The Attitudes of Family Physicians Toward the Peer Review Process

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We conducted a study to determine family physicians' attitudes and perceptions toward current peer review practices, and to discover if family physicians, general surgeons, and hospital-based physicians view the process differently. A survey instrument measured perceptions of physicians on the following four areas of the peer review process: (1) how peer reviews are administered, (2) the educational value of peer reviews, (3) the performance of peer review committees, and (4) the effect of the peer review process on physician morale. The survey was mailed to all 3528 practicing physicians who were members of a state medical society. A subgroup of 1695 family physicians, general surgeons, and hospital-based physicians was used for this study, of whom 774 (46%) responded to the questionnaire. Over one half of the family physicians responded negatively toward the peer review process on all items of the survey, with over 70% dissatisfied on five of the 17 items. Family physicians, general surgeons, and hospital-based physicians viewed the peer review process differently in the four areas measured. We found statistically significant differences of opinions regarding present peer review practices among the specialties cited. However, the overall dissatisfaction of the specialty groups studied may suggest that the concern resides more with the profession at large than with any one medical specialty group. *(Arch Fam Med. 1993;2:1271-1275)*

In the June 29, 1990, issue of *USA Today*, the cover story asked: "Who Is Minding the Doctors?" The article questioned whether state medical review boards were protecting the public from incompetent physicians. More than ever before, physicians are coming under close scrutiny by consumer groups and the public at large. Within the last two decades, sanctions against physicians by state medical review boards has soared; from 1982 to 1987 alone there was a 170% increase. An examination of the reviews has revealed that there are three factors causing this increase: the concern of the consumer advocacy movement; the influence of third-party payers, especially the US government; and the explosion of medicolegal litigation.[1]

Traditionally, society has given the medical profession substantial autonomy and self-analysis for ensuring high-quality service to the public. This autonomy is based on the recognition that physicians possess critical knowledge and skills that the public finds difficult to evaluate. In meeting the evaluative responsibility given to the medical profession by the public, the peer review process has evolved.

For many years, professional literature defined peer review as "an evaluation of one's work by his or her equivalents in their field of endeavor."[2] Recently, the definition of peer review has become more complex, for it is being defined as "any review of professional medical activity, whether directly or indirectly related to quality and whether performed by true 'peers' or by external parties".[1]

The writings of Cardwell and Gary[1] and Strawcutter,[3] show that there is little doubt that physicians have accepted peer

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review as a necessary part of their professional role. Recent trends in peer review practices, however, reveal that physicians are dissatisfied with the process. The main thrust of this dissatisfaction concerns the ever-increasing intervention of outside influences in the form of government-mandated peer reviews.

Because of widespread disenchantment with the peer review system, we conducted a study in a midwestern state to discover physicians' attitudes and perceptions concerning current peer review practices. To avoid any bias, researchers were invited from a state university other than the one that housed the medical school that conducted the study. Differences in attitudes of family physicians, surgeons, and hospital-based physicians (anesthesiologists, pathologists, radiologists) toward certain aspects of current peer review practices were compared. The following questions were asked: (1) What are the attitudes of family physicians toward the current peer review process? (2) Do family physicians, general surgeons, and hospital-based physicians view the peer review process differently?

For years, the medical profession performed its own peer review. As a completely autonomous profession, no outside input was sought or accepted.[4] Disciplinary actions were kept confidential. Revocations of medical licenses or hospital privileges were rare.[1] Before the 1960s, scant attention was paid to the Department of Public Health. However, as time passed, the federal government placed more emphasis on public health. (The advent of Medicare and Medicaid in 1965 established the US government as the largest third-party insurer in the nation.) In a speech to a forum for medicine and industry, Murchison,[5] a general practitioner, summarized the ever-increasing influence of the government in health care when he observed that, "Where federal money goes, federal control always follows."

Because of increasing Medicare and Medicaid costs, Congress established professional standards review organizations (PSROs) in 1972, which were responsible for assessing medical care. However, these PSROs did not give the same priority to quality assurance activities as they did to admission and continued-stay reviews.[6] At the insistence of the medical profession, quality assurance was included in the PSRO program. This was done to ensure that, in the enthusiasm for cost containment, the maintenance of high standards was not forgotten.[7] Lawmakers eventually viewed the PSRO system as too inflexible and restrictive, with insufficient professional participation in review processes.[3] In an effort to deregulate the health care industry, Congress passed the Peer Review Improvement Act in 1982 which delegated broad disciplinary powers to peer review organizations (PROs) throughout the country.[8] It replaced PSROs with what became known as PROs.

Holthaus[9] identified several states that have encountered difficulties with PROs. Hospitals in Florida and South Carolina entered into litigation with PROs. Every hospital in South Carolina was either suing the state PRO or had done so in the past. Hospitals in New York have expressed major frustrations with the state PROs. Also, in the state of Texas, hospital staffs have registered complaints concerning a lack of satisfactory communication with their PROs.[9] Goldman,[10] Harrop,[11] and Mattson[6] found similar dissatisfaction.

Physicians have not refrained from lively critiques of the individual processes. The majority of their comments can be found in state medical journals. Thomas Morford, the director of the Health Care Financing Administration's Health Standards and Quality Bureau, was quoted as saying, "Presently, we are working under a very antiquated review system. Our tools are limited to the judgment and experience of nurses and physicians conducting the review. Because this judgment varies, so does the review" (*Am Med News.* November 9, 1990;24:36-37). An essay written by Aronson[12] equated the plight of physicians with that of the character Yossarian in Joseph Heller's novel *Catch-22* who tried to function rationally in an irrational system. Murchison[5] recounted personal experiences on a similar theme.

A MEDLINE search from 1976 to the present included numerous articles on the practice of peer review. Most of these articles are in regard to the reliability, evolution, indictment, and future of PROs. We found no studies in the MEDLINE search that analyzed the collective perceptions of physicians toward specific aspects of the peer review process.

METHODS

The physicians' responses to items on the survey were used to answer research questions 1 and 2. Responses to question 1, "What are the attitudes of family physicians toward the current peer review process?" were analyzed based on how physicians responded to each item of the survey instrument. Responses to question 2, "Do family physicians, general surgeons, and hospital-based physicians view the peer review process differently?" were analyzed with a one-way analysis of variance model that also made use of the physician responses to the items on the survey.

SURVEY

The survey measured the following four categories related to peer review: administration, educational value, committee performance, and physician morale. It consisted of six demographic items, three categories to measure the peer review process, and one category to measure the effect on physician morale. The first category (administration) included five items to determine opinions concerning how well the peer review process was administered. The second category (educational value) included three items created to measure opinions concerning the educational value of the peer re-

Table 1. Comparison of Specialties Used in Study

Specialties	Population Total, No.	Survey Sample, No.	% of Population
Family physicians	925	519	56.1
General surgeons	227	109	48.0
Hospital-based	543	146	26.9
Total No.	**1695**	**774**	45.7

view process. The third category (committee performance) consisted of five items designed to measure opinions regarding the performance of peer review committees. The fourth category (physician morale) incorporated four items designed to determine how the process of peer review influenced physician morale. Each item was scored on a scale of 1 (strongly agree) to 5 (strongly disagree). The validity of this instrument was obtained by submitting it for review to seven practicing physicians (two general practitioners and one internist, pediatrician, surgeon, otorhinolaryngologist, and obstetrician each). These physicians were chosen because of their experience and interest in the peer review process. Most of them had acted as peer reviewers or had administered a peer review program. The reliability of the instrument was determined with the Cronbach α statistic.

POPULATION

The survey was mailed, with an enclosed return envelope, to all 3528 physicians belonging to a midwestern state medical society. Each of these members had earned a doctor of medicine or a doctor of osteopathy degree and was licensed to practice in the state. No follow-up was attempted as the responses were meant to be anonymous.

The focus of this study was on family physicians, general surgeons, and hospital-based physicians. These specialties constituted 1695 physicians (48%) of the total population.

RESULTS

Table 1 shows the representation of the specialties used in this study. The results were based on the following three groups: family physicians, general surgeons, and hospital-based physicians. The answer to question 1 was obtained by analyzing only the family physicians' responses to items on the survey. **Table 2** summarizes responses to each item. For purposes of clarity, the appropriate items are grouped within each category. The results of the study were supplied to each of the board members of a state

Table 2. Family Physicians' Opinions on Peer Review

Statements by Category	No. of Respondents	Responses, %				
		Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
Administration						
1. Standardized criteria exists	519	1	8	20	41	30
2. Process unbiased	516	3	14	22	32	29
3. Appeals processes adequate	518	2	19	22	31	26
4. Adequate legal recourse	516	3	9	30	27	31
5. Executed in time	518	1	14	27	28	30
Educational Value						
6. Reduces poor practice	519	4	25	17	31	23
7. Functions as an educational process	519	4	25	15	32	24
8. Encourages best medical decisions	519	3	12	12	41	32
Committee Performance						
9. Review committees are qualified	518	5	24	17	36	18
10. Consideration to clinical judgment	517	2	12	14	39	33
11. Adequate information available	519	2	14	14	33	37
12. Reviewers are careful and thorough	518	2	13	18	38	29
13. Reviewers are responsive	519	1	18	24	35	22
Physician Morale						
14. I am leaving the profession*	518	10	18	19	25	28
15. Quality of life has diminished*	517	19	31	20	20	10
16. Have increased stress*	519	45	39	3	9	4
17. Encourages doctors to remain	516	2	5	19	34	40

**Reversed ordering of response, ie, disagreeing was a positive statement.*

Table 3. Significance of One-Way Analysis of Variance for Comparisons Between Specialty Groups

Category	Overall F Ratio*
Administration	5.32
Educational value	8.00
Committee performance	7.61
Physician morale	9.40

**Differences were significant at the .05 level.*

PRO and referred to in their deliberations on reform of the state system.

Table 2 shows that over one half of the family physicians responded negatively toward the peer review process on all items in the instrument. On five items (1, 8, 10, 16, and 17), over 70% of the family physicians reported dissatisfaction. Item 17 (peer review encourages the best doctors to remain in practice) drew the most negative reactions, with 40% strongly disagreeing.

Descriptive analyses were used primarily to determine if there was sufficient internal reliability within categories to warrant using results based on category rather than on item. They were also used to compare results with those in Table 2. If categories were used, more depth from within the study could be obtained.

Values for internal consistency were obtained using Cronbach's α and were all above .70. Each category was concluded to have sufficient internal consistency to warrant using categories rather than items in the analysis of results. Mean values and ranges (minimum to maximum) were obtained from applying scores of 1 for "strongly agree," to 3 for "no opinion," to 5 for "strongly disagree." The descriptive information reinforces data in Table 2 because there was disagreement with the peer review process. The ranges of values by categories were all above 3, except for category four (physician morale). This supported data in Table 2.

Table 3 shows the results of the analysis of variance applied to responses to question 2 by the specialty groups. There was an overall statistical significance for scaled variance among the three groups across all categories. For example, there was a difference among the three groups regarding attitudes toward peer review administration, the educational value placed on peer review, their perceptions of peer review committee performances, and the effect of peer review on morale.

The result of a post hoc analysis (Tukey's B) to determine the cause for the significance of the differences of opinion among the three specialty groups for each category is presented in **Table 4**.

As it can be seen, general surgeons had the most number of negative responses, accounting for the largest proportional differences between the three groups on each of the first three categories. On the fourth category, physician morale, both family physicians and surgeons gave more negative responses than the hospital-based physicians.

COMMENT

While family physicians had a decidedly negative perception of the peer review process, surgeons expressed greater dissatisfaction. In the area of physician morale, family physicians and surgeons reported being more negatively affected by peer review than did the hospital-based physicians. However, the statistical differences among groups lack practical meaning since the maximum mean scale difference across the groups was only 0.40 on the 5-point scale. General surgeons caused the difference across all categories to be statistically significant, but the maximum mean scale difference among groups was less than 0.43 on the 5-point scale. This scale sensitivity resulted from the large sample sizes, suggesting that the significance was not meaningful and that the main area of concern may reside more with the profession at large than within any one medical specialty group.

These findings apply only to the three medical specialties studied. Further research is needed to determine if the same conclusions can be made regarding other specialties in the total population. Also, further research is necessary to determine if factors such as duration of experience, group or solo practice, and age alter physicians' perceptions of peer review.

Any issue concerning peer review is an emotional one. The threat of public humiliation or loss of livelihood is always present in the system. Changes are being proposed that might minimize the disaffirmations associated

Table 4. Mean Values of Opinions by Specialty on Peer Review Categories

	Category			
Specialties	Administration	Educational Value	Committee Performance	Physician Morale
Hospital-based	3.61	3.56	3.62	3.17
General surgeons	3.93*	3.99*	4.01*	3.57*
Family practice	3.74	3.62	3.71	3.51*

**Differences were significant at the .05 level.*

with the current individual case review method by replacing it with system-level approaches. For instance, Jencks and Wilensky[13] have argued:

> The goal of the Health Care Quality Improvement Initiative is to move from dealing with individual clinical errors to helping providers to improve the mainstream of care. Such a reform implies profound changes. First, the processes and criteria for review change: instead of having clinicians use essentially intuitive local criteria to find problems in individual cases, peer review organizations (PROs) will use explicit, more nationally uniform criteria to examine patterns of care and patterns of outcomes. Second, the immediate objective changes: PROs will focus primarily on persistent differences between the observed and the achievable in both care and outcomes and less on occasional, unusual deficiencies in care period. Third, the ultimate method changes: PROs will help providers identify problems and their solutions by monitoring patterns of care and outcomes and allowing providers to conduct the more intrusive and detailed study of who, when, and why.

The consensus among the government officials and peer review experts who participated in the 1990 annual conference of the American Medical Peer Review Association was that either PROs had to move away from an individual case review system and toward a system that uses data and promotes continuous quality improvement or face obsolescence.[5]

CONCLUSIONS

The following conclusions can be drawn from the findings of this study:

1. Although all specialty groups expressed dissatisfaction with the peer review process, surgeons were the most dissatisfied.

2. When the four areas of the peer review process were compared—administration, educational value, committee performance, and physician morale—family physicians and surgeons expressed the most dissatisfaction regarding physician morale.

3. Statistically significant differences of opinions exist regarding present peer review practices among the specialties cited. However, the overall dissatisfaction of the specialty groups studied suggests that the concern involves the profession at large rather than any one medical specialty.

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