The Peer Review Process and Patient Safety

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Abstract

The 1999 report from the Institute of Medicine (IOM), To Err is Human: Building a Safer Health System, claimed there are 44,000 to 98,000 preventable fatal medical mistakes made each year. More than a decade before the IOM report, a number of newspaper articles reported cases of physician ineptitude and substandard patient care. In response, the Centers for Medicare & Medicaid Services increased its efforts to limit the practice of incompetent physicians through implementation of professional peer review.

The peer review process promotes patient safety though application of professional standards of health care. Practitioners review qualifications, medical outcomes, and professional conduct of physicians to determine whether the reviewed physician met accepted standards of care. Voluntary, confidential reporting of medical errors publicly reported as aggregate data will encourage health care professionals to participate in reporting.

The peer review process should remain educational rather than punitive in order to encourage practitioners to participate in the process, thereby improving quality of care for all patients. Promoting a peer review system that allows for confidentiality, immunity, and the review of accumulated data, will encourage more health professionals to get involved with patient safety. Public access to aggregate data on care measures reported by physicians, hospitals, and insurance plans will give patients the information they need to intelligently choose their practitioner, facility of care, and health plan.