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Book Reviews

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Felix Cohen's Handbook of Federal Indian Law (1971), University of New Mexico Press, 1971 Pp. 662. Cloth $25.00.

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There is no reason why law should be free from revivial movements. Sometimes in rather bold ways we change our assumptions, our definitions of goals, our view of history. That process has occurred time and again in the field of federal-state Indian relations and is presently taking place once more. An important symbol of the process is the recent republication of the Handbook of Federal Indian Law. The version that was published by the United States in 1942 had fallen into official disrepute. In 1958, the Truman-Eisenhower theology of Indian law was recorded in a revised Handbook of Indian Law which was published "for the purpose of foreclosing, if possible, further uncritical use of the earlier (Cohen's) edition by judges, lawyers and laymen." The instrument of revival is the republication of the original text under the auspices of the University of New Mexico.

But the 1942-1971 book is more than the reprinting of a kind of codification. It is the revival of an aesthetic—an aesthetic about the United States as mirrored in its dealings with Indians and its hopes for Indians. Cohen is pluralistic: the idea of the tribe and its strengthening (both in terms of rights to land and power of its government) permeate Cohen's work. The assumption of the 1958 book is quite different: it is that the Indian minority, like other minorities, will become part of the mainstream and subject to the jurisdiction of the regular civil authorities.

The rival aesthetics are bases or apologies for very different federal policies and strategies. During the New Deal, tribes were induced (some say coerced) to accept a kind of federal corporate status giving them certain powers over

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1. U.S. DEP'T OF INTERIOR, FEDERAL INDIAN LAW 1 (1968).

their lands and their membership. Reservations were created (in Alaska, for example) and federal money was provided for the expansion of the Indian land base. From Felix Cohen's perspective, an important aspect of the New Deal Indian policy was the passage of the Indian Claims Commission Act which authorized suit against the federal government for legal and moral wrongs done to Indian groups from the outset of nationhood.

The policy of the Truman-Eisenhower era was quite different. In the period of the post-war boom, with television sets and cars and bungalows spreading through the countryside, preservation of Indian values (or other similar values) seemed of only antiquarian interest. Cultural pluralism meant states rights. Starting in the late 1940's, the federal government eagerly transferred much of its jurisdiction over Indian people and Indian land to the states. When jurisdiction had been in the federal government it was as a shield against state entry, against jurisdictional assimilation. In the hands of the state, jurisdiction was part of the process of terminating tribal existence.

In the sense that more rapid assimilation and less strengthening of tribal government did occur in the 1940's and 1950's, the redrafting of a book which purported to represent federal policy is not without reason. Undoubtedly, the Cohen *Handbook* was an embarrassment to the federal government in the late 1940's and 1950's because of the position it took before the public and the courts. The Land Division of the Department of Justice, particularly thorough in its defense of the federal treasury, consistently took positions violently opposed to statements contained in the Handbook. As Congress turned more toward a policy of relinquishing federal control and accelerating the policy of encouraging Indians to become less dissimilar, the 1942 Handbook simply did not reflect federal Indian policy.

If that were all, if the 1942 edition and the 1958 edition merely purported to state federal Indian policy and its precedents, then there would not be much room for emotional combat.

The different texts are bothersome not because they differ about the present but because they differ about the past. It is thought by many that the 1942 edition embodies truth as well as an excellent passionate perspective. It has been attacked as viciously as the 1958 edition, the latter Handbook. The 1958 Handbook has been attacked because the philosophy it put forward was thought to be wrong and immoral in that it validated the abrogation of fundamental rights. But it has also been considered dishonest and ephemerally compromising. There is much to be said for that view. Cohen's Handbook was by Cohen. It was his personal statement. The later book is anonymous, official and derivative. It takes Cohen's work and bowdlerizes it. Much is the same; but the conclusions are altered. Disfavored cases are omitted. It is a

clumsy job. The two works differ most in their view of the nineteenth century, particularly the course of dealing between the federal government and the Indian tribes with respect to land.

To Cohen, the history of federal Indian relations is one where the predominant theme is justice, wherein there was a consistent attempt by the United States to deal fairly. Always recognizing that there was a special claim of Indian sovereignty, a special claim to lands. If Cohen had been less of a romantic or idealist, the disastrous state of Indian affairs in the 1930's might have given pause to such a view of 150 years of federal principle. But Cohen believed, and believed sincerely in the "legal conscience." On the occasion of the decision in *Alcoa Band of Tillamooks v. United States*,[2] Cohen said "Today we can say from the Atlantic to the Pacific our national public domain consists, with rare exceptions, of lands that we have bought from the Indians. Here and there we have probably missed a tract, or paid the wrong Indians for land they did not own and neglected the rightful owners. But the keynote of our land policy has been the recognition of the Indian property rights."[3]

This was a rather rose-colored view of American history, including the history of the action of judges. But his view of the past was necessary as a basis for his policy for the present, for the completion of the task of justice: providing compensation to Indian tribes wronged in the past. From time to time, Cohen noted, "distinguished advocates have upheld what may be called the 'menagerie theory' of tribal property, under which no rights whatsoever are vested in the Indian tribe. In every case, however, in which this theory has been presented to the Supreme Court of the United States, it has been rejected."[4]

Unfortunately, in the years following publication of the great Handbook, the Supreme Court proceeded to do what Cohen said they had never done before. In *Tee-Hit-Ton v. United States*,[5] Justice Reed rather brutally concluded: "No case in this Court has ever held that taking of Indian title or use by Congress required compensation. Every American schoolboy knows that the savage tribes of this continent were deprived of their ancestral ranges by force and that, even when the Indians ceded millions of acres by treaty in return for blankets, food and trinkets, it was not a sale but the conquerors' will that deprived them of their land."[6] The purge of *Alcea's* taint was even more clearly suggested in the *United States v. Alcea Band of Tillamooks*,[7] which expressly

2. 329 U.S. 40 (1946).
3. Cohen, *Original Indian Title*, 32 MINN. L. REV. 28 at 36-37 (1947).
4. F. COHEN, HANDBOOK OF FEDERAL INDIAN LAW 288 (2d ed. 1971).
5. 348 U.S. 272 (1955).
6. *Id.* at 281.
7. 341 U.S. 48 (151).

reinterpreted th earlier *Alcea* opinions as not resting on constitutional takings as a ground for Indian recovery.[8]

Not every advocate who sought compensation for injustice would have been required, as Cohen felt he was, to reconstruct the past. For the more direct, it might suffice to argue that the systematic deprivation of the past demand more sensitivity to questions of right and justice in the present. There needs to be a discontinuity, not a continuation of the present. Cohen felt the need to see justice as an extension of the past. Only if one were obliged to be adulatory toward American institutions as well as attentive to Indian rights would the scholarly dilemma that Cohen faced arise. Because of Cohen's passionate feeling for the value of Indian land rights and because of his commitment to the integrity of American judicial institutions, his recitation and analysis of court precedents is graceful and nimble. It is an extraordinary lawyer's brief as much as a history. Another analyst might not be so charitable to judicial and legislative precedent. Curiously, both the 1958 Handbook and Cohen's work proceeded by defining present policy from the past; since they differed as to their sense of the needs of the present, they differed as to their definitions of the past.

There is another area of the Handbook which reflects the problem of policy and history: tribal jurisdiction over non-Indians residing on the reservation. Cohen wrote that ". . . attempts of tribes to exercise jurisdiction over non-Indians have been generally condemned by the federal courts."[9] This language was retained whole in the 1958 edition. Tribal governments have control, but not where it counts most. The issue is of greater importance now, of course, as the number of non-Indians living and doing business on Indian reservations has increased tremendously. The authority Cohen cites for the proposition is only barely applicable, Ex parte *Kenyon*,[10] and contrary authority is not invoked.[11] On the equally important matter of tribal power, whether tribes retain jurisdiction to prosecute their own membership for major crimes, Cohen was ambivalent and did not conclude that there was tribal jurisdiction.[12] For Felix Cohen too, there were limits to the legal conscience.

Federal policy and the form of the need for federal protection had changed again, and in ways which, while closer to Cohen, are not congruent with his Handbook. Since 1968, tribes are under clear quasi-constitutional constraints in their effect on citizens. There may not be, under the congressional view, as

8. *Id.* at 49.
9. F. COHEN, *supra* note 4, at 148.
10. 14 F. Cas. 353 (No. 7720) (C.C.W.D. Ark. 1878).
11. *See, e.g.*, Buster v. Wright, 135 F. 947 (8th Cir. 1905).
12. F. COHEN, *supra* note 4, at 147.

once there seemed to have been, the sovereignty to perpetuate forces of governance inconsistent with the Bill of Rights. Economic development programs encouraged by federal grant loan programs are placing different pressures on cultural integrity. Federal influence, once concentrated in the Bureau of Indian Affairs is now distributed throughout the federal government. Natural resources rights—the rights to water, to fish, to timber—have become much more valuable, and more subject to dispute. At the same time there is increasing state interest in the regulation and taxation of activities on Indian reservations. The economic development policies of the 1960's encouraged the growth of non-Indian residential subdivisons, recreational areas and industrial parks on reservation lands. Power plants have moved to reservations sometimes to escape state environmental regulation. In Palm Springs, Indian land is distinquished from non-Indian land only by the form of ownership which the non-Indians doing business there enjoy. Neither the 1958 Handbook nor its revered ancestor deal sufficiently with many of the issues which are pressing today.

The republication of Cohen's Handbook is like the rediscovery of a monument which was remembered in its impact but forgotten in its detail. It is a formidable piece of scholarship; a reference work which is indispensable. There are special exhaustive appendices which list thoroughly materials on Indian law indexed by tribes as well as an annotated table of statutes and treaties; a table of federal cases and other tables of federal materials. It is a monument because it inspires, invoking past, more principled battles, battles different from the ones presently being fought.

International Claims: Postwar French Practice, By Professor Burns H. Weston. Syracuse University Press, 1971 Pp. xv, 237 (Procedural Aspects of International Law Series, Vol. 9.)

Don Wallace, Jr.*

This is number nine in the Procedural Aspects of International Law Series, published under the general editorship of Professor Richard B. Lillich now of the University of Virginia Law School. The series also includes Professor Lillich's *International Claims: Their Adjudication by National Commissions* (1962); *International Claims: Their Preparation and Presentation*, by Professor Lillich and Gordon A. Christenson (1962); and Professor Lillich's *International Claims: Postwar British Practice* (1967). Forthcoming volumes include Professor Isi Foighel's *International Claims: Postwar Danish Practice* and *International Claims: Their Settlement by Lump Sum Agreements* by Professors Lillich and Weston. The series represents a useful and rather detailed discussion of material previously covered by such classics as Borchard, *The Diplomatic Protection of Citizens Abroad; or The Law of International Claims*; Dunn, *The Protection of Nationals, A Astudy in the Application of International Law* and also examined in general works by Moore,[1] Hackworth,[2] and Whiteman.[3] Greater reference to or at least a bibliography of such earlier sources would have been a useful addition to this volume.

Although the book is a survey of French practice in the international claims area, as Professor Weston's introduction[4] indicates, it is something more—a discussion of the French practice as one example of the general practice of states, the "synthesis" of which gives rise to international law. This aspect of the book is probably stronger than the examination of French administrative law—Professor Weston is after all a professor of international law. The premise of this book is in contrast to that of Professor Richard A. Falk's, *The Role*

* Professor of Law, Georgetown University Law Center; Director, Institute for International and Foreign Trade Law, Georgetown University; Yale B.A. 1953; Harvard LLB 1957.

1. J. MOORE, DIGEST OF INTERNATIONAL LAW (1906).
2. G. HACKWORTH, DIGEST OF INTERNATIONAL LAW (1940-44).
3. M. WHITEMAN, DIGEST OF INTERNATIONAL LAW (1963-68).
4. B. WESTON, INTERNATIONAL CLAIMS: POSTWAR FRENCH PRACTICE (1971).

of Domestic Courts in the International Legal Order (1964), the third volume in the same series. Professor Falk suggests that the national courts should play a somewhat limited role with respect to international legal matters subject to ideological controversy between nations. The Supreme Court adopted this position to some extent in *Banco Nacional de Cuba v. Sabbatino*,[5] a case which has been cited as a triumph of Professor Falk's views.[6] Professor Weston, by contrast, vigorously maintains that "horizontalism dictates, [that] these decisions, from country to country, help form over time that synthesis which is in large measure what we today call international law."[7] In conclusion, he states that "all domestic decision-making instituions . . . affect 'outward' or 'upward' the patterns of international authority and control that in turn affect so fundamentally 'inward' or 'downward' our everyday lives."[8]

Professor Weston has reviewed all the decisions of a number of French claims commissions, which are similar to our own Foreign Claims Settlement Commission. These Commissions distribute the proceeds of eight lump sum settlements entered into between France and certain Eastern European governments and the Cuban and Egyptian governments since World War II. Despite the secrecy which has surrounded these French commissions, of which Professor Weston complains, he has succeeded in collecting a good deal of data, principally about: (1) the terms of the various lump sum settlement agreements; (2) the so-called controlling texts, or French implementing legislation and commission regulations which govern the commissions and establish their procedures; (3) the review practiced by the Conseil d'Etat; (4) the problems of the nationality of claimants, successor claimants, etc.; (5) classes of protected property, including the rights of various classes of creditors (the French apparently are more generous than the British and the Americans in this area and Professor Weston suggests French practice may help to fill out the definitions of international law in this area);[9] (6) a discussion of which acts by the seizing government constitute "expropriation" subject to compensation; (7) a discussion of how the value of property is to be determined (notwithstanding the fact that each commission awarded only a percentage of such value); and many other related questions.

I have three marginal complaints. First, Professor Weston might have spent a bit more time on the fact that the French do not have a formal pre-

5. 376 U.S. 398 (1964).

6. Earlier expressed in *Falk, Toward a Theory of the Participation of Domestic Courts in the International Legal Order: A Critique of* Banco National De Cuba v. Sabbatino, 16 RUTGERS L. REV. 1 (1961).

7. WESTON, *supra* note 5 at 4.

8. *Id.* at 190.

9. *Id.* at 177.

adjudication settlement procedure in which prospective claimants may come to the French foreign office and state the amounts and bases of their claims and the impact this has on the final recovery.[10] Perhaps this will be covered in the upcoming book by Professors Weston and Lillich.[11] Second, although there is a discussion of "creeping expropriation," the book lacks a detailed analysis as to the point in time when such is deemed to amount to an actionable or espousable expropriation. This has relevance to the plaintiff whose citizenship in the espousing country has been established between the beginning of the "creep" and the culmination of the expropriation. Third, Professor Weston treats a few difficult questions a bit lightly, such as certain problems of mergers, liquidation and the like affecting a claim.[12] Because the book was originally submitted as a dissertation for a Yale law school doctorate, its organixation is that of an essay rather than a treatise. However, as Professor Lillich points out in his forward, the index will probably make the materials accessible. The table of contents, rather McDougalise in its terms, is not so helpful.

As I have suggested, one of the theoretical questions raised by the book is the relationship of Professor Weston's implicit assumption that decisions of domestic administrative commissions, like domestic courts, may contribute to international law, a view which this reviewer shares, to Professor Falk's suggestion that they may not, at least with respect to matters over which there is an ideological division between the domestic orders of the world. The area of expropriation of property and its compensation was explicitly stated as such an area by Professor Falk and this was apparently accepted by the Supreme Court in *Sabbatino*. To be sure, the French claimant and expropriating governments have in each case negotiated a lump sum settlement agreement in the cases in the book. However, notwithstanding the suggestion in his preface that one of the theses of the book is to "reconcile . . . the development of the Third World . . . with the oftentimes conflicting priorities of the Industrialized World,"[13] Professor Weston does not really address himself to the underlying theoretical question. Nevertheless, the book does have a useful message: that the concern to give the developing countries (and the centrally planned ones) sufficient freedom to reorganize their social and economic orders, involving as it may the seizure of property both domestic and foreign should not be immediately translated into a permissive analysis of the details of foreign claimant protection. The book seems to suggest that an elaborate development of such protection (through a broader definition of the class of protected

10. *Id.* at 61 n. 235, 187 n. 13.
11. *See* text prior to note 1 *supra*.
12. WESTON, *supra* note 5 at 146.
13. *Id.* at ix.

creditors)[14] is not inconsistent with the former, although it is not quite explained how this would work in terms of the funds needed to bridge this gap. Possibly something such as Professor Albert O. Hirschman's proposed *Latin American Disinvestment Corporation*[15] would fit in here.

I have one dissent. As suggested, the book was initially submitted as a dissertation for a doctorate at the Yale Law School, presumably to a committee at least including Professor Myers McDougal. Not having gone to Yale Law School, I fail to see why the McDougalian framework is still necessary. Its emphasis on the need for policy orientation has long been accepted. The related terminology is not, it seems to me, acceptable and detracts from the book in the places where it is used.

This is a useful book for people concerned with the subject matter of international claims, not merely French ones.

14. *See* text at note 4 *supra*.

15. Hirschman, "How to Divest in Latin American and Why" Essays in International Finance, Princeton University (1969)—pamphlet.

ONE LIFE—ONE PHYSICIAN, By Dr. Robert McCleery, et al. Public Affairs Press, Washington, D.C., 1971 Pp. 167. Cloth: $5.00.

George A. Silver, M.D.*

In addition to the Project Director, Dr. McCleery the authors of this "Report on the Medical Profession's Performance in Self-Regulation", are a lawyer, Terrence Quirin, two second-year medical students from Case Western Reserve Medical School, Mimi Lam and Russell E. Phillips, and a second-year law student from Catholic University Law School, Louise T. Keelty. Two other medical students are acknowledged in the introduction as having provided some additional help in documentation.

The report details the failures of the medical profession to regulate itself, drawing suitable illustrations from lay and professional journals and appropriate quotations from a variety of significant figures in the medical and legal professions.

No new evidence is presented, but *One-Life* is a useful compilation of a range of charges and study results which have been individually used as the substance of a series of books over the past 25 years.[1] This particular book is well organized and carefully put together, in effect, a brief.

If there is another edition, the authors might consider collecting the references into a definitive bibliography and provide an index. For those who will be using the book for reference or as a source book for debate or even legal argument such refinements would be quite helpful.

This report is unique in that the weight of the evidence is used, not to promote a new delivery system or method of financing medical care—the aim of most of the other books—but to attack the medical profession for failing to observe the rules of the game. In essence, the investigators have said, "You members

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1. *See, e.g.*, S. GREENBERG, THE AUALITY OF MERCY (1971); E. CRAY, IN FAILING HEALTH (1970); R. TUNLEY, THE AMERICAN HEALTH SCANDAL (1966); R. CARTER, THE DOCTOR BUSINESS (1958).

of the medical profession have been given *carte blanche* by society in ordering your professional knowledge for the provision of health care. In the process you were to assure society that all necessary care would be taken to protect the interests of the patients. You did nothing of the kind."

Thus, a good part of the book deals with the various places where care could be taken (hospital, doctor's office), and the people whom it ought to be taken (medical society, government, hospital board) and the failures of each. The aim of the study, in the reporters' words is:

> To examine evidence from the medical literature, and elsewhere, which indicates the general quality of physician performance and the variability of its quality—to disclose whether a quality-problem might exist.
>
> To note briefly those elements in physicians' preparative background that enhance the quality-potential of each physician entering and continuing the practice of medicine.
>
> To describe and judge the established legal and professional mechanisms of quality control and medical auditing of physician performance in the hospital or in his office.
>
> To judge on a specific premise: whether or not a patient being treated by any physician in the home, hospital, or office can be *reasonably sure* that his physician is reasonably competent to treat *that* ailment (or that the physician will refer him to another physician whom the first believes to be reasonably competent); that his physician is reasonably up-to-date on diagnostic and treatment techniques, and on drug therapy information; that his physician will keep such records as to afford reasonable assurance that his work can later be effectively evaluated; that his physician's performance, no matter where given, will be monitored with reasonable frequency, objectivity and expertness by his peers. While not within the purview of this report, the exemplary goal of achieving equality with respect to medical care cannot be forgotten.
>
> To make whatever proposals might seem indicated if the present system needs to move closer to those reasonable expectations.[2]

However, some of the language would lead the reader to conclude that much more than this quality control aspect is under scrutiny. The "Overview" deals with the great overall deficiency in health care services, the unavailability of resources and their uneven distribution; each undoubtedly, affects quality yet none are actually examined—and further, none would be corrected with the most meticulous attention to quality control. From this to the sense of social

2. McCLEERY, book under review at 6.

concern latent in the gross defects of our medical care system, the reader is left to imply that if the report's recommendations were followed, *all* the deficiencies would be corrected. With all respect to the investogators good intentions and purity of motivation this is at best a fallacy and at worst deliberately misleading.

One need not disagree with Mr. Nader or Dr. McCleery & Co. to disapprove of the technique. In the introduction Mr. Nader writes:

> In any market with demand exceeding supply, virtually exclusive market power, applied in largely unassessable manner by little monitored practitioners is a prescription for crisis. Such a situation is particularly critical in the practice of medicine. Few areas of specialization have been so amply documented in their gap between the presumption and performance of expertise and delivery than has medical care. As the crisis grows and the preventable deaths, injuries and diseases increase, the raw monopoly powers displayed by organized medicine have been a spectacular example of applied political science misapplied.[3]

The authors themselves are more cautious, in the beginning:

> Since our present study is restricted to only one of the elements affecting the overall qualityof medical care, we wish to acknowledge the importance of many other factors that affect the quality of care. . . .[4]

The list goes on to enumerate manpower, organization, cost and distribution of health services.

Dr. McCleery is a physician with broad experience as a surgeon, a teacher, and a government official. He was in the Food & Drug Administration for over six years and rose to Deputy Director of the Bureau of Medicine and Special Assistant to the Commissioner for a while. He has also been an official in a number of medical advertising firms and is familiar with the seamier side of the "selling of the profession." His views are bound to be colored by his experiences, and the conclusions and recommendations in the report echo stern and punitive approaches to ensure compliance.[5]

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3. Ralph Nader, in the introduction to the book under review, p. iii.

4. *Id.* at 4.

5. For example, recommendations in the section called "Conclusions", include, "public consideration be given to the need: To develop standards of optimal care. . . . To require standardized recording of medical care. . . . To develop truly effective 'peer group' evaluation. . . . To establish 'para-peer' groups from the profession, outside 'organized medicine' . . . which will periodically check on the function of local peer groups. . . . To arouse and involve university faculties to their human and social responsibilities to become involved in this problem. . . . To develop a national body of leading physicians to direct the establishment of

Strong as these proposals may be, they are somewhat diluted, a few pages later, when the report reads:

> The subject of this report, however, is a limited one. Our recommendations are confined to suggesting changes in the health care system that relate to its responsibility to afford each patient 'reasonable assurance' that any doctor he chooses will be competent and *will* protect his life and return him to liberty and his pursuit of happiness limited only by the extent of current medical knowledge.[6]

Putting these uncomfortable questions, raised more by the language than the substance of the report, aside the reader will find the material is comprehensive, and the proposition cogently argued. The chapter on record keeping clearly points out the general state of inadequacy well. This chapter presents best the proposition that what the profession needs most is an organization. The proposed requirements for record keeping, employment for specialists and supervision, and for consultant qualification read like an argument for group practice. Even if doctors are poorly trained, as the book points out in regard to foreign medical graduates, or are long past their green years and have not updated their knowledge, a structured organization may very well keep them out of trouble and protect the patient's interest. This point is not made. There is a kind of single-mindedness in this omission that is admirable, but somewhat self-defeating when it prevents the authors from recognizing support for their syllogism in their own evidence.

> While social, political, and economic forces all combine to prevent large numbers of people from obtaining medical care, there is a need for quality control within the medical profession to prevent poor quality of medicine from being practiced upon many of those who are able to see doctors at will and go to hospitals whenever necessary. . . . The rich often receive worse care from their private practitioners than the poor receive from the house staff doctors of municipal hospitals.[7]

I doubt that the most important problem in modern medical care delivery is that the rich get worse care than the poor. Yet putting together the above arguments, about the need for supervision and controls, and the values of group practice in making more efficicient and economical use of manpower, one might

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acceptable standards of care, and to establish and administer a valid quality control system. . . . To develop a system of controls to limit the entrance into, and continuation in, the practice of medicine to only those physicians who are sensible of the privilege of service, and sensitive to the moral premise that either the life and health of every person is important or that of no one is". McCLEERY, book under review, at 154-55.

6. *Id.* at 161.

7. *Id.* at 44.

see the problem not as "self-regulation" but as "socially organized services."

If medical care is a commodity to which everyone is entitled—and so we are coming to accept, then we are obliged to review the system in search of a mechanism for equitable distribution. Clearly, this is not to be left to the self-interest of the professionals and the workings of the market-place.

On the other hand, there are elements in the discussion that will have to be reviewed, no matter what the system of operation, control or administrative responsibility may be. Licensing laws and laxity or irrationality of State licensing procedures will have to be regularized. "Educational obsolescence" must be corrected. The do-nothing hospital boards who have ceased to represent the public must be changed, whether through community control mechanisms, worker management mechanisms or governmental accountability systems. These are matters that relate directly to the theme of the book and the formulations here are very helpful.

> [L]ittle is ever heard about continuing education of members of the medical profession or reexamination for continued licensure or reappraisal for continuation of Board Certification.[8]

> There can be no reasonable doubt that a hospital complying in spirit as well as form with the principles of "hospital standardization" . . . will furnish medical care of good quality . . . . Yet is it possible for such . . . standards to be met in a superficial manner . . . that . . . does not necessarily guarantee medical care of good quality.[9]

In regard to physician office practice, where no real progress has been made at all in establishing controls on quality Dr. McCleery makes an excellent point:

> The so-called right of a physician to continue to practice is in reality a privilege. It is, and should be, contingent on proper performance.[10]

Medical societies come in for their share of the blame and rightfully so, for having so long neglected their responsibilities regarding patient care and for being obviously more concerned with the physician's condition than that of the patient—*in general*. This latter statement must be understood in context because too often it leads to polemical argument in which the antagonists are not in the same arena. A particular physician may be conscientious, concerned and considerate of his individual patients. In his medical society or organized professional group he behaves as any trade association member does, considering the financial or occupational interest of his colleagues and himself.

8. *Id.* at 79. The reference is to the complaints physicians have with regard to malpractice judgments.

9. *Id.* at 105.

10. *Id.* at 131.

"Caveat emptor" is his motto. When the newspaper letter-writing spree begins however, he reacts to the accusation by citing his behavior to his personal private individual patient. On those grounds there is no case.

> [W]e stated that our study set out to discover what systems of quality control the profession has established to monitor each physician's services to his patients, to evaluate how well these systems perform, and to determine whether the profession merits the trust with which society has placed itself into the hands, and relied on the hearts, of all its physicians. We have had to conclude that the medical profession has failed to merit that trust.[11]

Possibly because Dr. McCleery himself is a surgeon, he selects that specialty for his strongest stricture.

> Surgery has economic consequences for both the patient and the surgeon. The dollar volume that surgery represents to those who perform it must be considered by those concerned with examining the workings of a surgical services.[12]

There is, of course, considerable merit to this statement. However, that is not to say that the economics alone can be corrected and will correct the deficiencies in surgical practice. There is some suspicion that academic surgeons, without financial incentive, or at least without the same financial incentive, are as insensitive to the needs of patients, or the problem of "informed consent" as the bloody-minded entrepreneurs when it comes to teaching or research "material."

Have academic surgical procedures ever been examined? Is the professor of surgery at Harvard less guilty than the chief of surgery in a voluntary hospital? Is there less "unnecessary surgery" in municipal hospitals (serving poor and minority patients) than there is in the voluntary hospitals where the well-to-do are cared for? I suspect that "teaching" or "learning" may be as productive of excess surgery as the dollar.

I am not enchanted with all of the recommendations, particularly the one proposing a National Board of Medicine like the Federal Reserve Board. That analogy strikes me as uncomfortable. "There is a crisis at the heart of our health care system"[13] but is it the lack of regulation that is the root cause? Dr. McCleery points out elsewhere that quality control of physician performance is "inadequate", doctors and organized medicine have failed, the

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11. *Id.* at 153.

12. *Id.* at 125. *See also* Bunker, *"Surgical Manpower in the U.S. and in England and Wales,"* NEW ENGLAND JOURNAL OF MEDICINE, 282:135-144, January 15, 1970. Bunker points out dryly that there are twice as many surgeons in the United States as in England and twice as much surgery.

13. MCCLEERY, book order review at 158.

hospitals have failed, the Joint Commission on Hospital Accreditation has failed. He quotes McNerney of Blue Cross to the effect that "system can't be fixed, it must be replaced."[14] What value has the Federal Reserve Board as analog?

Dr. McCleery and his associates seem to have missed an important reference, possibly because their book went to press before his book was out. But Eliot Freidson in *Profession of Medicine*[15] covered substantially the same ground in his sociological study although in somewhat different order.

A good part of several chapters in the McCleery report are laconically condensed in Freidson's section in chapter 7, "The Test of Autonomy: Professional Self-Regulation" which deals with county medical society, hospital review and Joint Commission on Hospital Accreditation activities. Freidson's conclusion was the same: "It seems clear that *formal* review procedures are not very common in most medical work settings.[16] It is plausible to believe that where they exist, performance will be on a somewhat higher average level than where they do not."[17]

Profession is helpful in organizing one's ideas about the thorny problems of self-regulation, quality and availability of good medical care. It is interesting to note that in England, the medical profession is not held much more accountable than here. "[F]ormal disciplinary powers are used solely to encourage the observance of moral rather than technical standards . . . ."[18] Dr. Friedson places more emphasis on the importance of standards for training and admission to practice as elements of control.

In addition to control elements he suggests many steps that will have beneficial effects on practice: recruitment from a wide variety of populations; teaching professional students outside the professional institutions to minimize the narrow sectarian dependence; discourage isolation in practice; encourge the community model of practice mixing academic and community practitioners; mechanisms for peer review associated with mechanisms for exclusion of deviant practitioners, *i.e.*, punishment in a variety of levels.

Profession of Medicine also concerns itself with *why* the profession will not or cannot police itself, a matter that one would otherwise deduce as pure greedy economically based self-interest from McCleery's rendition.

> Being supervised is synonymous with being a student . . . to be

14. *Id.* at 160.
15. E. FREIDSON, PROFESSION OF MEDICINE (1970). [Hereinafter cited as FREIDSON].
16. *Id.* at 139.
17. *Id.*
18. *Id.* at 161. He quotes E. CARR-SAUNDERS AND P. WILSON, THE PROFESSIONS (1936).

> granted freedom from supervision is a mark of . . . being a professional.[19]

And later, Dr. Freidson writes:

> For true regulation of performance continuing into the many years following qualification for licensing, the social setting of practice must be organized to minimize isolation from colleague scrutiny and public accountability so as to encourage humane performance at a high level.[20]

It is important to consider what will or might happen if stern outside regulatory mechanisms are imposed on the profession. The flexibility of the professional when he is self-regulated may be as often in the patient's interests as against them. Will a rigidly codified schedule of behavior inhibit bold and useful treatment? Will effective action by hobbled under these conditions? Will threats of punitive action, pecuniary loss, or loss of license impose extravagant caution? Will this militate against the patient? Where is it better to take the risk, in poor supervision over the product, or control of performance?

The problem of accountability needs to be separated from the problem of expertise. Freidson recognizes and describes this model much better than McCleery.

> It should be noted that while professionalism as an expression of *expertise* requires only control over the *content* of work . . . professionalism as an expression of *prestige* presses for control over the *organization* of work. While there are certainly areas in which organization bears on content, the two are not synonymous analytically or pragmatically.[21]

Chapter 16 "The Limits of Professional Autonomy" goes on to make a strong case for public control of the organization of medical practice since it is impossible for self-regulation to guarantee that "the profession organizes itself in such a way as to assure good work in the public interest irrespective of personal or occupational self-interest. . . ."[22]

> Whatever is done to the professional organization, it is essential that in order to protect the public interest the lay public dominate the formation of policy decisions guiding the planning of services and the determination of the economic and social terms of the performance of work.[23]

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19. FREIDSON 180.
20. *Id.* at 365.
21. *Id.* at 143.
22. *Id.* at 361. *See also* E. RAYACK, PROFESSIONAL POWER AND AMERICAN MEDICINE (1967).
23. *Id.* at 374.

He notes in passing, "This recommendation, like many of the others presented here, is meant to apply to University teaching, law, and other consulting professions as much as to medicine."[24]

> I do not single out medicine as an especially villainous profession. . . . As a profession medicine is better regulated and provides a more honest product than does university teaching.[25]

The two books should be read together so that the complexity of deciding how and what to do about this crucial matter might be addressed judiciously and not polemically.

It may be becoming clearer to the reader what has been so unsettling to the reviewer about this report. It isn't its intention—which is the best. It is the rather narrow approach, an oversimplification, that doesn't take into consideration the variety and complexity of human need and human experience, within and without the professional fold. Quality control is important. Measures need to be taken to ensure that the profession of medicine is better regulated. But a matter of detail remains. Mechanic, for example, in a review of two other books attacking the medical care system, writes:

> It serves as well to consider what people expect from the health care system, which is not necessarily what the providers wish to offer. Most basically, people seek to have a personal physician or a comparable source of care readily accessible and reasonably convenient to use. They want and expect their care to be competent, but they are equally concerned that those who provide it have an interest in them as people.[26]

But he also goes on to say:

> Perhaps most important, how do we develop a tighter, more efficient system of delivering health services without frustrating the essential personal and social elements of medicine as a humane institution?[27]

Abelson, editor of *Science*, wrote in an editorial in another issue of that journal after Mechanic's review had appeared:

> Expectations for magical cures are partly responsible for the growing frequency of medical malpractice suits. If a cure is not forthcoming, the patient assumes the doctor must be at fault. Sometimes he is at fault, but often too much is expected of him. So common have malpractice suits become that fear of them is adversely affecting the practice of medicine and is raising the cost

24. *Id.* at 373.
25. *Id.* at 380.
26. Mechanic, Book Review, THE POOR STATE OF HEALTH, 172 SCIENCE 701-03.
27. *Id.*

> of medical care. Today many doctors find it necessary to practice medicine defensively—that is, instead of concentrating only on the well-being of the patient, they must also order a large number of unnecessary tests and examinations to answer questions they may be asked in court.[28]

To return to Freidson, for the moment:

> There is a real danger of new tyranny which sincerely expresses itself in the language of humanitarianism and which imposes its own values on others for what it sees to be their own good.[29]

There is a comment current in the medical field, that Lawrence Henderson, a great Yale physiologist in 1935 noted that 1915 was the first year that the average patient, coming in contact with the average physician, had a fifty-fifty chance of benefiting from the encounter. With all the complications of modern technology, given the computer, the variety of laboratory examination, the perils of interpretation by "experts", and the like, what is the potential benefit experience of the patient of 1971?

Like Ed Zern's great review of "Lady Chatterley's Lover" in *Field and Stream* many years ago, the point of view of the reviewer may be all important in the image of the book presented to the reader of the review. For example, a scrupulous AMA official might prefer to start with this quote:

> We have compared what the profession *qua* profession has done to 'safeguard the public and itself against physicians deficient in professional competence' with the ideals in its Code of Ethics. That the reality is less than the ideal in so many areas of medical practice is not necessarily the fault of any one organization or group of individuals. Nor can it be explained simply as a consequence of a malevolent conspiracy to harm the public in order to protect the traditional domain of the private practitioner.[30]

exculpating him and his like-minded AMA members from responsibility in the litany of shame and deficiency the report concerns itself with. On the other hand, the seeker after villains and complots who make out lives the shambles they seem to be, might prefer the quote in Note 3 from Ralph Nader.

What is clear, from this, and the other books it draws on, as well as from the generality of present-day patient experience, is that all is not well in the domain of medical practice. Laxity in the observance of quality standards is prevalent. The profession must establish new standards of social responsibility and begin to walk new ways of social concern.

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28. Abelson, editorial *Unrealistic Demands on Science and Medicine*, 172 SCIENCE 701-03.
29. FRIEDSON, 381.
30. MCCLEERY, 121.

Like most of Ralph Nader's efforts this book and the report it attempts are both worthy and necessary. If more has to be considered let it also be studied and reported. It is no argument against these investigators that so much remains yet to be examined. They have looked at self-regulation and what that entails. From what they report, it is clear the whole system needs review. The training of doctors, and the role of the educational institutions, also require investigation. A whole nation cannot be held guilty, nor can a whole profession. But both nation and profession can be brought to recognize deficiencies that require correction and act as a single body to correct them.

Russell A. Nelson, M.D.*

One Life—One Physician; By Dr. Robert S. McCleery et al., Public Affairs Press, Washington, D.C., 1971 Pp. 167. Cloth: $5.00

Since Ralph Nader's "Raiders" reports are well known as aggressively critical of most "establishments," one would expect this report on medicine to begin and end with progressively more hostile attacks upon organized medicine—especially, the American Medical Association. Surprisingly, Nader's group does not do this in a way one would have imagined. The book is a fairly balanced presentation of a most important and difficult issue: the quality of medical practice and the mechanisms for regulation, especially self-regulation by the profession.

The authors of the book were at the time of publication: two medical students of Case Western Reserve University, M. Lam and R.E. Phillips; a law student at Catholic University, L.T. Keelty; and a 1970 graduate of Villanova Law School, T.M. Quirin: all working under the general supervision of the Project Director, Dr. Robert S. McCleery, a former member of the faculty of Vanderbilt University and well-known in Washington medical affairs in and around the federal government.

The authors made an extensive search of the literature pertaining to the regulations and quality of medical practice and presented more than 200 references, including most of the significant contributions on the subject. The book is an excellent reference to students of the field and the authors are to be commended for bringing it together. In their overview and discussion of the present general quality of physician performance, the authors cite, in a fairly traditional way, many of the traditional and contemporary thoughts and publications dealing with the "crisis" issue in health care and present, the good and bad parts of American medical practice. Once again, the wide difference in the quality of medical practice between the affluent and indigent populations and between the general population and minority groups is made starkly evident. In succeeding chapters, the authors discuss the influence of education, and the impact of the law of organixed medical societies, then the present self-regulatory systems in hospital practice of physician performance and quality.

Again and again, the positive and negative influences of organized medicine on the discipline and evaluation of quality standards for physicians are brought

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out. The discussion is balanced in the main, though a bias that the profession has not done enough regarding self control tends to creep in.

Despite this criticism, the authors record much of the positive. At times, they nearly laud the preogressive actions taken by the American Medical Association, the College of Surgeons and the American Hospital Association. There is a very good description of the origin and methods of operation of the Joint Commission on Accreditation of Hospitals—the one outstanding voluntary professional peer review set up for concern on the quality of physician practices in hospitals.

One of the missing link in any mechanism for monitoring quality of practice is the absence of measurable standards for these qualities. This has defeated many efforts at quality control and remains a major challenge to the profession for the future. *One Life—One Physician* did not elaborate on this important point.

Possibly because of the two law students among the authors, there is a lengthy discussion of licensure, certification, recertification and other aspects of the law on quality control. Perhaps this leaves the reader with the impression that much can be expected in quality control by the use of law. I believe most physicians, even those most dedicated to the status quo, would agree that licensure and certification have been of only limited value in control. In fact, which uncovered only a few disciplinary actions in the various states, shows how pitifully unsuccessful it has been in dealing with the issue.

Throughout the book a general theme and concept stands out: the only real mechanism we have for quality control is peer review of actual performance and education and training of physicians. This will continue to be true until objective quality standards and creditable medical records are better developed. It can hardly be otherwise in view of the general public's vast lack of even basic knowledge as to what quality medicine actually is.

The authors sum up some of these matters in a portion of the "Conclusions," as follows:

> [T]his report has sought to draw together information obtained from interviews with various officials and from studies in the medical literature related to questions concerning the quality and self-regulatory controls of physician performance. We have compared what the profession qua profession has done to "safeguard the public and itself against physicians deficient in professional competence" with the ideals in its Code of Ethics. That the reality is less than the ideal in so many areas of medical practice is not necessarily the fault of any one organization or group of individuals. Nor can it be explained simply as a consequence of a

> malevolent conspiracy to harm the public in order to protect the traditional domain of the private practitioner. The present health care delivery system—and the component relevant to this study—is the product of a disorderly and haphazard historical development. As such, it is the manifestation of contrasting needs and forces.
>
> When new realities based on new needs force themselves to our attention, we have certain options. We can persist in present practices because they have become hallowed in our traditions—until the system collapses of its own awkward weight. We can take steps to improve the most blatant flaws with a patch-work reform—until the unreformed parts of the system grow worse and become burdens in their own right. Or we can seek to restructure the entire system by setting standards for performance and allocating functions in light of the complexities of a rapidly changing society and body of knowledge.
>
> Effective reform cannot be done by fiat, and should not be done in a manner that disregards the intricacies of individual physician or patient needs in a mass society. It is manifestly desirable to have effective built-in quality control checks that the present system lacks, so that any new system becomes and remains responsive to the public need. Much can be accomplished by incorporating the benefits of new knowledge and instituting measures to insure that the professionals, who must remain primarily respnsible for the quality of health care, keep abreast of such advances. Continuing education should be a requirement for those granted the opportunity tocontinue to serve.

Except for excessive repetition, the book is well organized. However, the section on "Conclusions" is really a rehash of material presented earlier. Like all who have valiantly charged into the arena against the problem of monitoring quality practice, the authors had great difficulty in developing a workable set of recommendations for improvement. Their section on "Recommendations" seems to be a helter-skelter of thoughts and ideas, except for a major recommendation that the Federal Government declare quality of practice a matter of national concern and establish a National Board of Medicine. This Board is described as follows:

> Establishment of a National Board of Medicine, in the style of the Federal Reserve Board, with its own Board of Governors. These Governors would be appointed by the President to terms, for example, of seven years, subject to confirmation by the Senate.
>
> The Board would have sole jurisdiction over all health care programs which the federal government funds. As a reasonable condition for participation in any federally funded health care

> program, the individual states would be required to bring their laws into conformity with acceptable standards of utilization and quality control as established by the National Board of Medicine.
>
> The Board and its staff would have responsibility for the establishment of policies, programs, and standards and for the administration and regulation of these in the area of its jurisdiction.

A small point, but the title of the book is most undescriptive and almost "cute" when one considers the subject and substance. The book is quite readable. I enjoyed it and recommend it to everyone, and believe it would be especially good reading for all doctors!