UPDATE!

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Message From The Chair: Musings on Peer Review

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A 28 year old mother of three presented to the ED of an excellent WA hospital one weekend, a few days following a difficult GYN procedure. Her complaint was abdominal pain, and she was hypotensive and tachycardic. The ED physician diagnosed her as septic, and the on-call GYN was consulted (the operating surgeon was not available). The GYN assessed the patient and asked for a general surgery consult. Surgery suggested that GYN needed to resuscitate the patient in the ICU and to call back if necessary. The patient was admitted to the ICU and a pulmonary/intensivist was asked to see the patient. The intensivist suggested that the hospitalist could manage the sepsis. The hospitalist started fluids and antibiotics and left a message for the infectious disease consultant to see the patient in the morning. ID saw the patient and stated in their progress note that the sepsis was most likely of surgical origin, but there was no direct communication between providers. When the GYN made rounds, they were reassured that the patient seemed somewhat better with fluids and antibiotics, and didn't call general surgery back. Late that evening, the patient crashed and the intensivist was called again. The intensivist intubated and resuscitated the patient, and in the early morning hours again called general surgery. It was agreed that general surgery would see the patient first thing that morning. The general surgeon came in early to see the patient, but also saw a patient with acute appendicitis. They put the patient with acute appendicitis on first because that procedure would be quick. Nearly two days after admission and prior to beginning her surgery, the 28 year old wife and mother of three suffered a cardiac arrest from which she could not be resuscitated. Autopsy revealed a perforated viscus from the original procedure with the resultant sepsis as the cause of death. This case was reviewed by each department at their departmental peer review. It took more than a year for this case to make it through four separate departmental peer reviews, and each department concluded that

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WMC Mission

Promoting patient safety and enhancing the integrity of the profession through licensing, discipline, rulemaking, and education.

the physician in their department did everything right, but that the other departments could have done a better job. Yet the death of this young woman was avoidable, and any one of her very competent and well-meaning physicians could have orchestrated a different outcome.

No one likes to have a case reviewed, and we like it even less if we are told that we could potentially have done better; yet that is the function of peer review and is an important mechanism for improving the care we provide our patients. The act of requiring us to consider whether or not we could have provided better management is of value by itself, because physicians and PAs tend to be very self-motivated - if we can avoid being too defensive.

Unfortunately, there is a lot of room for improvement in the peer review process. Peer review requires time and preparation to be effective. Often, physicians with little time and less interest are being asked to do this complex job, with inadequate infrastructure and support staff, for little or no reimbursement. Peer review at most places is done as it has been for the last 50 years: by individual departments. But there are a number of problems with departmental peer review. First, current medical care is provided by a multidisciplinary team, and system issues that set up medical errors and poor outcomes are not in the control of individual departments. Second, departmental peer review is rarely timely, and memories of an event change with time. Third, departmental peer review is caught between specialty bias, which tends to excuse problems within a specialty and competitive bias. Bias tends to exaggerate problems of competitors, and lack of anonymity of the reviewer, which interferes with the performance of an impartial review.

As in the case presented at the beginning of this article*, the vast majority of significant patient care problems occur with good physicians doing the best they can. Ideally, the goal of peer review should be patient centered physician accountability, with continuous improvement through honest self-reflection and appropriate education.

**The case presented is a fictional case. It is presented as a base to consider the importance of good peer review*

This requires certain core principles:

1. Peer review proceedings should be protected from legal discovery.
2. Peer review should be multidisciplinary if possible, with ready access to unbiased specialty assessment.
3. Reviewer anonymity is critical in order to facilitate an impartial and honest review.
4. The process should be objective, reproducible, transparent and timely.
5. The outcome should be non-punitive and educational for the physician being reviewed, and exceptional work should be recognized as well.
6. The process should have the ability to identify and to facilitate the correction of system issues.
7. There should be clear separation between the peer review function and departmental disciplinary responsibilities.

The principles of just culture and highly reliable organization theory have been used by national professional organizations to establish what "best practice" for peer review ought to look like. While the process chosen should be developed by the physicians who will be undergoing peer review, it isn't necessary to reinvent the wheel. Help is available for those who want to develop a truly effective peer review process.

Much of what comes to WMC attention would have been much better managed by a high quality, local peer review process. The WMC does occasionally see that there are some organizations in Washington State who are doing an excellent job with peer review. The WMC can consider in its evaluation of a complaint what a respondent has already done to address the alleged issues. If the WMC finds that everything that would have been required through a disciplinary action has already been accomplished by the respondent, it may find that no disciplinary action is needed.

Peer review is one of the best ways to improve patient safety, but it requires physician leadership. It also requires monetary support necessary to provide adequate infrastructure, including staff support. Physicians and PAs with an interest and energy to invest the time can truly improve patient care by working on high functioning peer review processes.