DiagnosticImaging

Malpractice Movement Calls for Reporting Directly to Patients, Part 2 in a Series

By V. Katherine Gray, PhD | April 11, 2011

Communication — or failure to communicate — is an important issue in radiology malpractice lawsuits. Communication issues were ranked as the fourth largest cause of malpractice lawsuits in radiology, and it is the second highest average indemnification or compensation. Furthermore, it contributes to 80 percent of malpractice lawsuits as a causative factor.

However, in the past, radiologists have not been the primary communicators of imaging reports with patients, as that has been the responsibility of the referring physician. That is about to change.

The direct disclosure of findings by radiologists is believed by some experts as being an improvement that outweighs the risks. For example, one of the foremost experts on radiology malpractice, Dr. Leonard Berlin, explains that “a patient who has expectations of being promptly informed of imaging results, only to be disappointed in that regard, will grow frustrated and then angry — not toward the referring physician, but toward the radiologist prompting a call to a malpractice attorney.”

By the radiologist communicating directly, the radiologist might actually solve the errors in communication.

Recent malpractice judicial decisions point to clear expectations of direct communication with patients. At both state and federal appellate levels, several cases have found against the radiologist when abnormal findings were not directly communicated. These decisions focus on the “duty of care” that any physician has of warning a patient of abnormal findings when the physician is aware of the results, regardless of the reason for the testing or what another physician may be responsible for, so the patient can seek proper treatment.

Legislative action in 2010 also suggests that the expectation of reporting radiology results directly to patients is growing. Last year, Pennsylvania was the first state to introduce legislation that requires a summary of imaging findings to be sent to patients within 10 days of the full report being sent to the ordering physician. The concern by some radiologists is that the radiology report is too technical for patients to understand or interpret properly, and that will cause confusion. Another concern is the increased time for radiologists to meet such a requirement.

Also in 2010, California legislation required radiology facilities to alert patients if any unusual radiation dosages had been administered. This issue of radiation exposure is relatively new in radiology

malpractice. This increased awareness was based upon sensational cases about damage from imaging radiation exposure due to malfunctioning equipment, improper procedures, and poorly performing staff.

With this new awareness, patients have also become more concerned with the accumulated dosages over time from repeated radiation exposures. Patients are expecting information about the dosage — including the expected amount of radiation exposure, the amount received by a patient, and the accumulation. This suggests a need for radiation exposure reporting directly to patients.

These malpractice factors are pushing for direct communication to patients about findings and radiation exposure. Such transparency and work flow will be a major change in radiology reporting.

Coming up next in the series: Meaningful Use Outcomes will Change Reporting

Read part 1 in the series: Radiology Reports in the Age of Smartphones

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