Why Compliance is Important for Physicians

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The American Heritage Dictionary defines compliance as "the act of complying with a wish, demand, or request" and "a disposition or tendency to yield to others".

I. Compliance and the training of physicians
   a. Win (defeat disease) at any cost philosophy can be looked at many ways
   b. Compliance officer – We're here to make sure you follow the rules.
   c. Hospital ethics committee – We're here to make sure ethical issues are considered.
   d. Patient's advocate – We're here to make sure someone considers the patient's well being.
   e. Physician's perspective – I thought I was doing all of that.
   f. There are inherent conflicts built into these roles – failing to recognize them is a significant error.

II. Peer Review – a key failure but some room for hope
   a. Medical school honor codes and committees
   b. Credentialing process
   c. Re-credentialing
   d. Performance reviews
   e. Impaired physician
   f. Practice/behavior deficiencies

III. Initiatives of representative bodies
   a. LCME
   b. AMA
   c. ACP
   d. Institute of Medicine
   e. Other

IV. Professionalism

V. “Doing the right thing”

a. According to whom?
b. Conflicts of interest versus the appearance of a conflict of interest
c. Billing for a service rendered versus billing for a service documented in the chart

VI. The blur about many rules affecting physicians

a. They are not all logical.
b. They are not all clearly written, leaving significant latitude in interpretation.
c. They are not all correct or reasonable.
d. However, there is knowledge base that is not recognized by many physicians concerning compliance issues – the # of rules falling into the above three groups is not that high and most compliance rules do serve to improve key processes.

VII. The effects of poorly written or conceived rules on physician behavior and compliance officer behavior

a. Difficult to defend a bad rule
b. Conflict between institutional protection and reasonableness
c. Ultimately, a risk that other reasonable rules will be selectively followed

VIII. The Solution

a. Institutions must balance risk of non-compliance with risk of forcing 100% adherence, even in settings of conservative interpretation of vaguely written rules.
b. Rules governing clinical settings must have input from clinicians.
c. Rules governing research must have input from researchers.
d. Physicians must participate in sentinel event reviews, institutional review boards, peer review/grievance processes, and other similar activities.
e. Practitioners must become knowledgeable about rules affecting their practice and other aspects of their professional lives.
f. Lack of involvement will increase the # of bad rules and poor interpretation of existing rules and, ultimately, undermine the process.

IX. The Assumption

a. All parties (physicians, researchers, compliance officers, CEO's, government) want the same thing.
b. If poorly written or vague rules are not pursued with the appropriate agency (JCAHO, OHRP, OIG, CMS) because of fear of negative repercussions, the outcome will be the perpetration of these rules – and this is in no ones best interest.
c. There must be an open non-confrontational dialogue or process where errors can be reported, physicians can be disciplined, hospitals can acknowledge lapses in safety or quality, billing errors can be corrected, and scientific misconduct can be reported and addressed.
d. How do you know we don't already have such a responsive system?