# Risk management opportunities in Radiology

**Misreads and overly narrow diagnostic focus are at the heart of nearly 60% of radiology malpractice cases[1]. While "errors in interpretation" are attributed to knowledge gaps, there are many other opportunities for managing and reducing diagnostic liability risks.**

- Reduce the rate of perceptual errors through deliberate management of workload volume to minimize fatigue; minimize distractions, interruptions and the degree of stimuli that can result in inattentional blindness; and ensure ample time for reporting.
- Ensure high quality images to visualize the structural detail necessary for appropriate interpretation.
- Ensure receipt of adequate clinical information with reviews.
- Avoid "framing" bias by reviewing images before reviewing underlying clinical information.

**Nondiagnostic aspects such as communication and coordination are often critical factors in in liability cases:**

- Take initiative with actionable incidental findings. A failure to directly communicate an incidental finding is a common feature in a substantial number of liability cases. Ensure these actionable findings are reported in a timely and clinically appropriate manner. Strongly consider nonroutine communication by phone or in person to an ordering physician when judged appropriate and create a corresponding note to the health record with the time, date, method, and name of the recipient.
- Recommend further studies or the next appropriate procedure, especially when needed to fulfill the objective of the ordering clinician, and document accordingly. Your expertise in this regard can be the expectation of both ordering clinicians and patients.

## Radiologist Case Study

A 42-year-old married female and mother of two was involved in a motor vehicle collision during the evening. At the ED, a chest X-ray was obtained to rule out rib fracture. The preliminary read by the ED physician was negative. A radiologist reviewed the study early the next morning and noted a diffuse 2.5 cm soft tissue nodule with irregular, poorly defined borders in the superior lobe of the right lung. It was noted in the findings and impressions section of the final report, including a recommendation for follow-up studies to rule out malignancy. The radiologist may have asked an assistant to call the ED to report the potential malignancy, however, no one documented a call. Ultimately, the patient and PCP were unaware of the incidental finding and recommendation. Nearly two years later, during a work-up for chronic cough, wheezing, and hoarseness, the PCP ordered a chest X-ray. A 5 cm well circumscribed right superior lobe lung mass was identified and discovered to be in the same location identified previously. The patient was diagnosed with an adenocarcinoma of the lung, and she died from this disease within two years. The family members filed a wrongful death action against the radiologist, the ordering ED physician, the ED group, and the medical center. The plaintiffs alleged negligent failure to communicate the incidental finding, resulting in delayed diagnosis and treatment, preventing the likelihood of survival had there been treatment soon after the nodule was first identified at the time of the MVA.

**Outcome: A settlement was achieved in view of several weaknesses with the care and inadequate communication.**

Explore the **MIEC Knowledge Library**, which contains valuable patient safety and risk management content.

**Data Driven Risk Management:** MIEC partners with independent sources to supply detailed data that allows for analysis and insight. This information is intended to help MIEC members evaluate their practices and procedures.

**Note:** 1. Candello Discover event search, Event Year 2008-2023, Responsible Service: Radiology with all event types, subspecialties, care settings, major injuries, and clinical severities selected (accessed 6/8/2023).

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