ONE LIFE—ONE PHYSICIAN
An Inquiry Into the Medical Profession's Performance in Self Regulation

ROBERT S. MC CLEERY, LOUISE T. KEELTY, MIMI LAM,
RUSSELL E. PHILLIPS AND TERENCE M. QUIRIN

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At times in history the public has greeted the medical profession and its claims to cure disease with contempt and skepticism. In *The Splendid Century, A Study of Life in the France of Louis XIV,* W. H. Lewis refers to the generally "bad press" the medical profession received in seventeenth century France: "(I) n private correspondence, the physician is almost always presented as a cross between a murderer and a buffoon." Lewis ascribes two reasons for these attitudes: "Firstly, the physicians, particularly those of the Paris Faculty, had not yet learnt the unwisdom of washing their dirty linen in public, that first rule of all professions, that dog does not eat dog, was broken by a constant war of scurrilous and venomous pamphlets which was an intellectual treat to cynical laymen." And, secondly, graduates of the medical school of Paris University had a monopoly on practice in the French capitol, had little clinical knowledge and were convinced that medicine had reached perfection 12 centuries earlier.

In the past three hundred years many of the sources of criticism of the medical profession have been eliminated. For example, changes in medical education, a process that is now firmly embedded in experimental science and clinical experience, have helped undermine a good deal of the earlier "bad press." But new sources of criticism combined with other

unresolved problems such as high cost, problems of access, errors in medication, surgery and other new hazards to patients, cause the public to call the medical profession to account.

Although little evidence is seen of a "scurrilous and venomous" outpouring from members of the medical profession on the failures of colleagues, anxiety about the quality of care provided patients is reflected in the large number of studies appearing with regularity that seek to examine and find means to correct the shortcomings, and to reduce the controllable variability in the quality of care provided patients in increasingly more complex medical institutions. Indeed, health care providers themselves have sought to upgrade quality through instrumentalities such as the Joint Commission on Accreditation and the Specialty Boards. It is the present adequacy of these organizations that is being questioned. As government funds for health services begin to play an increasingly important role in the United States, standards set by private regulatory agencies are being incorporated into government agency regulations issued to assure judicious expenditure of funds in the public interest. This trend toward government intervention is taking place during a time of open controversy about the claims and performance of business, educational and professional groups including the processes of professional self-regulation in our society.

Other professions such as the law, accounting, teaching and engineering are being found fault with and are held to higher levels of responsibility and accountability. The questioners range from avowedly radical groups to individuals and associations who identify themselves as spokesmen for consumers and citizens. The layman would be at a loss in evaluating the performance of medical professionals in the absence of those self-critical organizations and individuals within the health professions who find an intellectual challenge and make a commitment to better the performance of health care professionals and to develop institutional arrangements that will foster improvements in the quality of medical care.

As government expands its role in health services, given the present climate of consumerism and growing skepticism of self-regulation, some will seek for government a major role as a monitor of health care quality. Such is the case with the Health Maintenance Organization and Resources Development Bill, S.3327, introduced by Senators Kennedy, Javits and Magnuson among others. As part of an omnibus bill for the expansion of prepaid group practice, the bill proposes to establish a Commission on Quality Health Care, an independent federal agency, not connected with any federal department. The body will have power to conduct investigations, establish quality health standards including but not limited to reports, processes and outcomes and to prescribe quality control systems for the Health Maintenance Organization and Health Service Organizations funded by the proposal.

Ralph Nader's group has made proposals that parallel some of the legislative proposals of the Kennedy Bill. *One Life—One Physician,* a publication sponsored by Ralph Nader's Center for Study of Responsive Law deserves study not only because of the auspices under which it was prepared but because of the relevance of the material it presents. A study group headed by Robert McCleery, a physician formerly associated with the United States Food and Drug Administration, having enlisted the aid of a lawyer, and several law and medical students, undertook an inquiry with the following goals:

1. To examine the medical literature and other sources to determine if a problem of quality of medical care exists.
2. To review elements in the education and training of physicians that might enhance the quality of their services.
3. To describe and judge present legal and professional quality mechanisms in hospitals or in offices.
4. To determine whether a patient can be "reasonably sure" that the physician he sees will be reasonably competent to treat and diagnose his illness, and whether this performance is objectively monitored.

5. To make proposals for improvement.

The inquiry did not seek to break new ground in its analysis. It relies heavily on articles in the medical and hospital literature including extensive quotations from these sources, the general press and medical news periodicals directed to audiences of physicians. To a lesser extent, interviews with staff of the Joint Commission on Accreditation and physicians in official health agencies, and other students of medical care have been referred to for support and illustration. No independent study of quality of physicians' care in hospitals, homes and offices was attempted. In style and tenor the book is in sharp contrast with the popular exposes of medicine that periodically appear on the book market and that depend heavily on anecdotes exploiting the apparent public interest in the dramatic aspects of the work of the physician. It is this interest that is also exploited by the television dramas, but in that media the treatment of the profession is usually much more sympathetic. Except for the attention-getting title, the book is sober in tone and avoids the flamboyant. It also lacks much of the dramatic quality of other Nader studies.

The major finding of the Nader Group is that great professional variability exists in the quality of medical care rendered patients and that continued reliance on professional self-regulation mechanisms is doomed to failure. It is recognized that at present, suitable criteria and objective evaluation procedures to measure quality of care are lacking, but relying on reports such as those published by the Commission on Professional and Hospital Activities, which publishes the PAS Reporter, the McCleery group cites as evidence variations in such matters as the rates of complications of hospital infections and variations in the management of electrolytic studies, acute coronary occlusions and tonsillectomy procedures. The present system of medical licensure is also condemned. It is proposed that a limited license be given to each qualified applicant and that a license be maintained by an individual physician only by providing evidence that his knowledge is current. Thus, the physician

should be reexamined periodically, but establishing the precise method of reexamination will be difficult.

The Nader Group agrees with the recommendations of the 1961 Medical Disciplinary Report to the American Medical Association, which suggested that discipline rather than entrance licensure become the primary function of the state medical boards. Although this report and the report of the AMA's Committee on Planning and Development (known as the Himler Committee, which was chaired by Dr. George Himler of New York) are praised, the failure of the AMA to help implement or to act on the recommendations of these two committees is presaged as an example of the AMAs' unwillingness to develop effective oversight over physicians' performance. Organized medicine is seen as not responding rapidly or effectively to its own pronouncements, such as a 1964 statement by the AMA's judicial council: . . . " (P) hysicians as a group have been permitted by society to exercise self-discipline. This privilege places on medicine the obligation to establish and support workable disciplinary mechanisms, to employ them without hesitation and to report results periodically.

"The profession may be expected to retain its privileges as long as it exercises its responsibilities to maintain high standards of ethical and professional competence." (p. 145) .

Some attention is also given to the workings of the Joint Commission on Accreditation of Hospitals described as "the only organization of the medical profession that has been established to monitor the quality of care, and therefore the only quality control mechanism for hospitalized patients." The Commission is characterized as serving "a useful function in improving the usually visible supporting elements (sterilizing equipment, lab., x-ray, etc., facilities) of hospital life and the physical environment of medical practice." Helpful as this role is, doubts are expressed whether the staff resources of the Joint Commission are such as to permit it to do an adequate job in monitoring the actual performance of hospital staff functions and committees rather than merely to assure that such ac-

tivities take place. The issue has been appropriately raised by this book as well as by the Federal Health Insurance Benefits Advisory Council in 1967, that if the government is delegating to a private agency much of its responsibility to safeguard quality of care, then "there is concern that JCAH standards are not applied with the frequency of inspectors' skills necessary to assure a high degree of effectiveness." (*The Health Benefits Advisory Council Annual Report on Medicare,* July 1, 1966 to December 31, 1967, p. 10). McCleery, *et al.,* concur with the recommendation of HIBAC that would give the Secretary of HEW authority to set health and safety standards for hospitals.

The major recommendation of the Nader Group report is that an independent agency be established to be known as the National Board of Medicine along the lines of the Federal Reserve Board, with its own board of governors. This agency would be responsible for the development of standards of optimal care, standardized recording procedures, stimulation of effective peer group evaluation and administration of quality control system that would have the sole jurisdiction over all health programs receiving federal government funding, and could require compliance with its standards as a condition for participation for receipt of federal funds. Note that this recommendation is followed to some extent in the recently introduced Bill, S. 3327.

The Nader Study Group's specific recommendations are perhaps less significant than the questions they raise for further careful examination. This was to be expected. McCleery, *et al.,* were faced with a difficult assignment in their study of the medical profession's performance in self-regulation. They could have analyzed in depth any of the particular areas that they chose to review only superficially. However, it is understandable that given limits of time, expense and access to data, they would be unable to come up with any new conclusions or an in depth review, but are merely able to suggest channels for further analysis.

One area that deserves more intensive analysis is the matter

of medical malpractice, which receives a relatively brief and cursory treatment. The rise in the number of malpractice claims and in the size of awards have drawn great expressions of concern from hospitals and doctors. This concern revolves around the malpractice situation's serious impact on the cost of health care, the physicians' view that many of their colleagues have been harshly judged and the emerging realization that the adversary process is needlessly expensive and humiliating to defendants and costly to plaintiffs. In addition, fears are emerging that the market for malpractice insurance is not functioning properly. From the point of view of the patient, the malpractice system operates like a "forensic lottery." (See T. G. Ison, *The Forensic Lottery,* London Staples Press, 1967, where this characterization is applied to the entire tort system). Although the sensationally poor result leads to a judgment, the less sensational mistake may never be disclosed. It would be also worthwhile to study the extent to which the malpractice system acts as an adequate measure of compensation for victims or a stimulus to improved quality of care. Attempts to join the solution of the malpractice litigation controversy to the development of new quality control mechanisms in medicine thus appear to be attractive.

The problem of monitoring quality of care is a complex one and is dependent on enlisting the skill, knowledge and dedication of the health professions. It also requires understanding and interest on the part of the public.

The present system of self-appraisal appears to be acting in ways that are unsatisfactory to physicians as well as to patients. The time is ripe for a review of all these mechanisms. The medical profession is no longer faced with a choice such as seemed to be confronting it in seventeenth century France—between "washing dirty linen in public," or a "professional conspiracy of silence." We do have the beginnings of objective procedures for evaluating medical care. Much of it derives from those public procedures of verification of hypotheses that have characterized scientific advance that is at the heart of medical progress.

We need to improve upon those procedures to ensure the safety of the public and to provide an environment for health professionals that fosters commitment to patients' well-being as well as to scientific development. Where the problem is a misallocation, an insufficiency or the need for redistribution of resources, public knowledge and support are necessary if desirable changes in public policy are to take place.

MARVIN LIEBERMAN