Consider Physician Assessment Programs as Alternative to Peer Review

Suppose you have concerns about the abilities of a physician on your medical staff or provider panel? You can have your peer review committee examine her patients’ medical records, hire an outside reviewer to do the same, or have a physician in her specialty follow her around for a day and observe her practice. But although these methods of peer review are often effective, you may sometimes deal with physicians who need more intense scrutiny.

Since the mid-1980s, several physician assessment programs have provided an alternative to peer review. Though the programs differ in some ways, in general they offer more in-depth scrutiny of a physician’s capabilities, strengths, and weaknesses, and most offer education programs to upgrade knowledge and skills. Health care organizations often use an assessment program to replace or augment peer review, or to credential applicants who have recently changed specialties or are returning to practice after taking time off.

To help you decide whether a physician assessment program is for you, and if so, which one best suits your needs, we’ll describe six programs available across the country. We’ll also compare important facets of the programs, such as their approaches for assessing competence.

Advantages of a Physician Assessment Program

Physician assessment programs have several advantages over traditional peer review. The programs are:

Unbiased. One major advantage is that the physician assessment is unbiased and not tainted by hospital politics, says Elizabeth J. Korinek of the Center for Personalized Education for Physicians. “I’ve seen several specialists collude to get rid of another specialist in the community by using peer review. But physicians don’t have to worry about the fairness of the process when an organization uses a physician assessment program,” says Dr. William A. Norcross of the Physician Assessment and Clinical Education Program. “This is especially important when the stakes are high, such as when a physician’s license is on the line,” he says.

Interactive. Physician assessment generally gives physicians more opportunity to demonstrate their clinical competence and to explain any educational deficiencies that may be perceived by the health care organization or medical board, says Korinek. “There’s a dialogue between the physician and the assessors. We probe what the physician actually knows, rather than what he has writing down in medical records,” she says. “We get at the breadth and depth of the physician’s knowledge and judgment to help an organization determine
if there are any competency issues, the extent of the problems, and whether it’s worth the resources and effort to try to fix the problems,” Korinek says.

More thorough. Physician assessment generally is more thorough than peer review or medical board review. Medical boards often simply review the “index case”—that is, the patient whose care caused concerns about the physician’s competence. Physician assessment programs generally look at numerous patients when reviewing the physician’s abilities. Also, the physician assessment programs generally look at the whole picture and try to determine whether there are reasons other than competence for problems with the physician’s performance or behavior.

“We base our assessments on the medical model for ‘ruling out’ causes,” says Dr. William D. Grant of the Physician Prescribed Education Program. “For example, we would find out if a misdiagnosis was caused by a physician with hearing problems having not heard a patient describe her symptoms,” he says. “It’s best to intervene and try to get at the root of a physician’s problem as early as possible,” notes Dale Austin of the Institute for Physician Evaluation. “Sometimes, waiting until a physician is before a medical board is too late,” he says.

Is It Worth the Cost?
The programs typically cost about $15,000 for assessment, education, and reassessment (when offered). But the fees can be much higher or lower, depending on: which program you choose; the physician’s specialty; the length of time of the education segment; and the educational activities provided. Health care organizations often require the physician to pay for the program, though sometimes the organization will pay for part or all of the fees.

“Although a physician assessment program can be expensive, it’s a good investment to help a physician become a capable practitioner again,” says Austin. Also, it can help you avoid costly patient lawsuits and challenges by physicians to termination actions.

Who Offers Assessment Programs?
We spoke with representatives of the following six assessment programs. For contact information, see “Insider Sources” at the end of the article. (Brownstone Publishers, Inc. received no payment for reporting about these programs and makes no endorsement of commercial products or services.)

Center for Personalized Education for Physicians (CPEP). CPEP is an independent nonprofit located in Denver.

Institute for Physician Evaluation (IPE). IPE is a division of the Federation of State Medical Boards of the United States, Inc., and operates in partnership with the National Board of Medical Examiners (NBME). IPE has locations in Philadelphia and Dallas, and plans to open one soon in Atlanta.

Oregon Medical Association Physician Evaluation and Education Renewal Program (PEER). PEER reviews only physicians who are currently practicing medicine. It specializes in assessing and educating disruptive physicians, as discussed below.
Physician Assessment and Clinical Education Program (PACE).
PACE is the biggest program in the country, having assessed and educated over 1,000 physicians. It’s affiliated with the University of California at San Diego Medical Center.

Physician Prescribed Education Program (PPEP). PPEP is affiliated with the Upstate Medical University, a component of the State University of New York.

Wisconsin Program for Physician Assessment and Individualized CME. This program is the oldest in the country. It’s affiliated with the University of Wisconsin Medical School.

How Do Programs Assess Abilities?
The programs assess a range of attributes, including medical knowledge, professionalism, clinical judgment and reasoning, data-gathering, case management, documentation, communication, and interpersonal skills. The assessment can take from one to four days of the physician’s time, depending on the program. “Determining competency is an incredibly complex task,” says Norcross. “We use up to five physicians to assess abilities in each case,” notes Korinek.

Here’s a rundown on the main ways programs assess competency:

Medical record review. All the programs, except IPE, use medical record review as part of the assessment. CPEP and PEER devote the most time—PEER reviews from 15 to 20 records, and CPEP about 20. PEER asks the physician to supply records from her 100 most recent patients, and reviews a subset of those. A key component of record review within the programs is discussing the findings with the physician.

“The assessor reviews the records about a week in advance of meeting with the physician,” says Dr. Thomas C. Meyer of the Wisconsin program. “Then they have a detailed discussion—as peers—about why the physician chose to do certain things for that patient at that time,” Meyer says. “Some physicians do well on standardized tests because they have a good knowledge base. But we find out that they don’t apply knowledge or make decisions well when our assessors review their patients’ medical records. We evaluate what physicians say they would do compared to what they actually do in daily practice,” adds Korinek.

The programs strive to match assessors with physicians by specialty and subspecialty. “We refer to the professionals who assess physicians and monitor their education programs as ‘mentors,’” says Dr. Roy Skoglund of PEER. “In addition to considering specialty, we assign mentors from a similar community so the mentor understands the physician’s practice,” he says. Likewise, the Wisconsin program focuses on the nature of the physician’s practice, in addition to the physician’s specialty, when assessing abilities, says Meyer.

“Standardized patient” encounters. All the programs, except PEER, observe physicians as they interview and examine “standardized patients”—individuals who have been trained to act like patients. IPE offers an extra full day of assessment using this approach, during which its physicians see 11 standardized patients. “It’s important to assess whether physicians know how to apply knowledge when they see patients,” notes Grant. Standardized patient encounters also allow the programs to assess communication and interpersonal skills. “We tell physicians how they did with the patients and get feedback from the patients,” says Meyer. “Most medical schools use this tactic for students,” he notes.

Written or computerized tests. The programs (with the exception of PEER) test physicians as if they were in school, sometimes using multiple choice tests, such as those from the NBME. IPE and PACE use standardized tests so they can compare the scores to the national norms. CPEP, PPEP, and the Wisconsin program use tests, but not standardized tests.

“We don’t use the standardized tests because they don’t relate to the physician’s individual practice. We never disclose the scores from the non-standardized tests to anyone, including the physician,” says Meyer. “Rather, we use the tests to stimulate discussion with physicians. We try to make them as relevant as possible to the physician’s specialty and individual practice,” he says.

Clinical interviews. CPEP, IPE, and PACE test physicians orally through clinical interviews. For example, CPEP requires two or three clinical interviews with assessors in the physician’s specialty or subspecialty. “We use over 200 physicians in 32 specialties and subspecialties to assess our physicians,” says Korinek.

PACE sometimes requires a one-hour specialty examination, which is generally oral. “The nature of the examination depends on the physician,” says Norcross. “For example, when the situation dictates, we observe anesthesiologists performing procedures on mannequins and using equipment. But for family practice specialists, the examination is mostly a discussion about hypothetical cases,” he says.

“Cognitive function screenings.” All the programs, except PEER, per-
form a “cognitive function screening,” a test that measures the physician’s brain functions, such as memory and abstract thinking. If the screening identifies a potential problem, such as dementia, the programs recommend that the physician see a specialist, such as a neurologist. Some programs look at problems related to disruptive behavior, rather than at competence. For example, you may have a physician who disrupts your organization’s operations by yelling, using inappropriate language, or even assaulting patients or staff. There are myriad behaviors that are considered “disruptive” by the medical community. (For more information about dealing with disruptive physicians, see “How to Properly Ban Disruptive Conduct in Your Bylaws,” Insider, July 2002, p. 1.) Sometimes physicians don’t maintain appropriate professional boundaries. For example, they may make inappropriate sexual comments to patients or staff.

IPE, PPEP, and the Wisconsin program don’t provide services to physicians who are disruptive or who don’t respect boundaries. But PACE takes these physicians, and PEER specializes in disruptive physicians. PEER also assesses physicians who have problems recognizing boundaries, and CPEP assesses physicians who have problems with disruptive behavior or boundaries—as long as there are competency problems also.

“Behavioral issues often arise when there are performance problems,” notes Skoglund. “Sometimes it’s hard to determine which came first,” he says. PEER conducts interviews at the physician’s organization to evaluate the degree to which the physician is disruptive. “We look for consistent reports about a physician’s behavior to determine whether it’s problematic,” Skoglund says. PEER also has a psychiatrist who assesses and treats physicians.

PACE has separate assessment programs for disruptive physicians and those with boundary problems. The Professional Boundaries Program is a three-day program that focuses on small group exercises such as role playing, rather than lectures. It includes one year of follow-up for support. “We examine the physician’s beliefs, values, and experiences to determine their impact on behavior,” says Norcross. “We see from the experience of our graduates that an over-emphasis on work and on medical and technical skills has left blind spots for many of them in terms of interpersonal skills,” says program co-facilitator Dr. William Sieber. “We try to increase our physicians’ understanding of their patients to navigate the very emotionally laden doctor-patient relationship,” he says.

**Insider Says:** In a future issue of the *Insider*, we’ll tell you about the education and reassessment portions of these physician assessment programs. We’ll also explain how the programs compare in cost.

**Insider Sources**

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JCAHO Clarifies H&P Requirements

As part of its 2004 hospital standards, JCAHO clarified its policy regarding histories and physicals (H&Ps) [MS.2.10]. The new standard sets tighter rules for medical staff responsibilities, but gives hospitals more discretion regarding physician “endorsement,” says medical staff consultant Sheryl Deutsch.

The medical staff has long been responsible for the quality of H&Ps. Under the new standard, the medical staff must specify the minimal content of H&Ps, which may vary by setting or level of care, treatment, and services. So an H&P for an elderly patient admitted to the ICU will differ from an H&P for a woman in labor.

Second, JCAHO now requires medical staff to monitor the quality of H&Ps. They can do this during medical record audits, says Deutsch. Audit results, both positive and negative, may be shared with physicians as problems arise and at reappointment.

Third, the medical staff must define when a licensed independent practitioner (LIP) must validate and countersign an H&P. “Although it makes more sense for this section to apply to H&Ps performed by non-LIPs who are eligible to do so under state law and hospital policy, JCAHO doesn’t rule out LIPs overseeing H&Ps performed by other LIPs,” notes Deutsch. “For example, a hospital may decide to have physicians validate and countersign all H&Ps performed by nurse-midwives, even though the nurse-midwives are LIPs in that facility,” she says.

Last, JCAHO deleted the requirement that physicians “endorse”—that is, approve—findings, conclusions, and assessments of risk before major high-risk diagnostic or therapeutic interventions. This deletion may not be significant, though, because JCAHO still may expect hospitals to be extra cautious when treating high-risk patients, says Deutsch. “Should a hospital fail to adequately assess risk before a high-risk intervention, JCAHO still could cite it under EP#6, which requires medical staffs to set ‘minimal content’ of H&Ps,” she notes. Hospitals that think physician endorsement is a good idea certainly should continue the practice, Deutsch adds.

Insider Source
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Get Ready for Federal Initiative to Register Practitioners for Disaster Assistance

To promote emergency preparedness, the federal government is working with the states, territories, and other jurisdictions to establish an “Emergency System for Advanced Registration of Volunteer Health Care Personnel” (ESAR-VHP). Each state has a “bioterrorism hospital preparedness coordinator,” who will be responsible for a database of volunteer physicians and other health care personnel. The actual data elements have yet to be identified but are likely to include credentialing and core privileging information about the health care personnel.

The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services is spearheading the initiative. “We won’t be credentialing or privileging practitioners on our own,” says Rick Smith, director of the Division of Health Care Emergency Preparedness at HRSA. “Rather, the states will be collecting information from other sources, such as state licensing boards, so information can be shared in a quick and systematic way,” he says.

But the system won’t work unless physicians and other practitioners volunteer. We’ll tell you what HRSA is planning, and what you can do to promote the initiative, which will make it easier to accept assistance from practitioners during a disaster.

How Will Databases Work?
HRSA hopes to improve and build on the current system under which many states have their own initiatives for dealing with practitioners volunteering during a disaster. One of the goals is to improve coordination among states during a disaster. Under the HRSA system, state health departments will operate the databases. But the state databases will be...
compatible, so different states will be able to share information under interstate or regional agreements, says Smith. “The goal is to have information available to hospitals in a time of crisis,” he says. “In September 2001, numerous practitioners went to New York hospitals to help out, but the hospitals couldn’t verify their qualifications,” Smith adds.

HRSA’s next step is to create a data-entry template for states to use when they set up their databases. The template will have required fields, such as board certification, but states will be allowed to add fields. “Our contractor will conduct pilot projects in several states. By January 2005, we expect the template to be ready,” says Smith.

Ultimately, HRSA must address other issues besides the scope of the information to be collected. For example, it must decide how hospitals will verify that an individual who volunteers at the hospital is the practitioner who’s listed in the database.

How HRSA’s Credentialing Requirements Differ from JCAHO’s

JCAHO set standards in 2002 for verifying credentials and granting privileges during and after a disaster [MS.5.14.4.1]. (For more information about the JCAHO standards, see “Write Flexible Disaster Policy to Allow for Best Privileging Under the Circumstances,” Insider, Feb. 2003, p. 1.) For example, under JCAHO standards a hospital may allow a physician to treat patients after checking her hospital photo ID. While the physician treats patients, the hospital must check hospital affiliation, licensure, OIG sanctions, and NPDB status through telephone and Internet communications with various primary sources.

ESAR-VHP will make it possible to go to one place to get the credentialing and privileging information necessary to allow a physician to treat patients during a disaster. It will be much simpler than the process developed by JCAHO as a stopgap measure.

Explain Initiative to Physicians to Encourage Volunteering

While HRSA is setting up its program, you can educate your physicians and other practitioners about the initiative. If you start early, you can make sure that they volunteer at the earliest possible date. That way, you’ll assist your community in preparing for a disaster. To keep apprised of HRSA’s progress, periodically check its Web page on bioterrorism and emergency preparedness at www.hrsa.gov/bioterrorism.htm. Also, next year, after HRSA has instructed states on how to set up databases, your state hospital or medical association may have information about your state’s status.

Insider Source

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Advise Physicians to Review and Sign Applications

Advise physicians to review applications and reapplications for your medical staff or provider panel for accuracy and completeness before submitting them, says Pittsburgh attorney Dan Mulholland. Also, tell them to sign the forms themselves, instead of relying on a staff member to sign for them. Although it’s better for physicians to fill out the applications and reapplications on their own, it’s difficult to persuade some physicians to take the time, notes medical staff consultant Christina W. Giles. When a physician asks a staff member to fill out the application, but doesn’t carefully review it, the application may be inaccurate or incomplete. You may decide to deny him or her privileges because of the mistake.

For example, the staff member may have left out a suspension of privileges at another facility. “Organizations aren’t usually sympathetic to the excuse ‘my office manager forgot to put it on the application and I never read it,’” says Austin attorney Joanne P. Hopkins. “An organization should hold the physician accountable for the application, though it may decide that the mistake is too minor to justify a denial,” adds Mulholland.

Some physicians may not realize that it’s necessary to sign the application in addition to reviewing it. But it’s important to do both, says Giles. By signing the application, the physician attests to its accuracy and truthfulness. “And he gives you his official signature for your files,” says Hopkins.
Peer Review Privilege Doesn’t Protect Documents Prepared for Litigation

After a patient’s death, the chairperson of an Illinois hospital’s “risk management committee” told the risk manager to prepare a document called the “Patient Safety Digest Professional Peer Review Occurrence Summary.” The risk manager also wrote four memorandums to the committee, describing her interviews with hospital physicians about the incident. The occurrence summary concluded that “the risk of litigation is high.” Each of the four memorandums began with the statement: “You have asked me to review the care of [the patient] to identify any issues of liability or potential patient safety.”

The patient’s family member sued the hospital for negligence and asked for those documents. The hospital refused to release them, claiming that they were protected by the state peer review law, which encourages self-evaluation by members of the medical profession. The risk manager swore in affidavits that the risk management committee’s purpose was to improve safety and quality of care, not to evaluate litigation risks. She explained that hospital attorneys had advised her to include the statements about liability for purposes of keeping the memorandums confidential. She also said that the attorneys never saw the documents, which were kept separate from litigation files.

The court ordered the hospital to release the documents because it wasn’t clear that the risk manager had prepared them for peer review, rather than for litigation. The court was bothered by an inconsistency in the affidavits—in one, the risk manager said that she’d given the memorandums to the committee, but in another she said that she’d given them to nobody. Also, the hospital couldn’t prove that the risk manager created the documents during the peer review process, because it didn’t have committee minutes and couldn’t otherwise prove when the process took place [Webb v. Mount Sinai Hosp. and Med. Ctr. of Chicago, Inc.].

Court Upholds Physician’s License Revocation for Consensual Sex with Patients

After receiving a complaint from a physician’s former patient, a Maryland regulatory board found that the physician had consensual sexual relationships with three patients, sometimes concurrently, during a five-year period. In one case, the physician, a family practitioner, repeatedly called the patient at home, at first to give her medical test results. In another case, he initiated the relationship after learning from the patient’s husband, also his patient, that the husband would be out of town on business.

The physician cohabited with one of the patients and her children and became engaged to her. During this time period, the patient attempted suicide, and the physician treated her at the hospital and afterwards. The physician treated the other two patients for emotional difficulties and anxiety, respectively, in addition to other medical problems. He asked all three patients to bear his child, counseling two of them to reverse tubal ligations and the third to seek infertility treatment.

The state board revoked the physician’s medical license because of “immoral or unprofessional conduct in the practice of medicine,” barring reapplication for three years. The physician appealed through the various levels of the Maryland court system until his case reached the state’s highest court. That court, too, upheld the revocation. It rejected the physician’s argument that his actions weren’t “in the practice of medicine” because he wasn’t “on duty” when he had sex with his patients. The physician used his position of power to “prey on his emotionally vulnerable female patients” and abused their trust. Also, he lost objectivity as a physician, sometimes prescribing care based solely on his own interests, such as when he recommended treatment related to procreation [Finucan Jr. v. Maryland Bd. of Physician Quality Assurance].

Show Your Lawyer

For more information about the cases and/or laws referred to in this issue, show your lawyer the legal citations listed below.


Many hospitals are setting up credentialing Web sites to save resources. Instead of sending reference letters about a particular physician when requested by hospitals and health plans, they’re routinely putting the information on the Internet, even if they haven’t received any reference requests. Generally, the information posted on a Web site tells credentialing officials that a physician is in good standing, and identifies his or her department and dates of affiliation with the hospital.

Although not having to send reference letters will ease your administrative burden, posting information on a Web site raises privacy concerns. Normally, before you send a reference letter to a health care organization that’s credentialing a physician on your staff, you ask the physician to sign a release. Or the organization that’s credentialing the physician sends you a copy of the release the physician signed as part of the credentialing application. In the release, physicians typically agree to let you give the confidential information to the other health care organizations.

But when you post information on a Web site, you don’t know ahead of time which organizations will be visiting the site, so you can’t write a specific release. The best solution to protect privacy in this situation is to get physicians to sign a general release related to information on your Web site. We’ll explain how to use a general release, and give you Model Language for it.

Ask Physicians to Sign General Release
It’s hard to use specific releases when posting information on the Internet. When you give information in response to an individual request, you can tailor the release to the request, and the physician knows precisely who will have access to the information. A specific release is your best defense against charges by a physician that you violated his or her privacy. But that doesn’t work when your information is online and open to the public.

Asking physicians to sign a general release covering everybody who accesses your Web site is the best alternative, says health care attorney Bob Hoban. You also should give the physicians an opportunity to review for accuracy the information you’re planning to post. That way, at least you’ll give them notice of the credentialing system and a chance to object to any inaccurate information. If you restrict access to the Web site to certain health care organizations through a password system, you should list the organizations in the release to give physicians as much information as possible about the information you’re posting, notes Hoban.

What Release Should Say
With Hoban’s help, we’ve suggested language for a general release. The release pertains to a Web site with unrestricted access, but you may adapt it for a restricted site. Consult your attorney before you use or adapt this language.

Model Language
I authorize XYZ Hospital to post truthful information about my affiliation with the hospital on its credentialing Web site. I acknowledge that I have read the information XYZ Hospital intends to post and agree that it is accurate. I understand that the public will have access to this information.

Insider Source
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