Joint Working Party Report on Radiological Services for General Practitioners

THE ROYAL COLLEGE OF GENERAL PRACTITIONERS
THE ROYAL COLLEGE OF RADIOLOGISTS

1. Value of direct access

THE Royal Colleges agree that direct access to radiological services is essential to family doctors. It shortens investigation time, improves the quality of service offered by general practitioners and increases the interest of their work. General practitioners should have a similar right of access to radiological imaging facilities as consultants. Trainee practitioners and junior hospital doctors should exercise corresponding rights subject to the jurisdiction of their principals.

2. Radiological services offered to general practitioners

We agree that the range of investigations, particularly those requiring contrast media, available to general practitioners has to be determined by the local radiologist, bearing in mind the resources provided by the district health authority. The examinations undertaken by different hospitals vary widely, but studies such as urography, cholecystography and barium enemas should be open to family doctors if proper indications are observed.

3. Allocation of resources

We agree that the overriding principle in allocation of resources must be clinical priority. When available radiological resources are limited, necessary examinations on hospital inpatients will normally have priority but, as indicated by the DHSS, constraints should fall equally on referrals from family doctors and on hospital outpatients subject to the radiologist's decision on medical priority. We can see no justification for the practice, which is found in some parts of the country, of maintaining a longer waiting list for patients referred by general practitioners.

4. Provision of facilities for direct access

All health authorities should ensure that direct access for general practitioners is provided and should liaise with radiologists as to how this is to be implemented.

5. Siting and control of x-ray facilities

The Royal Colleges agree that for the protection of patients from unnecessary irradiation and to maintain the quality of x-ray services, x-ray facilities should be provided in properly staffed departments under the control of a consultant radiologist. We are not generally in favour of the further provision of x-ray equipment in health centres or other small units as this dissipates scarce resources. However, we accept that such facilities are sometimes necessary for geographical and other reasons; in all cases they should be under the administrative charge of a consultant radiologist.

6. Restrictions on x-ray examinations in smaller units

General practitioners are often irked by restrictions in the range of examinations available in small units, in particular the widespread 'ruling' against contrast studies such as IVUs or cholecystograms. This arises from a failure to appreciate the potential difficulty or complexity of such examinations. Diagnostically adequate studies (convincingly positive or negative), even in apparently simple examinations such as cholecystograms, can only be regularly obtained if a radiologist is available to supervise them. During cholecystography upright films taken under fluoroscopic control are sometimes the only ones to show gallstones. Intravenous urography carries a definite risk of contrast reactions and requires proper supervision. Adequate studies may also involve the use of extra views such as oblique films or tomography. Unsupervised studies on basic equipment may therefore lead to misdiagnosis or in-

volve repeat examinations to reach a conclusive answer. Similarly, modern barium studies require image intensification fluoroscopy. It is in the patient's own interest that the best possible examination should always be performed.

7. Funding and installation of x-ray equipment

The cost of modern x-ray equipment is a further argument for centralization and for careful scrutiny of the type of equipment installed, whether monies come from Exchequer funds, from public appeals or private sources. The Radiology Advisory Committee of each region should be consulted before any new radiodiagnostic equipment or imaging device is installed in any DHSS premises.

8. Responsibility of radiographic staff

The first responsibility of a radiographer in any department is to the consultant radiologist in administrative charge. Family doctors are asked to keep this in mind, particularly where the consultant is able to attend only once or twice a week.

9. Clinical responsibility for patients in the x-ray department

While the family doctor has overall responsibility for the care of his or her patient, when the patient is in the x-ray department the radiologist assumes responsibility. This responsibility includes the choice of examination, whether or not to perform the examination, the conduct of the examination and the management of any complications, for example contrast reactions. It is part of the general practitioner's responsibility to notify the x-ray department of any relevant aspect of the patient's clinical condition.

10. The x-ray request as a form of consultation

Most x-ray requests, whether from hospital doctors or general practitioners, are entirely appropriate to the clinical problem and are performed without question. In some cases, however, the best examination for resolving the clinical problem may be a different form of x-ray or an ultrasonic or radioisotope study. In a complex and rapidly changing field the radiologist is in the best position to select the most suitable examination provided he or she is fully acquainted with the clinical details. An x-ray request is analogous to a request for a clinical outpatient consultation. The radiologist may decide that an examination is not necessary or that an alternative examination should be carried out. Whenever possible he or she should communicate with the general practitioner before taking such action, not only as a matter of courtesy, but because both may learn from such discussions. General practitioners should inform every x-ray department to which they refer patients where they may be contacted should the need arise.

11. Local communications and guidelines

There is a clear need for good communications between radiologists and general practitioners. Ways of improving liaison should be encouraged, so that case discussion and exchange of information can take place. It is helpful if the radiologist can work out local guidelines with family doctors, covering the examinations which are undertaken, the best times for referring patients to the department, the preferred studies for particular clinical problems and the usual lines of action which will be taken when abnormalities such as fractures are found. We agree that, unless a condition requiring urgent treatment is found, any patient in whom an acute lesion is shown on the radiographs should normally be referred back to his or her general practitioner, rather than being transferred to the care of a hospital consultant. Where a patient has to be transferred to the care of a hospital consultant, it is essential that the radiologist informs the general practitioner as soon as possible.

12. Reporting style

Some radiologists give reports which simply describe the abnormalities seen on the films. The implications of such reports may be well understood by hospital colleagues who will normally be able to see the films, but they are not necessarily clear to family doctors, who may not. In communicating with general practitioners it is therefore important that the report should give clear conclusions together with any recommendations as to further radiological examination or other studies which are indicated.

13. Availability of x-ray films

Whenever possible it is desirable for films on their patients to be kept available for viewing by general practitioners. In some situations a regular meeting between general practitioners and radiologists may be arranged.

14. Transfer of x-ray films

Difficulties may arise when a patient transfers from one hospital to another. Many x-ray departments are reluctant to release films when a patient has moved to the care of a different hospital or consultant. We can see no justification for this and agree that radiologists should be ready to transfer films in such circumstances; this reduces unnecessary irradiation, saves money and shortens investigation time.

15. Standardized request forms

Family doctors dealing with a number of hospitals find it tiresome to keep stocks of different x-ray request cards. The different layout of differing forms also hinders their rapid completion. The RCGP representatives also pointed out that many forms have space for clinical details which is totally inadequate to provide the kind of information needed in a proper consultation. These points were noted by the RCR, who agreed the desirability of a uniform card but saw considerable difficulties in its implementation.

16. Reporting by non-radiologists

Reporting by family doctors is sometimes urged as a means of reducing the load on radiologists. This overlooks the very considerable difficulties in learning to interpret x-rays. It is most unlikely that any family doctor could give sufficient time to become adequately trained in reporting to the extent of taking medico-legal responsibility for his or her reports. There should, however, be no hindrance to general practitioners who wish to see the films on their own patients and take decisions before full radiological reporting.

17. Education

The Royal Colleges were unanimous in supporting the need for more teaching of radiology and the essentials of other imaging procedures to non-radiologists. This should be provided:

1. For medical students to give them a firm grounding in the value of and indications for different radiological studies.

2. For general practitioners to further their understanding of the uses of x-ray investigations and their limitations as well as the significance of x-ray reporting. This would involve teaching both during vocational training and as part of continuing medical education.

Members of the Working Party

RCGP: Dr S. J. Carne, Professor R. Harvard Davis, Dr M. J. Linnett, Dr Lindsay Smith.

RCR: Dr G. J. Green, Dr W. B. James, Dr E. Rhys Davies, Professor C. J. Roberts, Dr H. M. Saxton, Dr K. Swinburne.

Birth Statistics 1979

The number of live births in the calendar year 1979 (638,000) was nearly seven per cent higher than in 1978 (596,000).

Source: *Birth Statistics 1979* (Series FMI, no. 6). London: HMSO.