IN THE

Supreme Court of Virginia

RECORD NO. 100052

ALYSSA CHALIFOUX,

Appellant,

v.

RADIOLOGY ASSOCIATES
OF RICHMOND, INC.,

Appellee.

BRIEF OF APPELLANT

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ASSIGNMENTS OF ERROR

1. The trial court erred by failing to properly apply the continuing care and treatment rule in granting defendant Radiology Associates of Richmond, Inc.'s plea in bar of the statute of limitations.

2. The trial court erred by failing to find that defendant Radiology Associates provided a continuing course of examination and diagnosis to its patient, Alyssa Chalifoux, for the same illness with the same or similar but progressively worsening symptoms from December 2002 through October 2005.

3. The trial court erred by granting defendant Radiology Associates' plea in bar since genuine issues of material fact are in dispute whether defendant Radiology Associates provided a continuing course of examination and diagnosis for the same illness to its patient, Alyssa Chalifoux, from Dec. 2002 through Oct. 2005.

QUESTIONS PRESENTED

1. Whether the trial court committed reversible error by failing to properly apply the continuing care and treatment rule to defendant Radiology Associates of Richmond, Inc. for its care of Ms. Chalifoux from December 2002 through October 2005 (**Assignment of Error No. 1**)?

2. Whether the trial court committed reversible error by failing to find that defendant Radiology Associates provided a continuing course of examination and diagnosis to its patient, Alyssa Chalifoux, for the same illness with the same or similar but progressively worsening symptoms from December 2002 through October 2005 (**Assignment of Error No. 2**)?

3. Whether the trial court committed reversible error by granting defendant Radiology Associates' plea in bar, since genuine issues of material fact are in dispute whether defendant Radiology Associates provided a continuing course of examination and diagnosis to its patient, Alyssa Chalifoux, for the same illness from Dec. 2002 through Oct. 2005. (**Assignment of Error No. 3**)?

NATURE OF THE CASE AND MATERIAL PROCEEDINGS IN THE LOWER COURT

The plaintiff, Alyssa Chalifoux (hereinafter Ms. "Chalifoux" or "Plaintiff"), respectfully submits her Brief of Appellant. A petition for appeal was previously granted from a final judgment entered on October 7, 2009 in the Circuit Court for the City of Richmond.

This case arises from a negligent failure by defendant Radiology Associates of Richmond, Inc. ("defendant" or "Radiology Associates") to detect an intracranial tumor in the trigeminal region on the right side of Ms. Chalifoux' face and head on five (5) separate occasions between December 2002 and Oct. 2005.

The defendant finally discovered Ms. Chalifoux' intracranial tumor on October 22, 2005, which was communicated to her on October 24, 2005. Ms. Chalifoux filed suit on October 9, 2007, within two (2) years of the termination of her physician-patient relationship with defendant Radiology Associates.

The defendant filed a plea in bar based on the Statute of Limitations on October 28, 2008 and requested an evidentiary hearing. After receiving written memoranda with exhibits from both parties, the trial court conducted a hearing on August 13, 2009. The Court delivered a bench ruling granting

the defendant's plea in bar on August 17, 2009. The court issued a letter opinion on October 1, 2009.

The plaintiff filed a formal Motion for Reconsideration on September 4, 2009, based on several grounds. *See* copy of Motion (Joint Appendix, pp. 193-195). The trial court overruled the plaintiff's Motion for Reconsideration and entered judgment on October 7, 2009.

The plaintiff filed her Notice of Appeal on October 28, 2009 and subsequently filed her Petition for Appeal on January 7, 2010. After reviewing the plaintiff's petition and defendant's brief in opposition, this honorable Court granted a *writ of certiorari* as to Assignment of Error nos. 1- 3 of plaintiff's Petition for Appeal on April 15, 2010.

STATEMENT OF FACTS

From Dec. 2002 – Oct. 2005, Alyssa Chalifoux was referred on six (6) separate occasions to defendant Radiology Associates for diagnostic radiology services (i.e. examination and interpretation of radiology studies) at Henrico Doctor's Hospital. In December 2002 Ms. Chalifoux initially saw her family physician, Dr. Stein, who referred Ms. Chalifoux for a brain MRI on Dec. 23, 2002 because of headaches and other symptoms on the right side of her face. Because of defendant Radiology Associates' failure to diagnose Ms. Chalifoux' intracranial tumor and because her symptoms did

not resolve, she was referred to neurologist, Dr. Blevins. *See* copy of plaintiff's Affidavit, (Joint Appendix, pp. 202-205).

Ms. Chalifoux continued to see Dr. Blevins for treatment and referral for follow-up radiological studies through October 22, 2005, when Ms. Chalifoux' intracranial tumor was finally discovered by defendant Radiology Associates. *See* Joint Appendix, pp. 202-205.

The examination and diagnosis by defendant Radiology Associates were for the following eight (8) radiology studies, (Joint Appendix, pp. 356-365):

1. **12.23.02 MRI Brain** examined and interpreted by defendant Radiology Associates employee, Robert Y. Fidler, M.D., and reported to plaintiff's family physician, David Stein, M.D., via written report electronically signed on 12.24.02.

2. **3.9.03 MRI Brain** examined and interpreted by defendant Radiology Associates employee, A. John Kuta, M.D. and reported to plaintiff's neurologist, John D. Blevins, M.D., via written report electronically signed on 3.11.03.

3. **3.9.03 MRA Brain** examined and interpreted by defendant Radiology Associates employee, A. John Kuta, M.D. and reported to plaintiff's neurologist, John D. Blevins, M.D., via written report electronically signed 3.11.03.

4. **3.20.03 MRI C-Spine** examined and interpreted by defendant Radiology Associates employee, Steven M. Wiebe-King, M.D. and reported to plaintiff's neurologist, John D. Blevins, M.D., via written report electronically signed on 3.24.03.

5. **8.2.03 RAD Skull** examined and interpreted by defendant Radiology Associates employee, J. Keith Thompson, M.D. and

reported to plaintiff's neurologist, John D. Blevins, M.D., via written report electronically signed on 8.4.03.

6. **8.2.03 MRI Brain** examined and interpreted by defendant Radiology Associates employee, J. Keith Thompson, M.D. and reported to plaintiff's neurologist, John D. Blevins, M.D., via written report electronically signed on 8.4.03.

7. **2.15.04 MRI Brain** examined and interpreted by defendant Radiology Associates employee, J. Keith Thompson, M. D. and reported to plaintiff's neurologist, John D. Blevins, M. D., via written report electronically signed on 2.16.04.

8. **10.22.05 MRI Internal Auditory Canal** examined and interpreted by defendant Radiology Associates employee, A. John Kuta, M. D. and reported to plaintiff's neurologist, John D. Blevins, M.D., via written report electronically signed on 10.24.05.

During this timeframe, Ms. Chalifoux was experiencing progressively worsening neurological symptoms concentrated on the right side of her face/ head, including headaches, facial pain, paresthesias, sensation disorder and trigeminal neuralgia. *See* Hearing, pp.103-104; (Joint Appendix, pp. 319-320); *see also* plaintiff's Affidavit (Joint Appendix, pp. 202-205).

It is admitted that defendant Radiology Associates is a healthcare provider under Virginia law (i.e. Va. Code §8.01-581.1) and had a physician-patient relationship with Ms. Chalifoux for each and every one of the eight (8) brain studies it examined, interpreted, diagnosed and reported above from Dec. 23, 2002 – Oct. 24, 2005, as both defendant's 4:5(b)(6)

corporate designee, Dr. Howard Faunce, and defense expert, Dr. Karsten Konerding, conceded. *See* Faunce dep., pp. 6, 27-28, 95, (Joint Appendix, pp. 392, 397, 414); Hearing, pp. 21,32, 62-63,108, (Joint Appendix, pp. 237, 248, 278-279, 324).

Each of these radiology studies was related to the same or similar symptoms of the same underlying condition, an intracranial tumor, which defendant Radiology Associates failed to properly diagnose until the Oct. 22, 2005 MRI. Hearing, p.73 (Joint Appendix, p. 289). It is admitted by defendant Radiology Associates that this intracranial tumor was present and visible on every brain study examined and interpreted by defendant Radiology Associates since Dec. 2002. *See* Oct. 24, 2005 Auditory Canal MRI report (Joint Appendix, pp. 364-365) (in which neuro-radiologist and Radiology Associates employee, Dr. Kuta, discovered the intracranial tumor and acknowledged that ***"[t]his probably has been the cause of the patient's clinical symptoms and in retrospect is visible on the previous exams dating to 12-23-02."***).

It is admitted that defendant Radiology Associates was the sole provider of diagnostic radiology services at Henrico Doctor's Hospital of the type that were performed by defendant Radiology Associates during this Dec. 2002 – Oct. 2005 timeframe as well as the sole provider of radiology

services to Ms. Chalifoux during this time period. All of the radiology studies were examined and interpreted by the defendant pursuant to a contract with HCA/ Henrico Doctor's Hospital and referrals from Dr. Stein and Dr. Blevins. See Faunce's dep. (Joint Appendix, pp. 396-397).

The record shows that Ms. Chalifoux was billed exclusively by defendant Radiology Associates for its diagnostic radiology services from Dec. 2002 – Oct. 2005. Hearing, pp.107-108 (Joint Appendix, pp. 323-324); Faunce's dep., pp.87-88. (Joint Appendix, p. 412). Ms. Chalifoux testified at the Aug. 13, 2009 evidentiary hearing that she went for diagnostic radiology with defendant Radiology Associates and not any one particular radiologist during this timeframe. Hearing, p.107 (Joint Appendix, p. 323). Moreover, it was her expectation each time a follow-up radiology study was ordered that defendant Radiology Associates would be the entity examining and interpreting the film as well as reporting its findings and diagnoses. Hearing, pp. 106-107 (Joint Appendix, pp. 322-323).

Ms. Chalifoux relied upon the expertise of defendant Radiology Associates, including its repeated misdiagnoses of normal brain studies leading up to the Oct. 2005 discovery of her intracranial tumor. Hearing, p110 (Joint Appendix, p. 326). It was also apparent to her that Dr. Blevins was relying upon the diagnoses of Radiology Associates in making his

treatment recommendations. However, after each misdiagnosis, Ms. Chalifoux knew and expected that she would need to continue treating with Dr. Blevins and likewise need additional follow-up studies, as her symptoms grew progressively worse over time. *See* Hearing, pp.106, 111 (Joint Appendix, pp.322, 327; *see also* plaintiff's Affidavit (Joint Appendix, pp. 202-205) (detailing Chalifoux treatment history).

In addition to her own testimony describing her continuing physician-patient relationship with and continuing course of examination and diagnosis by defendant Radiology Associates from Dec. 2002 – Oct. 2005, the following undisputed facts were also established through Dr. Howard Faunce, during his June 24, 2009 deposition as President of defendant Radiology Associates of Richmond, Inc. and Rule 4:5(b)(6) corporate designee. *See* Faunce dep., (Joint Appendix, pp. 390-419).

I. Ms. Chalifoux had a direct physician-patient relationship with defendant Radiology Associates.

- Ms. Chalifoux came to Radiology Associates [and not any individual radiologist] to have MRI and other x-rays done. (pp. 5-6)(Joint Appendix, pp. 391-392)

  - Radiologists and neuro-radiologists were on a rotating schedule for defendant Radiology Associates at Henrico Doctor's Hospital as far as who was assigned to hospital on a given day from Dec. 2002 – Oct. 2005. Whoever was on call at hospital at the time was the one who interpreted studies for Ms. Chalifoux. (p.113)(Joint Appendix, p. 418)

II. **Scope of Duties**

- Part of duty to patient and consulting relationship with referring doctor is to speak with treating physician to provide expertise. "There are numerous times where an attending doctor will call us and ask questions." (pp.104-105) (Joint Appendix, p. 416).

III. **Policy and practice regarding warehousing/ filing radiology studies for Ms. Chalifoux**

- Whenever radiology study is performed and report generated, the study and report are warehoused and accessible to radiologists and neuro-radiologists with Radiology Associates for review and comparison. (pp.51-52)(Joint Appendix, p. 403)

- When Ms. Chalifoux came for a series of studies over a number of years for the same symptom(s), the radiology studies were filed together as separate exams, in the same place, in a computer file under Ms. Chalifoux' name. (pp.105-107)(Joint Appendix, pp. 416-417)

IV. **Same symptoms for each study**

- Dr. Faunce believes that Ms. Chalifoux' symptoms were "constant" and "the same all along" for each radiology study performed by defendant Radiology Associates between Dec. 2002 – Oct. 2005. (p.102)(Joint Appendix, p. 416)

Both parties put on expert testimony at the Aug. 13, 2009 evidentiary hearing through their respective radiology experts - Dr. Maurice Lipper for the plaintiff and Dr. Karsten Konerding for the defendant. While the experts disagreed as to the nature of the care provided by defendant Radiology

Associates to its patient, Alyssa Chalifoux, from Dec. 2002 through Oct. 2005, there was consensus regarding several key facts:

- Defendant Radiology Associates had a physician-patient relationship with Ms. Chalifoux for each and every one of the eight (8) brain studies it examined, diagnosed and reported above from Dec. 23, 2002 – Oct. 24, 2005. Hearing, pp. 21-22, 32, 71-71(Joint Appendix, pp. 237-238, 248, 287-288).

- Radiology groups owe a duty of care to their patients to provide non-negligent examination and diagnosis of a patient's medical condition, which is a part of patient care. Hearing, pp. 32-33, 59, 71-72, 82, 100 (Joint Appendix, pp. 248-249, 275, 287-288, 298, 316).

- As part of defendant's duty of care to Ms. Chalifoux, it is expected that each radiology report from December 2002 to October 2005 would have been communicated to Ms. Chalifoux either directly or indirectly through the ordering physician relying upon the defendant's expertise. Faunce dep, pp. 31-32 (Joint Appendix, p. 398); Hearing, p. 82 (Joint Appendix, p. 298).

- If a radiologist believes that an exam ordered is inappropriate or that more exams are needed, then he should contact the referring physician to amend the order or recommend other studies. Hearing, p. 14, 16, 90-92 (Joint Appendix, pp. 230, 232, 306-308).

- Members of a group radiology practice have the power and authority to request referring doctor's treatment notes to get a history of patient's symptoms, especially if they believe the reported symptoms are vague or inadequate. Hearing, p.33, 82 (Joint Appendix, pp.249, 298).

- Moreover, if prior examinations and reports are available, "good practice" "very frequently" requires comparisons with previous studies. If a patient is reporting the same or similar symptoms that get progressively worse over time, as part of "good patient care" a good practitioner should compare prior studies with subsequent

ones to see if an abnormality was missed. Hearing, pp.16, 32, 82 (Joint Appendix, pp. 232, 248, 298).

Despite these uncontested facts, Dr. Konerding concluded that defendant Radiology Associates' care provided to its patient, Ms. Chalifoux, was episodic[1] in nature and any negligence by the defendant between Dec. 2002 – Oct. 2005 were isolated, discrete acts. Hearing, p.52 (Joint Appendix, p. 268).

By contrast, Dr. Lipper, who is licensed in Virginia and Board Certified in Radiology with an additional certification in Neuro-Radiology (which Dr. Konerding doesn't possess), concluded that there was a continuing course of examination and diagnosis as part of the physician-patient relationship between defendant Radiology Associates and Ms. Chalifoux from Dec. 2002 through Oct. 2005. Hearing, p.84 (Joint Appendix, p.300). His opinions are based, in part, on his over 30-year active clinical practice in diagnostic radiology and neuro-radiology, in which he has taught and trained residents at both MCV and the University of Virginia. He is

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[1] In fact, when asked if his entire radiology practice, Commonwealth Radiology, collectively examined, interpreted and diagnosed 29 successive brain MRIs for a patient over a three-year period complaining of the same or similar but progressively worsening symptoms on the right side of her face for the same underlying condition, Dr. Konerding refused to concede any continuing course of examination and diagnosis. Instead, he posited that all 29 exams were discrete, episodic events without any relationship to one another. Hearing, pp. 31-32 (Joint Appendix, pp. 247-248).

currently chairman of quality assurance as well as peer review and credentials for the Radiology Department at UVA Medical Center. Hearing, pp.67-68 (Joint Appendix, pp. 283-284).

Unlike Dr. Konerding, who failed to review any radiological films in preparation for his testimony, Dr. Lipper reviewed all radiological films from Dec. 2002 – Oct. 2005. In addition to his impeccable credentials, Dr. Lipper's opinions were based in part on actually reviewing all radiological reports *and* films. *See* Joint Appendix, pp.228, 284-285.

In addition to the facts agreed upon by both experts, Dr. Lipper also testified to the following, which undergird his ultimate conclusion that defendant Radiology Associates provided a continuing course of examination and diagnosis to Ms. Chalifoux from Dec. 2002 – Oct. 2005:

- All radiology studies examined and interpreted by defendant Radiology Associates from Dec. 2002-Oct. 2005 were directly related to the same or similar but progressively worsening symptoms of the same underlying medical condition (i.e. an intracranial tumor on the right side of face). Hearing, pp. 73-75 (Joint Appendix, pp. 289-291).

- As part of the radiologist's role, he will determine which study the patient should have, what kind of protocols are used for a particular study, whether the patient needs contrast administration, what area of the brain needs to be studied and then he will "see the study with the patient." Hearing, pp.70, 90-91(Joint Appendix, pp. 286, 306-307).

- As reiterated in the trial court's bench ruling, Dr. Lipper testified that "radiologists are empowered to change, modify, and

recommend different studies based upon the plaintiff's symptoms." *See* Joint Appendix, p. 349 (bench ruling); *see also* Hearing, pp. 84, 90-95 (Joint Appendix, pp. 300, 306-311).

- Defendant Radiology Associates owed a duty of care to detect and diagnose abnormalities present and visible for all radiology studies examined and interpreted by the defendant from Dec. 2002 through Oct. 2005. A tumor/lesion should have been a part of the differential diagnosis during this timeframe. Hearing, p. 72 (Joint Appendix, p. 288).

- As part of defendant Radiology Associates' continuing physician-patient relationship with Ms. Chalifoux, there was a duty of care to compare later studies with earlier studies performed during this time frame. Hearing, p. 82 (Joint Appendix, p. 298).

- As a radiologist, Dr. Lipper is copied on records by the referring doctor concerning his ongoing treatment with a patient (e.g. in cases where a mass was discovered). Hearing, p.98-99. In serious cases, the radiologist tends to follow-up with referring doctor concerning care of patient. Hearing, p.99 (Joint Appendix, p. 315).

- Defendant Radiology Associates created a chart for its patient, Alyssa Chalifoux, and all of the radiology studies created, examined, interpreted and reported between Dec. 2002 – Oct. 2005 were filed in the same chart and accessible for review. Hearing, pp.83-84 (Joint Appendix, pp. 299-300).

- Each time defendant Radiology Associates misdiagnosed Ms. Chalifoux' intracranial tumor, it created the need to prolong physician-patient relationship in order to perform additional, appropriate follow-up studies to discover the cause of her clinical symptoms. Hearing, pp. 76-81, 87-88 (Joint Appendix, 292-297, 303-304).

Moreover, Dr. Lipper provided additional testimony through an Affidavit submitted as part of plaintiff's Motion for Reconsideration. *See*

copy of Lipper Affidavit, (Joint Appendix, pp. 197-201). In the Affidavit, Dr. Lipper testified, among other opinions, that:

- Ms. Chalifoux' tumor grew by approximately 3 mm in all directions between Dec. 2002 – Oct. 2005, which correlates with Ms. Chalifoux' complaints of progressively worsening symptoms. The defendant's duty to compare each study performed with prior studies was especially critical, given this growing tumor and progressively worsening symptoms See Affidavit, ¶¶5, 7 (Joint Appendix, p.198); Hearing, p. 83 (Joint Appendix, p. 299).

- In his clinical experience, referring physicians such as Ms. Chalifoux' family doctor, Dr. Stein, and her neurologist, Dr. Blevins, rely upon the expertise of radiology groups to provide proper, accurate diagnoses of illnesses and conditions in order to develop treatment plans. *See* Affidavit , ¶13 (Joint Appendix, p. 199).

- As part of the physician-patient relationship between radiology groups and patients, patients are dependent and rely upon the expertise of radiology groups to provide proper, accurate diagnoses of illnesses and conditions in order to develop treatment plans. *See* Affidavit, ¶16 (Joint Appendix, p. 200).

- As part of their consulting relationships with referring physicians, radiology groups are an adjunct to referring physicians as part of the overall comprehensive treatment and care provided to patients. *See* Affidavit, ¶15 (Joint Appendix, p. 200).

The testimony of Dr. Lipper and Dr. Konerding is also corroborated by the American College of Radiology Practice Guidelines, which were received into evidence at the Aug. 13, 2009 evidentiary hearing. *See* Joint Appendix, pp.39-45. According to the ACR Practice Guidelines, radiologists should do the following in the exercise of good patient care:

- "A copy of the final report should be archived... as part of the patient's medical record... and be retrievable for future reference." ACR Guideline, §II(B)(6) (Joint Appendix, p.384).

- "Whenever possible, previous reports and images should be available for review and comparison with the current study." ACR Guideline, §I (Joint Appendix, p.384).

- "Comparison with relevant examinations and reports should be part of the radiologic consultation and report when appropriate and available." ACR Guideline, §II(A)(3)(e) (Joint Appendix, p.383).

- "A differential diagnosis should be rendered when appropriate." ACR Guideline, §II(A)(4)(c) (Joint Appendix, p.383).

- "Follow-up or additional diagnostic studies to clarify or confirm the impression should be suggested when appropriate." ACR Guideline, §II(A)(4)(d) (Joint Appendix, p.383).[2]

- "Regardless of the source of the referral, the diagnostic imager has an ethical responsibility to ensure communication of unexpected or serious findings to the patient. Therefore, in certain situations the radiologist may feel it is appropriate to communicate the findings directly to the patient." ACR Guideline, §III(B) (Joint Appendix, p.385).

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[2] The American College of Radiology (ACR) has also stated that "[o]ne goal of radiologists is to ensure that radiological examinations are appropriate for the clinical problems. Clearly, this is in the best of the patient and the referring physician and results in the most cost-efficient imaging care delivery." ACR also believes "that radiologists should have the authority to modify an order/referral for a radiological procedure, provided that the study's report or patient's medical records contain the rationale for the change. Educating your referring physicians on this matter is critical in minimizing these problems." *See* Joint Appendix, p.388.

STANDARD OF REVIEW

Defendant Radiology Associates, as the party asserting the plea in bar, has the burden of proof. Tomlin v. McKenzie, 251 Va. 478, 480, 468 S.E.2d 882, 884 (1996). Since it is dispositive in nature, a plea in bar is the functional equivalent of a summary judgment motion. *See* Robinson v. McLeod Co., 59 Va. Cir. 154 (City of Roanoke 2002) *citing* Gay v. Norfolk and Western Railway Co., 253 Va. 212, 214, n*, 483 S.E.2d 216 (1997). Like a summary judgment motion, a plea in bar is a drastic remedy, which may not be granted if there are any material facts genuinely in dispute. *See* Shevel's Inc. – Chesterfield v. Southeastern Associates, Inc., 228 Va. 175, 181, 320 S.E.2d 339, 342 (1984).

ARGUMENTS AND AUTHORITIES

There is ordinarily a 2-year statute of limitations period in which to bring medical malpractice actions. *See* Va. Code §8.01-243. According to the continuing care and treatment rule extending the normal 2-year limitations period, the cause of action for medical malpractice accrues when the improper course of examination and diagnosis terminates. *See, e.g.* Farley v. Goode, 219 Va. 969, 252 S.E.2d 594 (1979); *see also* Grubbs v. Rawls, 235 Va. 607, 369 S.E.2d 683 (1988) (holding that a patient can wait until the end of treatment to complain of any negligence

which occurred during that treatment, even if negligence of physician did not extend until conclusion of physician-patient relationship).

In this case, the continuing course of examination and diagnosis terminated on Oct. 24, 2005, when defendant Radiology Associates properly diagnosed and reported Ms. Chalifoux' intracranial tumor for the first time since it initially examined and misdiagnosed Ms. Chalifoux's MRI brain study in Dec. 2002. Thus, Ms. Chalifoux had 2 years in which to file suit from Oct. 24, 2005. Ms. Chalifoux filed suit on Oct. 9, 2007, within the prescribed 2-year period.

I. The trial court erred by failing to properly apply the continuing care and treatment rule in granting defendant Radiology Associates' plea in bar of the statute of limitations.

Contrary to the trial court's ruling in this matter, the continuing care and treatment rule applies to defeat defendant Radiology Associates' statute of limitation plea in bar in this case. According to established case law, Ms. Chalifoux needs to satisfy two criteria: (1) a physician-patient relationship between defendant Radiology Associates and Ms. Chalifoux between Dec. 2002 – Oct. 24, 2005; and (2) a continuous and substantially uninterrupted course of examination and diagnosis for a particular illness or

condition during this timeframe. *See* Farley v. Goode, 219 Va. 969, 252 S.E.2d 594 (1979).

For the reasons more fully discussed below, Ms. Chalifoux satisfies these criteria and timely filed her Complaint on Oct. 9, 2007, prior to the expiration of the 2-year statute of limitations in this matter.

A. The trial court's reliance on Baker v. Radiology Associates, 72 Ark.App. 193, 35 S.W.3d 354 (2000) is misplaced as it is inconsistent with Virginia law.

The primary source for the trial court's decision to grant defendant Radiology Associates' plea in bar is an appellate decision from Arkansas, Baker v. Radiology Associates, 72 Ark.App. 193, 35 S.W.3d 354 (2000). The court's reliance upon this decision is misplaced as it is inconsistent with prevailing Virginia law.

In fact, while the trial court contends that Arkansas' version of the "continuous treatment" rule is "similar to Virginia", it provides absolutely no basis of similarity.[3] *See* Oct. 7, 2009 letter opinion (Joint Appendix, p.213).

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[3] Moreover, it is clear that Arkansas rarely, if ever, applies the continuing treatment rule, regardless of compelling facts and circumstances, such as the Baker case. *See* Medical Liability Mutual Ins. Co. v. Alan Curtis Enterprises, Inc., 2006 WL 3542986 (E.D.Ark. 2006) (Arkansas federal court holding that "[t]he manner in which Arkansas courts have applied the doctrine suggests that it is rarely applicable. *See, e.g.* Baker v. Radiology Assocs., P.A. 72, Ark.App. 193, 35 S.W.2d 354 (2001) (each allegedly misread mammogram was a separate act)." The Court further stated that

In Baker, the court refused to recognize a continuing tort theory for a series of three mammograms on November 10, 1994, October 26, 1995, and December 5, 1996 in which radiologists with Radiology Associates repeatedly failed to detect breast cancer. When the plaintiff went back to the radiology group on January 22, 1996 for another mammogram, the breast cancer was finally discovered. The Baker court found that these misdiagnoses were a series of single, isolated acts of negligence as Arkansas does not recognize a continuing tort.

However, in contrast to Baker and Arkansas law, Virginia does recognize a continuing tort theory to extend the statute of limitations period. In fact, in the seminal case defining the continuing care and treatment rule, Farley v. Goode, 219 Va. 969, 252 S.E.2d 594 (1979), the Virginia Supreme Court affirmed that a continuing tort can toll the statute of limitations. After discussing several analogous cases, the Court held that:

> None of the foregoing cases controls a decision of the issue presented by this set of facts. In each of those cases, the cause of action stemmed from a single, isolated, non-continuing wrongful act. ***Here, the right of action arose from a***

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the continuing treatment rule was narrowly circumscribed in Arkansas and was specifically rejected in the context of other types of malpractice. Id. By contrast, Virginia has construed the continuing treatment rule more broadly and applied it to other forms of professional malpractice cases. *See, e.g.*, Keller v. Denny, 232 Va. 512, 352 S.E.2d 327 (1987) (legal malpractice); Boone v. C. Arthur Weaver Co., Inc., 235 Va. 157, 365 S.E.2d 764 (1988) (accountant malpractice).

> ***continuous tort in which the negligent failure to diagnose properly resulted in omission to perform or recommend necessary treatment.***

Farley, 219 Va. at 976, 252 S.E.2d at 599 (emphasis added).

In Farley, the plaintiff brought suit against his dentist for dental malpractice. The plaintiff saw his dentist multiple times from 1966 to 1969. Then he did not see his dentist for almost 3 years, from Sept. 1969 to June 1972. Then 9 months transpired between dental visits in 1974. The plaintiff again did not see his dentist for the entire 1975 calendar year. After several visits in 1976, the plaintiff last saw his dentist on August 23, 1976, when the dentist examined his teeth and diagnosed "bone loss". It was later determined that the plaintiff had advanced periodontal disease, which had grown progressively worse since 1971. In reversing the trial court's decision to grant the plea of the statute of limitations, the Virginia Supreme Court in Farley held that the cause of action did not arise from a "single, isolated non-continuing wrongful act" but rather "arose from a continuous tort in which the negligent failure to diagnose properly resulted in omission to perform or recommend necessary treatment." Farley, 219 Va. at 976, 252 S.E.2d at 599 (emphasis added).

Likewise, in this case Ms. Chalifoux' cause of action did not arise from a "single, isolated, non-continuing wrongful act" but rather

arose from a continuous tort, in which the negligent failure to properly diagnose Ms. Chalifoux' tumor on 5 separate occasions over 14 months resulted in both the need for repeated follow-up brain studies and the lack of necessary treatment for several years while Ms. Chalifoux' tumor grew and her symptoms grew progressively worse.

Moreover, this Court has held that, where a healthcare provider negligently causes injury to a patient, subsequent negligent acts will be construed as a "mere aggravation of the original injury" and *not* "separate and distinct torts" where those negligent acts could be reasonably anticipated. *See* Smith v. Kim, 277 Va. 486, 675 S.E.2d 193 (2009). In this case, the initial negligence of defendant Radiology Associates in failing to properly diagnose Ms. Chalifoux' intracranial tumor in December 2002 led to multiple, foreseeable negligent acts in March 2003, August 2003, and February 2004, which aggravated the original injury as Ms. Chalifoux' tumor grew larger and her symptoms grew progressively worse.

As such, whether viewed as a continuing tort or seen from a proximate cause perspective, Virginia recognizes a continuum of negligent care, which diverges from Arkansas law embodied in the Baker decision.

B. The trial court's reliance on Baker v. Radiology Associates, 72 Ark.App. 193, 35 S.W.3d 354 (2000) is inconsistent with an emerging judicial trend to apply the continuing care and treatment rule to radiology groups.

The trial court's reliance on Baker is misplaced not merely by failing to adequately examine whether Arkansas law comports with prevailing Virginia law concerning the continuing care and treatment rule; the court below also unfairly plucked one appellate decision from Arkansas, Baker v. Radiology Associates, 72 Ark.App. 193, 35 S.W.3d 354 (2000), to bolster its decision, without determining if there was persuasive adverse authority from other states which would assist in making a better informed ruling.

An excellent article written after the Baker decision reviews decisions from around the country, including Baker, to determine if the "continuum of care" doctrine should be applied to radiologists. *See* Leonard Berlin, *Malpractice Issues in Radiology – Statute of Limitations and the Continuum of Care Doctrine*, 177 AMERICAN JOURNAL OF ROENTGENOLOGY (Nov. 2001), attached as **Exhibit A.** The truly remarkable aspect of the article is that it is written in a journal for radiologists *by* a member of the Dept. of Radiology at Rush North Shore Medical Center and Rush Medical College in Chicago, IL. *See* id., fn.1.

In the article, the author reviews decisions from the various states which apply the continuum of care doctrine (i.e. continuing care and treatment rule) to toll the statute of limitations. For example, he details a decision from Delaware, Bissell v. Papastavros' Associates, 626 A.2d 856 (Del. Super. 1993), in which the court denied the defendant radiology group's motion to dismiss on statute of limitations grounds in a case involving a failure to detect breast cancer. The court found that:

> When there is a continuum of negligent medical care related to a *single condition* occasioned by negligence, [the continuum may be considered as a single occurrence].... [The second mammogram report] indicates that [it] was compared to the [earlier] mammogram....[The third mammogram report] also refers to the rereading of the [2nd] mammogram....Therefore, the test reports themselves establish a continuum....The... standard requires rereading the most recent prior mammogram as part of the interpretive process for the latest mammogram....Each test required not only its own analyses but a comparison to the last prior test.

Bissell, 626 A.2d at 863-864 (citations omitted) (emphasis in original). Thus, contrary to the rationale in Baker stressed by the trial court in its 10/1/09 letter opinion, courts in Delaware have come to the opposite conclusion and held that comparison with prior radiology studies is not merely "adherence to appropriate diagnostic procedure" but also establishes a continuum of care over time.

The author's review of a spate of recent state appeals court decisions "suggests that a judicial trend is emerging that extends, or imputes, to radiologists the continuum of care doctrine." *See* Berlin, *supra* at 1013. He closes the article with a review of two decisions issued 1 day apart in December 2000. One of those decisions was Baker. The other decision was a case, Montgomery v. South County Radiologists, Inc., 2000 WL 1846432 (Mo.App. E.D. Dec. 19, 2000).

In Montgomery, the Missouri Court of Appeals tolled the statute of limitations under the continuum of care doctrine against a defendant radiology group who had misinterpreted an MRI of the lumbar spine. As even the author of this medical article conceded, the Montgomery court "offered far-reaching and thought-provoking commentary about the practice of medicine and radiology in the 21st century." Because of the scope and compelling nature of the arguments laid out in this decision, it will be quoted extensively below.

> Other jurisdictions have addressed the issue of whether diagnostic services are considered treatment in order to prevent the running of the statute of limitations, thus constituting continuing care or continuing treatment.... These cases look at the relationship of the patient to a provider of health care services which is not the patient's primary care physician. The services rendered are of such underlying importance to the treating doctor, that the continuing care can be imputed to the service provider as a matter of law.

> [In this case, the patient] presented himself for care based on the medical services and expertise of the professionals at the hospital. He placed his trust in his neurosurgeon and those healthcare professionals who were involved in his medical care. He had no reason to doubt that during the course of his care and treatment of his back pain, he was receiving continuous care from all of the doctors who provided their services to him. The radiological services were an essential part of his care without which his neurosurgeon could not properly treat him....Therefore, [the patient] established a continuing relationship with his medical team... Since a doctor-patient relationship existed between [the patient] and the medical team charged with the duty of maintaining his health, the medical team was charged with the duty to inform and treat him for this condition.
>
> In our rapidly changing technological society, there are daily medical advancements and achievements. No longer do patients go to one physician expecting total treatment...; they realize that one doctor is neither capable nor competent in providing every medical specialty. However, patients do expect that their primary doctor will refer, consult, and rely on a team of duly qualified healthcare professionals....Patients understand that ...they will be assisted and monitored by...a team management approach to enhance medical care.
>
> *Yet, when medical specialists assisting the primary care provider make mistakes, there must be accountability for their actions....We do not want to immunize those providing specialist care from liability due to the fact they are providing a specialist treatment and/or diagnosis. [The patient's] radiological services were part of this whole treatment. [The radiologists] knew they were providing continuing care to those patients who routinely returned for radiological services*....Accordingly, [a radiology group] cannot be shielded from liability as an entity.

Montgomery, pp. 8-13 (emphasis added).

Other courts have also concluded that radiology groups are part of a healthcare team working together to provide comprehensive care to the

patient and share the same duty of care to the patient as the primary care physician.

> Once the physician-patient relationship has been found to exist, as could well be found here, the professional responsibilities and duties exist despite the lack of proximity, or the remoteness, of contact between the two as where a consulting physician is involved in only a limited manner. Therefore, all physicians involved in a case share in the same duties and responsibilities of the primary care physician to the extent of their involvement. It is incumbent upon these medical professionals to coordinate their efforts in a manner that best serves their patient's well-being.

Phillips v. Good Samaritan Hospital, *et al.*, 65 Ohio App.2d 112, 116, 416 N.E.2d 646, 649 (Ohio 1979).

Likewise, in this case Ms. Chalifoux routinely returned for radiological services with defendant Radiology Associates on six (6) occasions, as an integral part of the whole treatment offered by her treating providers. As part of their consulting relationships with referring physicians, radiology groups are an adjunct to referring physicians as part of the overall comprehensive treatment and care provided to patients. Ms. Chalifoux' referring physicians, Dr. Stein and Dr. Blevins, relied upon the expertise of defendant Radiology Associates to provide proper, accurate diagnoses of Ms. Chalifoux' underlying condition in order to develop treatment plans. *See* Joint Appendix, pp.199-200.

Despite this "emerging legal trend" and the presence of decisions from numerous states applying the continuing care and treatment rule to radiologists under various rationales, the trial court in the case *sub judice* failed to account for any adverse authority contrary to this lone decision from Arkansas, and failed to properly apply the continuing treatment rule to defendant Radiology Associates.

II. The trial court erred by failing to find that defendant Radiology Associates provided a continuous course of examination and diagnosis to its patient, Alyssa Chalifoux, for the same illness with the same or similar but progressively worsening symptoms from December 2002 through October 2005.

A medical group practice like defendant Radiology Associates is a "health care provider" within the meaning of the Medical Malpractice Act. Va. Code §8.01-581.1 *et seq.* as defendant conceded this point at the Aug. 13, 2009 hearing. *See* Hearing, pp. 21, 62 (Joint Appendix, p. 237). It is also admitted by the defendant that it had a physician-patient relationship with Ms. Chalifoux from Dec. 2002 – Oct. 2005. *See* Faunce dep., p.6 (Joint Appendix, p.392); Hearing, pp. 21-22, 62-63 (Joint Appendix, pp.237-238, 278-279).

The Virginia Supreme Court has clearly stated that an individual like Ms. Chalifoux may be a patient of a group practice. *See* Rosen v.

Greifenberger, 257 Va. 373, 375, 513 S.E.2d 861, 862 (1999). In fact, Rosen is very similar to the matter at hand. Rosen was a medical malpractice case dealing with the negligence of a group ob-gyn practice and its physician members. The Court found that,

> It is a matter of common knowledge and experience that physicians in a group practice regularly rotate "on-call" responsibility for a patient's treatment during non-office hours. Moreover, here the evidence showed that Greifenberger was aware that Dr. Rosen was a member of a group practice, that the other members of the group practice specialized in the same field of medicine, and that she had been treated by all three members of the group practice at various times.

Rosen, 257 Va. at 381, 513 S.E.2d at 865.

Likewise, in this case Ms. Chalifoux was examined and diagnosed by multiple radiologists at various times as part of the group practice, Radiology Associates of Richmond, Inc. These physicians examined and interpreted Ms. Chalifoux' radiology studies as part of their rotating "on-call" responsibility at Henrico Doctor's Hospital, as directed by defendant Radiology Associates, which billed Ms. Chalifoux each time as the exclusive provider of those diagnostic radiology services. As such, Ms. Chalifoux has testified that she believed she had an ongoing physician-patient relationship with the group practice and not any one radiologist.

Where a patient receives diagnostic radiology services from a group practice and not any one particular radiologist, Virginia courts have held

that the continuing care and treatment rule applies to defeat a statute of limitations plea in bar filed by a defendant radiology group. *See* Jones v. Gonzalez *et al.*, (Prince William Co. Cir. Ct. 2001) (Joint Appendix, pp.171-173). In denying the radiology group's plea of the statute of limitations, Judge Millette found that the plaintiff, Mary Jones, since 1987 or 1988, "went to Virginia Radiology Associates and not to one particular doctor and Virginia Radiology Associates continued to diagnose Jones in that period of time." *See* Joint Appendix, p.171.

Because the first prong of the Farley v. Goode test is clearly satisfied in this case – i.e. Ms. Chalifoux had a continuing physician-patient relationship with defendant Radiology Associates from Dec. 2002 – Oct. 2005 (as the trial court stated in its Oct. 1, 2009 letter opinion), Ms. Chalifoux needs only to show a continuing course of examination and diagnosis during this timeframe to defeat defendant Radiology Associates' plea in bar.

A. Ms. Chalifoux was repeatedly examined and diagnosed by defendant Radiology Associates on six (6) occasions for the same underlying condition from Dec. 2002 – Oct. 2005.

In the principal case establishing the continuous care and treatment rule, the Virginia Supreme Court held that a continuous course of "examination" and treatment through failure to properly "diagnose" met the

criteria for "continuous treatment".[4] *See* Farley v. Goode, 219 Va. 969, 252 S.E.2d 594 (1979). *See also* Jones v. Gonzalez *supra* (in which Judge Millette applied the continuing care and treatment rule to defendant radiology group, Virginia Radiology Associates, P.C., by finding that it had performed "a continuous course of examination and diagnosis." *See* Joint Appendix, p.171.

Moreover, the Virginia Supreme Court has held that the continuing care and treatment rule applies when there is "continuous and substantially uninterrupted treatment in which a particular illness or condition should have been diagnosed in the exercise of reasonable care." Fenton v. Danaceau, 220 Va. 1, 255 S.E.2d 349 (1979).

The record shows that Ms. Chalifoux was examined and diagnosed by defendant Radiology Associates for the same or similar symptoms of the same underlying condition on six (6) separate occasions from Dec. 2002 – Oct. 2005. During this interval, Ms. Chalifoux's neurological symptoms were growing progressively worse as her intracranial tumor was growing in size. Defendant Radiology Associates was engaged in a continuous and

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[4] *See also* Black's Law Dictionary, defining "treatment" as "[a] broad term covering all the steps taken to effect a cure of an injury or disease; including examination and diagnosis as well as application of remedies." BLACK'S LAW DICTIONARY, 1502 (6th Ed. 1990) (emphasis added).

substantially uninterrupted course of examination and treatment in which it repeatedly failed to diagnose a "particular illness or condition", an intracranial tumor, which was present and visible on brain studies in Dec. 2002, March 2003, August 2003, and Feb. 2004. Defendant Radiology Associates finally diagnosed Ms. Chalifoux' tumor on Oct. 22, 2005, which was reported to Ms. Chalifoux on Oct. 24, 2005. During this same timeframe, defendant Radiology Associates compiled a total of eight (8) radiology studies in a growing file for its patient, Ms. Chalifoux.

The sheer fact that Ms. Chalifoux had to repeatedly return to defendant Radiology Associates for brain studies with the same, progressively worsening symptoms is indicative of this continuing course of examination and diagnosis.

While there were periods of time between Dec. 2002 and Oct. 2005 in which the plaintiff did not see defendant Radiology Associates for several months and even over a year from Feb. 2004 – Oct. 2005, the plaintiff went back again and again and again, on <u>six (6) separate occasions</u>, to defendant Radiology Associates for the same underlying condition. On those visits, defendant Radiology Associates examined and interpreted the anatomical structures of Ms. Chalifoux' head/brain/neck through her

radiology studies in order to diagnose what was causing her progressively worsening symptoms on the right side of her face/head.

Furthermore, the Va. Supreme Court has never limited the application of the continuing treatment rule to a specific number of years. *See* Farley *supra* (Court found continuing treatment despite patient not seeing his dentist for almost 3 years, from Sept. 1969 to June 1972, 9 months in 1974, or the entire 1975 calendar year); *see also* Justice v. Natvig, 238 Va. 178, 381 S.E.2d 8 (1989) (continuing care and treatment rule applied despite the fact that over 8 years of non-negligent treatment had transpired between the final treatment date and the date of last malpractice.).

In its letter opinion, the trial court referred to a couple of Virginia cases in which the defendant's plea of the Statute of Limitations was granted in the medical malpractice context: Castillo v. Emergency Medicine Associates, P.A., 373 F.3d 643 (4th Cir. 2004) (involving Oct. 10 and 19, 1999 emergency room visits with 2 different ER physicians and 1 phone call to another ER doctor); and Hollingsworth v. Shenandoah Medical Imaging, Inc., 38 Va. Cir. 324, 1996 WL 1065478 (City of Winchester Cir. Ct. 1996) (involving a mammogram on June 4, 1990 and a follow-up mammogram on Oct. 7, 1991).

However, none of the Virginia cases cited by the trial court is comparable to the facts and circumstances in the matter under review showing a continuing course of examination and diagnosis. Ms. Chalifoux was examined and diagnosed by defendant Radiology Associates on (6) separate occasions for the same or similar symptoms related to the same underlying condition. By contrast, none of the Virginia cases above cited by the trial court involved more than 3 interactions with health care providers. Thus, Ms. Chalifoux was examined and diagnosed by defendant Radiology Associates twice as much as any of these other cases. Moreover, in the only Virginia case cited by the defendant dealing with radiologists, Hollingsworth, *supra*, the patient was seen by a radiologist once in June 1990 and again in October 1991. Thus, Ms. Chalifoux continued to be diagnosed by defendant Radiology Associates triple the number of times as occurred in Hollingsworth.

The fact that Ms. Chalifoux was examined and diagnosed on six (6) separate occasions (and misdiagnosed 5 successive times over 14 months) for the same or similar symptoms of the same underlying condition is compelling evidence that Ms. Chalifoux' cause of action did not arise from a "single, isolated non-continuing wrongful act" but rather "arose from a continuous tort in which the negligent failure to diagnose properly

resulted in omission to perform or recommend necessary treatment." Farley, 219 Va. at 976, 252 S.E.2d at 599 (emphasis added).

B. Evidence of continuing course of examination and diagnosis by defendant Radiology Associates is found in the continuing need for additional studies and other evidence showing relationship between each of the six (6) exams and diagnoses from Dec. 2002-Oct. 2005.

It is undisputed that each of the radiology studies examined and diagnosed by defendant Radiology Associates from Dec. 2002 – Oct. 2005 was related to the same or similar symptoms of the same illness, an intracranial tumor; and this intracranial tumor was present and visible on every brain imaging study examined and interpreted by defendant Radiology Associates since Dec. 2002. Moreover, unlike the Baker decision cited by the trial court, there is compelling evidence that on each and every visit with defendant Radiology Associates, Ms. Chalifoux exhibited the same or similar symptoms growing progressively worse over time as her tumor grew in size. It is this fact which provides the context and weaves together every examination and diagnosis by defendant Radiology Associates from Dec. 2002 through Oct. 2005.

The second linkage between these 6 exams and diagnoses are the repeated misdiagnoses on 5 recurring occasions by defendant Radiology Associates leading up to its Oct. 22, 2005 discovery of Ms. Chalifoux'

intracranial tumor. Each time Radiology Associates misdiagnosed Ms. Chalifoux' intracranial tumor, it resulted in the need for additional follow-up studies to determine the cause of her headaches, and right-sided facial pain, paresthesias, sensation disorder and trigeminal neuralgia.

As such, consistent with Judge Millette's opinion in Jones v. Gonzalez, "each diagnosis in this case rested upon the correctness of the previous diagnosis." *See* Joint Appendix, p.171.[5] Contrary to the Arkansas court's holding in Baker, the need for additional studies shows that Ms. Chalifoux *needed* follow-up care and treatment with her neurologist, Dr. Blevins, and defendant Radiology Associates, in whose expertise Dr. Blevins relied for his treatment plan. It was the defendant's "negligent failure to diagnose properly [which] resulted in [Dr. Blevins' and Radiology

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[5] *See also* Johnson v. Capital Area Permanente Group, 30 Va. Cir. 107 (Fairfax Co. Cir. Ct. 1993), in which Judge Lee denied the plea of the Statute of Limitations by corporate medical defendant, American Medical Laboratories (AML), which performed blood tests, including HIV testing, on the plaintiff in Dec. 1988 and Jan. 1989, falsely showing she was HIV-positive. AML's misdiagnosis of the plaintiff caused her to suffer many damages and unnecessary treatment from her treating physician who relied upon the diagnoses of AML. According to the Court in Johnson, the plaintiff received "diagnosis and treatment for the same or related illnesses or injuries, continuing after the alleged act of malpractice for the same or related illness." Johnson, 30 Va. Cir. at 110. While AML was not deemed a "health care provider", the "continuing treatment" rule applied since the "treatment Johnson received from her physician rested upon the correctness of the diagnosis." Id. *See* copy of the Johnson decision (Joint Appendix, pp.187-192).

Associates'] omission to perform or recommend necessary treatment." Farley *supra*.

Thirdly, it is uncontested that defendant Radiology Associates had a duty to compare brain imaging studies being interpreted with prior studies. While the Baker court discounts this fact, Ms. Chalifoux' growing patient chart of prior imaging studies and reports compiled by Radiology Associates and readily accessible for review, provides *context* and relational/patient care history between the defendant and Ms. Chalifoux sufficient to show a continuing course of examination and diagnosis rather than episodic care.[6] *See* Bissell, *supra*.

Finally, unlike the case in Baker, *supra*, there is evidence of "active consultation" by defendant Radiology Associates with the referring physicians throughout the course of its multiple examinations and diagnoses of its patient, Ms. Chalifoux, from Dec. 2002 through Oct. 2005.

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[6] In fact, defendant Radiology Associates had warehoused a head CT for an unrelated condition they had performed in June 2000, as part of Ms. Chalifoux' file. In Dec. 2002, defendant Radiology Associates compared this June 2000 head CT with the initial Dec. 2002 brain MRI. *See* Joint Appendix, p. 356. Ms. Chalifoux' intracranial tumor was present and visible on the Dec. 2002 brain MRI. Moreover, when Radiology Associate employee, Dr. John Kuta, finally detected and diagnosed Ms. Chalifoux' intracranial tumor in Oct. 2005, he compared this study with previous studies on file and stated, ***"[t]his [tumor] probably has been the cause of the patient's clinical symptoms and in retrospect is visible on the previous exams dating to 12-23-02."*** *See* Joint Appendix, pp.364-365.

The defendant maintains it had a consulting relationship with the referring physicians, Dr. Stein and Blevins, during this timeframe. *See* Faunce dep., pp. 6, 39, 104-105 (Joint Appendix, pp.392, 400, 416). As such, the defendant admits that Radiology Associates routinely communicates with the treating physician to provide expertise. "There are numerous times where an attending doctor will call us and ask questions." Faunce dep., pp.104-105 (Joint Appendix, p.416).

This fact is corroborated by Dr. Lipper who testified that he is copied on records by the referring doctor concerning ongoing treatment with a patient (e.g. in cases where a mass was discovered). In serious cases, the radiologist tends to follow-up with a referring doctor concerning care of the patient. Hearing, pp. 98-99 (Joint Appendix, pp.314-315).

Both experts also concur that if a radiologist believes an exam ordered is inappropriate or more exams are needed, then he should contact the referring physician to amend the order or recommend other studies. *See* Joint Appendix, pp. 230, 232, 306-308. Members of a group radiology practice have the power and authority to request referring doctor's treatment notes to get a history of patient's symptoms, especially if they believe the reported symptoms are vague or inadequate. *See* Joint Appendix, pp.249, 298.

C. Defendant Radiology Associates' continuing course of examination and diagnosis may be imputed from the continuing treatment of Dr. Blevins, who relied upon the defendant's repeated diagnoses for his treatment recommendations through October 2005.

Defendant Radiology Associates admits that it had a physician-patient relationship with Ms. Chalifoux and provided consulting expertise to Dr. Stein and Dr. Blevins as part of its duty to Ms. Chalifoux. *See* Faunce dep. pp.6, 39, 104-105 (Joint Appendix, pp.392, 400, 416). *See also* defendant Radiology Associates' Responses to plaintiff's 1st Request for Admissions (Joint Appendix, pp.174-185).

Moreover, Dr. Blevins relied exclusively upon the defendant to provide diagnostic radiology services during this entire time period and developed a continuing treatment plan for Ms. Chalifoux based on the diagnoses provided by defendant Radiology Associates. *See* Joint Appendix, pp.200, 204.

Thus, the continuing physician-patient relationship of defendant Radiology Associates is co-extensive with Dr. Blevins until the date of the final MRI report communicated to Dr. Blevins on Oct. 24, 2005 and his continuing course of treatment should be imputed to defendant Radiology Associates. *See, e.g.*, Montgomery *supra* (radiology "services rendered are of such underlying importance to the treating doctor, that the continuing

care can be imputed to the service provider as a matter of law.); Sharsmith v. Hill, 764 P.2d 667 (Wyo. 1988) (attending physician's treatment is imputed to the pathologist because the attending physician "continued to rely upon the missed diagnosis of the pathologists throughout his course of treatment."); *see also* Sander v. Geib, Elston, Frost Professional Assoc., 506 N.W.2d 107 (S.D. 1993) (imputing treatment of attending physician to pathologist where reasonably expect that treating doctor will rely on his diagnosis); *see also* Fonda v. Paulsen, 46 A.D.2d 540, 545, 363 N.Y.S.2d 841 (N.Y. 1975) ("where the pathologist should have reasonably expected that his work would be relied on by other practitioners in determining the mode of treatment, we feel it appropriate to impute to that pathologist or diagnostician constructive participation in that treatment so long as it continued.").

III. The trial court erred by granting defendant Radiology Associates' plea in bar since genuine issues of material fact are in dispute whether defendant Radiology Associates provided a continuing course of examination and diagnosis to its patient, Alyssa Chalifoux, for the same illness from Dec. 2002 through Oct. 2005.

There are genuine issues of material fact which are disputed by the parties in this matter, which thereby precludes granting defendant's plea in bar. *See* Rule 3:20 of the Rules of the Supreme Court of Virginia. In

particular, the parties dispute whether there was a continuous course of examination and diagnosis by defendant Radiology Associates from Dec. 2002 – Oct. 2005.

While the parties may agree on many of the facts for determination of this plea, the core dispute may still be deemed a factual one, as even counsel for defendant Radiology Associates argued to the trial court:

> [T]he question we have here is essentially a factual one, which is whether or not that the care provided by radiologists, in this case the radiology group through its doctors, was episodic or a continuing relationship.

Hearing, p.113 (Joint Appendix, p.329).

Because the record contains credible but diametrically opposing theories of the nature of the care provided by defendant Radiology Associates' to its patient, Ms. Chalifoux (i.e. continuing v. episodic), a genuine issue of fact exists precluding summary judgment. *See* Montgomery v. South County Radiologists, Inc., 49 S.W. 3d 191, 193 (Mo. 2001) (In a similar case involving application of the statute of limitations "continuing care" exception to a radiology group, the Missouri Supreme Court held that where "the record contains competent materials establishing two plausible but contradictory accounts of the essential facts, a "genuine issue" of material fact exists, and summary judgment cannot be granted.").

To the extent there are disputed material facts integral to resolution of the defendant's plea, this matter is not ripe for determination by the Court and should be decided by a jury at a trial on the merits. *See* Shevel's, *supra.*

CONCLUSION

For the reasons discussed above, the Plaintiff, Alyssa Chalifoux, respectfully requests that this Court reverse the decision of the trial court, remand this matter back to Richmond City Court for a jury trial consistent with this Court's holdings and such other and further relief as this Court deems appropriate.

Respectfully submitted,

Alyssa Chalifoux

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CERTIFICATE

a) The Appellant is Alyssa Chalifoux. She is represented by Philip S. Marstiller, Jr., Esquire, Emroch & Kilduff, LLP, 3600 West Broad Street, Suite 700, P.O. Box 6856, Richmond, VA 23230-0856; telephone number (804) 358-1568.

b) The Appellee is Radiology Associates of Richmond, Inc., which is represented by Brewster S. Rawls, Esquire, and Sandra M. Holleran, Esquire, Rawls & McNelis, 1111 E. Main Street, Suite 1701, Richmond, Virginia 23219.

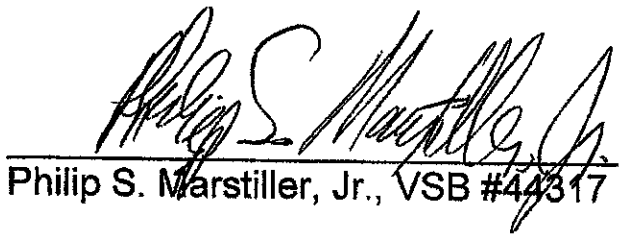
c) Three copies of the foregoing Brief of Appellant were hand-delivered this 25th day of May, 2010, to Brewster S. Rawls, Esquire, Rawls & McNelis, 1111 E. Main Street, Suite 1701, Richmond, Virginia 23219.

d) Counsel for the Appellant desires to state orally and in person the reasons why her Appeal should be granted.

e) That on the 25th day of May, 2010, an original and 15 copies of this Brief of Appellant were filed with the Clerk of this Court.

f) That on the 25th of May, 2010, an original Joint Appendix and 15 copies of this Joint Appendix were filed with the Clerk of this Court.

g) Three copies of the foregoing Joint Appendix were hand-delivered this 25th day of May, 2010, to Brewster S. Rawls, Esquire, Rawls & McNelis, 1111 E. Main Street, Suite 1701, Richmond, Virginia 23219.



Philip S. Marstiller, Jr., VSB #44317

Exhibit A

Malpractice Issues in Radiology

Statute of Limitations and the Continuum of Care Doctrine

Leonard Berlin[1]

The Case

A 65-year-old woman was referred by her family physician to a free-standing radiology facility for screening mammography. The findings on the mammograms were interpreted by a radiologist as normal except for "mild fibrocystic changes." One year later, the physician again referred the woman to the same radiology facility for screening mammography. On this occasion, the same radiologist interpreted the findings as normal except for "mild fibrocystic changes, unchanged since previous mammography 1 year ago."

Eight months later, the woman consulted her family physician because she noticed a lump in her left breast that appeared soon after her husband had accidentally struck her on the breast with a golf club. The physician examined the woman's left breast and found a lump, which he believed was due to the golf club incident. Nonetheless, the physician ordered a mammogram. The same radiologist who had interpreted findings on the woman's two previous mammograms as normal now interpreted the findings on the new mammograms as revealing microcalcifications in the left breast that were suspicious for carcinoma. The report was communicated to the family physician by telephone and in writing. However, the physician failed to inform the patient of the suspicious findings.

Eight months later the patient, noticing that the lump was growing, again consulted her physician. A biopsy, quickly obtained, disclosed infiltrating ductal carcinoma. Despite aggressive treatment that included surgery, radiation, and chemotherapy, the patient died 16 months after the diagnosis was established.

Three days before the patient's death, the woman and her family filed a malpractice lawsuit against the family physician and the radiologist. The lawsuit charged the family physician with negligence for failing to advise her that the findings on the mammogram obtained after the golf club injury had been suspicious for carcinoma, resulting in an 8-month delay in the cancer diagnosis. The lawsuit charged the radiologist with negligence for misinterpreting the patient's second screening mammogram—the one that had been obtained 16 months before the diagnosis of breast cancer had been established.

Medical-Legal Issues

The family physician and the radiologist had separate professional liability insurance carriers and defense attorneys. I will focus on the allegation of malpractice directed at the defendant radiologist and on the unique medical–legal issue it raised, the doctrine of continuum of care. In the documents outlining the details of the alleged malpractice, the attorney for the plaintiff included an affidavit executed by an expert radiology witness that stated that the patient's second screening mammogram, the one that had been interpreted as normal "except for fibrocystic changes unchanged since previous mammography of 1 year ago" had been "grossly" misinterpreted. The affidavit claimed that the carcinoma that had later been diagnosed was clearly evident on the patient's second mammogram and that, contrary to the defendant radiologist's report, the second mammogram had shown "marked changes" when compared with the patient's first screening mammogram that had been obtained 1 year before.

After carefully reviewing the medical records and relevant legal documents, the defense attorney concluded that the malpractice lawsuit against the defendant radiologist was not valid because it was filed more than 2 years after the alleged mammographic misinterpretation. The state's statute of limitations, the law that sets forth the period of time during which a legal claim for malpractice must be filed, was 2 years after the alleged incident of malpractice. This particular lawsuit was filed 2 years 8 months after the alleged act of malpractice and, in the opinion of the defense attorney, would be barred by the court. Consequently, the defense attorney filed a motion with the court to dismiss the malpractice lawsuit

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Case summaries are based on actual events and lawsuits, although certain facts have been omitted or modified by the author, who has supplied and obtained authorization for the reproduction of the radiographic images. All opinions expressed herein are those of the author and do not necessarily reflect those of the *American Journal of Roentgenology* or the American Roentgen Ray Society.

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EXHIBIT
A

against the defendant radiologist. On receipt of this motion, the judge ordered that written arguments be prepared by the respective attorneys and oral arguments be scheduled.

At the scheduled hearing, the attorney for the plaintiff argued that the 2-year period during which the malpractice action could be filed did not begin with the date of interpretation of the patient's second mammogram but, rather, on the date on which the defendant radiologist interpreted the last mammogram, the one interpreted as suspicious for cancer. The plaintiff's attorney contended that because all three mammograms obtained were interpreted by the same radiologist, the three examinations constituted a "continuum of care," not three separate and unrelated medical acts. The plaintiff's attorney also added that because the standard of radiologic care required the radiologist to reinterpret all previous mammograms at the same time that he interpreted the new mammograms, all three mammograms constituted "a single episode of continuing care related to the early detection of breast cancer."

The attorney defending the radiologist countered that the three mammograms were individually complete, separate, and unrelated and that therefore the doctrine of continuum of medical care did not apply.

After due consideration, the judge issued a written opinion denying the defendant radiologist's motion to dismiss, holding that the doctrine of continuum of care did apply and, therefore, the lawsuit against the defendant radiologist was not barred by the statute of limitations [1]. The judge explained his ruling by first acknowledging that...

> ...No action for the recovery of damages upon a claim against a health care provider for personal injury arising out of malpractice shall be brought after the expiration of 2 years from the date upon which such injury occurred....

The judge then continued:

> [However], when there is a continuum of negligent medical care related to a single condition occasioned by negligence, over a finite period of time, [the continuum may be considered as a single occurrence]. [The second mammogram report] indicates that it was compared to the [earlier] mammogram...[and] refers to the rereading of the [earlier] mammogram.... Therefore, the test reports themselves establish a continuum.... The standard requires rereading the most recent prior mammogram as part of the interpretive process for the latest mammogram.
>
> The allegation is that the [second] mammogram was misinterpreted when originally read. In addition, when reread 8 months later, according to the plaintiff, it was misinterpreted again. Thus, there are two negligent acts relating to one condition in a finite period of time. What is in dispute is whether the tests are separate and discrete as defendant claims or a continuum of negligent treatment as plaintiff claims.... [The patient] was tested by defendant three times in 2 years. Each test required not only its own analysis but also a comparison to the last prior test. The tests are designed to establish a benchmark and provide a basis for ongoing comparison.... [The plaintiff] has adequately pled a course of action for continuous negligent treatment.

After the judge's ruling, the defendant radiologist and the defendant family physician settled the lawsuit with the patient's family for an undisclosed payment.

Discussion

Because of the belief that the passage of time makes defending lawsuits unreasonably burdensome, all states have passed legislation in the form of statutes that specify the period of time during which a medical malpractice lawsuit may be filed—in other words, that limit the filing of such lawsuits to a specified time period after the alleged act of malpractice has taken place [2]. These statutes of limitations vary from state to state, but generally, the time allowed for filing lawsuits ranges from 2 to 3 years and begins on the date of actual occurrence of the alleged act of malpractice or the date on which the patient should reasonably have been expected to discover that the negligent act has occurred [3]. Most states will extend, or "toll," the running time prescribed in the statute if the injured patient is a minor, legally or mentally incompetent, or incarcerated [4]. The fraudulent concealment by a physician of any medical acts or errors will also extend the statutory period during which malpractice suits can be filed [5, 6].

The reason that the statutory period in which lawsuits can be filed varies among the 50 states and the District of Columbia is that state legislatures have differing opinions about which time periods are desirable. A longer statute of limitations is perceived to be beneficial to the injured patient who otherwise might be unable to discover his or her injury quickly; it may also arguably deter physicians from committing malpractice to a greater degree by making them pay for negligent care no matter when it comes to light [7]. A shorter statute, on the other hand, is perceived as beneficial to the defendant physician, who may otherwise be inappropriately held liable on the basis of stale evidence and hindsight medical testimony. However, a shorter statute of limitations may also encourage concealment of negligent acts committed by physicians because the shorter time decreases the likelihood that evidence of malpractice will be discovered during that period. Nevertheless, some legal commentators believe that shortening the statute of limitations is advantageous because it encourages patients who are injured by malpractice to act decisively, rehabilitate themselves, and generally "get on with their lives" [7].

As I have indicated previously [8], for public policy reasons courts give persons alleging injury from medical malpractice considerable latitude as to the evidence required to allow these persons to initiate litigation against physicians suspected of having committed malpractice. As a result, courts are often reluctant to apply the statute of limitations too strictly for fear that doing so would have a chilling effect on an injured patient's access to the courtroom.

One theory the courts have devised to toll the statute of limitations is to postpone the commencement of the limitations period in situations in which a physician provides continuing care over a period of time to a particular patient for a specific injury or illness until the treatment of the condition has ended or the relationship between the doctor and physician is terminated, notwithstanding the actual time of occurrence of the alleged act of negligence. Referred to as the continuum of care doctrine, this legal concept is based on the premise that a physician has a continuing obligation to correct an error made during the course of treatment and that the failure to make such correction constitutes continuing negligence [4]. Under this doctrine, the period covered under the statute of limitations commences from the last day of treatment, regardless of when the malpractice occurred. Another basis for adoption of the continuum of care doctrine is the court's recognition of the patient's right to trust the physician and, accordingly, not to be pressured because of an approaching expi-

ration of the filing deadline into bringing legal action against a physician while treatment is continuing [4].

Jurisdictions that recognize the continuum of care doctrine include Alaska, Arkansas, Colorado, Connecticut, Delaware, Illinois, Maryland, Minnesota, Missouri, Nebraska, New York, North Carolina, Ohio, Pennsylvania, South Dakota, Texas, Virginia, Washington, Wisconsin, Wyoming, and the District of Columbia [9]. Although initially applicable only to primary care physicians and therefore not controversial, the continuum of care doctrine has engendered controversy by virtue of its being extended to include consulting physicians such as radiologists who although not providing direct continuing care to patients, nonetheless provide diagnostic opinions on which primary care physicians base patient treatment decisions. A review of recent state appeals court decisions suggests that a judicial trend is emerging that extends, or imputes, to radiologists the continuum of care doctrine.

I shall begin with a 1998 decision of the Supreme Court of Wyoming that tolled the statute of limitations in a medical malpractice lawsuit filed against a pathologist, although the court's reasoning could apply to radiologists. A pathologist misdiagnosed a soft-tissue mass removed from the knee of a patient as a benign neurilemmoma. Later, it was discovered that the mass was a malignant schwannoma, and as a result, a medical malpractice lawsuit was filed against the pathologist. However, the lawsuit was filed after the expiration of the 2-year statute of limitations. The defendant pathologist argued that the malpractice case should be barred, but the Supreme Court of Wyoming ruled that the lawsuit was viable because of what it called the doctrine of continuous course of treatment. The court stated [10]:

> Wyoming's statute of limitations for medical malpractice actions begins to run at one of two alternative times: (1) the time of the alleged act, error, or omission giving rise to the plaintiff's claim or (2) the time of discovery of the alleged act, error, or omission.... [The defendants] assert that because plaintiff discovered the [alleged malpractice] within 2 years of its occurrence, the statute of limitations had run by the time [plaintiff] filed the lawsuit. [The plaintiff] argues that the statute did not begin to run until termination of [the attending physician's] continuous course of treatment...and that [the attending physician's] course of treatment should be imputed to the pathologists, because [the attending physician] continued to rely upon the missed diagnosis of the pathologists throughout his course of treatment. We agree that [the attending physician's] course of treatment should be imputed to [the pathologist].
>
> It was not the error in the diagnosis originally made by defendant but its adherence thereto and course of treatment that brought about the injuries. In the present case, it was [the attending physician's] adherence to [the pathologist's] diagnosis which dictated the nature and duration of plaintiff's treatment.... Until the alleged misdiagnosis was corrected, or until [the attending physician] ceased to rely upon it, [the pathologist's] constructive involvement in that treatment was sufficient to...prevent the running of the statute of limitations. We conclude that, for purposes of the statute of limitations, [the attending physician's] course of treatment should be imputed to [the pathologist,] on the grounds of fairness as well as on the basis of logic.

The Supreme Court of South Dakota also ruled that the doctrine of continuum of medical care can toll the statute of limitations when pathologists are defendants. A pathologist was sued for misinterpreting a Pap smear, thereby delaying the diagnosis of carcinoma of the cervix. The court stated [11]:

> The nature of a pathologist's work is such that he rarely, if ever, has a direct physician-patient relationship with an individual—in other words, he never treats patients in a conventional sense—but his work is often the basis upon which the nature of subsequent treatments to be given by the attending physician is determined.... Where the pathologist should have reasonably expected that his work would be relied on by other practitioners in determining the mode of treatment, we feel it appropriate to impute to that pathologist or diagnostician constructive participation in that treatment so long as it is continued. In this way, the practitioner guilty of the initial malpractice is subject to the same period of limitations as those who continued the malpractice as a...result of the initial wrong....

The likelihood that such reasoning would be equally applied to radiologists is obvious.

As indicated previously, courts in various states do disagree with each other, particularly when dealing with the question of whether the continuum of care doctrine tolls the statute of limitations. A recent decision of the Supreme Court of Missouri highlights these differences. There, too, a pathologist was sued for allegedly misinterpreting a Pap smear, and the lawsuit was filed beyond the expiration of the statute of limitations. The lawsuit was subsequently dismissed by the lower court, and the plaintiff appealed to the state's supreme court to reinstate the suit based on the doctrine of continuum of care. The supreme court rejected the plaintiff's argument and upheld the barring of the lawsuit. In its decision, the court first briefly reviewed the history of the state's statute of limitations [12]:

> The statute provides in pertinent part: All actions against physicians...for damages for malpractice...shall be brought within 2 years from the date of occurrence of the act of neglect complained of, except that a minor...shall have until his 12th birthday to bring action, and except that in cases in which the act of neglect complained of is introducing and negligently permitting any foreign object to remain within the body of a living person, the action shall be brought within 2 years from the date of discovery of such alleged negligence.... [The plaintiff] contends that because she had no damages until the pre-cancerous condition [missed on the Pap smear] allegedly developed into a cancerous condition, the statute of limitations began to run [when the plaintiff's] condition developed into a cancerous condition.... Her argument is grounded in a continuing tort theory...that the statute of limitations does not commence to run against a plaintiff patient until treatment by the medical defendant ceases....
>
> This court is constrained by the language of the statute from adopting any of the theories urged by [the plaintiff]... [The plaintiff's] argument is appealing and has some force, so far as justice is concerned; in that respect the

conclusion we reach is distasteful to us. But, the legislative branch of government has determined the policy of the state and clearly fixed the time when the limitation period begins to run against actions for malpractice. This argument addressed to the court properly should be addressed to the general assembly. Our function is to interpret the law; it is not to disregard the law as written by the general assembly.

The question of whether the statute of limitations can be tolled under the continuum of care doctrine in malpractice lawsuits involving diagnostic radiologists was the subject of two quite recent court decisions issued 1 day apart in December 2000. The two courts reached contradictory conclusions.

The decision of the Court of Appeals of the State of Missouri that did toll the statute of limitations on radiologists dealt with a defendant radiologist who was accused of misinterpreting an MR image of the spine. The defendant radiologist's interpretation was that of an extruded L5–S1 disk, although it was later alleged that the radiologist missed a sarcoma of the sacrum. The lawsuit was filed after the statute of limitations had run, but the plaintiff had argued that the lawsuit should be allowed because of the continuum of care doctrine. In its decision, the court offered a far-reaching and thought-provoking commentary about the practice of medicine and radiology in the 21st century [9]:

> The statute of limitations was created carefully by the legislature with an intent to protect health care providers against stale claims from healthcare consumers.... However, the Missouri Supreme Court recognized an exception to the statute of limitations in cases where there is a continuous relationship between the patient and the healthcare provider.... The statute of limitations does not begin to run against plaintiff until treatment by the doctor ceases.... By tolling the statute of limitations until the termination of the relationship, the doctor is given every opportunity to diagnose and treat the patient. This exception promotes honesty and open communication within the doctor-patient relationship. In turn, this allows doctors to explore the full panoply of diagnostic treatments without the fear of patients bringing a medical malpractice suit at the onset of each procedure within their course of treatment....
>
> Other jurisdictions have addressed the issue of whether diagnostic services are considered treatment in order to prevent the running of the statute of limitations, thus constituting continuing care or continuing treatment.... These cases look at the relationship of the patient to a provider of health care services which is not the patient's primary care physician. The services rendered are of such underlying importance to the treating doctor, that the continuing care can be imputed to the service provider as a matter of law.
>
> [In this case, the patient] presented himself for care based on the medical services and expertise of the professionals at the hospital. He placed his trust in his neurosurgeon and those healthcare professionals who were involved in his medical care. He had no reason to doubt that during the course of his care and treatment of his back pain, including the radiological services, he was receiving continuous care from all of the doctors who provided their services to him. The radiological services were an essential part of his care without which his neurosurgeon could not properly treat him.... Therefore, [the patient] established a continuing relationship with his medical team...he believed that the team of healthcare professionals was acting in such a manner as to efficiently, promptly, and professionally diagnose the cause of his pain.... Since a doctor-patient relationship existed between [the patient] and the medical team charged with the duty of maintaining his health, the medical team was charged with the duty to inform and treat him for this condition. In our rapidly changing technological society, there are daily medical advancements and achievements. No longer do patients go to one physician expecting total treatment; they realize that one doctor is neither capable nor competent in providing every medical specialty. However, patients do expect that their primary doctor will refer, consult, and rely on a team of duly qualified healthcare professionals.... Patients understand that...they will be assisted and monitored by...a team management approach to enhance medical care.
>
> Yet, when medical specialists assisting the primary care provider make mistakes, there must be accountability for their actions.... We do not want to immunize those providing specialist care from liability due to the fact they are providing a specialist treatment and/or diagnosis. [The patient's] radiological services were part of his whole treatment. [The radiologists] knew they were providing continuing care to those patients who routinely returned for radiological services.... The legislature in drafting the medical negligent statute clearly contemplated that medical entities could be held liable...for negligence, including any other entity providing health care services.... Accordingly, [radiologists] cannot be shielded from liability as an entity.

As an indication of the closeness of the court's decision relative to the role of the radiologist, there was a strong and intriguing dissenting opinion:

> [The radiologist] never met plaintiff and there is no indication in the record that [the radiologist] ever knew or had any reason to know what became of him until suit was filed.... [The radiologist] did not consider the diagnostic services he performed to be the provision of care. He further testified that he had no continuing duty to review or follow up after he rendered his report. He first learned that plaintiff was later diagnosed as having a mass or tumor in his sacrum when he was served with plaintiff's petition....
>
> [The radiologist's] only alleged act of negligence occurred more than 2 years before the suit was filed.... [The radiologist] provided radiological diagnostic services, not treatment. Although interpreting x-ray or MRI films may be essential to permit the treating physician to provide proper treatment of a patient's condition, it does not, in and of itself, in any way alleviate the condition for which the patient is seeking medical assistance. What, if anything, can or should be done to alleviate the condition

of which the patient complains is a decision made by the treating physician, not the radiologist. As indicated by [the radiologist's] report quoted above, he made no recommendation as to what, if any, treatment should be undertaken in response to his findings. That is not the function of the radiologist....

In the context of radiological diagnostic services, the necessity that gave rise to the physician-patient relation ceases to exist when the report interpreting what is viewed on the films is transmitted to the treating physician. That is the sole reason the "relationship" was established and that purpose is accomplished when the report is rendered.... Although the services performed by [the radiologist] provided essential information to his treating physician, [radiologists] were never consulted as to the proper course of treatment. There is no evidence of any participation by [radiologists] in any decisions about the proper course of treatment.... Because plaintiff failed to come forward with any evidence that [radiologists] were responsible for treating him, the continuing care exception [cannot] be applied.

The dissenting judge then recommended that the Missouri Supreme Court review the decision. As this article is being written, the court has not announced further action in the matter.

A decision rendered 1 day later by the Court of Appeals of Arkansas reached a conclusion opposite to that of the Missouri court. In this case, a radiologist had interpreted annual mammograms obtained over a 6-year period in the same patient. After the patient was found to have breast carcinoma with lymph nodes positive for cancer, it was alleged that two sets of mammograms obtained more than 2 years earlier disclosed the carcinoma but had been misinterpreted. The defendant radiologist was sued, but the radiologist's attorney moved for dismissal of the lawsuit because it had been filed after the expiration of the statute of limitations. In response, the plaintiff maintained that the complaint was timely under the continuum of care doctrine. She contended that under this doctrine the statute of limitations did not begin running until the date on which her final mammogram was interpreted. She filed an affidavit from an expert radiology witness who stated that the standard of radiologic care requires that previous mammograms be reviewed with current mammograms to determine what is normal for the individual and to detect changes in the breast. The trial court ruled that the continuum of care exception did not apply to the facts of the case, and the plaintiff appealed.

The Court of Appeals of Arkansas refused to impute the continuum of care doctrine to radiologists [13]:

If the treatment by the doctor...is of such a nature so as to impose on the doctor a duty of continuing treatment and care, the statute does not commence running until treatment by the doctor has terminated.... [In this case], the wrongs complained of are separate and distinct. [The plaintiff] contends that [the radiologist] committed 'malpractice in reading her mammograms [over several years]. The continuous treatment doctrine does not apply to single, isolated acts of alleged negligence. To set this case apart from that rule, [the plaintiff] contends that the doctrine should apply because current mammograms are viewed in conjunction with previous mammograms to determine if a change has occurred. We find this distinction unpersuasive under the circumstances of this case.... Where radiologists maintain no contact with a patient aside from the performance of the diagnosis, and the diagnosis is imparted directly to the treating physician, the performance of each diagnosis is complete and discrete and does not constitute continuous treatment, despite the fact that on successive occasions radiologists compared prior studies with the most recent ones.... A comparison of test results suggests adherence to appropriate diagnostic procedure, not a change in the [legal relationship] between patient and radiologist.

[The plaintiff] concedes that the mammograms were conducted for screening purposes only. As far as we can tell from the record, the reports made by the radiologist were sent to the [patient's] gynecologist, but there is no indication that the radiologist was engaged in any act of consultation. We affirm [the trial court's judgment that the malpractice complaint is barred by the statute of limitations].

Thus, state courts remain divided on the issue of whether the statute of limitations can be tolled because of the continuum of care doctrine when malpractice lawsuits are filed against physicians such as diagnostic radiologists who are not directly involved in patient care. The fact that radiologic standards call for comparison with previous studies whenever new radiologic studies are interpreted clouds the issue, because some courts have construed comparison to mean the same as reinterpretation. Under this reasoning courts could determine that the statute of limitations begins running not when the initial radiologic studies were obtained but rather when follow-up radiologic studies are interpreted.

In contrast to diagnostic radiologists, radiation oncologists and interventional radiologists whose involvement with a patient is episodic in nature or is characterized by continuing care or multiple follow-up visits over a period of time would probably fall directly under the continuum of care exception that tolls the statute of limitations.

Summary and Conclusions

Radiologists and other physicians can be sued for malpractice only within the period of time after the alleged act of malpractice that is prescribed in the statute of limitations of the state in which they practice. Certain conditions extend, or toll, the statute of limitations, such as fraudulent concealment, legal or mental incompetence of the patient, or minority age of the patient. These exceptions apply not only to medical malpractice but also to other civil litigation.

The continuum of care doctrine, the legal theory that tolls the statute of limitations in 40% of the states, is applicable to physicians who are involved in direct patient care. In certain states, the tolling of the statute of limitations due to the continuum of care doctrine can be extended, or imputed, to diagnostic radiologists by virtue of the fact that radiologists provide diagnostic consultations—consultations on which primary care physicians base ongoing patient treatment decisions. Some courts have held that because the standard of radiologic care requires radiologists to compare current radiographic studies with previous ones, radiologists are in essence reinterpreting all previous radiographs whenever they interpret new studies. Under this theory, the statute of limitations could begin running from the date on which radiologists interpret current radiologic studies rather than on the date on which initial studies were obtained.

The imputing to diagnostic radiologists of the continuum of care doctrine is a recent de-

velopment in the judicial system, and its applicability to radiology continues to evolve. It is likely that state appeals courts will have considerably more to say on the subject in the future.

Traditionally, statute of limitations laws that require potential plaintiffs to initiate medical malpractice litigation within a specific period of time after an alleged act of malpractice have provided radiologists and other physicians protection, a safe harbor if the litigation has not commenced within the specified time. Because of the continuum of care doctrine, the boundaries of this safe harbor are no longer well delineated. Radiologists who are sued for malpractice should be cognizant of the statute of limitations law in the states in which they practice and should discuss with their legal counsel the question of whether the lawsuit may be barred if it is filed after the statute has run.

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