist, and big government, that suffering human being, the patient, has become the "consumer," the dedicated physician who ministers to his ailments the "provider," and a respected profession and its allies are referred to as the "health care industry." One of the chief problems confronting anyone attempting to refute the charge of dehumanization is the difficulty of documenting objectively what is essentially a subjective impression. This applies also to the matter of the physician's concern for the welfare of his patients. It is my purpose this morning to document this tenet at least by an account of what I regard as "American Surgery's Noblest Experiment."

The renaissance of American medical education dates from the opening of Johns Hopkins University School of Medicine in 1893; however, 159 other schools, many of them disreputable diploma mills, continued to award the MD degree.[1] A few years later a sweeping reorganization of the American Medical Association took place and the Council on Medical Education was formed. In 1907 it released a highly critical report of its first inspection of medical schools. This attracted the support of the Carnegie Foundation and led to the famed Flexner Report. Within five years 65 inferior schools closed their doors and a great reform was accomplished.

There remained the matter of hospitals, in many instances walk-in garbage cans, which people entered reluctantly as a last resort before death. I need hardly remind this audience of the role played by surgeons in the upgrading of hospitals. It is this to which I refer to as "Surgery's Noblest Experiment," an effort which has saved countless lives and prevented or alleviated untold suffering.

Origins of Hospital Standardization

It all began with Franklin H. Martin's Clinical Congress of Surgeons of North America.[2] At its third annual meeting held in New York in 1912 a resolution was passed that "some system of standardization of hospital equipment and hospital work should be developed."[3] To this end a committee of which William J. Mayo was a member was appointed under the chairmanship of Ernest B. Codman of Boston. At this same meeting the organization of a College of Surgeons was proposed. Incorporation papers were obtained later in the year from the State of Illinois and May 5, 1913, an organizational meeting was held in Washington, DC. One of the avowed purposes of the newly formed College was "establishing standards of hospital construction, administration and equipment and all else that pertains to them." At the Clinical Congress in October, the Codman Committee gave its report. It recommended that the stamp of approval be given to an investigation of hospitals and Carnegie Foundation support be sought. The report was unanimously accepted and as Loyal Davis[4](p118) later wrote, "thus started one of the greatest contributions to the care of the sick which removed the fear of the hospital . . . from the minds of ill patients."

Unfortunately, the initial attempt to interest the Carnegie Foundation failed, so the help of other organizations was solicited. The American Hospital Association offered cooperation but no financial aid. The AMA declined to assume any responsibility because of the expense involved. Meanwhile, the case reports required

Accepted for publication Nov 24, 1972.

From the Surgical Service, Rockwood Clinic and Sacred Heart Medical Center, Spokane, Wash.

President's address, read before the 50th annual meeting of the Western Surgical Association, Rochester, Minn, Nov 16, 1972.

Reprint requests to 512 Eighth Ave, Spokane, Wash 99204 (Dr. Schlicke).

of the candidates for membership in the College were furnishing a sad commentary on the condition of the hospitals in which they worked. Sixty percent of otherwise approved candidates were rejected during the first three years because of poor records. It became obvious the College would have to carry on alone or its own program for the qualification of applicants would fail. In 1915 the Regents appropriated $500 to get things started, and a year later $30,000 was obtained from the Carnegie Foundation in an effort to improve conditions in the places where surgeons worked.

A one-page explanation of minimum standards was published. It was felt anything more stringent would be unacceptable to hospitals and to the public. In 1917 the Clinical Congress and the College merged and John G. Bowman, the former President of the State University of Iowa, who had accepted the position as Director of the College, began visiting hospitals. A committee of physicians, surgeons, administrators, and laboratory specialists met in Washington, DC, to formulate fundamental requirements for the care of the sick and to complete a questionnaire. Arthur Dean Bevan,[1,2,3] Chairman of the AMA Council on Medical Education, said "to my mind next to the work that has been done in medical education in this country, this problem that confronts your committee today is the most important thing in American medicine." Questionnaires were sent to 2,711 hospitals in the United States and Canada and Bowman traveled far and wide promoting the program.

The following year Bowman and his aides began to investigate hospitals of 100 or more beds in order to determine universally applicable standards. The results were unbelievable. Of 692 hospitals visited, only 89 could meet the simplest requirements. A list of approved hospitals was printed but the showing was so deplorable and there were so many "embarrassing omissions" that the Regents decided to suppress the report, releasing only the actual numbers involved. Alex Gerber[1] has given a graphic account of ". . . the pyre in the Waldorf cellar . . ." which he refers to as an irreparable ". . . act of intellectual and moral cowardice." In fact, the mere publication of the figures so shocked physicians, administrators, and trustees that widespread support of the program was obtained, whereas a less tactful approach might have caused the program to flounder. It then became possible for the Regents to adopt a formal program of hospital standardization which, as Reed Nesbit[1] has observed, was ". . . soon heralded over the world as one of the great advances of all time in promoting patient welfare." The beneficial effects of the program were soon apparent. Hospitals struggled to upgrade conditions and records submitted by the candidates improved in quality. This was reflected in the increasing number of hospitals approved each year. The program furthermore greatly enhanced the stature of the College and attracted additional Carnegie funds. Belatedly, overtures came from the AMA for a joint program which the College declined. Malcolm T. MacEachern became Associate Director of the College in charge of the hospital standardization program. Lists of approved hospitals were issued annually and certificates of approval awarded.

From the start the program was an unqualified success. McGraw,[1] in commenting on the striking effect that it had on hospitals said "the rapidity with which accreditation caught on and its far reaching influence are all the more remarkable in view of its voluntary status." However, its cost was becoming a source of concern. By 1941 its operating budget was $44,028; in 1949 the total was $68,577. By 1950 the College had invested $2 million in the program. This money came from the dues collected from members. The College took great pride in the fact that there were now 3,290 hospitals on the approved list, but the financial burden was beginning to hamper other educational programs of the College. The AHA was now a strong organization wishing to participate more actively and willing to assume the entire cost. Negotiations were begun and the College was promptly accused of a sellout to laymen.

JCAH Is Born

Evarts Graham proposed to the Board of Regents that an independent commission be set up financed by contributions from participating organizations. A committee was appointed to negotiate and work out representation with representatives of the AMA, the AHA, the American College of Physicians, and the Canadian Medical Association. Approval of the AMA House of Delegates was obtained in September 1951 and in December 1951 the Joint Commission on Accreditation of Hospitals (JCAH) was incorporated in Illinois. In March of 1952 JCAH was formally organized in Chicago. Edwin L. Crosby, former Director of Johns Hopkins Hospital and President-Elect of the AHA, was appointed Director. Inspections were to be made by field staffs of participating organizations. The Canadian Medical Association withdrew in 1959 to participate in its own national accreditation program. In 1961 JCAH developed its own staff of trained surveyors.

The governing body of JCAH is a Board of Commissioners who serve without compensation. There are three members from the American College of Surgeons, three from the ACP, seven from the AMA, and seven from the AHA. A large majority of the Commissioners are physicians. Standards are adopted or amended only with Board approval. Accreditation decisions are made by the Board or by the Accreditation Committee. Originally funding was entirely by member organizations. As the scope of JCAH activity and the number of hospitals seeking surveys increased, it became necessary in 1964 to start charging a survey fee. Members still make substantial contributions, eg, $266,000 in 1971.

Of the 7,123 hospitals in the United States, 5,075 (71%) are currently (1972) accredited (unpublished data). About 2,000 hospitals are not surveyed; those that have not applied or have been refused accreditation. They are, for the most part, small and often proprietary. The JCAH surveys about 12% of the 447 hospitals of less

than 25 beds, 74% of 1,713 with 50 to 100 beds, and practically all hospitals with more than 100 beds. Of 1,876 surveyed in 1970, a total of 1,457 (78%) received two-year accreditation, 360 (19%) one-year accreditation, and 59 (3%) no accreditation. Among 131 hospitals undergoing initial survey, only 59 or 45% received full accreditation. Hospitals have voluntarily sought accreditation as a stamp of higher quality than licensure alone, although they could legally operate without it. As a matter of fact, when the hospital standardization program was inaugurated, it long preceded any interest in quality control by government since there were no state licensing laws or regulations. It was initiated by professionals as a means of self-appraisal and self-improvement and for most of its existence it was financed mainly by the profession and yet it was never designed as a profession-serving instrument. Traditionally, hospitals have feared its effect on their standing in the community and physicians have regarded it as a threat to the prerogatives and practices of the medical staff. However, as McGraw[8] has pointed out, once accreditation became an established part of the prestige structure of American hospitals, it became a matter of competitive concern for these hospitals to be accredited and once the hospital was involved, the medical staff went along conforming to standards even if it meant surveillance of practice and loss of cherished independence. It has made the hospital, by virtue of its delegation of clinical privileges, the most powerful standard setter and police agent for the medical profession, completely superseding the token requirements of legal licensing agencies.

The JCAH increasingly emphasizes its consultative role as a stimulator of improved hospital practices. The conferences that are held with the medical staff at the time of surveys are a part of its educational program. In the last two years 43 accreditation workshops have been held in 31 states reaching over 10,000 people. The chief aim of JCAH is to help hospitals in their pursuit of excellence. It regards itself as the internal conscience of the professional providers.[9] Notwithstanding its voluntary nature and its disavowal of a policing role, it owes its strength not merely to its acceptance by the profession. The courts have taken frequent recognition of JCAH standards.[1] Accreditation is required for eligibility for Hill-Burton funds.[6] Membership in certain professional organizations is contingent upon accreditation. If a hospital is disaccredited, the continuation of its intern and resident training program is seriously jeopardized. Third-party payer contracts often depend on accreditation. Seventeen of 74 Blue Cross-Blue Shield plans include accreditation conditions. So there are economic as well as altruistic incentives for seeking accreditation, but chiefly this illustrates that both private and public bodies have found accreditation by JCAH "a useful and valid and for many years the only benchmark in identifying the quality of hospital performance and of professional services."[6] Crosby,[5] in one of his last addresses before his untimely death last summer, remarked "no other single idea has done as much over the past decades to upgrade American hospitals and assure . . . that the facilities of the hospitals maintain high standards of quality."

The Impact of Medicare on JCAH

For just a few years less than a half century the Hospital Standardization Program and its successor, the JCAH, carried on their beneficial work quietly, effectively, and virtually unknown save to the profession, a source of pride to their sponsoring bodies and a thorn in the side of those whom they chastised. And then in 1965 Congress passed Public Law 89-97, the Medicare Act. Under the provisions of this act, in order to qualify for medical payments, the hospital must meet such requirements as the Secretary of Health, Education and Welfare finds necessary, except that such requirements may not be higher than those presented by JCAH. Any JCAH-accredited hospital with an acceptable utilization review plan is deemed eligible. Parenthetically, what is often overlooked is that the ultimate power to determine whether a hospital meets the necessary health and safety requirements is conferred by the Medicare Act upon the Secretary and the states. In any event, because of the recognition afforded by the Medicare Act, suddenly and almost without warning, JCAH was catapulted on to the national scene and cast into an entirely new role as a quasi-public licensing body. (Porterfield[7] has defined quasi-public as the assumption of all the obligations of public office without the benefits of tax support.) No sooner had this occurred than the brickbats began to fly.

One of the first to call attention to JCAH was Marion B. Folsom,[10] former Secretary of HEW. While admitting that among others JCAH has "lighted many paths to good performance by providers of health services . . . ," he urged that existing licensure and accreditation procedures be strengthened, expanded, and enforced. It is of interest that a year before this was written the JCAH Board had voted to review, upgrade, and rewrite the hospital accreditation standards and bring them up to date. The emphasis was to be changed from minimum essential to optimum achievable. This was a task that required four years, involved a research staff of four people and 21 advisory panels including 320 experts, at a cost of $605,000, largely defrayed by grants from the Kellogg Foundation and culminating in the final adoption of the new standards in December 1970 (unpublished data). Mr. Folsom also suggested that accreditation should be extended to include nursing homes, rehabilitation facilities, and noninstitutional services such as home nursing and home care. As early as 1965 JCAH made available its prestige and expertise to other categories of health and health-related services.[11] It sought to encourage a more effective approach for the conflicting and overlapping programs being undertaken by a number of health care organizations. In 1966 standards and survey procedures were adopted for extended care facilities, nursing homes, and residential care facilities. The development of this program was greatly retarded by the failure of the

Department of HEW to equate JCAH accreditation with certification for Medicare. Had this been done, Congress might have been spared some of its current anxiety concerning the shocking conditions in many of the country's nursing homes. More recently, accreditation programs have been initiated for facilities for the mentally retarded and for psychiatric facilities. Standards are also being formulated for hospital-based home health care, hospital outpatient departments, neighborhood health centers, and facilities for the care of ambulatory surgical patients. The JCAH has recently undertaken a program of listing facilities with special capability in the field of heart disease, cancer, stroke, and renal disease in connection with the Regional Medical Programs.

In 1967 the Health Insurance Benefits Advisory Council reported to Congress that JCAH Standards were not applied with the frequency of inspection and range of inspector skills necessary and, in some cases, placed an undesirably low ceiling on health and safety standards. In response to this criticism JCAH introduced team surveys and reduced the maximum interval between surveys from three years to two, a change which congressman Saylor[11] of Pennsylvania has suggested was effected to increase the revenue of JCAH.

Although physicians are most often restive under JCAH requirements, some have faulted JCAH for not taking a firmer stand in the delineation of clinical privileges, particularly in regard to those performing surgical operations. Gerber[4] has suggested that the only thing that keeps JCAH from adopting a rule that surgery should be performed only by qualified surgeons is the roar of protest that would arise from the untrained doctors who would have to give up their lucrative practices. Moore[10] in his presidential address to the American Surgical Association accused JCAH of concerning itself with the stage setting rather than the performers and urged JCAH to make validation of specialty credentials by the hospital staff a part of the accreditation process. As a matter of fact, JCAH is presently preparing guidelines for the delineation of staff privileges. Gerber[4] along with many others, has insisted that JCAH must become responsible for regulating the quality of patient care in hospitals and not merely the quality of patient charts. No one as yet has determined a completely satisfactory way of doing this. The California Medical Association has made a pioneer effort and JCAH is planning joint surveys to determine whether appropriate procedures could be devised so as to expand this to a national scale.

Recent Legislative Proposals

Increasingly, government has questioned the validity, integrity, and capability of JCAH, obviously believing as Porterfield[14] remarked that "only from itself can any true blessings flow." This has led to a spate of legislation affecting JCAH directly or indirectly. There is the Bennett amendment which establishes Professional Standards Review Organizations. Senator Edward Kennedy's Health Maintenance Organization and Resources Development Act of 1972 provides for the creation of a Commission on Quality Care Assurance of 11 members appointed by the President.[1] This commission would promulgate standards; set up quality assurance systems; evaluate input processes, utilization, and outcome; and issue certificates of compliance. As Senator Dominick[7] has pointed out, this would be not only an advisory commission but the commission's members would have the power to be arbitrary czars over anyone receiving federal assistance with the power to require repayment of funds and to impose civil penalties. Certification would be a prerequisite to eligibility for receipt of federal funds. There would be an initiative award amounting to 2% of annual gross receipts for certified providers. The Ribicoff amendment authorizes the Secretary of HEW to carry out validation surveys of JCAH-accredited hospitals participating in Medicare, to conduct surveys of accredited hospitals on the basis of complaints alleging noncompliance with Medicare standards, and to establish standards higher than those of JCAH. Senator Javits has introduced a Bill of Rights for the Mentally Retarded which proposes a National Advisory Council which would replace JCAH's Accreditation Council for Facilities for the Mentally Retarded and would simply incorporate JCAH standards into federal statutes. Congressman Saylor has introduced three bills affecting JCAH. One of them[11] would supplant JCAH by establishing a federal commission with 32 members which would include the Chief Medical Officer of the Veterans Administration, six physicians appointed by the Secretary of HEW, with the remainder being administrators, engineers, representatives of allied health professions, nurses, and the public. Congressman Dellmers of California would put all health professionals on a salary and place all health care decision-making in the hands of consumers (*Med Economics*, July 3, 1972, p 54). When Congress adjourned in October, of these measures only the Bennett amendment and the Ribicoff amendment had passed both Houses. It is of interest that HR-1, the Social Security Amendments of 1972, the measure to which these amendments were attached, authorizes chiropractors to provide physician services under Medicare and Medicaid. It is a little difficult to rationalize this provision with the concern voiced by many members of Congress regarding the quality of medical care in the United States.

The Public Discovers JCAH

Finally, in 1970 the public became aware of the existence of JCAH. Representatives of the National Welfare Rights Organization met with the Board of Commissioners. From these discussions came the Preamble to the new Standards, a Patient's Bill of Rights which sought to assure him dignity, privacy, and impartial access to treatment and accommodations. A substantial number of National Welfare Rights Organization recommendations were reflected in the final version of the new Standards. Public information interviews became part of the survey. A Consumer Advisory Committee was established. Representatives of JCAH meet regularly

with representatives of the Consumers' Coalition on Health Care. But as Ann Somers[14] has observed,

> whether such developments, encouraging as they are, will lead to greater mutual understanding and a common attack on the nation's health care problems or will pass into history as only a temporary political expedient remains to be seen. A vast gulf in communications remains, especially between the poor and the medical establishment.

All has not been sweetness and light. A publication called *Body Politic* (1970, p 25) referred to JCAH as an elite and private organization accountable to its parent bodies, not the public. It described JCAH as a silent, enigmatic, and virtually invisible organization surrounded by an aura of voluntarism which announces the dates of its surveys so that hospitals that have little to fear from these "friendly, sociable visits" may reach an atypical level of compliance. The JCAH's position is that an accreditation survey is a voluntary paid professional consultation at which key members of the governing body, administration, and medical staff should be present. No-notice inspections are inconsistent with this concept.

Medical World News (May 10, 1972, p 4) referred to JCAH as a "hired hand" of the hospitals which pay for its reviews, and suggested that since loss of accreditation would mean a loss of patients and funds, a mutual accommodation was usually reached between hospitals and inspectors so that hospitals would not be obliged to face an inspection they could not pass.

Presently, unmet consumer demands include (1) that one third of the members of the Board should be representatives of consumer interest. No conflict of interest is seen in the suggestion that they should be subsidized by JCAH, (2) that each survey team should have a consumer member, (3) that consumers should have the right to appeal a positive accreditation decision, and (4) that survey findings should be made public. The JCAH has developed elaborate due process for hospitals denied accreditation status and hopefully the Ribicoff amendment will satisfy the demand for appeal of a positive decision. In responding to charges of secrecy, JCAH representatives have pointed out that maintaining confidentiality of detailed professional findings and technical recommendations makes it possible to learn more about a hospital's normal level of operation, encourages frank discussion during critiques, and is more likely to assure effective implementation of recommendations than if they were subjected to untutored interpretation or could become a source of inspiration for litigation.

A Senate Hearing

Representatives of JCAH were invited to testify at a hearing held to gain support for Senator Kennedy's Quality Control Commission.[15] Also invited was a "panel of activists" critical of JCAH. The JCAH was told that its standards were vague, minimal, and weak; that they were purposely so to reduce the hazards of malpractice liability and the risk of noncompliance. Enforcement was said to be lax and accreditation often accorded to institutions not meeting standards. Mr. Kennedy, after observing that his visits to many hospitals had showed him the painful humiliation of being a patient in a large hospital asked, "It has taken many years for the type of disintegration so evident in our municipal hospitals to take place. What was the Commission on Accreditation doing during those years?" I need hardly comment that JCAH is well aware of the scandalous condition of some of these institutions, in large measure due to the failure of government (in the case of Washington, DC, General Hospital, Congress itself[16]) to supply needed financial support. In 1969, when JCAH revoked the accreditation of Boston City Hospital, Mr. Kennedy[17] requested HEW Secretary, Robert Finch, to continue Title XVIII and XIX payments while efforts were made to regain accreditation. John Knowles,[11] often a critic of his own profession, suggested there were "shenanigans" going on. "If JCAH is putting the screws on municipal hospitals we should have been warned." When the accreditation of St. Louis City Hospital was revoked, certification to continue participating in Medicare was promptly granted by HEW. Yet, all the criticism is directed at JCAH, none at governmental certifying and licensing bodies. In answer to the laxity charge, Porterfield[18] stated that the low rate of nonaccreditation was a reflection of the improved quality of hospitals surveyed. As far as vagueness was concerned, he pointed out that in such a complex field as hospital performance, it is in many instances impossible to reduce standards whose aim is to encourage continuing improvement to precise quantitative measurements, and that of necessity decisions are in part judgmental and subjective.

Much was made at the hearing of the conflict of interest inherent in an organization composed of providers which not only did not represent the public interest but would rubber stamp approval of any hospital, no matter how deplorable the conditions. For anyone to suggest that men of the caliber of the Commissioners I have known during my six years on the Board, men whose lives have been dedicated to improving the quality of medical care, would willfully "tolerate unsafe, unsanitary, inhumane hospital conditions throughout the country" is too preposterous for serious consideration.

The Consumer Advisory Board was said to be "clearly just a façade" that received very little attention from JCAH. Survey methods were said not to be such as would be used by anyone interested in the truth of allegations regarding a hospital's deficiencies. The JCAH was accused of maintaining two levels of standards: those for the poor, virtually constituting malpractice, and those for the affluent who were fully protected. Having subpoenaed confidential JCAH and California Medical Association survey records, Mr. Kennedy castigated JCAH because of the occasional disparity between recommendations for approval of the two programs. When JCAH Director Porterfield pointed out the hardships that might ensue if a large hospital that was the principal source of care for a sizable

segment of population were closed down for noncompliance, he was accused of endorsing "marginal care." The whole concept of voluntary accreditation was regarded as obsolete and inadequate to carry on the tasks currently required, and it was stated that only by a federal commission could there be decent enforcement. It was said to be morally wrong for anyone accrediting hospitals for federal programs to feel responsibility to the hospitals rather than the patients. Porterfield pointed out that experience had shown that withdrawal of JCAH approval seldom stopped the flow of Medicare funds. A total of 1,010 nonaccredited hospitals are certified for Medicare. One hundred fifty-six hospitals continue to receive Medicare funds after accreditation has been refused. Toward the close of the hearing, Mr. Kennedy graciously conceded that "we cannot blame the Joint Accreditation Committee for every problem that is facing municipal hospitals."[19]

Litigation

The culmination of consumer disaffection with JCAH manifested itself in a lawsuit against JCAH and the Secretary of HEW now on the docket of the US District Court for the District of Columbia. The plaintiffs are five groups of elderly citizens from San Francisco and Washington, DC, who allege that Congress in the Medicare Law acted unconstitutionally by relinquishing public authority to a private agency when it empowered JCAH to determine if a hospital could participate in the program. The suit is largely the work of California legal assistance group lawyers, 80% of whose funding derives from the Office of Economic Opportunity (*Med World News*, Nov 5, 1971, p 18). The complaint is that unsafe, unsanitary, and inhumane conditions exist in many hospitals because Congress decided that the inadequate and poorly enforced JCAH standards were good enough for Medicare certifcation. Since JCAH proceedings are secret, and since JCAH standards and decisions are not subject to HEW surveillance, administration, or judicial review, Medicare beneficiaries allegedly are deprived of due process in violation of the First, Second, and Fifth Amendments to the Constitution. Completely ignored are the pressure that JCAH has brought to bear on improvident local government to upgrade scandalously neglected municipal hospitals and the inestimable improvements in hospitals in general which can be ascribed to JCAH's motivation. Moreover, government has been spared the necessity of inspecting over 5,000 hospitals and has had this done for it on a cost-free basis.

For Congress to delegate authority to a private body is nothing new and has heretofore gone unchallenged. Private education associations have long been in the business of accrediting institutions of higher learning. In 1952 Congress adopted legislation empowering the Commissioner of Education to designation accreditation agencies that would be authorized to identify institutions in which veterans could enroll and be eligible for financial benefits.[20] The AMA is vested with public power by statutory designation as the accrediting agency for training programs in the rapidly proliferating allied health occupations. Because of the chaotic state of accreditation in this field, a comprehensive study has recently been carried out.[21] Legislation in the past 20 years has deferred to voluntary accreditation as a primary base for federal funding.[22] Numerous voluntary agencies perform government-delegated functions in determining eligibility for participation in certain federal programs of aid to education. The threat to all such programs if JCAH is scuttled should be apparent to everyone.

A Look Into the Future

Porterfield[23] asks,

> Is there a continuing place in our world today for a contribution from the voluntary sector in the area of accreditation? Is there not a role to be played to be distinguished from government licensing or certification which is something different, something more, something completely divorced from the essential enforcement function of the state?

His answer in a written communication to Senator Jacob Javitz (May 18, 1972) and at the Conference on Organization[24] was as follows:

> If voluntary accreditation is to endure in the face of challenge in order to preserve its unique values, then it must be strong and useful. It must have efficiency and resources and capacities. . . . It is the belief of the Joint Commission and its constituent organizations that quality maintenance is appropriately professionally based and has an advantage in being voluntary in character. The proof of that and indeed the question of whether we will endure depends on how we keep step with the state of the art and with what honor and effectiveness we discharge our self-appointed tasks. Even more, in this authority questioning age, it will depend on our strength of purpose and our ability to demonstrate our capability and our unbiased integrity. . . . There is great inherent value in the voluntary approach. When this is recognized and supported by government the highest potential is created. For government to replace voluntary effort is no particular gain.

Voluntary accreditation was for many years the sole proponent of objective measurement of quality of health care, but now government, having at last awakened to its responsibilities in this area, is challenging the concept of voluntary accreditation as no longer necessary since everyone is doing what it once did alone. Has it outlived its usefulness? What are its virtues? Primarily it is a professionally recognized benchmark by which an institution may elect to be measured in its pursuit of excellence. It is objective in that it has no market to which accommodation must be made. It is free from political domination and interference. It allows freedom for experimentation and innovation. It is independent, flexible, and adaptable to change in the state of the art and the acquisition of new knowledge. At times we may despise it, but we can always draw comfort from the fact that we may change it if it isn't doing properly what it is intended to do. It has perspective since a broad spectrum of professionals play a role in setting up standards and making decisions. It is a bulwark against what Crosby[9] referred to as "the stultifying hand of government" with its encrusted statutes and regulations and its own

vested bureaucracy with a change-resistant cadre of civil service inspectors. It encourages continued improvement above and beyond the basic right to operate. It is national in scope and not subject to the fragmentation of 50 separate state codes.

The JCAH did not seek the role of screening hospitals for federal funds which was thrust upon it by the Medicare law. It was not designed to implement government policy or to effect social reforms. But if it is to survive and to carry on its traditional functions, it will be forced to fit into evolving patterns of sociologic thought.

The JCAH's claim that it meets its obligation of public accountability through individual hospital governing bodies will not satisfy the citizen of today who demands participation in affairs affecting his existence. Its philosophy of obligation to the health profession is at variance with the central tenet of the consumer movement that "no industry should be allowed to regulate itself." Its concern with the optimum environment for the practice of high quality health care will not go far enough in the view of the informed recipient of that care.

In my opinion, JCAH will have to broaden its base and include representatives of the public on its governing board. They should serve not as a disruptive minority group but as responsible participants in policy making. The JCAH needs their advice regarding the acceptability, accessibility, and aptness of health services. It probably should have representatives from nursing and from allied health professions as well, and possibly even from government. This it could do without sacrifice of any of its prerogatives in regard to professional decisions. In any event, as Sir Harry Platt[27] remarked in an address entitled "Medicine and Authority,"

> The authority of the medical man . . . can never rest on voting power . . . in the end it is the layman who decides . . . the minority position held by the experts is the essence of their power. They have to convince and carry with them the layman. It is the quality of their leadership, the capacity of their minds on which their ultimate authority rests.

The JCAH will have to develop and adopt methods of judging the substance and quality as well as the surroundings of medical care. It will have to have the courage to adopt and apply standards for the delineation of clinical privileges. If it will do these things, I believe it will endure.

Why is it so important that JCAH should endure? If the concept of self-regulation is untenable, the vary concept of self-government is at stake. Almost a century and a half ago Alexis de Tocqueville[28] wrote, "It may however be foreseen even now that when the Americans lose their Republican institutions they will speedily arrive at a despotic government." In his book *On Liberty* John Stewart Mill[29] protests against government interference, not only in restraint but

> in the matter of doing things for the benefit of its citizens instead of leaving it to be done by themselves. . . . The objections to government interference occur when the thing to be done is likely to be better done by individuals than by government.

Thomas Jefferson[30] hoped that a ". . . wise and frugal government . . ." would leave men . . . free to regulate their pursuits of industry and improvement." Let us hope that the Democratic tradition of voluntarism will not disappear from our land.

References

1. Freyman JG: Leadership in American medicine. *N Engl J Med* 270:710, 1964.
2. Davis: *Fellowship of Surgeons: A History of the American College of Surgeons*. Springfield, Ill, Charles C Thomas Publisher, 1960.
3. Gerber A: *The Gerber Report*. New York, David McKay Co, 1971.
4. Nesbit RM: The heritage and obligation of fellowship. *Bull Am College Surg* 52:383, 1967.
5. Mcgraw RM: *Ferment in Medicine*. Philadelphia, WB Saunders Co, 1966.
6. Porterfield JD: A brief discourse on the current status and future anticipation of the joint commission. *Bull Am College Surg* 56:13, 1971.
7. Springer EW: Medical staff law and the hospital. *N Engl J Med* 285:962, 1971.
8. Stone JM: JCAH standards emphasized better management, physician participation. *Mod Hosp* 116:108, 1971.
9. Crosby EL: Who will set hospital standards? Read before the Southeast Hospital Conference, New Orleans, 1971.
10. Porterfield JD: Report of the National Commission on Community Health Services and some future prospects. Read before the Texas Medical Association, Dallas, 1967.
11. Folsom MB: *Health is a Community Affair: Report of the National Commission on Community Health Services*. Cambridge, Mass, Harvard University Press, 1967.
12. Brewer JI: JCAH, an historical background of a changing organizational structure. *Bull Am College Surg* 56:74, 1971.
13. Saylor JP: Congressional record–House. Aug 17, 1971, p 7937.
14. Moore FD: Freedom and organization. *Ann Surg* 176:1, 1972.
15. Gerber A: Surgical pros and cons. *Surg Gynecol Obstet* 135:431, 1972.
16. Porterfield JD: Development and status of the joint commission. Read before the Conference on Organization, Chicago, 1971.
17. Congressional record–Senate. Sept 20, 1972, pp S15458-15524.
18. Somers R: *Health Care in Transition: Directions for the Future*. Chicago, Hospital Research and Educational Trust, 1971.
19. Transcription of the proceedings before the subcommittee on Health of the Committee on Labor and Public Welfare, US Senate. Health Maintenance Organization Legislation, April 26, 1972.
20. Accreditation loss feared by D. C. General Hospital, editorial. *Hospitals* 44:137, 1970.
21. Boston City Hospital officials trying to win back accreditation, editorial. *Mod Hosp* 114:36, 1970.
22. Selden WK: Problems in institutional and specialized accreditation. Read before the annual meeting of the American Association for Higher Education, Chicago, 1972.
23. *Study of Accreditation of Selected Health Educational Programs*, parts 1 and 2, working papers; part 3, commission report, 1971, 1972; National Commission on Accrediting.
24. Pennell MY, Proffitt JR, Hatch TD: *Accreditation and Certification in Relation to Allied Health Manpower*. US Government Printing Office, 1971.
25. Porterfield JD. Remarks before the annual convention of the American Hospital Association, Chicago, 1969.
26. Porterfield JD: Voluntary accreditation. Read before the Conference on Organization, Chicago, 1971.
27. Platt H: Medicine and authority. Read before the Wigan Division of the British Medical Association, 1967.
28. deTocqueville A: *Democracy in America*. London, Oxford University Press, 1965.
29. Mill JS: *On Liberty* New York, Appleton-Century-Crofts Inc, 1947.
30. Jefferson T: First inaugural address, Washington, DC, March 4, 1801, in *Great Americans Speak*, New York, Charles Scribner' Sons, 1948, p 19.

Printed and Published in the United States of America

Senator TALMADGE. The next witness will be Dr. James H. Stewart, president, Louisiana State Medical Society.

I see he is accompanied by the distinguished Congressman from Louisiana, Mr. Rarick.

We are honored to have you, sir.

Dr. Stewart, I was very pleased to meet with you and members of your society a few days ago, and I thought we got a very useful exchange of views, and I appreciate it, and I am glad to have you as a witness.

STATEMENT OF JAMES H. STEWART, M.D., PRESIDENT, LOUISIANA STATE MEDICAL SOCIETY, ACCOMPANIED BY HON. JOHN R. RARICK, A REPRESENTATIVE IN CONGRESS FROM THE SIXTH CONGRESSIONAL DISTRICT OF THE STATE OF LOUISIANA, AND PAUL PERRET, ASSOCIATE SECRETARY-TREASURER, LOUISIANA STATE MEDICAL SOCIETY

Dr. STEWART. It is a great honor to be here, and I feel that you have helped us a great deal, Senator.

The CHAIRMAN. Thank you.

Mr. RARICK. Mr. Chairman——

Senator TALMADGE. May we have order, please.

Congressman Rarick.

Mr. RARICK. I greatly appreciate your affording me this opportunity to appear before you and introduce your next witness.

Before I do so, I would like to express my personal appreciation to you and members of your subcommittee for scheduling these important hearings on this most vital subject.

It is indeed a pleasure to me to present to you at this time Dr. James Stewart, the president of the Louisiana State Medical Society. Dr. Stewart is a resident of New Orleans, La., and serves on the medical staffs of many hospitals in Orleans and Jefferson Parrishes. He also serves as an associate professor of surgery at Tulane University which by the way, happens to be one of my alma maters also.

Dr. Stewart has served as president of the State medical society for the last year, and has been a leading figure in the society's fight in Professional Standards Review Organization and its implementation. He is certainly an authority in his field, and I commend to you and the members of the committee his testimony and his sincere appreciation of quality medical delivery.

He is accompanied by Mr. Paul Perret, who is the assistant secretary of the medical society.

Senator TALMADGE. Thank you very much, Congressman, and Dr. Stewart, you may proceed, sir.

Dr. STEWART. As stated, I am accompanied by Representative Rarick of the sixth district, and Mr. Paul Perret, who is associate secretary-treasurer of our Louisiana State Medical Society.

We greatly appreciate the opportunity to appear before this committee.

Our medical society opposed the Professional Standards Review Organization concept prior to its enactment in law, and since its

enactment we have been actively working toward its repeal. It was following our request that Representative Rarick introduced H.R. 9375, the first House bill calling for the repeal of the Professional Standards Review Organization. Since that time numerous other bills have been introduced calling for repeal.

We are aware of the fact that the present hearing is not concerned with acceptance or rejection of the Professional Standards Review Organization law, but with the matter of implementation. We do plan to continue to work toward its repeal, but until such time as that goal is attained, we would enter a plea for substantially less than full-scale implementation for the following reasons.

No. 1, cost. Our estimates suggest that fully operational Professional Standards Review Organizations will cost in excess of $100 million per year, and this does not include the various support and advisory organizations that may be formed. Now, this is more than $100 million per year in added administrative costs of Federal health programs; not one cent would go to health care itself. The question of recovery of some or all of this cost by bringing about curtailment of services under this program is a theory lacking in substantive proof.

We are well aware of the number of prototype organizations across the country and we have made studies of several of these programs. In our evaluations we have not found a single one which saves more money than it expends.

With respect to many of these organizations, it is difficult to derive meaningful cost data for several reasons.

Senator BENNETT. Doctor, may I interrupt you?

Would you please read the last sentence in that paragraph that you skipped, for my benefit?

Dr. STEWART. Yes, sir.

Last fall, for example, we sent a committee to study the UPRO operation in Utah, and we reached a similar conclusion about that organization.

Senator BENNETT. The representatives of that organization are here, and I wanted them to hear that sentence. Thank you very much.

[General laughter.]

Dr. STEWART. I might say that that is being entered in the record. We are simply condensing our remarks here.

Senator TALMADGE. Your entire statement will be inserted in the record.

Senator BENNETT. I know that, but since they are in the audience and might not read the record after it is printed, I wanted them to hear that sentence.

Dr. STEWART. I have met Dr. Nelson a number of times, and we do think that their program is one of the best ones that we have seen.

Senator BENNETT. Thank you.

[General laughter.]

Dr. STEWART. With respect to many of these organizations, as I have stated, it is difficult to derive meaningful cost experience data for several reasons. For example, most are being operated by people who either believe in or want seriously to test the approach and are therefore willing to work at little or no pay. In several instances, the sup-

porting facilities such as the physical space and/or data processing equipment required are provided at either no charge or at substantially less than the true market cost.

We believe that $100 million is more than the taxpayers of this country should be asked to pay for implementation of inadequately tested theory.

Two is confidentiality. Much has been said previously about the compromise of confidentiality which this PSRO law implies and I shall not repeat it. However, this law states that the Secretary shall assure that confidentiality is to be maintained to the greatest extent practicable, consistent with carrying out the provisions of the law. This word "practicable" is an open door to widespread abuses of confidentiality. As more people view the contents of a private medical record, confidentiality begins to have less and less meaning. Even the translation of pertinent information to appropriate codes for data processing gives little assurance of privacy. Such codes have to be devised simply enough to permit easy translation from the patient's chart to the input form and it requires relatively little computer technology and/or cryptography experience to be able to decode such information.

Gentlemen, we submit that the citizens of this country should not be subjected to the loss of the basic right of privacy simply because they happen to become ill.

Three, regimentation of medical care. While it has been vigorously denied by proponents of PSRO, a certain amount of regimentation of the parameters of care is implicit in the construction of norms of care which will act as checkpoints for review. Admittedly, the physician is not required to conform to the norms, but the wary physician who fears bureaucratic entanglements or loss of patient benefits may be influenced to stay within these norms so as to avoid getting caught up in the review process, thus sublimating his professional judgment to a secondary role and compromising the quality of care.

Some of the outstanding discoveries in medical history have been made by men whose peers sharply disagreed with them. Such initiative would be stifled by PSRO.

Statistical profiles of care, to be meaningful as norms, should be derived from a data base of substantial experience. Yet patterns of care are constantly changing and one is left with one of three choices: No. 1, rigidly fixed norms based on large experience; No. 2, rapidly changing norms with each norm based on rather limited experience; or No. 3, reliance on the opinions of a numerically small panel of questionable experts.

Each one of these, we believe, embodies an element of injustice and risk to the sick patient who deserves the best possible professional judgment. The law in this instance leaves the choice to the Secretary.

Public Law 92–603 places in the hands of one man, the Secretary of HEW, the potential of more power over the practice of medicine than has ever been held by one man in the history of American medicine. Yet the original medicare law specifically states that nothing in its language "shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided."

No. 4, existing review mechanisms. The PSRO law implies that there have been widespread abuses of Federal medical programs by the physicians of this country and/or that something is substantially lacking in the quality of what we are providing that needs to be investigated and corrected. There have been abuses of these programs, it is true, and there has been overutilization, but these can be ascribed predominantly to the structure of prior laws which have made hospitalization appear to be free after an initial deposit, rather than due to physician generated causes.

To illustrate the degree of overutilization which typifies medical service which appears to be free, a study was made of New Orleans hospitals in 1968. This study showed that whereas the average length of stay in the private hospitals ranged from 6.1 to 10.4 days, the average stay in the New Orleans Charity Hospital averaged 14.1 days; that at the USPHS hospital, 17.7 days, and that at the USVA hospital, 22 days. Informal inquiry about other areas suggests that a similar pattern prevails elsewhere. Thus, the AMA recommendation of an amendment to provide for PSRO-type review of care delivered through Federal medical programs has substantial merit.

Internal review and discipline within our ranks and in our hospitals has been going on for many years and was being done effectively prior to the advent of the term "Peer Review." Such internal monitoring has been done quietly, without fanfare, and generally without cost to any governmental agency. We have a very carefully structured mechanism for appropriate review in Louisiana, and we are proud of our record. While we have not examined firsthand the workings of the other States, the reports that we have heard indicate a surprisingly small number of instances of fraud or other impropriety under these Federal medical programs, which leads us to believe that most other medical societies likewise are behaving responsibly.

In Louisiana we do have a few problem physicians in our ranks, and in recent years the courts have substantially diminished our ability to deal with them. Nevertheless, we try to assure that our profession in Louisiana continues to serve the public well, with honor and dedication, and we do not hesitate to question the impropriety of any sort whenever the suggestion arises. We believe that there should be accountability for expenditure of public funds for any purpose, and we do not hesitate to question the adequacy of monitoring by Federal bureaus. For example, it was the LSMS that first raised questions about the propriety of some of the operations of Family Health Foundation, with its millions of dollars of support largely flowing from the Department of HEW. As you may know, these questions led to appropriate investigations, to a grand jury hearing, and recently to the issuance of indictments. A few days ago, the DHEW announced withdrawal of all financial support of FHF.

Now, I would like to make a few remarks about steps toward implementation of PSRO in Louisiana which we feel are improper and ought to be changed.

In connection with the proposed geographic area designations under PSRO, representatives from the regional office in Dallas held two hearings in Baton Rouge, La., in late 1973. We presented a statement at each of these hearings, presenting arguments against

any division of Louisiana for this purpose, and disagreeing with the five alternative proposals prepared by the Department of HEW. Nevertheless, the State has been divided into four areas in a fashion which did not conform to any of the five proposals of the HEW, or to any plan presented before the hearings. Even now we are uncertain about the reasons for this pattern of area designation, which has been allowed to stand despite our appeal and protest. There are States with significantly larger physician populations which have received a single area designation and we believe that Louisiana likewise should be so designated.

One of the supporting arguments for single area designation for the State presented at the second hearing was the fact that the part B intermediary for the State of Louisiana, Pan-American Life Insurance Co., functions as such for the entire State and already has accumulated a data bank of substantial statewide experience. This intermediary was given a citation in June 1972 for its exemplary achievement in administering the medicare program. This same intermediary has been likewise commended by the Louisiana State Medical Society. I might mention that our society has aided the Pan-American in dealing with physicians who appear to be abusing the provisions of the medicare program, and had done so prior to the first public mention of PSRO.

Regardless of the specific pattern of area designation which may evolve in Louisiana, it is our belief that there is no part of the State in which 50 percent of the physicians are receptive to the PSRO law as it now exists.

Mr. Chairman and members of this committee, we from the Louisiana State Medical Society would like to recommend for your consideration the following measures with respect to PSRO implementation:

One, that full-scale implementation of the law be delayed until the validity of the concept is proven or disproven by actual demonstration on a limited basis;

Two, that a few of those areas and organizations which embrace the concept be allowed to proceed with a realistic trial, with payment at fair market prices for all elements of support;

Three, that federally operated institutions of health care be included in at least one such PSRO demonstration;

Four, that during such test periods the impact of the PSRO organization on confidentiality, cost and quality of care and on physician and patient acceptance be realistically assessed;

Five, that those areas, such as Louisiana, where organized medical societies are behaving very responsibly and are serving the public well, be evaluated by the Secretary of HEW.

Mr. Chairman and members of this committee, if the PSRO experiment proves as beneficial as its proponents predict, if it does not, in fact, compromise confidentiality or impair the quality of medical care, and if it appears better for our patients than what we are now doing, we physicians of Louisiana stand ready to reconsider our position with regard to this law.

This concludes our oral presentation. We would like to thank the committee for giving us the opportunity to be heard. We respectfully

request that the additional information and exhibits attached be entered into the record of this hearing.[1]

Senator TALMADGE. Thank you very much, doctor. I hate to call time on you, but we have a multiplicity of witnesses here, as you know, and we have to strictly limit the time.

Chairman Long?

The CHAIRMAN. Doctor, I have read your statement as well as supporting information, and I want to thank you for your testimony here today.

FUTURE CHANGES IN PSRO

I am very pleased at the recommendations that appear at the conclusion of your testimony because as I understand this PSRO law, your recommendations are very consistent with what is likely to occur during the next 18 months. For example, you state that full local implementation of the law should be delayed.

Now, in actuality, the implementation of the law will result in a phased implementation with operational PSRO's only in the relatively small number of areas in the next 6 to 12 months. At that point I would suggest we take another look to see how it is going.

You recommend that only those areas and organizations which embrace the concept proceed with the organization of PSRO's, and that, too, is what is going to happen.

Then you recommend that federally operated institutions of health care be included in at least one such PSRO, and I agree that this should be done. I understand that the Secretary of Health, Education, and Welfare intends to make the Public Health Service hospitals subject to PSRO review.

Fourth, you say that the impact of these conditional PSRO's on confidentiality, cost and the quality of care should be assessed, and this definitely should be done, and I believe it will be done.

Then you recommend that in areas which do not choose to organize PSRO's in the near future, presumably including Louisiana, the cost and quality of medical care and existing peer review activities should be evaluated by the Secretary of HEW. This last is the only thing that is not called for by the PSRO statute, but I would join you in any request to the Secretary of HEW to fully evaluate the existing review activities in Louisiana and wherever else you would like to have them evaluated.

Finally, you state in your second to the last paragraph that if experience under PSRO should indicate it is achieving what its advocates had hoped for, that you and your members would reconsider that position, and I think that that is fair, as fair as anyone has any right to ask.

As far as I am concerned, none of this should be decided on the question of who is right. It ought to be decided on the matter of seeing what is right.

I hope that you will read all of this testimony, just as I hope that everyone who has appeared here will read yours. I would like for you, if you would, to make available to me a list of Louisiana doctors whom you feel might find the time to sit down and read these hearings, because I think that it would help you and HEW and the various

[1] See p. 205.

other witnesses who have testified here, and analyze and give thoughtful consideration to their views just as I would like for them to study yours.

So, if you can make available to me a list of people in Louisiana—I had in mind doctors, of course—that you feel are likely to take the time to study it, I will see that they are provided with copies of these hearings so that they can analyze all the facts. I know that you will want a copy, and I would suggest that the others have it because what we really want to do is what is best for the patients in the last analysis.

Dr. STEWART. We, too.

The CHAIRMAN. Thank you very much.

Senator TALMADGE. Senator Bennett?

PSRO Costs

Senator BENNETT. Thank you, Mr. Chairman.

I notice that you estimate the overall cost of, the overall PSRO operational costs at $100 million a year. We agree with that estimate. It is four-tenths of 1 percent of the current cost of medicare and medicaid, and that is a very low percentage for the maintenance of quality, so I have no quarrel with you on that.

Louisiana State Medical Society and PSRO

Now, you express your displeasure with the fact that the Secretary carried out his mandate under the law and designated four PSRO areas in the State of Louisiana. Inasmuch as your society voted formally on April 30, 1973, not to enter into any PSRO contractual relationships 8 months before the Secretary designated these four, do you not think that your unhappiness is academic? You would be against any designation regardless of how the Secretary broke it up. You never intended to marry the girl in the first place.

[General laughter.]

Dr. STEWART. Senator, if I may respond, we realize that the prospect of repeal of this law is really an outside possibility, and we have to be realists. We realize that the time may come when this law perhaps appropriately amended will still be in effect, and there will come a time in which PSRO's will exist in Louisiana. We realize that prior to July 1, 1976, that there is no organization that we can presently see, at least, that would be acceptable as such in the State of Louisiana.

As you know, our medical society could not qualify prior to that time, but following that date, as I read the law, and as I have been advised the law allows, our medical society itself—and I speak of the Louisiana State Medical Society and its branches which are the component pair of societies—would qualify for designation.

Senator BENNETT. Let us say might qualify, not would automatically. The Secretary is under no mandate after January 1, 1976, to qualify your State society or any other State society.

Dr. STEWART. I realize that, sir.

Senator BENNETT. OK.

Dr. STEWART. But as the law has been interpreted to me, we could or might be able to qualify.

Senator BENNETT. That is right, Doctor.

Dr. STEWART. But we could do so only if the entire State were designated a single PSRO area. Otherwise we would somehow have to fragment our society along artificial lines which have never previously existed, and we would destroy an organization which in the past has functioned very effectively and responsibly, and I reiterate that we are proud of the record that we have compiled in Louisiana. I realize that there are problem areas elsewhere, but to give you some support for the argument that we have been very responsible in Louisiana, the number of complaints that our medical society has received from patients is quite small, extremely small.

Second, the malpractice experience in our State is either the best or perhaps second best in the entire Nation. That should say something with regard to the quality of care being delivered and the responsibility for that care.

Senator BENNETT. Thank you.

SOCIAL SECURITY REPORTS ON FIVE LOUISIANA HOSPITALS

Now, I suggest that the two of you sit back because I am going to read some material to you. You state:

> We have a carefully structured mechanism for appropriate review in Louisiana with steps outlined from the smallest hospital committee all the way to the House of Delegates of the Louisiana State Medical Society, and we are proud of our record.

I wonder about that in view of the social security audit reports on five hospitals in Louisiana. I have them here [indicating]. Under the rule of confidentiality I cannot allow you to read them, but I am going to read you some excerpts from them. Before I read these excerpts about what they found in these hospitals, I should point out that we have similar reports on hospitals in many other States.

Now, let me read you some of the things that have slipped through what you call your carefully structured mechanism.

Hospital A: "The Utilization Review Committee has never determined that there was no need for further hospital in-patient stay, despite the fact that the average Medicare in-patient's stay at this facility is 24.33 days. National average is less than 13 days."

Another one, another excerpt: "It is hospital policy for an EKG to be performed at admittance on every patient."

Another one, "Sixty-nine day hospitalization of an 88-year-old woman, progress reports were written only in the first 10 days. After the 10th day, the next note is the discharge note which concludes: 'The patient responded to suggestion therapy.' It is not evident that the physician had a clear understanding of how he was treating this patient. Arteriosclerotic heart disease, hypertension and incisional hernia are not usually responsive to suggestion therapy."

Another one, "Twelve-day hospitalization of a 74-year-old man, no admitting diagnosis recorded. On the first progress note, the physician notes that the patient probably has subclinical vitaminosis. Later the physician notes that the patient had a symptomatic backache.

"Although the record is fascinating to read, it is impossible to understand why the patient was admitted in the first place."

Another one, "40-day hospitalization of a man who had fallen down and broken some ribs. The discharge note of the attending physician stated that the patient had developed pneumonia with a high fever. According to the temperature chart, there was never a fever. All of the X-rays were normal except for the rib fracture. The nurse's note did not show that skilled care was required or given. Tentative conclusions to be drawn from this record include antibiotics were administered blindly, penicillin and streptomycin for 20 days, ampicillin for 10 days."

Hospital B: "Utilization review committee records indicate that the UR committee is approving continued hospitalization for extended duration cases based on unacceptable or insufficient evidence, specifically in the case of MC, who was admitted on August 18, 1970. The attending physician indicated continuing hospitalization was necessary because 'the family did not want the patient at home.' The estimated additional length of stay is 7 weeks. The UR committee concurred."

Hospital C: "Three adolescent sisters who were medicaid recipients were admitted with bellyaches to the same room, the younger two sisters sleeping in the same bed. This provider has a history of dual admission of medicare and medicaid patients. Dual admission in the case of medicare beneficiaries is one involving a husband and wife with concurrent stays on frequently identical admission and discharge dates. The team reviewed the medical records of 90 Medicaid beneficiaries with 137 admissions. Of this total, 110 involved concurrent husband and wife stays.

The records were, in the team's opinion, incredibly deficient. In many records there was no written evidence that A, the attending physician had ever seen the patient; and B, a medical history had been taken; C, a physical examination had been performed; D, a provisional diagnosis or impression had been considered; E, a rational course of diagnostic evaluation or therapy had been undertaken; F, a nursing plan had been developed; or G, orders were written by the physician or signed by him.

"Much of the therapy administered, especially in the use of antibiotics, B_{12} and B-complex, and sedatives was inappropriate and excessive. The physicians' tendency to overtreat is associated with the tendency to underdiagnose."

Hospital D: "The program evaluation review team did not find compliance with either the letter or the spirit of the utilization review requirement. Fourteen charts were reviewed to date to determine the presence of history and physical examination progress note. In none of these charts of currently hospitalized patients was there found a single progress note or history of physical examination. Several questionable nursing practices have been identified, dispensing medicine, including sedatives not ordered by the physician; administering blood labeled as incompatible; continuing to give the drug chloromycetin for 11 days after the order to discontinue the drug was written in the chart.

"Questionable physician services include the following: A, the history and physical examination progress notes were in almost every case written after the discharge or death of the patient; the orders

written were not based on findings documented in the history and/or progress notes; progress notes were often contradictory of what actually was happening; D, antibiotics were given, often in combination with no cultures or sensitivity testing order. Physicians at this facility use an unusual number of drugs concurrently, some of which possess dangerous synergistic physiological effects. In fact, one patient was at the same time being given sodium amitol, carbotol, valium, chlorhydrate, mepregan, laudanum and parabin, all of which are classed as depressants of one type or another.

"The same patient received varying quantities of 51 different drugs during her 53-day stay, and at one time was given 12 different drugs concurrently. She was admitted for a treatment of a fracture of the pelvis."

Hospital E: "The Utilization Review minutes were reviewed for the period July 1970 through January 1971. The UR committee reviewed 80 extended cases during that period of time. In none of these cases they reviewed did they determine that there was not a need for further hospital inpatient stay. This fact, coupled with the team questioning of 8 cases out of the 14 they reviewed, indicates a total disregard on the part of the UR committee for insuring appropriate utilization of hospital facilities. Two, review of the patient records indicated overutilization of services in the area of X-ray and lab. Four patients received excessive X-rays, and three patients received more laboratory tests than appeared medically necessary according to the documented file.

"Three, the patients' medical records review indicate that the physicians of this hospital are exceedingly liberal with the uses of drugs. Five cases were found where the patient received 10 different drugs every day.

"Four, antibiotic sensitivity studies for effective use of antibiotic drugs were found in only one case. This patient was treated with two antibiotics, both of which were reported as useless for the microorganism indicated."

Now, in view of that kind of a record, and these are only a few of the reports that exist on the quality of the review mechanism in your State, maybe I should apologize for picking your State out. I am sure that you can find this situation existing in many other States, but you have come here to tell us that you do not need PSRO because you have an adequate mechanism, and for that reason I think that you should go back and review your process, and maybe repent with respect to PSRO. [General laughter.]

Senator TALMADGE. Do you want to respond, sir?

Dr. STEWART. Senator Bennett has raised many points. Perhaps I can respond to a few of them. We have never claimed Louisiana is a medical utopia. We probably will never come close to it. However, I submit that even in retrospect after the other areas have tried the PSRO approach, I submit that Louisiana will be able to compile a comparable record. And I would still make the plea for that approach.

I might say that you have mentioned, I believe, seven hospitals, and I do not know what percentage of the hospitals of the State of Louisiana you have looked at. I do not know whether these are just the very bad cases you have cited out of the several hundred hospitals, nor

whether the number of cases you talked about represents a very small fraction of the total number of cases reviewed.

I would mention, for example, that on the matter of the routine order for electrocardiograms, I think if this is meant to be applied to patients under medicare and medicaid, I think it is a very sound judgment on the part of that particular medical staff. And that is the sort of thing that is determined by the medical staff that is to institute such a policy. It would be my particular judgment that that would be a sound routine order for patients in the over 65 age group.

An additional point that I might make is that, as I stated earlier, with the discovery of any significant improprieties, the Department of Health, Education, and Welfare has seen fit to come to our office and report the matter to us, and in some instances ask our assistance, and we have provided same.

I wonder if in this instance any of your people have reported these matters to any of our organizations?

Senator BENNETT. These have all been reported to the State government of Louisiana, Doctor.

Dr. STEWART. But they have not been reported to the organized medical societies, as I understand it. Is that correct?

Senator BENNETT. If the State of Louisiana wishes to report them to you, that is their responsibility. It is not the responsibility of the social security system. It is the social security system's responsibility to report them to the State of Louisiana.

Dr. STEWART. Our general philosophy has been, and my own individual philosophy has been, that when a physician serves his patient and both are satisfied with the arrangement and nobody makes a complaint about it, our philosophy has been to let them alone.

Senator TALMADGE. Senator Curtis?

Senator BENNETT. Would you let me just respond to that?

Senator CURTIS. Yes.

Senator BENNETT. You made the point that there are now third-party intermediaries in this process, and the Federal Government is paying $25 billion for the care of these people, and I wonder if it is fair to say that if the doctor and patient are satisfied, the Federal Government should pay the bill regardless of what is sound practice or a reasonable use of the facility. That is our problem, Doctor.

Dr. STEWART. Senator, I would submit that if the third party does have valid complaint, that we, the responsible medical society organization, should at least hear the complaint so that we have a chance to take action as well.

The CHAIRMAN. If I might just say a word about this, I recognize one of these hospitals, and one reason I recognize it is because HEW closed it, and they should have. In my judgment, they did the right thing. And it has been replaced by one of the most efficient and modern, best-operated hospitals in America. So that I would urge HEW to go back and take a look at that same hospital now.

This old hospital was bringing in all sorts of cases. Some old lady would come in and complain about the fact that she was not feeling good, and they would put her husband right in bed there beside her and charge for two instead of one. And he would not complain at all.

[General laughter.]

Actually, if I might be permitted, it reminds me of that story about the person who charged into the drugstore, banging on the door at night trying to get in; the druggist was mopping the floor. Let me in, let me in, I have got to have help.

So the druggist opened the door. And he said, what can you give me for hiccuping. And the druggist took the mop, hit the man in the face with it. And after he got off the floor, he said, why did you want to hit me in the face with the mop. And he said, well, you do not have the hiccups any more, do you? And he said, no, but it is my old lady out in the car who has got the hiccups. [General laughter.]

And in fairness, I believe that one of these other hospitals is also closed, and I believe that we will be successful in replacing that with a new, modern facility as well, and it will be properly run. And in that area, I think we must admit there have been situations—we have had them in Louisiana; I think they have existed all over the country—where someone has done a lousy job. And where that exists, somebody is going to have to call them up. Either you are going to have to do it through PSRO, or the State is going to have to do it, or HEW—somebody.

Now, with regard to this hospital I made reference to that was closed, I had complaints about that. HEW was moving to close it, and I just referred the complaints to the proper authorities at HEW, because it looked to me like HEW was doing the right thing.

Now, some of the complaints, I regret to say—and you, perhaps, know it, Doctor—some of the complaints about PSRO have to do with just such mischief, where people ought to be put out of business, as was done in this case, because they are either mistreating the patient or victimizing the Government. In a case like that, whoever is doing a poor job ought to be brought into accounting. And I think you would approve of that, Doctor.

Dr. STEWART. I agree with you, Senator. And I might say that we are as anxious as you are to eliminate these people from our ranks and to discipline them properly, because they reflect on all of us.

Senator TALMADGE. Senator Curtis?

Senator CURTIS. Doctor, early in your statement, you referred to two classes of hospitals in Louisiana and compared the length of stay for similar ailments. Would you repeat that?

Dr. STEWART. Yes, sir. This is not with regard to a specific ailment. This was the total number of patient-days divided by the number of patients. It was not further broken down. But the comparison was, in private hospitals the length of stay ranged from 6.1 through 10.4 days; but in the charity hospital, 14.1 days; the USPHS hospital, 17.7; and the VA hospital 22 days.

Senator CURTIS. Do you know whether these cases cited by the distinguished Senator from Utah were private hospitals or charity hospitals?

Dr. STEWART. Sir, I have not had the opportunity to study the material which he cited.

Senator CURTIS. Well, it seems to me, Doctor, that the situations described by the Senator from Utah certainly are not common in very many States. There is no such thing in my State. I really believe that.

And the fact that those things do happen sometimes in some States has nothing to do in my mind over the repeal of PSRO or the implementing it.

VOLUNTARY PEER REVIEW OR FEDERALLY RUN PSRO?

The question that this committee should decide is whether voluntary peer review without the interference of the Federal Government is better for the patients of the United States than PSRO run by the bureaucracy. Now, early in your statement you said that this law gave to the Secretary more authority over the practice of medicine than had ever been given any one man in this country—I agree with that. But would you elaborate on it?

Dr. STEWART. Yes, sir. In the law as written there are so many areas in which the matter of the promulgation of the various rules and regulations are left to the judgement of the Secretary. And while the various parameters of care, the norms would be evolved by physicians group, the final authority to accept or reject those norms again rests with the Secretary.

Senator CURTIS. The Secretary has the strength for the entire operation?

Dr. STEWART. Yes, sir.

Senator CURTIS. And they provide the staff that is the backup to this national council that is just called in periodically?

Dr. STEWART. Yes, sir.

As I understand it, the national council is primarily an advisory group to the Secretary. But the Secretary is the one who holds the authority.

Senator CURTIS. I am not so sure that 10 years from now you physicians are going to have anything to do with professional standards review, because the law authorizes such other public nonprivate or other agency or other organization which the Secretary determines in accordance with criteria prescribed by him. He determines and then writes his own criteria and regulation as to the professional competence and otherwise 10 years from now this could all be turned over to a group of Nader organizations, no question about it.

Senator BENNETT. May I interrupt you?

The law specifically says that the review of one physician may only be done by another physician. It is clear.

Senator CURTIS. No; the law says that the final determination shall be signed by a physician. You can have an army of bureaucrats and clerks and crusaders if the certificate is signed by a doctor that meets the requirement of law.

Thank you for your remarks.

Senator TALMADGE. Senator Dole?

Senator DOLE. Mr. Chairman, I have no questions.

I think I understand the position of the witnesses from the State of Louisiana. I think in many respects it parallels the view of many of the physicians in the State of Kansas. I am certain that there are some abuses in my State, maybe not as extensive as indicated, maybe more. I do not know. I assume there is a file on Kansas.

But it indicates what could happen if this thing really gets into swing. The file might be much larger.

Senator TALMADGE. Thank you, Dr. Stewart, for your valuable comments.

[The following material was submitted by Dr. Stewart. Hearing continues on p. 208.]

LOUISIANA STATE MEDICAL SOCIETY COMMENTS ON AMERICAN MEDICAL ASSOCIATION PROPOSED AMENDMENTS TO PSRO

While the Louisiana State Medical Society cannot fully endorse all of the American Medical Association proposed amendments to PSRO, we are in agreement with their intent as an interim measure, that is, until Section 249F and other sections of Public Law 92-603 are repealed. It is our understanding that the American Medical Association yesterday proposed 19 PSRO amendments. We look with favor upon the following AMA proposed amendments:

AMA (4) Consistent with policy in opposition to preadmission certification of institutional care, such authority presently existing in the PSRO law should be deleted.

AMA (9) Section 1167(c) should be repealed. Section 1167 purports in subsection (c), to limit the liability of an individual furnishing items or services when such individual has acted in compliance with the norms of care applied by a PSRO, provided that he exercised due care in his conduct. This provision could have the unintended and undesirable effect of pressuring practitioners to adhere to the norms. Moreover, the provision is at best meaningless because on its face it is applicable only when the practitioner has exercised due care—the very issue at the heart of the malpractice issues.

AMA (13) The law should be amended to provide for PSRO review of care delivered through all federal medical programs such as the Veterans Administration and Public Health Service.

AMA (14) Section 1155(b)(4) should be repealed. PSROs would be authorized under Section 1155(b)(4) to inspect the facilities in which care is rendered or services are provided by practitioners or providers. Institutions are currently subject to inspection by the Joint Commission on Accreditation of Hopitals, and, moreover, facilities are generally subject to regulation under state and local law. It has been observed that the further requirements of onsite inspections by PSROs would be an unwarranted duplication.

AMA (15) Section 1155(b)(3) should be repealed. Practitioners and providers are obligated to maintain supporting documentation substantiating the necessity and quality of care provided under Medicare and Medicaid. These record-keeping requirements (section 1160(a)(1)(C)) are duplicated by an ambiguous authorization under Section 1155(b)(3) allowing PSROs to "examine the pertinent records" of practitioners and providers. This authority is, at best, redundant and could be the subject of abuse. It should be observed that unrestrained examinations of medical records would jeopardize their confidentiality.

AMA (17) Section 213 of P.L. 92-603, which describes circumstances under which payment may be made under Medicare for certain otherwise noncovered items and services, and under which recovery can be made from providers and practitioners, should be repealed.

AMA (18) Provisions of Section 207 of P.L. 92-603, relating to utilization review procedures under Medicaid should be repealed.

AMA (19) Section 229 of P.L. 92-603, authorizing the creation of program review teams, should be repealed.

While we are confident that the other AMA proposed PSRO amendments are well thought out, and well intended, the Louisiana State Medical Society is reluctant to endorse any amendments to PSRO that are not amendments to repeal by deletion. It is the intention of the Louisiana State Medical Society to introduce a resolution at the AMA House of Delegates Annual Convention in June in Chicago asking the AMA to clarify its position on PSRO.

We believe PSRO has been the most divisive issue to face the medical profession. We believe all responsible physicians favor peer review to guard the quality of medical care. We do not believe that PSRO is the mechanism to accomplish this. We believe it is a bureaucratic cost control program being sold to the Congress and the public under the guise of a quality control program.

Exhibit A

Statement by the Louisiana, State Medical Society on Professional Standards Review Organization Area Designations

Mr. Chairman, I am James H. Stewart, M.D. of New Orleans, Louisiana, president of the Louisiana State Medical Society. I am accompanied by H. Ashton Thomas, M.D. and Mr. Paul Perret, who are respectively Secretary-Treasurer and Associate Secretary-Treasurer of this Society. We represent 3,300 physicians licensed to practice medicine in the State of Louisiana.

Our presence at this meeting is not to be construed as representing endorsement of the Professional Standards Review Organization section (249F) of Public Law 92-603. To the contrary, our Society opposed PSRO before it was enacted into law and now that it has been enacted, we are working for its repeal.

Historically the Louisiana State Medical Society and its component societies have followed the objects and purposes of our 1903 Charter which include "the advancement of medical science;" and "the elevation of the standard of medical education," * * * "so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in the prolonging and adding comfort to life."

This Society has practiced effective peer review in the past and continues to do so. The only new feature in recent years being the name "Peer Review."

We have followed the philosophy that the patient is best served by allowing the individual physician great latitude in his approach to caring for his patient as long as ethical, moral, and legal proprieties are observed and the patient is satisfied. Furthermore, we have favored an orderly step-wise approach to the handling of impropriety of any sort. Thus, we believe that an organized medical staff of a hospital which is keeping its house in order should be left undisturbed. When matters arise which cannot be effectively handled within these confines, the component Parish or regional medical society is the proper body to consider the matter. If the component society is unable to resolve the problem, or if the matter involves more than one component society, the State Medical Society offers the next logical forum for its consideration.

This carefully structured organization has been, is now, and will hopefully continue to be the appropriate mechanism for dealing with significant departures from the standards of medical practice in the State of Louisiana.

We are cognizant of the fact that under the law, the Secretary of HEW is required to designate geographic areas for the purpose of PSRO by January 1, 1974.

We realize that there is no way he can exempt Louisiana from such designation.

We have reviewed the preliminary area designations for Louisiana prepared by Dr. William I. Bauer's office. We have objections to each of the five suggested alternatives, which I shall not discuss individually. All of these proposals have in common the disruption of the integrity of a statewide professional organization which serves our public honorably and with dedication.

The law, as we interpret it, does not require that Louisiana be divided for PSRO area designation.

It is our hope and our plea that this state will not be divided in any way for such designation. To do so would be seriously disruptive to our organizational structure and would negate at least a part of an existing and effective peer review structure.

Exhibit B

Statement by the Louisiana State Medical Society on Professional Standards Review Organization Area Designations

Mr. Chairman, I am James H. Stewart, M.D. of New Orleans, Louisiana, President of the Louisiana State Medical Society. I am accompanied by H. Ashton Thomas, M.D. and Mr. Paul Perret, who are respectively Secretary-Treasurer and Associate Secretary-Treasurer of this Society. We represent 3,300 physicians licensed to practice medicine in the State of Louisiana.

At the meeting on August 22, 1973 we submitted a statement which we believe provides a valid basis upon which the Secretary of Health, Education and Welfare should designate the entire State of Louisiana as a single area for the purpose of PSRO area designation.

We have reviewed that statement and wish to reaffirm it today. We are prepared to submit additional copies as appropriate for this meeting.

In support of our pervious statement, there are several points which might be added here.

Designations of the State of Louisiana as a single PSRO area would conform with DHEW guidelines one, two, three, four and six (DHEW Publication No. (SSA) 74-11350).

DHEW guideline number five is subject to various interpretations, is being challenged not only by physicians' groups but by members of the Congress, and at times may be in direct conflict with guideline(s) three and/or six.

The fiscal intermediary for Medicare/Medicaid Part B in Louisiana is a single entity for the entire state and has compiled a substantial data bank based on statewide experience.

A less tangible but nevertheless very real consideration should be the opinion and feelings of the physicians of this state. We who represent them have sought their views in formal and informal meetings and in written polls. There is little doubt that designation of the State of Louisiana as a single PSRO area would evoke substantially less physician reaction than any of the other suggestions that have been made.

EXHIBIT C

LOUISIANA STATE MEDICAL SOCIETY,
New Orleans, La., January 9, 1974.

DIRECTOR,
Office of Professional Standards Review,
Parklawn Building, Rockville, Md.

DEAR SIR: The Executive Committee (Board of Directors) of Louisiana State Medical Society has directed me to strongly object to the Professional Standards Review area designations announced for the State of Louisiana in the *Federal Register* of Thursday, December 20, 1973.

We were shocked to find that your office has divided the State of Louisiana into four PSRO areas, while allowing other states with more than 2,500 physicans to be designated as single PSRO areas. Many of our members feel that Louisiana was the subject of retaliatory action because of the strong opposition by Louisiana physicians to Section 249 F of Public Law 92-603.

As you know, two public hearings were held in Louisiana on area designations. At the first meeting, all who presented testimony favored a single area designation, except for one physician who was speaking for a group of less than 20 physicians. He requested that the Caddo-Bosiser area be designated as a PSRO. No one spoke in support of his proposal.

The proposed areas, as published, appear to be based on so-called "A-95 Regions" that cannot be supported as being valid medical service areas in the state.

Therefore, we are asking your office to reconsider Louisiana area designations so that they will represent the views of the overwhelming majority of those medical care providers who presented testimony at the two Louisiana hearings on area designations. We sincerely hope that your office will not further antagonize Louisiana physicians by allowing these arbitrary area designations to stand.

Sincerely,

H. ASHTON THOMAS, M.D.,
Secretary-Treasurer.

EXHIBIT D

LOUISIANA STATE MEDICAL SOCIETY,
New Orleans, La., March 8, 1974.

HENRY E. SIMMONS, M.D., M.P.H.,
Deputy Assistant Secretary for Health, Director, Office of Professional Standards Review, Department of Health, Education, and Welfare, Washington, D.C.

DEAR DR. SIMMONS: We received from members of the Louisiana Congressional Delegation the OPSRO's rationale for proposing that Louisiana be divided into four PSRO areas.

We have carefully studied your letter and can only conclude your rationale to be a "canned" one. Of the six guidelines published by the OPSRO, there is conflict only with guideline 5, which states that the area should not exceed 2,500

licensed, practicing physicians. We have been informed that a number of PSRO areas have been designated with many times 2,500 licensed, practicing physicians.

If you will read the verbatim trancript of the two-area designation hearings held in Louisiana, we believe that you will agree with us that the decision to divide Louisiana into four areas was purely arbitrary, made by staff, and not based on the testimony presented.

We hope the OPSRO will reconsider this unwise decision.

Sincerely,

H. ASHTON THOMAS, M.D.,
PAN AMERICAN LIFE INSURANCE CO.,
New Orleans, La., April 17, 1974.

EXHIBIT E

New Orleans, La., April 17, 1974.

Re PSRO.

Dr. JAMES H. STEWART,
President, Louisiana State Medical Society,
New Orleans, La.

DEAR DR. STEWART: We, as Pan-American Life, are fully aware of the Louisiana State Medical Society's position with regard to the PSRO provisions of Public Law 92-603. The purpose of this letter is to more specifically inform you of Pan-American's position on those same provisions.

Pan-American Life has not and does not intend to promote PSRO in Louisiana. We have taken an "observing" position at this point in time, because we, like the Louisiana State Medical Society, have strong reservations about the thrust of PSRO's.

Our present position on PSRO is very similar to the position we took regarding the Medicare Program before it became law. Before Medicare became public law, Pan-American Life, as well as most commercial insurance companies, opposed the proposed Medicare legislation. However, once Medicare became law, our Company, with strong support from your Society, actively sought the role of Part "B" Carrier in Louisiana. We did this for two reasons. First, as a Louisiana-based company we had developed rapport with the Louisiana medical community and we were desirous of serving them and the citizens of our State. Second, we felt that private enterprise should not allow the administration of the Medicare law to be exclusively performed by the Federal Government.

We realize that the Louisiana State Medical Society is actively supporting the repeal of the PSRO Law. However, in the event that PSRO legislation is not repealed or altered, we at Pan-American offer our complete cooperation and support to the Louisiana State Medical Society, if you should eventually have to assume a role in PSRO administration.

Pan-American Life would be pleased to be a partner with the Louisiana State Medical Society in any PSRO venture you may undertake. We are ready to offer our technical and computer support, as well as our administrative, to such a project. We wish to reiterate that Pan-American Life will only get involved with a PSRO actively, if the Louisiana State Medical Society should become involved.

Our only involvement in PSRO to date has been an active attempt to have the State of Louisiana designated as a single PSRO area. This was done as an outward sign of our active support of the Louisiana State Medical Society's position on this aspect of the PSRO legislation. We both failed in this attempt.

Dr. Stewart, I trust that Pan-American's position on PSRO is now clarified. If you should desire any further information or wish to discuss further, please let me know.

Sincerely,

NORRIS V. FITZMORRIS.

Senator TALMADGE. The next witness is Dr. Matthew Marshall, president of the Pennsylvania Medical Care Foundation.

Doctor, your entire statement will be inserted in the record. You may summarize it, sir.

STATEMENT OF MATTHEW MARSHALL, JR., M.D., PRESIDENT, PENNSYLVANIA MEDICAL CARE FOUNDATION, ACCOMPANIED BY HENRY FETTERMAN, M.D., VICE PRESIDENT, PENNSYLVANIA MEDICAL CARE FOUNDATION

Dr. MARSHALL. Thank you, Mr. Chairman.

I am Matthew Marshall. I am president of the Pennsylvania Medical Care Foundation, accompanied by Henry Fetterman, the association's vice president.

The Pennsylvania Medical Care Foundation Board is composed principally of practicing physicians, including osteopathic physicians. However, the board includes consumers, representatives nominated by Governor Milton Shapp, Blue Shield, Blue Cross, the State Hospital and Dental Associations. The foundation has been designated by the Pennsylvania Medical Society as the organization to represent the society in matters relating to the implementation of the PSRO legislation.

In 1969 I had the opportunity to testify before this committee. The gist of that testimony was that certain voluntary utilization review techniques developed by physicians in cooperation with other interested persons and groups had proved their value in assuring the public of proper use of health care dollars, and second, that the medicaid program in Pennsylvania had proven a frustratingly ineffectual program.

Almost as soon as the PSRO legislation was introduced, it became obvious that health care accountability legislation was of far more importance than the public recognized. The PSRO legislation was, and continues to be, supported by the Pennsylvania Medical Society and the Pennsylvania Medical Care Foundation.

Testimony to that effect was presented to the House Ways and Means Committee in 1970. The legislation is also supported by the Pennsylvania Osteopathic Association. Physicians, and more importantly their patients, continue to be progressively frustrated by increasing amounts of redtape interposed in the patient care process by the regulations made and admini ed by those who apparently do not fully understand the problems of delivering health care.

A graphic example of this is the "Waiver of liability" provision in Public Law 92-603, which we feel is an extraordinarily confusing section. While it may be intended to benefit medicare beneficiaries, we believe that the confusion and detrimental effects it will create will far outweigh its usefulness. We would recommend that this section of the law be repealed or modified so as to make it understandable and workable.

The Bennett amendment was based on the willingness of the Senate Finance Committee to listen to the experience of voluntarily developed systems to assure proper quality and cost of medical care, that had worked and could be applied to medicare and medicaid beneficiaries.

The PSRO legislation is primarily a waste control and quality assurance measure, rather than cost control and benefit limitation legislation characteristic of cost control procedures in other sections of Public Law 92-603 and the approach currently used by our State

medicaid program, and which would be authorized to continue were it not for the PSRO legislation. PSRO defines appropriate professional responsibilities not called for in the original medicare and medicaid law. Thus, a positive step was taken by Congress toward the elimination of one of the deleterious effects of the original medicare-medicaid legislation. We are appreciative of Senator Bennett's letter indicating that, in his opinion, the Pennsylvania Medical Society's actions, including direction of the foundation to assist physicians in implementing the law, are consistent with the intent of the law.

One thing does amaze me. There appears to have been almost a total news blackout regarding PSRO.

Does the press consider that secrecy regarding national health insurance aspects of this legislation is essential to the national security?

Pennsylvania physicians' time and dues money has been spent to subsidize Federal efforts to make this legislation workable. These 4 years of preliminary efforts have been superficially disappointing. But from a public point of view the results are tangible.

Professional decisions to assure proper use of hospitals and appropriate medical care continue to be made by the Pennsylvania Medical Society and the Pennsylvania Osteopathic Medical Association Medical Advisory Committees on an advisory basis both to Blue Shield, Blue Cross, private insurance companies, and medicare. This includes skilled nursing home care review. Almost all hospitals are served by sophisticated data collection and analysis services, such as HUP and PAS, and considerable progress has been made to make the services more useful for quality of care review, as well as utilization review, through a cooperative project of the Foundation financed by the Pennsylvania Medical Society, the Pennsylvania Osteopathic Medical Association, private corporations, and to a lesser exent by HEW.

An appendix documenting this will be submitted later. Blue Shield and Blue Cross have cooperated in developing peer review systems which are described in the attached appendices.[1]

Individual medical staffs and hospital administrators utilizing such services as HUP and PAS, and by applying the Pennsylvania Medical Society Criteria for In-Patient Medical Care have improved the cost and quality of care under their supervision. This is reflected in a length of stay in Pennsylvania that has dropped about a day in 1973 and is still dropping. Blue Cross rate increases have either slowed or reversed. It reminds us that it is the motivation through coordination and cooperation by those responsible for health care, rather than the details of the regulations, that is primarily responsible for the changes which have occurred and are continuing to be progressively more effective. Paradoxically, this may result in a greater apparent cost control impact in Pennsylvania before PSRO is implemented than after PSRO's have become organized.

Our efforts have not come to fruition with the designation of the Pennsylvania Medical Care Foundation as the first statewide Professional Service Reserve Organization Support Center. Our efforts to develop reasonable PSRO areas were recognized at the HEW area designation hearing and were concurred in by all present. Our Founda-

[1] See p. 215.

tion has assisted our Professional Standard Review Organization areas in developing planning contract proposals and eight have completed their applications. These areas are served by approximately 14,500 physicians, which represents 92 percent of the practicing physicians in Pennsylvania.

In order to coordinate a smooth transition to Professional Standards Review Organization requirements, negotiations with medicare, with the State medicaid plan, and fiscal intermediaries have initiated and are proceeding in a satisfactory manner, limited mainly by the availability of staff time. We are hopeful that regional medical program activities will become fully coordinated with our responsibilities. As a support center, we shall try to assure that the various bureaucracies bend to the needs of the dedicated physicians and, more importantly, the need of patients to receive appropriate care from their physicians.

We feel our past record, our current activities, and designation as a statewide support center documents both our capability and our dedication to making Professional Standards Review Organization go. We are pleased to make this information, derived from voluntary projects, available to health ministers of four foreign countries involved in improving the quality and effectiveness of care in their countries.

What about potential amendments?

I trust that the committee will consider them in the light of strengthening, not weakening, the basic purposes of grassroots physician responsibility with appropriate public accountability and concern for the confidentiality and emphasis on assuring quality of care. I should urge the committee to continue to monitor this program to assure that the law is implemented in accordance with this intention.

Since the foundation is not a consumer organization, it may seem inappropriate to speak of their interests. However, Mrs. Frankie Jeter, a president of a welfare rights organization and a consumer on our board, has expressed the opinion that the principal oversight in the medicaid program has been in failure to deliver the comprehensiveness of benefits or the coordination of care promised when the legislation was passed, and its failure to have required any appropriate public accountability to consumers at the local level. As a result, our board recognizes as appropriate these public concerns:

1. Quality patient care must not be hindered, but rather, its availability must be improved.
2. Medical care must be of uniformly high quality to all patients.
3. Patients must not be confused or worried about PSRO utilization activities or overwhelmed by medical terminology and technology and must understand how decisions are made about the appropriateness of the care received with awareness of the participation in the decision process.
4. Assurance that continuity of care is fostered.

A threat to Professional Standards Review Organization lies in the legislative proposals, perhaps based upon the support given to Professional Standards Review Organization legislation by organizations such as ours, that Professional Standards Review Organization is an immediately available panacea for controlling health care costs. Pro-

posals to increase the scope of Professional Standards Review Organization activities, to control physicians' fees, or perhaps all health care expenditures, are most unrealistic. We must recognize that past experience suggests that the existence of peer review programs such as are contemplated by Professional Standards Review Organizations will, due to their visibility, peer pressures, and the educational programs, improve the quality, cost, and effectiveness of health care delivered to beneficiaries or subscribers of other programs. Furthermore, American consumer groups do not necessarily want a program that will limit their use of hospitals or skilled nursing facilities based on medical necessity as defined in the professional standards review program. Therefore, a broadened mandate to apply Professional Standards Review Organizations to all health care situations does not seem to be necessary or desirable at this point. At the same time, we cannot afford an additional wave of inflation in health care costs which will occur if additional health care programs are instituted without appropriate cost and quality review systems capable of assuming the responsibility before the increased benefits are offered. Assuring the public of the quality and cost effectiveness of its care should have a greater national priority than instituting new programs to underwrite the cost of care without effective and appropriate controls.

The 5 years between 1969 and 1974 have gone quickly, and I believe it will be at least that long before the Professional Standards Review Organization program can be fully evaluated. This demonstrates the critical need to allow for sufficient leadtime. In the interim, I hope Congress will provide a climate of legislative stability. A clear and appropriate delineation of authority is needed to minimize inevitable confusion. The general intent of the recent memorandum of agreement between health, BHI, and SRS was a needed step in this direction. Frequent changes in the direction of the responsibilities of programs, their staff, or funding could be disastrous to the Professional Standards Review Organization program. Since Professional Standards Review Organizations have primary responsibility to assure quality and appropriateness of health care, the need for Federal funding of parallel programs should be carefully and critically examined.

In summary, although we support the Professional Standards Review Organization legislation, making it go will be a big job. Professional Standards Review Organization cannot be overwhelmed by too many responsibilities assigned too soon. The public should first be assured of the quality and cost effectiveness of its health care before expanding benefits that cannot be appropriately evaluated at the present time. Therefore, we urge you to provide the necessary leadership, flexibility, encouragement, and time to evaluate the Professional Standards Review Organization program before rushing into a broad expansion of health care programs which will overburden the Professional Standards Review Organization system in the next few years.

Senator TALMADGE. Doctor, I hate to interrupt you. But your time has expired, and we have a great number of witnesses, as you know.

We appreciate your contribution, and your entire statement will go in the record and will be made available to the members of the Committee.

Any questions?

Senator CURTIS. I have one.

Senator TALMADGE. Senator Curtis?

PSRO REDTAPE

Senator CURTIS. Doctor, in your statement, you say: "Physicians and, more importantly, their patients, continue to be progressively frustrated by increasing amounts of redtape interposed in the patient-care process by the regulations made and administered by those who apparently do not fully understand the problems of delivering health care."

They do not say who is doing that.

Is it the doctors that are writing those regulations and administering them?

Dr. MATTHEWS. No, sir. I would say under other sections of 92-603, the State welfare agency was able to promulgate anecdotal criteria which no one was able to decipher, and which had no relationship with quality care. And their regulations were entirely unclear, and I believe in many cases unworkable. I believe PSRO places the appropriate responsibility for this in the hands of physicians, and I hope we will do a much better job.

Senator CURTIS. But the physicians do not write the regulations and impose the redtape, do they?

Dr. MARSHALL. No, sir. That is correct.

Senator CURTIS. Government does that, Doctor.

Dr. MARSHALL. Government can do it, and sometimes private insurance companies can get quite a bit of redtape involved, too.

Senator CURTIS. Did you have in mind private insurance companies when you wrote this?

Dr. MARSHALL. No. I did not. It was written for a statement in this particular legislation.

Senator CURTIS. Yes, and this State welfare agency in your State was administering a Federal program.

Dr. MARSHALL. It was a combined program. I am happy to say that since PSRO has been passed, they are more willing to come along to the PSRO philosophy than that which was authorized previously.

Senator CURTIS. That is all.

Senator TALMADGE. Senator Bennett?

SUPPORT FOR PSRO IN PENNSYLVANIA

Senator BENNETT. Dr. Marshall, I want to express my personal satisfaction to you again and the appreciation of those of us who have worked on the PSRO program for the tremendous support and cooperation you have given us, you and your colleagues from Pennsylvania, in working out the details of the program so that it could be

satisfactorily and effectively operated, and so that doctors can live and work under it.

In the efforts of the Pennsylvania Medical Society and the Pennsylvania Medical Foundation to establish and cooperate with the PSRO program, have you encountered any obstacles created by the American Association of Council of Medical Staffs?

Dr. MARSHALL. No, sir.

Senator BENNETT. What is your evaluation of the efforts of that group?

They are going to be the next witness.

Dr. MARSHALL. Well, I believe, since 1970 we have had four regular sessions of the house of delegates of our medical society and one special session in which, in the last two there were efforts to have certain groups take a stand to repeal PSRO. As you are well aware, the house of delegates considered those arguments, but its action was to continue to support PSRO.

Senator BENNETT. Thank you.

No other questions.

Senator TALMADGE. Senator Long?

PENNSYLVANIA'S COST FIGURES IMPRESSIVE

The CHAIRMAN. Doctor, I am impressed by your chart here, which indicates that your cost in western Pennsylvania is $91.11 on the average for 1972, compared to a national average of $105.21. But that is not as impressive to me as the fact that in your area you are surrounded by States like New York, Maryland, and the District of Columbia. Now the average cost for the District of Columbia, Massachusetts, New York, Connecticut, Rhode Island, Maryland, and Delaware, appears to run about $135, and your average in western Pennsylvania is $91.

Do you think that it is because of your peer review approach, or what would you think?

Do you think you are able to maintain the same quality of care?

What is it that accounts for that large differential in cost?

Dr. MARSHALL. Thank you, Senator.

When you speak of quality, the testimony of many people with regard to the kinds of hospitals and the kind of care they render show these hospitals are better equipped and render more services than the national average. So these cost decreases have not been accompanied by a lack of quality in the hospitals concerned, and I believe I can make more detailed information available to you to show that the service being rendered is of high quality.

The CHAIRMAN. Do you believe, then, that your review procedures are a major factor in that cost savings?

Dr. MARSHALL. I believe they are a major factor. But I believe everything has to be considered in the total picture. Western Pennsylvania was among the first places to have a hospital planning association, for example, and we have a good association with both the blues and the hospital people there. And I have to attribute this to a total community effort.

The CHAIRMAN. Thank you very much.

Senator TALMADGE. Thank you very much, Dr. Marshall. We appreciate your contribution.

[The following material was subsequently submitted by Dr. Marshall. Hearing continues on p. 250.]

PENNSYLVANIA BLUE SHIELD—PATTERNS OF CARE

Pennsylvania Blue Shield (PBS) became involved in the development of patterns of care at the request of the Pennsylvania Medical Society (PMS) through the Medical Care Appraisal Project. One of the goals of the Medical Care Appraisal Project was to develop more effective medical audit programs. The need for criteria to be used in a medical audit was evident, and PMS sought the aid of PBS in the development of criteria for medical care.

In undertaking the task of developing patterns of care, in 1972, PBS concentrated on patterns of physician care. There is a wealth of data and statistics available for institutional services, but very little work has been done for physician care in and out of hospital. Criteria and patterns of ambulatory care which have been developed represent the subjective opinion of panels of doctors. The intent of our study was to develop treatment patterns in an objective manner by using actual experience data.

Eighteen diagnoses (Appendix I) were selected which would reflect a high incidence on claims and would represent a broad spectrum of physician care so that most of the medical specialties would be studied. One day from each quarter of 1971 was selected. Medicare and Regular PBS claims that were received on that day were included in the sample. All claims for the eighteen diagnoses were selected and the following data retrieved: primary and secondary diagnoses (using ICDA-Eighth Revision), patient identification, age and sex, date(s) of service, service(s) provided, place of service, doctor identification, specialty and zip code.

This first claim rarely represented the total care provided for the treatment of the primary diagnosis. In order to develop a case, all related claims in the PBS claims file were reviewed. Additional services pertinent to treatment of the primary diagnosis were added to the case.

Since PBS benefit programs do not provide comprehensive coverage to the subscriber for all ambulatory services, a follow-up questionnaire to the doctor was designed to determine whether other services had been performed which did not become the subject of a claim. Cases which were considered incomplete because the doctor did not reply to the questionnaire were discarded.

All information was entered into a fairly sophisticated computer system which tabulated data into a form which could be easily analyzed to develop patterns of care. Examples of the resulting patterns are attached as Appendix II, A and B.

Each pattern of care was reviewed by PBS Medical Advisors in the appropriate specialty and then sent to the Pennsylvania Medical Society for review by the appropriate Specialty Advisory Committee. All eighteen patterns were completed, reviewed by PBS Medical Advisors, and sent to PMS by the end of 1973. Three patterns have received a general approval from the PMS Specialty Advisory Committees, and the remainder are still under review.

PBS is continuing to develop patterns of care for additional diagnoses but is able to devote only a minimum of effort to this task.

The patterns of care, once approved, can be used as guidelines to identify and isolate those cases which may be outside the realm of quality care. With our patterns for physician care and those that have been established by PMS for inpatient care, a comprehensive review of total patient management will be possible. In addition to their value to PBS in its claims processing role, such criteria should be useful to PMS in its continuing education program and to PSRO's when they are established.

Pennsylvania Blue Shield can utilize the patterns of care to improve upon their current claims review system. The concept of prepayment claims review by diagnosis was tested in two simulated projects—one in Medicare using three diagnoses and the other in Regular Business using five diagnoses. These projects are referred to as simulated because the claims which were studied were actually

processed and paid in the normal fashion while simultaneously being reviewed on a simulated basis against the patterns of care. Because of the obvious difficulty of securing additional information from the attending physician on a claim that had already been paid, it was decided to postpone professional review and peer review until a live project could be conducted. As a result, it was not possible to develop complete cost and savings figures for the proposed system. However, the comparisons that were made between the proposed system and the current system did indicate that the concept of prepayment claims review by diagnosis was feasible and that it could be used to improve the present claims processing system. Between 85 and 90% of the claims fell within the established parameters. In an automated system the computer would process these claims automatically, and only the remaining 10 to 15% would require individual review.

Prepayment review serves only to identify cases which might be outside the realm of quality care. Peer review should determine, in the individual case, what is quality care. In this review, the doctor's peers can evaluate extenuating circumstances and can consider other problems that the patient has which make him an individual and, therefore, make his case unique.

In a pilot project which is now being developed, the system of prepayment review by diagnosis will be fully tested. The pilot project will involve the review and payment of some claims using patterns of care as guidelines rather than the current review standards. Since the project is experimental and will not involve a large volume of claims, the review will be performed manually. If possible, the project will be conducted in both PBS Claims Review and Medicare Claims Review and will run for several months.

The project will be limited in scope by two factors: 1) only four diagnoses for each claims area will be selected for the study; and 2) only claims from physicians in a selected geographic area of the State will be utilized in the Review.

To the extent possible, the review procedure for the pilot project will follow the currently established procedure, which is attached as Appendix III. Claims will first be reviewed manually by claims examiners; those that cannot be approved will be reviewed by Blue Shield Medical Directors and Medical Advisors. Finally, cases which still seem questionable will be referred to special, local Peer Review Committees established by the Pennsylvania Medical Care Foundation.

In this manner, the entire system of prepayment review can be tested, its cost effectiveness measured, and its impact on the practice of medicine evaluated. Moreover, as the Foundation develops experience through its peer review committees, it will be in a better position to see the requirements for continuing physician education.

Attachments:

Appendix I

Study List I

1. Diabetes Mellitus.
2. Neuroses.
3. Cataract.
4. Otitis Media.
5. Hypertension.
6. Acute Ischemic Heart Disease.
7. Hemorrhoids.
8. Hypertrophied Tonsils & Adenoids.
9. Inguinal Hernia.
10. Cystitis.
11. Hyperplasia of Prostrate.
12. Disorders of Menstruation.
13. Displacement of Disc.
14. Bursitis, Synovitis, Tenosynovitis.
15. Lacerations.
16. Chronic Ischemic Heart Disease.
17. Acute Cerebrovascular Disease.
18. Warts and Verrucae.

Appendix II-A

Observed Pattern of Care

Inguinal Hernia Without Obstruction (ICDA Code 550.0)

Physician Services

I. Cases Requiring Hospitalization

A. Office Visits

1. Pre-hospital—1 visit in one month period prior to admission.
2. Post-hospital—3 visits in two months period subsequent to discharge; 1 additional visit in 3 to 6 month period subsequent to discharge.

B. Surgery

1. Herniarrhaphy, unilateral or bilateral.

Also with: a. Orchiopexy, b. Excision of hydrocele or varicocele, and c. Appendectomy.

C. Lab Studies

None (other than in-hospital).

D. Diagnostic Services

None (other than in-hospital).

Appendix II-B

Observed Pattern of Care

I. Diabetes Mellitus Without Mention of Acidosis or coma ICDA Code 250.9

PHYSICIAN SERVICES

A). Office Visits—(or home visits, if required)

(1) Age 15 and over/cases with Diabetes Mellitius only. Frequency—one per month.

(2) Age 15 and over/cases with multiple diagnoses. Frequency—two per month (dependent upon secondary diagnosis).

B). Lab Studies

(1) Blood Sugar and Urinalysis/age 15 and over/all cases. Frequency—one per month.

(2) Glucose Tolerance/age 15 and over/all cases. Frequency—once a year.

(3) Complete Blood Count/age 15 and over/all cases. Frequency—two to four per year.

(4) Lipid Profile/age 15 and over/all cases. Frequency—once a year.

(5) SMA12 *or* Cholesterol, Uric Acid, and Blood Urea Nitrogen/age 15 and over/cases with diabetes mellitus only. Frequency—one to two per year.

(6) SMA12 or Cholesterol, Uric Acid, and Blood Urea Nitrogen/age 15 and over/cases with multiple diagnoses. Frequency—four per year (dependent upon secondary diagnosis).

C). Diagnostic Services

(1) Chest X-rays and EKG/age 15 and over/case with dabetes mellitus only. Frequency—once a year.

(2) Chest X-rays and EKG/age 15 and over/cases with multiple diagnoses. Frequency—one to three per year (dependent upon secondary diagnosis).

Appendix III

Requirements for Claim Processing Review System, Medical/Surgical Claims, all Lines of Business

I. CLAIM EXAMINERS (CLAIMS PAYMENT DEPARTMENT)

1. Can approve a claim for payment.

2. Can deny payment if written instructions[1] are available.

3. Cannot deny payment without written instructions, but may question payment. In these instances the claim will be routed to the Medical Review Department.

II. CLAIM REVIEWERS (MEDICAL REVIEW DEPARTMENT)

1. Can approve a claim for payment.

2. Can deny payment if written guidelines[1] are available. (A system for approving written guidlines is in operation and includes distribution to the Vice President, Medical Affairs and the Executive Vice President. Planning and Pro-

[1] Written instructions or guidelines shall mean decision logic tables, policy bulletins, or other specific instructions.

fessional Affairs. Existing guidelines are being reviewed and revised under the current approval system.)

3. Cannot deny payment without written guidelines, but may question a payment. In these instances the claim will be referred for review to the Medical Director's Office.

III. INQUIRY ANALYSTS (BENEFICIARY/SUBSCRIBER SERVICE DEPARTMENT, EQUIVALENT TO CLAIM REVIEWERS)

1. Inquiry analysts can make a total adjustment payment, but not a partial adjustment.

2. Inquiry analysts can uphold the original denial if written instructions or guidelines* are available.

3. Any reviews which canot be disposed of under 1 and 2 above must be routed to the Medical Director's Office.

IV. MEDICAL DIRECTOR

1. Can approve or deny a claim for payment.

A. Claims for services of a specialty nature that fall within a Medical Director's area of competence can be approved or denied. A Medical Director has the option of consulting with the appropriate Medical Advisor if assistance is needed.

B. Claims for services of a specialty nature that are not in a Medical Director's area of competence will be referred to the appropriate Medical Advisor if the claim canot be approved for total payment. Telephone contacts are acceptable for simple questions, but any advice of a complex nature should be obtained in writing. All decisions must be documented in writing.

2. The Vice President, Medical Affairs can specify that claims for selected services of a specialty nature must be referred to Medical Advisors for initial adjudication. Reasons for recommending this type of action must be documented.

V. MEDICAL ADVISORS

1. Medical Advisors can approve or deny a claim for payment.

2. Medical Advisors have the option to recommend that a claim be referred to peer review for advice as to the proper payment.

VI. PEER REVIEW

1. All cases to be sent to professional societies will be forwarded by the Vice President, Utilization Division.

2. Professional societies shall have the final advisory recommendation to approve or deny a claim for payment.

3. Peer review will be done by the specialty review committees of the Pennsylvania Medical Society. A. PBS will specify the specialty committee that should review the claim.

4. Peer review for podiatrists will be done by the review committee of the Pennsylvania Podiatry Association.

5. Peer review for osteopaths will be done by the review committee of the Pennsylvania Osteopathic Medical Association.

6. Under Medicare the Social Security Administration Regulations for the fair hearing process and use of peer review will be followed.

---

*See page 249.

UTILIZATION CONTROL ACTIVITIES, BLUE CROSS OF WESTERN PENNSYLVANIA

CONTENTS

The following material is excerpted from a statement presented by William H. Ford, President of Blue Cross of Western Pennsylvania, on March 14, 1974, at a public hearing before the Public Health and Welfare Committee, Senate of Pennsylvania, Honorable W. Louis Coppersmith, Chairman:

"The Blue Cross Plans have played an important part in helping hospitals and doctors assure quality care for Pennsylvania residents at the lowest possible cost through their assistance in: establishing utilization review committees; establishing hospital computer sharing systems; developing utilization measurement studies to provide hospitals with data on comparative utilization patterns; establishing industrial engineering programs providing professional assistance to hospitals; cooperating in development of comprehensive health care planning programs; helping hospitals establish group purchasing programs; and conducting research and consulting studies aimed at increased efficiency and economy in hospital operations.

"For many years, Pennsylvania hospitals have maintained a record of lower costs and greater number of services than the national average. Pennsylvania's cost per day of hospital care is lower than that of any other heavily industrialized state in the nation. The latest national statistics available for purposes of state-by-state comparison are for the year 1972. These statistics show that the total expense per patient day in the hospitals of Pennsylvania average $98.42. The national average was $105.21. In other words, the cost per day of care in Pennsylvania hospitals was $6.79 less than the national average."

NOTE: The chart on the following page, TOTAL EXPENSE PER PATIENT DAY, is comparative per diem hospital costs throughout the United States.

TOTAL EXPENSE PER PATIENT DAY

Combined Inpatient and Outpatient Expense

Non-Federal Short-Term General and Other Special Hospitals 1972*

The Total Expense Per Patient Day in Western Pennsylvania hospitals in 1972 was $14.10 less than the national average and $7.31 less than the Pennsylvania average.

State	Total Expense Per Patient Day
California	$148.54
Alaska	148.49
District of Columbia	143.67
Massachusetts	140.64
New York	133.90
Connecticut	133.70
Rhode Island	126.78
Maryland	125.47
Arizona	122.90
Nevada	120.05
Delaware	117.82
Michigan	116.74
Washington	116.63
Illinois	109.83
UNITED STATES	105.21
Hawaii	104.70
Oregon	104.28
Colorado	104.03
New Mexico	103.77
Utah	102.22
Louisiana	100.93
Ohio	99.39
New Jersey	98.49
PENNSYLVANIA	98.42
Florida	98.15
Vermont	96.10
Georgia	91.13
WESTERN PENNSYLVANIA	91.11
Wisconsin	90.95
Maine	90.60
Indiana	90.31
New Hampshire	90.04
Texas	89.66
Minnesota	88.58
Missouri	88.15
Idaho	87.84
Oklahoma	84.64
Virginia	83.44
Kansas	81.57
Tennessee	81.50
Nebraska	81.06
Alabama	80.68
North Carolina	79.70
Iowa	79.49
Kentucky	78.11
North Dakota	77.22
Montana	75.40
South Carolina	73.85
West Virginia	72.61
Arkansas	71.18
Wyoming	70.99
Mississippi	70.25
South Dakota	68.57

*Latest figures available

Sources:
AHA HOSPITAL STATISTICS 1972
AHA 1973 GUIDE TO THE HEALTH CARE FIELD

UTILIZATION CONTROL ACTIVITIES

Blue Cross of Western Pennsylvania works diligently to fulfill its obligation of providing subscribers with quality health care coverage at reasonable cost, and to work closely with physicians, hospitals and other health care agencies in cost and utilization control activities.

UTILIZATION REVIEW COMMITTEES

For many years the Plan has worked with Participating Hospitals and their medical staffs in establishing Utilization Review Committees. The hospital's utilization committee analyzes and identifies factors that may contribute to unnecessary or ineffective use of inpatient services and facilities, and makes recommendations designed to minimize ineffective utilization.

The medical profession has a basic role in ensuring proper and effective utilization of hospital beds and services. The responsibility has been officially recognized through resolutions by county, state and national medical societies, and through extensive participation of doctors in utilization review activities.

In this work, Blue Cross of Western Pennsylvania has cooperated closely with the Medical Advisory Committee on Blue Cross Cases of the Pennsylvania Medical Society. This Committee has reviewed and evaluated nearly 31,000 subscriber hospital claims.

Prior to the Medicare requirement for such committees, more than 90 per cent of Blue Cross Participating Hospitals in Western Pennsylvania had utilization committees in operation.

HOSPITAL UTILIZATION PROJECT (HUP)

Blue Cross of Western Pennsylvania provided technical assistance and data processing facilities over a four-year period for the Hospital Utilization Project (HUP), a utilization measurement study which provides hospitals with valuable data on comparative utilization patterns. The Plan continues to provide assistance to HUP in the form of review and control services.

The following material is excerpted from a statement presented by Robert J. Schuler, Vice President of Blue Cross of Western Pennsylvania on January 20, 1972, to the Pennsylvania Department of Health Advisory Council for Comprehensive Health Planning Task Force on Health Costs and Finance:

"The third area of involvement concerns institutional and professional care review activities. Blue Cross has been active in utilization control programs for many years, and a formalized utilization program involving hospitals, doctors, and Blue Cross was developed in 1958. More than 30,000 subscriber hospital cases a year have been studied in depth since the formal review program was initiated.

"The acceptance of utilization review as a necessary function of community-responsive institutions and individuals is indicated by the fact that more than 90 per cent of Blue Cross Participating Hospitals in Western Pennsylvania had utilization committees in operation prior to the Medicare requirement for such committees.

"Blue Cross was also actively involved in the establishment of the Hospital Utilization Project, a statistical measurement program which provides hospitals and their medical staffs with data on comparative utilization patterns. We provided technical assistance and data processing facilities for the project during a four-year period, and continue to furnish assistance in the form of review and control services.

4

"Seventy-five percent of our Participating Hospitals, representing 83 percent of the hospital beds in Western Pennsylvania, are currently using the services of the Hospital Utilization Project. An additional seven percent of Blue Cross hospitals representing nine percent of the hospital beds, are using the Professional Activity Service which provides essentially similar services. In total, Western Pennsylvania hospitals, representing 92 percent of available beds, are currently making use of utilization review statistical programs.

"The entire range of utilization review activities in Western Pennsylvania -- including the work of the professionally staffed Blue Cross Medical Review Department, the individual hospital utilization committees, the Hospital Utilization Project, and the Medical Advisory Committee for Blue Cross Cases of the Pennsylvania Medical Society -- is directed toward analysis and identification of factors that may contribute to unnecessary or ineffective use of inpatient services and facilities."

MEDICAL ADVISORY COMMITTEE

In Pennsylvania, Blue Cross was created by the Commonwealth under a special enabling act. Under this Act the Pennsylvania Insurance Department has extensive regulatory powers over Blue Cross. Among other things the authority to regulate includes:

1. Subscription agreements with subscribers
2. Rates charged to subscribers
3. Reimbursement contracts with hospitals

Because of this authority we were the first Plan in the United States to have a public hearing on a rate increase request. This was back in 1956. Another hearing held late in 1957 resulted in an adjudication which set forth many requirements for increased efforts in cost and utilization control.

Prior to the adjudication we already had a number of claims review programs in effect. We had unilaterally reviewed hospital admissions to identify diagnostic admissions. We had a legal responsibility for this effort since most of our agreements contained an exclusion for diagnostic admissions which could have been performed on an outpatient basis. But, without question, this review process had its problems. When claims were denied, everybody was unhappy, particularly the subscriber and the physician. Physicians who came to our offices to discuss these problems were sincerely concerned by our review mechanism and continually emphasized a difference of opinion as to the need for inpatient hospitalization in specific cases.

After numerous meetings it was agreed to undertake a joint program of utilization review co-sponsored by the Tenth Councilor District of the Pennsylvania Medical Society, the Hospital Council and Blue Cross. The primary objective of this undertaking was educational -- that is, educating physicians as to the proper use of inpatient hospital facilities.

To carry out this program, the Pennsylvania Medical Society Advisory Committee for Blue Cross was established in 1958 with participation of most hospitals from Lawrence, Beaver, Allegheny, and Westmoreland Counties. In 1970, this mechanism was expanded to cover the entire 29 county area; with a total participation of 97 hospitals. The Hospital Council worked with their member hospitals and the medical staffs to develop utilization review committees in each institution and Blue Cross set up a claims review mechanism under which cases questioned as diagnostic admissions or for length of stay were referred back to the hospital utilization review committee for study and advice.

Where the hospital's review committee agreed with Blue Cross on a case, the matter was resolved at that point. Where there was disagreement, the case was held and referred to the Medical Advisory Committee. This Committee is a rotating one made up of a Chairman who is selected by Blue Cross from names supplied by the Pennsylvania Medical Society and five Chairmen of individual hospital utilization review committees. These meetings, which are held weekly, are attended by the Medical Director of Blue Cross and the Administrators of the various hospitals represented by the attending Utilization Review Committee Chairmen. The Blue Cross Medical Director presents the case for Blue Cross, and the Chairman of the Utilization Review Committee for the specific hospital

presents the case for that hospital. The four other Chairmen from other hospitals then vote on the case. In the case of a tie, the meeting Chairman casts the deciding vote. The resulting recommendation to Blue Cross is very seldom changed by us.

The Committee considers three types of cases known as List "A", List "B", and List "C".

"A" LIST

These are Blue Cross admissions to the hospital of all questionable cases for inpatient diagnostic reasons that are sent to Medical Review by the Claims Processing Department. Most Blue Cross contracts have broad outpatient benefits. These benefits were included in the new agreements, at the encouragement of the 10th Councilor District of the Pennsylvania Medical Society, the hospitals and the group members, in an effort to have medical care delivered in the least costly manner. At the same time, most of these agreements exclude inpatient diagnostic stays. The Medical Review clerk further scans these cases and sends for hospital medical records on the questionable cases. When the medical records are received, the cases are reviewed by a Registered Nurse and when necessary, the Medical Director. A decision of payment or denial is made. If the cases are deemed Diagnostic Denials, they will be identified for a Medical Advisory Committee meeting. Prior to the meeting, these cases will be sent to the Hospital Utilization Committee for their review. If their judgement is that the cases were "diagnostic," no records need be brought to the Medical Advisory Committee meeting. If the hospital Utilization Review Committee considers the cases to be "non-diagnostic," we request that all pertinent data be presented

to the Medical Advisory Committee in support of their opinion. At the meeting, if the Hospital Utilization Review Committee agrees with the decision of Blue Cross, the case is not discussed, but if they disagree, the medical records are presented and the committee of physicians vote on it. Blue Cross accepts the recommendation of the Committee.

"B" LIST

These hospital admissions are paid Blue Cross inpatient claims only, and are scanned by a Registered Nurse for a given hospital. The Registered Nurse's scan consists of:

1. Prolonged stays.
2. Prolonged pre-operative stays.
3. Prolonged post-operative stays.
4. Claims that appear by the billing not to have the complete diagnosis.
5. Consultation delays.
6. Laboratory, Radiology, Physio-therapy, Pharmacy Charges, etc.
7. Operating Room dates not listed.
8. Understays.
9. Inappropriate admissions.

The claims that the Registered Nurse selects are then sent to the Medical Director for further evaluation. The claims he selects will be held for a Medical Advisory Committee meeting. All "B" cases are reviewed at the meeting. If, after the case has been presented and the Committee agrees that it is justified, there is no further action. However, if they feel the stay is prolonged, the admission is

unnecessary, etc., they direct that a letter of admonition be sent to the attending physician from the Pennsylvania Medical Society.

In addition to the individual case review, pattern analysis is performed for most hospitals. See attached example of an analysis.

"C" LIST

These are Medicare inpatient hospital claims which are referred daily from Claims Processing to Medical Review. All claims under five days and over thirty days in length of stay, and three to five percent of all other claims between these limits are selected. Each Medicare claim is reviewed by a Registered Nurse prior to processing the claim for payment. Medical records are requested on questionable claims. The claims are held and a form letter is sent to the Business Office of the hospital notifying them that there will be a delay in the processing of the claims. After review of the medical records by the Registered Nurse, claims requiring no further investigation will be approved and put through for payment. Claims requiring furtner investigation for custodial, non-covered, or unnecessary admission are forwarded to the Hospital Utilization Review Committee for a decision. If the Medical Director does not agree with their decision, payment will be withheld and the case will be scheduled for discussion at the next Medical Advisory Committee meeting attended by the hospital involved.

Soon after we began to review Medicare cases, it became quite obvious that the Medical Advisory Committee structure needed to be revised to cope with the increased volume of work. So we again met with the physicians and as a result they established the Blue Cross Regional Steering Committee of the Pennsylvania

33-013 O - 74 - pt. 1 - 16

Medical Society. This Committee is responsible to the Pennsylvania Medical Society Council on Medical Services. It is composed of representatives of the six Councilor Districts, the Osteopathic Society, and Blue Cross. The responsibilities of the PMS/BC Regional Steering Committee are:

1. Coordinate activities of the Pennsylvania Medical Care Program and advise Blue Cross Plan and PMS about matters of policy and procedure.

2. Supervise all Review Activities and appoint chairmen to serve in review capacity.

3. Coordinate Medicare activities concerning
   a. Inspection of Hospital Utilization Committee activities, and
   b. SNF problems.

4. Act as primary liaison between PMS and the Blue Cross Plan.

It provides guidance to:

1. The Medical Advisory Committee which was started back in 1957.
2. A Committee for review of skilled nursing facility cases.
3. A Medicare Advisory Committee.

The Steering Committee also makes recommendations to us on policy matters and procedures affecting the medical profession.

Let us emphasize that the M.A.C. is an educational program, a function of the Pennsylvania Medical Society, an attempt to present and discuss various problems

relative to utilization and make physicians aware of these problems and to ask their cooperation. As an educational measure, a copy of the minutes of each meeting is sent to the Pennsylvania Medical Society and to the Hospital Administrator and President of the Staff of each hospital in attendance.

Since 1958 through December of 1973, there have been 373 meetings and the Committee has reviewed 6,096 cases on the "A" List. 1,170 decisions of Blue Cross were reversed. They have reviewed 23,536 cases on the "B" List. 4,919 letters of admonition have been written to physicians. A total of 1,200 "C" list cases were reviewed.

PATTERN ANALYSIS

Prior to a Medical Advisory Committee (MAC) meeting, the attached cover letter and study is sent to the Utilization Review Committee Chairman. This analysis is prepared for 68 hospitals that use the HUP Data System. The U.R. Committee is expected to review the study thoroughly and be prepared to discuss the patterns of care at the MAC meeting and have suggestions for resolving any problems identified.

Blue Cross
of Western Pennsylvania
Pennsylvania
Blue Shield

One Smithfield Street, Pittsburgh, Pa. 15222 • Phone (412) 391-0600

COVER LETTER - MEDICAL AUDIT

Dear Doctor:

The Social Security Amendments of 1972 P.L. 92-603 places increasing emphasis on the health care system to institute ongoing medical audits and to evaluate patterns of patient care and not to identify individual problems.

Blue Cross of Western Pennsylvania, as fiscal intermediary for Medicare and administrative assistant to the Tenth Councilor District of the Pennsylvania Medical Society has embarked on a new program to provide educational assistance to each hospital and their medical staff for the purpose of promoting more meaningful patterns of care evaluations.

The diagnosis chosen for study is obtained from review of data prepared by a computer program of the Hospital Utilization Project; therefore, identifying information will be in code and can only be interpreted by you. Also, your report will only be available to you and your administrator.

Enclosed is a summarization and analyzation of a diagnosis selected from the most recent six month HUP statistical report.

May I ask your cooperation in reviewing the enclosed report with your staff, further investigate those areas you feel necessary and come to the next Medical

Advisory Committee meeting, prepared to discuss the pattern of care (only in a general sense) and possible methods of resolving any problems you and/or your staff may identify. In the area of medical audit, we need the opportunity to learn from each other.

The information being used to formulate these reports is minimal and Blue Cross of Western Pennsylvania only wishes to offer educational tools, not punitive action. It should be understood that further study (of problem identification and resolution) can only be meaningful if accomplished within each hospital and not relinquished to those outside of medicine.

I know that you share my deep concern for the need for all physicians to be actively involved in this area of medical care delivery.

If you should have any questions regarding this letter or the enclosed report, please feel free to contact me.

May I thank you in advance for your cooperation.

Sincerely yours,

Michael A.Cambest, M.D.
Vice President - Medical Affairs

CHOLECYSTECTOMY STUDY

Medical record numbers of 80 cases in the study:

735310	730006
734621	730481
731462	735401
731003	735359
730621	735062
735208	735779
734240	734953
732980	733473
733643	733727
733152	732947
732091	733212
732244	734531
730900	734639
731420	734553
735431	732381
732597	731397
733546	730360
732215	733227
732318	732792
7211489	734364
7211611	7211662
730040	734021
734899	732883
734923	732946
733176	733788
733830	731770
734321	731382
733756	733881
733027	730975
732880	731564
731750	731392
731991	730518
732095	7211630
731890	734627
731671	731244
731676	731979
731002	735039
731360	733599
7211709	734281
7211676	733045

LENGTH OF STAY ANALYSIS

[redacted]

Diagnosis - Cholecystitis, Cholangitis and Cholelithiasis
I.C.D.A. Code - 574.0 thru 574.9 or 575.0
Procedure - Cholecystectomy
I.C.D.A. Code - 43.5
Time Period - January thru June, 1973

As a service to and educational tool for [redacted], its medical staff and others involved in medical audit programs, Blue Cross of Western Pennsylvania has summarized and analyzed the results of six months of data. We studied the length of hospital stay of eighty patients with the primary diagnosis of Cholelithiasis or Cholecystitis and Cholangitis; who had a primary surgical procedure of a Cholecystectomy. Deaths and patients remaining past 75 days are omitted. All patients were discharged during the period January thru June, 1973.

Comparative Information

[redacted] ranked eleventh of eleven hospitals in the group for average length of stay. The H.U.P. expected length of stay range is 8 to 17 days.

	[redacted]	Group Hospitals
Average length of stay	14.7 days	12.6 days
Percentage within the range	70%	70%
Percentage below the range	4%	14%
Percentage above the range	26%	16%

Median - The median is by definition the middle value in a distribution. Whenever the median is shown, one half of the cases have a stay equal to the median or smaller, and one half of the cases have a stay equal to or greater than the median.

[redacted] - 10 days Group - 10 days

Mode - The mode is the most commonly occurring value in the distribution. In other words, the mode values shown represents the most frequently occurring length of stay.

[redacted] - 10 days Group - 9 days

Population

The group of 80 patients ranged in age from 18 years to 81 years. The average patient age is 48.8 years with 23 patients or 29 percent being male and 57 patients or 71 percent being female.

The table below shows a breakdown of payment sources and length of stay for the 80 patients studied.

Payor	Number of Patients	Average L.O.S.
Blue Cross	37	11.6
Commercial Insurance	27	13.7
Medicare	9	21.3
Medical Assistance	7	12.0

Admissions, Discharges and Surgery
(Day of Week)

The table below exhibits admissions, discharges and surgery by day of the week.

	Mon.	Tue.	Wed.	Thu.	Fri.	Sat.	Sun.
Admission	14	11	11	13	9	7	15
Discharge	3	7	17	15	12	15	11
Surgery	30	11	12	14	13	0	0

Forty-five of the 80 patients admitted were classified as emergency admissions with the remaining thirty-five patients classified as elective. The following is a distribution of emergency admissions by day of week.

Emergency Admissions

	Mon.	Tue.	Wed.	Thu.	Fri.	Sat.	Sun.
Admissions	6	6	7	7	8	6	5

All patients were discharged alive with one transferred to another level of care and another left against medical advice.

Ninety-one (91) consults were recorded for the eighty patients studied which is an average of 1.1 consult per patient.

Length of Stay by Physician

The 80 patients studied were attended by 6 surgeons. The distribution and length of stay is as follows:

Physician	Number of Patients	Average Length of Stay	Average Pre-op Stay	Average Post-op Stay
10125	38	14.5	4.2	10.4
10305	16	15.6	5.2	10.4
10329	12	15.2	6.1	9.1
10107	12	13.7	5.1	8.6
10302	1	13.0	6.0	7.0
10123	1	16.0	7.0	9.0

The following is the distribution of pre-operative stays by physician for the 45 emergency admissions:

Physician	Number of Patients	Pre-op Stay
10125	19	6.4 days
10305	9	7.7 days
10329	8	8.4 days
10107	8	5.5 days
10123	1	7.0 days

Possible Points for Continuing Study

The following outline is to be used only as a suggested guide for a meaningful medical audit. To further investigate a particular area of interest, medical records should be used with the assistance of the medical record practitioner and/or the Utilization Review Coordinator, who can minimize physician time spent on the study by providing only those necessary records.

You may want to refer to your copy of the medical criteria for Cholecystectomy patients prepared by the Pennsylvania Medical Society and sent to the medical staff.

This criteria is a guide and is to be used only as a tool and not to be considered rigid law for further study of patterns of patient care.

I. Length of Stay

A. Twenty-six (26%) percent above the expected range (8 to 17 days) - Reasons for excessive length of stay could be studied by using the 26% above 17 days.

B. Group average length of stay (12.6 days) - All patients who stayed in excess of 12.6 days may also be used as an indicator for review. This group would consist of more cases than (A.) above.

C. Pre-operative length of stay - Areas that may prove worthy of further investigation may be:

1. Available pre-admission diagnostic facilities

2. Coordination of admission scheduling with operating room scheduling

3. Coordination of admission scheduling with x-ray scheduling

II. Admission Status

A. Emergency Admissions - The appropriateness of the 45 cases admitted with emergency status could be further investigated.

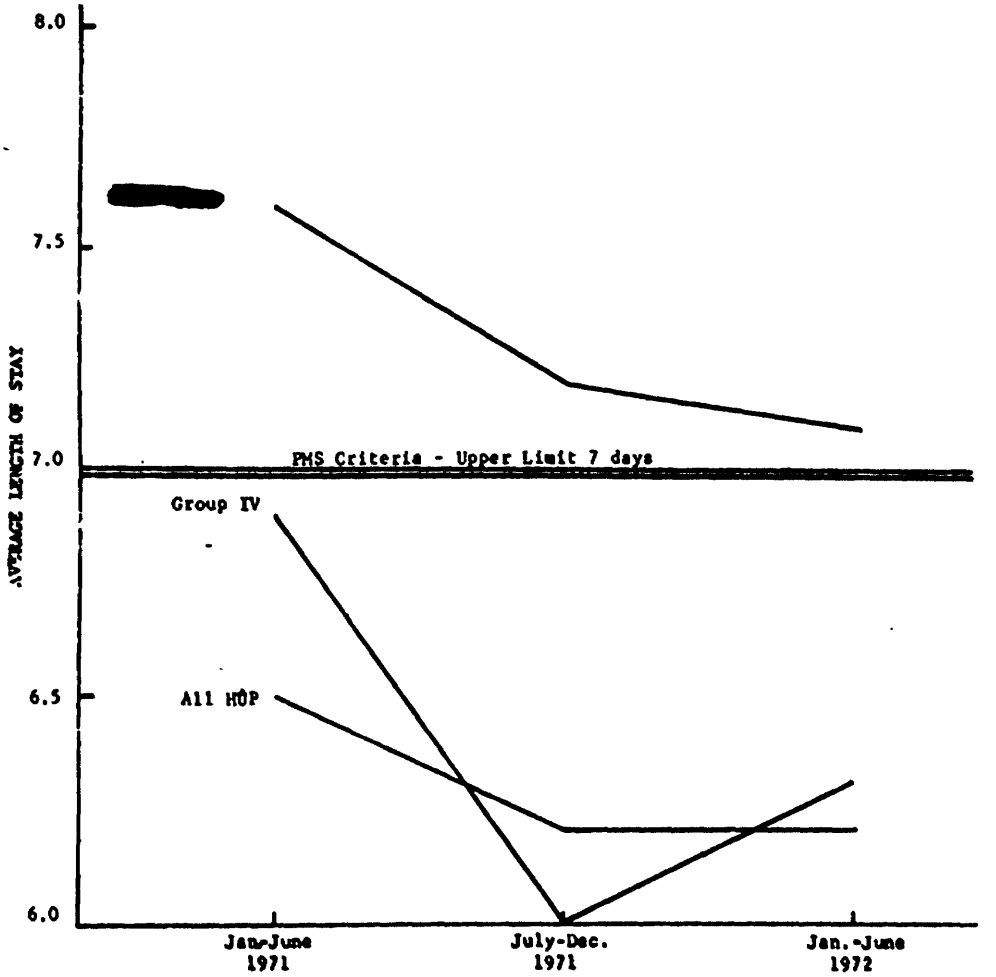
III. Consultations - The number of consultations which exceeded the number of patients may be further studied for appropriateness.

HOSPITAL PROFILE

The hospital's average length of stay for the particular diagnosis studied is graphically shown for the current period and for two past periods. This picture of the pattern relating to a specific diagnosis is shown at the Medical Advisory Committee (MAC) meeting and discussed in conjunction with the pattern analysis. An example of such a graph is attached. Comparisons are made with the Pennsylvania Medical Society's Criteria for the average length of stay for the diagnosis and with the average length of stay for all HUP hospitals and hospitals in their Group.

[redacted] HOSPITAL

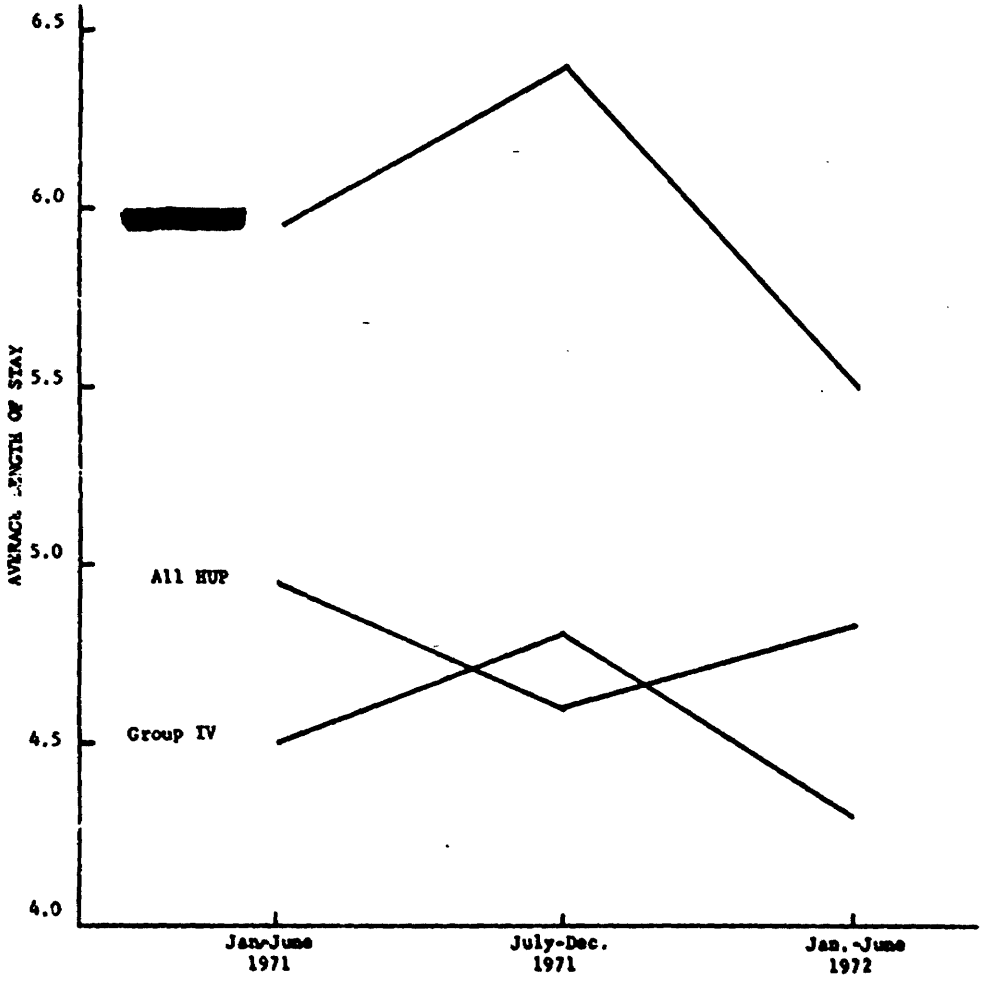
Gastroenteritis, Adult - Average Length of Stay



	Jan.-June 1971	July-Dec. 1971	Jan.-June 1972
ALL HOSPITALS	6.5	6.2	6.2
GROUP IV	6.9	6.0	6.3
[redacted]	7.6	7.2	7.1
[redacted] Cases	33	61	37

[redacted] HOSPITAL

Gastroenteritis, Pediatric - Average Length of Stay



	Jan.-June 1971	July-Dec. 1971	Jan.-June 1972
ALL HOSPITALS	4.9	4.6	4.8
GROUP IV	4.5	4.8	4.3
[redacted]	5.9	6.4	5.5
[redacted] - Cases	34	24	31

[redacted] - Acute Myocardial Infarction - July-Dec. 1971

- The 74 cases averaged 26.1 days. The 31 BlueCross cases averaged 26.4 days while the 43 non-Blue Cross averaged 25.9 days.

- Of the 31 BlueCross cases, 18 or 58.0% exceed the PAS 75th percentile for the age group involved. These 18 cases break down by physician as follows:

18242	25233	18351	18302	25254	18219	18149	TOTAL
3	1	1	7	3	2	1	18

- Patients at [redacted] were slightly younger than the population for this diagnosis at all HUP hospitals.

Age	All HUP	[redacted]
20-34 yrs	0.9%	1.3%
35-49	17.1%	17.5%
50-64	44.4%	51.4%
65+	37.6%	29.8%

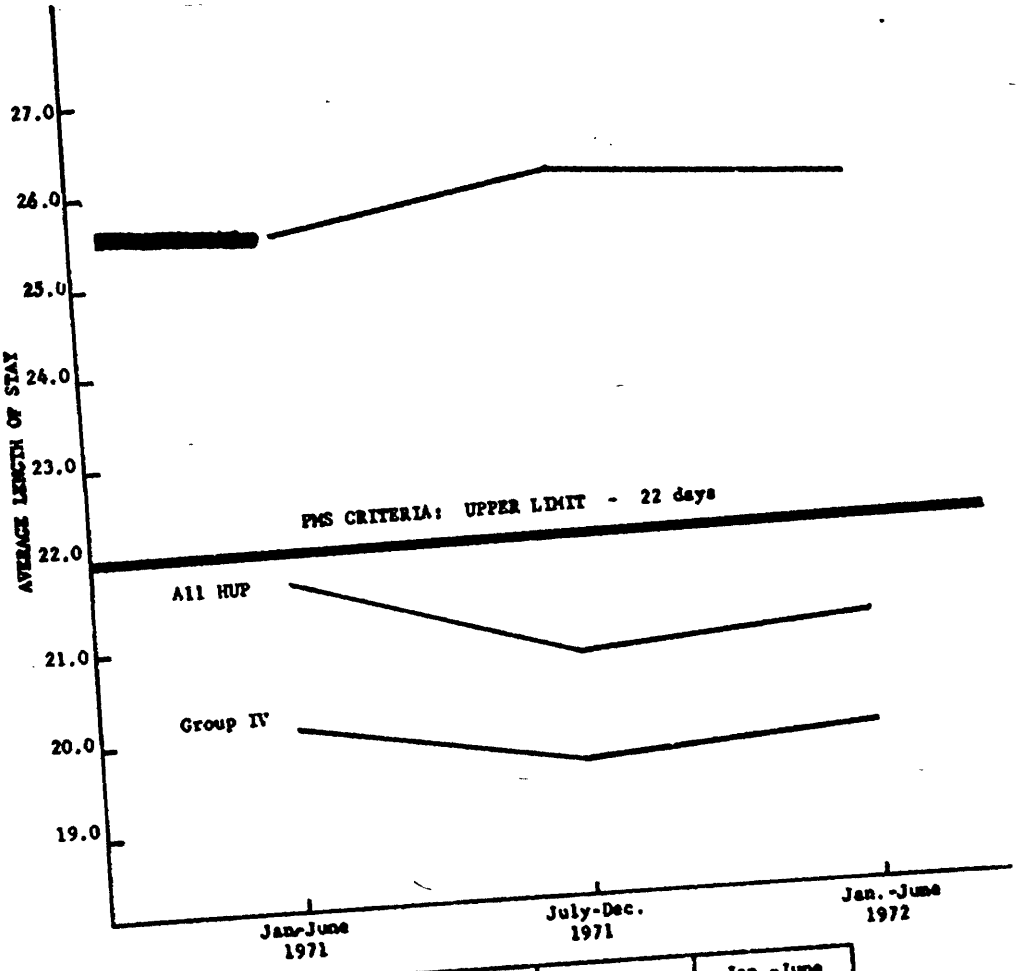
- A smaller percentage of patients at [redacted] had multiple diagnoses than in HUP hospitals as a whole.

	All HUP	[redacted]
Single dx	34.9%	47.3%
Multiple dx	65.1%	52.7%

- 16 different physicians handled the 74 cases. Only two had more than 10 patients. Physician 18302 handled 14 cases with an average length of stay of 30.5 days, and physician 18325 had 11 cases with an average of 18.5 days. The combined average for the rest of the physicians was 26.6 days (49 cases).

[redacted]

Acute Myocardial Infarction - Average Length of Stay



	Jan.-June 1971	July-Dec. 1971	Jan.-June 1972
ALL HOSPITALS	21.1	20.8	21.0
GROUP IV	20,1	19.6	19.8
[redacted] Avg.	25.5	26.1	25.9
[redacted] Cases	45	74	77

25

[redacted]

Cholecystectomies - Jan. - June, 1972

- The 35 cases averaged 18.0 days. The 19 Blue Cross cases averaged 15.6 days. The other cases averaged 21.1 days. Comparing Blue Cross cases with the others the pre-op average was nearly the same (5.6 and 5.9 days respectively,) while the post-op stay was 9.9 days for the Blue Cross cases and 15.2 days for the others.

- Eight of the cases exceeded the PAS 75th percentile for the age group of the patient; three of these were Blue Cross cases.

- Patients with this diagnosis at [redacted] were older than the population of all patients. 71.1% of [redacted] patients were over 50 compared to 50.0% of all HUP cholecystectomy patients.

Age	All HUP	[redacted]
0-19	1.5%	-
20-34	19.5%	10.5%
35-50	29.0%	18.4%
50-64	32.5%	50.0%
65+	17.5%	21.1%

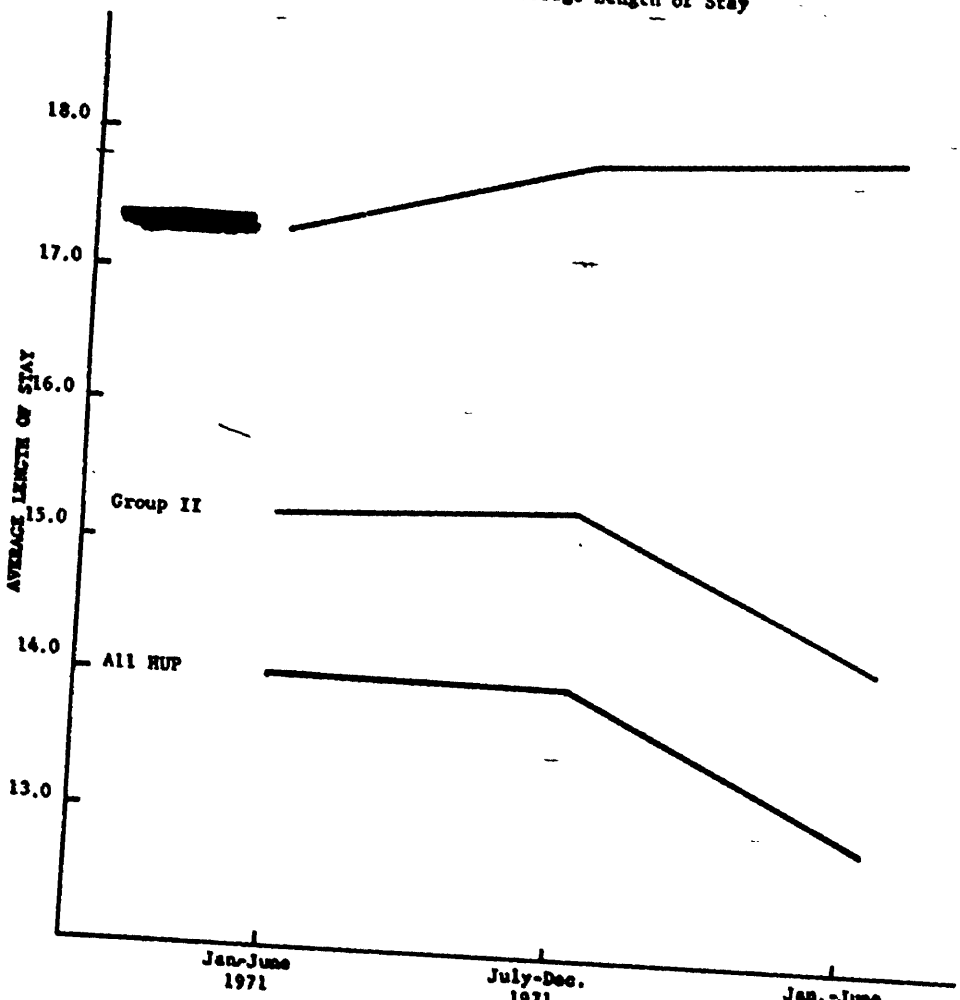
- Corresponding to the older age of the patients, there were a higher percentage of multiple diagnoses at [redacted] than in HUP hospitals as a whole.

	All HUP	[redacted]
Single dx	54.1%	36.8%
Multiple dx	45.9%	63.2%

33-013 O - 74 - pt.1 - 17

[redacted]

Cholecystectomy - Average Length of Stay



	Jan.-June 1971	July-Dec. 1971	Jan.-June 1972
ALL HOSPITALS	14.0 days	14.0 days	12.9 days
GROUP	15.2 days	15.3 days	14.2 days
[redacted]	17.3 days	17.9 days	18.0 days
[redacted]	36 cases	49 cases	35 cases

UTILIZATION REVIEW INFORMATION

BLUE CROSS PROGRAM - OUTPATIENT

Year	Visits/1000	Benefit Dollars Paid
1960	99	$ 2,564,645
1966	146	5,649,574
1967	178	7,136,055
1968	187	8,443,265
1969	198	9,274,823
1970	224	11,228,761
1971	257	15,008,582
1972	295	19,335,115
1973	340	19,488,319

SOURCE: BLUE CROSS OF WESTERN PENNSYLVANIA
MAY, 1974

UTILIZATION REVIEW INFORMATION

BLUE CROSS PROGRAM - INPATIENT

Year	Average Length of Stay	Admissions/ 1000	Days/1000	Benefit Dollars Paid
1960	8.1	139	1162	$ 59,987,688
1966	7.87	121	953	94,557,587
1967	7.82	132	969	99,834,000
1968	7.76	134	1043	109,006,568
1969	7.72	131	1011	127,256,525
1970	7.78	130	1016	149,838,809
1971	7.68	130	998	171,524,831
1972	7.59	128	976	177,040,268
1973	7.3	135	979	187,989,202

SOURCE: BLUE CROSS OF WESTERN PENNSYLVANIA
MAY, 1974

DIAGNOSTIC DENIALS

Some measurement of the effectiveness of a utilization review program is the number of claims denied. We have not changed our diagnostic inpatient denial criteria; however, there has been a continual decrease in the number of these denials made from 1965 through 1973 as shown by the date below. It would appear that people are not being admitted unnecessarily.

Year	Net Denials
1965	1536
1966	1103
1967	793
1968	748
1969	746
1970	679
1971	463
1972	344
1973	226

SOURCE: BLUE CROSS OF WESTERN PENNSYLVANIA
MAY, 1974

Senator TALMADGE. The next witness is Dr. Jose I. Garcia Oller, president of the American Association of Councils of Medical Staffs of Private Hospitals, Inc.

Doctor, your entire statement will be inserted in the record and you may summarize it, sir.

STATEMENT OF JOSE L. GARCIA OLLER, M.D., PRESIDENT, AMERICAN ASSOCIATION OF COUNCIL OF MEDICAL STAFFS OF PRIVATE HOSPITALS, INC., ACCOMPANIED BY DR. EDWARD S. HYMAN, SECRETARY, COUNCIL OF MEDICAL STAFFS, AND ROY F. GUSTE, ESQ., GUSTE, BARNETT & COLOMB

Dr. GARCIA OLLER. Thank you, Mr. Chairman, distinguished Senators, and the people of America.

The 10 minutes that we have been allowed, which is equivalent to all of the others, could hardly allow us to make a presentation on a fundamental issue of PSRO, which, in our view, constitutes the elimination of the private practice of medicine as we know it in this country. But basically, and perhaps more importantly, the fact that the American citizen will no longer be able to say, "I am going to see my doctor, not the doctor across the street, my doctor, whom I have chosen because of his reputation and his background, and I wish to rely on his judgment. I want this doctor to concentrate all of his professional attention to me as his patient, and disregard the position of the doctor down the street or in PSRO, a committee of doctors"—so I suggest the fundamental question before us as we have studied this is whether the constitutional right of the American men and women to choose the doctor and rely on the particular judgment of that doctor, unencumbered, unfettered, unpressured from Government institutions controlled by committees of practicing physicians who will then unquestionably bear down and change his point of view in a progressive erosion of his judgment.

You have seen before you witnesses who present a position for PSRO from time to time, not because they believe in it, but because it is the law, because we have PSRO. All of these groups are now jockeying together for a position of control, and I respect and acknowledge their position as legitimate because we have a law in this land that would say, never again will there be a patient and a doctor relationship under a private contract, but there shall be now a committee of physicians under the ultimate control of the infinite power of the Federal Government, which will be present at the third chair that is now empty in my room. Now we have the patient and we have the physician, and now we are going to have an empty chair in every room in this country which is the presence of the Federal Government.

So I would suggest in my emotional manner, for which I beg your pardon, that we are dealing with a fundamental constitutional right of the American men and women to choose his doctor and have that doctor unencumbered by the presence of the Federal Government, the Federal rulebook and the statement that PSRO says that there shall be access to the private medical records.

If we lose privacy and we lose judgment, there is no freedom. If we have a physician—and unfortunately, the presentation has been

that practicing physicians are going to do this, and therefore it is legitimate—and I submit that when practicing physicians have been subjected to the pressure of institutionalized Government control, that is no longer a practicing physician; it is a Federal quasi-agent. And that is what we are worrying about.

Now you are taking the independence of the doctor, and that has happened in other countries, and we recognize it, but we are now taking the right of the American to his doctor and their privacy and we have already had some examples this morning as to how the Federal Government handles privacy. We have seen records read now that were supposed to be private, and what is private today in the Federal Government? There shall be a regulation that the freedom of information that it shall be published tomorrow, and we do not recognize the assurances given that, when we have a patient in the office and gives private, confidential information, that that will ever again be private under PSRO.

We have, to the best of our ability, submitted for the record our PSRO book, which gives an analysis and a view of the program as it affects patients and doctors. I have included a one-page factsheet of the numerous abuses to the concept of patient-physician contract and relationship, and I will not discuss this.[1]

And on the second book, our formal testimony, the first 14 pages are our statement, and thereafter is our amicus curiae testimony presented as a memorandum in a court presentation. And I submit that for your study.[2]

And, of course, as the chairman mentioned, this will be part of the official record.

Senator TALMADGE. All documents will be inserted.

Dr. GARCIA OLLER. These documents, and in order to conserve the time, may I have a reading of the number of minutes that I have.

Senator TALMADGE. You have 4 minutes remaining.

Dr. GARCIA OLLER. I will do this mostly by titles so that there will be an opportunity for the committee to examine.

In our view PSRO is the rationing of medical care, on page 2. In an affluent society where a citizen may buy his medical care, he has a choice to his doctors. In an underdeveloped or socialized country, we then have an individual who is rationed under the system. In England this is done by the rationing system of the waiting line, and if there is a hernia or a hemmorrhoidectomy or a tonsilectomy, you may wait 6 months to 6 years. The system is free but it is rationed by time, free, by payment of taxes.

PSRO establishes the second type of rationing by challenging the judgment of a physician at every step of the way before the patient is admitted, preadmission certification, when he is admitted, admission revew, at computerized intervals, at length of stay, at every step of professonal judgment, there shall be a policing and certification system. This is rationing by limiting the type and amount of services. The rationing works to the committee's rationing of the board of admissions, the committee to investigate the private doctor's offices, and we do comment that in another context. We needed a plumber's union and a red wig and a voice falsifier to get into the psychiatrist's office.

[1] See p. 264.
[2] See p. 271.

But with a PSRO card, you have legal entry into the intimate affairs of every person in this country. [General laughter.]

And the third committee is the Federal Manual Committee, and I would like for you to consider the example of the treatment of the common cold in our book in which you have the number of visits in the home or in the office 3 or 4 days apart. The number of phone calls and whatnot is one of the examples of what could happen.

Now the next part of the testimony is that PSRO law contains provisions which directly interfere with the right to practice. Now this is a considered presentation and I will just mention one section, 1151, in which it states, "it is the purpose of this part to assure * * * that the services * * * conform to appropriate professional standards * * *" It does not say local rule and choice. It says that it shall assure that the physician shall conform.

I list the penalties for noncompliance, which are numerous and extremely, a high degree of pressure, which I will not list. I would then discuss the Supreme Court decisions, which, in the brief minute we have, I will read the Supreme Court opinion: "required acquiescence by copractitioners has no rational connection with a patient's needs and unduly infringes on the physician's right to practice."

And this, Mr. Chairman, I submit is the fundamental question, whether the right to seek advice on one's health and the right to place reliance on the physician of one's choice, are basic to the 14th amendment values. And this is what is at issue in PSRO. I discuss the various reasons, which you gentlemen had before you, for PSRO.

And finally, one word of caution. We believe that PSRO is not peer review, it is fiscal review. All of us here, and I am sure you Senators are for peer review, we are talking about fiscal review. And if I may have 10 seconds for the recommendations. To preserve privacy and confidentiality in a private doctor system in this country: No. 1, repeal PSRO; No. 2, establish prototype PSRO's in the Federal systems of hospitals, Veterans, Public Health Service; and for the purposes of medicare, establish fiscal cost containment and congressional restraint by a Federal Program Benefits Adjudication Board, whose function will be to clearly define the benefits to which a patient is entitled; to inform the patient of his benefits, based on adequate fiscal principles and actuarial data.

Thank you, Mr. Chairman.

Senator TALMADGE. Thank you, Chairman Long?

MARICOPA MEDICAL SOCIETY FOUNDATION

The CHAIRMAN. Dr. Hyman, I met with your group at Baton Rouge some time ago and I believe that you had a recording device at that meeting.

I ask that you make the transcript of that meeting available to us, if you have it.

Do you have it?

Dr. GARCIA OLLER. Just a minute. We are referring to the Maricopa Medical Society Foundation, the foundation for medical care, and the entire transcript—yes, we do have that, and if you would like we will submit this——

The CHAIRMAN. I would like to have a copy of the transcript, if I may.

Dr. GARCIA OLLER. We will prepare that at your request.

We visited Maricopa, and in our considered view, this is a foundation for medical care. Please remember that just this past month, I visited Maricopa again. The Maricopa Medical Society voted to go on record in no way to support PSRO, to go on record for repeal, and Mr. Jay Constantine was present there.

SOME STATES SAYING NO TO PSRO

Thereafter, there was a referendum and the referendum was against PSRO. And then, just 2 weeks ago, the State of Arizona went on record for the repeal of PSRO.

So I would say that the medical societies that are trying to implement PSRO because it is a law, have realized when they studied the principle involved that they cannot support it and maintain good medical care.

Also, in the State of Georgia, where we have foundations for medical care, there was a move to apply for PSRO again because it is the law. I believe that you should know, and I am sure that you do by now, that the State of Georgia is now on record for the repeal of PSRO and has a statewide public information campaign to let the people know that this is the end of good medical care.

So these are two examples on how the so-called foundation States, once the physicians have had an opportunity to view the facts, and that there is an alternative, under Senator Bennett's language, as he mentioned, for having voluntarism in PSRO to a degree because, as you know, after next year the Secretary of HEW will implement it.

So in Georgia and Arizona they have said no to PSRO. All we have is the smaller States or the smaller societies, Sacramento, with a few hundred positions, or New Mexico. And in Pennsylvania, where there was just a comment before, we have over 6,000 doctors now on the Council of Medical Staffs in the State of Pennsylvania. And I do hope and expect that as the rest of the physicians in the State have an opportunity to study this law, that they will be in a position to repeal.

So I believe that those witnesses that have appeared represent a very small section of American medicine and most of their testimony, as I have heard it this morning and yesterday evening, proves that the peer review system works.

Senator Bennett just read us examples of how the current system picks up some deviations, and we all admit that this is not the general view. The current system of peer review is the ones that are giving you this information. It is not the PSRO.

Senator BENNETT. This is the Federal Government, however.

Dr. GARCIA OLLER. Well, we have had a Federal Government since 1776, and I hope we continue to have it. We are talking about the Federal Government in my office, Mr. Bennett, and with due consideration, I make one comment on the fact that a doctor gave 10 drugs for 1 patient——

The CHAIRMAN. Might I just interrupt before we go any further.

It is all right for me to have a lengthy answer to the question. But

all I really wanted was just for your people to make available the transcript of that meeting, if you have it.

Dr. GARCIA OLLER. With pleasure. In fact, Mr. Chairman, we would like to present to your committee 3 years of hard data that we have developed.

Senator TALMADGE. I am sorry. Your time is up. Your time for the testimony has expired.

We appreciate your eloquence, but some of these Senators want to ask further questions.

Is the gentleman finished?

The CHAIRMAN. [Nods in the affirmative.]

Senator TALMADGE. Senator Bennett is recognized.

CMS MEMBERSHIP

Senator BENNETT. Doctor, you and I are going to have an interesting time in the next few minutes.

[General laughter.]

Senator BENNETT. You probably can yell louder than I can.

In your statement you say you have a voting membership of over 34,000 practicing doctors, and in bulletin, vol. 2, No. 1, of the Delaware Chapter, the Delaware Valley Chapter in Pennsylvania, you say:

> Beginning less than two years ago the Delaware Valley Chapter promptly enrolled over 25 medical staffs, hospitals in the area, each by an overwhelming affirmation to embrace membership. But the total number of physician members is between 3,000 and 4,000, and still growing.

And then let me read the fine print at the bottom of the page.

> Less than 10 percent of the membership paid the first year's dues, and the percentage who have paid since have gone down: Financial support is and has been at disaster levels. Only 40 percent of the first newsletter could be mailed because of insufficient money for postage from the beginning through the present, all clerical and administrative work is being done at the personal expense of Doctors—and I will omit the two names. Please, please, please, pay your dues.

And does that demonstrate that you have between 3,000 and 4,000 members in Pennsylvania? They have given you overwhelming affirmation and the program is still growing?

I think that indicates——

Dr. GARCIA OLLER. I would be happy to answer it. Is it a question?

Senator BENNETT. Yes.

Dr. GARCIA OLLER. Yes, from our records, I presume you are referring to a local newsletter of the Delaware Valley Chapter, for the record.

Senator BENNETT. Apparently, it is their own publication.

Dr. GARCIA OLLER. Yes, it is their own publication. Of course, we do not write that newsletter.

Senator BENNETT. Obviously.

Dr. GARCIA OLLER. However, these are the figures that we would be happy to read to you. We made a statement of 6,000, is that correct? We have in the Delaware Valley area 4,030 members. We have in the Allegheny Valley area in Pittsburgh, where we have just started—that is where Dr. Matthew Marshall was present—884 physicians. In the northeast Pennsylvania area and the Wilkes-Barre sector, 284 doctors.

In south central Pennsylvania, we just started there, we have 100 physicians.

So I would submit, Mr. Chairman, that we have close to 6,000 from the record, and these are the actual figures.

I will answer the second part of the question.

Senator BENNETT. How many of those are paid up? How many are just names on a piece of paper?

Dr. GARCIA OLLER. We are not the AMA. The AMA has compulsory dues and the physicians, in order to vote, have to pay a poll tax. The CMS was created to give every practicing doctor in this country their vote, and the dues are voluntary.

We have created, Mr. Senator, a grassroots organization.

Senator BENNETT. I hate to interrupt you, but I have a limited time to question. How many of those are paid-up members? Do you know?

Dr. GARCIA OLLER. This is from the Delaware Valley. They say 10 percent. I would suggest——

Senator BENNETT. So you would say in Pennsylvania that of the 6,000, 600 may be paid-up members?

Dr. GARCIA OLLER. But, yes. But this is by design because they are all voting members without a poll tax. We would like to get financial support, but our organization is designed to get votes.

Senator BENNETT. You said that before. May we leave it and go on to something else? You have said that before. I have got a lot questions and I think we have beaten that one to death.

ARTICLE CRITICAL OF CMS

I am talking about completing the record. I notice the material you have submitted is fond of quoting from articles from various medical publications. You did not include an article on your organization in the American Medical News of May 31, 1971. That article quoted the then president of the Louisiana Medical Society to say the following about your organization:

> We consider them right-wing extremists. I think we have an informed leadership already and Dr. Oller has not furnished anything.

Would you like to put that in your statement to kind of balance the others that you have given to us?

Dr. GARCIA OLLER. If that is the question, I would be happy to have everything on the record.

I would like to mention that this article was published in the AM News, not in the CMS News, and we did thereafter meet with their president and we asked him what did he know about our organization, and he had no information on the membership of CMS whatsoever. He had just been elected member. He is not from the New Orleans area. And therefore, we met with him and gave him the information. And he said he had a telephone call that was from someone that gave him the impression that the CMS in some way was attacking the position of the present State society and that he reflexively responded to it, and that he had no idea that this statement ascribed to CMS has not been done. So this was some sort of a bathing phone call, and Dr. Harold has stated since that he has no information or basis for the statement at that time.

Senator BENNETT. I would like to read another paragraph from that same article.

Dr. Harold said that the CMS recently asked the society to oppose the Joint Commission on Accreditation of Hospitals. The CMS asked the hospitals not to allow the joint commission to inspect anything but the physical plan. Action to oppose any of the procedures of the Joint Commission on Accreditation of Hospitals has been tabled by the society.

Did you ask them not to allow the joint commission to proceed with its accreditation procedures?

Dr. GARCIA OLLER. That is not factual and Dr. Harold, again, on the record, recognized that he had made a serious mistake. This was, on the record, again, the mistake by the president of the society. It had nothing to do with the CMS. Some doctor thought that hospitals should be hotels and doctors should take care of sick people and the joint commission should accredit the hotel. This is not the position of the joint commisison.

What the State society has done repeatedly on the record is recognize the Council of Medical Staffs as the appropriate organization whereby the State society has worked with the joint commission on the record for developing an independent or cooperative coserving mechanism. This was done for a period of several years.

So as far as the answer to your question, this is in complete error. It was not the CMS position and has never been. The Council of Medical Staffs' policy is to visit hospitals representing practicing physicians at the time of the survey of the joint commission, and cosurvey the institution representing the practicing doctors. This was the policy of the State society, which was presented by the Council of Medical Staffs, that there be a cosurvey. It is now the policy of the American Medical Association.

So in answer to your question, the AMA policy is the CMS policy. We wrote it with the official support of organized medicine.

CMS SEES PSRO RATIONING MEDICAL CARE

Senator BENNETT. You claim that the PSRO position calls for the rationing of medical care.

Will you explain specifically how you take the fact that the law calls for local physicians to utilize norms which they have developed as checkpoints in the review process, and then proceed to extrapolate that fact into the unconscionable distortion of this law, that it calls, in some way, for the rationing of medical care?

Can you explain to me why and how you think those steps represent the rationing of medical care?

Dr. GARCIA OLLER. I thought that I had already done this, but I would be happy to.

We are talking about the decision of a physician to treat a patient with a certain plan of treatment, and at the present time this is made with complete freedom of the physician to make that choice for that patient, there is the rationale.

This is PSRO——

Senator BENNETT. May I interrupt you at this point, because I want to take the point you have just made.

Do you object to any utilization review in the hospital as it is now carried on? Is that not equally rationing?

Dr. GARCIA OLLER. You missed the point of our presentation, that when you talk about utilization review, you are speaking about peer review.

We are for peer review. I am chairman of the organization at my hospital for about 4 years. That is peer review.

Senator BENNETT. But answer my question.

Dr. GARCIA OLLER. I am answering your question.

Senator BENNETT. What is the difference between the review by a group of doctors over here and the review by a group of doctors over here, if in fact each group should have come to the same conclusion?

If one is rationing, is not the other rationing?

Dr. GARCIA OLLER. It is a fundamental question that you have right now utilization review performed by these doctors which is legitimate and appropriate, because patient interest is the entire concern.

With PSRO, this other group of doctors are now under regulation from the Government.

So the hook, the bait is that we have a Federal Government system, while we have here a free and independent system. So it is a fundamental definition. This is fiscal review.

Senator BENNETT. You are avoiding my point. We are talking about the definition of rationing, and regardless of who does the review, if it comes to the same point, is it not rationing?

Dr. GARCIA OLLER. A peer review is not rationing. It is the evaluation of matters of care for the purpose of education and improvement of the profession. This is what it is. We do not say, you cannot admit the patient and we will not pay for you. The Federal Government PSRO review is rationing because it says, if we consider the treatment inappropriate, we are not going to pay for it. And there is a tremendous difference between the power of purse.

Senator BENNETT. That has been going on ever since medicare and medicaid have been in the law. The Government has been saying, under these circumstances, we will not pay for it.

Dr. GARCIA OLLER. And that is Government rationing. You have answered your own question.

Senator BENNETT. So you object to the Government having anything to say about the conditions of the service for which it pays.

Dr. GARCIA OLLER. We do not object to the Government doing whatever the Congress of the United States approves through our legal system. That does not make it legitimate in terms of the needs of the sick.

Dr. HYMAN. Senator, may I have one comment?

Senator BENNETT. Surely.

Dr. HYMAN. There is a major difference. When it is peer review in the hospitals, it is medical principles they are after. But in this particular program, no matter what the principles are, you are measured by some certain concrete criteria which may change tomorrow, it may take 10 years for the Government to change. And then, sir, that particular stratum is reviewed at the next stratum, where the consideration is not quality at all, but cost.

Senator BENNETT. That is your interpretation of the law and that is not the interpretation that is shared by about 90 percent of the people.

Dr. HYMAN. It is. That is recorded by you, sir.

Dr. GARCIA OLLER. I would like to state that we believe that Senator Bennett from the great State of Utah has supported this legislation under the original sponsorship of the AMA, which they do not now have.

AMA is now for repeal of PSRO. As far as the house of delegates, they have made a mistake and they recognize it. I believe that you supported this legislation with the best interests and we certainly respect your point of view.

I do think that the position of those of us who have read the law should be clearly that we recognize that this would make it impossible for the average physician to make a decision to admit a patient to a hospital without thinking first, can I have a look at the book and see if it is going to pass the muster for the board of review? Before that patient is kept in the hospital he is going to say, is this good, because when she goes home the husband is going to beat her up. Or because she has no one to take care of her. Or is he going to say, well, is my profile in the computer going to show on the wrong side?

This is the problem.

Senator BENNETT. Well, later on in the day we are going to have testimony which will completely straighten out the misunderstanding and the misinterpretation and the misinformation that, in my opinion, your organization has fostered and disseminated.

I disagree completely with your interpretation of the law and I think the majority of the physicians in America do, too. You are entitled to your interpretation. If you think you can get the law repealed, you are entitled to make a try at it. But I think that we are on the way to the successful implementation of PSRO, and I just regret that an organization such as yours is spending its time and money fruitlessly spreading false information and the kind of private interpretation which seeks to put the absolute worst face or worst interpretation on the law.

Yesterday we put into the record this ridiculous—and I say ridiculous advisedly—assumption of yours that if PSRO goes into effect, it will require the Federal Government to pay $34 billion to doctors for the treatment of the common cold.

To me that is the best example I could get of the ridiculous approach you make to the whole problem.

I am through, Mr. Chairman.

Dr. GARCIA OLLER. I would like for the record to accept the invitation, which I hope it is, that once has been stated to represent facts that have not been thoroughly checked out, if this was the intent of your presentation, that we would like to make ourselves available to bring the facts before you so that they can be checked out.

Thank you very much.

Dr. Hyman has a comment, perhaps.

Dr. HYMAN. Concerning the rationing, Senator Bennett. You need only refer to the study done by the Arthur B. Little Company, consultants to HEW, in which they refer to it as rationing also.

Senator BENNETT. Do you have a copy of that study?

Dr. HYMAN. I do not have it with me, but I have one.

Senator BENNETT. We would like to see it because we have not been able to find a copy.

Dr. HYMAN. Evidently, that has been taken off the press, and I wonder why?

One prominent writer in this company attempted to get it from J. B. Lippincott, and it is no longer apparently listed in the catalogue. However, we have two copies.

Dr. GARCIA OLLER. This was done under Federal contract. It was Federal money. It was published. One of the consultants is Dr. Russell Rothman of the AMA. We will be happy to send you a complimentary copy of how the Federal money gets peer review.

Do you have a statement to make?

Mr. GUSTE. Yes, I would like to say one word.

PSRO SEEN UNCONSTITUTIONAL

Senator Bennett, as attorneys for CMS, we conscientiously feel that the PSRO amendment is unconstitutional. We feel that it will be found to be so, particularly when it is implemented and we feel that this is easily substantiated by the current position of the U.S. Supreme Court in cases with which I am sure you are familiar.

We think that in attempting to implement your amendment, the Congress is riding a tightrope between the maintenance of the privacy of the American citizen and the deprivation of that privacy which the Constitution protects.

We do not believe that Congres should ride that tightrope. We think that the Congres should first be dedicated to the preservation of the principles of the Constitution, rather than to experiment to what extent it can go in extending the powers of government.

We do conscientiously feel that when this is put to the ultimate test, the U.S. Supreme Court will find it unconstitutional.

To repeat, when you talk about the CMS wasting its time attempting to protect the rights of American citziens, we think that it is much more serious that the Congress not waste its time in attempting to deprive the citizens of their most basic right and the right of privacy is as valuable a right as we as Americans possess. And this inevitably will transgress further upon the right of privacy of the American, you and me and everyone's right.

Thank you.

Senator BENNETT. This is in the courts and it will be decided and I have a different faith as to the outcome than yours.

Dr. HYMAN. May I, sir? May I continue?

Senator BENNETT. I think I have long since overstayed my time.

Are you going to have any questions?

Senator CURTIS. Oh, yes.

The CHAIRMAN. Dr. Hyman wanted to make a statement.

ABUSE OF ANTIBIOTICS

Dr. HYMAN. Yes, Senator. You asked Dr. Stewart this morning of the Louisiana State Society, some questions which, as a surgeon, perhaps it is inappropriate for him to answer, that is, concerning the abuse of antibiotics, which is unreal, and the drug-drug interaction or synergism between drugs which, you inferred, was not taken into account, and that is also unreal.

I want to point that out and should the hearings on drugs in the Senate ever be made open, perhaps that information may be introduced also.

Senator BENNETT. Referring to the excerpts I made from these reports, are you saying that the use is improper when you say it is unreal?

What do you mean, "unreal"?

Dr. HYMAN. Your inference is that the use is improper, and the data is inadequate to demonstrate that. The fact that a person is given three or four drugs in a category of something that depresses the central nervous system does not mean that the summation of the three is not monitored very readily by looking at that patient.

Senator BENNETT. I am not a doctor, but, obviously, I was quoting from reports made by doctors.

Dr. HYMAN. Yes, I am aware of those quotes, sir, and I think the record should be straightened out, if it is possible to get correct data in.

AMA NEWS ARTICLE

Now, concerning the unpleasant remark that was put in the AMA News, I suggest that you go to Dr. Harold, who is quoted in this very private conversation by the AMA News, and I suggest you turn to your colleague, Senator Long from Louisiana, and see whether the State society did not support this same position at the meeting he attended on Monday of this past week.

Senator BENNETT. I have no doubt that you are in favor of the repeal. That has been made perfectly clear.

Dr. HYMAN. Dr. Harold was in that audience, and I guess that makes us all right-wing extremists.

I think this name-calling has its limits. We are talking about integrity or infamy, not right or left.

Senator BENNETT. I do not think I am the one who has been calling names.

Dr. HYMAN. Name calling is popular.

Senator BENNETT. I think you have helped make it so.

Senator CURTIS. Mr. Chairman?

The CHAIRMAN. Yes, Mr. Curtis.

Senator CURTIS. I want the record to show that I am personally acquainted with a number of members of your organization who reside in the State of Nebraska. They are well-educated, cultured, dedicated men of medicine. They are not crackpots. They share your views. They do not believe that you or anybody else that is favoring the repeal of PSRO is trying to deceive the public or the Congress.

PSRO SEEN A GOVERNMENT INVASION INTO MEDICAL DECISIONS

Now, it is very, very easy to resolve the question of whether or not PSRO is a Government invasion into medical decisions. All you have to do is read the law. I inserted in the record yesterday or the day before a copy of the law where I took part of the places where the ultimate decision is in the Secretary to control the whole thing, to make it go. It is right there in plain English.

That does not refer to our distinguished Secretary, Mr. Weinberger. We do not know who will be there 5 or 10 years from now. But we also do know and should take cognizance of it, it will be a bureaucracy.

One of the gentlemen who appeared yesterday and supported PSRO asked that it be amended so that the National Council on PSRO be given administrative control. They are all appointed by the Secretary. They do not even have an independent staff as Government employees. This proponent of PSRO also contended that the Council report to the Secretary and act as a separate agency. That is fundamental. A referee should not be on one ball team, see.

Here is another recommendation, that the council has the authority to hire and fire its own staff and have control of its own budget. Whoever can control the staff of any committee or any Federal Agency can control that, particularly if they can control the budget. And I stated the other day when this man made these recommendations, it was one of the most severe condemnations of the law anyone could make.

He also recommended that the council be expanded to allow adequate elected representation on PSRO's. This council is the appointment of the Secretary. All of the authority under the language adopted rests in the bureaucracy. And the last recommendation was that the council elect its own officers.

Now, I think I was around here when this thing has been discussed all of the way through. I think that this committee thought that they were buying peer review and they bought something else. They bought something else; they bought Government review.

That is all, Mr. Chairman.

Dr. GARCIA OLLER. May I answer briefly to that?

The CHAIRMAN. I would like to ask one question.

DEALING WITH BAD HOSPITAL PRACTICES

How would you propose to deal with an admittedly bad practice? For example, reference was made to a situation existing in Louisiana. I am aware of it, and I was aware of it. A hospital where you had such practices as dual admissions. A person shows up for admission for whom the Government is going to pay. The fellow who runs the hospital puts grandpa in bed alongside of grandma, so that you look at the record, and you are showing that, where ordinarily you have one person in the hospital bed, you seem to be showing up invariably with two and paying for two. Frankly, that was the judgment of the Louisiana Department of Public Welfare about that same hospital before medicare got into the picture.

How would you propose to handle that type of thing?

Dr. GARCIA OLLER. Senator, I am very grateful for that question, because I think this gets to the core of it. You are very keen in doing that.

Again, what you are talking about is how do we have continuously better peer review? This is what we all want. I think this is what the good Senator Bennett wants. We want good peer review. We want to improve. And the question before this committee is whether PSRO is an improvement over this.

We believe that it is regressive because it eliminates some basic constitutional rights like privacy and puts the pressure upon a doctor that cannot be called progressive and then the cost to the taxpayer. But then the question, how do we do better peer review?

Now, we recognize the authority of the Congress to define benefits, limit them in any manner that they feel is appropriate by defining accurately the benefits. This is No. 1, it is true; but now we are talking about peer review.

This example that you brought to us, that the Senator stated in reading—and I made a few notes, and I cannot cover all of the points. Some patient had as many as 10 pills in 1 day, drugs.

I immediately asked myself, at age 65, what is the most common condition that we treat? I am a brain surgeon, but I am talking in terms of the general practice of medicine. Let us talk about a hypertensive patient after 65 who is older and may have some tremor. This is a fairly common experience. And what do we do for a patient with high blood pressure and Parkinsonism in day-to-day practice?

First, for high blood pressure we prescribe two drugs, one for high blood pressure and the other for his kidney functions, which is essential for high blood pressure, a diuretic. I am just using lay language, if you do not mind. The third drug we would use is potassium in certain instances, because when you give the diuretic you have to control the chemistry of the body or otherwise the patient is in trouble. So we have three basic drugs that we have to give.

Then we have the problem of Parkinsonism, tremors in the elderly people. We give for the tremor Artane, which is trihexyphenidyl—we are going to use generic words. And we have to give something for the tremor which is Dopar, under the UPAA, we use Dopar, the miracle drug invented by the free enterprise drug industry. We have to use, to counteract the bad effects of Dopar, we have now developed Symmetrel, S-y-m-m-e-t-r-e-l, which is amantadine, which is the chemical name, in order to avoid the excessive effects of it. So this is necessary. Then you have to have a specific kind of vitamin, because you cannot take vitamins when you take Dopar. It has to be a specific type of component. So all patients of Parkinsonism in modern medicine have Dopar, Symmetrel, and they have to have the specific vitamin.

Then we go on to the fact that all patients of Dopar who are under treatment have to have bowel regulators, and practically all of them with Dopar have sleepless nights.

The basic core treatment of a hypertensive, 65-year-old, with some tremor is a minimum of nine drugs. Now, if that patient happens to have a reason for being hospitalized, he has to have at least one more to have the PSRO necessity. So if the man has pain and gets an aspirin, that is 10 drugs. And I submit this is the minimum under true peer review. And I believe that these kinds of reports, when they are not submitted to professional peer review, and they are submited to this Federal system, do deprive the good practice of medicine, that the least the Government can do is submit to a competent peer review system, not a Government-authorized and paid and pressured PSRO. We are talking about responsible professional peer review.

So in answering your question—and I could answer all of these point-by-point—an EKG on every admission is absolutely necessary on patients past 65.

The CHAIRMAN. Doctor, that is all fine, but that was not the question.

What I asked about is what you would propose to do with this situation.

Dr. GARCIA OLLER. Repeal PSRO. This is what we have got to do.

The CHAIRMAN. Doctor, I know you want to repeal PSRO, but I would like to get an answer to a specific question. Here was a hospital where every time grandma shows up, her doctor puts grandpa in bed with grandma and charges for two, when all we ought to have to pay for is one.

Now, grandpa did not show up asking to be put in the hospital, but the doctor persuaded grandpa he ought to be in a bed in the same room with grandma, so we are paying for two of them instead of one. And it happens repeatedly as a practice.

Now, that was going on. And it was only one hospital that I knew of that was doing that, but it was being done.

Now, how would you handle that?

Dr. GARCIA OLLER. I would handle that as it was, Senator. It was handled by being discovered, exposed. And you cannot keep these things hidden under our present system without PSRO. The Federal Government discovered it through current mechanisms, and the hospital was closed. This is legitimate; it should be taken to a court.

The answer, then, is that we have capable, legitimate legal responses on the books to correct these ususual and rare instances. I presume the Senator agrees; I think you mentioned this was unusual—five hospitals compared to the hundreds in the State of Louisiana. So I think we have adequate remedies, and there is no question that in a small community with the hospital having substandard practice that it will see the light of day and be right with you, shoulder to shoulder. We do not need PSRO; PSRO will make this fraud legitimate.

Senator BENNETT. Mr. Chairman, these people are making speeches. We have got nine other witnesses. It is now a quarter after 12. I ask you, or I ask them to realize our situation and end their performance. I ask you to ask them.

The CHAIRMAN. Well, I cannot tell the witness not to answer the question if I am the person that asked it.

Dr. HYMAN. If I might answer that, we have to live a lifetime with this, not just until noon. I think in general you are absolutely right. This business of the grandmother and grandfather being admitted together, occasionally—and it is rare—for psychiatric reasons you have no alternative as a practicing physician, and that ought to be entered into the record. That is a rarity.

However, in general, there are a few offenders. And all of this recitation of excitement and melodrama that has been presented the reprisals that you have put forth are absolutely unnecessary to cope with the situation. This will make everybody suffer, and it will destroy

high quality care and the necessary versatility to practice excellent medicine. The response is inappropriate and poor. Essentially, sir, you have elected to go after a single culprit in a crowd using a machine-gun.

The CHAIRMAN. Thank you very much, gentlemen.

I think you have certainly added interest to this morning's session, and I appreciate the information that you brought to us.

Senator CURTIS. Mr. Chairman, may I have 10 seconds?

The CHAIRMAN. Yes.

Senator CURTIS. I do not know whether it is right or wrong in Louisiana for grandma and grandpa to be in the same bed, but that is no reason to impose PSRO on Nebraska.

[General laughter.]

Dr. GARCIA OLLER. Thank you, Mr. Chairman.

The CHAIRMAN. I hope you do not think I am against grandma and grandpa sharing the same bed.

[General laughter.]

The CHAIRMAN. I do not think we misunderstand each other.

Thank you very much, gentlemen.

Dr. GARCIA OLLER. Thank you.

[The following material was submitted by Dr. Oller:]

TESTIMONY OF THE COUNCIL OF MEDICAL STAFFS

SUMMARY INDEX

I. INTRODUCTION

I am Dr. José L. García Oller, President and Founder of American CMS. I am Puerto Rican. May I introduce to the Subcommittee our Chief Legal Counsel, Mr. Roy F. Guste of Guste, Barnett and Colomb; Dr. Edward S. Hyman, Secretary of CMS, he is the son of a Russian Jew; and Dr. Wesley N. Segre, our Treasurer, a Jamaican Negro and past President of the Louisiana Medical Association. I am a brain surgeon. Dr. Hyman is an internist and research biochemist and Dr. Segre is a pediatrician.

It is necessary that public policy in the field of health care be responsive to the needs of the patient. This is why we are here: to present the needs of the American patient by those most qualified to define that need, those acually delivering medical care on a day to day basis—the private doctors of America.

CMS holds that private medical care of the American Citizen is a highly specialized area, a combination of art and science, requiring intensive day to day experience with large numbers of flesh and bone sick people. Then, and only then, is a doctor qualified to speak for the sick. Full-time academicians, professors, researchers, educators, and a number of medical economists, who do not have the workday responsibility for the actual care of the sick, are not competent to represent the needs of the delivery of medical care.

It was for this purpose—to obtain and represent the consensus of the private doctors of America—that CMS was founded in 1968. Ours is a grass roots movement marshalling the votes of private doctors in the midst of their activity, through the medium of their hospital medical staffs.

American CMS is now he second largest medical organization in the U.S. with a voting membership of over 34,000 practicing doctors in the rosters of our participating staffs with 51 chapters in 28 states.

II. PSRO IS THE RATIONING OF MEDICAL CARE

The present American system of Private Medicine is made possible because most citizens are able to afford to have and to choose their own private doctor. The patient thereby becomes entitled to the treatment and the judgment of *his* doctor. The patient's interests are kept paramount.

Therefore, private medicine means personalized, individual care by the chosen physician's judgment with privacy and dignity at a reasonable cost and with the goal of early restoration of the patient to his work, home and family.

In underdeveloped countries and in countries with socialized medicine, the patient's individuality, the needs of his family and of his job, are subordinated

to those of the state. The state then determines what he should need or want, authorizes and rations his medical care based on the "public interest". Medical committees or boards are then usually enlisted to institute the rationing policy.

There are two forms of rationing:

A. Time Rationing, the waiting line system

Because "national health insurance systems" are prepaid through taxes, they appear "free" at the point of entry. To control overutilization, rationing is imposed. No more hospitals are built. No new beds are added, the system is not expanded. Entry becomes possible only through a long waiting line. This system is exemplified by the British National Health Service. The patients entering the waiting line may wait up to several years for hernia operations or for tonsillectomies. The system becomes a "health maintenance" system, because some patients recover during the prolonged waiting period; others become emergencies as the hernia strangulates or the infections become abscessed.

B. The second form of rationing is embodied in PSRO

It is the direct limitation of the type and quantity of services under a newly created concept of "medical necessity". Committees of physicians are then constituted as boards of rationing. Extensive documentation is demanded from the attending physician to establish "medical necessity". Successive decisions by the physician are challenged for further documentation. At all times, he is required to justify deviations from a prefabricated computerized manual of treatment. Such a rationing system is PSRO. Arthur D. Little & Associates (5) in a study under contract with HEW concludes that "PSRO is a form of non-price rationing of medical care". The PSRO rationing system is a second class, computerized, dehumanized system for the delivery of medical services.

The question before this committee is whether such a system of rationing of medical care is necessary and proper, and whether there is a more reasonable alternative for cost containment than to provide direct interference with the practice of medicine and with the patient's right to the judgment of the physician of his own choice. Our analysis will be directed towards this question followed by specific recommendations.

III. THE PROVISIONS OF THE LAW

A. How will PSRO rationing work?

A reading of the law reveals that the overall functions could be broken down into three principal areas, which, for the purposes of this document, we will assign to "three committees":

(1) The first committee will have authority to review the private medical records with intimate and personal information of private patients, in private medical offices, and to inspect the facilities of the physicians' offices. PSRO would authorize entry into private psychiatrists' offices, which has been classified as criminal action in a recent subject of national controversy. One may no longer need "a plumber's unit" or a "voice falsifier": all that is necessary is a "PSRO card". (Sec. 1155(b)(3)) "examine the pertinent records of any practitioner . . .; and (4) inspect the facilities in which care is rendered . . . of any practitioner. . . ."

(2) The second committee may be described as "the Board of Rationing for Hospital Admissions". Each PSRO has the authority "to determine, in advance, in the case of—(A) any elective admission to the hospital . . . whether such service . . ." is "medically necessary". (Sec. 1155(a)(2)(A)) Upon admission, the committee will establish the expected length of stay. Thereafter, the PSRO shall specify when the attending physician "shall execute a certification stating that further inpatient care . . . will be medically necessary . . ." "usually, not later than the 50th percentile of the length of stay for patients in similar age groups for similar diagnoses . . .". (See 1156(d)(1)(A) and (d)(2))

(3) The third committee we may describe as the Federal Manual Committee for the diagnosis, care and treatment of all disease. "Norms of Health Care Services for Various Illnesses or Health Conditions Sec. 1156(a) Each PSRO shall apply professionally developed norms of care, diagnosis and treatment . . .".

CMS believes that the three committee functions of invasion of privacy, advance certification of hospital admissions by the attending physician, and a Federal manual for the care and treatment of patients are a radical and unfortunate departure from good medical practice. Those are gross abuses of patient's rights

and physician's judgment. This is the PSRO concept. We believe this law must be repealed.

We now refer to the document "Memorandum on behalf of American CMS, amicus curiae in opposition to defendants' motion for summary judgment, to the United States District Court, Northern District of Illinois, April 1974", which constitutes an integral part of this Testimony. In this document we will find on page 3, Sec. A, the following:

B. "A. The PSRL (PSRO Law) contains provisions which on their face will severely impede the exercise of skill and judgment which is essential to the delivery of high quality medical care"

Section 1156(a) orders each Professional Standards Review Organization (hereafter PSRO) to "apply professionally developed norms of care, diagnosis, and treatment based upon typical patterns of practice . . ."

Section 1156(c)(1) directs the National Professional Standards Review Council to distribute "to each PSRO . . . appropriate materials indicating the regional norms to be utilized . . ."

Section 1156(c)(2) directs each PSRO to utilize these norms "as a principal point of evaluation and review for determining . . . whether . . . care and services are consistent with the criteria specified in section 1155(a)(1)."

Section 1155(a)(1) makes it the duty of each PSRO to "assume responsibility for review of the professional activities . . . of physicians.

It is argued that the doctor is not compelled to adhere to these prefabricated norms of care, diagnosis, and treatment; that these norms are mere guides for evaluation of his services.

They are more than that. By the very language of the statute, these norms are "principal point(s) of evaluation" of the necessity and quality of a doctor's care. And Section 1151 says that "it is the purpose of this part to assure . . . that the services . . . conform to appropriate professional standards . . ."

But the complexity of these procedures and the spectre of having to endure them in order to receive payment for services rendered creates a subtle but undeniable compulsion to adhere to the norms rather than the vast training and experience of the physician—to serve the administrative interest of government rather than the best interests of the sick.

Section 1156(d) compounds the pressure on the physicians to serve the government's interest rather than that of his patient. This section attempts to reduce length of hospital stay by requiring certification by the physician of the continued need of his patient for hospital care—in accordance with norms developed for this purpose—and "usually not later than the 50th percentile of lengths-of-stay for patients in similar diagnosis."

Thus, the PSRL implements a vast administrative network of medical norms, evaluation of physicians based thereon, and procedures for review thereof—all tending to impede the judgment of men and women whose mission heretofore has been to serve the sick. In its stead, this law gives birth to a patient who must be served before all others—the government. The doctor can, of course, treat his other patients first, but if he does, he undertakes the risk of enduring the administrative nightmares of the PSRL.

The PSRL further interferes with the right of a physician to practice his profession by creation and enforcement of the concept of medical necessity. Section 1160(a)(1)(A). Realistically, medical necessity is an artificial concept which at most can only be applied to obvious cases—broken bones, enlarged livers, measles, to name a few. But inherent in the enforcement of "medical necessity" is a rejection of the well-established fact that many symptoms of suffering are either psychosomatic or contain no documentable evidence of disease. The life of a doctor is devoted to relieving suffering. To require that every time a doctor relieves suffering he must document the medical necessity of his treatment is unrealistic and unreasonable. It is thus an interference with his right to practice his chosen profession which violates the Fifth Amendment to the United States Constitution.

(1) Penalties for Noncompliance. Again, referring to Am. cur., we find these sanctions: page 4 (a) Denial of payment by PSRO; page 5 (b) . . . judicial review . . . is only available where the amount in controversy is $1,000 or more. (Sec. 1159); page 6 (c) Immunity for Civil Liability is offered. A careful reading of the language of this section discloses that this does not provide immunity.

and therefore is deceptive to the doctors charged with PSRO; page 7 (d) Exclusion of physician from provision of services (Sec. 1160(b)), or (e) Payment of $5,000 (recovery clause); (f) Pressure on physician from other governmental agencies authorized (Sec. 1160(c)).

(2) Summary: PSRO introduces and requires, under penalty of fines and suspensions, a new and foreign philosophy of medical care in America; that henceforth, the care, diagnosis and treatment for private citizens by the private doctors shall comply with government rulebooks of medical care as approved by PSRO and the Secretary of HEW for beneficiaries of Social Security programs. (Sec. 1160)

PSRO is unethical. "In complying with PSRO, the doctor would act contrary to Sec. 6 of the Code of Medical Ethics which states, 'A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care'." (CMS PSRO Book, page 18)

C. The "Norms" for Medical Care

As an example of the norms for Medical Care, we refer to the Testimony of the San Joaquin Foundation for Medical Care.

At this point we introduce as part of our Testimony, the CMS "PSRO" book. On page 29 we find the Treatment for the Common Cold. The cost of Treating "Colds" under USRO could be $34 Billion!

CMS believes that such criteria are unscientific and inhumane and an unacceptable substitute for personal, individualized care.

D. The concept of "medical necessity"

This PSRO concept is a rationing device against which one must provide justification by objective documentation. But we submit the medical profession treats suffering, and disabled patients, not merely "disease by age and diagnosis", and documentation of "medical necessity" in many of these cases is impossible.

E. PSRO is defective as it is a contravention of Section 1801 of the SSA. (Am. cur. page 9)

F. The PRL will engender an unreasonable invasion of the right of privacy protected by the Ninth Amendment of the United States Constitution. (Am. cur. page 21)

IV. REQUIRED ACQUIESENCE BY CO-PRACTITIONERS IN PSRO UNDULY INFRINGES ON PATIENTS' AND PHYSICIANS' RIGHTS

To review Supreme Court Decisions applicable to PSRO we refer to Addendum A beginning on page 27 of the Am. cur. The United States Supreme Court in the case of *Doe* v. *Bolton*, 410 U.S. Rep. 179 (1973), said at page 199 (Am. cur. page 28).

"If a physician is licensed by the State, he is recognized by the State as capable of exercising acceptable clinical judgment. If he fails in this, professional censure and deprivation of his license are available remedies. Required acquiescence by co-practitioners has no rational connection with a patient's needs and unduly infringes on the physician's right to practice."

When Justice Blackmun said "required acquiescence by co-practitioners has no rational connection with a patient's needs and unduly infringes on the physician's right to practice," he struck a constitutional death knell for the PSRL. Taken literally, the PSRL does not require "acquiescence by co-practitioners" as a condition precedent to the delivery of health care by practitioners. But by the creation of norms of care and by penalizing a physician by making him substantiate the medical necessity for deviation therefrom, and by the creation and attempted enforcement of the illusory and unrealistic concept of medical necessity be reference to these norms, the PSRL in effect creates indirectly, but unmistakably, the same requirement that Mr. Justice Blackmun said infringes on the physician's right to practice. In effect, the PSRL does require "acquiescence by co-practitioners." For it is co-practitioners who will formulate these norms. It is co-practitioners who will evaluate whether a physician's services were rendered in accordance with these norms. And it is co-practitioners who will decide, often in retrospect, whether or not the services rendered by the physician were medically necessary. It is co-practitioners who will advise whether or not a physician

should be removed from the right to practice and/or whether or not be should be fined under the PSRL. (Am. cur. page 29)

Earlier in his opinion, at page 198, Mr. Justice Blackmun concluded ". . . that the interposition of the hospital abortion committee is unduly restrictive of the patient's rights and needs . . ."

(Am cur. page 30) In his concurring opinion Mr. Justice Douglas said that: "The right of privacy has no more conspicuous place than in the physician-patient relationship, unless it be in the priest-penitent relation."

Mr. Justice Douglas then went on to say: "It is one thing for a patient to agree that her physician may consult with another physician about her case. It is quite a different matter for the State compulsorily to impose on that physician-patient relationship another layer or, as in this case, still a third layer of physicians. The right of privacy—the right to care for one's health and person and to seek out a physician of one's own choice protected by the Fourteenth Amendment—becomes only a matter of theory, not a reality, when a multiple-physician-approval system is mandated by the State."

(Am. cur. page 31) Justice Douglas' statement that: "The right to seek advice on one's health and the right to place reliance on the physician of one's choice are basic to Fourteenth Amendment values. . . ."

As repeatedly stated, the over-all effect of the PSRL is to deny this fundamental right.

In summary, the PSRL stands in direct contravention to principles uttered with force and with certainty by the United States Supreme Court, as recently as January of 1973.

V. WHY, PSRO?

This law was designed to assure quality, to lower costs and to control fraud and overutilization. From our extensive data, briefly summarized on pages 6 and 7 of the "PSRO" book, the following conclusions obtain:

A. *PSRO will lower the quality of medical care*, as a dehumanized, numerical system with Federal rules which will stifle innovation and reward conformity.

B. *PSRO is certain to escalate costs.* PSRO will create a vast, new bureaucracy, with an initial cost of 0.1 billion dollars.

C. *Fraud by the Medical Profession* is shown to be insignificant by the government's own figures. PSRO provides a legal framework for fraud, for those who would carefully fit the guidelines.

D. *Certification on demand in PSRO* is based on Medicare certification which has been proven a failure in Medicare.

E. *There is no economic justification for PSRO.* "Medical Care" has increased the same as all other services in a recent 12-year period (1957–69).

VI. PSRO WILL CREATE A LARGE, NEW, EXPENSIVE AND UNNECESSARY BUREAUCRACY CERTAIN TO INCREASE TAXES

A. Experience with seven EMCROs (HEW Publication No. HSM 110–72–269) shows that Federal programs do not justify any expectation of savings.

B. Experiences from San Joaquin, Utah, Maricopa and other Foundations have thus far yielded no hard data on true savings vs. full costs. CMS recommends an independent audit of these foundations concerning their claims of savings.

C. Experience of "HASP Foundation" (Hospital Admissions Surveillance Program) in Illinois: $4 were spent for every dollar saved.

D. Maricopa figures show the cost of peer review is 3% of the claim dollar. In the review of the 90 billion dollar health care system this would be $2.7 billion. If physicians' fees alone are reviewed the cost is $0.54 billion.

VII. PSRO IS NOT PEER REVIEW. IT IS FISCAL REVIEW AND CONTROL. IT UNDERMINES TRUE PEER REVIEW.

Peer Review was initiated by Medicine as a mechanism for internal quality control, for continuing education of the profession and for the improvement of patient care. This Peer Review function can only exist when performed by the medical profession, and ceases to exist when third parties are involved. The contamination of this mechanism by the introduction of primarily financial goals of a third party destroys the very nature of peer review. Peer Review proceedings must remain confidential, performed only by designated representatives of the medical institutions, and are not to be made available to third parties or their representatives.

Senator Carl T. Curtis (R-Nebr.) has phrased the definition of Fiscal Review properly when he stated in his address to CMS, February 5, 1974:

"Many people were drawn into supporting PSRO because they felt they were supporting a proposal for peer review in the medical profession."

PSRO is not "peer". It is government review, regulation and control of the practice of medicine. I hold in my hand the public law which was originally designated as H.R. 1 and which contains this PSRO provision. It is 17 pages long, in fine print. It begins on page 101 and extends to page 117.

We have marked every place in these 17 pages where the Secretary of Health, Education, and Welfare is authorized to take action to make a decision or formulate regulations. These delegations of power in the 17 pages number 68.

Now when power is delegated to the Secretary of HEW, it is well known that the Secretary cannot personally exercise that power. It means the delegation of power to an unnamed, unelected, and oftentimes uncontrollable bureaucracy."

There is no alternative or substitute for True peer review: This is review by competent peers on a voluntary basis for educational purposes, for quality control on an individual basis. Fiscal review in PSRO and "Foundations" is 95% "computer-and-nurse-review", for cost control decisions of "pay-no-pay". This is sham review. These are all devices to avoid peer review.

VIII. WHAT IS THE LEGITIMATE ALTERNATIVE TO PSRO?

A. Repeal PSRO.

B. Establish prototype PSROs in the Federal system of hospitals (Veterans, Public Health Service). Such a massive restructuring of the medical care system as contemplated in PSRO should not be applied on a nationwide scale. The failure of such a system—and it is likely to fail—may have disastrous consequences. Therefore a prototype program in a well controlled system on a limited basis is the reasonable course. A system of regular and full cost-accounting should be made, so that the costs may be compared reliably with the private system.

C. For the purposes of Medicare, establishment of a "Federal Program Benefits Adjudication Board", whose function would be to clearly define the benefits to which the patient is entitled under the law; to inform the patient of these benefits; and to adjust yearly these benefits, based on adequate fiscal principles and actuarial data.

Thank you, Mr. Chairman.

BIBLIOGRAPHY

1. American CMS: "PSRO"—Council of Medical Staffs, Third Edition, Revised, May 1, 1973. CMS Press.
2. American CMS: Testimony of the Council of Medical Staffs Before U.S. Senate Committee on Finance on The Social Security Amendment of 1970, H.R. 17550 and Amendment 851 on Medicare and Medicaid, September 16, 1971
3. American CMS: A Report of the Medical Staff Liaison Committee of the NOAHPC to the Executive Committee on the U.S. Public Health Service Hospital Proposals, August 25, 1971
4. American CMS: Testimony of the Council of Medical Staffs (American Association of Councils of Medical Staffs of Private Hospitals, Inc.), Before U.S. Senate Committee on Finance on H.R. 1, February 9, 1972
5. Decker, Barry, M.D. and Bonner, Paul: PSRO: Organization for Regional Peer Review; Ballinger Publishing Company, Cambridge, Mass., 1973. Developed by Arthur D. Little & Co.
6. American CMS: Memorandum on Behalf of American Association of Councils of Medical Staffs of Private Hospitals, Inc., Amicus Curiae in Opposition to Defendant's Motion for Summary Judgment; U.S. District Court Northern District of Illinois Eastern Division; Association of American Physicians and Surgeons etc., et al., vs. Caspar W. Weinberger, Secretary of The United States Department of Health, Education, and Welfare, an Agency of the Federal Government, No. 73 C 1653; 1973
7. Utah UPRO: Dr. F. Michael Smith, Jr. and Dr. Elmo C. Boyd Report. Personal correspondence.
8. Myers, Robert J., "Medicare", Bryn Mawr: McCahan Foundation, February, 1970

9. Maricopa Foundation for Medical Care—CMS personal visit.
10. American CMS: Fact Sheet—The Seven Deadly Deceptions of the "Health Crisis" Fact Sheet No. 3 1973
11. American CMS: Statement to the Administration of the Social and Rehabilitation Service, Department H.E.W., Opposing the Proposed Certification Regulation Change in Medicaid of March 1971, by the American Association of Councils of Medical Staffs of Private Hospital, Inc., June 1971
12. American CMS: Statement on Certification, Feb., 1970
13. Department of HEW: Community Profile Data Center Technical Report, "The Cost of Standard Medical Services Under Alternative Delivery Systems", Roslyn Smith, James Snowden and Royal A. Crystal, October 1972
14. Department of HEW Publication No. HSM 110-72-269
15. San Joaquin and Sacramento Foundations Testimony, 1970 Hearings Before The Subcommittee On Medicare-Medicaid, April-June 1970

UNITED STATES DISTRICT COURT, NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION

No. 73 C 1653

ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, ETC., ET AL., PLAINTIFFS,

v.

CASPAR W. WEINBERGER, SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, AN AGENCY OF THE FEDERAL GOVERNMENT, DEFENDANT.

MEMORANDUM ON BEHALF OF AMERICAN ASSOCIATION OF COUNCILS OF MEDICAL STAFFS OF PRIVATE HOSPITALS, INC., AMICUS CURIAE IN OPPOSITION TO DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

CONTENTS

TABLE OF EXHIBITS

ENCLOSURES

1. The CMS PSRO booklet.
2. The CMS statement of council of medical staffs to the House Armed Services Committee on House bills 7480, 7733, 8014, and 9991 (Re: Health Maintenance Organizations) September, 1973.
3. Testimony of the CMS before U.S. Senate Committee on Finance on H.R. 1, February 9, 1972.
4. CMS handbook.
5. Testimony of the CMS before U.S. Senate Committee on Finance on the Social Security amendment of 1970, H.R. 17550 and Amendment 851 on Medicare and Medicaid, September 16, 1970.
6. Report of the Medical Staff Liaison Committee of the New Orleans Area Health Planning Commission to the Executive Committee on the U.S. Public Service hospital proposals, August 25, 1971.
7. Statement on certification by Jose L. Garcia Oller, M.D., president, American CMS.
8. Statement to the Administration of the Social and Rehabilitation Service, Department H.E.W., opposing the proposed certification regulation change in Medicaid of March 1971, by the American Association of Councils of Medical Staffs of Private Hospitals, Inc., June 16, 1971.

INTRODUCTION

Plaintiffs, Association of American Physicians and Surgeons, et al, have sought (1) a declaratory judgment that paragraph (b) of Secton 249F of the "Social Security Amendments of 1972" (October 30, 1972, Pub. L. 92-603, Title II, § 249F (B), 86 Stat. 1429), a copy of which is annexed hereto, is unconstitutional on its face and (2) permanent injunctive relief restraining Defendant from implementing or enforcing the provisions of said legislation.

Section 249F, Public Law 92-603, is now part B of Title II of the Social Security Act. For purpose of this amicus curiae brief, this law will be referred to as the Professional Standards Review Law (hereinafter PSRL).

The American Association of Councils of Medical Staffs of Private Hospitals (American CMS) as amicus curiae desires to submit a memorandum of law for the Court's consideration in the above matter. American CMS is a national organization with chapters in 29 states and representing approximately 34,000 physicians and osteopaths engaged in the private practice of medicine. It is incorporated under the laws of the State of Delaware.

BASIS FOR RELIEF

I. The PSRL is violative of the fifth amendment to the United States Constitution.

The United States Supreme Court in the case of *Greene* v. *McElroy*, 360 U.S. 474, 79 S.Ct. 1400 (1959), said: "the right to hold specific private employment and to follow a chosen profession free from unreasonable government interference comes within the 'liberty' and 'property' concepts of the provisions of the Fifth Amendment."

This utterance was not an isolated one. It followed a long line of decisions hallmarking the respect of the highest court in this land for the right of an American to pursue his chosen profession. *Schware* v. *Board of Bar Examiners*, 353 U.S. 232 (1956); *Slochover* v. *Board of Education*, 350 U.S. 551 (1955); *Peters* v. *Hobby*, 349 U.S. 331, 352 (1954); *Truax* v. *Raiche*, 239 U.S. 33, 41 (1915); *Allgeyer* v. *Louisiana*, 165 U.S. 578, 589-590 (1896); *Dent* v. *West Virginia*, 129 U.S. 114 (1889); *Powell* v. *Pennsylvania*, 127 U.S. 678, 684 (1887).

In the case of *People* v. *Dobbs Ferry Medical Pavilion, Inc.*, 33 N.Y. 2d 584 (1973), the Court of Appeals of New York affirmed a lower court ruling that a certain statute was unconstitutionally broad. En route to its decision the lower court cited *Greene* v. *McElroy*, *supra*, as authority for the position that the right to practice a profession free of unreasonable government interference is protected by the Constitution of the United States.

In the case of *Meyer* v. *Nebraska*, 262 U.S. 390, 43 S.Ct. 625 (1923), the Supreme Court discussed the meaning of liberty. Although the issue in that case arose out of the Fourteenth Amendment, the Court's comments are pertinent here since that provision of the Fourteenth Amendment is designed to afford indi-

viduals protection from state encroachments similar to the kind protected by the equivalent provision of the Fifth Amendment.

"While this Court has not attempted to define with exactness the liberty thus guaranteed, the term has received much consideration and some of the included things have been definitely stated. Without doubt, it denotes not merely freedom from bodily restraint but also the right . . . to contract, to engage in any of the common occupations of life, to acquire useful knowledge . . . The established doctrine is that this liberty may not be interfered with, under the guise of protecting the public interest, by legislative action which is arbitrary or without reasonable relation to some purpose within the competency of the State to effect . . ."

The precise issue for consideration by this Court, then, is this: Does the PSRL, in whole or in any of its provisions, constitute an unreasonable interference with the right of a physician to engage in the private practice of medicine? If it does, then it stands in contravention of the Fifth Amendment and should be declared unconstitutional.

In support of its position that the PSRL does constitute such an unreasonable interference by the government, American CMS offers the following propositions and proofs.

A. The PSRL contains provisions which on their face will severely impede the exercise of skill and judgment which is essential to delivery of high quality medical care.

Section 1156(a) orders each Professional Standards Review Organization (hereafter PSRO) to "apply professionally developed norms of care, diagnosis, and treatment based upon typical patterns of practice . . ."

Section 1156(c)(1) directs the National Professional Standards Review Council to distribute "to each PSRO . . . appropriate materials indicating the regional norms to be utilized . . ."

Section 1156(c)(2) directs each PSRO to utilize these norms "as a principal point of evaluation and review for determining . . . whether . . . care and services are consistent with the criteria specified in section 1155(a)(1)."

Section 1155(a)(1) makes it the duty of each PSRO to "assume responsibility for review of the professional activities . . . of physicians . . . in the provision of health care services and items for which payment may be made (in whole or in part) under this Act (Social Security Act) for the purpose of determining whether

"(A) such services and items are or were medically necessary: (B) the quality of such services meets professionally recognized standards of health care; and (C) in case such services and items are proposed to be provided in a hospital or other health care facility on an inpatient basis, such services and items could, consistent with the provision of appropriate medical care, be effectively provided on an outpatient basis or more economically in an inpatient health care facility of a different type."

It is argued that the doctor is not compelled to adhere to these prefabricated norms of care, diagnosis, and treatment; that these norms are mere guides for evaluation of his services.

They are more than that. By the very language of the statute, these norms are "principal point(s) of evaluation" of the necessity and quality of a doctor's care. And Section 1151 says that "it is the purpose of this part to assure . . . that the services . . . conform to appropriate professional standards . . ."

Furthermore, an examination of several other sections of the PSRL reveal subtle penalties for non-compliance. Should the physician deviate from the norms, he subjects himself to possible PSRO disapproval, and a possible denial of payment for the services he has rendered. If he chooses, he is entitled to reconsideration of an adverse determination in accordance with Section 1159(a) and 1159(b):

"Sec. 1159. (a) Any beneficiary or recipient who is entitled to benefits under this Act (other than Title V) or a provider or practitioner who is dissatisfied with a determination with respect to a claim made by a Professional Standards Review Organization in carrying out its responsibilities for the review of professional activities in accordance with paragraphs (1) and (2) of section 1155(a) shall, after being notified of such determination, be entitled to a reconsideration thereof by the Professional Standards Review Organization and, where the Professional Standards Review Organization reaffirms such determination in a State which has established a Statewide Professional Standards Review Council, and where the matter in controversy is $100 or more, such determination shall

be reviewed by professional members of such Council and, if the Council so determined, revised.

"(b) Where the determination of the Statewide Professional Standards Review Council is adverse to the beneficiary or recipient (or, in the absence of such Council in a State and where the matter in controversy is $100 or more), such beneficiary or recipient shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and, where the amount in controversy is $1,000 or more, to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). The Secretary will render a decision only after appropriate professional consultation on the matter."

But the complexity of these procedures and the spectre of having to endure them in order to receive payment for services rendered creates a subtle but undeniable compulsion to adhere to the norms rather than the vast training and experience of the physician—to serve the administrative interest of government rather than the best interests of the sick.

Examination of these procedures reveals that judicial review of a determination adverse to the doctor is only available where the amount in controversy is $1,000 or more. But in the Medical Tribune of May, 1973, figures compiled by the National Center for Health Statistics showed that only 1.1% of the population experienced physicians expenses in excess of $500. Presumably the percentage is smaller for amounts in excess of $1,000. It is thus apparent that to deny judicial review where the amount in controversy is less than $1,000 is to lock the courtroom door on the medical profession. On its face, this provision does havoc to substantial due process of law.

There are several other sections which contribute in varying degrees to subservience to these norms rather than to the needs of the patient.

Section 1167(c) says: "(c) No doctor of medicine or osteopathy and no provider (including directors, trustees, employees, or officials thereof) of health care services shall be civilly liable to any person under any law of the United States or of any State (or political subdivision thereof) on account of any action taken by him in compliance with or reliance upon professionally developed norms of care and treatment applied by a Professional Standards Review Organization (which has been designated in accordance with section 1152(b)(1)(A)) operating in the area where such doctor of medicine or osteopathy or provider took such action but only if "(1) he takes such action (in the case of a health care practitioner) in the exercise of his profession as a doctor of medicine or osteopathy (or in the case of a provider of health care services) in the exercise of his functions as a provider of health care services, and (2) he exercised due care in all professional conduct taken or directed by him and reasonably related to, and resulting from, the actions taken in compliance with or reliance upon such professionally accepted norms of care and treatment."

Section 1160(b) subjects the physician to the possibility of either being excluded from eligibility to provide medical services on a reimbursable basis, or in lieu thereof, to payment by the physician of $5,000.00. While deviation from the norm per se is not ground for incurring these penalties, their severity provides an unmistakable admonition.

And section 1160(c) gives each statewide PSRO "such authority . . . to enlist the support of any . . . governmental organization having influence or authority over health care practitioners . . . in assuring that each practitioner . . . shall comply with all obligations imposed on him."

Section 1156(d) compounds the pressure on the physicians to serve the government's interest rather than that of his patient. This section attempts to reduce length of hospital stay by requiring certification by the physician of the continued need of his patient for hospital care—in accordance with norms developed for this purpose—and "usually not later than the 50th percentile of lengths-of-stay for patients in similar diagnosis."

Section 1156(d) says: (d)(1) Each Professional Standards Review Organization shall—"(A) in accordance with regulations of the Secretary, specify the appropriate points in time after the admission of a patient for inpatient care in a health care institution, at which the physician attending such patient shall execute a certification stating that further inpatient care in such institution will be medically necessary effectively to meet the health care needs of such patient; and (B) require that there be included in any such certification with respect to any patient such information as may be necessary to enable such organization properly to evaluate the medical necessity of the further institu-

tional health care recommended by the physician executing such certification.

"(2) The points in time at which any such certification will be required (usually, not later than the 50th percentile of lengths-of-stay for patients in similar age groups with similar diagnoses) shall be consistent with and based on professionally developed norms of care and treatment and data developed with respect to length of stay in health care institutions of patients having various illnesses, injuries, or health conditions, and requiring various types of health care services or procedures."

Thus, the PSRL implements a vast administrative network of medical norms, evaluation of physicians based thereon, and procedures for review thereof—all tending to impede the judgment of men and women whose mission heretofore has been to serve the sick. In its stead, this law gives birth to a patient who must be served before all others—the government. The doctor can, of course, treat his other patients first, but if he does, he undertakes the risk of enduring the administrative nightmares of the PSRL.

The PSRL further interferes with the right of a physician to practice his profession by creation and enforcement of the concept of medical necessity. Section 1160(a)(1)(A). Realistically, medical necessity is an artificial concept which at most can only be applied to obvious cases—broken bones, enlarged livers, measles, to name a few. But inherent in the enforcement of "medical necessity" is a rejection of the well-established fact that many symptoms of suffering are either psychosomatic or contain no documentable evidence of disease. The life of a doctor is devoted to relieving suffering. To require that every time a doctor relieves suffering he must document the medical necessity of his treatment is unrealistic and unreasonable. It is thus an interference with his right to practice his chosen profession which violates the Fifth Amendment to the United States Constitution.

But it has been advanced that physicians need not choose to care for patients whose treatment is affected by this legislation. The absurdity of this position is obvious. Imagine if physicians collectively decided to refuse to treat Medicare and Medicaid patients. Medicare alone has in excess of 20,000,000 eligible persons while Medicaid has an estimated additional 15,000,000. ("'73 Socio-Economic Issues of Health" publication of the American Medical Association). Physicians themselves would be hurt financially but more importantly, the patients would suffer the denial of their right to the physicians of their choice.

The PSRL is further defective in that it stands in direct contravention of Section 1801 of the Social Security Act. Section 1801 is crucial to the overall spirit of the Act and reads as follows: "Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure or compensation of any . . . person providing health services, or to exercise any supervision or control over . . . such . . . person."

B. There is no justifiable need for the PSRL. Its stated purpose, in Section 1151, is to assure that services for which government payment may be made will conform to appropriate professional standards and that payment for such services will be made:

"(1) only when, and to the extent, medically necessary, as determined in the exercise of reasonable limits of professional discretion; and

"(2) in the case of services provided by a hospital or other health care facility on an inpatient basis, only when and for such period as such services cannot, consistent with professionally recognized health care standards, effectively be provided on an outpatient basis or more economically in an inpatient health care facility of a different type, as determined in the exercise of reasonable limits of professional discretion."

The implication here is impossible to overlook: that there is a need to assure that doctors only prescribe care which is medically necessary and in the most economical way.

That medical necessity is often undocumentable is clear. Equally apparent is the fact that doctors have no personal financial stake in whether a patient is treated on an inpatient or outpatient basis.

So this verbiage constructs a need which is at most theoretical.

The medical profession is highly skilled and already well policed; it needs no further regulation.

First, let us review the background of the person whose training the law seeks to regulate and normalize.

1. A doctor must complete 3 to 4 years of college with high grades.
2. Because there are only about one-half as many student positions in medical schools as students who wish to attend, only the most eligible applicants with the highest qualifications are admitted to medical school.
3. Four years of medical school are required for an M.D.
4. One year of internship in a hospital is required before examination for license.
5. "State Licensing Board" examination is required before a license to practice is issued.
6. If the doctor is to become a specialist, an additional three to five years is required in most fields.
7. An American Board Specialty Examination is required to be a "Board Specialist".
8. In some fields, two years practice are required before eligibility for the Specialty Board Certificate.
9. And finally, at any time, in his lifetime, because of malpractice, moral turpitude, criminal action or addiction, the State Board may remove his license to practice.

And now let us consider the elaborate system of peer review already existing within the medical community:

1. Local and state Medical Societies have ethical grievance committees to review professional conduct and fees.
2. Hospital Medical Staff Peer Review includes the following committees of doctors reviewing and judging each other's work:
(a) Medical Record Committee: review documentation for the treatment rendered.
(b) Surgical-Tissue Committees: reviews the report of the specimens for every operation performed. The tissue removed is compared with the diagnosis and operation made, to determine the appropriateness and necessity of the operation.
(c) Utilization Review Committees: review patient care, and all physicians in the hospital, to insure efficient utilization of available facilities and to review costs and timeliness of care.
(d) Emergency Admissions Committees: review necessity and appropriateness of these admissions and treatment.
(e) Credentials Committee: reviews physician's qualifications for Staff privileges.
(f) Infections Committee: reviews infections in hospitalized patients to prevent spread to other patients and supervises control measures.
(g) Transfusions Committee: monitors transfusion reactions.
(h) Emergency Preparedness Committees: (Disaster Committee).
(i) Regular Staff Conferences: to review morbidity, mortality, and patient care policies.
3. Over and above this private peer review system, the Federal Government has superimposed another system of computer review conducted by government Medicare carriers. Briefly, that system is as follows:
(a) All Medicare-Medicaid charges in hospitals and in offices are fed into a computer (Blue Cross, Blue Shield, others).
(b) A "Profile" in the computer is kept for every physician: every treatment given, all drugs prescribed, all procedures performed.
(c) The "Doctor Profile" is matched against his current services.
(d) The Profile is matched against all other doctors in his specialty or service.
(e) Standardized Treatment Norms for medical care of diseases, in and out of hospital, number of visits, consultation procedures, surgery indicated, are in the computer and all doctors are matched against these norms.
(f) Medicare clerks match doctor practices against these norms as to charges, frequency of treatment and "medical necessity".
(g) Length of stay of patients as to diagnosis and age are matched against computerized books ("Professional Activity Study of the Commission on Professional and Hospital Activities," Ann Arbor, Michigan, 1973).
(h) Physicians, hospitals, and patients are now regularly notified by Medicare clerks: 1. Whether the hospitalization was "necessary". 2. Whether the treatment was necessary. 3. Whether the injections, medications were excessive. 4. Whether the visits were excessive in frequency. 5. Whether the charges were "more than usual, reasonable and customary," and 6. Medical Medicare peer review con-

sultants are used to review cases spun out by computers where the clerk review needs review.

That physicians do not need further regulation is evidenced by the virtual absence of abuse of federal reimbursement under the Medicare Program. Documentation supplied by the Department of Health, Education and Welfare, Social Security Administration, at request of the American CMS, reveals that from January 1966 to July 1972, only 23 physicians were convicted for Medicare fraud in all 50 states—an average of about 3.83 per year in the entire United States (See Exhibit A). The significance of this very low conviction rate is also enhanced by the fact that across the United States, there is an average of 6.5 visits per Medicare patient per year. There were no prosecutions for Medicare fraud from 1966 to 1969.

And physicians costs have remained relatively stable.

The New York Times of March 25, 1973, reported that from January to February 1973, the cost of medical care rose only 0.1%, while food rose 2.4% and reading and recreation 0.4%. Testimony of the American CMS before the United States Senate Committee on Finance, September 16, 1970, revealed that in the 12-year period from 1956 to 1968 physicians fees rose annually at an average rate of 3.7% while wages rose 4.2%.

Medical costs have not risen any higher than the general cost of other services. Note that medical care is a service and not a commodity (See Exhibit B).

Substantial evidence for the proposition that the private practice of medicine needs no further regulation can be found by comparing the average cost of stay in a private hospital to that in a federal hospital (see Appendix C). An examination of these figures reveals unquestionably that private medicine has held costs down vastly lower than hospitals run by the federal government.

The median cost of a first office visit to a private general practitioner in 1971 was $8.00. This figure remained *the same* in 1972 and 1973. Medical Economics, January 7, 1974. But the 1972 U.S.V.A. "Budget in Brief" revealed that the cost of a visit to a V.A. Clinic office in 1966 averaged $24.00; in 1971, $35.00; in 1972, $40.00. Medical Economics, June 11, 1973, reported that "Average costs per medical visit are only about half as much in private fee-for-service offices as in the neighborhood health centers or the pre-paid group." This was based on an official HEW study ("The Cost of Standard Medical Services Under Alternative Delivery Systems," U.S. Department of Health, Education and Welfare, October 1972).

The May, 1973 Medical Tribune reported that "Out-of-pocket expenses for physician's services were incurred by 59% of the population during 1970. The cost averaged $80.00. All medical care costs averaged $209.00; the per capita cost was $83.00. Only 1.1% experienced cost for physician's services of $500.00 or more."

The AMA publication "'73 Socio Economic Issues of Health" reported that the average length of stay in private hospitals was 8.0 days while in federal hospitals an astounding 34.4 days.

The United States Supreme Court has itself recently indicated the lack of need of regulation of the medical profession by the government. In the recent case of *Roe* v. *Wade*, 410 U.S. 113, 93 S. Ct. 705, 733, said that "if an individual practitioner abuses the privilege of exercising proper medical judgment the usual remedies, judicial and intra-professional, are available."

C. The failure of existing programs shows that PSRL cannot work.

There are at least two mechanisms indicative of the inability of the PSRL to reduce the cost of medical care.

1. The Experimental Medical Care Review Organization program is a federally funded project similar to the PSRL. There are seven of these "EMCRO's" across the United States.

But Department of HEW Publication No. HSM 110-72-269 indicated that there is thus far no evidence that the EMCRO program has decreased the cost of medical care.

2. Section 1156(d) of the PSRL requires, of the physicians, mandatory certification of the need for further hospitalization, at points of time consistent with the "professionally developed norms".

But the experience of the now existing certification requirements has been that this mechanism has had no significant effect, if any at all, on patterns of hospital discharge. See Exhibit D. Vast research undertaken by the American CMS has shown that certification is unwarranted, unnecessary and ineffectual. See the attached documents on certification made by the American Association

of Councils of Medical Staffs of Private Hospitals, Dr. Jose L. Garcia Oller, President.

D. The PSRL sweeps unnecessarily broad in order to alleviate a problem which does not exist.

Time and time again, the Supreme Court has said that legislative enactments must be narrowly drawn to express only the legitimate state interests at stake. *Roe* v. *Wade*, *supra*; *Griswold* v. *Connecticut*, 381 U.S. 479, 481, 85 S. Ct. 1678 (1965); *Aptheker* v. *Secretary of State*, 378 U.S. 500, 508 (1964); *Cantwell* v. *Connecticut*, 310 U.S. 296, 307-308 (1940); see *Eisenstadt* v. *Baird*, 405 U.S. 438, 460, 463-464 (1972).

In light of our analyses of the alleged need for the PSRL, it is clear that a statute regulating the judgment of a physician every time he performs a reimbursable service sweeps without necessity into areas which violate a repeated message of the Supreme Court.

"Here we have a situation analogous to a conviction under a statute sweeping in a great variety of conduct under a general and indefinite characterization, and leaving to the executive and judicial branches too wide a discretion in its application." *Cantwell* v. *Connecticut*, *supra*.

E. Certain language of the PSRL is vague, in violation of the fifth amendment to the United States Constitution.

The United States Supreme Court in the case of *Lanzetta* v. *New Jersey*, 306 U.S. 451, 453, 59 S.Ct. 618, 619, (1939) said that a statute "which * * * requires the doing of an act in terms so vague that men of common intelligence must necessarily guess at its meaning and differ as to its application, violates the first essential of due process of law."

The term "medically necessary" in Section 1155(a)(1)(A), is vague. It is argued that reasonable men would not differ as to its application. But the fact that the PSRL requires a doctor to prove that his prescribed treatment was medically necessary speaks loudly for the conclusion that reasonable men *do* differ as to the meaning of this phrase.

The same can be said for the phrase "professionally recognized standards of health care" in part (B) of the same section. By admission of the authors of the PSRL, standards vary from region to region. See Section 1156(a). Thus, even reasonable men can only guess at what this phrase means and necessarily differ as to its application.

"Professionally recognized standards of medical care" is at most an illusory concept since medical care is administered on a personal and individual basis.

Section 1155(a)(1)(C) reads, as follows: "(C) in case such services and items are proposed to be provided in a hospital or other health care facility on an inpatient basis, such services and items could, consistent with the provision of appropriate medical care, be effectively provided on an outpatient basis or more economically in an inpatient health care facility of a different type."

"Appropriate" medical care could mean any one of several things. It could refer to that treatment which conforms to the standard norms. Or it could refer to treatment which is "correct" for that particular ailment. Unfortunately, the two are not necessarily one and the same.

Section 1155(a)(2)(B) gives the PSRO authority to determine "in the case of . . . any other health care service which will consist of extended or costly courses of treatment," whether such service was medically necessary, etc. The terms "extended" and "costly" are vague. Their meaning certainly varies at least according to income bracket and type of illness, and thus leaves men of common intelligence with no alternative other than to guess at their meaning.

Section 1156(a), in requiring the application of norms of care, diagnosis, and treatment, says that these norms shall be based upon "typical patterns of practice . . .". These norms are crucial to the enforcement of the PSRL. They are "principal points of evaluation and review." They are thus instrumental in determining whether a physician will be re-imbursed for his services. It would seem, then that the process of formulation of these norms must be carefully spelled out. But the PSRL only requires that they be based on "typical patterns of practice".

What is meant by "typical"? Could men of common intelligence differ as to its application? Does it mean the 50th percentile method of treatment? Or does it mean that method of treatment utilized in the majority of cases? Or in at least ninety per cent? Seventy-five per cent? Forty?

Section 1160(b)(1) reads, in pertinent part: ". . . if the Secretary determines that such practitioner or provider, in providing health care services over which

such organization has review responsibility and for which payment (in whole or in part) may be made under this Act has: "(A) by failing, in a substantial number of cases, substantially to comply with any obligation imposed on him under subsection (a), or "(B) by grossly and flagrantly violating any such obligation in one or more instances. "Demonstrated an unwillingness or a lack of ability substantially to comply with such obligations, he (in addition to any other sanction provided under law) may exclude (permanently for such period as the Secretary may prescribe) such practitioner or provider from eligibility to provide such services on a reimbursable basis."

The severity of exclusion from eligibility to provide re-imbursable services is undebatable. Certainly a physician is entitled to a more precise description of the conditions which will result in such a penalty. Failure to "substantially comply" in a "substantial number of cases" can only lead men of common intelligence to wonder when they've exposed themselves to sanction. The elusiveness of the terms invites years of administrative and judicial guess work—at the expense of both physician and patient.

Section 1160(b)(3), provides for the alternative sanction of a maximum $5,000.00 payment for care which was "medically improper or unnecessary". These two terms lead themselves to different meanings from patient to patient. They leave the physician with no alternative but to guess whether he will be able to convince a PSRO that at the time of the treatment and under the patient's medical circumstances at the time, that the services rendered were necessary and proper.

But, of course, if the physician followed the norms, he need not worry.

F. Government regulation of that which it subsidizes must be reasonable.

It is argued that the government can "regulate that which it subsidizes". *Wickard* v. *Filburn*, 311 U.S. 111, 131 (1942). This rule of reason is not absolute. It affords the government no protection where there is no subsidy. And even where there is subsidy it affords the government no protection if its method of regulating is unreasonable.

Examination of the Medicare program reveals that its participants voluntarily choose to pay monthly premiums in exchange for the health coverage thereunder. They are not, therefore, receiving a mere gratuity from the government when illness strikes and a portion of their bill is paid for them. They have paid for this coverage.

Even where there is subsidy, the government's method of regulation must pass constitutional muster. In the case of *United States* v. *Maciani*, 345 F. Supp. 325, 327 (1972), the district court, referring to *Fleming* v. *Nestor*, 363 U.S. 603, 80 S. Ct. 1367 (1960), said that. "The fact that payments made pursuant to an act of Congress are characterized as 'gratuties' does not totally immunize the Act from scrutiny under the Fifth Amendment. The interest of a recipient of such payments is 'of sufficient substance to fall within the protection from arbitrary government action afforded by the Due Process Clause.'"

By reason of all the foregoing, the PSRL creates an unreasonable interference with the professional private practice of medicine in violation of the Fifth Amendment to the United States Constitution. The government cannot, therefore, justify this interference by arguing that it is paying for it.

11. The PSRL will engender an unreasonable invasion of the right of privacy protected by the ninth amendment to the United States Constitution.

At the outset it is necessary to address the issue of whether or not physicians have standing to assert the unconstitutionality of this alleged invasion of privacy.

This issue was confronted squarely in the case of *Young Women's Christian Association of Princeton, New Jersey* v. *Kugler*, 342 F. Supp. 1048 (1972) Referring to *Griswold* v. *Connecticut*, *supra*, and *Barrows* v. *Jackson*, 346, U.S. 249, 257–258 (1952), the court in *Kugler* said at page 1055: "Moreover, the violations of their constitutional rights alleged by plaintiff-physician are closely interwoven with and inseparable from the allegations they make on behalf of their women patients for violations of their constitutional rights. The contention that the alleged rights to freely practice medicine according to the highest standard of medical practice, and to privacy in physician-patient relationships entitle physicians to advise and direct women patients concerning abortions, aid to perform abortions, is inextricably linked with and dependent upon adjudication of the alleged right to privacy or their patients in securing abortions. Thus, it is appropriate here to grant plaintiff-physicians standing to litigate the alleged deprivations of the constitutional rights of their women patients."

It thus appears without question that the issues involved in this alleged invasion of the right of privacy can be raised by physicians.

The right to privacy is not specifically mentioned in the Constitution. Several decisions of the United States Supreme Court, however, make it clear that there is a constitutionally protected right of privacy and that this right has existed from the inception of the Bill of Rights.

One such case is that of *Griswold* v. *Connecticut, supra*. In holding certain anti-contraceptives statutes unconstitutional as an unreasonable interference with the right of marital privacy. Justice Douglas, for the majority, cited the Ninth Amendment in his listing of constitutional provisions which mark out rights or zones of privacy through their penumbras. In his concurring opinion, Justice Goldberg, speaking for himself, Justice Brennan, and Justice Warren, said at pages 484–485: ". . . The language and history of the Ninth Amendment reveal that the Framers of the Constitution believed that there are additional fundamental rights, protected from governmental infringement, which exist alongside those fundamental rights specifically mentioned in the first eight constitutional amendments."

Justice Goldberg then went on to inquire whether or not the Ninth Amendment was properly invoked in considering the question of a right of privacy. In deciding that it was, he said, at pages 490–492:

"While this Court has had little occasion to interpret the Ninth Amendment, [footnote omitted], '[i]t cannot be presumed that any clause in the constitution is intended to be without effect.' Marbury v. Madison, 1 Cranch 137, 174 [2 L.Ed. 60]. In interpreting the Constitution, 'real effect should be given to all the words it uses.' Myers v. United States, 272 U.S. 52, 151 [47 S.Ct. 21, 31, 71 L.Ed. 160]. The Ninth Amendment to the Constitution may be regarded by some as a recent discovery and may be forgotten by others, but since 1791, it has been a basic part of the Constitution which we are sworn to uphold. To hold that a right so basic and fundamental and so deep-rooted in our society as the right of privacy in marriage may be infringed because that right is not guaranteed in so many words by the first eight amendments to the Constitution is to ignore the Ninth Amendment and to give it no effect whatsoever. Moreover, a judicial construction that this fundamental right is not protected by the Constitution because it is not mentioned in explicit terms by one of the first eight amendments or elsewhere in he Constitution would violate the Ninth Amendment, which specifically states that '[t]he enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people.'" (Emphasis in original)

Mr. Justice Goldberg then addressed the question of which rights are protected by the Ninth Amendment against unreasonable government interference. At page 493, he stated:

"In determining which rights are fundamental, judges are not left at large to decide cases in light of their personal and private notions. Rather, they must look to the 'traditions and [collective] conscience of our people' to determine whether a principle is 'so rooted [there] . . . as to be ranked as fundamental.' Snyder v. Massachusetts, 291 U.S. 97, 105 [54 S.Ct. 330, 332]. The inquiry is whether a right involved 'is of such a character that it cannot be denied without violating those "fundamental principles of liberty and justice which lie at the base of all our civil and political institutions." . . .' Powell v. Alabama, 287 U.S. 45, 67 [53 S.Ct. 55, 77 L. Ed. 1581.]"

Looking to the traditions and collective conscience of our people to determine whether the right of privacy in communications between physicians and patients is so rooted there as to be ranked as fundamental, we find that as early as 1829 the State of New York enacted into law (New York Revised Statutes 1829 Vol. II, Part III, C.7, Tit. 3, Art. 8 § 73.), a provision which in its original form reads:

"No person authorized to practice physic or surgery shall be allowed to disclose any information which he may have acquired in attending any patient, in a professional character, and which information was necessary to enable him to prescribe for such patient as a physician, or to do any act for him as a surgeon."

We also find that since then all but five (5) of the states have adopted similar legislation. (Medical Economics, February 18, 1974, page 87).

That the proper atmosphere for diagnosis and treatment demands strict privacy and confidentiality between physician and patient is unquestioned. The statutory physician-patient privilege "is founded on the ground of public policy to encourage full disclosures between physician and patient." In re *Myer*, 184 N.Y. 54, 76 N.E. 920. No less obvious are the consequences of compromise of the absolute trust which has veiled the doctor's office for a century and a half. But with the advent of federal and state participation in the distribution and financing of medical care, the shroud of confidentiality has been slit and torn.

Section 1155(a) of the PSRL reads, in pertinent part: "(4) Each Professional Standards Review Organization shall be responsible for the arranging for the maintenance of and the regular review of profiles of care and services received and provided with respect to patients, utilizing to the greatest extent practicable in such patient profiles, methods of coding which will provide maximum confidentiality as to patient identity and assure objective evaluation consistent with the purposes of this part. Profiles shall also be regularly reviewed on an ongoing basis with respect to each health care practitioner and provided to determine whether the care and services ordered or rendered are consistent with the criteria specified in clauses (A), (B), and (C) of paragraph (1)."

"The fact that the language directs each PSRO to "utilize to the greatest extent practicable" methods of coding which will provide confidentiality exposes the compromise of privacy inherent in the PSRL. It gives the PSRO leeway in an area where none is tolerable. It exposes the patient to a compromise of the confidential nature of his relationship with his doctor in those situations where administrative complications make privacy "impracticable".

The PSRL compounds its frustration of privacy by the provisions of Section 1155(b)(3) and 1155(b)(4), which authorize the area PSRO to: "(3) examine the pertinent records of any practitioner or provider of health care services with respect to which such organization has a responsibility for review under subsection (a)(1); and (4) inspect the facilities in which care is rendered or services provided (which are located in such area) of any practitioner or provider."

The fact that private insurers examine patient records as part of the claims-processing procedure cannot diminish the need for confidentiality. If an insurer examines a patient's record, it is because the patient voluntarily waived his right of privacy as part of his consideration for the insurance policy. But the PSRL inflicts an involuntary sacrifice of the privacy of a patient's medical records.

In the recent case of *Roe* v. *Wade*, supra, the Supreme Court, in striking as unconstitutional the Texas anti-abortion laws said that "where certain fundamental rights are involved . . . regulations limiting these rights may be justified only be a "compelling state interest". "The decision vindicates the right of the physician to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention . . ."

In light of our analysis, supra, of the complete absence of economic justification for the PSRL, the requisite compelling government interest is simply non-existent.

The PSRL must fall, because it invades a fundamental area of privacy without compelling justification, in violation of the Ninth Amendment to the United States Constitution.

ADDENDUM A

The United States Supreme Court in the historic case of *Dent* v. *West Virginia*, 129 U.S. Rep. 114 (1888) said at page 122: "Few professions require more careful preparation by one who seeks to enter it than that of medicine. It has to deal with all those subtle and mysterious influences upon which health and life depend, and requires not only a knowledge of the properties of vegetable and mineral substances, but of the human body in all its complicated parts, and their relation to each other, as well as their influence upon the mind. The physician must be able to detect readily the presence of disease, and prescribe appropriate remedies for its removal. Every one may have occasion to consult him, but comparatively few can judge of the qualifications of learning and skill which he possesses. Reliance must be placed upon the assurance given by his license, issued by an authority competent to judge in that respect, that he possesses the requisite qualifications. . . ."

Then the Supreme Court in the case of *United States* v. *Vutich*, 402 U.S. Rep. 62 at page 70, referring to the District of Columbia abortion law, said: "It would

be highly anomalous for a legislature to authorize abortions necessary for life or health and then to demand that a doctor, upon pain of one to ten years' imprisonment, bear the burden of providing that an abortion he performed fell within that category. Placing such a burden of proof on a doctor would be peculiarly inconsistent with society's notions of the responsibilities of the medical profession. Generally, doctors are encouraged by society's expectations, by the strictures of malpractice law and by their own professional standards to give their patients such treatment as is necessary to preserve their health. We are unable to believe that Congress intended that a physician be required to prove his innocence. . . ."

Citing both these cases, the United States Supreme Court in one of its famous abortion decisions, namely that of *Doe* v. *Bolton*, 410 U.S. Rep. 179 at page 200 said: "It is still true today that '[r]eliance must be placed upon the assurance given by his license, issued by an authority competent to judge in that respect, he [the physician] possesses the requisite qualifications'."

At page 199, Mr. Justice Blackmun had the following to say: "If a physician is licensed by the State, he is recognized by the State as capable or exercising acceptable clinical judgment. If he fails in this, professional censure and deprivation of his license are available remedies. Required acquiescence by co-practitioners has no rational connection with a patient's needs and unduly infringes on the physician's right to practice."

When Justice Blackmun said "required acquiescence by co-practitioners has no rational connection with a patient's needs and unduly infringes on the physician's right to practice," he struck a constitutional death knell for the PSRL. Taken literally, the PSRL does not require "acquiescence by co-practitioners" as a condition precedent to the delivery of health care by practitioners. But by the creation of norms of care and by penalizing a physician by making him substantiate the medical necessity for deviation therefrom, and by the creation and attempted enforcement o fthe illusory and unrealistic concept of medical necessity be reference to these norms, the PSRL in effect creates indirectly, but unmistakably, the same requirement that Mr. Justice Blackmun said infringes on the physician's right to practice. In effect, the PSRL does require "acquiescence by co-practitioners." For it is co-practitioners who will formulate these norms. It is co-practitioners who will evaluate whether a physician's services were rendered in accordance with these norms. And it is co-practitioners who will decide, often in retrospect, whether or not the service rendered by the physician were medically necessary. It is co-practitioners who will advise whether or not a physician should be removed from the right to practice and/or whether or not he should be fined under the PSRL.

In this atmosphere it is simple to see that physicians are being required to exercise the judgment of their co-practitioners rather than their own judgment. Again, as Mr. Justice Blackmun said, this has "no rational connection with a patient's needs and unduly infringes on the physician's right to practice."

Earlier in his opinion, at page 198, Mr. Justice Blackmun concluded ". . . that the interposition of the hospital abortion committee is unduly restrictive of the patient's rights and needs . . ."

It is true that the hospital abortion committee created by the statute attacked by Mr. Justice Blackmun had the power to deny an abortion. Although the review organizations established by the PSRL do not have the power to deny a patient admission to the hospital, nor can they refuse a patient treatment by a physician, they create an atmosphere which is certainly suggestive of these same results. In the case of an elective admission to the hospital, for instance, where the review committee decides that admission is not medically necessary under the norms, it will inform the patient and the physician that no payment of this is going to be made. The physician has already decided that hospitalization would be in the best interest of this patient but the PSRO says that the physician will not be paid. One can easily see that this could result in a decision by the patient against hospitalization and thus against a decision made by his physician in his best medical interest. It is thus clear that the interposition of a PSRO "is unduly restrictive of the patient's rights and needs. . . ."

In his concurring opinion, Justice Douglas analysed the Georgia abortion law in light of the right of privacy and the physician-patient relationship. In so doing, Mr. Justice Douglas said that: "The right of privacy has no more con-

spicuous place that in the physician-patient relationship, unless it be in the priest-penitent relation."

Mr. Justice Douglas then went on to say: "It is one thing for a patient to agree that her physician may consult with another physician about her case. It is quite a different matter for the State compulsorily to impose on that physician-patient relationship another layer or, as in this case, still a third layer of physicians. The right of privacy—the right to care for one's health and person and to seek out a physician of one's own choice protected by the Fourteenth Amendment—becomes only a matter of theory, not a reality, when a multiple-physician-approval system is mandated by the State."

Continuing his attack on the constitutionality of these statutes, Mr. Justice Douglas said: ". . . The good-faith decision of the patient's chosen physician is overridden and the final decision passed on to others in whose selection the patient has no part. THIS IS A TOTAL DESTRUCTION OF THE RIGHT OF PRIVACY BETWEEN PHYSICIAN AND PATIENT AND THE INTIMACY OF RELATION WHICH THAT ENTAILS." (Capitalization ours)

Once again, it is true that the PSRO cannot refuse a patient the services prescribed by his physician, at least in a literal interpretation of the provisions of the PSRL. As previously demonstrated though, the atmosphere engendered by the PSRL will undoubtedly lead to a denial, refusal, or choice against delivery of medical care in those circumstances where the medical necessity thereof is difficult or impossible to document. So in actuality, the good-faith decision of the patient's chosen physician is being overridden and the final decision is being passed on to others in whose selection the patient has no part. Thus, we have a substantial equivalent of what Mr. Justice Douglas referred to as a total destruction of the right of privacy between physician and patient.

A final blow to the constitutionality of the PSRL is found in Mr. Justice Douglas' statement that: "The right to seek advice on one's health and the right to place reliance on the physician of one's choice are basic to Fourteenth Amendment values. . . ."

As repeatedly stated, the over-all affect of the PSRL is to deny this fundamental right.

In summary, the PSRL stands in direct contravention to principles uttered with force and with certainty by the United States Supreme Court, as recently as January of 1973.

III. In summary, the Professional Standards Review Law violates the Constitution of the United States.

Because it will impede the free exercise by physicians of their skill and judgment acquired through years of training and experience, because it is legislation which is not needed, because it cannot work, because it sweeps unnecessarily broad, and because it is vague in its most crucial areas, this law constitutes an unreasonable interference with the right of physicians to engage in the private practice of medicine, in violation of the Fifth Amendment.

And because it violates without compelling government justification the privacy of physician-patient communication, this law violates the Ninth Amendment as interpreted by the United States Supreme Court: "Required acquiescence by co-practitioner's has no rational connection with a patient's needs and unduly infringes on the physician's right to practice."

The PSRL stands in direct contravention to principles uttered with force and with certainty by the United States Supreme Court, as recently as January of 1973.

EXHIBIT A

PROSECUTIONS FOR MEDICARE FRAUD
JANUARY 1969-JULY 1972
BY STATE, PROFESSIONAL CATEGORY, YEAR PROSECUTION UNDERTAKEN, DISPOSITION AND DATE

State	Professional Category	Criminal Information Filed or Indictment Obtained				Disposition and Date
		1969	1970	1971	1972	
Arizona	M.D.				x	Pending
Arizona	M.D.			x		Pending
Arkansas	M.D.	x				Acquittal 10/69
Arkansas	TXER			x		Conviction 5/72
California	D.P.M.			x		Conviction 12/71
California	M.D.		x			Acquittal 2/71
California	M.D.		x			Pending
California	M.D.			x		Conviction 12/71
California	M.D.		x			Dismissal 2/71
California	M.D.				x	Pending
California	D.S.C.			x		Conviction 3/72
California	M.D.		x			Conviction 6/70
California	AMB		x			Conviction 8/71
D.C.	OTH	x				Conviction 6/70
D.C.	OTH	x				Conviction 6/70
Florida	M.D.	x				Conviction 4/71

PROSECUTIONS FOR MEDICARE FRAUD
JANUARY 1969-JULY 1972
BY STATE, PROFESSIONAL CATEGORY, YEAR PROSECUTION UNDERTAKEN, DISPOSITION AND DATE

State	Professional Category	Criminal Information Filed or Indictment Obtained				Disposition and Date
		1969	1970	1971	1972	
Florida	M.D.			x		Pending
Florida	M.D.	x				Acquittal 4/71
Florida	M.D.		x			Conviction 10/70
Florida	D.S.C.		x			Conviction 1/71
Florida	M.D.	x				Pending
Florida	D.O.				x	Pending
Florida	M.D.			x		Conviction 10/71
Florida	D.O.			x		Conviction 6/71
Florida	M.D.	x				Conviction 4/71
Florida	M.D.			x		Pending
Florida	OTH	x				Acquittal 4/71
Florida	D.O.			x		Pending
Florida	M.D.		x			Dismissal 11/70
Florida	M.D.			x		Pending
Illinois	M.D.			x		Conviction 12/71
Indiana	M.D.	x				Dismissal 3/70
Indiana	M.D.				x	Pending

EXHIBIT A

PROSECUTIONS FOR MEDICARE FRAUD
JANUARY 1969-JULY 1972
BY STATE, PROFESSIONAL CATEGORY, YEAR PROSECUTION UNDERTAKEN, DISPOSITION AND DATE

State	Professional Category	Criminal Information Filed or Indictment Obtained				Disposition and Date	
		1969	1970	1971	1972		
Kentucky	M.D.			x		Conviction	11/71
Louisiana	M.D.		x			Dismissal	7/71
Louisiana	M.D.		x			Acquittal	1/71
Michigan	M.D.				x	Pending	
Michigan	M.D.				x	Pending	
Michigan	D.O.				x	Pending	
Michigan	M.D.				x	Pending	
Michigan	D.O.				x	Pending	
Michigan	D.O.				x	Pending	
Mississippi	M.D.	x				Conviction	8/69
Mississippi	M.D.			x		Conviction	11/71
Missouri	OTH				x	Conviction	8/72
Missouri	OTH				x	Conviction	8/72
Missouri	AMB				x	Pending	
New Jersey	M.D.			x		Conviction	11/71
New Jersey	M.D.			x		Conviction	4/72

PROSECUTIONS FOR MEDICARE FRAUD
JANUARY 1969-JULY 1972
BY STATE, PROFESSIONAL CATEGORY, YEAR PROSECUTION UNDERTAKEN, DISPOSITION AND DATE

State	Professional Category	Criminal Information Filed or Indictment Obtained				Disposition and Date	
		1969	1970	1971	1972		
New York	OTH				x	Pending	
New York	M.D.		x			Acquittal	2/71
New York	OTH				x	Pending	
Ohio	M.D.			x		Conviction	9/71
Oklahoma	D.O.				x	Pending	
Oklahoma	D.O.				x	Pending	
Oklahoma	AMB		x			Conviction	11/70
Oregon	OTH				x	Conviction	8/72
Pennsylvania	M.D.				x	Conviction	7/72
Pennsylvania	M.D.				x	Conviction	8/72
Pennsylvania	D.O.		x			Conviction	1/71
Pennsylvania	D.P.M.				x	Pending	
Pennsylvania	M.D.				x	Pending	
Pennsylvania	POD.D		x			Conviction	1/71
Pennsylvania	M.D.				x	Pending	
Pennsylvania	M.D.				x	Pending	

EXHIBIT A

PROSECUTIONS FOR MEDICARE FRAUD
JANUARY 1969-JULY 1972
BY STATE, PROFESSIONAL CATEGORY, YEAR PROSECUTION UNDERTAKEN, DISPOSITION AND DATE

State	Professional Category	Criminal Information Filed or Indictment Obtained				Disposition and Date	
		1969	1970	1971	1972		
Pennsylvania	M.D.				x	Pending	
Pennsylvania	D.S.C.			x		Conviction	5/72
Pennsylvania	D.O.			x		Conviction	7/71
Pennsylvania	D.O.			x		Conviction	8/71
Pennsylvania	D.O.		x			Conviction	4/71
Pennsylvania	D.O.			x		Conviction	4/72
Pennsylvania	M.D.				x	Pending	
Pennsylvania	M.D.			x		Pending	
Pennsylvania	D.S.C.		x			Conviction	10/70
Puerto Rico	M.D.			x		Pending	
South Carolina	M.D.	x				Conviction	12/69
South Carolina	OTH				x	Conviction	8/72
South Carolina	OTH				x	Conviction	8/72
South Dakota	M.D.		x			Pending	
Tennessee	M.D.		x			Conviction	3/71
Texas	M.D.				x	Pending	

PROSECUTIONS FOR MEDICARE FRAUD
JANUARY 1969-JULY 1972
BY STATE, PROFESSIONAL CATEGORY, YEAR PROSECUTION UNDERTAKEN, DISPOSITION AND DATE

State	Professional Category	Criminal Information Filed or Indictment Obtained				Disposition and Date	
		1969	1970	1971	1972		
Texas	M.D.				x	Pending	
Texas	M.D.			x		Dismissal	6/71
Texas	NHA				x	Pending	
Texas	NHA				x	Pending	
Texas	D.O.				x	Pending	
Virginia	M.D.				x	Acquittal	6/72
Virginia	M.D.		x			Nol Pros	6/70

EXHIBIT B

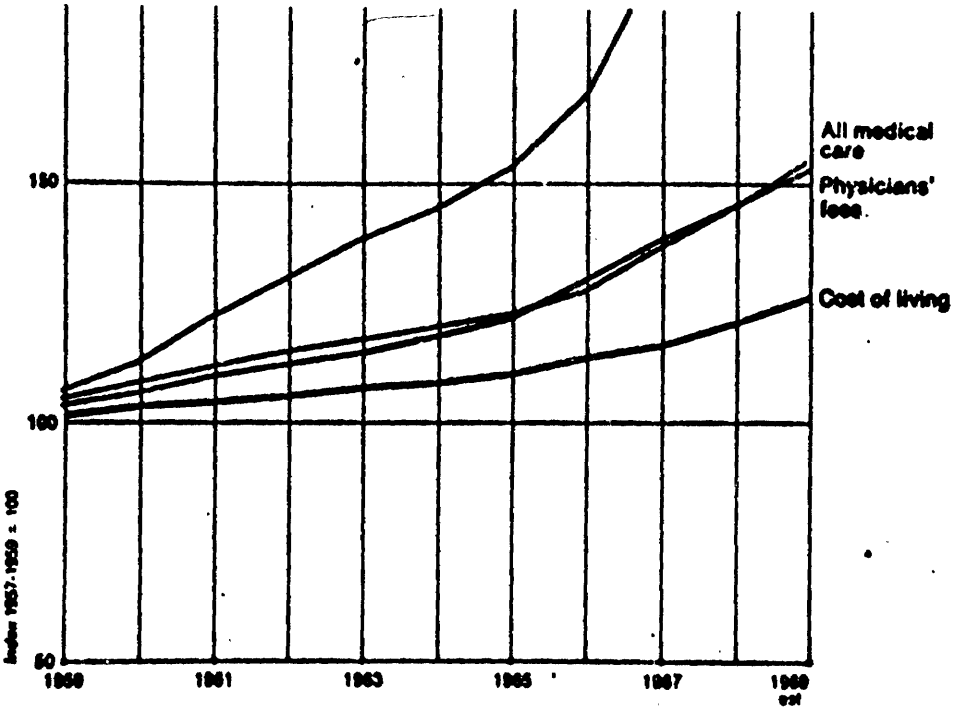
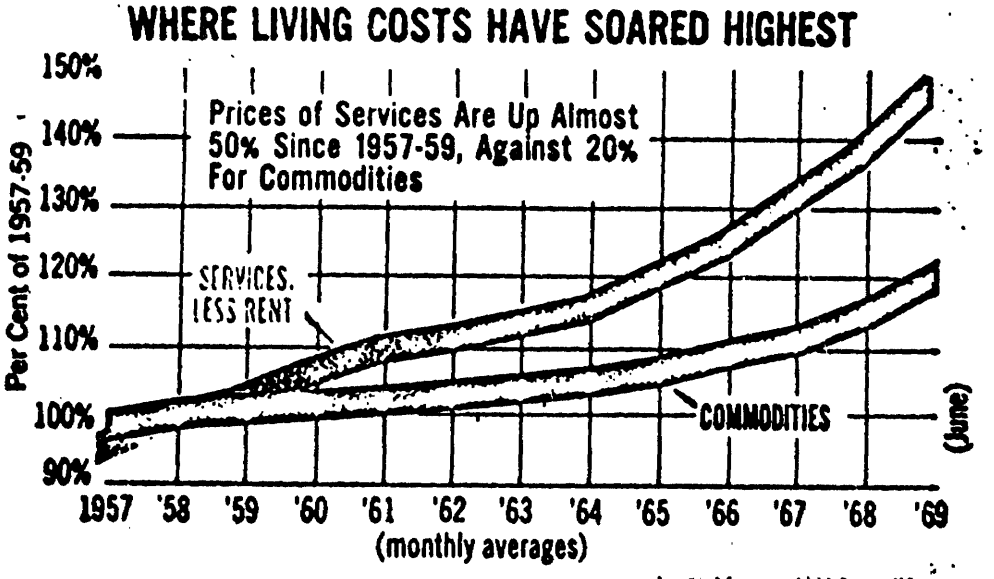


FIGURE 1



Source: Bureau of Labor Statistics, consumer price index

EXHIBIT C

Figure 1

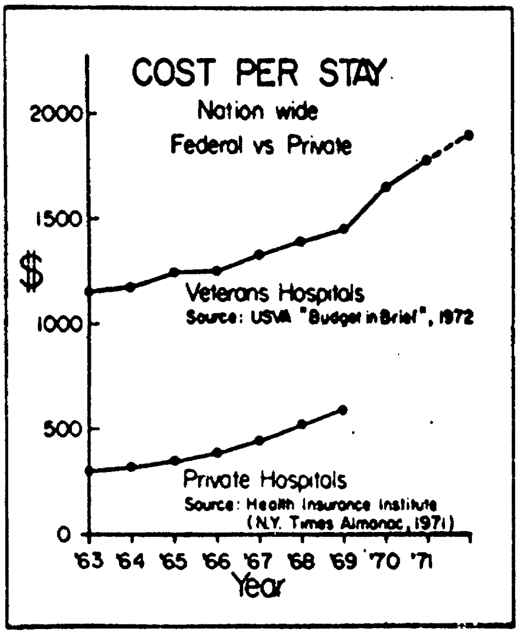


Figure 2

	[illegible]		[illegible]		[illegible]
[illegible]	[illegible]	x	[illegible] days	=	[illegible]
[illegible]	[illegible]	x	[illegible]	=	[illegible]
[illegible]	[illegible]	x	[illegible]	=	[illegible]
[illegible]	[illegible]	x	10.4	=	[illegible]
[illegible]	[illegible]	x	7.9	=	[illegible]
[illegible]	[illegible]	x	[illegible]	=	[illegible]
[illegible]	[illegible]	x	[illegible]	=	[illegible]
[illegible]	[illegible]	x	[illegible]	=	[illegible]
[illegible]	[illegible]	x	[illegible]	=	[illegible]
[illegible]	[illegible]	x	[illegible]	=	[illegible]

Source: [illegible]
Formula Used: [illegible]
[illegible]

Figure 3

[illegible]

	[illegible] Sept [illegible]	[illegible] Sept [illegible]	Difference
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]

Source: "Hospitals" [illegible] August [illegible]

Figure 4

[illegible]

	[illegible] Sept [illegible]	[illegible] Sept [illegible]	Difference
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	19
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]

Source: "Hospitals" [illegible] August [illegible]

PAS data were then studied for a period prior to Medicare. Illustration 2 shows that the physician's apparent preference for discharging patients after stays measured in weeks antedated Medicare.

EXHIBIT D

Illustration 2

DISCHARGE RATIO BY DAYS' STAY IN HOSPITAL
Patients 65 and Older Pre- and Post-Medicare
PAS Data

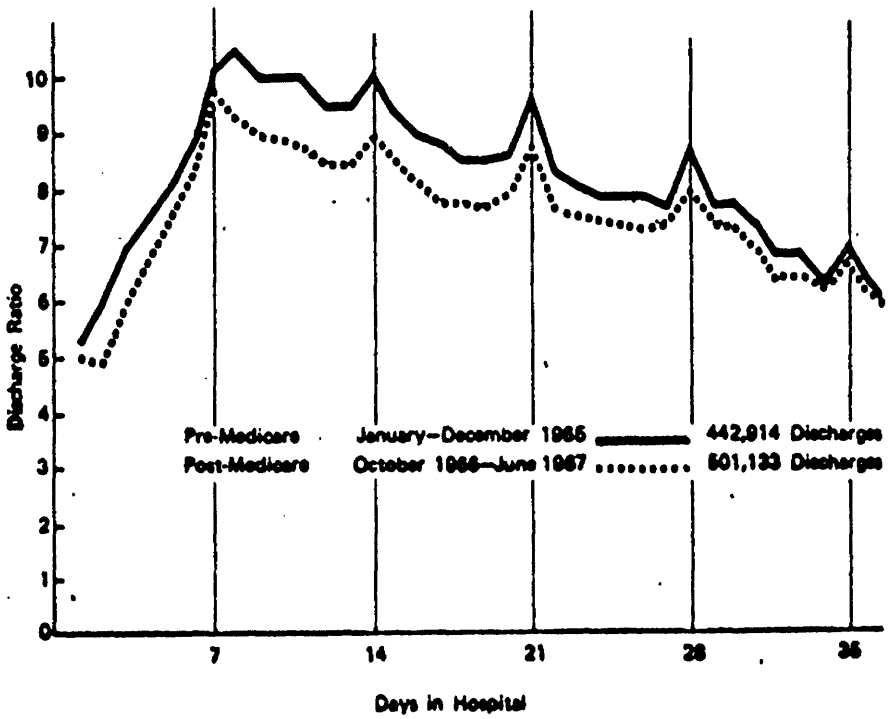


Exhibit 9

cms COUNCIL OF MEDICAL STAFFS

THE OFFICIAL NEWSLETTER OF THE AMERICAN ASSOCIATION OF COUNCILS OF MEDICAL STAFFS OF PRIVATE HOSPITALS, INC.

FACT SHEET

Fact Sheet 5 1973

Summary Of PSRO

PSRO (Professional Standards Review Organization) is a new amendment to the Social Security Act signed into law on October 30, 1972, Public Law 92-603. PSRO restricts Social Security beneficiaries to second-class medical care under a new double-standard – quality care for "private" patients, and homogenous mediocrity for government-regulated Medicare beneficiaries. PSRO is incompatible with good medical care because:

1. PSRO creates a massive and expensive new bureaucracy, which duplicates existing review.
2. Introduces a completely foreign philosophy, that medical care must conform to a federal rulebook for the treatment of all disease.
3. Denies admissions to the hospitals based on the patient's doctor's orders, and gives authority to a committee to decide on the admissions.
4. Invades the confidentiality of patients' medical records in private doctors' offices by government agents, as has already been done with hospital records.
5. Stifles innovation, as physicians are required to conform to the rulebook. Physicians are being offered immunity from liability if they follow the PSRO book.
6. PSRO is the rationing of medical services to cut costs, which must reduce quality.
7. Imposes such federal "guidelines medicine" under peril of fine and suspension of physicians.
8. Invites unethical practice as the computerized guidelines become an invitation to fraud.
9. Reduces the professional to a technician level as medical care is governed by PSRO rules, which will stamp cases for the number of days of treatment, and determine how and where and when to treat.
10. Dehumanizes and promotes impersonal medical care.
11. PSRO has no economic basis, because medical care has increased the same as other services in the Consumer Price Index for a recent 10 year period, and less in the past 2 years.
12. Documentation from government files proves that in Medicare doctor fraud is insignificant.
13. Takes valuable physician time away from patient care because he is required to justify in writing every decision which conflicts with government rules.
14. Discourages physicians from entering or remaining in medical practice.
15. PSRO may force the best physicians out of government programs.

CMS invites you to read the complete copy of the Law and its Analysis in the CMS book, "PSRO". Join the thousands of doctors and patients seeking repeal of this ill-conceived legislation.

AMERICAN ASSOCIATION OF COUNCILS OF MEDICAL STAFFS OF PRIVATE HOSPITALS, INC.
3402 BIENVILLE STREET NEWORLEANS, LOUISIANA 70119 TEL. 504—486-5891

PSRO

Revised Edition, May 1, 1973

TABLE OF CONTENTS

I. - 1. SIGNIFICANCE

American CMS

What You Must Know About PSRO

PSRO introduces and requires, under penalty of fines and suspensions, a new and foreign philosophy of medical care in America; that henceforth, the "care, diagnosis and treatment" for private citizens by private doctors shall comply with government rulebooks of medical care as approved by PSRO and the Secretary of HEW for beneficiaries of Social Security programs. (Sec. 1160)

Dear Doctor:

The Bennett Amendment (to H.R. 1), "PSRO", has been enacted into Public Law 92-603.

If the medical profession cooperates with PSRO, a free profession in a free society may cease to exist.

Consider the facts.

EVERY FACET OF YOUR PRACTICE WILL BE SUBJECT TO THE "REVIEW AND CONTROL" FUNCTIONS OF PSRO.

PSRO will, if practicing physicians participate, give government the power to demand documentation to justify the appropriateness of every act of professional judgment:

- diagnosis
- place of treatment
- nature, duration and frequency of treatment
- number of hospital and office visits
- interval between visits
- number of phone calls
- type and frequency of drugs, whether oral or by injection
- laboratory procedures allowed
- X-ray studies allowed, their type and number
- predetermination of length of stay in hospital
- type, frequency and number of operations
- whether surgery and treatment is done as in-patient or out-patient
- the frequency and type of follow-up visits and treatment

Each decision and documentation will be measured against a government-PSRO-approved manual with rules for the treatment of all illness, from the common cold to open-heart surgery.

TO OUR PATIENTS, PSRO WILL MEAN THE END OF PERSONALIZED INDIVIDUAL MEDICAL CARE UNDER PRIVACY AND CONFIDENTIALITY, which is the American system, for generations to come.

- The patient will be effectively denied the full and free exercise of judgment from the physician of his or her choice.
- It destroys the confidence of the patient in his doctor necessary for a diagnosis and treatment, because confidentiality will be effectively denied by a PSRO which is empowered to rifle through the patient's private medical record in the doctor's private office.

Page 1

- The patient's choice of physician, dentist and pharmacist will be limited. (Exhibit 3-B)
- Reimbursement for drugs, treatment and appliances may be denied retroactively.
- Individualized decisions and medical innovation will be stifled, as PSRO rewards conformity to a rule-book by immunity from civil liability.

I -2 What You Must Know About PSRO

HOW WILL PSRO BE ENFORCED?

-Deviations from the government norm shall be met not only by denying payments, but through a system of local, state and national PSRO committees, reporting to the final authority, who is the Secretary of HEW.
-The Secretary of HEW may impose a $5,000 fine, order the physician to pay the patient's bill and/or suspend the doctor from reimbursement in government programs.
-Under PSRO, deviations from the government-approved rules will be subject to review by PSRO. On the other hand, the doctor who follows the government's PSRO manual, will be immune to civil prosecution, while those who fail to perform under PSRO norms become subject to increased exposure to liability. (Exhibit 1-A)
-The threat of PSRO committee harassment may force the physician to dispose of his services under PSRO rules and conditions, thus effectively impeding the free and full exercise of his skill and judgment.
-Other providers, such as hospitals, may impose, under fear of financial reprisal, programs which require the doctor to follow PSRO regulations, in detriment of good medical care.

CONCLUSION:

It follows that PSRO is the subjugation of a free profession into renouncing its prerogative of independent decisions in diagnosis and treatment by submitting to the review and rules of the government-PSRO.

Professionals will be thereby progressively reduced to the level of technicians implementing the PSRO manual for the treatment of disease.

WHY, THEN, PSRO? - The next section will discuss the alleged reasons for PSRO.

* * * * * * * * * * *

I - 3. ANALYSIS

American CMS

What A Government PSRO Is Authorized to Do - Analysis Of The Sections Of The Law (P.L. 92-603)

I. 1. Review of all Health Care under Government Programs. (Sec. 1155(a)(1)p.105)

II. Rationing of medical care by denying payment on the judgment of the attending physician, and substituting the judgment of a committee of government (PSRO):

2. Determine whether the treatment is necessary by government-approved criteria. Sec. 1155(a)(1)(A), (B) p. 105

3. Introduce and enforce compliance with government regulations (federal standards) for each illness; this is called "quality" control. Sec. 1155(a)(B), 1160(c).

4. Determine where the patient is treated, whether as in-patient or out-patient, on the basis of least cost. Sec. 1155(a)(C)

III. Regulate kind, frequency, amount and type of Diagnosis and Treatment: Sec. 1156(a),(b), (d) pp. 107, 108; see Exhibit 3 (Example of Foundation criteria from Congressional Testimony on which PSRO is based), and Exhibit 4.

5. Determine how many visits, and where, for each illness.

6. Determine the duration of treatment and visits.

7. Determine which laboratory and x-ray procedures to be done.

8. Determine what medication may be prescribed for a given illness.

9. Whether medications are given orally or by injection.

10. How frequent and for how long will medication be given.

11. Number of phone calls allowed. (Exhibit 3)

IV. Require Physicians to follow government regulation of his practice: (Sec. 1160(a)(1) p.110).

12. He must assure and document the government of the
--necessity of treatment
--the duration of treatment is proper
--extent of treatment is indicated
--that location of treatment is the least expensive

13. Requiring certification of necessity on demand at any point in treatment. (Sec. 1156(d)(1)(A), (B) p.107)

14. Constant physician surveillance by: (Sec. 1155 (a)(4) p.105)
--profiles of every treatment for every patient
--computer matching of treatment against regulation ("standards") of PSRO.

15. Review and examination of physician's office records. 1155 (b)(1) to (3)

16. Inspection of physician's office facilities. 1155 (b) (4)

V. Regulation of Hospital Care (Sec. 1155, p. 105): Denial of hospitalization ordered by the doctor, limitation of length of stay, diagnosis and treatment.

17. Certification prior to hospital admission by government regulations. 1155 (a)(2)(A) p.105

18. Length of stay must be pre-determined. Sec. 1156 (d)(2) p.108

19. Review of the Utilization Review Committee of the hospital staff, which in turn reviews the staff doctors. Sec. 1155 (e)(1) p.107

20. Review of hospital utilization.Sec. 1155 (a)(5) p.105

21. Review pharmacists, therapists, technicians, all providers, etc. Sec. 1155 (a)(1) p.105

22. Review and monitor profile on each hospital provider. Sec. 1155 (a)(4) p.105

VI. Patient Surveillance

23. Patient profile in computer with record of all providers and doctors seen, Rx received, etc. Sec. 1155 (a)(4) (p.105)

VII. System of Sanctions, Fine and Suspension of Physicians:

24. Reporting to local, State, National PSRO, and the Secretary of HEW of violations of PSRO "standards". Sec. 1157, Sec. 1159 (a),(b),(c)(p.109)

25. Discontinue Payments (Sec. 1157, 1158(a)(p.109) as "Sanction".
--Promptly notify the agency having responsibility for claims payment.
--No payment may be made unless subject to review by PSRO.

26. Exclude practitioners from providing services in government programs on a reimbursable basis. Sec. 1160 (b)(2) (p.111)

27. Fine of $5,000. Sec. 1160 (b)(3) (p.111)

28. The physician shall pay the patient's bill. Sec. 1160 (b)(3) (p.111)

VIII. Enforce Conformity, Stultify Progress.
--If physician complies - held harmless (Sec. 1167)(c) (p.116)as long as he follows the rule book. (Exhibit 1-A)
--If he does not follow government standard: coercion, harassment and malpractice trap.

I - 5. ANALYSIS American CMS

VIII. (continued)

29. Statute to enforce compliance by enlisting support of "other government organizations having influence on" doctors and hospitals: (Sec. 1160 (c) (p.112) (Exhibit 1-B)

> "(c) It shall be the duty of each Professional Standards Review Organization and each Statewide Professional Standards Review Council to use such authority or influence it may possess as a professional organization, and to enlist the support of any other professional or governmental organization having influence or authority over health care practitioners and any other person (including a hospital or other health care facility, organization, or agency) providing health care services in the area served by such review organization, in assuring that each practitioner or provider (referred to in subsection (a)) providing health care services in such area shall comply with all obligations imposed on him under subsection (a)."

30. Increase liability of malpractice exposure to doctors who do not follow regulation, but exempt all who follow the government blueprint for treatment. (Sec. 1167 (c)(p. 116); (See Exhibit 1-A)

II - 1. American CMS

Why, Then, PSRO?

THIS LAW WAS OSTENSIBLY PASSED TO ASSURE QUALITY, LOWER COSTS AND CONTROL FRAUD AND OVERUTILIZATION.

Let us consider these reasons:

First, Quality:

PSRO cannot possibly assure quality.

PSRO will diminish quality.

(a) PSRO would eliminate the personalized, individual, quality care system and substitute a dehumanized, numerical average system with federal rules for the practice of medicine which will stifle innovation and reward conformity. Quality medical care must be based first and last on what is good for the individual patient, at a given time and under particular conditions, never on a standardized rule-book.

(b) PSRO rewards conformity by immunity for following rule-book.

(c) Those who innovate are subject to review, suspension, fines.

(d) PSRO requires proof of "medical necessity" of diagnostic and treatment procedures. How is this reconciled with "preventive medicine" where most early tests are "negative" and "unnecessary"?

Secondly, Costs:

PSRO cannot possibly lower costs.

PSRO is certain to escalate costs.

(a) PSRO requires the creation of a vast new bureaucracy, to supervise a network of PSRO's. Much of this would duplicate existing government carrier computer review programs, which maintain profiles of patients, doctors, and providers, and which have for years been operational in government for review of services.

(b) The establishment of 500 PSRO's would mean an initial minimum cost of one-tenth billion dollars! It can easily reach one billion the first year, as government estimates are historically very low.

(c) Dr. James Henry from Ohio, one of the proponents of PSRO, has stated that the cost in hardware alone may prove to be staggering. Dr. Harry Schwarz has stated that perhaps the only one to benefit from PSRO will be the computer industry.

Thirdly, Fraud and Overutilization:

(a) "Fraud by the Medical Profession" is shown to be insignificant by the government's own figures.

The Bureau of Health Insurance, Mr. Tom Tierney, has made repeated accusations that widespread fraud exists in the medical profession. CMS challenged this statement and obtained from Social Security Administration their actual figures which show that only 18 physicians have been convicted of fraud in 6 years of Medicare. This is only 3 physicians per year in all 50 states out of 220,000 doctors treating 20 million Medicare beneficiaries. For this do we need a one-tenth billion dollar national policing system? (Exhibit 2)

(b) Furthermore, PSRO may provide a legal framework for fraud, for those who would carefully fit within the PSRO guidelines. As an example of such legalized overutilization in PSRO, see Exhibit 3-A (Page 1), (example No. 1), for the treatment of the common cold, an estimate of the cost of treatment under the guidelines could amount to 34 billion dollars, not including the cost for PSRO review, based on guidelines of the San Joaquin Foundation for Medical Care presented to Congress and upon which PSRO is structured.

(c) The testimony showing examples of doctors and patients "overutilizing on visits and medication", "tonsillectomy", the "cutting of toenails", were used to "justify" PSRO. The savings from identification of these few "abuses" or even "patterns" of deviation do not justify the establishment of a massive federal PSRO network based on such scant, scattered and incomplete data. (Exhibit 3-C)

(d) Why Certification on Demand?

Data concerning certification from the Bureau of Health Insurance were fraudulently used to justify claims that doctors overutilized hospitals, as shown by "unnecessarily prolonged hospital stays." CMS has documented this to be fraudulent in testimony before the Senate Committee on Finance in 1972, and before the Medicare Advisory Committee (HIBAC) in 1972. The fraud has not been corrected and it reappeared in the General Accounting Office reports of 1971 and 1972. In spite of the fact that the certification program has been proved to be erroneous and unnecessary and a failure, it has now been expanded into "certification-on-demand" in PSRO. (Exhibit 5)

Fourthly, PSRO is unnecessary and further predicated on the fallacious concept of unwarranted medical care costs "spiraling" above the rest of the economy. CMS has brought to light in the Senate Committee on Finance Hearings on PSRO in 1970 and 1971, and has extensively documented that:

(a) Medical care costs have risen no more than all other services in the economy for a recent twelve year period.

(b) Physician fees have risen less than wages over a recent 13-year period. During the past two years, physicians' fees have risen less than the CPI (Consumer Price Index) of the general economy.

(c) The cost per stay in private hospitals is less expensive than in federal and state "regulated" hospitals, presumably under "government standards."

(d) The duration of a hospital stay in the United States has continued to decrease, not increase. It is considerably shorter than the stay in countries where national health insurance is in existence, presumably under "government standards."

However, if the private system becomes "federalized" under PSRO, as is now happening in Medicare, the private system will then approach the higher costs of the longer-stays in the federal medical system.

CONCLUSION:

PSRO is therefore unwarranted and cannot perform its stated purposes, as follows:

It will diminish quality and escalate costs. There is no widespread fraud to justify the massive policing of all doctors and of all patients. Medical care costs have risen the same as other services in the economy. The cost of PSRO is apt to prove staggering, and nothing in return except federalization of medical practice to homogenous mediocrity.

Who devised the plan to turn peer review authority to the Secretary of HEW? - The next section will take up this important question.

* * * * * * * * * * * * * *

III - 1.

American CMS

The Day That The AMA Asked The Government to Assume Authority Over Medical Society Peer Review

A. THE BASIC CONCEPT OF PSRO IS THAT THE GOVERNMENT SHOULD ASSUME AUTHORITY OVER WHAT WAS PREVIOUSLY A PRIVATE FUNCTION OF A PRIVATE PROFESSIONAL MEDICAL SOCIETY: THE PEER REVIEW. This concept was originated by the AMA Legal Department and introduced into Congress as the PRO Section of Medicredit, without the approval of the House of Delegates of the AMA.

The Medical Society thereby becomes a quasi-government agency, reporting to the Secretary of HEW. The Secretary of HEW assumes final authority to suspend physicians or otherwise sentence.

A tribunal pyramid system at local, state and national levels is created, reporting violations to the Secretary of HEW.

Public notice to patients shall be required of doctors if suspended by HEW.

If the Medical Society performance is considered inadequate by the Secretary of HEW, the Secretary shall cancel and seek a contract with another body.

These basic elements which constitute PSRO were written by the AMA into the Medicredit Bill that was called PRO, Title 21, Peer Review Organization, H.R. 18567, introduced into Congress July 21, 1970, as follows:

SEC. 210. The Social Security Act as hereby amended is further amended to add after title XX, as added by this Act, a new title XXI, entitled "PEER REVIEW ORGANIZATION", as follows:

"TITLE XXI—PEER REVIEW ORGANIZATION

"ESTABLISHMENT AND OPERATION

Figure 1. AMA PRO Section of Medicredit, HR 18567, 1970

III - 2. The Day That The AMA Asked American CMS

In Section 2103 of PRO under "Disciplinary Action" the Secretary of HEW is given authority over practitioners as follows:

"DISCIPLINARY ACTION

"SEC. 2103. (a) The Secretary is authorized, upon recommendation of the commission for disciplinary action pursuant to the provisions of section 2102(c)(7), to suspend or exclude a provider of medical or other health services from participation in any Federal Government health program under titles V, XVIII, XIX, or XX.

Figure 2. AMA PRO Section, HR 18567.

The AMA Bill also required "Notice to Patients" by physicians of their suspension by the Secretary of HEW as follows:

"NOTICE TO PATIENTS

"SEC. 2106. A provider of medical or other health services who is under suspension from the program shall take reasonable and necessary steps to advise persons to whom he is rendering medical or other health services that such services rendered during the period of such suspension are not compensible or reimbursable under titles V, XVIII, XIX, or XX. Failure to do so shall be a basis for peer review and further disciplinary action under this title.

Figure 3. AMA PRO Section, HR 18567

Finally, the Secretary had authority to suspend and terminate the Peer Review function of the Medical Society under contract with HEW as follows:

"TERMINATION OF PRO AGREEMENT

"SEC. 2110. (a) If in the opinion of the Secretary, after investigation, a State medical society (or related organization referred in section 2101(b)) under agreement to establish and operate a PRO has failed to discharge its obliga-

Figure 4. AMA PRO Section, HR 18567.

tions and responsibilities under such agreement, the Secretary shall give notice to such State medical society (or related organization) of his findings, together with the reasons therefor, and in the absence of a request for a hearing by such State medical society (or related organization) or upon final determination of such failure to discharge the obligations and responsibilities may terminate the agreement. The agree-

Figure 4. AMA PRO Section, HR 18567. (continued)

After rejection of PRO by the Louisiana State Medical Society and subsequent actions, "PRO" was removed from Medicredit. However, the AMA introduced a separate Bill from Medicredit, S. 1898, on May 19, 1971, in which the PRO-Section of Medicredit was written as a separate Bill!, as follows:

92d CONGRESS
1st SESSION

S. 1898

A BILL

To amend the Social Security Act by adding a new title to provide for the establishment of a system of review of medical and other health services rendered under titles V, XVIII, XIX, and XX of the Social Security Act.

By Mr. HANSEN

MAY 19 (legislative day, MAY 18), 1971
Read twice and referred to the Committee on Finance

Figure 5. AMA, S. 1898 which re-introduces "PRO" separate from "Medicredit"

Conclusion:

The AMA, therefore, is the originator of the PSRO concept of placing government authority over Medical Society Peer Review, in a Bill written for Congress as the Medicredit Bill, "PRO" Section.

B. Analysis showing that AMA's "PRO" and "PSRO" are basically the same.

COMPARISON OF PRO (AMA) AND PSRO (BENNETT AMENDMENT)

I. IDENTICAL GENERAL PROVISIONS:	PRO	PSRO
A. AUTHORITY		
1. ESTABLISHED BY	HEW	HEW
2. JUDGED BY	HEW	HEW
3. TERMINATED BY	HEW	HEW
B. DISCIPLINARY ACTION		
1. SENTENCE ISSUED BY	HEW	HEW
2. EXCLUSION FROM FEDERAL PROGRAMS BY	HEW	HEW
C. STRUCTURE		
1. MAY BY-PASS MEDICAL SOCIETIES	YES	YES
II. INDIVIDUALLY SPECIFIED PROVISIONS:		
A. DISCIPLINARY ACTION		
1. INITIAL PENALTY 1 YR.	‡	*
2. PATIENT NOTIFICATION REQUIRED	‡	*
3. ELABORATE SYSTEM OF APPEALS	‡	*
B. FUNCTION		
1. ON-SITE INSPECTION (OFFICES & RECORDS)	*	‡
2. ADVANCE CERTIFICATION OF HOSPITAL ADMISSIONS	*	‡

* TO BE IMPLEMENTED BY HEW REGULATIONS

Figure 6. CMS Comparison of PRO-PSRO

- AMA Testimony in Congress: PRO and PSRO - Bennett Response -

C. Why did the AMA write PRO? Mr. Bernard P. Harrison, Chief Counsel of the AMA, appeared before the Louisiana State Medical Society Special Meeting on PRO and PSRO, on September 13, 1970, and stated that he had written Medicredit and the PRO Section and that he had done so at the request of Chairman Wilbur D. Mills of the House Ways and Means Committee, on March 11, 1970, to control costs and to reduce abuses. Also, Senator Russell Long, on June 15, 1970, expressed interest to the AMA in the development of an appropriate peer review mechanism for Medicare and Medicaid. (Exhibit 6)

AMA recognizes a "need for surveillance" of doctors:

It was on this basis that the AMA wrote "PRO" according to its own report to the House of Delegates. Yet, the AMA testified before Congress that "PRO was incorporated with Medicredit because the medical profession recognizes the need for an appropriate means of providing surveillance over the provision of medical services rendered within the program." (Exhibit 7 -p.1091)

III - 5. The Day That The AMA Asked — American CMS

Corrected:

The AMA PRO Section was written and introduced in Congress on July 21, 1970. It was brought before Congressional sponsors, however, before it was presented to the House of Delegates. The PRO Section of the Medicredit Bill was approved by the House of Delegates in May 1970, as Report V, Report of the Board of Trustees. The complete report is reprinted in Exhibit 6 of this CMS document.

D. PSRO was introduced by Senator Bennett on August 20, 1970. It added the concept of national norms or standards for medical care and therefore added the "S" of Standards to PRO and became PSRO, Professional Standards Review Organization. It also added the imposition of a $5,000 fine and changed the Peer Review body from the Medical Society to practicing physicians.

E. Senator Bennett states that the AMA should "not desert its own child" - PSRO.

In testimony before the Senate Committee on Finance, September 1970, the AMA opposed the federal standards in PSRO: (Exhibit 7-p.1092)

" ...the published norm carries within itself a potential detriment to the provision of higher quality care....A physician may for these reasons, or reasons stemming from concern for legal ramification which may arise from departure from such norms or for fear of subjecting himself to the penalty and refund provisions, find compulsion to conform to these standards in derogation of better care. ...This new inquisitional character of peer review, however, based on the criminal aspects and fines, would change the character of the program and we believe that the beneficial aspects would suffer."

The AMA also opposes the invasion of confidentiality of medical files.

The AMA did state, regarding PSRO, that (p. 1091) "while its objective is similar to that of our PRO and such is laudatory, we find that significant changes should be made to Amendment 851."

Senator Bennett responded (Exhibit 8-p.1093), "But I hope the American Medical Association will not desert its own child and say now, that 'there are so many troubles with it that we would rather you went back to something else,' and I hope the Committee will study the proposal which has been carefully worked out with many of the factors in the situation, including the American Medical Association."

F. Senator Russell Long states that the AMA suggested that the Senate Committee on Finance write PSRO and that AMA asked Senator Bennett to sponsor PSRO.

Senator Russell Long stated to the Louisiana Delegation of CMS on February 14, 1973, when the Delegation expressed its disapproval of PSRO and requested consideration of its repeal, that it was the AMA who had requested that PSRO be written by the Senate Committee and the AMA had asked the sponsorship of Senator Bennett and that he, Senator Long, was surprised to see the opposition of the AMA, subsequently, to the Amendment.

In summary, the AMA is the author of the concept of government authority over medical peer review, introduced a bill in Congress for this, and initiated and helped develop PSRO.

III - 6. The Day That The AMA Asked — American CMS

G. State Medical Societies seek bills similar or identical with PSRO and introduces them: Devine Bill in Ohio and Daneelson Bill in California. These bills were initially introduced and supported by the medical societies without a vote from the membership.

H. Louisiana State Medical Society rejects PRO and PSRO after hearing the AMA's legal counsel who wrote PRO and Medicredit. Some other medical societies also rejected PRO and PSRO. The Louisiana State Medical Society called a special meeting to discuss PRO and PSRO in 1970, and unanimously rejected the concept. (Figure 7)

ACTIONS OF HOUSE OF DELEGATES
LOUISIANA STATE MEDICAL SOCIETY
AT
SPECIAL SESSION 9/13/70

Motion forbidding the officers of LSMS to enter into any agreement or contract with Secretary of HEW in the name of LSMS or any other governmental agency, state, federal, county-parish or any political subdivision or third party for the purpose of either PRO or PSRO or anything similar.

LSMS completely rejected PRO as it pertained to the Medicredit draft and PSRO as is being presented by Senator Bennett and maintained that the best means of physicians providing health services are within the confines of the free enterprise system wherein competition among physicians will best control costs, and a fee for service under direct billing will provide to the consumer the only means of obtaining the highest quality of care.

RESOLVED, that the present system of Peer Review operating through the State Board of Medical Examiners, organized Medical Societies, both Parish and State levels, and hospital staffs provides adequate supervision of the practice of medicine to maintain high ethical standards of the profession, and ensures quality medical care to our patients; it is tried and tested, and is the sole mechanism acceptable to the LSMS.

Figure 7. La. State Medical Society, Resolution opposing PRO and PSRO.

III - 7. The Day That The AMA Asked

American CMS

- Actions of Other State Societies -

Harris County Medical Society (Houston), 1971, rejected PRO and PSRO (Fig. 8); Oklahoma (Fig. 9), and others.

RESOLUTION

Whereas, the Harris County Medical Society for many years has had effective and adequate means to assure the public a very high quality of medical care provided by qualified physicians, and

Whereas, the major feature of these means consists of mandatory adherence to the principles of medical ethics through a forceful system of internal discipline, and

Whereas, the imposition of regulations emanating from the United States Government and its agents under the designations of "Peer Review" and "Professional Services Review" would preempt, disrupt, and invalidate the medical society's internal disciplinary mechanisms, and

Whereas, participation in said "Peer Review or Professional Services Review" by the medical society or any of its members would constitute violation of the very purpose of the medical society as set forth in the preamble to the by-laws, therefore be it

Resolved, that the Harris County Medical Society shall not participate in any program of "Peer Review" or "Professional Services Review" (typified by the programs detailed in the "Medicredit Bill"; HR 18567, or in the "Bennett Amendment", No. 851 to the Social Security Act of 1970, HR 17750), and further be it

Resolved, that any member of the Harris County Medical Society who participates in any program as above styled, shall be held in violation of the by-laws of the Harris County Medical Society and shall be subject to discipline accordingly, and further be it

Resolved, that, in the realization that intolerably rigid regulations, as above styled, are necessary and inevitable consequences of government subsidized medical care, Harris County Medical Society members would be well advised not to participate in government subsidized medical care programs, and further be it

Resolved, that the Delegates of the Harris County Medical Society be instructed to introduce and support this or a similar resolution to the House of Delegates at the April, 1971 Texas Medical Association meeting.

Figure 8. Houston:County Medical Society, Resolution opposing PRO and PSRO, 1971.

III - 8. The Day That The AMA Asked — American CMS

Introduced by: Oklahoma Delegation — Resolution:

Subject: PRO

Referred to:

The Peer Review Organization proposal embodied in H. R. 18567 was developed without consultation with state medical associations, yet they would have the responsibility to implement the plan under contract with the Secretary of the Department of Health, Education and Welfare.

PRO establishes a monolithic approach to peer review, disregarding the unique characteristics of the various jurisdictions. While it attempts to provide some flexibility, the generalized nature of the provisions leave much to Federal regulatory authority, and it is predictable that educationally-based "peer review" will be transformed into "peer enforcement" of Federal regulations.

Medical associations under PRO would become agencies of the government, and intraprofessional disciplinary powers which have been inherent in the peer concept would be transferred to the Secretary of the Department of Health, Education and Welfare.

Resolved, that the House of Delegates of the American Medical Association rescind its approval of Part C of H. R. 18567.

AMA: HDelegates: Nov. 70 .

Figure 9. Oklahoma State Medical Society, Resolution opposing PRO.

I. AMA House of Delegates strongly rejects PSRO in the 1971 San Francisco Convention.

J. In spite of the opposition of AMA, little support from HEW, opposition from the AHA, CMS, AAPS, the opposition of the House Conferees, PSRO was approved at the last minute of the Senate-House Conference under the auspices of Senator Long. PSRO was signed into law as Title II of the Social Security Act, PL 92-603, October 30, 1972.

K. AMA reverses its position of the House of Delegates 1972 Clinical Convention, and assumes leadership towards establishing PSRO's and to coordinate PSRO's activities. At this meeting Committee Report Z was approved (See Exhibit 9 of this CMS document). The AMA Board of trustees recommended and it was approved that the AMA should assist medical societies to recommend structures for PSRO's, develop and transmit operational procedures, help develop norms for health care services and "develop suggested continuing educational programs through which physicians can secure for themselves and their patients the full benefit of the application and refinement of Professional Standards Review.

DOES THE AMA NOW CONSIDER PSRO BENEFICIAL TO PATIENTS AND PHYSICIANS? The AMA has given no evidence, data, or explanation for this statement and position.

L. January 1973 - The President of the Oklahoma State Medical Society has called for non-compliance with PSRO. See next page. The Indiana State Medical Society is considering suit against PSRO.

III - 9. The Day That The AMA Asked

President of Oklahoma SMS asks for Non-Compliance - January 1973

OSMA JOURNAL/president's page
Oklahoma State Medical Association
Volume 66 - Number 1 - January, 1973

PSRO Is a Four Letter Word

The Bennett Amendment designed to take punitive action against doctors and other health providers, became law when Congress passed HR-1 with the Bennett Amendment or Professional Standards Review Organization (PSRO) as a rider. Significantly, Congress did not get a chance to vote on PSRO itself, but only on the freight train bill, HR-1, with its multiple peculiar riders. Each member of OSMA is urged to become intimately familiar with PSRO because:

1. It is a bad program which cannot possibly accomplish its objectives of promoting effective, efficient, and economic delivery of health care services of proper quality.

2. It will entail further endless bureaucratic harrassment to practicing physicians, who are already distracted enough by bureaucracy. It will, in fact, decrease efficiency of physicians by an endless number of inquiries and reports after the fact with built-in retrospective denials that the physician has to pay for up to $5,000. Have you noticed that bureaucrats or Junior G-Men have 20-20 hindsight?

3. It will surely increase the cost of medical care since the costs of administering the program will necessarily create a vast new bureaucracy. It will compound the shortage of physicians since sizeable numbers will have to be taken out of patient service in order to administer PSRO, and decrease working effectiveness of physicians doing patient service because of the additional time wasted on reports, answering inquiries, and attending judicial reviews.

4. It will not increase the quality of medical care, but will attempt to change private personalized health services into dehydrated computerized fittings of square pegs into round holes, with the holes varying in size, shape, and location at the discretion of the Secretary of HEW and his famous regulators. In addition, it will lower quality by making physicians practice increasingly defensive medicine.

5. In rural areas, where there is already a physician shortage, and where a large percentage of patients are on Medicare or Medicaid, it will compound the physician shortage by making rural practice even less attractive. The overall physician shortage will be increased due to the fact that many physicians would find practice under PSRO so unpleasant that they will retire.

6. It will pave the way for National Health Insurance. The Federal government cannot possibly afford NHI or socialized medicine until they get absolute control over practicing physicians through a mechanism like PSRO.

7. Although nominally under medical control, actual control of PSRO would be out of our hands as regulations are developed along the way and at the onset by PSRO advisory groups.

My Proposal: Non-Compliance!!

If we refuse as a group to be PSROed by anyone, the Federal Government has the option of discontinuing Medicare and Medicaid. It is not probable that they will do this because it would work a hardship on recipients. What other recourse would the government have but to make some acceptable bargain with us for care of Medicare and Medicaid recipients? We should be prepared for a decline in income. If we get PSROed, be prepared for a decline in income permanently.

If you share my low opinion of PSRO and the disastrous effects on the American doctor, please study PSRO, arrange debates at your county medical society meetings, encourage your fellow physicians to understand PSRO, and send your delegates to the annual meeting instructed to vote-against compliance. If OSMA votes for noncompliance, you can be sure that many states will follow suit and Congress will have to recognize PSRO as an unworkable concept. Congress can then negotiate with us for measures to accomplish proper objectives.

S.R. McCampbell, M.D.

American CMS

IV - 1. OPPOSE PSRO AND SEEK REPEAL:

The position of CMS regarding PSRO is that:
PSRO is a Bad Law:
- doctors should not be involved in the implementation of PSRO;
- that physicians should bill and receive payment only from their patients;
- should oppose PSRO by all legal means;
- should make every effort to have PSRO repealed.

For the past three years, the private doctors in American CMS have balloted their opposition to PSRO in votes of 1970, 1971 and twice in 1972. The American CMS Board, acting on the vote of its participating staffs approved a Resolution on February 14, 1973 to Oppose and seek Repeal of PSRO, printed on the next page (VI).

A "Constitutional Challenge" Committee has been approved by CMS to consider suit on the constitutionality of PSRO. CMS has requested the AMA for a top-level meeting with the Board of Trustees to request that the AMA also oppose PSRO and ask for repeal. The Association of American Physicians and Surgeons is also planning suit against PSRO.

V - SUMMARY

PSRO is incompatible with good medical care, it introduces government intervention in physician judgment, stifles innovation, reduces the professional to a technician level, impairs personalized care, invites unethical practice, invades the confidentiality of patient medical records, and introduces government agents into private doctors' offices.

PSRO has no economic basis, as documentation proves that Medicare fraud is insignificant, and that doctors' fees have increased less than the Consumer Price Index for over two years. PSRO is certain to escalate costs, create a vast new bureaucracy, which duplicates existing government review, takes valuable physician time away from patients, discourage physicians from entering or remaining in medical practice. It may force the best physicians out of government programs. PSRO is the rationing of medical services to cut costs.

PSRO would restrict Social Security beneficiaries to second-class medical care under a new double standard-- quality care for "private" patients, and homogenous mediocrity for government regulated beneficiaries.

33-013 O - 74 - pt. 1 - 21

VI - 1. Resolution on PSRO

Printed March, 1973
2/14/73 Washington Board Meeting

COUNCIL OF MEDICAL STAFFS

RESOLUTION ON PSRO

(Public Law 92-603, Sec. 249F,
Title XI of the Social Security Act)

1. WHEREAS, PSRO introduces and requires a new and foreign philosophy of medical care in America; namely, that henceforth, the "care, diagnosis and treatment" for private citizens by private doctors shall comply with government concepts of medical care as approved by PSRO and the Secretary of HEW for beneficiaries of Social Security programs. (Sec. 1160);

2. WHEREAS, PSRO imposes this obligation on doctors to meet PSRO-government approved "norms" of "health care", under "sanction" that the doctor shall pay "to the United States" the "cost of the service," or (if less), $5,000; or exclusion of the doctor from eligibility to care for patients on a reimbursable basis by the Secretary of HEW. (Sec. 1160(a)(1), (b)(1)(2)(3));

3. WHEREAS, Compliance with the above government-approved PSRO rule book for the care, diagnosis and treatment of his patients would interfere with the doctor's professional judgment, would diminish and impair personalized health care, and encourage conformity to stereotyped rules rather than to what he deems best for his individual patient in an individual illness.

4. WHEREAS, PSRO is certain to stifle innovation and encourage mediocrity, and to lower the quality of medical care by encouraging rule-book medical care;

5. WHEREAS, In complying with PSRO, the doctor would act contrary to Sec. 6 of the Code of Medical Ethics which states, "A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.";

6. WHEREAS, PSRO empowers government agents to enter and inspect private doctors' offices, therein also to invade the privacy of patients' medical records containing information on their private lives. (Sec. 1155(b)(3));

AMERICAN ASSOCIATION OF COUNCILS OF MEDICAL STAFFS OF PRIVATE HOSPITALS, INC.
3402 BIENVILLE STREET NEWORLEANS, LOUISIANA 70119 TEL. 504—486-5891

7. WHEREAS, PSRO, because PSRO diminishes the quality of medical care, the better physicians may not participate in government-reimbursable programs;

8. WHEREAS, PSRO, therefore, violates fundamental freedoms which are necessary for medical care;

> (a) Freedom of the patient to choose his physician.
> (b) Freedom of the physician to decide whom he will treat, except in emergencies.
> (c) Freedom of the physician to choose the method of treatment of his patients consistent with good medical practice in his locality.
> (d) Freedom of the physician to admit his patient to a hospital for treatment under the continuing concept that this is the sole prerogative of the physician, consistent with the official policy of the hospital medical staff, and irrespective of race, creed, color or political belief.
> (f) Freedom of the physician to have the right of direct billing, the right to determine the method of receiving payment for his service, and the right to a fee-for-service concept in the delivery of medical care.

9. WHEREAS, this punitive PSRO legislation has no economic basis for justification because the government's own records obtained by CMS displays a distinguished record, with only 18 doctors convicted of fraud in the fifty states in six years of the Medicare Program, with 20 million Medicare patients and 200,000 physicians; and,also, physicians' fees have risen less than the CPI in the past two years;

10. WHEREAS, PSRO is certain to escalate the costs of medical care by the creation of a vast new bureaucracy of PSRO networks with an estimated initial cost of at least one billion dollars; by duplication of existing computer fiscal reviews with profiles and norms in operation by government carriers in use for years; by diverting valuable physician time to unnecessary computer review work; by vastly multiplying paperwork documentation at every level of physician decision; by discouraging physicians from entering or continuing practice in a new PSRO era of total bureaucratic medical care;

11. WHEREAS, PSRO is ill-conceived legislation, which will result in the rationing medical care for Social Security beneficiaries, passed at the eleventh hour in Congress with opposition from practically all sectors of the organized medical profession and of the hospital association;

12. WHEREAS, the practicing physician has the obligation to inform the people as to what constitutes good medical practice, a responsibility he cannot delegate, and to object to the usurpation of our obligation by politicians;

13. WHEREAS, CMS, representing 30,000 private practicing physicians, based on the balloting of its member medical staffs for 3 years which have consistently opposed PSRO;

2/14/73 Washington Board Meeting

VI - 3 RESOLUTION ON PSRO

RESOLVED;THAT 1. Practicing doctors should DENOUNCE PSRO AS A BAD LAW and seek REPEAL because PSRO is incompatible with good medical care.

2. Because PSRO is VOLUNTARY under PL 92-603, practicing doctors may choose not to participate in PSRO, and, by using DIRECT BILLING, refuse PSRO. The government and its agents, not the practicing physician, would remain responsible for the denial of benefits to patients and for inferior rule-book medical care under PSRO.

3. Doctors request the President, Congress, State and local government to assist in repealing this bad law.

4. Doctors secure the cooperation of local, state and national medical, dental, hospital and health care and consumer organizations to seek REPEAL of PSRO.

5. Doctors alert the public --our patients-- on this ill-conceived legislation and request their help in repeal of PSRO.

6. The proper response and alternative to PSRO is:

- The physician should continue to practice ethical personalized care for his patients; uphold the free choice by patients for every aspect of their diagnosis and treatment; maintain the privacy of our offices and the confidentiality of our patients' medical records;

- Continue direct billing, receiving payment only from patients, in order that patients may have their free choice of care with dignity and responsibility;

- Uphold our professional quality peer review system consisting of the Board of Medical Examiners, Committees of our Medical Societies, and the numerous peer review committees of the medical staffs, without reporting to government. No other system can be effective in quality review. No other is compatible with good medical care, freedom of choice, ethical practice, and reasonable costs.

EXHIBIT 1

American CMS

Exhibit 1-A PSRO offers immunity from liability if the doctor conforms to PSRO regulations

Public Law 92-603, 92nd Congress, H.R. 1, October 30, 1972.

Section 1167(c)

Page 116

"(c) No doctor of medicine or osteopathy and no provider (including directors, trustees, employees, or officials thereof) of health care services shall be civilly liable to any person under any law of the United States or of any State (or political subdivision thereof) on account of any action taken by him in compliance with or reliance upon professionally developed norms of care and treatment applied by a Professional Standards Review Organization (which has been designated in accordance with section 1153(b)(1)(A)) operating in the area where such doctor of medicine or osteopathy or provider took such action but only if—

Infra, p. 1430.

Exemption from civil liability for treatment for any doctor who complies with PSRO regulations.

Exhibit 1-B Statute to enforce compliance by using influence of other organizations to assure compliance:

Section 1160(c)

Page 112

"(c) It shall be the duty of each Professional Standards Review Organization and each Statewide Professional Standards Review Council to use such authority or influence it may possess as a professional organization, and to enlist the support of any other professional or governmental organization having influence or authority over health care practitioners and any other person (including a hospital or other health care facility, organization, or agency) providing health care services in the area served by such review organization, in assuring that each practitioner or provider (referred to in subsection (a)) providing health care services in such area shall comply with all obligations imposed on him under subsection (a).

EXHIBIT 2
Page 1

American CMS

Letter of Transmittal of "Prosecutions for Medicare Fraud"
From HEW to CMS

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

REFER TO:
HI:R:AD

SEP 25 1972

Kenneth A. Ritter, M.D.
6109 Louis XIV
New Orleans, Louisiana 70124

Dear Dr. Ritter:

As you requested at the HIBAC meeting on September 15, I am enclosing a chart of Prosecutions for Medicare Fraud for the period January 1969 to July 1972. If you would like additional information, please let me know.

Sincerely yours,

Max Perlman
Executive Secretary
Health Insurance Benefits
Advisory Council

Enclosure

OCT 13 1972

Kenneth A. Ritter, M.D.
6107 Louis XIV
New Orleans, Louisiana 70124

Dear Dr. Ritter:

The report on prosecutions for Medicare fraud you recently received includes all data available, as there were no prosecutions or convictions prior to 1969.

Sincerely yours,

Max Perlman
Executive Secretary
Health Insurance Benefits
Advisory Council

ENCLOSURE II

PROSECUTIONS FOR MEDICARE FRAUD
JANUARY 1969-JULY 1972
BY STATE, PROFESSIONAL CATEGORY, YEAR PROSECUTION UNDERTAKEN, DISPOSITION AND DATE

State	Professional Category	Criminal Information Filed or Indictment Obtained				Disposition and Date	
		1969	1970	1971	1972		
Arizona	M.D.				x	Pending	
Arizona	M.D.			x		Pending	
Arkansas	M.D.	x				Acquittal	10/69
Arkansas	THER			x		Conviction	5/72
California	D.P.M.			x		Conviction	12/71
California	M.D.		x			Acquittal	2/71
California	M.D.		x			Pending	
California	M.D.			x		Conviction	12/71
California	M.D.		x			Dismissal	2/71
California	M.D.				x	Pending	
California	D.S.C.			x		Conviction	3/72
California	M.D.		x			Conviction	6/70
California	AMB		x			Conviction	8/71
D.C.	OTH	x				Conviction	6/70
D.C.	OTH	x				Conviction	6/70
Florida	M.D.	x				Conviction	4/71

ENCLOSURE II

PROSECUTIONS FOR MEDICARE FRAUD
JANUARY 1969-JULY 1972
BY STATE, PROFESSIONAL CATEGORY, YEAR PROSECUTION UNDERTAKEN, DISPOSITION AND DATE

State	Professional Category	Criminal Information Filed or Indictment Obtained				Disposition and Date	
		1969	1970	1971	1972		
Florida	M.D.			x		Pending	
Florida	M.D.	x				Acquittal	4/71
Florida	M.D.		x			Conviction	10/70
Florida	D.S.C.		x			Conviction	1/71
Florida	M.D.	x				Pending	
Florida	D.O.				x	Pending	
Florida	M.D.			x		Conviction	10/71
Florida	D.O.			x		Conviction	6/71
Florida	M.D.	x				Conviction	4/71
Florida	N.D.			x		Pending	
Florida	OTH	x				Acquittal	4/71
Florida	D.O.			x		Pending	
Florida	M.D.		x			Dismissal	11/70
Florida	M.D.			x		Pending	
Illinois	M.D.			x		Conviction	12/71
Indiana	M.D.	x				Dismissal	3/70
Indiana	M.D.				x	Pending	

ENCLOSURE II

PROSECUTIONS FOR MEDICARE FRAUD
JANUARY 1969-JULY 1972
BY STATE, PROFESSIONAL CATEGORY, YEAR PROSECUTION UNDERTAKEN, DISPOSITION AND DATE

State	Professional Category	Criminal Information Filed or Indictment Obtained				Disposition and Date	
		1969	1970	1971	1972		
Kentucky	M.D.			x		Conviction	11/71
Louisiana	M.D.		x			Dismissal	7/71
Louisiana	M.D.		x			Acquittal	1/71
Michigan	M.D.				x	Pending	
Michigan	M.D.				x	Pending	
Michigan	D.O.				x	Pending	
Michigan	M.D.				x	Pending	
Michigan	D.O.				x	Pending	
Michigan	D.O.				x	Pending	
Mississippi	M.D.	x				Conviction	8/69
Mississippi	M.D.			x		Conviction	11/71
Missouri	OTH				x	Conviction	8/72
Missouri	OTH				x	Conviction	8/72
Missouri	AMB				x	Pending	
New Jersey	M.D.			x		Conviction	11/71
New Jersey	M.D.			x		Conviction	4/72

ENCLOSURE II

PROSECUTIONS FOR MEDICARE FRAUD
JANUARY 1969-JULY 1972
BY STATE, PROFESSIONAL CATEGORY, YEAR PROSECUTION UNDERTAKEN, DISPOSITION AND DATE

State	Professional Category	Criminal Information Filed or Indictment Obtained				Disposition and Date	
		1969	1970	1971	1972		
New York	OTH				x	Pending	
New York	M.D.		x			Acquittal	2/71
New York	OTH				x	Pending	
Ohio	M.D.			x		Conviction	9/71
Oklahoma	D.O.				x	Pending	
Oklahoma	D.O.				x	Pending	
Oklahoma	AMB		x			Conviction	11/70
Oregon	OTH				x	Conviction	8/72
Pennsylvania	M.D.				x	Conviction	7/72
Pennsylvania	M.D.				x	Conviction	8/72
Pennsylvania	D.O.		x			Conviction	1/71
Pennsylvania	D.P.M.				x	Pending	
Pennsylvania	M.D.				x	Pending	
Pennsylvania	POD.D		x			Conviction	1/71
Pennsylvania	M.D.				x	Pending	
Pennsylvania	M.D.				x	Pending	

ENCLOSURE II

PROSECUTIONS FOR MEDICARE FRAUD
JANUARY 1969-JULY 1972
BY STATE, PROFESSIONAL CATEGORY, YEAR PROSECUTION UNDERTAKEN, DISPOSITION AND DATE

State	Professional Category	Criminal Information Filed or Indictment Obtained				Disposition and Date	
		1969	1970	1971	1972		
Pennsylvania	M.D.				x	Pending	
Pennsylvania	D.S.C.			x		Conviction	5/72
Pennsylvania	D.O.			x		Conviction	7/71
Pennsylvania	D.O.			x		Conviction	8/71
Pennsylvania	D.O.		x			Conviction	4/71
Pennsylvania	D.O.			x		Conviction	4/72
Pennsylvania	M.D.				x	Pending	
Pennsylvania	M.D.			x		Pending	
Pennsylvania	D.S.C.		x			Conviction	10/70
Puerto Rico	M.D.			x		Pending	
South Carolina	M.D.	x				Conviction	12/69
South Carolina	OTH				x	Conviction	8/72
South Carolina	OTH				x	Conviction	8/72
South Dakota	M.D.		x			Pending	
Tennessee	M.D.		x			Conviction	2/71
Texas	M.D.				x	Pending	

ENCLOSURE II

PROSECUTIONS FOR MEDICARE FRAUD
JANUARY 1969-JULY 1972
BY STATE, PROFESSIONAL CATEGORY, YEAR PROSECUTION UNDERTAKEN, DISPOSITION AND DATE

State	Professional Category	Criminal Information Filed or Indictment Obtained				Disposition and Date	
		1969	1970	1971	1972		
Texas	M.D.				x	Pending	
Texas	M.D.			x		Dismissal	6/71
Texas	HHA				x	Pending	
Texas	HHA				x	Pending	
Texas	D.O.				x	Pending	
Virginia	M.D.				x	Acquittal	1/72
Virginia	M.D.		x			Nol Pros	6/70

American CMS

EXHIBIT 3
Page 1

Examples of "Professional Standards" in Congressional Testimony presented by the San Joaquin Foundation for Medical Care to the Senate Committee on Finance.

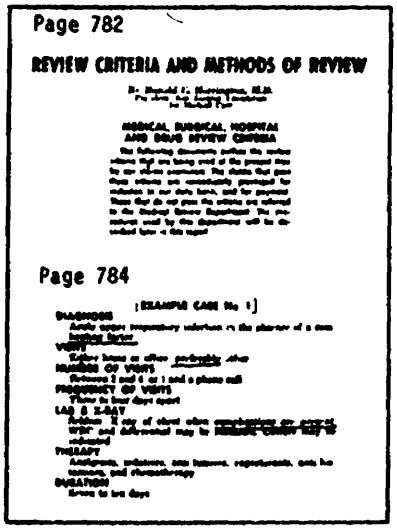
Exhibit 3-A

"Standards" for Care: The Common Cold

HEARINGS BEFORE THE SUBCOMMITTEE ON MEDICARE-MEDICAID OF THE COMMITTEE ON FINANCE, UNITED STATES SENATE, NINETY-FIRST CONGRESS, SECOND SESSION
Part 2 of 2 Parts. April 14 and 15, May 26 and 27, June 2, 3, 15 and 16, 1970

Page 782

REVIEW CRITERIA AND METHODS OF REVIEW



Page 784

Page 784

DIAGNOSIS
Acute upper respiratory infection in the absence of a complicating factor.
VISITS
Either home or office, preferably office.
NUMBER OF VISITS
Between 2 and 4, or 1 and a phone call.
FREQUENCY OF VISITS
Three to four days apart
LAB & X-RAY
Seldom. X-ray of chest when complications are present. WBC and differential may be indicated. Culture may be indicated.
THERAPY
Analgesics, sedatives, antitussives, expectorants, anti-histamines, and chemotherapy.
DURATION
Seven to ten days.

Cost of Diagnosis and Treatment per COLD! by PSRO:

CMS COMMENT: The diagnosis already states the case is not complicated. The diagnosis is uncertain and complications uncertain until after the patient recovers. If tests are done and complications found, the case changes and the computer files it elsewhere, and the statistics on colds are the same. If tests are not done, and a cancer of lung missed, the computer is just as happy. CMS is of the opinion that to Peer Review the diagnosis and treatment of every case of the common cold is an insult to the medical profession.

A. "PSRO" – TYPE GUIDELINES:

Office visit	$7.00	
Drugs - one cold	7.00	
WBC	7.00	
Culture and sensitivity	20.00	Total $41.00

B. "PSRO" – TYPE GUIDELINES: Cost of Treatment for Colds for U. S. Population.
For 200 million population, 4 colds per year at $41.00 per cold, plus one X-ray of chest out of 10 colds seen = $34 Billion.

200 Million x $41.00 x 4 = $32.8 Billion
200 Million x 4 x $15.00 X-ray / 10 = + 1.2 Billion = Total $34 Billion

All patients, of course, do not see doctors – but those who do will have the full treatment. With PSRO, more of them will have more of these "approved" visits and treatment. PSRO will create the Legal Framework for Fraud.

Comment: Cost of Treating "Colds" Under PSRO = $34 Billion!

EXHIBIT 3 (continued) American CMS
Page 2

Exhibit 3-B Limitation by a Peer Review Organization (Foundation) of choice of doctor and pharmacist thru "Prior Authorization and Permission before she can go to another physician."

Page 663

This has been corrected. This patient, if you will scan it here, saw four doctors in 1 day, received four prescriptions and went to four pharmacies. We worked with our welfare department. She is now on prior authorization and has one physician who is dedicated to take care of her and she must receive permission to go to another physician. Patient over-utilization is a problem, not as great as some people would believe but it is a problem.

[1] The book referred to appears as app. B of this hearing
42-133—70—pt 3---31

CMS asks: Just how much money is saved by seeking poor old women who see "too many doctors and take too many pills"? Does this justify a national computer network utilizing hundreds of physicians and a vast bureaucracy nationwide to become detectives for little old ladies?

Exhibit 3-C Letters to Doctors to question treatment:

HOW TO SAVE MONEY ON TOE-NAIL TRIMMING

Page 792

792

MEDI-CAL CLAIMS OFFICE
San Joaquin Foundation for Medical Care
445 WEST ACACIA STREET
TELEPHONE 948 9231
P O DRAWER "O", STOCKTON, CALIFORNIA 95201

March 6, 1968

Re:

Dear Doctor

Your patient , at Convalescent Hospital, received toenail trimming on January 31, 1968 by Dr.

If you authorized such care, please initial and return -- if not, would you so state, and return.

Sincerely yours,

M.D., Chairman
Review Committee

Yes; she has since had one become bed-ridden & under D.C.'s - However, because of ingrowing of Lat. edges she will require more treatment

CMS Comment: The treatment costs $7. The letter costs $4 each way. Add the cost of the computer and the reviewing. Is PSRO saving money on toe-nails?

EXHIBIT 4 American CMS

Page 1

FURTHER EXAMPLE OF "PROFESSIONAL STANDARDS" FOR MEDICARE COMPUTER REVIEW BY INSURANCE CARRIERS – 1970

In 1970, the Louisiana State Medical Society was asked to approve these Computer Professional Standards for Medicare. The Society refused.
A: Letter of Transmittal by Medical Society Committee.

OCHSNER CLINIC
1514 JEFFERSON HIGHWAY
NEW ORLEANS, LA. 70121
CABLE ADDRESS OCHSCLINIC

MERRILL O. HINES, M. D.
MEDICAL DIRECTOR
SEYMOUR P. OCHSNER, M. D.
ASSOCIATE MEDICAL DIRECTOR
WILLIAM L. G ARY, M. D.
ASSISTANT MEDICAL DIRECTOR
FRANK A. RIDDICK, JR., M. D.
ASSISTANT MEDICAL DIRECTOR

April 10, 1970

President
Orleans Parish Medical Society
1430 Tulane Avenue
New Orleans, Louisiana

Dear

You will find herewith a photostat of a letter I recently received from Mr. B. K. Osigian, Jr., asking for help. I am today writing to Dr. Achton Thomas of the State Society, asking how we can go forward with getting these guidelines approved by the Parish and State Societies.

With the pressure becoming greater to have peer review and other revisions, I believe this is something we should do.

Will you let me hear from you as to your recommendations as to how we should proceed.

When these were drawn up a year or two ago, it was my understanding that they would be sent to the Parish Medical Society, and on to the State Society for approval and implementation.

I will await instructions from you and from Sleepy Thomas as to how we should proceed. Thank you for your help in this and many other instances. Warm personal regards.

Yours very sincerely,

Merrill O. Hines, M.D.
Medical Director

mkw

EXHIBIT 4 (Continued) American CMS

Sample page of Professional Standards for Medicare Computer in 1970 in Louisiana. Other pages detailed surgical, medical and specialty care guidelines for in-patient and out-patient treatment.

MAINTENANCE CARE

Periodic observation and nonspecific treatment or established effective treatment

I. Asymptomatic or stabilized heart disease, hypertension, lung disease, arthritis, stroke, etc.

   A. Evaluation every six months

   B. Necessary laboratory, X-ray, EKG, etc., studies annually

II. Routine cancer followup (asymptomatic and more than one year after treatment)

   A. Evaluation every six months

   B. Special studies as indicated annually

III. Routine followup for chronic nervous system disorder

   A. Stroke -- evaluation every six months

   B. Organic brain syndrome -- evaluation monthly

   C. Psychiatric disease stabilized or in remission -- evaluation monthly

   D. Personality disorder -- evaluation weekly

& Diagnostic News Vol. 4, No. 14 July 15, 1971

'Deception' Charged to HEW In Medicare, Medicaid Changes

Internal Medicine News Service

WASHINGTON—The Council of Medical Staffs has confronted officials of the Department of Health, Education, and Welfare with evidence to show that deception was used in promulgating new regulations requiring earlier certification of Medicare and Medicaid hospital patients.

A showdown came at a meeting here presided over by Rep. Hale Boggs of New Orleans, the Democratic majority leader.

Dr. Jose L. Garcia Oller, president of the Council, said news releases from HEW erroneously implied that there was widespread cheating by practicing physicians in treating Medicare and Medicaid patients He noted that data which do not exist were cited to justify a proposal to require physician certification of Medicaid patients on the 12th and 18th days of their hospital stays rather than on the 14th and 21st as regulations now provide.

The Council asked that the proposed 12- and 18-day regulation for Medicaid patients not be adopted and that a similar regulation for Medicare, which went into effect in 1970, be rescinded.

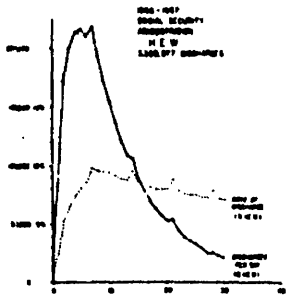
Thomas Laughlin Jr., associate commissioner of HEW's Social and Rehabilitation Service, and Thomas M. Tierney, director of HEW's Bureau of Health Insurance, said the Council's request would be studied.

The Council unsuccessfully opposed the regulation for Medicare when it was announced late in 1969. A news release from the Social Security Administration, dated Oct. 13, 1969, was challenged as being deceptively misleading.

The release said the new regulation "is expected to shorten hospital stays and thus reduce Medicare costs."

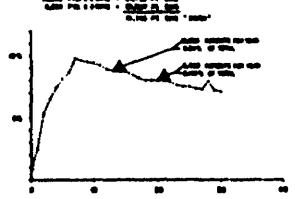
"To illustrate the potential cost savings to the program," the release continued, "Secretary (Robert H.) Finch noted that if each hospital stay by a Medicare beneficiary during 1970 is shortened by one day, Medicare costs will be reduced by approximately $400 million."

Dr. Garcia Oller said the $400 million figure used in the release was allowed to stand despite specific advice from Robert J. Myers, then chief actuary for HEW, that the actual savings would not be more than $5 million.



Vertical axis indicates number of patients discharged on the left column and discharge ratio on the right column. Horizontal axis indicates day of hospitalization since admission.

The curve shows 109,853 patients were discharged on the 13th day and 106,761 on the 14th day. This actual drop in discharges is a small shoulder in the curve of discharges (HEW), but becomes a peak in HEW's "discharge ratio." The tiny rise at 21 days and the unnoticeable rise at 28 days are also amplified into peaks by HEW and ascribed to "certification." Yet there is no certification on the 28th day, a Council spokesman notes.



Vertical axis indicates discharge ratio and the horizontal axis indicates days in hospital for the period October, 1966, to June, 1967.

The HEW claim of $400 million savings is fraudulent, says a spokesman for the Council of Medical Staffs. The correct estimate would be $4.17 million, at $100 per diem. Assuming the peaks of the ratio of discharge at 14 and 21 days are caused by certification and assuming that peaks are the termination of "unnecessarily prolonged hospital stays," HEW claimed to save $400 million by pushing these peaks back through a change in certification dates. If the 14 day peak is moved 2 days and the 21 day peak is moved 3 days, the saving would be 41,743 patient days per year nationwide. At a generous $100 per diem this amounts to $4.17 million, not $400 million as claimed by HEW. HEW was aware of this error when the claim was made, the Council spokesman says.

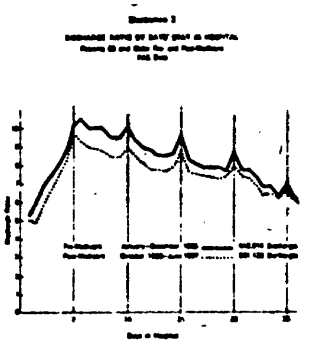
Mr. Myers calculated that to shift the peak discharge rate to the 12th and 18th days "is to reduce the average days of hospitalization by discharge by .014 days, which represents a savings of $5 million per year."

The 1969 HEW release contained the statement:

> 'Data on length of stays in hospitals under the (Medicare) program show that the number of discharges rises significantly on the 14th day and again on the 21st day,' Secretary Finch said. 'Since there is no apparent medical reason why discharges should peak on these days, it seems reasonable to conclude that the requirement for certification and recertification on certain days is in itself a factor contributing to the larger number of discharges on such days.
>
> 'We expect that a reasonable shortening of the certification periods will result in some decrease in the number of unnecessarily prolonged hospital stays.'

Dr. Garcia Oller said a reader of this release would infer that practicing physi-

33-013 O - 74 - pt. 1 - 22

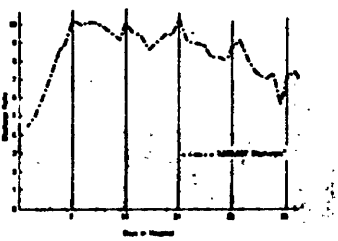


PAS data shown above establishes that the insignificant peaks of discharge ratios antedate Medicare and could have no relation to the requirement to certify.

cians were cheating the government by holding patients in hospitals without medical cause.

In addition, he cited HEW's own statistics showing that in the period October, 1966-June, 1967, the discharges of Medicare patients actually dropped from 109,053 on the 13th day to 106,761 on the 14th. There were 52,924 discharges on the 20th day, 53,614 on the 21st.

He stated that a discharge ratio invented by HEW to amplify minor deviations in the curve of discharges showed insignificant peaks on the 7th, 14th, and 21st days. HEW attributed these peaks to the Medicare requirement for certification and regarded this as proof that the regulation was effective in terminating "unnecessarily prolonged hospital stays." But, the Council noted, figures compiled by the Professional Activity Study of the Commission on Professional and Hospital Activities showed identical peaks for patients 65 years and older even before Medicare was established. This proves that the peaks were not the result of Medicare certification, he said. SSA did not collect this control data before making its assertion.



Certification change in 1970 fails to move discharge ratio peaks. On January 1, 1970, Medicare regulation was changed to require certification to the 12th day and recertification to the 18th day. If successful, the regulation would have moved the 14- and 21-day peaks to the 12th and 18th days. As shown, there was no change in the discharge pattern. Yet on March 30, 1971, HEW claimed that the Medicare regulation had "reduced hospital stays significantly," the Council spokesman notes.

"Thus the regulation really had no effect, and the rationale does not support the regulation." Dr. Garcia Oller commented.

An HEW news release on March 30, 1971 announced the department's intention to extend the 12- and 18-day regulation to Medicaid. A paragraph in the release read:

'Experience with Medicare has shown that requiring certification or recertification by physicians reduces hospital stays significantly,' Federal Social and Rehabilitation Administrator John D. Twinane said. 'Applying this requirement to Medicaid can cut its costs without lowering the quality of care. Thus we can provide for needed medical care, without unnecessary costs to the taxpayers.' "

The Council asked Rep. Boggs to obtain the data on the experience with Medicare which the news release cited, and was told by the Congressman: "The data used to justify the proposed regulations relative to certification and recertification of Title XIX. . . .is the same as that developed by the SSA in 1969."

"HEW said the experience with Medicare justified the new regulation for Medicaid, yet the department can cite no data to back up the claim," said Dr. Garcia Oller. Data on the effect of the new regulation do exist and have been published. A PAS study on a comparable number of Medicare discharges has shown that there has been no change in the 14- and 21-day discharge ratio peaks in spite of the change in certification to the 12th and 18th days in January, 1970.

By HEW's own yardstick, therefore, the Medicare experience with the January, 1970, regulation does not justify the claims of any savings or benefit from the certification regulation made in the March 30, 1971, HEW news release, Dr. Garcia-Oller said.

State Sen. William J. Guste Jr. of New Orleans, who made the Council's presentation at the Washington meeting, asked that the Medicaid regulation not be put into force because it is "unwarranted, unnecessary, ineffectual and against the public interest."

The Council was represented by members of its executive committee, including Dr. Garcia Oller; Dr. Kenneth Ritter, vice-president; Dr. Robert Meade, vice-president; Dr. Edward S. Hyman, secretary; and Dr Wesley Segre, treasurer.

HEW officials present included Mr. Laughlin; Mr. Tierney; Hugh Johnson, assistant SSA commissioner; Al Richter and the Rev. Homer Jolley, of the Medicaid administration.

Aides of Louisiana senators and representatives also attended, along with Rep. Boggs himself.

The Council of Medical Staffs lists a membership of more than 20,000 practicing physicians on the staffs of 300 hospitals in a dozen states. There are chapters in California, Louisiana, Michigan, Ohio Texas, Florida, New Jersey, Kansas, Oklahoma, Minnesota, Nevada, New Mexico and Rhode Island.

EXHIBIT 6
Page 1

American CMS

HOW THE AMA'S "PRO" CAME ABOUT: REPORT V – BOARD OF TRUSTEES

REPORT OF THE BOARD OF TRUSTEES

Report: V
(A-70)

Subject: Status of AMA Medicredit Bill

Presented by: Burtis E. Montgomery, M. D., Chairman

Referred to: Reference Committee B
(A. W. Neilson, Sr., M. D., Chairman)

The House of Delegates has adopted as policy a plan to encourage individuals and families to obtain comprehensive health insurance through the medium of tax credit incentives. For those in the lower tax liability group, the premiums would be paid by the federal government through a certificate issued to the beneficiary and redeemed by the carrier. This plan, known as Medicredit, has been cast in legislative language as a proposed bill.

Medicredit was the basis for the AMA's testimony before the House Ways and Means Committee on November 3, 1969. Speaking to the full House Committee, Dr. Russell B. Roth told of the AMA's interest and concern which led to the formation of the bill, described the purposes of the bill, and provided the Committee with a description of the bill's provisions.

On March 11, 1970, the AMA representatives were invited by Congressman Wilbur D. Mills, Chairman of the House Ways and Means Committee, to meet with the Committee in executive session to discuss problems of Medicare and Medicaid. The Committee indicated that it was particularly interested in suggestions for overcoming the deficiencies of Medicaid, recommendations for control of costs and charges under the program, and a method to handle and reduce abuses. In the discussion, it became evident that most members of the Committee were seeking a way to control and reduce the alleged abuses by providers under the Medicare and Medicaid programs. The AMA witnesses were repeatedly questioned on the validity and probable success of peer review mechanisms. At the conclusion of the hearing, both the Committee Chairman and the Minority Leader asked the Association witnesses to formulate a plan whereby physicians and medical societies would have the responsibility for effective peer review under the Medicare and Medicaid programs.

At about the same time the Administration developed the Health Costt Effectiveness Act, a proposal aimed at reducing costs under Part A and Part B and controlling alleged abuses. One section of this proposal called for the Secretary of HEW to establish "review teams" throughout the country to evaluate the costs and charges for services provided by physicians, the quality of services, and the quantity and the necessity for such services. These teams would include non-physician members. (If the recommendation of certain HEW advisory groups were to be accepted, more than 50% of the review panel members would be laymen.)

Past House Action: C-68:111-115, 197; A-68:193

EXHIBIT 6 (Continued) American CMS

Page 2

B. of T. Rep. V - page 2

On May 21, 1970, the House of Representatives passed H. R. 17550, the Social Security Amendments of 1970. It included in substantial part the Administration's proposal for program review as contained in the Health Cost Effectiveness Act.

On June 15, 1970, the AMA and the National Medical Association made a joint presentation before the Senate Finance Committee concerning current problems in Medicare and Medicaid. The Committee was informed by Dr. Dorman and Dr. Roth of our Medicredit proposal. At that time, the Chairman of the Committee, Senator Long, expressed strong interest in the development of an appropriate peer review mechanism for the two programs.

In view of the May 21, 1970, action of the House of Representatives in adopting the Administration's proposal for "Program Review Teams" rather than peer review, and in view of the House Ways and Means and Senate Finance Committees' interest in a Medicine organized and operated peer review plan, a structured peer review mechanism under the direction of state and local medical societies has been added to the Medicredit bill.

Thus, the latest draft of the AMA Medicredit bill consists of three parts. The first part provides assistance for the medically indigent family and is intended to meet the problems of the current Medicaid program. It requires the Federal government to issue certificates to lower income individuals and families which can be used by the beneficiary in meeting the full premium cost of a qualified health insurance program.

The second part encourages the purchase of qualified and comprehensive health insurance coverage through the use of a tax credit mechanism. On a sliding scale basis, dependent on their tax liability, individuals and families would receive a tax credit of a portion of the cost of the premium for such coverage.

The third part of the Medicredit proposal incorporates into the bill a provision for a structured peer review organization. Under PRO, the Secretary of HEW would contract with a state medical society (or any organization designated by a state medical society to enter into such agreement) for the establishment and operation of a peer review organization in the state. The agreement may provide for a peer review mechanism established in accordance with certain requirements set out in the bill or under a plan approved by the Secretary and state medical society which is intended to accomplish the same result.

If the parties agree to the first course of action, PRO would require the state medical society (or entity it designates) to appoint a Commission to administer the program and an Advisory Council. The Commission would appoint Local Review Panels to review the need for and quality of medical services furnished under federally supported programs and the appropriateness of charges for such services. The Commission would also appoint Local Advisory Councils.

EXHIBIT 6 (Continued)

American CMS

Each panel would determine, on information obtained, if there is sufficient cause for a hearing. If a hearing is called and the Panel determines that disciplinary action is warranted, it would make such recommendation to the Commission. Upon review, if the Commission agrees that any disciplinary action is warranted, it would so recommend to the Secretary of HEW. The Secretary could accept or reduce (but not increase) the recommended disciplinary action.

PRO also provides that the actions of the witnesses and Commission and Panel members would not be the basis for civil action for libel or slander; that the reasonable expenses incurred in the establishment and operation of the program would be reimbursed; that records and evidence developed in the hearing could not be used in other actions, civil or criminal; and that either party could terminate the agreement upon giving notice.

PRO answers criticism directed at earlier drafts of Medicredit — that it contained no provision for controlling rising costs and abuses under the Medicare and Medicaid programs.

Mr. Speaker and Members of the House of Delegates:

Reference Committee B makes the following recommendations on the matters referred to it and considered in open hearing with members, representatives of the Student American Medical Association, and guests present and participating in the discussion.

(1) REPORT V OF BOARD OF TRUSTEES - STATUS OF AMA MEDICREDIT BILL

Report V of the Board of Trustees is a status report on the AMA Medicredit proposal, with particular emphasis on a new provision which has been added to the draft bill -- "Peer Review Organization" (PRO). While the concept and design of AMA's Medicredit bill have been previously approved by this body, PRO, because it is new, deserves separate consideration at this time.

During the discussion, many physicians and representatives of the Student American Medical Association spoke in favor of PRO, citing the need for an effective peer review mechanism. There was no comment in opposition.

Mr. Speaker, we commend the Board and both the Council on Medical Service and the Council on Legislation for their expert work in the development of the AMA bill. We believe that PRO is a necessary and important addition to the bill and recommend its support.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that "Peer Review Organization" (PRO) be supported and that the Board of Trustees Report V be approved. Adopted.

EXHIBIT 7 American CMS

Page 1

AMA TESTIMONY ON PSRO 1970

SOCIAL SECURITY AMENDMENTS OF 1970
Hearings before the Committee on Finance United States Senate
91st Congress, Second Session
on H. R. 17550
September, 1970

(Pages 1083, 1090, 1091)

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION PRESENTED BY WILLIAM O. LAMOTTE, JR., M.D.

Mr. Chairman and Members of the Committee: I am Doctor William O. LaMotte, Jr., a physician in practice in Wilmington, Delaware, and presently the Chairman of the Council on Legislation of the American Medical Association. With me are Mr. Bernard P. Harrison, Director of the AMA Division of Medical Practice, and Mr. Harry N. Peterson, Director of the Legislative Department.

Page 1083

We are pleased to appear before this Committee again to present the American Medical Association's views on the Medicare and Medicaid Programs and specifically concerning certain provisions of H.R. 17550, the Social Security Amendments of 1970, as they relate to the two programs.

Last June, representatives of the AMA and the National Medical Association appeared before you to discuss the provision of health care through these programs. We also presented our own Medicredit Program for the provision of

MEDICREDIT

Page 1090

I will now turn briefly to our Medicredit proposal, which was presented to this Committee at the time we appeared in June. Since then it has been introduced in the House of Representatives, and has received the sponsorship of twenty-eight members. Under this tax credit program the federal government would assist in the financing of medical and hospital care for individuals and their dependents through participation in the cost of qualified insurance policies of their choice—100% premium payment for the low-income groups, and graduated participation in the payment of premiums for other persons, based on their federal income tax liability.

I shall not go into full details of this program, because they are already before you, and because your current hearings center on H.R. 17550 which we have discussed. However, the portion of Medicredit relating to Peer Review Organization (PRO) is particularly germane to these hearings.

1091

AMA recognizes need for "surveillance."

Page 1091

PRO was incorporated with Medicredit because the medical profession recognizes the need for an appropriate means of providing surveillance over the provision of medical services rendered under the program. PRO would act to review the reasonableness of charges made, as well as the need for and quality of the medical services provided.

Under this program, the Secretary would enter into agreements with a state medical society (or any organization designated or established by a state medical society), which, under a plan approved by the Secretary and the society, would provide a system of peer review of medical and other health services rendered under Titles 5, 18, and 19. The state program would be administered by a PRO Commission, consisting of five members who are doctors of medicine or osteopathy. The society would appoint an Advisory Council, composed of persons who are representatives of consumers, providers of health care, and insurance carriers. Local Review Panels consisting of physicians appointed by the State Commission are designated to administer the plan locally. A Local Advisory Council, created to advise the Panel, would include persons who are representative of consumers, providers of health care, and carriers administering Part B of Medicare.

Matters for review would first be heard by the Local Panel, which after notice and hearing, would make the initial determination on the case. Any recommendation for censure or discipline would be reviewed by the PRO Commission. A finding of the Commission for discipline would be forwarded to the Secretary of HEW who may implement the Commission's recommendation of discipline or, if he deems the recommended discipline to be excessive, may modify such recommendation. Discipline would include suspension or exclusion from further participation in the health programs. The right of judicial review is provided.

Mr. Chairman, the foregoing presents the essence of PRO, but does not include all of its provisions. The full program is contained in material already provided to you.

AMA TESTIMONY ON PSRO - Ct'd. EXHIBIT 7 (Continued) American CMS

SOCIAL SECURITY AMENDMENTS OF 1970
Hearings before the Committee on Finance United States Senate
91st Congress, Second Session
on H. R. 17550
September, 1970

(Pages 1091, 1092)

AMA Statement on Bennett Amendment (Amendment No. 851)

AMENDMENT NO. 851

This Committee has before it Amendment No. 851 for a Professional Standards Review Organization (PSRO). This amendment would establish a broad program for review of all services provided under Titles 5, 18 and 19. While its objective is similar to that of our PRO and such is laudatory, we find that significant changes should be made to Amendment 851.

PSRO objective is "laudatory."

The amendment provides that the Secretary should enter into agreements with qualified organizations to act as the Professional Standards Review Organization in a local area. While the amendment provides for the designation of a medical society as the PSRO, there is no requirement as in PRO that this should be the state medical society. Where the Secretary finds that the medical society is not qualified or willing, he may then designate such other public, nonprofit private, or other agency or organization, which the Secretary accepts as qualified to act in the area. The composition of the Professional Standards Review Organization is not specified in the amendment, and consequently there is no assurance that a physician's services will in fact be reviewed by his practicing peers. This is necessary if the profession is to be held accountable for its performance. This is necessary if the recipients of services are to be assured of quality care.

Page 1091

Another provision of the amendment requires that admissions to health care facilities for elective procedures, as well as extended or costly services, be reviewed in advance, and that prospective determination also be made whether contemplated inpatient hospitalization should be provided on an outpatient basis or at a less expensive facility. Mr. Chairman, we submit that the application of this requirement would often create difficulties and would not be in the interest of the patient. Corollary questions of responsibility and legal liability are also raised, as well as questions concerning the role of the institutional medical staff and the local PSRO concerning services provided in the institution. We believe that the provision for advance approval should be eliminated.

Opposes advance certification of hospital admissions.

PSRO also provides for the review of services of not only physicians and other health care practitioners, but also all institutional providers of health care service and here, again, is an area where PSRO differs from our PRO. We believe that the PSRO requirement is too broad; physician review of services should be confined to services of the physician and such other services over which he has direct control and responsibility.

Another provision of the amendment creates "Norms of Health Care Services for Various Illnesses or Health Conditions." Such national or regional norms

1092

must be approved by the National Review Organization. At the local level, each review organization, agency or person performing review functions shall utilize the norms developed as a principal point of evaluation as to whether the services are medically necessary, whether the quality meets professional standards, or whether inpatient services could be provided on an outpatient basis or more economically in a facility of a different type. Norms of treatment as to a particular illness or condition would further indicate appropriate methods and sites for treatment.

Opposes Norms for Health Care.

While the section provides for variation of practice different from the norm established, a tendency for adherence to the published norm carries within itself a potential detriment to the provision of higher quality care. On one side of the norm may be lower cost services as contrasted with a different service at a higher level of care. A review group looking to the costs of the program could find a level of institutionalization or treatment medically unnecessary. A physician may for these reasons, or reasons stemming from concern for legal ramifications which may arise from departure from such norms or for fear of subjecting himself to the penalty and refund provisions, find compulsion to conform to these standards in derogation of better care. We believe that the imposition of such national norms may impede, rather than strengthen, the development of the health programs. The imposition of such norms could well be looked on as a floor of acceptability, with an attendant lessening in quality care. Mr. Chairman, we believe that this provision for national norms, backed by the force of law, should not be adopted without an opportunity for a thorough evaluation of its consequences.

PSRO a potential detriment to quality medical care

Page 1092

The amendment further provides under certain circumstances for a monetary fine on a physician or provider of up to $5,000 for continued eligibility under the program, or for a refund of charges where the services were determined by PSRO to be medically improper or unnecessary. We believe that this imposition of a monetary fine subverts the purpose of peer review. Fundamentally, peer review is an educational mechanism, and this aspect is a positive benefit which redounds to the program. This new inquisitional character of peer review, however, based on the criminal aspects and fines, would change the character of the program and we believe that the beneficial aspects would suffer. While we see no place for a monetary fine in peer review, we, of course, recognize that where the facts warrant, separate civil or criminal action could be instituted.

Compulsion to conform to standards

True Peer Review is educational; PSRO is inquisitional in character of Peer Review.

Page 39

EXHIBIT 7 (continued) American CMS

AMA Statement on Bennett Amendment (Amendment No. 851), Page 1092 continued

Confidentiality of medical files

Page 1092

Other provisions, relating to the acquisition, ownership and control of profiles of patients', physicians', and providers' records of participation in the program, as well as concerning data required by the Secretary to be collected relevant to its functions and information, also differ from those in PRO. We believe that the confidentiality of these files should be protected and that they should be under the continuing jurisdiction of the appropriate review body, and should not become federal property.

The amendment also authorizes demonstration projects under which the PSRO would assume the responsibility and risk with respect to the review and payment of claims. It would appear to us an inappropriate mixing of functions—combining an underwriting concept with peer review.

In summary, then, Mr. Chairman, we believe that Amendment 851, introduced on August 20, 1970, requires additional critical evaluation. The amendment carries a potential for vast changes in the provision of health care programs. Differing views have been expressed from many quarters concerning the various proposals pending before you in the form of section 227 of H.R. 17550, PRO, and PSRO. Peer review itself is now ongoing. The concept of peer review as a structured mechanism is still new.

We believe that if the Committee cannot accept the Peer Review Organization proposal contained in the Ullman bill, consideration of review of services as to quality and charges should lay over to the next Congress. The future direction of peer review should not be cast in the statutory language of either section 227 or PSRO.

Mr. Chairman, we wish to thank you for this opportunity to present the Association's views on this important legislation, and we will at this time attempt to answer any questions which the Committee may have.

The CHAIRMAN. I think you have done a good job, Dr. LaMotte, in summarizing a very able statement that I, for one, will certainly carefully study, and we will certainly see that these points are considered as we go through this bill.

EXHIBIT 8 American CMS

SENATOR BENNETT RESPONDS TO AMA TESTIMONY ON PSRO.

SOCIAL SECURITY AMENDMENTS OF 1970
Hearings before the Committee on Finance United States Senate
91st Congress, Second Session
on H. R. 17550
September, 1970

(Page 1093)

I do not believe we have any further questions.

Senator BENNETT. May I have just a minute or two, since I am the author of the PSRO amendment and, of course, since the AMA should know that the basic concept behind the amendment is theirs, it seems to me we are talking about details of operation and not principles.

We are not locked into the language of the amendment, and I am sure as we study your suggestions we will try to develop whatever changes seem to be wise.

I think it would be very foolish to put this thing off because we are now working on the problem. It may be 5 years before we can get back to it again and the alternative to peer review is Government control and, as far as I see it, we are giving the medical association the medical fraternity, an opportunity to police itself through the peer review mechanism.

"I hope the American Medical Association will not desert its own child and say now . . ."

The mechanics of what kind of a peer review organization we set up and exactly how it operates are subject to study and change. But I hope the American Medical Association will not desert its own child and say now, "that there are so many troubles with it that we would rather you went back to something else," and I hope the committee will study the proposal, which has been carefully worked out with many of the factors in the situation, including the American Medical Association. Its officers have been consulted along the line, as this program has developed. We have not always agreed with them.

There are three comments that I would like to make today where changes might be made: First, there is probably no reason to cause the PSRO to maintain separate patient profiles as long as these records are readily available for review as necessary. It seems sufficient that carriers and the intermediaries have the patient records so that they can be made available.

Second, some of the superstructure of the PSRO arrangement probably can be dispensed with to streamline the administration, and to provide a more effective statewide supervision of local PSRO's.

Third, the preadmission certification procedure can be streamlined to make it clear that only reimbursement under medicare is at stake, not the health of the patient and not the right of the doctor to put his patient in a hospital; and, second, to give the PSRO discretion to waive preadmission certification for diagnosis when they feel that the area is more or less obvious or when they are dealing with a doctor whose pattern indicates that his judgment can be trusted.

I think the PSRO organization should have the right of review under any circumstances, but I think practical experience will dictate that it will not be a required procedure in every case, but will only be used when there is some indication that this review is necessary.

There are other things in your statement that I am going to study very carefully. It hit me pretty fast. I did not have an opportunity to see it in advance.

I do want to say we are not anxious to set up a rigid system which will so circumscribe the physician in his practice or the hospital in its service to the patient that we will lower the quality of medcal services. But I am sure you are aware that there have been rather gross misuses of the system. There has been overutilization that has been serious. I was not here yesterday, but I understand we had testimony that there are many physicians who have used medicare not only as a

EXHIBIT 9 American CMS

Page 1

REPORT OF THE BOARD OF TRUSTEES
AND
THE COUNCIL ON MEDICAL SERVICE

Report: Z
(C-72)

Subject: Professional Standards Review Organizations

Presented by: John R. Kernodle, M. D., Chairman, Board of Trustees
William B. Hildebrand, M. D., Chairman, Council on Medical Service

Referred to: Reference Committee A
(Robert C. Combs, M. D., Chairman)

Public Law 92-603 (HR 1), which enacted the Professional Standards Review program for Medicare and Medicaid programs, was signed into law on October 30, 1972. As yet, none of the details of the program, beyond what is contained in the language of the law itself, have been formalized; the process of writing the Federal regulations and of defining the boundaries of the areas in which Professional Standards Review Organizations (PSROs) will operate has not yet begun.

When this legislation was under consideration by the Congress, the American Medical Association questioned whether a government operated program of mandatory peer review geared in large part to cost control could be effective without reducing the quality of patient care.

Notwithstanding this concern, however, since P.L. 92-603 has been adopted, the Council on Medical Service and the Board of Trustees believe that the American Medical Association, as in the case of the Medicare and Medicaid programs, should provide a dominant role of leadership in the implementation of the PSRO program to assure that the best interests of the public and the profession are preserved.

The Board of Trustees and the Council on Medical Service therefore recommend that this House of Delegates authorize the Board of Trustees to create within the American Medical Association an Advisory Committee on Professional Standards Review, to include members from the Board of Trustees and the Council on Medical Service, and that the Board of Trustees be authorized to invite other appropriate organizations to participate in this Committee.

The Board of Trustees and the Council on Medical Service suggest that the initial assignment of this Advisory Committee include the following responsibilities:

(1) To provide input from the medical profession in the development of the rules and regulations which will govern the Professional Standards Review program;

(2) To assist state medical associations, or state medical associations in concert with county medical societies,

in developing Professional Standards Review Organizations, and to recommend structures and operating mechanisms for such PSROs;

(3) To aid in defining appropriate geographic boundaries for PSROs, especially in instances where more than one state may be involved;

(4) To develop and transmit to PSROs recommended operational procedures;

(5) To assure that the development of "norms of health care services" called for in the law in regard to medical necessity of care provided, length of stay, and appropriateness of the site of care shall have full input from the various medical specialties and the medical profession generally and shall recognize regional and local differences in patterns of medical care;

(6) To identify sources of existing data and experience which can be used as a basis for developing such regional or local norms of health care services, as well as identifying those areas in which current data are insufficient for this purpose and need further development;

(7) To develop suggested continuing education programs through which physicians can secure for themselves and their patients the full benefit of the application and refinement of Professional Standards Review;

(8) To develop and maintain liaison with appropriate governmental agencies involved in the Professional Standards Review program, as well as with other third parties and agencies involved and interested in the effective and efficient delivery of health care services.

Public Law 92-603
92nd Congress, H. R. 1
October 30, 1972

An Act

86 STAT. 1329

To amend the Social Security Act, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act, with the following table of contents, may be cited as the "Social Security Amendments of 1972". Social Security Amendments of 1972.

TABLE OF CONTENTS

LIMITATION ON INSTITUTIONAL CARE

Sec. 249D. Section 121(b) of the Social Security Amendments of 1965 is amended by adding at the end thereof the following new sentence: "After the date of enactment of the Social Security Amendments of 1972, Federal matching shall not be available for any portion of any payment by any State under title I, X, XIV, or XVI, or part A of title IV, of the Social Security Act for or on account of any medical or any other type of remedial care provided by an institution to any individual as an inpatient thereof, in the case of any State which has a plan approved under title XIX of such Act, if such care is (or could be) provided under a State plan approved under title XIX of such Act by an institution certified under such title XIX.". 79 Stat., 332. 42 USC 1396b note. 42 USC 301, 1201, 1351, 1381, 601. 42 USC 1396.

DETERMINING ELIGIBILITY FOR ASSISTANCE UNDER TITLE XIX FOR CERTAIN INDIVIDUALS

Sec. 249E. For purposes of section 1902(a)(10) of the Social Security Act any individual who, for the month of August 1972, was eligible for or receiving aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV of such Act and who for such month was entitled to monthly insurance benefits under title II of such Act shall be deemed to be eligible for such aid or assistance for any month thereafter prior to October 1974 if such individual would have been eligible for such aid or assistance for such month had the increase in monthly insurance benefits under title II of such Act resulting from enactment of Public Law 92-336 not been applicable to such individual. 42 USC 1396a. Ante, p. 408.

PROFESSIONAL STANDARDS REVIEW

Sec. 249F. (a) The heading to title XI of the Social Security Act is amended by striking out 42 USC 1301.

"TITLE XI—GENERAL PROVISIONS"

and inserting in lieu thereof

"TITLE XI—GENERAL PROVISIONS AND PROFESSIONAL STANDARDS REVIEW

"PART A—GENERAL PROVISIONS"

(b) Title XI of such Act is further amended by adding the following:

"PART B—PROFESSIONAL STANDARDS REVIEW

"DECLARATION OF PURPOSE

"Sec. 1151. In order to promote the effective, efficient, and economical delivery of health care services of proper quality for which payment may be made (in whole or in part) under this Act and in recognition of the interests of patients, the public, practitioners, and providers in improved health care services, it is the purpose of this part to assure, through the application of suitable procedures of professional standards review, that the services for which payment may be made under the Social Security Act will conform to appropriate professional standards for the provision of health care and that payment for such services will be made—

"(1) only when, and to the extent, medically necessary, as determined in the exercise of reasonable limits of professional discretion; and

"(2) in the case of services provided by a hospital or other health care facility on an inpatient basis, only when and for such period as such services cannot, consistent with professionally recognized health care standards, effectively be provided on an outpatient basis or more economically in an inpatient health care facility of a different type, as determined in the exercise of reasonable limits of professional discretion.

"DESIGNATION OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

"SEC. 1152. (a) The Secretary shall (1) not later than January 1, 1974, establish throughout the United States appropriate areas with respect to which Professional Standards Review Organizations may be designated, and (2) at the earliest practicable date after designation of an area enter into an agreement with a qualified organization whereby such an organization shall be conditionally designated as the Professional Standards Review Organization for such area. If, on the basis of its performance during such period of conditional designation, the Secretary determines that such organization is capable of fulfilling, in a satisfactory manner, the obligations and requirements for a Professional Standards Review Organization under this part, he shall enter into an agreement with such organization designating it as the Professional Standards Review Organization for such area.

"(b) For purposes of subsection (a), the term 'qualified organization' means—

"Qualified organization."

"(1) when used in connection with any area—

"(A) an organization (i) which is a nonprofit professional association (or a component organization thereof), (ii) which is composed of licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in such area, (iii) the membership of which includes a substantial proportion of all such physicians in such area, (iv) which is organized in a manner which makes available professional competence to review health care services of the types and kinds with respect to which Professional Standards Review Organizations have review responsibilities under this part, (v) the membership of which is voluntary and open to all doctors of medicine or osteopathy licensed to engage in the practice of medicine or surgery in such area without requirement of membership in or payment of dues to any organized medical society or association, and (vi) which does not restrict the eligibility of any member for service as an officer of the Professional Standards Review Organization or eligibility for and assignment to duties of such Professional Standards Review Organization, or, subject to subsection (c)(i),

"(B) such other public, nonprofit private, or other agency or organization, which the Secretary determines, in accordance with criteria prescribed by him in regulations, to be of professional competence and otherwise suitable; and

"(2) an organization which the Secretary, on the basis of his examination and evaluation of a formal plan submitted to him by the association, agency, or organization (as well as on the basis of other relevant data and information), finds to be willing to perform and capable of performing, in an effective, timely, and objective manner and at reasonable cost, the duties, functions, and

activities of a Professional Standards Review Organization required by or pursuant to this part.

"(c)(1) The Secretary shall not enter into any agreement under this part under which there is designated as the Professional Standards Review Organization for any area any organization other than an organization referred to in subsection (b)(1)(A) prior to January 1, 1976, nor after such date, unless, in such area, there is no organization referred to in subsection (b)(1)(A) which meets the conditions specified in subsection (b)(2).

"(2) Whenever the Secretary shall have entered into an agreement under this part under which there is designated as the Professional Standards Review Organization for any area any organization other than an organization referred to in subsection (b)(1)(A), he shall not renew such agreements with such organization if he determines that—

"(A) there is in such area an organization referred to in subsection (b)(1)(A) which (i) has not been previously designated as a Professional Standards Review Organization, and (ii) is willing to enter into an agreement under this part under which such organization would be designated as the Professional Standards Review Organization for such area;

"(B) such organization meets the conditions specified in subsection (b)(2); and

"(C) the designation of such organization as the Professional Standards Review Organization for such area is anticipated to result in substantial improvement in the performance in such area of the duties and functions required of such organizations under this part.

"(d) Any such agreement under this part with an organization (other than an agreement established pursuant to section 1154) shall be for a term of 12 months; except that, prior to the expiration of such term such agreement may be terminated—

"(1) by the organization at such time and upon such notice to the Secretary as may be prescribed in regulations (except that notice of more than 3 months may not be required); or

"(2) by the Secretary at such time and upon such reasonable notice to the organization as may be prescribed in regulations, but only after the Secretary has determined (after providing such organization with an opportunity for a formal hearing on the matter) that such organization is not substantially complying with or effectively carrying out the provisions of such agreement.

"(e) In order to avoid duplication of functions and unnecessary review and control activities, the Secretary is authorized to waive any or all of the review, certification, or similar activities otherwise required under or pursuant to any provision of this Act (other than this part) where he finds, on the basis of substantial evidence of the effective performance of review and control activities by Professional Standards Review Organizations, that the review, certification, and similar activities otherwise so required are not needed for the provision of adequate review and control.

"(f)(1) In the case of agreements entered into prior to January 1, 1976, under this part under which any organization is designated as the Professional Standards Review Organization for any area, the Secretary shall, prior to entering into any such agreement with any organization for any area, inform (under regulations of the Secretary) the doctors of medicine or osteopathy who are in active practice in such area of the Secretary's intention to enter into such an agreement with such organization.

Agreement exceptions, prior termination.

Waiver.

Agreement notice.

"(2) If, within a reasonable period of time following the serving of such notice, more than 10 per centum of such doctors object to the Secretary's entering into such an agreement with such organization on the ground that such organization is not representative of doctors in such area, the Secretary shall conduct a poll of such doctors to determine whether or not such organization is representative of such doctors in such area. If more than 50 per centum of the doctors responding to such poll indicate that such organization is not representative of such doctors in such area the Secretary shall not enter into such an agreement with such organization.

"REVIEW PENDING DESIGNATION OF PROFESSIONAL STANDARDS REVIEW ORGANIZATION

"Sec. 1153. Pending the assumption by a Professional Standards Review Organization for any area, of full review responsibility, and pending a demonstration of capacity for improved review effort with respect to matters involving the provision of health care services in such area for which payment (in whole or in part) may be made, under this Act, any review with respect to such services which has not been designated by the Secretary as the full responsibility of such organization, shall be reviewed in the manner otherwise provided for under law.

"TRIAL PERIOD FOR PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

"Sec. 1154. (a) The Secretary shall initially designate an organization as a Professional Standards Review Organization for any area on a conditional basis with a view to determining the capacity of such organization to perform the duties and functions imposed under this part on Professional Standards Review Organizations. Such designation may not be made prior to receipt from such organization and approval by the Secretary of a formal plan for the orderly assumption and implementation of the responsibilities of the Professional Standards Review Organization under this part.

Plan, approval.

"(b) During any such trial period (which may not exceed 24 months), the Secretary may require a Professional Standards Review Organization to perform only such of the duties and functions required under this part of Professional Standards Review Organization as he determines such organization to be capable of performing. The number and type of such duties shall, during the trial period, be progressively increased as the organization becomes capable of added responsibility so that, by the end of such period, such organization shall be considered a qualified organization only if the Secretary finds that it is substantially carrying out in a satisfactory manner, the activities and functions required of Professional Standards Review Organizations under this part with respect to the review of health care services provided or ordered by physicians and other practitioners and institutional and other health care facilities, agencies, and organizations. Any of such duties and functions not performed by such organization during such period shall be performed in the manner and to the extent otherwise provided for under law.

Duties.

"(c) Any agreement under which any organization is conditionally designated as the Professional Standards Review Organization for any area may be terminated by such organization upon 90 days notice to the Secretary or by the Secretary upon 90 days notice to such organization.

Termination, notice.

"DUTIES AND FUNCTIONS OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

"Sec. 1155. (a) (1) Notwithstanding any other provision of law, but consistent with the provisions of this part, it shall (subject to the provisions of subsection (g)) be the duty and function of each Professional Standards Review Organization for any area to assume, at the earliest date practicable, responsibility for the review of the professional activities in such area of physicians and other health care practitioners and institutional and noninstitutional providers of health care services in the provision of health care services and items for which payment may be made (in whole or in part) under this Act for the purpose of determining whether—

"(A) such services and items are or were medically necessary;

"(B) the quality of such services meets professionally recognized standards of health care; and

"(C) in case such services and items are proposed to be provided in a hospital or other health care facility on an inpatient basis, such services and items could, consistent with the provision of appropriate medical care, be effectively provided on an outpatient basis or more economically in an inpatient health care facility of a different type.

"(2) Each Professional Standards Review Organization shall have the authority to determine, in advance, in the case of—

"(A) any elective admission to a hospital, or other health care facility, or

"(B) any other health care service which will consist of extended or costly courses of treatment,

whether such service, if provided, or if provided by a particular health care practitioner or by a particular hospital or other health care facility, organization, or agency, would meet the criteria specified in clauses (A) and (C) of paragraph (1).

"(3) Each Professional Standards Review Organization shall, in accordance with regulations of the Secretary, determine and publish, from time to time, the types and kinds of cases (whether by type of health care or diagnosis involved, or whether in terms of other relevant criteria relating to the provision of health care services) with respect to which such organization will, in order most effectively to carry out the purposes of this part, exercise the authority conferred upon it under paragraph (2).

Case criteria, publication.

"(4) Each Professional Standards Review Organization shall be responsible for the arranging for the maintenance of and the regular review of profiles of care and services received and provided with respect to patients, utilizing to the greatest extent practicable in such patient profiles, methods of coding which will provide maximum confidentiality as to patient identity and assure objective evaluation consistent with the purposes of this part. Profiles shall also be regularly reviewed on an ongoing basis with respect to each health care practitioner and provider to determine whether the care and services ordered or rendered are consistent with the criteria specified in clauses (A), (B), and (C) of paragraph (1).

Patient profiles, maintenance and review.

"(5) Physicians assigned responsibility for the review of hospital care may be only those having active hospital staff privileges in at least one of the participating hospitals in the area served by the Professional Standards Review Organization and (except as may be otherwise provided under subsection (e) (1) of this section) such physicians ordinarily should not be responsible for, but may participate in the review of care and services provided in any hospital in which such physicians have active staff privileges.

Hospital care, physician review.

"(6) No physician shall be permitted to review—

"(A) health care services provided to a patient if he was directly or indirectly involved in providing such services, or

"(B) health care services provided in or by an institution, organization, or agency, if he or any member of his family has, directly or indirectly, any financial interest in such institution, organization, or agency.

Physician's family.

For purposes of this paragraph, a physician's family includes only his spouse (other than a spouse who is legally separated from him under a decree of divorce or separate maintenance), children (including legally adopted children), grandchildren, parents, and grandparents.

"(b) To the extent necessary or appropriate for the proper performance of its duties and functions, the Professional Standards Review Organization serving any area is authorized in accordance with regulations prescribed by the Secretary to—

"(1) make arrangements to utilize the services of persons who are practitioners of or specialists in the various areas of medicine (including dentistry), or other types of health care, which persons shall, to the maximum extent practicable, be individuals engaged in the practice of their profession within the area served by such organization;

"(2) undertake such professional inquiry either before or after, or both before and after, the provision of services with respect to which such organization has a responsibility for review under subsection (a)(1);

"(3) examine the pertinent records of any practitioner or provider of health care services providing services with respect to which such organization has a responsibility for review under subsection (a)(1); and

"(4) inspect the facilities in which care is rendered or services provided (which are located in such area) of any practitioner or provider.

"(c) No Professional Standards Review Organization shall utilize the services of any individual who is not a duly licensed doctor of medicine or osteopathy to make final determinations in accordance with its duties and functions under this part with respect to the professional conduct of any other duly licensed doctor of medicine or osteopathy, or any act performed by any duly licensed doctor of medicine or osteopathy in the exercise of his profession.

"(d) In order to familiarize physicians with the review functions and activities of Professional Standards Review Organizations and to promote acceptance of such functions and activities by physicians, patients, and other persons, each Professional Standards Review Organization, in carrying out its review responsibilities, shall (to the maximum extent consistent with the effective and timely performance of its duties and functions)—

"(1) encourage all physicians practicing their profession in the area served by such Organization to participate as reviewers in the review activities of such Organizations;

"(2) provide rotating physician membership of review committees on an extensive and continuing basis;

"(3) assure that membership on review committees have the broadest representation feasible in terms of the various types of practice in which physicians engage in the area served by such Organization; and

"(4) utilize, whenever appropriate, medical periodicals and similar publications to publicize the functions and activities of Professional Standards Review Organizations.

Review committees.

"(e)(1) Each Professional Standards Review Organization shall utilize the services of, and accept the findings of, the review committees of a hospital or other operating health care facility or organization located in the area served by such organization, but only when and only to the extent and only for such time that such committees in such hospital or other operating health care facility or organization have demonstrated to the satisfaction of such organization their capacity effectively and in timely fashion to review activities in such hospital or other operating health care facility or organization (including the medical necessity of admissions, types and extent of services ordered, and lengths of stay) so as to aid in accomplishing the purposes and responsibilities described in subsection (a)(1), except where the Secretary disapproves, for good cause, such acceptance.

Regulations.

"(2) The Secretary may prescribe regulations to carry out the provisions of this subsection.

Agreement requirements.

"(f)(1) An agreement entered into under this part between the Secretary and any organization under which such organization is designated as the Professional Standards Review Organization for any area shall provide that such organization will—

"(A) perform such duties and functions and assume such responsibilities and comply with such other requirements as may be required by this part or under regulations of the Secretary promulgated to carry out the provisions of this part; and

"(B) collect such data relevant to its functions and such information and keep and maintain such records in such form as the Secretary may require to carry out the purposes of this part and to permit access to and use of any such records as the Secretary may require for such purposes.

"(2) Any such agreement with an organization under this part shall provide that the Secretary make payments to such organization equal to the amount of expenses reasonably and necessarily incurred, as determined by the Secretary, by such organization in carrying out or preparing to carry out the duties and functions required by such agreement.

"(g) Notwithstanding any other provision of this part, the responsibility for review of health care services of any Professional Standards Review Organization shall be the review of health care services provided by or in institutions, unless such Organization shall have made a request to the Secretary that it be charged with the duty and function of reviewing other health care services and the Secretary shall have approved such request.

"NORMS OF HEALTH CARE SERVICES FOR VARIOUS ILLNESSES OR HEALTH CONDITIONS

"Sec. 1156. (a) Each Professional Standards Review Organization shall apply professionally developed norms of care, diagnosis, and treatment based upon typical patterns of practice in its regions (including typical lengths-of-stay for institutional care by age and diagnosis) as principal points of evaluation and review. The National Professional Standards Review Council and the Secretary shall provide such technical assistance to the organization as will be helpful in utilizing and applying such norms of care, diagnosis, and treatment. Where the actual norms of care, diagnosis, and treatment in a Professional Standards Review Organization area are significantly different from professionally developed regional norms of care, diagnosis, and

treatment approved for comparable conditions, the Professional Standards Review Organization concerned shall be so informed, and in the event that appropriate consultation and discussion indicate reasonable basis for usage of other norms in the area concerned, the Professional Standards Review Organization may apply such norms in such area as are approved by the National Professional Standards Review Council.

"(b) Such norms with respect to treatment for particular illnesses or health conditions shall include (in accordance with regulations of the Secretary)—

"(1) the types and extent of the health care services which, taking into account differing, but acceptable, modes of treatment and methods of organizing and delivering care are considered within the range of appropriate diagnosis and treatment of such illness or health condition, consistent with professionally recognized and accepted patterns of care;

"(2) the type of health care facility which is considered, consistent with such standards, to be the type in which health care services which are medically appropriate for such illness or condition can most economically be provided.

Preparation and distribution of data.

"(c)(1) The National Professional Standards Review Council shall provide for the preparation and distribution, to each Professional Standards Review Organization and to each other agency or person performing review functions with respect to the provision of health care services under this Act, of appropriate materials indicating the regional norms to be utilized pursuant to this part. Such data concerning norms shall be reviewed and revised from time to time. The approval of the National Professional Standards Review Council of norms of care, diagnosis, and treatment shall be based on its analysis of appropriate and adequate data.

"(2) Each review organization, agency, or person referred to in paragraph (1) shall utilize the norms developed under this section as a principal point of evaluation and review for determining, with respect to any health care services which have been or are proposed to be provided, whether such care and services are consistent with the criteria specified in section 1155(a)(1).

Ante, p. 1433.

"(d)(1) Each Professional Standards Review Organization shall—

"(A) in accordance with regulations of the Secretary, specify the appropriate points in time after the admission of a patient for inpatient care in a health care institution, at which the physician attending such patient shall execute a certification stating that further inpatient care in such institution will be medically necessary effectively to meet the health care needs of such patient; and

"(B) require that there be included in any such certification with respect to any patient such information as may be necessary to enable such organization properly to evaluate the medical necessity of the further institutional health care recommended by the physician executing such certification.

"(2) The points in time at which any such certification will be required (usually, not later than the 50th percentile of lengths-of-stay for patients in similar age groups with similar diagnoses) shall be consistent with and based on professionally developed norms of care and treatment and data developed with respect to length of stay in health care institutions of patients having various illnesses, injuries, or health conditions, and requiring various types of health care services or procedures.

"SUBMISSION OF REPORTS BY PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

"SEC. 1157. If, in discharging its duties and functions under this part, any Professional Standards Review Organization determines that any health care practitioner or any hospital, or other health care facility, agency, or organization has violated any of the obligations imposed by section 1160, such organization shall report the matter to the Statewide Professional Standards Review Council for the State in which such organization is located together with the recommendations of such Organization as to the action which should be taken with respect to the matter. Any Statewide Professional Standards Review Council receiving any such report and recommendation shall review the same and promptly transmit such report and recommendation to the Secretary together with any additional comments or recommendations thereon as it deems appropriate. The Secretary may utilize a Professional Standards Review Organization, in lieu of a program review team as specified in sections 1862 and 1866, for purposes of subparagraph (C) of section 1862(d)(1) and subparagraph (F) of section 1866(b)(2).

Post, p. 1432.

79 Stat. 325; 81 Stat. 844; 42 USC 1395y, 1395cc.

Ante, p. 1408.

"REQUIREMENT OF REVIEW APPROVAL AS CONDITION OF PAYMENT OF CLAIMS

Ante, p. 1409.

"SEC. 1158. (a) Except as provided for in section 1159, no Federal funds appropriated under any title of this Act (other than title V) for the provision of health care services or items shall be used (directly or indirectly) for the payment, under such title or any program established pursuant thereto, of any claim for the provision of such services or items, unless the Secretary, pursuant to regulation determines that the claimant is without fault if—

81 Stat. 921; 42 USC 701.

"(1) the provision of such services or items is subject to review under this part by any Professional Standards Review Organization, or other agency; and

"(2) such organization or other agency has, in the proper exercise of its duties and functions under or consistent with the purposes of this part, disapproved of the services or items giving rise to such claim, and has notified the practitioner or provider who provided or proposed to provide such services or items and the individual who would receive or was proposed to receive such services or items of its disapproval of the provision of such services or items.

"(b) Whenever any Professional Standards Review Organization, in the discharge of its duties and functions as specified by or pursuant to this part, disapproves of any health care services or items furnished or to be furnished by any practitioner or provider, such organization shall, after notifying the practitioner, provider, or other organization or agency of its disapproval in accordance with subsection (a), promptly notify the agency or organization having responsibility for acting upon claims for payment for or on account of such services or items.

"HEARINGS AND REVIEW BY SECRETARY

"SEC. 1159. (a) Any beneficiary or recipient who is entitled to benefits under this Act (other than title V) or a provider or practitioner who is dissatisfied with a determination with respect to a claim made by a Professional Standards Review Organization in carrying out its responsibilities for the review of professional activities in accordance with paragraphs (1) and (2) of section 1155(a) shall, after being

Ante, p. 1432.

notified of such determination, be entitled to a reconsideration thereof by the Professional Standards Review Organization and, where the Professional Standards Review Organization reaffirms such determination in a State which has established a Statewide Professional Standards Review Council, and where the matter in controversy is $100 or more, such determination shall be reviewed by professional members of such Council and, if the Council so determined, revised.

"(b) Where the determination of the Statewide Professional Standards Review Council is adverse to the beneficiary or recipient (or, in the absence of such Council in a State and where the matter in controversy is $100 or more), such beneficiary or recipient shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and, where the amount in controversy is $1,000 or more, to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). The Secretary will render a decision only after appropriate professional consultation on the matter.

53 Stat. 1368, 42 USC 405.

"(c) Any review or appeals provided under this section shall be in lieu of any review, hearing, or appeal under this Act with respect to the same issue.

"OBLIGATIONS OF HEALTH CARE PRACTITIONERS AND PROVIDERS OF HEALTH CARE SERVICES; SANCTIONS AND PENALTIES; HEARINGS AND REVIEW

"SEC. 1160. (a)(1) It shall be the obligation of any health care practitioner and any other person (including a hospital or other health care facility, organization, or agency) who provides health care services for which payment may be made (in whole or in part) under this Act, to assure that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this Act—

"(A) will be provided only when, and to the extent, medically necessary; and

"(B) will be of a quality which meets professionally recognized standards of health care; and

"(C) will be supported by evidence of such medical necessity and quality in such form and fashion and at such time as may reasonably be required by the Professional Standards Review Organization in the exercise of its duties and responsibilities;

and it shall be the obligation of any health care practitioner in ordering, authorizing, directing, or arranging for the provision by any other person (including a hospital or other health care facility, organization, or agency), of health care services for any patient of such practitioner, to exercise his professional responsibility with a view to assuring (to the extent of his influence or control over such patient, such person, or the provision of such services) that such services or items will be provided—

"(D) only when, and to the extent, medically necessary; and

"(E) will be of a quality which meets professionally recognized standards of health care.

"(2) Each health care practitioner, and each hospital or other provider of health care services, shall have an obligation, within reasonable limits of professional discretion, not to take any action, in the exercise of his profession (in the case of any health care practitioner), or in the conduct of its business (in the case of any hospital or other such provider), which would authorize any individual to be admitted as an inpatient in or to continue as an inpatient in any hospital or other health care facility unless—

"(A) inpatient care is determined by such practitioner and by such hospital or other provider, consistent with professionally recognized health care standards, to be medically necessary for the proper care of such individual; and

"(B)(i) the inpatient care required by such individual cannot, consistent with such standards, be provided more economically in a health care facility of a different type; or

"(ii) (in the case of a patient who requires care which can, consistent with such standards, be provided more economically in a health care facility of a different type) there is, in the area in which such individual is located, no such facility or no such facility which is available to provide care to such individual at the time when care is needed by him.

"(b)(1) If after reasonable notice and opportunity for discussion with the practitioner or provider concerned, any Professional Standards Review Organization submits a report and recommendations to the Secretary pursuant to section 1157 (which report and recommendations shall be submitted through the Statewide Professional Standards Review Council, if such Council has been established, which shall promptly transmit such report and recommendations together with any additional comments and recommendations thereon as it deems appropriate) and if the Secretary determines that such practitioner or provider, in providing health care services over which such organization has review responsibility and for which payment (in whole or in part) may be made under this Act has—

Report and recommendations.

Ante, p. 1427.

"(A) by failing, in a substantial number of cases, substantially to comply with any obligation imposed on him under subsection (a), or

"(B) by grossly and flagrantly violating any such obligation in one or more instances,

demonstrated an unwillingness or a lack of ability substantially to comply with such obligations, he (in addition to any other sanction provided under law) may exclude (permanently for such period as the Secretary may prescribe) such practitioner or provider from eligibility to provide such services on a reimbursable basis.

"(2) A determination made by the Secretary under this subsection shall be effective at such time and upon such reasonable notice to the public and to the person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of institutional health care services such determination shall be effective in the manner provided in title XVIII with respect to terminations of provider agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

79 Stat. 291, 42 USC 1395.

"(3) In lieu of the sanction authorized by paragraph (1), the Secretary may require that (as a condition to the continued eligibility of such practitioner or provider to provide such health care services on a reimbursable basis) such practitioner or provider pay to the United States, in case such acts or conduct involved the provision or ordering by such practitioner or provider of health care services which were medically improper or unnecessary, an amount not in excess of the actual or estimated cost of the medically improper or unnecessary services so provided, or (if less) $5,000. Such amount may be deducted from any sums owing by the United States (or any instrumentality thereof) to the person from whom such amount is claimed.

"(4) Any person furnishing services described in paragraph (1) who is dissatisfied with a determination made by the Secretary under this subsection shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

53 Stat. 1368. 42 USC 405.

"(c) It shall be the duty of each Professional Standards Review Organization and each Statewide Professional Standards Review Council to use such authority or influence it may possess as a professional organization, and to enlist the support of any other professional or governmental organization having influence or authority over health care practitioners and any other person (including a hospital or other health care facility, organization, or agency) providing health care services in the area served by such review organization, in assuring that each practitioner or provider (referred to in subsection (a)) providing health care services in such area shall comply with all obligations imposed on him under subsection (a).

"NOTICE TO PRACTITIONER OR PROVIDER

"SEC. 1161. Whenever any Professional Standards Review Organization takes any action or makes any determination—

"(a) which denies any request, by a health care practitioner or other provider of health care services, for approval of a health care service or item proposed to be ordered or provided by such practitioner or provider; or

"(b) that any such practitioner or provider has violated any obligation imposed on such practitioner or provider under section 1160,

such organization shall, immediately after taking such action or making such determination, give notice to such practitioner or provider of such determination and the basis therefor, and shall provide him with appropriate opportunity for discussion and review of the matter.

"STATEWIDE PROFESSIONAL STANDARDS REVIEW COUNCILS; ADVISORY GROUPS TO SUCH COUNCILS

Establishment.

"SEC. 1162. (a) In any State in which there are located three or more Professional Standards Review Organizations, the Secretary shall establish a Statewide Professional Standards Review Council.

Membership.

"(b) The membership of any such Council for any State shall be appointed by the Secretary and shall consist of—

"(1) one representative from and designated by each Professional Standards Review Organization in the State;

"(2) four physicians, two of whom may be designated by the State medical society and two of whom may be designated by the State hospital association of such State to serve as members on such Council; and

"(3) four persons knowledgeable in health care from such State whom the Secretary shall have selected as representatives of the public in such State (at least two of whom shall have been recommended for membership on the Council by the Governor of such State).

Duties.

"(c) It shall be the duty and function of the Statewide Professional Standards Review Council for any State, in accordance with regulations of the Secretary, (1) to coordinate the activities of, and disseminate information and data among the various Professional Standards Review Organizations within such State including assisting the Secretary in development of uniform data gathering procedures and operating procedures applicable to the several areas in a State (including, where appropriate, common data processing operations serving several or all areas) to assure efficient operation and objective evaluation of comparative performance of the several areas and, (2) to assist the Secretary in evaluating the performance of each Professional Standards Review Organization, and (3) where the Secretary finds it necessary to replace a Professional Standards Review Organization, to assist him in developing and arranging for a qualified replacement Professional Standards Review Organization.

Payments.

"(d) The Secretary is authorized to enter into an agreement with any such Council under which the Secretary shall make payments to such Council equal to the amount of expenses reasonably and necessarily incurred, as determined by the Secretary, by such Council in carrying out the duties and functions provided in this section.

"(e)(1) The Statewide Professional Standards Review Council for any State (or in a State which does not have such Council, the Professional Standards Review Organizations in such State which have agreements with the Secretary) shall be advised and assisted in carrying out its functions by an advisory group (of not less than seven nor more than eleven members) which shall be made up of representatives of health care practitioners (other than physicians) and hospitals and other health care facilities which provide within the State health care services for which payment (in whole or in part) may be made under any program established by or pursuant to this Act.

Member selection, regulations.

"(2) The Secretary shall by regulations provide the manner in which members of such advisory group shall be selected by the Statewide Professional Standards Review Council (or Professional Standards Review Organizations in States without such Councils).

Expenses.

"(3) The expenses reasonably and necessarily incurred, as determined by the Secretary, by such group in carrying out it duties and functions under this subsection shall be considered to be expenses necessarily incurred by the Statewide Professional Standards Review Council served by such group.

"NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL

Establishment; membership.

"SEC. 1163. (a)(1) There shall be established a National Professional Standards Review Council (hereinafter in this section referred to as the 'Council') which shall consist of eleven physicians, not otherwise in the employ of the United States, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

5 USC 101 et seq.

Term of membership.

"(2) Members of the Council shall be appointed for a term of three years and shall be eligible for reappointment.

"(3) The Secretary shall from time to time designate one of the members of the Council to serve as Chairman thereof.

Qualifications.

"(b) Members of the Council shall consist of physicians of recognized standing and distinction in the appraisal of medical practice. A majority of such members shall be physicians who have been recommended by the Secretary to serve on the Council by national organizations recognized by the Secretary as representing practicing physicians. The membership of the Council shall include physicians who have been recommended for membership on the Council by consumer groups and other health care interests.

Consultants.

"(c) The Council is authorized to utilize, and the Secretary shall make available, or arrange for, such technical and professional consultative assistance as may be required to carry out its functions, and the

Secretary shall, in addition, make available to the Council such secretarial, clerical and other assistance and such pertinent data prepared by, for, or otherwise available to, the Department of Health, Education, and Welfare as the Council may require to carry out its functions.

Compensation.

5 USC 5332 note.

"(d) Members of the Council, while serving on business of the Council, shall be entitled to receive compensation at a rate fixed by the Secretary (but not in excess of the daily rate paid under GS-18 of the General Schedule under section 5332 of title 5, United States Code), including traveltime; and while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in Government service employed intermittently.

Duties.

"(e) It shall be the duty of the Council to—

"(1) advise the Secretary in the administration of this part;

"(2) provide for the development and distribution, among Statewide Professional Standards Review Councils and Professional Standards Review Organizations of information and data which will assist such review councils and organizations in carrying out their duties and functions;

"(3) review the operations of Statewide Professional Standards Review Councils and Professional Standards Review Organizations with a view to determining the effectiveness and comparative performance of such review councils and organizations in carrying out the purposes of this part; and

"(4) make or arrange for the making of studies and investigations with a view to developing and recommending to the Secretary and to the Congress measures designed more effectively to accomplish the purposes and objectives of this part.

Report to Secretary and Congress.

"(f) The National Professional Standards Review Council shall from time to time, but not less often than annually, submit to the Secretary and to the Congress a report on its activities and shall include in such report the findings of its studies and investigations together with any recommendations it may have with respect to the more effective accomplishment of the purposes and objectives of this part. Such report shall also contain comparative data indicating the results of review activities, conducted pursuant to this part, in each State and in each of the various areas thereof.

"APPLICATION OF THIS PART TO CERTAIN STATE PROGRAMS RECEIVING FEDERAL FINANCIAL ASSISTANCE

"SEC. 1164. (a) In addition to the requirements imposed by law as a condition of approval of a State plan approved under any title of this Act under which health care services are paid for in whole or part, with Federal funds, there is hereby imposed the requirement that provisions of this part shall apply to the operation of such plan or program.

"(b) The requirement imposed by subsection (a) with respect to such State plans approved under this Act shall apply—

"(1) in the case of any such plan where legislative action by the State legislature is not necessary to meet such requirement, on and after January 1, 1974; and

"(2) in the case of any such plan where legislative action by the State legislature is necessary to meet such requirement, whichever of the following is earlier—

"(A) on and after July 1, 1974, or

"(B) on and after the first day of the calendar month which first commences more than ninety days after the close of the first regular session of the legislature of such State which begins after December 31, 1973.

"CORRELATION OF FUNCTIONS BETWEEN PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS AND ADMINISTRATIVE INSTRUMENTALITIES

"SEC. 1165. The Secretary shall by regulations provide for such correlation of activities, such interchange of data and information, and such other cooperation consistent with economical, efficient, coordinated, and comprehensive implementation of this part (including, but not limited to, usage of existing mechanical and other data-gathering capacity) between and among—

"(a) (1) agencies and organizations which are parties to agreements entered into pursuant to section 1816, (2) carriers which are parties to contracts entered into pursuant to section 1842, and (3) any other public or private agency (other than a Professional Standards Review Organization) having review or control functions, or proved relevant data-gathering procedures and experience, and

79 Stat. 297.
42 USC 1395h.
42 USC 1395u.

"(b) Professional Standards Review Organizations, as may be necessary or appropriate for the effective administration of title XVIII, or State plans approved under this Act.

42 USC 1395.

"PROHIBITION AGAINST DISCLOSURE OF INFORMATION

"SEC. 1166. (a) Any data or information acquired by any Professional Standards Review Organization, in the exercise of its duties and functions, shall be held in confidence and shall not be disclosed to any person except (1) to the extent that may be necessary to carry out the purposes of this part or (2) in such cases and under such circumstances as the Secretary shall by regulations provide to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care.

Penalty.

"(b) It shall be unlawful for any person to disclose any such information other than for such purposes, and any person violating the provisions of this section shall, upon conviction, be fined not more than $1,000, and imprisoned for not more than six months, or both, together with the costs of prosecution.

"LIMITATION ON LIABILITY FOR PERSONS PROVIDING INFORMATION, AND FOR MEMBERS AND EMPLOYEES OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS, AND FOR HEALTH CARE PRACTITIONERS AND PROVIDERS

"SEC. 1167. (a) Notwithstanding any other provision of law, no person providing information to any Professional Standards Review Organization shall be held, by reason of having provided such information, to have violated any criminal law, or to be civilly liable under any law, of the United States or of any State (or political subdivision thereof) unless—

"(1) such information is unrelated to the performance of the duties and functions of such Organization, or

"(2) such information is false and the person providing such information knew, or had reason to believe, that such information was false.

"(b) (1) No individual who, as a member or employee of any Professional Standards Review Organization or who furnishes profes-

sional counsel or services to such organization, shall be held by reason of the performance by him of any duty, function, or activity authorized or required of Professional Standards Review Organizations under this part, to have violated any criminal law, or to be civilly liable under any law, of the United States or of any State (or political subdivision thereof) provided he has exercised due care.

"(2) The provisions of paragraph (1) shall not apply with respect to any action taken by any individual if such individual, in taking such action, was motivated by malice toward any person affected by such action.

"(c) No doctor of medicine or osteopathy and no provider (including directors, trustees, employees, or officials thereof) of health care services shall be civilly liable to any person under any law of the United States or of any State (or political subdivision thereof) on account of any action taken by him in compliance with or reliance upon professionally developed norms of care and treatment applied by a Professional Standards Review Organization (which has been designated in accordance with section 1152(b)(1)(A)) operating in the area where such doctor of medicine or osteopathy or provider took such action but only if—

Ante, p. 1430.

"(1) he takes such action (in the case of a health care practitioner) in the exercise of his profession as a doctor of medicine or osteopathy (or in the case of a provider of health care services) in the exercise of his functions as a provider of health care services, and

"(2) he exercised due care in all professional conduct taken or directed by him and reasonably related to, and resulting from, the actions taken in compliance with or reliance upon such professionally accepted norms of care and treatment.

"AUTHORIZATION FOR USE OF CERTAIN FUNDS TO ADMINISTER THIS PROVISIONS OF THIS PART

"Sec. 1168. Expenses incurred in the administration of this part shall be payable from—

"(a) funds in the Federal Hospital Insurance Trust Fund;

"(b) funds in the Federal Supplementary Medical Insurance Trust Fund; and

"(c) funds appropriated to carry out the health care provisions of the several titles of this Act;

in such amounts from each of the sources of funds (referred to in subsections (a), (b), and (c)) as the Secretary shall deem to be fair and equitable after taking into consideration the costs attributable to the administration of this part with respect to each of such plans and programs.

"TECHNICAL ASSISTANCE TO ORGANIZATIONS DESIRING TO BE DESIGNATED AS PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

"Sec. 1169. The Secretary is authorized to provide all necessary technical and other assistance (including the preparation of prototype plans of organization and operation) to organizations described in section 1152(b)(1) which—

"(a) express a desire to be designated as a Professional Standards Review Organization; and

"(b) the Secretary determines have a potential for meeting the requirements of a Professional Standards Review Organization;

to assist such organizations in developing a proper plan to be submitted to the Secretary and otherwise in preparing to meet the requirements of this part for designation as a Professional Standards Review Organization.

"EXEMPTIONS OF CHRISTIAN SCIENCE SANATORIUMS

"Sec. 1170. The provisions of this part shall not apply with respect to a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts."

PHYSICAL THERAPY SERVICES AND OTHER THERAPY SERVICES UNDER MEDICARE

Sec. 251. (a)(1) Section 1861(p) of the Social Security Act is amended by adding at the end thereof (after and below paragraph (4)(B)) the following new sentence: "The term 'outpatient physical therapy services' also includes physical therapy services furnished an individual by a physical therapist (in his office or in such individual's home) who meets licensing and other standards prescribed by the Secretary in regulations, otherwise than under an arrangement with and under the supervision of a provider of services, clinic, rehabilitation agency, or public health agency, if the furnishing of such services meets such conditions relating to health and safety as the Secretary may find necessary."

81 Stat. 850. 42 USC 1395x.

(2) Section 1833 of such Act is amended by adding at the end thereof the following new subsection:

Ante, p. 1424.

"(g) In the case of services described in the next to last sentence of section 1861(p), with respect to expenses incurred in any calendar year, no more than $100 shall be considered as incurred expenses for purposes of subsections (a) and (b)."

(3) Section 1833(a)(2) of such Act (as amended by section 223(b) of this Act) is further amended by striking out the period at the end of subparagraph (B) and inserting in lieu thereof "; or", and by adding after subparagraph (B) the following new subparagraph:

Ante, p. 1411.

"(C) if such services are services to which the next to last sentence of section 1861(p) applies, the reasonable charges for such services."

(4) Section 1832(a)(2)(C) of such Act is amended by striking out "services," and inserting in lieu thereof "services, other than services to which the next to last sentence of section 1861(p) applies."

81 Stat. 851. 42 USC 1395z.

(b)(1) Section 1861(p) of such Act (as amended by subsection (a)(1) of this section) is further amended by adding at the end thereof the following new sentence: "In addition, such term includes physical therapy services which meet the requirements of the first sentence of this subsection except that they are furnished to an individual as an inpatient of a hospital or extended care facility."

(2) Section 1835(a)(2)(C) of such Act is amended by striking out "on an outpatient basis".

81 Stat. 851. 42 USC 1395n.

(c) Section 1861(v) of such Act (as amended by sections 221(c)(4) and 223(f) of this Act) is further amended by redesignating paragraphs (5) and (6) as paragraphs (6) and (7), respectively, and by inserting after paragraph (4) the following new paragraph:

Ante, p. 1394.

"(5)(A) Where physical therapy services, occupational therapy services, speech therapy services, or other therapy services or services of other health-related personnel (other than physicians) are furnished under an arrangement with a provider of services or other organization, specified in the first sentence of section 1861(p) the

The CHAIRMAN. Next we will call Dr. Lowell E. Bellin. Dr. Bellin is the Commissioner of Health for the city of New York.

STATEMENT OF LOWELL E. BELLIN, M.D., M.P.H., COMMISSIONER OF HEALTH AND ACTING HEALTH SERVICES ADMINISTRATOR, NEW YORK CITY

Dr. BELLIN. Thank you very much.

My name is Dr. Lowell E. Bellin. I am Commissioner of Health and Acting Health Services Administrator of New York City. I am currently on leave of absence from the Columbia University School of Public Health where I was head of the Division of Health Administration and professor of public health.

What are my credentials for testifying today on the PSRO before this august committee?

I am a board certified internist and hold the master of public health degree. Between 1967 and 1972, I was administratively responsible for New York City medicaid, initially as Executive Medical Director and thereafter as First Deputy Commissioner of the New York City Department of Health.

In 1970 I testified before the Senate Finance Committee and before the House Ways and Means Committee on the monitoring and policing techniques that my department had initiated to counteract the troika of medical abuses: fraud, poor quality, and overutilization. That testimony accelerated the development of the program we are discussing today.

I have been the author or coauthor of 20 papers in the professional literature on quality and cost control of health care services. I am currently a member of the task force to develop in Manhattan the first countywide PSRO in New York City. I have taught courses on quality and cost control of health care services.

I am not completely happy with the PSRO legislation as promulgated. I would have preferred that the job of review and enforcement of standards of health services had been assigned unambiguously to a governmental agency rather than to organized medicine.

But, in view of the political and organizational realities of health care delivery in this country, I acknowledge that the passage of Public Law 92–603 containing the PSRO provision was probably as far as Congress preferred to go at the present time. Public Law 92–603 represents one more historic step toward formal and substantive public accountability in delivery of health care services.

Despite our doubts, those of us who have participated in the agonies of administering medicaid and medicare since 1966 desperately want the PSRO to succeed. In order to enhance the possibility of success, it is obligatory to be candid about the serious problems implicit within the PSRO structure as legislatively contemplated. I shall identify the more important problems and shall seriatim suggest practical means of dealing with them.

Problem: The PSRO unit is the county medical society under a different name. The medical society is the trade organization of the practicing physician.

Even if we were to assume good faith on the part of all participants, how can we assure an operative arm's length relationship between (*a*) the practicing physician and (*b*) the PSRO physician who is supposed to assess objectively the quality of his colleague's performance? I have seen, at firsthand, the contortions that county societies have gone through when pressed for peer evaluation in first defending then justifying the soundness of the professional judgment of their members.

Arm's length evaluation remains the indispensable principle.

Answer: If this principle is compromised, within the next few years the PSRO program will be wracked with scandal. We shall witness the replication of the dismal record of the medicare utilization review committees. Medicare followed an incredible policy of quality control: Doctors from a specific hospital were actually called upon to assess the quality of professional work of their medical colleagues within their own hospital.

Depending upon the span of detachment, PSRO as proposed will range from the ineffectual to the unworkable unless we learn from the experience of medicare.

The problem is somewhat more soluble in the metropolis from whose populace PSRO physician assessors can be selected who are professionally and socially unacquainted with the practicing doctor under scrutiny. In New York City, for example, MD's from one borough could more objectively assess the performance of MD's from another borough.

The smalltown obviously poses a harder problem. Here all the doctors know each other, refer cases to each other, break bread with each other, play golf with each other. To make the PSRO program work here, it would be necessary to draw MD's from one town to evaluate the professional performance of MD's from another town.

Remember that the PSRO statutorily represents a major departure in policy from that of the medicare utilization review committee. The law forbids the PSRO physician from reviewing the quality of care within a hospital where he has staff privileges or a financial interest. This stipulation is prima facie evidence of congressional disenchantment with the objectivity of medicare utilization review committees where physicians from hospital A routinely checked other physicians from hospital A.

Problem: County and State medical societies run on the basis of voluntarism. Paid staff is limited to one or two members. The president receives no salary. The other officers are not paid. Individual MD members rarely manage anything more complex than a small office.

How will it be possible to assign to such a staffless medical society, with such limited programmatic experience, a quality control program that requires extraordinary administrative sophistication?

Answer: In the first phase of PSRO development, the medical societies will have to depend heavily on management and data processing consultants. To achieve inhouse PSRO capability, each medical society will have to become transmuted into an administratively adept organization. Each medical society will have to abandon its tradition of voluntarism and bring in paid staff.

Problem: Some medical societies will indefinitely resist such transition. Some medical societies will indefinitely delay real PSRO activities. What then?

Answer: Government must promptly exercise its statutory right to seek sponsorship of PSRO alternatives other than that of the local medical society. Among such PSRO alternatives are medical schools, schools of public health, and health departments.

Problem: Some physician academicians can be unrealistically rigid about applying performance standards. Some practicing physicians may be too lenient. If within each PSRO unit there is the problem of standardization, what of the problem between PSRO's? Who will calibrate? Who will promote concordance?

Answer: The PSRO should contain a mix of both academics and practitioners who support the objectives of the PSRO and who possess impeccable professional credentials. There is also need for an external monitoring authority capable of producing interareal standardization.

Problem: Some hospitals may slacken in their support of their traditional quality control activities—for example, tissue review committees, clinicopathological conferences, chart review, et cetera—on the assumption that the new PSRO mechanism will preempt the hospital's customary responsibilities.

Answer: PSRO policy must insist on maintenance of historic effort. All PSRO activities must supplement, not replace, previous quality control activities.

Problem: PSRO activities will tend to shorten the length of hospital stay. During the past few years, hospitals have already experienced a falling daily census and have been subjected to Blue Cross fiscal penalties because of empty beds.

Answer: If PSRO activities are to succeed, there must be a modification of Blue Cross policies that punish hospitals for having empty beds. Without such coordination of policies, PSRO effectiveness will be hobbled by resistant hospital administrators.

Problem: Where is the money to come from to support the PSRO? If the hospital per diem picks up the cost, then the source of funding is subscriber out of pocket, either directly as patient or indirectly through his carrier; Blue Cross, commercial health insurance, medicare, or medicaid.

Answer: The alternative is direct Federal subsidy. But, wherever the money comes from, there must be one unalterable principle: all PSRO staff time must be paid for. Nothing will destroy the integrity of the PSRO sooner and more thoroughly than staff work performed gratis.

Problem: PSRO can be as inexpensive or as expensive as Federal policy dictates. It depends primarily on the depth of quality control that is to be supported. Where do we start?

Answer: Nothing succeeds like success. The PSRO needs a few quick and early victories to give it courage and the will to proceed. The initial strategy should be to focus on a few sure things like elective surgery—for example, unnecessary hysterectomies and tonsillectomies. Subtler areas of analysis and control can follow as the PSRO gains confidence and experience.

Problem: It is a splendid idea to enlist the talents of some doctors to monitor the professional activities of other doctors. But how do we

establish operational accountability to the public—that is to say to Government? Recall that Government is paying directly or indirectly for the bulk of personal health care services.

Answer: Government cannot properly assign its ultimate programmatic authority to promulgate, monitor, and enforce health care standards to any nongovernmental agency, no matter how altruistically motivated that agency may be. Accordingly, the PSRO itself must ultimately be audited by a governmental agency accountable to HEW. The local or State health department could appropriately fill this role.

Final comment: If the presently structured PSRO program fails, then one of the following governmental decisions seems inevitable: One, be resigned. The problem is insoluble. Abandon it. Learn to live with the inadequate quality control of historic "peer review."

Two, contract out the job of quality control to fourth parties—to medical schools, schools of public health, and other educational institutions.

Three, try the third-party route again; that is, assign quality and cost control to fiscal intermediaries, but this time with more stringent monitoring by Government.

Four, assign the bulk of operational quality control responsibility to Government, but this time with real governmental inhouse capability. Put enough M.D.'s and other health care auditors on the governmental payroll to do the job.

Five, have a mix of some of all of the aforementioned options.

At present, the prognosis for success of the presently structured PSRO program is guarded at best.

I now want to add an unsolicited comment. Since 1966, my personal career has focused on the practicalities of implementing cost and quality control of publicly funded health services. The task has been a lonely one. As you know, 8 years ago there were not many of us in the country doing this on a serious basis. As time passed, the experience of medicare, medicaid, 314—(e) mounted; as scandals became increasingly routine, our numbers increased.

Throughout this evolution, those of us in the trenches took heart from the initiative, the courage, the imagination, and overall responsiveness of the Senate Finance Committee to the imperatives of the new realities of the American health care administration. Terms such as H.R. 1, the bedding amendment, the name Senate Finance Committee itself, the four sequential initials P, S, R, and O became rallying crises to us and became the antithetical expressions of opprobrium for the opposition.

A comment about the opposition to PSRO, some of which we heard today: the obtuseness of this opposition defies description. In good faith, this committee has fostered organized medicine's mechanism through the PSRO mechanisms; its last chance to demonstrate its devotion to the principle of autonomous peer review. Sometimes in derisive and insulting terms, this opposition, a minority in organized medicine, rejects this generous offer of the committee. Invariably, this same opposition has been quick to characterize this proposed PSRO mechanism as tyrannical governmental incursion into the private M.D. turf.

To be sure, we live in an age of nostalgia, but such rhetorical posturing hearkens back to the political zeitgeist of the 1930's, when certain enclaves within organized medicine considered even Blue Cross and Blue Shield suspect.

We call upon this committee to remain steadfast, to maintain its skepticism about much of the self-serving, self-righteous testimony it has heard and will continue to hear in opposition to the PSRO. The behavior of this magnificent Senate Finance Committee and talented staff has restored luster to the concept of public service and governmental concern for the well-being of the citizenry.

My colleagues and I acknowledge our pride in this committee for its durable commitment to public accountability of publicly funded health care services. All of us are grateful. Please continue. Thank you.

The CHAIRMAN. Thank you very much, Doctor.

Senator BENNETT. Thank you. You can understand why, for me, this has been a refreshing breeze after what we heard. And maybe "breeze" is the right way to describe it, because, Doctor, you have a very rapid delivery, and I am glad that you got through all of it.

Is PSRO Rationing Medicine?

In the material that you wrote and read from your notes at the end, maybe you answered the question that was the first on my list. As a practicing physician and administrator with as much experience as anyone in the country in the operation of medicaid utilization and medical appropriateness problems, what are your specific responses and reactions to the allegations of the Council of Medical Staffs?

Is this program rationing medicine?

Dr. BELLIN. No, this is not rationing medicine. I think you properly took apart that testimony. I think the witnesses, with all due respect to him and them, were being unresponsive and evasive to the questions you were pursuing. There is no rationing whatsoever. I cannot imagine what they are talking about.

Confidentiality

As far as some of the other problems that they raised, I think all of the problems deserve study but can equally be taken apart. I am always a little bit concerned about the question of confidentiality. Quite properly, this is a question that has to be studied very carefully. But I think that we ought to keep in mind how much confidentiality currently exists. The typical chart in the typical hospital today goes through at least 10 to 15 hands, which I can identify very easily: One, the nurse on the ward, the practical nurse, the messenger who brings the chart, the insurance company that reviews the chart, Blue Cross, Blue Shield, so on.

I do not know what they mean by confidentiality. Normally it is not Government that turns over these kinds of data, these kinds of delicate data to the press. These kinds of data are found elsewhere. I do not think that is a serious problem at all.

Fundamental Difference Between PSRO and Peer Review?

Senator Bennett. The previous witness seemed to feel—and my colleague from Nebraska reemphasizes—that there is a fundamental difference between peer review and PSRO. Do you accept that concept?

Dr. Bellin. Not at all. When they speak about peer review, they are talking about physicians on their payroll. I think when you speak about peer review, Senator Bennett and your colleagues, you are speaking quite properly of peer review ultimately on the payroll of the Government. That is where it belongs. Government is paying for this, and it is quite appropriate for the people who carry on the peer review ultimately to be accountable to Government.

Senator Bennett. Do you feel that the hospitalization utilization committees, the tissue committees, and others which have been conducting something which might be called peer review have been a complete success, and if the job were turned back to them it would continue to be a complete success?

Dr. Bellin. They have been less than a complete success. They have been remarkably inadequate.

Let me share with you the events that have taken place in just New York City in the past year or so. Despite all of the techniques that have traditionally been available to hospitals, there was serious concern on the part of at least one of the important unions of New York City with respect to the necessity for much of the surgery that was being given to their members, so they approached Cornell Medical School.

Cornell Medical School sat down with them and developed a technique to have preelective surgical screening, not for any kind of emergency surgical procedure, of course, but any kind of elective surgery. This had been reviewed by members of the Cornell Medical School faculty.

During the past year and half, there has been a decline by 20 to 25 percent of elective surgery for these union members who have been subjected to this kind of screening. We see similar statistics in the State of California where the same preelective screening is going on in the medicaid program.

Senator Bennett. Do you think this has damaged the patients whose elective surgery was rejected on the basis of that?

Dr. Bellin. Not at all. I think it increased their longevity. [General laughter.]

Consequences in the Absence of PSRO

Senator Bennett. In the absence of a professional review program, what do you think the consequences would be for the quality of care and the cost under medicare and medicaid, as well as any new programs for national support or for national health care supported by the Federal Government?

Dr. Bellin. I would rather answer that in the positive. I think that the implementation of this most important PSRO legislation can only increase the quality of care, enhance the quality of care that the American citizenry deserves.

Court Challenges

Senator Bennett. When you were running medicaid in New York, you instituted the one-side sample audit of medicaid patients record in the doctor's office, I believe in 1968 or 1969. This was challenged in the courts.

What was the result of that court challenge?

Dr. Bellin. We won every one of the court challenges, and I presume the same thing is going to take place when the challenges occur on this legislation.

NYC Audit of Medical Records

Senator Bennett. What are the findings, if any, of your sample audit of medicaid records in doctors offices?

Dr. Bellin. We found a variety of things. The troika of abuses, as you are aware, of poor quality, fraud, but the most important abuse is overutilization.

Let me share the following example with you: There seems to be a random distribution of morality in the profession which does not necessarily correlate with the amount of education, incidentally. And I remember one of my auditors bringing in the following.

We had a series of cases of otitis media, that is inflammation of the cardrum; a very common condition and normally responsive to a shot of penicillin. If you want to make the American Heart Association happy, you give them long-acting penicillin to prevent rhuematic fever.

Here we had enormous bills being attached to each case of otitis media. What did we find as we looked into these kinds of cases?

We found that every kid who came into this group—it was a group fee-for-service-owned group practice and doing very well, incidentally, for the following kinds of reasons. First, he would be seen by the pediatrician. The pediatrician would say, "It looks like you have got an inflamed ear," which is an incredible diagnosis, which is what the child had of course. Our nurses do it right now, our public health nurses in New York City can make that diagnosis.

"We had better have a consultant see this child." This child is then ping-ponged, as we call it, to the otolaryngologist in the group who learned, looked at the eardrum and said, "This is an inflamed ear." That was another $20 fee incidentially; that is part of the milking process.

We have to have a blood count, we have to have a urinalysis, we have to have an erythrocyte sedimentation rate. The erythrocyte sedimentation rate goes up in any case of inflammation, so they came back with an extraordinary conclusion, that the sedimentation rate goes up in the borough of Brooklyn as well when there is inflammation. And then you have to have a throat culture and an ear culture, and we want you to come back.

And the child would come back, come back, and come back, and the bills would be revved up $50, $75 for an inflamed ear.

I think that we have found a fair amount of that type of thing. One cannot expect a patient to protest. The patient is not paying this kind

of money. One cannot expect the doctors to protest if the doctor benefits financially from this type of thing. Surely Government must protest.

I think that this type of activity by this Senate Finance Committee is appropriate and deserves the support of all of us. I will tell you it has the support of me and my colleagues.

Ethics and Medicine

Senator Bennett. I am interested in your comment about the moral content of the decision, because when I was home last my personal physician met me on the street and said, "Senator, the problem with American medical education today is that they have no courses in ethics." He said we ought to add to their courses very substantial education in basic and fundamental ethics, and I think you might agree with that.

Dr. Bellin. I would certainly agree with that. I think at the same time it is useful, in order to keep those ethics rather durable in their operation, that somebody be watching the people. I think that is the whole basis of accountability.

Senator Bennett. That is right.

Confidentiality

Do you believe that authorization of access to medicare and medicaid records is necessary and appropriate in monitoring publicly financed programs?

Dr. Bellin. I do. I do not see any other way one can possibly know what is going on. One has to have access to those records with the appropriate types of programs to prevent abuses of confidentiality. I don't anticipate any abuse of confidentiality.

Senator Bennett. That probably presupposes my next question.

To your knowledge, have any medicaid patients complained that their privacy was violated by the process of review of patients' records?

Dr. Bellin. Quite the contrary. We have received nothing but gratitude on the part of patients where we reviewed the quality of care they had received.

Senator Bennett. I have no further questions, except to again express my deep appreciation to Dr. Bellin for this rapid but, to me, very convincing presentation of what is the basic thrust and intent of the PSRO legislation.

PSRO and Erroneous Diagnoses

The Chairman. Doctor, do you think that the PSRO approach will give us any help in the area of erroneous diagnoses?

For example, I have in mind the type of situation that happens from time to time—we hope it does not, but it does—where a doctor—and I have known very good doctors to make this mistake—examine a patient, make an erroneous diagnosis and subsequently it turns out that the patient has a missed malignant growth that eventually results in the patient's death. If it had been diagnosed sooner, the patient might be living today.

Now, do you think that we have a better hope of catching those erroneous diagnoses sooner by the peer review approach that PSRO seeks to implement than we have been doing in the past?

Dr. BELLIN. Absolutely, Senator. I think when physicians are aware that at least a random sample of their professional activities are going to be subject to review, people tend to behave somewhat differently. They tend to be a good deal more careful of what they are doing, and this has to make itself manifest, ultimately, in a statistical sense.

The CHAIRMAN. I am not here to embarrass the medical profession or anything like that, but I have had examples come to my attention where the medical profession, at least some members, have been inclined to think that these problems are bad, but that we do not want the public to think that these kinds of things happen.

I will give you an example of that. As I mentioned yesterday, a very good friend, the former head of the State medical society of Louisiana, went to the hospital. Nobody could understand why he was not recovering under the oxygen tent, and the reason was that whoever was supposed to turn the oxygen on was not doing so. He was not getting any oxygen; he was almost suffocating beneath the oxygen tent. I know his wife told me subsequently that it was embarrassing.

They do not like for the public to find out that that type of thing happens. They like to keep it quiet. But it seems to me that if that is the case, someone should put in a corrective procedure in that hospital or any hospital, if it is a problem broader than that.

Dr. BELLIN. Senator, we keep our banks in this country honest by having bank examiners come in periodically to watch the auditors who are presumably keeping the books honest on an internal basis.

I think the same principle has to be applied to health care service in this country as well. I think if people were to come around periodically and to check precisely into that type of problem, we would have fewer instances of the type of obscene problems that you have just described.

The CHAIRMAN. I have not had one person complain to me about an interference with a person's right to confidentiality since we have had the medicare and medicaid program, and we have had it for several years now. So it sounds to me like it is not the patient complaining, it must be someone else. I would think that, generally, as far as patients are concerned, they would like to know that, if there is some bad practice of unnecessary surgery being sold to them, or—or if there is a failure to turn on the oxygen—it seems to me that whatever approach the medical profession, after studying that matter, might feel is the best way to keep it from happening again, patients would appreciate and approve of it, even if it did mean that somebody had to review the case history of how they had been treated in order to arrive at that result.

Dr. BELLIN. Senator, I know you share with me concern for the civil rights of everyone. But I would add the following: I am very concerned about the civil rights of your friend and colleague, the right to breathe and to breathe oxygen, and that right was denied him.

The CHAIRMAN. Well, thank you very much.

Senator BENNETT. No further questions.

The CHAIRMAN. The hearing will resume at 2 o'clock.

[The appendix to Dr. Bellin's statement follows:]

Appendix

QUALITY AND COST CONTROL BIBLIOGRAPHY

(BY LOWELL E. BELLIN, M.D., M.P.H.)

1. Medicaid in New York: Utopianism and Bare Knuckles in Public Health—III. Realpolitik in the Health Care Area: Standard Setting of Professional Services. AJPH 59:8, 820–825, 1969.

2. With Kavaler, Florence, M.D., M.P.H., and Haber, Zipporah, G., M.A., M.P.H., Materia Medicaid—The Private Sector, New York City Health Department, 1969

3. With Kavaler, Florence, M.D., M.P.H., Green, Alex, Ph.D., Gorelik, Elihu, A, M.S. and Alexander Raymond S. M.B.A., M.S. A. Publicly Funded Pharmacy Program under Medicaid in New York City. Medical Care VII, 5, 361–371, 1969.

4. With Kavaler, Florence, M.D., M.P.H., Watkins, Benjamin, W., Pod.D., Schumann, Norman, Pod.D. and Herbst Eugenia B.A., Publicly Funded Podiatry—First Data from Office Audits of New York City Medicaid Practice. Journal of the American podiatry Association 59:11 442–445, 1969.

5. Podiatry's Future Through the Medicaid Crystal Ball. Journal of the American Podiatry Association 59:11, 437–441, 1969.

6. With Kavaler, Florence, M.D., M.P.H., Najac, Harold, M.D., Rosenthal, Jesse, M.S., O.D., and Alexander, Raymond S., M.B., A.M.S. Optometric Participation in the Medicaid Program of the City of New York. Public health Reports 84:11, 1008–1012, 1969.

7. Testimony. Hearings before the Subcommittee on Medicare-Medicaid of the Committee on Finance, U.S. Senate, 91st Congress, Second Session, June 2, 1970. Part 2 of 2 parts, U.S. Government Printing Office, Washington, 1970. p. 511–538; p. 558–562.

8. With Kavaler Florence, M.D., M.P.H., Folsom, W., O.D., Rosenthal, J., M.S., O.D., and Herbst E., B.A. A Review of on-site Visits in Optometry under The New York City Medicaid Program. Amer. J. of Optometry and Archives of Amer. Acad. of Optometry, 47:9, 729–735, 1970.

9. With Schumann, N.S., Pod.D., Kavaler, Florence, M.D., M.P.H., Lieberman, David, J., M.D., Watkins, Benjamin W., Pod.D., and Haber, Zipporah, G., M.A., M.P.H. Publicly Funded Podiatry: The New York City Medicaid Experience Medicaid Care, 0:2, 117–126, 1971.

10. With Kavaler, Florence, M.D., M.P.H. Policing Publicly Funded Health Care for Poor Quality, Overutilization, and Fraud—The New York City Medicaid Experience. AJPH 60:5, 811–820, 1970

11. With Kavaler, Florence, M.D., M.P.H., An Inventory of Medicaid Practitioner Abuses and Excuses vs. The Counter Strategy of the New York City Health Department. AJPH 61:11, 2201–2210. 1971.

12. Can We Have "Quality Control" in Health Care? Perspective (Fourth Quarter) 81–82, 1971.

13. Medical Audit: The Bitter Pill is Here and Now. Medical Opinion 7:12, 22–24, 1971.

14. Optometry: Future Shock and Present Imperative. Journal of American Optometric Association 43:7, 721–723, 1972.

15. With Kavaler. Florence, M.D., M.P.H., Schwarz, Al, A.C.S.W., Phase One of Consumer Participation in Policies of 22 Voluntary Hospitals in New York City. AJPH 62:10, 1370–1377, 1972.

16. If We Know What Quality Care Is Why Don't We Get It? Modern Hospital, p. 87–88, December, 1972.

17. With Kavaler. Florence, M.D., M.P.H., Weitzner, Martin, Ph.D., Feldman. Louis, M.B.A., and Hamlin, Rovert, M.D., Hospital Cost and Use Control via New York City Health Department. Health Services Reports 88:2, 133–140, 1973.

18. With Kavaler, Florence, M.D., M.P.H. and Haber, Zipporah, G., M.A., M.P.H. Proprietary Nursing Homes in New York City—Some Notes on Services, Payment, Patients, and Regulation. Bulletin of the New York Academy of Medicine, 49:9, 793–803, 1973.

19. Should a Paper on The Administration of Chiropractic Have Been Published in *Medical Care*? With Comments on Derivative Questions, Medical Care 11:5, 441–448, Sept.-Oct., 1973.
20. How to Make Ambulatory Care Start Ambulating, in Reshaping Ambulatory Care Programs, based on Conference on Ambulatory Care, Cherry Hill, New Jersey, Nov, 14-17, 1971, American Hospital Association, 1973, p. 3–8.
21. Ever Subtler Refinement vs Stat Implementation of "Crude" Quality Control of Health Services—The PSRO as Implementation or Gimmickry? (submitted for publication).
22. Foreshortened Frank Memoirs of a Former Medicaid Administrator. (submitted for publication).

[Whereupon, at 12:45 p.m., the subcommittee recessed, to reconvene at 2 p.m.]

AFTERNOON SESSION

Senator BENNETT [presiding]. Ladies and gentlemen we still have a long list of witnesses and I am sure I have the approval of the chairman in beginning this afternoon's session because the time has come and it is my great privilege to welcome my friends from Utah, Dr. J. Louis Schricker, president of the Utah State Medical Association, and Dr. Alan R. Nelson, president of the Utah Professional Review Organization, who will be accompanied to the table by Mr. Charles W. Carter, past president of the Association of Federal Government Employees Utah Council, and Dr. Robert W. Head, chairman of the Utah Professional Review Organization and Allied Health Professionals Council.

Gentlemen, I hope we have got chairs enough.

Dr. Schricker are you going to start it?

STATEMENTS OF J. LOUIS SCHRICKER, JR., M.D., PRESIDENT, UTAH STATE MEDICAL ASSOCIATION; AND ALAN R. NELSON, M.D., PRESIDENT, UTAH PROFESSIONAL REVIEW ORGANIZATION, ACCOMPANIED BY MR. CHARLES W. CARTER, PAST PRESIDENT, ASSOCIATION OF FEDERAL GOVERNMENT EMPLOYEES UTAH COUNCIL; AND ROBERT W. HEAD, M.D., CHAIRMAN, UTAH PROFESSIONAL REVIEW ORGANIZATION ALLIED HEALTH PROFESSIONALS' COUNCIL

Dr. SCHRICKER. Yes, sir, I am going to start the discussion.

I am Louis Schricker, president of the Utah State Medical Association. I am proud and happy to appear before this committee on behalf of the physicians of Utah. We will describe our efforts to establish a professional program of medical care, review, and assessment.

In late 1970 the leadership of the Utah State Medical Association recognized the need to expand its efforts in assuring the quality of medical care provided in Utah, and to establish a system of medical care accountability for professional performances. In that spirit in 1970 a study was undertaken in order to determine a feasible approach for such a program, and a decision was made at that time to form the Utah Professional Review Organization.

This was presented to the house of delegates in July of 1971, and the incorporation of the Utah Professional Review Organization was

made at that meeting. Immediately thereafter, the Utah State Medical Association Board of Trustees advanced the funds needed for the establishment and the early operation of the Utah Professional Review Organization.

In addition to its initial decision to form a corporation to begin with, the Utah State Medical Association on two other occasions has endorsed and reaffirmed their support of the principles of the Utah Professional Review Organization programs. As a matter of fact, in its most recent action at the house of delegates meeting in March of 1974, the house instructed its delegates to the AMA to support the implementation of the professional standards review organization program within the principles established by UPRO. The latter part is rather an important aspect of this within the principles established by UPRO.

In addition to the continuing and ongoing support of the State medical association and I might add that the Utah State Medical Association is comprised of 95 percent of the practicing physicians of the State of Utah the Utah Professional Review Organization has also received the approval and endorsement of the medical staffs of the hospitals. In addition to this, we have received the approval and endorsement of the administrators at each of the hospitals where the Utah Professional Review Organization program has been instituted and activated.

The Utah State Medical Association and the Utah Professional Review Organization sponsored the formation of a professional standards review organization for Utah last fall. In the sponsoring of this PSRO for Utah, a mailing was made, a single mailing was made to all of the physicians of Utah, and it is of significance that more than 60 percent of the physicians responded in the affirmative to this single mailing. I think this is extremely significant that this number responded to a single mailing. It is rather unusual.

Support of Utah professional review efforts has been most favorable from other community interests. The program has been presented to the Governor. It has his support and endorsement. Consumer groups, including labor, have been most supportive. The presence of Mr. Charles Carter here as the labor or rather consumer representative on our Board of Trustees of Utah Professional Review Organization is evidence of this support.

Other allied health professionals have also taken an active role in the Utah program, and this is typified by the presence here today of Dr. Robert Head, an optometrist, who is the chairman of our council of allied health professionals and as such, sits as a member on our board of trustees.

With this brief background, I would like to turn the balance of our time over to Dr. Alan Nelson, who is the president of our Utah Professional Review Organization and I might add, is a member of the National PSRO Council. I think it is appropriate at this time, and I would like to do it in the presence of this committee, to express for the Utah Medical Association a vote of thanks for the leadership and expertise which Dr. Nelson has lent to this program. It is a most imaginative program, and one that I am happy to say is working well in Utah.

Senator BENNETT. Thank you, Dr. Schricker.

And may I observe for the record that the Utah PSRO program has been notified that it will probably be the No. 1 approved in the country, and I think they are ready for it.

I think the record should also show that this program was developed at the local level. It was not handed down by the Secretary or by any of the Federal offices.

Is that right?

Dr. SCHRICKER. This is correct. It was developed entirely at a Utah State Medical Association level in 1970, and it expresses and reflects our concern.

Senator BENNETT. Against that then, Dr. Nelson, we will be very happy to hear from you.

Dr. NELSON. Thank you very much, Senator Bennett.

We then established a review organization which would be consonant with the objectives and methodologies mandated by PSRO. We initially have been reviewing the private sectors, the Federal employee program, educators mutual, and HMO. The Veterans' Administration hospital has asked for us to implement a program of quality assessment in the VA hospitals. We then added the medicaid population, and with PSRO, we in a sense reach a point of victory because we will now be able to extend the benefits of peer review to the medicare population.

When Senator Curtis asked if the physician community were in favor of PSRO, I can say yes, indeed, in this sense we are because we have been trying for over a year to extend the benefits of peer review, successful peer review to the medicare population, unsuccessfully so because of a number of reasons, largely dealing with fiefdoms and bureaucratic conflicts of interest. Our review is conducted for the necessity for admission——

Senator CURTIS. Bureaucratic interference within the medical profession?

Dr. NELSON. No, sir, within the Federal implementation of their current medicare program.

Senator BENNETT. Is not what you are saying, there has been what you think has been an unnecessary delay in getting the PSRO program off the ground, and getting to the point where you could make your application?

Dr. NELSON. Absolutely. We established our peer review program because it concerned us as physicians that our patients said they could no longer afford health insurance, and because we recognized that unevenness of the quality of care delivered to our people, and we recognized that it was in the highest ethic of a professional organization to try to do something about this, and we have been struggling to extend the benefits of peer review to additional patient groups over this 2-year period of time. Now PSRO permits us to do this good thing for the medicare patients as well.

I would like to speak to some of our experience, particularly as it relates to some of the caveats and concerns that we have heard expressed today. You have to recognize that we have been doing PSRO type review on one-fourth of our total State population everytime they enter the operational hospitals. These hospitals draw 60 percent of our population. We have been reviewing not only for the necessity for

admission and length of stay, but also the appropriate level of care, and also doing quality analysis against objective criteria. Objective criteria is an essential part of our review program because it then permits uniform and equal and fair application of the review process to all physicians.

Our criteria are put together by our peers. We have no arguments with that. It permits a number of things to be done. One, it permits trained nurse coordinators to do the screenings so physicians do not have to spend all of their time going through hospital records. By virtue of their screening against criteria put together by my peers, they can sift out from the total load of patient care those things that require greater inspection by peers.

The quality assessment does nothing more than compare what physicians are doing against what they say they ought to be doing in the delivery of ideal care, and that permits us to identify educational objectives and construct education programs. In no sense is this cookbook medicine. This is textbook medicine, and it is fair and equal application of review.

I would like to talk about cost effectiveness. We have 2 years of experience now with the population four times greater than our medicare population. We found for Educators Mutual, and they are the best data available, our goal was to contain the increasing cost of health care. After the first year of experience, the length of stay dropped 10 percent, dropped from 5 days, 5.1 days, to 4.6 days. The number of admissions per thousand dropped slightly, and the average daily hospital cost did not increase. And for that group we have a control group in hospitals where the review program was not operational. In that group there was not this decrease in cost.

If one estimates, if one could equate the cost of an empty bed as being a total savings, which we understand may not be done because there are certain fixed costs that do not change just because the bed is empty, but if we were able to do that, the cost of review would be a small fraction of what the projected savings are.

Our experience regarding confidentiality is of interest. You have already heard that the pre-PSRO level of confidentiality in hospitals is relatively low. PSRO will permit the physicians in an area to manage the level of confidentiality in its application and permit us to protect our patients' rights in a way we have never had the opportunity to do in the past.

I must mention that in 2 years of operation we have had not one instance or complaint in regard to confidentiality. It is because we have taken pains to insure patient rights. We train our nurse coordinators. We emphasize to them the importance of protection of patient rights. We remove patient identification from abstracts leaving the hospital and so forth.

One hears a great deal about professional liability. I must mention that. I will not say that our peer review program is responsible for these changes, but coincidence, in the same timeframe we have been operating our program, there has been no increase in the premiums for our group liability program versus the 10-percent per year increase nationwide, and up to 120-percent increase in neighboring States.

A 5-percent dividend was declared for physicians participating in the MASA group liability program. It amounted to $33,000 in liability premiums returned, and the decreased liability insurance premiums for higher risk categories decreased up to $155.

Partnership surcharge, which had previously been levied, was reduced 50 percent. Our experience there is also a good one.

What are some potential problems under PSRO? The ones I will speak to have not been described because these are second generation kinds of problems. The first caveat that I could express is that excessive bureaucratic rigidity will stifle initiative and vigor of capable professional organizations engaged in medical service research. I am somewhat heartened by my experience on the national council, to find that the Office of Professional Standards Review has been sensitive and aware of our needs, and is permitting this kind of research to continue under PSRO.

I have a great deal of concern because the baseline data necessary to evaluate the effectiveness of PSRO is often lacking. If we want to know the number of admissions per thousand that has decreased as a result of altering physician behavior, one must know how many admissions there were. And the medicare program in many areas now can tell you how many hospital claims, but not how many hospital admissions.

Senator BENNETT. Under the rules, Dr. Nelson, you have had the 10 minutes.

Senator Curtis, do you want to question my colleagues?

Senator CURTIS. I am sorry I came in a little bit late.

UTAH PROGRAM

This program has been carried out in Utah. What are the dates of that?

Dr. NELSON. We began the program in July of 1971. We started—well, actually, we started in September of 1971 and began actual implementation in July for the big population, July of 1972.

Senator CURTIS. Some activity in September 1972?

Dr. NELSON. No; 1971.

Senator CURTIS. And your compilation of results take you clear up to the present time?

Dr. NELSON. Yes. The results I quoted were based on the first year.

Senator CURTIS. Now, what do you call this program?

Dr. NELSON. The Utah Professional Review Organization, onsite concurrent hospital review program. It is called OSCHUR, Senator.

Senator CURTIS. I see.

Who runs it?

Dr. NELSON. It is sponsored by the State medical association. It is a nonprofit corporation sponsored by the medical society.

Senator CURTIS. Who finances it?

Dr. NELSON. The initial financing came from the physicians themselves, the first $15,000 to get it off the ground. Then we were assisted by a research grant for certain quality assessment programs we have had ongoing that I have not mentioned.

Senator CURTIS. Assisted by whom?

Dr. NELSON. The National Center for Health Services Research and Development.

Senator CURTIS. Which is what?

Dr. NELSON. Department of HEW.

Senator CURTIS. Well, now, you would call this program peer review, would you not?

Dr. NELSON. Yes, sir.

Senator CURTIS. And has PSRO taken effect in Utah yet?

Dr. NELSON. Not under that name, but we have——

Senator CURTIS. I mean under the Federal law?

Dr. NELSON. No. No; it cannot.

Senator CURTIS. Well, I am very strong for peer review. And I think that is what this committee thought they were getting in PSRO, and I commend you for doing an excellent job without the Federal statute, which you have done. I think it is very outstanding, and I am glad to learn that without direction from government at any level, and without direct Federal financing of your staff and so on—I understand you got something for some research—that you have been able to accomplish these things, to lower liability insurance and do these other things.

I have no quarrels with peer review. I think it is wonderful. I am deeply concerned about the content, if anyone takes time to read it, of the Federal statute, and how it will operate a few years from now.

That is all, Mr. Chairman.

Dr. NELSON. May I reply?

Senator CURTIS. Certainly.

IMPLEMENTING PSRO IN UTAH

Dr. NELSON. Under the PSRO program, the precise same methodology that we have employed in our pilot program will be employed under PSRO, and we will have peer review managed at the level of the physician community as we have had in the past, and we will be able to extend the benefits of peer review to the public sector, to the medicare population as we have not heretofore been permitted to do. And I am sanguine about the capability, about the opportunity to do that if it were not for PSRO.

Senator CURTIS. Now, does not the law fix the ultimate authority on all important points in PSRO in the Secretary?

Now, if you read the law, is that not true?

Dr. NELSON. Yes; of course it does.

Senator CURTIS. Yes; and that will not be a continuation of what you have done. What you have been doing now has the absence of the very thing that I feel is going to bring danger.

Dr. NELSON. I am gratified that I have no unpleasant experience insofar as the application of our previous program for the private sector within PSRO. In other words, the fear that the Secretary is going to make us alter the way we have found best of carrying out our mandate of accountability to our patients, that has not materialized, and as a member of the national council, I have been gratified to find that this terrible ogre called the Secretary has been nothing but helpful in permitting us to carry out the mandate of locally managed review operated by the physician community.

Senator BENNETT. Do you anticipate—I think you have answered this, but I would like to get it again on the record.

Do you anticipate any problems, any necessity to change any of your methods of operation or any of your norms of criteria when your application to become a PSRO is accepted?

Dr. NELSON. No; we will always be modifying our norms and criteria, updating them, improving them, alterations based on our experience, but this is generated from within ourselves, and we have not had anyone tell us of any external constraints on this.

Senator BENNETT. Is that not the genius of PSRO, that it was set up to permit physician groups like yourselves to organize and develop a system under which you could carry out the review?

Dr. NELSON. Further, it gives us the resources to be able to do it effectively for all of the patients that should be receiving.

Senator BENNETT. After you become a PSRO, who will pay your operating costs?

Dr. NELSON. The portion——

Senator BENNETT. I mean the portion devoted to medicare.

Dr. NELSON. The portion devoted to medicare will be paid for by the Office of Professional Standards, whoever it is it will be who is distributing those funds.

RATIONING OF MEDICAL CARE UNDER PSRO?

Senator BENNETT. A great point was made this morning that when PSRO's are in operation, they immediately ration medical care.

Do you feel that during your period of, shall I say, private operation, that you have been rationing medical care?

Dr. NELSON. As a matter of fact, for the first time for the medicaid population, we will not have rationing of medical care because the determination of what care is received will be based on medical need as judged by practicing physicians in the area rather than being based on artificial adjustments of the benefit package, with that decision being made on an administrative level. And that has been the previous experience. So if a man required a hernia operation in order to work, he could not get it because someone within the bureaucracy or within the agency said, well, we will not pay for hernias this month. From now on, the physicians engaged in the review effort will be able to make sure that the people needing the care get the care.

Senator BENNETT. Well, now, when you move over and become a federally sponsored PSRO, will you then automatically begin to ration medical care?

Dr. NELSON. I see PSRO as one of the few ways to avoid a rationing of medical care.

Senator BENNETT. You heard a witness earlier testify to a half a dozen points in the process at which medical care would be rationed. Maybe you had better describe for the record how you handle the problem from the time a patient is admitted to the hospital until you are through with him.

Do you go through this trauma—and they made the point that the decisions were going to be made by committee. Do you go through the trauma of committee decisions at five or six steps?

Dr. NELSON. No. The patient enters the hospital. One of our trained nurse coordinators who is supervised by us, by the physician community, not by that particular hospital administrator or whatever, matches the information on the chart against her criteria, and 90 percent of the time the admission is clearly justified and fits within the criteria. That service then is automatically guaranteed.

Senator BENNETT. And does the reviewer ever see that case?

Dr. NELSON. No. All of those that are screened in are not subject to peer review. If it does not fit clearly within the criteria, then a peer becomes involved. Then peer review actually takes over, and generally this involves a question being asked by the reviewer of the physician under review to provide more information, and generally this dialog is effective in altering physician behavior while the patient is receiving the care in a way that is acceptable to all parties without any punitive implications.

In 20,000 admissions coming under our review, we have only been forced to remove our certification or our endorsement in 20 instances. That means in only 20 instances of care that the review mechanism failed to bring about the desired effect without an actual head butting going on. Physicians are generally reasonable people.

As a matter of fact, one of the real testimonies of the success of this PSRO prototype is the fact that our physicians who are living with it like it, and when we have a town meeting and all of the physicians come in to air their gripes about PSRO, hands go up around the room and say it is working in our hospital, and we have no argument.

Most of the real solid objections to PSRO come from areas where they are not doing it.

CONFIDENTIALITY

Senator BENNETT. Have you encountered any problems of violations of patient confidentiality? You made a positive statement that you thought you could improve the control of patient confidentiality.

Have you encountered any problems?

Dr. NELSON. No.

DEVELOPMENT OF NORMS AND PARAMETERS IN UTAH

Senator BENNETT. You have already indicated that you use norms and parameters. Who developed them?

Dr. NELSON. We had 17 separate committees, each representing a speciality, and each of them put together their criteria norms for their speciality.

Senator BENNETT. Did they make them up out of their own heads, or did they make use of material that might have been available through their specialty organizations?

Dr. NELSON. Both, and now we are in the process—the same panel that put together the criteria gets the data and compares what is being done with what should be done, and has an opportunity to validate the criteria.

Senator BENNETT. You have already said that you consider this textbook medicine rather than cookbook medicine.

Dr. NELSON. Yes, sir.

A Consumer's View of UPRO

Senator Bennett. A word that was used or that became a part of the discussion yesterday because it was in the title of a certain publication, the word "deleterious."

Do you consider that your service is deleterious to the patient?

Dr. Nelson. Well perhaps a patient should answer that, because Mr. Carter is a consumer.

Senator Bennett. Mr. Carter, I would appreciate your comments, and will you identify yourself for the record, please?

Mr. Carter. Charles Carter. I am the president of the Hill Air Force Base Union American Federation of Government Employees.

Senator Bennett. How big is your union?

Mr. Carter. We represent 12,000, the people at Hill Air Force Base, Senator.

I am also the past president of the Utah State Council, which represents additionally 8,000 Government employees in the State of Utah, and of which we have a total of 45,000, and we have 20,000 members seeking recognition.

Senator Bennett. Of your 20,000, have all of them been covered by this PSRO contract?

Mr. Carter. I got involved in this and I found out that there was a review being made, and it was being made in regards to Federal employees. Being one of the largest unions in the State of Utah, and a Federal union at that, we were concerned about what was going on, and we wrote a very derogatory article about UPRO, and it got the attention of Dr. Alan Nelson, who in turn contacted me, and then I was enlightened as to what was going on in UPRO, and invited to attend a meeting, and I suddenly found out that here was an organization that finally was going to do something about the holier than thou attitude of some medical people in the profession. And I was very happy to join with them and to learn more about what peer review would be and what it would provide for us.

We have been so subjugated to considerable increases in the last year by Blue Cross-Blue Shield, 25 percent this year, 17 percent the year before, Waldie has tried to take these people to task and say, hey, explain and justify rising medical costs, and for the first time I found an organization who was not out witch hunting but was taking a positive approach to improving medical care and a possible avenue of reducing benefits on premiums for the people I represent and myself.

Senator Bennett. Do you think you might be a lightning rod to attract complaints about the quality of medical care given to your members?

Mr. Carter. Definitely. We are well known throughout the area, and as I said, first we got a couple of complaints because people did not understand what was happening. In the case of tonsils that were taken out of a young girl, 14. She overheard someone saying she was going home, and the mother got upset because someone was sending her daughter home and did not know why. And we contacted her physician, and the case was discussed, and he explained the reasons why, and everybody was totally happy.

But ignorance was the first problem we had with UPRO. Nobody knew what UPRO was doing, and once it became knowledgeable to people, once some publications were put out in our newspapers, local

newspapers, people began to accept UPRO, and I personally have made reviews of hospitalized patients. I have talked with nurse coordinators to see what was going on as a consumer representative. I was apointed by the Governor to that position and all of it has been positive, everything has been positive. And I am very happy to report this to this committee.

PSRO IN CONJUNCTION WITH UPRO

Senator BENNETT. Of course, when it moves over and adds the PSRO responsibility to its present responsibility, you expect it to continue to serve you?

Mr. CARTER. Yes, I do.

Senator BENNETT. In other words, the Utah operation will be federally supported to the extent that it reviews the medicare and medicaid cases, but its private customers will continue their contracts with the UPRO half of this Siamese twin.

It that your understanding?

Mr. CARTER. That is my understanding.

Senator BENNETT. Do you want to comment on that, Dr. Nelson?

Dr. NELSON. Only to say that it is appropriate that we not have a double standard of review and quality, one for the public sector and one for the private sector. And as physicians we do not make this distinction, one patient from another, and neither should our review efforts.

One hears that currently my profession has effective review. This can never really be so as long as review is based on testimonials or gut judgments, one to one kind of thing that has been the case in the past. It can only be effective if it is organized broadly, applies to all patients as they come into the hospital, and is based on objective criteria, and has an educational component, all of which our program has.

Senator BENNETT. Senator Curtis asked what you mean by the public and private sector.

Dr. NELSON. The public sector being those people who are receiving their care under some Government program, whereas the private sector is the guy working down the street in a newspaper office.

Senator BENNETT. This group serves both, the same reviewers in the same hospital, is that right?

Dr. NELSON. Yes, sir.

And PSRO will pay for the review for the medicare and medicaid recipients, and the people like Mr. Carter, who are employed in some other fashion, they pay for the review themselves as part of their insurance premium.

Senator CURTIS. It is the first time I have heard of that characterization. I thought all of these Government programs were to continue the private practice of medicine for both doctor and patient.

Dr. NELSON. Speaking only to the payment source, Senator.

Senator CURTIS. It raised a question in my mind when you referred to it as the public sector. I wondered if they were getting a different kind of treatment.

Dr. NELSON. They may in the future be subject to a different kind of treatment if the review that is providing quality of care for one does

not also extend to the other, but when I speak of private-public sector, I am speaking only of the payment source by which their medical care is covered.

Senator CURTIS. But the work you have done in the past since you started this activity 2 or 3 years ago has been beneficial to all patients, has it not?

Dr. NELSON. Yes, I think so. But those patients who are receiving direct review I think have a higher uniform level of quality and of efficiency than the people who are not engaged in review.

Senator CURTIS. Why did you not cover those?

Dr. NELSON. We have been trying to, but whoever the payment source is for that patient must subscribe or participate in our review effort and help pay for some of our expenses, and that has been the problem with medicare, and our inability up to this point to be able to provide this service for medicare.

Senator BENNETT. Senator Talmadge has a question. I want to come back afterwards.

MALPRACTICE SUITS AND PSRO

Senator TALMADGE (presiding). Gentlemen, I am sorry I did not get here in time to hear your testimony in chief. There is one question I would like to ask. As you know, the medical profession has been subjected in recent years to quite a number of malpractice suits. Sometimes the judgments have been extraordinarily high, and the insurance doctors now have to buy to protect themselves from malpractice is becoming extremely high. It seems to me that peer review, PSRO's, would be one of the finest safeguards to malpractice in the medical profession that I could possibly think of.

Would you give us your experience, first as to whether or not that has reduced the malpractice suits in the State of Utah, and second whether or not it has reduced the insurance payments the doctors have to pay for that insurance?

Dr. NELSON. Yes, sir. I cannot say that it is a result of our review activity, but concurrent with that there has been a decrease in the number of suits and a decrease in the number of premiums, such that neighboring States have had an increase of up to 120 percent per year in their premiums that physicians must pay for malpractice insurance. And since your program has been operational there has been no increase, first of all.

Second, the participants in the group program have had a 5 percent dividend declared and returned to them. The high risk categories have had up to almost 40 percent decrease in their premiums. And we have been able to increase the benefits of coverage under the liability program. So the liability experience has been very favorable.

Again, I cannot say that it is because of the review, but I say that this did occur along with.

Senator TALMADGE. Thank you, sir.

Senator Bennett?

REVIEW IN THE DOCTOR'S OFFICE

Senator BENNETT. Are you preparing to move from review in the hospitals to review in the practitioner's office, the doctor's office?

Dr. NELSON. Yes, sir. We are already doing that in two ways. First of all, in the quality assessment of care delivered in the neighborhood health centers, we were asked to provide a control group of private practitioners to subject themselves to the same quality audit in their office. We had ten times more physicians volunteer than we could accept for the control, ten times more than we could use.

This has been going on for 2 years and we have reviewed something like 6,000 patient charts, quality assessment.

AMBULATORY REVIEW

And the second quality review effort for ambulatory services utilizes the claims forms from Medicaid population to identify the physicians who are not doing as many tests as they should or are giving too many injections or whatever. Both of these projects have been successful.

Senator BENNETT. Physically, how do you operate the ambulatory review process?

Dr. NELSON. For the neighborhood health center and its control group, we have a trained nurse coordinator that goes into the physician's office. He has flagged the records that have a certain diagnosis that we are studying, and she abstracts from the chart information which permits us to compare what physicians are doing against what they say they should be doing. And then we can identify educational targets.

SPECIAL EDUCATIONAL PROGRAMS

Senator BENNETT. As a result of your 2 years of experience, have you embarked on any special educational programs?

Dr. NELSON. Indeed, we have. Indeed, we have. As a matter of fact, we have established, our medical society has established a sister corporation, the Academy for Continuing Medical Education, whose goal, whose job it is to translate the findings from PSRO and peer review into meaningful educational programs. And already we have identified a series of projects that they are embarking on.

The appropriate use of injectible antibiotics in the office is one. Identifying areas of noncompliance, where physicians, say for instance, for tonsilectomy that it is critical to ideal care to find out if the patient has had abnormal bleeding for it, so if they have hemophilia we find out about it earlier. We find out that indeed only 50 percent of the physicians are doing that.

When we have the data, then we can go to the physicians and say, these are the data. Then we can accomplish change. If I go to a physician and say, you are doing something wrong, no change occurs. Peer review must collect data that apply equally to everyone, and then you can apply change.

Senator BENNETT. I have no further questions.

I very much appreciate your presence, and again I want to say how grateful I am for the support of the doctors from my own State. This has made it possible for me to continue to fight on for PSRO. Thank you.

Dr. NELSON. Thank you very much.

[The prepared statement of Drs. Schricker and Nelson follows:]

STATEMENT OF
THE UTAH STATE MEDICAL ASSOCIATION
AND
THE UTAH PROFESSIONAL REVIEW ORGANIZATION
TO THE
U. S. SENATE COMMITTEE ON FINANCE
SUBCOMMITTEE ON HEALTH
May 9, 1974

Witnesses: J. Louis Schricker, Jr., M. D.
President, Utah State Medical Association

Alan R. Nelson, M. D.
President, Utah Professional Review Organization
Member, National Professional Standards Review Council

The Utah State Medical Association (USMA) and the Utah Professional Review Organization (UPRO) are pleased to be represented at these hearings on Professional Standards Review Organizations and to provide testimony to the fact that the principles embodied in the PSRO legislation (Section 249F, Public Law 92-603) can be translated into a program of physician managed review. The material which follows outlines the origins, functions and accomplishments of UPRO, an organization which was created by USMA, and specifically designed to anticipate what ultimately became PSRO. Also described here is the more recent formation of the Utah Professional Standards Review Organization (Utah PSRO) and the relationship which would be established between the two organizations.

Three actions of the Utah State Medical Association House of Delegates, reflecting their initial approval of UPRO and continuing endorsement of its principles and operations, are attached as Exhibit A.

UPRO HISTORY

The Utah Professional Review Organization (UPRO), a non-profit corporation, was established July 14, 1971 under the sponsorship of the Utah State Medical Association (USMA). The objectives of UPRO are the promotion of quality medical care and the effective and efficient delivery of health care services. This is effected through:

1. Quality evaluation of physician services according to guidelines established by peer committees.

2. Physician education to correct quality deficiencies identified by the review process.

3. On-site concurrent review of hospital and ECF care, attentive to both quality audit and appropriate utilization.

4. Ongoing review of the effectiveness of physician education techniques.

The scope of activity began in the population-dense areas of the State and is being extended peripherally as education and development make it practicable to do so, aiming ultimately to involve all physicians within the State of Utah.

UPRO was formed following affirmative action of the Utah State Medical Association House of Delegates which endorsed the proposed concepts and objectives of the organization. The USMA Board of Trustees voted to advance funds for the initial operation of UPRO and this seed money was used to prepare an application for grant funds which was submitted to the National Center for Health Services Research and Development (NCHSRD).

The initial grant application was approved by the National Center, thus enabling UPRO to begin a planning and development activity in early August, 1971. During its one-year planning phase, UPRO brought its inpatient hospital review project to an operational, and essentially self-supporting, stage while two other projects, primarily of a research nature, were drafted. Additional funding from NCHSRD was then sought. That grant was approved July 1, 1972, providing the necessary resources to implement the two research projects and to expand existing activities.

During the succeeding two years, UPRO has fulfilled all of its major objectives. The On-Site Concurrent Hospital Utilization Review (OSCHUR) program for review of inpatient hospital care has been expanded and extensively tested. OSCHUR is a prototype PSRO review system in that it incorporates all of the essential features of the legislation, including concurrent review of admissions and continued stay, as well as quality assessment studies.

In terms of the immediate objectives of the PSRO program, UPRO's experience with OSCHUR is of primary interest. UPRO, however, has also been exploring methods for reviewing the quality and utilization of ambulatory care in two ways. One involves an analysis of data recorded by physicians and other providers on the claim forms they submit to third parties. The other is examining the feasibility of reviewing care through a direct examination of the physician's office record. These two projects are described more fully in subsequent sections of this document.

In the course of its development, UPRO has recognized the importance of involving other health professions and representatives of the general public in the review effort. Two advisory councils, representing allied health professionals and consumers, respectively, have been created and have been functioning actively. The chairman of each group sits as a member of UPRO's Board of Directors. Not only do the two councils add depth to consideration of UPRO's immediate concerns, they also represent an opportunity to involve others in the effort to better utilize the health system of our community.

UTAH PSRO

The Utah Professional Standards Review Organization was formed in October, 1973 under the joint sponsorship of the Utah State Medical Association and UPRO. The primary purpose for establishing Utah PSRO was to assure the existence of a non-profit corporation which would meet the technical requirements of the PSRO legislation.

Coincident with the formation of Utah PSRO, the incorporators authorized the solicitation of Utah physicians to become members of the Corporation. A single mailing to all licensed resident physicians has resulted in the return of 946 signed membership cards. This represents nearly 60 per cent of the physicians in the State.

It is the intent of Utah PSRO to adopt the principles for inpatient review which have been implemented by UPRO and to maintain a consistency of operation between the two programs.

OSCHUR BACKGROUND

The On-Site Concurrent Hospital Utilization Review program was conceived during the summer of 1971 and from September, 1971 through January, 1972, it was tested in a pilot study on one ward of Holy Cross Hospital, Salt Lake City. On April 1, 1972 a contract with Blue Cross - Blue Shield was executed and the program became operational in four of the largest hospitals in the State, two in Salt Lake City and two in Ogden. The contract with Blue Cross - Blue Shield calls for OSCHUR review of all patients insured under the Federal Employees' Program administered by Utah Blue Cross - Blue Shield.

On July 1, 1972 Educators Mutual Insurance Association joined the program and all EMIA patients admitted to the four project hospitals are now being reviewed. The Salt Lake Neighborhood Health Center contracted for OSCHUR review on October 1, 1972; and coincident with that action, the program was expanded to include the University of Utah Medical Center in Salt Lake City.

On August 1, 1973 UPRO and the Utah State Department of Social Services completed an agreement for OSCHUR review of Medicaid beneficiaries in the five project hospitals.

These four organizations are financially supporting the OSCHUR program to the extent that they pay the full cost for the direct review activities in the hospitals. Under each contract UPRO certification of care represents a guarantee to the patient and to the hospital that reimbursement will be made by the carrier.

To indicate the scope of the OSCHUR program, the following chart shows the approximate number of persons covered by those financing programs currently being reviewed, along with the percentage of hospital admissions which occur in the project hospitals.

Program	Total Enrolled	Estimated % Admitted To Project Hospitals	Population At Risk
Federal Employees' Program	125,000	65%	81,250
Educators Mutual Ins. Assoc.	70,000	40%	28,000
Neighborhood Health Center	8,000	70%	5,600
Medicaid	60,000	70%	42,000

During the first twenty-three months of operation, the program has reviewed a total of 28,030 admissions. Currently, about 1,800 admissions per month are being reviewed.

Program Operations

The operation of the OSCHUR program has been documented in considerable detail; however, in the interests of brevity, only the key features are presented here.

1. Responsibility is assigned to each hospital medical staff for implementing the review process in its hospital. A physician Medical Advisor is selected for each hospital by UPRO on the recommendation of the hospital medical staff. The Medical Advisor represents the major link between his hospital and the UPRO review process, and he chooses his own Committee of Consultants. Typically, this Committee is identical to the hospital's utilization review committee. The physician members represent a cross-section of medical specialties and assist the Medical Advisor in the review of individual patients and in

managing the program within the hospital. Medical Advisors and Consultants are reimbursed by UPRO for the time they spend in direct review functions.

2. Guidelines or standards are developed by UPRO physician committees.

3. Utilizing UPRO standards and functioning under the direct guidance of a Medical Advisor, the UPRO Nurse Coordinator(s) monitors the care of individual patients throughout the course of their hospital stay. Review encompasses necessity for admission, level of care, length of stay, use of ancillary services and quality of care. The Nurse Coordinator reports all questionable cases to the Medical Advisor and/or a Consultant for his consideration and action. Nurse Coordinators are hired, trained and supervised by UPRO, thus assuring consistency of application in all hospitals and maintaining in each Nurse Coordinator a personal sense of responsibility to program goals.

4. Contracts with third party carriers assure that all covered hospital care which is certified by the OSCHUR review process will be reimbursed and that retroactive review by a carrier cannot result in a claim denial. Conversely, when UPRO certification is withdrawn, the carrier is free to use this action as a basis for declining reimbursement and such denials are expected. Certification withdrawals always involve the Medical Advisor, and specialty Consultants as necessary, and are made only after the attending physician, the patient and the hospital are notified that care can no longer be certified.

5. Data reflecting physician performance in relation to UPRO quality criteria are collected by the Nurse Coordinator on all patients admitted for selected diagnoses or problems. Those data are processed and analyzed through a computerized system developed by UPRO and the results are reviewed by UPRO physician committees. Conclusions reached as a result of these reviews form the basis for activation of appropriate educational processes.

OSCHUR Criteria and Standards

A major activity of UPRO has been the development of criteria and standards to support the review effort. (It should be noted here that in the prior absence

of PSRO definitions for certain terms, UPRO has often used the word "guideline" to alternately mean "criteria" or "standard" as these are defined in the present lexicon. In reviewing the sample material in the Exhibits, this semantic issue should be kept in mind).

Physician committees representing seventeen distinct medical specialties have been organized by UPRO with the support and participation of medical specialty societies in the State. These committees have developed a set of Quality Care Guidelines covering over 120 diagnoses and surgical procedures which include both indications for hospital admission and sets of criteria listing the critical elements of care for each diagnosis/procedure. The indications for admission constitute a basis for certifying hospital admission in the concurrent review process, while the critical elements of care provide a method for instituting one level of medical care evaluation studies. In developing these criteria sets, emphasis was given to the inclusion of items which are objective and which are sufficiently defined to permit non-physicians to determine whether a particular criterion is met for an individual patient.

In addition, UPRO has developed, using a variety of published sources and professional input, guidelines/standards relating to general indications for admission, expected length of stay and level of care. Sources for these guidelines/standards include: data available from local hospitals, national studies of hospital utilization, local hospital guidelines for level of care, physician committees of UPRO, hospital medical staff committees, etc. Here again, the complete documentation has been published in the form of a Nurse Coordinator's Handbook and it is available. The Handbook is now in its fourth edition which suggests the continuing nature of the expansion and refinement of these guidelines.

RELATIONSHIP WITH HOSPITALS

Prior development of a review methodology consistent with the intent of PL 92-603 (as part of UPRO's ongoing review for the private sector and Title XIX recipients) permits a smooth and integrated extension to the additional populations mandated under PSRO. Thus, Utah PSRO will utilize the existing mechanism to extend review to Medicare patients in the current operational hospitals within weeks of the initial contract date. Statements of understanding or formal expressions of support by each operational hospital are on record and permit compliance with Chapter V, Page II of the PSRO program manual (Hospital Review). While "delegation" is thereby accomplished through this joint agreement between the Utah PSRO and the hospital administrative and medical staff structure, decisions regarding the effectiveness of in-house review will clearly be made by Utah PSRO reviewers who are not members of that hospital staff.

This consolidation of review activity within each hospital, employing a review system directed by the hospital staff itself and coordinated through the use of Nurse Coordinators, norms and criteria, and data system-evaluative capability permits a joint attack on mutual problems. More important, such a combined effort prevents a double standard of review for the public and private sector, obviates competing review functions, assists the hospital in meeting quality assurance requirements for accreditation, and assures the accurate collection of data for management analyses and evaluation.

This particular division of labor has several advantages and meets a number of objectives. In terms of the professional aspects of review, it involves a significant number of physicians in the review process. In UPRO's experience, upwards of sixty physicians in five hospitals have active review responsibilities at any one time, and the gradual rotation of review physicians can be accomplished without any significant reduction in effectiveness. It is apparent that physician willingness to serve in a review capacity is thereby improved. In addition, the review physicians are intimately aware of the idiosyncracies of their own institutions and the personalities of the members of the staff, and are able to structure the approach to each situation in a way that enhances successful resolution.

The centralized management of the review support system has the advantage of generating a consistent approach to review throughout the community. UPRO's experience clearly indicates that hospitals and hospital medical staffs are concerned that the performance of review be consistent among hospitals and UPRO has been able to respond in a timely manner to situations where the application of criteria and standards has appeared to vary. Consistency can also be achieved in the sense that the collection of data for the conduct of medical care evaluation studies, the development of profiles, and the reporting of results and progress can be closely supervised and audited. Utah PSRO considers this a vital issue in deciding on the preferred structure for organizing review.

The fact that this arrangement is currently in place at five of the largest hospitals in the State is significant in laying plans for Utah PSRO. In addition, the medical staffs of four of the remaining major hospitals have indicated their interest in participating in review on the same basis. Collectively, these nine hospitals represent over 75 percent of the hospital beds in the State and approximately the same percentage of Medicare and Medicaid admissions.

IMPACT OF OSCHUR

As others have discovered, measuring the effect of a professional review program is a difficult and delicate task given the multiple variables

influencing medical care utilization at any point in time. Nonetheless, UPRO is pursuing a rather extensive evaluation methodology utilizing both study and control populations and measuring comparative change over time of the utilization patterns for the two groups. This study will be completed later in 1974.

In the meantime, preliminary figures are available from Educators Mutual Insurance Association, one of the OSCHUR clients, which support the conclusion that some change is occurring. A comparison of claim data for the years prior to OSCHUR with data for the first year under review indicates that the length of stay for reviewed patients has dropped from 5.1 days to 4.6 days. The number of hospital admissions has also decreased slightly. In addition, total daily hospital costs have not increased beyond that expected by inflation, which tends to refute the notion that increased services are squeezed into the shorter stay.

CONFIDENTIALITY

UPRO has given major attention to the issue of confidentiality and has adopted a basic operating policy that the patient's name be omitted from reports or data collection instruments that are transmitted outside the facility where care was provided. In those instances where a positive patient identification by name is required for verifying the performance of review to a third party, access to this information is limited to professional personnel who are sensitive to the ethical concerns about confidentiality.

No known breech of confidentiality has occurred in the two years of the OSCHUR program's operation.

PROFESSIONAL LIABILITY

The matter of professional liability has also been of interest to UPRO in two respects. One is the exposure of the review program itself and the other is the indirect effect that review might have on the frequency of malpractice litigation.

With regard to the former, UPRO has not been the subject of any legal action or threatened legal action of any kind. The objectivity of the review process based on guidelines and standards, as well as the personal interaction involved in each review situation, apparently serve to minimize the personal antagonisms which might lead to legal action.

We also find it interesting to note that coincident with the activation and operation of UPRO, a significant improvement in the malpractice environment, as

measured by professional liability rates, has occurred. This year the USMA group liability program had no increase in premiums, while rates are up 10 per cent nationally and as much as 120 per cent in neighboring states. In fact, Utah physicians have received a 5 per cent dividend. Further, physicians in the higher risk categories have been notified of a premium decrease for the coming year and the partnership surcharge has been reduced 50 per cent.

A causal relationship between this experience and the existence of UPRO cannot, of course, be proved but there is little doubt that review can have a positive effect on professional liability.

PHYSICIAN AMBULATORY CARE EVALUATION (PACE)

On July 1, 1972 the Utah Professional Review Organization began development of an ambulatory review system as a part of its overall effort to review and improve the quality of care provided by physicians. The project has been specifically designed to test the extent to which it is possible to judge quality of care using the relatively limited data generated from health insurance claim forms containing information on physician generated services.

As with all of UPRO's projects, the analysis of the quality of care is performed on the basis of objective criteria which have been developed by UPRO's physician committees. These criteria are designed to be responsive to two questions:

1. Is the therapy or procedure critical to ideal care for that condition?

2. Is the therapy or procedure inconsistent with ideal care for that condition?

The criteria act as screens through which data on actual performance can be passed. Some criteria are keyed on single encounters, some analyze a patient's history of care and still others apply to profiles of a physician's complete practice.

An agreement was reached with the State of Utah, permitting UPRO to have access to physician claim forms received by the State during the project period. Approximately 12,000 claim forms per month are being processed. It was agreed that UPRO access to the forms would occur after the State has essentially completed its processing, thus assuring that the forms would be checked for accuracy and completeness when they are received by UPRO.

UPRO and the State of Utah have also agreed to provide a revised claim form which will generate information in a format designed to permit a more accurate

evaluation of the quality of care rendered. The structure of the new form enables the physician to relate each service provided to a specific diagnosis and requests an identification of medications injected by the physician.

UPRO has contracted with Optimum Systems, Inc. (OSI), a commercial data processing firm, to create a computerized data processing system and to function as a facilities management organization for this project. The OSI data processing system provides a mechanism for comparing the data collected from the Medicaid claim forms with UPRO's quality of care criteria.

Basic system development was completed in late 1972 and histories and profiles have been accumulated over an 18-month period. Reviewing physicians have immediate on-line access to the complete computerized data base through cathode ray tube remote terminals. For any situation requiring review, the reviewing physician is able to call up all pertinent information from the profile of any patient(s) or physician(s) involved in the review.

It is important to note that UPRO's primary aim in this project has been to review physician performance primarily from the standpoint of quality. As initially formulated, the project did not involve UPRO in any fee judgments or in any utilization fiscal control. Through experience with the system, however, it has become clear that, with minor modification, the system would support a complete review program addressing the full range of quality and utilization issues for physician office care.

The data base already collected by UPRO appears to offer a singular opportunity to assess the effect and impact of such a review effort through a comparison of performance over time. A proposal outlining such a project, including a major evaluation component, has been circulated to state and federal agencies, indicating that UPRO is prepared to operate a comprehensive review system in conjunction with the Utah Medicaid program at an early date.

NEIGHBORHOOD HEALTH CENTER PROJECT

UPRO has contracted with the Salt Lake Neighborhood Health Center to develop and implement a review project designed to evaluate the quality of care provided by NHC staff and by a group of physician volunteers from the Salt Lake County community. The methodology chosen for this project involves the application of peer-generated criteria for selected diagnoses and procedures to data abstracted from the office records of participating physicians. Evaluation techniques include both independent and comparative analyses of the performances of the two physician groups.

Funding for the project is shared by UPRO and NHC on approximately a 50-50 basis.

The Project Manager was employed in September, 1972 and spent approximately two months in preparing data collection systems, assisting in criteria development, orientation sessions for participating physicians and other personnel, and generally planning for implementation. Actual data collection began in November, 1972.

The objective of this review project is an evaluation of the quality of medical care provided by the physician staff of the NHC. Volunteer physicians in the Salt Lake County community are reviewed similarly as a comparison group and to validate the general applicability of the criteria. Other objectives include establishing a record of medical care at NHC through recorded review by a Nurse Coordinator and designing criteria that may work in evaluating a doctor's office practice by abstracting information which is included on the patient's office record.

The methodology for this project involves the application of peer-generated criteria for selected diagnoses and procedures against data abstracted from the office records of the NHC and the participating control physicians.

The elements selected for review during the current phase of the project are designed to permit the early accumulation of a wide data base, and at the same time, to be broadly representative of physician skills. These elements fall into three categories as follows:

1. Diseases of normally short duration in which review emphasis is on therapy and outcome. Examples are otitis media and pharyngitis.

2. Activity in which the recording of a complete data base and the interpretation of routine data are the critical care components. Included here are well baby care, pre-natal care and routine physical examinations.

3. Conditions involving more complex care which require both complete data recording and the pursuit of therapy and investigative modalities. Diabetes, hypertension and recurrent urinary tract infections are examples.

During the past eighteen months, over 6,000 patient records have been abstracted and physician review of the data produced has been accomplished.

This information has been returned to the Neighborhood Health Center for initiation of indicated educational programs for the medical staff.

While the continued application of this review system is unresolved, the project does demonstrate that a productive relationship between a community based review program and an HMO can be established and that a cooperative spirit can be maintained.

The Utah State Medical Association and the Utah Professional Review Organization appreciate the opportunity to present these views to the Sub-Committee. Thank you.

EXHIBIT A

UTAH STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-74)

Resolution: 2

Introduced by: Reference Committee F

Subject: AMA Delegates Instruction Concerning PSRO

Referred to:

Resolved, That the Utah State Medical Association House of Delegates instructs its delegates to the AMA to support implementation of PSRO insofar as it is consistent with the accepted principles developed by UPRO and the Utah State Medical Association; namely, that peer review:

(1) Is managed at the level of the physician community and implemented through the hospital staff structure.

(2) Is attentive to quality as well as utilization.

(3) Is concurrent review, thereby nonpunitive through retroactive action.

(4) Is managed by utilizing registered nurses to collect data thereby freeing physician reviewers from all but decision-making roles.

(5) Is a review conducted according to uniformly applied objective parameters.

(6) Compensates physician review consultants.

(7) Involves no additional paper work for physicians.

(8) Is linked to a program of continuing physician education.

RESOLUTION APPROVED
MARCH 27, 1974
USMA HOUSE OF DELEGATES

UTAH STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-73)

Resolution: 2

Introduced by: USMA Board of Trustees

Subject: Designation of UPRO as State PSRO Agency

Referred to: Reference Committee E

Whereas, The Utah State Medical Association (USMA) founded the Utah Professional Review Organization (UPRO) for the purpose of improving the quality and efficiency of medical care in Utah; and

Whereas, The Utah Professional Review Organization is successfully asserting the prerogatives of the physician in the review of medical services having developed into a model for other medical organizations throughout the nation to follow; and

Whereas, Professional standards review for health care services funded through governmental programs has been mandated by Public Law 92-603; therefore be it

Resolved, That the USMA House of Delegates reaffirm its previous action identifying UPRO as the professional standards review organization supported by its physician members and instruct UPRO to develop PSRO activity for Utah in accordance with the federal legislation.

RESOLUTION NO. 2 UNANIMOUSLY APPROVED
USMA HOUSE OF DELEGATES INTERIM SESSION
APRIL 4, 1973, HOTEL UTAH

UTAH STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES (S3-71)

Resolution: 1

Introduced by: Board of Trustees

Subject: Utah Professional Review Organization (UPRO)

Whereas, The quality and effectiveness of delivery of medical care is a matter of major and continuing concern to the Utah State Medical Association; and

Whereas, The accelerating costs of medical care require even greater attention to efficiency and propriety in the utilization of health services; therefore be it

Resolved, That the Utah State Medical Association hereby endorses and encourages the formation of a non-profit corporation to be known as Utah Professional Review Organization (UPRO) under the sponsorship of the Utah State Medical Association. It shall be the purpose of this corporation to promote effective and efficient delivery of superior medical care by developing and implementing a peer review mechanism.

RESOLUTION APPROVED AS PRESENTED
USMA HOUSE OF DELEGATES, SPECIAL SESSION
JULY 14, 1971

Senator TALMADGE. The next witness is Dr. Donald Quinlan, President, Association of American Physicians and Surgeons, Incorporated, accompanied by Dr. Thomas G. Dorrity, Legislative Chairman, and Mr. Frank K. Wooley, Executive Director.

Doctor, you may insert your statement in full in the record, and summarize it, please

STATEMENT OF DONALD QUINLAN, M.D., PRESIDENT, ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC., ACCOMPANIED BY THOMAS G DORRITY, M.D., LEGISLATIVE CHAIRMAN, AND FRANK K. WOOLEY, EXECUTIVE DIRECTOR

Dr. QUINLAN. Thank you, Mr. Chairman. We appreciate this opportunity to present the views of the Association of American Physicians and Surgeons.

I am Donald Quinlan, M.D., president, and with me are Thomas G. Dorrity, M.D., chairman of our legislative committee, and Mr. Frank K. Wooley, executive director.

Our testimony will demonstrate the basic concept of this law is coercive and punitive. Therefore it cannot be satisfactorily amended. It should not be implemented. It should be abolished.

We are asking the Federal court to declare it unconstitutional, and we are asking Congress to repeal it. Basically, the law will require, as soon as Federal Government functionaries can get organized in every area of the country to the satisfaction of the Secretary of HEW, that medical care be "standardized" for Medicare and Medicaid patients. Patients and their doctors will be forced to comply with a system of pre-set standards of medical diagnosis, treatment and care in accordance with the regulation of one man—the Secretary of HEW. Although he is not a licensed physician, he is the final judge of regulations controlling physicians' judgment governing the type of treatment physicians may prescribe for their patients, whether, when and where they may be hospitalized, and for how long. Under his direction and control, a swarm of federally paid and directed functionaries will exercise case-by-case surveillance over the medical judgment of physicians during the course of care of these patients.

This surveillance will determine whether the care proposed to be given by the physician is appropriate and necessary, and to otherwise insure that the physicians' judgments conform to regulations of the Secretary. Patients and their attending doctors will be denied the right to decide what is best for patients.

Among the little understood provisions of this incredible law, not only will physicians be forced to subordinate their best medical judgement of what is "medically necessary for their patients", but when overruled by government functionaries, will be obligated to use their influence to convince their own patients the government is right and that they, the doctors, are therefore wrong.

In certain cases, the patient may be denied the doctor or hospital of his choice.

The AAPS has filed suit in the Federal court to have the law held unconstitutional as being an overbroad interference with the funda-

mental rights of patients and their doctors, unjustified by any legitimate and compelling legislative interests.

As might be expected, in answering the complaint, the Government attorneys say, in effect, that the Federal Government can regulate anything it subsidizes. Other Government employees go on to say, "We intend to subsidize medical care for everyone and control that care."

This is a shocking situation in a country that prides itself on the fact that the central government is restrained by the Constitution from interfering with the private lives of its citizens.

Political medicine is bad medicine. Doctors licensed by the States who now are free and ethically obligated to practice medicine of the highest quality will be forced to follow central government bureaucratic directions, and therefore be denied the right of providing patients with the best care of which they are capable.

We have stated before and we state again—PSRO is punitive in concept. Its purpose is to entrap doctors in a system of government-imposed controls. But what has been created is a trap that is going to catch the patients. They, not doctors, will suffer the most, because medicine compressed into a standardized mold by political pressures will not be first-class care. Who will be deprived of first-class care? Obviously the patient, not the doctor.

Furthermore, no publicity has been given to the fact that this authority for detailed dictation and control was planned by the bureaucracy of the Federal Government as a part of a scheme of nationalization of medicine for everyone in the country.

In our steadfast opposition to PSRO and our determination to inform the public and the medical profession of the truth about PSRO, we have been accused of misrepresentation. Let's examine who is, in fact, indulging in misrepresentation. Let us start out with Dr. Simmons' statement as published in Medical Tribune to the effect that he challenges PSRO critics to show that anyone other than local physicians will determine PSRO standards.

The PSRO law plainly states that the National Professional Standards Review Council shall (please note the word is "shall" not "may") "provide for the preparation and distribution of appropriate materials indicating the regional norms to be utilized." Furthermore, the law specifies that if there is to be any deviation from prescribed norms, the PSRO is to be notified and may utilize different norms if the National Professional Standards Review Council consents.

The essence, the substance, the very purpose of this law is control. It was intended to smother the medical profession in uniformity established by bureaucratic fiat. You should know that 17 State medical associations and many county societies are on record for repeal. I can assure you, Mr. Chairman, most doctors in this country are not being fooled or hoodwinked into accepting a bad law just because someone says it's a good law. I can also promise you that the physician members of our organization are not going to turn tail and run just because someone in HEW or in Congress snarls at them.

We are going to continue to tell the truth about this law. It is a bad law. We know that misrepresentations about it by its promoters and propagandists will continue because it is so bad there has to be a coverup.

We can demonstrate to any reasonable man's satisfaction that once a doctor accepts a medicare or medicaid patient, he is caught in the PSRO trap.

Are you aware, as just one example, that if a physician sends a medicare or medicaid patient to a laboratory for diagnostic procedures or for therapy, that doctor is required to police the laboratory to assure PSRO that the lab is not doing something medically unnecessary or economically too costly?

Furthermore, according to a recent opinion of the Senate Finance Committee staff director, the doctor is trapped even though he does not take a penny directly from the Government. According to this opinion, the doctor who has nothing to do with the Government—who takes no money or does not deal with Government in any way—is just as subject to punishment for displeasing the bureaucrats as the doctors who do deal directly with Government.

We also wonder if official Washington is ever going to level with the American people that PSRO will condone wholesale violation of the privacy of records of any patient of any physician who takes care of medicare or medicaid patients. Officials are now hiding the truth.

Under this law, the Government official who wants confidential information to use against a patient or for some other purpose, will no longer have to burglarize a doctor's files such as the White House ordered in the *Ellsberg* case. All confidences of all patients of all doctors covered by this law, and this is practically all of them, will be available to the politicians.

The plain truth about confidentiality is that this pernicious law is a vast and unholy grant of power to the Secretary of HEW to acquire confidential information from records of any patient and to use it in whatever manner he decides will further, in his opinion, the purposes of the law. The plain truth is that the PSRO law will protect individuals who rifle patient records for use by PSROs and HEW, not punish them.

The Supreme Court said in 1973 a patient has the right of privacy, and a committee should not come between a patient and her physician and be denied the best judgment of her physician.

The evidence is clear that the PSRO is the gear in the "nationalized medicine machine" with teeth in it.

A book on PSRO financed by HEW before Congress approved the law—and this is published by Decker and Bonner—admits PSRO: one, is rationing; two, is a precursor to control of all medical care; three, although not authorized by law, must be applicable to private care; four, is designed to ensure uniformity, modify individual behavior, systematically impose constraints on physicians. The book tells how to have local PSROs conform to national norms, asserts the National Council will probably have no authority over PSROs, and discloses how they are to interfere with doctors' judgments.

Talk about coverup. There are enough leads in that book to keep many congressional committees busy.

The public knows nothing about these plans for control. Furthermore, the people do not know how, or that, huge sums of Federal money are being granted by Government employees to influential educators and others to study how to extend Government intervention and

control of medicine, and then how large numbers of these grantees testify for more intervention and more money.

Only a few Federal legislators know what is in Public Law 92–603 and what its implications are.

The news media has not told the full story; in fact, the true nature of "standardization" was buried in the omnibus social security law of 1972. Stories about it stressed benefits and what was being done for people through politics, instead of what was being done to them.

This committee has the constitutional duty and responsibility to blow the cover off this scandal before it is infinitely more disastrous to individual freedom and responsibility than Watergate.

We do want to emphasize that the attempts of Government officials and other advocates of Government intervention in medicine to blame doctors for wild Government spending and inflation is ridiculous. For example, HEW is scheduled to spend $111 billion for the year beginning this July. Of that amount, only $4.242 billion is for physicians' services. Deduct everything HEW will pay to physicians this coming year and HEW will still be spending over $106 billion, which is more than all of the expenditures of the entire Federal Government in 1960.

This committee and all the people of this country should know that a governmental system of "police doctors" to ration and control medical care, rather than allow citizens to willingly exchange services and considerations without Government interference, is not new or novel.

Such a system as PSRO or "police doctors" which originated in and flourishes in all totalitarian countries goes hand in hand with socialized medicine. Information about these "police doctor" systems and nationalized medicine in alien countries is readily available through the AAPS.

We will be pleased to supply each member of this committee who wants it a copy of the book "Medicine and the State" by Lynch and Raphael.

Senator TALMADGE. Doctor, I hate to call time on you, but your time has expired. Your full statement will be in the record, and a summary thereof will be made available to each member of this committee.

Dr. QUINLAN. Thank you, Senator.

Senator BENNETT. Well, we have just had a most interesting situation. We have had testimony from a group of men who have been operating a PSRO-type review system, who say it can be moved in to serve medicare without change. And then we have had the description of a system, a theoretical description of a system that has never existed, that was never intended. And I cannot see the two of them in the same law. So I think that Dr. Alan Nelson's testimony is complete refutation of the fears that these gentlemen have expressed about the operation of a system they have dreamed up by their interpretation of the law, which these other men are operating to the benefit of the patients. And you have heard one of the representatives of the consumers testify to their satisfaction.

So I do not think there is any need to go into further questioning. We heard similar testimony this morning from the Council of Hospital Staffs. They are two of a kind. They represent the same point of view.

They remind me of a famous saying. I think I quoted it yesterday. "Even if it was good, I would not like it."

Senator TALMADGE. Senator Curtis?

BOOK ENTITLED "MEDICINE AND THE STATE"

Senator CURTIS. Doctor, will you display that book you were referring to?

Dr. QUINLAN. Certainly, sir.

Mr. Woolley, will you——

Senator CURTIS. Well, who is the author of it?

Mr. WOOLLEY. The author of this book is Decker and Bonner.

Senator CURTIS. Who are they?

Mr. WOOLLEY. Decker and Bonner are employees of Arthur D. Little, Inc., which had a contract with the Department of Health, Education, and Welfare to write this book. And it is very interesting that the book was initiated during July 1972 under a contract with HEW; and as this committee will recall, the law was passed, not in July 1972, but was passed later and signed on October 30, 1972. So it was authorized by these people, but it was developed—and I think this is very interesting—on page x of the preface of the following appears—very interesting:

"All of us are deeply indebted to our project officers, Sheridan L. Weinstein, M.D., and Leonard J. Jankar, M.D., of the Community Health Service." That is, of the Department of Health, Education, and Welfare. "In addition to financial support, they graciously gave their time, interest, advice, and frequently participated in the panel discussions."

So from our point of view, we think you could say quite clearly that this was developed by people in the Department of Health, Education, and Welfare, under their financing.

Senator CURTIS. Now, Dr. Quinlan, in referring to that book, you quoted language very adverse, from my point of view, to the PSRO statute.

Whose words were they?

Dr. QUINLAN. Mr. Woolley, I think you have the book in your hand. Perhaps you——

Mr. WOOLLEY. The words that were in the statement are the words that came right out of this book with respect to rationing. There was quite a bit of discussion about the question of rationing. They said that there was not any rationing, there was not any intention of there being rationing, and so forth and so on. And on page six of this book, this statement is made:

> Whether any national health insurance plan works or not will depend in good measure upon its ability to equitably distribute scare medical resources. The failure of such rationing will lead to market competition and so forth.

That is on page six. And then on page seven it says:

> PSRO is a necessary precursor to the further public assumption of responsibility for the financing of health care, and in effect—and these are all quotes—in effect, PSRO is a form of nonprice rationing.

This is the Bible that is being used in HEW and is the basis that has been used there with respect to the preparation of their manual.

Senator CURTIS. Did they finance it?

Senator BENNETT. I challenge that, that this is the Bible that HEW is using with respect to PSRO. This was a private contract executed by these two gentlemen, paid for with HEW money, but has never been distributed to this committee, has never been referred to by HEW in its conferences with this committee. It certainly was not referred to by the Secretary or Dr. Simmons.

I think it is the Bible of your organization.

Mr. WOOLLEY. This is not a private contract. This is a public contract between HEW on PSRO and you spoke about the proposition of the people that appeared just before us with respect to it. They are also financed by HEW.

Senator BENNETT. All right.

Mr. WOOLLEY. Their EMCRO study was by HEW. Here is the record out of HEW that these are contracts by Government employees. So don't try to say to us——

Senator BENNETT. Well, now, wait a minute, wait a minute. When I say it is a private contract——

Mr. WOOLLEY. Yes.

Senator BENNETT (continuing). It was a contract executed by a private firm. It was paid for by HEW, but HEW had no responsibility to accept the ideas that those men put in that book. They are not bound by it.

Mr. WOOLLEY. No, of course they are not bound by it. But it says right in here that HEW employees were the ones who sat in and participated in it, and they are very indebted to their participation.

Senator BENNETT. That does not mean that HEW is bound by it.

Mr. WOOLLEY. Of course they are not bound by it.

Senator BENNETT. And when you say this is the Bible of HEW you offend the intelligence of this committee.

Mr. WOOLLEY. Well, we can say this, Mr. Chairman—I mean, Senator Curtis—we can say this: Every place where they have had socialized medicine, every place in the world, they have had a PSRO program. They have not called it PSRO, but they have police doctors set up in every one of them, and they interfere between the doctor-patient relationship in order to try to hold down the cost of the government program. And that is what these people are talking about right in here. And so we did not dream it up at all. This is their book, not ours.

Senator TALMADGE. Any further questions?

Senator CURTIS. Just a minute, Mr. Chairman.

How much of this discussion about the Bible is charged to my 10 minutes to ask questions?

I have only asked one. I think it took about 30 seconds.

Senator BENNETT. I suggest we let the Senator start with 10 from scratch.

Senator TALMADGE. I agree.

Senator CURTIS. Well, that is most generous.

[General laughter.]

UTILIZATION REVIEW REQUIREMENTS

Senator CURTIS. Now, some contend there are no new requirements for review in the PSRO law, but that some previous utilization review

requirements were preempted by PSRO provisions less onerous to physicians.

Do you concur in this?

Mr. WOOLLEY. That, of course, is not true at all. Before PSRO participation by physicians was voluntary. Presumably it is voluntary now, but practically it is involuntary, since practically all physicians care for some medicare or medicaid or disabled patients who might qualify to have some of their health care services paid for in whole or in part from social security funds.

The net effect is to make every physician subject to the law. Now, in the defendants' argument that they submitted in the case that we are now in the process of trying, the following appears:

> Plaintiffs are perfectly willing to accept the fees under medicare and medicaid programs. They are apparently unwilling, however, to accept any regulation over the payment of such fees.

The issue is not payment. Any physician can now refuse to accept assignments. But under this law now, according to the testimony, or to a written statement by a member of the staff of this committee, assignments—a doctor will no longer be able to avoid involvement in PSRO by refusing to take assignments. He is going to be involved just the same as anybody else, those who take assignments.

So it is a long ways from being voluntary.

Now, there are a number of other things. There are about 15 or 20 big differences. No requirement existed before PSRO that a physician, against his will and the ethics of the medical profession, become an agent of the Government. Under this he has to become an agent of the Government whether he wants to or not.

Before there was no requirement that the attending physician supervise, limit or otherwise interfere with the exercise of medical judgment being exercised for his patient by another physician. Now there is. See Section 1160(a).

Under the present law, norms of diagnosis, treatment and care were not established to prescribe the standards to which a physician must conform. Under PSRO law, they are.

For eligible patients who have not utilized benefits provided under Medicare and Medicaid, no preadmission requirement was required before. A preadmission requirement is now.

I can go on and on. I have got a whole list of them. There are 20 of them, and I would be glad to put them in the record for you, because this idea that there is no difference between what was in the law before PSRO and now—if that was true, then why do you not repeal the PSRO law?

Senator CURTIS. You may supply the additional things, because I would like to go on to the next question.

CONFIDENTIALITY

Senator CURTIS. Does the fact that some insurance clerks now have access to certain medical records justify the surveillance of medical records authorized by PSRO?

Mr. WOOLLEY. Absolutely not. There is no basis for the violation of confidentiality under any circumstance, and the fact that it has been

violated under a law prior to the PSRO law does not justify the PSRO law being the basis for the same thing.

Senator CURTIS. A recent PSRO memo indicates that one basis for the development of guidelines and regulations relating to privacy is the report to the Secretary's Advisory Committee on Automated Personal Data Systems entitled Records, Computers and Rights of Citizens.

Do you consider this a dependable basis for protection of the rights of patients to privacy?

Mr. WOOLLEY. There is no basis at all for the Federal Government to first violate under a statute the confidential relationship of information between a doctor and patient, and then come along and have some committee to advise the Secretary of HEW with respect to the subject. Now, everybody on this committee and everybody in this room knows about the Ellsberg case. Everybody knows that confidentiality is a very serious matter that is being violated and being violated by Government. And the place that this needs to be protected is in the courts, and not by some specious operation under the Secretary of HEW.

Senator CURTIS. Well, I might say in passing, I live in a small community of 2,600 people, and to remove the name of the patient and then circulate the record does not acomplish anything, because everybody could identify the patient.

Mr. WOOLLEY. Right.

POWERS OF THE SECRETARY UNDER PSRO

Senator CURTIS. Are private practicing physicians reassured by statements of HEW officials that they intend to let local physicians manage the PSRO policing program?

Mr. WOOLLEY. Of course, the answer is no, because the law says specifically that the authority is in the Secretary of HEW, and when the authority is in the Secretary of HEW that means that he can control it, as has been brought up before this committee many, many times. We are not talking about people; we are talking about laws, and this should be a Government of laws and not a Government of men. But PSRO says it will be a Government of men.

SECOND-CLASS CITIZENSHIP SEEN FOR SOME UNDER PSRO

Senator CURTIS. Now, would the implementation of these provisions make second-class citizens out of some people?

Mr. WOOLLEY. It will make second-class citizens out of everybody that is under it, and the people that are in the position of being made second-class citizens will have a real case against the Government. This is a part of the point we are making in the lawsuit.

Senator CURTIS. Why?

Mr. WOOLLEY. For the very simple reason that it says, the provisions of the act itself say that you have to use the most economical sort of treatment. All right, if the patients that are under PSRO are forced to have the most economical treatment, that means, then, that someone else is going to have a better quality of treatment than they are. And also, if we can possibly have doctors take care of patients outside of

PSRO, then they are going to be free to exercise their best judgment, which they are not free to do under PSRO.

PSRO Seen Violating Constitution

Senator Curtis. Well, can Congress, through the use of taxing power, evade express limiting provisions of the Constitution with respect to certain subjects?

Mr. Woolley. It is our opinion that the Congress of the United States and the President, in passing the PSRO law, violated the constitutional provisions with respect to confidentiality of information, as contained in the first amendment. We think it is a violation of the fourth amendment with respect to unreasonable search and seizure without a warrant. We think it is a violation of the due process of law under the provisions of the fifth amendment to the Constitution. We think it violates the right of trial by jury of the seventh amendment, and we think it also violates the provisions of the Constitution with respect to the ninth amendment. And our complaint that was filed in the Federal district court June 26, 1973, so states, and we would be happy to make available for this committee the complaint, the memorandum of law, filed by the attorneys for the Government, and also the memorandum of law that we filed. And you would be interested in knowing that there is a lot of things in those documents which will shed considerable light on what has been discussed here.

Senator Curtis. Mr. Chairman, I ask unanimous consent that it be received in the record.

Senator Bennett. Mr. Chairman, I ask unanimous consent that the reply from the Federal Government be included.

Mr. Woolley. This I would want you to have.

Senator Talmadge. Without objection, the memorandum and the answer will be inserted in the record.*

Powers of the Secretary Under PSRO

Senator Curtis. Now, I think the strongest argument against PSRO that can be made is to have somebody read the law.

Mr. Woolley. We agree.

Senator Curtis. It has been stated that, here he goes again. Now, as a matter of fact, it would be most difficult to pick out a single sentence in there that does not refer to the power of the Secretary to do something.

Dr. Quinlan. Yes, sir, that is correct.

Will PSRO Advance Medicine?

Senator Curtis. And that is not peer review.

I would like to ask these doctors, do you feel that the retention and implementation of PSRO will, over a period of years, advance medicine in this country?

Dr. Quinlan. No, sir. I do not. And my experience of 8 years working under the British national health scheme from 1948 to 1958, ex-

*See Appendix H, page 869, of these hearings.

cluding 2 years I was in residency in Switzerland, indicates that this is the thin edge of the wedge. And it would be interesting, I think, for this committee also to read a book written by the former Minister of Health, J. Enoch Powell, who for 3 years was in that office there (England), called A New Look at Medicine and Politics, where he points out the complete failure of that system.

Senator TALMADGE. Doctor, I hate to call time on you again, but we have got five more witnesses to be heard from all over the United States, and the hour is getting late.

Dr. QUINLAN. Thank you, Mr. Chairman.

Senator TALMADGE. Thank you very much for your contribution.

[The prepared statement of Dr. Quinlan follows:]

PREPARED STATEMENT OF THE ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

(By Donald Quinlan, M.D., President)

We appreciate this opportunity to present the views of the Association of American Physicians and Surgeons. I am Donald Quinlan, M.D., President, a physician in the private practice of medicine in Chicago, Illinois. With me are Thomas G. Dorrity, M.D., a surgeon in the private practice of medicine in Memphis, Tennessee, who is also Chairman of our Legislative Committee; and Mr. Frank K. Woolley, Executive Director, with headquarter offices in Oak Brook, Illinois. With your permission, Dr. Dorrity and Mr. Woolley will assist me with our Statement and any questions you have concerning it.

The Association is a free, independent, non-governmental, voluntary organization of members of the medical profession. We are united for the purpose of analyzing the profession's problems and formulating actions to improve medical care for all Americans, preserve freedom of choice for patient and doctor, protect the practice of private medicine, and educate physicians and the public to recognize and resist schemes that would weaken or destroy our free-choice system of medical care.

With your permission, Mr. Chairman, we will present a summary statement today and file for the record later on a more detailed analysis of the problems of the PSRO law.

We welcome this Committee holding "hearings to evaluate present and proposed implementation of the professional standards review legislation" because of its grave implications for individual freedom and responsibility as we have known it in this country since the founding of the Republic.

Our testimony will demonstrate the basic concept of this law is coercive and punitive. Therefore, it cannot be satisfactorily amended. It should not be implemented. It should be abolished. We are asking the federal court to declare it unconstitutional and we are asking Congress to repeal it.

Basically, the law will require, as soon as federal government functionaries can get organized in every area of the country to the satisfaction of the Secretary of HEW, that medical care be "standardized" for Medicare and Medicaid patients. Patients and their doctors will be forced to comply with a system of preset standards of medical diagnosis, treatment and care in accordance with the regulations of one man—the Secretary of HEW. Although he is not a licensed physician, he is the final judge of regulations controlling physicians' judgment governing the type of treatment physicians may prescribe for their patients, whether, when and where they may be hospitalized, and for how long. Under his direction and control a swarm of federally paid and directed functionaries will exercise case-by-case surveillance over the medical judgment of physicians during the course of care of these patients. This surveillance will determine whether the care proposed to be given by the physician is appropriate and necessary and to otherwise insure that the physicians' judgments conform to regulations of the Secretary. Patients and their attending doctors will be denied the right to decide what is best for patients.

Also, under this law, a physician can be forced to turn over to federal employees all medical notes taken in his office or in a hospital, including the most confidential information about all his patients. Likewise, it is planned to have massive,

detailed, computerized files on patients and doctors which will be instantly available to federal employees as an aid to the surveillance program and for such other purposes as the Secretary of HEW may provide.

Among the little understood provisions of this incredible law, not only will physicians be forced to subordinate their best medical judgment of what is "medically necessary for their patients," but when overruled by government functionaries, will be obligated to use their influence to convince their own patients the government is right and that they, the doctors, are, therefore, wrong.

In certain cases, the patient may be denied the doctor or hospital of his choice. In fact, if government paid agents or employees decide hospitalization is unnecessary, contrary to the judgment of the patient's physician, the patient may not be put in the hospital under the Medicare or Medicaid program. If he gets hospitalization, he'll have to find a way to pay for it himself. These patients, of course, are the elderly and the poor that government has promised to take care of.

And, naturally, the law has teeth in it which take the form of many sanctions to be imposed against physicians. Penalties can amount of $5,000 for failure to conform to regulations.

The AAPS has filed suit in the Federal Court to have the law held unconstitutional as being an overbroad interference with the fundamental rights of patients and their doctors, unjustified by any legitimate and compelling legislative interests.

As might be expected, in answering the Complaint, the government attorneys say, in effect, that the federal government can regulate anything it subsidizes. Other government employees go on to say, "We intend to subsidize medical care for everyone and control that care."

This is a shocking situation in a country that prides itself on the fact that the central government is restrained by the Constitution from interfering with the private lives of its citizens.

The AAPS et al Complaint and Memoranda of Law by Plaintiffs and Defendant will be filed for the record of this hearing.*

The people have no idea that legislation has been enacted to inject politics into medicine and to authorize one man, or a committee at his direction, to come between a patient and a physician and change their behavior in violation of the Constitution of the United States. Neither do they nor many of their representatives in Congress understand that authority has been given to one man and his subordinates to force all doctors to conform to their idea of the appropriate medical diagnosis, treatment and care that must be followed in caring for patients.

Political medicine is bad medicine. Obviously, political considerations will control the actions of those in the bureaucracy and those serving as paid agents of the bureaucracy. Doctors licensed by the states who now are free and ethically obligated to practice medicine of the highest quality will be forced to follow central government bureaucratic direction and, therfore, be denied the right of providing patients with the best care of which they are capable. Inferior and mediocre quality medicine must be the result. Furthermore, PSRO is a scheme designed to place the blame on doctors for broken political promises that patients would be given the best quality medical care they wanted at the cheapest price. It calls for rationing and price control at the expense of patients. Even the Secretary of HEW, Caspar Weinberger, admitted to a House Committee on March 19, 1974 that: "I would be less than candid if I did not express to you the feeling that I have that there is a potential danger of a very substantial governmental interference into the practice of medicine by this kind of statute."

Government interference means political interference. Obviously, anyone subservient to political considerations must be less than the best physician.

Patients will be badly served by adherence to the short-sighted policy of political interference with the best judgment of the patient's doctor.

We have stated before and we state again—PSRO is punitive in concept. Its purpose is to entrap doctors in a system of government-imposed controls. But what has been created is a trap that is going to catch the patients. They, not doctors will suffer the most, because medicine compressed into a standardized mold by political pressure will not be first-class care. Who will be deprived of first-class care? Obviously the patient, not the doctor.

Furthermore, no publicity has been given to the fact that this authority for detailed dictation and control was planned by the bureaucracy of the federal

*See p. 869.

government as a part of a scheme of nationalization of medicine for everyone in the country.

MISREPRESENTATIONS

In our steadfast opposition to PSRO and our determination to inform the public and the medical profession of the truth about PSRO, we have been accused of misrepresentation. Let's examine who is, in fact, indulging in misrepresentation.

The May 1, 1974, issue of MEDICAL TRIBUNE published a somewhat hysterical diatribe against the "American Association of Physicians and Surgeons" by Dr. Henry Simmons, the man in HEW who has been tapped for the unenviable task of trying to persuade the nation's physicians that if they just hold their noses and swallow, PSRO won't be all that bad. Dr. Simmons accused the AAPS and another medical organization of "misleading the profession, doing a "disservice" to the public and promoting a "climate of misunderstanding" about PSRO.

We assume Dr. Simmons was referring to our organzation, the Association of American Physicians and Surgeons, which we readily agree is undoubtedly the nation's most nagging critic of the vicious, punitive PSRO law. We submit that AAPPS has been steadfastly telling the truth about PSRO. Those who have been misrepresenting PSRO have been officers of HEW and other public officials.

Let's start out with Dr. Simmon's statement as published in MEDICAL TRIBUNE to the effect that he challenges PSRO critics to show that anyone other than local physicians will determine PSRO standards.

"I don't know when people will start to believe," Dr. Simmons is quoted, "that under the legislation and under the regulations—and they are available to anyone in the country who cares to read them—the local PSRO decides what standards to practice under."

The very statement is misleading. Dr. Simmons doesn't define standards. HEW's recently issued PSRO manual identifies three categories of medical practice controls—norms, standards and criteria. While it is true that the manual aserts that PSROs will be responsible for developing and modifying criteria and standards and selecting norms, we contend that this assertion is a clever and calculated misrepresentation which is intended to con the nation's physicians into believing they will be allowed to exercise control over the PSRO review process.

We challenge Dr. Simmons and other HEW officials, including Secretary Casper Weinberger and Assistant Secretary for Health Dr. Charles Edwards, to identify the section of this law which states clearly and unequivocally that PSROs are responsible for setting standards, norms or criteria of medical practice to which this country's doctors will be forced to adhere.

The PSRO law plainly states that the National Professional Standards Review Council shall (please note that the word is shall, not may)—and I quote—"provide for the *preparation and distribution* . . . of appropriate materials indicating the regional norms *to be* utilized . . ." Furthermore, the law specifies that if there is to be any deviation from prescribed norms, the PSRO is *to be notified* and *may* utilize different norms *if* the National Professional Standards Review Council consents.

You know and I know, and so does Dr. Simmons and Dr. Edwards, who approved a recently distributed PSRO information pamphlet which is misleading in the extreme—we know that PSROs are not going to be allowed to do anything without HEW approval.

Each PSRO, for instance, will be required to serve a probationary period to prove it is capable in HEW's eyes of performing the PSRO policing operation. Even before that, the PSRO must submit a plan of operation, including norms, standards and criteria to be used—and they had better get them right or the Secretary will turn them down. Even after serving probation, an organization must get HEW approval to become a full-fledged PSRO.

Do Dr. Simmons and Dr. Edwards seriously want the American people to believe they plan to defy the requirements of this law and let local doctors control PSROs, including the development and application of compulsory norms, standards and criteria?

The essence, the substance, the very purpose of this law is control. It was intended to smother the medical profession in uniformity established by bureaucratic fiat.

Under that kind of alien system, the people of this country—our patients and your constituents—will be the worst losers.

Dr. Simmons alleged that there is growing support for PSRO among physicians. But he also complains, in seeming contradiction, that the bureaucracy has failed in its campaign to propagandize the doctors into swallowing the poison of PSRO. The fact is that when doctors discover the truth, they recognize it is a bad law. You should know that 17 state medical associations and many county societies are on record for repeal.

Dr. Simmons said he was disturbed that—and I quote—"there are associations that are trying to mislead." And he warns: "That's going to change."

MEDICINE THREATENED

Dr. Simmons didn't clarify what he proposes to do to organizations which exercise the freedom of disagreeing with him and other government officials. But it is not the first time the medical profession has been threatened in a transparent attempt to force it into a Socratic decision to drink the PSRO hemlock.

Last January, for example, Senator Bennett, Jay Constantine of the Senate Finance Committee staff, and Dr. Simmons, among others, discussed PSRO at a meeting of the American College of Radiology. According to the March, 1974 ACR BULLETIN, these officials threw out blunt threat after blunt threat that unless physicians drop their opposition to PSRO and get in there and make it work the way the bureaucracy wants it to work, the wrath of Congress and the bureaucracy will descend upon them and they will get something a lot worse.

Is this the way this law is going to be forced down the throats of the people—by threat and intimidation? If PSRO had all the virtues claimed for it, why would such tactics be necessary?

We think this committee should take a good, hard look at the facts and find out just who is misrepresenting these facts and who is doing a disservice to the people.

I can assure you, Mr. Chairman, most doctors in this country are not being fooled or hoodwinked into accepting a bad law just because someone says it's a good law. I can also promise you that the physician members of our organization are not going to turn tail and run just because someone in HEW or in Congress snarls at them.

We are going to continue to tell the truth about this law. It *is* a bad law. We know that misrepresentations about it by its promoters and propagandists will continue because it is so bad there has to be a *cover up*.

In an interview published in the April 1, 1974, issue of AMERICAN MEDICAL NEWS, Dr. Simmons implied that if physicians did not institutionalize Medicare or Medicaid patients, they would not be affected by the PSRO law.

We submit that that is at best misleading. We can demonstrate to any reasonable man's satisfaction that once a doctor accepts a Medicare or Medicaid patient, he is caught in the PSRO trap.

Are you aware, as just one example, that if a physician sends a medicare or medicaid patient to a laboratory for diagnostic procedures or for therapy, that doctor is required to police the laboratory to assure PSRO that the lab is not doing something medically unnecessary or economically too costly?

Furthermore, according to a recent opinion of the Senate Finance Committee staff director, the doctor is trapped even though he does not take a penny directly from the government. According to this opinion, the doctor who has nothing to do with government—who takes no money or does not deal with government in any way—is just as subject to punishment for displeasing the bureaucrats as the doctors who do deal directly with government. His medicare and medicaid patients can be denied his services and he can be subjected to a fine if he doesn't knuckle under and practice medicine the way HEW's paid agents tell him to.

Why, we wonder, doesn't Dr. Simmons and Senator Bennett and Dr. Edwards explain to physicians and to the people just how this great PSRO boon to the nation can, in fact, deny the poor and the elderly the services of the doctor of their choice?

Isn't it a monumental disservice to the citizens of this country *not* to tell them such things?

So, who's misrepresenting?

A few months ago, Senator Bennett spoke on PSRO to the Essex County (New Jersey) Medical Society. He said, among other things, that PSROs would have

"sole power to determine the acceptability of the parameters applicable to the area."

We challenged that assertion in the December, 1973, issue of the AAPS NEWS LETTER. An AAPS wrote Senator Bennett for clarification. He replied: "I suppose I did overstate somewhat in saying the members of each PSRO would have *sole* power to determine the acceptability of the parameters applicable in the area." He then acknowledged—as we have repeatedly pointed out—that there is a higher authority in Washington with veto power over PSROs.

TRUTH IS HIDDEN

We also wonder if official Washington is ever going to level with the American people that PSRO will condone wholesale violation of the privacy of records of *any* patient of any physician who takes care of medicare or medicaid patients. Officials are now hiding the truth.

In that PSRO pamphlet approved by Dr. Edwards and distributed a few months ago to U.S. physicians, an attempt was made to establish as fact the fiction that "any data or information collected by a PSRO is to be held in strict confidence" on pain of strong penalties. Senator Bennett in a statement in the April 2 CONGRESSIONAL RECORD even sought to allay fears by stating the law permits access only to records of medicare and medicaid patients.

Both these assertions are false. Senator Bennett cited Section 1155 (b) (3) as limiting examination to medicare and medicaid records. But Section 1155 (b) (3) and (b) (4) authorize any PSRO "to the extent *necessary and appropriate* for the proper performance of its duties and functions" to "examine the *pertinent records* of any practitioner or provider of health care services * * *" and "services provided * * * of any practitioner or provider." And those are direct quotes from the law. I emphasize it does not limit scrutiny to medicare and medicaid patient records.

The law prohibits disclosure of information *except* to the extent necessary to carry out the purposes of the law. All it requires of the Secretary is *adequate* (not full, mind you, but only *adequate*) protection of the rights and interests of patients. And guess who decides what is adequate? Obviously the Secretary.

Under this law the government official who wants confidential information to use against a patient or for some other purpose will no longer have to burglarize a doctor's files such as the White House ordered in the Ellsberg case. All confidences of all patients of all doctors covered by this law, and that is practically all of them, will be available to the politicians.

The plain truth about confidentiality is that this pernicious law is a vast and unholy grant of power to the Secretary of HEW to acquire confidential information from records of *any* patient and to use it in whatever manner *he* decides will further, in his opinion, the purposes of the law. The plain truth is that the PSRO law will *protect* individuals who rifle patient records for use by PSROs and HEW, not punish them.

That pamphlet of Dr. Edwards also falsely asserts or implies that:

A. The PSRO program is to be controlled by physicians,

B. The purpose of the PSRO program is to improve the quality of care and not to discipline physicians. (It is the Secretary and his subordinates and agents who do the controlling, not physicians.),

C. PSRO will cause little change in the way physicians practice medicine. (The opposite is true.),

D. Local physicians who make up PSROs will determine standards and criteria to be used "in determining the necessity and quality of care,"

E. The primary emphasis of the PSRO program is assuring the quality of medical care. (Actually, it will guarantee a deterioration in the quality of medical care.)

If local doctors are going to do all this standard setting and criteria determining and all this controlling, what, in Heaven's name, is the purpose of this law?

Another alarming thing about this pamphlet is that it omits important facts which would expose just how bad this law really is and how detrimental it is to the best interests of the people.

For example, patients may be denied admission to a hospital for either elective or extended or costly services—even though the physician believes they are necessary for the health of the patient.

Nothing is said either about the fact that PSROs are required to harass and intimidate doctors who don't follow orders to get them into line. Nothing is said about the requirement that PSROs in carrying out this mandatory bullying must enlist the support of other professional and governmental organizations that have influence on the doctor.

(An evaluation of the numerous false and misleading statements in the HEW pamphlet have been filed with our Statement.)

But there is constantly more to worry about—as there always is when bureaucrats begin meddling. For a long time, for example, everyone was led to believe that PSRO was a device by which government could decide what was medically *necessary* for medicare and medicaid patients. But lately, officials at HEW have been talking and writing and laying out guidelines for determining also what is medically *appropriate* in caring for these patients.

Necessary and appropriate are vastly different things in medicine. It is dangerous enough to give bureaucrats the power to decide for a patient whether it is necessary for him to have an appendectomy, but it is compounding the danger beyond rational bounds to grant bureaucrats the power also to determine whether the surgical procedure is appropriate—in other words, the right one.

The evidence is clear that:

1. Federal government employees as part of their plans to change the behavior of individuals have plotted the PSRO Controls this Committee is considering. PSRO is the *gear* in the "nationalized medicine machine" with teeth in it.

2. The public knows nothing about these plans for control.

3. Furthermore, the people do not know how, or that, huge sums of federal money is being granted by government employees to influential educators and others to study how to extend government intervention and control of medicine and then how large numbers of these grantees testify for *more* intervention and *more* money.

4. Only a few Federal legislators know what is in Public Law 92-603 and what its implications are.

5. The news media has not told the full story—in fact, the true nature of "standardization" was buried in the omnibus Social Security Law of 1972. Stories about it stressed benefits and what was being done *FOR* people through politics instead of what was being done *TO* them.

6. This Committee has the constitutional duty and responsibility to blow the cover off this scandal before it is infinitely more disastrous to individual freedom and responsibility than Watergate.

Obviously, ten minutes is insufficient to bring such a tragic situation and its consequences into sharp focus, particularly when it has been skillfully blurred by adept promoters of unlimited bureaucratic power. However, we have quickly flagged as many points as we could in the time allotted and will submit additional information for the record.

We do want to emphasize that the attempts of government officials and other advocates of government intervention in medicine to blame doctors for wild government spending and inflation is ridiculous. For instance, HEW is scheduled to spend $111 billions for the year beginning this July. Of that amount, only $4 billions 242 millions is for physicians' services, $3 billions 586 millions for Medicare and $656 millions for Medicaid. Deduct everything HEW will pay to physicians this coming year and HEW will still be spending over $106 billions ($111 billions minus $4 billions 242 millions=$106 billions 758 millions). The $106 billions, which excludes all payments to doctors, is more than all of the expenditures of the entire federal government in 1960. (For more information on who is responsible for inflation, see the attached copy of AAPS testimony before the House Ways and Means Committee, April 26, 1974 opposing nationalized medicine schemes which incorporate PSRO.)

In view of the fact that many millions of dollars of federal funds may have come into the hands of witnesses who will testify before this Committee for this totalitarian scheme, we suggest that you ascertain from every witness whether he or she is paid federal empolyee, whether they have or will receive anything of value from the federal government for studies or writings bearing on this subject, and whether or not they have or anticipate a contract with the federal government with respect to any part of this plan of standardization or any part of a plan for nationalization of medicine.

This Committee and all the people of this country should know that a governmental system of "Police Doctors" to ration and control medical care, rather than allow citizens to willingly exchange services and considerations without government interference, is not new or novel.

Such a system as PSRO or "Police Doctors" which originated in and flourishes in all totalitarian countries goes hand in hand with socialized medicine. Information about these "Police Doctor" systems and nationalized medicine in alien countries is readily available through the AAPS.

We will be pleased to supply each member of this Committee who wants it a copy of the book: "Medicine and The State", by Lynch and Raphael.

It is the most seminal study available on socialized medicine. It is objetive, complete and factual. It was *not* paid for and its development was *not* directed by anyone having a vested interest in channeling more money of society through government or centrailizing more power in government.

Clearly it documents how the dignity and freedom of both individual patient and physician have been undermined by unfulfilled and treacherous but believeable promises of Utopia. It explains how confidentiality, mutual trust and rapport, so essential to optimum medical care, have been destroyed. It does this by documenting the irreconcilable conflicts that are created between the professional obligations to their patients and their legal responsibilities to government to police patients.

"Medicine and the State" examines and appraises, without hiding the truth, country by country, political promises and results regarding medical costs and quality, preventive medicine, doctor-patient relationships, vital health statistics and effects on national economics.

We urge you without prejudice to study the facts for yourselves so you may avoid being influenced by anyone who has a conscious or unconscious interest in betraying individual freedom.

You dare not rely on the bureaucracy and its allies to do the spade work upon which you base your judgment in this case since the awesome power it now commands and aspires to expand is the gravest threat to freedom facing America today.

EVALUATION OF FALSE STATEMENTS IN A PAMPHLET ON THE PROFESSIONAL STANDARDS REVIEW ORGANIZATION LAW—"PSRO: QUESTIONS AND ANSWERS"—WRITTEN AND DISTRIBUTED IN DECEMBER BY THE U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

Evaluation of this pamphlet—distributed to the nation's physicians—forces the conclusion that it is a flagrant and calculated misrepresentation of the PSRO law and, as such, is a willful fraud upon American doctors by officials of HEW.

In a preamble to the pamphlet, Charles C. Edwards, M.D., Assistant HEW Secretary for Health, states:

"By providing a *uniform* basis for professional review of the institutional care paid for under Medicare, Medicaid and Maternal and Child Health programs, PSRO will enable physicians *themselves* to determine that such care is necessary and of recognized quality, that it properly meets the needs of the patient, and that it is provided in the most appropriate setting.

"*Most practitioners are striving to meet these objectives through the exercise of professional judgment and in cooperation with peer committees in institutions throughout the country.*" (Emphasis added)

A. Dr. Edwards seeks to leave the impression that PSRO will aid physicians in their voluntary review of health care by establishing a uniform basis for review. However, Dr. Edwards is confessing that review will be standardized throughout the country. Standardization requires a central authority—in this case the federal government—to develop the standards and to enforce them. Standardization, or enforced uniformity, is the antithesis of voluntarism. It is, therefore, false to assert, as the body of this pamphlet does, that PSRO is a program to be controlled by physicians.

B. If "most practitioners" are voluntarily striving to do what PSRO ostensibly requires, as Dr. Edwards admits, *why is PSRO necessary?* If the nation's physicians are voluntarily striving to improve the quality of medical care, what purpose is served by the law? Why invoke the power of government to force doctors to do what they are doing voluntarily? Dr. Edwards' admission brings into seri-

ous question the statement in the pamphlet that "the purpose of the PSRO program is to improve the quality of care, not to discipline physicians".

The fact is that the PSRO law is punitive in its conception and in its provisions. If it were not, the law would speak for itself and no disclaimer that it was not intended to discipline would be necessary.

"WHAT IS A PSRO?"

The pamphlet asks the question and then answers by describing PSRO as "a program organized, administered and *controlled* by local physicians". *The statement is false.* The language of the law so testifies. (Note: Underscoring or italic type has been used throughout this evaluation for emphasis.)

A. Section 1152(a) of the PSRO law provides that "such an organization (PSRO) shall be *conditionally* designated" as the PSRO for an area and that during the trial period, the Secretary of HEW will determine whether "such an organization is *capable* of fulfilling, in a satisfactory manner, the obligations and requirements for a Professional Standards Review Organization . . ."

B. Section 1152(b)(2) defines a PSRO as "an organization which *the Secretary . . . finds* to be willing to perform and *capable* of performing, in an effective timely, and objective manner and at reasonable cost, the duties" of a PSRO.

C. Section 1152(d)(2) authorizes the Secretary to terminate a PSRO agreement when *he has determined* "that such organization is not substantially complying with or effectively carrying out the provisions of such agreement".

D. Section 1154(a) and (b) require that the Secretary designate PSROs on a conditional or trial basis (the period of trial not to exceed 24 months). At the end of the trial, Section 1154(b) stipulates, "such organization shall be considered a qualified organization *only* if the Secretary *finds* that it is *substantially* carrying out *in a satisfactory manner*, the activities and functions *required* of Professional Standards Review Organization . . ."

E. Section 1154(a) rquires PSROs, even before they can enter a trial period, to draft plans of operation. These plans must be approved by the Secretary before he can give a conditional designation to a PSRO.

F. Section 1155(f)(1)(A) specifies that a PSRO will "perform such duties and functions and assume such responsibilities and comply with such other requirements as may be required by this part *or under regulations of the Secretary* . . . Section 1155(f)(1)(B) requires each PSRO to "collect such data relevant to its functions and such information and keep and maintain such records in such forms as *the Secretary may require* . . . and to permit access to and use of any such records *as the Secretary may require* . . ."

G. Section 1156(a) makes it mandatory that each PSRO apply "professionally developed" norms of care, diagnosis and treatment and Section 1156(c)(1) provides that the National Professional Standards Review Council "shall provide for the preparation and distribution . . . of appropriate materials indicating the regional norms to be utilized. . . "

Section 1156(c)(1) declares that "the approval of the National Professional Standards Review Council of norms of care, diagnosis and treatment shall be based on its analysis of appropriate and adequate data".

Section 1156(a) further provides that if different norms are to be used in a PSRO area, the PSRO will be notified and "may apply such norms in such areas as are approved by the National Professional Standards Review Council".

Finally, Section 1156(b) empowers the Secretary to develop regulations governing what "such norms with respect to treatment for particular illnesses or health conditions shall include . . ."

It is unmistakably clear from a study of Sections 1152, 1154, 1155 and 1156 of the law that the Secretary of HEW, not local physicians as Dr. Edwards and this pamphlet contend, will control PSROs. The Secretary alone will promulgate and enforce the rules and regulations under which PSROs will function—and nothing in the law even by implication gives physicians in PSRO areas any right or opportunity to help draft these regulations or to veto any of them. The Secretary alone will determine whether PSROs are capable of performing and whether they are performing duties prescribed in the law and in regulations.

PSROs, it is clear, must perform to the satisfaction of the Secretary of HEW or perish!

The law confers on the Secretary veto power over operating plans of PSROs.

The law also leaves no room for dispute that norms of care, diagnosis and treatment will be developed in HEW and enforced by HEW and PSROs and physicians will be told by HEW what these standards are and how they must be applied.

The PSRO law no less than two dozen times grants the Secretary specific power to regulate PSROs and to make findings and determinations affecting their functions. PSROs, meaning local physicians, have no input into these decisions, and it is a fraud on the American people to claim otherwise.

"HOW WILL PSRO AFFECT A PHYSICIAN'S PRACTICE OF MEDICINE?"

"PSRO will cause little change in the way most physicians practice medicine." claims the pamphlet. "The PSRO program does require that the services of a physician provides in institutions to Medicare and Medicaid patients be subject to review by his peers in the local PSRO. The PSRO will only review care delivered in institutions and will not cover care delivered in a physician's office, clinic or other ambulatory setting unless the physicians in a PSRO request that it do so. As long as a physician's pattern of practice falls generally within the norms and criteria which he will help establish for his PSRO, his practice will not be significantly affected."

The opposite is true. The application of the PSRO law will profoundly affect the way most physicians practice medicine. This fact can be indisputably demonstrated by an objective appraisal of the law.

First, however, it must be stated again that there is nothing in this law which will enable physicians to help establish the norms and criteria to which they will be forced to comply.

These and similar statements suggesting that local physicians will control PSROs are inexcusably fraudulent. They are intended to try to seduce physicians into accepting government control over the practice of private medicine by attempting to sugar coat the oppressive provisions of a law that is viciously punitive in concept.

Every physician who treats Medicare, Medicaid or other patients whose care may be paid in whole or in part from Social Security funds will be affected by this law—and that's virtually every practicing physician. It is a deliberate abuse of the truth to declare that a physician's practice will not be significantly affected when he is forced by the power of government to accept governmentally decreed standardization of medical care, when he must justify professional decisions in advance to agents of government, when he must submit to inspection by government employees of the private medical records of any of his patients, when he knows he will be punished if he departs from standards even though his judgment tells him the welfare—perhaps the life—of his patient demands it.

"WILL PSROS TELL PHYSICIANS HOW TO PRACTICE MEDICINE"

The first sentence of the HEW answer to that important question is false. "The local physicians who make up each PSRO will establish the standards and criteria to be used in determining the necessity and quality of care." The law does not confer that responsibility on local physicians. On the contrary, as noted elsewhere in this pamphlet evaluation, Section 1156 requires the National Professional Standards Review Council—a paid agency of the HEW Secretary—to develop and distribute norms of care, diagnosis and treatment. Another section of this pamphlet also gives the lie to the statement that local physicians will establish these standards. Discussing the question of "norms, standards and criteria", the pamphlet states: "The national specialty societies are preparing model criteria which will be made available to the PSROs and which they can adopt or adapt to meet local circumstances." If specialty societies are preparing criteria to be passed on to PSROs by HEW, it obviously cannot be true that local physicians will establish the criteria. It is also erroneous to state that PSROs can adopt or adapt criteria. Nothing in the law authorizes PSROs in their discretion to adopt (which implies the power to reject) or to adapt (which implies the right to alter) standards developed by HEW.

"WILL THE CONFIDENTIALITY OF PATIENT AND PHYSICIAN INFORMATION BE PROTECTED?"

"Any data or information collected by a PSRO is to be held in strict confidence," claims the HEW pamphlet. "The PSRO legislation contains strong penal-

ties for breaches of confidentiality by any reviewer or employee of a PSRO."

The statement is a clever attempt to skirt the truth!

A. Section 1155(a)(4) mandates PSROs to establish and keep up-to-date profiles of care received by and provided to patients "utilizing to the greatest extent practicable . . . methods of coding which will provide maximum confidentiality as to patient identity . . ."

There is no guarantee of confidentiality of a patient's identity in the development and use of profiles. Further, it should be clear to anyone that confidentiality is breached when any outsiders—in this case hirelings of government—have access to patient records. By the terms of this section of the PSRO law, laymen would have access to such records.

B. Sections 1155 (b)(3) and (b)(4) empower the HEW Secretary to promulgate regulations authorizing any PSRO "to the extent necessary or appropriate for the proper performance of its duties and functions" to "examine the pertinent records of any practitioner or provider of health care services . . ." and "services provided . . . of any practitioner or provider."

Section 1155 without question opens the door for examination of records of any patient of any physician taking care of Social Security patients. And it will be the HEW Secretary who decides the extent these examinations are necessary and appropriate.

C. After the Secretary directs a PSRO to examine private patient records, he can then, under authority of Section 1155(f)(1)(B), order the PSRO to "collect such data relevant to its functions and such information and keep and maintain such records in such form as the Secretary may require to carry out the purposes of this part (of the law) and to permit access to and use of any such records as the Secretary may require for such purposes".

This gross violation of the privacy of patient records is not discretionary. The law makes it mandatory on both the Secretary and the PSRO as part of the contract between them.

It should be emphasized that it will be the Secretary—not local physicians—who will decide what information is relevant and how it is to be used.

The provisions of Section 1155 must be interpreted as permitting an invasion of the privacy of patient records and, therefore, makes breach of confidentiality public policy.

D. The "strong penalties" mentioned in the pamphlet "for breaches of confidentiality" are more fiction than fact.

Section 1166 is labeled a "Prohibition Again Disclosure of Information". What it really is is a grant of authority to the Secretary of HEW to decide in his wisdom how much and what kind of information should not be held in confidence.

Section 1166(a) proclaims that information acquired by a PSRO must be held in confidence. That enjoinder, however, is promptly rendered meaningless by the interjection of exceptions. The prohibition applies except (1) "to the extent that may be necessary to carry out the purposes of this part," and (2) "in such cases and under such circumstances as the Secretary shall by regulations provide to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care".

Section 1166(b) is the so-called Penalty section, which says that it shall be unlawful (on penalty of fine or imprisonment) to disclose any such information (acquired by PSROs) other than for such purposes, such purposes being whatever and under what circumstances the Secretary decides it is necessary to divulge the information.

So it is that protection of confidentiality is a monstrous fraud. Under regulations of the Secretary, confidentiality can be breached indiscriminately so long as the Secretary rules the action is necessary to carry out the provisions of the law.

E. The pernicious fact is that the law actually will work to protect individuals who rifle patient records for use by PSROs and the Secretary. Section 1167(a) serves notice that no person furnishing information "shall (for that reason) be held to have violated any criminal law or to be civilly liable under any law of the United States or of any State," unless the information is unrelated to PSRO duties and functions or is false and the person knew or had reason to believe it was false.

Section 1167(b)(1) protects a PSRO member, employee or counsel from criminal or civil liability "by reason of the performance by him of any duty, function, or activity authorized or required of PSROs . . ." provided the action was not motivated by malice. A duty or activity could be examining patient records in a doctor's office and reporting findings to PSRO personnel or to the HEW Secretary or some other official or employee of HEW.

Any claim—directly or by implication—that confidentiality of patient records will be zealously protected is sheer sophistry.

"IS THE PURPOSE OF PSRO TO ASSURE QUALITY OR CONTROL COST?"

According to this HEW pamphlet, "the primary emphasis of the PSRO program is on assuring the quality of medical care".

Undoubtedly, it is possible to persuade a layman with only a sketchy knowledge of the practice of medicine that standardizing medical care, forcing doctors to conform to a set of government-dictated norms, will assure the quality of medical care.

But such a statement approved by a doctor of medicine who has been in active practice is incredible in the extreme.

Standardizing care, diagnosis and treatment will not assure quality, but it will guarantee a deterioration of quality medical care for the millions of patients this law presently covers. All physicians, including Dr. Charles C. Edwards of HEW, know that medical care cannot be bound in a mold. People respond to treatment in different ways. Drugs in kind and quantity affect people differently. Recovery time from illness or surgery, even without complications, varies with individuals. Norms for a segment of the population would tend to become the standard for all patients and, as a consequence, the innovative spirit of medicine would disappear and with it the spectacular progress that has elevated American medicine to world preeminence over nations with socialized medicine.

"WHAT WILL BE THE RESPONSIBILITIES OF A PSRO?"

This section of the HEW pamphlet contains a glaring omission which is inexcusable in a pamphlet endeavoring to explain a law to the nation's physicians. Among other things, the pamphlet says, "The PSRO will have the authority to approve in advance the medical necessity of elective admissions to institutions as well as extended or costly services". What this section of the pamphlet omits is vitally important to physicians, particularly specialists—that under terms of this law, agents of government will have the power to choose what doctors' patients will be permitted to go to in certain circumstances.

Section 1155(a)(2)(B) declares in part that "each Professional Standards Review Organization shall have the authority to determine, in advance, in the case of any other health care service (besides elective admission to a hospital) which will consist of extended or costly courses of treatment whether such service, if provided, or if provided by a particular health care practitioner . . ." would be medically necessary.

As noted above, the HEW pamphlet asserts that "the purpose of the PSRO program is to improve the quality of care, not to discipline physicians". If this were wholly true, why would it be necessary to write into this law a provision mandating harrassment and intimidation of physicians to compel them to comply with obligations of the law?

Section 1160(a) states that it shall be the obligation of doctors and hospitals to assure that their services "will be provided only when, and to the extent, medically necessary, will be of a quality which meets professionally recognized standards of health care, and will be supported by evidence of such medical necessity and quality . . ." That section of PSRO law states a similar obligation in negative terms, declaring that doctors and hospitals "shall have an obligation . . . not to take any action . . . which would authorize any individual to be admitted as an inpatient in or to continue as an inpatient in any hospital or other health care facility" unless the care is medically necessary and cannot be provided cheaper elsewhere.

In order to force physicians to knuckle under, Section 1160(c) sets up a mandatory mechanism for harrassing, threatening and intimidating them into compliance. Section 1160(c) baldly states: "It shall be the duty of each Professional Standards Review Organization and each Statewide Professional Standards Review Council to use such authority or influence it may possess as a professional organization, and to enlist the support of any other professional or governmental organization having influence or authority over health care practitioners and any other person (including a hospital or other health care facility, organization, or agency) providing health care services in the area served by such review organization, in assuring that each practitioner or provider . . . providing health care

services in such area shall comply with all obligations imposed on him under subsection (a)".

The viciously punitive concept of the PSRO law is nowhere more apparent than in that section of the law imposing a nondiscretionary duty on PSROs and State Councils to bully doctors into compliance and to enlist support of other professional and governmental organizations having influence and authority over doctors. This clearly means that medical societies, state licensing boards and other organizations and agencies will be called upon to participate in this nefarious business.

In light of the misrepresentations in this HEW pamphlet, perhaps Truth in Government legislation is in order.

Senator TALMADGE. The next witness is Dr. Kenneth A. Platt, medical director, the Colorado Foundation for Medical Care.

Dr. PLATT. Mr. Chairman, distinguished Senators——

Senator TALMADGE. Would you yield on that for a moment, Doctor?

We have got a vote on the Senate floor and it is necessary for us to go cast a vote. We will do so and come back just as punctually as possible. So if you would, please make yourself comfortable until that time.

Senator BENNETT. Well, I would be glad to wait until one of you comes back.

Senator TALMADGE. Well, if Senator Bennett will preside, I will go over and vote, and then I will come back and relieve you while you go vote.

You may proceed, Doctor.

Senator BENNETT [presiding]. Dr. Platt?

STATEMENT OF KENNETH A. PLATT, M.D., MEDICAL DIRECTOR, THE COLORADO FOUNDATION FOR MEDICAL CARE, ACCOMPANIED BY DR. KENNETH A. KAHN, PRESIDENT OF THE COLORADO FOUNDATION FOR MEDICAL CARE, AND DONALD G. DERRY, EXECUTIVE VICE PRESIDENT OF THE COLORADO FOUNDATION FOR MEDICAL CARE AND EXECUTIVE DIRECTOR OF THE COLORADO MEDICAL SOCIETY

Dr. PLATT. Thank you.

Gentlemen, my name is Kenneth A. Platt. I am medical director of the Colorado Foundation for Medical Care, a past president of that organization, as well as past president of the Colorado Medical Society.

With me on my right, Dr. Kenneth A. Kahn, president of the Colorado Foundation for Medical Care and the Colorado Medical Society, and Mr. Donald G. Derry on my left, Executive Vice President of the Colorado Foundation for Medical Care and executive director of the Colorado Medical Society.

The Colorado Foundation for Medical Care was created by the Colorado Medical Society in June 1970. Since that time the foundation has made substantial progress toward the goal of creating a statewide physician-controlled organization that could have an impact on the health care systems of Colorado.

Broadly speaking, the foundation's central theme is to improve organized health care services through the voluntary cooperation of providers, consumers, and payers in programs led by physicians. Some of our major objectives have been to improve the quality and accessibility of health care while containing costs and also to obtain the facts needed to plan and manage health care.

Since the early discussions of Professional Standards Review Organizations, our foundation and our medical society have supported the concept, since we feel that the basic goals and objectives of our foundation and that of PSRO are substantially the same. We have recognized the necessity for the profession to be accountable to the public and the Government for medical services provided under Government medical care programs.

It has been our goal through the foundation to develop the mechanism to provide this accountability and to substantiate the efforts of the providers of health care in Colorado in a creditable manner. We believe the PSRO will help us provide this mechanism.

Our foundation has been fortunate these past few years since its creation in 1970 in that it has participated in an active role in several programs of peer review and health care facility utilization review. As a result of this experience, we have learned a great deal about the activities that are required by PSRO legislation.

In spite of our efforts to include all medical and osteopathic physicians, regardless of membership in any medical organization, as active participants in the foundation, we have had difficulty in meeting some of the specific organizational requirements of the PSRO program manual. You must understand, our organization was created 3 years prior to the passage of PSRO legislation and has been functioning statewide in most of the activities of a PSRO for 3 years prior to the passage of PSRO legislation.

We have expressed our willingness to make changes in our organization in order to comply. However, we would urge this committee to consider the problems of organizations such as ours who have actively supported the PSRO concept since the beginning, who have pursued the goals and purposes even prior to the legislative creation of PSRO. We have creditability in our State and we can function now as an effective PSRO. Hopefully, the proposal we have presented to be a PSRO will be acceptable without additional major changes in the organizational structure of our foundation.

The first encounter our foundation had with the Federal Government occurred shortly after the official creation of the foundation when discussions were initiated with what was then the National Center for Health Services Research and Development. In May of 1971, a contract was awarded by the National Center which provided initial support for the foundation's program. Since expiration of that contract, we have been functioning under an EMCRO grant.

This original contract provided the funds to have a full-time staff and consultative support for the organizational development of the foundation and the design of a Technical Data System.

Vital to the peer review procedure are diagnostic criteria to assess utilization and treatment. Each of the major medical specialty organizations in Colorado were contacted and asked to participate in the development of Model Treatment programs for a number of basic procedures or diagnosis that make up the major portion of their particular specialty practice. This effort resulted in nearly 350 Model Treatments developed by specialty organizations in Colorado. When finally evaluated and validated, these Model Treatments can be basis for futher developments of the foundation's peer review efforts.

One of the most significant developments in foundation activities in 1971 began to evolve when the Colorado Department of Social Services requested the foundation to develop a proposal for the peer review of physician services under the State medicaid program.

You heard testimony yesterday that the physicians would reluctantly concur with the PSRO law if it did not invade their offices and the privacy of outpatient care. In contrast to that, we have been involved in this activity for approximately 2 years with relatively smooth implementation, relatively little physician disagreement.

On October 12, 1971, the initial proposal was submitted to the State for their review. In the creation of the proposal our consultant worked with Blue Cross-Blue Shield and the Department of Social Services to review the present processing systems and to define the data input and computer processing modifications necessary to produce computer output for peer review.

Two major factors that were critical to the successful execution of the program was the ability of the State to provide necessary funds for the program and the ability of the State in consort with the Blue Cross-Blue Shield to make data processing alterations so as to make the peer review process operational.

The contract was for the period between March 1, 1972 and June 30, 1973. The original contract has since been extended through June 30 of 1974.

Since the medicaid project became operational in March 1972, over 400 physicians have been involved as individual reviewers or members of regional peer review committees.

In mid-January 1972, the foundation began discussions with officials of the Region VIII Office, Bureau of Health Insurance, Social Security Administration, regarding a pilot medicare review project. This was the beginning of our efforts to create a formalized hospital admission program in Colorado. Subsequently, the Colorado Admission program, or CAP, was designed and became operational in its first phase as a prototype PSRO in August of 1973. Currently, every hospital in the State, with the exception of three mental health institutions, participate voluntarily in the CAP program.

CAP is a prospective hospital utilization program combining preadmission, concurrent peer review, and discharge planning to determine quality care, medical necessity for admission, and medical necessity for length of stay.

Our experience with the CAP program has been most enlightening. The lessons we have learned are invaluable and will be of particular help to us in the further development of our foundation as a PSRO.

Parenthetically, I might add that while we are basically concerned with quality, you have heard a great deal of concern expressed in the last 2 days about cost to the program versus cost savings. While this is not meant to be strictly a cost oriented program, there are spinoffs the Federal Government might be interested in.

Our program was brought into operation in three phases with the final hospital becoming operational in January of 1974. The total dollar amount of our 16-month contract with the Bureau of Health Insurance and the Colorado Department of Social Services was in the amount of $1,519,662.

Senator BENNETT. At this point I will have to leave you, and will you stop the clock so that he will not lose any of his time. But that tells me I have got 5 minutes to get over there and vote.

[A brief recess was taken.]

Senator TALMADGE [presiding]. The committee will please come to order.

You may continue, Doctor.

Dr. PLATT. Our experience with the CAP program has been most enlightening. The lessons we have learned are invaluable and will be of particular help to us in the further developments of our foundation as a PSRO.

As I mentioned to the Senators previously, some of the concerns expressed in this committee hearing have been what the costs of the program are versus cost savings. Again, to reiterate, the emphasis should be on quality, but the Government obviously is most interested in costs.

Our program was brought into operation in three phases, with the final hospital becoming operational in January of 1974. The total dollar amount of our 16-month contract with the Bureau of Health Insurance and the Colorado Department of Social Services was in the amount of $1,519,622. This amount includes the preoperational development and training program up to the first phase of operation when most of the Denver hospitals became operational. Because of some changes in our estimate of admissions to the hospital, as well as various savings we have been able to initiate in our operation of the program, we estimate now that we will underrun our negotiated budget for a net estimated savings in our operations, and a return to the Federal Government, of $225,000.

A more dramatic savings is apparent in the cost-effective analysis that we have prepared on a very conservative basis. This analysis was developed with data provided by the fiscal intermediary, Bureau of Health Insurance and the Colorado Department of Social Services, as well as information that our foundation has gathered generally. All our estimates have been projected for 1 year, and we stress our estimates are only based on the best available information.

We project total hospital admissions for the 1-year period for medicare and medicaid and all of the acute care institutions in Colorado at 107,623 admissions. We currently indicate an average length of stay in the hospital for both programs combined to be 8.15 days. Prior to the CAP program, the average length of stay in hospitals for both programs combined was 8.50. Using an average cost of $100 per day in the hospital, this would indicate a conservative estimate of savings of $2,925,805 for 1-year operation of the CAP program over and above the savings in our operating costs of the program—indicating for every dollar spent in the operational aspect, the foundation could conceivably save $2.53.

These figures are conservative estimates and are the figures that the foundation chooses to use in evaluating its own performance. There are other ways of estimating the possible savings of our CAP program in Colorado, that are far more optimistic. Utilizing one of these optimistic estimates, our actuaries came up with a possible savings of as much as $9.5 million, or approximately $8.30 for every dollar spent. We believe that this estimate is far too optimistic, and

reality lies somewhere between our conservative and our optimistic estimates.

Our experience with our CAP program has demonstrated conclusively for us the necessity for developing a data collection system outside of any that are currently available to us through fiscal intermediaries or Government agencies involved in medicare–medicaid. We look upon the foundation or PSRO as a professional intermediary charged with responsibility under the law of assessing and assuring the quality of medical care along with the cost control responsibilities. Our studies and experience with the data collection systems currently available indicate that the data we need to accomplish medical care evaluation studies and the profiling required by PSRO legislation are not readily available in the current data systems. Our nurse coordinators operating in most of the hospitals in Colorado are able to gather for us information that cannot be found at any other source. We feel it is an absolute necessity for us to have the opportunity to develop and to work with this data so that we can perform our responsibilities as a PSRO. As we learn to utilize this information properly, we will then be able to provide better management information than we are currently able to develop through any of our contacts with fiscal intermediaries or Government agencies.

There is a summary here which basically I will leave for the insertion into the record.

In final summary, we appreciate your allowing us to testify before you. We are in every respect at this point in time operating as a PSRO. We have had excellent support from the physician community, from the hospitals in which we are functioning.

Senator TALMADGE. Thank you, Doctor, for your very fine statement. The entire statement will appear in the record.

COLORADO SUCCESS WITH PSRO-TYPE SYSTEM

Senator TALMADGE. Now, you are operating in Colorado as something at the present time that for all practical purposes is a PRSO?

Dr. PLATT. Yes, Sir.

Senator TALMADGE. And it has met with the approval of the physicians?

Dr. PLATT. Yes, sir. We put it to a test just a month ago.

Senator TALMADGE. And it saved the Government and the State money?

Dr. PLATT. Yes, sir.

Senator TALMADGE. How about the quality of the service? Has it enhanced it or diminished it?

Dr. PLATT. In our opinion, it has enhanced it.

Senator TALMADGE. How?

Dr. PLATT. Well, we are in the process now, like everyone in the country, of trying to decide how can you truly assess quality; that is, by outcomes, measurements or process criteria, and so on. But basically, I think it has enhanced quality in several ways.

First of all, anytime a patient is placed in an institution which he basically should not be, that is in essence not quality practice. By making physicians alert to their responsibilities, not only of considering the admission of a patient but where they were admitted,

under what form and in what arena is he cared for, at the same time he was admitted to think in terms of discharge planning and discharging the patient to a lesser care institution is in essence a form of quality assessment.

We have also been doing ambulatory review for approximately two years. And in that ambulatory review mode, which is for Medicaid in the State of Colorado, we have over the past two years picked up areas of concern. The inappropriate use of antibiotics, as we have heard mentioned many times in this particular setting, and have directed our attention to educating the physician community to the inappropriate use of antibiotics, to the inappropriate hospitalization for diagnostic workups.

All of those are partially at least quality evaluations and assessments.

Now, when you go into the acute care institutions and begin to gather data from the care of the patient in the institutions, the use of ancillary facilities in a hospital, the timing of the use of ancillary facilities in a hospital—and all of us as practicing physicians are subject to the patient on whom you order an EKG and it is done three days later—as we begin to do these things, that will impact on the quality of care. There are many ways in this program that will help us improve the quality of care of a patient.

Confidentiality

Senator Talmadge. Now again, based on your experience, have you encountered any problems with violations of patient confidentiality?

Dr. Platt. We have none, sir.

Norms and Parameters

Senator Talmadge. Do you utilize norms and parameters and checkpoints in evaluating care?

Dr. Platt. Yes, sir.

Senator Talmadge. Does this constitute deleterious cookbook medicine?

Dr. Platt. Well, Senator, in our view it does not. I will qualify that, however. This is perhaps one of the concerns of everyone who is implementing this program, and that is, the rigidity of the application of norms, standards, and criteria—not only as you have heard expressed here many times at the Federal level, but even at the local level. But if they are used only as flexible checkpoints, if they are constantly monitored, evaluated, and updated, if they are used basically as a broad screen to flag problems for peer review, they will not be a cookbook approach to medicine.

Senator Talmadge. Norms and parameters provided by doctors themselves?

Dr. Platt. That is right; professional men in professional areas of expertise. If they become a refuge, they could be——

Reasons for Objections to PSRO

Senator Talmadge. Let me ask you one other thing, Doctor.

As I read these acts that have been passed by the Congress from time to time, long before we passed PSRO, the Secretary and his

subordinates and Government clerks and insurance clerks had every authority that has been delegated to PSRO's and more.

Why would doctors object to doctors doing what had previously been delegated to insurance and Government clerks? Could you answer that?

Dr. PLATT. Well, I think basically I can answer it in two ways.

First of all, what was being done before by intermediaries and governmental clerks was at best not obvious. In other words, the doctors were not continually confronted with the problem. It was lost somewhere in a Blue Cross/Blue Shield building in some anonymous way, and they were not in direct basic, day-to-day contact with it.

Under PSRO it is a very obvious program in which they are constantly in contact, so they are more aware of it.

The second thing, I think, is that many of the areas of opposition in this country are basically areas which are created by ignorance of the law and ignorance of the application of the law. And I have had an opportunity in the last 2 years to go widely across this country to discuss—in Texas and Arkansas and many places with varying areas of the physician community—what the law really should mean and how it should be used. And in those areas and at those times, I had run into basically, first the concerns you have expressed and have heard expressed here today. And then after they are aware of the law and how it was meant to be implemented and is being implemented, those concerns have lessened.

So part of the problem is strictly ignorance of the physician community about the provisions of the law.

Senator TALMADGE. The reason I voted for PSRO was because I thought the medical profession was better qualified to police itself than insurance and Government clerks. And yet that was clearly the law until we passed PSRO's.

Dr. PLATT. I agree with you, Senator.

Senator TALMADGE. Senator Bennett.

EFFECTIVENESS OF CONCURRENT REVIEW UNDER PSRO

Senator BENNETT. Just along that same line, under the rules that existed prior to the passage of the PSRO law, was the review not ex post facto?

Dr. PLATT. Yes, sir.

Senator BENNETT. And under PSRO, can it not be concurrent?

Dr. PLATT. It can be concurrent. In fact, it should be concurrent. It can also be restrospective.

Senator BENNETT. Yes; but to be successful, it must be concurrent. If you are going to be retrospective, the chief value you get out of that is to make sure that your norms and your standards and your methods of operation are set up right and are operating effectively.

Maybe I should not put this in the record, I have reached the age now where Mrs. Bennett and I are medicare recipients, and we have just had the experience of having a claim denied about 9 months after the service was rendered. Now, we can afford it, but I can imagine the situation that might hit some people who are on medicaid if as a result of a review by an insurance clerk working for Blue Cross-Blue Shield

or one of the private insurance companies, they were notified that the Federal Government would not pay that claim, to me that is one of the chief values of the PSRO program. It can be concurrent.

Dr. PLATT. May I just briefly respond to that.

Under the current contract in Colorado, the bureau of health insurance and the department of social services, the benefits have been increased to the medicaid recipients. The physician reimbursement formula has been improved. It was a substandard reimbursement formula to begin with. And retroactive denial is no longer a problem, either to the medicaid recipient or to the medicare recipient or to the hospital or to the physician.

When the PSRO CAP program certified that this is a necessary treatment and necessary admission, it is an accepted debt of both obligatory agencies.

In addition to that, the department of social services had dropped the artificial stipulation of 12 visits per year per medicaid patient, and they now leave it to the foundation to certify that any number of visits that are carried out are indeed justified.

So, in contrary distinction to some of what you have heard today, we are expanding the programs and the benefits under a program that has been characterized by some of the testimony you have heard as a constrictive regulatory agency.

Senator BENNETT. I made a little note to ask you your reaction to the previous witness and his counterpart earlier this morning.

Are there any other comments you would like to make in addition to the one you just made?

EXAGGERATION SEEN IN CHARGES AGAINST PSRO

Dr. PLATT. Well, I think some of the concerns expressed—although in a somewhat flamboyant manner and one that I will not try to duplicate—are concerns expressed less flamboyantly but obviously at different times across the country.

I think that those charges, although there is, as with any area, some legitimate concerns, have been exaggerated. In our area of the country, working totally with the cooperation of the medical profession and the hospitals with which we have worked, we have not run into those particular problems.

In closing, I might say also that basically there is only one Bible that I basically read, and that is one which the Gideon community provides me with at almost every hotel in which I reside.

Senator BENNETT. Thank you very much.

Senator TALMADGE. Thank you very much, doctor, for your contribution.

[The prepared statement of Dr. Platt follows:]

PREPARED TESTIMONY OF THE COLORADO FOUNDATION FOR MEDICAL CARE PRESENTED BY KENNETH A. PLATT, M.D., MEDICAL DIRECTOR OF THE FOUNDATION

My name is Kenneth A. Platt. I am Medical Director of the Colorado Foundation for Medical Care; a past president of that organization, as well as past president of the Colorado Medical Society. I am a doctor of medicine with a large family practice in Westminster, Colorado. My work with the Foundation for Medical Care is part-time, utilizing approximately 30 percent of my working time. With me today are Dr. Kenneth A. Kahn, President of the Colorado

Foundation for Medical Care and the Colorado Medical Society, and Mr. Donald G. Derry, Executive Vice President of the Colorado Foundation for Medical Care and Executive Director of the Colorado Medical Society.

The Colorado Foundation for Medical Care was created by the Colorado Medical Society in June, 1970. Since that time the Foundation has made substantial progress toward the goal of creating a statewide physician-controlled organization that could have an impact on the health care systems of Colorado.

Broadly speaking, the Foundation's central theme is to improve organized health care services through the voluntary cooperation of providers, consumers and payors in programs led by physicians. Some of our major objectives have been to improve the quality and accessibility of health care while containing costs and also to obtain the facts needed to plan and manage health-care.

Since the early discussions of Professional Standards Review Organizations, our Foundation and our Medical Society have supported the concept since we feel that the basic goals and objectives of our Foundation and that of PSRO are substantially the same. We have recognized the necessity for the profession to be accountable to the public and the government for medical services provided under government medical care programs. It has been our goal through the Foundation to develop the mechanism to provide this accountability and to substantiate the efforts of the providers of health care in Colorado in a creditable manner. We believe the PSRO will help us provide this mechanism.

Our Foundation has been fortunate these past few years since its creation in 1970 in that it has participated in an active role in several programs of peer review and health care facility utilization review. As a result of this experience, we have learned a great deal about the activities that are required by PSRO legislation. Before expanding upon the activities of our Foundation for Medical Care in PSRO related activity, it would perhaps be helpful to describe the organization of the Foundation. The CFMC was created by the Colorado Medical Society. Membership in the foundation, however, is open without dues to every Doctor of Medicine and Doctor of Osteopathy in the state. In order to obtain acceptance of the Foundation by physicians in Colorado, it was necessary to maintain a close relationship between the Medical Society and the Foundation. This necessity, however, has not smothered the initiative of the Foundation nor has it resulted in an organization that does not have credibility with most physicians and osteopaths in our state. The Board of Directors of the Foundation consists of 21 members. Of these 21 members, one is an official representative of the Colorado Osteopathic Association, one an official representative of the Colorado Hospital Association, one who is an official representative of the Colorado Health Care Association which represents nursing homes and one from the Colorado Pharmacal Association. Our state has been divided into five regions for Foundation purposes based on physician population, specialty services, referral patterns, health facility cachment areas and other demographic factors. Each region also has a regional council consisting of representatives of the special organizations represented on the Board as well as other physicians in the area.

In spite of our efforts to include all medical and osteopathic physicians, regardless of membership in any medical organization, as active participants in the Foundation, we have had difficulty in meeting some of the specific organizational requirements of the PSRO Program Manual. You must understand, our organization was created three years prior to the passage of PSRO legislation and has been functioning statewide in most of the activities of a PSRO for three years prior to the passage of PSRO legislation. We have expressed our willingness to make changes in our organization in order to comply, however, we would urge this Committee to consider the problems of organizations such as ours who have actively suported the PSRO concept since the beginning; who have pursued the goals and purposes even prior to the legislative creation of PSRO. We have credibility in our state and we can function now as an effective PSRO. Hopefully, the proposal we have presented to be a PSRO will be acceptable without additional major changes in the organizational structure of our Foundation.

The first encounter our Foundation had with the federal government occurred shortly after the official creation of the Foundation when discussions were initiated with what was then the National Center for Health Services Research and Development. In May of 1971 a contract was awarded by the National

Center which provided initial support for the Foundation's program. The scope of work of that contract provided for:

(1) Exploring effective methods of expanding the present level of organization and coordination among all health care provider groups in the state;

(2) Developing a technical system to support peer review with quality effectiveness and costs of health care;

(3) Considering the feasibility of a statewide Uniform Hospital Discharge Abstract; and

(4) Undertaking a survey of met and unmet health needs of the people in Colorado.

This original contract provided the funds to have full time staff and consultative support for the organizational development of the Foundation and the design of a Technical Data System.

Vital to the peer review procedure are diagnostic criteria to assess utilization and treatment. A key committee of the Foundation, the Health Care Standards Committee, began development of special criteria after having reviewed the work in this area of many other foundations for medical care. Each of the major medical specialty organizations in Colorado were contacted and asked to participate in the development of Model Treatment Programs for a number of basic procedures or diagnosis that make up the major portion of their particular specialty practice. This effort resulted in nearly 350 Model Treatments developed by specialty organizations in Colorado. When finally evaluated and validated, these Model Treatments can be the basis for further developments of the Foundation's peer review efforts.

Another early effort of the Foundation was to determine what data was necessary to support a comprehensive peer review program. It was necessary in this effort to define the content of medical care data to be collected and define the data sources and the techniques of data collection. With the aid of one of our consulting firms we performed a study of existing health care data collection systems in Colorado which included those for Medicare, Medicaid, Blue Cross-Blue Shield, commercial insurors, self insured group insurance programs, various government institutions, closed panel plans and miscellaneous state government programs.

Analysis of the information collected by the study and interviews with the organizations involved led to the conclusion that third-party sources would not be adequate for the Foundation's system. The reasons were two-fold:

(1) Information captured by some of the systems lacked comprehensiveness; and,

(2) There was no guarantee that the Foundation would have access to the data.

This conclusion dictated that physicians and other providers will have to be the primary sources of data.

One of the most significant developments in Foundation activities in 1971 began to evolve when the Colorado Department of Social Services requested the Foundation to develop a proposal for the peer review of physician services under the state Medicaid program.

On October 12, 1971, the initial proposal was submitted to the State for their review. In the creation of the proposal, our consultant worked with Blue Cross-Blue Shield and the Department of Social Services to review the present processing systems and to define the data input and computer processing modifications necessary to produce computer output for peer review.

The proposal defined the format of the patient and provider history displays; developed a claims inventory control; developed a pended notification system; and defined display media and methodology for integration of data from the two Medicaid processing systems. In addition, a cost estimate report for the Foundation to perform peer review service was developed. Also included were recommendations on procedures for measuring the cost effectiveness for the various services of the Colorado Medicaid Program.

Two major factors that were critical to the successful execution of the program was the ability of the State to provide necessary funds for the program and the ability of the State in consort with the Blue Cross-Blue Shield to make data processing alternations so as to make the peer review process operational.

In early January, 1972, the contract for Medicaid peer review was signed by the Foundation and the State Department of Social Services. Peer review was

to be done on physician claims that failed to meet the diagnostic screening at Blue Cross-Blue Shield. Thereafter, claims were submitted to professional peer review after preliminary screening by a Foundation staff physician.

Those claims which were not disposed of in the preliminary screening and which were turned over to professional peer review are reviewed not on the basis of diagnostic criteria but in accordance with the professional judgment of the peer review physicians.

The contract was for the period between March 1, 1972 and June 30, 1973. The original contract has been extended through June 30, 1974.

Since the Medicaid project became operational in March, 1972, over 400 physicians have been involved as individual reviewers or members of regional peer review committees.

In mid-January, 1972, the Foundation began discussions with officials of the Region VIII Office, Bureau of Health Insurance, Social Security Administration, regarding a pilot Medicare review project. This was the beginning of our efforts to create a formalized hospital admission program in Colorado. Subsequently the Colorado Admission Program (CAP) was designed and became operational in its first phase as a prototype PSRO in August, 1973. Currently, every hospital in the state with the exception of three mental health institutions participate voluntarily in the CAP program.

CAP is a prospective hospital utilization program combining pre-admission, concurrent peer review and discharge planning to determine quality care, medical necessity for admission and medical necessity for length of stay.

CAP has incorporated the following elements into its operational system:

(1) Criteria for both admission and length of stay.

(2) Responsible review by physicians and allied professionals of individual hospital cases.

(3) Reimbursement by the third party payment sources for services which are certified as medically necessary.

(4) Procedures to assist Hospital Utilization Review Committees to gather and analyze recommendations based upon information regarding facility utilization, patient care, and treatment practices.

(5) Practices and procedures to facilitate discharge planning and continuity of care prior to the expiration of certified days of hospital stay.

The CAP Steering Committee, consisting of three physicians, three hospital administrators, and a consumer, directs the policy aspects of the program.

The existing Foundation Regional Councils are utilized to coordinate the program in each of the Foundation's five regions.

Physician advisors who make all medical judgments regarding CAP are nominated by the local hospital. In the local hospital, nominations are screened by the Regional Council and appointments will then be made by the Steering Committee. The physician advisor is reimbursed on a fee-for-time basis.

Program coordinators are employed to conduct the administrative aspects of CAP in the hospitals to which they are assigned. The coordinators conduct ongoing monitoring of patients while patients are hospitalized, assist in discharge planning, and complete a uniform hospital discharge abstract on each patient.

There are also local physician appeals panels to provide timely review of any appeals of decisions made by the physician advisor. Appeals panels physicians are selected in the same manner as physician advisors.

Our experience with the CAP program has been most enlightening. The lessons we have learned are invaluable and will be of particular help to us in the further developments of our Foundation as a PSRO.

Our program was brought into operation in three phases with the final hospital becoming operational in January of 1974. The total dollar amount of our 16-month contract with BHI and the Colorado Department of Social Services was in the amount of $1,519,662.00. This amount includes the pre-operational development and training program up to the first phase of operation when most of the Denver hospitals become operational. Because of some changes in our estimate of admissions to the hospital, as well as various savings we have been able to initiate in our operation of the program, we estimate now that we will underrun our negotiated budget for a net estimated savings in our operations of $225,000.

A more dramatic savings is apparent in the cost effective analysis that we have prepared on a very conservative basis. This analysis was developed with

data provided by the fiscal intermediary, Bureau of Health Insurance and the Colorado Department of Social Services, as well as information that our Foundation has gathered. All our estimates have been projected for one year and we stress are estimates only based on the best available information.

We project total hospital admissions for the one year period for Medicare and Medicaid in Colorado at 107,623 admissions. We currently indicate an average length of stay in the hospital for both programs combined to be 8.15 days. Prior to the CAP program, the average length of stay in hospitals for both programs combined was 8.50. Using an average cost of $100 per day in the hospital, this would indicate a conservative estimate of savings of $2,925,805.00 for one year operation of the CAP program over and above the savings in our operating costs of the program. This would indicate that for every dollar spent in the operational aspect of our program, the Foundation saved $2.53. These figures are conservative estimates and are the figures that the Foundation chooses to use in evaluating its own performance. There are other ways of estimating the possible savings of our CAP program in Colorado that are far more optimistic. Utilizing one of these optimistic estimtes we indicate that we might possibly have saved as much at $9,590,405.00 in one year of operation of the CAP program. This would amount to a savings of $8.30 for every dollar spent in the operation of the CAP program. We believe that this estimate is far too optimistic. Reality may lie somewhere between our conservative estimate and the optimistic estimate.

Our experience with our CAP program has demonstrated conclusively for us the necessity for developing a data collection system outside of any that are currently available to us through fiscal intermediaries or government agencies involved in Medicare-Medicaid. We look upon the Foundation or PSRO as a professional intermediary charged with the responsibility under the law of assessing and assuring the quality of medical care along with the cost control responsibilities. Our studies and experience with the data collection systems currently available indicate that the data we need to accomplish medical care evaluation studies and the profiling required by PSRO legislation are not readily available in the current data systems. Our nurse coordinators operating in most of the hospitals in Colorado are able to gather for us information that cannot be found at any other source. We feel it is an absolute necessity for us to have the opportunity to develop and work with this data so that we can perform our responsibilities as a PSRO. As we learn to utilize this information properly, we will then be able to provide better management information than we are currently able to develop through any of our contacts with fiscal intermediaries or government agencies.

IN SUMMARY

The Colorado Foundation for Medical Care was created by the Colorado Medical Society in June, 1970. Both the Foundation and the Medical Society have supported the PSRO concept since its inception, feeling that the goals of PSRO and the Foundation are substantially the same.

The Foundation has applied to be a PSRO and has met all or most of the organizational requirements, however a plea is made for consideration by the Committee for those organizations such as the Foundation which were created prior to PSRO legislation but who have been prototype PSRO's and are willing to continue to perform as a formal PSRO.

The Foundation has had considerable experience in ambulatory peer review and utilization review functions and has, since August, 1973, performed as an operational prototype PSRO providing the Colorado Admissions Program in every hospital in the state. The Foundation reviews all Medicare and Medicaid hospital admissions. Based on its experience as a prototype PSRO and utilizing data available to it from fiscal intermediaries, the Bureau of Health Insurance and the Colorado Department of Social Services, the Foundation has projected its one-year operational experience and conservatively estimates savings of $2,995,805.00. Thus, for every dollar spent in operation of its program, the Foundation has saved $2.53 on a conservative estimate. A more optimistic estimate has been projected at savings of $9,590,405.00 for one year of operation. However, the Foundation believes realistically the savings are somewhere between the conservative estimate and the optimistic estimate.

Senator TALMADGE. The next witness is Dr. Joseph Painter, chairman of the Steering Committee, Texas Institute for Medical Assessment.

Dr. Painter, your entire statement will appear in the record, and you may summarize, sir.

Dr. DAVIS. Thank you, sir. Dr. Painter could not appear, and I am here in his place.

Senator TALMADGE. Dr. Davis, thank you, sir.

STATEMENT OF MILTON V. DAVIS, M.D., ON BEHALF OF THE TEXAS MEDICAL ASSOCIATION

Dr. DAVIS. Mr. Chairman, members of the committee, I am Dr. Milton Davis, a practicing surgeon in Dallas, Tex.

You certainly are aware that the hour is late; with your permission, sir, I would like to summarize very briefly the reason why I am here, and request that the statement and the appendices be placed in the record.

Senator TALMADGE. Your full statement will appear in the record, Doctor; and those of us who have been around here a while have found brevity is the most persuasive thing we could have in the Senate.

Dr. DAVIS. I shall try.

Even though the doctors in Texas did not agree with the need for Public Law 92-603, our house of delegates voted by a ratio of 85 to 15 to implement it.

We chartered an organization, created a nonprofit corporation which meets all of the legal requirements, which is open to all licensed physicians, and which attracted all of the members of the health care team in Texas.

We petitioned the Secretary of the Department of Health, Education, and Welfare to accept the TIMA—the Texas Institute for Medical Assessment—as the PSRO for the entire State of Texas. A public meeting was held—the dates are in the testimony—sponsored by region VI of the Department of HEW in Dallas. Other States than Texas were invited. We had a special meeting with Dr. Henry Simmons, prior to his assumption of his current responsibilities.

After all of this, and in spite of the fact that we documented in detail that we were not only ready and willing to implement the law, but to follow it in detail, the Department of Health, Education, and Welfare imposed eight areas upon us instead of one. Included with this, under the law, is the mandatory State Professional Standard Review Council.

We forwarded a formal request for review; it was ignored. We petitioned our Congressmen and our Senators, and 22 of the 24 Representatives from the State of Texas in the U.S. House of Representatives saw fit to petition the Secretary of the Department of HEW formally by letter requesting that they grant us a single State PSRO.

Both of our distinguished Senators—one of whom is present here in the committee at this time and serves, as do you gentlemen, with distinction on the full Finance Committee—agreed with our position and passed our viewpoint on to the Secreeary of HEW.

After this show of unanimity, the Hospital Association, the Medical Association, the Osteopathic Medical Association, the nurses, the podiatrists, the whole kit and caboodle of all of our team—plus 22 of 24 Representatives and both of our Senators—the Secretary of HEW then granted us nine instead of eight areas.

We are here today to tell you that we are ready to carry out the law. In addition to that willingness, we would like to suggest that in your purview of implementation of this law—and incidentally, we applaud the committee and the subcommittee for taking your valuable time to hear everybody and get the viewpoints, because certainly I know it cannot be other than educational for all parties concerned—we would like to recommend that the definition of a qualified organization should be expanded so that existing medical societies can do that job.

We would like to see that the Secretary be granted the authority to enter into PSRO contracts with groups other than professional associations, such as are provided in the sections that are on page 6 of our testimony. We would like to see the law amended to provide for some appropriate appeal mechanism for area designations.

We feel that the Secretary acted in an arbitrary and capricious manner in our request and did not deal with us the same as he dealt with other States. And we feel that properly under a good law we ought to have some kind of reasonable appeal mechanism.

We would like to see the role of the State medical society be augmented by allowing the Secretary to enter into direct management contracts with State medical societies, if he could be satisfied himself that they would meet the criteria.

And in addition to this, we would like to make three other suggestions.

That the Secretary be instructed by the committee to consider allowing a third model for PSRO development—the large State single area designation—if and when such States could meet the requirements.

We think the law should be amended to allow the Secretary to revise area designations previously made to conform to changes in circumstances. And we would like to see, according to our viewpoint—and I understand that of Senator Bentsen—that the Secretary should be actually restrained from imposing multiple State PSRO areas on a State which chose to do otherwise.

Having made this statement, of course, I will welcome questions and do my very best to answer them. I want to thank the committee for hearing us.

Senator TALMADGE. Dr. Davis, thank you very much for a very fine statement.

Senator Bentsen.

Senator BENTSEN. Thank you very much, Mr. Chairman.

SINGLE STATEWIDE PSRO REQUESTED

It seems to me it really does not make any difference what the local people want as far as some people in Washington are concerned—or even their own delegation to the Congress. We are going to continue to see if we cannot turn that around, Dr. Davis.

The Texas Medical Association indicates that significant economies of scale would accrue from the operation of a single statewide PSRO.

Can you give any estimates of savings, in terms of both dollars and man-hours, that might result?

Dr. DAVIS. I really cannot, Senator Bentsen, and should not take the time to deal in conjecture. I will say this, that simple arithmetic would lead us to an answer.

For example, if you are going to have a basic superstructure that is going to be applicable all over the State, then it is going to take something like nine times as much space—people, man-hours—to run nine of them. And I really think I should stop there because I do not believe I can give you an adequate answer to your very pertinent question.

Senator BENTSEN. Well, you have indicated that the Dallas HEW office has twice endorsed a statewide plan.

Dr. DAVIS. That is correct, sir.

Senator BENTSEN. Do you know what the points of contention are between the Dallas office and the Washington office, and why they are so omniscient and omnipotent in Washington about what we should have in Texas?

Dr. DAVIS. Well, we have heard testimony here today while you have been doing other work, Senator, that we do not trust these people. I think probably you could find in Exodus 7 and 8, when Joseph came back and said what happened to my people, and they said, well, they got a new pharaoh and they knew not Joseph. And that is the way we feel about Government people. It is not a matter of how much we might trust the incumbent Secretary or a current Congress or an incumbent administration. We have learned by experience that these things change.

Now, the Dallas office is a regional office involving more States than Texas. They definitely favored our viewpoint and forwarded a recommendation. I cannot tell you why the Secretary did not follow it.

Senator BENTSEN. Had you been led to believe that the Secretary was going to approve the Dallas office recommendation?

Dr. DAVIS. I really do not think so. I think that as I looked at this—I am sort of middle way between young and old, but I have had a little to do this type of thing before. The message that came across to me was that they had decided not to accept our recommendation from the very beginning, and just spent some of the Government's money in holding these conferences for reasons of their own.

Senator BENTSEN. Well, my amendment to the bill would give you a trial period in which to demonstrate the effectiveness of a statewide PSRO in Texas. And if at the end of that period the Secretary was not satisfied, he could order implementation of the Department's plan.

Are you convinced that the TIMA statewide system would be effective and that it should satisfy HEW?

Dr. DAVIS. I am very convinced of it, and I do not think that he could fault us in any way, because we deliberately set about to conform to the law. We deliberately set about to implement the law, not to block it. We deliberately studied the law and met with people to tell us what would be required. And we have formulated all of our plans on the basis of compliance.

I feel that we are quite capable of doing it, and without any question we would be able to qualify.

Senator BENTSEN. Would it be fair to say that at least in the beginning, that Texas doctors strongly opposed PSRO, but came around to the viewpoint of supporting one on a statewide basis, and that the polls reflected that they have?

Dr. DAVIS. Well, our viewpoint, I think, can be summarized as follows: We recognize that there must be change. We recognize that changes come about all of the time. We recognize the most important thing—that I personally recognized—was that we are going to be collecting data, lots of data. I wanted us to have input, I wanted us to have input into the data. I actually made such a speech on the floor of the House, and we had a special meeting about this, and they bought it. They did not want it; they still favor repeal; but as long as we were going to have a law like this, they want to have their own input into it. I feel that is for the best interest of their patients.

Senator BENTSEN. Thank you very much, doctor.

Senator TALMADGE. Senator Bennett.

Senator BENNETT. Just to follow up what Senator Bentsen said, his amendment is in conference. I do not know whenever we will ever get to conference on that bill. But it is in conference, and I have an amendment to it which more or less nullifies it, as you might expect. [General laughter.] And so when we get to conference, we will have to see what happens.

But I would just like to make one comment. I think Texas is completely in character. They want the biggest PSRO in the business. [General laughter.]

Senator TALMADGE. Thank you, Dr. Davis, for your contribution to our deliberations.

Dr. DAVIS. We thank you gentlemen.

[The proposed statement of Dr. Davis, with attachments, follows. Hearing continues on p. 473.]

PREPARED STATEMENT OF THE TEXAS MEDICAL ASSOCIATION

(By Milton V. Davis, M.D.)

Mr. Chairman and members of the committee, I am Doctor Milton V. Davis, a practicing physician in Dallas, Tex. I am a member of the Executive Board of the Texas Medical Association and the Steering Committee of the Texas Institute for Medical Assessment which was formed to present proposals to the Department of Health, Education, and Welfare relating to the PSRO Section (Sect. 249) of P.L. 92-603.

I am pleased to represent the TMA and the Texas Institute for Medical Assessment (TIMA) in response to an invitation issued by Mr. Stern, the Staff Director of the Senate Finance Committee. I wish it were possible for more of my colleagues of TMA to be with me today, however, the Annual Session of the Texas Medical Association is taking place in Houston, Texas, at this time. Our Session began the 8th of May and runs through May 12th.

I am grateful for the opportunity to present the TMA's views concerning the subject of your hearings—the evaluation of present and proposed implementation of the PSRO legislation.

At the outset and in all candor, I must inform this Committee that the House of Delegates in May, 1973, voted to work toward repeal of the PSRO section of P.L. 92-603. It would be my assessment that this is the view of the vast majority of the physicians of Texas.

At the same meeting of the TMA House of Delegates it was recognized that even though we favored repeal of the PSRO law, we recognized that it was the law of the land and the Board of Trustees of TMA were instructed to authorize, create and support an organization that qualifies under all applicable law to perform all the functions of a PSRO throughout the State of Texas under a single organization, the sole guiding principle of this organization to be to insure the continued improvement of the quality of care in this state as Texas physicians have always done.

From that point in May of 1973, the Texas Institute for Medical Assessment or (TIMA) was chartered to comply with the desires of the TMA and comply with P.L. 92–603 and HEW.

TIMA caused something to happen which is rare these days and that is unity and cooperation between groups who have been known to have some differences. I am sure that you as Committee members have been exposed to these differences. For the first time in a long time TIMA brought together the active support and assistance by the Texas Osteopathic Medical Association, Texas Medical Association, medical specialty societies and county medical societies, Texas Hospital Association, Texas Osteopathic Hospital Association, Private Hospitals and Clinics Association of Texas, all medical schools in Texas, both M.D. and D.O., Texas State Department of Health, State Office of Comprehensive Health Planning, Texas Nursing Home Association, Texas Dental Association, Texas Pharmaceutical Association, Texas Nursing Association, Texas Podiatric Association, Blue Cross-Blue Shield of Texas, the Governor of Texas, 22 of the 24 members of the U.S. House of Representatives from Texas and both U.S. Senators of Texas, one of which, the Honorable Lloyd Bentsen, is a distinguished member of the full Senate Finance Committee.

The organizations meet for untold hours under the direction of Dr. Joseph Painter of Houston, one of the outstanding physicians in the U.S. in the areas of peer review and utilization review.

I might pause and explain to you why we felt a single statewide area designation was advisable from the standpoint of Texas. We felt that it was imperative that TIMA be designated as the PSRO for Texas. Not that TIMA would be performing statewide review because it has always been our intent and as a matter of fact insistence that local components perform the review activity. We felt that a single organization could promote a rapid development and implementation of the system as well as achieve the highest level of economy, efficiency, uniformity and coordination of review activity.

From May, 1973, until August, 1973, a systematic program was developed to the satisfaction of all interested organizations.

The Department of HEW held a public hearing August 24, 1973, in Dallas, Texas, on the subject of area designation. The TIMA proposal was the only plan submitted and the District Office of HEW endorsed the proposal.

Between August, 1973, and October 18, 1973, work on the concept and organization of TIMA was brought from only an idea to a viable and realistic organization.

On October 18, 1973, the Department of Hew (OPSR) had another hearing in Dallas, Texas, on the subject and again the plan presented on August 24, 1973, was unanimously supported by the various organizations heretofore mentioned. Copies of our presentation at both of these hearings are attached to my statement for your record.

On December 20, 1973, the Office of PSR–HEW published in Vol. 38, No. 244, its area designations as they concern Texas slicing us into eight unrecognizable areas.

This action on the part of HEW was of great disappointment to all the organizations concerned not the least of which was the TMA. Still making every effort to comply with the law consistent with our interest, we filed comments in response to the initial designations. (A copy of this statement is attached with my comments.) In that statement we submitted an analysis of factors considered by OPSR in determination of PSRO areas, an analysis of recognized medical service areas and distances within proposed PSRO designations, a comparison of the TIMA plan and OPSR proposal, a proposed solution to the area designation controversy, a comparative analysis of number of physicians, beneficiaries and facilities under OPSR proposed areas and the results of a poll of physicians and organizations regarding PSRO law, area designations and TIMA.

In spite of our plea, on March 18, 1974, the Secretary of HEW issued the final area designations and only changed them insofar as Texas is concerned by revising the map slightly and increasing the number from 8 to 9 PSRO's.

The point of my recounting this sequence of events is to point out to this Committee our activities in relation to implementation of PSRO in Texas and to make you acquainted with the fact that in my opinion and that of TMA HEW has made a very basic mistake relating to implementation of PSRO in Texas by their ignoring the clear preference of the people and organizations in Texas who they must be dependent upon for the implementation and effective operation of PSRO in Texas.

The arguments for a single statewide PSRO are fully covered in attached materials but briefly they are (1) centralized *uniform* data system, (2) administrative support for local review units, (3) educational programs on the methodology, process and evaluation of utilization review and quality assessment, (4) objective systems of evaluation of the methods employed and the performance of local review units with recommendations for improvement, (5) impartial arbitration of appeals, (6) ongoing planning for improvement in review and education process, (7) research in the methodology, organization, operation and evaluation of the entire professional standards review program but most of all in my opinion is the aspect that there are just not that many qualified and interested physicians to set up and operate a PSRO. It makes sense to me to have one good organization rather than 9 fragmented and separate entities. We have a shortage of physicians rendering patient care now and 9 entities will only siphon off 9 times as many man hours away from our primary purpose of treating sick and injured patients.

The effect on implementation of the area designation controversy can only be described as a major hurdle if not an obstacle that can not be overcome.

The TMA House of Delegates this week will consider policy as to the TMA's position on PSRO and there are many resolutions to withdraw all support for further on implementation of PSRO in Texas and support total repeal. The decision if it comes to no longer provide financial aid and support for TIMA could set the entire program to drift and as Committee report on finance relating to the Bennett amendment indicates, the major shortcoming of present utilization controls is the insufficient professional participation in and support of claims review.

Mr. Chairman, again I would say that the preference of the TMA is that the PSRO section be repealed, however, as a minimum the amendments proposed by the AMA should be adopted and insofar as Texas is concerned, it would be particularly applicable if:

(1) The definition of "qualified organization" under Section 1152(b)(1)(A) should be expanded so that existing medical societies and organizations designated by them, including foundations will be specifically eligible for consideration as a PSRO.

(2) Authority for the Secretary to enter into PSRO contracts with groups other than professional associations, as provided as Section 1152(b)(1)(B), should be postponed from January 1, 1976, to January 1, 1978.

(3) The law should be amended to provide for the appeal of area designations.

(4) The role of the State medical society should be further augmented by allowing the Secretary to enter into direct management contracts with the State Medical Society, or its designated organization, for the administration of PSRO program.

In addition to these AMA proposals, I would like to make these additional suggestions for amendments.

(1) That the Secretary should be instructed, in view of the provisional designations of PSRO contracts, to enter into a contract with a State of the size of Texas, if a proper proposal is submitted, to allow the third model for PSRO development—the large State single area designation with authority to subdivide into internal geographic regions and use separate systems as appropriate to perform professional standards review. This subject was the concern of an amendment by Senator Bentsen to H.R. 3153. This would allow additional information to be generated as to operational experience and if at the end of the provisional period the Secretary does not think this advisable to continue he would be free to do so under current law.

(2) The law should be amended to allow the Secretary to revise area designations previously made to conform to changes in circumstances such as the above proposal and further experience.

(3) That Section 1162 of the PSRO Law should not be amended to provide for a Statewide Professional Review Council where there are one or more PSRO's. My opinion is that the functions, responsibilities, and duties of such council are vague and would only cause another layer of administrative red tape in relation to the program.

CONCLUSION

Mr. Chairman, once again thank you, the Committee and your Counsel for the invitation to appear today.

TEXAS INSTITUTE FOR MEDICAL ASSESSMENT
PROPOSAL FOR PSRO AREA DESIGNATION
FOR THE
STATE OF TEXAS
AND
PRELIMINARY NOTIFICATION FOR A CONTRACT WITH DHEW
August 24, 1973

The licensed physicians of the State of Texas, acting in concert and unity, formally request that a single, statewide Professional Standards Review Organization conforming to the boundaries of the state be designated. We believe that such action would meet the expressed desires of the licensed physicians, would permit a functioning organization to assure uniform implementation and support of institutional review processes in the state while maintaining the actual professional standards review at the local level, and would fulfill the qualifications for physician organizations which are specified in Section 249 F, P.L. 92-603.

STATEMENT OF INTENT

The licensed physicians of this state wish to inform the Secretary of the Department of Health, Education and Welfare of our intention and desire to comply fully with all obligations and requirements of professional standards review as outlined in P.L. 92-603. We have developed a state organization - the Texas Institute of Medical Assessment - which meets the specifications stipulated for a physician sponsored group and are engaged actively in working toward the rapid implementation of a statewide system of medical care review, evaluation, and education. It is the intent of TIMA to apply to the Secretary of the Department of Health, Education, and Welfare for designation as the provisional PSRO for the State of Texas.

FUNCTIONS OF A SINGLE STATE PSRO IN TEXAS

While recognizing that the functions of a single statewide PSRO system are tangential to the issue of area designation, we believe that a description of its role may permit a better understanding of the reasons for requesting a single designation in the state.

The licensed physicians of Texas fully subscribe to the functions identified in a recent communication by Senator Bennett: " . . . (1) coordinate the activities of, and disseminate information and data . . . ; (2) assist the Secretary in the development of uniform data gathering procedures and operating procedures; (3) assist in the establishment of a common data processing operation to provide assurances of efficient operation and objective evaluation of comparative formulas of the several areas . . . within our review structure; (4) assist the Secretary in evaluating performance . . . " of local review units. Such a coordinating and assistance role is essential. In addition, we believe certain other centralized functions can be performed without impinging upon the right of the local review groups to determine the medical necessity, appropriateness and quality of medical care.

1. Centralized uniform data system.

2. Administrative support for local review units.

3. Educational programs on the methodology, process, and evaluation of utilization review and quality assessment.

4. Objective systems of evaluation of the methods employed and the performance of local review units with recommendations for improvement.

5. Impartial arbitration of appeals from any party which may result from decisions of the local review units.

6. Ongoing planning for improvement in the review and education process.

7. Research in the methodology, organization, operation and evaluation of the entire professional standards review program.

These additional duties will permit, in our judgment, a single state professional standards review organization to function in an efficient and effective manner while clearly recognizing and perpetuating the absolute need for the review function to be performed at the local level.

DHEW GUIDELINES FOR AREA DESIGNATION

The single state Professional Standards Review Organization (TIMA) fulfills Guidelines Nos. 1-4 and No. 6. We believe Guideline No. 5 to be impractical in Texas for reasons previously stated and to be cited. Moreover, P.L. 92-603 does not prohibit the designation of a single state PSRO and the precedent exists for such a designation by prior decisions of DHEW nationally and within Region VI. Finally, the large geographic area, the urban-rural problems, and the distribution of physicians and facilities makes mandatory the presence of a single state coordinating and support system to assure the uniform development and application of the standards of professional review throughout every region of the state.

DHEW PROPOSED AREA DESIGNATIONS FOR TEXAS

The four alternatives conceived in the distributed materials from DHEW do not meet the requirements by practicing physicians for an efficient economical uniform non-duplicative single system supported by the Texas Institute for Medical Assessment.

IMPLEMENTATION OF PSRO IN TEXAS

In order to fulfill the expectations of the law, we believe that it is imperative that a single state corporation (TIMA) be designated as the Professional Standards Review

Organization for the State of Texas with the authority to designate local components to perform the review activity. This position is supported by the licensed physicians of Texas and by the various organizations representing physicians in the state.

TIMA, acting as a statewide single PSRO contractor, will promote a rapid development and implementation of the system as well as achieve the highest level of econonomy, efficiency, uniformity and coordination of review activity.

TIMA will result in UNITY:

It has already stimulated the process of unifying the health and allied professionals in the health field and in our state. This unity can be maintained and expanded by utilizing TIMA to coordinate and service PSRO. We believe unity will be sacrificed without it. TIMA has the solid support of Texas health care providers and associates, as is indicated here today.

Recognizing that any designation is provisional for two years, we suggest that a third model approach to PSRO is needed in addition to the small, single-state PSRO, and the large-state, multiple, direct-contract PSROs. We believe that a unified health profession in a large state should be given the opportunity to prove that this vigorous and vital force can be the most effective and efficient approach of all toward achieving the goals of Section 249 F, PSRO.

TIMA would insure UNIFORMITY through:

1. Uniform data gathering procedures and operating procedures.

2. Objective evaluation of the performance of professional review activity at the local level and place the review process in perspective and assure delivery of quality medical care to the citizens of Texas.

3. A data reporting system which would assist in identifying deficiencies in medical practice and an educational program to provide a positive stimulus to assure high quality care and improve the methods of review.

In addition, the performance of physicians in all components of the delivery system as well as the high quality of medical care provided the citizens of Texas will be maintained and improved.

TIMA would promote ECONOMY of operation by:

1. Allowing the Department of Health, Education, and Welfare to negotiate a single contract.

2. Minimizing the additional staffing requirement of DHEW for maintaining liaison with review organization.

3. Reducing administrative expenses of the review effort by permitting the utilization of central staff support, thus eliminating the duplication of staff services at the local level.

4. Encouraging the use of existing staff and professional expertise and experience within the review mechanisms of the professional organizations and hospital review committees. These people have been working with the concept of review for many years and have developed a keen understanding of the mechanics of review and data collection.

TIMA would encourage EFFICIENCY because it would:

1. Take advantage of existing and ongoing programs for review by integrating hospital review techniques and medical society mechanisms into a meaningful review program. This mechanism will allow utilization of existing and ongoing programs of the various professional organizations (including the Texas Osteopathic Medical Association and the Texas Medical Association) and provide effective utilization of the experiences of physicians in implementing the new program.

2. Establish common procedures and utilize single strong administrative and structural base in the state.

3. The local review areas do not cut across existing governmental jurisdictional lines and structure.

TIMA would encourage COORDINATION by:

1. Integrating existing professional review activities with the objective of insuring the same professional standards of care for every person in the state.

2. Working to continually upgrade the practice of medicine within the State of Texas. Professional standards in medicine are not static, but subject to dynamic change. As patterns of practice change for the State, the continuing education program of the statewide PSRO would insure that local areas are informed of these changes, thus adding the vital ingredient of flexibility to the standards of care.

3. Only a statewide body can provide a mechanism for appeal and arbitration. Reasonable investigation of complaints by patients, physicians, third party payors, and others can best be achieved through a single, objective party which can review the problem within its proper perspective.

TIMA would improve the ACHIEVEMENT of physicians by:

1. Objective evaluation and analysis of the data generated through the system.

2. Education of physicians regarding identifiable areas where performance can be improved.

3. Utilization of existing medical educational networks to transmit information and materials to the physicians of the state.

4. Assistance and support of professional medical organizations.

TIMA will improve the ACHIEVEMENT of allied professionals in the health field within the health care delivery system through ongoing evaluation of the efficiency and effectiveness of these components in the delivery of medical care within the state.

TIMA will assure the maintenance and improvement of the high QUALITY of medical care delivered within the state through:

1. Uniform objective evaluation of and improvement in the performance of components of the delivery system in every area of the state.

2. Education at the state and local levels related to demonstrated needs identified through the review process.

3. Involvement of individuals as well as organizational groups (hospitals, nursing homes, dentists, podiatrists, intermediaries, etc.) within the medical care field in a close advisory relationship at the state and the local areas to insure all components are contributing and responding to the goal of the provisions of the highest quality of medical care to all of the people of the state.

Utilizing TIMA, the Department of Health, Education, and Welfare can guarantee the orderly, timely, and rapid IMPLEMENTATION of the provisions of P.L. 92-603 in the state by:

1. The support of the licensed physicians of Texas.

2. The support of the organizations representing physicians.

3. The support of organizations representing hospitals.

4. The combining of the existing ongoing tiered professional review systems operated by professional organizations into a new comprehensive approach to meet and exceed the requirements stipulated for professional standards review under P.L. 92-603.

5. The support of staff personnel and physicians experienced in review methods, process and administration as the base upon which to build a complete system.

6. Service to meet the full intent of the law by acting as a qualified replacement Professional Standards Review Organization in the event that local units were not fully operational by the deadline stipulated in the law.

CONCLUSION

In conclusion, for the reasons stated, the licensed physicians of Texas acting through the Texas Institute for Medical Assessment, formally request that the State of Texas be designated as a single PSRO area. Therefore, at the appropriate time, we intend to submit this plan as the basis for the implementation of a single contract for PSRO between DHEW and TIMA.

The moral force of the support of the profession - individually and collectively - which strongly favors this action, will be a major determinant in success or failure of the implementation of this legislation within our state.

TIMA will be a moving force in promoting quality care and patient satisfaction by its emphasis on quality, accessability to services and economy.

TEXAS INSTITUTE FOR MEDICAL ASSESSMENT

PROPOSAL FOR A SINGLE PSRO AREA DESIGNATION
FOR THE
STATE OF TEXAS
AND
DECLARATION OF INTENT OF THE TEXAS INSTITUTE FOR MEDICAL ASSESSMENT
TO SUBMIT A PLAN FOR DESIGNATION OF PROVISIONAL PSRO STATUS
October 18, 1973

The licensed physicians of the State of Texas resubmit the formal request of August 24, 1973, for the designation of our entire state as a single area for professional standards review.

The proposal presented at the initial hearing was made after careful study of the four alternatives furnished by the Office of Professional Standards Review, fulfilled five of six guidelines promulgated by that office and indicated the presence of an existing organization (Texas Institute for Medical Assessment) which fulfilled the requirement for a physician sponsored group under PSRO. The proposal further clearly delineated the separation of the coordinative-supportive-assistance role of the state system from the local review process in medical service areas and advanced valid arguments for a single area designation (stimulation of unity of the profession, creation of uniformity in the method and process of review, utilization of existing methods of review, promotion of economy of operation, mandate of efficient operation, assure coordination, upgrade medical care, and guarantee the timely implementation of PSRO through the support of physicians). Testimony also added three significant points: none of the governmental subdivisions (or combinations thereof) met the requirements for utilization review as proposed under P. L. 92-603 or the guidelines promulgated by OPSR; internal flexibility to use different regional systems for different types of institutional review (e.g.: hospital and nursing home review) was imperative; and local review units to evaluate the effectiveness of the institutional utilization review process would be derived after consultation with the physicians in each region of the state. The proposal also established the intent of TIMA to apply for designation as the provisional PSRO for Texas.

The hearing on August 24, 1973 demonstrated the unanimity of the support for a single area designation within the State of Texas. Physicians' organizations (Texas Medical Association, Texas Osteopathic Medical Association, medical specialty societies and county medical societies), hospital associations (Texas Hospital Association, Texas Osteopathic Hospital Association, Private Hospitals and Clinics Association), medical schools (both M.D. and D.O.), Texas State Department of Health and the State Office of Comprehensive Health Planning. None of the four alternatives proposed by OPSR received support.

RESTATEMENT OF INTENT

The licensed physicians of this state again wish to inform the Secretary of the Department of Health, Education and Welfare of our intention and desire to comply fully with all obligations and requirements for professional standards review as outlined in P. L. 92-603. Our state organization - the Texas Institute for Medical Assessment - which qualifies as a physician sponsored group under the PSRO definition is continuing its work towards the rapid implementation of a statewide system of medical care review, evaluation, and education. TIMA will submit a plan to the Secretary of DHEW and request designation as a provisional PSRO for the State of Texas.

DHEW GUIDELINES FOR AREA DESIGNATION

1. PSRO areas shall not cross state lines.

A single state area designation is in conformity with this requirement.

2. In general, PSRO areas should not divide a county.

Designation of the state boundary would meet this stipulation. Proposed local review units under the single state area designation would recognize this qualification.

3. Existing boundaries of current local medical review organizations should be considered.

Designation of the state as a single PSRO area would allow full use of all existing review systems and organizations. All medical review in Texas is organized on a state-regional-local basis. Each professional organization has different subdivisions for its peer review process. The single state area designation - and single statewide PSRO - would allow coordination of the peer review efforts by multiple groups while preserving the internal flexibility to have multiple systems of subregions contributing to professional standards review.

4. A PSRO area would, to the extent possible, coincide with a medical service area and insure broad, diverse representation of all medical specialties.

Recognition must be given to the differences in the types of review in different institutional settings. Hospital utilization review is dependent on utilization review committees composed of the medical staff and acting on a day-to-day basis. Local review units under a single statewide PSRO would have to meet frequently to assess the performance of the individual institutions. Nursing home review, however, requires less frequent medical audit because of the chronicity of the illness and the longevity of the stay. Further, each institutional

setting has different medical service areas. TIMA, representing the licensed physicians of Texas, believes that each must have a separate system and different regions for the review mandated under PSRO.

a. Hospitals:

Distribution of physicians, facilities, beneficiaries, and population centers was considered as well as the factors of time and distance. Approximately 38 local review unit areas have been determined by TIMA as being geographically contiguous with central population centers and sufficient numbers of beneficiaries, beds, and physicians for valid review. These multiple small local review units would provide local determination of the effectiveness of the hospital utilization review committee and utilize local variations of the state norms. Each unit would report to the single state PSRO which would retain the ultimate evaluation and review authority.

Maps of these units have been prepared; however, before final decision regarding the validity of the boundaries of the local review unit divisions, each locality would be requested to contribute knowledge of local physicians, hospital and beneficiary practices.

The number of local review units and the boundaries of each would remain flexible within the single state area designation - and single state PSRO - and would be able to respond rapidly to experience and/or change in condition. The final geographic subunit of the single state PSRO will reflect more accurately medical practice in service areas than any of the existing governmental subdivisions developed for other purposes.

b. Nursing homes:

The State Department of Welfare (DPW) currently operates a system of medical review teams for nursing home review under the Medical Assistance Program. This sytem is divided into 11 regions. While not applicable to hospital utilization review because of differences in the types and distribution of patients and facilities as well as the geographic distances to be traveled, the program has worked well, and, with the internal flexibility of a single PSRO determination, would permit use of this program under the state organization.

5. A PRSO area should generally have a minimum of approximately 300 licensed practicing physicians. While the maximum can be expected to vary with local circumstances, it should not exceed 2500 licensed practicing physicians.

The total of 12,944 licensed practicing physicians exceeds the arbitrary limit of 2500 established as the guideline. TIMA, however, would qualify if the recommendation of the National Professional Standards Review Council is accepted: that . . . "Where the professional association(s) concerned demonstrate a desire and capability of successfully sponsoring a state level PSRO, the option

of an essentially statewide area designation should be considered even though the 2500 physicians general limit is exceeded". Moreover, the subdivision of the single state PSRO into multiple small local review units as the first level of evaluation for professional standards review activity would meet the basic intent of the guidelines and foster local medical care review. Of the proposed subdivision within TIMA, only two would slightly exceed the upper limitations. Finally, we believe that the advantages of the economy, efficiency, uniformity, and flexibility of a single statewide PSRO as well as the support of physicians far outweigh the artificial numerical limits imposed under Guideline 5.

6. The designation of a PSRO area should take into account the need to allow effective coordination with the Medicare/Medicaid fiscal agent.

Blue Cross-Blue Shield of Texas is the fiscal agent for both Medicare and Medicaid and operates on a statewide basis. While taking no position at the first regional hearing regarding area designation, Blue Cross-Blue Shield has assigned the medical director and vice president for medical affairs to the Steering Committee of TIMA to establish a close working relationship.

DHEW PROPOSED AREA DESIGNATIONS

The medical assistance districts, the Texas State Department of Health regions and the Texas Planning Regions were developed for purposes other than institutional utilization review. As pointed out earlier in this testimony, the physicians of Texas believe there must be separation of hospital from nursing home review as well as retention of the flexibility permitted within a single statewide PSRO area to use any and all qualified existing systems regardless of the geographic organization. If professional standards review is to be implemented successfully, the organizational format must recognize and conserve the physicians' time and be adaptable to local conditions.

The drawing of lines on a map to create comparable numbers of beds and physicians ignores the concentration of beneficiaries as well as the time and distance factors which are fundamental considerations if physician participation is to be secured.

None of the proposed area designation alternatives meet the requirements of the licensed physicians of Texas for an effective, economical, uniform, non-duplicative single system supported by TIMA.

CONCLUSION

1. The licensed physicians of Texas formally resubmit their request for designation of the State of Texas as a single PSRO area.

2. The licensed physicians of Texas have developed a qualified, physician sponsored group - the Texas Institute for Medical Assessment - to support rapid implementation of professional standards review within the State.

3. The licensed physicians of Texas - with the full support of medical schools, hospitals, nursing homes, state agencies, fiscal intermediary, and the professional organizations of the providers - intend to meet fully any and all obligations under the law through the implementation of a single state PSRO under the Texas Institute for Medical Assessment.

Texas Institute for Medical Assessment

1905 North Lamar Blvd., Austin, Texas 78705 AC 512 474-2471

January 31, 1974

Director, Office of Professional Standards Review
Parklawn Building, Room 17-64
5600 Fishers Lane
Rockville, Maryland 20852

Dear Sir:

The following comments and supporting materials are submitted by the Texas Institute for Medical Assessment (TIMA) regarding the proposed area designations published in the Federal Register for the State of Texas, which proposed regulations are posted as new Part 101, "Professional Standards Review," Title 42, Code of Federal Regulations, Section 101.48, Texas.

TIMA, acting on behalf of physicians, hospitals and other providers with the unanimous support of provider organizations, medical schools, state agencies and Blue Cross-Blue Shield as fiscal agent for Medicare and Medicaid, strongly objects to the proposed area designations for the following reasons:

1. The proposed area designations fail to recognize the unanimous support of the providers and their organizations for a single area designation for the State of Texas.

   See Attachments #1 and #2: Testimony Submitted at the Consultation Hearings on August 24, 1973, and October 18, 1973. Refer to transcripts of the proceedings and to accompanying letters of support.

2. The proposed area designations reject the recommendations of the Hearing Officer and Regions VI, DHEW, for a single area designation in Texas. Refer to the report of Region VI with recommendations submitted following the August 24 meeting.

3. The proposed area designations do not fulfill the DHEW guidelines and policies used to determine PSRO areas.

   See Attachment #3: Analysis of Factors Considered by OPSR in Determination of PSRO Areas.

4. The proposed area designations do not recognize time, distance or geographic factors vital to timely and effective professional standards review.

   See Attachment #4: Analysis of Recognized Medical Service Areas and Distances Within Proposed OPSR Designations.

5. The proposed area designations do not recognize existing medical practice and referral areas.

   See Attachments #3 and #4.

6. The proposed area designations do not conform to existing governmental or medical organizational regions.

   See Attachments #3 and #5: Analysis of Proposed Area Designations.

   Although generally based upon combinations of health planning districts and areawide planning geographic areas, the basic districts, areas and combined proposed areas bear no relationship to existing facilities, the number of physicians who provide and review medical care, the number of beneficiaries regarding care or the institutional review process required under PSRO in existing institutions.

7. The proposed area designations do not recognize existing and functioning medical review systems.

   See Attachments #2 and #3.

8. The eight proposed area designations do not represent an economical nor efficient approach to implementation of PSRO. Reduplication of personnel and costs; fragmentation of effort and process; lack of uniformity of review; and inability to change geographic boundaries or operating techniques in each independent PSRO will hamstring the orderly and timely implementation process.

9. The proposed area designations do not fulfill the intent of the law to maintain the determination of medical necessity, appropriateness and quality of care at the local level.

   See Attachments #2, #3, #4, and #5.

10. The proposed area designations fail to recognize a third model for PSRO development - the large state single area designation with authority to subdivide into internal geographic regions and use separate systems as appropriate to perform professional standards review.

The above statements and supporting materials clearly establish that the proposed eight area designations for the State of Texas are artificial, disruptive, and unacceptable.

Director, Office of Professional Standards Review
January 17, 1974

TIMA has proposed an alternative model which

- fulfills the intent of the guidelines
- maintains medical review within identifiable local medical service areas
- provides a central administrative support system
- retains internal flexibility to have different regions and systems for different types of institutional review
- guarantees uniform and objective utilization review on a statewide basis
- preserves the economical, efficient organizational structure and operational system with centralization of common functions
- will use the information derived from professional standards review to improve medical care in the state through specifically targeted educational programs

Attachments #1 and #2 document the reasons for a single PSRO area designation. Attachment #6, "Comparison of the TIMA Plan and OPSR Proposal," analyzes and compares the two approaches. Attachment #7, "Proposed Solution to the Area Designation Controversy," is a seven point statement attempting to recognize and incorporate the legitimate concerns of TIMA and DHEW into a workable alternative program. Attachment #8, "Comparative Analysis of Numbers of Physicians, Beneficiaries and Facilities Under OPSR Proposal Areas," supports the reasonable adjustment of medical service centers, distance, medical practice and referral areas, and numbers of physicians, beneficiaries, and facilities to achieve practical geographically compact areas with sufficient number of patients, doctors and beds to assure valid review.

Attachment #9, "Results of Poll of Physicians Regarding the PSRO Law, Area Designations, and TIMA," documents the overwhelming support of the physicians of Texas for a single area designation for the State of Texas and acceptance of TIMA - and its plan - as the single professional standards review organization in Texas.

Director, Office of Professional Standards Review
January 17, 1974

TIMA formally requests withdrawal of the eight proposed PSRO areas for Texas and designation of the entire state as a single area.

Sincerely yours,

Joseph T. Painter, M.D., Chairman
Steering Committee
Texas Institute for Medical Assessment

JTP:nf

Attachment #1	Testimony Submitted at August 24, 1973, Region VI Consultative Hearing
Attachment #2	Testimony Submitted at October 18, 1973, Region VI Consultative Hearing
Attachment #3	Analysis of Factors Considered by OPSR in Determination of PSRO Areas
Attachment #4	Analysis of Recognized Medical Service Areas and Distances Within Proposed OPSR Area Designations
Attachment #5	Analysis of Precedents for Proposed Area Designations
Attachment #6	Comparison of TIMA Plan and OPSR Proposal
Attachment #7	Proposed Solution to Area Designation Controversy
Attachment #8	Comparative Analysis of Numbers of Physicians, Beneficiaries and Facilities Under OPSR Proposal Area
Attachment #9	Results of Poll of Physicians and Physician's Organizations Regarding the PSRO Law, Area Designations, and TIMA

ATTACHMENT #1

TEXAS INSTITUTE FOR MEDICAL ASSESSMENT
PROPOSAL FOR PSRO AREA DESIGNATION
FOR THE
STATE OF TEXAS
AND
PRELIMINARY NOTIFICATION FOR A CONTRACT WITH DHEW
August 24, 1973

The licensed physicians of the State of Texas, acting in concert and unity, formally request that a single, statewide Professional Standards Review Organization conforming to the boundaries of the state be designated. We believe that such action would meet the expressed desires of the licensed physicians, would permit a functioning organization to assure uniform implementation and support of institutional review processes in the state while maintaining the actual professional standards review at the local level, and would fulfill the qualifications for physician organizations which are specified in Section 249 F, P.L. 92-603.

STATEMENT OF INTENT

The licensed physicians of this state wish to inform the Secretary of the Department of Health, Education and Welfare of our intention and desire to comply fully with all obligations and requirements of professional standards review as outlined in P.L. 92-603. We have developed a state organization - the Texas Institute of Medical Assessment - which meets the specifications stipulated for a physician sponsored group and are engaged actively in working toward the rapid implementation of a statewide system of medical care review, evaluation, and education. It is the intent of TIMA to apply to the Secretary of the Department of Health, Education, and Welfare for designation as the provisional PSRO for the State of Texas.

FUNCTIONS OF A SINGLE STATE PSRO IN TEXAS

While recognizing that the functions of a single statewide PSRO system are tangential to the issue of area designation, we believe that a description of its role may permit a better understanding of the reasons for requesting a single designation in the state.

The licensed physicians of Texas fully subscribe to the functions identified in a recent communication by Senator Bennett: " . . . (1) coordinate the activities of, and disseminate information and data . . . ; (2) assist the Secretary in the development of uniform data gathering procedures and operating procedures; (3) assist in the establishment of a common data processing operation to provide assurances of efficient operation and objective evaluation of comparative formulas of the several areas . . . within our review structure; (4) assist the Secretary in evaluating performance . . . " of local review units. Such a coordinating and assistance role is essential. In addition, we believe certain other centralized functions can be performed without impinging upon the right of the local review groups to determine the medical necessity, appropriateness and quality of medical care.

1. Centralized uniform data system.

2. Administrative support for local review units.

3. Educational programs on the methodology, process, and evaluation of utilization review and quality assessment.

4. Objective systems of evaluation of the methods employed and the performance of local review units with recommendations for improvement.

5. Impartial arbitration of appeals from any party which may result from decisions of the local review units.

6. Ongoing planning for improvement in the review and education process.

7. Research in the methodology, organization, operation and evaluation of the entire professional standards review program.

These additional duties will permit, in our judgment, a single state professional standards review organization to function in an efficient and effective manner while clearly recognizing and perpetuating the absolute need for the review function to be performed at the local level.

DHEW GUIDELINES FOR AREA DESIGNATION

The single state Professional Standards Review Organization (TIMA) fulfills Guidelines Nos. 1-4 and No. 6. We believe Guideline No. 5 to be impractical in Texas for reasons previously stated and to be cited. Moreover, P.L. 92-603 does not prohibit the designation of a single state PSRO and the precedent exists for such a designation by prior decisions of DHEW nationally and within Region VI. Finally, the large geographic area, the urban-rural problems, and the distribution of physicians and facilities makes mandatory the presence of a single state coordinating and support system to assure the uniform development and application of the standards of professional review throughout every region of the state.

DHEW PROPOSED AREA DESIGNATIONS FOR TEXAS

The four alternatives conceived in the distributed materials from DHEW do not meet the requirements by practicing physicians for an efficient economical uniform non-duplicative single system supported by the Texas Institute for Medical Assessment.

IMPLEMENTATION OF PSRO IN TEXAS

In order to fulfill the expectations of the law, we believe that it is imperative that a single state corporation (TIMA) be designated as the Professional Standards Review

Organization for the State of Texas with the authority to designate local components to perform the review activity. This position is supported by the licensed physicians of Texas and by the various organizations representing physicians in the state.

TIMA, acting as a statewide single PSRO contractor, will promote a rapid development and implementation of the system as well as achieve the highest level of econonomy, efficiency, uniformity and coordination of review activity.

TIMA will result in UNITY:

It has already stimulated the process of unifying the health and allied professionals in the health field and in our state. This unity can be maintained and expanded by utilizing TIMA to coordinate and service PSRO. We believe unity will be sacrificed without it. TIMA has the solid support of Texas health care providers and associates, as is indicated here today.

Recognizing that any designation is provisional for two years, we suggest that a third model approach to PSRO is needed in addition to the small, single-state PSRO, and the large-state, multiple, direct-contract PSROs. We believe that a unified health profession in a large state should be given the opportunity to prove that this vigorous and vital force can be the most effective and efficient approach of all toward achieving the goals of Section 249 F, PSRO.

TIMA would insure UNIFORMITY through:

1. Uniform data gathering procedures and operating procedures.

2. Objective evaluation of the performance of professional review activity at the local level and place the review process in perspective and assure delivery of quality medical care to the citizens of Texas.

3. A data reporting system which would assist in identifying deficiencies in medical practice and an educational program to provide a positive stimulus to assure high quality care and improve the methods of review.

In addition, the performance of physicians in all components of the delivery system as well as the high quality of medical care provided the citizens of Texas will be maintained and improved.

TIMA would promote ECONOMY of operation by:

1. Allowing the Department of Health, Education, and Welfare to negotiate a single contract.

2. Minimizing the additional staffing requirement of DHEW for maintaining liaison with review organization.

3. Reducing administrative expenses of the review effort by permitting the utilization of central staff support, thus eliminating the duplication of staff services at the local level.

4. Encouraging the use of existing staff and professional expertise and experience within the review mechanisms of the professional organizations and hospital review committees. These people have been working with the concept of review for many years and have developed a keen understanding of the mechanics of review and data collection.

TIMA would encourage EFFICIENCY because it would:

1. Take advantage of existing and ongoing programs for review by integrating hospital review techniques and medical society mechanisms into a meaningful review program. This mechanism will allow utilization of existing and ongoing programs of the various professional organizations (including the Texas Osteopathic Medical Association and the Texas Medical Association) and provide effective utilization of the experiences of physicians in implementing the new program.

2. Establish common procedures and utilize single strong administrative and structural base in the state.

3. The local review areas do not cut across existing governmental jurisdictional lines and structure.

TIMA would encourage COORDINATION by:

1. Integrating existing professional review activities with the objective of insuring the same professional standards of care for every person in the state.

2. Working to continually upgrade the practice of medicine within the State of Texas. Professional standards in medicine are not static, but subject to dynamic change. As patterns of practice change for the State, the continuing education program of the statewide PSRO would insure that local areas are informed of these changes, thus adding the vital ingredient of flexibility to the standards of care.

3. Only a statewide body can provide a mechanism for appeal and arbitration. Reasonable investigation of complaints by patients, physicians, third party payors, and others can best be achieved through a single, objective party which can review the problem within its proper perspective.

TIMA would improve the ACHIEVEMENT of physicians by:

1. Objective evaluation and analysis of the data generated through the system.

2. Education of physicians regarding identifiable areas where performance can be improved.

3. Utilization of existing medical educational networks to transmit information and materials to the physicians of the state.

4. Assistance and support of professional medical organizations.

TIMA will improve the ACHIEVEMENT of allied professionals in the health field within the health care delivery system through ongoing evaluation of the efficiency and effectiveness of these components in the delivery of medical care within the state.

TIMA will assure the maintenance and improvement of the high QUALITY of medical care delivered within the state through:

1. Uniform objective evaluation of and improvement in the performance of components of the delivery system in every area of the state.

2. Education at the state and local levels related to demonstrated needs identified through the review process.

3. Involvement of individuals as well as organizational groups (hospitals, nursing homes, dentists, podiatrists, intermediaries, etc.) within the medical care field in a close advisory relationship at the state and the local areas to insure all components are contributing and responding to the goal of the provisions of the highest quality of medical care to all of the people of the state.

Utilizing TIMA, the Department of Health, Education, and Welfare can guarantee the orderly, timely, and rapid IMPLEMENTATION of the provisions of P.L. 92-603 in the state by:

1. The support of the licensed physicians of Texas.

2. The support of the organizations representing physicians.

3. The support of organizations representing hospitals.

4. The combining of the existing ongoing tiered professional review systems operated by professional organizations into a new comprehensive approach to meet and exceed the requirements stipulated for professional standards review under P.L. 92-603.

5. The support of staff personnel and physicians experienced in review methods, process and administration as the base upon which to build a complete system.

6. Service to meet the full intent of the law by acting as a qualified replacement Professional Standards Review Organization in the event that local units were not fully operational by the deadline stipulated in the law.

CONCLUSION

In conclusion, for the reasons stated, the licensed physicians of Texas acting through the Texas Institute for Medical Assessment, formally request that the State of Texas be designated as a single PSRO area. Therefore, at the appropriate time, we intend to submit this plan as the basis for the implementation of a single contract for PSRO between DHEW and TIMA.

The moral force of the support of the profession - individually and collectively - which strongly favors this action, will be a major determinant in success or failure of the implementation of this legislation within our state.

TIMA will be a moving force in promoting quality care and patient satisfaction by its emphasis on quality, accessability to services and economy.

ATTACHMENT #2

TEXAS INSTITUTE FOR MEDICAL ASSESSMENT

PROPOSAL FOR A SINGLE PSRO AREA DESIGNATION
FOR THE
STATE OF TEXAS
AND
DECLARATION OF INTENT OF THE TEXAS INSTITUTE FOR MEDICAL ASSESSMENT
TO SUBMIT A PLAN FOR DESIGNATION OF PROVISIONAL PSRO STATUS
October 18, 1973

The licensed physicians of the State of Texas resubmit the formal request of August 24, 1973, for the designation of our entire state as a single area for professional standards review.

The proposal presented at the initial hearing was made after careful study of the four alternatives furnished by the Office of Professional Standards Review, fulfilled five of six guidelines promulgated by that office and indicated the presence of an existing organization (Texas Institute for Medical Assessment) which fulfilled the requirement for a physician sponsored group under PSRO. The proposal further clearly delineated the separation of the coordinative-supportive-assistance role of the state system from the local review process in medical service areas and advanced valid arguments for a single area designation (stimulation of unity of the profession, creation of uniformity in the method and process of review, utilization of existing methods of review, promotion of economy of operation, mandate of efficient operation, assure coordination, upgrade medical care, and guarantee the timely implementation of PSRO through the support of physicians). Testimony also added three significant points: none of the governmental subdivisions (or combinations thereof) met the requirements for utilization review as proposed under P. L. 92-603 or the guidelines promulgated by OPSR; internal flexibility to use different regional systems for different types of institutional review (e.g.: hospital and nursing home review) was imperative; and local review units to evaluate the effectiveness of the institutional utilization review process would be derived after consultation with the physicians in each region of the state. The proposal also established the intent of TIMA to apply for designation as the provisional PSRO for Texas.

The hearing on August 24, 1973 demonstrated the unanimity of the support for a single area designation within the State of Texas. Physicians' organizations (Texas Medical Association, Texas Osteopathic Medical Association, medical specialty societies and county medical societies), hospital associations (Texas Hospital Association, Texas Osteopathic Hospital Association, Private Hospitals and Clinics Association), medical schools (both M.D. and D.O.), Texas State Department of Health and the State Office of Comprehensive Health Planning. None of the four alternatives proposed by OPSR received support.

RESTATEMENT OF INTENT

The licensed physicians of this state again wish to inform the Secretary of the Department of Health, Education and Welfare of our intention and desire to comply fully with all obligations and requirements for professional standards review as outlined in P. L. 92-603. Our state organization - the Texas Institute for Medical Assessment - which qualifies as a physician sponsored group under the PSRO definition is continuing its work towards the rapid implementation of a statewide system of medical care review, evaluation, and education. TIMA will submit a plan to the Secretary of DHEW and request designation as a provisional PSRO for the State of Texas.

DHEW GUIDELINES FOR AREA DESIGNATION

1. PSRO areas shall not cross state lines.

A single state area designation is in conformity with this requirement.

2. In general, PSRO areas should not divide a county.

Designation of the state boundary would meet this stipulation. Proposed local review units under the single state area designation would recognize this qualification.

3. Existing boundaries of current local medical review organizations should be considered.

Designation of the state as a single PSRO area would allow full use of all existing review systems and organizations. All medical review in Texas is organized on a state-regional-local basis. Each professional organization has different subdivisions for its peer review process. The single state area designation - and single statewide PSRO - would allow coordination of the peer review efforts by multiple groups while preserving the internal flexibility to have multiple systems of subregions contributing to professional standards review.

4. A PSRO area would, to the extent possible, coincide with a medical service area and insure broad, diverse representation of all medical specialties.

Recognition must be given to the differences in the types of review in different institutional settings. Hospital utilization review is dependent on utilization review committees composed of the medical staff and acting on a day-to-day basis. Local review units under a single statewide PSRO would have to meet frequently to assess the performance of the individual institutions. Nursing home review, however, requires less frequent medical audit because of the chronicity of the illness and the longevity of the stay. Further, each institutional

setting has different medical service areas. TIMA, representing the licensed physicians of Texas, believes that each must have a separate system and different regions for the review mandated under PSRO.

a. Hospitals:

Distribution of physicians, facilities, beneficiaries, and population centers was considered as well as the factors of time and distance. Approximately 38 local review unit areas have been determined by TIMA as being geographically contiguous with central population centers and sufficient numbers of beneficiaries, beds, and physicians for valid review. These multiple small local review units would provide local determination of the effectiveness of the hospital utilization review committee and utilize local variations of the state norms. Each unit would report to the single state PSRO which would retain the ultimate evaluation and review authority.

Maps of these units have been prepared; however, before final decision regarding the validity of the boundaries of the local review unit divisions, each locality would be requested to contribute knowledge of local physicians, hospital and beneficiary practices.

The number of local review units and the boundaries of each would remain flexible within the single state area designation - and single state PSRO - and would be able to respond rapidly to experience and/or change in condition. The final geographic subunit of the single state PSRO will reflect more accurately medical practice in service areas than any of the existing governmental subdivisions developed for other purposes.

b. Nursing homes:

The State Department of Welfare (DPW) currently operates a system of medical review teams for nursing home review under the Medical Assistance Program. This sytem is divided into 11 regions. While not applicable to hospital utilization review because of differences in the types and distribution of patients and facilities as well as the geographic distances to be traveled, the program has worked well, and, with the internal flexibility of a single PSRO determination, would permit use of this program under the state organization.

5. A PRSO area should generally have a minimum of approximately 300 licensed practicing physicians. While the maximum can be expected to vary with local circumstances, it should not exceed 2500 licensed practicing physicians.

The total of 12,944 licensed practicing physicians exceeds the arbitrary limit of 2500 established as the guideline. TIMA, however, would qualify if the recommendation of the National Professional Standards Review Council is accepted: that . . . "Where the professional association(s) concerned demonstrate a desire and capability of successfully sponsoring a state level PSRO, the option

of an essentially statewide area designation should be considered even though the 2500 physicians general limit is exceeded". Moreover, the subdivision of the single state PSRO into multiple small local review units as the first level of evaluation for professional standards review activity would meet the basic intent of the guidelines and foster local medical care review. Of the proposed subdivision within TIMA, only two would slightly exceed the upper limitations. Finally, we believe that the advantages of the economy, efficiency, uniformity, and flexibility of a single statewide PSRO as well as the support of physicians far outweigh the artificial numerical limits imposed under Guideline 5.

6. The designation of a PSRO area should take into account the need to allow effective coordination with the Medicare/Medicaid fiscal agent.

Blue Cross-Blue Shield of Texas is the fiscal agent for both Medicare and Medicaid and operates on a statewide basis. While taking no position at the first regional hearing regarding area designation, Blue Cross-Blue Shield has assigned the medical director and vice president for medical affairs to the Steering Committee of TIMA to establish a close working relationship.

DHEW PROPOSED AREA DESIGNATIONS

The medical assistance districts, the Texas State Department of Health regions and the Texas Planning Regions were developed for purposes other than institutional utilization review. As pointed out earlier in this testimony, the physicians of Texas believe there must be separation of hospital from nursing home review as well as retention of the flexibility permitted within a single statewide PSRO area to use any and all qualified existing systems regardless of the geographic organization. If professional standards review is to be implemented successfully, the organizational format must recognize and conserve the physicians' time and be adaptable to local conditions.

The drawing of lines on a map to create comparable numbers of beds and physicians ignores the concentration of beneficiaries as well as the time and distance factors which are fundamental considerations if physician participation is to be secured.

None of the proposed area designation alternatives meet the requirements of the licensed physicians of Texas for an effective, economical, uniform, non-duplicative single system supported by TIMA.

CONCLUSION

1. The licensed physicians of Texas formally resubmit their request for designation of the State of Texas as a single PSRO area.

2. The licensed physicians of Texas have developed a qualified, physician sponsored group - the Texas Institute for Medical Assessment - to support rapid implementation of professional standards review within the State.

3. The licensed physicians of Texas - with the full support of medical schools, hospitals, nursing homes, state agencies, fiscal intermediary, and the professional organizations of the providers - intend to meet fully any and all obligations under the law through the implementation of a single state PSRO under the Texas Institute for Medical Assessment.

ATTACHMENT #3

ANALYSIS OF FACTORS CONSIDERED IN
DESIGNATION OF PSRO AREAS

Publication of area designations in the Federal Register contained the following statements regarding factors considered in determination of the geographic boundaries:

"DESIGNATION OF PSRO AREAS

The initial statutory responsibility of the Secretary of the Department of Health, Education and Welfare for the establishment of Professional Standards Review Organizations (PSROs) is to designate tentative PSRO service areas by January 1, 1974. By way of background, this document provides a summary of the legislative history relevant to the question of area designations, an explanation of the area designation guidelines utilized by the Department in developing the specific designations, and a description of the consultation processes undertaken to assist in the formulation of recommendations.

A. Guidelines for Designation of Areas

Based on the legislative history and intent the following area designation guidelines were developed and issued by the Department as part of a general Department policy statement on area designation:

1. PSRO areas should not cross State lines.

2. In general, a PSRO area should not divide a county.

3. Existing boundaries of current medical review organizations should be considered.

4. A PSRO should, to the extent possible, coincide with a medical service area and assure broad, diverse representation of all medical specialties.

5. A PSRO area should generally include a minimum of approximately 300 licensed, practicing physicians. While the maximum can be expected to vary with local circumstances, generally it should not exceed 2,500 licensed, practicing physicians.

6. The designation of a PSRO area should take into account the need to allow effective coordination with Medicare/ Medicaid fiscal agents.

These guidelines have resulted in the Department proposing local and statewide PSROs. They reflect adherence to the provisions of the law and to the intent of Congress as embodied in the Report

of the Senate Committee on Finance, which states that 'peer review should be performed at the local level' . . . and . . . 'priority in designation as a PSRO would be given to organizations established at the local level.' Although the statute does not address itself specifically to the appropriate size or physician population of a PSRO area, the statute and the committee report taken together give support guidance. The committee report states that, '. . . in smaller or more sparsely populated States, the designations would probably be on a statewide basis. Each area, defined in geographic and medical service area terms, would generally include a minimum of 300 practicing physicians --in most cases substantially more than that number. Because of the minimum number of physicians required--intended to assure broad, diverse, and objective representation--it is expected that there will be many multicounty PSRO areas."

COMPARISON, EIGHT PSRO AREA DESIGNATIONS PROPOSED BY OPSR AND SINGLE STATE PSRO AREA DESIGNATION PROPOSED BY TIMA. IN RELATION TO PUBLISHED DHEW GUIDELINES FOR AREA DESIGNATION.

GUIDELINES	1	2	3	4	5	6
1. PROPOSED OPSR REGIONS (8)	+	+	-1	-2	+	-3
2. PROPOSED TIMA REGION (1)	+	+	+	+4	-5	+6

1. BOUNDARIES DO NOT CONFORM TO EXISTING MEDICAL REVIEW ORGANIZATIONS

2. BOUNDARIES DO NOT COINCIDE WITH MEDICAL SERVICE AREAS IN STATE

3. BOUNDARIES ARE NOT CONSISTENT WITH SINGLE STATEWIDE INTERMEDIARY (BLUE CROSS-BLUE SHIELD) IN TEXAS

4. LOCAL REVIEW UNITS ESTABLISHED UNDER SINGLE PSRO IN PHYSICIAN AND HOSPITAL DETERMINED RECOGNIZED MEDICAL SERVICE AND REFERRAL AREAS THROUGHOUT THE STATE

5. TOTAL PHYSICIAN POPULATION EXCEEDS GUIDELINES: LOCAL REVIEW UNITS UNDER SINGLE PSRO RECOGNIZE GEOGRAPHIC LIMITATIONS AND MAY BE UNDER, EQUAL TO, OR EXCEED THE NUMERICAL GUIDELINES

6. SINGLE AREA DESIGNATION CONSISTENT WITH STATEWIDE FUNCTION OF INTERMEDIARY IN TEXAS

Analysis of Factors Considered in
Designation of PSRO Areas

"8. Consultation with Medical Organizations

The committee report prescribes that tentative PSRO area designations be made following 'consultation with national, State and local, public and private medical care organizations, and medical societies.' Preparatory to holding these consultations, considerable work was done, both centrally and in the regional offices, to collect, tabulate, and evaluate information relevant to PSRO area designation. A package entitled, Consultation Materials for Designation of Areas, containing appropriate background information on the law and guidelines and describing various districting precedents and possibilities, was prepared for each State and given wide distribution. The DHEW Regional Offices conducted open consultation meetings in each State (with the exception of a few States where the very sparse physician population made statewide area designation the only feasible alternative), prepared detailed reports on the conduct and results of these meetings and submitted their recommendations to the Office of Professional Standards Review.

In cases where there was no clear indication of consensus or where the consensus indicated an alternative substantially at variance with the area designation guidelines, further formal and informal discussions were conducted.

The Notice of Proposed Rule Making will open the final phase of the consultation process. The publication of this notice will provide interested organizations and individuals with a comprehensive statement of the Department's policy and proposed designations, and will serve as a mechanism by which comments can be made."

Testimony in support of a single area designation was presented by TIMA at the two hearings held in Texas on August 24 and October 18. (See attached copies for details.) This position had the unanimous endorsement of organizations representing all segments of the delivery system: Texas Medical Association (including county medical societies representing 75% of practicing physicians, and medical specialty societies), Texas Osteopathic Medical Association (including 15 districts), Texas Hospital Association, Texas Osteopathic Hospital Association, medical schools (D.O. and M.D.), Texas Nursing Home Association, Texas Podiatric Association, Texas Pharmaceutical Association, Texas Nurses Association, Texas Association of Homes for the Aging; state agencies: Texas State Department of Health and Office of Comprehensive Health Planning; and the intermediary for Medicare and Medicaid (Blue Cross-Blue Shield of Texas).

The facts presented in the testimony documented the need for a single state PSRO area designation for Texas to insure an orderly, rapid, uniform implementation of professional standards review within a flexible statewide system.

Analysis of Factors Considered in
Designation of PSRO Areas

The unanimous support of the medical organizations of the state for a single state PSRO area designation at both hearings was rejected as were the recommendations of the Hearing Officer and the DHEW Regional Office for acceptance of the plan proposed by TIMA following the initial consultation.

TIMA followed up the consultation process with a seven point statement intended to bridge the differences between the OPSR proposal and TIMA plan while recognizing the legitimate concerns of each. This was rejected without comment.

"C. Designation of Metropolitan Areas

Designation of appropriate PSRO areas for a major metropolitan area of the country raises problems of extraordinary complexity. High physician density within a relatively small geographic compass makes the application of our general guideline on physician population impractical. Similarly, the distribution of Medicare and Medicaid beneficiaries and significantly varying patterns of care from one locale to another within the major metropolitan centers present districting problems which cannot be resolved through the rigid application of the general guidelines employed elsewhere. After considerable discussion with the medical groups representing the major metropolitan areas, we have adopted a special policy for designating these areas which has met with the approval of the medical community. Under this approach, major metropolitan areas, despite the density of the physician and institutional population, have been designated as single PSRO areas with the proviso that the PSRO for the area will establish a DHEW-approved subdistricting pattern under which the review activities would be carried on by the local physician in each subdistrict."

No recognition is given to this important factor or to the differences in urban and rural practices in the OPSR proposal for eight regions.

The TIMA plan for local review units under a single statewide PSRO employs the "subdistricting pattern" noted above and has identified four metropolitan counties as single units: Tarrant, Dallas, Harris and Bexar.

"D. Relationship to CHP and other Districting Precedents

One difficulty encountered in establishing appropriate PSRO areas within a State is the variance between existing State subdistricting patterns, such as CHP 'B' agency boundaries, Statewide Planning and Development areas, and State Medical Society districts. Since all of these districting precedents have some validity, it was necessary in each case to evaluate the differences and attempt to

reconcile them in such a way as to minimize the discrepancies. In many cases the divergences were such as to preclude reconciliation and it became necessary to depart from one or another of the existing lines."

The OPSR proposal for eight regions does not recognize any existing government or organizational districting precedents.

The TIMA plan for a single statewide PSRO conforms to existing medical organizational, medical review and medical practice areas and, with few modifications, can be adapted to existing health planning and health department district for purposes of comparative data.

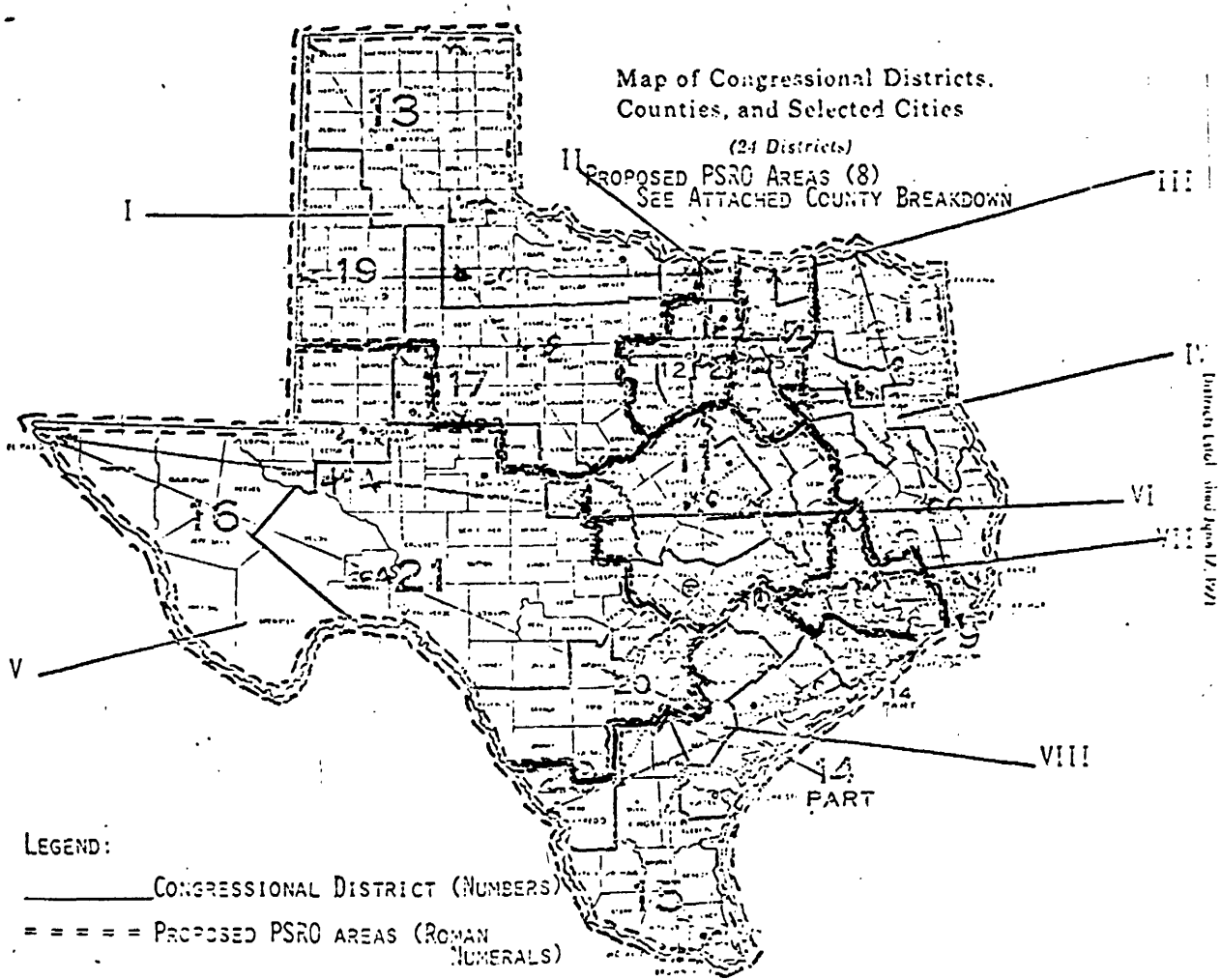
ATTACHMENT #4

ANALYSIS OF RECOGNIZED MEDICAL SERVICE AREAS AND DISTANCES WITHIN EIGHT PROPOSED DHLW AREA DESIGNATIONS

MEDICAL SERVICE AREAS	DISTANCES
REGION I	
1. AMARILLO	NS . 258 MILES
2. LUBBOCK	EW . 309 MILES
3. ABILENE	DIAGONAL 428 MILES
4. WICHITA FALLS	CENTRAL ± 200 MILES
REGION II	
1. FORT WORTH	NS . 128 MILES
2. DENTON	EW . 90 MILES
	DIAGONAL 154 MILES
	CENTRAL ± 78 MILES
REGION III	
1. SHERMAN/DENISON	NS . 135 MILES
2. McKINNEY	EW . 52 MILES
3. DALLAS	DIAGONAL + 141 MILES
4. GREENVILLE	CENTRAL 52 - 78 MILES
5. CORSICANA	
REGION IV	
1. PARIS	NS . 300 MILES
2. TEXARKANA	EW ± 116 MILES
3. TYLER	DIAGONAL 310 MILES
4. LONGVIEW .	CENTRAL 52 - 154 MILES
5. KILGORE	
6. MARSHALL	
7. PALESTINE	
8. NACOGDOCHES	
9. LUFKIN	
10. BEAUMONT	
11. PORT ARTHUR	
REGION V	
1. EL PASO	NS . 310 MILES
2. MIDLAND/ODESSA	EW . 484 MILES
3. BIG SPRING	DIAGONAL ± 668 MILES
4. SAN ANGELO	CENTRAL 154 - 284 MILES
5. SAN ANTONIO	
REGION VI	
1. WACO	NS . 180 MILES
2. TEMPLE	EW . 180 MILES
3. AUSTIN	DIAGONAL 180 MILES
4. BRYAN	CENTRAL ± 100 MILES

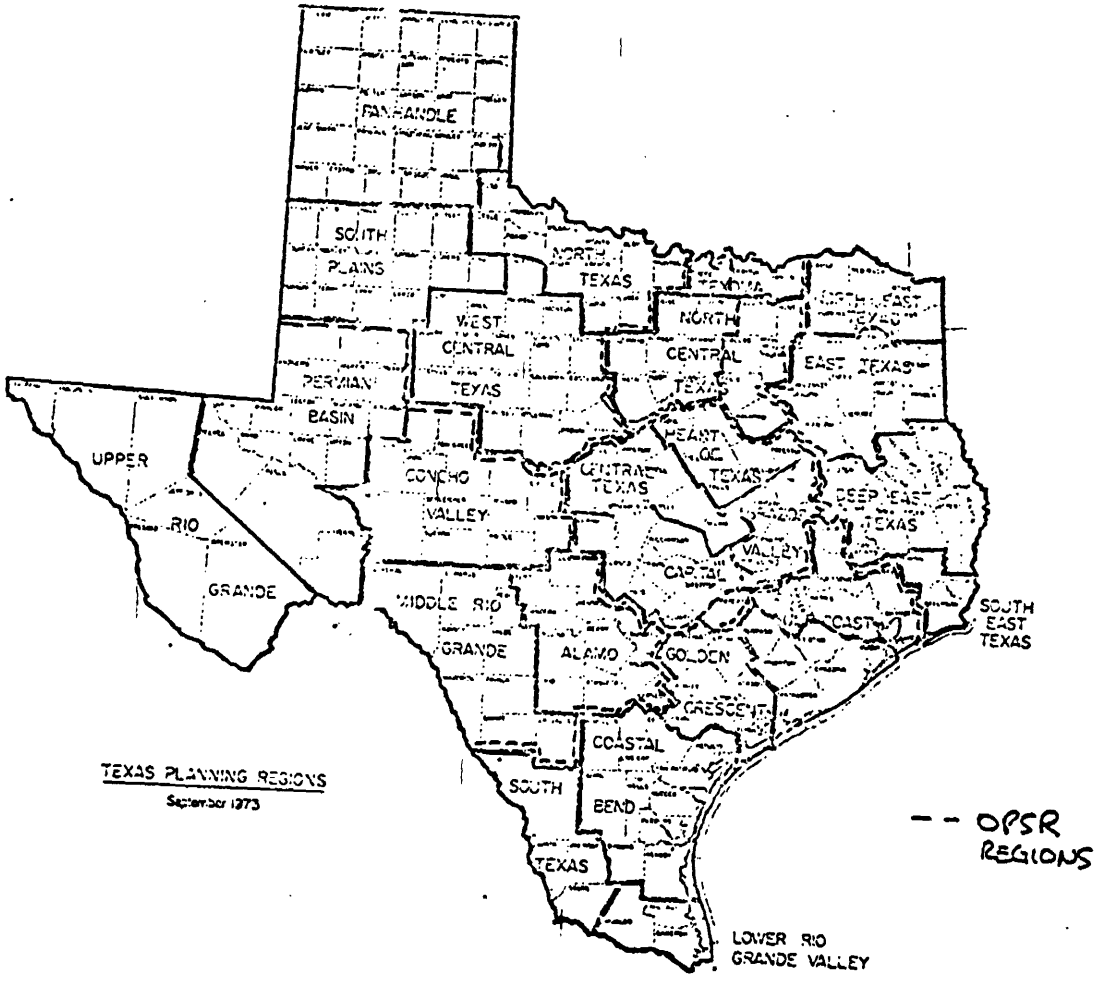
Analysis of Recognized Medical Service Areas and Distances
Within Eight Proposed DHEW Area Designations

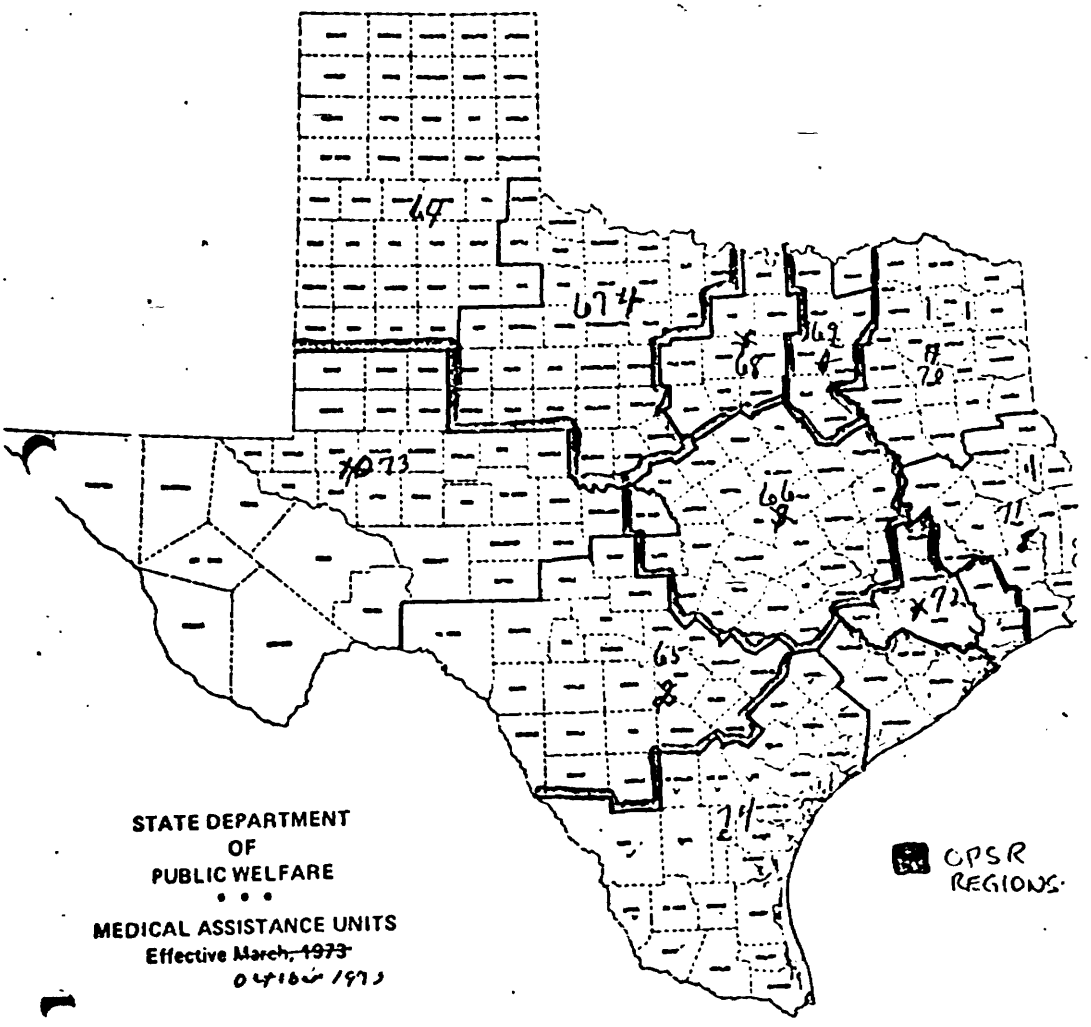
MEDICAL SERVICE AREAS	DISTANCES
REGION VII	
1. HUNTSVILLE	NS . 130 MILES
2. BAYTOWN	EW . 130 MILES
3. HOUSTON	DIAGONAL 80 - 130 MILES
	CENTRAL ± 80 MILES
REGION VIII	
1. WHARTON	NS . 310 MILES
2. VICTORIA	EW . 310 MILES
3. GALVESTON	DIAGONAL 310 MILES
4. CORPUS CHRISTI	CENTRAL 180 MILES
5. HARLINGEN	
6. BROWNSVILLE	
7. McALLEN	
8. LAREDO	


Map of Congressional Districts, Counties, and Selected Cities
(24 Districts)
PROPOSED PSRO AREAS (8)
SEE ATTACHED COUNTY BREAKDOWN
I
II
III
IV
V
VI
VII
VIII
13
19
17
12
6
21
14
PART
LEGEND:
CONGRESSIONAL DISTRICT (NUMBERS)
= = = = = PROPOSED PSRO AREAS (ROMAN NUMERALS)

ANALYSIS OF
PROPOSED AREA DESIGNATIONS FOR TEXAS

REGION I	.	COMBINATION OF 4 PLANNING REGIONS: PANHANDLE, SOUTH PLAINS, WEST CENTRAL TEXAS, NORTH TEXAS
	.	COMBINATION OF 2 DPW REGIONS
REGIONS II & III	.	COMBINATION OF 2 PLANNING REGIONS: CENTRAL TEXAS DIVIDED NS RATHER THAN EW
	.	EACH IS DPW REGION (EXCEPT 1 COUNTY)
REGION IV	.	COMBINATION OF 4 PLANNING REGIONS: NORTHEAST TEXAS, EAST TEXAS, DEEP EAST TEXAS, SOUTHEAST TEXAS
	.	COMBINATION OF 1½ DPW REGIONS
REGION V	.	COMBINATION OF 5 PLANNING REGIONS: UPPER RIO GRANDE, PERMIAN BASIN, MIDDLE RIO GRANDE, CONCHO VALLEY, ALAMO
	.	COMBINATION OF 2 DPW REGIONS
REGION VI	.	COMBINATION OF 4 PLANNING REGIONS: HEART OF TEXAS, BRAZOS VALLEY, CENTRAL TEXAS, CAPITAL (PLUS 1 COUNTY AND MINUS 1 COUNTY)
	.	SINGLE DPW REGION
REGION VII	.	UPPER ½ OF GULF COAST
	.	SINGLE DPW REGION (- TWO COUNTIES)
REGION VIII	.	COMBINATION OF 4¼ PLANNING REGIONS: LOWER ½ GULF COAST, GOLDEN CRESCENT, COASTAL BEND, SOUTH TEXAS, LOWER RIO GRANDE VALLEY
	.	COMBINATION OF 1½ DPW REGIONS


PANHANDLE
SOUTH PLAINS
NORTH TEXAS
WEST CENTRAL TEXAS
NORTH CENTRAL TEXAS
EAST TEXAS
PERMIAN BASIN
UPPER RIO GRANDE
CONCHO VALLEY
CENTRAL TEXAS
HEART OF TEXAS
DEEP EAST TEXAS
MIDDLE RIO GRANDE
ALAMO
GOLDEN CRESCENT
SOUTH EAST TEXAS
COASTAL BEND
SOUTH TEXAS
LOWER RIO GRANDE VALLEY
TEXAS PLANNING REGIONS
September 1973
-- OPSR REGIONS


STATE DEPARTMENT
OF
PUBLIC WELFARE
• • •
MEDICAL ASSISTANCE UNITS
Effective ~~March, 1973~~
October 1973
OPSR
REGIONS

ATTACHMENT #6

COMPARISON OF TIMA & OPSR PROPOSALS

TIMA PROPOSAL:

1. SINGLE ORGANIZATION OF PROVIDERS TO BE THE PSRO FOR TEXAS WITH THE FOLLOWING FUNCTIONS:
   - COORDINATION
   - ASSISTANCE
   - STIMULATION OF LOCAL REVIEW UNIT DEVELOPMENT
   - CENTRALIZED UNIFORM DATA SYSTEM
   - ADMINISTRATIVE SUPPORT
   - EDUCATION
   - EVALUATION OF METHOD & PROCESS OF REVIEW & PERFORMANCE OF LOCAL REVIEW UNITS
   - ARBITRATION
   - PLANNING
   - RESEARCH
   - CERTIFICATION OF DUE CARE
2. SINGLE AREA DESIGNATION FOR STATE OF TEXAS. THE SINGLE PSRO WITH THE AUTHORITY TO ESTABLISH LOCAL REVIEW UNIT IN GEOGRAPHIC COMPOSITE AREAS AND TO USE EXISTING QUALIFIED STATEWIDE UTILIZATION REVIEW SYSTEMS AS REQUIRED TO PERFORM PROFESSIONAL STANDARDS REVIEW.
   - SEPARATION OF HOSPITAL & NURSING HOME REVIEW REGIONS & METHOD
   - FUNCTIONS OF LOCAL REVIEW UNITS WITHIN HOSPITAL REGIONS
     - EVALUATION OF HOSPITAL UTILIZATION REVIEW COMMITTEE
     - ASSISTANCE IN UTILIZATION REVIEW PROCESS
     - ARBITRATION

OPSR PROPOSAL:

1. ROLE OF STATEWIDE ORGANIZATIONS: TECHNICAL & PROFESSIONAL ASSISTANCE SUCH AS
   - ADVICE AND ASSISTANCE IN THE DEVELOPMENT AND EVALUATION OF MEDICAL CARE CRITERIA AND PROFESSIONAL NORMS
   - ADVICE ON THE DEVELOPMENT, IMPLEMENTATION AND EVALUATION OF PEER REVIEW METHODS
   - ADVICE AND ASSISTANCE IN ESTABLISHING THE PSRO'S ORGANIZATIONAL STRUCTURE: e.g., DESIGNING BYLAWS, WRITTEN MEMBERSHIP POLICIES, METHODS FOR INVOLVING PHYSICIANS IN THE PSRO'S REVIEW ACTIVITIES, ACCOUNTING SYSTEMS, REPORTS MANAGEMENT SYSTEMS, ETC.
   - ASSISTANCE IN DESIGNING AND IMPLEMENTING PROFESSIONAL EDUCATIONAL ACTIVITIES TO BE PERFORMED BY PSROS
   - CONSULTATION AND ADVICE ON THE ORGANIZATIONAL AND MANAGEMENT ASPECTS OF PSRO OPERATIONS
   - OTHER TYPES OF SERVICES MUTUALLY AGREED UPON
2. DIVIDE STATE INTO MULTIPLE AREAS, EACH TO BE UNDER DIRECT CONTRACT WITH DHEW WITH FUNCTIONS AS FOLLOWS:
   - EVALUATION OF INSTITUTIONAL UTILIZATION REVIEW COMMITTEE PERFORMANCE
   - REPLACEMENT FOR UTILIZATION REVIEW COMMITTEE IF NOT FUNCTIONING
   - CERTIFICATION OF DUE PROCESS TO INTERMEDIARY

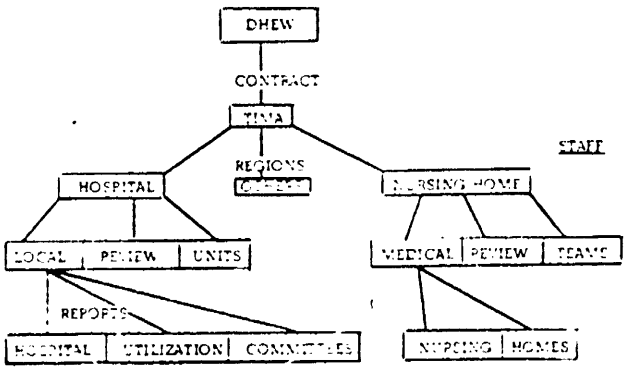
TINA PROPOSAL

- EDUCATION IN METHOD & PROCESS OF REVIEW
- REFINEMENT OF "NORMS"
- DATA COLLECTION FOR REGION
- REPLACEMENT OF U.R. COMMITTEE IF NON-FUNCTIONING

FUNCTIONS OF NURSING HOME REGIONS

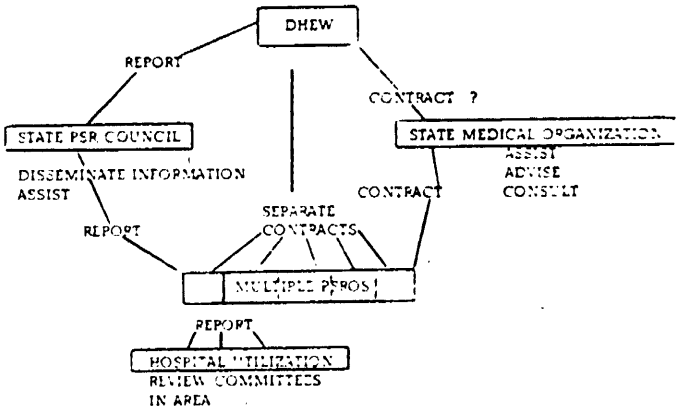
- EVALUATION OF NURSING HOMES
- DATA COLLECTION FOR REGION

DIAGRAMATICALLY, THE ORGANIZATIONAL LEVELS WOULD BE:



OPSR PROPOSAL

DIAGRAMATICALLY, THE ORGANIZATIONAL LEVELS WOULD BE:



DIFFERENCES BETWEEN

TIMA

- SINGLE AREA DESIGNATION
- SINGLE CONTRACT
- SINGLE ADMINISTRATIVE UNIT
- NO STATE PSR COUNCIL
- SINGLE AREA DESIGNATION WITH MULTIPLE FLEXIBLE REGIONS FOR DIFFERENT TYPES OF REVIEW

OPSR

- MULTIPLE AREA DESIGNATIONS
- MULTIPLE CONTRACTS
- MULTIPLE ADMINISTRATIVE UNITS
- STATE PSR COUNCIL TO ASSIST SECRETARY, DISSEMINATE INFORMATION, AND AID IN SECURING PSRO REPLACEMENT
- ALL REVIEW WITHIN PSRO AREA MUST CONFORM TO AREA DESIGNATION
- STATE MEDICAL ORGANIZATION TO ASSIST, CONSULT, AND ADVICE PSROS

POINTS OF COMMON AGREEMENT

- LEVELS OF REVIEW (HOSPITAL UTILIZATION REVIEW COMMITTEE, LOCAL REVIEW UNIT OR PSRO, & STATE SUPPORT SYSTEM)
- FUNCTIONS AT EACH LEVEL (EXCEPT CERTIFICATION OF "DUE CARE")

MAJOR POINTS OF CONTENTION

- DETERMINATION OF PRIME CONTRACTOR
- AREA DESIGNATION
- LEVEL AT WHICH CERTIFICATION OF DUE PROCESS IS MADE

COMPARISON OF TIMA & OPSR

TIMA	OPSR
1. ECONOMY & EFFICIENCY	
. SINGLE ORGANIZATION WITH TOP-DOWN STRUCTURE, CLEAR LINE OF AUTHORITY & RESPONSIBILITY	. MULTIPLE INDEPENDENT PSROS (UNDER DIRECT CONTRACT WITH OPSR) WITH SEPARATE MULTIPLE STAFFING REQUIRED FOR EACH
. GEOGRAPHICALLY SMALL LOCAL REVIEW AREAS	. APTIFICIAL AREA DESIGNATIONS BASED UPON GOVERNMENTAL REGIONS CREATED FOR OTHER PURPOSES
- REDUCED TRAVEL TIME & DISTANCE WHICH AFFECTS POSITIVELY FREQUENCY OF MEETINGS ONSITE VISITS, IF REQUIRED	- LARGE GEOGRAPHIC AREAS WHICH WILL AFFECT ADVERSELY FREQUENCY OF MEETINGS OF PSRO ONSITE VISITS
- MINIMAL STAFFING FROM THE CENTRAL CORE STAFF REQUIRED FOR MEETINGS, NO FULLTIME LOCAL REVIEW UNIT STAFFING	- REDUPLICATION OF STAFFING IN EACH PSRO
- LOCAL DETERMINATION OF MEDICAL NECESSITY APPROPRIATENESS & QUALITY OF CARE BY HOSPITAL UTILIZATION REVIEW COMMITTEES UNDER REVIEW IN GEOGRAPHIC LOCALITY BY REVIEW UNITS OF STATEWIDE SINGLE PSRO	- "LOCAL" DETERMINATION OF MEDICAL NECESSITY, APPROPRIATENESS & QUALITY OF CARE BY LARGE GEOGRAPHICAL AREAS CONTAINING MULTIPLE INTERNAL MEDICAL SERVICE AREAS, BUT NOT TRUE "LOCAL" REVIEW OF PERFORMANCE
. SINGLE MASTER CONTRACT WITH DELINEATED AUTHORITY AND RESPONSIBILITY	. MULTIPLE CONTRACTS, WITH EACH PSRO & WITH CENTRAL SUPPORT SYSTEM
. SINGLE ONSITE DHEW STAFFING	. MULTIPLE ONSITE DHEW STAFFING

TIMA	QPSR
. USE OF QUALIFIED EXISTING STATEWIDE & REGIONAL REVIEW SYSTEMS (e.g.: DPW NURSING HOME REVIEW) WITHOUT NEED FOR REDUPLICATION OR REORGANIZATION	. DISREGARD FOR & DISRUPTION OF EXISTING STATE-WIDE & REGIONAL REVIEW SYSTEMS AS ALL ARE ORGANIZED ON STATE - REGIONAL - LOCAL BASIS WITHOUT RELATION TO PROPOSED AREAS/GOVERN-MENTAL REGIONS
. EMPLOYMENT OF UNIFORM METHOD & PROCESS OF PROFESSIONAL STANDARDS BY ALL LOCAL REVIEW UNITS	. MULTIPLE METHODS & PROCESS OF REVIEW AS DETERMINED BY EACH PSRO
. USE OF STATEWIDE & REGIONAL EDUCATIONAL SYSTEMS FOR IMPROVEMENT IN UTILIZATION REVIEW & MEDICAL CARE	. INABILITY TO UTILIZE EFFECTIVELY EXISTING STATE-WIDE & REGIONAL EDUCATIONAL SYSTEMS DUE TO LACK OF CONFORMITY WITH EXISTING STATE - REGIONAL - LOCAL ORGANIZATIONAL STRUCTURE OF MEDICAL SCHOOLS & PROFESSIONAL ORGANIZATIONS
. USE OF EXISTING STATEWIDE DATA SYSTEMS	. NEED FOR MULTIPLE DATA PROCESSING SYSTEMS TO SUPPORT EACH PSRO
. MINIMAL REASONABLE COST DUE TO: (1) SMALL CENTRAL CORE STAFF (2) USE OF EXISTING QUALIFIED REVIEW MECHANISMS (3) SMALL GEOGRAPHICALLY CONTIGUOUS REVIEW UNITS TO REDUCE TIME & DISTANCE FACTORS (4) BUILTIN SUPPORT SYSTEM	. INCREASED REASONABLE COSTS DUE TO: (1) MULTIPLE STAFFING REQUIREMENTS (2) NEED TO DEVELOP NEW REVIEW SYSTEMS (3) LARGE GEOGRAPHIC AREAS WITH INCREASED TIME & DISTANCE (4) NEED TO DEVELOP SEPARATE CENTRAL SUPPORT & ASSISTANCE SYSTEM TO HAVE MULTIPLE REDUPLICATION SYSTEMS (5) SUPPORT COST OF BOTH STATE PSR COUNCIL AND STATE MEDICAL ORGANIZATION TO ASSIST PROGRAM
2. COORDINATION	
. PROFESSIONAL STANDARDS OF REVIEW DEVELOPED BY MEDICAL SPECIALTY SOCIETIES WITH LOCAL VARIATIONS	. MULTIPLE PROFESSIONAL STANDARDS FOR USE IN REVIEW WITH NO STATEWIDE MEDICAL SPECIALTY & NO LOCAL VARIATIONS BY MEDICAL SERVICE AREAS WITHIN EACH PSRO

TIMA	OPSR
. INTEGRATION OF QUALIFIED STATEWIDE REGIONAL REVIEW SYSTEMS	. NO INTEGRATION OF EXISTING STATEWIDE & REGIONAL REVIEW SYSTEMS POSSIBLE AS PROPOSED PSRO AREAS BEAR NO RELATION TO UTILIZATION REVIEW
. STATEWIDE EDUCATIONAL EFFORTS IN PROCESS OF REVIEW & IMPROVEMENT IN MEDICAL CARE BY STATE PROFESSIONAL ORGANIZATION BASED ON LOCAL REVIEW UNIT FINDINGS	. DIFFICULTY IN COORDINATION WITH STATEWIDE & REGIONAL EFFORTS DUE TO LACK OF RELATIONSHIP OF PROPOSED PSRO AREAS TO INSTITUTIONAL MEDICAL SERVICE & UTILIZATION REVIEW AREAS
. APPEALS & ARBITRATION FROM LOCAL REVIEW UNITS TO SINGLE STATE PSRO	. APPEALS & ARBITRATION HANDLED THROUGH STATE PSR COUNCIL
COMMON DATA SET & REPORT MECHANISM	. COMMON DATA SET & REPORTING MECHANISM POSSIBLE THROUGH STATE PSR COUNCIL
. INTERNAL FLEXIBILITY TO CHANGE FOR STATEWIDE PROBLEM SOLVING	. MULTIPLE INDEPENDENT PSROS ANSWERABLE TO DHEW
3. ASSISTANCE	
. STIMULATION OF DEVELOPMENT OF PROFESSIONAL STANDARDS REVIEW BY LOCAL REVIEW UNITS	. NO PROVISION FOR STIMULATION OF PHYSICIAN SPONSORED GROUP WITHIN ARTIFICIAL AREA DESIGNATION: TECHNICAL ASSISTANCE BY DHEW
REFINEMENT OF AND IMPROVEMENT IN THE PROCESS OF REVIEW	. MULTIPLE INDEPENDENT PSROS COORDINATED BY STATE PSR COUNCIL WITHOUT CENTRAL FOCUS FOR STATEWIDE REVIEW OF PROCESS OF REVIEW
. STAFF SUPPORT FROM STATE STAFF OF SINGLE STATE PSRO	. NO PROVISION FOR STAFF SUPPORT FROM STATE PSR COUNCIL
4. IMPLEMENTATION	
. EXISTING QUALIFIED STATEWIDE PHYSICIAN SUPPORTED & SPONSORED GROUP DESIGNED FOR PSRO REQUESTING DESIGNATION AS REGIONAL PSRO	. NO QUALIFIED PHYSICIAN GROUP AVAILABLE IN PROPOSED PSRO AREAS

TIVA	OPSR
. PHYSICIAN LEADERSHIP WILL STIMULATE DEVELOPMENT OF PSRO	. NO LEADERSHIP STIMULI'S AVAILABLE
. LOCAL AS WELL AS STATE PHYSICIAN & HOSPITAL SUPPORT FOR STATEWIDE AREA DESIGNATION & ORGANIZATION & ACCEPTANCE OF STATE ROLE	. NO LOCAL PHYSICIAN OR HOSPITAL SUPPORT FOR MULTIPLE PSRO AREAS
. RECOGNITION & USE OF EXISTING QUALIFIED REVIEW SYSTEMS - e.g., DPW NURSING HOME REVIEW TEAMS	. NO RECOGNITION OF AND PROBABLE INABILITY/ DESIRE NOT TO USE EXISTING QUALIFIED REVIEW SYSTEMS
. REALISTIC GEOGRAPHICALLY CONTIGUOUS REVIEW AREAS BASED UPON LOCAL PHYSICIAN & HOSPITAL KNOWLEDGE OF MEDICAL PRACTICE AND SUPPORT	. ARTIFICIAL AREA DESIGNATIONS BASED UPON GOVERNMENTAL REGIONS ESTABLISHED FOR OTHER PURPOSES
. STATE ORGANIZATION OF OPERATIONS BY & SUPPORT OF THE INTERMEDIARY	. MULTIPLE AREAS FOR PROCESSING OF PSRO INFORMATION & DECISIONS CREATING NEED FOR MULTIPLE NEW METHODS OF DATA PROCESSING & OPERATION
. INTERNAL FLEXIBILITY TO MEET STATEWIDE PROBLEMS WITH APPROPRIATE CHANGE	. MULTIPLE INDEPENDENT PSRO ANSWERABLE TO DHEW WITHOUT STATEWIDE CAPABILITY TO RESPOND
5. FLEXIBILITY	
. INTERNAL AUTHORITY TO ALTER INTRASTATE LOCAL REVIEW UNIT AREAS IF EXPERIENCE DEMONSTRATES VALID NEED	. BOUNDARIES ESTABLISHED BY REGULATION FOR PSRO AREAS FOR ALL REVIEW FUNCTIONS
. INTERNAL AUTHORITY TO USE OR CHANGE EXISTING STATEWIDE REVIEW SYSTEMS TO MEET OBLIGATIONS OF PSRO	. PROBABLE INABILITY TO USE EXISTING QUALIFIED REVIEW SYSTEMS WITH NO AUTHORITY OVER STATEWIDE SYSTEMS OUTSIDE OF PSRO AREA
. INTERNAL AUTHORITY TO MODIFY METHOD OF STATEWIDE PROFESSIONAL STANDARDS REVIEW FOR VALID INDICATIONS	. MULTIPLE INDEPENDENT PSROS WITH CONTRACTUAL RESPONSIBILITY TO DHEW WITHOUT STATEWIDE CAPABILITY TO MODIFY METHOD

TIMA	OPSR
. INTERNAL CAPABILITY TO EXPAND REVIEW PROCESS TO AMBULATORY CARE ON STATEWIDE BASIS WHEN INDICATED	. MULTIPLE INDEPENDENT PSROS WITHOUT CENTRAL STIMULATION OR CAPABILITY TO BROADEN REVIEW
6. ACCOUNTABILITY	
. SINGLE STATE PSRO LEGALLY & ETHICALLY RESPONSIBLE FOR PROFESSIONAL STANDARDS REVIEW IN TEXAS	. MULTIPLE INDEPENDENT PSROS RESPONSIBLE FOR PROFESSIONAL STANDARDS REVIEW AND TO DHEW
. LOCAL REVIEW UNITS FOR HOSPITAL UTILIZATION REVIEW COMMITTEE EVALUATION AND DPW NURSING HOME REGIONAL MEDICAL REVIEW TEAMS - ALL REVIEW SYSTEMS - RESPONSIBLE TO SINGLE STATE PSRO	. ALL REVIEW WITHIN THE AREAS RESPONSIBLE DESIGNATED TO AND UNDER PSRO WITH COORDINATION OF MULTIPLE PSROS THROUGH STATE PSR COUNCIL BUT RESPONSIBILITY TO DHEW
. AUTHORITY VESTED IN SINGLE STATE PSRO TO EVALUATE PERFORMANCE OF LOCAL REVIEW UNITS FOR HOSPITALS AND OF REGIONAL REVIEW TEAMS FOR NURSING HOMES	. AUTHORITY FOR REVIEW & COMMENT ON PERFORMANCE OF MULTIPLE PSROS BY STATE PSR COUNCIL; DIRECT RESPONSIBILITY OF DHEW FOR EVALUATION
. AUTHORITY VESTED IN SINGLE STATE PSRO TO ACT FOR AND FIND REPLACEMENT FOR NON-PERFORMING LOCAL REVIEW UNIT OR DPW SYSTEM	. STATE PSR COUNCIL ASSISTS IN DEVELOPMENT OF & ARRANGEMENT FOR REPLACEMENT PSRO; AUTHORITY RESIDES WITH DHEW
. SINGLE COST FOR CENTRALIZED ASSISTANCE, SUPPORT, COORDINATIVE AND EVALUATIVE FUNCTION (INCLUDING DATA SYSTEM, MANAGEMENT, STAFF, ETC.)	. REDUPLICATIVE COSTS FOR MULTIPLE SUPPORT SYSTEMS BY MULTIPLE PSROS
. SINGLE COST FOR EACH IDENTIFIABLE STATEWIDE OR REGIONAL REVIEW SYSTEM USED	. DUAL COSTS FOR THE DEVELOPMENT AND OPERATION OF NEW TOTAL SYSTEM WITHIN EACH PSRO
. PROVISIONAL STATUS FOR UP TO 2 YEARS & YEARLY CONTRACTS OF STATE PSRO TO FULFILL OBLIGATIONS OF THE LAW	. SAME

TIMA	OPSR
. REVIEW GUARANTEED TO BE LOCAL: EACH HOSPITAL UTILIZATION REVIEW COMMITTEE REPORTING TO A LOCAL REVIEW UNIT FOR EVALUATION OF PERFORMANCE, THE STATE PSRO SERVING AS SUPERVISOR & EVALUATOR OF THE PERFORMANCE OF EACH LOCAL REVIEW UNIT TO ASSURE ADHERENCE TO LEGAL OBLIGATIONS. EACH NURSING HOME REVIEW BY MEDICAL TEAM WOULD BE WITHIN THE INSTITUTION, THE STATE PSRO SERVING AS ABOVE.	. REVIEW WITHIN ARTIFICIALLY DETERMINED AREAS NOT "LOCAL" IF TERM IS DEFINED BY OPSR AS MEDICAL SERVICE AREAS; FUNCTION OF STATE COUNCIL TO ASSIST IN EVALUATION OF PSRO PERFORMANCE
MISCONCEPTIONS:	
1. THE LAW REQUIRES DETERMINATIONS OF HOSPITAL UTILIZATION REVIEW COMMITTEE TO BE ACCEPTED "IF REVIEW TIMELY & EFFECTIVE." THEREFORE, REVIEW IS PERFORMED WITHIN THE HOSPITAL BY A COMMITTEE OF PHYSICIANS WHO DETERMINE MEDICAL NECESSITY, APPROPRIATENESS AND QUALITY OF CARE; THE FUNCTION OF THE PSRO (OR ITS SUBDIVISIONS) EVALUATE THE EFFECTIVENESS & EFFICIENCY OF THE HOSPITAL UTILIZATION REVIEW COMMITTEE IN MAKING THE LEGALLY IMPOSED DETERMINATIONS.	
. THE SINGLE STATE PSRO WOULD SUBDIVIDE THE STATE INTO LOCAL MEDICAL SERVICE AREAS AFTER CONSULTATION WITH PHYSICIANS & HOSPITALS IN THE LOCALITY AND FORM LOCAL REVIEW UNITS (§38) TO PERMIT LOCAL EVALUATION OF THE PERFORMANCE OF THE HOSPITAL UTILIZATION REVIEW COMMITTEE	. MULTIPLE PSROS BASED UPON ARBITRARILY DETERMINED BOUNDARIES WOULD EVALUATE PERFORMANCE OF EACH HOSPITAL UTILIZATION REVIEW COMMITTEE WITHIN THE AREA AND CERTIFY "DUE CARE"
. THE SINGLE STATE PSRO WOULD SUPERVISE THE OPERATION OF THE LOCAL REVIEW UNITS, EVALUATE EACH UNIT'S CONFORMANCE TO THE OBLIGATIONS OF THE LAW & CERTIFY "DUE CARE" PERFORMANCE FOR THE STATE	. THE MULTIPLE PSROS WOULD REPORT TO THE STATE PSR COUNCIL WHICH WOULD ASSIST IN THE EVALUATION OF THE PERFORMANCE OF PSRO'S PERFORMANCE
2. THE LAW REQUIRES ACCEPTANCE BY PSRO OF THE FINDINGS OF REVIEW COMMITTEES OF OTHER FACILITIES IF TIMELY & EFFECTIVE. 882 NURSING HOMES GENERALLY DO NOT HAVE FUNCTIONING INTERNAL REVIEW COMMITTEES IN TEXAS BUT RELY ON MEDICAL REVIEW TEAMS OF THE MEDICAID PROGRAM	
. THE SINGLE STATESIDE PSRO AREA DESIGNATION COULD UTILIZE THIS ESTABLISHED SYSTEM FOR LOCAL REVIEW WITHIN THE INSTITUTION AND REPORT OF THE RESULTS OF THE EVALUATION TO THE SINGLE STATE PSRO	. MULTIPLE PSROS WOULD BE REQUIRED TO DEVELOP A NEW DUPLICATIVE SYSTEM FOR NURSING HOME REVIEW

TLMA	OPSR
. THE SINGLE STATE PSRO WOULD SUPERVISE, EVALUATE AND CERTIFY THE PERFORMANCE OF THE MEDICAL REVIEW TEAMS	. THE MULTIPLE PSROS WOULD REPORT TO THE STATE PSR COUNCIL WHICH WOULD ASSIST IN THE EVALUATION OF THE PSRO'S PERFORMANCE IN NURSING HOME REVIEW
3. A SINGLE STATE PSRO WILL SUPPRESS LOCAL PHYSICIAN INDEPENDENCE AND COERCE CONFORMITY	
. SINGLE STATE PSRO MEMBERSHIP IS VOLUNTARY, BASED ON LICENSURE	. SAME
. ELECTION OF GOVERNING BOARD BY GENERAL MEMBERSHIP	. SAME
. SINGLE STATE PSRO REVIEW IS LOCAL - WITHIN HOSPITAL UTILIZATION REVIEW COMMITTEE "IF PERFORMING EFFECTIVELY"	. SAME
. SINGLE STATE PSRO LOCAL REVIEW UNIT AREAS WILL BE DETERMINED ONLY AFTER CONSULTATION WITH AND CONCURRENCE OF PHYSICIANS AND HOSPITALS WITHIN THE GEOGRAPHIC LOCALITY;	. PSRO AREA DESIGNATION ARBITRARY WITHOUT LOCAL CONSULTATION; PHYSICIAN RECOMMENDATIONS SUBMITTED TO DHEW AT TWO HEARINGS IGNORED.
. FLEXIBILITY OF STATEWIDE PSRO ASSURES CHANGE AS REQUIRED	NO LEGAL PROVISIONS FOR CHANGE OF AREAS
. EVALUATION OF LOCAL REVIEW UNITS WILL BE ACCEPTED AS LONG AS SINGLE STATE PSRO INDICATES SATISFACTORY PERFORMANCE	. EVALUATION OF MULTIPLE PSRO PERFORMANCE BY DHEW ASSISTED BY STATE PSR COUNCIL

ATTACHMENT #7

PROPOSED SOLUTION TO THE
AREA DESIGNATION CONTROVERSY

Following is a seven point statement recognizing and incorporating the legitimate concerns of the Texas Institute for Medical Assessment (TIMA) and DHEW into a workable program which complies with P.L. 92-603 and the "Guidelines." The designation of Texas as a single PSRO area is essential if effective implementation of Section 249 (f), P.L. 92-603 is intended.

1. Single area designation for the State of Texas.

2. Single master contract with TIMA as the single PSRO for the State of Texas.

3. Recognition in the master contract of the principles of separation into multiple regions depending upon the type of review to be performed and the existence of qualified review systems.

4. Authority contained within the master contract for TIMA to subcontract with:

   A. Local review units for hospitals as determined jointly in conference with area physicians and hospitals with the following stipulations:

      (1) That local review units have authority to perform local evaluation of hospital utilization review committee performance unless such evaluation is ineffective or not timely.

      (2) That state PSRO retains the authority to review and evaluate the performance of local review units.

      (3) That state PSRO may serve as replacement of local review unit until that unit improves performance if determined to be ineffective.

      (4) That state PSRO retains the authority to certify "due care" under Section 213.

   B. Confer with Nursing Home Advisory Committee representatives of TIMA and DPW in subcontracting for nursing home review.

5. Funding of support services and central administrative costs be identified and accounted for separately from local review unit-DPW medical review team costs.

6. Accountability requirements of the Department of Health, Education and Welfare be included in the master contract and subcontract.

7. Appeals and arbitration will occur through the local review unit to the single state PSRO.

REGIONS: Population, M.D.'s, D.O.'s, Hospitals, Hospital Beds, Beneficiaries

Region	Population (12-31-71)	Non-Federal M.D.'s in Patient Care (12-31-71)	D.O.'s (3-15-72)	M.D.'s & D.O.'s	Hospitals (12-1-71)	Hospital Beds (12-1-71)	Beneficiaries	Population/ M.D.'s & D.O.'s	Population/ Beds
I.	1,154,200	890	82	972	88	5,547	166,412	1,187	208
II.	1,012,300	823	139	962	29	3,297	109,544	1,052	307
III.	1,746,800	2,267	229	2,496	50	5,764	202,353	700	303
IV.	1,223,000	969	74	1,043	73	5,641	223,331	1,173	217
V.	1,930,600	1,816	70	1,886	76	7,002	240,729	1,024	276
VI.	1,041,500	952	33	985	55	3,586	163,479	1,057	290
VII.	1,991,700	2,721	120	2,841	47	8,698	189,275	701	229
VIII.	1,465,700	1,380	62	1,442	59	6,148	211,471	1,016	238
STATE	11,565,800	11,818	809	12,627	477	45,683	1,506,594	916	253

ATTACHMENT #9

RESULTS OF POLL OF PHYSICIANS REGARDING
THE PSRO LAW, AREA DESIGNATIONS, AND TIMA

To establish beyond challenge that the Texas Institute for Medical Assessment speaks for the physicians of Texas, a poll ballot was sent to each physician, and within the restricted time frame, the response has been tremendous.

The universe polled was 11,000 physicians in active practice of medicine in Texas. The poll was released to the mail on January 4, 1974. To date, 3770 replies have been received, representing 34% response.

Significantly, 86.3% of the replies support a single PSRO area designation and 89.2% support the TIMA Plan for Texas. 78.5% reject the eight HEW PSRO area designations.

A summary tally of the poll follows:

		Number of Responses	% of Responses
1.	I support a single, statewide PSRO for Texas.	3257	86.3%
2.	I do not support a single, statewide PSRO for Texas.	217	5.7%
3.	I support the TIMA PSRO area designation and program.	3363	89.2%
4.	I do not support the TIMA PSRO area designation and program.	258	6.8%
5.	I support the policy of seeking repeal of the PSRO section of P.L. 92-603.	2885	76.5%
6.	I do not support the policy of seeking repeal of the PSRO section of P.L. 92-603.	326	8.6%

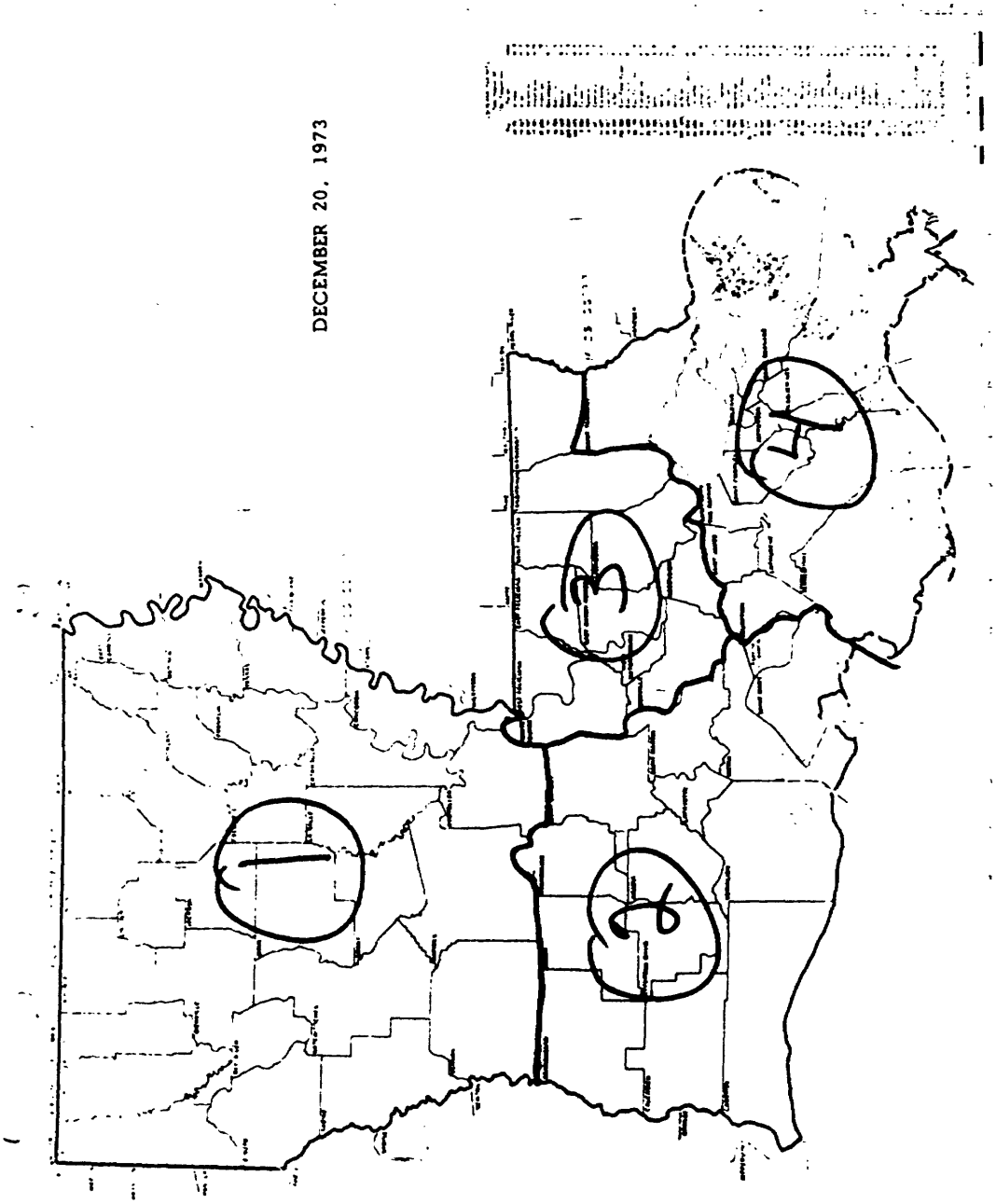
We also call to your attention, as was done in the August and October, 1973, regional area designation meetings in Dallas, that not only is a single PSRO designation and the TIMA Plan fully supported by the individual Texas physician, but also these have the unqualified support of the following listed organizations plus others:

Results of Poll of Physicians Regarding
the PSRO Law, Area Designations, and TIMA

Texas Medical Association
The 113 County Medical Societies of the Texas Medical Association
Medical Specialty Societies
Texas Osteopathic Medical Association
Texas Osteopathic Hospital Association
Texas Hospital Association
Texas Private Hospitals and Clinics Association
Texas Medical Schools
Texas State Department of Health
"A" Agency, Comprehensive Health Planning
Blue Cross-Blue Shield of Texas
Texas Nursing Home Association
Texas Nurses Association
Texas Pharmaceutical Association
Texas Podiatric Association
Texas Association for Homes of the Aging

In fact, a single statewide PSRO has the unanimous support of health professionals, the individuals who understand the patterns and geographical essentials of health care delivery in Texas, and who must provide the services. Yet OPSR has chosen to ignore this informed body of professionals, and substitute therefore impractical and arbitrary designations which violate OPSR guidelines, and multiply administrative problems and costs.

STATE COUNTY OUTLINE MAP



Senator TALMADGE. The next witness is Dr. Hugh Woodward, president of the New Mexico Foundation for Medical Care, accompanied by Mr. Richard Heim, director of Social Services Department, the State of New Mexico, representing the New Mexico Medical Society.

STATEMENT OF HUGH WOODWARD, M.D., PRESIDENT, NEW MEXICO FOUNDATION FOR MEDICAL CARE, AND ARMIN KEIL, PRESIDENT, NEW MEXICO MEDICAL SOCIETY

Dr. WOODWARD. Thank you, Mr. Chairman.

I am Hugh Woodward, president of the New Mexico Foundation for Medical Care, and interim president for the New Mexico Professional Standards Review Organization.

Mr. Heim was not able to join us today. I have with me Dr. Armin Keil, who is a practicing internist in Raton, N. Mex., and is president of the New Mexico association.

I would like to ask Dr. Keil if he would make our initial comments.

Senator TALMADGE. Proceed, Doctor.

STATEMENT OF DR. ARMIN KEIL

Dr. KEIL. Mr. Chairman, Senator Bennett, the New Mexico Foundation for Medical Care was the first organization to implement a statewide professional review system for a Government program. We began medicaid review on September 1, 1971. Even before the foundation, the New Mexico Medical Society had a long tradition of professional review activities. We are proud of this tradition.

We have actively supported the broad concept of PSRO and we have submitted an application for designation as a conditional PSRO in order to continue and expand professional review responsibilities in New Mexico.

Because we support the principle, we would like to make several constructive suggestions for amendments to the law, which we believe would make it more workable and also make it more acceptable.

A broad area of desired change would be amendments to limit the use of PSRO files, minutes, discussions, or decisions to those areas germane to the PSRO. This can be done by amending section 1167 to provide that the written records of PSRO shall not be subject to subpena or discovery proceedings in any civil action; nor should the discussions or deliberations of the PSRO be subject to subpena or discovery proceedings in any civil action.

Knowledge that the deliberations or records relating to the review of a difficult case may become evidence in a civil liability suit is going to needlessly restrict the scope of review as well as the willingness of physicians to actively participate in the review of cases.

Similarly, the PSRO law should be amended to provide protection against the use of norms, criteria, and standards in civil cases. In New Mexico, our clerical guidelines are deliberately designed to pull out a range of cases for physician review. By seeing a range of cases, the physician is truly exercising his medical judgment when he reviews. Our guidelines are very effective for this purpose, but I would hate to try to label them a statement of good medical practice. They are not designed for that purpose, nor should they ever be.

Again dealing with reasonable confidentiality of the review activities of the PSRO's, we feel that that part of section 229 which authorizes the creation of program review teams consisting of physicians, nonphysician professional personnel in the health care field and consumer representatives should be repealed.

Program review teams with nonphysicians involved in reaching conclusions on provision of services substantially in excess of the needs or harmful to a patient or of a grossly inferior quality conflicts with what we see as the intent of PSRO—physician acceptance of the responsibility of review.

Finally, the New Mexico Foundation for Medical Care has received nationwide recognition for its review efforts as one prototype PSRO. The New Mexico Foundation has open membership for physicians and uses physician reviewers who may or may not be members of either the medical society or the osteopathic association. It has improved quality and has contained costs. Parenthetically, because of these results, we have been able to have removed arbitrary restrictions on patient benefits, such as the limit of 30 days hospitalization per year, limiting visits to physicians to 12 visits per year, and limitations on necessary hospital consultations. We have also been able to increase reimbursement to physicians from the 50th percentile of a 1968 base to the 75th percentile of 1970. This has increased physician willingness to cooperate and participate.

It is accomplishing all of the activities the law wants for PSRO. Notwithstanding, the foundation will not qualify as a PSRO because the broad policy of the foundation is established by the medical society house of delegates. The unfortunate result is that the organization that we set up to be a model PSRO—an organization that proved that PSRO's could work—had to be replaced with a new corporation that has a different structure.

We would strongly like to see the law modified to allow us to qualify the foundation and its current structure as a PSRO. This could be done by amending section 1152 to provide that the secretary may, at his discretion, waive the requirement of section 1152(b)1(a)(V).

We will continue to support the concept of peer review and we will do everything possible to make it successful. These suggested amendments would help us to do so.

Thank you.

STATEMENT OF DR. HUGH WOODWARD

Dr. WOODWARD. As Dr. Keil mentioned, the foundation for medical care has been reviewing for medicaid since September 1971. To date we have reviewed almost 1 million claims and had a significant impact on both the quality and the cost of health care for title XIX patients.

In the area of quality, we have greatly reduced, if not eliminated, unnecessary surgery; we have improved drug therapy by supporting the use of oral medication instead of injections; and through a variety of methods of continuing education we have improved the quality of medical practice.

In the area of cost containment, the total cost of review has returned between $3 and $5 of benefit savings for every dollar spent. This in-

cludes an annual savings on nursing homes of 7 percent, or over $400,000, and a reduction of 16.8 percent in hospital days. Very conservatively, the first year savings were in excess of $1.3 million on a $20 million program.

Significantly, by education and concurrent review systems, we have also reduced the number of retroactive denials. Instead of denying for inappropriateness after the fact, we have prevented the inappropriate service from occurring.

This was not accomplished overnight, and was not always easy. We feel that we are fortunate to have most of our growing pains behind us. We feel that we are uniquely equipped to be a PSRO.

We do, however, have a great amount of concern over how the newly developing PSRO program will be administered. After our study of the manual, we have become concerned that the regulations on PSRO may be so directed toward the details of the mechanics of the process that they totally ignore, or even hinder, achieving the goals of quality assurance and cost containment.

In the written testimony, I have discussed several recommendations concerning PSRO recommendations. In addition, there are certain amendments to the law which we have supported. New Mexico was, is and will continue to support the concept of professional review. We want PSRO to work.

We do, however, continue to have concern over the possibility of a lack of flexibility and overcontrol of the program by overregulation. Needless to say, if the administration of the program does go in this direction, in spite of our active support for the concept, we will have difficulty continuing professional review in New Mexico under the PSRO law.

It is my opinion that PSRO, as implemented for medicaid in New Mexico, is an asset to everyone—to the patients, to the providers and institutions, including hospitals, and to the Government. The Government gets a bargain in having the best minds of the medical profession contribute to an organized system of monitoring a huge program. The operation of the PSRO for medicaid in New Mexico has utilized the talents of all segments of the medical community—physicians in solo and partnership practice, in rural and metropolitan practice, group and institutional practice, and the important contributions of the medical school. How else could the Government possibly obtain the participation of this quality and quantity of professional manpower?

The medical profession in turn has profited by being given an area of responsibility and authority in the management of a huge medical care program. The opportunity is welcomed by the New Mexico physicians because we know that the alternative to professional review is a system of regulation by administrative dictation. Assurance of good utilization and appropriate quality results in the best kind of cost containment.

The ultimate benefactor of these joint efforts by a partnership arrangement between the Government and the medical profession is, of course, the people of the country. We wish that everyone will have available a high quality of medical care, when and where it is needed, and at a cost that can be supported. If properly implemented, PSRO can go a long way toward that goal.

Senator TALMADGE. Thank you, gentlemen, for a very excellent statement.

I have only one question.

PAYMENT TO DOCTORS FOR REVIEW WORK

If a doctor does review work, does he do that review work on his own time or is he paid for it?

Dr. WOODWARD. We have a reimbursement of $25 an hour currently. In our proposal, we would plan to increase this to $35 per hour for review activity. All the committee activities are on a voluntary basis.

Senator TALMADGE. Thank you, sir.

Senator Bennett, any questions?

Senator BENNETT. I just wanted to recognize the tremendous leadership that New Mexico has shown over these past few years. I am glad there has been a record made in New Mexico, because I have talked about it all over the United States, and asked the doubting Thomases why they did not go out there to see how it operated.

I hope you can work out the mechanical difficulties that you say disturb you. And if I can help in any way, I will be glad to do it.

Dr. WOODWARD. Senator Bennett, we can trace your travels by identifying where our visitor comes from. We can see you have been there.

Senator TALMADGE. Thank you, gentlemen.

[The prepared statements of Drs. Keil and Woodward follow:]

PREPARED SUMMARIES OF ARMIN KEIL, M.D., PRESIDENT, NEW MEXICO SOCIETY AND HUGH WOODWARD, M.D., PRESIDENT, NEW MEXICO FOUNDATION FOR MEDICAL CARE AND NEW MEXICO PROFESSIONAL STANDARDS REVIEW ORGANIZATION

DR. KEIL

The New Mexico Foundation for Medical Care was the first organization to implement a statewide professional review system for a Government program. New Mexico supports the broad concept of PSRO and seeks to be designated as a conditional PSRO. Constructive suggestions for amendments to the law should include:

Limiting the use of PSRO files, minutes, discussions and decisions so that they are not subject to subpena or discovery proceedings in a civil action.

Providing protection against the use of norms, criteria and standards in civil cases.

Repealing the section of the law authorizing the creation of program review teams of physicians and nonphysicians to reach conclusion on the appropriateness of physician services.

The law should be amended to permit an organization such as the New Mexico Foundation for Medical Care to qualify as a PSRO under the FMC's current structure.

DR. WOODWARD

New Mexico has improved quality, strengthened continuing medical education and contained cost. First year savings were conservatively in excess of $1.3 million on a $20 million program.

New Mexico has concern over the area of over-regulation (such as limiting terms of chair-persons to 2 years, et cetera) and lack of flexibility such as the apparent intent to dictate what types of profiles can be developed and used.

New Mexico is concerned in that the state of the art of computer support to professional review is still in its infancy and no single system should be decided on at this time.

The long delay between signing and implementation of PSRO has hurt New Mexico and will be much more of a problem in other areas. New Mexico urges that the alternative of contracting with groups other than professional associations be delayed from January 1, 1976 until 1978.

New Mexico wants PSRO to work, however if there is a lack of flexibility, or overcontrol of the program by over-regulation, or further lengthy delays, New Mexico will have difficulties implementing PSRO. PSRO can be an asset to everyone—patients, the providers and Government. There is no other way Government could possibly obtain the participation of the quality and quantity of professional manpower that has been active in New Mexico. If properly implemented, PSRO can go a long ways towards the goal of high quality medical care for everyone.

TESTIMONY OF ARMIN KEIL, M.D., PRESIDENT, NEW MEXICO MEDICAL SOCIETY, MAY 9, 1974—WASHINGTON, D.C.

Mr. Chairman, members of the subcommittee, my name is Armin Keil and I am president of the New Mexico Medical Society.

The New Mexico Foundation for Medical Care was the first organization to implement a statewide professional review system for a governmental program. We began medicaid review on September 1, 1971. Even before the foundation, the New Mexico Medical Society had a long tradition of professional review activities. We are proud of this tradition.

We have actively supported the broad concept of PSRO. We have submitted an application for designation as a conditional PSRO in order to continue and to expand professional review responsibilities in New Mexico.

Because we support the principle we would like to make several constructive suggestions for amendments to the law which we believe would make it more workable and also make it more acceptable.

A broad area of desired change would be amendments to limit the uses of PSRO files, minutes, discussions, or decisions to those areas germane to the PSRO. This can be done by amending section 1167 to provide that the written records of PSRO's shall not be subject to subpena or discovery proceedings in any civil action. Nor should the discussions or deliberations of a PSRO be subject to subpena or discovery proceedings in any civil action.

Knowledge that the deliberations or records relating to the review of a difficult case may become evidence in a civil liability suit is going to needlessly restrict the scope of review as well as the willingness of physicians to actively participate in the review of cases.

Similarly, the PSRO law should be amended to provide protection against the use of norms, criteria and standards in civil cases. In New Mexico, our clerical guidelines are deliberately designed to pull out a range of cases for physician review. By seeing a range of cases, the physician is truly exercising his medical judgment when he reviews. Our guidelines are very effective for this purpose, but I would hate to try to label them a "statement of good medical practice." They are not designed for that purpose nor should they ever be.

Again dealing with reasonable confidentiality of the review activities of the PSRO's we feel that that part of section 229 which authorizes the creation of program review teams consisting of physicians, nonphysicians professional personnel in the health care field and consumer representatives should be repealed.

Program review teams with nonphysicians involved in reaching conclusions on provision of services "substantially in excess of the needs" or "harmful" to a patient or "of a grossly inferior quality" conflicts with what we see as the intent of PSRO—physician acceptance of the responsibility of review.

Finally, the New Mexico Foundation for Medical Care has received nationwide recognition for its review efforts as one prototype PSRO. The New Mexico Foundation has open membership for physicians and uses physician reviewers who may or may not be members of either the medical society or the osteopathic association. It has improved quality and has contained costs. It is accomplishing all of the activities the law wants of a PSRO. Notwithstanding, the foundation won't qualify as a PSRO because the broad policy of the Foundation is established by the Medical Society House of Delegates. The unfortunate result is that the organization that we set up to be a model PSRO—an organization that proved that PSRO's could work, had to be replaced with a new corporation that has a different structure. We would strongly like to see the law modified to allow us to qualify the Foundation and its current structure as a PSRO. This could be done by amending Section 1152 to provide that:

". . . except that upon application by an organization that documents support from a majority of licensed doctors of medicine and doctors of osteopathy engaged in the practice of medicine or surgery in such area, the Secretary may, at his discretion, waive the requirement of Section 1152 b 1 a V."

We will continue to support the concept of peer review and we will do everything possible to make it successful. These suggested amendments would help us to do so.

STATEMENT OF HUGH WOODWARD, M.D.

Mr. Chairman, Members of the Subcommittee: My name is Hugh Woodward and I am both President of the New Mexico Foundation for Medical Care and Interim President of the New Mexico Professional Standards Review Organization.

As Doctor Keil mentioned, the Foundation for Medical Care has been reviewing for Medicaid since September 1971. To date we have reviewed almost one million claims and had a significant impact on both the quality and cost of health care for Title XIX patients. In the area of quality, we have: greatly reduced, if not eliminated unncessary surgery; improve drug therapy; and through a variety of methods of continuing education improved the quality of medical practice.

In the area of cost containment, the total cost of review has returned between $3.00 and $5.00 of benefit savings for every dollar spent, including annual savings on nursing homes of 7% or over $400,000 and a reduction of 16.8% in hospital days. Very conservatively, first year savings were in excess of 1.3 million on a 20 million dollar program.

Significantly, by education and concurrent review systems we have also reduced the number of retro-active denials—instead of denying for inappropriateness after the fact, we have prevented the inappropriate service from occurring.

This was not accomplished overnight, and was not always easy. We feel that we are fortunate to have most of our growing pains behind us. We feel that we are uniquely equipped to be a PSRO.

We do, however, have a great amount of concern over how the newly developing PSRO program will be administrated. After our study of the manual, we have become concerned that the regulations on PSRO may be so directed toward the details of the mechanics of the process that they totally ignore, or even hinder, achieving the goals of quality assurance and cost containment.

As an example, the manual has a limit of two consecutive one year terms for nonphysician members of advisory committees. If you happen to have an extremely good advisory committee member, you lose him at the end of two years. These details and many other should be left to the discretion of the PSRO.

Another major concern is the possible lack of flexibility. Part of the manual says, "When the capacity exists to develop them in their area, PSRO's will be required to review practitioners, patient, hospital and diagnoses profiles as the department defines the content of these profiles, the period of time which they will encompass, the mode by which they will be generated, the frequency of analysis and the general nature of the norms, criteria, and the standards to be used, guidelines will be issued to assist PSRO's in organizing and performing profile analysis."

I think one of the best aspects of New Mexico's data support system is the ability to generate a great variety of different types of profiles to assist in different types of review. We do not need to be restricted in the use of our profiles.

While I think New Mexico has an excellent data support system, I am equally confident that somebody, somewhere, is going to develop an even better one. We are very much concerned that the dictation of a single type of profile will mean that PSRO's with a greater amount of data management ability will be forced into mediocrity. Paralleling this concern is a conviction that no single system has all the answers that can be used by all the PSRO's to effectively and efficiently fulfill their review responsibility. Greater flexibility than the regulations describe now is required if PSRO's are to take effective advantage of existing and future data management capabilities.

A major impact on us in New Mexico has been the long delay between the signing of the law and the beginning of the implementation of the law. We are pleased to see actions being taken now. In the last seventeen or eighteen months, there has been a sizable amount of PSRO opposition generated. Not infrequently, this opposition has been based on inaccuracies and emotionally generated rhetoric, but there has been so much time to repeat the inaccuracies and the catch phrases that some of it is now believed. At best, many physicians admit to being totally confused. Because we have been successful with the Foundation in New Mexico, we sometimes think that New Mexico has been a specific target for much of this opposition.

It would have been far, far easier for New Mexico to implement PSRO fifteen months ago than it will be now. We were ready to do it fifteen months ago. We are still ready, but there is no question that the delay has hurt us. In other areas around the country, the delay is going to make implementation very difficult. Because of this delay, I would like to urge that the alternative of contracts with groups other than professional associations be delayed from January 1, 1976 to 1978. This will permit potential PSRO's more time to learn of the benefits of professional review, to counter some of the opposition, and to effectively tool up for PSRO operations.

New Mexico was, is, and will continue to strongly support the concept of professional review as embodied in the PSRO law.

We have seen that professional review can be highly advantageous to the provider—to the patient—and to the organization paying the bills.

We have contained costs through utilization review and we have improved quality through utilization review.

We want PSRO to work.

We do, however, continue to have major concerns over the possibility of a lack of flexibility, possible over-control of the program by over-regulation, and particularly of the damage that could be done by further lengthy delays. Needless to say, if the administration of the program does go this way, in spite of our active support for the concept, we will have difficulties implementing PSRO in New Mexico.

I will conclude my remarks on a personal note. It is my opinion that PSRO as implemented for Medicaid in New Mexico is an asset to everyone—the patients—the providers including institutions—and the government. The government gets a bargain in having the best minds of the medical profession contribute to an organized system of monitoring a huge program, providing continuing medical education, and in those unusual and distressing situations to apply an appropriate level of discipline both moral and legal. The operation of the PSRO for Medicaid in New Mexico has utilized the talents of all segments of the medical community—solo and partnership, rural and metropolitan, group and institutional, and the important contributions of the medical school. How else could the government possibly obtain the participation of this quality and quantity of professional manpower?

The medical profession has profited by being given an area of responsibility in the management of a huge medical care program. The opportunity is welcomed by New Mexico physicians because we know that the alternative to professional review is a system of regulation by administrative dictation. Assurance of good utilization and appropriate quality results in the best kind of cost containment.

The ultimate benefactor of these joint efforts by government and the medical profession is, of course, the people of the country. We all wish that everyone will have available a high quality of medical care, when and where it is needed, and at a cost that can be supported. If properly implemented, PSRO can go a long ways towards this goal.

Our next witness is Dr. Kay Partride, director, Womens Clinic, the Johns Hopkins Hospital, Baltimore, Md.; accompanied by Dr. Allen N. Koplin, deputy executive officer, United Mine Workers of America Welfare and Retirement Fund.

We are delighted to have you with us, Doctor.

STATEMENT OF KAY PARTRIDGE, PH. D., DIRECTOR, WOMENS CLINIC, THE JOHNS HOPKINS HOSPITAL, BALTIMORE, MD.; ACCOMPANIED BY DR. HAL HUNTER, AMERICAN PUBLIC HEALTH ASSOCIATION

Dr. PARTRIDGE. Thank you, Mr. Chairman.

Dr. Koplin was called away, and may arrive momentarily.

At my left is Dr. Hal Hunter from APHA staff.

Senator TALMADGE. Fine. We are delighted to have you.

Dr. PARTRIDGE. Although I do work at Johns Hopkins Hospital, I am here testifying on behalf of the American Public Health Asso-

ciation. I am chairman of the Action Board of the American Public Health Association, which is an organization which, including its State affiliates, represents over 50,000 members. These individuals come from a wide variety of health and health-related disciplines and interests which share a common bond in their concern for improved health care for our Nation. We are pleased to have this opportunity to state our views on the provisions of Public Law 92–603, which established professional standards review organizations. These hearings are important for they represent an opportunity to examine what has transpired since the passage of the act and to determine what should be done to strengthen and improve the act.

There has been a growing awareness of the need for improved measures to both control the costs of medical care and to assure that the care being given is of high quality. As well, the consumer grows increasingly aware of and interested in pursuing his role in health care.

We believe that the PSRO reflects these needs and trends in the organization, financing, and delivery of health care, and it represents one approach to monitoring health care costs through the examination of both utilization patterns of institutional providers and of the cost of services offered under Federal financing programs. Also, because it presents a mechanism for gathering relevant data and for the systematic review of health care, the monitoring of the quality of that care is also possible. While the PSRO is not a panacea that will solve all the ills of the system, it is a valid approach that deserves testing. Even though it is basically a new concept, and previous similar experience is limited, there is no doubt that current and future health care needs require some review of the process of care by all interested parties.

We support the concept of the PSRO's and recognize the need for them. However, we would like to make the following suggestions for strengthening the law and its implementation.

First, APHA strongly believes that the quality of care can be adequately assessed only by a diverse group of health care providers. Nurses, dentists, nutritionists, podiatrists, and other types of health personnel, both professional and paraprofessional, are involved in delivering health care. Without involving these individuals in the review process, we limit the scope of information necessary to make decisions regarding both the cost and quality of health services. Similarly, physician participation must not be limited only to those physicians in a community who are members of the local medical society or health care institutions. Creative mechanisms to achieve consumer participation should be found so that the health care system is responsive to their needs. While the consumers cannot pass judgments on medical decisions, they can speak to other significant aspects of the treatment and recovery process. A balance, then, is necessary, and can only be achieved through broadening the process to include others than physicians alone.

Second, presently, Congress is considering a number of proposals to strengthen the health planning process and to increase the regulatory authority of health planning agencies. We would strongly urge that, wherever possible, area designations for PSRO's be congruent

with the areas served by health planning agencies. Quality assurance and cost containment are intimately related to the number, mix, distribution, and quality of health resources. To not include planning agencies weakens professional standards review in its most functional form. There is enough overlap in their activites and in their need for similar data and continued communication to justify congruent boundaries.

Three, the public, in order to make intelligent choices about securing health care, must have access to enough of the right information to make those decisions. It is somewhat ironic and, possibly, even tragic, that we have such information about the restaurants we eat in or the movies or shows we see, but do not have it for our health care institutions. Consequently, we believe that if the PSRO's are to fulfill their mandate in promoting high quality care, they must provide for full disclosure. This can be done through reports and aggregate data without jeopardizing the individual's right to privacy. A cloak of secrecy around such data has no justification in protecting the health of our citizens, and serves to protect no one, particularly the highly capable physicians in this Nation.

Four, quality assessment and cost control are still comparatively new and somewhat inexact sciences. We believe there is a great need to provide continued support for future development of the techniques and mechanisms that will be used by PSRO's. Also, to assure an ample supply of the personnel needed to staff these programs, sufficient moneys must be made available to educational institutions to train the needed manpower.

In summary, we hope that quality and cost review mechanisms will not be limited, in the future, to only Federal moneys nor solely to institutional providers. The entire health care system requires such monitoring. Further, we recognize that certain groups in this Nation view the PSRO concept, as well as all other governmental review and regulation, as contrary to their principles. We reject such an argument, for we see these mechanisms not as a form of interference with the practice of medicine, but rather, as a means to preserve the integrity of that profession as well as to protect the public's health and welfare. To ferret out the abuses and excesses within a system will in no way affect the majority of physicians who are skilled and dedicated, and are a credit to their profession.

We thank you for this opportunity to offer the view of the American Public Health Association and would be pleased to answer any questions that you might have.

Senator TALMADGE. Thank you very much for your contribution.

Any questions, Senator Bennett?

FULL DISCLOSURE REQUESTED

Senator BENNETT. I just have one question, which is a request for additional information. I am interested in your proposal No. 3, which says consequently, we believe that if the PSRO's fulfill their mandate in promoting high quality care, they must provide for full disclosure. This can be done through reports and aggregate data and so on.

What kind of reports are you talking about? Reports of the performance of a single physician? Are you talking about an attempt to evaluate the equipment or the type of service in a hospital?

This is a general statement. I am interested in it.

Dr. PARTRIDGE. There has been a great deal of interest, and I think it is growing, to get further information on performance of individual physicians in commuities. This was not what we were speaking to, particularly, but rather information concerning beds, utilization, norms that do appear in local—either in small communities that would depend upon the area designation of the PSRO. But I think these are the sorts of questions that consumers are asking. Why is it that there are differences in occupancy rates between different hospitals, between different communities, different standards? Why do different areas have different——

Senator BENNETT. I think that is completely consonant with the purpose of the PSRO.

Dr. PARTRIDGE. We feel it is also.

Senator BENNETT. I have great difficulty in trying to figure out how you could measure and put on a chart the performance of a doctor.

Dr. PARTRIDGE. Well, I think that one of the things that we are speaking to, Senator, is that we feel there is more in it than just the performance of the doctor.

Senator BENNETT. It is much easier to handle.

Dr. PARTRIDGE. It is a very difficult——

Senator BENNETT [continuing]. To handle the institution. You have got facts that you can measure with.

Dr. PARTRIDGE. It is a very difficult, thorny problem.

Senator BENNETT. No other questions, Mr. Chairman.

Senator TALMADGE. Thank you very much.

Dr. PARTRIDGE. Thank you.

Senator TALMADGE. Our next and final witness today is Dr. William Blaisdell, Indiana State Medical Association.

Doctor, we are delighted to have you.

STATEMENT OF WILLIAM BLAISDELL, M.D., INDIANA STATE MEDICAL ASSOCIATION

Dr. BLAISDELL. Thank you.

Mr. Chairman, members of the subcommittee, Senator Bennett, I am Dr. William F. Blaisdell of Seymour, Ind. I have been designated by the Indiana State Medical Association to present to you the situation in Indiana regards the implementation of the provisions of Public Law 92-603, the so-called PSRO law.

First, let me read to you a brief resolution from the Indiana State Medical Association House of Delegates meeting in the fall of 1973:

Resolved, that the Indiana State Medical Association be permitted to establish an independent corporation to accomplish peer review and quality control. Such review to be conducted only if requested by the local reviewing body; and be it further resolved that the Indiana State Medical Association urges the members of the House of Representatives and the Senate from the State of Indiana to repeal the PSRO provisions of Public Law 92-603.

On April 21, 1974, at Indianapolis, Ind., at a meeting of the board of trustees of the Indiana Medical Association, a motion requesting ap-

proval for an ISMA-connected organization to accept federal funds for formation of a PSRO Support Center was disapproved. At the same meeting, the board of trustees voted unanimously to reaffirm its position in opposition to the concepts of PSRO and in favor of the repeal of Public Law 92–603.

Additionally, you should know that the 98th session of the Indiana General Assembly, as a result of their awareness of PSRO legislation and with both houses voting unanimously, requested the U.S. Congress and the national administration to reevaluate current Federal policy regarding provision of health care services and to take appropriate steps to eliminate unwarranted interference with the private practice of medicine. Further, the Indiana Academy of Family Practice at its recent annual meeting moved for repeal of PSRO. A majority of the members of the Indiana Delegation to the U.S. House of Representatives now oppose this law. We believe it is noteworthy that some 34 repeal bills have been introduced in the U.S. Congress to date.

Gentlemen, I spoke with our statehouse this morning. Governor Bowen authorized me to insert his statement which is not in the printed text. If that is permissible.

Governor Otis Bowen, of Indiana, himself a physician, has testimony to the Subcommittee on Public Health and Environment of the Interstate and Foreign Commerce Committee of the House of Representatives.

He stated: "My concern is that freedoms and ingenuities of our physicians not be shackled, and that the quality of care for our citizens not be jeopardized by well-intentioned yet unworkable legislative and bureaucratic requirements. Full and complete consideration must be given to the fact that the basic element of all medical practice is the patient, and care should be standardized in only the broadest sense."

What is the impact of the Indiana State Medical Association position relative to the implementation of the provisions of the PSRO law in Indiana? The ISMA cannot, in good conscience, with the best interests of the medical patients of Indiana and with exercise of the highest principles of medical ethics, participate in the implementation of the professional standards review organizations provisions. The Indiana State Medical Association has taken no action to influence individual physicians or other groups of physicians in the exercise of their judgment regarding the issue of PSRO, except through the promulgating of factual information regarding provisions of the law.

The ISMA believes that an explanation of our position based on a few principal points is in order. At the outset, let us clearly enunciate the concept that we see in the PSRO law, no political or financial issues which in any way substantially affect the practicing physician, although we object in principle to the areas of punitive payment of benefits and fines provided in the law. Our deep concerns about this law are based primarily upon the effects that the patient will suffer. The law establishes norms of care, diagnosis, and treatment of "particular illnesses and health conditions." That is from section 1156(b). The law fails to recognize that the discipline of medicine requires the treatment of the patient, not the disease, thus the establishment of norms must by necessity limit full individualization of care, diagnosis,

and treatment. It may seem surprising to proponents of this legislation that a diagnosis as common as appendicitis is highly individual. Additionally, the attempt to qualify it through establishment of norms of care, diagnosis and treatment will severely limit medical innovation. Medical progress has often come through innovation that was out of keeping with the norms of the time in history at which they occurred; how could the contributions of Semmelweiss, Pasteur, Salk and countless others have been made under PSRO?

This law provides for "examination of pertinent records of any practitioner or provider of health care, et cetera." We believe the traditional confidentiality of medical records will be jeopardized with the result that important historical information will be withheld from the physician by the patient. Recent revelations regards the loss of confidentiality at very high levels within the government give us no reassurance that the privacy of medical information is likely to be well safeguarded.

We believe no one will argue that cost control is one of the major purposes, if not a major purpose of this act. If cost reduction is to be accomplished, it is obvious that it will have to be largely through decreased utilization because of the inescapable fixed costs in the health system. The inevitable result will likely be that availability of certain high cost treatment will probably be withheld. ISMA concurs with the concept that the U.S. Government or any other entity has the right to inquire as to the cost and quality of a service or of goods it buys. However, in the case of medical care, the government alleges to act as an insurer in medicare, for example, when in fact it acts as a purchaser under the provisions of the PSRO law and especially in the area of pre-hospital admission certification. It should be the patient who has the right to inquire as to quality and necessity of use of a service for his health care. Who can know better than a patient in conference with his physician what his health needs really are. I can assure you that very, very few patients are willing to accept hospitalization without a real perceived need on their part. The patient, through the hospital preadmission certification provisions of Public Law 92-603, is preempted involuntarily by the law in the making of a crucial decision with his physician as to whether hospitalization is in his best interests.

The Indiana State Medical Association does oppose PSRO from the physicians' standpoint as well as the standpoints noted above. The principal areas of objections will be outlined briefly. Let me quote from the Hippocratic oath, "The regimen I adopt shall be for the benefit of my patients according to my ability and judgment." One must realistically wonder when a physician under the provisions of PSRO is confronted with a judgment that does not fall within the norms of care, diagnosis, or treatment, how many physicians can realistically exercise their judgment for the patient's well-being when the physician must be confronted with the possibility of fine, other severe sanctions, and the loss of protection from civil liability when failing to conform to norms, as established as a result of this law. Many have argued this law provides a formalized peer review mechanism to be used in the United States in place of a so-called hit and miss system,

which some would hold has been inadequate. We submit that this law is not peer review. In fact, that terminology is really not used in the law. We note that the reviews are by bureaucratic approved and designated groups which are approved only so long as they perform in a manner acceptable to the Secretary of Health, Education, and Welfare who is himself a final authority in all matters of dispute. This law impugns the very qualities for which physicians are chosen and which are emphasized in their training, qualities such as decisiveness, inquisitiveness, confidence, self reliance, integrity, and a sense of moral and ethical purpose.

Also, the provisions of this law propose a system which duplicates already existing utilization review activities in United States hospitals.

Public Law 92-603 will interfere with true peer review by substitution of an unwieldy and impersonal approach in the place of true peer review programs. Truly useful peer review can only succeed at the local hospital and medical society level where professionals are judged by actual peers in an atmosphere of respect and dignity. In this setting deficiencies can be explored and corrected. The physician in question can be helped to continue to contribute to the total health care of the Nation to the maximum extent possible.

From the foregoing many standpoints and most especially from that of the loss of freedoms by our patients, we of the Indiana State Medical Association oppose the concept of PSRO and we cannot aid in its implementation in the State of Indiana. Finally, we suggest that medicine is a science and that in the United States it is a science of the highest order. Medicine is also an art, and perhaps the crucial fault of the PSRO legislation is the failure to recognize the very considerable and vitally necessary part of medicine that is art.

Thank you.

Senator TALMADGE. Senator Bennett?

Senator BENNETT. Obviously I do not agree with the interpretation which the doctor has made of the law, and since I assume you have been in the hearing room all day, you will find that there are several States where the prototype PSRO's have been operating that do not quite fit to your interpretation of what the law means. But it is late and there is no use riding around that track again.

I would just like to note for the record that we have had two applications for PSRO designations from the State of Indiana, one from the Calumet Professional Review Organization, and the other from the Marion County Medical Society. I assume that even though the Indiana Medical Society opposes PSRO, and wants to see it repealed, it will not interfere with these applications, or will it?

Dr. BLAISDELL. Senator, you are correct. We have no intent of interfering in any way. I should note for your information that the people involved with the two applications you referred to were present at the debate in April at the board of trustees meeting and did in fact vote for repeal even though they are in a sense covering themselves with applications.

Senator BENNETT. Well, maybe I could interpret it that they have repented, and it is repentance and not repeal that makes the difference.

Thank you very much, Mr. Chairman.

Senator TALMADGE. Thank you very much, Doctor, for your contribution.

Without objection, the subcommittee will stand in recess subject to the call of the Chair.

[Whereupon, at 4:15 p.m., the subcommittee recessed subject to the call of the Chair.]

○