Why Patients Sue Their Radiologists

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Members often ask us why patients choose to sue their radiologists. The easy answer is that, with very few exceptions, patients do not think of any radiologist as “theirs.” In fact, most patients don’t even know the names of the radiologists who read their studies. Going even further down this path, many patients and other members of the public don’t recognize that radiologists are physicians but instead think of them as highly specialized technologists.

Once again, we confront the fact that most diagnostic radiologists rarely “see” their patients. In fact, many patients think that radiologists are technologists because the tech is often the only medical professional with whom the patient comes into contact in a radiology facility. Over the years, this reality of radiology practice has generated concern over its potentially negative impact on the doctor-patient relationship and, ultimately, on the course of treatment. However, the same lack of direct patient contact also can determine who is sued when there is a real or imagined injury to a patient.

Many doctors believe that because lawyers, rather than patients, choose which physicians to sue in a medical malpractice case, the doctor-patient relationship has no effect on the decision. While this is largely true, the first instinct of many lawyers is to take a “shotgun” approach and file against all physicians whose names appear in the chart or other record in relation to the treatment (or lack of treatment) of the claimed injury. Ignoring the psychological impact on the physicians involved, these lawyers rationalize that they can always drop an individual defendant if and when the facts become clearer. Meanwhile, there is always the possibility that a physician will simply make a settlement payment in order to get out of the case.

What’s often not recognized is that while lawyers may decide who to sue, it is patients who most often decide who not to sue. Just as being sued is an emotional experience for physicians, deciding to sue is an emotional process for patients. When patients believe they have been harmed by substandard medical treatment, they usually seek a specific target for their ire. How do they choose the target? Anecdotal reports tell us that many patients are reluctant to bring claims against their obstetricians and gynecologists. This is thought to be because the patients have developed strong emotional ties with those physicians. On the other hand, it is possible that if other specialists have been involved in her treatment, a patient may choose to target those other physicians, rather than the ob-gyn with whom she has developed a bond. The same may be true in any long-established physician-patient relationship.

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Unfortunately, radiologists almost always fall into this “other specialist” category. A patient who has never met or even heard of the radiologist does not have to overcome any guilt about suing a “friend” or trusted caregiver. It is just easier for patients to sue someone they don’t know. It is also easier for patients to believe the physician they do know and trust when that physician says that the radiologist is the one who missed something or made a mistake and is therefore the one responsible for the misdiagnosis, the improper treatment, and ultimately, the claimed injury.

**WHY IS THE PROBLEM SO HARD TO SOLVE?**

So what is the solution to this problem? It’s the same as it’s always been — radiologists should meet, talk to, and get to know radiology patients. It seems almost too simple, yet it still proves difficult to implement in practice.

First, there is the issue of time. Meeting and talking to each patient, even briefly — before the study, after the study, or both — is quite time-consuming and certainly reduces the hours available for formal, uninterrupted diagnostic work.

Next is the issue of who actually interprets the study. Many current group practice arrangements may collect studies for later interpretation by a radiologist who is not present contemporaneously with the patient, thus making it difficult, if not impossible, to meet in person to discuss the study or results.
Then there is the issue of where the interpreting radiologist is physically located. In some practice settings, the interpreting radiologist isn’t located on-site, so even if the radiologist is interpreting during or immediately after the study is completed, it is very difficult to make a face-to-face connection with the patient. Although the radiologist might be able to discuss the findings with the patient by telephone or computer, this is still not the same as meeting and establishing a formal relationship.

All of these factors are magnified in situations where group tele-radiology is in routine use. In addition, nighthawk or dayhawk use can make it even more difficult for the patient to feel connected to either the radiologist or the radiology group. Even if the practice setup favors patient-radiologist interaction, some referring physicians strongly object to radiologists speaking directly to patients and specifically request that radiologists neither deliver reports to patients nor discuss the implications of the reports with patients.

Finally, there is the question of whether physicians choose diagnostic radiology as a specialty because they prefer not to deal directly with patients. While it is never wise to attribute a characteristic to all members of a large group, if this one is true for any significant percentage of diagnostic radiologists, it obviously affects the likelihood that they will voluntarily increase face-to-face contact to facilitate the doctor-patient bond.

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THE SOLUTIONS

So what’s the answer? As some commentators have suggested, the first step might be to include patient contact skills as part of all residency and fellowship training. This would involve providing classroom training in the psychological aspects of interacting with patients and providing more opportunities for mentored patient contact. Additionally, as has been the case with integrating interventional radiologists into radiology groups, group leaders must be willing to restructure practice processes to provide patient contact time. This would involve allowing, and perhaps requiring, interpreting physicians to be on-site with patients for whom they are interpreting as well as insisting that those physicians meet with “their” patients.

None of this will be easy, and it will require leadership and resources to achieve such a significant change in radiology practice. However, such changes have the potential to improve the radiologist-patient relationship and thus reduce legal risk, while at the same time helping ensure the long-term survival of the profession.

REFERENCES


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The ACR Legal Department welcomes questions from members on general legal topics. We cannot provide specific legal advice but will answer questions that apply broadly to radiologists and their practices.

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