COMMITTEE REPORT
OPERATIONS MANAGEMENT

Reviewing the Peer Review Process: The Reginelli Case

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The Reginelli case highlights the semantic nature of law in contrast to the **SPIRIT OF MEDICINE.**

Most emergency departments (EDs) have a chart review process, often completed by the department medical director or a designated departmental quality officer, which is done both for quality control and to review any cases that raise concern for patients or providers. These chart reviews are typically kept in a file for each provider. Some cases merit further review. While the vast majority of these cases are screened, reviewed and addressed at the department level, the few more concerning cases are escalated to the hospital Peer Review Committee, which consists of representatives from different disciplines within the hospital. In Pennsylvania, as in most states, this process is protected as confidential under the Peer Review Protection Act (PRPA), which is for the "proceedings and documents of a review committee."

However, this protection may not be as straightforward as the act implies. The following case and subsequent lawsuit, both a matter of public record, put the peer review process under review.

Monongahela Valley Hospital (MVH) is a modest rural hospital that contracts their ED physician services to an outside group that was part of a larger university medical center. The ED physicians, including the director, were employees of the university group. In 2011, Eleanor Reginelli was seen in the ED at MVH with a complaint of gastric discomfort. She was treated and released by the ED physician. Unfortunately, several days later, the patient had a myocardial infarction. The ensuing lawsuit alleged failure to diagnose the myocardial infarction at the time of presentation in the ED.

In the multiple depositions that followed, among them was the director of the ED. She testified that she maintained a "performance file" on the defendant physician, as she did on all the ED medical staff. This consisted of, among other things, charts that were randomly reviewed for quality control purpose as part of each provider's Ongoing Professional Practice Evaluation. The plaintiffs in the case requested the "performance file" on the defendant physician. Naturally, the ED group and MVH resisted, because publicizing the peer reviewed material would be in violation of the PRPA.

The protections of PRPA apply to "professional healthcare providers," which applies not just to physicians, but to institutions as a whole. MVH asserted that the contract group hired to staff the ED was hired to manage all facets of the department, including, "evaluating the quality and efficiency of services ordered or performed by health care providers," and therefore, was part of the hospital institution. However, despite this argument, the court granted the motion to compel release of the performance file. Following that decision, the ED group contended that the performance file was maintained solely on behalf of the management group, and that the work of the Medical Director was an "outside peer review process." This outside process had never been shared with MVH and was therefore irrelevant in the actions against MVH. The ED group and MVH were effectively presenting two different arguments – an institutional vs an outside peer review process – both in attempts to protect the peer review process.

Ultimately, the courts ruled that the performance file maintained by the ED director was not confidential. Part of their reasoning was that the ED group does not qualify as a "healthcare provider" under a strict interpretation of the statute. Another rationale was that an "individual physician" does not qualify as a peer review "committee." As a result of this case, hospitals and management groups across the state struggled to find a workable solution to ensure compliance with the PRPA in this new legal realm.

At MVH, a two-pronged approach was used. First, MVH officially formed an ED Peer Review Committee. The statute did not require that the committee be composed of physicians, but rather allowed for nurses and administrators to be part of the committee, so the members included the hospital's own director of quality and a senior vice-president whose domain included risk management. At MVH, cases are still primarily reviewed by the ED director, but then following the initial review, a written assessment is placed in a confidential file, and that file is shared with the other members of the ED Peer Review Committee. If needed, any significant issues are still elevated to the broader Peer Review Committee of the hospital. Secondly, the management group created a confidential file for medical directors of various EDs within the group's system that could be used to review cases that merited some further discussion or input, as deemed by the ED director and the ED Peer Review committee at the respective hospital.

The obvious need for confidential peer review to allow continued improvement of patient care is supported by the PRPA. The intent of the PRPA, while seemingly obvious to any healthcare provider, is not as simple when viewed through a legal lens. The Reginelli case highlights the semantic nature of law in contrast to the spirit of medicine. We hope that sharing our experience will enable other ED providers to better protect themselves, and their peers, in the future. ●

COMMITTEE REPORT
WELLNESS

Physician Burnout – A Systems Problem Requiring a Systems Solution

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Physician burnout. What does this mean? Concepts such as exhaustion, wellness, mental, and emotional health are just some of the phrases that the term "burnout" conjures up in my mind.

My journey with this notion started in residency. I have always experienced an internal struggle managing my personal and professional life. Given our erratic work hours, it was a challenge to make sure I spent quality time with my husband, especially since he also has a demanding job requiring a fair amount of travel. This feeling only increased exponentially after the birth of my children and the increasing demands my husband experienced in his work. At the same time, busy shifts with large volumes and high acuity of patients were making me feel more emotionally drained. I had no mental or emotional energy to contribute to my family at home. This was a cycle that then affected my empathy for patients and my experience at work.

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While personally dealing with these concerns, I began to think that maybe some of my colleagues were feeling the same way. The six months I spent researching the topic of physician burnout sparked my passion into seeing what I could do to create a culture of wellness within first my ED group, and now my hospital organization.

I started by working within my ED group. I took a data-driven approach to addressing wellness by creating interventions based on the results of semi-annual surveys. The goal of these interventions was to address the issues driving burnout and disengagement within my own section. There were many different concepts incorporated, including a biweekly "wellness email."

After two years, I wanted to do more and expanded my focus on physician wellness to the hospital level. It is important to understand that burnout is a systemic issue that requires change on an institutional level. We need to work to change the system so we can address factors affecting quality, efficiency, and access to medical care as well as patient satisfaction and compliance. It is vital that we work toward creating a culture of wellness in our community to address those drivers of burnout we encounter every day and that it be a physician that advocates for this change for his/her colleagues.

This starts with leadership. For me, this meant meetings with our senior leadership team as well as our medical executive board. It is imperative that these key leaders are on board with the importance of addressing physician burnout within an institution. All organizational change must have leadership support to be effective and buy in from senior leadership is essential if we are ever to enact the cultural change we desire. So, during these meetings, we worked towards aligning my goals for creating a culture of wellness within our institution with the values of our hospital leadership so we could work together. The feedback from these meetings held recently was positive and I am optimistic about our ability to create significant improvements in our organization regarding physician burnout.

As "wellness champions," my partner and I are now working on taking a top down approach to enlist community and peer support via colleagues from multiple medical departments. By working together, we hope that innovative and creative solutions to attack the issues of burnout that are specific to our hospital will arise. With the support of leadership, I believe much can be accomplished to decrease burnout and create a wellness culture within our hospital.

One challenge I have encountered along the way is maintaining patience. As John Heywood famously said "Rome was not built in a day" and solving the broad problem of physician burnout does take more than a few weeks or months, no matter how passionate one is. Much ground work needs to be accomplished before attacking this issue head on and creating a culture of wellness within any organization is often a paradigm shift that requires years to complete.

It is an arduous road with many a speed bump and detour along the way. But it feels good knowing that with each step I take, I am one step closer to decreasing burnout, improving mental and emotional health and working towards a culture of wellness within my organization. ●

References:

1. E.E. Frezza. "Moral Injury: The Pandemic for Physicians". *Texas Medicine* March 2019, p7.