Liability Exposure in Radiology
Purpose

Review specialty specific claims trends from a patient safety and malpractice perspective.
Areas of Liability Exposure


- Documentation: 21%
- Communication: 17%
- Systems: 6%
Documentation Issues

Breakdown of Radiology Documentation Issues

- Inadequate documentation: 75%
- Apparent alterations: 15%
- Erroneous documentation: 10%
Documentation Issues

- Documentation must be specific
- “Report was telephoned to Emergency Department” is not sufficient
- ACR Practice Guidelines:
  - All non-routine communication should be documented
  - Include specifically the name of the person to whom communication was delivered
- Documentation is best placed in radiology report or patient’s medical record
- Documentation preserves a history for substantiating findings or events
Documentation Issues: Examples

- **Case Example 1:**
  - Radiologist used "Impression" section to definitively diagnose hemangioma
  - No suggestion for further follow-up or alternative diagnoses

- **Case Example 2:**
  - Radiologist did not note finding of retained lap pad
  - Assumed to be incidental finding in the abdomen

- **Case Example 3:**
  - Consent form for EBRT and an implant had no details of risk discussed with patient who suffered radiation burns
Documentation Issues
Erroneous Documentation and Apparent Alterations

Erroneous Documentation

- Proofread Reports
- Minimize typos, deleted words, and confusing statements
- Inaccuracies can look sloppy

Communicate indifference and lack of care or concern
Highlight or bold directional terms
Provide clarity and focus for ordering providers
Documentation Issues
Erroneous Documentation and Apparent Alterations

Alterations

Do not alter after medical condition declines
Causes jury to question integrity and objective nature of record
Dictation after patient deterioration appears self-serving
May place your professional liability coverage for the incident at risk
Lost requisitions represent another documentation issue
Appears as deliberate attempt to hide evidence of an error
Communication Issues

Breakdown of Radiology Communication Issues

- Physician to Staff: 19%
- Inadequate Consent: 19%
- Physician to Physician: 62%
Communication Issues

Breakdown in Communication Between Physicians:

◆ Case Example:
  – Initially normal pelvic ultrasound amended three hours later to include large staghorn calculus
  – No phone call made to treating physician
  – Patient required nephrectomy

◆ Case Example:
  – CT Scan ordered on patient to rule out pulmonary embolus
  – Patient discharged after negative report for pulmonary embolus
  – Remainder of report significant with incidental finding of 7-10 millimeter nodule in right upper lobe
  – Radiologist did not call finding to hospitalist; PCP also never saw report
  – Patient diagnosed with metastatic stage 4 squamous cell carcinoma and a lawsuit was filed
Communication Issues

Physician to Physician Breakdowns:

- ACR Guidelines – 3 Situations Where Direct Communication May Be Necessary:
  1. Findings suggest a need for immediate or urgent intervention
  2. Findings are discrepant with previous interpretation of the same exam and failure to act may adversely affect patient health
  3. Findings that the interpreting physician reasonably believes may be seriously adverse to the patient’s health and may not require immediate attention but, if not acted on, may worsen over time and possibly result in an adverse patient outcome

- Increasing onus placed on radiologists to ensure reports are properly communicated
- Develop a process for handling direct communication situations
Communication Issues: Inadequate Consent

The Consent Process:

- Legal and ethical obligation
- Helps to establish patient rapport and compliance
- Discuss risks and alternatives and document the discussion in report
- Create procedure specific consent form for practice
- Radiologist performing procedure ONLY one who can legally obtain consent from patient for that procedure
- Ensure patient is no longer under effects of sedation before obtaining consent
Communication Issues

Physician to Staff Breakdown:

- Primarily between Radiologist and technologists
- Radiologist must communicate with technologists whenever presented with suboptimal images
- Radiologist responsible for ensuring static images are acceptable
- Include reasons for suboptimal studies in your report and consider suggesting a repeat exam
Systems Issues

Breakdown of Radiology Systems Issues

- Scheduling/Requisition Issues: 33%
- Patient Mis-identification: 17%
- Wrong site/person/procedure: 50%
Breakdown of Systems Issues

- Half involved performing a wrong procedure or performing correct procedure on wrong person or wrong site
  - 49 year old patient
  - Lumpectomy performed at wrong site
- Scheduling and requisition issues manifested by Emergency Department orders that were entered incorrectly
- Patient mis-identification:
  - Radiologist admitted failure to verify name on study was the same as on the CT he interpreted
  - Patient told he had a pulmonary embolus when he did not
Medical Judgment Issues

Most Common Allegations When Radiologist are Sued for Errors in Medical Judgment

Misreads: 74%

“The blunt fact is that it is difficult to argue in the courtroom that a radiologist who is supposed to be well trained and well paid to detect all abnormalities should be excused for failing to perceive a radiologic abnormality that, many years later with the benefit of 20/20 hindsight, can be seen not only by the radiologist but by other observers as well.”

Medical Judgement Issues: Examples of Misreads

- CAT Scans
- Mammograms
- Missed fractures
- MRI with missed spinal tumor
- Chest x-rays with missed lung mass
Medical Judgment Issues

Most Common Allegations When Radiologist are Sued for Errors in Medical Judgment

- Failure to recommend proper follow-up imaging: 11%
- Reasonable medical judgement may be defended even when wrong
  - Evidence of previously discussed risk issues associated with patient harm increases difficulty for defense
  - Radiologist must have proper systems and processes in place
Conclusions

Communicating the results of radiologic examinations has become just as much the duty of radiologists as is the rendering of interpretations. Both the courts and the ACR have clearly stated that radiologists must communicate urgent or significant unexpected findings to referring physicians.

Conclusions – Lessons Learned

- Make sure the ordering provider is notified of all test results
- Communicate non-routine findings to the referring physicians
- Document all non-routine communications: date, time, person spoke with and what was relayed
- Implement systems to communicate significant abnormal findings where patient has been discharged without receiving results or has no PCP
- Directly communicate when immediate treatment or surgical intervention is needed or when there’s a change between preliminary and final reports
Conclusions – Lessons Learned

- Look at films before comparing with past reports and document efforts to obtain prior reports
- Recognize shared liability and when presented with incomplete or questionable studies, seek additional information
- Be aware you are responsible for the content of reports you sign for colleagues
- Remember – perception and interpretation can improve with clinical information
- Minimize distractions when reading studies
- Note all potential limitations or factors that might compromise sensitivity or specificity of exam
Resources

- Risk Evaluation Department 1-800-342-2239
- www.acr.org
- www.svmic.com