BMUS Position Statement: Patient Access to Medical Imaging Reports

With the advent of electronic patient records and the development of the NHS app, patients have increasing access to medical notes and findings that were previously held within confidential NHS systems. The sharing of all medical letters and results in this digital format includes imaging reports. However, there is a potential lack of awareness from imaging practitioners that the imaging report they have produced for the referrer is also shared on the patient's own records immediately. Thus, the patient may have read the report even before the clinician has had an opportunity to review it.

Whilst it is common practice in the obstetric arena for patients to have 'hand-held' notes, containing ultrasound reports, this has not been routine practice within non-obstetric ultrasound. Ultrasound practitioners are now faced with challenges in terms of content and phrasing of reports to avoid unnecessary ambiguity, misunderstanding and increased anxiety for this large cohort of patients whilst conveying important ultrasound findings to the referrer. The following recommendations offer best practice guidance to any practitioner undertaking and reporting on ultrasound images.

It is acknowledged that, even when following best practice guidance, there will be instances where patients have concerns or queries about their imaging report. BMUS firmly maintains that the responsibility for discussing imaging reports with patients sits with the referrer. BMUS advises that practitioners do not engage in direct dialogue about the content of their imaging reports with patients other than that agreed within local protocols or in exceptional circumstances where there are queries regarding typographical inaccuracies.

Imaging practitioners may not be fully cognisant of any prior or planned investigations nor relevant previous medical history of an individual patient. As such, any discussion regarding individual imaging reports may be made out of context and lead to mismanagement or delays in seeking appropriate consultation with referring clinicians.

BMUS recommendations for report writing

- The integrity of imaging reports needs to be maintained. The primary role of the report remains the primary source of communication of findings between the imaging practitioner and the referrer.
- Ultrasound images should clearly reflect the report and any sub optimal images stored should be explained in the report.
- Reports need to remain accurate. They must contain relevant clinical information and describe any limitations which may have contributed to a suboptimal examination. However, statements related to patient habitus, raised BMI or other limiting factors need to be documented sensitively and without personal comment. For example:
    - "Imaging of the renal tract is of poor detail due to the patient's raised BMI."
    - "Owing to mobility difficulties that the patient experiences, only a limited examination of the pelvis could be performed. Where seen, the pelvic organs demonstrated no overtly abnormal features."
- Ensure the referral has a clear clinical question. It is essential to provide this at the start of the report to ensure both the patient and referrer understand what the examination and

report is attempting to answer. The report should then focus on answering the inferred question.

- Where there is relevant previous imaging, it is good practice to document this in the report. For example:

    - "Note is made of the US exam/MRI from 6 months ago."

  Changes or stability in comparison of findings should be documented within the conclusion.

- Whilst incidental findings are commonplace and frequently require follow up or alternative imaging, the consequence of the finding should be documented to prevent unnecessary anxiety. For example:

    - "There is an incidental finding of a 12mm hyperechoic lesion within the liver. This is likely a benign haemangioma but characterisation with contrast ultrasound is required for reassurance purposes."

- Ultrasound practitioners are strongly advised to liaise with radiologist and clinical governance leads within Radiology to ensure that a departmental standard for reporting is agreed and that standardised practice across imaging is implemented.

- Non-medical practitioners are advised to seek collaboration, agreement and support from radiologists or their lead clinicians as practice changes to accommodate this shift in patient's access to imaging reports.

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References

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3. Mezrich JL, Jin G, Lye C, Yousman L, Forman HP. Patient electronic access to final radiology reports: What Is the current standard of practice, and is an embargo period appropriate? Radiology. 2021;300(1):187-9.