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GUIDELINE

ESR communication guidelines for radiologists

European Society of Radiology (ESR)

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Abstract These guidelines are an educational tool designed to assist the radiologist in providing effective communication and a high standard of care to patients. High quality care is heavily dependent on clear communication for thorough understanding of procedure outcomes and further treatment decisions. Radiologists should encourage communication and interaction between physicians through concise discussions to minimise the risk of communication error. The sole purpose of these guidelines is to provide helpful information to radiologists on how to conduct an effective discussion between patients, referrers, colleagues, and students.

Main Messages

- *Effective communication is a critical component of diagnostic imaging.*
- *Communication methods are dynamic and varied.*
- *Concise communication techniques reduce error and increase coherence.*

Keywords Guidelines · Radiology · Diagnostic imaging · Communication

Introduction

Good communication is an important professional attribute for radiologists. Depending on the nature of their practice, radiologists have variable degrees of direct contact with patients, but all radiologists must be able to communicate well with other medical and non-medical staff and with their patients. Their professional role also requires that they communicate their radiological findings and opinions clearly and concisely, both verbally and in written reports [1].

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Communication with patients

1. *Introduction*. The patients need to know the name of the radiologist, and his/her professional role in their care. It is advisable to ensure that the patients are also aware of who else is in the room at the time of their examination, e.g. radiological trainee/nurse/radiographer, and their role(s).
2. *Establishing the purpose of the examination*. This may entail taking a short clinical history relevant to the clinical request.
3. *Explanation and consent*. Here local protocols and procedures are likely to be in place for explaining the procedure to the patients and obtaining either verbal or written consent to undergo the examination, even though these may vary between countries. The patients must be fully informed in order to give their consent, and must therefore have the opportunity to voice any concerns, or ask any questions they may have before the examination is carried out. It is important that the radiologist is satisfied that the patients have willingly given appropriate informed consent.
4. *Communication of findings to patients*. Local custom and practice may determine by whom and under what circumstances, radiological findings are communicated to patients [2]. All doctors, as well as radiologists, must answer patients' questions truthfully, trying not to cause premature or unnecessary alarm, and not entering into conversations about treatment options which are outside their area of knowledge or expertise. There will be times when radiologists will be directly asked questions which lead to them having to give bad news to the

patients. Ideally, this should be part of radiologists' training.

5. *Confidentiality*. The patients will expect radiology staff to maintain their medical confidentiality, and not to communicate any details about their case with others unless this is directly relevant to their care.
6. *When things go wrong*. If an error has been made, or a complication arisen, some evidence suggests that it is better for all concerned if appropriate discussion takes place between the medical staff involved and the patients [3]. Although medico-legal considerations may affect local policy for disclosure and admission of fault, no attempt should be made to deliberately hide any facts related to the case.

Communication with referrers

The provision of an accurate and timely radiological report is part of a process which requires reliable communication between the referrers, radiology department and reporting radiologists. All have duties in respect of clear communication.

1. *Departmental responsibilities*. Clear lines of communication must be inherent in the radiology system. This includes contact details for all referrers and clarity about who is responsible for the clinical care of the patients and how they may be contacted, including in an emergency. Departments (including administrative assistants/medical staff involved in booking/accepting an appointment) should ensure that referrer contact details are available for all patients referred for imaging or interventional procedures.
2. *Referrer responsibility*. Referrers have a duty to ensure that accurate patient information is available on the request card or electronic referral, with relevant clinical information and a clear indication of the reason for the investigation, together with their own contact details. The referrers also have a duty to alert radiology departments to safety issues which may affect the examination, such as MR safety hazards and contrast contraindications. Clear examination checklists and the teaching of junior staff can be helpful to promote this. If an individual refers a patient for a radiological test or procedure, this carries with it a duty to ensure that he or she reads the written report which is generated unless he or she has clearly delegated this task to someone else appropriate.
3. *Radiologists' responsibilities*
   (a) *Contactability*. Radiologists must be contactable for queries related to the appropriateness of different imaging modalities and questions/clarifications related to their reports. It is not possible to always be available, but clear lines of communication within the radiology department, and who is responsible for answering queries, should be apparent to referrers.
   (b) *Direct verbal communication with referrers*. This may be necessary in an emergency situation when imaging findings indicate that urgent action needs to be taken. Appropriate local protocols about the circumstances under which direct communication will be initiated, and how it is carried out will ensure that both radiologists and referrers are clear about what the radiologist will undertake as their duty of care. When a radiological finding is communicated verbally, the name of the person contacted should be recorded. A formal written report should still be issued, including details of how the report was verbally communicated and to whom [4, 5].
   (c) *Clinical radiological meetings*. Meetings between referrers/clinical teams can be very useful to focus discussions about patient management. These will often involve images which have already been reported being reviewed. The radiologists in the meeting will convey their own interpretation of the investigation. This may be identical to, or may differ from, the written report. Sometimes interpretation will be different because additional relevant clinical information is available and sometimes an error or misinterpretation in the original report will be revealed. Where there is a difference of opinion from the original report, appropriate action should be taken, such as adding an addendum to the report, or following the local protocol for dealing with error or discrepancy in the reporting opinion.
   (d) *Written communication*. The ESR has issued broad guidelines on reporting [6]. In summary, reports should be structured into sections on clinical details, technique, imaging findings and conclusion. It is not possible to detail the 'perfect' report because this will depend on referrer expectation as well as radiologists' varying opinions, but there is evidence that long free text reports which do not reach a clear conclusion are those that are least favoured by referrers [7].

Communication with other radiologists

1. *Second opinions*. No individual is equally highly skilled in all areas. It is a sign of strength and not weakness to

seek a second opinion from an expert, subspecialist, or just another colleague when unsure about how to interpret an examination. A second opinion is important in cases of doubt and should be readily sought. Equally, it should be readily given when requested, as individuals should be willing to help colleagues for the benefit of patients.

2. *Feedback to others on differences of opinion or error.* This should be done promptly but sensitively for patient protection, and to reduce future error. For best practice, clear local protocols on how an addendum is added to a report, and how error is notified to the referrer, patient and reporting radiologist should be in place. 'Collecting' series of others' errors without alerting the individual that they are making those errors so that they can learn and improve their practice is not ethical as it does not help to reduce error. Ideally there should be departmental mechanisms for sharing examples of error in a blame-free meeting environment, preferably with the images viewed by the group with the same information as was available at the time of reporting, and the reporter not named to the group. This ensures that there is group learning from error, and repeated errors can be identified to increase general awareness of pitfalls in interpretation. There are guidelines available on precisely how these meetings can be conducted to make them effective, blame-free and educational for all [8].

Communication with other staff and co-workers

1. *Professional behaviour.* All staff and co-workers should be treated with respect and courtesy. In the case of personal or professional disagreement, this should be dealt with calmly, and if necessary, proper employment processes and complaints procedures used.
2. *Teamwork*. Radiologists work closely with other staff within the radiology department, including radiographers, nurses and clerical and secretarial staff. They have a particularly close working relationship with radiographers, and their roles and responsibilities, particularly in respect of communication with patients, may overlap. There should be clarity on the duties of each; for example, explaining procedures to patients and asking relevant safety questions. Radiologists should listen to the opinions and concerns expressed by other staff members. There is evidence that this reduces error and helps to prevent medical accidents.
3. *Education*. Whenever possible, radiologists should convey to other staff the rationale for choosing a particular investigation, and the clinical importance of following/adjusting examination protocols. Teaching and educating other staff will help to improve the quality of the service as a whole.
4. *Confidentiality.* Communication with other staff should preserve the patient's right to confidentiality and cases should not be discussed amongst staff unless relevant to their individual care or for teaching. Staff members who become patients themselves share the same right to confidentiality as all other patients.

Teaching

1. When teaching, those learning should be treated fairly and with respect and not singled out for criticism.
2. Teaching should be focused to the needs of learners and evaluated with feedback from them. Radiologists who have significant teaching responsibilities may benefit from undertaking specific training to enhance their teaching skills

The role of audit

All structures, processes and outcomes can be audited [9–11]. This involves deciding what the standard of achievement should be, then sampling and comparing the results with the expected performance. If the standard is not reached, remedial action should be taken and then a re-audit carried out to ensure that the expected improvement has been achieved.

Communication is no exception. All the issues described can be audited. Examples include: the information on imaging requests, patient perception of the quality of communication, completion of consent forms, contractibility of staff, completion of report addenda, audit of teaching quality, access to confidential patient information on PACS, etc. Audit is a powerful tool to improve all aspects of the working of a radiology department and the quality of care it provides to patients.

Conclusion

Much that goes wrong does so because of poor communication. Good communication ensures better and safer outcomes for patients, and a more satisfactory working environment for staff.

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