

Volume 13 - Issue 2, 2013 - Imaging Insights

Medicolegal Issues in Radiology

Author

Dr. Peter Mackenzie

Head of Membership Governance

Medical Protection Society Edinburgh, UK

peter.mackenzie@mps.org.uk

Clinical negligence claim costs continue to increase in many parts of the world. The growth in preventative screening measures involving radiologists and the increasing use of interventional radiology by providers of healthcare carries with it emerging risks for both clinicians and the provider hospitals. In this article, we look at what we can learn from studying claims against radiologists.

Claims Experience and Trends

The general rise in litigation against doctors appears to be continuing apace. The Medical Protection Society (MPS) is a mutual indemnifier of doctors and healthcare professionals around the world, and has seen claims against private hospital consultants in Ireland increase by more than a third during 2012 (Medical Protection Society 2013). We are not alone: the NHS Litigation Authority, which manages claims on behalf of National Health Service hospitals in England, commented that it had seen a 30 percent increase in clinical negligence claims reported between 2010 and 2011, and an increase of 58 percent over the previous three years (NHS Litigation Authority 2012; Porter and Beckford 2011).

The picture for radiologists is starting to look remarkably, and unfortunately, similar to that for other groups of doctors. From a low base, MPS has seen a significant upward spike in the number of clinical negligence claims reported by UK radiologists since 2008. A recent review of medical malpractice suits against radiologists in the United States showed that nearly a third of radiologists have now had at least one claim in their career (Whang et al 2013). In the UK, this was mirrored by a study of twelve years' worth of claims against radiologists which found that nearly half of these claims related to delayed diagnosis or misdiagnosis of cancer, with nearly a third of these in relation to breast radiology (Halpin 2009).

With the increasing range and scope of interventional procedures, it is perhaps unsurprising that we are starting to see claims arising from alleged negligence in this arena, relating to both technical performance and a 'failure to warn' of potential side effects. As interventional radiology moves apart from its diagnostic sibling towards recognition as a specialty in its own right, we are likely to see further differentiation between the claims brought against each group. The interventionalists may find that their claims become more akin to those surgeons; improving availability and reduced cost of complex investigations such as CT and MRI may draw diagnostic radiologists to the fore in claims for misdiagnosis across a range of specialties.

MPS classifies a claim as an explicit demand for financial compensation due to alleged clinical negligence by a member, which puts MPS funds at risk. MPS does not require members to notify us of a claim (as insurers are required to under a claims-made policy) but in practice, the vast majority of members do notify us when they learn they are being sued.

MPS captures the reasons for recommending settlement to a member on each clinical negligence case.* For the purpose of this article we have reviewed a sample of claims brought against radiology members worldwide, where we have recommended settlement, since December 2007. This article highlights a few key points from this sample, as well as sharing our broader experiences of assisting over 280,000 doctors and dentists in over 40 countries around the world.

By far the most common reason for settlement on behalf of radiologists was over concerns of misdiagnosis (nearly two-thirds). The underlying pathology in most of these cases involved delay in the diagnosis of cancers (approximately a third).

All of the failure to diagnose breast cancer cases were a result of incorrect interpretations of mammograms. It is interesting that Reynolds reports that surveys have indicated that the public attributes 100 percent sensitivity to mammography whereas its actual sensitivity is approximately 79 percent (Reynolds 2012). This reinforces our experience at MPS that managing patient expectations is a vital element in patient care. If patients

© For personal and private use only. Reproduction must be permitted by the copyright holder. Email to copyright@mindbyte.eu.

have unrealistic expectations of the outcome of a test or procedure they are about to undergo, this can contribute to patient dissatisfaction if complications do develop.

Our experiences of the most common underlying pathologies in settled radiology claims relate to patients with cancers (approximately one third of settled radiology claims) and fractures (also approximately one third). The imaging modality most commonly involved in cases where the claim is settled is plain film (just under a third of settled radiology claims), followed by CT and MRI.

Case Report

A 43 year old woman presented with a palpable breast lump. At the surgeon's request a radiologist performed an ultrasound and a mammogram. The ultrasound showed a 1.2cm well-defined low echogenic soft tissue mass. The report suggested this to be a fibroadenoma. The rest of the breasts were clear, there was no specific abnormality and no further clinical investigations were arranged.

Unfortunately, the suggestion of the radiology report was taken as fact and no further treatment, investigation or follow up was undertaken. With hindsight the most appropriate action at the time of the events in 2006 would have been triple assessment, which would have included core biopsy of the lesion. There was a nine month delay in the diagnosis with an adverse effect on treatment and prognosis. The case settled for nearly ½ million euros on behalf of the surgeon.

Managing Risks and Improving Practice

At MPS over 14,000 cases were opened worldwide for doctors in 2011 alone (Medical Protection Society 2012). From our experiences in assisting our members with complaints and lawsuits (claims), we make the following observations. To help prevent claims from occurring, we suggest radiologists and the referring clinicians who requested the radiological intervention should focus on the following areas:

1. Patient Consent

: Before conducting any invasive procedure you should ensure your patient has given valid consent including warning the patient of relevant rare but serious side-effects, as well as common side-effects. Specific risks should be mentioned and documented. You should assess the expectations patients have of the radiological investigation/treatment. If expectations are unrealistic, these should be addressed prior to the intervention itself. You should endeavour to check that your patient has understood the information and has an adequate time period to consider their treatment options, where possible.

2. Reporting:

Ensure that the history given to the radiologist has all relevant historical issues. Radiologists should ensure their reports accurately reflect the image they are commenting on; wherever possible including the degree of clinical confidence when suggesting any diagnostic possibilities (see case report on page X). If the imaging reports indicate an abnormality, ensure you can reasonably exclude serious underlying pathology before suggesting benign diagnoses. Your report should be qualified depending on how confident you are in the abnormality you have identified and not be overly reassuring if significant clinical uncertainties remain. Between yourself and the referring physician/surgeon who requested the imaging intervention, you should ensure there have been adequate steps taken to rule out serious underlying pathology.

MPS experience highlights that issues around getting the diagnosis right are the most common reason for settling claims on behalf of radiologists, and in particular, delays in diagnosing cancers. This shows the importance of ensuring that if there is still reasonable doubt over whether cancer is present following an image study, further investigation/ assessment is warranted. Share your diagnostic uncertainty with the referring clinician. As Halpin explains in his article, errors in reading imaging films may involve errors in perception (not seeing an abnormality that is present;) or, we suggest, errors in interpretation (e.g. wrongly suggesting a lesion is fluid filled when solid) (Halpin 2009). When providing possible clinical diagnoses in a radiology report, the radiologist must take care to provide the appropriate level of clinical confidence and not overstate this.

For interventional radiologists, patients increasingly want to be involved in decisions about their care as part of a shared decision making process. Patients who have been involved in a discussion about the advantages and disadvantages as well as the risks (including collateral injury) involved will have fewer grounds for a successful claim should an adverse outcome occur, particularly if these have been documented.

Conclusion

Fortunately, only a small proportion of adverse outcomes due to medical error actually result in a complaint or claim. This is in large part due to a trusting relationship between the doctors and their patients, along with effective interpersonal skills, both before and after an adverse outcome. In the vast majority of clinical interactions in radiology, the radiologist's contact with the patient is at best transient and often there is none at all; the radiologist reports on an examination image in isolation and after the event, so it can be difficult to build a rapport with a patient. This can make radiologists more vulnerable to a claim as the patient does not see them as someone with whom they have developed a bond of trust and

confidence – they are just a name on a report.

Published on : Thu, 19 Sep 2013