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Challenges in radiology

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Risk is defined as a chance or possibility of danger or incurring loss or injury. It is recognized that harm may befall a patient even in the best hospital and departments delivering the highest possible standard of care and the practice of medicine is often a process of balancing a risk against efficacy of a diagnostic or therapeutic procedure. Risk management is proactive approach involving the systematic identification, quantification and assessment of risks, the approval of options to eliminate or reduce them and recognition by all concerned of the implications of the risks.

In seeking consent the radiologist must ensure that the patient is competent to give consent, the information provided is timely, accurate and understood by the patient and consent is given without duress. Sufficient information must be given to the patient to ensure that they understand the nature and are aware of all consequences and any significant risk of the examination or procedure proposed. A permanent record of the obtaining of consent should be made in the relevant health records.

Complications are most frequently associated with interventional techniques. All radiologists should be aware of the risks of injecting contrast agents and should have a comprehensive knowledge of the substance being injected. Protocols must be in place for dealing with reactions. All members of the radiology department should be trained in resuscitation skills.

Failure to communicate is an important source of radiological mishaps and can result in an inappropriate investigation being performed on an individual patient or the wrong patient being sent for an examination. There may be insufficient clinical information on the request form which may also be inadequately filled in. The radiologist must receive information regarding previous examinations that have been undertaken and whether previous results have affected clinical management. Radiologists must ensure that the appropriate information is available before justifying an examination.

The communication of the report of the examination is an important source of error. It is essential that procedures are in place to transmit the report of the examination a quickly as possible. Where an urgent clinical situation is present or there is a major unsuspected finding which involved urgent patient management decisions, the radiological opinion should be transmitted directly to the attending physician.

Risk management, however, is dependent on the acceptance that mistakes will be made and that things will go wrong. The key is to try to anticipate them and to alleviate them. In good risk management practice it is therefore essential to have a forum where reporting discrepancies, errors, near misses and complications are demonstrated and evaluated. Discussions should conclude with an analysis of how the error or discrepancy could be avoided in the future.

The original reporting radiologist should be informed of the case in a confidential fashion and the clinical team should be informed of the discrepancy, if they are not already aware, to ensure that harm to the patient is avoided. Any general lesson learnt should be promulgated throughout the department.

Equipment should be up to date, should be serviced regularly and proper maintenance and replacement program should be in place. There is a duty of radiologists to advise the hospital of deficiencies in equipment which may contribute to patient risk. Procedure should be reviewed and complications should be audited. Individual radiologists may consider keeping a database of all patients on whom they have performed procedures, any adverse events and overall outcome.

All radiological departments should aspire to a high quality of radiological services at the lowest possible risk to the patient. It is important to address their potential areas of weakness in advance and also try to reduce the sources of errors as far as possible. Proper departmental protocol should be in place for all investigation in order that potential complications are identified prior to the investigation and all attempts are made to eliminate or when not possible to alleviate them.

Finally patients have a right to know of errors that have adversely affected their care management. Communication of this information to the patient must be undertaken in a sensitive manner after discussion between the radiologist and the clinical team.

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Conflicts of interest

None