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Peer review

A safety and quality improvement initiative in a general practice

Background

A general practice in inner city Melbourne (Victoria), committed to ensuring quality standards of clinical care, developed a process for peer review of their doctors' performance. The aim was to ensure that there was a robust and fair process for evaluation of doctor performance from both a safety point of view, and from the perspective of contribution to team based practice.

Objective

This article describes the process and outcomes of this appraisal process.

Discussion

From the springboard of weekly clinical meetings which address critical incidents and near misses, the practice doctors developed an annual process of formal performance review incorporating hard and soft indicators of clinical performance and compliance with professional and practice standards. This type of activity falls within the scope of quality improvement in general practice.

Keywords: peer review; general practice; quality assurance, health care

Since 2007, the author's practice, a five doctor practice in inner city Melbourne (Victoria), has successfully run an in-house medical peer review program. This program arose out of a sense of imbalance at the practice. The reception and administration team were trained in the business of ensuring a good patient experience, and their performance was regularly reviewed by the practice manager. However, the doctors' professional certification, which ensured their safety to practise, did nothing to ensure that they functioned as good team members and contributed to the overall patient experience and satisfactory operation of the business. In effect, doctors were treated differently. There was no internal review of their work, which involves a lot more than just their professional competence. It seemed sensible to ensure a mechanism was in place to troubleshoot problems at an early phase, and to provide a framework for remediation.

Of course many problems affecting performance in a team based general practice fall well short of reportable, but they can just the same compromise the work environment. A recent paper explored the question of quality improvement in Australian general practice and primary care.[1] Among their findings was that 'practice determined organisation of quality management, using targeted feedback to healthcare workers with supported reflection' may improve effectiveness, capability, safety, responsiveness and efficiency. This is a more organised way of expressing what has been a grassroots development at our practice.

At the time this idea arose, the practice's clinical team of five doctors and two nurses had already established a high degree of trust through weekly clinical meetings that focused on critical incidents and near misses. This was a 'level playing field' with both senior and junior doctors equally raising problems and solutions. Over a few months all practitioners had contributed, and we had developed a positive culture of support including implementing changes where necessary. Issues discussed included misreading of pathology reports, delayed receipt of important results, diagnostic delays, and inadvertent breaches of privacy. In many cases, one doctor's adverse experience had already been experienced by another practitioner and shared experiences and solutions were considered. After discussion, the proposal was that we

develop an annual review encompassing: professional behaviour, ie. how competent and safe are we as individual doctors; employment behaviour, ie. how do we fit into the practice team; and ideas for change, eg. self improvement and team improvement.

From the outset we felt that one rule should apply and that all doctors should be assessed in the same way. This process is still evolving and one decision that has been implemented informally, but not yet formally, is that participation in this quality assurance process will be a term of engagement for employee or contracted GPs, and a term of associate membership for practice owners. At this stage we have not had to enact any remedial action. Our doctors are keen to report back from year-to-year, eg. a low yield of endocervical cells by one practitioner led to participation in an education activity on taking Pap smears.

An initial list of desirable behaviour was drawn up, analogous to the standards expected of our nonclinical staff.

- General: attendance and punctuality; courteous treatment and relationships with practice support and administrative staff; and professional demeanour and presentation
- Professional care and continuity of care
  - each doctor carries professional responsibility for actions in consultations with patients
  - compliance with in-house protocols for coding incoming pathology and radiology, including abnormal tests and follow up
  - where any doctor carries out tests on the patient of another doctor, clear steps must be taken to ensure follow up
  - participation in internal clinical and staff meetings.

At this time the Medical Practitioners Board of Victoria[2] published a checklist of doctor behaviour within the domains of professional practice (*Table 1*). This summary seemed ideal as a starting point. Once we started discussing this within the group, many other sources of information were recognised as likely to contribute usefully to the holistic appraisal of doctor performance within our practice. These included:

- Medicare Item number usage and billing profile. Review of the Medicare and internal billing data might disclose unusual patterns of item number usage. It would also show doctors' utilisation of the nurses' skills (eg. Team Care Arrangements)
- National Prescribing Service data might show consistently unusual patterns of prescribing
- Victorian Cytology Registry data would indicate any systemic performance problems (eg. low yield of endocervical cells from a Pap smear)
- use of Schedule 8 drugs (including doctor's drug books) and permits to prescribe (eg. how many in use, clearly recorded on patients files, how appropriate).

In the data listed, deviations from norms are common as individual practices vary greatly. The important point was that the process would enable each of us to recognise our practice patterns and discuss this with colleagues. There was no expectation that we should change our practices – unless on reflection or discussion there were areas felt to be inappropriate. For example, a busy doctor may have forgotten to apply

Table 1. Medical Practitioners Board of Victoria Classification Framework

Clinical care
Inadequate examination or assessment
Wrong, delayed or missed diagnosis
Inappropriate clinical management • Failure to investigate/inappropriate investigation • Failure to refer/inappropriate referral • Inappropriate treatment/failure to institute treatment • Insufficient information or advice
Inadequate follow up/failure to review
Poor outcome
Prescribing • Overprescribing • Known allergy • Inappropriate drug use • Doctor dispensing inappropriately
Cosmetic treatment
• Inadequate examination or assessment • Inappropriate or wrong treatment • Inadequate follow up • Failure to obtain informed consent
Conduct or behaviour
Doctor's manner • Rudeness, arrogance • Dismissiveness, impatience/lack of compassion • Inappropriate behaviour • Abuse of patients/relatives • Abuse of staff
Examinations • Rough or painful examination • Inappropriate/unnecessary • Inappropriate or intrusive questioning or comments • Discrimination or bias • Harassment (not sexual) • Intoxicated/drug affected/incapacitated
Ethics • Breach of confidentiality • Failure to obtain informed consent/other issues relating to consent • Failure to provide assistance in an emergency • Refusal to treat • Unethical prescribing • Falsifying records • Biased opinions • Breach of Medical Practitioners Board of Victoria imposed conditions

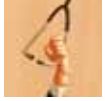

Table 1. (continued)

Sexual misconduct
• Serious sexual misconduct
• Sexual assault, sexual relationship with a patient
• Sexual impropriety: inappropriate comments, unnecessary/inappropriate examination, discomfort (inadvertently offensive)
Personal conduct outside the patient-doctor setting
• Sexual harassment of staff or colleagues
• Other inappropriate behaviour
Practice management
• Breach of infection control procedures
• Unsafe conditions
• Complaints about staff
• Lack of availability of service
• Refusal to attend
• Failure to record, convey or respond to messages
• Failure to follow up abnormal results
• Complaints about billing
• Lack of privacy (physical examination): screens, gowns/covering, other
Medical reports, medical records, certificates
• Medical certificates: inaccurate, invalid or improper
• Inadequate or inaccurate medical records
• Failure to transfer medical records or information
• Medical reports: inaccurate/inadequate/delay
• Failure to provide
Offences
• Overservicing
• Medicare billing offences
• Fraud
• Drugs and poisons offences
• Indictable offences
Other
• Referred to other agencies
• Health Services Commissioner
• Medicare Australia
• Victorian Workcover Authority
• Not within jurisdiction of the Medical Practitioners Board of Victoria

for Schedule 8 permits, or may have got into the habit of not keeping up with medical record keeping.

The process

As all members of the medical team were to be treated equally in this process we considered various options, and chose a simple round-robin where names are pulled out of a hat, eg. A is reviewed by B and C, B by C and D. The practice manager is then asked to arrange the timetable, and collate the documents for each doctor for their self appraisal, and for the reviewers. All nominated sources of doctor performance data are collected. The practice manager already confirms the doctors' registrations and insurance annually. In addition, the practice manager now prepares a confidential staff questionnaire inviting receptionists to provide feedback on doctors' performance from their unique perspective. Other data could be easily generated in-house such as patterns of utilisation of Medicare Item numbers. Preparation for each meeting takes up to 1 hour, including the reviewer selecting five medical records of patients managed by the reviewee over the previous period. These records are assessed for compliance with practice accreditation criteria. A 1 hour time slot is set aside with no interruptions for each meeting. One of the reviewers chairs the meeting, and the other takes minutes and prepares a short report.

Doctors' comments include: 'I value the opportunity for reflection on my performance and input from my peers on my progress'; 'The process enables us to reflect on our professional conduct and through the collaborative yet honest approach enable a degree of spring cleaning and then goal setting to improve in areas of weakness or vulnerability that need change or strengthening'; and 'The peer review process has been constructive and we see it as a safe, supportive forum to identify areas of our practice where there is room for improvement and confirm areas where we are performing well'.

As the practice approaches its fourth annual appraisal, we are confident about the process and regard it as embedded in our practice culture. To date we have not included our two practice nurses in the appraisal process, but that will be our next important step. It is a process where trust and goodwill are paramount, and one of the ways this is protected is ensuring that senior doctors or associates are not treated differently from junior doctors. Common sense applies in performance expectations, such as an experienced doctor might have a billing profile that is skewed toward a particular interest. With the process open to scrutiny we expect to detect any serious deviations at an early stage.

Key points

- Commitment and contribution to a regular meeting of the clinical team to review critical incidents and near misses leads to a high level of trust.
- A round-robin peer review process ensures that both senior and junior doctors are fairly appraised.
- This type of activity falls within the scope of quality improvement in general practice.

Author

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References

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