Medical Monitor

Outfit That Accredits Hospitals Helps Set Quality of Patient Care

Criticism and Competition Spur Tougher Inspections; Giving a Six-Week Notice

Are Surveys 'a Whitewash'?

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CHICAGO — You're a little nervous as you enter the hospital for a gallbladder operation. You've heard so many horror stories about hospitals. How can you be sure this is a good one?

There's a framed certificate on the lobby wall that reads: "The Joint Commission on Accreditation of Hospitals (JCAH) has accredited St. Jones Hospital." You never heard of the organization. Does the certificate mean anything?

"It's the best guarantee a man on the street has that when he goes into a hospital, he won't be butchered," says John Norwood, administrator for St. Louis' Bethesda General Hospital.

Not so, counters Dr. Sidney Wolfe. "The comfort of going to a JCAH-approved hospital is illusory at best," argues Dr. Wolfe, director of Ralph Nader's Health Research Group in Washington.

The debate concerns organized medicine's private policeman, the Joint Commission on Accreditation of Hospitals. For nearly 25 years, this little-known nonprofit corporation has been the primary monitor of safety, cleanliness and care quality for most of the nation's hospitals.

Surveys of 4,800 Hospitals

The commission draws up standards and evaluates health institutions through biennial surveys of the 4,800 U.S. hospitals that request and pay for its visits; there are 8,200 hospitals in this country. How well the JCAH motivates hospitals to improve health care affects the well being of nearly two-thirds of the 34 million Americans who are admitted to hospitals each year.

The present dispute over the JCAH's functions and effectiveness casts light on the tangles that plague the hospital-regulation field. That's important because probably no other industry needs good quality-control mechanisms more than hospitals, which spend $36 billion annually to save lives and restore health.

To begin with, the Joint Commission is just one of a dozen or so private and governmental groups that are involved in regulating hospital performance. Others include state health departments, which license and regularly inspect hospital buildings for soundness, and Medicare, which conducts certification inspections of hospitals that [illegible] JCAH accreditation, which isn't mandatory. Medicare surveys are patterned after the JCAH's review of medical and nursing services and the adequacy and maintenance of hospital equip-

In addition, PSROs, or Professional Standards Review Organizations, are being set up nationwide to scrutinize the costs and quality of medical services provided under federally financed programs for the poor and elderly.

Unclear Enforcement

Besides this overlapping, another problem is that the JCAH's enforcement powers are unclear. A hospital must be accredited to receive Medicare funds, sponsor internship and residency programs for physicians and be eligible for 12 of the 74 Blue Cross insurance plans that operate nationally. Yet federal dollars are rarely cut off following disaccreditation and no institution has ever lost its training programs or Blue Cross reimbursement after failing to measure up to JCAH standards.

There also is disagreement over what the Joint Commission's future role will be when some form of national health insurance becomes a reality, which may happen in the next few years. Should the federal government replace the private sector entirely as the enforcer of quality in the nation's hospitals?

Hospitals clearly would prefer the status quo. The JCAH is doing an adequate policing job, hospital administrators say. Its surveys "forced us to do things that we probably wouldn't have done otherwise—like establish an emergency water-supply plan," says Benjamin Seed, assistant administrator for Pittsburgh's St. Clair Memorial Hospital.

Hospitals have other reasons for seeking JCAH accreditation besides Medicare reimbursement. No major malpractice insurer will issue a policy to an unaccredited hospital, and institutions lacking the JCAH seal of approval find it difficult to recruit nurses and doctors.

"A Whitewash"

But the JCAH's critics don't believe the industry-sponsored organization is strict enough. "We feel the Joint Commission is a whitewash for hospitals," says Donald Rubin, president of the Consumer Commission on Accreditation of Health Services, a New York consumer-activist group. "Accreditation should be a government process."

Accreditation of hospitals began in 1918 when the American College of Surgeons drew up a one-page list of standards. Just 89 of the 700 hospitals visited by the college that year passed the requirements. Ashamed of the results, college regents burned the list of the 611 institutions that flunked.

The Joint Commission was created in 1951 and headquartered in Chicago to take over the ACS accrediting program. Its board is made up of 20 commissioners, seven each from the American Medical Association and the American Hospital Association, and three each from the American College of Physicians and the surgeons' group.

With a staff of 250, the JCAH derives its $7 million annual budget primarily from hospital accreditation fees. The people who make the inspections are called surveyors and are mostly retired nurses, physicians

Please Turn to Page 17, Column 1

WALL STREET JOURNAL
28585000
MONDAY
JAN. 13, 1975

(PAGE 1)

200 W. Monroe St
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WALL STREET JOURNAL
JANUARY 13, 1975
MONDAY
PAGE 2

Medical Monitor: Accrediting Body For Hospitals Is Coming Under Fire

Continued From First Page

and hospital administrators. The length of their inspections depends on health facilities' size and may last from one day to a week. They measure a hospital's compliance with the commission's 186 pages of standards. The gamut of hospital life is covered in the standards—including fire drills, drug-recall procedures, staff training and infection control in kitchens.

Every year, typically, the Joint Commission disaccredits 2% to 5% of the hospitals it surveys and grants a probationary, one-year accreditation to another 20%. Accreditation is withheld, or probation imposed, for such reasons as a rundown physical plant, inadequate fire protection, insufficient nursing coverage, unethical surgical practices or incomplete medical records.

Pressure from senior-citizen and welfare-rights groups in recent years has forced the JCAH to become more of a patients' advocate. It has expanded its policy of making unannounced spot checks of hospitals when patients or workers warn that a life-threatening situation exists, such as the employment of unlicensed doctors.

Community organizations and hospital employes now can voice complaints about their hospitals' conditions during accreditation visits; before, only administrators and medical directors could participate. Public gripe sessions have been held recently at hospitals in New York, Chicago, Miami, Washington and Los Angeles. One presentation by interns and residents about overcrowding and the rundown plant at New York's Lincoln Hospital contributed to the removal of its accreditation in September. (The hospital successfully appealed and in late December received a one-year accreditation.)

Giving Warning

However, the vast majority of JCAH surveys are still conducted as friendly consultations. Only surveyors and hospital officials are present, and the hospital gets six weeks' prior warning of the visit. This removes the element of surprise, but as JCAH supporters like to point out the time lag allows hospitals to bring medical records up to date, paint wards, check electrical wiring and make other improvements that may have been neglected for two years. "You like to put on your best face, obviously," says Mr. Norwood, the Bethesda General administrator.

Mr. Norwood's institution, a 610-bed hospital and nursing home, was inspected by the Joint Commission for two days in October. Steve Beaudry, one of three surveyors, toured the facilities from basement to roof, looking mainly for fire and infection hazards. He found plenty—ranging from dirty rags in the janitor's workshop to a soiled-linen storage room whose windows aren't fire resistant. He urged the hospital to correct the deficiencies, warning that otherwise federal work-safety inspectors might come and impose a fine.

Some critics say JCAH surveyors such as Mr. Beaudry, a former hospital administrator, aren't qualified to judge a hospital's fire safety. Medicare currently is conducting validation surveys of a sample of accredited hospitals that seem to support this contention. State fire marshals employed by Medicare found that 69 of the 105 hospitals visited in 1974 failed to meet the government's fire-safety standards. The fire officials encountered such hazards as long corridors without fire exits and inadequate sprinkler systems.

The two other JCAH surveyors at Bethesda General inspected the equipment and personnel at the more medically complex areas of the hospital—nursing stations, the emergency room, the pharmacy, the operating room and so on.

Nurse surveyor Olga Dean was particularly concerned about checking the adequacy of nursing coverage. Among other things, the JCAH cited the hospital for insufficient nurses when it granted Bethesda General a one-year accreditation last year. As she reviewed the nurses' work schedules, she assumed the records weren't falsified. "I don't come back at night to check," observes Dr. Albert Brewer, the physician on the survey team.

If a hospital wants to deceive the surveyors (and some do, commission officials concede), this defeats the JCAH's role as a hospital's defense counsel. "We're here to throw up a stop sign before there's a crash at the intersection," Dr. Brewer tells a Bethesda General nurse anesthetist after finding that an operating-room machine hasn't been checked for volt leakage in 14 months. (A few weeks later, the JCAH put the hospital on a one-year probation for the second consecutive year.)

To drive home his point, the surveyor spent a full morning educating the hospital's physicians about the JCAH's new involvement in direct policing of patient care. This is being done through "retrospective medical audits," an evaluation tool developed by the Joint Commission to counteract the federal PSROs' invasion of its traditional regulation territory. Under guidelines issued in August, hospitals that adopt the JCAH medical-audit system can escape PSRO monitoring of their care quality.

About 1,200 hospitals already have implemented the audits so far, according to the JCAH. Any hospital that fails to institute the procedures by July 1 will lose its accreditation.

The JCAH admits that it tolerated a "nonsystem" of evaluating medical care for years. Small groups of hospital doctors would scan a few casually selected patient records and then judge a colleague's performance subjectively. Medical critics say this resulted in incompetent doctors being allowed to practice, which they blame for the recent rise in the number of malpractice judgments of $1 million or more.

Auditing "Outcomes"

By contrast, medical audits can detect mistakes or treatment gaps on an objective, systematic basis, JCAH officials assert. An audit focuses on "outcomes," asking, did the patient leave the hospital relatively whole and healthy? Physicians draw up criteria for their institution's most common diseases and surgeries. The criteria cover the expected symptoms, diagnoses, tests and treatments.

For example, doctors at Grant Hospital in Chicago decided that a child must have four bouts of tonsillitis to meet their criteria for a tonsillectomy. Within a month, such surgeries "fell off" dramatically, recalls Dr. Randolph Seed, who heads the hospital's surgery department. "Very few" of Grant's tonsillectomies turned out to be justified, he adds.

An audit at another Midwest hospital disclosed that one surgeon's patients were always going home sick from complications, a pattern which had not been apparent before. He was stripped of his right to practice surgery—a first for the hospital. A third institution fired an ulcer surgeon after audits disclosed that he was prematurely removing ulcers without first treating patients through medication.

But critics argue that if the Joint Commission directs more energies toward evaluating professional services, it should give up inspecting physical-plant conditions. In fact, because of JCAH's poor record on fire-safety surveys, Medicare administrators say that they intend to seek congressional approval to take over the Joint Commission's fire-safety inspection function.

The commission isn't terribly reluctant to give up this role. Measuring door frames for fire resistance "really isn't our bag. We're not an engineering consulting firm," explains Dr. John A. Poterfield, executive director. In its place, the commission has begun branching out into new areas where it can monitor health professionals' performance. These include accreditation of nursing homes, mental hospitals, alcoholism-treatment facilities and neighborhood health centers.

"The JCAH is expanding its capabilities and doing a better job," says Dr. Michael Goran, head of the Bureau of Quality Assurance, which supervises PSROs in the U.S. Department of Health, Education and Welfare. If the commission continues to improve its policing of care quality through medical audits, Dr. Goran adds, then national health insurance may use the present "pluralistic approach to hospital regulation."