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Australian rural radiographers' perspectives on disclosure of their radiographic opinion to patients

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ABSTRACT

The role of Australian rural radiographers in radiographic interpretation, communication and disclosure of their radiographic opinion with a specific focus on plain film radiography was examined in a two phase, exploratory interpretive study. Data were collected using questionnaires and interviews and analysed thematically. This reports one of the key themes identified in the thematic data analysis. 'Disclosure of Radiographic Opinion to Patients' comprises the three interrelated sub-themes *Acting Ethically*, *Selective Disclosure* and *Filtered Truth*. It is wholly concerned with the ways in which rural radiographers choose to disclose their radiographic opinion to patients. Without a clear picture of where they stand medico-legally, rural radiographers draw on experience and a strong ethical framework as the basis for these complex decisions. Rural radiographers frame their disclosures to patients in a manner that is governed by the diagnostic, therapeutic and emotional impact the information disclosed may have on the patient. Disclosure to patients was found to be selective, often diagnostically vague and ethically filtered.

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Introduction

Reform of the Australian diagnostic imaging workforce and radiographers role in radiographic image interpretation and reporting of plain radiographic images is gaining momentum in the literature. Much of the debate concerns role demarcation existing between radiographers and radiologists, where image reporting lies within the professional jurisdiction of radiologists and outside that of radiographers. The Royal Australian and New Zealand College of Radiologists (RANZCR) holds the position that '… the radiology report, which communicates the medical interpretation of the patient's imaging in a clinical context, cannot be currently delegated to those who are not trained initially as medical practitioners and then as medical imaging specialists'.[1] This position differs little from that taken in the mid-1920s when the occupational divide between radiologists and radiographers was defined.[2] Notwithstanding this, the legislation surrounding radiographers' role in disclosure of their professional opinion is ambiguous and this has particular implications for radiographers in more isolated practices.

The widening in the gap between the supply of radiologists and the demand for their services is increasing their workloads resulting in delays in reporting times.[3,4] In rural areas delays can be protracted because there may not be a radiologist on site. Despite the use of digital technologies such as Picture Archiving and Communication Systems (PACS) reporting delays continue and contribute to the formation of a diagnostic gap.[5] The diagnostic gap is a metaphoric description of the period of time between image acquisition and when the patient's referring clinician is in possession of an interpretation of the patient's radiographic images, which they are able to act upon and pass onto the patient. It is a troublesome gap because waiting for a diagnosis is a time of uncertainty and anxiety for patients.[6,7] Not content with waiting to receive their results from their referring clinician[8] some patients want to be told the results at the time of the examination[9,10] and so may question the radiographer.[11]

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Radiographic image interpretation and subsequent disclosure to patients are practices that sit outside radiographers' traditional scope of practice.[5] Legislative ambiguity has led some authors to claim that no statutory limitations exist on communicating diagnostic information to patients.[12,13] Others disagree[11,14] and this reflects the uncertainty surrounding disclosure that radiographers experience.[15] Consequently, diagnostic conversations between radiographers and their patients require radiographers to make difficult decisions about whether to respond and how to frame their responses.

The aim of this study was to use exploratory interpretive research methods to investigate Australian rural radiographers' experiences in interpretation of plain radiographic images; communication and disclosure of their radiographic opinion. The intention was to generate a substantive theory about how rural radiographers construct this role in the context of the ethical and social dimensions of their clinical practice. This paper focuses on the findings in relation to disclosure of results to patients using a research framework that draws upon ethical theories.

Methods

This two-phase doctoral study was completed in 2012. Ethics approval was granted by the Human Research Ethics Committee (Tasmania) Network. Initial data was collected from radiographers practising in rural New South Wales, Western Australia and Tasmania by postal questionnaire in order to provide a demographic snapshot of Australian rural radiographers and to inform the subsequent inductive, exploratory and iterative interviews. The targeted radiographers were those who held an Australian Institute of Radiography Statement of Accreditation or were registered with Medical Radiation Technologists Registration Board of Western Australia and who provided radiographic services to a population of less than 100,000. The questionnaire which had a return rate of 32.4% ($n = 185$), was accompanied by an invitation to volunteer for an in-depth semi-structured interview.

Twenty three radiographers from twenty three practice environments volunteered to be interviewed and convenience sampling led to nine face-to-face or telephone interviews which ranged in duration from 25 to 80 min. The interviews comprised demographic, knowledge, experience, behaviour and attitude questions relating to radiographic image interpretation and disclosure of radiographic opinion. Interview informants were all experienced rural practitioners with an age range of 36–62 (mean 53.4) years who had been practising for 16–42 years (mean 32.9) in either private practice or public hospital setting. Five were female; two provide radiographic services in regions with estimated populations of less than 50,000 and the remainder in regions with population of less than 30,000.

Interviews were carried out in quiet, mutually agreed locations, and were audio-recorded and transcribed verbatim. Data were analysed using coding and a continuous cross comparison technique supported by QSR NVivo 8®. Recurrent patterns of relevance and significant themes were then established.[16]

Results

This paper is based upon one of the six key themes identified in the thematic data analysis, 'Disclosure of Radiographic Opinion to Patients'. The other key themes are reported elsewhere. 'Disclosure of Radiographic Opinion to Patients' is wholly concerned with the ways in which rural radiographers' make choices around disclosure of their radiographic opinion to their patients. Three interrelated sub-themes (Acting Ethically, Selective Disclosure and Filtered Truth) constitute the theme. Each is described below with illustrative data excerpts and their relationships are shown in Fig. 1.

Acting ethically

Acting ethically emerged as a sub-theme directly influencing not only decision making but also the other themes. Informants confirmed that patients frequently ask for diagnostic information and this placed pressure on them to respond:

> *RR 2: … I think they want you to tell them, I think…they feel that you should tell them straight away what's wrong with them … I would say 90% of your patients would say to you at the end, so what's on it?*

> *RR 5: Then they come to us, who they know is going to have the result and they put a lot of pressure on you to sort of tell them what's happening*

Despite the tension that exists for radiographers around disclosure to patients, the informants are providing diagnostic information to their patients and demonstrated a preference for being truthful. For example:

> *RR 3: No, as I say, I usually like to be honest with them.*

> *RR 6: … I am going to tell you because well a – you have asked me and I am not going to lie to you…*

While honesty is preferable, informants acknowledged there are instances where they might not be absolutely honest. These relate to the 'medico-legality' of disclosure, the ambiguous legal standing of radiographers disclosing diagnostic information, and ethical issues of 'advocacy' and 'protection', wishing to shield the patient, and themselves from the effects of a threatening diagnosis. The concepts are interrelated as illustrated by this informant:

> *RR 4: … there's obviously a need for further discussion … I think it is more the medico-legal thing comes more from that further discussion because if they have results there is obviously a psychological effect, if you have cancer or if you've got cancer I can't send you home … without you having had counseling …*

Another informant commented similarly that:

> *RR 9: Well, if they have got something dreadful, well who knows what they will do. I think if you tell them there is nothing wrong in actual fact there probably may be I think that's when you are really going to get into strife because that's when they will go and talk to other people about it and … you could even end up with a law suit maybe I don't know.*

While acting ethically can at times involve disclosing the results of an examination to the patient, in different circumstances ethical action may require restraint and a continuum of disclosure appears to exist with radiographers making decisions about the degree to which they will disclose.

Selective disclosure

This second sub-theme is about navigating the disclosure continuum. The radiographers indicated that they moderate their level of disclosure based in part on the perceived impact of the ensuing diagnosis.

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