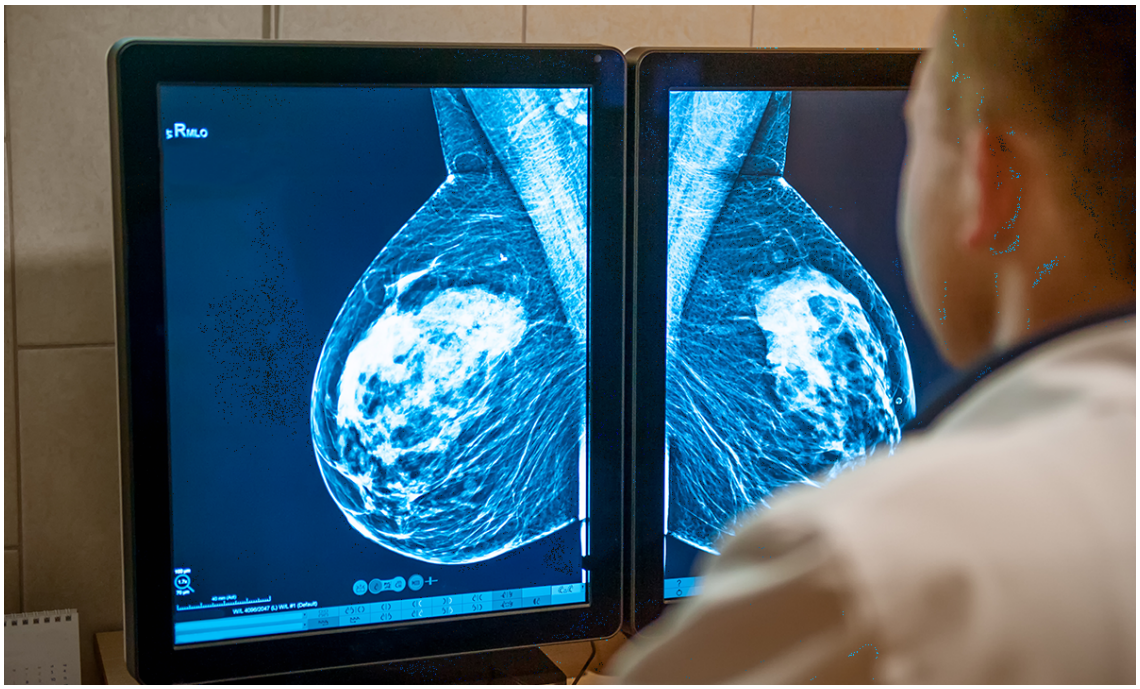
Clear Communication Is Critical



By Brent Kinney, J.D.

“Tell the audience what you’re going to say, say it; then tell them what you’ve said.” This quote is attributable to Dale Carnegie, but it is also something that was impressed upon me by a supervising attorney early in my legal career regarding how to write effective and persuasive legal briefs. I was reminded of this advice while reflecting on the following closed claim review involving a radiologist’s mammogram report.

On September 18, Ms. Tilley[1], a 57-year-old female, presented to a mobile mammogram bus for a routine mammogram. The mammogram was read and reported by Dr. Wall. Dr. Wall noted the following in the findings of the mammogram report: “Asymmetrical 3.2 cm density is seen in the right breast at 10:00 position posteriorly. Additional imaging needed.” The impression of the mammogram report, however, provided the following inconsistent statement: “NO EVIDENCE SEEN TO SUGGEST MALIGNANCY.” Subsequent to the impression, Dr. Wall’s report recommended a follow-up mammogram in one year. On September 20, a letter from the breast center, signed by Dr. Wall, was sent to Ms. Tilley informing her that there were no abnormalities seen on the mammogram. Additionally, Dr. Wall’s detailed mammogram report was sent to Ms. Tilley’s primary care provider.

On May 12, approximately eight months later, Ms. Tilley presented to her primary care provider with concerns of a self-detected mass in her right breast. The primary care provider performed an examination and confirmed that Ms. Tilley would need a mammogram. The primary care provider also informed Ms. Tilley, for the first time, that the September 18 mammogram report indicated there was a mass seen in the right breast (the primary care provider admittedly failed to review the entire mammogram report when it was received eight months earlier). Unsurprisingly, Ms. Tilley was “shocked” and “floored” to learn that approximately eight months had elapsed without being informed of a mass in her right breast.

Ms. Tilley had another mammogram performed on May 18, which confirmed the right breast mass. Ms. Tilley was seen the same day for a biopsy, which confirmed grade 3 invasive ductal carcinoma. Ms. Tilley’s breast surgical oncologist presented Ms. Tilley with the options of segmentectomy versus mastectomy (single or bilateral depending on genetic testing). One month later, Ms. Tilley underwent a modified radical mastectomy of the right breast, with lymph node evaluation, and a prophylactic left mastectomy. The tumor measured 5.7 cm and was characterized as estrogen receptor positive, progesterone receptor negative, and HER2 negative. The tumor was graded at 3 of 3. Four out of nine evaluated lymph nodes, at the time of surgery, were positive for metastatic carcinoma with evidence of extranodal extension present. Ms. Tilley’s tumor had an anatomic stage of IIIA and a prognostic stage of IIIB. Ms. Tilley also received chemotherapy and radiation treatment.

Ms. Tilley filed suit alleging that Dr. Wall, the primary care provider, and the hospital (breast center) were negligent. SVMIC insured only Dr. Wall. The allegations against Dr. Wall included: (a) failing to properly read the September 18 mammogram; (b) failing to identify certain conditions visible on the September 18 mammogram; and (c) failing to properly report the conditions visible on the September 18 mammogram.

As the case proceeded, and although there was evidence of a “flaw” in the hospital’s software systems used to view mammograms and generate reports,[2] it was evident that there was no viable standard of care defense available to Dr. Wall. Despite Dr. Wall correctly identifying the mass in the findings and correctly recommending additional imaging in the findings, Dr. Wall “signed off” on a report where the impression

communicated that the mammogram was normal. Also, despite Dr. Wall having expert support to show that the eight-month delay did not change the treatment that Ms. Tilley received or her long-term prognosis, Dr. Wall elected to pursue mediation. All Defendants participated in mediation where an agreement was reached with Ms. Tilley to settle the case.

As in universal precautions, when every needlestick is presumed infected, it may be prudent to assume that the Impression is the first section of the report to be read. If the Impression is incorrect, critical information may be lost or overlooked. That is the precise scenario that played out in this closed claim review – the ordering provider only read the impression and never learned, until the patient presented eight months later with a self-detected mass, that Dr. Wall had identified a mass on the September 18 mammogram and had recommended additional imaging. Thus, it is imperative that the impression accurately communicate to the ordering provider the radiologist's meaning and interpretation of the findings. Ultimately, the impression may be the only chance for the radiologist to tell the ordering provider what was just conveyed in the findings in a way that provides the most direct and meaningful patient care.

The lessons to learn from this closed claim review do not only apply to radiologists. As John T. Ryman, JD stated in the September 2023 Sentinel newsletter, "communication, communication, communication" is often the most important thing in healthcare. Whether it's a radiology report, a letter to a patient, a consultation note, etc., the provider must always be cognizant of their intended audience and effectively communicate what needs to be said. Effective communication is essential to providing appropriate patient care.

[1] All names have been changed.

[2] The breast center required the radiologists to utilize two separate software systems to view mammograms and generate reports. For example, when reviewing a new mammogram, the radiologist had to first open the mammogram through one software system on one monitor, while opening the same mammogram in a separate software system on a second monitor to generate the mammogram report. As a result, the radiologist could inadvertently have one patient's mammogram pulled up on the first monitor while dictating the report for a different patient on the second monitor.