



The Radiology Reporting Chasm

Ask a group of family physicians, internists, orthopedists, and other medical specialists a simple question: “Are you satisfied with the quality of the reports you receive from radiology?” Ask the same question in a slightly different manner: “Having read radiology reports recently, is it clear to you *what* is documented and recommended?”

It is not uncommon to hear complaints about radiology reports. If it is not the lack of clarity in the report, concerns are raised about timeliness of the information. Still others shake their heads in dismay when a radiology report recommends further evaluations. “The insurance company is really going to be happy when I request that MRI!” And then there is the patient who is alarmed that “something must be wrong if the doctor wants me to have that very expensive test.”

A United States District Court Case from Kentucky¹ highlights a number of issues involving the “radiology reporting chasm.” It also addresses the issue of informed consent, but for present purposes the focus is on the matter of radiology reports. The court’s decision points to the importance of radiology documentation as well as provider discussions about the results of a radiology study.

The Kentucky Case.

The patient, N.W. underwent a tubal ligation procedure on June 20, 2007. The procedure was performed by defendant Dr. L. The operation proved complicated. N.W. had undergone previous surgeries that had created surgical adhesions. The result was a distorted impression of the patient’s pelvic anatomy. Along with her excessive weight, the patient’s condition made it difficult to visualize the tubes and ovaries. Dr. L. did not complete the tubal ligation. She continued the procedure. It would later be claimed that Dr. L. burned the

patient's bladder when performing cauterization and that she destroyed a part of the small bowel.

Dr. L. discharged N.W. from the hospital later that day. She did not know that she had not undergone a tubal ligation. Within 8 hours, N.W. began experiencing complications, including severe nausea, abdominal pain and vomiting.²

Dr.L. saw N.W. the next day at her office. She ordered N.W. readmitted to the hospital. Included in the admitting orders was a requisition for an abdominal CT scan. The scan was completed and between 8:30 PM and 9:30 PM Dr. B. interpreted or "read" the results.³

Dr. B. claimed that he telephoned the nurse on duty to report that the scan contained abnormalities. He claimed that he remembered doing so in this situation because the findings were so unusual:

"Specifically, he testified that the scan showed an abnormality in the pelvis and based upon same, he determined that N.W. needed to be reevaluated and may possibly need surgery."⁴

Dr. B. claimed that the nurse said that Dr. L. was in attendance and that that Dr. B. should speak with her directly. None of the nurses deposed in the case recall this specific encounter. Furthermore, Dr. L. claimed that she did not speak with Dr. B. about the scan. Dr. B.'s report was "ambiguous at best."⁵ It did not include any direction with respect to follow-up action.⁶

On the following day, Dr. L. examined N.W. The patient's symptoms had become worse and Dr. L. ordered a general surgery consultation with Dr. D. After he examined N.W. he performed an emergency laporotomy the same day. Dr. L. scrubbed in during the operation and performed a tubal ligation. For her part, Dr. L. did not write any notes or records or a surgical report about her role in the second operation. It was Dr. D. who noted Dr. L.'s involvement in his post-operative report.⁷

Post-operatively, N.W. had an infection that necessitated a prolonged hospital stay. She was unable to return to work until Fall 2007.⁸

Litigation followed against Dr. L. for negligence and lack of consent for the second tubal ligation procedure. She also named as a defendant Dr. B. for failing to meet the applicable standard of care with regard to interpreting some of the

radiology images taken following the first procedure. Dr. L.'s medical group and Dr. B.'s radiology group were also named as defendants.⁹

The court decision involved defense motions for both Partial Summary Judgment and Summary Judgment. Following legal precedent from the U.S. Supreme Court¹⁰ and rules governing civil proceedings,¹¹ the court said:

“Summary judgment is mandated against a party who has failed to establish an essential element of his or her case after adequate time for discovery. In such a situation, there is no genuine issue of material fact as the failure to prove an essential fact renders all other facts irrelevant.”¹²

With these criteria in mind for summary judgment, the U.S. District Court found that with regard to the claim of battery, there was sufficient evidence to establish such a claim. The court rejected the idea that the consent form signed by the patient prior to the first operation also authorized the second tubal ligation. Hence, the court denied a grant of summary judgment for the defense on this count.¹³

The court did agree with the defense on the claim based on fraudulent concealment. Noting that there are three elements that must be met to prove fraudulent concealment, the court said that the facts presented were more appropriate for an allegation of negligence and medial malpractice. Thus the court granted a defense motion for summary judgment on this issue.¹⁴

Perhaps the most telling aspect of the case involved the issue of the standard of care for radiology. The plaintiffs had two expert witnesses who were prepared to testify that Dr. B. deviated from the expected standard of care and this departure caused the patient's injuries. Indeed, one of the experts noted that in reviewing the scan he could see abnormalities. There was a perforation present but the radiologist did not note it in the report.¹⁵

Additionally, an expert witness who was prepared to testify on behalf of Dr. L. was also critical of the radiologist's written report. Looking at the written report standing alone, "...there would appear to be no abnormalities which would call for further tests or other follow-up."¹⁶

The court pointed out that the differences between Dr. L. and Dr. B. about verbal communication in the care of N.W. created a material issue of fact with respect to the liability of the radiologist. Dr. L. stated that:

“...she does not read the CT scans. Rather she relies upon the reports of the radiologist in this regard. She testified that based upon Dr. B.’s written report, she saw no need for emergent follow-up.”¹⁷

The court took note of the disputed testimony of the two physicians. Notwithstanding the testimony of Dr. L. on the subject, Dr. B. stated that Dr. L. was told about abnormalities on the CT scan that warranted follow-up, including possible surgical intervention.¹⁸

Because the two explanations were so different, the court determined that it would be imprudent to grant the defense motion for summary judgment on the issue of the standard of care. In reaching this result, the court pointed out a key portion of the radiologist’s testimony that might serve as “fodder” for the jury in deciding on compliance with the applicable standard of care:

“Finally, Dr. B. himself acknowledges the discrepancy between his written report and his alleged statements to Dr. L. He gives not explanation for the conflict between his written and oral reports....Although not tantamount to malpractice, the incongruity between the reports call into question Dr. B.’s role in N.W.’s serious medical condition.”¹⁹

The court completed the opinion by noting that this was a non-appealable, interlocutory order.²⁰

Observations on the Kentucky Case.

As is so often seen in professional liability claims, breakdowns in verbal and written communication are at the core of civil litigation. The Kentucky case reinforces this point.

However, the Kentucky case begs the question about standards of care that go beyond the issue of alleged substandard practice by the radiologist. If Dr. L. had not completed the first tubal ligation, was there any indication of this result in the post-operative report? In such a report, was there any discussion of intra-operative complications? Such information would be important, especially when soon after her discharge from the hospital the patient experienced the onset of serious problems.

A related concern was the failure of Dr. L. to file a post-operative report following the second procedure. She did not merely scrub-in to observe; she actually

performed a surgical intervention. But for the fact that the general surgeon noted the intervention in his report, there might not have been any record of Dr. L. completing the tubal ligation. Such information is important not only for continuity of patient care; it is also valuable data for purposes of performance improvement, billing and coding, and peer review.

If the hospital did not know about the alleged incompleteness during the first procedure and Dr. L. doing a repeat intervention during the second operation, that too is a serious communication failure. There is also a serious systemic documentation issue that merits careful analysis with a view to process improvement.

Risk Management Strategies for Handling the Radiology Reporting Chasm.

The rapid evolution in electronic medical record systems may help improve the timeliness of documentation practices. However, absent attention to detail in report content, no amount of EMR activity will address concerns about the quality and accuracy of such information. The issue of communication is a focal point in the radiology-reporting chasm. It extends to verbal reports. Timely and accurate reporting methods can be developed to replace tentative, and ambiguous observations in both verbal and written reports. Several risk management strategies can be used for this purpose, including the following:

- 1. Develop A Written Radiology Report Format.**
Work with end-users and radiologists to develop a common format or template for written radiology report. Consider length, layout, and paragraph headings, such as findings, observations, recommended actions, and conclusion. Build into the report boxes for the radiologists to sign, date, and time the report.
- 2. Develop An EMR Template for Written Radiology Reports.**
Build on the hard-copy design described above. Once again, seek input from end-users as well as radiologists. Consider drop down or “free text” boxes in which the radiologist can add more detail. Avoid the use of rigid checkbox statements that may convey the wrong meaning to the end-user. Incorporate into the EMR template a process for closing the loop in terms of the end-user reading the radiology report. Think about including the e-signature of the end-user, and time and date-stamping the entry radiology report once the end-user has

read it.

- 3. Refresh the Taxonomy of Terms in Written Radiology Reports.**
Assemble a team of radiologists and end-users to develop an agreed-upon taxonomy of terms to use in written or electronic radiology reports. Avoid the use of terminology that is ambiguous or subject to multiple interpretations. Discourage use of words and phrases that do not convey the urgency of recommended follow-up action. Refer to national guidelines, pronouncements, and position statements in developing the acceptable taxonomy of terms.
- 4. Develop a Radiology SBAR Approach.**
Encourage radiologists and end-users to consider shaping a new verbal communication approach based on SBAR [Situation-Background-Assessment-Recommendation]. Encourage care provider-to-care provider communication, eliminating the need for other individuals to convey verbal reports. Recognize that in taking such an approach much can be done to enhance patient care, and avoid misinterpretation and possible delays in treatment.
- 5. Provide Written and Verbal Communication Education.**
Recognize that care providers often model their verbal and written communication practices on what they have learned from attendings and preceptors. Reduce the risk of ineffective communication. Have radiologists and other care providers complete baseline communication competencies testing. For those in need of improvement in either written or verbal communication skills, provide them with adult learner-oriented education programs. Reinforce with those who balk at the idea that some accreditation bodies and specialty boards now insist on effective communication as a competency requirement.
- 6. Monitor for Written Radiology Report Opportunities for Improvement.**
Think about implementing a monitoring process for radiology report documentation practices. Recognize that such a step can help to identify systemic and individual areas of improvement and that such activity can help support quality patient care. Note too, that good radiology documentation practices can play a pivotal role in billing and coding practices.

7. Address Identified Issues in Radiology Reporting.

Recognize that with the transition to electronic documentation systems, there may be some challenges in new formats for electronic radiology reports. Factor in as well electronic transcription from voice-recognition software. Obtain input from radiologists so that redesigns are effective in producing timely, accurate, and usable reports

Conclusion.

The radiology-reporting chasm can be a challenging issue for healthcare organizations and care providers. Like other communication issues in the healthcare field, poorly written reports can result in misunderstandings or delays in care. The same is true of vague verbal reports.

From a risk management perspective, there are a number of practical steps to consider in reshaping radiology reporting methods. Taking advantage of the shift to electronic record formats provides a good opportunity to shape documentation into formats that are easy-to-use and read. Getting design assistance from radiologists and end-users may help to assure acceptance and use.

Verbal radiology reports may be ripe for a stylized version of SBAR, a technique that has been seen as fostering good communication practices. To the extent that verbal radiology reports are used, it is very important that once completed, the process should be documented.

Education is important, particularly as new documentation and verbal reporting formats are put into use in a healthcare organization. Working with radiologists and end-users, such steps can help to close the chasm on radiology reporting.

If you would like assistance with developing a risk management program, please contact us at (860) 242-1302.

¹ N.W. v. B.L AWH, T-S R, PSC and M. B., 2010 U.S. Dist. LEXIS 35217 (C .A. No. 08-81-HRW (E.D. KY. April 8, 2010).

² Id.

³ Id.

⁴ Id.

⁵ Id.

⁶ Id.

⁷ Id. Dr. L. asserted that during the second operation she discovered that the tubes were intact and that she proceeded to do the tubal ligation. The plaintiff claimed that Dr. L. knew she had not performed the tubal ligation the first time and that she participated in the second surgery in order to repair the damage without the plaintiff's knowledge. In her lawsuit, the plaintiff claimed that Dr. L. performed a second tubal ligation without her consent.

⁸ Id.

⁹ Id. N.W. asserted that she experienced severe pain, emotional distress, lost income and lost earning capacity. She argued that she had incurred medical expenses and sustained permanent injuries and disfigurement. N.W.'s husband also sought damages for loss of consortium.

¹⁰ *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986), *Celotex Corp. v. Catrett*, 477 U.S. 317, 106 S. Ct. 2548, 91 L. Ed. 2d 265. 477 U.S. 317, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986), and *Matsushita Electric Industrial Co. v. Zenith Radio Corp.*, 475 U.S. 574, 106 S.Ct. 1348, 89 L.Ed.2d 538 (1986).

¹¹ Fed.R.Civ.P. 56(c).

¹² Id. referencing *Celotex Corp. v. Catrett*, 477 U.S. at 322-323.

¹³ *N.W. v. B.L AWH, T-S R, PSC and M. B.*, 2010 U.S. Dist. LEXIS 35217 (C .A. No. 08-81-HRW (E.D. KY. April 8, 2010).

¹⁴ Id.

¹⁵ Id.

¹⁶ Id.

¹⁷ Id.

¹⁸ Id.

¹⁹ Id.

²⁰ Id.