FAILURE OF RADIOLOGIC COMMUNICATION:
AN INCREASING CAUSE OF MALPRACTICE LITIGATION

SCORCH
(Society of Chairs of Radiology at Children’s Hospitals)

Chicago, IL - October 19, 2012
Leonard Berlin, MD, FACR
Department of Radiology
Skokie Hospital, Skokie, IL
Professor of Radiology
Rush University Medical College
and
University of Illinois
Chicago, IL
Disclosure of Commercial Interest

Neither I nor my immediate family members have a financial relationship with a commercial organization that may have a direct or indirect interest in the content.
Root Cause Information for Delay in Treatment Events Reviewed by The Joint Commission

(Resulting in death or permanent loss of function)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2004 through 2011 (N=677)</td>
<td></td>
</tr>
<tr>
<td>The majority of events have multiple root causes</td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>549</td>
</tr>
<tr>
<td>Assessment</td>
<td>537</td>
</tr>
<tr>
<td>Leadership</td>
<td>467</td>
</tr>
<tr>
<td>Human Factors</td>
<td>462</td>
</tr>
<tr>
<td>Information Management</td>
<td>210</td>
</tr>
<tr>
<td>Continuum of Care</td>
<td>188</td>
</tr>
<tr>
<td>Care Planning</td>
<td>126</td>
</tr>
<tr>
<td>Physical Environment</td>
<td>122</td>
</tr>
<tr>
<td>Medication Use</td>
<td>52</td>
</tr>
<tr>
<td>Patient Rights</td>
<td>19</td>
</tr>
</tbody>
</table>
Failure to Communicate

- Resulted in second highest average indemnification
- Causative factor in 80% of malpractice lawsuits

PIAA – ACR, 1997
Survey Of Error Reports Among Family Physicians

- Communication problems in 71%
- Diagnostic testing errors in 47%
- Communication errors are a component of many errors, but may not be the primary focus.

Fernald, Ann Fam. Med 2004;2:327
Delays in Communication of Results

- 83% of physicians reported delay in test results
- Only 41% of physicians satisfied with how test results are managed
- 52% of physicians reported keeping a record of tests ordered
- 32% reported having system to detect whether patient had missed test

Poon et al, Arch Intern Med 2004;164:2223
Communication of Abnormal Test Findings by Physicians

- 75% of physicians did not routinely notify patients of normal test results.
- 33% of physicians did not always notify patients about abnormal test results.
- Less than 25% had reliable method of identifying patients who were overdue for follow-up.

Gandhi, Ann Int Med 2005;142:352
Physicians Ignore Abnormal Radiological Results

- 1,017 outpatient reports of abnormal imaging results were transmitted by computer to referring physicians.
- Physicians failed to acknowledge receipt in 368 (36%) cases.
- In 45 (4%) cases, imaging study was completely lost to follow up. 65% were reported as possible CA.

Singh (Baylor, Houston) J. Am Med Inform Assoc. 2007;14:459
Frequency of Failure to Inform Patients of Clinically Significant OP Test Results

- Survey of 5,500 pt records from 19 community-based, and 4 academic medical centers
- Average failure rate was 7% of doctor to patient communication of abnormal test results, but as high as 26% among medical practices

Casalino, Arch Intern Med 2009;169:1123
Abnormal Test Results May Not Get to Patients

By NICHOLAS BAKALAR

If you think your doctor will automatically tell you if you have an abnormal test result, think again. Researchers studying office procedures among primary care physicians found evidence that more than 7 percent of clinically significant findings were never reported to the patient.

down from one person to another to another before the doctor actually sees it.”

Unsurprisingly, practices that used electronic medical records had lower failure rates than those that used only paper documents. But offices that used a combination of paper and computer records had the worst results of all.
These communication problems involve clinical physicians. They have nothing to do with radiologists, right?
Wrong!
Prevalence of Communication Malpractice Lawsuits in Radiology

- Between 1999 and 2003, number of radiology lawsuits related to communication failures averaged 9 per year.
- 25% of all ACR members responding to a survey acknowledged being involved in at least one malpractice claim involving failure to communicate.
- Payment to plaintiff’s in communication cases averaged $1.9 M per case.

Kushner, JACR 2005;2:15
Failure to Communicate Liver Abnormality on CT

- 59 y.o. man admitted to ED for chest/abdominal pain, undergoes CT
- Radiologist notes liver findings suspicious for CA, fails to notify ED MD
- Dx delayed for 34 mo.
- Lawsuit settled for $2.5 million

Anonymous v Northwestern Mem Hosp. Chgo, IL June 2010
Failure to Communicate CT Finding of Pancreatic CA

- 44 y.o. male had CT that showed suspicious lesion in pancreatic tail
- Written report issued, but patient never told of report by MD
- CA pancreas diagnosed 2 yrs. later
- Patient died 3 yrs. after
- Jury verdict: $4,776,000
$20.5 Million Awarded in Lawsuit Over Husband’s Lung CA Death

- Patient underwent chest film for chest pain at urgent care center in Las Vegas.
- Patient told film was normal.
- Radiologist later reported density in lung but patient not notified.
- 2 years later, carcinoma diagnosed. Pt later died.

Las Vegas Review-Journal, 7-12-07
Failure to Communicate

- 9 y.o. boy enters hosp. ED with cough, chest pain, fever
- EDMD orders and reads chest x-ray as pneumonia. Discusses with Ped. Prescribes Azithromycin and admits to hospital
- Next AM, rad reads film as showing cavities, suggests TB or fungus, but does NOT call ED or Ped about discrepancy
- Ped does not call consultation with Pulmonologist or ID MD, discharges pt in 2 days
- Six days later, pt returns in septic state; x-ray shows bilateral disease; diagnosed with blastomycosis.

Hogans v Scaletta, Cook Cnty 04-L-13574, Med Malp Verdicts 9/09
Failure to Communicate II

- Treated with amphotericin, but child dies of necrotizing blastomycosis pneumonia
- Lawsuit filed against hosp., Ped, ED MD, and rad
- Hosp and Ped settle for $1,390,000 before trial begins
- Trial continues against ED MD and rad
- Jury find ED MD not liable, rad found liable for full verdict of $4,016,929

Hogans v Scaletta, Cook Cnty 04-L-13574, Med Malp Verdicts 9/09
Failure to Communicate Abnormal CT Findings I

- 2 y.o. boy fell at home, hitting head, taken to ED
- CT obtained, reported as “normal except for focal densities in 4th ventricle and posterior skull base, suggest follow-up studies
- Neither referring physician nor parents ever received report

Brauns v Group Health Cooperative, King Cnty, WA, 2011, Case #09-2-21539-1SEA
Failure to Communicate Abnormal CT Findings II

- 14 mo. later, child returns to same ED with headaches and vomiting
- CT discloses large ependymoma
- Child eventually dies
- Lawsuit settled for $5 million

Brauns v Group Health Cooperative, King Cnty, WA, 2011,
Case #09-2-21539-1SEA
Failure to Communicate and Contact Radiologist: $12.2 Million Verdict

- 2 mo baby girl brought to ED with apparent abd pain/tenderness
- Abd. X-ray read by ped res. as free air, fails to call ped
- Ped eventually paged, comes to hosp 2 hrs later, reads X-ray as negative
- 5 hrs later, new x-ray taken read by ped rad as necrotizing enterocolitis with free air
- Pt suffered anoxic brain injury, serious perm disabilities
- Malp lawsuit filed, jury renders verdict of $12.2 Million

The Radiologic Information Chain

Generation of Image
Perception of Image
Interpretation of Perception
Communication of Interpretation
  ➢ Medical Record
  ➢ Referring Physician
  ➢ Patient
“No calls for an hour, Edna. I’m going to rest on my laurels.”
Communication

Radiologist ➔ Referring Physician
In nearly 60% of malpractice lawsuits involving radiologists, the referring physician had never been directly contacted with urgent or significant or significant unexpected findings.

PIAA – ACR Claims Survey, 1997
Communication of the Urgent Finding
• 38 y.o. female with regional ileitis, required hyperalimentation
• Surgeon inserts feeding catheter into superior vena cava
• Radiologist notes eccentric position of catheter tip on post-op chest film
• Tries to call surgeon, unable to reach him.
• Rad calls floor nurse, is told alimentation is occurring without problem
• Rad goes home
• Pt later has cardiac arrest, dies
• Autopsy shows perforation S.V.C. with large pericardial effusion
• Lawsuit filed
Lawsuit settled against radiologist for undisclosed amount of money.

Radiologist felt it was important enough to initiate communication with attending physician, but failed to follow through.
Communication of the Significant But Not Urgent Finding
41-year old man admitted to hospital for minor urological procedure. Routine chest radiograph read as “possible tumor in right lung, suspicious for cancer.” Wrong physician’s name and address was placed on radiologic report which was sent to incorrectly listed doctor, who ignored report. Urologist who ordered chest film never received copy.

21 months later, patient developed weight loss and cough. Biopsy following new chest film showed carcinoma. Patient died 8 months later.

Malpractice lawsuit filed against hospital, urologist and radiologist.
Testimony of Defendants

- Radiologist blamed hospital for wrong physician’s name, urologist for not seeking out report, and physician who received report for not returning it.
- Urologist made no effort to see report because it was routine and he assumed radiologist would call him if it were abnormal.
- Hospital said it was the radiologist who possessed responsibility for administration of radiology dept.
- Case settled for $3.25 million, shared equally by 3 defendants.
Woman admitted for reduction of fracture had routine chest film showing probable carcinoma. Neither physician nor patient informed until 4 months later. Radiologist denied liability beyond dictating report. Court disagreed.

“Communication of unusual finding in an X-ray…is as important as the finding itself. In certain situations direct contact with the treating physician is necessary beyond communication through administrative personnel.”

Jenoff v Gleason, NJ 1987
Malpractice Issues: Communication

“Radiologists who provide indirect medical care cannot escape liability by doing no more than relaying information through ordinary hospital channels. All physicians involved share in the same duties and responsibilities of the primary care physician.”

Phillips v Good Sam Hosp, Ohio 1971
Malpractice Issues: Communication Of Urgent Findings

“When a patient is in peril of his life, it does him little good if the radiologist has discovered his condition, unless that radiologist informs the patient, or those responsible for his care, of that fact.”

Courteau v Dodd, Ark 1989
"The standard of care requires the rad to protect the pt against that occasional negligence which is one of the ordinary incidents of human life, and therefore to be anticipated. The rad has an obligation to protect the patient from being misdiagnosed by relating the urgency of his findings to the ref MD. The rad is not free to rely upon others to avert the danger which he created by shifting blames.

Duckworth v Lutheran Med CTR, 1995 WL 33070, OH App
As part of the duty the physician must reveal to the patient that which in his best interest he should know. The radiologist, although he correctly diagnosed the injury, must share liability if he has failed in adequately communicating the diagnosis to the attending physician.

Duckworth v Lutheran Med CTR, 1995 WL 33070, OH App
Medical Guidelines and Standards

• Developed by specialty societies beginning in 1980s
• Used more often to strengthen position of plaintiffs than that of defendant-physicians

ACR Standards

We do not hold that the *Standards* in and of themselves establish a standard of care, but published standards or guidelines of specialty medical organizations are useful in determining the duty owed or the standard of care applicable to a given situation.

*Stanley v McCarver, AZ App 2003*
Changes in ACR Communication Practice Guideline (Updated 10-1-10):

In non-routine clinical situations, the delivery of a diagnostic imaging report should be expedited in a manner that reasonably ensures timely receipt of the findings.
ACR Practice Guideline for Communication (Updated 10-1-10)
Examples Requiring Non-routine Communication

- Need for immediate or urgent intervention
- Findings that are discrepant from preceding interpretation
- Findings that may seriously be adverse to patient’s health and radiologist reasonably believes are unexpected by physician
Timeliness of reporting varies with the nature and urgency of clinical problem.

Referring physicians also share in responsibility of obtaining results of studies they have ordered.
As soon as possible a change between the preliminary and final interpretation should be reported in a manner that reliably ensures receipt by the referring or treating physicians when such changes may impact patient care. Documentation of communication of any discrepancy should be incorporated into the final report.
ACR Practice Guideline on Communication

“While other methods of communication may be considered, including text pager, facsimile, voice messaging, and other non-traditional approaches, these methods do not ensure receipt of the communication. Therefore, the radiologist may consider initiating a system that requests confirmation of receipt of the report.”
A note made on report vs log contemporaneous with the event carries great weight legally.
Two Most Common Settings for Failed Communication:

1. Outpatient interpretation of non-emergent findings: Incidentaloma
2. Emergency department exams during or after usual working hours
Is fax sufficient?
Is e-mail sufficient?
Is PACS sufficient?

Maybe “Yes”
Maybe “No”

(Depends on “reasonable assurance of receipt”)
High Error Rate With Speech Recognition I

- Survey of complex imaging reports involving digital mammography, ultrasound, and MRI
- Half were generated by voice recognition (Speech Magic, Nuance), half prepared using conventional transcription
- 52% of speech recognition reports contained at least one error, compared with 22% of conventional transcription reports
- Common mistakes included word omissions, word substitution, added words, poor punctuation

Basma, Toronto, AJR 10/11
High Error Rate With Speech Recognition II

- At least one major error, defined as mistake that affects understanding of the report, was found in 23% of automated reports, and 4% of conventional reports.
- Errors were independent of native language of radiologist.
- Errors more frequent when radiologist edit reports immediately after dictation, because they are acting on memory rather than on objective reading.
- Errors can be reduced by letting reports sit for few hrs before editing.

Basma, Toronto, AJR 10/11
Curbside Consultations

A physician, who is paged away from another activity is in a noisy, crowded hallway enroute elsewhere, or is button-holed outside the radiology department or hospital, for example, “on the curb,” may be distracted from offering the kind of thoughtful opinion that may come from a formal consultation or a thorough discussion.

Golub, JAMA, 1998;280:929
First old gentleman: Is this Wembly?

Second old gentleman: No, Thursday.

First old gentleman: You are? Let’s go and have a drink.
Radiology Miscommunication in Newborn Resuscitation

• Newborn required immediate resuscitation
• Endotracheal (ET) tube inserted, along with EG tube
• Chest film requested
• Radiologist reports ET tube in esophagus, later goes to nursery
• ET tube remains in esophagus
• Baby suffers permanent damage
• Who said what?
Curb That
“Curbstone” Consultation!
Or,
At least Document It!
Curbing Curbstone Consultations

• All outside rad studies are placed in PACS and reinterpreted
• In 2008, 7.6% of 7000 exams differed from outside interpretation; 83% of these were originally inaccurate
• More than 70% of reinterpretations are reimbursed
• Department now averages 2000 outside exams monthly

Yousem, Johns Hopkins, JACR 2010, 480
Question Re: Outside Film Interpretations

Request clinician to ask specific question; then report only answer to question; 
Add: “Please refer to outside report for further detail.”

OK?
Answer: Probably Not

Duty of the Radiologist When Interpreting Imaging Exam

Look at “all four corners of the film” and everything within them. Then, report everything of significance you see.
Directing clinician to accept as accurate an outside interpretation is tantamount to saying, “I have proofread the outside report and I attest to its accuracy.” Any error made by the outside reader is now your error.
Communication

Referring physician → Radiologist
A request for imaging should include relevant clinical information, a working diagnosis, and/or pertinent clinical signs and symptoms.

Such information helps tailor the most appropriate imaging study, and promotes optimal patient care.
Clinical Information and Accuracy of Diagnostic Tests

- Clinical information improves test reading accuracy
- But clinical information may bias perception, and incorrect data may decrease interpretation of tests

Loy, JAMA 2004;292:1602
Communication

Radiologist → Patient
Patients Want to Know, But Are Not Offered All Options

- Survey of 1168 adults
- 90% want MD to offer options for tests and Rx, not just options for their MD wants
- 67% want to know all risks, but are comfortable having their MD make best decision for them
- Admit large gap exists between want they want and what they receive

Novelli et al. (Georgetown U, DC) JAMA online 9/26/12
Should radiologists communicate results of exams directly to patients?
Individual’s Right to Know

“Any human being of adult years and sound mind has a right to determine what shall be done with his own body.”

Cardozo, Schloendorff 105 NE92 NY 1914
The Radiologist’s Duty to Communicate I

- 20 y.o. man undergoes P.E. for induction into military
- Radiologist contracted by Selective Service reads chest x-ray as suggesting lymphoma
- Recruit is rejected without explanation; never informed of x-ray finding
- 6 mo later, patient diagnosed with Hodgkin’s Disease, later dies
- Family sues government, claiming radiologist had duty to inform recruit of x-ray findings
- Fed Appeals Court rules radiologist is liable

Betesh v USA, 400 F Supp 238, (DC 1974)
A physician undertaking a physical exam has a duty to disclose what he had found and to warn examinee of any finding that would indicate the patient is in any danger. The radiologist owed a duty of care to the patient and breached that duty when he failed to notify patient of his abnormal x-ray, causing patient’s death.

Betesh v USA, 400 F Supp 238, (DC 1974)
Radiologist Has Duty to Communicate I

- Radiologist hired by VA hospital to interpret x-rays
- Radiologist interprets chest-film as sarcoidosis.
- Pt never informed of dx; later dies of sarcoidosis.
- Family sues radiologist for failing to give diagnosis to patient.
- At trial, jury rules for patient. Rad appeals but loses.

Daly vs USA 946 F2d, 1467 (9th Cir 1991)
Radiologist Has Duty to Communicate II

In setting of pre-employment exam, the radiologist should notify plaintiff of any abnormality. This duty is hardly burdensome and recognizes that those who place themselves in the hands of a person who is skilled in the medical profession have a reasonable expectation that the expert will warn of any dangers of which he is cognizant. By failing to inform patient of the abnormality, the radiologist prevented the pt from halting the progress of the disease at an early stage.

Daly vs USA 946 F2d, 1467 (9th Cir 1991)
Duty to Inform Patient of Radiographic Results I

- Woman undergoes chest films as part of pre-employment PE in nursing home
- Rad contracted to read films and report to nursing home finds possible lesion and suggests CT
- Nursing home fails to inform patient of result

Stanley v McGarver, AZ App 2003
Duty to Inform Patient of Radiographic Results II

- Dx of lung cancer delayed 2 yrs
- Patient sues nursing home and radiologist, but nursing home now bankrupt
- Radiologist sole defendant, charged with failing to give report directly to patient.

Stanley v McGarver, AZ App 2003
Duty to Inform Patient of Radiographic Results III

“The issue presented is whether a radiologist, to whom a person is referred, who detects a medical condition for which further inquiry or treatment is appropriate, has a duty to inform that person. We conclude that the radiologist does have such a duty.

Stanley v McCarver 63P3d 1076, AZ App 2003
Duty to Inform Patient of Radiographic Results IV

The patient’s primary physician should obtain, and then advise patient, of results. If there is no referring physician or physician is unavailable, the duty shifts to the radiologist. The radiologist bears the duty of direct communication with the patient.

Stanley v McCarver, AZ App 2003
Duty to Inform Patient of Radiographic Results V

• A doctor who undertakes to read x-rays, on which he observes serious abnormalities, must act reasonably in reading the x-rays and reporting the results.

• (What constitutes reasonable reporting) must be determined by a jury

Stanley v. McCarver, 92 P3d 849, AZ Sup Ct, 2004
The Radiologist’s Duty to Communicate I

- Woman undergoes Doppler ultrasound because of pain and discomfort in calf.
- Radiologist finds deep vein thrombosis in right lower leg, attempts to telephone referring physician to give verbal report
- Radiologist reaches automatic telephone answering system, unable to speak with ref doctor

Williams v Le, 662 SE2d 73 (VA Supr Ct, 2008)
The Radiologist’s Duty to Communicate II

• On following morning, pt telephones referring physician’s office and was told by PA that report had not been received
• PA telephones imaging center to request FAX of report
• PA schedules pt for appointment in 3 days
• PA receives report, places it in office computer
• Referring physician never reads report.

Williams v Le, 662 SE2d 73 (VA Supr Ct, 2008)
The Radiologist’s Duty to Communicate III

- Two days later, patient dies of PE
- Referring MD states in deposition that he expects radiologist to contact him directly if findings are abnormal.
- Says if he had received report from radiologist, he would have started pt on anticoagulant Rx “immediately”
- Lawsuit against ref MD settled, but suit against radiologist proceeds to trial.

Williams v Le, 662 SE2d 73 (VA Supr Ct, 2008)
The Radiologist’s Duty to Communicate IV

The Court said:

Communication problems in this case were begun and put in motion by radiologist’s failure to make direct contact with MD or the patient. An intervening cause does not exempt radiologist from liability if that cause is put into operation by the radiologist’s wrongful act or omission. The radiologist’s alleged negligence contributed to the death of the patient.

Williams v Le, 662 SE2d 73 (VA Supr Ct, 2008)
“Swiss Cheese” Model of Accident Causation:

Diagnostic errors that harm patients result from the alignment of multiple breakdowns, which stem from a confluence of contributing factors.

Gandhi, Ann Int Med 2006;145:488
There are theoretical safeguards and individuals that should fall in place to prevent errors; but sometimes they all fail.
Swiss Cheese Holes Line Up
Testimony of Radiology Expert Witness

Q: As a radiologist, when you dictate a radiology report and a copy of it is sent over to the ED, you certainly expect somebody to read it over there, don’t you?

A: (Exp Witness) Yes, but I don’t count on it.

Q: That’s why you make the call, correct? It’s a backup. Too many times you have seen where physicians don’t read these reports, correct?

A: That’s correct.
The Patient Test Result Information Act

The General Assembly of Pennsylvania

House Bill 1358, Session of 2008

Introduced by Maguerite C. Quinn, District 143 PA

The House of Representatives
The Patient Test Result Information Act

An entity performing Diagnostic Imaging Services with the exception of routine obstetrical ultrasounds used to monitor the development of a fetus in which no adverse medical condition is diagnosed shall send directly to the patient a written copy of the summary of the test results of diagnostic imaging services performed on the patient within 10 days of sending the test results to the patient's prescribing physician. The written copy of the summary of the test results may be sent directly to the patient electronically by e-mail or facsimile.
ACR Practice Guideline for Communication (Updated 10-1-10)

Regardless of the source of the referral, the diagnostic imager has an ethical responsibility to ensure communication of unexpected or serious findings to the patient. Therefore, in certain situations the radiologist may feel it is appropriate to communicate the findings directly to the patient.
Patients were asked if they wanted radiologists to tell them results that were normal or abnormal, or if they preferred to hear results from their own MD.

- 92% of the patients wanted radiologists to tell them if results were normal.
- 87% wanted radiologists to tell them if results were abnormal.

Schreiber, 1995; AJR 165:467
Patient’s Desire for Rapid Communication of CT Results

- Survey of 557 pts undergoing CT and MRI exams
- 31% preferred to receive normal results by fastest method, whereas 35% preferred to receive abnormal results by telephone
- No preference regarding which physician communicated results; they cared only about speed of delivery

Basu, AJR 2011; 196:605
Waiting for doctors to read your X-rays must be like waiting for the jury foreman in a capital punishment trial to read your verdict. All it takes is a little spot on the X-ray to indicate that you have cancer.

Sick, Scared, and Waiting

- Woman with history of breast cancer underwent CT to evaluate lung lesion.
- Waited by phone for 2 days with “racing pulse, dry mouth, total preoccupation with what-ifs to the point that real life doesn’t exist, willing the phone to ring.” Didn’t let anyone else use phone.
- Doctor never called. “I never spoke to him again.”

Kolata, NYT 8-20-05
tunnel syndrome and BlackBerry thumb, that arise because we’re experiencing something entirely new to human beings. For millennia, doctors and patients would have given almost anything to be able to look inside the human body. Now we have an ailment for the fear of what we might find when we do.

The name scanxiety hints at the larger ambiguity we feel toward these medical miracles. On the one hand, as someone who was once months away from being overcome by cancer, I know that scans saved my life. Yet they could be killing me too. One aspect of scans that’s rarely discussed is the damage the radiation leaves behind. I broke my left femur in a bicycle accident when I was 5—the same spot where my cancer appeared 38 years later. When I asked my oncologist what I might have done differently had I known such an outcome was possible, he said, “Nothing. If you’d gotten regular scans, the scans might have given you cancer.” What about all the radiation I’m currently receiving? “I’m trying to protect you from the cancer you have now,” he said, “not one you might have in the future.”

The medical profession is aware that patients suffer stress as our scans approach. Dr. Jimmie Holland, a psychiatrist at Memorial Sloan-Kettering Cancer Center, refers to the condition as PSP, or prescan psychosis. “Everybody feels it to one extent or another,” she tells me, “particularly people who feel they have to know what’s coming next. And if there’s anything true about cancer, it’s the unpredictability about what’s coming next.”
Road To The Courtroom

- Expectation
  - Disappointment
    - Anger
      - Litigation
Should Radiologist Communicate Findings To Patient?

MQSA
Mammogram reporting may bypass physicians

AT A GLANCE

REPORTING | A proposed congressional mandate that requires testing facilities to notify patients of the results of their mammograms could disrupt the physician-patient relationship.

Stephanie Stapleton
AMNEWS STAFF

Washington Women may soon be notified directly of their mammogram screening results instead of relying on their physicians for the good or bad news, if a proposal moving through Congress becomes law.

This “direct notification” requirement, which would mandate that all testing facilities provide patients with easy-to-understand, written notification of the results of their mammograms, was included in legislation passed by the House last month to renew the Mammography Quality Standards Act. Originally enacted in 1992, the MQSA has been heralded as a success in establishing national minimum standards by which all mammography facilities are inspected and accredited by the Food and Drug Ad-
“We believe women are entitled to know the results of their exams and that it is the facilities’ responsibility to inform them. It is unfortunate, but we believe necessary to require such communications. Women simply cannot rely on referring physicians to notify them,” said the President of the National Breast Cancer Coalition.

A.M. News 10-5-99
U.S. Plan Would Boost Access to Lab Results

BY LAURA LANDRO

A new federal proposal to give patients direct access to lab results without waiting to hear them from a doctor could make it easier for patients to track important health markers like cholesterol and the body’s response to blood thinners.

The rules proposed by the Department of Health and Human Services are part of a broader effort to give patients greater access to medical data electronically so they can become more engaged in their care. They would replace a con-

HHS says labs would see higher costs, but they would be able to impose a “reasonable cost-based fee” for providing access to results. Quest says it may consider a fee in the future.

While some physician groups are concerned patients might misunderstand results before discussing them with a doctor, HHS Secretary Kathleen Sebelius said in announcing the rules last week that patients who have their lab results are “more likely to ask the right questions, make better decisions and receive better care.”
HHS Proposes Rule to Give Patient Direct Access to Lab Results

- Current law permits release only if authorized by health-care provider, (except) DE, MD, NV, NH, NJ, OR, WV, PR, OR, DC
- Sibelius: “Patients will ask more questions, make better decisions, and receive better care.”

Landrow, WSJ, 9/20/11
Should Patients Get Direct Access to Their Laboratory Test Results?
An Answer With Many Questions

Traber Davis Giardina, MA, MSW
Hardeep Singh, MD, MPH

In the outpatient setting, between 8% and 26% of abnormal test results, including those suspicious for malignancy, are not followed up in a timely manner. \(^1\)\(^2\) Despite the use of electronic health records (EHRs) to facilitate communication of test results, follow-up remains a significant safety challenge. In an effort to mitigate delays, some systems have adopted a time-delayed direct notification of test results to patients (ie, releasing them after 3 to 7 days to allow physicians to review them). \(^3\)\(^4\)

Patient Perspectives

Patients have expressed interest in being involved in medical decision making and desire access to their health information. \(^6\) Patients want to be notified of their test results, including normal and abnormal results, \(^6\)\(^7\) in less time than current norms. Although prompt direct notification of test results might help patients make decisions about their care, adequate data to support this idea are lacking. To our knowledge, only one US study has evaluated the effectiveness of direct notification (mailing of bone density test results in this case), but the study included a follow-up telephone call by a nurse educator. Patients who received this intervention were more likely...
Proposal on Access to Lab Tests Not Advisable

• Could lead patient to confusion
• Could undermine relationship between patient and physician
• “People will misinterpret insignificant values, creating apprehension”
• “Result might be truly abnormal; this is not the way to get bad news”

AMA, A C Phys Acad Peds (AMA News 12-12-11)
Attitudes of Patients and Physicians Regarding Directly Communicating Abnormal Radiology Results to Patients

- Regarding direct pt on-line access to results, both rads and RPs were concerned pts would not understand rpts and thus lead to greater anxiety and demands on RPs’ and Rads’ time.
- Rads concerned they do not have knowledge to discuss findings with pts.

Johnson, JACR 2010;7:281
Informed Consent

- What radiologist will do
- Why radiologist will do it
- Risks
- Benefits
- Options – Alternative
- Risks of not doing it
- Patient’s decision to grant it
- Patient’s decision to withdraw it
Informed Consent: Disclose Rare Complication?

• Postoperative visual loss (POVL) is a devastating and life-altering morbidity, occurring in .2% during spinal fusion surgery, 4X more likely than in abdominal surgery, and patients undergoing prone surgery are more than 2X likely.

• Surgeons are reluctant to discuss because of rarity and severity.

• Survey shows 80% of pts want full disclosure from surgeon, before they have surgery.

Statue of Limitations: Discovery of Potential Negligence I

• Legislation that specifies period of time to which a medical lawsuit may be filed after alleged act of negligence
• Most commonly, two years in adults, age of majority in children
• Mrs. Arroyo became pregnant and received prenatal care from health clinic in Chgo Clinic that received federal funds for underinsured and low income individuals
• Delivered baby boy on 5-17-03 at Chicago’s NW Mem Hosp.

Arroyo vs. USA, US Ct Appeals, No. 10-2311, 9-1-11
Statue of Limitations: Discovery of Potential Negligence II

- Baby was 1 mo premature, and thus mother was never tested for Group B Strep (GBS), usually tested during last mo of pregnancy
- GBS in mother is innocuous, but GBS infection in newborn must be treated immediately so as to prevent brain injury
- Baby developed GBS infection that was not recognized by either OB or Ped
- Antibiotic Rx was delayed

Arroyo vs. USA, US Ct Appeals, No. 10-2311, 9-1-11
**Statue of Limitations: Discovery of Potential Negligence III**

- Resulted in severe permanent brain injury to baby, with CP, spastic quadriplegia, seizure disorder, inability to swallow, communication deficit, and incontinence.
- Doctors told mother baby suffered injury caused by “exposure to mother’s blood during birth;” **NOT** told that injury could have been prevented if infection had been recognized and treated earlier.
- Baby discharged 7/11/03

Arroyo vs. USA, US Ct Appeals, No. 10-2311, 9-1-11
Statue of Limitations: Discovery of Potential Negligence IV

- In 7-04, mother delivered second son, and told that she was given antibiotics prior to delivery
- In 10-04, parents saw TV ad where lawyers discussed antibiotic administration prior to delivery to avoid infection of baby with brain injury
- In 12-05, patients filed med-mal lawsuit against OB and Ped and NW Hosp.
- Because doctors had worked in federally funded clinic, the primary defendant was US Government

Arroyo vs. USA, US Ct Appeals, No. 10-2311, 9-1-11
Statue of Limitations: Discovery of Potential Negligence V

- In 1-10, Federal judge in bench trial, found defendants liable for failing to recognize GBS infection in baby and awarded $29 Million
- US Appeal, claiming that lawsuit was not valid because it was filed after 2-year SOL
- US claimed SOL began running at time of delivery in 7-03
- Court of Appeals, 7th Circuit, upheld verdict

Arroyo vs. USA, US Ct Appeals, No. 10-2311, 9-1-11
Statue of Limitations:
Discovery of Potential Negligence VI

• “SOL starts on date when a reasonably diligent person acquires info that would prompt him to make a deeper inquiry into a potential cause of his injury. He need not be certain of negligence, but mere knowledge of potential existence of negligence is sufficient to start clock ticking.”

Arroyo vs. USA, US Ct Appeals, No. 10-2311, 9-1-11
SOL: Justice Richard Posner

“Reasonable man” is defined as a man of ordinary intelligence and prudence. But “ordinary” is the required level of care that has to be within the person’s ability to attain. Arroyos did not have the level of medical knowledge of an average person in American society. Had Arroyos been doctors, they would have suspected baby’s infection could have been preventable with antibiotics. Persons of limited education living at or near poverty line are probably deferential to medical staff. Told only that child’s injuries were result of mother’s infection, they had no reason to suspect cause could have been related to failure to treat with antibiotics.

Arroyo vs. USA, US Ct Appeals, No. 10-2311, 9-1-11
Had Arroyos been informed it was “highly possible” that child’s injury was caused by lack of antibiotics, SOL would have started then.

If Drs want to avoid stale med-mal suits, it must level with patients concerning possible causes of a medical injury. Drs said nothing to Arroyos about possibility that a medical act of omission contributed to infection.

Arroyo vs. USA, US Ct Appeals, No. 10-2311, 9-1-11
Doctors did not have to confess liability; all they had to do was to give Arroyos a reasonably full account of circumstances of child’s injuries, that antibiotics could have been administered to mother before birth and to child after birth, and that had this been done, injuries might have been averted, or less serious.

Doctors have ethical responsibility to disclose unanticipated negative outcomes. If a patient dies due to a doctor’s failure to dx a curable condition such as appendicitis, it is a deceptive half-truth to tell the grieving parents that the patient died of appendicitis; death was jointly caused by appendicitis and medical negligence. Disclosure of possible medical errors in simple, intelligible terms would give medically unsophisticated patients enough info to recognize that medical decisions might have contributed to their injuries.

Arroyo vs. USA, US Ct Appeals, No. 10-2311, 9-1-11
I do not say that a breach of the ethical duty of disclosure is itself malpractice, or that disclosure must go beyond an acknowledgement of possibility of medical error; there need not be a confession of medical error. The concealment of the fact that the doctors had contributed to child’s injuries prevented the Arroyos from discovering the doctors’ potential negligence. SOL does not begin to run until discovery is or should have been made by a reasonable person of the plaintiffs’ education and socioeconomic background.

Arroyo vs. USA, US Ct Appeals, No. 10-2311, 9-1-11
• A 1988 Canadian survey of referring physicians revealed that of all the elements characterizing radiology report, clarity was the most valued.

• Similar findings were reported in an American Study.

Lafortune, Can Assoc Radiol J 1988;39:140
McLoughlin, AJR 1995;165:803
Soporific: Radiology reports that lull the referring physicians into inaction and lethargy.

Goldsmith, JNM 1996;37:3A
Perception of Radiology Reports by Ref. MDs and Radiologists

- 37% of MDs feel their interpretation is better than radiologists’ (Rads: 10%)
- 15% of MDs do not read rads’ reports
- 50% of MDs believe rad did not look at organ or structure if not mentioned
- 18% MDs and 68% rads say reports are proofread

Bosmans et al (Belgium), RAD 2011;259:184
ACR Practice Guideline for Communication of Diagnostic Imaging Findings (Updated 2010)

The final report should include an Impression that includes a precise diagnosis, a differential diagnosis, and follow-up or additional diagnostic studies to clarify or confirm the impression.
Improving Reports

- What do I see
- What do I think it means
- What do I want physician to conclude
- What do I want physician to do
Referring physicians value the radiologist as a lesion detector more than a lesion interpreter. They want radiologists to tell them what they see and trust in their own abilities to determine what it means.

Referring physicians actively dislike radiologists’ recommendations because they feel that radiologists recommend too many additional studies that are not really indicated, yet must be performed for medical legal reasons, once mentioned in the radiology report.

Gunderman, Ped Rad 2000;30:307
Survey: I don’t need radiologist to interpret my X-rays.

Court: I relied on radiologist
“If radiologist had told me the lesion was suspicious for carcinoma, I would have followed up immediately.”
The Radiology Report

“Interpret” is defined in the dictionary as “to set forth the meaning of something not plain or clear; to clarify the meaning of; elucidate; to expound the significance of or bring out the meaning in a revealing manner.”

The radiology report must be understandable not only to the radiologist and the referring physician, but also to other physicians, patients and their families, attorneys, judges, and jurors, any or all whom may have occasion to review that report in the future.
R. J. HARWELL

Born 1914
Gave up smoking 1959
Gave up booze 1973
Gave up red meat 1983
Died anyway 1991

[Signature]
THE END.COM