NEWS / PEER REVIEW

Professional Standards Review Organizations

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Of major interest to the medical, legal and insurance communities is quality control in medical care delivery. In this area careful, sensible planning can be most effective in helping physicians to render treatment (both preventive and curative) of the highest caliber, reducing the spiraling costs of providing medical care, and stemming the tide of malpractice litigation.

Formulation of a mechanism for providing such control, however, is no easy task. The instinctive desire of the medical profession for self-evaluation naturally clashes with the interest of third party payors in policing the care they finance, and with the needs of attorneys and legislators for a means of independent evaluation of the care furnished consumers.

One of the most recent and promising developments in this area is the creation of Professional Standards Review Organizations (referred to as PSROs). PSROs are to be established pursuant to P.L. 92-603, the 1972 Social Security Amendments, to review the need for, and quality of, institutional services provided for Medicare and Medicaid beneficiaries.[1] Eventually, they may affect the practice of every physician who cares for Medicare and Medicaid patients. Although the current budget for the PSRO office is $1.5 million, $32 million is to be transferred to it from other agencies in HEW. The purpose of a PSRO is to ensure that institutional care received by Medicare and Medicaid patients is appropriate, and is of a quality which measures up to medical profession standards.[2]

Recently, Dr. Henry E. Simmons (Deputy Assistant HEW Secretary, who has been described as "an idealist, but a tough-minded one")[3] replaced Dr. William I. Bauer as the Director of Professional Standard and Review. Dr. Simmons sees the value of the PSRO program as providing the medical profession with a mechanism to monitor the quality of medical care it delivers and, simultaneously, identifying inadequate, poor-quality care.

Various sanctions may be invoked against physicians who are chronic violators of the locally-set norms (they can be denied payment of claims, although fees will not be regulated by the PSROs; they can be declared ineligible to participate in Medicare and Medicaid programs; they can be fined up to $5,000; and they can have their questionable professional behavior made public). However, as Dr. Simmons has noted, the ultimate punitive effect of such sanctions often is on the patients, rather than the physicians. Thus, he believes the upgrading of quality will have to come about through the force of peer pressure.[4]

At present, PSROs are limited to evaluating care in institutions, except under exceptional circumstances.[5] The functions of PSROs may, however, eventually be expanded to include the evaluation of care provided in physicians' offices and clinics.

The target date for area designations of PSROs is January 1, 1974, and very shortly the country will be divided up geographically into PSRO areas in which at least 300 physicians practice. A controversial question as to what should be the appropriate PSRO unit appears to have been resolved by the decision that local groups of doctors - - not the state medical societies - - will petition HEW to become the local PSRO agency for peer review. This group of doctors will set standards of care for its geographical location and make certain that variations from that norm are medically justified.[6] The operations of the local PSROs will be overseen by an eleven-physician advisory council, whose responsibilities are to include guiding the operations of the local PSROs by establishing appropriate operating guidelines and standards of care.

An established PSRO will scan the records of Medicare and Medicaid patients, and trained clerks will review the data and pick out any unusual patterns of care for more intensive review by physicians.

Although peer review will not be used to provide evidence for malpractice suits, and such suits no doubt "will still be the external quality control for individual patients",[7] the setting of such standards is likely to pose some perplexing questions in the area of malpractice litigation. For example, will the standards set by the local PSRO (or the national advisory council) constitute legally binding norms for medical treatment? Under what circumstances will attorneys or third party payors have the right to be informed of, or to challenge, such standards? Questions such as these must be grappled with and answered with foresight, in light of the (sometimes conflicting) objectives and needs of the medical, legal and insurance communities, as well as those of the consumers of health care.

An institution which already has its own review mechanism may have it adopted by the PSRO (rather than requiring the PSRO to undertake another review itself), if the PSRO is satisfied that the mechanisms employed by the institution are effective.

Recently, many rank-and-file members of the A.M.A. have expressed their strenuous opposition to peer review under the new law and have accused the A.M.A. leadership of "selling out" to the federal government. Nevertheless, the A.M.A. leadership recognizes that strong Congressional support for the concept of PSROs makes it politically unrealistic to expect that the law might be repealed.

REFERENCES

1. "The ABCs of PSROs" 22 GROUP PRACTICE 29 (April, 1973).
2. "The PSRO Prognosis" 22 GROUP PRACTICE 17 (May, 1973).
3. "Washington Rounds", MED. WORLD NEWS (October 19, 1973) at 47.
4. ID.
5. "Washington Report" 53 POST-GRADUATE MED. 39 (June, 1973).
6. Hicks, "Nation's Doctors Move to Police Medical Care", NEW YORK TIMES, October 28, 1973, at 1.
7. ID. (quoting Charles m. Jacobs, Esq., Assistant Director of the Joint 'commission on Accreditation of Hospitals) at 52.

See generally, Welch, "Professional Standards Review Organizations - Problems and Prospects" 289 NEW ENG. J. MED. 291 (Aug. 9, 1973).