

Preparing for revalidation

Peer review: guidance on the use of double reporting

Tools for improving professional practice in
clinical radiology

This tool is designed by The Royal College of Radiologists (RCR) to help clinical radiologists to collect the supporting information required for revalidation.

The RCR would also recommend using these methods to help improve professional practice, irrespective of when the first round of revalidation is implemented.

A series of further tools and pro formas is currently in development and will be added in the future.

As the revalidation process develops and changes with implementation, the RCR will review its tools and would expect the portfolio to evolve. Any feedback to assist with this process would be most welcome.

Relevant background RCR guidance related to professional performance

1. *Standards for Self-Assessment of Performance* – includes a range of methods for monitoring personal professional performance
2. *Standards for Radiology Discrepancy Meetings* – including recommendations for attendance rates and documentation of cases discussed
3. *Cancer Multidisciplinary Team Meetings – Standards for Clinical Radiologists* – includes recommendations for attendance and dealing with discrepancies
4. *Standards for patient confidentiality and PACS* – guidance on professional standards for confidentiality related to radiologists' routine work, teaching and research
5. *Standards for the communication of critical, urgent and unexpected significant radiological findings* – includes professional guidance on compliance with NPSA safer practice notice 16 and recording of action taken
6. AuditLive – a selection of recommended audits <http://www.rcr.ac.uk/CRAuditLive>

List of radiology-specific tools published

- *Multisource feedback: recommended specialty-specific questions, generic questions related to performance and guidance for use*
- *Personal reflection on discrepancies and adverse events*
- *Self-review of practice for clinical radiologists undertaking interventional procedures*
- *Self-review of practice for diagnostic radiologists*
- *Recording attendance at radiology discrepancy meetings*
- *Case-based discussion for diagnostic radiologists*

List of generic tools published

- *Reflection on complaints: a tool for clinical oncologists and clinical radiologists*
- *Reflection on compliments: a tool for clinical oncologists and clinical radiologists*
- *Reflection on serious untoward incidents (SUIs): a tool for clinical oncologists and clinical radiologists*
- *Revalidation audit tool*
- *Revalidation continuing professional development (CPD) summary tool*
- *Reflection on 'near miss' incidents: a tool for clinical oncologists and clinical radiologists*
- *Attendance at mandatory training: a tool for clinical oncologists and clinical radiologists*
- *Supporting information for health for use in appraisal and revalidation*
- *Supporting information for probity for use in appraisal and revalidation*

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Foreword

Whether or not a statutory requirement for all UK doctors to revalidate becomes a reality will depend on legislation and the electorate over the next six months. Whatever happens, good medical practice and the public will demand that all doctors practise to the highest standards. This used to be a good definition of clinical governance. Audit of practice is vital to this and coupled with reflective learning is a powerful tool for improvement.

The purpose of this guidance is to provide all radiologists with a tool for audit of practice by suggesting ways in which double reporting can be incorporated into everyday working life. It should be seen as a companion to the *Standards for Radiology Discrepancy Meetings* published in 2007. If revalidation becomes a reality, this tool will be indispensable.

The College would like to thank Huw Lewis-Jones (lead), Rob Manns (Chair) and the Standards Sub-Committee for their work in producing this document.

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Dean of the Faculty of Clinical Radiology
The Royal College of Radiologists

Introduction

The process of medical revalidation requires a doctor's performance to be assessed in as objective a way as possible. Double reporting can be used as one of the tools to provide evidence to support an individual's revalidation portfolio.

It can provide evidence of reflective practice and has the potential to change an individual's personal professional practice.

This document aims to suggest a framework whereby the individual radiologist can be assured that the process is as fair, objective and confidential as possible, with a clear understanding of the potential outcomes and actions that the process may produce.

It is not proposed that double reporting be compulsory for radiologists but should be considered as an option for the individual's portfolio.

In 2007, The Royal College of Radiologists (RCR) produced *Standards for Radiology Discrepancy Meetings*¹ and that publication should be considered in parallel with this one as it underpins the concept of reporting discrepancy and deals with departmental analysis of those discrepancies. The reporting of all imaging studies remains a subjective process and despite appropriate training, errors and discrepancies still occur.

This document is concerned with the individual radiologist and his/her performance and it does not deal directly with standards for double reporting when used as part of direct service delivery.

Methods for double reporting

There are many possible methods for double reporting. These range from informal inspection of another radiologist's report alongside the original dataset of images to a formal triangular process where two radiologists report randomly allocated cases independently and a third radiologist evaluates the two reports and images. This is a new development for all radiology departments in the UK and it is important, therefore, that this guidance is pragmatic. At this stage, it is fundamental that the guidance is encouraging and supportive so that departments can at least initiate double reporting with the minimum of adverse effects on workload and service provision. It is hoped that these early steps into double reporting will reveal its value to the radiologist and the employing trust, providing support for the primary concern of patient safety.

For these reasons, two simple methods for double reporting are proposed but it is acknowledged that some departments may well have developed their own appropriate double reporting tools.

Double reporting swap

Two or more radiologists in the department with a similar case mix agree to double report a defined number of each other's cases. These cases should come from routine radiology practice within a defined period of time and in a defined modality or set of modalities. The modalities should be restricted to those centring on image interpretation only such as computed tomography (CT), magnetic resonance (MR), radionuclide radiology and plain radiographs. Positron emission tomography – computed tomography (PET-CT) is currently double reported routinely.

The radiologist evaluating the reports completes a form (Appendix 1) for each case reviewed. A possible grading system is proposed which parallels the discrepancy meeting findings:

- 0 = no disagreement
- 1 = minor disagreement
- 2 = moderate disagreement
- 3 = major disagreement.

The two radiologists should discuss all cases with disagreement between them and come to a consensus view. In those rare cases where no agreement can be reached, the cases could be reviewed by a departmental adjudicator. The departmental adjudicator, who may well also be the discrepancy convenor, can either pass his/her opinion or refer the case to the discrepancy meeting for discussion. Departments may also have the option to refer all moderate or major disagreements to this meeting as these cases often offer a valuable learning experience.

On completion of the double reporting sample, the radiologist produces a summary detailing modality type, number of examinations and the grading results. This report and supporting pro formas should be then part of the individual's consultant annual portfolio and should be presented at appraisals.

Multidisciplinary team (MDT) peer review cases

The role of the MDT in clinical management of patients has expanded enormously over the last five years. The MDT does, however, present a unique double reporting opportunity with low impact in terms of workload for the radiologist.

The publication *Cancer Multidisciplinary Team Meetings – Standards for Clinical Radiologists²* lays out the requirements of the radiologist. It emphasises the time requirements for image review before the MDT meeting. In those cases where the images have been reported by another radiologist within the department, the double reporting form can be completed and then passed back to the reporting radiologist.

However, it should be acknowledged that the MDT meeting radiologist is usually a specialist in that field and the double reporting form should reflect knowledge appropriate to a general radiologist reporting that area.

The scope of this process could be expanded to cases reported within the network and the forms returned to individuals in other hospitals. This issue should be discussed at the relevant cancer and radiology network groups who may wish to formalise this process.

This is an area with great opportunity for the generation of double reports using existing workload and just requires a single layer of paper work linked into the MDT meeting

Where double reporting is to be used as part of a department's revalidation portfolio, the trust should develop software in the picture archiving and communication systems (PACS)/radiology information systems (RIS) to facilitate this process electronically and ultimately link in directly to the individual's e-portfolio.

This information could be of great value to the radiologist who has the skills to report oncology cases in a particular area but cannot attend the MDT meeting due to other workload commitments. The double report summary has the potential to provide some evidence of competency in these specific areas.

Each department will need to decide the most appropriate method for their circumstances after considering factors such as subspecialisation, consultant numbers, workload, IT facilities and team dynamics.

Technical requirements for double reporting

All individuals involved in the process should have the same information available to them at the time of image interpretation.

- This should include all the images performed for the original study viewed on an appropriate PACS workstation with the original referral clinical details.
- Cases where further imaging has been performed should not be included in the evaluation unless this can be electronically hidden at the time of double reporting. For this reason, it makes sense for double reporting to occur as close as possible in time to the original report. This is of particular concern where MDT cases are being used as part of double reporting. The MDT forum often provides greater clinical information and/or other relevant imaging. The double reporter must be careful not to allow this information to bias the double reporting assessment and it may be necessary to exclude such cases from the evaluation.
- The double reporter must be careful not to introduce any bias related to his/her own individual area of special interest.
- The evaluation should be set at the expected skill of a general radiologist reporting examinations.

Selecting the sample

There are a number of principles to consider regarding sample selection.

Number of cases

The sample size will depend a great deal on the facilities available in the department. A minimum of 30 cases a year in an individual modality would be reasonable but the principle of some rather than none applies strongly. It is important at this stage to embark upon the process at whatever level can be achieved.

Case mix

The sample must reflect the reporting radiologist's normal workload referral pattern. Tertiary referral cases outside the radiologist's area of special interest would not be an appropriate choice.

Frequency of evaluation

It is suggested that the exercise be performed once a year but this may have to be reviewed when considering the available resource.

Who should oversee double reporting?

The vast majority of cases double reported can be agreed between the reporters and presented through the discrepancy meeting anonymously. Discrepancies should be recorded in the usual way for the individual radiology department. In the very rare instance of a disagreement of evaluation, the double reporting adjudicator may have a key part to play.

The adjudicator should be selected by their peers and be of appropriate experience and expertise to evaluate the imaging studies and reports.

The process must be confidential with clear lines of responsibility between the initial reporter, the double reporting radiologist and the adjudicator.

The adjudicator should have the clinical respect of their peers which should be free of any professional or personal prejudice.

Summary

Double reporting is one of many tools which can be used to assess a radiologist's performance and the decision to use it rests with the individual radiologist.

These guidelines are intended to be an encouragement to radiologists in the UK to start double reporting as a means of effective and useful peer review.

The evidence generated has the ability to form the backbone of revalidation as well as providing an interesting learning tool.

The MDT meeting provides a double reporting framework which can be used with minimum extra workload, while the double reporting swap exercise – although more time consuming – can provide a more structured approach.

It is anticipated that the structure and scope of double reporting will alter with time.

Trusts should acknowledge the value of peer review through double reporting but be aware that it is inevitable that this process will result in loss of some clinical activity. For those radiologists taking part in double reporting, appropriate time must appear within their job plan as a clearly defined contribution to supporting professional activity.

Approved by the Board of the Faculty of Clinical Radiology: 19 June 2009

References

1. The Royal College of Radiologists. *Standards for Radiology Discrepancy Meetings*. London: The Royal College of Radiologists, 2007.
2. The Royal College of Radiologists. *Cancer Multidisciplinary Team Meetings – Standards for Clinical Radiologists*. London: The Royal College of Radiologists, 2005.

Appendix 1. Double reporting pro forma

Formal double reporting or MDT _____

Date of review: ____ / ____ / ____

Reporting radiologist: _____

Evaluating radiologist _____

CRIS no of study _____

Date of study: ____ / ____ / ____

Date of report: ____ / ____ / ____

Examination type and site _____

Technical merit of examination	0	1	2	3
	artefact +++	adequate	good	excellent
Language of report	0	1	2	3
	No disagreement	Minor ambiguity	Moderate ambiguity	Major ambiguity
Opinion of clinical report	0	1	2	3
	No disagreement	Minor disagreement	Moderate disagreement	Major disagreement

Where cases have recorded 0 or 1 for technical merit, they should be discarded from the results of any report.

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