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Radiology Events Register case reports

Every QUDI eNews will present sample case reports from the Radiology Events Register (RaER), which is a database that collates and supports analysis of adverse events and near misses in radiology. The aim is to provide evidence to support improvements in what radiologists do. The RaER project is a collaboration between RANZCR-QUDI and the [Australian Patient Safety Foundation](#). For more information please visit www.raer.org.

Health information technology, medical devices and their convergence: The path ahead

Background

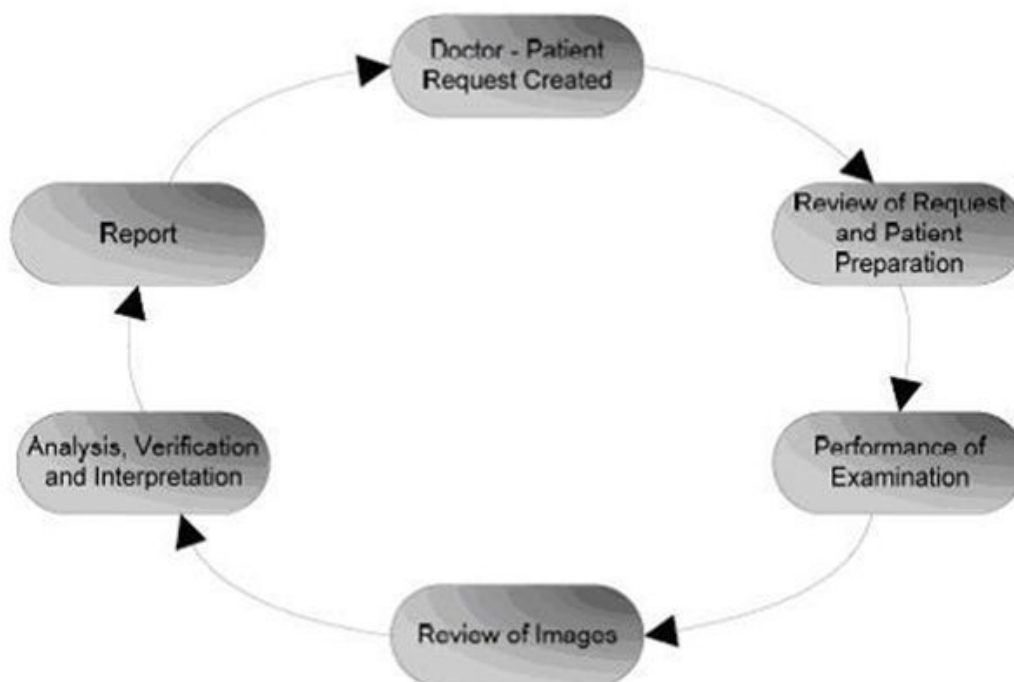
Healthcare, and medical imaging in particular, are undergoing significant change as they adapt and evolve to cope with society's current and future healthcare needs. Health Information Technology (IT) and medical devices are well known to radiologists, who have witnessed tremendous growth and advances in both. They have also witnessed their progressive integration via networking and interfacing, as medical devices have become increasingly software based and computer dependent. In fact, there has been a marked intertwining or convergence of these technologies^{1,2}. While quality and patient safety can clearly be enhanced, it is also apparent that these technologies, and their convergence, can perpetuate or create new safety risks, and cause or contribute towards serious adverse events. Somebody once said to err is human, but to really stuff things up you need a computer². These adverse events usually arise from human-machine interfaces and/or organizational and system design and governance³. Safer information management is key in the entire process, as this represents transferred, exchanged and processed medical

data of critical value.

The transition of processed film and manual interpretation to the fully electronic and networked Picture Archiving and Communication System (PACS) environment is a very good example of this evolution². PACS and its networked medical devices continues to undergo further integration, interfacing, networking, and convergence. Geographic separation of image acquisition and image review is now feasible, but is associated with its risks and challenges, many related to communication failure. Many electronic databases and information systems are an integral component of PACS, and this is increasing; for example, Hospital Information System (HIS), Radiology Information System (RIS), PACS, Speech Recognition, Electronic Health Record (EHR), electronic decision support/knowledge transfer, Computerised Provider Order Entry (CPOE), advanced visualisation software, and business intelligence. Image exchange and sharing, and the incorporation of business logic via web services, are on their way⁴. Each interface and convergence creates risk. These advances also create referrer and patient expectations of instantaneous and error-free system transactions².

The following collection of Radiology Events Register (RaER) (<http://www.raer.org>) case studies is based on reported incidents involving Health Information Technology, medical devices, and their interfaces. As can be seen from the descriptions below, these occur throughout the imaging care cycle (Figure 1).

Figure One: The medical imaging care cycle



RaER case reports

1. Computerised referral (order) entry (PRE-PROCEDURE - see Figure One): Referring doctors name not always included on electronic referral (blank or incorrect - see [QUDI eNews December 2008](#)).

2. Selection of patient from a list in the RIS, on computer monitor (PRE PROCEDURE): HIS and RIS are not integrated. Staff need to manually locate inpatient and their details in RIS. This involves typing in patient name, running a search of RIS, and selecting patient from list displayed on monitor. Often, several names on list. Incorrect patient selected from list led to identification error.

3. Date format image acquisition (PROCEDURE): Software upgrade on Gamma camera reset the date/time/year format on the acquisition PC to the USA format (MM/DD/YYYY) from DD/MM/YYYY. The images had the USA format stamped on them (potentially misleading/ambiguous), but PACS had "correct" format (DD/MM/YY).
4. CT breakdown during interventional radiology procedure (PROCEDURE/ INTERVENTIONAL): CT scanner hardware failure.
5. Prostate external beam radiotherapy: fiducial marker insertion under transrectal ultrasound guidance (PROCEDURE/ INTERVENTIONAL): Fiducial gold beads not all accounted for on post-procedure radiograph: difficult to visually identify beads during placement procedure.
6. MRI incidents (PROCEDURE): See QUDI eNews December 2008 for a report on multiple incidents.
7. Near miss patient data loss (POST PROCEDURE, PRE INTERPRETATION): Transfer of data from CT to PACS failed. Image data deleted from CT hard drive (overwritten). Fortunately the data had also been sent to a networked PC and image data could be retrieved.
8. Patient scan data loss: disk drive (POST PROCEDURE, PRE INTERPRETATION): Disk failure on image acquisition device at end of scan led to loss of patient scan data. Scan had to be repeated.
9. PACS display problem 1 (POST PROCEDURE, INTERPRETATION): Following PACS software upgrade, display of some CT image files incorrect (wrong order of images, some missing) depending on how the images are selected for viewing. Potential for diagnostic error.
10. PACS display problem 2 (POST PROCEDURE, INTERPRETATION): Following PACS software upgrade, occasionally the hospital site default display protocols revert to the manufacturer display defaults. Depending on user preferences, this can flip multi-monitor loading of current and prior imaging studies, and increase risk of radiologist reporting the "current" study based on interpretation of the "prior" study images, leading to diagnostic error. In this case, detected and communicated promptly to referrer. Near miss.
11. PACS-RIS HL7 broker software failure (POST PROCEDURE, POST INTERPRETATION): Interface software failure resulted in lack of transfer of imaging reports into PACS and Electronic Health Record. Clinicians called radiology department to enquire why the imaging studies were not being reported.
12. PACS loading of CD (POST PROCEDURE, POST INTERPRETATION): Neurosurgeon required CT images loaded from a CD-ROM onto PACS, for pre and intra-operative planning. CD-ROM would not load onto PACS.

Towards the safer implementation of health information, medical device and converging technologies

The Joint Commission (USA) has recently released a Sentinel Event Alert¹: "Safely implementing health information and converging technologies (11 Dec, 2008)". Sentinel Event Alerts identify specific sentinel events, describe their common underlying causes, and suggests steps to prevent occurrences in the future. The following represents a summary of the key themes from this document^{1,2}.

1) It is important that planning occurs prior to procurements and implementation of new technology. This can avoid poor product selection, poor adaptation to the clinical setting, or insufficient training and testing. Lack of planning and integration can also complicate and/or slow workflow, and can create new work. It is important that a technology or device is designed to be safe, as well as be implemented and operated safely within a safe workflow

process. Consider the impact on care processes, workflow, safety. Consider best practices. Be aware that technologies often shift staffing allocations rather than reduce them. Assess organization's technology needs beforehand; learn about real-world capabilities of potential systems; look at integrated systems where possible and beneficial, to avoid multiple vendor interfaces. Review prior safety reviews/alerts and prior experience of technology.

2) Correct flawed processes in the current manual workflow processes and procedures first. Resolve these prior to introduction of technology. Use a multidisciplinary team.

3) Note potential problems and risks that can arise from lack of integration, interfacing or updating of healthcare information systems, eg. manual data entry between systems.

4) Ensure active involvement of front-line clinicians and staff, and experienced technical and scientific staff in planning, selection, design, QA. Obtain objective third party expert oversight.

5) Be aware that the interplay between technology and humans, or "human factors", is critically important, and often does not get recognized or resourced. Learning and training takes time and attention. Poor planning and implementation can lead to resentment, new risks, alert fatigue, redistribution of work, and cognitive overload/worker stress. Limit distractions to staff where data entry needed.

6) Factor in ongoing future maintenance resources and costs, and also training programs.

7) Monitor for problems and issues. Consider "emergent issues" help desk with rapid resolution of critical problems. Be aware that failure to fix issues promptly can promote dangerous workarounds. Develop graduated system of safety alerts; review rejected ones; decide on "hard stops". Use error tracing tools. Use, analyse and learn from incident reporting, near misses, serious adverse events. Important to stay aware of recalls and hazards, reviews and alerts.

8) Develop and communicate policies for technology-related staff authorisation and responsibility. Ensure all guidelines developed and tested. Require departmental sign off on practices outside normal /usual parameters.

9) Periodically reassess security/confidentiality, as more medical devices converge and get networked.

10) Consider overall electronic information requirements, eg. planning of information management; safeguarding data/information against loss, destruction, tampering; disaster recovery plan and testing.

11) Consider the specific issue of technology in safety program and standards.

The rapid and dramatic changes occurring in the healthcare landscape, which include the expanding use of medical devices, information and communication technologies, and their convergence and interfaces, are a major feature of medical imaging. As can be seen from the issues noted above, significant input and oversight is and will be required, from a team and multidisciplinary perspective. From the radiologist's viewpoint, the required adaptive and evolutionary response will involve a fundamental breakdown of the historical envelopes that have defined and constrained their "role". In the integrated healthcare system, radiologists have the potential to adopt a much more central and pivotal position, thereby unleashing and adding significantly more value to the overall healthcare system⁵. Some examples of specific areas where radiologists can positively participate, as well as take on leading roles, include⁵:

- Appropriate imaging: participation in undergraduate and postgraduate education and curriculum development; development of imaging clinical pathways; multidisciplinary clinical meetings; the use of IT to support appropriate imaging.

- Local, National and International Oversight Programs: involvement in setting of standards and accreditation; active involvement in "technology governance"³.
- Safety oversight: interface and convergence of medical devices and information technologies; imaging appropriateness; incident and near miss reporting and analysis; investigation of serious adverse events; cultural change; communication failure.
- Continuous quality improvement: systems and patient safety oriented; anticipation of problems.
- Information Management: radiologists must be able to understand and manage information, communication and their technologies, and are very well positioned in the healthcare system to take on a leading role; develop the use of IT and communication technologies to expand the value added by radiologists, while concurrently understanding the important "human factors" issues; assist in development of patient safety systems and patient-centred IT projects including personal health records.

Teamwork, communication, and collaboration will also become important central themes. Medical technologies have created substantial benefits for patients but at the same time have presented new challenges to health professionals, scientists and developers of complex medical devices. The increasing importance of technology in medicine and healthcare demands that all involved in the process - from research and development to applications to healthcare providers – have a thorough understanding of the key issues at the interface of technology and medicine. The focus in healthcare today must be on ensuring performance reliability, providing technological "best-fit" solutions and, in particular, achieving the highest quality in performance and results. An intensive exchange of knowledge among scientists, researchers, developers and healthcare providers must be fostered and maintained as a major driving force for improving quality and safety, and innovation.

In 2009, a Combined Scientific Meeting which marks the joining of the The Royal Australian and New Zealand College of Radiologists (RANZCR, including the Faculty of Radiation Oncology (FRO)), The Australian Institute of Radiography (AIR) and the Australasian College of Physical Scientists & Engineers in Medicine (ACPSEM) will be held in Brisbane Australia, 22-25 October 2009. The Combined Scientific Meeting has been planned around a theme of 'Collaboration: Working and Learning Together' to facilitate a better understanding of the various roles of the professions working in radiology and radiation therapy treatment services and to provide a multidisciplinary education environment⁶.

References

1. The Joint Commission, [Sentinel Event Alert](#), accessed 7 Jan 2009
2. ECRI Institute, [JC Press Briefing on Sentinel Event Alert 42](#), 11 Dec 2008, accessed 7 Jan 2009
3. Balka E, Doyle-Waters M, Laczmarowicz D, Fitzgerald, J. Technology, governance and patient safety: Systems issues in technology and patient safety. *Int J Med Inform* 2007;76S:S35-S47.
4. Mendelson D, Bak P, Menschik E, Siegel E. Informatics in Radiology: Image Exchange: IHE and the Evolution of Image Sharing. *Radiographics*, 2008;28:1817-1833
5. Knechtges P, Carlos R. The Evolving Role of Radiologists within the Health Care System. *J Am Coll Radiol* 2007;4(9):626 - 635.
6. <http://www.csm2009.com/> accessed 7 Jan 2009

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What happens when your patient is unable to communicate?

Case study 1

A 55 year old man was referred to radiology for insertion of a PICC line. There was minimal clinical information on the referral form, in particular the referring doctor had not completed the safety checklist. The patient's ability to speak English was limited. The treating radiologist recognised the patient's name as he had been involved in the care of the patient a few days earlier when the patient had been referred for a CT scan.

Insertion of the wire and catheter was not easy: there was resistance to the passage of the wire through the subclavian vein. The radiologist thought that this was probably due to a stenosis. Normally, the radiologist would have injected iodinated contrast medium to confirm the cause and extent of the problem. Fortunately in this case he did not.

The reason that the patient's name had stayed in the radiologist's mind was that he had had a long discussion with a different referring doctor about the limitations of CT without intravenous contrast medium, having been told on that occasion that the patient had had an anaphylactic reaction to iodinated contrast medium in the past in another hospital. This information had not been noted on the referral form. The patient's English was poor and neither an interpreter nor a relative able to translate were available.

Case study 2

A mentally retarded 24 year old was referred to CT because of increasing frequency of fits. The patient was incapable of answering any questions. Her mother did not mention any concerns about the CT scan, stating that her daughter had had many tests in the past. Intravenous contrast medium was administered and the CT performed. Some minutes later the patient sat up, had a seizure and collapsed. Her condition deteriorated rapidly, she developed severe hypotension and pulmonary oedema. A code blue was called and, after prolonged resuscitation, her condition stabilised but she required admission to the intensive care unit and inotropic support for one week. Eventually she recovered. On speaking to the mother afterwards the radiologist was told that the patient had had a 'funny turn' after an injection for a scan on a previous occasion but the mother was told not to worry about it. In this hospital, a patient's medical record did not normally accompany the patient to radiology.

Key points:

In both these cases failures in communication of essential information threatened the wellbeing of patients, with near fatal consequences in one case. Several important issues need to be considered. Hazards can be classified into five groups:

1 Determining important information: There needs to be a robust process to determine whether a patient is allergic to contrast media or has other important contra-indications to a procedure. We are well aware of the need to carefully check patients before MRI but the need to do so before CT is often seen as less important. Whilst anaphylactic reactions are rare, iodinated contrast medium is a relatively common pharmaceutical cause. It is important to determine if there is a relevant past medical history, regardless of the patient's ability to communicate, be that due to inability to speak English, as in the first case, mental impairment, either longstanding as with the second patient or due to an acute process such as a reduced Glasgow coma score or delirium, or immaturity. If it is not possible to determine the past history then it is probably not wise to administer intravenous contrast medium.

2 Documentation: A written checklist, completed by an appropriately trained staff member, is a good way of ensuring important checks are not forgotten and recording the relevant information. This can be filed with the request, with

the report, or scanned into the patient's electronic medical record. This is not only a good way of ensuring that this important information is sought but also provides good documentary evidence should the patient, despite checking carefully, have an adverse reaction to contrast media. Checklists are used routinely in many other critical risk areas such as aviation and failure to use them is considered a failure of professional conduct and standards.

3 Is contrast enhancement really likely to improve the safety and diagnostic accuracy of the procedure?: The radiologist supervising a procedure bears responsibility for the patient's safety. It is important to determine whether intravenous contrast medium is really likely to improve the safety or diagnostic accuracy of a test and only use it if the balance of risk is in favour of doing so. Uneventful administration of contrast media in the past does not guarantee safety on future occasions. A reported reaction in the past means that caution should be used. If it is absolutely essential to use contrast media then appropriate premedication prior to the test and the presence of staff well trained in resuscitation during the test will help to minimise the risk to the patient. This may involve consultation with an anaesthetist or resuscitator.

4 Education of referrers: The importance of the patient's past medical history when referring patients to radiology is not widely understood or taken seriously. Referrers often have little understanding of the radiology environment and the problems in obtaining vital information such as a past history of contrast reactions. This information is often more easily obtained by the referrer (who is often able to talk to family members and referring doctors). There is a need to educate referrers about the risks of procedures and of the need to know this information before referring patients to radiology, and the importance of communicating this to the radiology department

5 Resuscitation skills: It was, perhaps, fortunate that the second patient was being investigated in a large hospital, in-hours and at a time when there were no other code blues in progress. Had this happened in a small practice, without access to a resuscitation team the outcome may have been different, possibly involving a coronial inquest. Have you had resuscitation training in the last three years? Have the other staff with whom you work had resuscitation training? Is there a plan, known to all staff, to deal with a medical emergency?

The current [RANZCR Standards of Practice](#) (version 9) state:

4-2-1 Qualifications - Radiologist

INDICATORS:

4. Each radiologist or medical practitioner holding equivalent specialist recognition maintains current CPR training which is renewed at least three yearly (page 24)

3-5 Equipment - Resuscitation

Resuscitation equipment shall be immediately available for intravenous and other contrast reactions.

INDICATORS:

1. The practice maintains current inventories for resuscitation equipment and associated drugs.

2. This equipment is immediately available and maintained so that it is in working order whenever intravenous or other contrast administration takes place.

3. The practice has a process for checking that resuscitation drugs are current, and not out of date, and records these checks. (page 15)

and:

6-5 Use of Contrast Media

The practice shall ensure the safe use of contrast media and have a protocol for the management of adverse reactions to contrast media. Notes: Practices may wish to assign 'the Resuscitation Officer' as the designated CPR training officer in order to efficiently and economically manage CPR training across the practice.

INDICATORS:

- 1. The practice has implemented a procedure for the use of contrast media which ensures that the service complies with the current versions of the RANZCR Contrast Guidelines.*
- 3. It maintains a documented plan of management for likely adverse events due to contrast reactions which includes a prominently displayed documented procedure describing the management of reactions, and reference to 'Emergency management of anaphylaxis in the community'.*
- 4. It has designated personnel who hold current CPR certification, and are trained in the appropriate management of contrast reaction and the use of resuscitation equipment to support the management of adverse reactions to contrast.*
- 5. It has a clearly identified staff member who is designated as the Resuscitation Officer, who ensures that resuscitation equipment and drugs etc are present and in a state of readiness.*

Radiologists should maintain the currency of their resuscitation skills. Did you know that the compression and breath rates for CPR have changed? The current recommendation is 30 compressions followed by two breaths with the compression rate being approximately 100 compressions/minute. Information on resuscitation is available from the Australian Resuscitation Council <http://www.resus.org.au/>.

6 Informing patients: Patients have a right to know the potential risks and benefits of any test or procedure. Well informed patients are better able to make the radiologist aware of important information: this may help to avoid a disaster.

Conclusion

Whilst most radiology procedures are successful and uncomplicated, there is always the potential for things to go wrong. This risk can be minimised by careful checking of safety matters, education of referrers and patients and a properly equipped practice with staff well trained in resuscitation and the management of emergencies.

References

Anaphylaxis

'Emergency management of anaphylaxis in the community', *Australian Prescriber*, 30 (5) 2007.

Tramèr M, von Elm E, Loubeyre P, Hauser C. 'Pharmacological prevention of serious anaphylactic reactions due to iodinated contrast media: systematic review', *BMJ* doi: 10.1136/bmj.38905.634132.AE (published 31 July 2006)

Resuscitation

Australian Resuscitation Council (ARC), *Guideline 7: Cardiopulmonary Resuscitation*, Australian Resuscitation Council, 2006

This and other publications, including basic and advanced life support flow charts are freely available from the ARC website, <http://www.resus.org.au/>.

RANZCR publications

[RANZCR Intravenous Contrast Guidelines, 2001.](#)

[RANZCR Standards of Practice, Version 9.0](#)

Other sources of information

There is a series of publications freely available from the Royal College of Radiologists website <http://www.rcr.ac.uk>.

The Australian and New Zealand College of Anaesthetists also has relevant documents: <http://www.anzca.edu.au>.

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RaER incident report: December

Project leaders: Dr Neil Jones and Dr Catherine Mandel

Six new events have been posted to the RaER database in December, covering a number of issues, as outlined below:

Practice setting: 6 public

Patient type: 2 inpatients, 3 outpatients, 1 other

Location: 6 in South Australia

Clinical management

- Communication breakdown between Emergency Department (ED) and MRI staff on weekend. Patient MRI delayed.
- Poor communication, patient received chest x-ray in ED then consultant reviewed and ordered another one, which was performed as it was not handed over that this had already occurred.
- Nil referral form available when attending for portable CXR, waste of resources and CXR delayed.

Documentation

- Incorrect patient for CT scan due to labelling error on the form. Patient did not receive scan as they questioned need for CT Head. Near Miss.
- Referral form taken to Nuclear Medicine and case being discussed and noted patient already having scan. Poor communication.
- Incorrect labelling of CT request form. Procedure not performed due to radiographer correctly checking 3C's. Near Miss.

If you would like to report an incident, please visit www.raer.org.

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QUDI project updates

Jane Grimm, Manager, QUDI Program

The holiday season provided us with a brief opportunity to reflect on the achievements of the QUDI 2008-09 Program at the halfway point, and look

forward to the finalisation of an enormous portfolio of work.

Consumer-focused information about radiology procedures

Project leader: Ms Ann Revell, Consumer Representative, QUDI Executive Committee

By far the most time and resource intensive project of the QUDI Program 2008-09, this project is well on track to become a world leading resource for consumer information about radiology procedures.

Content writers, consumer writers and sub-editors around the country are producing and revising the content material to produce information that meets the needs of consumers. Additional material for health professionals is also being prepared, designed to provide technical and clinical information to meet the needs of those referring patients for the various examinations or procedures.

This project initially planned to produce information for over 50 examinations and procedures. However, due to the enthusiasm of our content authors and sub-editors, this has now been extended to over 70 items. The completion of all of this material and the final editorial panel meeting to "approve" the items for publication will take place on April 30-May 1. The final products will be freely available on our website described below.

CT dose optimisation quality improvement activity

Project Leader: Mr Anthony Wallace, Medical Physicist

This project is a successful partnership between QUDI, Queensland Health, [ARPANSA](#) and public and private radiology practices. This project is based on a [previous QUDI project](#). A baseline audit collected adult and paediatric dosimetry data from 10 Queensland radiology practices using an online audit tool (MedAudit) supported by Tina Soblusky, a radiographer funded through Queensland Health.

This data has now been analysed and will be presented at a workshop in early February attended by an imaging team (radiologist and radiographer) from each of the participating radiology practices. This workshop will also provide the teams with up-skilling in CT dosimetry and dose optimisation. A re-audit will occur in the months following the workshop to measure any change in practice.

Critically Appraised Topics (CAT) Program

Project leader: Dr Taryn Bessen, radiologist, NICS Fellow

This project has two major areas of work:

(a) *Promoting and evaluating educational resources for critical appraisal of literature skills:* A number of radiology registrars have participated in an evaluation of the essential modules that support skill development for critical appraisal of radiology literature. On completion of these modules, the participants completed a brief survey designed to evaluate their opinions not only of the content but the online educational environment. Preliminary results were provided to the RANZCR Directors of Training at last year's ASM. The evaluation of these resources will continue in 2009.

“Journal Club with a Difference” workshops have also been held to provide an alternate educational approach to teaching critical appraisal skills. These workshops have all been evaluated by participants as of high educational value.

(b) *Developing a CAT website:* A website to support writing and publication of radiology specific Critically Appraised Topics has been developed by the College and will be launched early in 2009. This website will allow appropriately skilled individuals to write a CAT, and includes a quality control process to support authors and a peer review process of all completed CATs prior to publication.

Diagnostic imaging reporting guidelines

Project leader: Dr Michael Carr, radiologist, QUDI Executive Committee member

Following the completion of a literature search and a summary of the results of this search, a survey is currently under design. It is anticipated that the survey will test the acceptability of the key characteristics of report writing that have been identified through the literature search.

Radiology Events Register (RaER)

Project leaders: Dr Neil Jones, radiologist; Dr Catherine Mandel, radiologist

The RaER database has continued to receive incident reports throughout the last six months. These incident reports include details of procedures not only where there has been an adverse outcome, but importantly where there has been a near miss, protocol failure, missed diagnosis, failure of communication or similar event.

One of the key outcomes of this project has been the regular publication of case reports in the form of a discussion of a single event or a cluster of similar events that have been reported to RaER.

The Project Leaders have undergone training in incident coding and analysis to ensure that the data analysis remains clinically relevant. Work is also underway to allow the migration of the RaER data into a new version of the database that will permit more rigorous and systematic analysis of the data, as well as support the importation of de-identified radiology data from other sources. Discussions are underway with both state governments and medical defence organisations.

QUDI website - Inside Radiology

Project leader: Jane Grimm, Manager, QUDI Program

The main purpose of the QUDI website is to host the outcomes of the current QUDI Projects – in particular, the consumer-focused information about radiology procedures project.

The basic architecture of the site has been completed and the interface has been modified to ensure ease of use of the website. The site is also being designed to meet all criteria for health information websites defined by both HealthInsite (the Australian Government's Health information site) and the Health on the Net Foundation (an international health information accreditation organisation). It is anticipated that this will encourage consumers and referrers of diagnostic imaging to feel confident in the quality of the information being

provided and satisfied with the ease of finding and accessing this information.

The website will be officially launched in May 2009.

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