

Malpractice Issues in Radiology

Communication of the Urgent Finding

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The Case

The patient was a 23-year-old female with a long history of Crohn's disease of the small bowel. She had undergone multiple small-bowel resections when she was admitted to the hospital in a state of cachexia. Late the following morning, a Friday, her surgeon inserted a dual-lumen Groshong catheter into the superior vena cava via the right subclavian vein for hyperalimentation. A portable chest radiograph was obtained (Fig. 1). Shortly thereafter, the surgeon went to the radiology department to view the radiograph, but the radiologist was eating lunch and was not available for consultation. After examining the radiograph by himself, the surgeon left, asking the radiology technologist to have the radiologist call him if he saw anything unusual on the film.

After returning from lunch, the radiologist gave this interpretation: "A subclavian catheter has been placed from the right side. The tip is slightly more medially placed than usually seen. However, the superior vena cava in this area is frequently quite distensible and the catheter most likely does lie within the lumen. Heart and lungs are normal. A left subclavian catheter is noted." The radiologist asked the technologist to call the surgeon on the telephone so they could discuss the report. The technologist could not reach the surgeon and was told by the answering service that the office was closed for the afternoon. He left a message for the surgeon to call the radiologist, but a return call never came. The radiologist called the hospital nurse involved in the patient's care and inquired whether there was a good blood return

from the feeding catheter. The nurse answered that everything seemed fine. There was no further communication between the radiologist and any other party for the rest of the day or weekend.

Later Friday evening, after receiving hyperalimentation fluid through the catheter, the patient developed dyspnea and hypotension, went into shock and cardiopulmonary arrest, and died. Autopsy revealed that the catheter had perforated the vena cava and the hyperalimentation fluid had filled the right pleural cavity.

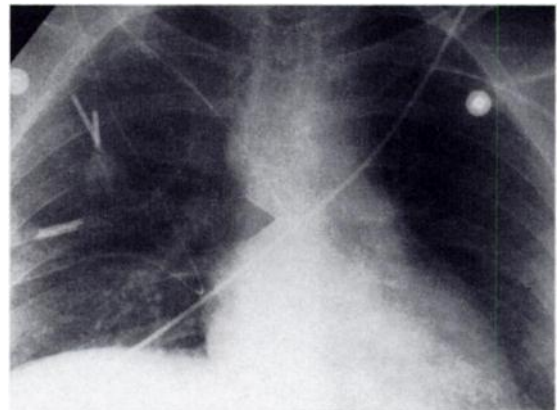


Fig. 1.—Anteroposterior portable chest radiograph shows location of tip of hyperalimentation catheter (arrow).

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Case summaries are based on actual events and lawsuits, although certain facts have been omitted or modified by the author, who has supplied and obtained authorization for the reproduction of the radiographic images. All opinions expressed herein are those of the author and do not necessarily reflect those of the *American Journal of Roentgenology* or the American Roentgen Ray Society.

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The Malpractice Issues

A malpractice lawsuit on behalf of the deceased patient was filed against the radiologist and others involved in the patient's care. The suit alleged that the radiologist was negligent because he failed to communicate the possibility of vena cava perforation to the referring physician in a timely fashion so that corrective action could have been taken to avoid the cardiopulmonary arrest and death. During the pretrial discovery, the radiologist testified that after interpreting the radiograph, he had had sufficient concern as to the exact location of the catheter tip that he had attempted to call the attending physician, but when he was unable to do so, was satisfied by the assurances of the patient's nurse that the catheter seemed to be functioning well. The surgeon claimed that he would have immediately corrected the catheter placement had he been notified by the radiologist that a problem existed. While he himself had inspected the postprocedure radiograph, he relied on the radiologist's higher degree of expertise in radiographic interpretation. A radiology expert retained by the plaintiff testified that the radiologist breached the standard of care by abandoning his efforts to immediately communicate the findings to the surgeon. He also opined that the radiologist showed a lack of concern for the patient's well-being by the fact that, failing to reach the surgeon with the report, the radiologist went home for the weekend and made no effort to contact anyone at the hospital until the following Monday morning.

The malpractice case was settled prior to trial.

Discussion

The radiology issues in this case centered on the radiologist's duty to communicate findings. Traditionally radiologists have believed their duty to communicate results did not extend beyond dictating and signing their report. As a matter of courtesy and good medical practice, the radiologist might decide to telephone the patient's physician if the radiographic findings seemed to warrant immediate treatment, but this was not mandated, nor was there any requirement to document the process [1]. Malpractice litigation alleging failure to communicate by radiologists is not common. A review of 20 years of medical malpractice litigation in the Chicago area beginning in 1975 [2] disclosed that in fewer than 2% of cases involving diagnostic radiology was communication an issue. In 1990, Liston [3] pointed out that the number of legal actions against radiologists claiming failure to properly communicate diagnoses seemed to be rising. This was confirmed by Schwinger [4] the same year, who stated that communication breakdowns comprised over 15% of radiology liability cases in New York State.

Kline and Kline [5] in 1992 comprehensively reviewed a number of state appellate and supreme court decisions that dealt with radiologic communication, most of which ruled that radiologists have definite legal duties to communicate radiologic findings to referring physicians and sometimes to patients themselves on a timely basis—immediately if the patient's care requires it. That the courts are expanding the communicative responsibilities of radiologists is highlighted in two court decisions.

An Ohio appellate court, dealing with the failure of a radiologist to immediately communicate the presence of a distal humeral fracture, noted that radiologists have direct obligations to patients even though they may never see them personally [6]:

In some situations indirect service may provide justification for the absence of direct communication with the patient, but that does not in any way justify failure of communication with the primary care physician...We are unable to agree...that radiologists...who merely provide what they term "indirect medical care" may somehow categorically escape all liability once such a practitioner has made a correct analysis and has done no more than to relay this information through ordinary hospital channels. Once the physician-patient relationship has been found to exist...the professional responsibilities and duties exist despite the lack of proximity, or the remoteness of contact between the two as where a consulting physician is involved in the case in only a limited manner. Therefore, all physicians involved in a case share in the same duties and responsibilities of the primary care physician to the extent of their involvement.

Emphasizing that radiologists cannot escape the duty to immediately communicate with the referring physician when they discover a radiologic finding that requires immediate treatment, the Arkansas Supreme Court, in a case wherein a radiologist failed to immediately report to the referring physician that a chest radiograph showed that an endotracheal tube had become dislodged, stated (underscoring added) [7]:

Knowing that the tube was not in place, the [radiologist] nevertheless handled the situation as a matter of routine. While this routine was taking its course, [the patient] was in a life-threatening situation and indeed almost died. He deserved more than routine care under these circumstances...When a patient is in peril of his life, it does him little good if the [radiologic physician] has discovered his condition unless the physician takes measures and informs the patient, or those responsible for his care, of that fact.

In 1991, recognizing the importance of diagnostic radiology communication, the American College of Radiology issued its *Standard for Communication* [8] and revised it in September 1995 to state: "If there are urgent or significant unexpected findings, radiologists should communicate directly with the referring physician or other health care provider, or an appropriate representative who will be providing clinical follow-up...Documentation of actual or attempted direct communication is appropriate."

Summary and Risk Management

That timely and appropriate communication of radiologic results to referring physicians is essential has been recognized by the courts and codified by the American College of Radiology in its standards. All radiologists must familiarize themselves with and comply with these standards.

Risk management in radiology practice can lessen the likelihood of incurring a medical malpractice lawsuit and maximize the chances for a successful defense if a suit is filed, while at the same time enhancing good patient care. The following risk management communication pointers will help radiologists meet all three of these objectives.

- If the radiologist has any reasonable belief that a radiologic finding requires treatment of the patient before delivery of a written report in the mail or onto a patient's hospital chart, the radiologist should telephone a report to the referring physician immediately.

- If the referring physician cannot be located, a message may be left with the physician's nurse or associate, with the acknowledgment by that individual that he or she will assume the responsibility of notifying the referring physician or undertaking care of the patient himself. If none of these individuals can be located, the radiologist should attempt to locate an alternate physician who is covering for the primary physician. In rare situations where the radiologist cannot locate the referring physician or his or her delegate and the radiologist feels that immediate treatment of the patient is necessary, the radiologist should contact the patient directly and inform the patient to come to a hospital emergency room for care.

While radiologists traditionally report results to the referring physician rather than to the patient directly (except for self-referred patients undergoing mammography), from a legal point of view, the radiologist's ultimate responsibility is to the patient. If the radiologist cannot transmit urgent reports to the patient's physicians, then he or she must transmit them to the patient directly.

- Once a radiologist decides that a finding needs a telephone report, he or she must continue efforts to reach the referring physician or an acceptable alternate to complete the communication. Terminating attempts at communication because the referring physician is not easily available, as was done in the case described, places the radiologist in greater medical and

legal jeopardy than not having attempted to telephone in the first place.

- Once verbal communication is completed, it should be documented. A medicolegal truism states, "If it wasn't documented, it wasn't done." A radiologist who, several years after an incident, says to a jury, "I think I called the referring physician, but I can't remember for sure and have no documentation that I did," loses credibility. Nothing is worse in defending a medical malpractice lawsuit than having two physicians pointing fingers at each other, one saying, "I called you," and the other saying, "No, you didn't." Documentation at the time an event takes place is credible evidence in a court of law.

- Documentation of verbal communication should be placed in the radiology report if possible. If the verbal communication has not been completed until after the radiology report has been dictated and signed, then the radiologist should keep a log in the department and document all pertinent discussions as they occur. An acceptable alternative would be to issue an addendum report that documents the communication.

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