Fuzzy precision: The art of saying nothing well in print

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The hedge is indeed the national plant of the diagnostic radiologist.

I chose radiology as a specialty for several reasons, chief among them to escape internal medicine, but also to enjoy the real science and precision afforded by looking at living anatomy. After all, what could bring more certitude to a diagnostic dilemma than a direct picture of the anatomy and its pathology? Pitted against a question like this, the "art of medicine" seemed just too ethereal and progressively less worth pursuing, especially as diagnostic imaging came into its own with CT, MR, sonography, PET and all their spin-offs. Radiology had become the go-to specialty—the one with all the answers; the one with all the gurus sitting on the mountain top.

Maybe it's just me, but that doesn't seem to be so accurate a picture anymore, especially when I look at the reports we radiologists generate for our referring physicians and their patients. As I review my own reports and those of others in my department, I sense overwhelming degrees of self-doubt, imprecision, buttocks-covering and other defensive postures. I sense that the art of seeming to say a lot while saying nothing is becoming a well-developed skill, acquired in residency and perfected during one's career. I sense the hedge is indeed the national plant of the diagnostic radiologist. And I fear the problem is growing steadily worse. Let me provide some examples, most of which I believe you will know well—and likely recognize from your own daily practice.

Appears to be. One of the most common ways to describe a finding in all of radiology, this three-word phrase pops up in such statements as, "There appears to be a pneumothorax." Compare it to its more precise and more confident brother, "There *is* a pneumothorax." Even shakier phrases such as, "it probably appears to be" or "this suggests the possibility that it could be" are two steps deeper into the defense zone and virtually saying that the finding may actually be normal.

Overt. As in, "There are no overt pleural fluid collections" or overt anything else you might wish to include in your report. But it raises a question: If the finding were in fact overt, would anyone need a radiologist to see it? The damn thing would be staring you right in the face. It would be so obvious you could practically feel it on the screen.

Further clinical information may be of value. This is one phrase I have more sympathy for. It is a given that more accurate clinical information would *always* be of value. Actually, I would place a disclaimer at the beginning of every report stating something to the effect of: "Pertinent findings from physical examination, including other study

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results, and medical history may strongly influence the interpretation of this study."

This is a true statement and might just motivate the requesting MD to do more than simply check a box on an order sheet or on-screen PDF to obtain a study.

Further diagnostic studies such as … may be warranted. What a tightrope this one is! Does a statement like this in your report compel the referring physician to order the studies? Could it put you into conflict with the referring physician if he or she doesn't want to have studies performed? One potential reaction could be, "Who the hell does he think he is telling me what to do?" The referring physician may also think you're just taking a self-referral gambit. What obligation, after all, are radiologists under to do more than report study findings and render a diagnostic opinion? Does straying into the world of more direct patient care involvement, which will be documented in the medical record, exceed our mandate as radiologists? Should these opinions be communicated only at multispecialty case review conferences, via self-destructing tapes or well-encrypted e-mails? Should we perhaps just skip the whole exercise?

Repeating impressions in the body of the report. This is a pet peeve of mine that, quite frankly, I am guilty of committing more often than I would like to admit. The body of the report describes the appearances, or findings, on the study. The "impression" portion of the report, meanwhile, translates those findings into a diagnosis—or, hopefully, at least makes an advance in that direction. These portions always get mixed together. If your impression is just a repetition of the body you are wasting your own time and effort and those of anyone who reads your report. Similarly, a long-winded report is not usually better; it's just longer. Most people would prefer not to read it.

Granted, some boilerplate has to appear in particular specialty reports, but do try to get to the important stuff without touching on every organ in the body. If you do not mention an organ, you can be confident—usually—that your reader will not assume such horrible, disgusting pathology is present that you could not bring yourself to even mention it. The questioning response my terse polytrauma reports usually inspire is, "Oh, your report did not mention whether the aorta was injured?—" to which my super-sarcastic response is typically, "Oh right, thanks for bringing that up. I was just going to hold that finding back for a while."

Lots of elderly patients have a zillion typical, age-related findings. If you take the time to describe all these in your reports, take my word for it, you *will* die young from exhaustion. I don't mention these unless they are in some fashion directly producing symptoms, much like spinal stenosis, bladder outlet obstruction, etc. Otherwise, at the bottom of the report I just state that typical senile or degenerative changes are present (if I feel compelled to mention them at all). If age-related anatomy really looks bizarre you might mention it only to assure your reader it is not really as horrible or unusual as it looks.

Finally, once you have dictated the type of study and any technical factors that must be included, it really is perfectly OK to go right into the impression with "normal study" or even just "normal". I know you feel you're somehow cheating the referring docs, but you are actually giving them what they really need. They can always call with burning questions; in helping them then, you can show off how smart and confident you are.

Some of the phrases and personalized style we apply to our reports lead to wide variation in the usefulness and accessibility of the information we are trying to communicate, as well as in how germane it is to the clinical question. Granted, when there is no clinical question to be addressed, a meandering report with extraneous verbiage should be expected. Frankly, I do not know if structured reporting is the way to mitigate these problems. I like injecting some personal style into my reports to brighten them up a bit; perhaps making people actually want to read them. Maybe it would make sense for specialty radiology groups to develop consistent report styles for less variation and greater emphasis on meaningful content. Residency programs should definitely take time each year not only to review what information must be provided to get paid for a study, but also to explain what goes into generating a clear, concise, targeted and—dare I say it—*elegant* report.

In short, the *real* end product of all our reading effort as radiologists is our written report, and we should give it a lot more attention than we do.