

# Peer Review of Radiologist Performance

## The Problem

To meet requirements from regulatory groups, to understand the nature and frequency of diagnostic errors and to improve the quality of diagnostic radiology performance, an anonymous, comprehensive and practice-representative peer review process is necessary. Since none exists, we sought to develop such a process.

## Aim/Goal

To develop and implement an anonymous web-based peer review process that permits fair review of a representative number and spectrum of randomized diagnostic studies from all diagnostic radiologists.

## The Team

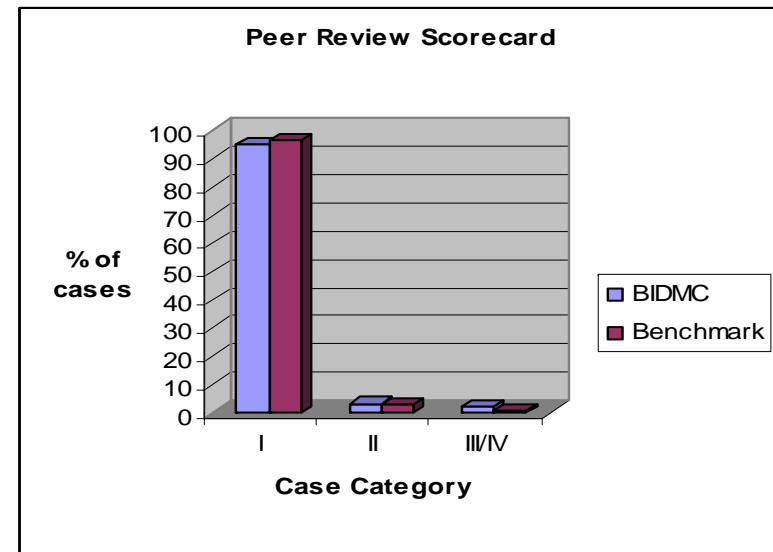
- Jonathan Kruskal, MD, Team leader, Radiology
- Sam Yam, PhD, Radiology Software engineer
- Katherine Krajewski, MD, Radiology QA elective resident

## The Interventions

- Developed a web-based reporting tool for monitoring compliance and case review with faculty participation
- Developed web-based process for scoring and reviewing cases
- Established metric for number of cases to be reviewed (320/year)
- Educated staff about process for review and selection of cases
- Developed process to review and analyze peer-reviewed cases
- Benchmark results data with American College of Radiology.

## The Results to Date

- In the first 6 months of use, 8125 cases were reviewed.
- Vast majority (95%) were category 1 (fully agree with read).
- 56 of 59 faculty participated by 3 months (range 2-1014 cases).
- Participation was enhanced by link to incentive bonus system.
- Review scores correlated with national benchmarks.
- 100% of faculty has their own cases randomly reviewed.



## Lessons Learned

- Peer review process is not part of historical workflow
- An electronic reminder system is essential.
- A system for selecting and randomizing cases is necessary.
- Very few of category 4 cases (miss) had impact on patient care
- Category 4 cases all communicated to ordering physician.

## Next Steps/What Should Happen Next:

- Process must be developed to identify appropriate case mix
- Analyze factors contributing to diagnostic and interpretive errors
- Establish educational process to minimize errors
- Continue to monitor incidence and nature of errors



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