Medical Accidents due to Unread Radiology Reports

1. In 2016 to 2017, many medical accidents were reported due to unread radiology interpretation reports regardless of the size of the hospitals in Japan.

2. This issue of communication errors became a big social problem, and many hospitals were accused of inappropriate measures.

3. We, radiologists in our hospital, decided to start reviewing that issue.

Our New Strategy

1. We, radiologists in our hospital, decided to start reviewing that issue.

2. We were able to avoid communication errors that could lead to medical accidents in at least 23 cases in one year.

3. Our new strategy has the great advantage of our new strategy.

Our New Strategy (continued)

1. This study was performed in a university hospital, and the efficacy of the proposal measure should be confirmed in other academic institutes and private hospitals, although we suspected that this measure may be effective regardless of the size of the hospitals.

2. The decision of whether or not to add stars was left to each radiologist, and detailed protocol was not defined. Although we could have prepared detailed guidelines, we suspected that complicated rules would have decreased efficacy. Ease is a great advantage of our new strategy.

3. We defined semi-emergencies as medical issues needing addressing within two weeks, but we did not have any evidence that “two weeks” was the appropriate period for this definition. If medical issues needed addressing in less than two weeks, the radiologists in our department had the option of adding three stars.

4. The definitions of semi-emergent and emergency should be defined according to the characteristics of the facility.

5. In many cases with emergency findings, if radiologists thought that communication was totally secured, they did not paste three stars. Thus, the incidence of emergency findings was much underestimated in this study.

Conclusions

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Future

We suspect that it possible for AI technology to replace this system.

Study Limitations

1. Referring physicians may depend on this system and may become not to carefully read un-reviewed reports.

2. We have to reconfirm that it is the basic responsibility of the referring physicians to timely and carefully read the reports.

Possible Drawbacks

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References

1. Standards for the communication of radiological reports and fail-safe alert notification by The Royal College of Radiologists.