

Chapter 46

Liability of Radiologists

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THE PROBLEM

The probability of a physician being sued for medical malpractice in the United States is about one out of four. The incidence of lawsuits has increased for all fields of medicine. What is most alarming is the increase in the number of million dollar or higher jury awards. Approximately 45% of jury awards from 1998 to 1999 were a million dollars or more compared to 39% from 1997 to 1998. This overall increase in jury awards has raised the *median* malpractice award from \$750,000 in 1998, to \$800,000 in 1999, and to \$1 million in 2000. The average jury award for medical malpractice more than tripled between 1994 and 2000, from \$1.1 million to \$3.5 million.

Going to trial in a medical malpractice case is an expensive ordeal for both sides. When going to trial for the specific liability of childbirth injuries, missed diagnosis of cancer, or delayed treatment, the median award was over \$1 million in the year 2000. Settling out of court for these three specific liabilities was less costly, with the median settlement of \$750,000 for childbirth injuries and \$665,000 for delayed treatment. The overall median settlement for all categories was \$500,000 in the year 2000.¹

Radiology has its own special problem with liability insurance. While the average indemnification has doubled in the last 15 years for all physicians, it has tripled for radiology. Furthermore, one-third of all medical malpractice claims are lost by the radiologist. If a "missed diagnosis" is alleged, 41% are lost. The most commonly missed diagnoses are breast cancer, lung cancer, and fracture of the spine.

MANAGING RISK

A very practical reason for studying risk management is to attempt to understand why we get sued. The risk of being sued is high in all of medicine, not just radiology. However, there are some positive risk management steps that you can take to reduce the possibility of being sued and losing. The more you understand the risk management process, the better you will be able to minimize or manage your risk. Risk management involves the identification, analysis, and evaluation of the risk and selecting the most advantageous method of addressing it. From a practical standpoint, this means identifying situations where you are at greatest risk of being sued and doing something to minimize that risk.

The first step of the risk management process involves identification of the risk. This may vary depending upon the practice. For example, if the practice involves interpreting studies from a busy trauma center or a mammography center, the practice involves higher risk than a free-standing MRI center. Once the risk is identified, it needs to be analyzed. Do the lawsuits occur with certain radiologists, during the evening, or during teleradiology reads? Once the risk is analyzed, implementation of risk management techniques needs to be instituted. Should radiology staffing be changed to address these risks? Finally, there needs to be a method to monitor the results. If not, you won't know if any change you made was effective or not.

Certain areas of radiology practice are associated with a significantly higher incidence of lawsuits, and risk management techniques can be effective in reducing the risk of being sued and losing. In general, there are four main reasons why radiologists get sued: errors in perceptions, errors in interpretation, failing to suggest the next appropriate procedure, and failure to communicate.²

TYPES OF ERRORS

Perception Errors

Perception errors occur quite often and are the most common reason why radiologists get sued.³ In cases involving perception errors, the abnormality is seen in retrospect but it is missed by the radiologist when interpreting the initial study. Some perception errors occur because the radiologist does not possess sufficient knowledge. Whether the abnormality is subtle or not may depend upon whether the observer error falls below the standard of care. This is despite the fact that the error rate in radiology is approximately 30%.⁴ Ultimately, it will depend upon the final outcome of the missed findings. Lawsuits involving perception errors are usually settled by the radiologist since the radiologist loses approximately 80% of these cases if it goes to a jury verdict.

The abnormality is always perceived in retrospect, but the real question is: was it below the standard of care for the radiologist not to have seen the abnormality?⁵ Although there have been a few cases in which the jury was convinced that missing a radiographic abnormality was not malpractice, they have been few and far between.

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In 1997, a Wisconsin Court of Appeals determined that errors in perception by radiologists viewing x-rays can occur in the absence of negligence. To require the average radiologist to see all abnormalities, even subtle ones, would elevate the standard to which the radiologist is held to perfection.⁶ However, this concept has not been accepted in other jurisdictions. It may be difficult to defend the radiologist before a jury when the radiologist has failed to perceive an abnormality that even the jurors can see. It is unfortunate, but the public seems to believe that every radiology perception error represents a negligent act.⁷

An additional source for error results from the influence a radiology report has over another radiologist. This type of perceptual error, sometimes called an alliterative error, occurs because the radiologist reads the old report first before looking at the imaging study and is more apt to adopt the same opinion as that rendered previously.⁸ If the first radiologist misses an abnormal finding, the next radiologist will often miss it as well.

Interpretation Errors

With interpretation errors, the abnormality is perceived but it is incorrectly described. This is not a perception error because, in this situation, the abnormality is identified, but it is called the wrong thing. Interpretation errors most often occur due to lack of knowledge or faulty judgment. This is also called a “misdiagnosis” and most often occurs when a malignant lesion is incorrectly attributed to a benign finding. A misdiagnosis can also occur when a normal structure, or variant of normal, is called abnormal. This situation occurs more commonly in ultrasound and computed tomography studies. When lawsuits involving interpretation errors go to trial, approximately 75% are found in favor of the radiologist.

Having an appropriate differential diagnosis can be of great help here, especially if the correct diagnosis is included in your differential diagnosis. This is especially true if the actual abnormality is extremely rare but your differential was at least “in the ballpark.” However, a “blanket diagnosis,” such as “probably benign, but malignancy cannot be ruled out,” is usually not successful if the results are grave.

Error of Failing to Suggest the Next Appropriate Procedure

While some radiologists might suggest additional studies to increase referrals, the prudent radiologist will suggest the next appropriate study or procedure based upon the findings and the clinical information. When a radiologist recommends or suggests an additional study or procedure, one of the criticisms raised is that the referring physician does not want to “feel forced” to order a study or procedure merely to minimize his or her potential liability. If the radiologist fails to recommend or suggest the next appropriate study or procedure for fear of upsetting the referring physician, the radiologist may become a defendant in a lawsuit for not suggesting the very procedure or study the referring physician did not want recommended.

Some physicians may be unaware of the efficacy and appropriateness of the newer radiologic modalities, such as functional MRI scans for cognitive dysfunction, diffusion MRI scans for recent infarction, and PET/CT scans for recurrent metastases. Radiologists must ensure that the recommendations or suggestions for any additional diagnostic studies or procedures are appropriate and will add meaningful information to clarify, confirm, or rule out the initial impression. Sometimes the next appropriate procedure may merely be a follow-up study.

In 1993, the American College of Radiology (ACR) realized that there would be a premium placed on the efficient use of resources in health care, especially involving the appropriate use of radiologic services. The ACR recognized the need for nationally accepted, scientifically based appropriateness criteria to assist radiologists in referring physicians in making appropriate imaging decisions. The ACR Appropriateness Criteria were thus created for this purpose. The ACR established these guidelines based upon validity assessment to determine if they would lead to better outcomes. It should be emphasized that the ACR Appropriateness Criteria are used as clinical practice guidelines to apply to the majority of patients. Be aware that ACR Appropriateness Criteria may suggest a nonradiologic procedure such as transthoracic or transesophageal echocardiography. Also, the complexity and severity of a patient’s clinical condition may dictate the selection of appropriate imaging procedures and treatments. Furthermore, the availability of equipment or trained personnel may influence the timely selection of appropriate imaging procedures. The ultimate decision on the appropriate use of any imaging procedure should be made by the referring physician in consultation with the radiologist in consideration of the clinical circumstances.⁹

A radiologist is usually not expected to follow up on a recommendation or suggestion to obtain additional procedures or studies. However, a recent Missouri Supreme Court decision held that a radiology group has a duty of continuing care, including follow-up, to ensure that the treating physician acts on unexpected or adverse findings. This duty arose because the radiology group did not formally withdraw from a physician–patient relationship but rather kept interpreting the images on three separate occasions. Therefore, the court held that the “continuing care” exception to the medical malpractice statute of limitations applied. However, the court noted that if a physician specifically advises a patient that his or her relationship with the patient has ended, the statute of limitations will run from that date forward.¹⁰ This decision is only in one state and, as such, does not suggest a trend. But it does show the court’s willingness to consider all physicians to share responsibility for the care of the patient, which would place the radiologist in the same position as a primary health care provider.

Error of Failure to Communicate

The final written report has always been considered to be a routine communication and the definitive means of

communicating the results of an imaging study or procedure to the referring physician. However, there are times when direct or personal communication of results must be made immediately and can vary with the nature of the urgency of the clinical problems. At times, this may require the radiologist to immediately communicate the results directly to the referring physician by nonroutine communication. Failing to communicate in a timely and clinically appropriate manner has been evolving as an increasing reason why radiologists are sued. In addition to rendering an official interpretation, the radiologist is responsible for communicating these findings directly to the referring physician, other health care provider, or appropriate representative in situations in which the radiologist feels immediate patient treatment is indicated. In nearly a third of cases, failure to communicate was the major factor in the error in diagnosis.

The American College of Radiology (ACR) Guideline for Communication indicates that nonroutine communication can be accomplished in person or by telephone to the referring physician or an appropriate representative.¹¹ This is an oral report that should be documented, as a final written report does not substitute for direct communication of the need for emergent care. Prior to 2002, the ACR Standard for Communication required direct communication for both significant unexpected findings as well as for urgent findings. Since then, the term "standard" was changed to "guideline" and the radiologist could communicate unexpected findings to the referring physician, other health care provider, or an appropriate individual in a manner that reasonably ensures receipt of the findings. After January 1, 2002, the radiologist no longer has to directly communicate unexpected findings. However, the radiologist who insists that the written report provides all the information the referring physician needed will be perceived as uncaring and callous if a simple telephone call could have averted a bad outcome. Furthermore, written reports are inaccurate in 18% of cases, affecting outcome in almost half of these cases. In 10% of cases, the written report was not issued in a clinically appropriate or timely manner, affecting outcome in 75% of these cases.

In some practices, a preliminary report or a "wet read" is issued by the radiologist or the emergency room physician prior to the preparation of the final report. Any significant change between the preliminary report or wet read and the final report should be reported directly to the referring physician by nonroutine communication and documented in the final report.

If the author of an interpretive report is not available to sign the report, a colleague will often sign the report, substituting their signature for the author's signature. There is a danger to signing a colleague's interpretive report because, if he or she is sued for malpractice, you will almost certainly be sued as well. If you are signing a colleague's report, you should review the images and make corrections to the report, if necessary, with the full understanding that you will most likely be held responsible for the contents of the report.¹²

Correctly diagnosing an abnormality may not be enough if the findings are not communicated. A radiologist who

correctly diagnosed a radial head fracture of a child, which was missed by the emergency room physician, argued that his liability should end when he correctly dictated the report. The Court of Appeals of Ohio disagreed and noted that radiologists have direct obligations to patients even though they may never see them personally. The court stressed that the communication of a diagnosis, if it is to be beneficial, is sometimes as important as the diagnosis itself.¹³ Similarly, a New Jersey Appellate Court has held that communication of an unusual finding so that it may be beneficially utilized is as important as the finding itself.¹⁴ The Arkansas Supreme Court held that a radiologist cannot escape the duty to immediately communicate with the referring physician when they discover a misplaced endotracheal tube on a chest radiograph. It does the patient little good if the radiologist discovers this condition but does not inform those responsible for his care.¹⁵ The ACR acknowledges that the ACR Guideline for Communication are not rules, but are guidelines that attempt to define principles of practice that should generally produce high-quality radiologic care. Whether you like it or not, the ACR Guideline will be interpreted to mean "reasonable care"—anything less will be *below* the standard of care.¹⁶

The ACR Guideline may be a double-edged sword for some. Certainly, the ACR Guideline can be used against you if you deviated from it and did not document why you did so. You may be justified in not following the ACR Guideline based upon the clinical situation. The ACR Guideline is minimal, but you must document why you chose not to follow it. On the other hand, the ACR Guideline may result in a case being dismissed against you if you can demonstrate that you followed the ACR Guideline.

THE "SOLUTION" Improve Perception

Studies have shown that perception errors will occur even with the best-trained radiologist. However, some perception errors can be minimized by paying proper attention to clinical information when it is given, or obtaining clinical information when it is not. Knowledge of pertinent clinical history has been shown to increase the accuracy of the interpretation. Also, look at the films before reading prior reports. A "negative" prior report makes it easier for you to arrive at the same conclusion too.

Provide a Meaningful Interpretation

Errors in interpretation can be reduced through continuing education. Attending conferences and meetings and reading journals will help broaden your horizon and improve your differential diagnosis. The ACR Guideline for Communication indicates that a precise diagnosis should be given whenever possible and that a differential diagnosis should be given when appropriate. Having an appropriate and meaningful differential diagnosis will

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reduce your exposure. Your chances of losing are less if the actual diagnosis is included in your differential diagnosis.

Do not attempt to interpret studies in an area in which you do not feel comfortable or have not had sufficient training. Be aware that the ACR Guideline has criteria for qualification as well as maintenance of competence and continuing medical education requirements for various imaging studies and procedures. Unfortunately, studies have shown that more things are missed because they are not thought of, rather than what is known.

Suggest the Next Appropriate Procedure

When it is appropriate, a radiologist should not be reluctant to indicate that an additional study or procedure may be of diagnostic or confirmatory value when the initial diagnosis is not clear or in doubt. In fact, it is recommended to do so in the ACR Guideline for Communication. With many of the newer diagnostic and therapeutic modalities now available in diagnostic imaging, not all referring physicians will be familiar with what procedures to do next. Most ordering physicians actually do know the next appropriate procedure to order when an abnormality is found on the study they originally ordered. However, if they are named in a lawsuit for failing to order that procedure, they will certainly blame it on you if you did not recommend it.

The keyword here is “appropriate.” The radiologist should read the ACR Appropriateness Criteria and be familiar with the next appropriate procedure. It is usually, but not always, a radiologic study or procedure that can help define or amplify the initial findings. The radiologist should be aware of all imaging modalities, even if that modality is not offered in their department, institution, or office. If a deviation from the ACR Appropriateness Criteria is made due to the clinical circumstances or availability of equipment, it is recommended that the justification for the deviation be documented in the report.

Communicate the Results in a Timely Manner

Lack of appropriate and timely communication appears to be one of the greatest problems confronting radiologists today. This is made even more burdensome by the difficulty in being able to quickly speak to a busy referring physician and the increasing workload that radiologists now have to bear. However, this is the one area in which the radiologist can dramatically improve the odds against being sued, and that is by communicating and documenting the communication.

The radiologist needs to be especially careful in communicating a “significant unexpected finding” on a “routine” or “pre-op” chest radiograph. Referring physicians may be less likely to expect abnormalities and might not even receive the written report prior to discharge of the patient.¹⁷ Especially under these circumstances, the radiologist should make sure the communication is in a manner that reasonably ensures receipt of the findings. A federal court in

Indiana found a radiologist negligent for correctly interpreting a skull fracture on Christmas Day in a child but not calling the referring physician when the radiologist knew that the report would not be transcribed for 2 days. The radiologist should have foreseen that the 2-day delay would have prevented the referring physician from instituting treatment in a timely manner.¹⁸

The ACR Guideline on Communication recommends that all communications be documented. Even though it is only a recommendation, the lack of documentation has been used in court to imply that the urgent or significant unexpected finding was not directly communicated. If the official report has already been dictated, then an addendum documenting the communication should be performed. This should be done contemporaneously with the communication. Finally, the ACR Guideline for Communication should be thoroughly read, understood, and implemented by every radiologist.

CONCLUSION

Obviously, there is no “solution” but merely recommendations: pay attention to clinical information or obtain it when not given; be qualified to interpret or perform a procedure and maintain your competence; suggest the next appropriate study or procedure; use the ACR Appropriateness Criteria; when appropriate, suggest a follow-up study; directly communicate findings by nonroutine communication when immediate patient treatment is indicated and document the communication; read, understand, and implement the ACR Guideline for Communication into your practice. Adhering to these measures certainly will not prevent you from being sued. It will, however, reduce the risk of being sued and losing.

Endnotes

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