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The radiology report: a clinician and a radiologist perspective in a resource-limited setting.

Le compte-rendu radiologique : un point de vue du clinicien et du radiologique en contexte à ressources limitées.

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RÉSUMÉ

Objectif : Comparer les opinions et les attentes des radiologues et des cliniciens référents concernant le compte rendu radiologique et identifier les tendances, les discordances et les concordances des points de vue.
Méthodes : Étude transversale de douze mois dans des hôpitaux universitaires de Yaoundé impliquant des cliniciens et radiologues spécialistes ou en spécialisation. Les participants étaient invités à donner leur opinion et leurs attentes concernant les rapports de radiologie selon une échelle de Likert à cinq niveaux.
Résultats : Le taux de réponse au questionnaire était de 72% (86/120). La très grande majorité des personnes interrogées conviennent que le compte-rendu de radiologie est indispensable à la pratique et que les radiologues sont les mieux placés pour interpréter les images. Les informations cliniques étaient jugées importantes pour rédiger un bon compte-rendu. Les personnes interrogées se sont généralement montrées très satisfaites des comptes rendus qu'elles reçoivent et étaient favorables aux comptes rendus structurés. Les cliniciens pensaient qu'apprendre à rédiger un compte-rendu devrait être une partie obligatoire de la formation des radiologues.
Conclusion : Un compte rendu radiologique efficace est essentiel aux soins des patients, nécessitant un contexte clinique, des formats structurés pour les examens simples et une formation dédiée afin de garantir précision et clarté.

ABSTRACT

Aim: Compare the opinions and expectations of radiologists and referring clinicians regarding the radiology report and to identify trends, discordance and concordance of the views.
Methods: Twelve months cross sectional study at teaching hospitals in Yaounde involving specialist or specializing clinicians and radiologists. Participants were asked to give their opinion, views, and expectations concerning the radiology reports according to a five tiered Likert scale.

Results: 86/120 completed forms corresponding to 72% response rate. Respondents strongly agreed that the radiology report was indispensable to medical practice and that radiologists were best positioned to interpret images. They recognized that a patient's medical condition and clinical questions were important in establishing a high-quality report. Additionally, respondents generally expressed great satisfaction with the reports they received and showed a preference for structured reporting. Clinicians believed that learning to report should have been an obligatory and well-structured part of radiologists' training.
Conclusion : Effective radiology reporting is essential for patient care, requiring clinical context, structured formats for simple exams, and dedicated training to ensure accuracy and clarity.

1. Introduction

Communication is a very important part of a radiologist's career, and it permits the clinician to take major decisions on patient care if it is well understood. The radiology report is the most important method of communication from the radiologist to either the clinician, patient or patient surrogates that is currently used in our setting [1]. It is a medico legal document and a tool against which clinicians "judge" the performance of radiologists. If poorly written and understood, it might be a source of confusion and mitigation.

Since the early 1980s, a considerable number of studies on the radiology report have been published [2] and many authors identified clinicians as well as radiologists' preference for "itemized," "tabular," "schematic," or "structured" reports of complex examinations rather than for reports in free text [1]. And despite this rich literature on this subject in the western world, local data is lacking for most African countries and Cameroon in particular.

Also, despite this wealth in literature, so many questions still linger:

- Do clinicians really need a written radiology report in all circumstances?
- Are they convinced that the availability of clinical information and a clinical question will improve the quality of the report?
- How many still believe information about the patient will bias the radiologist?
- Are radiology reports clear enough?
- Is making a good report a matter of talent, or a skill you can acquire—and if so, should teaching to report be part of the training program of future radiologists?

In Cameroon, radiology examinations are requested by specialist, General Practitioner, para medical and even non-medical personnel. Again, it is commonplace to have poorly filled request forms in radiology services.

Radiology report is not harmonized in our setting and, reporting radiologist do not usually consider the qualification of the referring clinician when reporting. It seems obvious that depending on referring clinician qualification, understanding, expectations and perspectives of radiology reports would be different.

Furthermore, no study has ever been carried out in our setting to understand why we lag in our practice in spite the tremendous advances in these domains elsewhere.

Also radiologist perspectives on reporting may be varied depending on their experience, field of interest, environment of work, and qualification of referrers.

Amidst these questions and in the process of quality insurance, knowing about the opinions and expectations of referring clinicians may help radiologist to improve the quality and understanding of their reports. Conversely, knowing about the opinions and expectations of radiologists on their reports may help clinicians to better fill requests forms and better understand reports, and may also help to harmonize radiology reports.

It is for this reason that we modelled our work after the **COVER AND ROVER survey** adapted to our setting and we also referred to the guidelines recommendations on reporting of the Royal Australian and **New Zealand College of radiology** because it is evidence based and recent in literature.

Although imaging technologies have undergone dramatic evolution over the past century, radiology reporting has remained largely static, in both content and structure. Existing free-text (prose) reports have been criticized for several inherent deficiencies, including inconsistencies in content, structure, organization, and nomenclature. Many new initiatives and technologies now present the radiology community with the unique opportunity to fundamentally change the radiology report [3].

These new developments include a standardise nomenclature, automated information technologies (picture archiving and communications systems and electronic medical records), and automated data tracking and analysis software (natural-language processing). Despite the increasing availability of these tools and technologies for revolutionizing reporting, clinical, psychologic, legal, and economic challenges have collectively limited structured reporting to mammography for instance [3].

These challenges are most evident in the current environment of heightened expectations for improved quality, timeliness, and communication, along with increasing stress, fatigue, and malpractice concerns [3].

The wide variety of style in radiologic reporting is evidence that an optimum format for the report has not been found, or at any rate, has not been generally accepted.

In the recent literature, interest has been focused on computerized reporting, but there are more basic aspects of the dictated report that deserve analysis and discussion [3].

The features of a report include the identification of the subject and the examination performed; a description of the findings, and a diagnosis or impression [3]. Other elements that may be included are a brief recapitulation of the clinical history or problem and recommendations for further radiologic examination or follow-up. It is remarkable that such a simple set of requirements can produce such a variety of results. In recent years, since cost has become a prominent concern in medicine, concise reporting has appeared increasingly advantageous [3].

The aim of this study was to investigate and compare the opinions and expectations of radiologists and referring clinicians regarding the radiology report and to identify trends, discordance and concordance of the views.

We expected findings that would serve as the basis for expert panel discussions and resolution on radiologic reporting in our context. Results could also be used to modify conception of reports through the institution of lecture time on communication.

2. Materials and Methods

We carried out a 12 months cross sectional study from July 2013 to September 2014 in teaching hospitals in Yaounde (Yaounde General Hospital, Yaounde Central Hospital, University Hospital Center and Yaounde Gyneco-Obstetric And Paediatric Hospital).

Our participants included Residents and Specialists doctors (clinicians or radiologists) serving in the aforementioned Hospitals were given similar enquiry forms (written in the language of their preference and adapted to their orientation) divided into two sections: the first section with demographic data and the second section containing thirty-eight (38) statements (addressing aspects of opinion, views, and expectations concerning the radiology reports) on the radiology report for which participants gave their level of agreement according to a five tiered Likert-scale (disagree entirely, rather disagree, neutral, rather agree, agree entirely).

These enquiry forms were pretested to check for consistency before administration to the participants. The pretested entries were not included in the data analysed.

Data collected from these forms were analysed using SPSS 20.0. Likert Scale data was analysed after combining the results into two categories (agree total= rather agree and agree entirely, disagree total= disagree entirely and rather disagree). These data were presented in tabulated form and a total of 50% or more in a column was considered the threshold value for a "yes" or "no" expression on the statement, while 50% or more in the "neutral" column was considered a "neutral" expression. Statements for which neither 50% agreement nor 50% disagreement nor 50% neutral answers were obtained were considered "undecided.'' Different groups of participants were compared using the Student's chi squared test.

Our forms were screened for completeness and consistency before the responses were entered to the SPSS software for analysis.

Ethical and administrative approvals were obtained from the Faculty of Medicine and Biomedical Sciences' Ethical Committee and the participating hospitals, respectively.

Table I. Response rate for clinicians and radiologists

	Total number of forms delivered	Completed forms	Response rate (%)
Radiologists	30	23	77
Clinicians	90	63	70
Overall	120	86	72

The most completed forms in our study were obtained from doctors of the Yaounde Central Hospital.

Table II. Distribution of participants per institution.

Institution	Clinicians	Radiologists	Total
HCY	29	4	33
CHU	14	8	22
HGY	13	4	17
HGOPY	7	5	12

Table III. Importance of radiology report to the clinician

Survey question	Disagree	Neutral	Agree	Total
C: The radiology report is an indispensable tool in my medical practice	**7(11.1)**	5(8.0)	**51(80.9)**	63(100.0)
C: I am better able to interpret an imaging study from my own specialty than the radiologist	**21(33.3)**	19(30.2)	**23(36.5)**	63(100.0)
R: Most clinicians are better able to interpret an imaging study from their own specialty than the radiologist	**20(87.0)**	1(4.3)	**2(8.7)**	23(100.0)
C: The radiology report often mentions important issues I would not have noticed myself on the images.	**1(1.6)**	17(27.0)	**45(71.4)**	63(100.0)
R: The radiology report often mentions important issues the clinician would not have noticed himself on the images	**1(4.3)**	1(4.3)	**21(91.4)**	23(100.0)
C: I read a radiology report as soon as it is available	**3(4.8)**	11(17.4)	**49(77.8)**	63(100.0)
C: I only read a radiology report at the end of the hospital stay or the observation period (in-patients)	**55(87.3)**	6(9.5)	**2(3.2)**	63(100.0)
R: Clinicians often do not read the radiology report	**5(21.7)**	5(21.7)	**13(56.6)**	23(100.0)
C: The conclusion of a radiology report is most important since the body is hardly read by anyone	**22(34.9)**	19(30.2)	**22(34.9)**	63(100.0)
R:The body of a radiology report is not important, since it is hardly read by anyone	**5(21.7)**	1(4.3)	**17(74.0)**	23(100.0)

3. Results

In total, 86 completed forms were assessed fit for analysis, corresponding to an overall response rate of 72% (86/120). The average response rate of radiologists was higher than clinicians (**Table I**). The clinicians from Yaounde Central Hospital had the best response rate meanwhile the best response rate for radiology was obtained at the University Hospital Center (**Table II**).

3.1 Importance of radiology report to the clinician (table III)

Clinicians mostly (80%) accept radiologic reports is an indispensable tool in medical practice but remain undecided in their ability to run imaging proceedings in their specialties; meanwhile, 86.9% of the radiologist recognize the fact that clinicians are not well placed to interpret imaging studies from their specialties.

Clinicians (77.8%) say they read the radiologic report as soon as they are available and hardly at the end of patient stay. However, 56.5% of radiologists feel clinicians do not read the radiology report.

Clinicians (71.4%) and radiologists (91.3%) accept the assertion that there are findings the clinicians would not have noticed on the images that appear on the radiology report.

Clinicians are undecided as to which part of the report is most important though radiologists (73.9%) think clinicians only read the conclusions of radiology reports.

Table IV. Need for clinical information and an unequivocal clinical question

Survey question	Disagree	Neutral	Agree	Total
C: To make a good report, the radiologist has to know the medical condition of the patient	**5(8.0)**	5(7.9)	**53(84.1)**	63(100.0)
R:To make a good report, the radiologist has to know the medical condition of the patient	**1(4.3)**	2(8.7)	**20(87.0)**	23(100.0)
C: To make a good report, the radiologist has to know what the clinical question is	**3(4.8)**	5(7.9)	**55(87.3)**	63(100.0)
R: To make a good report, the radiologist has to know what the clinical question is	**00**	00	**22(100.0)**	22(100.0)
C: It is better that the radiologist does not know much about the patient, to avoid bias	**50(79.4)**	7(11.1)	**6(9.5)**	63(100.0)
C: Any physician who requests a radiologic examination that is not part of any routine, should state a clear clinical question	**1(1.6)**	4(6.3)	**58(92.1)**	63(100.0)

3.2 Need for clinical information and an unequivocal clinical question (table IV)

In this study, 84.1% of clinicians believe that to make a good report, radiologist has to know the medical condition of the patient and 87.3% of these clinicians holds a clinical question can improve the accuracy of the imaging process (that is establishing a protocol and phrasing the conclusion); 92.1% of clinicians think a clear clinical questions should be stated in non-routine demands for imaging. Again, they mostly believe prior knowledge of the clinical condition of the patient has negligible bias.

3.3 As concerns satisfaction with reports (table V)

82.9% of radiologists in this study were contented with their reports though clinicians are not sure of the quality of these reports. This is also true for the style, concision, language and the ease with which their reports are understood.

Furthermore, radiologists feel everything being equal, that their reports are better than their colleagues' and they have issues understanding reports written by their colleagues.

More than 50% of clinicians (57.7%) just barely don't have issues understanding what radiologist's means in their reports even though 73.9% of radiologists have issues understanding their colleagues' reports.

A significant discrepancy exists between clinicians and radiologists regarding radiology report style. Only 50.8% of clinicians believe reports should be adapted to their level, while 82.6% of radiologists feel the responsibility is on the clinician to understand the report..

3.4 As regards the structure and style of reporting (table VI)

Clinicians are indifferent as to whether reports are better understood when written in French though 50% of radiologists feel it's the ideal language of reporting in out context.

Most clinicians (58.7%) and 65.2% of radiologists think "No abnormal findings" is enough when reporting simple studies without pathologic lesions such as the chest X-ray. Again, 69.9% of clinicians feel this same response is enough when reporting an Ultrasound exam without pathologic finding; though 78.3% of radiologists are not in accordance.

Both radiologists (69.6%) and clinicians (87.3%) strongly holds that a report greater than a few lines should have a conclusion. Also, if a particular organ or body part is not mentioned in a report, it has not been examined.

3.5 Should radiologists receive instruction on how to make a good report?

96.8% of clinicians think learning to report should be an obligatory and well-structured part of the training of radiologists

Table V. Satisfaction with the report

Survey question	Disagree	Neutral	Agree	Total
C: Generally, i am satisfied with the reports i receive	**11(17.5)**	22(34.9)	**30(47.6)**	63(100)
R: Generally, I am satisfied with my own reports	**1(4.1)**	3(13.0)	**19(82.9)**	
C: Not taking into account radiologic slang, I often have trouble understanding what the radiologist means	**36(57.7)**	21(33.3)	**6(9.5)**	63(100)
R: When reading another radiologist's reports, I often have great trouble understanding what my colleague means	**17(73.9)**	6(26.1)	**00**	23(100.0)
C: The language and style of radiology reports are mostly clear	**8(12.7)**	11(17.5)	**44(69.9)**	63(100)
R: The language and style of radiology reports are mostly clear	**5(21.7)**	4(17.4)	**14(60.9)**	23(100.0)
R: A radiology report can be read more easily if the radiologist uses common words and expressions instead of medical slang	**15(23.8)**	21(33.3)	**27(42.9)**	63(100)
R: A radiology report can be read more easily if the radiologist uses common words and expressions instead of medical slang	**4(17.4)**	3(13.0)	**16(69.6)**	23(100.0)
C: In a radiology report simple things are often said in a complicated way	**24(39.7)**	23(36.5)	**15(23.8)**	63(100)
R: In a radiology report simple things are often said in a complicated way	**7(30.4)**	4(17.4)	**12(52.2)**	23(100.0)

C: One should be able to understand a radiology report without great effort	**2(3.2)**	8(12.7)	**53(84.1)**	63(100)
R: One should be able to understand a radiology report without great effort	**3(13.0)**	4(17.4)	**16(69.5)**	23(100.0)
C:Radiologists proofread their reports thoroughly before they are being sent	**7(11.1)**	17(27)	**39(61.9)**	63(100)
R:I proofread my reports thoroughly before they are being sent	**5(21.7)**	3(13.0)	**15(65.2)**	23(100.0)
C: The style and choice of words of the radiologists should be adapt to the level of the clinician	**16(25.4)**	15(23.8)	**32(50.8)**	63(100)
R: If the clinician has trouble keeping up with my style or word choice, that is his problem, not mine	**19(82.6)**	2(8.7)	**2(8.7)**	23(100.0)
R: My reports can be understood without effort	**2(8.6)**	7(30.4)	**14(60.8)**	23(100.0)
R: My reports are concise	**2(8.6)**	7(30.4)	**14(60.8)**	23(100.0)
R: Not taking into account my competence as a radiologist, my reports are better than my colleagues'	**7(30.4)**	16(69.6)	**00**	23(100.0)
R: My reports are direct; I do not practice the hedge	**1(4.5)**	12(54.5)	**9(40.9)**	22(100.0)
R: My reports are aimed at answering the clinical question	**00**	2(8.7)	**21(91.3)**	23(100.0)

Table VI. Structure and style of the report

Survey question	Disagree	Neutral	Agree	Total
C: Reports are better understood when written in French	**13(20.6)**	30(47.6)	**20(31.7)**	
R:Reports are better understood when written in French	**5(22.7)**	5(22.7)	**12(54.2)**	22(100.0)
C: When a simple examination (eg, a chest x-ray) does not show anything abnormal, the report can be limited to a mere: "No abnormal findings"	**22(34.9)**	4(6.3)	**37(58.7)**	
R: When a simple examination (eg, a chest x-ray) does not show anything abnormal, the report can be limited to a mere: "No abnormal findings"	**15(65.2)**	2(8.7)	**6(26.1)**	23(100.0)
C: When a complex examination (eg, an ultrasonography of the abdomen) does not show anything abnormal, the report can be limited to a mere: "No abnormal findings"	**44(69.9)**	4(6.3)	**15(23.8)**	
R: When a complex examination (eg, an ultrasonography of the abdomen) does not show anything abnormal, the report can be limited to a mere: "No abnormal findings"	**18(78.3)**	2(8.7)	**3(13.0)**	23(100.0)
C: A radiology report that is longer than a few lines should end with a conclusion	**00(00)**	8(12.7)	**55(87.3)**	
R: A radiology report that is longer than a few lines should end with a conclusion	**2(17.6)**	3(13.0)	**16(69.6)**	23(100.0)
C: If a radiologist does not mention a particular organ or body part, he will not have looked at it closely	**14(22.2)**	15(23.8)	**34(53.9)**	
R: Clinicians usually only read the conclusion of a radiology report	**5(21.7)**	4(17.4)	**14(60.9)**	23(100.0)
R: The descriptive part of a report should also be read, not only the conclusion	**1(4.3)**	00	**22(95.7)**	23(100.0)
R: If I do not mention a particular organ or body part, the clinician will assume I have not looked at it closely	**6(26.1)**	1(4.3)	**16(69.6)**	23(100.0)
C: Even if the report is short, I assume the radiologist will have looked at the examination thoroughly.	**14(22.2)**	26(41.3)	**23(36.5)**	
R: Even if the report is short, the clinician will assume I have looked at the examination thoroughly	**10(43.5)**	9(39.1)	**4(17.4)**	23(100.0)
C: A report should consist of a fixed list of short descriptions of the findings	**11(17.4)**	14(22.2)	**38(60.4)**	

R: A report should consist of a fixed list of short descriptions of the findings	**5(21.7)**	5(21.7)	**13(56.5)**	23(100.0)
C: A report should consist of prose, like a composition	**22(36.0)**	28(45.9)	**11(18)**	61(96.8)
R: A report should consist of prose, like a composition	**9(39.1)**	9(39.1)	**5(21.7)**	23(100.0)
C: When reporting complex examinations (CT, MR imaging, US) it is better to work with separate headings for each organ system	**3(4.8)**	15(23.8)	**45(71.4)**	
R: When reporting complex examinations (CT, MR imaging, US…) it is better to work with separate headings for each organ system	**3(13.0)**	7(30.4)	**13(56.5)**	23(100.0)
C: The simpler the style and vocabulary of the report, the better the message will be understood.	**00**	10(15.9)	**53(84.1)**	
R: The simpler the style and vocabulary of a radiology report is, the better the message will be understood.	**2(8.7)**	00	**21(91.3)**	
C: In CT and MR imaging reports the technical details of the examination should be mentioned explicitly	**5(7.9)**	9(14.3)	**49(77.8)**	
R: The style of radiology reports is mostly pleasant in CT or MR imaging reports the technical details of the examination should be mentioned explicitly	**7(30.4)**	10(43.5)	**6(26.1)**	23(100.0)
C: Clinical information, the clinical question, the descriptive part of the report, the conclusion and remarks should be put into separate paragraphs	**00**	8(12.9)	**54(87.1)**	62(98.4)
R: Clinical information, the clinical question, the descriptive part of the report, the conclusion and remarks should be put into separate paragraphs	**00**	1(4.3)	**22(95.7)**	23(100.0)
In some countries a standard lexicon of radiologic terms is being prepared. If such a system would exist in my language, I would want our radiologists to use it	**8(12.9)**	22(35.5)	**32(51.6)**	62(98.4)
R: In some countries a standard lexicon of radiologic terms is being prepared. If such a system existed in my language, I would use it	**1(4.3)**	2(8.7)	**20(87.0)**	23(100.0)

Table VII. Should radiologists receive instruction on how to make a good report?

Survey question	**Disagree**	Neutral	**Agree**	Total
C: Making a good report is a matter of talent: either you are able to make one or you are not	**19(30.6)**	20(32.3)	**23(27.1)**	62(98.4)
C: Learning to report should be an obligatory and well-structured part of the training of radiologists	**00**	2(3.2)	**61(96.8)**	63(100.0)
C: Not taking into account their knowledge of radiology, staff radiologists make better reports than residents-in-training.	**11(17.5)**	36(57.1)	**16(25.4)**	63(100.0)
C: Writing in the broadest sense of the word is something I like very much	**6(9.5)**	31(49.2)	**26(41.3)**	63(100.0)

4. Discussion

4.1 Response rate for clinicians and radiologists

The radiologic report, "a two sided concept" has been the corner stone to the practice of radiology ever since its introduction early this century.

Firstly, it highlights the radiologist's ability to analyze images from an examination, recognize normal and abnormal findings, integrate these findings into his or her personal medical knowledge database, and summarizes it to a diagnosis or a suitably ordered differential diagnosis and, sometimes, make suggestions for further diagnostic evaluation [2].

Conversely, reporting implies that the radiologist is able to generate a written document that presents the former in an unequivocal, accessible, and useful way. While both in training and in practice much more emphasis is

placed on the first aspect, the second aspect is equally indispensable [2].
However, many studies have been centered on the former rather than the later [7] and as such explains why the study design to include clinicians.
Our study results strongly portrays the radiology report as an indispensable medium to medical practice.

4.2 Importance of radiology report to the clinician

Clinicians accepted the radiologic report as an indispensable tool in medical practice but remain undecided in their ability to run imaging proceedings in their specialties. Radiologist recognize the fact that clinicians are not well placed to interpret imaging studies from their specialties.
This finding is quite conflictual and similar to those obtained by Jan M. et al. [2] were respondent strongly believed that clinicians are unable to interpret imaging in their fields of specialization more than radiologists. In an attempt to explain this finding we suggest, limited exposure of clinicians to images of different modalities in our setup. Again, it is possible our narrow sample size might have had an impact on this finding.
Clinicians and radiologists agree that radiology reports reveal findings clinicians might have missed in images and acknowledge that important issues could be overlooked by clinicians when reporting on imaging modalities. This finding conforms to that of Weiner [8] where he showed that radiologists consistently provided higher-quality medical imaging reports than non-radiologists. This could be due the increasing complexity of radiologic examinations, with large numbers of images, and the increasing need for analysis of functional or three-dimensional data sets. Radiologists are accustomed to interpreting complex imaging studies and have the computer skills and software tools to do so. Clinicians lack these qualities and exposures for the most. Again, clinicians most often lack the necessary background knowledge and tools for advanced image analysis and interpretation associated to limited access to images in a resource poor setting like ours.

4.3 Need for clinical information and an unequivocal clinical question

Most clinicians believe radiologist needs to know the patient's medical condition to create a quality report, and they also agree that having a clear clinical question enhances the accuracy of the imaging process, including protocol establishment and conclusion phrasing. Again, they overwhelmingly believe prior knowledge of the clinical condition of the patient has negligible bias.
This is, however, an enticing surprise to observe because although hopeful, incomplete requisition forms, still have a pride of place as Moifo et al. [9] demonstrated, amidst other irregularities, that 76.3% of request forms had no clinical question at the same study sites. This is always a source of frustration to radiologists as there is no internal phone service system in our setup to reach clinicians promptly for precisions. The reasons for this phenomenon remain a subject of research but maybe instituting electronic request forms for radiology exams with mandatory details to be included could attempt to resolve this problem.

4.4 As regards the structure and style of reporting

Conventional radiology reports are stored as free text, so information is trapped in the language of the report, making it difficult to find specific details without reading the whole text. In structured reporting (SR), the information is standardised and presented in a clear, organised format, tracking the attributes of each finding (size, location, etc.) and prompting the radiologist to complete all required fields. It has been suggested that SR is more time-efficient than dictation, facilitates automated billing and order entry, and supports analysis for research and decision-support [10, 11]
SR is usually displayed in modular format with section headings, contains a consistent ordering of observations in the form of templates or checklists, and uses standardised language and lexicon [10-12]. There is also the potential to integrate additional information, such as clinical data, technical parameters, measurements, annotations, and key (relevant) images and multimedia data, giving the potential to reduce ambiguity and increase confidence in the findings. There is also the future potential for multilingual translation.
Though studies have shown clinicians and radiologic preference to itemized reporting, credited for greater clarity, completeness, time efficient in reporting, reproduction and exploitation for research thus yielding greater satisfaction [4, 10, 13]. There is no significant influence of form to reading time and comprehension and structured report is not a standard way of reporting complex examinations [13].
Findings from our study concord with these as an average of 6/10 respondents said yes to questions directed to the style, structure and the use of a fixed and standard lexicon. For example, both groups of respondents believe “Normal” organ system should be reported as “normal” in itemized reporting and no further detail needed. Again, they are not sure of the quality and completeness of prose reports.

Furthermore, both radiologists and clinicians are not sure whether a said exam is thorough if the report is short. This issue is addressed by structured reports.
Finally, 1 out of 2 clinicians and 9 out of 10 radiologists would be glad to use a standard lexicon of radiologic terms is being prepared it they are made available by the local authorities in our settings.

4.5 Should radiologists receive instruction on how to make a good report?

Clinicians mostly believe that learning to report should be a mandatory and well-organized part of radiologists' training. This finding is in line to the conclusion arrived at by Gunderman et al [2]. Learning to write well could help residents to develop their communication skills in ways that surpass the daily routine.
Secondly, they are not certain making a good report is dependent on skill, knowledge or experience. Similar conclusions have been arrived at by Bosman et al [2] were they demonstrated that reports of supervisors were not necessarily better than those of in-training residents
Several studies with similar objectives but different designs have investigated different aspects of reporting and the findings have been consistently similar irrespective of the site of study and how the practice of radiology is carried out. Our study, tailored from the ROVER and COVER surveys, is no different even though our questionnaires were not electronically administered and the practice of radiology in this resource poor setting is different.
Though, a small sample size, we however, had a higher response rate than those obtained in the ROVER AND COVER survey (72% against 21%).
These, only go a long way to highlight the similarities in the problems plaguing radiology reporting in spite the technical plateau or level of technology employed for reporting.
Besides limitations inherent to the study design, restricting participation to only residents and specialists means limited representation of views and opinion of those prescribing and receiving radiologic reports

5. Conclusion

Based on the observed trends, several key conclusions can be drawn from our study.
First, the radiology report is an essential tool in medical practice, playing a critical role in patient diagnosis and management. A well-prepared report ensures that clinicians receive accurate and relevant information to guide treatment decisions.
Additionally, understanding the patient's condition and clinical questions is fundamental to developing high-quality reports. Without this context, radiologists may struggle to provide meaningful interpretations that directly address the referring physician's concerns.
To enhance consistency and clarity, structured report formats should be developed specifically for simple examinations such as chest X-rays, CT scans of the brain, and abdominal ultrasounds. However, structured reporting is not a universal solution and should be reserved for these types of straightforward exams, as more complex cases may require a more flexible approach.
Finally, producing a good report is not solely dependent on skill, knowledge, or experience. Instead, report writing is a learned skill that should be incorporated into radiology training to ensure accuracy, clarity, and clinical relevance.

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