Clinical perspective: creating an effective practice peer review process—a primer

Q9 Q1 Manisha Gandhi, MD; Frances S. Louis, JD; Shae H. Wilson, JD; Steven L. Clark, MD

Peer review serves as an important adjunct to other hospital quality and safety programs. Despite its importance, the available literature contains virtually no guidance regarding the structure and function of effective peer review committees. This Clinical Perspective provides a summary of the purposes, structure, and functioning of effective peer review committees. We also discuss important legal considerations that are a necessary component of such processes. This discussion includes useful templates for case selection and review. Proper committee structure, membership, work flow, and leadership as well as close cooperation with the hospital medical executive committee and legal representatives are essential to any effective peer review process. A thoughtful, fair, systematic, and organized approach to creating a peer review process will lead to confidence in the committee by providers, hospital leadership, and patients. If properly constructed, such committees may also assist in monitoring and enforcing compliance with departmental protocols, thus reducing harm and promoting high-quality practice.

Key words: hospital privileges, patient safety, peer review, practice improvement, quality, medical malpractice

Peer review of medical practice, originally initiated by the American College of Surgeons in 1913, can serve as an important component of quality improvement and patient safety programs in medicine.[1] This process charges medical providers with the responsibility of overseeing the quality of medical care given by their peers.

Peer review has become an important aspect of granting staff credentials, annual evaluation of staff reappointments, and monitoring the general quality of the medical staff within an institution. Yet effective peer review is rare: in a recent publication of the Journal, it was noted that "peer review is alive only in rare pockets in this country," and hospitals were urged to institute "real, honest, robust" peer review systems.[2]

Given the importance of this process and the recognized need for improvement, it is surprising that the medical literature contains few references to the medical peer review process and virtually no guidance in the establishment or proper functioning of an effective obstetrical peer review committee.[3,4] A PubMed search for the term "peer review committee" yielded just 20 references from all years and in all languages. Most dealt with dental or legal issues; none contained guidance on establishing and running an effective peer review committee, and no article specifically addressed obstetric issues.

From the Baylor College of Medicine and Texas Children's Hospital, Houston, TX.

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Corresponding author: Steven L. Clark, MD. slclark@bcm.edu

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In our experience, many medical leaders recognize this problem and are anxious to improve the current processes in their facilities yet have few resources to assist them in this process. The authors of this Commentary have had extensive experience in establishing, directing, and evaluating successful obstetric and gynecologic peer review programs throughout the United States. This experience includes a large regional nonprofit hospital system; a national for-profit hospital system, which is the world's largest nongovernmental provider of health care services; and several university and university-affiliated hospitals.[5-10]

Whereas one size does not fit all, certain principles and approaches are effective in most settings and will be described here as one workable approach to the establishment of an effective practice peer review committee.

Although practice peer review serves as an important adjunct to hospital quality and safety programs, the 2 processes are uniquely different. Most hospital quality and safety programs are directed at identifying needed systems changes and building internal redundancies that will avoid patient harm, even when medical errors are made.[5-18]

In these endeavors, assignment of individual provider error is often unproductive and is generally avoided.[19-22] In contrast, peer review is specifically directed at the critical assessment of individual physician performance. It is, by its very nature, highly judgmental. This process involves a determination of whether a physician did or did not meet applicable standards of care in the treatment of a specific patient in whom an adverse outcome occurred or was narrowly avoided. These 2 processes are complementary; neither can be effective as a stand-alone program.

The goals of a peer review committee

Peer review committees serve several important functions including the following:

1. To monitor the practice of all physicians with admitting privileges.
2. To identify errors in the practice of individual physicians that have led to, or may lead to, preventable adverse

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TABLE 1
Cases that might trigger automatic peer review

Unplanned hysterectomy
Uterine rupture
Venous thromboembolism
Transfusion of >4 U of blood
Fourth-degree laceration
Maternal death
Neonatal brachial plexus injury
Neonatal cooling
Term gestation with 5 minute Apgar <7
Cord gas pH <7.1 with BE >−12
Early elective delivery not meeting Joint Commission requirements
Physician behavioral complaints

Gandhi. Creating an effective practice peer review process. Am J Obstet Gynecol 2016.

outcomes or near misses so that these events may be avoided in the future.

3. To identify and track trends in individual physician practice while ensuring due process rights of each physician.
4. To facilitate the remediation of substandard practice patterns. Such steps may range from formal discussions with the provider (common) to the restriction or suspension of privileges (rare).
5. To evaluate reported behavioral issues, including sexual harassment, hostile work environment, or physician impairment, and recommend appropriate remediation to the department chair and medical executive committee.

Organizing the committee

Most departments of obstetrics and gynecology include multiple providers with differing medical and surgical backgrounds in their peer review committees. A typical peer review committee for obstetrics and gynecology might include the following individuals:

- Providers whose practices are focused in different areas of the specialty. This may include those with primarily obstetric or gynecologic practices, or in larger departments this may include representatives from recognized subspecialties.
- Representatives from different group practices.
- In facilities with an academic affiliation, representatives from both academic and private practices.
- Certified nurse midwives.
- A senior nursing representative.
- A representative from risk management and/or medical staff legal counsel.
- Representatives from allied departments (anesthesiology, neonatology, general surgery, internal medicine) either as permanent members or to be called upon on an ad hoc basis.

Such diverse membership will facilitate a comprehensive, multidisciplinary, and unbiased evaluation of provider actions.

Consider carefully the size of your committee. Many experienced clinicians may be tempted to conclude that the ideal size for any committee is zero. Although a desire for inclusiveness and impartiality makes this goal impractical, available data clearly suggest that committee efficiency declines as membership expands; too large a committee is a recipe for paralysis.

Studies dealing with committees in general suggests that beyond 7 members of a committee, each additional member reduces decision effectiveness by 10% and that beyond 20 members, gridlock is common.[23,24] In very large departments, smaller working subcommittees can be created, each of which addresses specific types of adverse outcomes. Committee members should receive instruction and training regarding committee function and goals, individual responsibilities, and their absolute duty to maintain confidentiality.[25]

The choice of a committee chair is also critical. The type of decision making necessary for efficient functioning of this committee will, of necessity, involve some degree of subjectivity regarding the appropriateness of care and the choice of cases that merit full committee review and discussion. A senior, seasoned, and confident department member who is respected for her/his fairness and clinical skills and who has no interest in building his/her practice is ideal in this role. This individual should also have the ability to run a meeting efficiently and prevent unfocused case presentation, long-winded speeches and complaints, and mean-spirited sniping, all of which can derail the function of a peer review committee.

Which cases get reviewed?

It is important to ensure a balance between a desire to review all adverse outcomes and near misses and the number of cases generated to maintain a manageable caseload and workflow. Table 1 presents a list of events that could be used by a Department of Obstetrics and Gynecology to trigger automatic referral for peer review. In an individual department, this list might be expanded as time goes on if this is found to be appropriate for a given institution.

How does the committee function?

One effective approach is for the committee chair to assign primary case review to an individual committee member for evaluation and presentation of the full committee meeting. This member may contact the involved provider if information supplemental to the medical record is needed. If no fault is found, recommendation for simple closure is made without discussion.

To ensure transparency and fairness, a very brief written case summary may be provided to all committee members; the primary reviewer should be prepared to present case details if requested, even for cases in which the standard of care was felt to be met. When the individual whose care is being reviewed is a committee member, she/he is generally excused during this discussion. Following formal consideration, the committee makes a decision regarding case disposition. The Figure represents one possible form that may be utilized to assist in this process.

Timely review and feedback is critical to performance improvement. In general, committee meetings should be

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