



## A Radiologist's Duty to Communicate with the Treating Physician

By Dean P. Laing and Laura J. Now

Radiologists are often viewed as “doctors’ doctors,” i.e., specialized consultants contracted to read x-ray films of patients referred to the radiologists by treating physicians.<sup>1</sup> In such capacity, radiologists typically review films and dictate their reports, which are then forwarded to the treating physicians without any direct communication with those physicians.

However, beginning in the early 1970s, courts began to recognize a duty on the part of radiologists to directly communicate their findings to the treating physicians under certain circumstances. Since that time, additional case law, as well as the creation of communication guidelines by the American College of Radiology (ACR), has solidified that duty. Failure to directly communicate with a treating physician when the circumstances require direct communication, i.e., immediate disclosure of a finding, may expose a radiologist to legal liability. One study found that the fourth most frequent primary allegation against radiologists was errors in communication.<sup>2</sup>

Yet, while the duty of radiologists to directly communicate radiological findings has been firmly recognized by the courts for a number of years, courts have not been as consistent in articulating when that duty is triggered. As a result, since 1991, the ACR has sought to provide some guidance to radiologists with regard to the communication of radiological findings by establishing a set of communication standards. These standards have since been revised several times, and despite the ACR’s explicit statement that the standards are not to be used to establish a legal standard of care, some

courts have done just that. Consider the following case studies.

### Case Studies

A young mother of two went to see her family practitioner when she, rather suddenly, began experiencing severe headaches and blurred vision. The physician ordered an MRI scan of her brain. The next day, the patient had the MRI. The radiologist dictated his report the same day, noting the existence of an aneurysm. The radiologist did not telephone the patient’s family practitioner to report his findings. He merely sent his report, by ordinary mail over a holiday weekend, to the patient’s treating physician.

Two days after the MRI, the patient collapsed when her aneurysm ruptured. The patient survived, but was left with severe permanent neurological and cognitive deficits. The patient sued the radiologist and the treating physician, alleging, in part, that they were negligent in failing to communicate with each other and that had the radiologist immediately informed the treating physician of his findings, the patient would have had the aneurysm clipped before it ruptured.

In another situation, a middle-aged man went to the emergency room complaining of chest pains and shortness of breath. The emergency room physician ordered, among other tests, chest x-rays. The x-rays were reviewed by a radiologist, who noted the likelihood of a tumor highly suspicious of cancer. The radiologist dictated a report, but the findings were not communicated to the emergency room doctor or the patient; the report was simply placed in the patient’s hospital

chart. A year later the patient died of cancer. His estate brought suit against the radiologist for failing to communicate the findings to the emergency room doctor.

These case studies illustrate a reoccurring issue in medical litigation: the duty of a radiologist to directly communicate his or her findings to a treating physician when the circumstances dictate immediate notification of an emergent condition. A radiologist is the first person to review the results of diagnostic imaging tests used to diagnose and treat disease. This puts radiologists in the unique position of having superior knowledge about a patient’s condition before anyone else. Because of this unique knowledge that radiologists possess, courts have recognized a duty on their part to directly communicate their findings when circumstances so require.

### The Development of a Radiologist’s Duty to Communicate<sup>3</sup>

In September 1991, the ACR adopted its first Standard for Communication-Diagnostic Radiology. The creation of this standard was triggered, at least in part, by several published cases in which the courts were critical of radiologists for not immediately communicating significant findings to the 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 the treating physician was *Keene v. Methodist Hospital*,<sup>4</sup> a 1971 case venued in an Indiana federal court. In that case, the patient received head injuries in a fight shortly after midnight on the morning of December 25, 1966. At about 2 a.m. 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 a.m. and 10 a.m. 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 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 finding 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."<sup>5</sup>

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.<sup>6</sup>

The next published case to address this issue was *Merriman v. Toothaker*,<sup>7</sup> 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

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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 the patient was discharged, a radiologist read the patient's x-rays and 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. However, the attending physician denied ever receiving the report.

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 the emergency room physician 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 . . . (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.<sup>8</sup>

The third published case involving a radiologist's duty to communicate was *Phillips v. Good Samaritan Hospital*,<sup>9</sup> a 1979 Ohio decision. In that case, the patient, a four-year-old child, was injured while playing. She went to a hospital emergency room for treatment. The emergency room physician ordered x-rays, 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 the radiologist's inconsistent diagnosis. Several months later, the patient's fractured arm was diagnosed by another physician, and she underwent surgery. Because the fracture was in a growth area of the bone, there was concern about possible deformity and potential future surgery.

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.

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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.<sup>10</sup>

When determining the appropriate level of communication response needed, the court recognized that the method of communication required by a particular situation depends on the specific facts of the case, but went on to list various factors to be considered in making that determination, including "[s]everity of condition, urgency of treatment, potential for interim injury, suffering from delayed response, need for further analysis and consultation, and the patient's awareness of the extent of injury or the nature of the condition." "Certain medical emergencies," the court held, "may require the most direct and immediate response involving personal consultation and exchange."<sup>11</sup>

The next published case on that issue was *Jenoff v. Gleason*,<sup>12</sup> a 1987 case from New Jersey. The patient in that case fractured her left wrist at work and was hospitalized on September 13, 1980, for surgery. X-rays were ordered of the patient's 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 two-centimeter nodule within the left lower lobe, suggesting a possible lung tumor. The radiologist prepared his report but did not otherwise communicate his findings to the patient's treating physician. 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

[C]ommunication 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. The exigencies of the medical situation may call for different levels of response.<sup>13</sup>

### The ACR Standard

Triggered by these published cases, the ACR adopted its first Standard for Communication-Diagnostic Radiology in September 1991.<sup>14</sup> 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."

This standard has been revised several times since its initial creation. It was first revised in 1995 and then again in 1999, 2001, and most recently in 2005. The current ACR communication standard contains significant changes from the standard as originally implemented.

First, the standard is, in reality, no longer a "standard." What was once the ACR Standard for Communication-Diagnostic Radiology is now titled the ACR Practice Guideline for Communication of Diagnostic

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Imaging Findings. While this shift is partly a matter of semantics,<sup>15</sup> the new name more effectively reflects the intent of the ACR and the nature of the provisions set forth in the Practice Guideline. The ACR has, itself, stated that the guidelines it puts forth are to be used as an educational tool; they are "not inflexible rules or requirements of practice and are not intended, nor should they be used, to establish a legal standard of care."<sup>16</sup>

The current ACR communication guideline recognizes that

Effective communication is a critical component of diagnostic imaging. Quality patient care can only be achieved when study results are

conveyed in a timely fashion to those ultimately responsible for treatment decisions. An effective method of communication should: (a) be tailored to satisfy the need for timeliness, (b) support the role of a diagnostic imager as a physician consultant by encouraging physician to physician communication, and (c) minimize the risk of communication errors.<sup>17</sup>

The Practice Guideline further provides assistance with regard to when non-routine communications should be used to "expedite the delivery of a diagnostic imaging report (preliminary or final) in a manner that reasonably ensures timely receipt of the findings." Situations recognized by the guideline that may require non-routine communication include

1. Findings that suggest a need for immediate or urgent intervention. Generally, these cases may occur in the emergency and surgical departments or critical care units and may include pneumothorax, pneumoperitoneum, or a significantly misplaced line or tube.
2. Findings that are discrepant with a preceding interpretation of the same examination and where failure to act may adversely affect patient health. These cases may occur when the final interpretation is discrepant with a preliminary report or when significant discrepancies are encountered upon subsequent review of a study after a final report has been submitted.
3. Findings that the diagnostic imager reasonably believes may be seriously adverse to the patient's health and are unexpected by the treating or referring physician. These cases may not require immediate attention but, if not acted upon, may worsen over time and possibly result in an adverse patient outcome.



Non-routine communications are to be “handled in a manner most likely to reach the attention of the treating or referring physician in time to provide the most benefit to the patient,” including “by telephone or in person.”

### Interpretation of the ACR Guidelines

Since the inception of the ACR guidelines, various medical journal articles have discussed how the guidelines relate to a radiologist’s duty to directly communicate his or her findings to a treating physician. One such article 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.<sup>18</sup>

While the disclaimer in the Practice Guideline warns that the guideline provisions are “not intended, nor should they be used, to establish a legal standard of care,” and despite the name change from “standard” to “guideline” reflecting the ACR’s intent that its provisions be treated with less rigidity, the ACR guidelines do “take[] on an air of professional prominence and play[] an important role in medico-legal disputes.”<sup>19</sup> Indeed, another medical journal article 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.”<sup>20</sup>

The weight given to the ACR communication guidelines may seem to be somewhat contrary to the view typically held by courts that a deviation from a published guideline will not, in itself, constitute a breach of the standard of care. Courts have seemed more willing to apply the ACR communication guidelines as evidence of a standard of care with which radiologists should comply. For example, while ultimately it is the expert witness’s task to testify as to the proper standard of radiologic care in a given case,<sup>21</sup> some courts have allowed testimony about the ACR guidelines to be considered as evidence of the standard of care applicable to radiologists.<sup>22</sup> Further, some courts have expressed that expert testimony is not needed with regard to the adequacy of a radiologist’s communication, under some circumstances.<sup>23</sup> But regardless of the existence of expert testimony, “[o]nce the need for a communication, and the necessary information that it should contain, have been established, the trier of fact should be able to pass on the issue of adequacy of the communication bearing in mind the facts available to the parties at the time the communication was made.”<sup>24</sup>

With increased reliance on the ACR guidelines as evidence of a standard of care for the communication of radiologic findings, and with the relaxation of the requirement for expert testimony in regards to the adequacy of that communication, at least in some circumstances, radiologists should be especially diligent in communicating directly with a treating physician when the circumstances

surrounding the radiologist’s findings mandate immediate communication.

### Conclusion

Whether relying on established case law or the guidelines established by the ACR, a radiologist’s duty of care is not circumscribed to issuing a formal report, at least when urgent or unexpected findings are discovered. Radiologists should directly communicate to the patient’s treating physician all findings that suggest a need for immediate or urgent intervention; all findings that are discrepant with a preceding interpretation of the same examination and where failure to act may adversely affect patient health; and all findings that the radiologist reasonably believes may be seriously adverse to the patient’s health and are unexpected by the treating or referring physician.

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 unexpected finding, so that it may be beneficially utilized, is as important as the finding itself.

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### Endnotes

1. Leonard Berlin, *Communicating Findings of Radiologic Examinations: Whither Goest the Radiologist’s Duty?*, 178 AM. J. RADIOL. 809, 810 (April 2002).
2. *Id.* (citing a 1997 study by the Physician Insurers Association of America and the American College of Radiology).
3. The discussion of the historical development of a radiologist’s duty to communicate and the creation of the ACR standards draws

substantially from Dean P. Laing, *A Radiologist's Duty to Directly Communicate with the Treating Physician*, 102:5 WIS. MED. J. 13 (2003).

4. 324 F. Supp. 233 (N.D. Ind. 1971).
5. *Id.* at 234.
6. *Id.* at 235.
7. 515 P.2d 509 (Wash. Ct. App. 1973).
8. *Id.* at 511-12.
9. 416 N.E.2d 646 (Ohio Ct. App. 1979).
10. *Id.* at 648.
11. *Id.* at 649.
12. 521 A.2d 1323 (N.J. Super. Ct. App. Div. 1987).
13. *Id.* at 1327.
14. ACR Standard for Communication-Diagnostic Radiology (1991).
15. See Leonard Berlin, *Standards, Guidelines, and Roses*, 181 AM. J. RADIOL. 945, 949 (Oct. 2003).
16. ACR Task Force on Standards Name and Construct Report to the Board of Chancellors

(April 2, 2003).

17. ACR Practice Guideline for Communication of Diagnostic Imaging Findings (2005).

18. Leonard Berlin, *Communication of the Urgent Finding*, 166 AM. J. RADIOL. 513, 514-15 (March 1996).

19. Marc D. Ginsberg, *Beyond the Viewbox: The Radiologist's Duty to Communicate Findings*, 35 J. MARSHALL L. REV. 359, 374 (2001-2002).

20. Philip N. Cascade and Leonard Berlin, *American College of Radiology Standard for Communication*, 173 AM. J. RADIOL. 1439, 1442 (Dec. 1999).

21. See Leonard Berlin, *Duty to Directly Communicate Radiologic Abnormalities: Has the Pendulum Swung Too Far?*, 181 AM. J. RADIOL. 375, 381 (Aug. 2003).

22. Marc D. Ginsberg, *Beyond the Viewbox: The Radiologist's Duty to Communicate Findings*, 35 J. MARSHALL L. REV. 359, 374

(2001-2002). See also *Vaughan v. Oliver*, 822 So. 2d 1163 (Ala. 2001); *Aldoroty v. HCA Health Serv. of Kan., Inc.*, 962 P.2d 501 (Kan. 1998). But see *Stanley v. McCarver*, 92 P.3d 849 (Ariz. 2004) (where the court refused to find a duty to report x-ray results directly to the patient based upon medical ethics standards (including various ACR standards) "because such a notion conflates the existence of a duty with the standard of care."

23. See *Phillips*, 416 N.E.2d at 650; *Jenoff*, 521 A.2d at 1327-28. But see *Courteau v. Dodd*, 773 S.W2d 436 (Ark. 1989) (where the court held that expert testimony was required where the question was not simply one of the adequacy of the mode of communication, but instead dealt with the urgency of the communication).

24. *Phillips*, 416 N.E.2d at 650.