

Institutional external peer review: A unique National Cancer Grid initiative

Peer review refers to a process of evaluation of scientific, academic, or professional work of an individual or institution by others working in the same field. Review of medical institutions or physicians by their peers is a time-honored way of evaluating the quality of healthcare provision and is probably the most effective, if done properly. However, there have been two concerns raised about the process of peer review within the medical profession: First, that the end-result of identifying and improving poor quality is an exercise in futility due to the lack of practical, implementable remedial measures. Second, the lack of objective criteria for a fair peer review could make the process ineffective by either giving glowing reports for institutions (or physicians) when there are obvious deficiencies, or worse, making innocent victims of competent institutions.^[1]

One of the best definitions for the objectives of peer review is found in the Singapore Ministry of Health Directives for Peer Review Learning for Prescribed Healthcare Institutions document^[2] which states that “*the peer review learning framework allows for practice-based learning and improvement to take place through regular and structured meetings during which specialist doctors review and learn from one another’s clinical practice and performance within a collegial and protected quality assurance environment.*” Institutional peer review has been proven to have improved outcomes both with patient care and costs of treatment.^[3]

Accreditation and peer review in Indian healthcare providers has been the exception rather than the rule. There have even been publications of proceedings of high-level meetings which concluded that universal accreditation was “not practical” in a country like India!^[4] Traditionally, fears of criticism and public reporting of infrastructural and other deficiencies have been deterrents to widespread adoption of this practice. In addition, Indian medical practice — Government funded or private providers, has been inherently resistant to regulation — whether by self or otherwise. However, more and more institutions are realizing the benefits of accreditation or certification by organizations such as the NABH, JCAHO, and JCI. However, an oft-repeated criticism of these forms of review is that the evaluation is done primarily about the systems, processes, and documentation rather than

the medical and humane aspects of healthcare delivery. Peer review, on the other hand, while being relatively more subjective than formal accreditation, takes a more holistic view of patient care and their outcomes from a fellow clinician’s perspective. Medical peer review should, however, instill trust by being fair and transparent, failing which it may be taken over by nonmedical teams, which would be detrimental both to the public and profession.^[5]

The National Cancer Grid (NCG) of India has the mandate of reducing disparities in cancer care based on geography and socio-economic status.^[6] Some of the measures planned or undertaken include adoption of a uniform set of evidence-based guidelines for management of common cancers, continuing medical (cancer) education, exchange of expertise, and experience between centers, data sharing, and peer review.^[6] One of the long-term solutions to reducing disparities in the provision of cancer care is to promote quality improvement exercises across centers by an atmosphere of openness with respect to evaluating institutions involved in the delivery of cancer care. Sustained improvement in infrastructure, systems, and processes of patient care is viable by a continuous cycle of peer review, identification of gaps, remedial measures (short-, medium-, and long-term) and completion of the review cycle by re-evaluation by a follow-up peer review.

While the Tata Memorial Centre had undergone an intensive, international peer review in 2010, the first peer review under the NCG was conducted at the Cachar Cancer Centre (CCC), Silchar in November 2014. This voluntary peer review by the CCC is highly commendable as this was the first brave step taken by a relatively small, rural cancer center in North East India; words are inadequate to convey the foresight, vision, and courage shown by the center’s leadership. Equally commendable is the willingness and enthusiasm of the first NCG peer review team, which voluntarily took on this task and spent a lot of time and effort, working under tight timelines, and a tighter budget.

To understand the process of the NCG peer review, it is best to break it up into its constituent phases: Preparation,

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survey, and the report. The preparation phase involved several sub-phases including the (voluntary) request to be peer reviewed, constituting the peer review team, self-assessment by the institution, the review plan (agenda) and presurvey activities. The request to be peer reviewed also provides an opportunity to decide on the nature and size of the evaluating team and in this case helped finalizing a nine-member team comprising of a quality manager, medical, surgical (two) and radiation oncologists, a medical physicist, a palliative care specialist, an epidemiologist, and a pathologist/laboratories expert.

The review plan and the presurvey activities involved several virtual meetings on email and teleconferences where the agenda for the site visit was confirmed. The review plan is the agenda or the timetable for the site visit; it is important that this be shared with the center so that the institution knows what is being evaluated and when rather than being a surprise visit.^[7] The duration of the site visit is dependent on the nature and complexity of the healthcare provider being reviewed; in the case of the CCC, 2 full days were considered necessary and adequate. Presurvey activities are aimed at letting the institution know what data and information are required from them, and sharing them with the peer review team, preferably prior to the visit to enable optimum utilization of the team's time during the site visit. This would also help the peer reviewers focus on the most relevant areas during the site visit.

As the process began, the NCG peer review team soon realized that they had their work cut out for them — while radiation^[8] and medical oncology,^[9] the laboratories^[10] and palliative care^[11] had some preexisting document to work on, there were no established guidelines for peer review in surgical oncology as a whole; the closest available documents were either site or organ specific and not with the specialty as a whole. Hence, the team had to improvise — Identifying that two main areas for assessment would be outcomes data (short-term, as evaluated by postoperative morbidity and mortality, and long-term, by disease-free and overall survival) and the breadth of surgical services offered (e.g., for breast cancer, whether mastectomy, breast conservation, and sentinel node biopsy or axillary sampling are offered to patients depending on the extent and stage of disease). The peer review team accepted that not all the above, for example, long-term survival data would be available from all centers. While documentation and timely delivery of services would be considered, the focus would be more on whether the patient actually receives the appropriate treatment for a particular stage of the disease. A four-point gradation system was then devised to objectively evaluate all the services provided. It is almost certain that these tools for peer review will continue to evolve as experience with the process increases.

The committee communicated intensively with the center several weeks in advance of the site visit, spent hours in preparation in addition to 2 full days at the center, and delivered a peer review report which was comprehensive, fair, and thorough. The entire process was done with extreme sensitivity, in a way that the institution's employees felt that this peer review team had a common vision of quality improvement and not remotely a fault-finding exercise or unnecessary nitpicking. The peer reviewers were also impressed by the genuine passion with which the center's employees worked, often in extenuating circumstances. The team outlined steps that could be implemented at little or no cost to the institute and separated more major initiatives regarding increased manpower and infrastructure requiring significant financial investments. Several steps have already been taken by the center's administration to address many of the issues raised by the peer review committee. Efforts are ongoing to find resources for initiatives requiring substantial funding — it is expected that the peer review document, by virtue of being authored by an independent, external expert group, is likely to lend considerable strength to centers' funding proposals for infrastructure and manpower strengthening. The success of this first NCG peer review is manifest by the fact that soon after the peer review process was described both by the institutional leadership and the peer review team during the fifth NCG meeting in May 2015, it was met with universal praise, with six more NCG centers voluntarily opting for their institutions to undergo a peer review.

The World Medical Association has in its preamble^[12] the following: “*The purpose of health care is to prevent, diagnose and treat illness and to maintain and to promote the health of the population. The goal of quality review in health care is a continuous improvement of the quality of services provided for patients and the population, and of the ways and means of producing these services. The ultimate goal is to improve both individual patient outcomes and population health.*” We believe that an impartial, unbiased, balanced external peer review provides precisely that. The simple truth is that the ultimate aim of peer review is quality improvement — once healthcare institutions, physicians, peer reviewers, general public and policy makers understand this fundamental truth, voluntary and universal uptake is far more likely. This path-breaking initiative by the NCG could well be the model on which other healthcare systems and verticals could be based to improve overall healthcare in India.

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