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PSROs
A LITTLE TOE IN THE DOOR

"T"his potential to improve the quality of medical care in this country is virtually unlimited," says Dr. Henry E. Simmons, Director of the Office of Professional Standards Review of the Department of Health, Education and Welfare (HEW). It's "the beginning of the end of the private practice of medicine as we know it in this country," says Dr. José L. Garcia Oller, President of the American Association of Councils of Medical Staffs of Private Hospitals. Both gentlemen are talking about Professional Standards Review Organizations, commonly known as PSROs, a form of peer review attached to the Medicare and Medicaid programs by the 1972 Amendments to the Social Security Act. In the short run,
the hopes and fears reflected by these assessments are probably unjustified, for in the short run the program is destined to have a greater effect on the practice of computer technology than it will have on the practice of medicine.

From a longer-range perspective, however, PSROs represent a landmark and possibly a precedent, as the first attempt of the federal government to contain the escalating costs of federally funded health care by intervening in the practice of medicine. While the attempt has to date been largely emasculated in the process of legislation and implementation, the program may in the future become the basis for more direct federal intervention in health care if and when enactment of national health insurance sends health-care costs on another upward spiral.

**Physician Control As Cost Control**

In fiscal 1966—the last fiscal year before implementation of Medicare and Medicaid on July 1, 1966—the total American health bill was slightly over $42 billion, representing 5.9 percent of the gross national product (GNP). By fiscal 1973, health-care costs had risen to slightly over $94 billion, representing 7.7 percent of the GNP. The total dollars coming from the public till for health care increased from $10.8 billion to $34 billion in the same period, and the anxieties of administrators and legislators increased proportionately. (The Senate Finance Committee report accompanying the PSRO legislation lamented that the cost of Medicare was then expected to overrun the estimates made in 1967 by $240 billion over a 25-year period.)

By providing a public subsidy for a largely private health-care system—in particular, by promising hospitals reimbursement of the "reasonable cost" of treating a patient—Medicare and Medicaid had of course made it financially rewarding for the system to provide more units of care at a greater cost per unit. Safeguards against overutilization were rather rudimentary—hospitals serving Medicare patients were required to have in-house utilization review committees, and fiscal intermediaries and carriers were expected to review individual claims and reject those for uncovered or unnecessary care. In Medicaid, the individual state Medicaid agencies were admonished to establish mechanisms to safeguard against unnecessary utilization of services.

By 1970 concern in government circles over the obvious inadequacy of these mechanisms as cost-containment measures was great enough for HEW to ask Congress for authority to establish so-called program review teams of professionals and consumers at the state level to evaluate cost and utilization of federally funded services and identify areas of abuse. The American Medical Association (AMA) reacted with a counterproposal for so-called peer review organizations, to be established by state medical societies, to do the job. This notion came to the attention of Sen. Wallace F. Bennett, a conservative Republican from Utah and the ranking minority member of the key Senate Finance Committee. He proceeded to adapt the AMA proposal to a model more closely resembling the review systems in use by doctor-sponsored foundations for medical care (see BULLETIN, February 1973). The Bennett Amendment was unsuccessfully introduced in 1970 but succeeded in navigating the murky legislative waters of 1972's HR 1 to become part of the mammoth 1972 Social Security Amendments, now known to the cognoscenti as Public Law 92-603 (see BULLETIN, May, 1973).

The Senator's strategy, reflecting his anti-interventionist inclinations, was to conduct a rear-guard action aimed at warding off direct government interference with the practice of medicine by establishing a privately controlled mechanism for containing runaway government costs. He touted his amendment on the Senate floor as "the best, and perhaps the last, opportunity to fully safeguard the public concern with respect to the cost and quality of medical care while, at the same time, leaving the actual control of medical practice in the hands of those best qualified—America's physicians."

**A New Kind of County Medical Society**

America's physicians under Sen. Bennett's amendment are to construct the guts of the PSRO review system by creating—in 203 local areas throughout the country, designated by HEW—nonprofit, tax-exempt incorporated membership organizations, with boards of directors, staff and an elaborate committee structure, and with membership open, without dues, to all (and only) licensed doctors of medicine and osteopathy practicing in their designated area. Having come into being
and having persuaded HEW of their ability to carry out a PSRO's legally mandated functions, such organizations will enter into agreements with HEW whereby they will receive formal recognition as the PSRO for a given area. Should an area's practicing physicians balk at carrying out this statutory scenario, the law permits HEW after January 1, 1976 to recognize another qualified agency or organization—say, a medical school, local health department or insurance company—as that area's PSRO.

The functions and powers of PSROs are a case of the legislative right hand giving and the left hand taking away. The giving part of the equation comprises a legislative directive to PSROs to ensure that health care paid for under Medicare, Medicaid and the Maternal and Child Health program is medically necessary, consistent with professionally recognized standards of care and provided in the least costly possible setting. They must arrange for the maintenance and review of profiles of practitioners, providers and patients. They have the authority, should they care to exercise it, to review in advance elective admissions to hospitals or other institutions. A PSRO's standards for review are to be "professionally developed norms of care, diagnosis, and treatment based upon typical patterns of practice" in its geographical area.

Provisos and Qualifications

This impressive-sounding scope of authority becomes much less so when one delves into the statutory fine print, where one finds a couple of sleeper clauses that render the law's net effect much less than meets the eye. One such provision limits the functions of a PSRO to "the review of health care services provided by or in institutions," except in the unlikely event that the PSRO requests HEW to charge it with the duty of reviewing non-institutional care and HEW grants the request. (This limitation, it must be said, was not Sen. Bennett's idea but somehow appeared when the bill emerged from a Senate-House conference committee.)

The other limiting provision, which the staff of the American Hospital Association (AHA) takes credit for inducing Sen. Bennett to include, requires PSROs to use the services and accept the findings of in-house review committees established by a hospital or other facility, provided that such committees have demonstrated their capacity to perform PSRO-type review. HEW's PSRO Program Manual advises hospitals that if they have beat their local PSRO to the punch in the development of the criteria, standards and norms required for the performance of required review activities, they may go ahead and use these parameters at least until the PSRO has established committees for their development, at which point those committees may accept the hospital's parameters or require changes. (This is known in the trade as a word to the wise, and the AHA has heard it, of which more later.)

Just as PSROs are designed to insulate the medical profession generally from outside intervention, this delegation provision is designed to insulate the medical staffs of particular hospitals from outside intervention, even by other physicians. Assuming that the hospitals in a given area take advantage of the opportunity thus to protect themselves from PSRO review, the concrete functions of the PSRO itself are limited to the occasional monitoring of hospitals' review mechanisms and the collection of data. (For a description of the operation of the particular review mechanisms required of a PSRO or hospital under HEW's interpretation of the law, see box page 4.)

The Toothless Giant

Legislators and administrators are unanimous in their view that the intended effect of the PSRO legislation on an erring practi-
tioner is to be educative rather than punitive. In the words of an HEW pamphlet, PSRO—Questions & Answers, "If a physician's pattern of practice indicates that he is delivering excessive or insufficient health care or otherwise improperly treating his patients, his peers in the PSRO will advise the physician and recommend appropriate remedies, such as professional consultation and education. Only in rare cases would sanctions provided by law be imposed . . ."

Those sanctions initially provide that no Medicare or Medicaid payments may be made for services that have been "disapproved" by a PSRO or in-hospital review system. (It seems safe to assume that an in-hospital medical staff committee will be reluctant to reduce the income of a colleague or the hospital.) More generally, if a PSRO determines that a practitioner or provider has furnished or ordered care that was not medically necessary or in accordance with professionally recognized standards, it is to give the offender "reasonable notice and opportunity for discussion," following which it may invoke an elaborate review mechanism that involves sending a report and recommendation to the Statewide Professional Standards Review Council to be established in states with three or more PSROs, thence (with the

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**The Nuts and Bolts of**

Talking about health care review initially requires introducing the jargon. To begin with, review may be *prospective, concurrent* or *retrospective*. That is to say, the case may be looked at prospectively, or before care is rendered (should this patient be hospitalized or treated as an outpatient?), concurrently, or while care is being rendered (should this patient have been admitted to the hospital and, if so, for how long?) and retrospectively, or after care has been rendered (was this patient, now discharged from the hospital, properly cared for?). The bulk of the activities of a PSRO (or of an in-house hospital review mechanism operating under the law's delegation provision) are concerned with concurrent review of hospital care.

The benchmarks of review, in the terminology of HEW's PSRO Program Manual, are *norms, standards* and *criteria*. Norms are statistical measures of usual performance e.g., the average length of stay for a term delivery without complications in a given geographical area is five days. Standards are "professionally developed expressions of the range of acceptable variations from a norm or criterion." Criteria are "predetermined elements against which aspects of the quality of a medical service may be compared," which are to be "developed by professionals relying on professional expertise and on the professional literature." Sample sets of norms and criteria are to be adopted by the National Professional Standards Review Council, a body of 11 physicians (see box page 18), and provided to PSROs, which in turn are to establish specialty committees for development of parameters reflecting local practices, either through modifications of the national samples, selection of others already existing or development of their own. (How HEW's gobbledygook definitions will translate into something concrete concerning medical care remains to be seen; none of the parameters in question, even at the level of national samples, has yet been published.)

The PSRO (or hospital) activities that these norms, standards and criteria are used for comprise *concurrent admission certification* and *continued stay review, retrospective medical care evaluation* and *analysis of hospital, practitioner and patient profiles.*

What concurrent admission certification concretely means is that someone performing what is known as the screening function, probably a nurse with the title of review coordinator, examines the patient's chart within a day of admission with reference to a set of criteria specifying indications for admission (e.g., acute myocardial infarction). If such indications appear, the patient's admission is certified as being medically neces-
Council's comments and recommendations) to the HEW Secretary.

If the case is sufficiently outrageous (the law uses language like "grossly and flagrantly violating" the law's obligations), the Secretary may temporarily or permanently disqualify the practitioner or provider from Medicaid or Medicare reimbursement or may require him, her or it to cough up the cost of the unnecessary or improper services or $5,000, whichever is less. (The practitioner or provider is afforded a panoply of rights to reconsideration, review and, in some cases, judicial review whenever an adverse determination comes down.) Between the cumber-someness of the mechanism, the professional ethos of the medical profession and the insulation from PSRO oversight of in-hospital review committees, it's unlikely that the Secretary will be overburdened by recommendations that the law's sanctions be invoked.

The Combatants Come Out of the Woodwork

Before the ink was dry on the PSRO legislation, the major contending forces on the health-care scene—organized medicine, organized hospitals, foundations for medical care and Blue Cross/Blue Shield—had begun maneuvering to shape the implementation of the

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**Professional Standards Review**

sary and the patient is assigned an initial certification period based on length-of-stay norms, probably the median length of stay for patients in the area with the same diagnosis and age. (This means that Medicare or Medicaid reimbursement is assured for at least that length of stay.)

If admission does not appear to the screener to be medically necessary, a physician reviewer is brought into action; he must notify the attending physician within two working days of admission to give the latter an opportunity to present his case before the final determination is made as to whether the admission was medically necessary. If the final determination is against admission, the Manual requires that the review committee verbally notify the attending, the patient and, in a Medicaid case, the state Medicaid agency within two working days following admission. (The thought occurs that if the review mechanism doesn't function that speedily, the admission may end up being deemed medically necessary.) Over time, the PSRO (or hospital) may identify hospitals, physicians or diagnoses that no longer require admission certification. Certification of emergency admissions may be performed on a random basis.

What continued stay review concretely means is that the review coordinator periodically checks on the patient's need for continued hospitalization, starting on or before the day initially assigned during admission certification. If the criteria being used indicate that further stay is justified, the reviewer assigns another certification period. If further stay appears unjustified, the case is again referred upward and the attending physician again consulted. If the final review decision is against further stay, the hospital, the attending, the patient and, if appropriate, the state Medicaid agency are notified; notification must take place prior to the expiration of the certified period "except under unusual circumstances." As with admission certification, the PSRO (or hospital) may over time identify hospitals, physicians or diagnoses that no longer require continued stay review.

In addition to these activities, each PSRO or hospital is required to have at least one medical care evaluation study going at any given time. These are retrospective in-depth reviews, usually based on data relating to the care provided a number of patients by a number of practitioners and "focusing on particular potential problem areas." The results, the Manual admonishes, "should be used by a hospital or PSRO in the development of curriculum for and in the monitoring of the effectiveness of its continuing education efforts."
program so as to maximize the advantage, or
at least minimize the disadvantage, to their
respective constituencies. Their initial battle­
ground was HEW itself, the battle being over
the locus within the massive agency of final
authority over PSROs. One possibility was
the Office of the Assistant Secretary for
Health, a result the AMA lobbied for because
that post is one it has some influence in fill­
ing. The other option was the Bureau of
Health Insurance of the Social Security Ad­
ministration, which administers Medicare
and which the AHA favored because it has
developed good working relations with that
branch of HEW.

Internal bureaucratic machinations were
the main preoccupation of the agency that
was supposed to be putting the PSRO show
on the road from the law’s enactment in Oc­
tober 1972 until April 1974, when a Memo­
randum of Understanding was negotiated by
the warring parties with some prodding from
their congressional overseers on the Senate
Finance Committee, who had complained to
HEW Secretary Caspar Weinberger that
PSRO implementation was getting nowhere.
The terms of the truce place overall direction
of the program, including formulation of
policy, in the Office of the Assistant Secre­
tary, while directing the Bureau of Health
Insurance to develop and implement operat­
ing procedures relating to such matters as de­
development and oversight of the PSRO budget
and reimbursement system and coordination
of data collection.

"American physicians wel­
come PSRO with the kind of
enthusiasm usually reserved
for a major epidemic."
—Medical Opinion
December 1973

Needless to say, conducting a civil war
had somewhat handicapped HEW in making
the PSRO program a concrete reality. It
barely made the statutory deadline of Janu­
ary 1, 1974 for designation of PSRO areas,
publishing proposed designations of such
areas in the Federal Register of December
20, 1973 and final designations on March 18,
1974. Its first set of final PSRO regulations
didn’t appear until May 7, and these dealt
solely with the procedural niceties of designa­
tion of PSROs. As to regulations governing
the substantive operations of a PSRO, HEW
has to date only managed to produce the first
seven chapters of a projected 17-chapter
PSRO Program Manual (issued March 15,
1974), which are described by HEW as only
"interim guidelines."

The Great Boundary Dispute
For the AMA, the locus of final PSRO au­
thority within HEW wasn’t the only question
of program implementation affecting its con­
stituency; equally important was the ques­
tion of how the lines would be drawn deline­
ating the PSRO areas to be established
throughout the country. Geography may
seem like a dull subject, but when it has a di­
rect connection with control it acquires inter­
est. Control for the AMA meant the maxi­
mum possible number of PSROs constituting
entire states, for the simple reason that such
boundaries would coincide with those of a
state medical society, which would then be
in a position to spawn a companion organiza­
tion without dues that would qualify as a
PSRO. (County medical societies outside of
New York City weren’t of much help, the
number of doctors in most single counties not
being sufficient to fill the PSRO minimum
of 300.)

HEW took the position that it would desig­
nate statewide areas only in states having
fewer than 3,000 physicians. In this stance
the agency was backed by Sen. Bennett,
who insisted that local review of local med­
ical practice was the whole point of the PSRO
concept. (The law itself speaks only of "ap­
propriate areas," although the Senate Fi­
nance Committee report speaks of the ad­
vantages of local sponsorship and operation
of PSROs.)

The AMA then tried to sell HEW the idea
of awarding contracts to statewide organiza­
tions in large states, which in turn would sub­
contract with, and funnel funds to, local
PSROs for the conduct of review activities
under statewide supervision. HEW compro­
mised by creating the concept of statewide
PSRO support centers to provide technical
assistance to local PSROs within the state;
existing state organizations, it was indicated,
would be welcome to apply for federal fund­
ing for this purpose. (The concept’s legal
base rests, somewhat shakily, on the law’s
directive to HEW itself to provide technical assistance to PSROs.)

Thus compromised, HEW published proposed area designations in December including 26 states and the District of Columbia as single PSRO areas. The final designations, published in March—after a period for comment that the AMA unsuccessfully sought to extend through April—added Georgia and Washington, both states with over 5,000 physicians, to the statewide list. In April HEW awarded its first contract to a statewide support center, a $250,000 grant to the Pennsylvania Medical Care Foundation for the purpose of stimulating creation of PSROs in the state and helping them develop review procedures. Applications for support center grants had been received from 13 of the remaining 21 eligible states by the April 30 application deadline for fiscal 1974 funding.

**Organized Medicine Disorganizes**

The general stance of the AMA leadership toward PSROs—and originally the official policy of the Association—has been one of acceptance of the legislation, with a view toward having a hand in its implementation and working for ameliorating amendments. Shortly after the law's passage the Association formed an Advisory Committee on PSROs with eight task forces and reportedly at one point had more people working on PSROs than HEW. The AMA rank and file, however—regrettably for the sake of organizational unity—includes physicians, largely from places like Southern California, the South and the Midwest, who are intent on repeating the battle of Medicare. These elements succeeded in muddying the waters at the December 1973 meeting of the 244-member House of Delegates, held appropriately at Disneyland in Anaheim, California.

The Board of Trustees presented the delegates with a report observing that repeal of the law was an unrealistic prospect but that amending it was within the realm of possibility and recommending that the Association "continue to exert its leadership" in implementing the law, while pushing for its amendment and attempting to take part in drafting its regulations. The heated debate that followed climaxed with the introduction of an amendment to the report put forth by the ultraconservative Association of American Physicians and Surgeons and a coalition of state medical societies. Adopted by the House, along with the rest of the Trustees' document, the amendment states that "the best interests of the American people, our patients, would be served by repeal of the present PSRO legislation." The Trustees and the Council on Legislation are instructed to "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."

(Continued on page 14)
Southern Empire

Durham, North Carolina, has one of the highest venereal disease rates in the country. The fetal death rate is nearly twice the national average. People in Durham are not very healthy, and all indications point to their getting less so.

The health problems of Durham are not due to a lack of doctors or facilities. In fact, health is the leading industry in the city. More than 9,000 people in this city of 135,000 are employed by health institutions. Together the three general hospitals have 1,141 beds. Durham County also has lots of specialized medical services. It has four times the ratio of radiologists to population as the average for the rest of the country, five times that of neurosurgeons, three times the ratio of psychiatrists and six times that of orthopedic surgeons. However, the area has only one-seventh the ratio of general practitioners to population as the country as a whole.

A 1973 study sponsored by the Health Planning Council of Central North Carolina documented Durham’s priority health needs as emergency services, preventive health programs and accessible primary care. The study reported that “there appears to be no need to increase the number of beds to serve Durham residents.” Undaunted, Durham’s powers that be are about to add 250 more beds at two new hospitals, a new medical research center and more specialists per capita. Not surprisingly, these plans coincide with the priorities of Duke University. And according to Terry Sanford, Duke’s President, “Our University can only be great with a great Medical Center.” The crown jewel of this complex is to be a brand-new, sparkling $91 million hospital.

Duke University was created by the family of Washington Duke, founder of the American Tobacco Company. Mr. Duke’s descendants and their various financial interests are intertwined with the expansion of Duke’s medical center. Just as American Tobacco grew into one of the largest and richest corporations in the country (41st in net profits), so Duke grew into a major university.

In order to be a great medical center, Duke needs access to a community hospital from which to draw its teaching material and an academic hospital in which to do its research and make its money. The power structure of Durham has been obliging in both respects. A new community hospital is now under construction, and work is about to begin on the new university hospital.

Dukes, Durham and Duke

Durham derives its very name from a bit of health enterprise in 1854, when Dr. Bartlett Durham sold a tract of land to a railroad company. The company set up a very profitable railroad station, which became an active trade and commerce center. But it was not until after the Civil War that Durham really began to take the shape of the Southern city it is today, with the health and tobacco fortunes so closely tied together. In 1865, Washington Duke, together with his two sons, started a tobacco firm which soon became the American Tobacco Company. Along with the Duke factories and warehouses came the bankers, brokers and builders who together built the foundation of what is today Durham’s power structure.

Tobacco was not the only booming indus-
try of Durham, for it made the banking business possible. A most important name is that of G. W. Watts, who came to Durham in 1878 as treasurer of the Duke tobacco firm and ventured into banking, laying the groundwork for the Watts family’s ties to one of Durham’s largest banks today. The local textile manufacturers also ventured into banking, and by the turn of the 20th Century, the banking-tobacco-textile interests had control of Durham and had set the stage for the beginning of the health industry.

Trinity College, a small men’s school affiliated with the Methodist Church, moved into booming Durham in 1892. Twenty-two years later it became Duke University as a result of an endowment provided by the James B. Duke Trust Fund, set up to honor one of Washington Duke’s sons. Not to be outdone by places like Johns Hopkins, the Duke Hospital and Medical School was opened in 1930, bankrolled by one of the largest shareholders in the tobacco company, John D. Rockefeller.

Duke Hospital was the third hospital established by the Dukes and their compatriots. Durham’s first hospital was founded by Dr. A. R. Carr, the brother of a textile magnate. George W. Watts, the tobacco-treasurer turned banker, financed the hospital. Watts Hospital, which opened in 1895, remained a segregated all-white institution until the mid-1960’s. Around the turn of the Century, according to local legend, Washington Duke was dissuaded by his butler from building a monument to the slaves who fought with the Confederacy and instead founded Lincoln Hospital to serve the Black population. (The only other hospitals on the scene are for specialized populations—a Veterans’ Administration Hospital, a cerebral palsy hospital and an eye, ear, nose and throat hospital.)

**Health in the Land of Wealth**

Lincoln and Watts Hospitals are both old and deteriorated. It has been clear for some time that new facilities are needed. A new hospital that will combine the two old ones into one unit is now under construction. But this $21-million, 500-bed hospital is not being designed to meet the health needs of Durham’s people.

Construction of the Durham County Hospital is being financed through a local bond issue and federal Hill-Burton funds. Public money, however, does not bring public accountability. The hospital’s board of trustees is self-selecting and represents the elite of the Durham business community and Duke University. Its 15 members include a number of bank directors and the leaders of the insurance and real estate industries; Duke is represented by its architect and former Vice-Provost. (For the full composition of the board, see box page 10.)

The site of the new hospital serves the interests of those who sit on its board, not of those who will depend upon it for their care. Durham County Hospital is being built miles away from the center of the city. Although promised when the new hospital opens, there is not now a bus line which travels out to it. The site is in a section of Durham County owned by a leading real estate developer and the city’s biggest banker. Together they are promoting nearby suburban residential development. To enhance the attractiveness of the area to the upper and middle classes and maximize the developers’ profits, a “medical park” for private practitioners is being built adjacent to the new hospital.

The people of Durham are not getting the accessible primary care that the Health Planning Council (HPC) study documented as their number one health need. Most people will have difficulty traveling out to the new hospital. But Duke Medical School couldn’t care less as long as its needs are being met. Its medical students will rotate through the hospital; the Medical School will run the department of surgery; and the family medicine training program, which Duke now operates at Watts, will be transferred to the new hospital. And finally, the County Hospital’s 30 percent “service” beds will function as the receiving end of Duke’s policy of refusing admission to persons “when other facilities are available . . . more appropriate to the patient’s financial circumstances.”

**From Dukedom to Kingdom**

Long content to be just a quiet monument to J. B. Duke’s memory, in the past ten years Duke University has decided to “go national.” This decision represents not only the desire to create an institutional name (the Harvard of the South), but also reflects the ambitions of the men in power at Duke. A growing and powerful institution is an important base for their own personal advancement.

The University as a whole is in an excel-
lent position to grow. Its trustees come from deep within America's ruling elite. Native North Carolina industry is well represented by such giants as Burlington Mills (in the person of Henry Rauch, retired board chairman), R. J. Reynolds Tobacco Company (Charles Wade, Senior Vice President), Hanes Corporation (Clifford Perry, Treasurer) and the state's largest bank, the Wachovia (pronounced "walk over ya") Bank (three leading officials). A major financial resource is the Duke Endowment Fund, the world's third largest foundation.

The University's national connections are no less prestigious and wealthy. Representatives of the Ford Motor Company, Mobil Oil, the Shell Oil Foundation and the Chicago Board of Trade sit on its board, along with two ambassadors from the Rockefeller empire—John Knowles, formerly of Massachusetts General Hospital, now president of the Rockefeller Foundation, and Nancy Hanks, a former Nelson Rockefeller assistant and executive secretary of the Rockefeller Brothers Fund.

A major asset in Duke's climb to national power was the recent acquisition of Terry Sanford as its president. A liberal ex-governor of North Carolina, Sanford ran for president in 1972, posing as a Southern Jack Kennedy. In addition to his political credentials, Sanford is an agile fund raiser. In 1973 he announced an "Epoch Campaign" to raise $162 million for the University's endowment; as of May 1974, over $40 million had been received.

A major focus of the University's expansion has been its Medical Center. During the past decade, while the Duke budget has tripled, the Hospital's budget has increased at about twice the rate. In 1964 Duke Hospital's operating expenses were $8.04 million. By 1973, $49.24 million was spent with only a 35 percent increase in the number of beds.

The man most responsible for the Medical Center's expansion is Dr. William G. Anlyan, Duke's Vice-President for Medical Affairs. Anlyan, a surgeon by training, is no stranger to national health politics. He has been on the executive board of the Association of American Medical Colleges (AAMC) for a number of years and was its chairman in 1970-71. He has also been chairman of the Coordinating Council on Medical Education. He was recently named chairman of the newly formed Association of Academic Health Centers, which claims to speak for the nation's schools of medicine, dentistry, nursing and other health occupations. Close to home, he sits on the Durham board of the Wachovia Bank, an office he assumed just two weeks before a branch office was opened in Duke Hospital. His recent book, The Future of Medical Education, articulates a view of an ideal health system dominated at the top by the academic medical center.

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The People's Reps
(DURHAM COUNTY HOSPITAL BOARD)

George Watts Carr, Jr., President of Southland Association, Durham's largest landlord and member of Chamber of Commerce executive board.

W. A. Roseborough, retired attorney and well-to-do farmer.

Spurgeon Boyce, a director of Central Carolian Bank and President of Boyce Supply Company.


Frank de Vyver, economics professor at Duke, former Vice President of Erwin Cotton Mills and former Vice-Provost of Duke.

Mrs. Joseph Robb, wife of Durham realtor and sister of the President of the Chamber of Commerce, who is also chairman of First Union National Bank Board.

A. C. Sorrell, a director of Guaranty State Bank.

Frank Kenan, President of Kenan Oil Co. and a director of Central Carolina Bank.

Edwin Clements, County Commissioner and owner of Clements' Funeral Home.

Howard Fitts, professor of health education at North Carolina Central University.

John Stewart, President of Mutual Savings and Loan Association.

John Wheeler, President of Mechanics and Farmers Bank, a director of North Carolina Mutual Insurance Co. and a director of Mutual Savings and Loan.

W. G. Pearson, attorney and a director of Union Insurance and Loan Association.

R. C. Foreman, retired executive of North Carolina Mutual Insurance Co.

W. J. Walker, Vice President of North Carolina Mutual.
Duke's mission, he is fond of stating, is research and teaching; patient care is a poor third.

The power behind the throne at Duke is J. Alexander McMahon, Chairman of Duke's Board of Trustees. After several years as President and chief operating officer of North Carolina Blue Cross/Blue Shield, he was named President of the American Hospital Association. McMahon served on the Health Services Committee of the Cost of Living Council, which administered President Nixon's Phase II wage-price freeze.

McMahon's presence on the Duke Board of Trustees provides the major link between the Duke group, with its national connections and aspirations, and Durham's local power structure. McMahon became the first President of a unified Blue Cross/Blue Shield in North Carolina. Before him, the Blues had been a collection of insurance agencies with loose ties to each other. McMahon presided over their merger and coordinated the construction of a $9 million glass and steel structure in Durham to serve as headquarters for the merged organization. In 1971, as the new building opened, the Blues reported a net loss of $5.4 million and announced a 32 percent rate increase, all the time insisting that the building and the rate increase were not related. For the past two years the Blues have finished in the black, a record marred only slightly by a lawsuit lodged by the Internal Revenue Service for overcharging 40 percent of their subscribers. They were charged with violating 15 pricing guidelines, a "mistake" affecting 650,000 North Carolinians. It seems that McMahon as head of the Blues was violating the pricing guidelines he was helping to make in Washington, as a member of the Cost of Living Council's Health Services Committee.

The man who brought McMahon to Durham is George Watts Hill, Sr. Founder of the state's Blues, Hill served for 25 years as the Board Chairman of Watts Hospital and for 38 years as Chairman of the Blue Cross Board. Although he retired last year (he's Chairman Emeritus), Hill still goes to the new building and terrorizes employees about such things as his preference for glass ashtrays over plastic ones.

Hill is Durham's dominant business man. He controls the city's largest bank (the Central Carolina Bank, CCB), the largest white insurance company (Home Security Life), another bank (Guaranty State), the largest hotel, the largest dairy and the town's railroad. His son sits on the Board of Directors of Southland Associated, Durham's largest landlord.

Hill's power in the local health establishment is cemented through his benevolent bestowal of board seats on his banks and/or on the Board of North Carolina Blue Cross/Blue Shield. For example, at the head of the quasi-public body that will run the new County Hospital sits Spurgeon Boyce, a compliant member of Hill's CCB board. The director of the hospital is Thomas Howerton, whom Hill proudly boasts he "brought to Durham." Howerton was given a seat on the Blues' Board. The chairman of Duke's Department of Medicine also sits on Hill's bank board. Hill himself is a member of the Regional Health Planning Council of Central North Carolina, the local comprehensive health planning agency. He was responsible for the recruitment and hiring of that agency's executive director, George Stockbridge.

The Crown Jewel—
Duke's New Hospital

No medical empire is complete without its imperial headquarters. All of Duke's power, with its national and local connections, has coalesced around its proposal for a new Duke Hospital. Deciding that 200 of the beds in its existing 800-bed hospital are obsolete, Duke commissioned a major accounting firm to establish the financial feasibility of a new hospital. It conveniently concluded that the resources were available for the construction of a $91 million, 1,000-bed facility. All 1,000 units will be single-bed rooms, thus further emphasizing Duke's highly specialized inpatient priorities.

To provide the operating costs of the new hospital, Duke projects a 73 percent increase in average gross costs a day—from $151 to $263. This increase, of course, will be reflected in the Blue Cross premiums paid by local people and in the amounts of public money turned over to the Hospital from Medicaid and Medicare.

Sixty million dollars of the cost of the new hospital is to be raised through long-term debt floated at the local banks. The remaining $30 million or so is to be obtained from hospital operating funds and private sources. Duke Hospital is freeing up this money in
predictable ways. Those services that are most profitable are expanded, and the rest are either constricted or the fee scale is raised. For example, visits to Duke's profitable private diagnostic clinic have increased 73 percent since 1967, while the public clinics have seen only a 4 percent increase in the same period. Since 1971 the private clinics have continued to grow while public clinics have remained at the 1971 level.

In the double-think language of Wallace Jarboe, Director of the University's Office of Project Management, "We are not cutting back on outpatient services. That is the terminology of the auditing firm. . . . What we are doing is freezing our losses."

Another method employed by Duke for generating funds for the new building is through lowering personnel costs at the existing institution. A hiring freeze has been in effect for many months. A recent memo from the director of employment at the hospital, Robert A. Duncan, instructed the deans, department heads and division chiefs that "No one is to be hired for the biweekly payroll at a rate above the minimum for the position unless approved by me" and that "new employees may be hired below the minimum" up to 10 percent. Jobs requiring skilled technical people are going to untrained workers to save money. One repercussion of this policy has been three job actions by various categories of employees. The dietetic workers, the microbiology technicians and the data terminal workers have walked out because of low pay and understaffing.

The microbiologists' job action was the most recent and also the most dramatic of the three walkouts. Immediately after they walked off their jobs in late May, Duke Hospital suspended them for 30 days. Although there were only six workers in this job category, they appealed to their fellow hospital employees and were successful in gaining support at rallies and meetings. Because of the extensive coverage in the press, the unsanitary, overcrowded and understaffed Duke labs became a local scandal. Because of the support of other hospital workers, the press coverage and the indispensable nature of their work, Duke had to capitulate to the technicians' demands. Three weeks after the walkout began, the microbiologists were reinstated at a higher salary, four more technicians are being recruited and the lab space is being cleaned up and expanded.

As Duke increasingly squeezes its employees to raise the necessary money for the new hospital, job actions may become more frequent and more militant.

Heavy-Handed Duke

As Duke Medical School has expanded, so has the opposition of people in Durham to Duke's imperial plans. When the new hospital proposal was first announced, a coalition of community people and health workers formed in opposition to it. Since all new

Chinks in The Armor

Duke is committed to raising $30 million for its new hospital from its own funds. But, according to the hospital accounting firm's financial feasibility study for the new hospital, several lawsuits now pending against the medical center might seriously undermine the solvency of the project. It seems that back in 1966, at the beginning of Medicaid/Medicare, Duke was a little too anxious to get its hands on the money. The state and federal government are suing Duke for more than one million dollars for overcharging its public patients. The federal government is also after Duke Hospital on another front. It is suing Duke for violating the Fair Labor Standards Act. Duke paid its employees below the minimum wage to the tune of another one million dollars.

Duke's potential financial problems extend to yet another area. Several people, conceivably over thousands of patients who had been hospitalized or have used the outpatient clinics, have received bills not only for the services they received but also mysterious, unitemized bills from the Private Diagnostic Clinic. None of these people ever used the private clinic or remember making the acquaintance of any of the doctors whose names appear on the bills. Litigation is being considered by both individuals and community groups.

If all of these suits are successfully litigated, Duke is going to have to figure out some other ways to skin the cat.
capital construction that is either publicly financed or underwritten must be approved by the local comprehensive planning agency, this coalition was able to voice its disapproval at a public hearing.

About 60 people turned out for the first public hearing. The angry audience was made up of lower-income Blacks and whites who depend upon hospital clinics for their primary care, young middle-level employees of Duke Hospital, workers from other Durham institutions and union representatives. The group had been brought together by a Durham health collective—the local chapter of the New American Movement (NAM).

I. B. Holley, Duke history professor and Chairman of the Project Review Committee of the HPC, presided. When questions about both the financing of and need for the new hospital were raised at the hearing, Holley took the position that “None of the questions raised can be answered here. This is an informational hearing and it is not the proper place and time for answering questions.” After two hours of testimony about Durham’s priority health problems, the working conditions of health workers, the poor quality patient care provided at Duke Hospital and the unanswered questions about financing, the hearing was adjourned. The audience demanded another hearing, which was reluctantly agreed to by the HPC committee.

At the second hearing, the committee unexpectedly voted against the Duke proposal. In most other cases a rejection by the committee meant a rejection by the entire Health Planning Council. But, according to George Stockbridge, Director of the HPC, those who voted against the proposal only “wanted more information and assurances for them to support the proposal.” Stockbridge attempted to set up a meeting between those who voted against the proposal and Duke officials, but it was called off when, according to one committee member, word of the meeting leaked out. To make certain it did, leaflets containing this information were distributed by the opposition coalition at all the hospitals and in downtown Durham.

But more was in store at the HPC. Within two weeks the HPC’s entire board was called to a meeting at the new Blue Cross building. The Project Review Committee had barely time to make its presentation when George Watts Hill, making a rare public appearance, made a motion that the project be approved. Hill reminded all present that it was he who brought Stockbridge to Durham and his judgment was to be trusted. Although the Council has a 42-member board, Hill’s motion was passed with only 18 voting for and three against. (The rest abstained.) Whatever intimidation and back-room arm twisting Hill applied apparently worked. (One footnote to all of the above is that every building in which a meeting of the HPC was held to consider Duke’s plans is owned, controlled or donated by George Watts Hill, Sr.)

The Duke proposal has already passed its second step in the necessary chain of approval. Here again the power and influence of Duke and Company are apparent. Its proposal was approved by the Division of Facil-

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**Tooling Up At Duke**

Duke will have a new community hospital, a new academic hospital and, thanks to the generosity of Edwin C. Whitehead, Chairman of the Technicon Corporation, a major research institute. Mr. Whitehead, who owns more than 90 percent of the medical instruments company, announced that his year-long search for an appropriate university to receive his gift had ended. He chose Duke over such other worthy contenders as Harvard, MIT and Stanford because it is “the ideal environment for a research center.”

The Whitehead endowment of the soon-to-be-opened Whitehead Institute is estimated to be in the neighborhood of $200 million, making it a close second to the Rockefeller Institute. In making his announcement Whitehead emphasized that the new institute would concentrate on “purpose-oriented” research, concentrating on particular problems and attempting to translate the solutions as quickly as possible into patient care. Mr. Whitehead waxes, “Too much research is stuck off in the laboratory and never sees the light of day.”

One can reasonably assume that the translation of research into the light of day will involve the use of sophisticated diagnostic instruments. Mr. Whitehead’s benevolence will most likely be well rewarded.
ities Services of the North Carolina Department of Human Resources. On the board of this agency sits an official of the Duke Endowment Fund, the tobacco family’s major foundation. The health coalition opposing the Duke expansion contacted a state agency official and asked if the agency had seen a copy of the HPC committee report disapproving the project. The official answered that they had not. He added that there was no recourse at the state level in any event and that all objections regarding the proposal now had to be referred to the Department of Health, Education and Welfare.

The Duke experience had been a result of that convergence of factors that make for the growth of a medical empire. An impressive array of nationally connected figures has been drawn to Duke to abet and encourage its expansion. There is a local power structure both unified and determined to back up with its money and influence the wide-ranging plans of the University—plans that not only put feathers in their caps but also money in their banks. Despite the opposition of community people and health workers, this mixed chorus sings a familiar song—the people be damned.

—Paul Bermanzohn and Tim McGlone. The authors are members of the Durham chapter of the New American Movement (NAM).

## PSROs
(Continued from page 7)

A high AMA official, who chose to be unidentified, was quoted after the meeting as observing that the original report and the added-on amendment “appear to have slight contradictions—at the very least.” The Trustees subsequently adopted the position that the pro-repeal language of the amendment was “a considered opinion” of the House of Delegates and not a “directive.” Whatever it was, it reportedly led HEW to change its mind about awarding the AMA a contract for running a training institute on PSROs, which had been close to approval before the Anaheim debacle.

As if that episode weren’t enough for the destruction of the credibility of medicine’s principal organization, the AMA followed it up in March with an information kit titled “PSRO, Deleterious Effects,” which it mailed to 400 state and county medical societies and the 500 members and alternate members of the House of Delegates. The packet included canned editorials and a canned speech on “Exorcising the Devil from PSRO,” all of which contended that the law favors hospital staff and “HMO-type” doctors over private, fee-for-service practitioners; that it will discourage individual physician judgment and retard medical progress; that it is too punitive and that the FSRO concept is untested.

All of this was a bit much for Sen. Bennett, who blasted the kit as representing “new heights of distortion and misrepresentation, exposing the most non-professional and least credible aspects of the American Medical Association.” One HEW official wryly observed that “Some people think it [the kit] could have been the best thing to happen to PSRO. It upset those people who were not sure about the program and switched them over to PSROs.”

Whether or not the backlash effect had anything to do with it, favorable positions toward PSROs have been forthcoming from such bodies as the American Society of Internal Medicine, the American Academy of Pediatrics, the American College of Surgeons, the American College of Physicians, the Association of American Medical Colleges and the American Osteopathic Association. By late spring, HEW officials were being quoted making statements like “Enough doctors are willing to work with the program so that it’s no longer an issue whether the AMA backs us up or not.”

The AMA thought it was still an issue, however; its Board of Trustees presented another report and recommendations to the House of Delegates meeting at the annual convention in Chicago, June 22-27. This time the House, by a lopsided majority, rejected a number of pro-repeal resolutions and accepted the Board’s position that the Association should “continue on its present course of
leadership” in influencing implementation and seeking amendment of the legislation.

**Foundations Get It Together**

Unlike the diehards of the AMA, doctorsponsored foundations for medical care, now numbering well over 100, have been savvy enough to view PSROs as a bandwagon worth climbing on. After all, medical-care foundations were created in that bastion of conservatism, Southern California, as a means of keeping out the liberal menace in the form of the Kaiser Foundation Health Plan with its salaried physicians (see BULLETIN, February, 1973).

Foundations have developed both as health plans (preserving the independence of the solo, free-for-service practitioner) and as review systems, either monitoring their member physicians for unnecessary services or contracting with insurance companies and Medicaid agencies to review claims. The foundation model became the basis of the PSRO concept; the Senate Finance Committee report on the PSRO amendment approvingly cites the fact that medical-care foundations “have developed patient and practitioner profile forms and approval certification and other review methods which may provide the bases for development of uniform data gathering and review procedures capable of being employed in many areas of the Nation.”

President Donald Harrington of the American Association of Foundations for Medical Care (AAFMC) observed in September, 1973 that “In every instance we know of, medical societies that have formed foundations are relying on them to take the lead in setting PSROs up.” Shortly thereafter, the AAFMC spawned the AAPSRO—the American Association of Professional Standards Review Organizations—whose active membership is limited to member foundations of the AAFMC. A two-day conference on PSROs held by the AAPSRO in April drew over 500 registrants eager to learn the ins and outs of how to apply for a PSRO contract and how to comply with the PSRO Program Manual. And among applicants that met the April 30 deadline for fiscal ’74 contracts with HEW as statewide support centers, conditional PSROs or groups doing PSRO planning, medical-care foundations were prominently represented.

**Hospitals Play It Cool**

The hospital establishment was of course responsible for the provision of the PSRO law instructing PSROs to accept the findings of existing in-hospital review committees that can pass muster as doing the kind of review required of a PSRO. In the alphabet soup of the field, the AHA’s QAP now floats to the top.

The Quality Assurance Program was developed by the AHA while the PSRO legislation was in the works. QAP contemplates two working committees of a hospital’s medical staff, operating under the general direction of a QAP committee including trustees and administrators as well as physicians. A utilization review committee would run a utilization review program with some or all of five elements—preadmission certification, preadmission testing program, length-of-stay certification, length-of-stay review and discharge planning. A medical audit committee would develop criteria (criteria that confirm a diagnosis, criteria for management of therapy and outcome criteria) through which allied health personnel would screen patient charts and refer to the committee for retrospective review patterns of care that do not conform to them. The committee’s armament for corrective action comprises educational programs for individuals or groups, administrative changes and, as a last resort, limitation of physician privileges.

Development of QAP mechanisms by its member hospitals is urged by the AHA as “the best safeguard of the voluntary sector.” Acceptance of QAP under the PSRO program would free the hospital from the risk of retroactive denials of claims for Medicare and Medicaid payments. Ultimately it is anticipated that private health insurers would similarly accept QAP in lieu of review of individual claims. This will mean, notes Dr. Thomas Ainsworth, the architect of QAP, that “physicians, not third-party purchasers, will be making all determinations of the medical necessity of care.” It also means of course that the hospital’s cash flow will be appreciably more certain.

A byproduct of all this will be increasing institutional control over the conduct of physicians who practice in the institution. In the euphemistic words of the AHA: “The utility of such a hospital-based quality assurance program is that it enables the board of trustees, the administration, and the medical staff
to control the quality of care that their hospital provides.” It conversely gives the short end to the little guy who’s not a big muck-a-muck in hospital medical staff circles, a fact that may partly explain the divergence within the medical profession between those who feel they can live with PSROs and those whose adrenalin flows at their very mention.

The AHA has done its work well in selling QAP’s virtues to HEW. It has long insisted that QAP exceeded the requirements of PSRO review, and in March HEW announced that the two programs were compatible. This may, by the way, have been a bitter pill for the AMA to swallow—the infamous December meeting of its House of Delegates passed a resolution in opposition to QAP.

Academic hospitals, it should be said, are a little less sanguine than the AHA about PSROs. Their fear is that norms and criteria developed with respect to community hospitals may be imposed on their operations, which might cramp their orientation toward the requirements of teaching and research. The Association of American Medical Colleges (AAMC) has urged that the next revision of the PSRO Program Manual include a statement acknowledging the special circumstances of teaching hospitals and instructing PSROs to take them into account. And officials of the National Medical Association have expressed the fear that standards developed with respect to suburban hospitals serving a middle-class clientele may hurt the care of poor patients using inner-city institutions.

Blues for the Blues

PSROs are not such good news for Blue Cross and Blue Shield, which in their capacity as fiscal intermediaries and carriers under Medicare have made review of claims a big business, much of which is slated to be phased out as PSRO review is phased in. All is not lost, however, for the Blues have something that PSROs need—a sophisticated computerized data processing system that would be expensive to duplicate. The Senate Finance Committee report notes that while the Blues will be left out of the responsibility for review, where they “have existing computer capacity capable of producing the necessary patient, practitioner, and provider profiles … on an ongoing expeditious and economical basis, it would certainly be appropriate to employ that capacity” for PSRO purposes.

And the PSRO Program Manual instructs that “Data flowing from the Medicare and Medicaid claims process is to be utilized to the maximum extent possible.”

Meet the Professional Standards Review Council

The PSRO law provides for the creation of a National Professional Standards Review Council of 11 physicians “of recognized standing and distinction in the appraisal of medical practice,” to be appointed by the HEW Secretary. A majority of the members must be physicians recommended by national organizations of physicians; the membership must include physicians recommended “by consumer groups and other health care interests.” The law directs the Council to advise HEW on the administration of the program, review the effectiveness of the operation of PSROs and Statewide Professional Standards Review Councils, sponsor studies intended to develop recommendations to HEW and Congress for means of more effectively achieving the law’s objectives and at least annually submit to HEW and Congress a report of its activities including the findings of its studies and its recommendations.

From something like 200 nominations submitted from something like 50 organizations, the Secretary has appointed the following balanced ticket, in alphabetical order:

Dr. Clement R. Brown, nominee of the American Hospital Association, Director of Medical Education at Mercy Hospital in Chicago.

Dr. Ruth M. Covell, nominee of the American Public Health Association, Assistant to the Dean at the Medical School of the University of California at San Diego.

Dr. Merlin K. DuVal, HEW’s own candidate, formerly HEW Assistant Secretary for Health, now Vice President for Health Sciences at the University of Arizona in Tucson.

Until his death in March in an auto accident, Dr. Thomas J. Green, the Council’s
The data question—which represents both money and control—is on its way to becoming a battleground between the Blues and the foundations. A delegation from the Blues to

Black member, a Detroit surgeon who was a trustee of the National Medical Association and a member of the AMA's Advisory Committee on PSROs.

Dr. Robert J. Haggerty, nominee of the National Urban Coalition Health Project, professor of pediatrics at the University of Rochester Medical School and head of the study section of the National Center for Health Services and Development.

Dr. Donald C. Harrington, nominee of the Senate Finance Committee, Medical Director of the San Joaquin Foundation for Medical Care and President of the American Association of Foundations for Medical Care.

Dr. Robert B. Hunter, a family physician from Sedro Woolley, Washington, who is a member of the AMA Board of Trustees and Chairman of the AMA's Advisory Committee on PSROs.

Dr. Alan R. Nelson, an internist from Salt Lake City, Utah, who helped develop a PSRO prototype in Utah and is an alternate delegate to the AMA House of Delegates.

Dr. Raymond J. Saloom, an osteopath from Harrisville, Pennsylvania and President-elect of the Pennsylvania Osteopathic Association.

Dr. Ernest W. Saward, former Medical Director of the Kaiser Foundation Health Plan, now Professor of Social Medicine at the University of Rochester Medical School and President of the Group Health Association of America, an organization of prepaid group practices.

Dr. Willard C. Scrivner, an obstetrician-gynecologist from Belleville, Illinois and President-elect of the Illinois State Medical Society, reportedly a candidate of the House HEW Appropriations Subcommittee.

A statement made by Dr. DuVal when he was HEW Assistant Secretary described the Council as having been "intentionally created by the Congress to represent the concern and interests of the private practicing physician, giving him, in effect, direct access to the HEW Secretary and assuring him constant input on PSRO policy development and implementation."

Consumers Get the Short End

The whole point of the PSRO program is of course that medical care will be judged only by physicians. (Indeed, the law includes a provision that a final determination as to the propriety of care may only be made by a "duly licensed doctor of medicine or osteopathy.") Thus consumers are relegated to an almost nonexistent role in the program's operation: Statewide Professional Standards Review Councils, to be established in the 18 states having three or more PSROs, are to include in their membership "four persons knowledgeable in health care" from the state, who need not be physicians, two of whom are to be nominated by the Governor and two chosen independently by HEW. These four are outnumbered by one physician representative from each PSRO, two physicians designated by the state medical society and two physicians designated by the state hospital association. And the functions of the Councils are limited to such tasks as the coordination of activities of and dissemination of data among the state's PSROs; the PSRO Program Manual makes clear that "the State Council has no direct authority over PSROs."

Given this limited arena in which to operate, such consumer activities as have existed around PSROs have centered on the question of data availability. Robert E. McGarrah Jr. of the Nader-affiliated Health Research Group (HRG) urged at Senate Finance Committee oversight hearings on PSROs held in May that a PSRO's norms, standards and criteria and the profiles it develops of practitioners and providers be made public documents. (HEW's current inclination is reportedly to mandate release of PSRO parameters, but the question of public availability of profiles is a hot one and remains unsettled.) "Data is our main focus," explains McGarrah, "because with this legi-
lation there is very little consumer input."

A position paper produced by the HRG and the Consumer Health Project of the National Urban Coalition urges consumers to submit nominations for seats on the Statewide Councils; their argument is that the Councils are worth serving on because "they will have access to extremely valuable information on the cost and quality of medicine in the different regions of a state."

Being left out of things might not be worth complaining about if consumers could rest assured that PSROs presage an improvement in the quality of the health care they receive. It seems safe to predict that the program's direct effect on patient care will for the foreseeable future be minimal at most. The fact that predetermination certification of elective hospital admissions is voluntary and thus unlikely to be engaged in means that the threshold decision to hospitalize will not be examined in a setting where such examination could make a real difference. Once a patient is hospitalized, the concern of the review mechanism is limited to the question of length of stay (see box page 4). The question of quality is only addressed through retrospective studies of groups of patients, whose effect on any individual can only be indirect and long-term.

The program may have the byproduct of indirectly inducing physicians to practice a form of medicine by protocol, known variously as "cookbook medicine" or "textbook medicine" by its detractors and proponents. PSROs are mandated to develop criteria of care for various diagnoses, primarily for their use in retrospective medical care evaluation studies. Physicians may decide that conformance to such criteria will bring protection against suits for malpractice, a decision the law encourages through a provision that no physician may be held civilly liable for action taken in compliance with a PSRO's norms, provided he exercised "due care." Thus in the long run PSROs may have something of a levelling effect on the practice of medicine, with conditions whose treatment is amenable to standardization being uniformly well cared for, while treatment by medical geniuses for more esoteric conditions may suffer. Much of course depends on the actual content of the parameters developed, whose language may be so general and so hedged with qualifications ("as indicated," "where appropriate," etc.) that almost anything goes.

Publication of the profiles of practitioners and hospitals to be developed by PSROs—if it happens—potentially would have the further effect of beginning to make it possible for consumers to make informed choices as to what physician and what hospital they should patronize. Such data may, however, be a long time in coming—HEW has told PSROs to date only that they must review such profiles "when the capacity exists to develop them in their area." The data will of course cover only hospital-based care, and within that category may be so sketchy as to be of limited practical usefulness. And its potential usefulness in any event depends on the consumer being sufficiently well-situated geographically and economically to be able to exercise a choice among sources of care.

Health Workers to the Periphery

Nonphysician practitioners of the healing arts are only slightly less neglected than are consumers in the scheme of things under PSROs. They too get a few seats to sit in—these on advisory groups attached to the Statewide Professional Review Councils or to PSROs in states without Councils. (Only licensed doctors of medicine or osteopathy of course are eligible for membership in a PSRO itself.) These advisory groups are to include representatives of "health care practitioners" other than physicians, as well as representatives of hospitals and other facilities; their mandate is simply to "advise and assist" Councils or PSROs in carrying out their functions. Although the law and HEW pronouncements to date are unclear as to how broadly the term "practitioner" is to be defined, it seems to contemplate primarily folks like dentists, podiatrists, optometrists, pharmacists and professional nurses.

As to the involvement of such practitioners in the review process itself, the PSRO Program Manual admonishes that "while the PSRO retains ultimate responsibility for the decisions made under its aegis, it should
seek the participation of all health care practitioners” in the development of review parameters applicable to their professions, the establishment of review mechanisms to review the care they give and the actual conduct of such review. Given their absence from the seats of power in the PSRO or on in-hospital medical staff review committees, the influence of nonphysician practitioners appears destined to be peripheral at best.

PSROs will, however, increase the job market for nurses. Most of the review mechanisms involved (see box page 4) contemplate a fairly mechanical screening function as the first stage of review, a task to be performed by someone usually called a review coordinator, whom it is apparently contemplated will be a nurse. When the process gets close to real decision-making, her role becomes essentially that of a nag—nudging a physician reviewer to either convince an attending physician to discharge a patient because his certified length of stay has expired or else to certify that the stay should be extended so the hospital won’t lose its reimbursement.

But Is It Cost-Effective?

It will of course prove something of an embarrassment to HEW and the Congress if the cost of the PSRO review system—which will include a network of potentially very expensive data processing systems—turns out to be greater than the money saved from elimination of unnecessary health care. An argument for this possibility can be found in the case of the Hospital Admission Surveillance Program (HASP), a venture of the Illinois Foundation for Medical Care, under contract with the state’s Medicaid agencies, that certifies hospital admissions and lengths of stay for Medicaid patients. A six-month study of the program’s operation at Cook County Hospital found that $129,820 was saved from denials of admissions and of extensions of stay—this at a cost of $228,578 to Cook County Hospital plus $267,654 to HASP, for a total cost of almost $500,000.

That $500,000 figure also represents one estimate of the annual cost of operating a single PSRO (the first PSRO contract, awarded in June to the Utah PSRO, was in fact for $951,000); half a million dollars multiplied by 203 PSROs equals something over $100 million, to which must be added the cost of maintaining HEW’s PSRO staff, now number-

The law requires HEW to reimburse PSROs for “expenses reasonably and necessarily incurred” in carrying out their functions; HEW has yet to issue the chapter of its PSRO Program Manual that promises to detail exactly what that means. One unanswered question concerns payment of physicians for the time spent as members of a PSRO’s specialty committees in the development of local standards; the national specialty medical societies have volunteered to write sample standards free of charge, but it’s not clear whether their local counterparts will be that generous. There’s also the fact that if PSROs succeed in reducing the length of stay in hospitals, the cost per patient day will be increased; this because the most expensive care is given a patient during the first few days of his hospitalization.

Missing the Point

If PSROs fail as a cost-containing strategy, then such options as their mandatory extension to noninstitutional care, the reimposition of price controls on health-care providers or even the introduction of direct government intervention in the practice of medicine become real possibilities. All such approaches, however, ignore the cost-effectiveness question that would have a real effect on the collective health of the American people—the question of priorities. All such approaches, that is to say, fail to ask whether the finite supply of health-care dollars would better be spent on the screening and treatment of hypertension than the performance of open-heart surgery, or whether an infusion of resources into the state of Mississippi might not bring more value for the money than an infusion of resources into the island of Manhattan.

Such a strategy is not even attempted by PSROs, even if expanded and strengthened—not for that matter by national health insurance, however comprehensive—for such an approach requires appreciably more than funding or regulating an essentially private system. It requires what the AMA would have good reason to get mad at—a nationalized health system.

—Louise Lander
Peer Review

ANOTHER WORD ON CHIP

Dear Health/PAC:

I would like to add one observation to Ronda Kotelchuck's excellent dissection of Nixon's Comprehensive Health Insurance Plan, CHIP, in the March/April BULLETIN. CHIP is a leading member of one of the two general types of national health insurance proposals before Congress. The CHIP group, which includes the AMA's "Medi-credit," the commercial health insurance industry's "Health Care," and the Long/Ribicoff "Catastrophic Health Insurance Plan," would operate directly through the private insurance industry. The other group, which includes the Big Labor-backed, Kennedy/Griffiths "Health Security Act," the new Kennedy/Mills "Comprehensive National Health Insurance Act," and the old Javits expansion of Medicare plan, would eliminate the insurance industry entirely (Kennedy/Griffiths), or restrict it to a Medicare-like fiscal intermediary role. This, in my view, is the major issue concerning NHI proposals presently before Congress: what role will the private health insurance industry play?

CHIP gives it a major role, as Kotelchuck points out. That major role would lead not only to administrative complexity but would also lead to enormous profits for the private insurance industry, at taxpayer expense. According to the Social Security Bulletin (February, 1974, p. 32, Table 13), on the $11 billion in premium income which the private, commercial insurance companies (not including Blue Cross Blue Shield) currently take in, they suffer an "underwriting loss" of about 6 percent. That is, they pay out, in benefits and administrative costs, 6 percent more than they take in. However, they do not make public the figures indicating the money which they make by investing the premiums while they have them. They could break even simply by putting the money in a good savings bank! If they make a 15 percent return on investment, they are netting about $1 billion per year in profit!

This is a key to CHIP, which would tremendously boost the growth of the private insurance industry, and support it with federally-mandated employer/employee (read employee/consumer) payment and tax funds. Yet another area of potential profit to the insurance industry (which MCHR's Billions for Band-aids shows to be at the center of American corporate and banking capitalism) is actually running the health care system with all employed health workers, including doctors and dentists. The profit potential from fees now paid to private-entrepreneurial medical and dental practitioners is truly enormous, particularly if the product is mechanized, expanded by introducing large numbers of lower-paid "physician-extenders" and marketed vigorously. But that's another story. The main point is that CHIP represents American capitalism's drive to produce the real profits potentially recoverable from the health care industry.

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at Stony Brook
STRIKING SAN FRANCISCO RNs WIN PATIENT-CARE IMPROVEMENTS, PAY INCREASES

Over 4,000 registered nurses, represented by the California Nurses Association, struck 43 hospitals in the San Francisco Bay area June 7-27. The RNs' primary demands were for assurances that untrained personnel would not be assigned to specialized units (such as intensive care units) and for the right to take part in the determination of the nursing needs of each patient and each hospital service. They also sought a 5.5 percent salary increase, which management countered by offering an 11 percent increase, apparently in an attempt to undercut the RNs' patient-care demands. The House of Delegates of the American Nurses Association, meeting at the ANA's annual convention in San Francisco during the strike, voted a resolution of support for the striking nurses, affirming in particular the RNs' right "to participate in the decision-making process in their respective agencies."

Negotiations with the three hospital groups being struck (Kaiser-Permanente, Affiliated Hospitals and Associate Hospitals) at one point broke down over management's refusal to discuss the issue of adequacy of nurse staffing. Negotiations resumed when the parties, as well as HEW Secretary Caspar Weinberger, requested the mediation services of W. J. Usery Jr., head of the Federal Mediation Service.

The settlement package, ratified June 27, includes salary increases averaging close to 11 percent, an agreement that specialized training will be provided nurses assigned to seven specialized units, except in emergencies, and a pledge that nurses will be permitted to "participate" in determining patients' needs for nursing care. (In its September-October issue, the BULLETIN hopes to include a detailed analysis of the strike.)

NEW JOURNAL TACKLES BLACK HEALTH ISSUES

A bimonthly journal, the Journal of Black Health Perspectives (JBHP), is now being published by Masks, Inc., a nonprofit health education and research organization located in Berkeley, California (PO Box 2243, Berkeley 94702). A statement of editorial philosophy appearing in the Journal's first issue stresses its belief that "imperative to Black control over what happens to Blacks is the notion that we must develop an understanding of all forces that impinge upon the health status of people in our communities." The first issue also includes articles dealing with such subjects as experimental research, family planning and an overview of Black-related diseases, as well as regular JBHP features including an editorial forum, an interview and a discussion of legal issues relating to health.

HEALTH PRICE CONTROLS END, INFLATION BEGINS AGAIN

The lifting of price controls from the health sector April 30 was followed, not surprisingly, by an increase in May in the medical care services component of the Consumer Price Index (CPI) double that of the previous month, namely 1.2 percent, or an annual
rate of 14.4 percent. (The overall CPI rose 1.1 percent for the month.)

HEW Secretary Caspar Weinberger had attempted to forestall such a development by summoning to his office May 3 representatives of 20 medical, hospital and health insurance groups, whom he lectured on the virtues of exercising voluntary self-restraint. The alternative, he warned, was a parade of horrors ranging from "congressionally imposed shock treatment controls" to legislation creating "a federal monopoly... to replace the private health system." The American Hospital Association, it must be said, is doing its part for the cause; the AHA sells for $63 a cost-containment training program complete with slides and manuals tailored to "the hospital's own needs." The AMA, for its part, has written its members that they should consider "the political, economic and personal consequences of fee adjustments" at a time when "impulsive action could seriously and irreversibly affect the health of the public, the future of the individual physician and the nature of the medical profession."

LABORPOWER POLICIES UNDER FIRE

Administration policies on the training of health professionals came in for some hard knocks in June. First, the General Accounting Office released a report on current aid programs to health professions students, finding that medical and dental schools frequently use "inequitable and ambiguous methods and criteria for determining financial need" for federally supported loans under the Health Professions Student Assistance Program, that HEW has failed to develop adequate regulations or otherwise properly monitor the program and that the program overall has not significantly increased the output of medical and dental schools, improved the quality of their students or influenced the distribution of physicians and dentists.

Later in the month Senators Kennedy and Javits leaked to the press a confidential study conducted by HEW's Health Resources Administration, which sharply challenged the assumption underlying current Administration health labor-
power policy that a sufficient supply of health professionals is being produced by currently existing educational programs. The study cited estimates of a current shortage of 30,000 physicians, with more serious problems caused by their maldistribution, accused the Administration of underestimating future demand for health services and overestimating future increases in health laborpower productivity and warned that the Administration was pursuing a "high-risk strategy" through its policy of freezing the nation's capacity for training health professionals at present levels.

IF YOU CAN'T BUILD 'EM, MANAGE 'EM

What does a proprietary hospital chain do when comprehensive health planning and high interest rates make new hospital construction more difficult to bring off? Ten such corporations have decided that the thing to do is go into the business of managing nonprofit hospitals under contract. Leaders in the field are Hospital Affiliates, Inc. (HAI), with 30 such contracts, and Hospital Corporation of America (HCA), with nine. The Federation of American Hospitals, the proprietaries' trade association, calls contracting "the most exciting aspect of the growth potential" for hospital chains and claims that "Management contracts, especially with financially troubled hospitals, are winning new converts to the investor-owned sector."

In most cases where management contracting is employed, the hospital's administrator has departed; his replacement is provided by the contractor. If the administrator is still there, he usually becomes the company's employee. HCA insists that its administrator be made either chairman or secretary of the hospital's board of trustees; HAI asks that its administrator be a board member. Both firms insist on autonomy from board interference in day-to-day operations, pointing out that the board retains ultimate authority because it can terminate the contract. In addition to the administrator, a typical contract will involve sending in consultants such as accountants, nursing specialists, dieticians and medical records librarians. Fees range from 4 to 6 percent of gross annual revenue at HCA, while at HAI the typical rate is 5 to 8 percent.

HOSPITALS POLISH THEIR IMAGE

The J. Walter Thompson ad agency has a new half-a-million-dollar account, namely the American Hospital Association. The AHA is buying four 30-second spots to run during network news broadcasts of all three networks in September, as well as during the Washington, D.C. telecast of NBC's "Today" show to catch the congressional audience. According to the AHA, "The spots are designed to show that hospital people are responsible and efficient, that hospital care has been consistently improving, and that rising costs are necessary to provide high-quality care."

In the meantime, Johns Hopkins Hospital in Baltimore has hired TWA's Special Marketing Training Services to provide instruction by a former stewardess to 450 of its non-professional employees on the benefits of a "positive self-image." The one-day, six-hour class, at a price of $10 per student, includes such lessons as "Feel cheerful on the inside, and you will look cheerful on the outside." TWA reports that hospitals in three other states have bought the course, which most hospitals provide to their admissions personnel. According to a TWA spokesman, "Whether or not professional personnel receive the training depends on the climate at the individual hospital. Needless to say, attempting to teach doctors or professional nurses requires an enormous amount of tact. We must imitate Henry Kissinger in how we approach this."

ARIZONA JOINS THE UNION

Nine years after passage of federal Medicaid legislation, the Arizona legislature —on its sixth attempt—has voted to end its status as the only state without a Medicaid program, starting in October 1975. The state's projected share of the program's cost, $56 million, is $3 to $6 million less than what the present state-run program of medical care to the poor would be costing by then, and will be supplemented by $87 million in federal funds.
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