



The Royal Australian and New Zealand College of Radiologists®

Mr Kevin Allan
Deputy Health and Disability Commissioner
Health and Disability Commissioner's Office
PO Box 1791
Auckland
New Zealand

Via email: HCrompton@hdc.org.nz

16 April 2021

Your ref: 19HDC01606

Dear Mr. Allan,

Thank you for your letter of 9 February 2021.

We would first like to express our sincere condolences to the family of the man whose care has been the subject of this case and to acknowledge their suffering. We also want to recognise the expression of remorse, acceptance of responsibility, and the impact of this patient's death on the radiologist involved in his care.

The Royal Australian and New Zealand College of Radiologists ("the College") is appreciative of the opportunity to respond to the concerns of the Office of the Health and Disability Commissioner in relation to this matter. In particular, you have asked the College to address the following:

"I would appreciate it if RANZCR considers what actions could be taken to further minimise perceptual error in radiography reports".

The College is responsible for setting and maintaining professional standards for clinical radiology and radiation oncology, for overseeing and accrediting postgraduate training and examinations in both disciplines, credentialing specialists and creating and maintaining systems for participation in and recognition of continuing medical education that are compliant with the requirements of medical registration boards in Australia and New Zealand

As has been recognised by the radiologist themselves and experts asked to provide opinions in this case, perceptual or diagnostic errors are an unfortunate and inevitable part of radiological practice of which radiologists are well aware. A great deal has been published over decades in the radiological literature, but also in general medical and human factors research literature, regarding diagnostic errors and how they may be caused and mitigated. Knowledge of potential contributors to perceptual error such as distraction, workload, interruptions, tiredness, multitasking, the equipment used to view images, and working environment cannot eliminate errors completely because of the complex nature of the cognitive task radiologists perform. In addition, some of these contributors to error are a fact of life in daily clinical radiology and are not in the control of the radiologist. It would be welcomed by many general radiologists, particularly those working in solo practice or regional, rural or otherwise relatively remote settings, to be able to refer cases of higher complexity, such as cancer surveillance, to subspecialist radiologists in larger metropolitan or academic centres. However, this requires consideration and potential reform of current funding, operational, teleradiology linkages and contractual arrangements that are in place in New Zealand radiological practice. Without doubt, it would cost more but the impact on the quality, safety and efficiency of patient care are potentially considerable through reduction of diagnostic errors.

Discretionary seeking of second opinions by the radiologist is likely to be a less desirable option for a number of reasons:

- a. Without formal arrangements in place, the radiologist may have no one to call upon to provide a second opinion nor the IT infrastructure to securely transfer the images

- b. In the current case, if an abnormality is not perceived in the first place, there may be no impetus to ask another radiologist for their opinion about what the abnormal finding could be.
- c. It is well – recognised in the medical literature relating to perceptual and cognitive errors in radiological diagnosis that most diagnostic errors relate to lack of perception and less often to cognitive bias resulting in a wrong conclusion about what the abnormal finding represents
- d. It is also recognised that the way in which an “expert” reader compared with a “novice” or non-expert evaluates image data (based on computer analysis of eye movements) is different. The expert will more often detect an abnormality even though the novice has looked at it and the expert will do so more quickly, The cognitive processes underlying this are not surprisingly poorly understood but are being studied because of the recognition that this understanding would potentially help to accelerate the transition from novice to expert and consequently reduce errors. It is often said by radiologists that the “eye sees what the brain knows” and perception of abnormalities is to some extent dependent on what the brain is looking for or expecting. It is also true that the person who has seen a condition before is the person most likely to recognise it when they see it again. The implications for subspecialisation are obvious.

The College’s role in relation to this issue is to set, and continually review, high standards of professional practice through the appropriate training, examination, credentialing, continuing professional development and specialist recognition of its members. It is through all of these mechanisms that it supports its members to deliver high quality health care to our patients and the community at large. The matters raised in your letter are important ones that partially overlap with the College’s remit but that also speak to the growing subspecialisation of medicine and the resourcing and support for non - tertiary regional, remote and rural practice in many disciplines.

Thank you again for the opportunity to provide a response on this matter.

Yours sincerely



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