Letter from . . . Victoria

Peer review

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Peer review is one of the problems facing the medical profession in Australia, but the first problem is to define what we mean by it. Perhaps it is best to start with some extracts of the report of a symposium on peer review organised by the Australian Medical Association (AMA) 24-26 February 1977.¹ In this report the Minister of Health of the Federal Government is reported to have said in a speech on 20 May 1976 that "The Government attaches considerable importance to this matter [control of cost escalation] and will ask the medical profession to institute systems of professional standards review, both to assess the quality of, and to seek the justification for, services rendered. . . . Failure to have workable systems in operation within three years could result in the introduction of mandatory systems." During the symposium the minister claimed that this statement was not a threat but a challenge.

We can see that what the politicians want from peer review is control of costs. What doctors think of as peer review depends on where they got their ideas. Certainly few doctors in practice see it as a cost-control exercise. Most see it as an attempt at quality control, which tends to emphasise the attainment of a set of minimum standards. Others see it as an inquisition into clinical freedom.

Overseas experience

The report of the symposium¹ makes interesting reading as it outlines what is called peer review in other countries. As I understand it, the Canadians have a system of health care insurance in some ways similar to the Australian system, but with major differences. Most of the funding is from the central government, and it is administered by the provinces. The similarities are that the citizen pays a premium and the doctor can claim his fee direct from the insurance organisation. The provinces have tight controls on the fee structure, which is not the case in Australia. It would appear from the report that peer review means different things to doctors and administrators in Canada. The doctors see it as a method of controlling hospital privileges and assessing the appropriateness and quality of professional care, and as complementary to a programme of continuing education. The result is a system of subjective assessment designed to avoid conflicts. It is costly in doctors' time and focuses on the individual and not on the hospital. It appears that to administrators the expression might almost be limited to the assessment of computer patterns of consulting and other medical costs.

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The report devoted a lot of space to a review of professional standards review organisations in the United States. Here the concern is with cost control—the control of hospital costs. The review procedure, which requires good records and a specialised clerical staff, is concerned with eliminating inadequate reasons for admission and over-long hospital stays. Once departures from the agreed norms are detected by the clerical staff the treating doctor has to justify the departures to a committee of the medical staff. The process is expensive and any benefits have yet to be shown. The whole exercise had needed large amounts of government money to start and maintain it.

In West Germany the expression appears to be applied to the analysis of insurance claims generated by their system of medical care.

Australian experience

It was obvious from the report that in the Australian context doctors see peer review as a form of quality control. But what form? Nothing emerged from the symposium, which was held to explore ideas and to consider overseas experience. The major costs of Australian health care occur in hospitals. It is fashionable to attribute much of the cost of hospitals to medical decisions about treatment. There is obviously a case for attributing the drug bill to the doctors' decisions. The costs of treating renal failure with dialysis and transplantation can at first sight be attributed to medical decisions. But could we, even if doctors were willing to, put the clock back and refuse to treat renal failure to keep costs down? I doubt whether even the most cost-conscious politician would be willing openly to advocate such a course.

Perhaps our hypothetical politician might be willing to advocate a policy of neglect for crippling arthritis of the hip: the successful procedure costs several hundred dollars for the prosthesis, quite apart from the cost of admission to hospital and the operation itself. But I doubt if he would be game to try this. Too many voters' elderly relatives have had a new lease of life with a Charnley total hip replacement. That is not to say that every new hip joint fitted can be justified. It is in this grey ground where expensive operations and investigations may or may not be justified that the potential for cost cutting lies. As things are, it is the treating doctor who decides on the test or procedure, and it is carried out.

In Australia these days there is a fear of litigation on the American scale for alleged malpractice. After all, Australia follows the USA in everything. So extra tests are undertaken to be on the safe side. I understand the same holds in England and there is enough evidence in the Medical Defence Union's annual report to show that some doctors are either careless or incompetent. The fear of litigation is mistaken in Australia, I believe, as we have an English-style legal system whereby the American practice of contingency fees (a case being accepted on the basis of no fee if the case is lost and a fixed, and usually large, proportion of the damages if the case is won) is illegal.

It should not be fear of litigation that provokes the weeding out of incompetence—it should be a positive desire for the patient's protection. And it is this that is missing from the minister's "challenge." How to preserve the freedom for the treating doctor to do what he decides is best for his patient and at the same time control costs seems to me an insoluble problem.

As a practising anaesthetist I would not relish having to justify each step of an anaesthetic procedure when I chose to use a different technique from the standard for that operation. I cannot see that surgeons would be happy at having to justify their own particular steps in any common operation when these varied from the laid-down protocol (if there could ever be agreement in detail on that). Where does the inquiry start and stop when it comes to competence? So far studies of hospital records are the only type of inquiry that seems to be thought feasible, and obviously even these cost money and take a lot of doctors' time. Frankly, I cannot see them achieving much in the way of cutting costs or even containing the rapid rise.

In a similar situation—the cost of pharmaceutical benefits—the Government has tried to contain costs by removing the cheaper items from the benefit list, by raising the patient's contribution from 50c to \$2.00 over the years, and by restricting the prescription of various drugs. Some may be supplied on the \$2.00 prescription only if the Commonwealth Department of Health gives approval before the prescription is presented. Others can be supplied for \$2.00 only for "specified purposes," abbreviated to SP on the prescription. It is common knowledge that this is unpoliceable and some of the SP prescriptions are being prescribed for other than the official indications. The restrictions apply only to the subsidised prescriptions. One is supposed to give the patient a private rather than an NHS (subsidised) prescription if the "specified purposes" are not met. But there is no check unless the doctor's prescribing habits are far removed from the computer's norm, so in many cases the doctor's concern for his patient's pocket outweighs his concern for the Government's pocket (and rules). Little progress has been made in educating patients out of wanting a prescription with every consultation. Doctors are in business, and no patients means no income, so the patient tends to get what he wants. From my reading of the *BMJ* the same seems to apply in the UK.

Doctors' income

Recently *The Australian*² had an article on the rising costs of medical and hospital care. One thing that will stick in every reader's mind is the figure of \$70 000 as the average doctor's income. The computer lies only occasionally, so we can assume that this figure is arrived at by dividing the total paid out in medical benefits by the number of doctors paid. What was not

mentioned in the article was the fact that this is a gross income for the business of being a medical practitioner, and a varying amount will go in expenses, probably from 30% to 60%. It is difficult to see how the payout can be reduced as most of the consultations are patient-caused and the investigations and treatment are those usually needed to practise "good modern medicine." With the continuing epidemic of motor car collisions and injuries there is a large and steadily increasing number of patients needing emergency and follow-up hospital care each year.

It has been suggested that doctors' fees should be held down, but the Federal Government has no power to impose price controls except in its territories; that power resides with the States, whose governments on the whole are not willing to introduce price control of doctors' fees. At present the Government sets a scale of fees on which the patients' rebates are based while the AMA sets a higher scale of fees which it recommends. As the Government's scale of fees is set by arbitration, the Government and the AMA representing the two sides, it seems likely that doctors' fees will continue to rise as the costs of conducting a practice rise and can be shown to rise.

Cost

At this stage no one has suggested that peer review, in the form of an audit of a patient's treatment, is possible in Australian hospitals as they are staffed at present. One attempt at peer review was abandoned when a doctor whose treatment of a patient was criticised threatened to sue for libel. In any case it is agreed that to use the American style of assessing patients' treatment requires "better" (presumably more detailed) medical records and more medical record staff and clerks. The money for all this is most unlikely to be provided by a cost-cutting Federal Government. It is also clear that more medical time would have to be devoted to committee work, presumably at the cost of contact with patients.

So we go on working and earning our livings while various AMA committees ponder the possibilities of peer review. Someone is going to have to make political decisions about where the cost savings are to be made in the health cost pyramid. It is unfair to expect the medical profession to accept the odium of making these decisions. So far as I know the AMA has not yet said to the Federal Government, "If you want peer review you will have to pay for it. Put up the money and we will start producing trial schemes." That is what needs to be done.

References

- ¹ *Medical Journal of Australia*, special supplements, 2 and 9 April 1977.
- ² *The Australian*, 30 December 1977.

Doing routine colour vision testing recently, a young boy proved to have a red-green deficiency on the Ishihara test. When he used a pair of colour spectacles (red lens to right eye, green lens to left) his responses were those of a boy with normal colour vision. What is the explanation of this? Would such a pair of spectacles help when he comes on to practical biochemistry? Already he is experiencing difficulty in the science laboratory.

The suggested use of coloured spectacles to improve defective colour vision is not new.¹ In certain cases they may appear to sharpen colour discrimination, but in fact they render colour gradations as differences in brightness. Thus a red object will appear brighter through the red lens than through the green. The red sensation if absent, as in a protanope, could not be restored. Whether the spectacles would help the boy to perform certain chemical tests depends on the nature and extent of the defect. The Ishihara test is rather a blunt probe and "red-green deficiency" is not a precise diagnosis. It would be interesting to try more discriminating tests such as AO H-R-R and

Farnsworth 100-hue. Since red and green spectacles reduce the sensitivity to blue (which is usually unimpaired in a "red-green" defect) the overall performance is unlikely to be improved.

- ¹ Rosenstock, H B, and Swick, D A, *Journal of the Optical Society of America*, 1974, **64**, 1386.

Can fungus infection of the feet and hands cause local oedema? If so, what is the treatment?

Local oedema is associated with certain deep fungal infections. In the common superficial fungal infections local oedema is associated with secondary bacterial infection and kerion; in the latter the inflammation is believed to be caused by an immune response to the fungus, most often a cattle ringworm. The oedema regresses with adequate treatment of the primary cause, though lymphoedema may persist after deep infections.