

## Occasional essay

### Peer review: standards, judgment and sweet charity

Intensive care medicine is like no other specialty, in that we work in very close quarters with our peers. We hand over patients at the end of our shift and take over from others at the end of their shift. Within such an arrangement we have a unique view of our colleague's work and often judge, either overtly or covertly, the standard of care we perceive they practice. Working in such close proximity may even provoke one, or more, of the seven deadly sins (e.g. envy, pride, anger, avarice). Fragile egos can get bruised when the care of a patient is handed over to another, treatment is altered and the patient gets better. Worse still, a diagnosis is made that has been missed by the predecessor.

Early in my career, I worked in an intensive care unit where the approach to the critically ill patient by one of my peers, I felt, was of a more 'considered' ('slower' is probably not the right word) nature than mine. As the fellow also had an anaesthetic list on one day in his working week, I often wondered if he 'weaned' his patients from the ventilator at the end of each surgical procedure. Nevertheless, during his week 'on', while patients may have been extubated later than would have occurred during my rostered week, they always seemed to survive while under his care. In retrospect, they may have even prospered. Moreover, I was taught, by this gentle practitioner, the power of tenacity in the management of an intensive care patient. He believed that if a critically ill patient "lasts for a week; they shouldn't die", a lesson I found valuable in 'pressing on' during the management of patients who appear not to improve with therapy (but refuse to die) and in trying to understand the edge of possibility and the beginning of futility.

That there are differences in the practice of intensive care clinicians is not in doubt. The nurses and trainee medical staff often state provocatively 'but Dr. X doesn't do that - he does Y'. I tend to explain that I cannot comment on his or her practice, but can only explain my own practice. Stating that in a teaching institution the strength of a unit is in the *reasoned* disparity of practice. With an exposure to as many different approaches to the management of a patient, an environment is created where sound medical judgment can be learnt, as the predicted and real outcomes can be carefully observed by the trainee.

Even with evidence-based medicine, clinical practice often presents cases that do not 'fit' the inclusion criteria of a 'landmark' study. Judgment is difficult in such cases and treatment will inevitably vary between practitioners. One study even found that the same practitioner, given the same clinical problem, often varied his or her advice with time.<sup>1</sup>

It is almost impossible to judge a peer's practice without exhibiting positive or negative bias, particularly when judging one who works within the same institution. If we are asked to do so informally, our opinion is probably best kept to ourselves, particularly if it is a disparaging one. However, if we are asked to give a formal opinion concerning a colleague's practice, then while our judgment must be sound and cogent, particularly within a legal environment, it must be tempered with humility and understanding.

To assess the standard of medical care and the 'culture of care' within a given intensive care unit, a regular unit audit is often performed. This may take the form of a review of a patient's management irrespective of the outcome (e.g. a weekly or monthly random selection of case records to review whether the care was acceptable, could have been improved, or whether a change in the care would have altered the patient's outcome) or a review of morbidity and mortality during a defined period (e.g. weekly or monthly death audit, or review of specific medical complications).<sup>2</sup> The review of the medical care of a patient who survives, is easily tempered with humility and understanding, as a sound medical practice is implied with the patient's survival. On the other hand, reviewing the care of a patient who died; poor medical management is often implied even though death may be the result of good medical practice just as much as bad medical practice. What is easily forgotten is that death is the end point of life well managed as well as an adverse outcome of a therapeutic intervention.

Nevertheless, a death review may be useful in considering the unit's overall standard of care. Particularly when reviewing issues such as 'futility' where a reflex response to critical illness of considering the most pessimistic outcome (particularly when the intensive care unit is full) may result in the patient receiving less than optimal care (contributing to a self-fulfilling prophecy<sup>4</sup>), an acceptance of substandard practice and a culture where withdrawal of therapy becomes commonplace. On the other hand, admission of patients with terminal conditions is also wrong, as it wastes an expensive resource and reduces staff morale.

However, audits are not flawless. Even a death audit may not detect an aberrant practice. Part of a report of an audit of the practice of the former family doctor Harold Shipman carried out in January, 1998, stated "Great to see a single-handed enthusiastic GP with a

rolling programme of audit – keep up the good work”.<sup>5</sup> This report occurred just 9 months before the arrest that led to his conviction for killing 15 patients. An official enquiry concluded that he was probably responsible for at least 200 more murders.

As with any judgement, there are no short cuts. The process has to be impartial. An audit of any clinical practice requires one who has the necessary experience, vigilance and charity to provide a report that is credible and just.

*“We should be gentle with those who err, not in will, but in judgement”*

Sophocles 496 – 406 BC

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#### REFERENCES

1. Rutkow IM. Surgical decision making. The reproducibility of clinical judgement. Arch Surg 1982;117:337-340.
2. Brook RH, McGlynn EA, Cleary PD. Quality of health care. Part 2: measuring quality of care. N Engl J Med 1996;335:966-970.
3. Siegler M. Pascal’s wager and the hanging of crepe. N Engl J Med 1975;293:853-857.
4. Fitzpatrick M. Auditing deaths. Lancet 2003;362:586.