

Editorial:

Sham Peer Review: Abuse of the P.U.L.S.E. Survey

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The P.U.L.S.E. (Physicians Universal Leadership Skills Survey Enhancement)¹ survey is a formal workplace behavioral assessment tool² that is increasingly being used to monitor physician behavior in medical schools, residencies, hospitals, and clinics.^{3,4} The survey is also used by treatment centers that specialize in evaluation and treatment of disruptive physicians.^{5,6} It is similar to 360-degree survey methods used in many *Fortune* 500 companies today.

P.U.L.S.E. was developed in 2002 by a psychologist, Larry Harmon, Ph.D., who is cofounder and co-director of a company known as Physicians Development Program (PDP) in Miami, Fla.^{7,8} P.U.L.S.E. has been cited in a number of publications, including a chapter on “Managing Difficult and Disruptive Physicians” in a book titled *The Business of Healthcare*. Harmon co-authored the chapter with Susan Lapenta, a “partner in the law firm Horty, Springer & Mattern, P.C., of Pittsburgh, Pa.” The firm specializes in healthcare law, and Lapenta “has worked extensively with hospitals and their medical staffs on peer review investigations and hearings. She has also assisted medical staffs in the revision of bylaws and related projects. Additionally, Lapenta has served as counsel in litigation stemming from credentialing decisions, including the defense of antitrust claims.”⁹ The Horty-Springer firm is well-known for its numerous publications and course offerings on peer review, credentialing, and other matters affecting medical staff governance.

P.U.L.S.E. purports to look at both motivating behaviors and disruptive behaviors and the impact they have on the healthcare team.¹ The Physicians Development Program also offers another survey tool known as the B.A.D. (Behavioral Assessment of Disruptiveness) survey.¹ The P.U.L.S.E. survey is typically conducted by e-mail or online, and raters are allowed to remain anonymous. The survey can be administered to all physicians in a department, or to all members of the medical staff.

Surveys are often administered at 3, 6, or 12-month intervals. The results are typically graphically displayed and color-coded,⁸ green for acceptable conduct, red for unacceptable conduct, and yellow for borderline unacceptable conduct, or another similar color scheme. Survey results are compared to results from other physicians at the hospital or other group norms. Results can be used in peer reviews and at the time of reappointment and renewal of hospital privileges.

Unfortunately, like other tools used to assess physician conduct and competence, P.U.L.S.E. is subject to abuse.

Quantifying Subjective Opinions

Although P.U.L.S.E. results are said to “provide objective feedback to upper management,” [2] in actuality they are nothing more than a quantification of the subjective opinions of

the raters. Subjective opinions, of course, are influenced by many factors. If a physician, for example, has been appropriately and respectfully critical of poor nursing performance or poor performance of O.R. technicians, the survey provides the perfect opportunity to “get back at” that physician. If a physician competitor or group of physician competitors decides to try to reduce or eliminate competition, the survey provides the means to achieve that goal. A hospital administration can also manipulate the selection of raters so as to retaliate against a physician whistleblower. And, although allowing raters to remain anonymous may provide a more candid view of the physician, it can also serve as an invitation for raters who dislike the physician to make false and/or trumped up charges against the physician.

Rater Selection Subject to Manipulation

Although physicians subject to the P.U.L.S.E. survey are often asked to provide a list of physicians and hospital staff they work with (the raters), medical staff leadership and the hospital administration can add to or manipulate the final list of raters. Much like hospitals that stack a peer review panel with physicians who dislike the physician under review, biased selection of raters, based on improper motives, is an effective means of assuring a negative outcome. And, since different physicians often work with different raters, the so-called comparative norms do not necessarily represent true comparisons between physicians at the hospital.

It also has been claimed that a scatter plot of P.U.L.S.E. results for a group of physicians at a hospital is able to identify the “bad apple” physician and distinguish between truly disruptive behavior and a physician who is a political target at the hospital. In the chapter about managing “difficult” and “disruptive” physicians, Harmon and his co-author stated: “Once completed, a scatter plot can be prepared designating where each physician falls compared to his colleagues, thereby identifying the so-called bad apple.”⁸ Another article on P.U.L.S.E. stated: “It’s also the best way to find out if a physician isn’t being disruptive, but may be a political target at the hospital.”⁷ The scatter-plot argument, however, fails to consider bias in rater selection by those who want to eliminate the physician from the hospital based on improper motives.

Singling Out the Targeted Physician

Selecting a single physician at a hospital to undergo a P.U.L.S.E. survey sends a clear message to the raters, and anyone with whom they communicate, that there is a behavior problem with the targeted physician and the hospital is seeking documentation. In some cases, the hospital is specifically

seeking to obtain documentation to be used in a sham peer review against the targeted physician. Hospitals that use sham peer review to eliminate certain physicians use this tactic in an attempt to objectify the disruptive physician label.

AAPS has been contacted by physicians who have had this tactic used against them in a hospital. These physicians, who were outspoken in their attempts to make improvements at their hospitals, were labeled “disruptive” following a P.U.L.S.E. survey that the hospital demanded. In one case, some nurses even reportedly “joked” with the physician that he had better be nice to them; otherwise they will give him a bad survey rating.

Hospitals that use this tactic against physicians who are targeted for sham peer review take advantage of their built-in information gathering and distribution network of employees to spread negative information about the physician throughout the hospital and medical community.

Consequences of Being Labeled “Disruptive” Following a P.U.L.S.E. Survey

The consequences of being labeled “disruptive” following a P.U.L.S.E. survey range from informal collegial intervention to termination of hospital privileges. A behavioral contract or Personalized Code of Conduct may be required. Such contracts can be used to limit the physician’s due process rights in the hospital. In detailing the “Top Six Steps for Dealing with Disruptive Physicians,” authors Harmon and Lapenta acknowledge: “Personalized Code of Conduct may narrow rights.”⁸

Remedial programs, including anger management programs and/or personal coaching, are sometimes required after a physician has been labeled “disruptive” following a P.U.L.S.E. survey.

A physician who is labeled “disruptive” following a P.U.L.S.E. survey may also be required to travel to a specialized treatment center for “disruptive” physicians.¹⁰ According to one article, “Inpatient and residential programs may be helpful if the underlying disorder is sufficiently severe to likely prevent the physician from benefitting from outpatient interventions, or less intensive interventions have failed.”¹¹

Physicians who are treated at these centers often receive additional psychiatric diagnoses, including narcissistic and obsessive-compulsive personality traits or disorders, and personality disorder NOS (not otherwise specified). The article by Harmon and Pomm noted: “Many physicians referred for disruptive behavior have an Axis I mood disorder, Axis II personality disorders, or both, especially those with narcissistic and obsessive-compulsive traits.”¹¹ The article also provided a list of inpatient/residential treatment centers.¹¹

Treatment at inpatient/residential treatment centers may involve intensive group therapy, individual psychotherapy, and treatment with medications. According to Harmon and Pomm, “Medication management for physicians with underlying psychiatric disorders also may be indicated. In particular, medications that increase emotional control, decrease impulsiveness, and improve mood generally are recommended.”¹¹

One physician also reported that electroconvulsive shock (ECS) therapy was recommended, apparently as a means to alter his view toward authority in the hospital setting (personal communication). Fortunately, ECS was never administered in that case.

Conclusions

Although proponents of P.U.L.S.E. claim that “...ongoing and periodic surveying of disruptive physicians gives physicians an opportunity to ‘see themselves as others see them,’...”¹¹ if a hospital administration singles out a targeted physician for a P.U.L.S.E. survey and selects biased raters, then it may be more like looking at oneself in a funhouse mirror at the entrance to a house of horrors.

Physicians need to be aware that abuse of P.U.L.S.E. exists, and that hospitals that do sham peer reviews are using this tactic to eliminate certain physicians based on motives that have nothing to do with the furtherance of quality care. Physicians who serve on peer review panels or are involved in re-credentialing need to be vigilant and diligent in examining how P.U.L.S.E. data was generated.

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