

A radiologist's duty to directly communicate with the treating physician

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Introduction

Typically, radiologists review films and dictate their reports without any direct communication with the treating physician or patient. Direct communication is, however, required where the radiologist feels that immediate patient treatment is indicated; where a significant change exists between a preliminary report and a final report; or where the findings, while not warranting immediate treatment, constitute significant unexpected findings. Failure to directly communicate with the treating physician or patient in these situations may expose the radiologist to legal liability.

Case Summary

On December 27, 1999, a 63-year-old Wisconsin resident felt the right side of his body go numb for approximately 30 seconds.

The next day, the patient called his primary care physician, an internist, and told him about the numbness. The internist told the patient to immediately go to the emergency room, which he did.

The emergency room physician ordered a CT scan of the patient's brain. The CT scan was read as containing an area of hypodensity for which the radiologist listed four possibilities: 1) a low grade cancerous brain tumor; 2) a benign brain tumor; 3) an old area of ischemia; or 4) a focal area of subacute ischemia.

The CT report was dictated on December 28, 1999, and transcribed the next day. The report labeled the four possibilities as "differential considerations," and concluded by indicating that an "MRI scan is recommended for further evaluation."

On December 29, 1999, the patient had an MRI done at the same hospital. A different radiologist reviewed the MRI films and dictated his report that day.

The next day, the patient picked up the CT films, the CT report, and the MRI films from the hospital, and took them to his appointment with the internist. The patient was not given a copy of the MRI report, as the report had not yet been transcribed.

During the December 30 office consult, the internist put the CT and MRI films up on a shadow box and pointed out to the patient an area on the films that he said represented a brain tumor. The internist referred the patient to a neurosurgeon, and told the patient that the neurosurgeon would most likely immediately schedule a biopsy to determine whether the tumor was benign or malignant.

The next day, the patient called the neurosurgeon's office and scheduled an appointment for January 5, 2000, the earliest appointment he could get.

However, the patient did not have a brain tumor. The radiologist reading the MRI films on December 29, concluded that the patient had an "acute infarct . . . caused by an occlusive process." The MRI report, which was transcribed on December 30 and sent to the internist the next day, indicated that the pre-MRI diagnosis was "[r]ight sided body numbness with possible low grade brain tumor," and concluded that "I believe that the abnormality is due to an infarct involving the left basal ganglia caused by occlusion of the left lenticular striate artery," and "I doubt that we are looking at a tumor."

The radiologist did not telephone the internist or the patient with his findings. Because of the holidays, the internist did not receive the report until January 4, 2000.

In the early hours of January 5, 2000—the same day he was scheduled to see the neurosurgeon—the patient suffered a major stroke. The patient is now confined to a wheelchair, is partially paralyzed, and has no use of his right arm. Additionally, he has difficulty with his speech.

The patient sued the internist and the radiologist, alleging that they were negligent in failing to communicate with each other and with the patient, and that,

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had the patient been advised that he had suffered an acute infarct, he would likely have undergone immediate carotid endarterectomy surgery, which would have prevented his major stroke.

The case settled prior to trial for \$1.4 million. The internist paid \$1.3 million, and the radiologist paid the remaining \$100,000.

Case Law

In September 1991, the American College of Radiology (ACR) adopted its first Standard for Communication-Diagnostic Radiology. The creation of this standard was triggered by several published cases in which the courts were critical of radiologists for not directly communicating significant findings to treating physicians.

The first published case to address the issue of whether the standard of care requires a radiologist to directly communicate significant findings to treating

In finding the radiologist negligent for not directly communicating his findings to the treating physician, the Indiana court stated:

The Court is also of the opinion that [the radiologist] was negligent in failing to immediately bring his report to the attention of the proper persons. [The radiologist] knew that there would be a delay in the transcription of his report under the normal Hospital procedures. Given the fact that these procedures were inadequate, when [the radiologist] noted the possibility of a serious injury, due care would have required that he telephone his report to the attending physician, the Emergency Room, or the Hospital administration.³

The second published case to address this issue was *Merriman v. Toothaker*,⁴ a 1973 case from Washington. In that case, the patient went to a hospital emergency room on February 23, 1968 for treatment of injuries sustained in an automobile accident. He was seen there by an emergency room physician. The physician ordered x-rays of the patient's neck and shoulder, reviewed those x-rays himself, was unable to detect any sign of bony injury, and concluded that the patient had sustained a bruised and sprained neck. The patient was admitted to the hospital, placed in traction and discharged the next day.

After his discharge, the patient's x-rays were read by a radiologist, who issued a report on February 27, 1968 indicating that the patient had anterior compressions at C5 and C6. The emergency room physician testified that he received a copy of the report on February 27, 1968, and mailed it to the patient's attending physician that day. The attending physician denied ever receiving the report, however.

The following month the patient's lower back pain worsened, and he underwent a lower back fusion.

The patient later sued the emergency room physician alleging, among other things, that he failed to communicate the x-ray diagnosis to the attending physician by telephone when he received it from the radiologist. The trial court dismissed the patient's case, but the Washington Court of Appeals reversed that decision, holding that:

Our review of the medical opinion evidence interpreted in a light most favorable to [the patient] convinces us that the trier of fact could conclude with reasonable medical probability:

Communication of radiologic findings is an inseparable and critical component of all radiologic procedures.

physicians was *Keene v. Methodist Hospital*,¹ a 1971 Indiana case. In that case, the patient received head injuries in a fight shortly after midnight on the morning of December 25, 1966. At about 2 AM that day, the patient was taken to the emergency room at a local hospital with a large hematoma over his right eye. Four skull x-rays were taken; he was examined by an emergency room physician, and he was released without treatment. A radiologist examined the x-rays sometime between 8 AM and 10 AM that day. He noted a possible skull fracture and suggested additional x-rays be taken. His conclusions were dictated that day and transcribed two days later. The radiologist's findings and recommendations were not otherwise communicated to the attending physician or anyone else. Shortly after noon on December 25, 1966, the patient was found unconscious. He was returned to the hospital, where he was found to have a skull fracture and a large epidural hemorrhage. He died later that day. The evidence at trial established that had the findings of the radiologist been immediately communicated to the treating physician, "it would probably have been possible to perform surgery on [the patient] before the damage to his brain had been so serious that he could not recover."²

... (2) Because of the medical significance of the x-ray report and the great danger to the [patient] if his neck was not immobilized, the community medical standards of that area would require telephone communication to [the patient's attending physician] by [the emergency room physician] of the x-ray diagnosis. . . .

... In support of the dismissal by nonsuit, defendant urges that both doctors, on cross-examination, testified that mailing the x-ray report to [the patient's attending physician] was good medical practice and that [the emergency room physician] had a right to rely on the attending physician's taking appropriate action assuming that he received the records. But the testimony was that [the attending physician] did not, in due course, receive the records. The reason he did not see them was not established and we consider the reason immaterial. The fact that [the attending physician] did not receive the x-ray report adds weight to his opinion, that because of the serious implications of the report, a personal contact was required to insure prompt action. [The attending physician's] testimony established a standard of care sufficient to submit this issue to the jury.⁵

The third published case to address this issue was *Phillips v. Good Samaritan Hospital*,⁶ a 1979 Ohio decision. In that case, the patient, a minor, was injured while playing. She went to a hospital emergency room for treatment. The emergency room physician ordered x-rays and read them himself, diagnosed the injury negative for fracture, and discharged the patient. Early the next day, a radiologist read the x-rays and, contrary to the diagnosis of the emergency room physician, found a fracture of the distal portion of the humerus. The radiologist dictated a report, but the emergency room physician was never made aware of his inconsistent diagnosis. Several months later, the patient's fractured arm was diagnosed by another physician, and she underwent surgery. Since the fracture was in the growth area of the bone, deformity and potential future surgery were concerns.

The trial court dismissed the case on summary judgment against the radiologist. The Ohio Court of Appeals, however, reversed that decision, holding that:

As a result of a serious breach of communication of the medical professionals in this action, a child may be found to have suffered serious and even permanent injury. It is a wrong for which the law provides a remedy. The primary

question posed in this case is who is responsible. [The patient's family] argue[s] that the radiologist, although he correctly diagnosed the injury, must share liability if he is found to have failed in adequately communicating the diagnosis so as to reveal the error of the attending physician. They look to the harm that may result. [The defendants] argue that the liability of the radiologist stops once he has made a correct medical interpretation that is circulated through established channels of the hospital, justifying a limitation for the reason that radiologists are merely indirect providers of patient care.

The effect of an affirmance of the judgment of the trial court would be to hold that a doctor could not be found liable for malpractice where there was a proper diagnosis despite what may have been a failure on the doctor's part to adequately communicate that diagnosis, thereby denying the suffering patient the opportunity to benefit from the consultant's services. Such a proposition we are unable to accept. As the facts so glaringly reveal, the communication of a diagnosis so that it may be beneficially utilized may be altogether as important as the diagnosis itself.⁷

The fourth published case to consider this issue was *Jenoff v. Gleason*,⁸ a 1987 case from New Jersey. The patient in that case fractured her wrist at work and was hospitalized on September 13, 1980 for surgery. X-rays were ordered of the patient's left wrist and chest at that time. The chest x-rays were read by a radiologist on the day they were taken, at which time he dictated a report of his findings. The report reflected a finding of a 2 cm nodule within the left lower lobe, suggesting a possible lung tumor. The radiologist did not communicate his findings to the patient's treating physician other than by preparation of his report. The report was typed on September 16, 1980 and arrived at the nurses' station on the floor where the patient was hospitalized on September 17, 1980, but the patient had already been discharged.

On November 26, 1980 the patient's hospital records were reviewed by a nurse on behalf of her worker's compensation carrier. The nurse noted the chest x-ray finding of a possible lung tumor, and advised the patient's physician of this fact. The physician then ordered additional chest x-rays, which revealed a growth of the tumor. Unfortunately, the disease had spread in the interim, and the patient died less than two years later.

The trial court dismissed the claims of the patient's estate against the radiologist during trial. The New Jersey Court of Appeals reversed that dismissal, however, concluding that:

We conclude that communication of an unusual finding in an X-ray, so that it may be beneficially utilized, is as important as the finding itself. The fact that a physician may only be an indirect provider of medical care is but one relevant circumstance. In some situations, indirect service may provide justification for the absence of direct communication with the patient, but that does not in any way justify failure of communication with the primary care physician.⁹

The ACR Standard

Triggered by these published cases, the American College of Radiology (ACR) adopted its first Standard for Communication-Diagnostic Radiology in September 1991.¹⁰ That standard provided that "[r]adiologists should attempt to coordinate their efforts with those of the referring physician in order to best serve the patient's well being," and that "[i]n some circumstances, such coordination may require direct communication of unusual, unexpected, or urgent findings to the referring physician in advance of the formal written report." That standard further provided that "[a]ny discrepancy between an emergency or preliminary report and the final written report should be promptly reconciled by direct communication to the referring physician or his or her representative."

In 1995 the ACR revised the standard to make it more stringent.¹¹ It was revised again on January 1, 2000¹² and again on January 1, 2002.¹³ The current standard provides as follows:

Direct communication is accomplished in person or by telephone to the referring physician or an appropriate representative. Documentation of direct communication is recommended. In those situations in which the interpreting physician feels that immediate patient treatment is indicated (e.g., tension pneumothorax), the interpreting physician should communicate directly with the referring physician, other healthcare provider, or an appropriate representative. If that individual cannot be reached, the interpreting physician should directly communicate the need for emergent care to the patient or responsible guardian, if possible.

Under some circumstances, practice constraints

may dictate the necessity of a preliminary report prior to the preparation of the final report. A significant change between the preliminary and final interpretation should be directly reported to the referring physician.

In those situations in which the interpreting physician feels that the findings do not warrant immediate treatment but constitute significant unexpected findings, the interpreting physician or his/her designee should communicate the findings to the referring physician, other healthcare provider, or an appropriate individual in a manner that reasonably insures receipt of the findings.

Interpretation of the ACR Standard

Various medical journal articles discuss the ACR Standard relating to a radiologist's duty to directly communicate his or her findings to the treating physician or patient. One such article¹⁴ states as follows:

That timely and appropriate communication of radiologic results to referring physicians is essential has been recognized by the courts and codified by the American College of Radiology in its standards. All radiologists must familiarize themselves with and comply with these standards.

... If the radiologist has any reasonable belief that a radiologic finding requires treatment of the patient before delivery of a written report in the mail or onto a patient's hospital chart, the radiologist should telephone a report to the referring physician immediately.

Another medical journal article¹⁵ concludes that "the [ACR] communication standard does indeed reflect the standard of radiologic care," and that "[r]adiologists should be cognizant of the now well-established legal duty to verbally communicate in a timely fashion to the referring physician unsuspected or significant findings, whether they are believed to be urgent or not."

Conclusion

Radiologists should directly communicate to the patient's treating physician all findings in which they feel immediate patient treatment is indicated; all findings that result in a significant change between the preliminary and final interpretations; and all findings, while not warranting immediate patient treatment, that constitute significant unexpected findings.

If the treating physician cannot be reached, the radiologist should directly communicate all such findings to the patient or the patient's responsible guardian.

Communication of radiologic findings is an inseparable and critical component of all radiologic procedures. As the courts have observed, the communication of a significant or unsuspected finding, so that it may be beneficially utilized, is as important as the finding itself.

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