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Good Peer Review: Improves Outcomes for Patients and Physicians

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The Peer Review process can bring out the best and the worst in a medical staff. It not only is critical for the safety of patients but it is also critical for the protection of physicians. Often this dichotomy is a source of tension. It is well established that the provision of high quality, safe and efficient care requires more than the right diagnosis and good medical judgment.

Unfortunately, many physicians think that the peer review process should judge only the patient care ability of a doctor, his or her knowledge and their practice of medicine, but this is just one of the areas of physician competencies that peer review, by statute, must evaluate. Other areas include continued medical education, professionalism, interpersonal skills and communication, and even systems-based practices or citizenship.

In order for your peer review process to be a positive force within the medical staff, the expectations must be well defined and the process must be equitable and then perceived as such by the patients, staff and physicians. Without all of these components, the process will become a persistent source of friction between doctors and lead to a dysfunctional medical staff. If your medical staff seems to be perpetually in conflict, there are behavior issues that go unaddressed, or you have a hard time keeping good nurses, your peer review process is most likely one of the central problems. Recognizing your staff as conflict-ridden is the first step to improving the culture of the medical community often done through changes to the peer review process. Of course, for physicians to relinquish their positions of power can sometimes be difficult. However, this can and does occur if a committed core of physicians understands that without a process where everyone is treated fairly and equitably, on a consistent basis, things will not change for the better.

Drs. Marder, Smith and Sheff wrote in their book "Effective Peer Review" about the five polarities, or points of tension, found within any medical staff. It is on this continuum, between these opposing concepts listed below, that doctors find themselves trying to find a balance so they can have a successful practice and a successful personal life. It is important for physicians to be aware of these points of tension because it will help them navigate between these very important but competing needs.

1. *Collegiality vs. Excellence:* Does unconditional respect for your peers, i.e. getting along, trump honest and fully transparent review of a colleague?
2. *Freedom vs. Commitment:* Is personal success and time valued over the success of the medical community or the outcomes of the patient?
3. *Appropriate Independence vs. Mutual Accountability:* Do you find it hard to change your own firmly held clinical practice, because "it has worked for me" rather than to move toward a less variable and more evidence-based decision making process? Are you even open to that possibility?
4. *Appreciation vs. Continuous Performance Improvement:* How many times have you been sent a thank you note for a job well done from your Peer Review Committee? That would be a good thing to do and would be appreciated. But if you make a mistake, or if there is a better way to do

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something, do you appreciate the feedback from the committee so you can improve? The peer review process needs to do both.

5. *Stability vs. Change:* In the practice of medicine, by its very nature, change has to be deliberate in order to be safe. However, change is a constant; it cannot be prevented. Attempts to halt change will lead to frustration. But it is important to remember change can be difficult and to treat it accordingly.

Each polarity mentioned above is a legitimate concern for the practicing physician. If only the extremes along the continuum are found between the docs on your medical staff, however, there will be a lot of wasted time, stress and less than desired outcomes. This failure to achieve a balance has led to many physicians and entire medical staffs to become dysfunctional to the point where patients as well as physician practices and their families have suffered.

How your peer review process is structured can enhance the medical staff culture and bring it more into balance. Or peer review can be structured in such a way as to almost guarantee poor performance with persistent conflict and mistrust.

There are several peer review models. At one end of the spectrum is the one person reviewer model and at the other end there is a committee comprised of a diverse group of specialties and practices, including the hospital quality department. The group model is the best. However, the physician leadership may not be educated about the best practices of peer review, or they may not trust other staff members, often their competitors, with such a powerful tool. In these cases, changing the peer review process may not only require a change in the bylaws but it will also require a change in the culture of the medical staff. Better education of the leadership is always important but it might take younger although experienced physicians to step forward, and get involved in the governance of the medical staff. The administration cannot and should not take charge of this process but it does have a role in supporting a functional medical staff culture through education and developing a truly consistent working relationship with the physicians. Having an open door policy with the quality department in order to improve the handling of concerns and complaints from patients, staff and physicians is critical to a successful peer review process.

We must always remember that a well-designed and functional peer review process will enhance the quality and safety of medical care. This improvement will protect our patients, but also our physicians. It is a goal that every medical staff must have high on its priority list.

Muskogee Community Hospital and Muskogee Regional Medical Center to become one health system

CAPELLA HEALTHCARE ACQUIRES MUSKOGEE COMMUNITY HOSPITAL

The partnership between Muskogee Regional Medical Center and Muskogee Community Hospital that will unite the hospitals into one comprehensive health system has been finalized.

Both hospitals are now operated jointly by Capella Healthcare, which entered into a long-term lease and assumed management of Muskogee Community Hospital.

"The goal of this collaboration is to be able to better meet the healthcare needs of Muskogee and the surrounding communities," said Dan Slipkovich, chief executive officer of Capella Healthcare.

Brad McIntosh, MD
Family Practitioner

"This partnership will allow us to enhance existing services and eventually attract new services for the region we serve," said Kevin Fowler, chief executive officer of Muskogee Regional Medical Center, who assumes the position of CEO for the new system. "We are driven by one goal above all others – to build the strongest possible healthcare system that puts quality patient care first."

In preparation for the transition, Family Practitioner Brad McIntosh, MD, represented Muskogee Community Hospital at Capella's National Physician Leadership Group conference earlier this year.

"Combining our two hospitals will be very good for the community," said Dr. McIntosh. "Both have strengths and balance each other and we can use the best of both to make us each better. We're going to be able to grow Muskogee into the regional medical center it should be."

A transition team, including employees and physicians from both campuses as well as community leaders, is working on the system unification plan which will include where future services are located as some service lines are consolidated.

Capella has operated Muskogee Regional Medical Center, a 275-bed acute-care hospital, since 2007. Muskogee Community Hospital, licensed for 45 beds, was opened in 2009. Both hospitals are accredited by The Joint Commission and just earned re-accreditation as a single facility.

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