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PHYSICIAN PERFORMANCE MEASUREMENT BARRIERS IN PRIVATE GENERAL HOSPITALS AROUND MEDAN CITY

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Abstrct

Study results from early 2016 across 20 private general hospitals around Medan city, show there are 10 hospitals that have a physician performance measurement. However, the Medical Committee perceived some unknown barriers on measurement of physician performance. Should it be known, the hospitals can improve and enhance physician performance measurement effectively and efficiently. Therefore, this study aims to uncover the barriers on physician performance measurement in Private General Hospitals around Medan city. From the interviews with 10 Medical Committees and 6 document studies in 10 Private General Hospitals around Medan city which have a physician performance measurement, we found that the barriers on physician performance measurement are: unsupportive human resources, improper Medical Committee monitoring, unwillingness of physicians to be assessed, and assessors tendency toward giving moderate and good score. Therefore, we recommended that Medical Committee in each Private General Hospital around Medan or supervisors who will assess the performance of the physicians to attend performance measurement training to minimize biases and errors in filling out the sheet of physician performance measurement. Training should also be followed by an explanation that physicians should treat this performance measurement as a positive thing, because it can help medical profession improve its professionalism.

Introduction

A hospital is a very complex and high risk institution, especially in conditions of global and regional environment that is changing dynamically. One of the pillars of medical service is Clinical Governance, a way to guarantee the implementation of quality health services. In line with the mandate of the legislation related to the health and hospitals (Act of the Republic of Indonesia Number 36 in 2009 about health and ACT Number 44 in 2009 about the hospital), hospitals must guarantee the implementation of the quality health services by organizing a clinical governance to protect patients, where medical staff performance will greatly affect the safety of patients (Peraturan Menteri Kesehatan Republik Indonesia Nomor 755 tahun 2011).

Institute of Medicine (IOM) in the United States estimated that up to 44.000 – 98.000 deaths occur each year due to medical errors. The incidence of medical errors in hospitals in North Carolina, USA is 91 incidents for every 1.000 patients each day (Classen, 2011; Pujilestari, 2014).

Similar condition also happened in Indonesia. Since 2006 to 2012, 182 cases of medi-

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cal negligence were committed by physicians throughout Indonesia. The cities which have the most complaints are Jakarta, Bandung, Tangerang, and Medan (Adisasmito, 2010; Panggabean, 2014). This indicates poor performance from physicians – one of them in the city of Medan – in providing health services. The performance of physicians in conducting daily clinical practice had become the public spotlight, where buyers wanted to know if the health services provided by physician were the best.

One way to solve the problem is to apply Clinical Governance. The Western Australian Clinical Governance Framework defines four pillars of Clinical Governance which includes (1) Consumer value; (2) Clinical performance evaluation; (3) Clinical risk; and (4) Professional development and management. Clinical performance evaluation requires that the health care system devised clinical performance measurement indicators to be included in the performance measurement of physicians (Hidayati, 2015).

It is important to measure physicians' performance in hospitals. This is to spur physicians to continue to improve its performance in order to be better than ever. Performance measurement was among the fundamental roles of the Medical Committee, which was in the hospital. Performance measurement could be an effective tool for improving performance, productivity, and the development of the physician if implemented properly. For the physician himself, performance measurement was one way to know the result of the effort and exertion as their contribution to the survival of hospitals (Wijayanti, 2012; Sulistiyawan, 2013; Koeswanto, 2016).

The success of any performance measurement system depended on good implementation, results, and the impact of the results of the measurement. The results have implications for good performance on gift-giving; the physician would complete its work with more enthusiasm, more creativity, and with his best ability. But if the result of the performance measurement indicates there were weaknesses from the physician, the best way to fix these weaknesses and improve performance could be sought out immediately (Daoanis, 2012).

However, hospitals did not always succeed in conducting performance measurement and use it for strategic policy on their businesses. Their implementations were often riddled with problems. Barriers to the performance measurement system could be affected by several factors, that is unqualified good performance, unapplied evaluation of good performance, improper communication, inappropriate consequence for the organization, unsupportive human resources, and improper monitoring. In addition, the management did not fully understand the basics of performance measurement. Consequently, measurement procedures were often difficult to understand. Performance measurement is an activity that deals with emotional and social conditions and biases in measurement due to different perspectives are very likely to occur. Factors that can affect the performance of physicians outside the control of the physicians and should be considered when conducting performance measurement of physicians are severity of the patient's disease, patient compliance, and support of additional health services (Landon, 2003; Rivai, 2008; Moeheriono, 2012).

Based on the study by Zulfendri (2014), the audits have not been carried out on a regular basis and there were no coaching specialists in private hospitals in Medan city. This was in line with the results of an initial interview with one of the private hospitals in the Medan city, which showed less supervision quality. One of the physicians who practice internal medicine at the hospital did not know how the hospital assessed his performance because the hospital had never done a measurement of his performance.

From the initial results of a study in 20 private general hospitals around Medan city, only 10 hospitals already have physician performance measurement sheet, while the other 10 hospitals did not (Lubis, 2016). The fact that 10 Private General Hospitals around Medan did not have a physician performance measurement altogether was in contrast to the rules of the Minister of Health number 775 in 2011, that is the Medical Committee of the hospital is

obliged to verify the validity of the competence of medical staff, and according to Hospital Accreditation Standards 2012 version (the standard of KPS 11), hospitals must continuously evaluate the quality and safety of the clinical care provided by each medical staff (Peraturan Menteri Kesehatan Republik Indonesia Nomor 755 tahun 2011; Komisi Akreditasi Rumah Sakit, 2012).

From the initial interview of the Medical Committee in 10 Private General Hospitals around Medan city which did not have physician performance measurement, physician performance measurement was not performed because of the following reasons: the physician was not a permanent employee, Accreditation 2012 had passed, there were no cooperation with the Agency Organizer of Social Security (BPJS), there were no time, there were unwillingness to confront the physicians, and there were little understanding of the benefits of performance measurement. However, the resistance perceived by the Medical Committee on the implementation of the physician performance measurement in the hospital is not yet known. Therefore, this study aims to uncover the resistance perceived by the Medical Committee on the implementation of the physician performance measurement in 10 hospitals that have performance measurement, so that the hospital could improve and enhance physician performance measurement effectively and efficiently.

Method

To understand barriers on physician performance measurement in Private General Hospitals around Medan city, Medical Committees were interviewed and document studies of the physician performance measurement in 10 Private General Hospitals around Medan city which have a physician performance measurement were performed. The data obtained are then analyzed using theories and studies concerning barriers to performance measurement from different sources.

Result and Discussion

From the 10 Private General Hospitals around Medan city which followed the research, we found that only 6 hospitals were willing to give their sheet of physician performance measurement, namely RSU MT, RSU D, RSU MSW, RSU Mt, RSU BM, and RSU KMB. While RSU Mh and RSU S were unwilling to provide their sheet of measurement of physicians performance they were willing to give us an idea of their performance measurement through interviews.

RSU BK and RSU AMAU did not have a document of physician performance measurement. Physician performance measurement was based solely on day-to-day observations, then once a month the Medical Committee convened an evaluation and monitoring of the performance of physicians in a conference room, led by Operations Manager. This practice was in contrast to the opinion of the Mudayana (2012), who stated that performance measurement must be able to provide an accurate and objective picture about the performance of the employees and must also be documented.

We found some barriers on the physician performance measurement from the interviews of Medical Committee at 10 hospitals which have a physician performance measurement, and that is: Medical Committee in RSU MT and at RSU BK, head of the IGD in RSU Mh and at RSU S, head of sub-division BINFO in RSU BM, The Section in RSU KMB, and head of the hospital in RSU AMAU felt no barriers or problems on physician performance measurement.

Staffs of RSU D felt some physicians rarely went into RSU D to work, so they could not monitor the physician's performance and conduct performance measurement. Staffs of RSU Mt were having difficulties finding their physicians. So they left the measurement file in the clinic where the physicians practiced outside the hos-

pital. These instances indicated that to-be-assessed physicians were involved in the performance measuring process. Based on the opinion of Moeheriono (2012) and Wijayanti (2012), when human resources assessed – in this case the physician – were not involved in the measurement process, a sense of belonging would not arise. The physicians were often not in the hospital; hence the staff could not monitor the activities of physician performance measurement.

The head of the medical services in RSU MSW felt its physicians were less willing to be assessed. Based on the opinion of Moeheriono (2012), the reluctance of physicians was among the obstacles in performance measurement of physicians. This was due to an autonomy-profession-physician which gave them the freedom to work as a physician. Other professions were not permitted to evaluate and regulate their work as a physician. The autonomy was also instilling values that the physician was a very responsible profession. They could work well without supervision, and could be trusted to be able to bear the risk when they could not work properly. This is called professional self-regulation. However, it will be different when the physicians became an employee and worked at a company. Performance measurement must be carried out in order to make the management process run effectively. The effectiveness of the implementation of the performance measurement could be seen when employees can receive a positive measurement system, which lead their motivation and morale to continue improving their work achievements. Therefore, physicians should view performance measurement as a positive thing, because it could help the medical profession in developing its professional side. This performance measurement is part of Continuing Medical Education and can ensure the quality of practice of physicians (Irvine, 1997; Lefaan, 2006; Syamsudin, 2015).

From the results of document studies in 6 hospitals which were willing to provide their sheet of physician performance measurement, among the barrier of physician performance measurement is a distribution error of leniency. The distribution error of leniency is the tendency of assessors to consistently provide a value that is too high – "good" or "excellent" – to all staff or his subordinates – in this case the physicians. This leniency distribution error had also occurred in one of the nurses at the Hospital of Southern California (Riggio, 2000). This was usually done when the assessors hesitated to give a negative measurement (fact), or because there was an element of immediacy (the assessor and the assessed know each other well). Error in conducting the measurement was one of the obstacles in performance measurement i.e. biased measurement made the measurement process inaccurate and unobjective. Measurements like this can happen because the evaluator did not have an accurate definition or restrictions of the many factors being rated. This also includes the measurement of barriers in the political obstacles in which the assessors rated too high because the assessors wanted to avoid a conflict with subordinates and to make the measurement looked successful. The performance measurement system that wasn't conducted well would affect the perception of the physicians on the benefits of the system itself (Rivai, 2008; Moeheriono, 2012; Wijayanti, 2012; Javidmehr, 2015).

In RSU D, from the analysis of physician performance measurement sheet, we found that the barrier on physician performance measurement was central tendency distribution errors. The distribution error of central tendency is the tendency of the assessors to consistently provide middle score to all staff or his subordinates – in this case the physicians. This measurement error was among the obstacles in performance meas-

urement i.e. biased measurement made the measurement process inaccurate and unobjective. These measurement errors also include political barriers, in which the assessors wanted to avoid controversy or criticism with their subordinates. An improperly carried out performance measurement system would affect perception of the physicians on the benefits of the system itself (Rivai, 2008; Wijayanti, 2012; Javidmehr, 2015).

From the analysis of the sheet of physician performance measurement in RSU KMB, we found that the barriers on physician performance measurement were a distribution error of leniency and central tendency. If the implementation of performance evaluation was not conducted well, it would affect perception of the physicians on the benefits of the system itself (Rivai, 2008; Wijayanti, 2012; Javidmehr, 2015).

From the analysis of the sheet of physician performance measurement in RSU Mt, we were unable to determine barriers to performance measurement, because the staff only gave the physician the performance measurement documents that have not been filled.

Conclusion

From the interviews and document studies in 10 Private General Hospitals around Medan city which have a physician performance measurement, we found that barriers on physician performance measurement are unsupportive human resources, improper Medical Committee monitoring, unwilling to-be-assessed physicians, and leniency and central tendency distribution error. Therefore, we recommended that Medical Committee in each Private General Hospitals around Medan or supervisors who will assess the performance of the physicians to follow the training prevent biases and errors in filling out the paperwork of physician performance measurement. Training should also be followed by an explanation that physicians should view this performance measurement as a positive thing, because it could help the medical profession in developing its professional side. This performance measurement is part of Continuing Medical Education and could ensure the quality of practice of physicians.

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