Radiology reporting—where does the radiologist's duty end?

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> "Nothing in life is more important than the ability to communicate effectively"
>
> *Former US President Gerald Ford*

In the USA, and more recently in Europe, an increasing onus is being placed on radiologists to ensure reports are communicated to the referring clinician, particularly when an urgent or unexpected diagnosis is made. In the UK, the position is less clear, but this is likely to change after the 2004 publication of *The Manual of Cancer Measures* by the Department of Health in England. Delayed communication is a major cause of radiological litigation in the USA, and legal rulings place great responsibility on radiologists. So far, little evidence shows that UK radiologists are altering their practice.

A 1997 survey showed that communication failure was the fourth most common primary allegation in malpractice lawsuits against US radiologists, and that 60% of communication-related claims resulted from failure to highlight an urgent or unexpected abnormal result.[1] The Florida Radiological Society disclosed that 75% of claims against radiologists in 1997–99 stemmed from communication errors.[1] The Physicians Insurers Association of America (PIAA) dealt with 243 communication-related radiology claims in 1994–2004 with a total indemnity liability of US$16 million (C S Nastro Bernstein, PIAA, personal communication).[2] In 2005, the American College of Radiology updated their 1991 guidelines for the communicating of diagnostic imaging findings (panel 1).[2] The European Association of Radiology also acknowledges that communication failure is an important source of radiological errors and litigation.

In the UK, the 2004 Manual of Cancer Measures[3] identifies the need for a robust system "over and above the normal reporting mechanism", to ensure that patients with a new or unsuspected diagnosis of cancer after radiological investigation are highlighted to the referring clinician. Such systems have been slow to evolve in the UK and there is a lack of unambiguous guidance from professional organisations. Communication failure is clearly an important risk management issue for radiologists. This Viewpoint reviews available guidance and suggests a way forward.

The US position

The US courts have placed a clear onus on the radiologist to communicate abnormal radiology findings,[1,4–9] with many cases in which the radiologist has been found personally negligent for not making such efforts. Furthermore, where efforts were made to contact clinicians, the radiologist was still found negligent because communication was inadequately documented.

Two articles have reviewed the relevant ongoing and evolving legal situation in the USA and are recommended for anyone who wishes to understand the many issues involved.[1,10] One such article touches on some of the issues implicated in radiologists communicating results directly to patients.[1] The recent guidelines from the American College of Radiology (panel 1) are less explicit than earlier versions. In our opinion, this could represent an attempt to reduce the use of the guidelines in cases involving litigation.

The European position

In two publications,[11,12] the European Association of Radiology emphasise direct communication, and acknowledge that direct contact with clinicians may be time-consuming (panel 2).

The UK position

The Royal College of Radiologists has not published formal standards on this issue. However, two publications by the College[13,14] mention effective communication (panel 3), indicating that it remains the clinician's responsibility to read and act on the report issued while acknowledging the radiologist's responsibility to issue a timely report and have a robust auditable system for communicating urgent reports.

Panel 1: American College of Radiology practice guidelines for communication of diagnostic imaging findings (revised in 2005)

- Effective communication is a critical component of diagnostic imaging. Quality patient care can only be delivered when study results are conveyed in a timely fashion
- In emergency or other non-routine clinical situations, the delivery of a diagnostic imaging report should be expedited by the diagnostic imager in a manner that reasonably ensures timely receipt of the findings
- Diagnostic imagers should document all non-routine communications

Panel 2: Published findings from the European Association of Radiology

- Communication of the report of the examination is an important source of error
- Where an urgent clinical situation is present or there is a major unsuspected finding that involves urgent patient-management decisions, the radiological opinion should be transmitted directly to the attending physician
- It is the responsibility of the Radiologist to ensure that the information is received precisely, unambiguously and is fully understood
- A clear record of the conversation should be made

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The provision of important or urgent findings directly to the patient is raised but remains controversial, since we believe that most UK radiologists would not have the time, training, or the support network available for patients to be informed of a serious diagnosis in the radiology department. The position is changing in the USA, where pressure from patients resulted in the Mammography Quality Standards Act 1999, which mandates that mammography results should be given directly by the radiologist to the patient. This authorisation has virtually eliminated litigation related to poor communication in the diagnosis of breast cancer.[1]

More recently in the UK, the Department of Health has issued the *Manual of Cancer Measures* (panel 4),[3] creating a national standard for health-care workers communicating unexpected cancer diagnoses. This advice will probably be extrapolated in the future to encompass all unexpected medical findings.

The two largest medical defence organisations in the UK have been asked, in the light of publication of the *Manual of Cancer Measures*, to comment. The Medical Defence Union (MDU) states: "We know that a significant proportion of claims and complaints arise from some form of underlying systems failure. Failure of communication is one of the more common systems problems . . . Members are likely to be criticised and consequently more difficult to defend successfully, if they were not complying with national standards . . . As these systems come into accepted practice it is likely to become increasingly difficult to find an expert radiologist who would be prepared to support the practice of not having a system for rapid notification of unsuspected cancer" (S Green, MDU, personal communication).

Dr Janet Page, the spokesperson for the Medical Protection Society (MPS), states: "the radiologist has a duty to provide a timely, accurate and unambiguous report, and to quote the GMC, 'to communicate this effectively with colleagues within and outside the team'. In making a judgement as to what constitutes effective communication and how far he must go in order to satisfy his legal and professional obligations to the patient, the radiologist will need to consider the circumstances of the abnormal finding and the effectiveness of the reporting system in place . . . This is particularly so where the result is an unanticipated abnormality or otherwise requires urgent action by the referring clinician. With the current emphasis on multidisciplinary team working, in my view it is unlikely that liability in this situation will rest exclusively with any one individual". On the issue of where the radiologist's duty ends, Page goes on to state: "I do not believe that there is an onus placed on the radiologist to pursue a reluctant clinician through the hospital corridors to ensure that he has received, understood and acted upon an abnormal report".

***Panel 3*: Published findings from the Royal College of Radiologists**

- Most reports will be issued in type written form. This is appropriate for reports that are normal, confirm a clinical suspicion and/or identify a pathology where immediate treatment is not required
- Where there is an unexpected finding which may affect patient management or where the severity of the condition is greater than expected, it is the responsibility of the radiologist to communicate this information to the clinical team either by direct discussion or other means
- Emergency communication methods must be in place to ensure that such reports are brought rapidly to the attention of the referring department or the relevant clinician responsible for the patient

Panel 4: Manual of Cancer Measures

- Systems should be put in place regarding the rapid notification of possible or probable cancer
- The person generating the request is informed of the results
- Patients with suspected or known cancer can be excluded
- The method of communication should be a more rapid notification than the normal means of reporting and distributing reports

Conclusions

The view, widely held by UK radiologists, that their duty of care ends when a timely and accurate report is issued, looks increasingly suspect. Many radiology reports are not read.[1,15] Radiology departments distribute reports to referring clinicians in a variety of ways that are poorly documented and prone to system or human failure. There is increasing pressure in the USA and Europe to develop robust systems to ensure that important diagnoses are communicated effectively and rapidly and this pressure will probably become the norm in the UK. Some radiologists are concerned that, should such alert systems become commonplace, the onus will be removed from clinicians to read other reports. Furthermore, what constitutes a critical or urgent report is left to the radiologist. More than one radiologist has suggested to us that every report should be highlighted, which would clearly be counterproductive.

For a pragmatic way forward, some common sense is needed. The evidence emerging from the USA and Europe, the recommendations from the *Manual of Cancer Measures*, and the opinion of two UK defence organisations suggests that radiologists need to reconsider the issue of the communicating of urgent results. Departments need to take account of the effectiveness of their reporting systems but also need to

***Panel 5:* Reporting codes assigned to radiology reports of unexpected findings**

Short, reporting codes (eg, CRN)
Appropriate text appears in bold in report

Alert
This report contains abnormal or critical or unexpected findings arising from the requested investigation. Medical secretary bring to attention of doctor urgently

CRN
Possible colorectal cancer; please contact colorectal nurses (on ext number XXXX) to discuss this case

LCN
Possible lung cancer; for inpatients, please contact lung cancer nurse (on bleep number XXXX); for outpatients, please contact Rapid Access Lung Clinic (on number XXXX)

establish an additional notification system for unsuspected or clinically urgent findings. The threshold for highlighting abnormal reports needs to be agreed, ideally by discussion between radiologists and clinicians. Annual policy review and audit should ensure the system is used appropriately.

In our institution, we differentiate between critical findings (requiring clinical action within hours), which are usually telephoned directly to the clinician and reports with other unexpected but clinically urgent findings. For the unexpected findings, we append a series of short reporting codes (panel 5) to a dictated report. Trained clerks run daily computer searches for highlighted reports, inform a nominated person from the responsible clinical team, and record the discussion. This system is capable of handling all unexpected reports and recognises the need to move towards the US and European model.

By use of sophisticated IT systems including PACS (picture archiving communication systems), urgent reports could be highlighted, and receipt acknowledged electronically. Clerks would only make telephone contact when reports remain unread after an agreed interval. Experience has taught us that installation of a new computer rarely fixes inadequate systems and radiologists should not wait for PACS before resolving this issue. A large UK department will typically produce 150 000 to 300 000 reports every year. Radiologists, with their expertise and wide clinical knowledge, are ideally placed to identify clinically important reports. Effective communication of critical radiology reports can only enhance patient care.

Conflict of interest statement
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