

Handling the Unexpected or Poor Outcome

Just like other physicians, radiologists may encounter challenging situations where a patient's outcome has been less than optimal. These situations place physicians at risk and how they are handled can directly impact a patient's care either positively or negatively. In this session, we will discuss several radiology-specific scenarios where unexpected or poor outcomes have occurred and how best to handle them. By the end of the session, we hope to improve patient communication skills and understand when apology may be helpful in patient care.

Radiology-specific scenarios: For each of these scenarios, several possible responses are included, some or none of which may be appropriate.

1. Resident X and an attending both miss a fracture that could have been treated with a cast. The patient then returns several weeks later with a displaced fracture that now requires surgery. What should you do?
 - a. Not mention the previous study as a comparison
 - b. Visit the patient and apologize profusely for making an error
 - c. Say nothing to anyone
 - d. Contact risk management about what happened

2. Resident X pre-dictates a chest radiograph and fails to detect a subtle nodule in the lung apex. The attending points out the finding and suggests that the patient return for an apical lordotic view or dedicated chest CT. Resident X makes a note of this change, but in the chaos of multiple telephone calls, the piece of paper is inadvertently misplaced and no change is made to the dictated report. Six months later, the patient returns with a large peripheral lung mass. What should the resident do?
 - a. Not mention the previous study as a comparison
 - b. Mention that in the area of the now-obvious mass, there was a questionable nodule on the previous image
 - c. Describe the finding on the current study with no mention of whether there has been a change
 - d. Visit the patient and apologize profusely for making an error
 - e. Say nothing to anyone
 - f. Contact risk management about what happened

3. A high risk patient has been undergoing yearly mammography and no abnormality has been detected. However, on the most recent study, you notice an asymmetry which clearly has been there for at least 4 years but to your eye, is suspicious. You recommend a biopsy which confirms cancer. The patient asks you whether it was on the prior mammogram. How should you respond?

- a. Tell the patient that it was not visible
- b. Tell the patient that it was there but “missed”
- c. Apologize to the patient that it was “missed”
- d. Explain how in retrospect, it can be easy to “see” the cancer but it probably could not have been picked up prospectively
- e. Contact risk management about what happened

The patient now wants to know why no one told her to get MR screening since her lifetime risk is > 25%. She is convinced that the cancer would have been found sooner if she had undergone the MR screening. What should you say to the patient?

4. Resident Z injects contrast material into a patient with no allergic history, but the patient has an anaphylactic reaction and dies. What should the resident do?
 - a. Let someone else (such as the technologist, attending, or primary care physician) talk to the patient’s family
 - b. Visit the family and express deepest sympathy and explain that this was a rare complication that could not have been anticipated
 - b. Say nothing to anyone
 - c. Contact risk management about what happened
5. The referring physician orders a non-contrast CT on a patient for staging of a malignancy (but does not specify the exact type). The technologist asks the covering resident for a protocol and the resident requests a contrast-enhanced study. Contrast is administered. The study is dictated appropriately. Two days later, the referring physician contacts you and is very upset because you changed his request and he tells you the patient now cannot receive their radioactive iodine treatment for their thyroid cancer for at least several months. What should you do?
 - a. Call the patient and apologize profusely
 - b. Explain how imaging protocols are decided to the referring physician
 - c. Apologize to the referring physician
 - d. Contact risk management about what happened
6. Resident X performed their first MR-guided core biopsy of a suspicious enhancing area in the right breast. At the end of the procedure, the patient experienced some bleeding but compression for 10 minutes seemed to give adequate control. The patient was sent home. Two hours later, the patient calls saying that blood is soaking through her bandage and clothing. You tell her to apply pressure for 10-15 minutes and if the bleeding does not stop to go to the emergency room. You do not hear back from the patient. The biopsy comes back positive for mucinous cancer so you appropriately recommend surgical excision of the area. Two weeks later, you overhear one of the breast surgeons complaining that the surgery is delayed due to the large hematoma and now there is concern that the entire area may be seeded with tumor. What should you do?

- a. Explain to the referring physician that hematomas are not uncommon
 - b. Explain to the patient that this was an expected complication
 - c. Apologize to the patient that she had such a large hematoma and that her surgery is delayed
 - d. Say nothing to anyone
 - e. Contact risk management about what happened
7. Resident A inadvertently punctures a major abdominal vessel during an image-guided interventional procedure. The patient survives emergency surgery and a prolonged hospital course. What should the resident do?
- a. Visit the patient and explain how sorry he/she is for this iatrogenic complication
 - b. Say nothing to anyone
 - c. Contact risk management about what happened