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A longitudinal study of clinical peer review's impact on quality and safety in US hospitals.

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Development of high reliability remains an elusive goal for health care organizations. A robust safety culture, in which reporting of errors is encouraged and errors are analyzed in a blame-free fashion, is a cornerstone of achieving high reliability. However, prior studies have found that hospital peer review programs often inhibit safety culture, because they are perceived as focusing on punitive actions rather than quality improvement. This survey of 300 health care organizations found that this state of affairs did not improve between 2007 and 2011. The peer review process at most hospitals failed to emphasize a systems approach to improving safety and instead focused on individual clinician performance. An earlier commentary describes the peer review process in a true high-reliability industry—nuclear power—and suggests how this model may be applied in health care. This study was conducted by an AHRQ-certified patient safety organization.