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Assessing Physician Quality: More than Peer Review

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During fiscal years 2009 and 2010 (July 1, 2008 through June 30, 2010), the Office of Health Care Quality received more than a dozen reports of Level 1 hospital adverse events in which inadequate systems for physician quality review either contributed to the adverse outcome or impeded progress in correcting the contributing factors to the adverse outcome. Since the goal of the hospital's patient safety system should be to identify and remediate unsafe systems and processes, thereby protecting patients from harm, the Office of Health Care Quality recommends that prospective and retrospective review of the safety and effectiveness of physician care be included as part of the hospital's overall quality assurance and measurement functions. All hospital employees are subject to annual performance appraisals, yet most hospitals do not do the same for physicians. Unlike peer review, which usually requires a more in-depth review of a single case or group of cases, and is done following an adverse outcome of some kind, the type of quality review recommended should occur on a regular basis just as it does for hospital employees.

None of the legal requirements for periodic quality and performance reviews specify that they may only be done on a physician-to-physician basis. While it is probably preferable to limit the disciplinary process to peers, it is feasible and cost-effective for non-physicians to track physician quality metrics, including outcomes, complaints, morbidity, adverse events, infection rates, etc. Another physician can then focus on any issues with clinical decision making. Since the physician appraisal process should be impartial, nurses, especially those trained in QA and performance appraisal and who presumably have no economic incentive, seem like the appropriate discipline to track these quality metrics. In order to ensure fairness and validate the approach, all physicians should be appraised in this way; those who admit a lot of patients or otherwise bring in a lot of revenue should not be exempt. The following cases illuminate what may happen with an inadequate system of appraisal:

Adverse Event 1: An elderly patient was admitted to the hospital with a pulmonary embolus and other co-morbidities. She was started on heparin intravenously with increasing doses for three days until her coagulation studies were in the therapeutic range. She was then started on oral warfarin. She continued to receive both a high dose of heparin with the warfarin for another three days, during which the physician failed to order any anticoagulation studies, and neither the nurses nor the pharmacy requested any labs. During an assessment on day seven of the hospitalization, the nurse noted the patient's abdomen was firm and bruised. Soon after this, the patient had a mental status change and then started bleeding from the GI tract. She died of a massive hemorrhage. The hospital determined that while they had an evidence-based, medical staff approved, pathway for managing anticoagulation, many physicians considered the pathway to be more of an optional guideline.

Comments: As with most adverse events, this event was complicated by a multidisciplinary failure of critical thinking. However, the hospital bears some responsibility for the outcome because the pathway was released for use and no follow-up was done to determine how often it was being used, which providers were using it and which were not, or if there were barriers to its use. The hospital's quality department should have tracked at least those three metrics, along with a comparison of outcomes between those patients for whom the pathway was used versus those for whom it was not used.

Adverse Event 2: A morbidly obese patient with several co-morbid conditions was admitted to the hospital for a fairly minor surgical procedure. The anesthesiology assessment showed he was an ASA 3 (a patient with severe systemic disease, that limits function, but is not incapacitating) with a Grade III airway (neither the structures at the back of the throat nor the vocal cords were visible). The original surgical procedure was apparently completed without incident, but several hours later, the patient started hemorrhaging. He was managed overnight in the ICU by a Resident who resuscitated the patient with almost a dozen units of blood, but

was unable to get the surgeon to respond to phone calls until early in the morning. The surgeon arrived around 5 AM and decided to do upper and lower GI endoscopies at the bedside rather than call the on-call GI staff. Even though the surgeon knew that the patient had a difficult airway, he elected to go ahead with the procedure without anesthesia or respiratory therapy back-up. The patient went into respiratory failure immediately after he received sedation. After 20 minutes of trying to establish an airway at the bedside, the patient was rushed to the operating suite where attempts to establish a surgical airway were unsuccessful.

Comments: The only root cause for this event identified on the RCA was the dire nature of the patient's condition. Internal peer review of the case determined that the surgeon's decision to go ahead with the procedure was appropriate. The RCA did not discuss the surgeon's lack of responsiveness to repeated phone calls, or the failure of the Resident or nurses to move up the chain of command.

Adverse Event 3: A patient in his 90s had a laparoscopic cholecystectomy in the hospital's outpatient surgery center. Two weeks prior to surgery he had had a hypotensive, unresponsive episode following a diagnostic procedure that required the use of sedation. The hospital's rapid response team had been called for that event. Following surgery on the day of the terminal event, the patient was recovered in the post-anesthesia unit. As soon as he met the surgeon's standard criteria for discharge, he was discharged. As the nurse was assisting him into the family car, he arrested and could not be resuscitated.

Comments: The RCA focused solely on the events surrounding the attempted resuscitation. Mention was made of the nurse's reluctance to question the physician about discharging the patient because the surgeon was known to be "nasty" and a stickler for insisting his outpatients be discharged on time. There was no discussion about the appropriateness of performing an outpatient laparoscopic cholecystectomy on a 90-year old who had had a recent near-arrest following a diagnostic procedure done by the same surgeon. No mention was made of this surgeon's intimidating behavior and its contribution to the adverse outcome, and no mention was made regarding the apparent freedom of this physician to set his own criteria for outpatient surgical appropriateness and determine his own discharge criteria without review of the criteria by other members of the medical staff.

Adverse Event 4: A surgeon received training in a complex new procedure for which no one else at the hospital was proficient. The procedure was a percutaneous procedure with a mortality rate of less than 1%. On one day, the surgeon's first two patients died soon after surgery from complications related to the surgical procedure. The hospital had never reviewed the surgeon's proficiency in performing the procedure because they had no one on staff competent to review the indications and surgical prowess. The surgeon essentially performed peer review on himself—with the expected outcome.

Adverse Event 5: A young patient died following a mix-up between topical and injectable medications during a simple surgical procedure. Along with the issues of set-up and labeling of the surgical tray, analysis revealed that this surgeon was the only one of the five surgeons performing the procedure that preferred to use the topical medication along with the injectable. The other four surgeons used only a newer injectable medication with fewer side effects and better evidence-based outcomes than the topical.

Adverse Event 6: A patient had to go back to surgery for retrieval of a retained foreign body. The RCA identified that the physicians were not held accountable for remaining current on hospital policies and other minimal standards, including those for counting in the operating room.

Systems of accountability in hospitals must include the physicians and require that individual physicians take ownership of patient safety. Physicians should meet and exceed the minimum standards of knowledge and conduct that are expected of all members of the healthcare team. The hospital culture that allows the kind of disruptive behavior seen in adverse event 3, or that allows the physician to set his or her own standard of care, as in events 1, 2, 4, and 5, is no longer acceptable and should no longer be the tolerated. Organizational systems and culture should neither expect nor allow physicians to adhere to lower standards than other practitioners. Everyone involved in patient care must be accountable for maintaining safety, civility, professional standards, and minimal competencies.

A proactive, regular assessment of the clinical performance of physicians might have alerted hospital leadership to the presence of a dysfunctional or unsafe practice before a patient was injured. For instance, the hospital should have been well aware that the physician mentioned in Event 3 had an attitude problem, and that the physician in Event 4 was setting his own practice standards. The surgeon in Event 5 was allowed, through the use of OR preference cards, to use methods for which there was no longer any scientific validation and which created

an unsafe combination of medication routes on the surgical tray.

Besides the moral imperative to assess the quality of care of all who come into contact with patients, there is legal support for a proactive approach. In 1986, Congress enacted the Health Care Quality Improvement Act (HCQIA), which provided members of medical review committees immunity from lawsuits when peer review is conducted in good faith; and the burden of proving a lack of good faith is assumed by the sanctioned physician. Medical peer reviewers are protected from liability as long as they satisfy the following HCQIA fairness standards that require the peer review and sanction be done:

- In good faith for achieving quality improvement,
- After reasonable efforts to obtain the facts,
- After "adequate notice and hearing" to ensure fairness, and
- In the belief that the sanction is warranted by the facts.[1]

The Maryland Health Occupations Article §1-401(c)(d) protects the confidentiality of medical quality review by stating that the proceedings, records, and files of a Medical Review Committee are confidential and are not discoverable in any civil matter as long as the Committee is:

- Evaluating and seeking to improve the quality of health care provided,
- Evaluating the need for and the level of performance of health care providers,
- Evaluating the qualifications, competence, and performance of health care providers, and
- Evaluating and acting on matters that relate to the discipline of any health care provider.[2]

In addition, both the Joint Commission (Standard MS 4.40)[3] and the Centers for Medicare and Medicaid Services (§482.22(a)(1) of the CFR)[4] require periodic quality appraisals of health care providers, including physicians. A hospital quality assurance program that pro-actively and impartially reviews all physicians, and is set up as a Medical Review Committee should be protected from discovery and lawsuits.

Just as utilization and medical record delinquency are reviewed on a regular basis, quality, including the medical necessity for procedures, interactions with staff, patient outcomes, ethical issues, and use of evidence-based practices should be reviewed. Any requested privilege or procedure that is outside the list of privileges common to the applicable category of practitioner requires greater scrutiny of the provider's qualifications and competency. The process of approving additional privileges should include a decision by the hospital administration as to whether the hospital can support patients undergoing the procedure in question. Hospitals may decide to require practitioners to perform a determined minimum number of procedures per year in order to justify continued privileging. In addition to minimums, the threshold for a targeted review of the professional performance of members of the medical staff should be acute enough to flag instances where the number of procedures performed may exceed what is usual and customary—regardless of outcomes.

The Office of Health Care Quality would like to suggest some other methods of ensuring the impartiality and effectiveness of physician quality review. Along with the peer-to-peer post-event review that occurs as part of the disciplinary process, we would like to see random cases chosen for review, and perhaps chosen for review by someone other than the Department Chair. The reviews should:

- Include an assessment of the medical necessity for invasive procedures, especially high cost, high risk procedures,
- Include compliance with hospital policies, bylaws, and evidence-based guidelines, especially in high risk areas like surgical procedures and infection control,
- Include an appraisal of team dynamics measured by outcomes associated with poor communication, and responsiveness to changes in patient condition or calls for help, and
- Occur on a regular basis—the Office of Health Care Quality recommends annual reviews for all physicians on the active staff.

Hospitals that do not perform appropriate and timely reviews of physician quality may be found out of compliance with the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation (COPs) for Governing Body, Medical Staff, and Quality Assurance and Performance Improvement (QAPI). For instance, §482.21(e) states that:

> "The hospital's governing body… medical staff, and administrative officials are responsible and accountable for ensuring the following: (1) That an on-going program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained."

And §482.12(a)(5) states that "the governing body must ensure that the medical staff is accountable to the governing body for the quality

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of care provided to patients."

Failure to correct a known deficient or defective process puts hospitals, providers, and patients at risk. Since we all are now, or will be in the future, using the health care system, it benefits us to encourage physicians to take their rightful places in the culture of safety.

References:

1. http://www.aaos.org/news/aaosnow/oct08/managing9.asp
2. Maryland Health Occupations Article §1-401 (c)(d)
3. The Joint Commission Hospital Accreditation Standards, 2009
4. The Code of Federal Regulations, 42 CFR, Part 482.22