Received:
30 June 2016

Revised:
22 September 2016

Accepted:
27 September 2016

<https://doi.org/10.1259/bjr.20160586>

Cite this article as:

Walton ERJ, Gandhi S. Record keeping in radiology: are we doing enough? *Br J Radiol* 2016; **89**: 20160586.

COMMENTARY

Record keeping in radiology: are we doing enough?

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ABSTRACT

In modern medical practice, there is an ever-increasing rise in litigation. A strong emphasis is placed on good record keeping as an integral part of patient care and the clinician legal defence. This commentary describes the potential flaws and vulnerabilities in the radiologist record keeping and the potential implications for patient care.

With the rising complexity of modern medicine, record keeping is becoming increasingly important in the provision of good patient care. There is also a strong emphasis on good record keeping as an integral part of the clinician legal defence.^{1,2} In modern medical practice, there is ever-increasing medicolegal pressure largely due to a recognized overall rise in litigation. This is reflected with an increase in patient claims for clinical negligence; for example, the Medical Defence Union helped their medical and dental members with a record 14,000 new cases opened for medicolegal issues in 2014.³ Data from the National Health Service Litigation Authority have shown a stepwise annual increase in litigation cases against radiologists from <20 cases in the year of 1998–1999 to >100 cases in the year of 2013–2014.⁴

The radiological report is the radiologist primary form of medical record keeping, whether this is a diagnostic report or written report of an interventional procedure. This can take the form of a handwritten report in the patient notes or now more commonly an electronic report. This electronic report is then stored on the radiology information system (RIS). However, there is a whole other sphere of clinical interaction that radiologists regularly undertake in the form of verbal communication with clinicians, including clinical advice which could impact on patient care. It is often viewed that this clinical advice given to hospital clinicians and general practitioners does not need to be documented. For example, if an imaging request is delayed or an alternative suggested, the reason for this decision may not always be documented. As with clinical advice given by any specialist, this has the potential to be ignored or misinterpreted with serious consequences and the radiologist has no record or evidence regarding this advice to act in their defence. Not recording this information may also have a detrimental

effect on patient continuity of care and future decisions regarding patient management. A potential further flaw in the radiologist documentation comes in the form of expert subspecialist opinions. For example, if a regional radiology subspecialist, a neuroradiologist for example, is giving advice or a different interpretation regarding a radiological examination that has already been reported by another radiologist. The original report for that investigation may not be changed by the subspecialist; so, how is their interpretation and advice recorded? This interpretation may play a key role in future decisions regarding patient care. Part of the problem lies in poor accessibility to a system to record this information. Increasingly, radiologists are recognizing the use of the RIS to allow documentation of important clinical information and advice that is not appropriate for the content of the diagnostic report. Most modern systems recognize this requirement and have a section whereby this record can be entered. Computerized radiology information system (CRIS®) provided by Healthcare Software Solutions is the most widely used RIS in the UK and has a section for clinical documentation named “event details”. There is guidance from the Royal College of Radiologists on the correct way to transfer important examination findings, but there is no guidance on how or if radiologists should be documenting verbal advice. Also in the Royal College of Radiologists guidelines for RIS,⁵ it is not currently a requirement for information systems to have a function that allows this information to be recorded.

We designed and distributed an anonymous questionnaire to radiology registrars and consultants working in our deanery, trying to ascertain how many are using the CRIS “event details” section to document important clinical information outside of the diagnostic report.

We received 20 complete responses; 50% of respondents were consultants (response rate of 14%) and 50% registrars (response rate of 33%). When asked “if you refuse an order request on CRIS, delay or suggest an alternative, do you ever document the reason for this decision in the “event details””, 20% of respondents answered always, 20% respondents answered occasionally and 60% respondents answered never. When compared with trainees, a greater number of consultants answered “always” (3 vs 1), suggesting that such documentation rate is higher in the consultant group. This overall low level of documentation also extended to the remote reporting environment, for example if the radiologist is “on-call” and dealing with an imaging request from home; when asked if they documented information when working from home and speaking directly over the phone, respondents answered 0% for always, 50% for occasionally and 50% for never. This cannot be simply attributed to not knowing how to document, as over 70% of respondents said they knew how to document information in “event details” on the CRIS system. We also discovered that by general principle, radiologists do feel this is an important subject. When asked “should radiologists be documenting incidents when scans are refused, deliberately delayed or alternatives are suggested”, 90% radiologists answered “yes”. There was no significant difference in opinion between radiology trainees and consultants regarding this question. Both groups answered “yes” at a 90% response.

The major shortfall in radiology documentation is encountered when no order has been placed on the RIS and therefore, that patient does not have an “event”. This was commented on by two of the respondents in the questionnaire. There is not a robust method for recording this information in our deanery. There was a handwritten logbook being used sporadically for on-call shifts to record such information in one of the trusts, but no regional system in place. It is well recognized that other diagnostic specialities in hospital will record advice and discussions with radiologists in the patient notes, but the radiologist often produces no record of this conversation. Other diagnostic specialities such as haematology and pathology have methods for documenting important verbal advice that they have given. The requirement for this is secondary to the large amount of telephone conversations

and advice that they give to other clinicians, which is similar to radiology. This also holds true for general practice, where there is an ever-increasing use of telephone consultations with patients. These conversations are now often recorded as a means of maintaining a permanent record. General practitioners may also document advice they have received from hospital specialists, including radiologists, and this information is stored electronically in the patient record. Heard et al⁶ discussed these issues in the diagnostic speciality of microbiology and stated “clinical discussion and exchanges are part of the bread and butter of clinical life; advice about patients given in such circumstances may be taken, may be misinterpreted, or may be misunderstood. Patients may or may not benefit and often the advice may not be recorded”. The method of record keeping varied greatly; 65% of respondents used a daybook, 62% of respondents used the back of the clinical request card, 57% of respondents used a computer record and 22% of respondents used an index card system to record microbiological advice. What was apparent from this is that microbiologists do identify that clinical advice to other clinicians should be documented and should be an important part of the patient record.

Good record keeping is an integral part of patient care. The diagnostic speciality of radiology is not immune to this and it must be recognized that documentation should extend beyond the confines of the diagnostic report. We propose all RIS should have a compulsory integrated “event details” section to allow important information to be recorded. This information should then be made easily available to the ward clinicians through an integrated clinical environment platform. This information would then be available as part of the patient clinical notes and discharge summary, thus reducing the risk of conflicting information between patient information held on the RIS and information in the patient notes.

This would lead to more consistent continuity of patient care and help to inform future decisions regarding patient management and radiological examinations. This commentary has hopefully highlighted the potential serious flaws in our everyday record keeping.

REFERENCES

- Office of the Ombudsman. Report to the Health Service Executive concerning complaints against the Public Health Service. [Accessed May 2016]. Available from: <http://www.ombudsman.gov.ie/en/publications/investigation-reports/health-service-executive/report-to-the-health-service-executive-concerning-complaints-against-the-public-health-service/>
- The General Medical Council. Good medical practice. [Accessed May 2016]. Available from: http://www.gmc-uk.org/guidance/good_medical_practice/record_work.asp
- The Medical Defence Union. Annual report and accounts. [Accessed May 2016]. Available from: <http://www.themdu.com/about-mdu/annual-report-and-accounts>
- Aunt Minnie.com. UK litigation figures come under close scrutiny. Available from: <http://www.auntminnieurope.com/index.aspx?sec=ser&sub=def&pag=dis&ItemID=6124425>
- The Royal College of Radiologists. Radiology information systems. [Accessed May 2016]. Available from: www.rcr.co.uk
- Heard SR, Roberts C, Furrows SJ, Kelsey M, Southgate L. Corridor consultations and the medical microbiological record: is patient safety at risk? *J Clin Pathol* 2003; **56**: 43–7. doi: <https://doi.org/10.1136/jcp.56.1.43>