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Rethinking Peer Review: Detecting and Addressing Medical Malpractice Claims Risk

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A medical center department chair has just been notified that a physician in his department, "Dr. G," is being sued for the fifth time in seven years. The CEO of co-defendant hospital wants the chair to solve Dr. G's "claims problems." At the chair's request, the hospital peer review committee evaluates Dr. G's malpractice cases. While committee members note some minor concerns in the cases, they conclude that in each circumstance he has met the standard of care. They cannot identify any specific technical or educational need, nor can they supply justification for a disciplinary action.

The chair is in a vexing situation. Is Dr. G. the victim of bad luck, or is something more systematic at work? Is there some failure or deficiency other than technical incompetence which is making this physician vulnerable to malpractice suits? If so, is it remediable?

In this Article, we analyze the ability of peer review to recognize and reduce physicians' risk of medical malpractice claims. Critics argue that peer review neither consistently identifies substandard physicians, nor ensures their removal, while it unfairly targets colleagues for reasons such as economic competition. They suggest that the solution may be to modify statutes governing privilege and immunity, or to increase penalties for healthcare institutions that violate reporting statutes. Critics' concerns may be misplaced. We will argue that peer review is not deficient in its basic conception, but rather aspects of its design and implementation which often do not directly link it to an institution's risk management activities. We assert that peer review can effectively identify a physician's risk of generating a disproportionate share of medical malpractice claims *ex ante*, and present a sample methodology which allows peer review to more effectively help physicians address that risk.

Part I of this Article discusses the background and authority for peer review. Part II outlines common criticisms of peer review and discusses shortcomings in these analyses. Part III describes background medical malpractice research and introduces the Patient Advocacy Reporting System ("PARSSSM") program for peer review. In Part IV we conclude with a discussion of programmatic elements which, if incorporated into the legal framework for peer review, may allow peer review committees to systematically evaluate, monitor, and, potentially reduce physicians' medical malpractice claims risk.

I. BACKGROUND OF PEER REVIEW

A. Traditional Peer Review

“Peer review” is a generic term representing a range of processes established by hospitals, medical groups, and other health care entities to ensure qualified and competent medical staff and quality care.³ Three premises underlie traditional peer review. The first premise is that due to their unique and specialized training, only physicians can properly evaluate and judge other physicians’ medical practices and detect when colleagues pose a risk to patient care.⁴ The second premise is that a milieu supporting candid communication is most likely to foster recognition of both exemplary and substandard care.⁵ The third premise is that peer review participants are motivated to maintain high standards of care in their group or institution and act in good faith.⁶

The idea of peers reviewing each other as a quality control measure would appear to have several advantages.⁷ Peer review offers an incentive for similarly trained physicians working in the same environment to identify colleagues with knowledge gaps or deficiencies in technical skills, facilitate their remediation, and monitor their progress and performance, in preference to external

3. See Kenneth R. Kohlberg, *The Medical Peer Review Privilege: A Linchpin for Patient Safety Measures*, 86 MASS. L. REV. 157, 157 (2002) (“Peer review is a process by which physicians analyze critically the medical services performed by their colleagues for the purpose of decreasing instances of medical malpractice.”); see also David L. Fine, *The Medical Peer Review Privilege in Massachusetts: A Necessary Quality Control Measure or an Ineffective Obstruction of Equitable Redress?*, 38 SUFFOLK U. L. REV. 811, 811–13 (2005) (discussing peer review as a tool to reduce medical error); George E. Newton, Commentary, *Maintaining the Balance: Reconciling the Social and Judicial Costs of Medical Peer Review Protection*, 52 ALA. L. REV. 723, 723 (2001) (“Medical peer review is a process by which physicians evaluate the quality of work performed by their colleagues for the purpose of determining compliance with appropriate standards of health care.”).

4. Newton, *supra* note 3, at 723.

5. See, e.g., TENN. CODE ANN. § 63-6-219(b)(1) (2005) (“to candidly, conscientiously, and objectively . . . review their peers’ professional conduct, competence, and ability to practice medicine. Tennessee further recognizes that confidentiality is essential . . .”).

6. ATUL GAWANDE, *COMPLICATIONS: A SURGEON’S NOTES ON AN IMPERFECT SCIENCE* 57–62 (2002) (stating that surgeons take weekly Mortality and Morbidity conferences seriously, and that case review raises awareness and improves the ability to anticipate and head off problems). *But see* Susan O. Scheutzow, *State Medical Peer Review: High Cost But No Benefit-Is it Time for a Change?*, 25 AM. J.L. & MED. 7, 26 (1999) (discussing how physicians have little incentive to conduct effective peer review except as required to maintain hospital privileges).

7. See, e.g., Newton, *supra* note 3, at 723 (“The fundamental rationale behind the peer review process is efficiency. . .”).

parties assuming this responsibility.⁸ In addition, when serious problems are identified, appropriate steps can be taken to limit doctors' contact with patients well before government agencies are involved or can act.⁹ Peer review may also lead physicians to seek and accept help for medical, psychiatric, or impairment issues. Finally, peer review groups can promptly refer safety and quality issues they identify to committees or authorities empowered to address them within an institution.¹⁰

B. The Statutory Scheme

One mechanism by which the medical community has attempted to address the problem of substandard medical care¹¹ is institutionalized peer review. The first peer review efforts were voluntary in nature and established by medical professionals.¹² Recognizing that frank and open discussion of quality and safety problems is critical for improving care, Congress and most state legislatures in the 1980s and 1990s enacted statutes to encourage the process by minimizing the risk that participants in peer review activities would later be subject to litigation for those very activities. State statutory schemes grant differing levels of protection to peer review, but they all incorporate at least one of three types of protection:¹³ (1) immunity from liability; (2) evidentiary privilege for

8. See, e.g., CAL. BUS. & PROF. CODE § 809(a)(7) (2006) ("It is the intent of the Legislature that peer review . . . be done . . . with an emphasis on early detection of potential quality problems and resolutions through informal educational interventions."); see James R. Jensen, *Medical Staff Peer Review – A Peek Behind the Veil*, RISK MANAGEMENT REPORTS, May 1998, at 1 (stating that peer review should not be performed by physicians in the same clinical setting so personal relationships do not interfere with ability to perform the review properly); Fine, *supra* note 3, at 829 (using Amtrak and USDA as examples, suggests supplanting peer review statutes with third party review).

9. See, e.g., JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS., COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS: THE OFFICIAL HANDBOOK 2005, Standard MS.1.20, 12–13 (addressing suspension of privileges or medical staff membership, and the procedures to accomplish this).

10. See, e.g., H.H. McGuire et al., *Measuring and Managing Quality of Surgery. Statistical vs. Incidental Approaches*, 127 ARCHIVES OF SURGERY 733, 736 (1992) (suggesting tactics to maximize patient safety and minimize error).

11. Kohlberg, *supra* note 3, at 157.

12. See Scheutzow, *supra* note 6, at 12–13 & n.39 (citing Murray G. Savsgeen & Jennifer L. Thompson, *The Evolution of Medical Peer Review in North Dakota*, 73 N.D. L. REV. 477, 478 (1997)) (discussing how several professional healthcare associations joined together to establish the Joint Commission on Accreditation of Hospitals (JCAHO) which required, as an accreditation standard, that hospital medical staffs implement uniform peer review guidelines for new and current medical staff).

13. *Id.* at 27 & n.152 (discussing the spectrum and frequency of state statutory schemes and listing state peer review laws). See also OHIO REV. CODE ANN. 2305.25(E)(1), (2) (West 2006)

documents furnished,¹⁴ utilized, or created;¹⁵ and (3) denial of access to documents for third parties for extra-judicial purposes.¹⁶ The statutes generally provide that peer review is protected only if it is conducted in good faith.¹⁷

Congress took a role in promoting professional peer review by enacting the Health Care Quality Improvement Act of 1986 (“HCQIA”).¹⁸ HCQIA immunizes peer review participants from liability for damages,¹⁹ but does not grant an evidentiary privilege.²⁰ Peer review must be conducted in good faith and meet minimum requirements for due process in order for federal immunity to attach.²¹

(defining peer review committees and listing included types); Fine, *supra* note 3, at 814–15 (stating that a lack of uniformity among state statutes and application by federal courts creates conflicting results); Lisa M. Nijm, *Pitfalls of Peer Review: The Limited Protection of State and Federal Peer Review Law for Physicians*, 24 J. LEGAL MED. 541, 547 n.44, 549 n.54 (2003) (listing state peer review statutes with privilege provisions and state statutes with immunity protection).

14. See, e.g., ALA. CODE § 6-5-333(d) (2006) (protecting “[a]ll information, interviews, reports, statements, or memoranda furnished to any committee [under (b)]”); see also *Marshall v. Planz*, 145 F.Supp.2d 1258, 1264–67 (M.D. Ala. 2001) (holding that privilege covers a communication to a peer review committee by a non-committee member); Gail N. Friend et al., *The New Rules of Show and Tell: Identifying and Protecting the Peer Review and Medical Committee Privileges*, 49 BAYLOR L. REV. 607, 609–43 (1997) (examining the expansive scope of the privilege conferred by TEX. REV. CIV. STAT. ANN. art. 4495b, § 5.06 and TEX. HEALTH & SAFETY CODE ANN. § 161.032). But see *Newton*, *supra* note 3, at 731 (explaining that “original source” documents, even if utilized by peer review committees, are still discoverable).

15. Fine, *supra* note 3, at 824.

16. Nijm, *supra* note 13, at 548 n.50 (listing 13 states which do not address the issue of confidentiality); see also Scheutzwow, *supra* note 6, at 53–54 & n.352 (stating that confidentiality statutes do not have the effect of denying plaintiffs access to information in the absence of a privilege statute).

17. Scheutzwow, *supra* note 6, at 30 & n.183. See, e.g., CAL. BUS. & PROF. CODE § 809(a)(3) (West 2006) (“peer review, fairly conducted, preserves . . . [the] highest standards of medical practice”); see also *Marshall v. Planz*, 145 F.Supp.2d 1258, 1270–72 (finding that ALA. CODE § 6-5-333(a) requires peer review action to be done without malice to preserve immunity, but (d) does not require good faith to preserve evidentiary privilege).

18. 42 U.S.C. § 11101 (2006). Under § 11115(a), HCQIA will not preempt states’ programs with greater immunities than the federal law provides. See, e.g., CAL. BUS. & PROF. CODE § 809 (West 2006) (California’s opt out provision).

19. 42 U.S.C. § 11111(a)(1)-(2) (2006). However, civil rights violations are not protected under this immunity clause. *Id.* § 11111(a)(1).

20. See, e.g., *Virmani v. Novant Health Inc.*, 259 F.3d 284, 291–92 (7th Cir. 2001) (declining to recognize a privilege under the HCQIA); *Mattice v. Mem’l Hosp. of South Bend*, 203 F.R.D. 381, 385–86 (N.D. Ind. 2001) (finding peer review materials discoverable and weighing state interests in peer review privilege against interests protected by federal anti-discrimination laws); Alissa M. Bassler, Comment, *Federal Law Should Keep Pace with States and Recognize a Medical Peer Review Privilege*, 39 IDAHO L. REV. 689, 707–12 (2003) (arguing U.S. Supreme Court’s application in *Jaffee v. Redmond*, 518 U.S. 1 (1996), of the “reason and experience” clause of FED. R. EVID. 501 should be extended to recognition of peer review activity).

21. See 42 U.S.C. § 11112(a) (2006) (setting forth four federal immunity prerequisites: belief that the review furthered the quality of healthcare; good-faith effort to obtain the facts; reviewed physician given adequate notice and afforded due process; hospital had reasonable belief action

In the preface to HCQIA, Congress states that it found a pattern of incompetent physicians moving from state to state without disclosure of their past history.²² To address this particular gap, HCQIA established the National Practitioner Databank ("NPDB"), a central repository for mandatory reports from hospitals regarding disciplinary actions involving curtailment, suspension, or revocation of privileges.²³ All malpractice payments made on behalf of a physician named in a lawsuit must also be reported to the NPDB.²⁴ Credentialing bodies are required to check the NPDB database before granting privileges to physicians or re-appointing them.²⁵ Reports made to the NPDB are confidential, and access is restricted to licensing boards, health care entities, and involved practitioners.²⁶

C. Private Standard Setting

Peer review is closely connected with a more general concept of regulation that relies on private standard setting.²⁷ In the case of peer review, much of this private standard setting is performed by private

was warranted); Scheutzow, *supra* note 6, at 32 & n.197 (stating that failure to satisfy HCQIA's due process requirement is sufficient to prevent federal immunity, but claims of bad faith are immaterial to a § 11112(a) inquiry (citing *Mathews v. Lancaster Gen. Hosp.*, 87 F.3d 624, 635 (3d Cir. 1996); *Bryan v. Holmes Reg'l Med. Ctr.*, 33 F.3d 1318, 1335 (11th Cir. 1994); *Austin v. McNamara*, 979 F.2d 728, 733 (9th Cir. 1992))).

22. 42 U.S.C. § 11101(2) (2006).

23. See Scheutzow, *supra* note 6, at 35–57 (providing evidence for under-reporting of adverse disciplinary actions).

24. 42 U.S.C. § 11131(a)-(b) (2006). See Phyllis Maguire, *New Data Bank Casts Wider Net*, ACP-ASIM OBSERVER, Jan. 1999, <http://www.acponline.org/shell/cgi/printhappy.pl/journals/news/jan99/databank.htm> (noting that "corporate loophole" malpractice payment reporting is circumvented if the physician is dropped as a named defendant when the health plan, medical group, or hospital makes a settlement payment. If the NPDB report contains incomplete information about the circumstances of an incident, the doctor who settles but is not at fault may have trouble getting insurance or obtaining privileges.); see also Lawrence E. Smarr, *A Comparative Assessment of the PIAA Data Sharing Project and the National Practitioner Data Bank: Policy, Purpose, and Application*, 60 LAW & CONTEMP. PROBS. 59, 60 (1997) (stating that the NPDB does not screen reports, so payments are not necessarily indicative of negligence).

25. 42 U.S.C. § 11135(a) (2006).

26. *Id.* § 11137(b)(1).

27. See Robert D. Cooter, *Decentralized Law for a Complex Economy: The Structural Approach to Adjudicating the New Law Merchant*, 144 U. PA. L. REV. 1643, 1649–50 (1996) (explaining how norms generated within civil society become informally codified by private institutions and serve as standards for the relevant parties; norms may be incorporated into the legal system by serving as sources of common law decisions or templates for positive enactments by statute or regulation); see also John P. Marren et al., *The Hospital Board at Risk and the Need to Restructure the Relationship with the Medical Staff: Bylaws, Peer Review and Related Solutions*, 12 ANNALS HEALTH L. 179, 206 (2004) (discussing JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS., COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS: THE OFFICIAL HANDBOOK 2002, Med. Staff Standard 2, at MS-3e). The Accreditation Manual is consistent with the case law of *Darling, Johnson*, and *Siqueira*. See *infra* note 32.

organizations, including the American Medical Association (“AMA”)²⁸ and the Joint Commission on Accreditation of Healthcare Organizations (“JCAHO”).²⁹ Institutional accreditation by JCAHO has become so widely accepted and desired that compliance with its standards is considered a measurement of quality.³⁰

For standard setting to be effective, a healthcare facility’s governing board must endorse standards and enforce them.³¹ Hospital governing boards generally delegate peer review to the medical staff, but are ultimately accountable for the quality of care.³² By-laws delineate an institution’s procedures for imposing discipline including curtailment, suspension, or revocation of physicians’ privileges.

28. See Philip L. Merkel, *Physicians Policing Physicians: The Development of Peer Review Law at California Hospitals*, 38 U.S.F. L. REV. 301, 308 (2004) (noting that the California Medical Association annotated Model Medical Staff Bylaws use federal and state requirements and JCAHO standards as a model for medical staff bylaws); see also AMA Code of Medical Ethics, Ethical Opinion E-4.07, E-9.10 (due process requirements), Policy H-230.989 (goal of peer review is patient safety and quality), H-225.992, H-230.989, H-375.983, H-375.997, H-375.984 (peer review is an ethical obligation). The AMA proposes to incorporate into its policy the Massachusetts Medical Society’s “Model Principles for Incident-Based Peer Review for Health Care Facilities,” which support remediation over punitive measures and transparent safeguards for a fair process. See AMA, REPORT OF THE BOARD OF TRUSTEES 17-I-04, PRINCIPLES FOR INCIDENT-BASED PEER REVIEW AND DISCIPLINING AT HEALTH CARE FACILITIES 1, available at <http://www.ama-assn.org/ama1/pub/upload/mm/465/bot17i04.rtf> (discussing the benefits of adopting the Massachusetts Medical Society’s Model Principles); MASS. MED. SOC’Y, MODEL PRINCIPLES FOR INCIDENT-BASED PEER REVIEW FOR HEALTH CARE FACILITIES 7–8 (2005), available at http://www.massmed.org/AM/Template.cfm?Section=Search§ion=PPRC_Legal_Issues&template=/CM/ContentDisplay.cfm&ContentFileID=725 (summarizing the disciplinary process under the Massachusetts Model Principles).

29. See, e.g., JOINT COMM’N ON ACCREDITATION OF HEALTHCARE ORGS., COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS: THE OFFICIAL HANDBOOK 2005 ACC-13, MS.4.90 (stating that ACC-13 requires linkage of results of peer review and focused monitoring to medical staff credentialing and privileging, and MS.4.90 requires hospitals to “identify a minimum set of circumstances” to trigger review of specific individuals’ performance by peers; medical staffs must provide for “measurement and assessment activities,” and evaluate practitioners’ competence).

30. See *Trinity Med. Ctr., Inc. v. Holum*, 544 N.W.2d 148, 155 (N.D. 1996) (finding that peer review privilege is limited to committees mandated by law, JCAHO or internal medical review or quality assurance committees).

31. Marren, *supra* note 27, at 231–32 (summarizing recommendations for hospital governing boards to discharge their duty to insure quality).

32. *Id.* at 196–207 (citing *Darling v. Charleston Cmty. Mem’l Hosp.*, 211 N.E.2d 253, 257 (Ill. 1965) (concluding that hospitals must exercise due diligence in hiring, assure continued qualifications of physicians, and supervise all care); *Siqueira v. Northwestern Mem’l Hosp.*, 477 N.E.2d 16, 20 (Ill. App. Ct. 1985) (finding that the board of directors maintains power of ultimate resolution); *Johnson v. Misericordia Cmty. Hosp.*, 301 N.W.2d 156, 164 (Wis. 1981) (finding that the doctrine of corporate negligence requires due diligence in hiring and granting privileges as part of governing body’s non-delegable accountability for quality of care)).

However, precise guidelines defining the terms under which privileges may be restored are rarely outlined.³³

II. THE VALUE OF PEER REVIEW

A. Critiques of Peer Review

Peer review was the subject of intense scholarly controversy even before statutory enactments by the federal and state governments, and remains so today.³⁴ As in the past, fairness in the review and discipline of doctors continues to be a concern. More recent debate also centers on whether peer review is meeting its goals of advancing the quality and safety of healthcare.³⁵ In this latter regard, critics of peer review focus on a number of related issues, including (1) the effect of immunity and evidentiary privilege statutes on public welfare; (2) peer review's ability to detect problem physicians and remediate or remove them; and (3) the impact of mandatory reporting statutes.

The courts play a role in interpreting statutes that establish an evidentiary privilege or rule of confidentiality for the peer review process.³⁶ When they deny judicial or extra-judicial access to information about peer review proceedings and results, critics argue, peer review operates to the disadvantage of both patients who have experienced substandard care and physicians who have been accused of it.³⁷

33. *But see* AMA, Proposed Amendment to Policy H-265.998(9), <http://www.ama-assn.org/ama1/pub/upload/mm/465/bot17i04.rtf> (last visited May 31, 2006) (amending "Guidelines for Due Process" to read, "when feasible, the hearing body should include terms that permit measurement and validation of the completed remediation process").

34. *See, e.g.*, *Summit Health Ltd. v. Pinhas*, 500 U.S. 322, 329–33 (1991) (finding that plaintiff's allegation of conspiracy to exclude him from Los Angeles market by terminating privileges through peer review satisfied Sherman Act's jurisdictional requirements); *Patrick v. Burget*, 486 U.S. 94, 98 n.3, 101–06 (1988) (noting the Ninth Circuit's assessment that the peer review in this case was "shabby, unprincipled, and unprofessional" and finding that the state action doctrine does not protect peer reviewers from federal anti-trust liability); *see also* Josephine M. Hammack, *The Antitrust Laws and the Medical Peer Review Process*, 9 J. CONTEMP. HEALTH L. & POL'Y 419, 425–37 (1993) (explaining that participants in peer review are at risk under federal anti-trust law and suggesting how to minimize the risk). *But see* Friend, *supra* note 14, at 656 (citing a trilogy of 1996 cases – *Mem'l Hosp.-The Woodlands v. McCown*, 927 S.W.2d 1 (Tex. 1996); *Irving Healthcare Sys. v. Brooks*, 927 S.W.2d 12 (Tex. 1996); *Brownwood Reg'l Hosp. v. Eleventh Court of Appeals*, 927 S. W.2d 24 (Tex. 1996) – finding strong peer review privilege in Texas).

35. Sheutzow, *supra* note 6, at 8 (arguing that peer review statutes are ineffective to meet their goal of high quality medical practice and should be "eliminated or reformed").

36. *See, e.g.*, Fine, *supra* note 3, at 822–25.

37. *Id.* at 825.

With respect to patients' claims, some critics assert that peer review shields information that may reasonably be related to the subject matter of the contested issues in a malpractice case,³⁸ such as incident reports³⁹ "furnished to" peer review committees, when deemed nondiscoverable.⁴⁰ Despite a recent trend towards making such records available to plaintiffs,⁴¹ in many jurisdictions they are still difficult to obtain.⁴²

Court decisions,⁴³ legislation, and public referenda reflect a shifting view of the relative benefits and burdens of keeping peer review a closed process.⁴⁴ These battles may well be a result of disappointment with a process that is perceived as failing to identify problem physicians before they become involved in malpractice claims. Recent events in Florida illustrate the tension between providing patients with access to peer review materials and the principles underlying the protection of "quality-of-care" records.

In 2004, voters in Florida approved Amendment 7 to the state constitution⁴⁵ giving patients "a right to have access to any records made or received in the course of business . . . relating to any adverse medical incident,"⁴⁶ including incidents "reported to or reviewed by any . . . peer review, risk management, quality assurance, credentials, or similar committee."⁴⁷ On enacting an implementing statute, the state legislature specifically found that the amendment was not intended "to repeal or otherwise modify existing laws governing the

38. *Id.* at 813 n.14.

39. Incident reports are created for unusual occurrences such as medication mis-dosing or slips and falls.

40. *See* Fine, *supra* note 3, at 824 (citing *Carr v. Howard*, 689 N.E.2d 1304 (Mass. 1998) (explaining that an incident report utilized by a peer review committee is privileged).

41. *See, e.g.*, *Sisters of Charity Health Sys. v. Raikes*, 984 S.W.2d 464, 466 (Ky. 1998) (finding peer review discoverable in a medical malpractice case); *Burrows v. Redbud Cmty. Hosp. Dist.*, 187 F.R.D. 606, 611–13 (N.D. Cal. 1998) (allowing peer review discovery for federal EMTALA claim); *Kalb v. Morehead*, 654 N.E.2d 1039, 1042 (Ohio Ct. App. 1995) (holding that hospital did not have immunity that would shield it from a negligent credentialing action).

42. *See, e.g.*, *Newton, supra* note 3, at 738 (citing *St. Luke's Episcopal Hosp. v. Agbor*, 952 S.W.2d 503 (1997)) (finding that peer review statutes bar plaintiff's negligent credentialing claim absent a showing of bad faith in credentialing).

43. *See, e.g.*, David E. Willett, *Protecting Peer Review Records in the Wake of Dal Cielo*, CAL. FAM. PHYSICIAN, May/June 1997, at 13, 18 (citing *Arnett v. Dal Cielo*, 923 P.2d 1 (Cal. 1996)) (explaining that the peer review privilege in CAL. EVID. CODE § 1157 is not applicable to subpoenas by investigative state agencies and that investigations are not "discovery").

44. *See, e.g.*, Fine, *supra* note 3, at 814 ("[I]f the cost of limiting the rights of malpractice plaintiffs and aggrieved physicians outweighs the benefit conferred on the public in reducing medical error, peer review should be either overhauled or eliminated entirely.").

45. FLA. CONST. art. X, § 25 (2006).

46. *Id.* § 25(a).

47. *Id.* § 25(c)(3).

use of these records,” and that immunity and privilege statutes for quality-of-care-committees remain in “full force and effect.”⁴⁸ The statute allows patients to obtain incident records pertaining to other de-identified patients’ adverse medical incidents so long as they pertain to the “same or substantially similar condition, treatment, or diagnosis as that of the patient requesting access.”⁴⁹

Florida courts have since considered the issues of whether Amendment 7 is self-executing (i.e., that the voters mandated direct access to quality records), if it may be applied retroactively, and the constitutionality of the implementing statute. There are four appellate decisions.⁵⁰ Declaring Amendment 7 to be self-executing, *Buster* found no retroactive application.⁵¹ *Bowen* determined the amendment to be self-executing, retroactive,⁵² and the statute unconstitutional. *Michota* denied certiorari to let stand a lower court decision consistent with *Buster*. The appellant in *Neavins* asserted trial court error in finding the amendment to be self-executing, arguing that legislative implementation is required to address the significant policy and practical issues raised by the amendment.⁵³ Certiorari was denied on grounds that passage of the implementing statute mooted the appeal. The Florida Supreme Court has agreed to hear *Bowen* and *Buster*.

Other commentators emphasize their concern that shielding statutes have a harsh effect on disciplined physicians.⁵⁴ They argue that courts interpret them to the detriment of plaintiff physicians challenging disciplinary action imposed as a result of peer review by

48. FLA. STAT. § 381.028(2) (2006).

49. *Id.* § 381.028(7).

50. *Florida Hosp. Waterman, Inc. v. Buster*, No. 5D05-2195, 2006 WL 566084, at *7 (Fla. Dist. Ct. App. Mar. 10, 2006) (holding that Amendment 7 is self-executing); *Notami Hosp. of Fla., Inc. v. Bowen*, No. 1D05-4149, 2006 WL 1041542, at *4 (Fla. Dist. Ct. App. Apr. 21, 2006) (holding that Amendment 7 is self-executing and that the statute purporting to implement Amendment 7 is unconstitutional); *Bayfront Med. Ctr., Inc. v. Michota*, 922 So. 2d 199 (Table) (Fla. Dist. Ct. App. 2006); *Bayfront Med. Ctr. v. Neavins*, 920 So. 2d 185, 186–87 (Fla. Dist. Ct. App. 2006) (dismissing petition for writ of certiorari as mooted by passage of the “Patients’ Right-to-Know About Adverse Medical Incidents Act”).

51. See *Buster*, 2006 WL 566084, at *7 (“Amendment 7 should be applied prospectively.”).

52. See *Bowen*, 2006 WL 1041542, at *4 (“Because the plain language of the amendment expresses a clear intent that it be applied to include records created prior to its effective date, doing so is not an unconstitutional retroactive application.”).

53. *Neavins*, 920 So. 2d at 186 (appellant claimed that the amendment failed “to meet the test set forth in *Gray v. Bryant*, 125 So. 2d 846, 851 (Fla. 1960),” for construing an amendment as self-executing).

54. See Fine, *supra* note 3, for a view of challenges faced by physicians fighting disciplinary actions; see also Gail G. Weiss, *Is Peer Review Worth Saving?*, MED. ECON., Feb. 18, 2005, at 46, 46–48 (explaining that physicians have a hard time defending themselves against peer reviewer allegations).

not allowing discovery of the very materials upon which the suit is based.⁵⁵ They also claim that participants abuse the peer review process for economic reasons.⁵⁶ In addition, some writers worry that, short of filing a lawsuit, disciplined physicians may be unable to challenge the fairness of peer review⁵⁷ unless external independent review is made available.⁵⁸ The low likelihood of success and high cost of fighting disciplinary actions⁵⁹ leave some physicians without real

55. See Newton, *supra* note 3, at 741 & n.156 (citing *Irving Healthcare Sys. v. Brooks*, 927 S.W.2d 12 (Tex. 1996)) (explaining that statutes “would be emasculated” if a “simple allegation of malice” was all that was needed to open up peer review to discovery). *But see* Yann H. van Geertruyden, Comment, *The Fox Guarding the Henhouse: How the Health Care Quality Improvement Act of 1986 and State Peer Review Statutes Have Helped Protect Bad Faith Peer Review in the Medical Community*, 18 J. CONTEMP. HEALTH L. & POL’Y 239, 250–51 (2001) (noting that seventeen states permit access to peer review materials when a physician challenges disciplinary action); Nijm, *supra* note 13, at 548 & n.46 (discussing how Maryland suspends privilege in suits by subjects of peer review); AMA, H-265.998 GUIDELINES FOR DUE PROCESS, available at http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/H-265.998.HTM (stating that voluntary adherence to guidelines should meet each jurisdiction’s requirements, including giving the physician an “opportunity to be present at the hearing and hear all of the evidence against him” as well as “to present a defense”).

56. See, e.g., *Patrick v. Burget*, 486 U.S. 94, 97–98 (1988) (“[P]etitioner contended that the Clinic partners had initiated and participated in the hospital peer-review proceedings to reduce competition from petitioner rather than to improve patient care.”); see also van Geertruyden, *supra* note 55, at 240 (describing how peer review presents the opportunity to be used for corrupt economic or political motives).

57. See van Geertruyden, *supra* note 55, at 250, 253, 256–57 (“Faced with the legal burden of proving bad faith, combined with the confidentiality and immunity protections provided at both the state and federal level, the chances of an unemployed, or negatively affected physician pursuing a court battle are slim.”); see also Diane Gupton, *Health Law—The Tenth Circuit Lowers the Evidentiary Burden to Overcome Peer Review Immunity Under the Health Care Quality Improvement Act—Brown v. Presbyterian Healthcare Services*, 28 N. M. L. REV. 625, 625 (1998) (“The Brown court found that physician plaintiffs need show only that a difference of opinion exists among medical experts on whether the scope of the review was reasonable to create an issue of fact for the jury.” (citing *Brown v. Presbyterian Healthcare*, 101 F.3d 1324, 1334 (10th Cir. 1996), *cert. denied*, 117 S. Ct. 1461 (1997))).

58. See, e.g., van Geertruyden, *supra* note 55, at 251, 267–68 (finding that there is a “lack of any meaningful appellate procedure available,” and stating the need for “a quick and fair review”; author favors state control of peer review or expeditious access to state courts to appeal decisions); see also AMA D-375.996 PEER REVIEW IMMUNITY, available at http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/DIR/D-375.996.HTM (recommending that medical staff bylaws establish an external review when a physician alleges that a peer review is not objective and impartial).

59. See Merkel, *supra* note 28, at 311–12 (explaining that appellate courts are loathe to second guess hospital and medical professionals’ opinions regarding discipline or granting of privileges (citing *Gill v. Mercy Hosp.*, 245 Cal. Rptr. 304 (Cal. Ct. App. 1988); *Cipriotti v. Bd. of Dirs. Of Northridge Hosp. Found. Med. Ctr.*, 196 Cal. Rptr. 367 (Cal. Ct. App. 1983); *Austin v. McNamara*, 731 F. Supp. 934 (Dist. Cal. 1990), *aff’d*, 979 F.2d 728, 733 (9th Cir. 1992))); see also *Hongsathavij v. Queen of Angels/Hollywood Presbyterian Medical Center*, 73 Cal. Rptr. 2d 695, 704–07 (Cal. Dist. Ct. App. 1998) (holding that the “abandonment of patient” decision was supported by the evidence; plaintiff was not denied a fair administrative hearing). *But see* Gupton, *supra* note 57, at 625 (noting that after *Brown v. Presbyterian Healthcare Services*,

recourse in the face of events with the potential to devastate their careers.⁶⁰ When disciplinary actions are reported to the NPDB,⁶¹ a physician is left fighting on several fronts for his or her professional life.⁶²

Critics also allege that peer review for a variety of reasons does not adequately improve healthcare quality and safety.⁶³ One charge is that many quality and safety issues are not referred for review.⁶⁴ Other studies suggest incomplete compliance with reporting requirements,⁶⁵ including a suspicion that physicians facing imminent discipline or dismissal resign, and that despite NPDB's provisions their hospitals fail to report circumstances of departures.⁶⁶ Although some writers propose greater penalties for hospitals and medical

physicians need only minimal evidence that the peer review was conducted unreasonably because the burden shifts to defendants to show the review precluded difference in opinion).

60. See van Geertruyden, *supra* note 55, at 256–58 (arguing that NPDB may lead to destruction of good physicians' careers rather than achieve monitoring of bad ones); see also Edward H. Livingston & John D. Harwell, *Peer review*, 182 AM. J. SURGERY 103, 103–09 (2001) (suggesting less punitive intermediate forms of reporting when appropriate).

61. See 42 U.S.C. § 11133(a)(1) (2006) (describing when and how to report certain professional review actions); 45 C.F.R. § 60.5(c) (2006) (explaining when to report adverse actions to the NPDB). NPDB's procedure to contest a report, 45 C.F.R. § 60.14, may not be helpful in cases of disciplinary action. The prompt reporting requirement may lead to an erroneous report which is difficult to expunge. Inquirers to NPDB may de-credential a physician from health plans or deny privileges at another hospital, further impacting income and reputation. See, e.g., van Geertruyden, *supra* note 55, at 257–58 (“Due to the reporting requirements of the NPDB, the reviewed physician is essentially ‘blacklisted.’”).

62. See van Geertruyden, *supra* note 55, at 256–57 (discussing how a reviewed physician will have difficulty maintaining his professional reputation after a report is submitted to the NPDB).

63. See, e.g., Fine, *supra* note 3, at 825 (“[S]tudies . . . indicate that implementation of a peer review program actually has little bearing on incidents of medical error at any given health care institution.”); Scheutzow, *supra* note 6, at 15–16 (“The peer review system . . . should address problems of physicians before they impact a physician's license to practice medicine.”).

64. Lori Andrews, *Studying Medical Error in Situ: Implications for Malpractice Law and Policy*, 54 DEPAUL L. REV. 357, 369 (2005) (noting that safety and quality issues readily recognized on work rounds are frequently not reported to official channels for follow-up and that there are prior occurrence reports on file for only 13% of claims brought).

65. Scheutzow, *supra* note 6, at 54.

66. HCQIA requires reporting in this circumstance under 42 U.S.C. § 11133(a)(2), but some suspect such reports frequently are not filed, thereby defeating one of the databank's purposes. See, e.g., Laura-Mae Baldwin et al., *Hospital Peer Review and the National Practitioner Data Bank: Clinical Privileges Action Reports*, 282 J. AM. MED. ASS'N 349, 354 (1999) (concluding that there is a low level of “clinical privileges action reporting”); see also van Geertruyden, *supra* note 55, at 254–55 (citing OFFICE OF INSPECTOR GEN., U.S. DEPT. OF HEALTH HUMAN SERVS., PUB. NO. OE-01-94-00050, HOSPITAL REPORTING TO THE NATIONAL PRACTITIONER DATA BANK (1995)) (postulating that hospitals have an incentive to under-report because they are averse to the possibility of negative publicity); Scheutzow, *supra* note 6, at 54 (discussing how the loss of immunity under HCQIA as a penalty for failure to report has never been invoked so hospitals have little incentive to report unless an applicable state statute has a strong penalty).

groups who fail to report,⁶⁷ others consider underreporting to the NPDB to be a symptom of its perceived inability in many situations to achieve a proper balance between the interests of the public good and the physicians.⁶⁸ Still other critics worry that peer review may be under-used⁶⁹ and therefore may fail to identify, remediate, or remove doctors who pose a danger to patients. They are even more troubled by the notion that institutions that engage in little or no peer review may use immunity and privilege protections to bar challenges to their lack of due diligence.⁷⁰

B. A More Realistic Assessment

Academic critiques of peer review often speak in abstractions. They focus not on medical and hospital committees' routine reviews but on legal texts, most notably judicial decisions.⁷¹ Legal texts are an accessible information source, but they may not accurately reflect the complex realities of modern medical centers. Judicial cases in deferring to the substantive judgments made by hospital and medical professionals,⁷² instead address alleged breakdowns in the peer review process, inquiring, for example, whether an institution followed its own procedures, or if bad motive was present. Courts do not examine underlying structural issues which may be inherent in the essence of peer review itself and which raise questions such as whether traditional peer review can ever avoid some perception that a disciplined physician was treated in an uneven manner relative to his colleagues. As a result, the scope of judicial inquiry in adjudicated cases directly influences which issues scholars explore and about

67. See, e.g., Scheutzow, *supra* note 6, at 57 (considering stronger state and federal penalties for non-reporting).

68. See, e.g., Maguire, *supra* note 24 (explaining how hospitals circumvent reporting rules by disciplining physicians for less than thirty days or by using mechanisms which do not require reporting); Julie Barker Pape, Note, *Physician Data Banks: The Public's Right to Know Versus the Physician's Right to Privacy*, 66 FORDHAM L. REV. 975, 1028 (1997) (noting that when physicians cannot control dissemination of information to databanks they act to protect their privacy interests, e.g., resist settling malpractice cases due to mandatory malpractice payment reports).

69. Scheutzow, *supra* note 6, at 47 (extrapolating from the premise that the number of reports of adverse actions would correlate with the amount of peer review activity going on in the institution and concluding that peer review protection statutes are not working sufficiently by themselves to promote peer review).

70. *Id.* at 11.

71. See, e.g., *Trinity Med. Ctr., Inc. v. Holum*, 544 N.W. 2d 14, 153 (N.D. 1996) (noting that state peer review statutes differ and courts interpret them differently).

72. See *supra* note 59 and accompanying text.

which they make policy recommendations, perhaps without all the relevant information.

Similarly, critiques which focus on shielding statutes involving discovery of peer review documents for judicial or extra-judicial purposes or peer review participant liability, which are relevant only in a litigation setting, place undue emphasis on the relatively small number of cases that may merit litigation.⁷³ Peer review situations that exhibit more subtle problems of inadvertent or subconscious behaviors rather than bad faith, however, are unlikely to be litigated, and so shielding statutes are not relevant to them.

The authors of this Article have extensive clinical, research, consultative, and administrative experience in the areas of peer review, risk management, and professional liability. On the basis of this experience, we suggest that analysis of peer review in legal literature does not always convey a realistic sense of the peer review process. By focusing on outlier results, the legal literature does not recognize the seriousness and commitment with which most participants approach this responsibility or the profession's strong ethical charge regarding peer review.⁷⁴ In light of these realities, we will address the criticisms of peer review.

The defect in the peer review process may not be reviewers' bad motives, but instead a failure to recognize that problematic outcomes perceived to be attributable to over- or under-scrutiny may be due to something else. Given the seriousness of such unsatisfactory outcomes, the process should be analyzed to determine possible causes for questions about the trustworthiness of its outcomes. Perhaps critics should focus on designing a system of peer review that supports fairness, rather than simply continue to admonish participants to be fair. If the process is easily subverted by bias or arbitrariness, more systematic methods to assess physicians' performance would seem to be desirable.⁷⁵

With respect to patients' interests, we agree that peer review often fails to identify a problem physician. Studies of the peer review process suggest an inability to reliably identify substandard care when it is present because, except in an obvious case, physicians reviewing a

73. See Fine, *supra* note 3, at 828 (asserting that peer review pits physicians against one another).

74. See, e.g., *supra* note 28; *infra* note 77.

75. See Eric J. Thomas & Laura A. Petersen, *Measuring Errors and Adverse Events in Health Care*, 18 J. GEN. INTERNAL MED 61, 63-65 (2003) (explaining that common methods used to measure errors and adverse events are subject to bias, questions of inter-rater reliability, and the Hawthorne effect).

case often differ in their conclusions.⁷⁶ Even in the face of bad clinical outcomes, it can be difficult to discern whether one or even several incidents represent an emerging pattern or just random events. Multiple malpractice claims against a particular doctor suggest real problems with a physician's practice, but traditional peer review may not reveal why. It would appear then that traditional peer review does not always identify those physicians at increased risk for claims, nor does it offer doctors any information or insight to help them address it.

We also are in agreement with commentators that human factors may undermine the self-policing goal of peer review.⁷⁷ Reviewers may suggest that they would have made medical decisions differently, yet decline to find fault if the reviewed doctor's approach to the patient's medical issues is at least understandable, even if not ideal. They may hesitate to judge close colleagues who do good work in most circumstances, particularly if serious consequences, such as sanctions and loss of income and reputation, could result. Notwithstanding the practical obstacles disciplined physicians face when fighting sanctions, peer reviewers may also fear the potential for legal challenges. Thus, committees have incentives to refer none but the most obviously mismanaged cases to an executive governing board.⁷⁸

76. See, e.g., R.A. Caplan et al., *Effect of Outcome on Physician Judgments of Appropriateness of Care*, 265 J. AM. MED. ASS'N 1957, 1957 (1991) (concluding that "knowledge of the severity of outcome can influence a reviewer's judgment of the appropriateness of care"); Rodney A. Hayward & Timothy P. Hofer, *Estimating Hospital Deaths Due to Medical Errors: Preventability is in the Eye of the Reviewer*, 286 J. AM. MED. ASS'N 415, 419 (2001) ("Reviewers may be reluctant to second-guess the care of fellow clinicians, and many errors may not be documented in the medical record or identifiable by chart review."); Rhoda D. Levine et al., *The Effect of Group Discussion on Interrater Reliability of Structured Peer Review*, 89 ANESTHESIOLOGY 507, 514-15 (1998) (recommending that peer review not be used in certain circumstances because of the high variability in the opinions of reviewers); A. Russell Localio et al., *Identifying Adverse Events Caused by Medical Care: Degree of Physician Agreement in a Retrospective Chart Review*, 125 ANNALS INTERNAL MED. 457, 460-63 (1996) ("[A]ssessments based on medical records, especially when implicit and not guided by objective criteria, produce disagreement among physicians on the appropriateness and quality of care . . ."); Karen L. Posner et al., *Variation in Expert Opinion in Medical Malpractice Review*, 85 ANESTHESIOLOGY 1049, 1049-54 (1996) (noting the frequency of diverging opinions on the appropriateness of care among anesthesiologists); Eric J. Thomas et al., *The Reliability of Medical Record Review for Estimating Adverse Event Rates*, 136 ANNALS INTERNAL MED. 812, 814 (2002) (finding "poor inter-rater reliability among physicians trying to identify adverse events and negligent events by medical record review").

77. But see AMA, Ethical Op. E-4.07, available at <http://www.ama-assn.org/ama1/pub/upload/mm/465/bot17i04.rtf> ("[P]ersonal friendships, antagonisms, jurisdictional disputes, or fear of competition should not play a role in . . . decisions. Physicians . . . have an ethical responsibility to be guided [by the patients' best interests].").

78. ROBERT M. WACHTER & KAVEH SHOJANIA, INTERNAL BLEEDING: THE TRUTH BEHIND AMERICA'S TERRIFYING EPIDEMIC OF MEDICAL MISTAKES 322-25 (2004).

Support for peer review may also have been eroded by the Institute of Medicine's reports "To Err is Human" and "Crossing the Quality Chasm."⁷⁹ These reports, which estimate that medical error causes 44,000 to 98,000 deaths per year,⁸⁰ suggest that a focus on addressing faulty systems rather than individual accountability would decrease error rates. These reports could promote skepticism regarding peer review's effectiveness, unless we recognize that personal accountability must still be addressed.

Critics who cite the health care industry's safety record may convincingly argue for changes in the law to combat under-use of peer review or under-reporting to the NPDB, and to assure public access to the results of peer review. However, such measures may backfire and have a chilling effect on physicians' willingness to participate or to be fully candid. Critics rarely suggest alternative ways to help the peer review process achieve better outcomes, which in turn would fulfill the public's quality and safety needs.

C. The Underlying Problem

The underlying problem with peer review is not inadvertent leniency (which is unfair to patients), or subtle bias (which is unfair to physicians under investigation). Rather, it is that the peer review process is often not directly linked to an institution's ongoing risk management activities. The failure to link these logically related functions has isolated most medical institutions' peer review process, ignoring peer review's potential as a mechanism for *ex ante* risk reduction and relegating it to an *ex post* adjudicatory role. It is in the former role that peer review might credibly address future malpractice claims risk.

Consider the earlier case of a physician who was sued five times but retrospective medical records review revealed no clearly substandard care. Presumably the institution did not identify, nor was the physician aware, that he was at high risk of malpractice

79. COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (Linda T. Kohn et al. eds., 2000); COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY (2001).

80. Estimates of the number of deaths from medical error are controversial. See Lucian L. Leape, *Institute of Medicine Medical Error Figures are Not Exaggerated*, 284 J. AM. MED. ASS'N 95, 95-97 (2000) (discussing factors that suggest medical error figures are not exaggerated); Clement J. McDonald et al., *Deaths Due to Medical Errors are Exaggerated in Institute of Medicine Report*, 284 J. AM. MED. ASS'N 93, 94 (2000) ("Clearly, more study with careful attention to risk levels is needed to determine the true impact of adverse events on death rates among hospitalized patients.").

claims. Even in the face of a new lawsuit against the physician, the peer review committee is now poorly positioned to advise a physician of his or her risk or tell the physician what to do to avoid future claims. In fact, if they communicate their impressions based on quality review of his patients' medical records, these may or may not be correct. The committee cannot determine if the doctor is simply unlucky or if there are other factors at work which they can neither identify nor articulate. Adjudicatory, *ex post* peer review cannot respond to issues of future loss reduction. Therefore, traditional peer review does not help risk managers, medical group administrators, healthcare institutions, and physicians address these important issues.

Given the structure of peer review, these gaps are hardly surprising. Generally, limited numbers of charts and cases are reviewed. Peer reviewers rarely compare similar cases attended by different physicians. Trending is generally not done, and patterns may not be easily discerned. Even when a theme seems to exist, it is often based on anecdotes from a small number of cases rather than a systematic review of the physician that quantifies his risk of malpractice claims relative to that of his colleagues'. Reviewers focus on the question as to whether or not the physician met the standard of care, and may ignore or deem irrelevant other forms of care judged not to have directly contributed to or had much impact on the ultimate outcome.⁸¹

Another weakness of traditional peer review is that reviewers are unable to evaluate aspects of care not documented in the medical record.⁸² While the written record may show that the physician effectively evaluated and treated a patient's medical issue, the patient's assessment that she experienced an exceptionally long response time to her telephone inquiry or that her doctor didn't listen well or communicate adequately is rarely discernible from the chart.

While the healthcare environment and the ability of systems to prevent lapses are important, the physician-patient relationship is still at the heart of medical care. Many fundamental drivers of safety and quality are largely under a physician's control: the thoughtfulness with which patients' needs are addressed, communication with patients and families to acquire critical information and achieve consensual care plans, and accessibility to care. The patient-physician

81. *But see* Andrew A. White et al., *Cause-and-Effect Analysis of Risk Management Files to Assess Patient Care in the Emergency Department*, 11 ACADEMIC EMERGENCY MED. 1035, 1038-40 (2004) (noting that shared causes, some potentially correctable, account for real or perceived adverse outcomes).

82. Andrews, *supra* note 64, at 362.

interaction plays a pivotal role in healthcare outcomes. When that interaction goes awry, health care goes awry. Patients may become mistrustful or angry. They may fail to act on medical advice (non-adherence) or delay action, or become convinced that their poor outcome was caused by an aspect of their medical care. Peer review seldom provides insight into a physician's accessibility, how well he communicates, or whether he displays empathy. In particular, peer review does not link these "soft" aspects of care to risk of being the subject of medical malpractice claims.

Assume now that in our case scenario the peer review committee found obvious substandard medical care in most of the physician's malpractice cases. The reviewers would be confident that the doctor poses a risk to patients and refer the case to the hospital's governing board for further action. Loyalty to their colleague would be overcome, and not even fear of litigation would stop them from taking steps to limit privileges or remove the doctor from the staff.

Would peer review have achieved the right goal? The answer is likely yes, if, repeatedly, some aspect of technical skills or decisionmaking is the clearly and unambiguously identified deficiency. However, in most cases the committee will not find documented technical weaknesses, and yet, the institution must still deal with the physician's recurring malpractice claims problem. Perhaps our goal should be to identify physicians at high risk of malpractice suits before such claims materialize and take action to reduce that risk.

Many observers are rethinking how to approach the goal of improving health care. Traditional peer review could consider incorporating features of recent successful initiatives within the healthcare industry.⁸³ The usefulness of aggregate data has been demonstrated by the first comprehensive state reporting program, Pennsylvania's Medical Care Availability and Error Reduction Act of 2002 ("MCare").⁸⁴ Analyses of aggregated reports of serious events or incidents ("near-misses")⁸⁵ filed by hospitals have led to the development of educational tools and guidelines that assist in the delivery of safer care.⁸⁶

83. See, e.g., Josh Goldstein, *Medication Errors Cut in Area*, THE PHILADELPHIA INQUIRER, Jan. 6, 2005, at C1 (discussing how a regional effort launched in Feb. 2001 by the Delaware Valley Healthcare Council at 49 hospitals resulted in a 22% improvement toward meeting the Council's goal).

84. 40 PA. CONS. STAT. § 1303.101 (2006).

85. *Id.* § 1303.302. An "incident" is defined as "an event . . . which could have injured the patient but did not. . . . The term does not include a serious event." *Id.*

86. Thirty percent of hospitals responding to the PA PSA survey implemented patient safety protocols as a result of Patient Safety Advisory Reports. PATIENT SAFETY AUTH., ANNUAL

Peer reviewers might similarly find tools which provide analyzed aggregate data helpful. As patients become more involved in their own care,⁸⁷ asking questions, maintaining alertness, and bringing observations of potential compromises in safety and quality to the attention of healthcare professionals or administrators at medical facilities, many also file complaints with offices of patient relations (“ombudsmen”) established for this purpose. Complaints may offer a rich source of such information to discover patterns of dissatisfaction that provide insight into physicians’ malpractice claims risk.⁸⁸ We will discuss this possibility further in Part III of this Article.

We need to also consider other paradigms within the healthcare industry to support new models for peer review. The shift towards a “continuous improvement” model⁸⁹ encourages efforts to improve processes rather than focus on weeding out “bad apples.” While not denying the need to regulate dangerous outliers,⁹⁰ the model assumes that most healthcare workers have good intentions, work hard, and do not make willful errors.⁹¹ In an environment which removes fear of blame, healthcare workers given data about processes are empowered to make changes by designing and implementing strategies to improve patient safety and reduce medical error.⁹² We

REPORT FOR 2004 EXECUTIVE SUMMARY 3 (2005), available at <http://www.psa.state.pa.us/psa/cwp/view.asp?a=1275&q=445714>.

87. See, e.g., ROSEMARY GIBSON & JANARDAN PRASAD SINGH, WALL OF SILENCE 239–45 (2003) (discussing how patients can protect themselves); PRESIDENT’S ADVISORY COMM’N ON CONSUMER PROT. & QUALITY IN THE HEALTH CARE INDUS., FINAL REPORT APPENDIX A: CONSUMER BILL OF RIGHTS AND RESPONSIBILITIES (1997), available at http://www.hcquality.commission.gov/final/append_a.html (arguing that “[g]reater individual involvement by consumers in their care increases the likelihood of achieving the best outcomes and helps support a quality improvement, cost-conscious environment”).

88. Kecia N. Carroll et al., *Characteristics of Families that Complain Following Pediatric Emergency Visits*, 5 AMBULATORY PEDIATRICS 326, 326 (2005) (finding that black patients are underrepresented in complaint files compared to white patients, relative to percent of emergency department visits, after controlling for factors such as payer status).

89. See van Geertruyden, *supra* note 55, at 269 (“An alternative approach to the peer review process that has been advocated by many in the medical profession views quality of care not from an adversarial, aggressive standpoint, but rather from a theory of continuous improvement.” (citing Donald M. Berwick, *Continuous Improvement as an Ideal in Health Care*, 320 NEW ENG. J. MED. 53, 53 (1989))); see also COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS: THE OFFICIAL HANDBOOK 2005, *supra* note 27, at ACC-12 (noting that on-site survey has shifted to model assessing “continuous operational improvement in support of safe, high-quality care, treatment, and services”).

90. Berwick, *supra* note 89, at 54.

91. *Id.* at 55.

92. See *id.* at 54 (arguing that the best way to improve health-care quality is to adopt the Theory of Continuous Improvement which focuses all personnel in a production process on improvement); see also Anne C. O’Neil et al., *Physician Reporting Compared with Medical Record Review to Identify Adverse Medical Events*, 119 ANNALS INTERNAL MED. 370, 370 (1993) (finding

believe that physicians also need useful information to facilitate their self-improvement, which current modes of peer review do not always provide. We propose a complementary model to encourage peer-driven self-improvement and correction.

Finally, methods of peer review should also be able to demonstrate that they are effective. Effectiveness is an outcome of utilizing evidence-based practices developed through systematic data acquisition and analysis which are shown to achieve better long-term results in the quality of care than alternatives.⁹³ The impetus to improve patient safety with information acquired in a blame-free, cooperative, solution-seeking milieu will be reassuring only if it is effective. Peer review may yet have a robust part to play in putting to rest the underlying concerns of some scholars, courts, and the public.

III. UNDERSTANDING AND ADDRESSING MALPRACTICE CLAIMS RISK THROUGH PEER REVIEW

A. Correlates of Medical Malpractice Risk

Medical malpractice research studies conducted over the past two decades asked such questions as why patients sue their doctors, which doctors get sued, and whether some doctors attract more suits than others. The results of these studies suggest some reasons why traditional peer review may not be able to identify and address important components of risk. This Section argues that an expanded model of peer review, however, can identify at least some of these components.

Consider some research findings. Medical record reviews suggest that adverse events (injuries due to medical care rather than underlying disease) occur in up to 6 percent of hospital stays.⁹⁴ About one-third of those adverse events has a component attributable to

that housestaff-identified adverse events are more likely to be preventable than adverse events identified by chart review).

93. Troyen A. Brennan et al., *Accidental Deaths, Saved Lives, and Improved Quality*, 353 NEW ENGL. J. MED. 1405, 1408 (2005).

94. See, e.g., Stephen Zuckerman, *Information on Malpractice: A Review of Empirical Research on Major Policy Issues*, 49 LAW & CONTEMP. PROBS. 85, 94 & n. 40 (1986) (discussing the CAL. MED. ASS'N AND CAL. HOSP. ASS'N, MEDICAL INSURANCE FEASIBILITY STUDY (D. Mills ed., 1977), which found that "injuries, negligent or otherwise . . . [resulted from] 4.65% of all hospital inpatient stays. . ."); Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I*, 324 NEW ENGL. J. MED. 370, 371 (1991) ("We estimated the . . . incidence rate of adverse events to have been 3.7 per cent . . ."); *id.* at 375, Tbl. 3 (showing that over age 65, the rate of adverse events was 5.7% (+/-0.6%).

negligence,⁹⁵ and therefore, represents a medically valid potential lawsuit. Interestingly, in only 2 percent of these cases is a lawsuit filed, but five to seven times more patients sue in cases where medical record review suggests no negligence.⁹⁶

A number of studies have asked why patients sue.⁹⁷ In one study conducted by Vanderbilt University researchers (“Vanderbilt group”), former obstetrical patients in Florida who filed suit for alleged injuries to their infants were asked what prompted them to seek legal representation.⁹⁸ While money damages was a motivation for 24 percent of the parents, their most frequent reason was that someone they trusted (commonly another physician) suggested they had been victims of poor care. Other factors that prompted them to file were the need for information about what happened, their sense that there was a cover-up, the child’s limited future, or “revenge.”⁹⁹

95. See, e.g., Brennan, *supra* note 94, at 371 (“The percentage of adverse events due to negligence was 27.6 percent (95 percent confidence interval, 22.5 to 32.6).”); Eric J. Thomas et al., *Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado*, 38 MED. CARE 261, 261 (2000) (“In Utah, 32.6 +/- 4% of adverse events were due to negligence; in Colorado, 27.4 +/- 2.4%.”). But see Andrews, *supra* note 64, at 361–62 (finding that medical error occurred in 45.8% of patients in surgical units in one teaching hospital and “seriously impacted” 17.7% of these patients, “ranging from temporary disability to death”).

96. See A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due To Negligence: Results of the Harvard Medical Practice Study III*, 325 NEW ENGL. J. MED. 245, 248, Tbl. 3 (1991) (showing 1/6–1/7 of total claimants suffered adverse events caused by negligence).

[The ratio of adverse events caused by negligence to medical malpractice claims of] 7.6 to 1 does not mean . . . that 13 to 14 percent of injuries due to negligence lead to claims. . . . [T]he fraction of medical negligence that leads to claims is probably under 2 percent. The difference is accounted for by injuries not caused by negligence . . . that give rise to claims.

Id. at 249; see David M. Studdert et al., *Negligent Care and Malpractice Claiming Behavior in Utah and Colorado*, 38 MED. CARE 250, 253–54, Tbl. 1 (2000) (“The adverse event was attributed to negligence in 4 claims. Thus, 14 of the 18 claims (78%; 95% CI, 56 to 92) were made in the absence of negligence . . .”); *Id.* at 254–55 (“The probability of a claim after a negligent adverse event is 2.5% (95% CI, 0.1 to 4.9).”). But see Tom Baker, *Reconsidering the Harvard Medical Practice Study Conclusions about the Validity of Medical Malpractice Claims*, 33 J. L. MED. & ETHICS 501, 502 (2005) (“[T]he finding that most medical malpractice claims are not based on either iatrogenic injury or provider negligence stands on a small and precarious empirical base. Indeed, the . . . data are as likely to support a . . . finding . . . that most malpractice claims are reasonably related to medical management injuries and provider negligence.”).

97. See, e.g., Marlynn L. May & Daniel B. Stengel, *Who Sues Their Doctors? How Patients Handle Medical Grievances*, 24 LAW & SOC’Y REV. 105, 118 (1990) (discussing the results of a study examining the dispute resolution method of choice between patients and doctors); Charles Vincent et al., *Why Do People Sue Doctors?*, 343 THE LANCET 1609, 1609–13 (1994) (examining why patients and their relatives bring malpractice suits).

98. Gerald B. Hickson et al., *Factors That Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 J. AM. MED. ASS’N 1359, 1359 (1992).

99. *Id.* at 1361 (discussing study results indicating that the most common reasons (average 1.4 per claimant) for filing claims are: advice by others (33%), need for money (24%), revenge or deterrence (19%), perception of a cover-up (24%), desire for more information (20%), and

Are all physicians at equal risk for suits? Sloan, et al., in examining the claims experience of Florida physicians, found that for each discipline, 75-85 percent of awards and settlement costs over a five-year period were made on behalf of only 3-8 percent of that group of physicians.¹⁰⁰ According to another study, it appeared that physicians' risk of malpractice claims was stable and persistent; in other words, high risk today means high risk in the future.¹⁰¹

Why might some physicians attract a disproportionate number of claims? Several factors may be at work. Demographic characteristics of patients who sue vary from study to study.¹⁰² Looking for other factors potentially associated with claims, Entman et al., conducted a study in which they evaluated whether there was a difference in technical competency between high-suit and low-suit physicians.¹⁰³ They sorted obstetricians into four groups based on their malpractice experience over a six-year period.¹⁰⁴ Blind reviews of their medical records by obstetric, neonatal intensivist, and pediatric specialists revealed no significant group differences in the obstetricians' technical competence. The researchers also found no difference in patient risk factors among the physician groups.¹⁰⁵ In a

realization that child will have no future (20%); May & Stengel, *supra* note 97, at 118-19 ("Suers extensively seek input from friends and relatives, lawyer friends, and unnamed confidants in making their dispute resolution choices. They question their doctor's competence and concern about the personal effects of their medical problem, and believe that they have experienced a serious injury.").

100. See Frank A. Sloan et al., *Medical Malpractice Experience of Physicians: Predictable for Haphazard?*, 262 J. AM. MED. ASS'N 3291, 3293 (1989) ("More than 85% of the payments for physicians in the medical specialty group were made on behalf of only 3% of physicians. . . . In the obstetrics-anesthesiology group, more than 85% of payments were incurred by approximately 6% of physicians. For the surgical specialty group, three fourths of the total payment was made on behalf of 7.8% of physicians.").

101. Randall R. Bovbjerg & Kenneth R. Petronis, *The Relationship Between Physician's Malpractice Claims History and Later Claims: Does the Past Predict the Future?*, 272 J. AM. MED. ASS'N 1421, 1424 (1994) (finding that physicians with claims (whether paid or unpaid) during a baseline six-year period were two to four times more likely to have new claims over the subsequent three years than those with no claims during the baseline period).

102. See, e.g., Andrews, *supra* note 64, at 371 (stating that white and wealthier patients more likely to bring claims); Sloan, *supra* note 99, at 29 (finding that patients who sued reflected the demographic and financial spread of Floridians and the US population in general); Frank A. Sloan & Chee Ruey Hsieh, *Injury, Liability, and the Decision to File a Medical Malpractice Claim*, 29 LAW & SOC'Y REV. 413, 427-28 (1996) (finding that for birth injuries, Catholics were more likely to claim; blacks less likely to claim than whites; income had no effect on likelihood of claiming); Helen R. Burstin et al., *Do the Poor Sue More?*, 270 J. AM. MED. ASS'N 1697, 1701 (1993) (finding that in the face of medical injury, the poor, elderly and uninsured are less likely to sue than other patients).

103. Stephen S. Entman et al., *The Relationship Between Malpractice Claims History and Subsequent Obstetric Care*, 272 J. AM. MED. ASS'N 1588, 1588 (1994).

104. *Id.* at 1590.

105. *Id.* at 1589.

second study, women randomly selected from Florida vital statistics were sorted into four groups based on their obstetrician's malpractice experience.¹⁰⁶ None had filed lawsuits against their obstetricians.¹⁰⁷ Patients answered open-ended questions about their obstetric care.¹⁰⁸ The researchers found significant differences among the four groups' responses regarding their physicians' communications, care and treatment, access and availability, and concern for them as valued persons.¹⁰⁹ At least twice as many patients complained about the high-suit physicians compared with low-suit physicians.¹¹⁰ The authors concluded that the same small percentage of physicians responsible for high numbers of malpractice cases were also associated with higher numbers of patient complaints, even among patients who never sued.¹¹¹

B. Physicians' Malpractice Claim Risk According to Their Patient Complaint Files

Since the research suggested an association between patient dissatisfaction and malpractice claims risk, the Vanderbilt group sought to examine whether a common and readily available source of patient complaints—unsolicited concerns recorded by a patient relations department—would be similarly associated with malpractice risk. Using patient relations and risk management data covering a six-year period at a large academic medical center, the first analysis revealed that 9 percent of the medical group physicians were associated with 50 percent of all physician-related complaints.¹¹² Logistic regression analyses showed that the two strongest variables for risk were the physician's area of practice (for example, Surgery was at higher risk than Medicine¹¹³) and the volume of unsolicited patient complaints.¹¹⁴ All physician-related types of patient

106. Gerald B. Hickson et al., *Obstetricians' Prior Malpractice Experience and Patients' Satisfaction with Care*, 272 J. AM. MED. ASS'N 1583, 1583 (1994).

107. *Id.*

108. *Id.*

109. *Id.* at 1586.

110. *Id.*

111. *Id.*

112. Gerald B. Hickson et al., *Patient Complaints and Malpractice Risk*, 287 J. AM. MED. ASS'N 2951, 2953 (2002).

113. For the purpose of this Article, "Surgery" includes all general and subspecialist fields of surgery, including otolaryngology, obstetrics-gynecology, neurosurgery, and orthopedics, and "Medicine" includes primary care fields, including pediatrics, internal medicine, family medicine, as well as medicine and pediatric subspecialties.

114. Hickson, *supra* note 112, at 2955.

complaints (i.e., communication, care and treatment, concern for patients, access and availability, environment) appeared to indicate dissatisfaction and were associated with a higher risk of claims.¹¹⁵

The logistic regression equations were next used to further describe the risk management experiences of the medical group members (Table 1).¹¹⁶ A "risk score" was calculated for each physician by inserting values for his or her type of practice (Medicine or Surgery), service volume, and number of unsolicited patient complaints into the regression equation. Every medical group member was sorted into one of five empirically determined risk categories. Next, the mean risk management payouts (dollars and percentage of dollars paid out) for each of the five groups was calculated, and each group's mean number of complaints per physician was assessed.

Table 1
Risk Management Expenses and Patient Complaints for 5 Groupings
of a Medical Center's Physicians Based upon Calculated Risk Scores.

Predicted Risk Category	# (%) MDs	Mean Dollars Paid Out*	Percentage of Total Dollars Paid Out	Mean Number of Complaints per MD
1 (low)	318 (49)	1	4%	2
2	147 (23)	6	13%	6
3	76 (12)	4	4%	10
4	52 (8)	42	29%	16
5 (high)	51 (8)	73	50%	42
Total	644 (100)		100%	

* Dollar value of low risk group adjusted to one. All other physician groups represented in multiples of low risk group.

Nearly half (49%) of the medical group (Category 1) had risk scores that clustered at the low end of the distribution. Each

115. *Id.*

116. Previously unpublished data.

physician in the group averaged two unsolicited complaints in the six-year study period. By contrast, 8 percent of physicians whose calculated risk scores clustered at the high end (Category 5) of the distribution averaged forty-two complaints each. The low risk group was responsible for 4 percent of all risk management-related costs, whereas the highest risk group was responsible for 50 percent of dollars paid out (including court costs, attorneys' fees, and payments to claimants). Even more startling is that physicians in the high risk group had an average payout seventy-three times that of their low risk colleagues.¹¹⁷

C. An Opportunity to Reduce Malpractice Claims Risk

Given the association between complaints and malpractice claim risk, the Vanderbilt group developed the Patient Advocacy Reporting System ("PARSSSM") to investigate how complaint data might be used to reduce risk and promote quality care. Research using this program has been ongoing for the past six years at multiple sites. In brief, patient complaints are coded,¹¹⁸ analyzed, and a complaint index is generated for each physician and compared with other medical group members. A higher index reflects higher risk for medical malpractice claims. Physicians with an index greater than the ninety-fifth percentile are candidates for peer-to-peer intervention.

We have developed and implemented a training program at all facilities that have adopted the PARSSSM process. Each institution establishes a committee in compliance with its state's requirements for protected peer review. Committee members are nominated to be trained as "messenger peers" on the basis of several criteria: they are distributed among practice types, in current active practice, respected by colleagues, committed to confidentiality, and willing to serve. Their own complaint scores are mostly satisfactory, but on occasion, some high risk physicians have served as messengers. Peer physicians receive six to eight hours of training to help them deliver the data and the essential message to high-complaint colleagues. Various intervention support materials are explained and peers role play to practice delivering the data and responding to common reactions.

117. While the risk management payouts generally increased with increasing risk score groupings, an exception occurred in the second risk category: one physician with very few unsolicited patient complaints was associated with a single large jury verdict, so the prediction, while evidently quite good, results in small numbers of both false positives and false negatives.

118. See Gerald B. Hickson et al., *Development of an Early Identification and Response Model of Malpractice Prevention*, 60 LAW & CONTEMP. PROBS. 7, 13-14 (1997) (discussing in detail how the system used a coding method to turn raw patient reports, such as 'doctor was rude,' into a data set that is easily analyzed using statistical tools).

Most institutions adopt three levels of interventions. Level 1 involves a confidentially delivered, non-punitive peer awareness intervention. Level 2 involves an authority figure, usually a department chair or chief of service, and development of a specific action plan. Level 3 involves higher levels of administration and the institution's disciplinary process.

A typical Level 1 intervention proceeds as follows:¹¹⁹ The committee chair gives each high-complaint physician's intervention support materials to one messenger, who sees only the materials for the physician(s) whom he will visit. Folders contain: (1) a signed letter from the messenger which describes the program and reveals the doctor's rank in both the overall medical group and broad areas of either "Medicine" or "Surgery"; (2) a table showing the physician's complaint type distribution (Table 2); (3) text of complaint narratives; (4) a "Report Card" illustrating the specific individual's ranking in the physician group (Figure 1), and; (5) wherever applicable, a copy of the institution's policy regarding this program. The positive intent of the process is emphasized, and the letter concludes with a request to meet and discuss the data. When they meet, messengers are urged to give no diagnoses or prescriptions. They are only to share the data, encourage creative thinking, and promise to return when follow-up data are available.

119. See James W. Pichert et al., *Using Patient Complaints to Communicate Concerns to Colleagues*, in *ACADEMIC COMPENSATION AND PRODUCTION REPORT* (Med. Group Mgmt. Ass'n ed., 2004) 16, 16–19 (describing a typical intervention program).

Table 2
 Complaint Type Summary
 Medical Center Name
 Period 1 - Period 2
 Care Provider: Dr. John Doe

<u>Complaint Type</u>	<u>NUMBER OF COMPLAINTS</u>		<u>PERCENT OF TOTAL</u>	
	<u>Your Complaints</u>	<u>Average for Medicine</u>	<u>Your Complaints</u>	<u>Average for Medicine</u>
Communication	6	2.0	10.3%	15.4%
Care and Treatment	16	5.4	27.6%	41.5%
Concern for Persons	26	2.7	44.9%	20.8%
Accessibility	5	1.3	8.6%	10.0%
Environment Problems	0	0.0	0.0%	0.0%
Billing Issues	5	1.6	8.6%	12.3%
Total	58	13	100%	100%

Figure 1
 Facility Index Distribution Graph

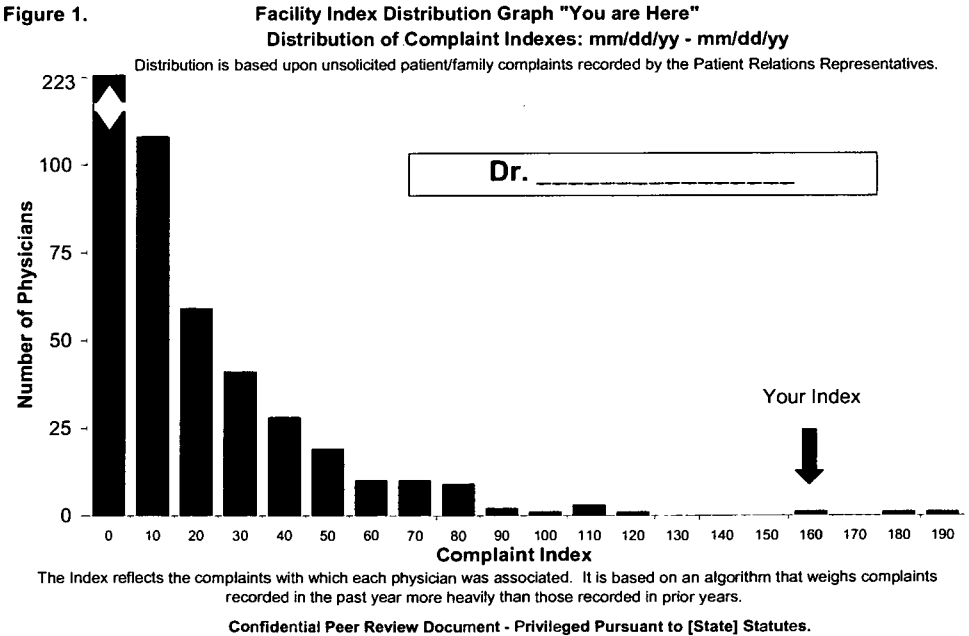
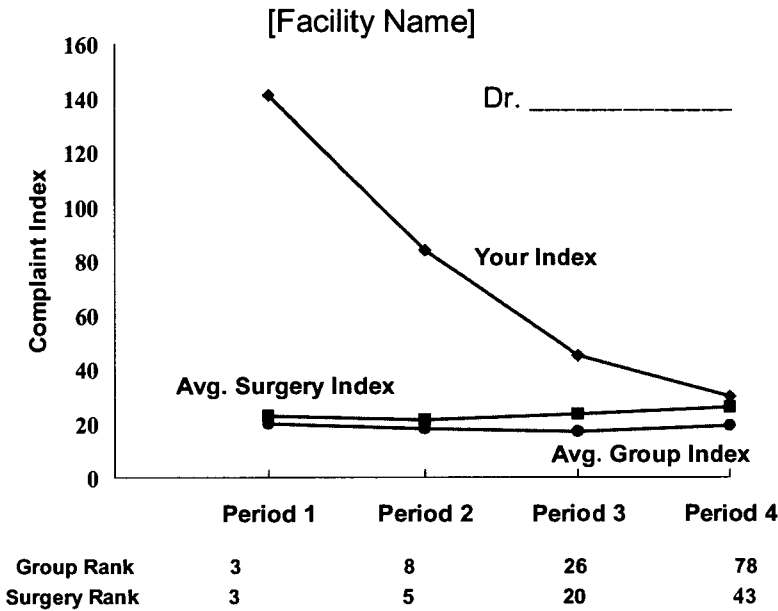


Figure 1 illustrates calculated indexes for all facility physicians based on age of complaint (more recent complaints are given more weight) and intensity of complaint (multiple sub-complaints contained within a complaint report). Physicians are shown where their index lies on the grid, which vividly demonstrates that colleagues practicing

under the same conditions are associated with fewer complaints. For follow-up visits, a line graph (Figure 2) shows change in the physician's index over time relative to his or her area of practice and facility.

Figure 2.
Physician's Index Over Time Relative to Facility and Area of Practice



Physicians whose indexes do not improve are considered candidates for Level 2 interventions. Level 2 interventions involve an authority figure, such as a section chief or chair of a department, with whom data is shared. They develop a plan, tailored to the extent and severity of issues. The plan may be designed to help a doctor with practice management, referral for health or psychiatric evaluation, or continuing education-based skills training.

Follow-up is ongoing for all physicians. If a physician shows positive trending, he or she will receive positive feedback. If and when the index falls to the normal range, physicians are congratulated on their success, and meetings with the peer are suspended. Surveillance continues for the entire medical staff, and if a doctor's index increases, he or she is intervened upon again. If Level 2 results in no improvement, Level 3 interventions involve higher level administrators who may invoke the institution's disciplinary process.

As of this writing, composite intervention results are available for ten institutions. To date, 283 initial Level 1 and close to 400 follow-up interventions have occurred. Most have been well-received; fewer than 2 percent met with overt hostility. Most intervenees respond professionally. They may request to be shadowed to get suggestions for improvement, seek resources from their chair which they think will help improve their service, or reorganize their unit. At seven sites, 202 physicians have been tracked long enough to have follow-up data (Table 3).

Table 3
PARSSM Follow-Up Data After Level 1 Interventions
(202 Physicians at 7 Sites)

	No. (%)
Complaint indexes improved	118 (59)
Complaint indexes unimproved or worse, but interventions remain at Level 1	42 (21)
Departed after Level 1 intervention(s)	35 (17)
> Departed soon after Level 1	19
> Index improved	8
> Index unimproved or worse	8
Interventions moved to Level 2	7 (3)
> Departed after Level 2, unimproved	3
> Index improved	1
> No further data yet available	3

Overall, about two-thirds of physicians receiving interventions demonstrate improved indexes. Level 2 interventions occurred in three institutions, involving seven physicians, three of whom have since departed.

Thirty-eight physicians in total are no longer at their facilities. Departures were related to job location changes or retirement (n=34), and, in four cases, death. We can only speculate that perhaps these physicians "solved" their issues by moving on, were experiencing work-related dissatisfaction which somehow communicated itself to patients, or an existing illness or impending retirement left them less focused on patient care. Because very good doctors can be caught in and decide to leave unsupportive environments, we also make no judgments about their qualifications at the time of departure.

Finally, preliminary data from a large academic medical center (Figure 3)¹²⁰ suggest that the initiation of interventions in two waves during late 1998 and early 2000 is associated with reduction in claims¹²¹ and lawsuits¹²² based on volume of service.¹²³ Rates of the institution's general liability (e.g., premises liability) and professional liability claims, both adjusted per 10,000 Relative Value Units ("RVUs") of care delivered each year, were analyzed to understand the institution's trends in risk management activity over time. The trends for general and professional liability claims differed significantly (Year X Type of Liability interaction, $t=3.5$, $p=0.006$). There was a significant downward slope in the institution's professional liability data ($t=-3.39$, $p=0.02$), whereas the general liability data showed no significant change over time.¹²⁴ In other words, the salutary effects seemed specific to professional liability actions, and the reduction did not appear to be an artifact. Several factors besides the PARSSM intervention program may have contributed to the trend, including changes in the risk management process, medical procedures, staff, patient/payor expectations, case mix, legal climate for malpractice claims, institutional marketing, and internal quality and safety programs. Whether interventions account for a small or large proportion of the positive effect cannot now be determined, but these preliminary results are encouraging.

120. Previously unpublished data.

121. Claims are defined as pre-suit risk management files associated with at least one of the following: demand for payment by patient or patient's legal representative, payment of legal fees or consultant fees, or payment made to a potential plaintiff (patient or other party-in-interest).

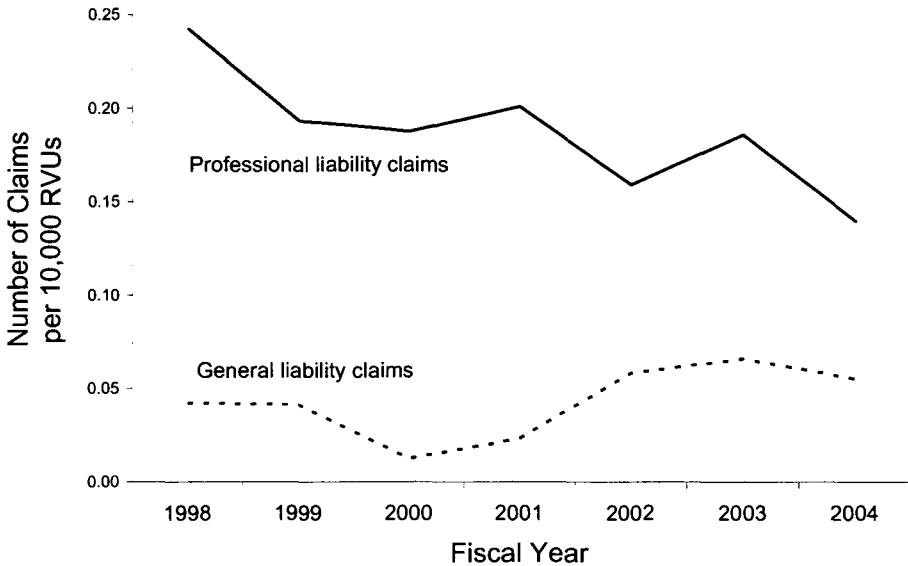
122. Lawsuits are defined as filed suits regardless of ultimate disposition or outcome.

123. Patient volume is defined in Relative Value Units, or RVUs. WILLIAM C. HSAIO ET AL., A NATIONAL STUDY OF RESOURCE-BASED RELATIVE VALUE SCALES FOR PHYSICIAN SERVICES: HARVARD UNIV. PHASE III STUDY. FINAL REPORT, REVISED vol. 1:215 (1992).

124. Analyses employed the R statistical package, general linear model analysis. As Figure 3 shows, the overall rate of PL and GL claims differed significantly ($F_1 = 12.3$, $p<.01$), but this difference is not interesting. It is the differential slopes of the lines that suggest that interventions directed at reducing PL appear to have had a greater effect than any concurrent interventions designed to reduce GL.

Figure 3.

Number of Claims per 10,000 Relative Value Units (RVUs) over Time.



IV. CONCLUSION

Despite legal protections established by federal and state legislatures to encourage medical peer review, many observers assert that its outcomes fall short of expectations. Critics of peer review rarely attribute peer review's perceived inability to adequately protect interests of patients and reviewed physicians to its *ex post* method of review. We suggest an alternative view that peer review may be used very effectively to address, *ex ante*, the disproportionate malpractice claims risk of some physicians.

In this Article, we introduce and discuss the use of the Vanderbilt PARSSM program as part of institutions' peer review framework. The program aggregates patient complaint data into comparative indexes to share with physicians at high risk for malpractice claims. Follow-up data show that indexes improve for the majority of physicians who learn about their status from a peer. Our study of this methodology at five institutions provides empirical evidence that suggests the program may identify physicians at increased risk of malpractice claims and have an impact on improving their patient complaint profile. At one site, we have demonstrated a possible reduction in malpractice claims for the institution related to

the implementation of the program. Further research on PARSSM data is ongoing and may determine the magnitude of the effect.

There are several features of the PARSSM program which promote success. We recognize that this program is just one of several potential strategies for strengthening medical peer review, and feel strongly that similar elements should apply to any effective peer review program. First, whenever possible, peer review is likely to be more effective when based on aggregate data, not single events, and designed to apply to all physicians equally. Comparison with peers strengthens the contextual quality of the data. Second, data presented in graphic form, and conveyed in person in a non-punitive, non-judgmental, non-directive fashion, respects a colleague's professionalism, dignity, and problem-solving abilities, and encourages creative thinking. Third, peers need to be carefully selected based on commitment to confidentiality, willingness to participate in the process, reputation among the medical staff, and when feasible, matched by discipline. If disinclined to continue, peers should be free to drop out of a peer review program. Fourth, peers should be trained to share data comfortably, and prepared to deal with predictable pushback from physicians. Finally, an escalating process must be built in to assure that administrators become involved when physicians do not respond to a peer-based program. We believe that if these principles are consistently incorporated into peer review programs to complement traditional peer review, a clearer picture of physicians' risk for malpractice claims will emerge which can be constructively addressed in most cases and result in better patient care.

Finally, we believe that PARSSM and other peer review programs need continued legal protections in order to operate most effectively. Confidentiality of peer review data beyond those with an administrative need-to-know is essential, and protection from legal discovery—so long as they are genuinely used to promote quality and safety—is paramount. Interests of institutions, physicians, and patients are harmed if there are disincentives to implement and utilize methodologies which serve those interests.