PSROs, The Medical Profession, and the Public Interest

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The federal legislation mandating Professional Standards Review Organizations to monitor the decision making of physicians regarding their patients is a method unique to the United States to control medical care costs according to prevailing professional criteria. Other countries, so far, depend largely on health service structures, reimbursement methods, and arbitrary government budget limitations. Our dislike of highly structured delivery systems has pragmatically moved us in the direction of monitoring diagnostic and therapeutic decision making. PSRO is mandated at a time when there is no systematic methodology with validated criteria for monitoring medical practice. This will likely lead to subtle sabotage of PSRO by the medical profession justified by quality standards which are the professions' prerogative.

It is conceivable that quality standards will rise and, therefore, costs. The drive for monitoring physician decision making is understandable even when there is no methodology. It then behooves medical schools to conduct research on methodologies of monitoring services, a possible favorable side-effect of the legislation. An unfavorable side-effect may likely be that the criteria will be based exclusively on technical medical considerations and ignore the personal and social attributes of patients which should affect the decision making of physicians. Medicine will then become even more technocratic than it is now. All countries are converging at various degrees of intensity in establishing planned limits to expansion, examining possibilities of monitoring physician decision making and capping this off with arbitrary budget ceilings. The state of the art of health services management appears to permit no other recourse.

Introduction

The federal legislation mandating Professional Standards Review Organizations deserves some examination as to its implications for medical practice, the patient, and the sources of financing of health services in this country. I have the temerity to attempt this, inspired by one of the Nine Laws of the Disillusionment of the True Liberal. One of these laws (Levy, 1970) is: "Anticipated events never live up to expectations."[1] Still, we cannot just stand there; we must do

[1]Another law is: "Good intentions randomize behavior," i.e., it is not possible to deal rationally with randomized behavior. It is too unpredictable. Levy's view is that in wicked intentions "there is a strong possibility, in theory, of handling the wicked by outthinking them." The PSRO law is well-intentioned, and the PSRO committees will be "wicked."

something! PSRO is a prime example of this very American, activist philosophy. I start with an international perspective.

In the management of the health services delivery system the United States is unique among countries in that we are moving directly into monitoring the decision making of doctors. I believe this is so because we lack the health services organizational structures and relatively closed-ended financing true of European health insurance or health services systems, particularly that of Great Britain or Scandinavia. Even with more structure than in the United States, costs in all countries have gone up faster than other segments of their economies. It may seem an anomaly that I find no relationship between ownership, sources of funding, the organizational structure of health, and the amount a country spends for health services. The factor establishing the limits is the implicit and explicit public policy on how much a country wants to spend for health services. This amount is in the main a political decision in the murky area of tradeoffs in resource allocation among parties at interest. Until very recently the sky seemed to be the limit, but now health services expenditures are beginning to nudge both governmental and private budgeting limits. Even so, only one country is actually retrenching—Great Britain—and mainly because of the difficulties that country is having with its economy. Great Britain would actually spend more if it could in relation to other priorities. Other countries are not yet retrenching, but agonizing over slowing the pace of increases in expenditures even though their Gross National Products (GNP) may still be expanding. No country has dared to find out what the saturation level of demand would be. It seems reasonable, however, to assume that there is such a saturation level as is true of all goods and services. The country which appears to be closest to the saturation level is the Soviet Union as measured by the lavish number of units of service provided per person as compared with North America and Western European countries. In general, countries in North American and Western Europe reveal about four to six visits per person a year to physicians, whereas the Soviet Union reports 10 visits and is making projections to 16 in the near future (Anderson, 1973; Pustovoy, 1975), with a commensurate increase in resources. The Soviet norms are set by medical professionals and such norms are inherently generous.

I wish to elaborate on my first statement, i.e., that the United States is unique in moving directly into monitoring the decision making of doctors. The reasons for this, I believe, are that costs were

rising rapidly at the same time that some form of national health insurance was being considered seriously, plus our painful expenditures experience with Medicare. These took place in a context of very vague organizational and fiscal boundaries. We do not like visible boundaries and structures with visible limits on budgets, although we are—as are other countries—moving ineluctably in that direction. The pace in each country is a matter of degree.

It seems that we are hoping that a properly functioning PSRO mechanism will establish for us the proper level of expenditures, rather than have the level of expenditures determined arbitrarily from year to year by the processes of government budgeting, competing with the national priorities. It is then ironical that in this country the medical profession faces more direct monitoring of its decision making prerogatives than do its colleagues in government systems elsewhere. This is due in part—if you can believe it—to greater deference shown to doctors in European systems. Nevertheless, health administrators and politicians in Europe are looking enviously at the PSRO developments in the United States and naturally exaggerating their impact here. Their attitudes are somewhat analogous to our penchant for overidealizing the government systems abroad. What universal government systems abroad and in Canada have accomplished is to free the citizens from high-cost episodes of serious illnesses, an accomplishment which appears to be forgotten after other problems emerge, both unintended and unexpected. Now cost containment is the political battle cry elsewhere as it is here. To contain cost, we start with PSRO, the descendant of utilization review mandated by the Medicare Act as a device to shorten length of stay and eventually to limit admissions. The trend may continue to monitor office visits as well—not to mention admonishing patients to see the doctor only when necessary (a presumably precise judgment), and to strike a balance between hedonism and asceticism in their life styles.

The PSRO development is, indeed, remarkable. At first the profession fought it; now predictably it is likely to co-opt it; and I personally see no other alternative unless doctors are handed a manual of instructions to follow. This hardly seems either likely or tenable. If, in their judgment, the doctors are pressed too hard, they will sabotage the monitoring system by many subtle or not so subtle means at their disposal or threaten to strike on the seemingly unassailable reason that good patient care is being jeopardized. Witness house officers in hospitals across the country—preceded by nurses—

who brilliantly intrude into their bargaining processes the issue of proper professional standards for proper patient care. This is a tactic which has not been thought of, for example, by automobile assembly-line workers—who might claim that the quality of workmanship is being jeopardized and in turn the quality of the cars coming off the assembly line.

In attacking the cost imperative through the PSRO mechanism, I agree with Havighurst and Blumstein (1975:25), as they put it in their cogent article, that Congress has not sufficiently faced the *quality imperative*, a powerful weapon in the professional arsenal: "Because the quality imperative dictates that no one should very obviously enjoy better health care than anyone else on the basis of income, the ideal to be striven for is likely to be higher." Further (Havighurst and Blumstein, 1975:41), "A great deal of the discussion surrounding the PSRO concept in the period since its enactment has been rendered almost unintelligible by operation of the quality imperative in a highly charged political and professional environment."

The Situation

After this rambling introduction, where are we? In my more rational moments I deplore broadside legislating for a performance-monitoring mechanism such as PSROs before there is even the semblance of a systematic methodology to monitor performance according to validated criteria. At the same time, in my more pragmatic moments, I agree that we need to work toward some form of performance monitoring, and the issue is then not the principle but the pace and form the performance monitoring will take. I will also observe that, admitting the desirability of some form of performance monitoring, it is unlikely that the profession and the medical schools would voluntarily initiate action and research on performance criteria other than the ones they share informally among themselves in day-to-day practice. At least PSRO is forcing systematic attention to medical performance criteria which may not have come about otherwise. May the medical schools and organizational research agencies respond to the call for research on performance indicators!

In this connection, I recall an interview I had with that brilliant political strategist Wilbur Mills during the maneuvering surrounding the enactment of the Medicare Act in 1965, particularly Part B,

physicians' services. I talked with him a year later. The question I posed to him was that in the preamble to the Act there was an explicit statement that the Act should not interfere with the private practice of medicine. Then a few paragraphs later there was spelled out and mandated utilization-review committees in hospitals to monitor length of stay. Is this not interfering with the private practice of medicine? He grinned and said no, the mandating of utilization-review committees was simply to make the doctors talk to each other. Presumably, it was hoped that this legislation would stimulate the formulation of more explicit professional criteria.

This is quite a charge considering the very considerable portion of medical practice which is considered an art rather than a science. It is a reasonable assumption, as Eliot Freidson (1970) puts forth forcefully in his writing, that the medical profession (indeed, any profession) is inclined to exaggerate the extent to which performance is beyond systematic monitoring, given the quality and equality imperative. A reasonable observation is that we do not know at present to what extent medical practice is capable of being monitored according to validated criteria, short of cookbook medicine, which nobody wants. Perhaps, the best that can be done is the strengthening of formal and informal peer review as is presumed to be done in well-organized group practices.

Very little research has been done on the methodology of monitoring physicians' services. A great deal of routine data needs to be collected on physicians' decision-making profiles. In Ontario, for example, the province compiles a tremendous data bank of physician decision-making profiles (Badgley et al., n.d.), but so far has done little with it in terms of comprehending decision-making in medical practices. The monitoring system exposes gross deviations from the average and calls the doctors so exposed into account. Similar methods are in use in the medical care foundations in California. I get the impression that the deviations are so gross that the deviant doctors would be known to their colleagues anyway, without the elaborate record system entailed to isolate these very few.

Medical decision making is, of course, a very difficult problem to analyze, not to mention developing a methodology for application. Medical practice is essentially a one-to-one relationship between a doctor and a patient, and doctors face understandable dilemmas in making decisions on individual patients on the basis of group statistics. The tendency, I would assume, would be to err on

the side of safety. Referring again to Havighurst and Blumstein (1975:23): "It seems that sooner or later, government will have to face the dilemma of how to place limits on the commitment of funds to catastrophic disease. Its unwillingness to address this dilemma in the case of renal disease seems directly traceable to the advocates' ability to frame the issue in terms of *identifiable* rather than *statistical* lives." (Italics added.) Yes, indeed, it will take very sophisticated public policy decisions *not* to do something to save the lives of a few in favor of the many when the technology is present. Somehow in personal health services we do not like to deal with statistical lives, although we accept this concept in the carnage on our highways in order to have and drive our automobiles.

On a large-scale basis there appears to have been only two attempts to set up monitoring standards for hospital admissions. Both studies took place in the 1960s. Anticipating the interest in physician decision making as it applied to hospital admissions and discharges, I conducted a survey with Paul Sheatsley (1967) and the National Opinion Research Center (NORC), University of Chicago, of a representative sample of 2,000 surgical, medical, and diagnostic discharges in the state of Massachusetts for a 12-month period. Obstetrical cases were excluded. We queried the patients and their referring and attending doctors about the chain of events and decisions that led to hospital admission and discharge within a few weeks after discharge.

One table stands out in that survey, relating to the doctors' judgments after the fact as to degrees of urgency in admitting their patients to the hospital. We established four categories of urgency-nonurgency as determined by the attending doctors: (1) hospitalization absolutely necessary, the procedures could not have been carried out except in the hospital; (2) quite urgent, would have been difficult to carry out procedures except in the hospital, although maybe possible outside; (3) would have been possible to carry out procedures outside of the hospital, but desired to reduce the margin of error; and (4) finally, made no difference.

The other survey (Fitzpatrick et al., 1962) was conducted on a representative sample of 5,000 discharges in Michigan. The Michigan study selected 18 diagnoses (including maternity cases) which were relatively clear-cut disease entities and for which it was quite easy for committees of physicians to arrive at a consensus for each diagnosis regarding appropriateness of hospital admission and discharge. These 18 diagnoses comprised 46 percent of all general

Surgical Cases		
Absolutely necessary	74%	89% necessary
Quite necessary	15%	
Safety margin	7%	11% could be eliminated
No difference	4%	
Medical Cases		
Absolutely necessary	46%	83% necessary
Quite necessary	37%	
Safety margin	14%	17% could be eliminated
No difference	3%	
Diagnostic Admission		
Absolutely necessary	45%	77% necessary
Quite necessary	32%	
Safety margin	15%	23% could be eliminated
No difference	8%	

hospital admissions. For the purpose here it is sufficient to summarize that "overuse" represented 2.3 percent of the admissions and 6.8 percent of the days. The Michigan study criteria were either/or instead of a range as formulated in the Massachusetts study. It is seen that in relying on professional criteria, there was very little purely wasteful use of hospital services.

I refer to these old—but still new—surveys, because they are the only ones that have been done which give some idea of the "softness" of decision making among doctors for hospital admissions and, given a control mechanism, what proportion of admissions might be eliminated before both doctors and patients would begin to protest in visible numbers. I make the prediction that costs will continue to rise so that stabilized PSRO criteria will not be possible. Rising expectations and the quality imperative will continue to affect expenditures. Criteria need to be revised and tightened periodically unless the body politic is willing to accept what the medical profession as a whole and the public who seek their services regard as appropriate medical care.

Observations and Conclusions

The legislation and discussion regarding PSROs appear to emphasize exclusively the role of doctors in decisions regarding their

patients. The tendency is toward purely technical medical decision criteria and the ignoring of extenuating factors regarding the social and family environment of the patients and the patients' psychological state.[2] PSROs will, therefore, make medical practice even more technocratic and their alliance with administrative staffs of hospitals will allow patients even less to say about decision making in the enlarging bureaucracy than now. Can patient points of view be brought into the PSRO-type of decision monitoring? I am not sanguine. We are certainly entering a period of tensions and possible standoffs among patients, doctors, hospital managers, and government funding agencies. Due-process suits from doctors are already appearing (Blum, 1976).

While the United States tries to contain costs by monitoring physician decision making, the country is also laying the groundwork for a structure to contain supply as well in the newly implemented National Health Planning and Resources Development Act of 1974 (Public Law 93-641), following the failure of the comprehensive health planning and regional medical legislation in the late 1960s. In other countries the idea of monitoring physicians is following the creation of organizational structures, because costs are not contained by that means either. Thus, all countries are heading at various degrees of intensity in the direction of establishing planned limits to expansion, examining possibilities of monitoring physician decision making, and capping this with arbitrary budget ceilings.[3] The actors can then sort themselves out in these contexts and arrive at some politically tolerable equilibrium. This seems to be the fate of health services delivery systems.

[2]In a study of 252 admissions to a teaching hospital (Mushlin and Appel, 1976), 79 percent of the patients were judged to be admitted for purely biomedical factors. The remaining 21 percent were admitted for extramedical reasons.

[3]These impressions were gained from my attending three international conferences on the rising costs of health services everywhere. In October 1974, a conference (Ehrlich, 1975) was held in Geneva, Switzerland, sponsored by the International Red Cross through the Henry Durant Institute. This conference was attended mainly by administrators. In June 1975, the John E. Fogarty International Center for Advanced Study in the Health Sciences sponsored the Conference held in Bethesda, Maryland, attended mainly by academicians. In September 1975, the American College of Hospital Administrators sponsored a European seminar on health services in the nine countries belonging to the European Economic Community, in Brussels and Bruges, Belgium. This was attended mainly by hospital administrators. The seminar was arranged by Jan Blanpain, MD, and staff of the Institute for European Health Services Research, Leuven, Belgium.

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References

Anderson, Odin W.
1973 Health Services in the USSR. Selected Papers No. 42. Chicago: University of Chicago Graduate School of Business.

Anderson, Odin W., and Paul Sheatsley
1967 Hospital Use—A Survey of Patient and Physician Decisions. Research Series No. 24, Center for Health Administration. Chicago: University of Chicago.

Badgley, Robin F., Catherine Charles, and George M. Torrance
n.d. The Ontario Health System. Unpublished manuscript.

Blum, John D.
1976 " 'Due process' in hospital peer review." New England Journal of Medicine 294 (January 1) : 29–30.

Ehrlich, David A. (ed.)
1975 The Health Cost Explosion: Which Way Now? Bern, Switzerland: Huber.

Fitzpatrick, Thomas B., Donald C. Riedel, and Beverly C. Payne
1962 "Character and effectiveness of hospital use." Pp. 361–591 in McNerney, Walter J., and Study Staff, Hospital and Medical Economics; A Study of Population, Services Costs, Methods of Payment, and Controls. Vol. I. Chicago: Hospital Research and Educational Trust.

Freidson, Eliot
1970 Professional Dominance: The Social Structure of Medical Care. New York: Atherton Press.

Havighurst, Clark C., and James F. Blumstein
1975 "Coping with quality cost tradeoffs in medical care: the role of PSRO's." Northwestern University Law Review (March-April): 23, 25, 41.

Levy, Marion
1970 "Levy's nine laws of the disillusionment of the true liberal." Midway 10 (Winter): unpaged.

Mushlin, Alvin I., and Frances A. Appel
1976 "Extramedical factors in the decision to hospitalize medical patients." American Journal of Public Health 66 (February): 170–172.

Pustovoy, Igo V
1975 Health Care Planning in the USSR; Its Role in Improving Medical and Preventive Services. The 1975 Michael M. Davis Lecture, Center for Health Administration Studies. Chicago: University of Chicago Graduate School of Business.