

# Malpractice Issues in Radiology

## Radiologic Malpractice Litigation: A View of the Past, a Gaze at the Present, a Glimpse of the Future

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*We can chart our future clearly and wisely only when we know the path which has led to the present.*

Adlai Stevenson [1]

In 1794, 5 years after George Washington was inaugurated as the first President of the United States, the new nation's first medical malpractice lawsuit was adjudicated by a Connecticut court. The husband of a woman who had died as a result of surgery sued the physician for operating in "the most unskillful, ignorant, and cruel manner, contrary to all the well-known rules and principles of practice," and violating "his promise to the plaintiff to perform said operation skillfully and with safety to his wife" [2]. The lawsuit, the primary allegation of which was breach of contract, was won by the plaintiff. The jury found the physician liable and awarded damages of 40 English pounds.

Two hundred nine years later, our nation finds itself engulfed in a malpractice quagmire that physicians all over the nation are calling a malpractice crisis [3], and radiologists are very much in or near the eye of the storm. How did we reach this point? This ar-

ticle will explore this question and then address the issue of what the medical community—particularly physicians who practice radiology—can expect as it moves forward to the future on a road embedded with malpractice minefields.

To gain a more meaningful understanding of the current state of affairs with regard to medical malpractice litigation in the United States, we must begin by looking back at the path that has led us to the present.

### A View of the Past

Although it may be fascinating to delve into the history of medical malpractice as far back as the ancient Chinese, Persian, Greek, and Roman periods, such an endeavor is beyond the scope of this article. Nevertheless, a brief overview of rules governing responsibilities and potential liability of physicians in biblical times serves as an appropriate starting point and will assist us in developing an understanding of the Judeo-Christian concept of the role of the physician in society.

Interpretations of and commentaries on the myriad laws and regulations set forth in the Old Testament were codified in the Jew-

ish Talmud, a monumental compendium and diverse collection of opinions and dissertations of scholars developed over the course of nearly 1,000 years, from 500 BC to 500 AD. In his book on *Biblical and Talmudic Medicine*, medical historian Fred Rosner [4] pointed out that Talmudists interpreted biblical law as acknowledging that the "divine arrangement of the world" required the existence of physicians. Because they realized that if physicians were liable for every error no person would wish to engage in the profession of medicine, Talmudists held that if a physician caused injury to the patient after an error, the physician would be considered blameless "because of the public good." On the other hand, if the physician intentionally injured a patient, the physician would be judged liable and be required to make restitution for damages. The privilege of blamelessness granted in case of error applied only to experienced or expert physicians who "healed at the request of the authorities"—in other words, who were considered to be "licensed" physicians in the community. The nonlicensed physician was subject to the same restrictive general law that applied to ordinary citizens.

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Case summaries are based on actual events and lawsuits, although certain facts have been omitted or modified by the author. 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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In the case of a patient's death, the Talmud drew a distinction between Jewish law and Greek law that, at the time, did not recognize any liability of the physician, even for the premeditated killing of a patient. The Talmud explicitly decreed that this "heathen regulation" could not take effect in Judaism and that for premeditated acts the general laws of crime and punishment would apply equally, or perhaps even more so, to the physician [4].

### The Common Law

American law under which we are governed today derives from three sources [5]. The first is constitutional law, founded on federal and state constitutions and the interpretations given them by the courts. Second is statutory law, rules and regulations enacted by various state legislatures and the United States Congress. Finally, there is the common law, law that is based on judicial decisions that serve as precedents on which courts base future decisions.

Let us consider the early settlers of the North American continent. At one time or another, many European countries colonized the land that was to become the United States, but it was the culture, customs, and laws of England that exerted the greatest influence. During the pre-Revolutionary period, the American colonies inherited not only the English language but also English common law; and for the most part the English law has remained our system of law to this day [6]. Only Louisiana has remnants of French law, and some Western states retain traces of Spanish law.

The common law as we know it today is therefore a legacy from the English to the United States. It comprises published decisions of state and federal appellate and supreme courts that serve as bases on which subsequent similar cases are decided. Simply stated, the fundamental characteristic of both English and American common law is adherence to precedent, more formally referred to as the doctrine of *stare decisis* [5].

In 1765, British legal scholar Sir William Blackstone published *Commentaries on the Laws of England* [7], a compendium of legal principles that was to become the second most widely read book (the first being the Bible) in the American colonies [6]. In his book, Blackstone referred to the "neglect or unskillful management of a physician or surgeon" as "*mala praxis*" [7]. It is from this term that the modern word "malpractice" is derived [8].

Although the first recorded American medical malpractice lawsuit was in 1794, many

malpractice cases had occurred in England before that. The 1769 case of *Slater v Baker and Stapleton* is frequently cited as the first medical negligence case in which a court articulated the standard of care against which the conduct of a physician would be measured [9]. The standard enunciated at the time had the effect of shielding physicians from most professional liability, for not only did the court rule that a physician could be found liable only if another physician testified that his conduct breached the standard of care, but the court also held that the only physician who could testify regarding the standard of care of a defendant physician was a physician in the defendant's own locality.

One of the earliest state supreme court decisions in the United States setting forth the standard of care for physicians was rendered in 1832, also in Connecticut. A physician was accused of negligence for "unskillfully and carelessly making an incision into the plaintiff's arm to insert [smallpox] vaccine, such that she suffered great pain and her arm was irreparably injured" [10]. The jury found in favor of the plaintiff, and the defendant physician appealed. Although the Connecticut Supreme Court upheld the jury verdict, its eloquent commentary regarding not only what legal duties should be imposed on physicians but also the hardships that physicians face when sued for malpractice seems as relevant in 2003 as it was 171 years ago. The court began by reviewing the defendant's argument [10]:

A physician and surgeon, in the performance of his professional duties, is liable for injuries resulting from the want of ordinary diligence, care, and skill. The defendant physician contends that it ought to be borne in mind that physicians never warrant their work. They make no promise, except to do as well as they can, and as well as they know how to do. There is nothing like mechanical perfection in the healing art. The only reasonable rule on this subject—which is in accordance with the settled law in Connecticut, England, and elsewhere—is that nothing short of gross ignorance or gross negligence will subject the surgeon to damages. What man, even of skill and talent, would undertake to practice in the healing art, if some little failure of ordinary skill or ordinary diligence, or even some trifling want of carefulness, might sweep from him the whole earnings of a life of toil and

drudgery? Restricted to the narrow ground of the charge, many skillful and able physicians would not escape liability a single year of their practice. "Ordinary" means usual, common. The difference between a want of ordinary or useful skill and gross negligence is essential and important. If you were to draw a line of distinction just halfway between the eminently learned physicians and those grossly ignorant, would you not hit exactly on those styled ordinary?... To say that a physician did not perform a certain operation with ordinary skill conveys a very different idea from the assertion that he performs it with gross negligence.

The court then rendered its opinion:

The defendant physician prayed the court to charge the jury that, unless the plaintiff had proved the defendant guilty of great and gross negligence in vaccinating the plaintiff, she could not recover [damages]. The court told the jury on this point that if there was either carelessness, or a want of ordinary diligence, care, and skill, then the plaintiff was entitled to recover. The principle laid down by the court is entirely correct. If in the performance of the operation there was a want of ordinary diligence, care, and skill, or if there was carelessness, then the defendant physician was liable.

The motion for a new trial must be denied.

Further refinement regarding the duties that physicians owe patients and an opinion on the question of whether physicians must warrant cures were expressed by the Pennsylvania Supreme Court in 1853. A man whose leg had become deformed and shortened as a result of a comminuted fracture of the tibia and fibula sustained during an accident sued the physician who had treated him, alleging negligence. A trial was held, and the jury found in favor of the patient and awarded him \$850. The physician lodged an appeal that was eventually heard by the state supreme court, which reversed the jury decision and ordered a new trial [11]:

The only question of any importance presented for our consideration is whether the trial court erred in charging

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that the defendant physician was bound to bring to his aid the skill necessary for a surgeon to set the leg so as to make it straight and of equal length with the other, when healed; and if he did not, he was accountable in damages, just as a stonemason or bricklayer would be in building a wall of poor materials and the wall fell down, or if they built a chimney and it should smoke by reason of a want of skill in its construction.

It is impossible to sustain this proposition and it was inapplicable to the circumstances of the case under investigation. The implied contract of a physician or surgeon is not to cure—to restore a fractured limb to its natural perfectness—but to treat the case with diligence and skill. The physician deals not with insensate matter like the stonemason or bricklayer, who can choose their materials and adjust them according to mathematical lines; but he has a suffering human being to treat, a nervous system to tranquilize, and will to regulate and control. The evidence before us makes this strong distinction between surgery and masonry, and shows how the judge's inept illustration was calculated to lead away the jury from the true point of the cause... The question is not whether the doctor had brought to the case skill enough to make the leg as straight and long as the other, but whether he had employed such skill and diligence as are ordinarily exercised in his profession. For less than this he is responsible in damages, but if he be held to the measure laid down by the trial court, the implied contract amounts on his part to a warranty of cure for which there is no authority in law.

We have stated the rule to be reasonable skill and diligence, by which we mean such as thoroughly educated surgeons ordinarily employ. The law demands qualification in the profession practiced—not extraordinary skill such as belongs only to few men of rare genius and endowments, but that degree which ordinarily characterizes the profession.

The trial court judge in his charge fell into error in stating the amount of skill required in the treatment of the case. We reverse for that reason. When we decide the legal point, we are done with it. We

are not an authority on questions of surgery. Our hands are abundantly full of questions which belong to our own profession, without volunteering opinions on sciences which relate to others.

Seven years later, in 1860, in a malpractice lawsuit that also alleged that a physician had negligently reduced a fracture, the Illinois Supreme Court outlined the duties of a physician in similar wording [12]:

When a person assumes the profession of physician and surgeon, he must, in its exercise, be held to employ a reasonable amount of skill and care. For anything short of that degree and skill in his practice, the law will hold him responsible for any injury which may result from its absence. While he is not required to possess the highest order of qualification, to which some men attain, still he must possess and exercise that degree of skill which is ordinarily possessed by members of the profession.

In the same year, the Supreme Court of Georgia ruled similarly [13]:

The profession of the physician is one of the learned professions; and in regard thereto, as in all professions in the practice of which learning and skill are required, the rule of law is that every person who enters into a learned profession undertakes to bring to the exercise of his profession a reasonable degree of care and skill. He does not undertake to use the highest possible degree of skill, for there may be persons who, for having enjoyed a better education and greater advantages, are possessed of greater skill in their profession; but he undertakes that he will bring a fair, reasonable, and competent degree of skill... The physician is called in for the very purpose that by his skill he may judge what is necessary to be done, and by his skill to do it; and he is not responsible for an error in judgment on such an occasion, if such error arises from the peculiar circumstances of the case, and not from the want of proper care or competent skill on his part.

Most malpractice lawsuits in the United States filed during the second half of the nineteenth century and first part of the twentieth century were related to orthopedic treatments of

fractures, dislocations, and amputations [6]. While state courts were adding to and modifying the common law, state legislatures were developing statutory law with enactment of state licensing of physicians. Texas, in 1870, was the first state to pass a modern state licensing law; and by 1905, 39 of the then 45 states had similar licensing laws [6].

For the next century, courts in every state of the nation consistently held that the standard of care of a physician is essentially the same as that enunciated in these mid nineteenth century decisions. In 1996, a Wisconsin appellate court decision echoed similar sentiments, but because the case under review dealt with missed radiologic findings, the court's words are particularly noteworthy. The court acknowledged that radiographic abnormalities were indeed missed, but in commenting on whether the missing of all radiologic findings constitutes malpractice, the court stated [14]:

They were not mistakes based upon negligence.... There is no evidence... to establish that [the radiologist's] errors in having failed to detect those defects came as a result of his failure to conform to the accepted standard of care in the field of radiology.... True, physicians too often have attempted to encourage an aura of infallibility they do not possess. Theirs is not an exact science, and even the best of them can be wrong.

The test is not whether [the radiologist] failed to detect what the average radiologist should have detected, but whether [the defendant radiologist] exercised reasonable care.... [The radiologist] used reasonable and ordinary care, and his failures to detect the abnormalities were "errors in perception"... All radiologists miss abnormalities in X rays, but such errors do not, in and of themselves, constitute negligence in treatment.

The Wisconsin court's ruling regarding what constitutes negligence in diagnostic radiology has not been adopted by courts in other states [15].

### Radiologic Malpractice: A View of the Past

A new chapter in the saga of medical malpractice began with Roentgen's discovery of the X ray in 1895. Early cases in which radiographs were submitted as evidence in personal

injury trials in the United States have been chronicled previously [16]. In this article, however, we focus on radiologists and nonradiologist physicians as defendants in medical malpractice actions. Medical historian James Mohr [8] provides an introduction to this topic:

Within 20 years of their introduction, radiographs had become one of the nation's most prolific sources of malpractice actions (too much radiation, failure to read the films properly, and so forth). Litigation concerning radiographs produced many of the highest damage awards (in excess of \$5,000) in the decade prior to World War I and generated a whole new body of evidentiary disputes (for example, ownership of films, interpretation of faint images). Radiographic tests also opened to exposure other sorts of medical mistakes that were previously difficult to demonstrate in court.

One year after Roentgen's discovery, a malpractice lawsuit was filed against a Colorado surgeon, a founder of the American College of Surgeons, claiming that the surgeon negligently treated a fractured femur of a young boy who had fallen from a ladder [17]. The plaintiff attempted to admit as evidence a "roentgen picture" of the fractured femur. The defense attorney argued against admitting such evidence, but in a historic decision the judge admitted into evidence the pioneer-era radiographs:

We have been presented with a photograph taken by means of a new scientific discovery, the same being acknowledged in the arts and in science. It knocks for admission at the temple of learning; what shall we do or say? Close fast the doors or open the wide the furrows? These photographs show the present condition of the head and neck of the femur bone, which is entirely hidden from the eye of the surgeon. Nature has surrounded it with tissues for its protection and there it is hidden; it cannot by any possibility be removed nor exposed that it may be compared with a shadow that developed by means of this new scientific process.... These exhibits are only pictures or maps to be used in explanation of a present condition... and may be shown to the jury as illustrating or making clear the testimony of experts.

The law is the acme of learning throughout all ages. It is the essence of wisdom, reason, and experience.... Let the courts throw open the door to all well-considered scientific discoveries. Modern science has made it possible to look beneath the tissues of the human body, and has aided surgery in telling of the hidden mysteries. We believe it to be our duty in this case to be the first, if you please, to so consider admitting in evidence a process known and acknowledged as a determinate science. The exhibits will be admitted in evidence.

In a 1956 article reviewing all published state and Supreme Court cases rendered in the United States between January 1946 and 1956, Sandor [5] found that orthopedic problems headed the list of professional liability hazards. The one single incident that gave rise to most of the claims in orthopedics was the failure to take radiographs of patients with suspected fractures. There were 14 cases involving "X-ray and radium burns," but not even one case alleging failure to diagnose a neoplasm. The findings in this survey are in stark contrast to those of a survey of radiologic malpractice lawsuits that was to be published 40 years later.

A review of malpractice litigation during a 20-year span from 1975 to 1994 in the greater Chicago area disclosed that radiology-related cases accounted for 12% of all medical malpractice cases filed against physicians [18]. Physical injuries sustained by patients in or being transported to or from a radiology department accounted for 5% of the total; radiation oncology complications, 8%; complications of radiologic procedures, 16%; failure to order radiologic studies, 22%; and radiographic misses, 42%. Miscellaneous causes accounted for the remaining 7%.

A more realistic indication of the prevalence among diagnostic radiologists of lawsuits claiming radiologic misses is obtained by excluding those lawsuits alleging complications of radiation oncology and those in the failure-to-order category. With this approach, allegations of missed radiologic diagnoses accounted for an average of 55% of diagnostic radiology-related lawsuits for the period 1970–1974 but rose to 71% in the 5-year period between 1990 and 1994. Between 1975 and 1984, malpractice litigation related to missed bone abnormalities of all types accounted for the greatest percentage of radiologic misses, but the ranking changed considerably in the period between 1985 and 1994,

when lung and breast cancers became the most commonly missed radiographic diseases.

Similar data have been reported in other geographic areas. Diagnostic mishaps accounted for 75% of all adverse events related to negligence experienced by patients admitted to hospitals in New York State between 1985 and 1988 [19]. A report in the *ACR [American College of Radiology] Bulletin* in 1985 disclosed that missed fracture or dislocation cases represented 25% of all radiologic malpractice cases nationally and that claims of failure to diagnose cancer, at 8%, were a distant second in frequency [20]. However, 2 years later a report of malpractice cases involving the federal government found that a missed diagnosis of cancer had become the most common claim, accounting for 30% of all cases [21]. Yet another report found that missed cancer cases accounted for 47% of medical malpractice lawsuits lodged against radiologists between 1985 and 1987 [22]. By the early 1990s, surveys disclosed that missed carcinomas on chest radiographs and mammograms were the most frequent and costly allegations of malpractice filed against radiologists [23, 24].

In the two decades after World War II, the frequency of malpractice lawsuits increased gradually, as did financial recoveries [9]. It was not until the 1970s, however, that the number of medical malpractice lawsuits filed against all physicians, and the insurance premiums charged by malpractice carriers, began to skyrocket [9, 18]. The degree to which the medical malpractice phenomenon spiraled dramatically upward is illustrated by the following statistics: As of 1957, the largest sum awarded in a medical malpractice case by any trial court in the United States was \$230,000. Median damages in malpractice litigation hovered in the \$200,000 range in the early 1980s, rose to \$300,000 in the late 1980s, and exceeded \$400,000 in the 1990s [25]. Insurance payouts for radiology lawsuits in 1983 averaged \$104,000, accounting for 6% of all medical malpractice claims paid [26]. In Illinois, the average payment per paid claim increased from slightly less than \$129,000 in 1980–1984 to almost \$500,000 in 1995–1999 [27]. Texas has experienced a 500% increase in the size of judgments awarded just in the past 10 years. Settlement payments have also steadily risen during the past two decades. The average settlement payment per paid claim increased from approximately \$110,000 in 1987 to \$250,000 in 1999 [27]. As of 2002, the median jury award in malpractice cases exceeded \$1 million, and the average was nearly \$4 million [28].

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The average annual cost of a physician's malpractice insurance in 1957 in metropolitan New York was \$106, in upstate New York \$64, and in California between \$300 and \$400 [5]. In 1975, the cost of all premiums paid for medical malpractice liability insurance in the United States was \$2 billion, and its percentage of the gross national product was 0.02%. By 2001, the total premiums paid for malpractice insurance had jumped to \$21 billion, and its percentage of gross national product had grown to 0.25%. In 2002, obstetricians in Miami paid as much as \$210,000 for liability insurance, and general surgeons were charged as much as \$174,000 [29].

### The Present: Guidelines and Standards

In an attempt to provide consistency, promote better medical practice, and improve medical quality, various medical organizations and specialty societies in the late 1980s began to publish written guidelines and standards [30, 31]. By promulgating the best available scientific evidence on efficacy and safety, these organizations hoped that the guidelines and standards would not only elevate the level of patient care but also diminish the incidence and related costs of malpractice litigation. It appears, however, that the goal specifically pertaining to malpractice litigation did not materialize, for studies have disclosed that published guidelines and standards have been used more often to strengthen the position of plaintiffs than that of defendant physicians [32].

A recent *John Marshall Law Review* article surveyed state, appellate, and Supreme Court decisions to determine how the judiciary has viewed the ACR standards. Most of the decisions available thus far have focused on the standard that deals with communication [33]. Courts have generally given the ACR standards considerable weight and have ruled that although the ACR standards themselves do not establish a standard of care, they are nevertheless useful in assisting the courts in determining the radiologic standard of care applicable in a given situation [34].

Because it was perceived by many in the radiology community that ACR practice policies entitled *Standards* would be confused with the legal standard of care in the minds of jurors, the College Council, at its 2003 annual meeting, voted to change the name of those policies dealing with conduct in specific areas of clinical practice to *Practice Guidelines*. Those ACR standards that consist of specific recom-

mendations for patient management or equipment specifications or settings have been renamed *Technical Standards* [35]. It is intuitive to believe these name changes will lessen the likelihood of jurors' concluding that any deviation from a recommended ACR policy, no matter how minor, is tantamount to a deviation from the legal standard of radiologic care. Whether this intuitive belief will be transformed into reality remains to be determined.

### A Glimpse at 2004 and Beyond

In 2002, physician-lawyer-historian Fillmore Buckner [6] addressed the question of how long the present medical malpractice conundrum in the United States will continue. Here is a portion of his answer:

The only reasonable answer appears to be "for the foreseeable future." The reasons for this answer should be obvious, given the history that has gone before. We are still in an extremely innovative stage of medical research and development, an appreciable amount of which is in the realm of a high-technology, high-risk nature. Such periods of massive innovation are almost always a stimulus for a new wave of malpractice cases... A period of increased depersonalization of medical care with third-party health plans and fourth-party auditors increases career dissatisfaction among physicians and frustration on the part of patients... In the depersonalized atmosphere of the future, there is little hope communication will improve; poor communication with patients will inevitably lead to increased malpractice suits.

When we speak of innovation and new technology, radiology steps to the forefront. The introduction into the medical community of new radiologic technology is inevitably followed, with varying periods of latency, by medical malpractice lawsuits alleging negligence in the use—or nonuse—of such technology. The first medical malpractice lawsuit in the nation alleging negligence in the use of diagnostic sonography was filed in 1982, more than a decade after its introduction [18]. The first medical malpractice lawsuit in Chicago alleging negligence in interpreting CT was filed in 1982, 8 years after its introduction in Chicago. The first malpractice lawsuit alleging misuse of MRI was filed in 1983, 4 years after the modality was introduced. In the past several years, PET scanning, com-

puted-assisted detection, digital radiology, highly sophisticated CT and MR techniques, and PACS (picture archiving and communication systems) have been introduced to and adopted by a rapidly increasing number of members of the radiology community. Although only a few, if any, lawsuits may have been filed thus far in the nation alleging negligence in the use or nonuse of these modalities, assuredly such lawsuits will occur.

Ever since the Institute of Medicine released its report on errors in medicine in 1999 [36], the news media and scientific literature have reported much discussion about the frequency and severity of errors in medical practice. It should therefore not be surprising that a recent survey disclosed that 70% of layperson respondents believe that physicians responsible for errors that result in fatal consequences to patients should be sued and subjected to suspension of their medical licenses [37]. A great many physicians apparently think the same thing, for more than half the physicians polled also believed that a physician who makes a medical mistake that results directly or indirectly in a patient's death should be sued for malpractice.

Malpractice lawsuits that are resolved either by negotiated settlement or by jury award with a multimillion dollar payment to the injured party, a phenomenon that the *Wall Street Journal* has called "jackpot justice" [38], seem to be immediately publicized in newspapers and television news reports, often with great fanfare. Multimillion dollar salaries paid to athletes and entertainers are often prominently publicized. Lottery winnings, sometimes reaching hundreds of millions of dollars, are also well publicized. Is it any wonder, then, that patients who suffer an adverse event while receiving medical care are inclined to file a malpractice lawsuit? Is it any wonder, then, that patients with serious illnesses on whose radiologic studies a radiologist has committed a diagnostic error, or in whom a therapeutic complication results, are inclined to file a malpractice lawsuit? Is it any wonder, then, that even patients so injured who initially may not be inclined to file a medical malpractice lawsuit will nevertheless be encouraged or convinced to do so by friends, relatives, or attorneys soliciting business? The answers to these questions may well be that given recently by a *Chicago Tribune* columnist [39]:

Litigiousness appears to be a disease of near-plague proportions. Can't hack your

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life? Blame someone else, hire a lawyer, and retire early. The cost? Your lawyer's one-third contingency fee and your pride.

The United States is one of the few countries in which a jury determines whether a physician has committed malpractice. In Germany, the United Kingdom, and many other nations, including most provinces in Canada, medical malpractice cases are adjudicated only by judges [40]. Other nations such as Sweden and New Zealand have no-fault systems of evaluating and paying malpractice claims. The American legal system in which civil litigation is tried before juries is not likely to change in the foreseeable future, nor is the manner in which the amount of compensation to be awarded is determined. Notwithstanding repeated attempts to convince the United States Congress to enact tort reform legislation, it has thus far failed to do so.

We have followed a portion of the dictate of Adlai Stevenson quoted at the beginning of this article by tracing the path of malpractice lawsuits that has led us to the present. Unfortunately, we are unable to adhere to the remainder of the quotation, for radiologists—indeed, the entire medical profession—lack the ability to chart their own future clearly and wisely, particularly as it pertains to the malpractice quagmire. The outlook is rather grim in that there is nothing to suggest that either the frequency or severity of medical malpractice lawsuits will abate. In fact, most experts expect that the malpractice crisis will deepen and spread [41]. A recent *Chicago Tribune* editorial appears to sum up the situation in realistic terms [42]:

This is not the first, nor will it be the last, malpractice rate crisis. It should be abundantly clear now that there's no simple, painless solution to this problem. But a solution is needed, one that caps the more outlandish jury awards and reduces the medical errors that produce them.

### Acknowledgment: Lee F. Rogers, MD

This article is appearing in the December 2003 issue of the *American Journal of Roentgenology*, the last issue that will bear on its masthead page the name of Lee F. Rogers, MD, as editor in chief. During his stewardship, Lee has overseen the publication of 102 issues of the *AJR*. I have been granted the privilege and good fortune of having an article published on the subject of malpractice issues in radiology in the past 93 consecutive issues, an

accomplishment that would never have been possible without Lee Rogers. It was Lee who conceived the idea of having a series dealing with radiologic malpractice, and it was Lee who gave me the constant inspiration, encouragement, guidance, and support to keep the series running. For all that Lee Rogers has done for the radiology community at large and for me personally, I publicly express to him my heartfelt and everlasting thanks and gratitude.

We usually call graduations from schools and universities "commencements" and usually think of these milestones as endings of an era or a phase of one's life. In reality, of course, graduations and commencements are not endings, but beginnings—the beginning of a new direction, a new vocation, a new avocation. Lee Rogers is about to celebrate his figurative graduation, or commencement, from being editor in chief of the *AJR*. One era is ending, another is beginning. Wherever this new beginning leads him, whatever endeavor or activity Lee decides to pursue in this new beginning, I wish Lee F. Rogers, his wife Donna, and their family contentment, happiness, and Godspeed.

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