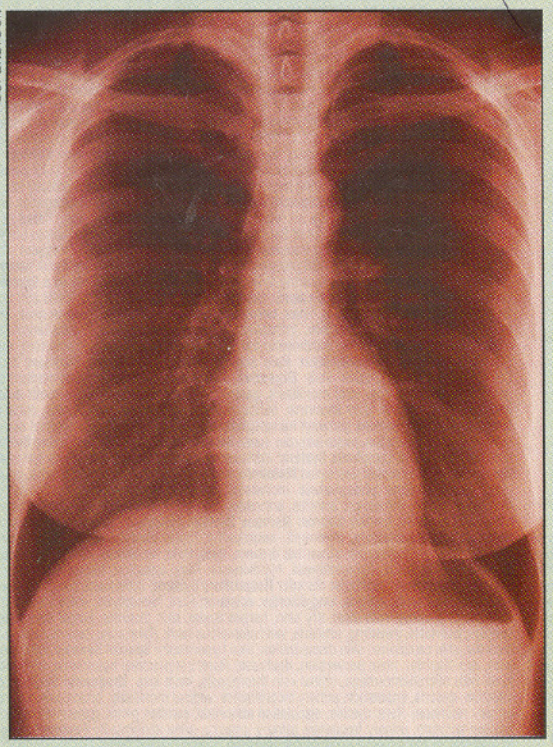

SUPERSTOCK

X-RAY WORTH REPEATING?

A clinician unwisely chooses not to repeat a chest x-ray during an annual exam.

By David S. Starr, MD, JD

After several years of working in a private practice clinic, Ms. F, PA-C, accepted an offer to work in the student health clinic of a university in the Southwest. She loved everything about her new job, particularly the vibrant campus environment, the students she treated, and the regular hours that the opportunity provided. The job was busy but not onerous, and her patients were not as demanding as the ones she had dealt with in private practice. Her responsibilities at the clinic included administering routine physical examinations to university staff members.

One of her patients was an associate professor in the fine arts department. Each year, as his contract required, he submitted to a physical at the on-campus clinic. In 1995, the physician who examined him had ordered a chest x-ray because of the professor's age and history of heavy smoking. The results revealed a small nodule in the periphery of the right middle lobe. A radiologist suggested that the growth was "probably benign." Several related investigations then followed, including a CT scan of the lungs and a consultation with a pulmonologist, who agreed with the radiologist's initial assessment of the lesion. Two chest films taken over the next two years showed that the lesion had not changed in size.

Ms. F's involvement began in 1998, when the professor came in for his yearly checkup. She reviewed the chart and noted that the previous x-rays had all shown a likely benign lesion of constant size. The professor expressed concern that he was "getting too much radiation." After consideration, Ms. F decided against ordering a chest x-ray that year. It was a decision that she was to regret. Although Ms. F never saw him again, he was treated outside the university clinic system. Within a year, the patient was diagnosed with stage 3 large cell carcinoma of the right lung, which was unsuccessfully treated by resection and radiotherapy. He died within the year.

The professor's family sued the university clinic for what the plaintiff lawyer described in court documents as Ms. F's "gross negligence and incompetence" in failing to order a repeat chest x-ray in 1998 and neglecting to follow up on the fate of the nodule detected three years earlier. As the case progressed through discovery and depositions, the respective positions of the parties became more evident. The plaintiff lawyer argued through his experts that Ms. F's failure to order another chest x-ray in 1998 resulted in a missed diag-

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