

THIRD EDITION

Effective *Peer* Review

The Complete Guide
to Physician Performance
Improvement

Robert J. Marder, MD

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to Effective Physician
Performance Improvement

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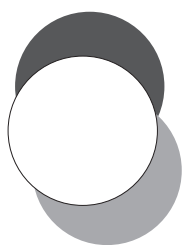
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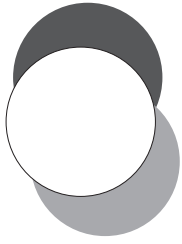
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About the Author

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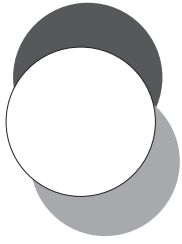
Marder is the former vice president of The Greeley Company, a division of HCPro, Inc., in Danvers, Mass., and served as practice director for medical staff consulting. In this role, for over 12 years he has consulted with hospitals and healthcare systems throughout the country in the areas of hospital and medical staff performance improvement, peer review, patient safety, medical staff development, and case management.

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Marder is a board-certified pathologist and former assistant director of laboratories and director of the clinical immunology laboratory at Chicago-based Northwestern Memorial Hospital. He received his undergraduate degree from the University of Illinois-Champaign and his medical degree from Rush Medical College.

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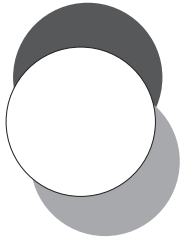


Dedication

This book is dedicated to physicians on medical staffs across the country who perform this difficult task, without any or minimal compensation, to fulfill their professional responsibility to improve the profession's standards and performance for the good of our patients and communities.

I would like to thank Dr. Mary Hoppa from The Greeley Company for her assistance in reviewing the regulatory standards chapter and for her consulting work with me in peer review redesign over the past six years. I would also like to acknowledge the consultants from The Greeley Company who served as co-authors for the previous editions of this book. In particular, I want to thank Dr. Richard Sheff, whose work in this area formed the basis for the approach used to create a performance improvement focused peer review.

Finally, I would like to dedicate this book to my wonderful wife of 36 years, Susanne, whose demonstration of grace beyond anything I ever deserved has been a continuous inspiration to me.



Introduction

In 1916, E.A. Codman, a founder of the American College of Surgeons and an early crusader for quality improvement, stated the need for peer review and a quality program for healthcare delivered at the hospital level. Today, peer review—the practice of physicians reviewing the work of other physicians—is considered a crucial element of ensuring that patients are provided with quality medical care.

There is no question that peer review has evolved from the professional obligation physicians have long felt to ensure that safe care was being provided in their community. Today, accreditors, federal and state laws, and medical staff bylaws require that hospitals have a process by which to review physician performance. In addition, the legal doctrine of corporate negligence imposes a duty on hospitals to select and maintain competent staff. Finally, as government and commercial payers' interest in the quality of patient care has expanded beyond the acute care setting, evaluating physician care will be a necessary element of that process.

The methods of peer review have also evolved. It is no longer limited to physicians reviewing individual charts with poor clinical outcomes or conducting a subjective evaluation at the bi-annual reappointment evaluation. Following the lead of other high risk industries, such as aviation and nuclear power, peer review is being challenged to become a data driven, ongoing performance improvement process.

As with the previous two editions, this book discusses how to create an effective peer review program based on these contemporary concepts. Recognizing that this process will vary depending on each hospital's and each medical staff's culture, resources, and circumstances, this book is designed to help you in two ways. First, it provides a background and framework to help the reader understand how peer review can be a positive force for physician improvement. Second, it provides practical, tested strategies based on working with medical staffs across the country over the past 12 years to make that change a reality.

So why have we updated this book? In the first edition, this broader approach to peer review was predominately considered a best practice rather than a regulatory requirement. By the second edition,

INTRODUCTION

regulations had caught up with best practice (the changes in 2007 Joint Commission medical staff standards) so the book's goal was to incorporate the regulatory needs into the best practices. In addition, I was also the lead author on two other related books published by HCPro, *Measuring Physician Competency* and *Peer Review Best Practices: Case Studies and Lessons Learned*, designed to fill in some of the gaps related to the implementation of these concepts.

This third edition is designed to combine all three related books into a single volume that provides a comprehensive view of peer review. While recognizing the regulatory needs for peer review, the overriding theme of this edition is how to keep the focus of peer review on physician improvement and the pursuit of excellence. Today, most medical staffs have figured out how to meet the minimal regulatory requirements. However, many still struggle with how to effectively improve physician care in a non-punitive culture; despite their best intentions, their peer review program is still perceived as punitive.

While this edition certainly builds on the previous ones, most of the chapters of this edition have been substantially revised to reflect what has been learned by experience in the past five years. This edition also addresses the evolving need for peer review in non-hospital settings. As physicians are challenged with new organizational structures for delivering patient care, how physician care will be evaluated and improved and who will be accountable for that function will be critical to the success of these new ventures.

Thus, I hope that this book can assist physicians, whether they are in a hospital medical staff, primary care group, multi-specialty group practice, or accountable care organization, as they perform this role in a manner that maintains their professional obligation to their patients with the collegiality and dignity they deserve.



Peer Review: Why Do We Need to Evaluate Physician Competence?

"The thing that hath been, it is that which shall be; and
that which is done is that which shall be done: and there is no new thing under the sun."

Ecclesiastes 1:9 (KJV).

Peer review is not new. As a profession, physicians have long shown the desire to evaluate and improve the care they provide to their patients. They have done this, and still do it, because of the very reason physicians choose this profession: to help make people well to the best of the physician's knowledge and ability.

However, in contrast to the verse from Ecclesiastes, some things have changed. In the past, physician performance evaluation was considered the sacred province of the medical staff, not to be shared with the rest of the world. Patients never considered asking a physician for data regarding the outcomes of care. Even accreditation bodies only looked to be sure a process was in place with the medical staff to conduct this performance function, but did not evaluate the actual results.

Today is a different story. Although the concept of sharing data publicly goes back to Ernest Codman in the late 1800s, in the past decade, through the combination of growing public interest and advances in information technology, healthcare data that was once secret is now transparent. Data that once focused on the hospital level is increasingly becoming physician-specific and available to the public; and there is no indication of any reversal of this trend.

What about the evaluation of that data by other physicians? Peer review is still protected from disclosure in the vast majority of states. However, since the raw data is becoming more available, the public may draw its own conclusions without the benefit of the more in-depth understanding of underlying factors that might explain the data.

So if the public will have the data, why should physicians even bother to perform peer review?

First, accrediting bodies have been increasing their scrutiny of the peer review process to justify its

effectiveness and eventually its existence. Peer review is a privilege that society, through the accreditation process, has granted physicians. It is not a right.

Beyond the need to meet regulatory requirements, a compelling reason for renewed engagement by physicians is that when peer review is done well, it provides the opportunity for the medical profession to get ahead of the curve with respect to data transparency. If physicians can identify and address the issues driving physician performance early on, then the subsequent data available to the public will be substantially better. The overall goal of this book is to assist physician leaders to help make the transition from regulatory-driven to performance improvement–driven peer review.

What Peer Review Is

Peer review is the evaluation of an individual physician’s professional performance by other physicians, the identification of opportunities to improve physician care, and a way to help physicians achieve those improvements. Traditionally, this process has been executed by physician peers reviewing charts of individual cases that were selected for review based on adverse outcomes criteria, such as complications or mortality.

Psychologist Abraham Maslow said, “If the only tool you have is a hammer, everything looks like a nail.” Today, medical staffs have more tools to evaluate a physician’s performance than just the “hammer” of individual chart review. Such tools include rate and rule indicators, which will be discussed in later chapters. Most medical staffs are in the process of adding these tools to their belts.

Moreover, there is growing recognition that there are more dimensions to physician performance than just the technical quality of care provided. This is reflected in The Joint Commission’s adoption of the Accreditation Council for Graduate Medical Education’s (ACGME) and the American Board of Medical Specialties’ (ABMS) six core competencies, which will be discussed in Chapter 7. The six core competencies are:

- ✦ Patient care
- ✦ Medical knowledge
- ✦ Interpersonal skills
- ✦ Professionalism

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- ✦ Systems-based practice
- ✦ Practiced-based learning

As a result, this book suggests a more contemporary definition of peer review:

Peer review is the evaluation of all dimensions of current competency of individual physicians using all appropriate and relevant sources of performance data available.

Peer review is required by The Joint Commission, the American Osteopathic Association Healthcare Facilities Accreditation Program, and Det Norske Veritas (DNV) hospital-accreditation standards, federal laws such as those governing Medicare and Medicaid programs, state laws, and each hospital's own bylaws. As will be discussed in Chapter 15, peer review is also becoming an important element in ambulatory care and accountable care organization quality programs.

The physician peer review process has two components. The first is the initial review of a physician's qualifications to determine whether that physician may be granted the privilege to perform specific procedures or treat specific diseases. Once the privilege is granted, the organization may evaluate the initial use of the privilege by the physician in its own setting for a focused period of time (e.g., three months). This peer evaluation, now termed focused professional practice evaluation (FPPE), is typically performed by the hospital credentialing committee and occurs at the physician's initial appointment or when a new privilege is requested. This component of peer review is not the subject of this book.

The second component of peer review is the ongoing monitoring of a physician's use of those privileges for patient care. There are two phases of this ongoing review. The first phase, termed ongoing professional practice evaluation (OPPE), involves the systematic collection and review of individual physician data to identify potential improvement opportunities. The second phase, also termed FPPE, which follows OPPE, involves either more in-depth data collection or working with the physician to improve and then monitor the results. The results of both OPPE, and any related FPPE, are then used for the decision every two years to either renew or restrict a physician's privileges or membership. This component of peer review is the primary focus of this book. However, as discussed in Chapter 2, peer review is much more useful if it is done with the goal of physician improvement and not just as a mechanism for reappointment.

What Peer Review Is Not

As approaches to peer review have evolved, two methods for understanding and improving patient care, mortality and morbidity (M&M) conferences and root cause analysis (RCA), are sometimes confused with peer review. Although these improvement activities may look at similar events, it is critical to recognize the difference between these methods and official peer review and to keep them as separate functions to ensure that peer review is conducted consistently and fairly.

How does peer review differ from an M&M conference? While the M&M conference can be a valuable component of a medical staff's overall strategy to improve patient care, it needs to be separated from formal peer review because it violates two main principles of peer review:

1. The application of clear conflict-of-interest standards. During an M&M conference, the physician under discussion is present and often actively participates.
2. The variability of the participants that can affect the due process required for peer review. Also, since an M&M is designed as a “y’all come” process, there will be inherent variability in the composition of the group from meeting to meeting.

Because of these issues, when peer review is done through an M&M model, medical staffs often report difficulties in arriving at fair decisions and defining effective improvements. Therefore, the M&M conference should be solely an educational session. In this context, it can be a collegial open discussion of clinical cases or situations without the burden of making final determinations that will end up in a physician's quality file. This discussion can also involve nonphysician healthcare professionals with an interest in the clinical case. There should be a connection between the peer review process and the M&M conference in two ways:

1. The conference is used as a source of case identification for peer review.
2. Cases from peer review may be later discussed at M&M for educational purposes.

How does peer review differ from RCA? An RCA is a systems analysis required after significant or sentinel events have occurred, such as a wrong site surgery. It is a multidisciplinary effort to identify the causal factors that lead to a variation in performance. As such, RCAs focus primarily on systems and processes, not on individual performance. For example, in a wrong site surgery, an RCA asks the question, “How did our systems and processes fail that we allowed a physician to operate on the wrong site?” Although

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an RCA looks at human factors most directly associated with the sentinel event, it does not deal with the individual performance of physicians or clinical staff. For the clinical staff, the human resource function would address those issues. For the medical staff, this would be handled by peer review.

Unfortunately, when the medical staff peer review program is ineffective, the multidisciplinary RCA team may be tempted to assume the task of evaluating individual physician performance. The best way to fix this problem is to address its root cause—that is, to strengthen your medical staff peer review process.

13 ANGRY MEN?

Some of the most dramatic movie scenes involve a jury deliberating the fate of a defendant. In fact, the 1957 film *12 Angry Men* was set almost entirely in the jury room. But what if the screenwriter had decided to place the defendant in the jury room and allowed him to comment while the jury argued about the case and determined his fate? You would think that something is terribly wrong with the script.

I pose this scenario because I recently received the following question regarding how to handle a potential conflict of interest during a peer review evaluation:

If a case comes before the peer review committee to discuss and assign a rating, and the case involves a member of the peer review committee, does that member:

1. *Remain in the room to discuss the details of the case?*
2. *Get asked to leave the room when it is time to assign a rating?*
3. *Take part in the entire process, including discussion and rating?*

The best answer is “None of the above.” Any practitioner, not just a member of the committee, should not be present during either the discussion or the rating of his or her case. This would be akin to a defendant sitting in a jury room. And yet, The Greeley Company consultants witness this occurrence in many peer review committees. Why do some medical staffs consider having a practitioner present at his or her own case a reasonable approach, but any layperson would be surprised—if not aghast—with this script?

This misconception most likely has its roots in the evolution of peer review, which started as morbidity and mortality (M&M) conferences. During these conferences, the basis for learning required the practitioner to be present so that he or she could explain the case and receive feedback. But M&M conferences are no substitute for peer review. Peer review committees must eliminate, or at least minimize, conflicts of interest through clear policies that are

13 ANGRY MEN? (CONT.)

always adhered to even if they seem inconvenient or not collegial because the practitioner happens to be a committee member.

How should committee members respond when a fellow member's performance is under review? The first step is to inform the practitioner in advance when the case will be discussed so he or she is not caught off-guard and embarrassed. This is best done by the committee chair (rather than by support staff) out of courtesy and respect. The chair should also remind the member of the committee's policy that requires any members who are under review to be absent from the decision. During that discussion, the chair should also ask whether it would be more convenient for the member if the committee discussed the case toward the beginning or end of the meeting, so the member can leave.

The peer review committee should approach cases involving members the same as it would for nonmembers. If your policy states that the peer review committee will write a letter to a practitioner under review asking for an explanation of the case, the same approach should be used for the member. When the committee discusses the response, again, the member cannot be present.

By the way, if your policy does allow for a practitioner to attend the meeting to provide a response, then the policy should limit the practitioner (or the member) to respond only to the committee's questions; the committee should ask the individual to leave during its discussion of the response.

If your medical staff policies allow practitioners to be involved in the review of their own cases, perhaps it is time to re-write that script. One of the most important ways the peer review committee can maintain the credibility of the peer review process is to effectively manage conflicts of interest.

Editor's note: This article was originally published in Medical Staff Leader Insider, May 6, 2009.

Who Is a Peer?

Traditionally, a peer has been defined as an individual in the same specialty. However, as inpatient medical practice has become more complex, with multiple specialties involved in patient care, numerous handoffs made among practitioners, and increased societal demands for a comprehensive framework that defines quality of care, that definition has proved to be too limited to provide effective peer review.

Many medical staffs have adopted this more contemporary definition of a peer:

A peer is an individual practicing in the same profession and who has expertise in the subject matter under evaluation. The level of subject matter expertise required to provide meaningful evaluation of a provider's performance will be based on the area of competency and the nature of the issue or data being evaluated.

This definition implies that, although a peer of a physician must be another physician, he or she does not necessarily have to be board-certified in the same specialty as the physician whose work is being reviewed. If the question is one of general medical care, or if it is related to issues of responsiveness or communication, any unbiased physician—MD or DO—can serve as a peer reviewer. However, if the question requires evaluation of specialty-specific clinical issues, such as the technique of a specialized surgical procedure, the peer reviewer must be trained and competent in that specialty. The impact of this definition on options for selecting an effective peer review structure is discussed in Chapter 4 and reviewer assignment is discussed in Chapter 6.

For example, assume that an interventional cardiologist, Dr. Coeur, performed a cardiac catheterization. The patient began to bleed in the retroperitoneum and became hypotensive and anuric. Dr. Coeur delayed fluid resuscitation and blood transfusion, and as a result, the patient developed acute renal failure. Did the cardiologist provide appropriate care? Although the question involves care provided by an interventional cardiologist, the actual event that required medical care was a textbook example of basic hemorrhagic shock. Therefore, any physician could be considered capable of evaluating the care provided under this set of circumstances.

Consider another example involving the same cardiologist. This time, Dr. Coeur received a report that a patient who is post-catheterization developed a hematoma at the site of puncture, had decreased hemoglobin by one gram, and was now hypotensive. Dr. Coeur decided not to make any changes and

ordered only a follow-up hemoglobin for the morning. By morning, the patient had developed acute renal failure in addition to his earlier problems. Again, any competent physician would recognize that Dr. Coeur's failure to provide sufficient fluid resuscitation and transfusion led to the renal failure.

According to Dr. Harvey Wachsman, a former neurosurgeon who specializes in medical malpractice law, "approximately 70% of all malpractice lawsuits involve the type of slip-ups that would be obvious even to a first-year medical student," such as a physician's failure to be present when needed, failure to take an adequate medical history, or failure to perform an adequate examination. In other words, most of the time, the issue is one of general medical care.

However, there are times when the reviewer must have specialized clinical training. For example, assume that Dr. Coeur had placed multiple stents in a patient's coronary arteries and the patient later suffered a myocardial infarction. Although the general question, "Did Dr. Coeur provide appropriate care?", is the same, this time, however, the answer requires a more technical assessment that only another board-certified interventional cardiologist could make.

Impartiality and Conflicts of Interest

Physician peer review should be as objective and impartial as possible. Unfortunately, individual bias can never be completely eliminated from any form of human evaluation, much less in the context of a medical staff where individuals often know each other. However, peer review bias can be reduced in a number of ways that will be discussed in later chapters.

One of the most important means of bias reduction in peer review is the management of conflict of interest. Because physicians are used to more informal means of interacting in the medical staff meetings, they often are not aware of the need to handle conflicts of interest in a manner that would be considered typical ethical practice in our society.

The ethical obligations of any individual to avoid conflicts of interest are recognition and disclosure. It is the responsibility of the deliberating body to determine whether the disclosed conflict is substantial enough to prevent the individual from participating in the deliberations at hand. For example, a physician peer reviewer with a potential conflict of interest, such as being a weekly golf partner of the physician under review, is ethically obligated to disclose it to the rest of the peer review committee. The committee then will determine whether the conflict is substantial enough to preclude the individual from participation in its discussion and decision. There are a few absolute conflicts of interest, such as when the issues in the case directly involve a:

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- ✦ Reviewer
- ✦ Committee member
- ✦ Spouse
- ✦ First-degree relative

Just as judges who have a personal interest in cases must recuse themselves to avoid even the appearance of impropriety, peer reviewers should recuse themselves in such situations.

Most conflict-of-interest situations, however, are not that clear. For example, some people argue that being a partner or a competitor should be considered an absolute conflict. If it were, however, internal peer review on technical quality of care issues would be virtually impossible. Therefore, these types of conflicts are typically handled as potential conflicts that are addressed on a case-by-case basis.

Another quandary is what to do if a committee member was involved in the care after the event under review occurred—perhaps that physician was even the expert consultant who “rescued” the patient. Some might see that situation as a conflict; others might see that physician as being an excellent source of in-depth information.

Three actions are necessary in order to resolve these potential conflicts of interest so that there will be no question that the peer review was conducted in good faith.

1. The medical staff needs a clear, written conflict-of-interest policy and procedure for peer review to provide guidance on how to handle these situations.
2. All physicians who serve on the peer review committee must be scrupulously honest about disclosing potential conflicts; including relevant personal issues (e.g., the physician under peer review is also engaged in a bitter dispute over a house that was purchased from a committee member).
3. The peer review committee itself must adhere to the policy and use its judgment and wisdom when determining whether a particular physician can render a reasonably objective opinion. This judgment may be based both on the physician’s reputation for fairness and on the nature and intensity of the conflict. If the committee has doubts, it should always err on the side of safety and either assign a different reviewer or obtain an external review.

Sham Peer Reviews

Another potential peer review impartiality concern is whether an individual peer reviewer or peer review committee as a whole could be seen as acting in retaliation for a physician's whistle-blowing or raising concerns about patient care. Peer reviews that are biased against the physician for retaliatory or other reasons are sometimes called sham peer reviews.

If a physician has his or her privileges restricted as a result of a sham peer review or of a good-faith peer review that looks biased to an outsider, that physician is much more likely to sue. And when plaintiff physicians challenge the peer review process and are able to prove a case of retaliation or malice, they have, in some instances, been awarded millions of dollars in civil damages. It is easy for a plaintiff's attorney to allege bias, even when none exists, so in this situation, appearances do matter. For this reason, hospitals should carefully define how to handle conflict-of-interest situations so they can avoid even the threat of litigation.

The Duty to Perform Effective Peer Review

A physician's duty to perform good-faith peer review is based in two fundamental principles of medical ethics: the principle of beneficence, or the duty to "do the right thing" and the duty to avoid malfeasance, or "do no harm." In the world of medicine, the duty of beneficence means that physicians have a fiduciary responsibility to act in the best interest of their patients. The Illinois Supreme Court described it well, noting that the physician is "learned, skilled and experienced in those subjects about which the ... [patient] ordinarily knows little or nothing ... Therefore the patient must necessarily place great reliance, faith and confidence in the professional word, advice and acts of the physician ... The essence of the fiduciary relationship is that the patient's interests must be paramount." ¹

The duty to do the right thing for the patient includes a duty to improve care continuously, both for a physician's own patients and for the patient population at large. By joining a medical staff, a physician assumes the obligation to all patients to improve the care provided by all physicians on the staff through participation in peer review.

Physicians aren't the only ones with this duty. The hospital's governing board also has the responsibility to ensure the quality of patient care. However, because most governing boards have little or no expertise in medical quality, they have historically delegated the responsibility of monitoring and

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improving physician performance to the organized medical staff. Thus, physicians are accountable to the governing board for carrying out effective peer review.

The duty to avoid malfeasance relates to the need to do peer review fairly. When peer review incorrectly determines that a physician has provided poor care, it can do harm to that physician, especially if such a label undermines the physician's ability to grow and sustain a practice. Similarly, when a physician's care is correctly identified as inappropriate, not addressing this issue puts future patients at risk. The key to avoid harmful peer review is to follow clear policies and practices that protect the physician under review and invest in information technology and support that provides a realistic picture of the physician's care.



The Question of Compensation

A medical staff professional submitted the following question:

"During our medical staff quality committee meeting, one member commented that committee members should be compensated for their time, especially when serving on committees that involve reviewing material prior to the meeting. I have inquired with my counterparts at other area hospitals. The consensus was that no one is paying committee members. However, the chief of staff, chief elect, department chairs, and vice chairs do receive a stipend.

What are your thoughts on compensating committee members? Should it be all committees or those that require additional time spent outside the actual meeting? Should we pay a flat fee across the board no matter what the physician's specialty, or should the fee reflect the physician's specialty?"

As physicians are more pressed for time to devote to medical staff responsibilities, the burden falls unequally on some more than others. In the past, this was seen as a physician's duty, and compensation was unheard of. Even today, in many medical staff cultures, physicians who are paid for nonclinical work, such as case management or serving as physician advisors or medical directors, are viewed as being "in the pocket" of administration.

So what is the right course? The response to this question should not be construed as either advocating or not advocating physician payment but as a way to begin discussion when approaching the issue with your staff.

There are really four decisions you must make to address this issue:

- Should you pay?



The Question of Compensation (cont.)

- Who should get paid?
- Who should pay?
- How much should you pay?

Should you pay? There is nothing illegal about doing so as long as you are in bounds for the last question of how much to pay. The real issue is what your medical staff members think about physicians getting paid. If your medical staff would react negatively, you need to either work to change that culture or abandon the issue. It's best to discuss this question with your medical executive committee, not with the committee that potentially would be paid.

Who should get paid? Most medical staffs focus on those who go above and beyond rather than on those who just show up at a meeting. Attendance at a committee is part of your citizenship responsibilities within a self-governing medical staff. But for those who do more, if you can define what that scope of work is, you can develop a fair compensation mechanism. This may be based on time spent or on tasks performed. You can pay for meeting attendance if the meeting is seen as burdensome because of preparation requirements. If someone is a paid medical director and the expectation is that part of his or her responsibilities is to review physician care, you may wish to exclude this person from receiving additional payment for carrying out quality improvement initiatives.

Who should pay? Typically, the hospital will be the source of compensation. Sometimes the hospital may provide the medical staff with a lump sum of funds to pay physicians for various activities and let the medical staff determine the precise distribution. Or the medical staff will provide some or all of the funds from medical staff dues. The latter two approaches work particularly well if the medical staff culture is suspicious of physicians who receive funds from the hospital. Whatever mechanism is used, it needs to be based on a consensus of the medical staff, the administration, and the board on the best approach.

How much should you pay? The legal issue here is based on the Stark Law for inurement. You need to establish an administrative hourly rate for physicians and apply it equally to all physicians, regardless of specialty. Usually this rate is in the range of \$75–\$150 per hour. Then you need to establish a method to quantify the actual work being performed. You can either require the physician to track his or her actual time for reviewing cases or establish general per-case compensation. For example, if the average case review takes 30 minutes and your rate is \$100 per hour, a physician reviewing three cases in a month would be paid \$150.

This discussion should not be construed as an endorsement of paying physicians for peer review. If you choose to adopt this approach because it is right for your medical staff, this will help you evaluate the options.

Should Physicians Be Paid to Perform Peer Reviews?

Due to rising costs and tighter reimbursement, many physicians feel they need to spend as much time as they can on their individual practices. The challenge of balancing this time with a life outside of medicine means that many physicians are not willing to volunteer to participate in peer review activities, especially those that are inefficient and time-consuming.

Since the first edition of this book, this question has been raised by medical staff leaders and committee members more frequently than in the past. No physician will ever get rich from serving on a peer review committee. However, the increasing economic pressures on physicians to maintain high levels of productivity in their office practices and the desire for lifestyles that are less committed to the hospital has caused a decline in voluntary participation in peer review for many medical staffs.

The answer is not a simple one. It is based on a number of factors, including to what degree your medical staff culture will even accept payment of physicians for performing administrative tasks. As you look to create an effective peer review program, it is important that you at least consider this issue. The box below provides questions and approaches that can help you make a decision that best suits your medical staff.

Physician Leader–Driven Peer Review: A Medical Staff Leader’s View

Note: The following is a speech by Dr. Michael McNamara given at High Point Regional Health System at the quarterly medical staff meeting in January 2006. Dr. McNamara was the incoming chair of the new medical staff peer review committee, redesigned as the central multi-specialty committee and titled the professional improvement committee. He was asked to acquaint the staff with the purpose of the reformulated committee. I found his presentation particularly articulate and compelling and asked if I might share his thoughts in this book. Here are his remarks:

“For those of you who read the quarterly update, you know that our mission is to bring exceptional healthcare to the people of the area that we serve. I have some good news for you. We have already assembled and credentialed an exceptional medical staff at our hospital. Reflect on the many medical and surgical specialties that we represent. Think of how many thousands of hours of advanced training in residencies, fellowships, and continuing medical education are part of the science of medicine that we bring to bear. Reflect on our collective experience of managing thousands of cases of acute and chronic care and the lives saved, the thousands of surgeries performed and suffering eased, and

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the thousands of new lives brought into the world with our hands. We are filled with the skills of the science of medicine.

“And by training, choice, and inherent compassion, we bring the art of medicine to the bedside of the ill and suffering. Our empathy, our patience, and our skill of listening speak to the art of our profession. I think that we do it well, and we honor the profession. We don’t employ a trade. We administer with gifts.

“We do well in the art and the science of medicine. But in the day-to-day practice of our skill, the profession of medicine, we may measure less well. Each of us brings with us to our medical duty and service the baggage of pressures each day. Lack of sleep, constraints of time to see more patients and make quicker judgments, the nagging pinch of diminishing reimbursements, demands on our time for the business of medicine grab an ugly hold. And many days we cannot leave behind our personal worries, be they financial, family, or failing health. Thus, there are days when each of us may function within our practice of medicine at a level that falls below what we expect of ourselves and of each other.

“We as a medical staff have a duty to measure our own performance. Should we fail to faithfully carry this out, someone else will step in and assess and measure us. We have the responsibility to keep the scales and balances of professional assessment in house. I have been asked to chair the professional improvement committee. This is the committee tasked to carry the scales and balances—to measure the staff with a plan to continually improve our professionalism. This implementation may not be easy.

“For those of you who feel that this committee is instituted to be critical, judgmental, and punitive, then I want you to know that my first job as chairman is to prove to you that you are wrong. This committee does receive, and will continue to receive, written requests to evaluate aspects of patient care when someone (patient, family of patient, hospital staff, or your professional peers) has concerns that the practice of the profession of the science and art of medicine failed their expectations, or failed their understanding of a perceived standard. We will ask you to give us information to enable us to make an evaluation. If there is no merit to the report, we will let you know. If there are system errors in this hospital that interfere with efficient professional practice, we will work to fix them. If you are a physician who through lack of sufficient training, personal arrogance, or honest error falls below the standard we hold ourselves to, then we will give encouragement and assistance, and if need be, outside intervention and training to help you lift your professionalism to better the collective us.

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“As I told the committee on our first meeting, we will succeed by that which we do not know. Our impact will be measured by the patient who does not die, the postoperative infection that never occurs, the length-of-stay outlier that goes home on time, and by being spared the blot of rancid community publicity for an event that never occurs.

“We are an intelligent group of men and women with great gifts of knowledge, compassion, and service, and we are capable of change. We can change for the worse, or we can change for the better. I’m counting on the better. We will need your help.”

The privilege society has granted us to have a self-governing medical staff will only remain if medical staff leaders take on the responsibility of mutual accountability for physician performance that Dr. McNamara has so clearly articulated.

REFERENCE

1. Witherell v. Weimer, 85 Ill. 2d 146 [1981].

THIRD EDITION Effective *Peer Review*

The Complete Guide to Physician
Performance Improvement

Robert J. Marder, MD

Peer review continues to rate as a top problematic issue in healthcare organizations. Even if they are meeting regulatory standards, most organizations struggle to develop a peer review program that is meaningful to physicians, causing them to resist participating in this critical function.

This book will help you:

- Engage physicians in the peer review process
- Refocus your peer review culture from punitive methods to a positive approach and the pursuit of excellence
- Minimize bias and improve case review efficiency
- Design OPPE profiles using the six core competencies and create a plan for distributing the information to physicians
- Create policies that are useful for your medical staff and comply with regulatory standards

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