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Failure to Communicate- What is the Radiologist's Responsibility?

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Whereas failure to diagnose is the commonest cause of medical malpractice litigation involving radiologists, failure to communicate is a close second. It is a causative factor, if not the primary one, in 80% of medical malpractice lawsuits.A survey of American radiologists showed that from 1999 through 2003, 25% of all radiologists were involved in at least one medical malpractice lawsuit claiming failure to communicate. The number of such lawsuits in the US averages nine per year, with payment to the plaintiffs averaging $1.9 million per case.

Some examples of recently-resolved communication cases include:

• A $900,000 settlement paid to a woman whose CT revealed a 2mm nodule in her right lung, the report of which was never communicated by the interpreting radiologist to the referring physician. A three-year delay in diagnosis resulted.

• A $1.7 million settlement paid to a patient whose lymphoma, correctly identified on a chest radiograph, was never communicated to the referring physician by the interpreting radiologist. Diagnosis was delayed for 15 months.

• A $4.7 million jury verdict awarded to a 44 year-old male whose CT showed a probable carcinoma of the pancreas, but whose diagnosis was delayed two years because of failure of communication by the radiologist to the referring physician.

American courts have repeatedly emphasised their position regarding radiologic communication. Twenty years ago, the Supreme Court in the State of New Jersey stated, "Communication of an 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." Two years later the Arkansas Supreme Court echoed a similar sentiment: "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."

ACR Practice Guidelines

For the past twenty years the American College of Radiology has published Practice Guidelines (previously called Standards). Updated periodically, the current ACR Practice Guideline on Communication divides all radiologic communications into two categories: routine and non-routine. Routine communication of imaging findings is accomplished through usual administrative channels. "In non-routine clinical situations," states the ACR Practice Guideline, "the delivery of a diagnostic imaging report should be expedited in a manner that reasonably ensures timely receipt of the findings."

According to the practice guideline, examples requiring non-routine communication include those situations where there is a need for immediate or urgent intervention, where the findings are discrepant from a preceding interpretation, and where findings that may seriously be adverse to the patient's health and the radiologist reasonably believes are unexpected by the physician.

It should be pointed out that policies regarding radiologic communication issued by the Royal College of Radiologists, and the European Association of Radiology, are quite similar to the ACR Guideline.

Other portions of the ACR Practice Guideline on Communication should be emphasised: “As soon as possible, a change between the preliminary and the final interpretation should be reported in a manner that reliably ensures receipt by the referring or treating physician when such changes may impact patient care. Documentation of communication of any discrepancy should be incorporated into the final report.” Furthermore: “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.”

Shared Responsibility

Communication is, of course, a two-way street, with the radiologist on one end, and the referring physician on the other. Responsibility of communication is thus a shared one. Indeed, the Communication Guideline states that “Referring physicians also share in the responsibility of obtaining results of studies that they have ordered.” Nonetheless, radiologists must realise that irrespective of whether a referring physician has or has not breached the standard of care of his or her specialty, the radiologist is obligated to comply with the standard of care of radiology. Twenty-five years ago an Ohio Appeals Court ruled, “When a radiologist’s conduct is negligent and the patient’s injury is the probable consequence of that conduct, the fact that the negligence of another physician unites with the negligence of the radiologist who caused the injury, does not relieve the radiologist of liability.” In other words, the fact that the referring physician breached the duty to attempt to retrieve the radiologic result of an examination ordered by the physician, does not lessen the duty of the radiologist to effect appropriate communication.

Clearly, from the perspective of the law, radiologists are required to communicate important unexpected findings to referring physicians in a manner that reasonably insures receipt, or alternatively, to the patients themselves. From the perspective of a moral imperative, radiologists should want to effect such communication.

Part one of this series, covering the rise of medical malpractice and its causes, is available on request to the Managing Editor, Dervla Gleeson, at editorial@imagingmanagement.org.

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