

Physician, Police Thyself: The Origins of Medicare Fraud and the Problem of Self-Regulation

In 1972, the Nixon administration mounted a “silent revolution” against the medical profession.¹ That year, legislation was signed that established Professional Standards Review Organizations. “PSROs” were regulatory bodies that radically altered the social controls over medical practice, mainly concerning procedural standards and physician-prescribed utilization of services. These were federally-mandated physician peer-review organizations meant to provide checks against unwarranted extensions of medical care for the sake of profiting from federal insurance programs, namely Medicare. While it may sound innocuous today, contemporary medical groups considered these review organizations an unprecedented intrusion on their right to practice medicine.

Health professionals turned to the media to complain. Dr. Jay Winsten, a research fellow at Harvard Medical School (later the director of the Office of Health Policy Information at Harvard), wrote in a 1973 *Wall Street Journal* article that, “There’s no doubt on the part of friends or foes alike that it is the most radical health legislation in this country’s history ... Doctors for the first time will be held publicly accountable for the quality, medical necessity, efficiency and cost-effectiveness of the health care they provide.”² It was reported that dozens of speakers at the annual conference of the American Medical Association that year condemned the law as

¹ Harris S. Cohen, “New Directions in Regulating Health Manpower,” in *Review of Allied Health Education: 2*, ed. Joseph Hamurg (Lexington: University Press of Kentucky, 1977), 19-34, p. 19.

² Jay A. Winsten, “Imposing Controls on Doctors,” *Wall Street Journal* December 6, 1973.

unconstitutional and threatened to sue, or at least strike. Even those favorable to the law were humbled by its presence. Dr. Harris Cohen, a political scientist working for the Assistant Secretary in the Department of Health, Education, and Welfare, the agency that oversaw Medicare, wrote in 1975 that it was “one of the most far-reaching forays into regulation to be legislated by Congress.”³

The provocations of this law, accompanied by the recoiling amongst those targeted for regulation, were especially vivid against the historic background of successful resistance by organized medicine against government interference. Much has been written about the opposition to nationalized health insurance by professional bodies such as the American Medical Association (AMA), and likewise their defense of professional autonomy in the medical marketplace. Indeed, organized medicine had for decades indefatigably crafted the perception that medical work was so expert and technical that no layperson or bureaucrat could know how to judge it. In his pioneering 1970 book *Profession of Medicine*, medical sociologist Eliot Freidson argued that the *sine qua non* of professionalism was autonomy. “In one way or another,” wrote Freidson, “through a process of political negotiation and persuasion, society is led to believe that it is desirable to grant an occupation the professional status of self-regulative autonomy.”⁴ In 1954 the AMA came close to saying that the state itself delegated its authority to organized medicine, reinforcing a *laissez-faire* approach to medical practice. “Much state legislation originates with the state [medical] societies,” noted the authors of an AMA report published in

³ Harris S. Cohen, “Regulatory Politics and American Medicine,” *Am. Behav. Sci.* 19:1 (1975), 122-136, p. 134.

⁴ Eliot Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (New York: Dodd, Mead & Company, 1970), 83.

the *Yale Law Journal*, “bills are often drafted with the aid of counsel, and such measures are easily introduced.”⁵ Such a powerful cultural profile made the medical profession seem unassailable, even when national health insurance was beginning to spread across the country against the wishes of organized medicine.

In 1982, ten years after the passage of the PSRO legislation, the sociologist Paul Starr published his now classic opus on *The Social Transformation of American Medicine*.⁶ He observed that the spirit of social and political activism of the 1960s gave rise to a “crisis of legitimacy” for the medical profession that helped to explain the flurry of reforms in the 1970s. “For the first time in a century,” Starr wrote, “American physicians faced a serious challenge simultaneously to their political influence, their economic power, and their cultural authority.”⁷ But the introduction of regulatory laws was not an automatic or ideological consequence of enabling access to national health care against the forces of a medical monopoly. A major concern facing Congress and expressed in public outcry was skyrocketing health care costs. As Starr wrote, “the key was the structure of financing.”⁸ Since Congress designed the structure of Medicare financing, they, in part, had themselves to blame for creating the problem.

But while cost control provided an impetus for Congress to act, the focus of the legislation was more grievous. It was a response to problematic patterns of practice created by organized

⁵ D.R. Hyde, et al., “The American Medical Association: Power, Purpose, and Politics in Organized Medicine,” *Yale Law J.* 63:7 (1954), 937-1022, 958.

⁶ Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982).

⁷ *Ibid.*, 380.

⁸ *Ibid.*, 385.

medicine itself. Congress didn't need to blame itself for the present condition in the face of mounting evidence that health care providers were financially abusing the health care system, defrauding the government, and potentially putting patients' lives in jeopardy. The profession's alleged lack of moral probity was more damaging to their self-regulatory privileges than their perceived dominance over health care. Clamping down on physician fraud and abuse was, as argued in this article, the "key" that unlocked the potential for broader administrative reforms in Medicare.⁹

The history of Medicare and Medicaid has received considerable attention in the context of American struggles to legislate national health insurance. Historians of medicine including Rosemary Stevens, Ron Numbers, and Jacob Hacker have examined its early years in the context of historiographical conceptions of the ideologies of the welfare state.¹⁰ Publications by political historians and policy analysts such as Richard Harris's *A Sacred Trust* (1966), Theodore Marmor's *The Politics of Medicare* (1970), Daniel M. Fox's *Health Policies, Health Politics* (1986), and Jonathan Oberlander's *The Political Life of Medicare* (2003) examine the contentious interactions between the government and organized medicine in the struggle to legislate nationalized health

⁹ Although Medicare and Medicaid were both established through amendments to the Social Security Act in 1965 (Titles XVIII and XIX), this article is only focused on fraud and abuse against Medicare. Medicaid is administered differently state by state and has structural differences to Medicare, requiring a separate analysis.

¹⁰ Robert Stevens and Rosemary Stevens, *Welfare Medicine in America: A Case Study of Medicaid* (New York: Free Press, 1974); Ronald Numbers, *Almost Persuaded: American Physicians and Compulsory Health Insurance 1912-1920* (Baltimore: Johns Hopkins University Press, 1978); Ronald Numbers, ed., *Compulsory Health Insurance: The Continuing American Debate* (Westport, Ct: Greenwood, 1982); Jacob Hacker, *The Divided Welfare State: The Battle over Public and Private Social Benefits in the United States* (New York: Cambridge University Press, 2002).

plans.¹¹ Through these works and others like them, the overarching political and ideological struggles to transform American medicine are well documented. However, when it comes to examining the minutiae of how Medicare and Medicaid were implemented, and how the government amended the legislation multiple times to correct for structural weaknesses in the decades following its initial passage, one has to scrutinize the congressional record, policy-focused publications and law review journals for historical insights. But within incremental legislative reforms, certain broader narratives emerge revealing how the medical profession adjusted to the presence of these government programs. One theme that has been largely overlooked among historians but should be of considerable interest as a contribution to the history of biomedical ethics and medical conduct is the perceived problem of fraud and abuse against Medicare among health care practitioners.¹²

¹¹ Richard Harris, *A Sacred Trust* (New York: New American Library, 1966); Theodore Marmor, *The Politics of Medicare* (New York: Transaction Publishers, 1970); Daniel M. Fox, *Health Policies, Health Politics: The British and American Experience 1911-1965* (Princeton: Princeton University Press, 1986); Jonathan Oberlander, *The Political Life of Medicare* (Chicago: University of Chicago Press, 2003).

¹² A note on defining “fraud and abuse.” In brief, in the 1970s (the period under review) fraud was defined as “an intentional deception” resulting in “unauthorized benefit” to the person committing the act. Abuse was defined as acts by health care providers that are “inconsistent with accepted, sound medical or business practices resulting in excessive and unreasonable financial cost.” These definitions have a history of their own, and a catalog of legal challenges and interpretations of each word. In the present analysis, the terms are considered together because, in the period under review, Congress was concerned at how both impacted medical costs. Intentional deceit and moral probity are important issues considered here, but both fraud and abuse were equally problematic as underlying causes of rising health care costs, and were brought together as targets for regulatory measures. See: U.S. Department of Health, Education

In *License to Steal*, Malcolm Sparrow, professor in the Kennedy School of Government at Harvard, demonstrated that Medicare fraud and abuse has persisted despite considerable efforts from both within organized medicine (through codes of ethics statements and peer-review committees) and government (through regulations and laws). Sparrow's book, although primarily focused on interviews conducted in the 1990s, is the closest available to a "grand narrative" of the pathology of fraud and the history of the "failure of controls" to detect and prevent it.¹³ The present article takes a closer look at the beginning of the story, in the years immediately following the enactment of Medicare and Medicaid in 1966, to see how Congress began to understand the existence of the problem of fraud and what early steps they took in an effort to remedy it.

The article examines congressional hearings where testimony about alleged occurrences of malfeasance were reported, and situates the problem within the context of legislative weaknesses that plagued the programs owing not only to political lobbying but to political theories of regulatory authority. The article culminates with an examination of a piece of legislation that was at the time the most aggressive attempt to clamp down on inappropriate conduct. Since we know that fraud and abuse continue to the present day, I conclude with some remarks about why this first legislative foray into regulating medicine fell short of its desired goals.

Medical Autonomy and the Structure of Medicare

and Welfare (HEW), *Part A Intermediary Manual*, HIM-13 (Washington: Government Printing Office, 1976), §3450-52.

¹³ Malcolm Sparrow, *License to Steal: Why Fraud Plagues America's Health Care System* (Boulder, CO: Westview Press, 1996), 1.

Throughout the 1950s and 1960s in America, organized medicine—structured through the activities of bodies including the American Medical Association (AMA), the American Hospital Association (AHA), and the American Colleges of Physicians and Surgeons (ACP and ACS)—was making strides to ensure standards of practice and discipline within the profession. Moving beyond the proliferation of licensing boards, the establishment of the reconfigured Joint Commission on Accreditation of Hospitals (JCAH) in 1951 established rigorous reviews of staff training and patient treatments for quality control. Such manifestations of professional surveillance enabled organized medicine to lay further claim to its professional autonomy, “implying an immunity from the political process,” or controlling and conducting its business without external interference.¹⁴ In 1974 Robert Reiff, a professor at Albert Einstein College of Medicine, reflected on the idea that the basis of professional power was not knowledge itself, but the control of knowledge. “Not only are the helping professions given the authority to define the terms of their practice,” he wrote in reference to professional autonomy, “but collectively they claim a legal, moral, and intellectual mandate to determine for the individual and society at large what is healthy, moral, ethical, deviant, normal, and abnormal.”¹⁵ Historically, such autonomy has been fiercely protected by professional organizations, asserting their ability to “self-regulate” practice.

¹⁴ Louis Jaffe, “The Illusion of the Ideal Administration,” *Harvard Law Rev.* 86:7 (1973), 1183-1199, 1168.

¹⁵ Robert Reiff, “The control of knowledge: The power of the helping professions,” *J. Appl. Behav. Sci.* 10:3 (1974), 451-461, 452.

According to the renowned medical sociologist Eliot Freidson, who in the 1960s and 1970s studied features of professionalization, “Medicine in the contemporary United States provides us with a fairly good example of a profession with considerable socioeconomic as well as technical autonomy.” Examining the important role that the American Medical Association played in this process, he adds that this central organization “has been delegated many of the powers that the state elsewhere has reserved for itself, and its practitioners have otherwise been quite free of lay interference.”¹⁶ So important was the concept of professional autonomy that when momentum was gaining for the passage of Medicare in the mid-1960s, organized medicine stepped up campaigns opposing nationalized (also called “socialized”) health care out of concern that the federal government would strip away its autonomy and dictate how medicine would be practiced and paid for.¹⁷

It has been well documented that Medicare emerged from a cauldron of hostility not only from conservative politicians (both Republican as well as right-of-center Democrats, mainly from southern states) but from major health organizations, namely the American Medical Association and American Hospital Association.¹⁸ Recognizing themselves as “the most powerful legislative lobby in Washington,” and gloating in its success at quashing social security bills, the AMA launched a propaganda war admonishing against the dangers of allowing politicians to control

¹⁶ Freidson, *Profession of Medicine* (n. 4), 25-26.

¹⁷ Harris, *Sacred Trust* (n. 11).

¹⁸ Numbers, *Almost Persuaded* (n. 10); Oberlander, *Political Life* (n. 11); also Judith M. Feder, *Medicare: The Politics of Federal Hospital Insurance* (Lexington, MA: Lexington Books, 1977).

medical decisions.¹⁹ The concepts of professional autonomy and self-regulation were socially and politically powerful when negotiating the terms of government-structured health care administration. When deliberating their position on a number of congressional moves to introduce national health care insurance stemming back to the 1930s, the AMA was clear: “Organized medicine opposed anything which might divest it of any part of its control over medical services.”²⁰

In the lead-up to congressional votes on the amendments to the Social Security Act (where Medicare laws were embedded), and in an effort to prevent their derailment through non-participation or physician strikes, when drafting the Medicare statute lawmakers spelled out the limits of the government’s powers in interfering with the business of providing health care. One of the first paragraphs of the Medicare act (1965), Section 1801, is titled “Prohibition Against Any Federal Interference,” and states that:

Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to

¹⁹ Hyde, “The American Medical Association” (n. 5), 955; see also American Medical Association, “A.M.A. Advertising Program,” *JAMA* 143 (June 24, 1950), 744.

²⁰ Hyde, “The American Medical Association” (n. 5), 1008.

exercise any supervision or control over the administration or operation of any such institution, agency, or person.”²¹

According to Wilbur Cohen, one of the main architects of the Medicare act and person dubbed “Enemy Number One” by the AMA, Section 1801 was included with the law “to offset the criticism made by opponents of the proposal that Federal legislation would give Federal officials the opportunity and the right to interfere in the diagnosis and treatment of individuals.”²² Many policy analysts and historians who have examined the structural problems that subsequently beleaguered Medicare put this edict against regulatory power in the context of the AMA’s concerns to protect its autonomy. In addition to the fantasy of a bureaucrat determining a diagnosis, there was concern within the AMA regarding how Medicare payments were to be made for medical services. In Eliot Freidson’s words, “The issue has essentially been that of control over the *terms* of physician participation in such plans—the social organization of practice, and the type and level of physician compensation for such practice. To meet AMA approval the terms of practice in such plans have in the past had to be set by a committee representing all the doctors in the community”²³ The salient message is that the government made assurances not to interfere with “medical practice” or the “manner in which medical services are provided,” importantly maintaining a fee-for-service billing structure. But the

²¹ U.S. House, 89th Congress, 1st Session, *H.R. 6675, An Act to Provide a Hospital Insurance Program for the Aged Under the Social Security Act* (Washington: Government Printing Office, 1965), 4: <https://www.govtrack.us/congress/bills/89/hr6675/text> (accessed online April 11, 2018)

²² Wilbur J. Cohen, “Reflections on the enactment of Medicare and Medicaid,” *Health Care Financing Rev.* 1985 (Suppl), 3-11, 8.

²³ Freidson, *Profession of Medicine* (n. 4), 32.

additional language that prohibits *supervision* of any compensation to anyone or institution, rendered the administration of Medicare vulnerable to exploitation and fraud.

Particular areas of compensation and accounting for reimbursement claims by physicians, hospitals, and other health care facilities received almost no oversight because of a government promise not to meddle in minutiae. In terms of political maneuvering, it was a sensitive matter. The American Hospital Association had specifically registered its concern that a government-run insurance program would lead to bureaucratic hassles in payment structures. The AHA pointed out that it already had a close alliance and protocols in place with the private health insurance industry, in particular with Blue Cross and (under separate terms) with Blue Shield.²⁴ However, in a surprise move, in 1962 the AHA passed a resolution where it suddenly broke course with the AMA and declared support for a government insurance program on the condition that the program was administered by Blue Cross. While the leadership of the AHA and the Blue Cross found themselves navigating a precarious path to consensus among their boards of directors, this is generally seen as a tipping point in the House Ways and Means Committee to gain important support for the passage of the Medicare bill.²⁵ Between 1962 and 1964 congressional hearings discussed the logistics of using insurance companies, referred to as “fiscal intermediaries,” to administer Medicare payments to hospitals (under Part A of the 1965 act). In 1965, Walter McNerney, president of the Blue Cross Association, testified before Congress that delegating

²⁴ Robert Cunningham III and Robert Cunningham, Jr., *Blues: A History of the Blue Cross and Blue Shield System* (DeKalb: Northern Illinois University Press, 1997).

²⁵ David Rothman, *Beginnings Count: The Technological Imperative in America Health Care* (Oxford: Oxford University Press, 1997).

fiscal oversight to them “would create less of a confrontation.”²⁶ Yet it appears that few within Congress questioned the wisdom of this plan or worried about potential conflicts of interest.

It is an understatement to say that the American Hospital Association had a close alliance with Blue Cross. Blue Cross itself was created through the efforts of the AHA who wanted a guarantor for hospitalization fees among a population that was unable to save money for medical costs. Until 1972, when Blue Cross became a nonprofit corporation of its own, the AHA who sought to promote and control a monopolistic development of a private national health care insurer owned the name and insignia. The Blue Cross organization was characterized by Sylvia Law, a New York University lawyer and health law expert, as the “financing arm” of hospitals, there to provide stable income to hospitals through subscription costs and federal funds.²⁷ Blue Cross was perfectly positioned to provide an administrative structure for hospital health provision financing. Within five years of the enactment of Medicare, the amount of money administered by Blue Cross as a fiscal intermediary to the federal government, as well as within their role as private insurer, was sizable. In 1970 they provided roughly half of total hospital revenues, administering over \$11 billion. Public funds comprised over half of these payments to hospitals – \$4.9 billion under Medicare, \$1.2 billion under Medicaid, and \$545 million under other federally financed programs.²⁸

Conceding to the pressures of organized medicine that wished to protect professional autonomy, along with prohibiting “federal interference” with health care practices, and structuring the

²⁶ Feder, *Medicare* (n. 18), quoted on p. 38.

²⁷ Sylvia Law, *Blue Cross: What Went Wrong?* (New Haven: Yale University Press, 1974).

²⁸ *Ibid.*, 2.

payment system without disinterested checks and balances, amounted to what the political scientist Jonathan Oberlander called “the politics of consensus” in the creation of Medicare.²⁹ Relegating itself to the position of a bank distributing funds that it doesn’t closely monitor, the federal government established a “nationalized” program that relied on the notion of the medical profession “self-regulating” to ensure its integrity.

The Politics of Self-Regulation

“Self-regulation” is a term frequently invoked to refer to a non-specific set of peer-review protocols that are meant to ensure standards of practice among the medical profession. Sometimes synonymous with “self-policing” or quality control, recognition of self-regulation has historically been embedded within principles of ethics or general professional codes of conduct. In 1986, the American Medical Association reviewed its history of self-regulation and noted that, “Physicians and their professional organizations have established a variety of mechanisms to protect the quality of the care of patients. The quality standards of U.S. medical education, residency training, and hospital care derive from physicians and from organizations that physicians helped establish and that physicians maintain today.”³⁰ Despite reaching back to the origins of organized medicine in the early nineteenth century, it was unclear just how effective the application of self-regulation was in safeguarding public welfare.

²⁹ Oberlander, *Political Life* (n. 11), 8.

³⁰ American Medical Association (Board of Trustees), “AMA Initiative on Quality of Medical Care and Professional Self-Regulation,” *JAMA* 256, No. 8 (1986), 1036-1037, 1036.

Throughout the history of medicine in the United States, each state's government has had a role in establishing and enforcing laws of medical practice. While it varies from state to state, and has evolved over the past two centuries, a state's legislature has generally set the parameters for granting licenses and has written statutes determining the course of action to be taken by medical boards when disciplining its members.³¹ Medical examination boards were often appointed by, and are accountable to, a state's governor, and their actions are subject to review by the state's judiciary. In practice, however, state officials were known to keep their distance from daily routines of medical practice. In the 1950s and 1960s, state medical boards operated as quasi-judicial, independent agencies within state government. "In general," wrote researchers at UCLA and George Washington University, "there is no supervision of the operations of these boards except for the power of the courts to review some of their actions upon complaint of an aggrieved candidate or licensee."³²

While states retained the power to impose regulations and enforce laws, state licensing boards historically worked closely with legislators to compose or amend laws that impacted medical practice. As a 1971 report commissioned by the federal Department of Health, Education, and Welfare (HEW) put it: "The State licensing boards may work more or less discretely to present the profession's position regarding legislative proposals. In some States, professional associations work in conjunction with examining boards to initiate legislation, make additions or deletions, draft the preliminary and final proposed bills, persuade the legislator to introduce the bills, and

³¹ Harrison Shryock, *Medical Licensing in America, 1650-1965* (Baltimore: The Johns Hopkins University Press, 1967).

³² Edward Forgotson, Ruth Roemer, and Roger W. Newman, "Licensure of physicians," *Washington Uni. Law Rev.* (1967), Article 3, 249-331, 262.

then work for their passage.”³³ Far from being boxed-in by legal dictates, the medical profession historically has had a remarkably free path to police itself under its own terms. “In fact,” wrote medical ethicists Marshall Kapp and Bernard Lo, “the medical profession has aggressively co-opted the legal system over the years and used the law’s authority to serve its own ends.

Illustrations of this interaction include the medical profession’s traditional power to determine for itself the standards of care to be applied in a malpractice action, the standards of information disclosure that constitute informed consent, and licensure/discipline standards for determining who is allowed to be part of the medical profession.”³⁴ When it came to ensuring standards of care and overseeing proper medical practice, these boards were afforded considerable power.

The adage “be careful what you wish for ...” seems apt for the situation that the medical profession found itself in after asserting its autonomy and ability to self-regulate. Having boards that were small (an average of eight people) and almost entirely composed of physicians from a local community, the responsibility “to assume multiple roles of investigators, prosecutors, juries, judges, and executioners” was burdensome.³⁵ One pragmatic question for professional societies and medical boards was just where to focus their attention. “We must remember,” wrote Robert Derbyshire, MD, a leader in the Federation of State Medical Boards in the 1960s, “that the boards of medical examiners are legally constituted bodies of the state governments and as such

³³ Quoted in Ruth Horowitz, *In the Public Interest: Medical Licensing and the Disciplinary Process* (New Brunswick: Rutgers University Press, 2013), 60.

³⁴ Marshall Kapp and Bernard Lo, “Legal Perceptions and Medical Decision Making,” *Millbank Quart*, 64:2 (1986), 163-202, 164.

³⁵ Robert Derbyshire, *Medical Licensure and Discipline in the United States* (Baltimore: The Johns Hopkins University Press, 1969), 76; see also Forgotson, “Licensure” (n. 32), 259 for composition of medical boards.

they confine their activities to investigations of violations of the laws. Minor infractions of medical ethics or disputes between patients and doctors about fees do not concern the boards and are best referred to the local county societies or the hospital staffs.”³⁶ While “infractions of medical ethics” may not have had such obvious boundaries separating them from criminal behavior as Derbyshire implies, with the passage of Medicare in 1965, disputes over fees added a new dimension to the challenges of self-regulation. As the University of Pittsburgh physician and lawyer Sidney Shindell wrote in *JAMA* in 1965: “It has become increasingly apparent that more and more aspects of the law are impinging on medical practice. Not only do we have the problems of professional liability and malpractice to be concerned with, but as there is a growing tendency for third parties to be paying for physician’s services, there must be greater concerns for the kinds of disputes which may arise between the insurance carrier on one hand and the doctor and his patient on the other.”³⁷ However prescient the admonition to express “greater concerns” over such potential conflicts, the true scope of the emerging problems and struggles for federal and state agencies to address them was yet to be revealed.

As indicated earlier, state medical boards were, throughout the first half of the twentieth century, responsible for investigating and disciplining practitioners alleged to have violated professional standards. Throughout this time, little attention was paid to the actual performance of medical boards in administering discipline; indeed, their powers remained “virtually unchecked.”³⁸ Statistics on the frequency and types of sanctions or license revocations were not gathered on any

³⁶ Derbyshire, *Medical Licensure* (n. 35), 76-77.

³⁷ Sidney Shindell, “A survey of the law of medical practice,” *JAMA* 193:7 (1965), 601-606, 601.

³⁸ Stanley Gross, *Of Foxes and Hen Houses: Licensing and the Health Professions* (London: Quorum Books, 1984), 107.

credible scale. In 1958, however, the AMA's Board of Trustees established a Medical Disciplinary Committee to canvass information from state boards and medical societies across the nation to assemble a composite portrait. After attempting to collect data for two and a half years, the Committee published its report in 1961. Its rather incensed findings "recounted the failure of the Committee to stimulate either interest or cooperation from state boards" in their endeavor, and suggested that there was a veritable lack of disciplinary action pursued.³⁹ This was an alarming conclusion that substantiated public perceptions that the profession veiled the existence of physician incompetence with its failure to pursue disciplinary measures. It also appeared to reinforce the sentiment expressed a year earlier by the long-term Secretary-Treasurer of the Federation of State Medical Boards (and past president of the AMA), Walter Bierring, that self-regulation as a disciplinary framework was flawed. "If a state cannot, or does not, for just cause, revoke a license or discipline a physician," he wrote, "... a fatal weakness exists. If no machinery exists for investigations and hearings ... discipline does not really exist."⁴⁰ It was a conclusion similarly reached by Robert Derbyshire in 1969 when, while president of the Federation, he took a special interest in professional incompetence. "As a result of many years of observing medical licensing and discipline in America," he wrote, "I have concluded that there is no system."⁴¹

³⁹ Andrew Dolan and Nicole Urban, "The Determinants of the Effectiveness of Medical Disciplinary Boards, 1960-1977," *Law and Human Behavior* 7 (1983), 203-217, 207.

⁴⁰ Walter Bierring, "The status of discipline in the medical profession," *Federation Bull.* 47 (1960), 3-4, 4; see also David A. Johnson and Humayun J. Chaudhry, *Medical Licensing and Discipline in America* (Toronto: Lexington Books, 2012), 156.

⁴¹ Derbyshire, *Medical Licensure* (n. 32), xii.

While the AMA's Medical Disciplinary Committee report of 1961 did make recommendations for maintaining the integrity of the profession after licensure through initiatives such as continuing medical education, events that were brought to the public's attention in the years immediately after the passage of Medicare reignited the concern over medical regulation.

Fraud and the Limits of Self-Regulation

In 1967 a non-profit organization called The Associated Physicians of Cook County Hospital was incorporated in Illinois. A number of full-time staff physicians at the hospital joined the organization as "volunteers," and started treating Medicare patients. With what was essentially a click of a button, the Cook County hospital database changed the designation of 105 physicians from "staff doctors" to "administrators," each retaining their salary of \$20,000 to \$30,000 a year. However, since they were now also "volunteers" working at the Associated Physicians organization, they were able to bill the government for the extra time they spent treating Medicare patients. Because Medicare reimbursement provisions at the time prohibited staff physicians who received salaries for providing patient care from claiming Medicare payments, this maneuver "allowed" them to charge \$1.5 million to Medicare for having volunteered their service, charges which included back-billing Medicare for some 17,000 cases. When the fiscal intermediary, Blue Cross-Blue Shield, asked for supporting documents, the hospital administrator prepared a carefully-worded letter for all physicians to sign, along with a reference to hospital bylaws that stated "all attending physicians will care for patients without compensation by Cook County." That presentation satisfied Blue Cross-Blue Shield, and at the end of 1968 the hospital had collected just over \$3 million for hospitalized Medicare patients. However, as revealed by two outraged physicians who observed the antics and referred them to a journalist for *Chicago's*

American newspaper (a forerunner to the *Chicago Tribune*), there was no such statement in the bylaw.⁴²

With other public reports of questionable conduct and inflated costs of health care becoming regular headline news in the years immediately following the passage of Medicare, Congress launched investigations. In 1968, Senate Finance Committee staffers had spent a year investigating physicians' reimbursements and discovered a plethora of disturbing practices. In 1969, the Committee (which oversaw the budget for Medicare) held hearings that focused on "the methods to improve the programs and to eliminate any possibility of or opportunity for fraud and abuse."⁴³ Senator Russell B. Long, a Democrat from Louisiana and chair of the Committee, began a Senate hearing with additional examples. He spoke of a physician who had 49 Medicare patients and billed Medicare \$58,000 for house calls. That would have meant each patient received a personal visit two or three times a week, every week of the year. "Who says you can't get a doctor to make a house call anymore!" Senator Long quipped.⁴⁴ Another physician visited 54 patients in a nursing home. Collectively in one year they received 4,560 visits from that doctor. He also claimed to have provided 8,275 injections to patients—amounting to 60 per patient per year in his claims—for which he received \$42,000.

⁴² All quotations in this paragraph are from Effie Alley, "Medicare Millions Tapped—How County Hospital Doctors Became Supervisors," *Chicago's American* March 21, 1969, A6.

⁴³ U.S. Senate, Committee on Finance, *Medicare and Medicaid: Hearings Before the Committee on Finance, United States Senate, Ninety-First Congress, First Sessions, July 1 and 2* (Washington: Government Printing Office, 1969), 54.

⁴⁴ *Ibid.*, 2.

For two days, the Senate discussed example after example of cases where physicians or organizations appeared to be involved in fraudulent or abusive behavior toward the system. Among those in the hot seats were two government officials charged with administering Medicare: Robert M. Ball, Commissioner of Social Security, and John G. Veneman, Under Secretary in the Department of Health, Education, and Welfare. But this was not a criminal investigation. However egregious some of the acts appeared, the ultimate question for the Finance Committee was how to prevent the overall costs of the Medicare and Medicaid programs from rising uncontrollably. Fraud was an extreme example of fiscal waste, and by various estimates would amount to a savings of 10% if eliminated, but its existence raised deeper questions about oversight.

Whether the problems were caused by intentional deceit or honest mistakes, it was quickly apparent to the committee that there was a laxity in oversight and controls in the flow of money. “Medicaid is both victim and cause of the superinflation in the medical care field through the increased demand on scarce resources which it has generated,” said the staff report following their investigation. “Federal officials have been lax in not seeing to it that States establish and employ effective controls on utilization and costs.”⁴⁵

Senator Al Gore, Sr., a democrat from Tennessee, reminded those offering testimony that medical groups such as the AMA had staunchly opposed the passage of Medicare until various concessions were made. Concessions that might have been a mistake, he added. Referencing the role of fiscal intermediaries, he said: “it seems to me the carriers are seriously at fault in this

⁴⁵ Ibid., 32.

program and we may have erred, in the enactment of this program, in providing for an almost unbridled discretion in the carriers.” When Commissioner Ball and Secretary Veneman cautioned the Senator against making blanket assertions about the conduct of intermediaries like Blue Cross, Gore pressed the point about the lack of audits. “Mr. Ball and Mr. Secretary, the picture that is unraveling here is that the carriers are, in a pro forma way, a routine way, paying every bill that comes in without investigation as to whether it is for medical necessity, for how many calls, or how many times a call is being made on a given patient. Now, something is seriously wrong, either with the administration or the law.”⁴⁶ In answer to this, Ball admitted, “When the program started out, we let the carriers do it pretty much the way they would run their own business.” “I cannot imagine,” Gore replied, “they would run their own businesses this way.”⁴⁷

With all the concern, supervision over payments for Medicare services was likely to increase precisely where organized medicine did not want it to: the agencies in the federal government who were being publicly pressed on where taxpayer money was going, and why health care bills did not appear to match medical treatments. The Social Security Administration was tasked with becoming directly involved in cases of suspected fraud, and during the Senate hearings Commissioner Ball reported that 1200 cases had been identified and investigated, although “most of them were found to be innocent mistakes in bookkeeping or one thing or another.” A mere fourteen cases were forwarded to and pending investigation with the Justice Department.

⁴⁶ U.S. Senate, *Medicare and Medicaid* (n. 43), 76.

⁴⁷ All quotations from *ibid.*, 81.

When asked whether anyone had been convicted of fraud, Ball replied: “I believe that in the only Medicare case disposed of by a court so far, they entered a plea of no contest.”⁴⁸

In his preliminary statement to the Senate committee, Under Secretary Veneman pointed to structural weaknesses that he believed Congress should address in order to bolster the security of the Medicare system. One observation was that professional self-regulation was inadequate. “I think we need some new machinery in addition to self control by the providers,” he said. “I find that too often, ‘peer review’ becomes ‘peer justification’ and I think that the public and the patients deserve better than that.”⁴⁹ As a consequence, what seemed necessary was more staffing in the Department of Health, Education, and Welfare to investigate claims. In 1966, the year Medicaid was enacted, 32 people were assigned to supervise the entire Medicaid program across the nation. That amounted to overseeing 7000 hospitals, 200,000 physicians, 7300 extended care and home health agencies, and 2600 private laboratories. It also meant checking the work of some 130 fiscal intermediaries, mainly regional offices of Blue Cross and Blue Shield, who processed the claims of up to 9 million people a year.⁵⁰ In 1967, when the Medical Services Administration (a sub-agency of HEW) was established, 100 government workers were assigned the job.⁵¹

When President Nixon was inaugurated into office in January 1969, he appointed Robert H. Finch, a former Republican Lt. Governor of California, as Secretary of HEW. Just days after the

⁴⁸ Ibid., 99.

⁴⁹ Ibid., 52.

⁵⁰ Ibid., 105-106.

⁵¹ Ibid., 51.

Senate Finance Committee hearings in July of that year (discussed above), Finch, alongside Under Secretary Veneman and Assistant Secretary Roger Egeberg, attended a White House press conference to answer questions about their report on the “Nation’s health care problems and programs.” When asked to clarify a statement in the report which called upon the medical profession to discipline those who are involved in abuses against Medicare, Secretary Finch replied: “Well, the most effective discipline of all is the discipline of your peer group. States can de-certify a physician who abuses—a very small percentage of them who have been involved in abuses—but to be condemned by your own medical society, I think, is the worst kind of discipline you can inflict.”⁵² Apparently here supporting the existing model of self-regulation to discourage malfeasance, a reporter asked a paradoxical follow-up question about who would enforce what he called “self-discipline”: “Is the AMA going to supervise this or are the county medical societies going to be left on their own?” The answer, provided by Dr. Egeberg (former dean of the USC medical school, a registered democrat, and member of the AMA) replied, “The county societies.”⁵³

In addition to the task forces set up by HEW that were mentioned by Secretary Finch, the Medicare law itself originally established the Health Insurance Benefits Advisory Council (HIBAC), composed of people drawn from various health care fields and industry. The Council was charged with advising HEW on policy formation for Medicare’s administration, and, following amendments to the law in 1967, it replaced the short-lived National Medical Review

⁵² National Archives and Records Administration, *Weekly Compilation of Presidential Documents*, July 14, 1969, folios 963-969, 965.

⁵³ *Ibid.*, folio 967.

Committee to study the utilization of hospital and other medical services “with a view to recommending improvements in the way such care and services are utilized”⁵⁴

One area of immediate concern to the Council was whether hospital standards for ensuring quality medical care were adequate. These standards were voluntarily established by the Joint Commission on Accreditation of Hospitals (JCAH), a non-government agency responsible for awarding accreditation to hospitals, but already criticized by the medical profession itself for their “controls ... not being uniformly applied.”⁵⁵ This was a concern for HIBAC because hospital accreditation – purely under the control and supervision of the Joint Commission – was designated the requisite condition for a hospital to qualify for Medicare and Medicaid reimbursements. Indeed, the Secretary of Health, Education, and Welfare was prohibited by law to set standards higher than the Joint Commission’s for becoming a certified vendor for federal funds. HIBAC questioned this logic, commenting that “it is inappropriate to continue statutory delegation to a private agency of all the Government’s authority to safeguard quality of care paid for by a government program [T]he council has found reason for concern that JCAH standards are not applied with the frequency of inspection and range of inspector skills necessary to assure a high degree of effectiveness.”⁵⁶

⁵⁴ U.S. Department of Health, Education, and Welfare, Bureau of Health Insurance, *Health Insurance Benefits Advisory Council Annual Report on Medicare, Covering the Period July 1, 1966 – December 31, 1967* (Washington, D.C.: U.S. Department of Health, Education, and Welfare, 1969), quotation on vi.

⁵⁵ American Medical Association, *Report on Physician-Hospital Relations* (Chicago: American Medical Association, 1964).

⁵⁶ Bureau of Health Insurance, *Health Insurance* (n. 54), 10.

In their first annual report submitted to HEW in 1969, the Council offered a number of recommendations to improve Medicare, such as adding coverage for additional medical services like mental health. But the very first recommendation of the report was that Medicare should be allowed to discontinue reimbursement for services of a physician or supplier “when one or more of the following is found: evidence of fraud; repeated overcharging of the program or its beneficiaries; a pattern of rendered services substantially in excess of those justified by sound medical practice; persistent failure to cooperate with the program in clarifying cases which may involve excessive charges or services; or documented rendering of services or supplies which were harmful to beneficiaries or found to be grossly inferior by peer review.”⁵⁷ Whatever other limitations to Medicare there were, eliminating opportunities for fraud and abuse was paramount.

The fact that the Council was advising legislative change to empower HEW to impose disciplinary action against physicians or suppliers (by way of barring reimbursement to abusers) represented the first step toward increasing the involvement of a federal agency in the peer-review process. Since the outcomes of peer review would be (in part) acted upon by HEW, it suggested that HEW might increasingly become more interested in the availability and assessment of the documentation that was collected, such as any “evidence of fraud.” To be sure, when HEW subsequently drafted the amendment to the law, “they proposed establishing ‘program review teams’ to review individual cases and overall utilization data.” According to a staff memorandum, the new teams were targeted to weed out “bad actors” and were “not

⁵⁷ *Ibid.*, xi.

intended to supplant existing peer review structures, but rather to complement and enhance present arrangements.”⁵⁸

It appeared that HEW was creating a space for itself at the table of peer review, potentially occupied by someone other than a physician. To astute observers, these amendments to the law foretold the possibility of increased scrutiny of the self-regulatory process. To stay ahead of the curve, the AMA assembled its own task force to draw up plans for more robust peer review protocols. The hope was that their pre-emptive efforts would influence the outcome and keep things under their control. The main thrust of the AMA proposal was to have state medical societies convene “Peer Review Organizations” to consider allegations of fraud and abuse in physician services billed under Medicare Part B (physician reimbursement) and to recommend disciplinary actions accordingly to the Secretary of HEW.⁵⁹ Their proposed organizations were to consist of “Local Review Panels,” each with a membership of three physicians to act as a committee where others can submit their grievances. This proposal was discussed and approved at the AMA convention in 1969, though observers were skeptical of how fully adopted it would become. Reporters from *Medical World News* who attended the conference wrote that, “while adopting this rhetoric, the delegates showed only a limited willingness to endorse specific ‘get tough’ policies in professional policing.”⁶⁰

⁵⁸ All quotations from Feder, *Medicare* (n. 18), 43.

⁵⁹ *Ibid.*, 44.

⁶⁰ Robert McCleery, Louise Keelty, Mimi Lam, Russell Phillips, and Terrence Quirin, *One Life-One Physician: An Inquiry into the Medical Profession’s Performance in Self-Regulation* (Washington, D.C.: Public Affairs Press, 1971), 91.

In May 1970, staff members of the AMA sent their proposal to Senator Wallace Bennett, ranking Republican member of the Senate Finance Committee, who was now responsible for drafting amendments to the laws governing Medicare and Medicaid. Despite Nixon's election as Republican president, the majority party on both sides of Congress remained Democrat. Wallace was therefore the leading minority member of the Committee, but the only person in a position of influence most likely to support the AMA's canvassing for the terms of less government intervention in its professional affairs. He had a good history with the AMA. As a candidate for the Senate in 1952, the Utah Republican was elected with the help of the AMA who supported Bennett's strong opposition to national health insurance.⁶¹

Upon reviewing the proposal and sharing it with Finance Committee staff, Bennett was informed that it was "definitely a step in the right direction" but that it was "unduly limited" in "making the present system workable and acceptable."⁶² With an eye to creating a "review program which would eliminate much of the present criticism of the profession and help enhance their stature as honorable men in an honorable vocation willing to undertake necessary and broad responsibility for overseeing professional functions," it was to the dismay of the AMA that Bennett offered his own proposal to establish a "Professional Standards Review Organization" ("PSRO").⁶³

⁶¹ Paul Starr, "Medicine and the waning of professional sovereignty," *Daedalus* 107:1 (1978), 175-193.

⁶² Sen. Bennett, "Professional Standards Review Organization Act of 1970," *Congressional Record: Senate*, 116, Pt. 17 (July 1, 1970), bound page: ff. 22475-22477; <https://www.gpo.gov/fdsys/pkg/GPO-CRECB-1970-pt17/pdf/GPO-CRECB-1970-pt17-1-1.pdf>. Accessed April 11, 2018.

⁶³ Oberlander, *Political Life* (n. 11), p. 117.

The salient features of Bennett’s proposed amendments to the law that would establish PSROs extended professional review to “include in the review groups’ mandate, responsibility for reviewing the totality of care provided patients—including all institutional care.”⁶⁴ In other words, anything reimbursable under Part A of Medicare (pertaining largely to hospitalization), where costs were notably sky-rocketing. Bennett’s proposal set out to keep review organizations lodged in local communities, but it differed from the AMA vision by suggesting that groups other than state medical societies become involved in composing review membership, providing, for instance, a role for larger HMOs such as the Kaiser Foundation. Significantly, Bennett’s proposal suggested that in cases where local medical societies were unable or unwilling to create a local PSRO, the Secretary of HEW would work with State or local health departments to establish one for them.

Two other areas of Bennett’s proposal departed from the status quo. First, he wanted the creation of a national advisory council that would assemble and compare data to derive and apply “norms of care and treatment [to] be used as checkpoints in evaluating the appropriateness of treatment,” thereby establishing practice “standards” (as in the organization’s title). Second, Bennett ramped up the disciplinary penalties for improper conduct, ranging from monetary fines to civil or criminal prosecution.⁶⁵ This was a major change in the way “discipline” could be imposed on medical practice, and, in historic terms, a dismantling of a tenet of professional autonomy that embraced self-policing.

⁶⁴ Sen. Bennett, *Congressional Record* (n. 62), f. 22476.

⁶⁵ *Ibid.*

After almost two years of routine legislative tinkering, in 1972 Bennett’s amendment establishing PSROs was signed into law, stipulating that they must be established locally by January, 1976. (Designated PSRO regions were to be determined by January 1974.)⁶⁶ If no PSRO was formed in a designated area by that time, the Secretary of HEW had the authority to create one and determine its membership.

Representatives of the AMA were unhappy with this outcome. In a 1974 commentary in *JAMA*, Martin Dale, the executive secretary of Kern County Medical Society in Bakersfield, California, and author of a “primer” on PSROs, suggested that Senator Bennett succumbed to political pressure to hastily pass the bill. It was “because he was a member of the Senate committee charged with reaching a compromise with the House of Representatives on PSRO, because Mr. Nixon needed the support of his party’s ranking [minority] member on the Senate Finance Committee, and because there was general support for attempts to control the cost of Medicare and Medicaid,” PSROs were now law.⁶⁷

Assessing Self-Regulation

“History will be made in June, 1974, when the House of Delegates of the American Medical Association must decide whether to support the concept of PSRO ... or to adopt a position of non-cooperation.”⁶⁸ Thus began an article on the pros and cons of PSROs written by Claude

⁶⁶ “General Provisions and Professional Standards Review” (Public Law 92-603, 1972), Section 249F, on p. 1431 *United States at Large*, 1429-1444.

⁶⁷ Martin Dale, “Commentary: PSROs—A primer,” *JAMA*, 229:2 (1974), 157-158, 157.

⁶⁸ Claude Welch, “PSROs—Pros and cons,” *NEJM*, 290:23 (1974), 1319-1322, at 1319.

Welch, MD, a renowned surgeon and instructor at Harvard Medical School, president of the Massachusetts Medical Society, and delegate at the AMA. In 1973 he was appointed Chair of an AMA Task Force on Guidelines of Care, a sub-unit of the AMA Advisory Committee on PSROs. The AMA knew its members were confused if also conflicted about whether to embrace PSROs and try to proactively manage their accountability to HEW, or to disavow the federal interference and potentially strike by rejecting the terms of engagement with Medicare and Medicaid patients. It was a decision that seemed disproportionate to the ostensible cause for creating the new review system: the presence of a few “bad actors” in an otherwise honorable system.⁶⁹

One can argue that the real concern had less to do with professional misconduct and more with introducing scrutiny of the whole system to find answers as to why the overall cost of health care was rising at such an alarming rate. The rhetoric of “fraud and abuse” might have been useful because condemning unethical, if not criminal, behavior was a bi-partisan concern. No party, democrat or republican, could stand to ignore the headline-grabbing issue that could also be used as a “key” to unlock regulations used to provide check and balances on how health care was provided.

Nevertheless, for the AMA, PSROs posed the sort of threat to autonomy that they had long resisted. According to Claude Welch, writing in the *New England Journal of Medicine* just days before the crucial AMA decision, the first question was this: “Who’s in charge?” Welch suggested that if the AMA cooperated, then doctors at all levels might be able to provide the direction of

⁶⁹ Feder, *Medicare* (n. 18), p. 43.

PSROs, but if they didn't, maybe the Secretary of HEW "becomes a health czar," a person who by law "must approve or disapprove of any PSRO and ultimately invoke any sanctions. Because one man could not possibly carry out so many tasks, his name would become a front for an established bureaucracy that would furnish true power structure."⁷⁰ Because the debate was generally dominated by concerns over costs, this might also mean that quality of care would collapse, and creating "standards" would lead to "cookbook medicine," the essence of critiques of having a bureaucrat at the bedside.

There were other critiques that Welch addressed, but the problem, he went on to point out, was that the AMA might have used all its political capital and lost its bargaining power when they circulated a dossier called "Deleterious Effects on PSROs" which "served to identify the AMA with reactionary groups and has hardened the position of Congress in favor of PSRO and against the AMA."⁷¹ The AMA had accused Congress of passing a law "that was a creature of impulse"; they said the costs would outweigh savings; they claimed that the threat of fines would "stultify" medical practice.⁷² Seemingly perturbed by the response to his plan by organized medicine, in April 1974 Senator Bennett took to the Senate floor to deliver a speech addressing, point by point, the AMA's allegations.

Quite simply, the AMA played bad politics at the wrong time. Invoking an image of a Federal "health czar," reminiscent of the vitriolic campaigns of the 1950s when the AMA warned of the

⁷⁰ Welch, "PSRO" (n. 68), p. 1319.

⁷¹ *Ibid.*, p. 1320.

⁷² U.S. Senate, Finance Committee, *Background Material Relating to Professional Standards Review Organizations (PSROs)* (Washington, DC: Government Printing Office, 1974), 19-21.

dangers of “socialized medicine” and communist control over health care, did not work during the very months that the Watergate scandal caused the White House to crumble.⁷³ It was two months before Nixon would resign from office. The last two Secretaries of HEW, both appointed by Nixon, had left Washington. Robert Finch, Secretary of HEW for a brief period from 1969-1970, became Counselor to the President but departed in December 1972 when Watergate began to unfold. Eliot Richardson, who succeeded Finch as Secretary of HEW, was subsequently appointed U.S. Attorney in 1973 but resigned when Nixon pressured him to fire the Special Counsel investigating Watergate. Nixon’s appointment of Secretary of HEW who was in office in 1974 was Caspar Weinberger, former Director of the Office of Management and Budget who earned the sobriquet “Cap the Knife” for his cost-cutting record.⁷⁴ This was not the time to characterize the Republican-appointed Secretary of HEW of undermining the health of Americans.

Indeed, it was Dr. Welch’s conclusion when weighing pros and cons that the AMA should cooperate. Was there really all that much for the AMA to complain about? Welch had to admit that Senator Bennett had made “unusual concessions” to organized medicine, giving doctors “enormous amounts of power.”⁷⁵ Given that Congress had already passed the amendments into law, Welch wanted the AMA delegates to consider what options were ultimately available to them: “will medicine sit behind the table in co-operation with the government, which serves as

⁷³ Brian Dolan, “Socialism, Medicine, and the Yoke of European Dictatorship,” *Medical History for Medical Students* 3 (2016): <http://ucmedicalhumanitiespress.com/magazines/socialism-medicare-and-the-yoke-of-european-dictatorship/> Accessed February 20, 2018.

⁷⁴ Clyde Farnsworth, “The Call Him Cap the Knife,” *New York Times* May 3, 1985, p. 6.

⁷⁵ Welch, “PSRO” (n. 68), p. 1319.

the representative of the public, or will it stand on the carpet to be judged by others?”⁷⁶ Indeed, it appeared to be in the interests of the AMA, facing a public increasingly skeptical of its motives, to do some damage control, and the AMA decided to cooperate.

Public skepticism was becoming manifest in media other than broadsheets and popular magazines. In 1971 the political activist Ralph Nader attacked “the often criminally negligent” conditions of medical care, saying that the “endless reports of such conditions by physicians, government investigations and other reliable inquiries and testimony present macabre scenes so repeatedly that they evoke resigned or indifferent responses.”⁷⁷ Acting under the aegis of his Center for Study of Responsive Law, a team of “Nader’s Raiders,” lead by Dr. Robert McCleery, former official of the Food and Drug Administration, questioned whether professional enrichment was coming at the cost of patient care and a result of failures in self-regulation. Issues surrounding the administration of Medicare were central. “The rocketing cost of health care with the advent of socialized payment of physicians’ bills through Medicare has not improved the quality of care,” wrote Nader, “but it has enriched the medical profession to an unprecedented degree.”⁷⁸

Resistance to calls for more rigorous surveillance of peer-review, such as often articulated by the AMA, was usually couched in a defense of professional autonomy. But there was suggestion that such resistance might be ingrained in the psyche of a profession that simply feared being second-guessed, regardless of whether it might protect and improve patient care. Considering that there

⁷⁶ Ibid., p. 1322.

⁷⁷ Ralph Nader, “Introduction,” in McCleery, *One Life* (n. 60), iii.

⁷⁸ Ibid.

may be “psycho-social” issues that work against the effectiveness of PSROs, however robust the law, the Department of Health, Education, and Welfare convened a conference of social scientists and health care administrators to ask the following about the concept of self-regulation: could it ever work?

The conference, held in Washington, D.C. in 1975, examined the expectations of the new PSROs within a framework of problems of “social control.” Rather than assuming an adherence to ethical codes of conduct, some participants introduced a sociological view of problems that seemed to be embedded in the “socialization” of physicians that led to normative behavior which worked against efficiency and, perversely, against integrity where personal profit was to be made. One observation regarded the de-personalization of patients; physicians “tendency to ‘distance’ themselves from patients, their brusqueness, insensitivity to the patients’ feeling”⁷⁹ Such “distancing” was seen not only toward patients but toward colleagues.

Professional “autonomy” was reduced to the level of the individual, where clinical judgment was personal, insulated from external pressures. Thus offering peer review, where one physician critiqued another, was likely to create suspicion and hostility. Medical sociologist Eliot Freidson, referred to earlier, was a speaker at the conference and contemplated the effects of impersonal interactions within the medical system. “The social psychological virtue of impersonal, automatic

⁷⁹ Scott Greer, “Introduction: Professional Review Standards Organization,” in U.S. Department of Health, Education, and Welfare, *Conference on Professional Self-Regulation: Working Papers on PSROs* (Health Resources Administration: DHEW Publication No. (HRA) 77-621, 1975), 1-3, quotation on 2.

review,” he wrote, “is that it avoids interpersonal confrontation and embarrassment.”⁸⁰ The sociological problem with professional review, Freidson said, was that it suggested a norm that is “correct,” and deviation from it as “incorrect.” In medical practice, however, one is socialized to negotiate disagreements as matters of “opinion” rather than “error.” Standards and norms in medicine were conceptualized as subjective and relative. Importantly this applied to “standards” of costs as much as to treatment options. Freidson warned that it was misguided to think that physicians would automatically comply with standards—something true of many disciplines. “Most workers in most forms of work,” Freidson wrote, “are not merely passive reflexes of their situations. Rather, they are active, calculating, and manipulative.”⁸¹

While conceding that health care workers, like most workers, are “manipulative,” he cautioned that when generalizing about such behavior “it is important to rule out imputations of widespread fraud.” Just as anyone might be loose with tax returns, he wanted to imply a difference between intentions and interpretations of procedures. Just as patients were objectified and reduced to units of illness tethered to billable codes, so the whole reimbursement form was depersonalized and manipulated.

The process of filling out forms is almost always arbitrary, and one is more likely to give oneself the benefit of the doubt in his choice of what to put in than he is likely to bend over backwards against himself. Crude words like fraud or dishonesty obscure what is an everyday, universal experience, wherever records are found. Just as we can remember

⁸⁰ Eliot Freidson, “Speculations on the Social Psychology of the PSRO Operations,” in U.S. Department of Health, Education, and Welfare, *Conference* (n. 79), 33-38, 36.

⁸¹ *Ibid.*, 37.

how physicians ‘unnecessarily’ hospitalized patients with Blue Shield coverage in order to gain insurance benefits for them, deliberately adapting their utilization practices to rules of insurance coverage, and just as we can recognize how physicians over the past ten years, confronted with Medicare, Medicaid, and Utilization Review standards adjusted their practices (and their claims) to gain benefits for their patients, so we can expect that to continue when PSRO standards are established. The practice of manipulating and adapting to bureaucratic forms (including the PSRO form) is one that should be considered inevitable and normal, especially if their use is tied to rewards, and if it is largely impersonal in character.⁸²

Freidson applied his socio-psychological understanding of stretching the rules in an unusually favorable way in relation to the problem of fraud. While it is true, and interesting, that physician practices could have changed to a degree to benefit patients, the definition of fraud, which so concerned the government as to push for PSROs, was that it benefitted the claimant, the physician. Thus issuing a warning that it was “inevitable and normal” to adjust practices and manipulate claims forms suggested an inevitable failure of the PSRO legislation to eliminate the fringe practices that allegedly drove up the costs of Medicare, rendering it ineffectual as an instrument of cost-containment.

Inevitable Failure?

⁸² Ibid.

Almost from the moment the PSRO program was established, criticisms were leveled against its structure, its own limited financing, its vague language about “standards,” and its lack of objectives to determine the success of the review program. According to the law professor Timothy Jost, who interviewed eighty PSRO experts to assess the law, “PSROs never succeeded in meeting the expectations of their supporters or overcoming the criticisms of their increasingly vocal detractors.”⁸³ In 1976, Odin Anderson, a professor at the Center for Health Administration Studies at the University of Chicago, wrote that:

The PSRO development is, indeed, remarkable. At first the profession fought it; now predictably it is likely to co-opt it; and I personally see no other alternative unless doctors are handed a manual of instructions to follow. ... If, in their judgment, the doctors are pressed too hard, they will sabotage the monitoring system by many subtle or not so subtle means at their disposal or threaten to strike on the seemingly unassailable reason that good patient care is being jeopardized.⁸⁴

While overutilization was an overarching target for PSROs, if we focus more specifically on the occurrences of fraud and abuse that billed for unnecessary treatments and prolonged hospital stays, it is difficult to determine whether PSROs accomplished anything. For the PSROs to work, fraud and abuse first had to be detected, then it had to be reported to the organization, and

⁸³ Timothy Jost, “Administrative Law Issues Involving the Medicare Utilization and Quality Control Peer Review Organization (PRO) Program: Analysis and Recommendations,” *Ohio State Law J.* 50, Issue 1 (1989), 1-71, 5.

⁸⁴ Odin Anderson, “PSROs, the Medical Profession, and the Public Interest,” *The Milbank Memorial Fund Quart. Health and Society* 54, No. 3 (1976), 379-388, 381.

finally the review organizations had to go through the proceedings and recommend a disciplinary action. Licensing boards before PSROs had a pre-existing problem that continued to plague the system: poor record keeping. In their angst to protect disciplinary data from further tarnishing medicine's image if opened to public scrutiny, a dearth of data was available to assess the number, severity, or consequences of review boards' activities.⁸⁵ Furthermore, severe limits in medical licensing laws (and the activities of licensing boards, who imposed "discipline" on its members) further complicated surveillance on a national level. The fact that state medical licensing boards did not have a national database recording disciplinary actions, nor communicate with each other regarding sanctioned physicians, allowed individuals to elude the system. For instance, a 1984 report of the U.S. General Accounting Office (GAO) pointed to the "undetected movement" of physicians seeking a license in another state after being sanctioned by a medical board in their home state.⁸⁶

The intention behind PSROs was to raise awareness of best practices and to increase surveillance of billing patterns as a means of preventing fraud and abuse rather than prosecute it *post facto*. The response of many medical boards was to enhance educational interventions (such as establishing continuing medical education (CME) programs) and gesture toward doing what Odin Anderson (noted above) mused was a solution, to hand doctors "a manual of instructions." Yet the constant refrain of budgetary constrictions to manage the review task, and claims that the expense of enhanced peer-review was greater than the savings, further hampered the

⁸⁵ Stanley Gross, *Of Foxes and Hen Houses: Licensing and the Health Professions* (London: Quorum Books, 1984), p. 87.

⁸⁶ Johnson and Chaudhry, *Medical Licensing* (n. 39), 202

performance of PSROs. In fact, a 1978 Congressional Budget Office report found that PSRO program costs exceeded reported savings by twice the amount.⁸⁷

As a result of further hearings that continued to report instances of fraud and abuse, Congress was beginning to explore other means of imposing discipline on the medical profession outside the compromise of professional peer review.⁸⁸ In 1977, the Office of Inspector General (OIG) was established within the Department of Health, Education, and Welfare to coordinate all investigative functions pertaining to Medicare and Medicaid and to act as primary liaison between HEW, the Department of Justice, and the FBI. It was the first OIG to be established in the U.S. Government, and marked a significant move to create an apparatus for future criminal prosecutions. Also in 1977, Congress passed the “Medicare-Medicaid Anti-Fraud and Abuse Amendments” of the Social Security Act. This increased penalties for misconduct, required more robust reporting to HEW by PSROs, and it provided federal funding for states to establish “Medicaid Fraud Control Units.”⁸⁹ While this part focused on Medicaid (not Medicare), it began the process of legislating more formal codes to procure data and put more weight on accountability in review procedures.⁹⁰

⁸⁷ U.S. House, 96th Congress, 2nd Session, *PSRO Program: Hearing Before the Subcommittee on Health of the House Committee on Ways and Means* (Washington, D.C.: Government Printing Office, 1980).

⁸⁸ U.S. Senate, 97th Congress, 1st Session, *Proposed Phaseout of PSROs and Utilization Review Requirements: Hearing Before the Subcommittee on Health of the Senate Committee on Finance* (Washington, D.C.: Government Printing Office, 1981).

⁸⁹ “H.R. 3023 — 95th Congress: Medicare-Medicaid Anti-Fraud and Abuse Amendments.” [www.GovTrack.us](https://www.govtrack.us/congress/bills/95/hr3023). 1977. April 17, 2018 <<https://www.govtrack.us/congress/bills/95/hr3023>>

⁹⁰ Byron Lee, “Fraud and Abuse in Medicare and Medicaid,” *Administrative Law Rev.* 30:1 (1978), 1-43.

Exactly one decade after PSROs were established, it was clear that Congress needed to repeal and replace the law. In 1983, Congress enacted the “Peer Review Improvement Act of 1982,” eliminating PSROs and establishing Peer Review Organizations, or PROs. Placed under the administrative control of the new Health Care Financing Administration, this program was in no obvious way better than the last. But this was not the only legislative change to the structure of Medicare and Medicaid. Also in 1982, the Tax Equity and Fiscal Responsibility Act was passed, changing the way hospitals were reimbursed for in-patient stays, replacing a per-diem charge with a “diagnosis-related group” (DRG) derived payment structure. Instead of reimbursing hospitals for however long a hospital stay was, provided utilization committees deemed it “medically necessary,” reimbursement figures were now based on one of 468 permissible diagnosis and a predetermined cost for normal treatment.⁹¹

Examining the success, or failure, of each subsequent legislative reform to the peer-review process is beyond the scope of this article. Focusing on the fact that the PSROs themselves were unsuccessful invites us to reflect on the repeated weaknesses of congressional action to combat something as publicly offensive as fraud and abuse against taxpayer programs. The PSROs were an administrative method of control. At the time they were proposed, PSROs were a regulatory apparatus framed to offer guidelines for how reviews should be conducted. Just as with the original proclamation against “federal interference” with Medicare payments, the PSRO law was written with a spirit of keeping governmental regulations at a minimum. Here it may be useful to

⁹¹ Peter Mellette, “The Changing Focus of Peer Review Under Medicare,” *University of Richmond Law Rev.*, 20:2 (1986), Article 5, 321.

reflect on contemporary notions of the “regulatory ideal” that were debated by theorists of administrative law who examined congressional intent around the time PSROs were introduced.

One writer, the Harvard University law professor Louis Jaffe, discussed the “delegation model” of government that proposed “that administrative powers should not be precisely defined” because the perception of “broad power” was thought to be more daunting.⁹² With only broad and loosely defined objectives, the government’s role was to delegate to presumed experts the job of solving particular problems as they emerge in the field, such as local review organizations dealing with local fraud issues. The congressional acts that established PSROs reflected a *laissez-faire* role for government that was long celebrated in the influential publication *The Administrative Process* (1938) by James Landis, known as “dean of the regulators” as well as guardian of cost-effective government.⁹³ However, Harris Cohen when working for HEW in the mid-1970s pointed out the problem with these theories of government delegation: the “experts” will seize on the self-imposed limits on government authority and co-opt the system for their benefit. “The agency is thus converted, over time, from functioning as a check on the regulated interest to that of an ally or even subsidiary of the nominal subject of regulation.”⁹⁴ Such an inversion in regulatory authority subverts the intended efforts. In Jaffe’s words, “the more vague a delegation, the more likely the charge that an agency has failed to fulfill its congressional mandate.”⁹⁵

⁹² Jaffe, “The Illusion” (n. 14), 1185.

⁹³ Donald Ritchie, *James M. Landis: Dean of the Regulators* (Cambridge: Harvard University Press, 1980).

⁹⁴ Cohen, “Regulatory Politics” (n. 3), p. 123.

⁹⁵ Jaffe, “The Illusion” (n. 14), p. 1184.

In short, when the limits of self-regulation became apparent with the rise of reported cases of fraud and abuse, the government's solution to set up additional peer-review organizations was an example of the weakness of the "regulatory ideal" in government symptomatic of the time.⁹⁶ By letting local, physician-controlled committees contemplate what defined appropriate utilization of medical services, all the while billing Medicare and Medicaid for continued hospitalization and treatment, the intent behind the PSRO legislation was lost. By prioritizing vague notions of "cost-containment," the government relinquished the authority to focus on disciplinary action, thus allowing for fraud and abuse to continue.

⁹⁶ Nicholas Johnson, "A New Fidelity to the Regulatory Ideal," *Georgetown Law J.* 59 (1971).