Whither peer review?

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Abstract

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Full Text

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Has the time come to go back to the drawing board?

Grena Porto , a principal consultant with QRS Healthcare Consulting in Delaware, has made a career out of advocating for patient safety and improved quality. It should not have surprised some people, then, when she posted on a patient listserv all the reasons why she believes peer review doesn't work and detailed a number of cases to illustrate why.

In her August post, she wrote: "Beyond these...stories, which some might be tempted to cast as individual instances and 'outliers,' I have had the experience...of being told by physicians and nurses of bad practices on the part of physicians which have gone unaddressed by the organizations in which they occurred. In two instances, the physicians engaged in practices that were so egregiously inappropriate that they could have been charged with criminal conduct but were not only because no one would report them. In these same two instances, the organizations dealt with the situation by simply 'talking' to the physician. No further action, including documentation of the behavior, was taken."

Porto says that rather than such cases being rare, as many assert, we can't know the prevalence of such cases because they are often hidden away and not reported. "My guess is that there is at least one such situation ongoing right now in all 5,000 or so hospitals in this country -- no exceptions," she wrote.

"How many people have to be injured, assaulted and sexually abused before we finally figure out that we have a system that does not do anything but protect physicians at the expense of patients? I have respected colleagues that will argue that peer review does work," according to Porto. "My question is -- how is that possible if physicians get away with criminal conduct, sometimes for years, while colleagues look the other way?"

In an interview with HPR , Porto says that peer review is a great idea that just doesn't work the way people want it to. "It's like communism -- a nice theory, but in action it doesn't pan out," she says. "It doesn't work because people can't put aside their personal agendas to make it work. And we are asking it to deal with things that it wasn't designed to address -- like bad actors and situations where it isn't just about good practice versus bad practice, but also about bad behavior -- sometimes criminal, sometimes intentionally bad behavior."

Cases in which bad behavior isn't dealt with effectively can be chilling on others who want to report patient safety and quality problems to their facility's peer review program, says Mark Smith , MD, MBA, FACHE, a principal consultant with HG

Consultants. It's almost as bad as not having a program, to have one and have reports of problems go unheeded, he says. "It makes people wonder why they should bother and is very bad for morale."

Smith acknowledges that peer review isn't perfect, but he thinks it is getting better and that the cases Porto refers to are not only few and far between, but getting fewer over time. "I believe that 10 or 15 years ago, egregious behavior was more prevalent," Smith says. "But I'll be the first to say that there is still too much of it around. These instances are proof that something is wrong in these places and it isn't working there."

The fundamentals of peer review are sound -- a place where you can gather to discuss cases where there was an adverse event or harm was done and determine its cause, counsel those involved, and work to create an environment where the error isn't repeated, he says. But there is no statutory regulation as to what peer review is, and even those best practices that are known don't result in everyone doing them the way they should be done, he says. "It is true that there may be instances where bad behavior and heavy hitters who add revenue are the same people," he says. "Those heavy hitters may be dealt with differently. And while I believe it's getting better, there is truth to that."

Physicians still find it difficult to confront their peers, too. They may need them for referrals, says Smith. Conversely, they may be competition, and some of what is said during peer review can be as bad to a good physician as it can be good to a bad physician, he says. "Historically, peer review was something done only by specialties, so there is a history of your partners and competitors doing the review. And everyone has a bias in those situations."

But even among those who see big problems with peer review, there is no consensus that it should be scrapped completely, that it is imperfect universally, or that it should be handled by some third-party organization rather than by physicians themselves.

Improving the process

However, experts in the field do have many suggestions for improving the process. Among them:

1. Open up the party. Smith suggests making peer review multidisciplinary. That reflects the move toward teams and interdisciplinary cooperation in healthcare, too. Fay Rozovsky , principal and founder of the risk management consultancy The Rozovsky Group in Bloomfield, CT, says there is an argument to be made for team credentialing and reviewing, too. What happens to a patient is the result of a whole slew of people working together -- hopefully working well. But only the physician is subject to peer review in most states.

2. Look at a wider array of data. Move away from case review where the specifics of a single case may never recur, Smith says, and look instead at rate data. "Let's say a gastroenterologist does a colonoscopy and causes a perforation. He recognizes it, calls a surgeon, and it is taken care of with no complications or lasting harm to the patient." Typical peer review will note that perforations are a known risk, and the physicians acted appropriately. But if you knew that no one else in the hospital, or the county, or the state, had a perforation rate as high as this physician, there may be something to learn. "If the national average is 0.5% and his is 1%, you need to see what he is doing differently," says Smith. "And if his is 0.1%, you still may want to see what he does differently so others can mimic it."

3. Create a culture of accountability. Physicians are competitive by nature, and Smith says the best organizations are those where physicians want to see their data and how it compares to their peers. "They know that concerns will be acted upon and not swept under the table, and that there will be change."

4. Check your litigation files. If you don't see every single case that is subject to legal action in peer review, Smith believes something is wrong with your peer review system.

5. Make credentialing incremental. If hospitals gave provisional privileges to physicians, it would be easier to dislodge bad actors more quickly, says Skip Freedman , MD, the executive medical director of AllMed, a Portland, OR-based independent review organization. "You can extend provisional privileges if you have concerns, and you can review their body of work -- or some part of it -- before you allow them to advance," he says. While the peer review process is the same for those with provisional and full privileges, the former do not have all the protections of the latter.

6. Review prospectively and regularly. Don't wait for a problem, says Freedman. Rather, do a certain number of cases in all high-risk areas -- and a few in areas that have less risk -- at regular intervals.

7. Use external reviewers. Having someone working in a similar-sized hospital of a similar type from outside your organization and area of operation removes the potential for bias to creep into reviews, says Freedman. You can easily ensure that someone from a teaching hospital isn't reviewing someone at a small rural facility and vice versa, he says, and it is not prohibitively expensive, as many administrators and executives fear. Indeed, while many see peer review as it is now as a pure cost, having a good external peer review system can lead to reductions in insurance premiums because insurers see that kind of rigor as evidence you are serious about reducing risk, he notes. "Never mind that no one looks at peer review and calculates the economic benefit of patient safety."

8. Create qualifications for reviewers. Rozovsky says that people make assumptions that those who sit on peer review committees are qualified to do so. "How do you train them to do that, though?" Whether internal or external, there is often no training in place for this group of people who sit in judgment of their peers.

9. Remember the patient's role. As CMS and other payers extend their payment rules to include 30 days after discharge, some attention needs to be paid to the patient's role in bad outcomes, says Rozovsky. "You can have a patient with congestive heart failure or pneumonia who has a great discharge planning process and still comes back within 30 days with the same diagnosis. But if the patient refuses to follow the care plan, and the outcome is bad, then the hospital is dinged by CMS, the attending comes up for peer review, and they call him on the carpet for patients bouncing back. The physician can be faulted for patient behavior, over which he has no control."

10. Get the information you need from the start. Rozovsky says many of these cases seem to revolve around physicians who moved from organization to organization or from state to state and were given positive or neutral references by the organizations they left as part of their exit agreements. "All institutions should have a release form that says if you want privileges, it's not a right and you have to abide by our rules," she says. "If a physician wants privileges, then they have to sign documents allowing us to collect data from the places listed as references. If they refuse, they cannot be credentialed."

With all the changes afoot in healthcare, this is a good time to look at your peer review process and fix what is not working, says Rozovsky. There is no real national guidance on what peer review should look like -- there is some criteria from The Joint Commission, and some state agencies mention how to evaluate peer review programs. There are other resources, however, such as specialty colleges and professional groups, as well as a variety of consulting and law firms that offer training on the topic.

Look beyond the usual suspects and common approaches, though, she says. For example, the Citizen Advocacy Center in Washington, DC, has tried to use a different way to improve care that doesn't involve punishment such as losing a license, but instead advocates retraining and returning to practice under supervision. The system is used in places like North Carolina, where the Board of Nursing has used it with good effect, says Rozovsky, and UC San Diego has a program for disruptive providers.

Porto believes that large-scale restructuring of peer review is long overdue. While it may be true that peer review has improved over the years, it is still far from where it needs to be. She believes that payers, accreditation organizations and CMS need to get behind such an effort, not because peer review itself is a bad idea, but because it doesn't work reliably enough to serve as the primary foundation for review and improvement of care. "Maybe there are cases where it works some of the time. But no one gets it right all of the time."

Freedman doesn't think things are as dire as Porto contends. "It works most of the time because most things in medicine turn out okay, and the ones that don't aren't usually anyone's fault," he says.

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