Standards for interpretation and reporting of imaging investigations

The Royal College of Radiologists

This document defines the expected standard of care for reporting radiological investigations. It underpins radiologists' role as leaders and experts in medical imaging but should apply to all who interpret and report imaging, regardless of their professional background.

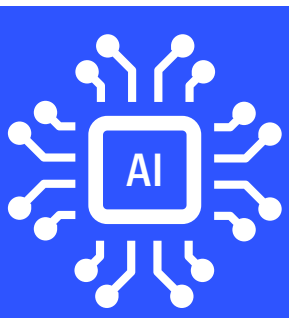
Service organisation

- Providers should create SOPs that comply with national guidelines.
- Timely, accurate and actionable reporting is required for patient safety and optimal outcomes.

Reporting authors

- Should comply with all ongoing CPD, audit standards and revalidation processes.
- Should be trained in accordance with their professional body's standards and work within their defined scope of practice.
- Must be able to evaluate the quality of the images as per the RCR Clinical Radiology specialty training curriculum.

Infrastructure and technology



- Providers should ensure that patients' imaging history and reports can be automatically communicated to other IT systems accessed by clinicians.
- Voice recognition is encouraged to enhance workflow.
- AI-generated content should be clearly identified and verified by a named human author.
- Validated AI tools should be integrated to enable safer and actionable reporting.
- Remote reporting must comply with the same technical specifications and governance as in-hospital settings.
- Those reporting remotely should have access to clinical documentation and imaging records to ensure accurate interpretation within the correct clinical context.

The report

- Reports should include name, job title or professional status, registration body and number.
- **Clinical Details:** Include referrer's text and relevant additional detail and context.
- **Scan protocol and technical detail:** Include if it aids understanding, justifies technical parameters, adds value, or details potential deficiencies.
- **Observations:** Focused, relevant findings; avoid irrelevant incidental findings or negative observations.
- **Standardisation:** Structured templates are encouraged where suitable. Must not imply scrutiny beyond what was performed.
- **Conclusion:** Directly answer the clinical question in a way that is clear, actionable, and tailored to the referrer.
- **Interventional reports:** Should be prompt, detailed, include consent and follow-up instructions.

Patient access

- Timeliness of patient access should be balanced with arrangements for supportive communication of any findings.
- Reports should be written for the referring clinician but may be accessed by patients via patient-facing platforms. A standard phrase should be included in the report or added to the platform suggesting patients direct questions to their referring clinician.