



*The slogan, “Speed kills,” has been used to get drivers to slow down on the highway; it can also be applied to radiology...”*

## Advice on avoiding a malpractice lawsuit

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**M**edical negligence is defined as conduct that breaches a reasonable or ordinary standard of care. This is the pivotal point of disagreement between the defense and plaintiff and their expert(s). In establishing medical negligence, four criteria must be met.

These include 1) the duty to care for the patient; 2) breach of that duty; 3) causation of injury by treatment; and 4) actual loss or damage. The duty to care for the patient would include the medical imaging request that establishes the duty to care or interpret the examination. The breach of duty is the failure of the physician to meet the standard of care. The standard of care calls for reasonable skill and knowledge applying equally to all physicians who are engaged in a given imaging study at the time of the alleged injury.<sup>1,2</sup>

In radiology, most problems leading to a medical malpractice lawsuit are due to the oversight of abnormalities or misinterpretation of radiology images. These can be attributed to one of four failures: in detection, in interpretation, in communication

of results, or in suggesting appropriate follow-up action. These failures, in turn, are generally related to problems with visual perception, cognition errors in diagnosis; or system errors, such as those related to communication of significant findings, reading room lighting, or overly long shifts or excessive workloads.<sup>3</sup> A detailed discussion of each of these types of errors is beyond the scope of this editorial.

However, it's worth noting that the authors of one study estimated that the American College of Radiology (ACR) Standard of Communication was used by the plaintiff or the defense in 30% of all medical malpractice cases involving radiologists. Furthermore, while the ACR states that the Standard is not a set of “rules” and, therefore, is not deemed inclusive of all proper methods of care, the ACR standards are nonetheless “perceived” by the legal community as a codification of the radiology standard of care throughout the U.S.<sup>4</sup> Indeed, one area that can result in an accusation of medical negligence against a radiologist is lack of timely communication.

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Radiology reports should always be timely so they can play an active part in the patient's care. The radiologist must document any pertinent verbal communication with covering health-care providers.<sup>3</sup>

Besides not always knowing if a particular finding is critical, radiologists may not always have the time to review the patient's electronic medical record to see if a finding is new or potentially medically significant. However, critical findings should always be relayed to the referring and/or responsible covering physician. The date, time and person who receives this communication should be noted within the radiology report. In today's healthcare climate, many radiologists may feel they are so pressed for time they cannot communicate significant findings to referring physicians. Reliable, efficient mechanisms, including support staff, should be available to facilitate radiologist communication of significant findings.<sup>3</sup>

There have been improvements in communication of imaging findings with 24/7 coverage of radiology services. This has helped improve the timeliness of reports. Situations may arise from these circumstances, however, in which the appropriate subspecialist radiologist is not available to interpret specialty examinations after hours. The level of the interpreting radiologist's training and experience

should be sufficient to the modality of imaging being covered. For instance, a mammographer will have far less experience than a fellowship-trained neuroradiologist in interpreting a CT or MRI of the brain. When possible, a direct or on-call subspecialist interpretation is preferred.

Another issue relates to that of perception error. All radiologists experience some level of perception error. How, then, do we minimize these errors? The slogan, "Speed kills," has been used to get drivers to slow down on the highway; it can also be applied to radiology, where many of us, especially when on call, are frequently trying to interpret studies too quickly to be safe; ie, to be accurate.

This doesn't mean we always have to work in the slow lane. But it does mean *we need to be working at our own optimal speed.*

A few other things can be helpful:

For one thing, the physician should always be involved in establishing image quality. If a film is underexposed, the physician is ultimately responsible for this deficiency. While it is annoying to have the patient return for repeat imaging, such action must be weighed against the possibility of a significant missed finding and potential litigation.

Establish regular work breaks, look away from the computer screen at least

twice an hour, ensure proper ambient lighting, and optimize workstation ergonomics. Long hours, while good for increased productivity, are associated with increased physician fatigue and more diagnostic errors. Strong consideration should be given to reducing the duration of shifts and study volume associated with after-hours coverage. Structured reporting may be helpful as a radiology checklist to help avoid errors as satisfaction of search.

As radiologists, if we read enough studies, our number may still be called in the litigation pool. Nevertheless, taking action on these proactive strategies to diminish diagnostic errors can help to reduce the chances that your opponent's side will win and increase the chances that you will if and when your number is called.

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