Mala Praxis: A Study of Malpractice Claims and Litigation in the Field of Radiology*

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EXECUTIVE SUMMARY

• Risk management plays an integral role in the mitigation of malpractice claims in the radiology environment. This holds true for the radiologist and professional association as well as the facility that supports the radiologic service.
• The radiologist and the radiology department or imaging center are separate entities which have a symbiotic relationship. Radiologists may function as an independent contractor, yet their function is dependent on the facility with which it contracts. The function of the radiology department is directly related to the radiologist’s performance, staff competency, and equipment performance.
• Mammography poses particular concern with regard to medical malpractice, as there is an inherent subjectivity in the differential diagnosis with regard to breast cancer in mammography.

“Mala praxis” is defined as the neglect or unskilled management by a physician or surgeon. The modern word “malpractice” is derived from this term. The general public is well aware of medical malpractice and subsequent litigation or settlement. As the healthcare profession improves in terms of medical and technological advancement, the incidence of malpractice allegations increases. It is an ironic situation: patient care is improved and the public reacts with scrutiny. Medical malpractice in the field of radiology poses a unique aspect relative to medical malpractice. It is in the nature and science that this uniqueness exists. Radiologic exams are not only prone to malpractice suits; they also expose other types of medical mistakes that would be difficult to demonstrate without radiographs.

The radiologist (or radiologist group) in most cases functions as an independent contractor. Yet their function is dependent on the facility with which it contracts. The function of the radiology department is directly related to the radiologist’s performance, staff competency, and equipment performance. Furthermore, the mislabeling of radiologic images, a task which is the technologist’s responsibility, affects the radiologist’s performance. The radiologist and the department are separate entities which have a symbiotic relationship. The radiologist often never sees or touches the patient who could potentially bring suit. However, by virtue of the referral for a radiological exam from the patient’s physician and the implied agreement by the radiologist to provide the service, a physician/patient relationship has been established. Thus, there is a duty of care.

Shortly after the introduction of x-rays, the radiograph became “the nation’s most prolific source of malpractice actions.” As the saying goes, a picture is worth a thousand words. Careful review of malpractice claims and suits around the field of radiology are focused on the following areas: misdiagnosis, complications arising from radiologic procedures, failure to inform clinicians...
There is a certain subjective nature to the interpretation of radiographic images... This can lead to vague, open ended recommendations that may not answer the question the ordering physician was asking and subsequent medical care is then affected.

The intention of this research paper is to highlight the aspects of radiology that have historically lent themselves to medical malpractice situations. Furthermore, the impact of the subsequent decisions and settlements will be discussed in terms of how they shaped the practice and operations of the radiologist and radiology department.

The Nature of Radiologic Science

Historically, radiologic services have been intended to serve as an adjunct to clinical correlation. Often, the field exists in a vacuum. At the time of exam interpretation, the radiologist sometimes has no patient to examine, no physician, and no technologist with which to interact. The radiologist sometimes interprets studies without the benefit of clinical data, such as a history and physical.

In addition, there is a certain subjective nature to the interpretation of radiographic images. This is especially true in the area of mammography. Radiographic findings are not always specific and apparent. Further, clinical correlation may be needed. This can lead to vague, open ended recommendations that may not answer the question the ordering physician was asking and subsequent medical care is then affected. One can easily see how the nature of this field lends itself to negligence claims. "Radiology related litigation occurs most often because of objective or subjective patient injuries... radiologists do not intend to injure patients. Unfortunate outcomes do occur, however, because of oversight and complications." Lawyers generally agree that some cases involving negligence by the radiologist are affected by the relationship between the radiologist and the patient. In fact, many cases that could have gone to litigation did not because of the way the issues were handled and the patients were treated after an incident (personal communication with Ann Maloney, an RT and malpractice lawyer).

Another innate situation that influences the nature of radiology as a science is the criteria used to define the extent of radiologic involvement. With the advent of interventional radiology (exams that offer diagnosis and treatment of illness), the radiologist has crossed over from diagnostician to clinician. In these cases, clinical correlation of all pertinent data is paramount. This totally changes the role of the radiologist as an adjunct to a final diagnosis. Rather, the radiologist is providing clinical treatment: embolization, ablation of tumors, and stent placement for example. A survey of radiologists and departments providing interventional services yields the general consensus that the level of risk management that should accompany this expanded role may not be at the level required (personal communication with Ann Maloney).

The Affect of the Department on the Radiologist's Role

There are certain factors inherent to the radiology department that are directly related to the radiologist’s performance. These include the competency of the technologists (specific to modality), the image quality (relative to equipment performance), and the various processes of communication (interdepartmental, intradepartmental, and beyond the facility itself). It is essential that the radiology department and the radiologist develop a collaborative working relationship that supports the individual roles. Situations can arise from the time patients enter the facility to the time they leave. One case that demonstrates the role of the department involved a mother who was upset at the way she was treated at the registration desk in the radiology department. She cancelled her child’s head CT and left in anger. She returned several days later to learn that her child had a fatal condition that could have been treated if the child had received the CT when it was initially scheduled. The case was settled. In a special report of the Radiologic Society of North America (RSNA), a survey was conducted regarding jury verdicts of radiology malpractice law-suits in the state of California. The goal of the survey was to raise the awareness of malpractice suits in this area of medical specialization and improve risk management. The study showed that 9% of cases reviewed were brought because of failure to inform the clinician of urgent information. This is tied to not only the communication processes of the radiologist but also the support staff. In the same study, 82% of the cases involved both the radiologist and the department. This demonstrates the very close ties between these entities. And 30% of the cases were misdiagnoses of malignancies. This speaks to the dependency of the radiologist on the department to produce high quality images for the most accurate interpretation.

To a large degree, the radiologist is an invisible facet to the patient’s total care in the treatment of a disease process or illness. There is more value placed on a radiologist that possesses a good reputation of...
Techs are at the lowest level of the litigation chain. It is more likely that the facility would be named in a suit by virtue of its responsibility to employ competent staff.

In response to the expanding role of the technologist, both within a hospital and free standing imaging facilities, the Joint Review Commission on Education in Radiologic Technology (JRCERT), mandates that courses in medical ethic and law be included in the essentials of the curriculum. According to the ASRT, "Problems related to negligence, informed consent, malpractice, and child abuse are ethical as well as legal issues."

In regards to teaching techniques, the ASRT writes: "Radiographers must have the basic knowledge of medical law in today’s health care environment. Today radiographers are recognized as professionals. There is an increased responsibility that goes along with this recognition."

As stated earlier, techs are at the lowest level of the litigation chain. It is more likely that the facility would be named in a suit by virtue of its responsibility to employ competent staff. The radiologist is also in the position to be recognized in competency prior to a patient related incident taking place. In reality, the high risk, high performance tasks are not assigned to techs that do not possess the level of competency required to perform the task. This is the basic operational standard of any radiology department.

The specific concern deals with failure to diagnose the presence of breast cancer. "Failure or delay in diagnosis is one of the most prevalent and expensive conditions in malpractice claims lodged against physicians." The author of this paper was involved in a case where a claim was filed because a patient alleged her breast cancer was missed. The patient had a known history of ovarian cancer. Medical statistics show a link between the incidence of a subsequent breast cancer and a history of ovarian cancer. The patient was diagnosed with breast cancer over 12 months after having a mammogram that was read as negative. The patient’s claim was that the radiologist should have detected her breast cancer because of her prior history. The radiologist’s defense was that her cancer was an interval development. In other words, it developed sometime after her negative mammogram and therefore could not be considered a missed cancer. Thus, the mammogram performed more than a year earlier was a true negative, not a false negative in terms of the radiological finding. Furthermore, the patient failed to follow the radiologist’s recommendation, which was to return for imaging in 12 months. At this time the patient was undergoing radiation therapy for the ovarian cancer. The suit was withdrawn after review by a pre-litigation panel. One could argue that the primary care physician or oncologist is liable. She was under their care and the link between ovarian and breast cancer should have been considered in the treatment plan.

The medical audit, which will be discussed in detail later, is a method that...
One-third of all radiologists have considered withdrawing from the interpretation of mammography. The potential of this occurring would have a serious affect on the care of women in the United States.

Professional Liability

The following narrative demonstrates the comparative risk of malpractice for radiologists and other medical specialists:

“The slide below [Figure 1] shows the relative frequency of malpractice claims directed at radiologists and the mean professional liability insurance premiums paid by radiologists. Radiology is not one of the highest risk medical specialties for malpractice litigation but it is certainly not the lowest. Radiologists are frequently involved in malpractice lawsuits in which it is difficult to understand exactly how the radiologist became involved. Usually, this results from some unfavorable clinical outcome and, during the case preparation, the plaintiff’s attorney discovers that there is some technical glitch in the radiologic part of the patient’s management. It may be a late report or some discrepancy in dates of reports. Occasionally, requested studies are not done or not reported. Any of these technicalities can lead to the radiologist being included in the lawsuit. Sometimes, it seems this is done simply to extend the insurance coverage (find a deeper pocket).
so that it might be possible to obtain a larger settlement or judgment."14

Box 1 highlights the most common problems in radiology-related litigation.

**Risk Management Initiatives**

As a rule, when there is a case for malpractice, everyone listed in the patient’s medical record is named in the suit. Through the preponderance of evidence and discovery, certain parties will be dropped from the suit. In most cases, the first parties dropped are the allied health professionals, radiologic technologists, nurses, and residents. In many cases, radiologists are subsequently dropped. Radiology is usually peripheral to malpractice claims because the radiologist is acting as a consultant, with a more extended role for interventional procedures (personal conversation with Ann Maloney).

The first essential risk management initiative should be obvious to the radiologist and staff: develop a relationship with the patient and the patient’s interested persons. This opportunity may present itself prior to an incident or subsequent to an incident. In either case, the actions that are taken play a major role in potential future litigation (personal conversation with Ann Maloney). From a prospective vantage point, the radiologist and professional group should be very active in the medical executive board. The board should be active in the credentialing and competency demonstration of all physicians, new and incumbent. It should be on going and constantly revisited and privileges revised as needed. New radiologists (new to the field and new to the facility), should have a senior radiologist that acts as a preceptor for a designated period of time until compliance and competency is established (personal conversation with Ann Maloney). Likewise, peer review and mandatory continuing education places a certain amount of pressure on radiologists to consistently perform to a competent level.

The single most important risk management initiative is the medical audit. For example, the Mammography Quality Standards Act (MQSA) governs the practice guidelines of all facilities that provide mammography service. The MQSA mandates the medical audit for mammography services. However, the principles set forth in this act of congress could be applied across other radiologic modalities. The medical audit serves to quantify a mammographic practice in terms of performance by both the facility and the radiologist. The radiologists are held to a national standard and therefore are mandated to take some action if the performance falls above or below the established standard.

The last initiative that will facilitate effective risk management is consistent compliance with the practice guidelines of the American College of Radiology (ACR). "Courts have generally given the ACR standards considerable weight and have ruled that, although the ACR standards themselves do not establish a standard of care, they are nonetheless useful in assisting the courts in determining the radiologic standard of care applicable in a given situation."

**Conclusion**

Risk management plays an integral role in the mitigation of malpractice claims in the radiology environment. This holds true for the radiologist and professional association as well as the facility that supports the radiologic service. Risk management functions best when there is a well planned and established process that is in place long before an incident or injury occurs.

Competency of the staff at all levels facilitates risk management. If a pattern of competency demonstration for radiologists,
technologists, and support staff can be established it is useful in establishing standard of care upon litigation. This aspect is one that cannot be done in retrospect. It cannot be contrived. Rather, there has to be an established pattern.

Adherence to the policies, procedures, and bylaws of the respective individuals that could potentially be brought to suit can also mitigate risk. If there is a history of compliance with practice standards as well as other regulatory standards, a pattern is established. Once again, this history cannot be contrived.

If these measures are put in place and observed, the court is left with circumstances that may or may not have been a concomitant risk of the radiologic procedure. The best scenario is to ensure that the radiologist practices works in tandem with the department and the facility in a harmonious, joint effort. With regard to the concomitant issues that arise, how the professionals respond initially and follow up subsequently is the greatest measure of whether or not the radiology service is named in a suit.

References


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QUESTIONS

Instructions: Choose the answer that is most correct.

1. The neglect or unskilled management by a physician or surgeon is:
   a. Mala praxis
   b. Malpractice
   c. Both a and b
   d. None of the above

2. Which of the following statements is true?
   a. As healthcare improves in terms of medical and technological advancement, the incidence of malpractice allegations increases.
   b. As healthcare improves in terms of medical and technological advancement, the incidence of malpractice allegations decreases.
   c. There is no relationship between healthcare improvements in terms of medical and technological advancement and the incidence of malpractice allegations.
   d. Malpractice allegations have remained constant for the past 50 years.

3. Why does radiology pose a unique aspect relative to medical malpractice?
   a. Radiologic exams are prone to malpractice suits
   b. Radiologic exams expose other types of medical mistakes
   c. Both a and b
   d. None of the above

4. From a legal standpoint in most cases, the radiologist or radiologist group associated with a radiology department, functions as a(n):
   a. Equal partner
   b. Independent contractor
   c. Dependent participant
   d. None of the above
5. According to this article, soon after the introduction of x-rays what became the "nation's most prolific source of malpractice actions?"
   a. The radiologist  
   b. The technologist  
   c. The radiograph  
   d. The radiographic equipment

6. Careful review of malpractice claims and suits around the field of radiology are focused on which of the following areas?
   a. Misdiagnosis  
   b. Complications arising from radiologic procedures  
   c. Failure to inform clinicians of urgent information  
   d. All of the above

7. What are some of the factors that can negatively impact the interpretation of a radiologic exam?
   a. Sometimes there is no patient for the radiologist to examine  
   b. There is no physician or technologist with which to interact  
   c. There is no clinical data available  
   d. All of the above

8. With the advent of interventional radiology, the radiologist has crossed over from:
   a. Faculty member to diagnostician  
   b. Clinician to diagnostician  
   c. Diagnostician to clinician  
   d. Both a and b

9. There are certain factors inherent to the radiology department that are directly related to the radiologist's performance. These include, but are not limited to:
   a. The competency of the technologists  
   b. The image quality  
   c. The various processes of communication  
   d. All of the above

10. In a survey conducted in California regarding jury verdicts of radiology malpractice law suits:
    a. 82% of the cases involved both the radiologist and the department 
    b. 82% of the cases involved only the radiologist 
    c. 82% of the cases involved only the radiology department 
    d. 82% of the cases involved misdiagnoses of malignancies

11. Generally, in malpractice claims, the courts recognize the radiologic technologist as acting as an agent for the institution based on the doctrine of:
    a. Duty of care  
    b. Respondeat superior  
    c. Independent contractor  
    d. All of the above

12. Who reside at the lowest level of the litigation chain in medical malpractice suits?
    a. Nurses  
    b. Technologists  
    c. Radiologists  
    d. Both a and b

13. The basic operational standard of any radiology department should be that the high risk, high performance tasks are not assigned to technologists that do not possess:
    a. ARRT certification  
    b. Bachelor degree  
    c. The level of competency required to perform the task  
    d. All of the above

14. According to a survey done at the University of Washington, 3 out of every 4 radiologists surveyed expressed concern about the impact of mammography on:
    a. Productivity  
    b. Practice standards  
    c. Malpractice  
    d. None of the above

15. What is one of the most prevalent and expensive conditions in malpractice claims lodged against physicians?
    a. Failure or delay in the diagnosis of breast cancer  
    b. Missed fractures in the elderly  
    c. Ordering unnecessary radiologic examinations  
    d. None of the above

16. A medical audit for mammography interpretations should include:
    a. Percent of call backs  
    b. Percent of true positives  
    c. Percent of false negatives  
    d. All of the above

17. According to a study published in *Radiology*, what percent of all radiologists have considered withdrawing from the interpretation of mammography?
    a. 33%  
    b. 20%  
    c. 10%  
    d. None of the above

18. In the California study, it was estimated that 15 million patients per year are examined by radiologists and:
    a. 1 in every 100,000 resulted in a lawsuit  
    b. 1 in every 50,000 resulted in a lawsuit  
    c. 1 in every 1000 resulted in a lawsuit  
    d. None of the above

19. According to this article, the largest concentration of radiology malpractice cases involving failure to diagnose include:
    a. Bone and chest images  
    b. CT images  
    c. Upper GI images  
    d. None of the above

20. With regard to post-procedure complications in interventional procedures, these include:
    a. An undiagnosed pneumothorax  
    b. Inadvertent puncture of vessels  
    c. Incorrect tube or stent placement  
    d. All of the above
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