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## **ACR PRACTICE GUIDELINE FOR COMMUNICATION: RADIATION ONCOLOGY**

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### **PREAMBLE**

These guidelines are an educational tool designed to assist practitioners in providing appropriate radiologic care for patients. They are not inflexible rules or requirements of practice and are not intended, nor should they be used, to establish a legal standard of care. For these reasons and those set forth below, the American College of Radiology cautions against the use of these guidelines in litigation in which the clinical decisions of a practitioner are called into question.

The ultimate judgment regarding the propriety of any specific procedure or course of action must be made by the physician or medical physicist in light of all the circumstances presented. Thus, an approach that differs from the guidelines, standing alone, does not necessarily imply that the approach was below the standard of care. To the contrary, a conscientious practitioner may responsibly adopt a course of action different from that set forth in the guidelines when, in the reasonable judgment of the practitioner, such course of action is indicated by the condition of the patient, limitations on available resources or advances in knowledge or technology subsequent to publication of the guidelines. However, a practitioner who employs an approach substantially different from these guidelines is advised to document in the patient record information sufficient to explain the approach taken.

The practice of medicine involves not only the science, but also the art of dealing with the prevention, diagnosis, alleviation, and treatment of disease. The variety and complexity of human conditions make it impossible to always reach the most appropriate diagnosis or to predict with certainty a particular response to treatment. It should

be recognized; therefore, that adherence to these guidelines will not assure an accurate diagnosis or a successful outcome. All that should be expected is that the practitioner will follow a reasonable course of action based on current knowledge, available resources, and the needs of the patient to deliver effective and safe medical care. The sole purpose of these guidelines is to assist practitioners in achieving this objective.

### **I. INTRODUCTION**

Timely, accurate, and effective communications are critical to quality and value in contemporary medical practices. As both a consultant oncologist and the provider of radiation oncology services, the radiation oncologist has a dual role. Radiation therapy incorporates the science of complex, integrated treatment delivery and the art of individual cancer management. Through written focused reports and direct communications, the contribution of radiation oncologists concerning patient care, responsible utilization, and quality are provided, especially to primary care physicians, other oncologists and specialists, and allied healthcare providers (nurses, tumor registrars, quality assurance personnel, third-party reviewers, etc).

Radiation oncology activities must be clearly and simply articulated for communications objectives to be met. While not all the technical aspects of treatment have to be included, several basic functions must be reflected in any correspondence: an evaluation and assessment of the patient's clinical problems from the radiation oncologist's perspective; the participation in multidisciplinary cancer

care; as required, the plan and delivery of radiation therapy treatments; and the monitoring of response, side effects, outcome, and any subsequent care. These should be communicated by at least an initial consultation, treatment (completion) summary, and follow-up evaluation.

There remains no substitute for direct, timely personal communication on all clinically relevant matters with the patient, family or support system, and physicians or other allied healthcare services.

## II. COMMUNICATIONS: GENERAL

### A. Medical Record

Guidelines have been established and continually revised regarding medical record documentation for professional and technical components of services delivered in the outpatient clinics, offices, or other facilities, and in inpatient settings. Criteria unique to radiation therapy services are also contained in the [ACR Practice Guideline for Radiation Oncology](#) and its associated guidelines, the ACR Radiation Oncology Practice Accreditation guidelines, and elsewhere. Communications in radiation oncology should be direct, verbal, or in writing.

### B. Written Communications

The following should be addressed in all written correspondence:

1. Permanent documents should be prepared legibly and in a timely, useful, and clinically appropriate manner. In general, consultation notes, progress notes, letters, follow-up notes, and treatment summaries should be in the chart within 1 week of the visit.
2. The content must be in compliance with healthcare or regulatory agencies and must meet the requirements of any clinical trials, treatment guidelines, or practice pathways associated with patient management.
3. The material should be reviewed to minimize typographic errors and confusing or conflicting statements. Abbreviations and other notations should follow prevailing standards.
4. Proper mechanisms for signature (authentication) and policies for distribution of any correspondence should be in place, assuring security and confidentiality.
5. The timely distribution of the final document must be assured by transmission via direct mail, fax, and/or electronic means as dictated by the nature and urgency of the clinical setting.
6. The communications are a part of the patient's permanent medical and treatment chart.

### C. Electronic Communications

Electronic charting and record-and-verify systems are becoming increasingly available and more user friendly. Some offer streamlined, standardized formats, forms, and templates to help ensure the appropriate recording of all pertinent services. Any reports from these systems, including voice-recognition-generated documents, should be reviewed by the radiation oncologist for clarity, content, and ease of understanding by recipients in and outside of the radiation oncology department.

Where applicable, reporting of this nature should be in accordance with evolving Digital Imaging and Communication in Medicine (DICOM) standards.

### D. Doctor-Patient Communication

Effective communication between physicians and patients must remain a primary goal of the radiation oncologist in all clinical and treatment services. Efforts should focus on encouraging collaborative relationships with patients and support systems to ensure that necessary information is provided and understood, management options are clarified, and patient needs are addressed in a timely fashion. Such relationships maintain a patient-oriented perspective. Usually the communication with patients is verbal, but it is also enhanced through various printed materials and other aids concerning cancer in general, specific tumor types, treatment options, and radiation therapy interventions, all of which can improve the patient's understanding.

### E. HIPAA

The communication of certain patient Protected Health Information (PHI) is regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the HIPAA Privacy Rule. Any use, disclosure, or creation of PHI must be in accordance with the Privacy Rule.

## III. RADIATION ONCOLOGY REPORTS

### A. Consultation

#### 1. Introduction

The consultative report should reflect prevailing evaluation and management (E & M) documentation guidelines for various levels of service. While this report will include an appropriate history (with required elements including current and past history, review of systems, family and social history) and physical examination, particular attention should be given to documenting oncology aspects and any comorbid diseases and risk factors that may affect aspects of patient care. The consultation

should include statements reflecting the decision-making process and recommendations for subsequent care.

## 2. Specifics

### a. Introductory data

The introduction should include patient's name, birth date or age, other identifying data if needed, and location and reason for consultation.

### b. History

The patient's history should follow the standard format including chief complaint, history of present illness, chronology of symptoms, and the problem and events as organized and interpreted from an oncology perspective. The patient's past medical and surgical history, family and social history, and review of systems usually follow. The extent will be commensurate with the cancer condition and proposed treatment plan.

### c. Physical examination

Depending on the situation, there should be a comprehensive detailed notation of the clinical findings using either a multisystem body region or organ system approach (prevailing E & M guidelines). Evaluation important to the oncology problem should receive special attention, including those physical findings at the primary site, regional disease extent including lymphatics, and potential distant site(s). An overall functional activity or performance classification (e.g., Karnofsky, ECOG, RTOG) should be documented.

### d. Medical decision making

Formulation of the clinical impression and accompanying management recommendations should be explained in clear, concise language, including documenting which items were discussed with the patient.

- i. A statement concerning the pertinent diagnostic data reviewed to stage the tumor.
- ii. The clinical impression, acknowledging any underlying conditions that may influence the treatment plan options.
- iii. A discussion, as appropriate, of any differential diagnoses and the natural history of the underlying condition.
- iv. Treatment options, including the intent of therapy (e.g., cure, adjuvant, palliation, local control). This section can also include other items such as risk/benefits and prognosis.

v. The plan of care, including any other suggested tests, combined modality approaches, and plans coordinated with other disciplines. A summary of the indications for radiation therapy, likely response, and treatment sequelae as discussed with the patient may be recorded, along with informed consent, if applicable.

vi. The anticipated treatment area and dose estimate can be stated. Any protocols, guidelines, or references being followed can be noted.

As local norms prevail, radiation oncologists may prefer to send a letter to the referring physician noting only the pertinent aspects of history, physical examination, clinical assessment, and treatment plan. An internal detailed report should be generated, which remains in the patient's radiation therapy permanent record to fulfill documentation requirements.

## B. Treatment (Completion) Summary

### 1. Introduction

The technical details of actual clinical management and radiation therapy delivery must be in the radiation oncology permanent record. A summary should be generated that accurately describes the treatment process, the doses delivered to the target/tumor volume and other key organs, relevant assessment of tolerance to and progress towards the treatment goals, and subsequent care plans.

The style will reflect the radiation oncologist's individual practice convention and the referral provider's needs. Some may use a "standardized" reporting format, others a more descriptive personal letter. Narrative explanations of highly technical aspects of the treatment may be included when considered to be informative, but these, at a minimum, should be contained in the permanent record.

### 2. Specifics

The treatment (completion) summary's key elements should include the following:

- a. Components for the summary of radiation therapy delivery include:
  - i. Patient identification and report date.
  - ii. Recipients of report (including tumor registry, if appropriate).
  - iii. Diagnosis and stage of disease.

- iv. Treatment dates.
  - v. Treatment status (e.g., treatment course completed as planned, changed, suspended.)
  - vi. Treatment response with details deemed clinically useful, including activity/performance status.
  - vii. Clinical course, including side effects and management thereof and use of ancillary services (nutritional, psychosocial, etc.).
  - viii. Dose summary, whose minimal elements include:
    - For external beam applications: total dose, treatment fractions, dose to tumor/target volumes, and any key regions (including nodal areas and key organs), as appropriate.
    - For brachytherapy applications: isotope, treatment type (e.g., high-dose/low-dose radiation [HDR/LDR], permanent/temporary) and dose to volume of interest (describe), as well as any dose specification points/regions.
    - Radionuclide injections: the administered isotope (chemical form [colloidal, tagged to antibody, etc.], and name), total activity, any dose to target/tumor volume, and time administered.
  - ix. Follow-up plans.
  - x. Referrals to other healthcare providers, instructions, tests, etc.
- b. Items, especially those technical in nature can also be included
- i. Organ localization techniques and methods of simulation.
  - ii. Treatment aids, devices, and physics/dosimetry aspects.
  - iii. Beam description (energy, orientation, techniques).
  - iv. Treatment fractionation scheme.
  - v. Other treatment specifics, such as three-dimensional conformal, intraoperative, electron beam, or orthovoltage applications, concomitant/concurrent therapies, etc.
  - vi. Pertinent quality assurance measures (e.g., TLD, diodes, port films.)

The style, content, and detail of this summary must be tailored to the clinical setting and prevailing practice norms. It should contain elements that accurately and succinctly reflect the program of care administered in a language understandable to the non-radiation oncologist.

## C. Follow-Up Visits

### 1. Introduction

The continuity of patient care after radiation delivery is reflected by the initial and subsequent clinical evaluations performed by the radiation oncologist. Although other oncologists and general and specialty physicians participate in patient surveillance, the nature of the oncologic problem and treatments, coupled with the specific training and experience that radiation oncologists possess, is important in subsequent follow-up. Discerning acute, subacute, and late effects from either single or combined modality programs; detecting recurrent disease; and advising on additional diagnostic and treatment strategies are examples of activities provided. The independent assessment offered is inherent to quality patient care.

### 2. Specifics

The form and content should remain consistent with the initial consultation and treatment summary. (Systems such as the SOAP designation of Weed is one example of how to organize reporting.)

#### a. Subjective

- i. History in the interval since the last patient encounter.
- ii. Cancer-related symptoms, problems with general and oncologic system review.
- iii. Status of symptoms related to radiation treatment.
- iv. Other clinical issues, including quality of life.

#### b. Objective

- i. Pertinent clinical findings in any irradiated field(s).
- ii. Multisystem examination to detect evidence for active disease.
- iii. General examination, as appropriate.
- iv. Statement reviewing any pertinent diagnostic data.

When applicable, an assessment of radiation therapy's late effects on tissues and organs (several designations are available, including RTOG, EORTC, LENT, etc.) can be incorporated into the report. A comparison to prior examination reflects continuity of care.

#### c. Impression or assessment statement

- i. General patient and cancer status.

- ii. Time since diagnosis and/or completion of therapy.
  - iii. Performance or functional activity status.
- d. Disposition and plan of care
- i. Pertinent recommendations to patient, referral physicians, etc.
  - ii. Recommendations for subsequent diagnostic studies and treatment strategies.
  - iii. Next follow-up visit.

If it is anticipated that the radiation oncologist will not follow up the patient, it is suggested that, the report to the referring physician include a request for periodic updates on the patient's progress. These updates will facilitate continuity of care should the patient require further radiation therapy.

#### D. Miscellaneous Communications

1. Clinical treatment management notes (including in-patient communication)

Radiation oncologists evaluate the progress of patients who are under routine therapy at least weekly. This is usually noted in the radiation therapy chart but can also be sent to referring physicians. Details may include:

- a. Patient's tolerance, accumulated dose, and progress towards the treatment goal, with analysis of any collected data.
- b. Issues raised with the patient or treatment team (dietary, social service, etc.).
- c. Documentation on any clinically relevant status or treatment plan change (change in treatment intent, need for treatment break, etc.).

In-patients receiving radiation therapy should have their daily treatment documented in the patient's hospital medical chart.

Based on local practice, there may be direct communication concerning the above with the patient's referring physician(s). This can be in person or by phone.

2. Hospital activities

The above reports (Sections III. A to III. D) apply to both free-standing and hospital-based facilities. Hospital-based radiation oncology departments also have to abide by the medical staff bylaws for documentation, existing management information systems, and administrative and regulatory agencies. For those

without in-house facilities, the activities of radiation oncology as consultants must be documented, as appropriate.

#### IV. SUMMARY

The radiation oncologist's participation in the multidisciplinary management of patients with cancer and other benign conditions treated with radiation is reflected in timely, medically appropriate, and informative correspondence. Written reports contain recognized and standard components as a matter of compliance with accepted norms. However, they must remain sufficiently individualized by the practicing radiation oncologist to reflect what is important and relevant to the patient's actual clinical setting and management. It is critical for the radiation oncologist to remain an effective communicator in routine daily clinical practice to patients, their support systems, other managing physicians, and the healthcare system.

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