Can a Radiologist Be Liable for Missing Something on an X-Ray, CT Scan, or MRI?

What Florida Law Requires When a Radiologist Misreads a Scan

Radiology errors on an X-ray, CT scan, or MRI can set off a chain of delayed care for Florida patients. A tumor, fracture, brain bleed, or blood clot that goes unreported may keep getting worse while everyone assumes the scan was clear. Many patients never even meet the radiologist who read their images.

A missed finding does not automatically mean medical malpractice, though. Under Florida Statutes Section 766.102, the patient must prove that the radiologist breached the prevailing professional standard of care and that the breach caused the injury. That usually requires an independent review of the images, the report, the clinical history the radiologist received, and what happened next.

At The Law Offices of Casey D. Shomo, P.A., Florida medical malpractice attorney Casey D. Shomo brings more than three decades of medical malpractice litigation experience to diagnostic error claims, and he personally oversees every case. Radiology cases often turn on details that the written report alone does not reveal.

Key Takeaways

- **Standard of Care Is the Test** – A radiologist is judged by what a reasonably prudent similar specialist would have recognized at the time, not by what hindsight reveals.
- **Communication Counts** – A correct reading can still lead to harm when an urgent or changed result never reaches the doctors treating the patient.
- **More Than One Provider May Share Fault** – The radiologist, the ordering physician, and the hospital may each have played a part in a delayed diagnosis.
- **Deadlines Can Start Late** – Florida's two-year deadline can run from discovery, but a four-year outer limit generally still applies to the claim.

What Kinds of Imaging Mistakes Can Support a Malpractice Claim?

A radiologist is expected to interpret a study with the care a reasonably prudent similar specialist would use under the same circumstances. The question is not whether another radiologist, looking back with hindsight, could find something different. It is whether the original reading fell below the applicable standard of care.

Potential errors can include:

- **Missing a Visible Abnormality** – A tumor, fracture, internal bleed, blood clot, infection, or other finding may be present on the images but absent from the report.
- **Mischaracterizing a Finding** – An abnormality may be seen but described as benign, insignificant, or unrelated when the images reasonably called for a different interpretation or follow-up.

- **Skipping an Important Comparison** – Earlier studies can show whether a lesion is new, growing, or changing, so comparison matters when prior imaging is available.
- **Overlooking a Significant Incidental Finding** – A scan ordered for one reason can reveal another serious condition that still needs to be reported to the patient's doctors.
- **Failing to Communicate an Urgent Result** – Identifying a dangerous condition may not protect the patient if the finding does not reach the treating team in time to act.

What if the Radiologist Missed Cancer, a Blood Clot, or Internal Bleeding?

The consequences depend on what was missed and how much time passed before the condition was found. A missed fracture may lead to continued use of an injured limb, and a missed brain bleed can allow neurological damage to progress.

A missed pulmonary embolism can delay treatment for a life-threatening blood clot, and an overlooked mass can postpone the workup needed to learn whether cancer is present. When the harm is permanent, the claim may need to account for years of future care.

These cases fall within the broader category of misdiagnosis and delayed diagnosis. The key issue is usually not that the diagnosis came later, but whether the delay caused additional harm, such as disease progression, more extensive surgery, or lost treatment options. When a delayed diagnosis ends in a patient's death, certain family members may pursue a wrongful death claim based on medical negligence.

Can a Radiologist Be Liable Even if the Ordering Doctor Also Made a Mistake?

Yes, depending on the facts. A radiologist interprets the images, while an emergency physician, primary care doctor, surgeon, or other clinician decides what to do with the result. When more than one provider contributed to the delay, each provider's conduct has to be evaluated separately.

A radiologist might miss a suspicious lung mass on a CT scan, for example. In another case, the radiologist flags the mass, but the ordering physician never acts on the result or refers the patient to the right specialist. In a third, the report recommends follow-up imaging that nobody schedules.

Those are different failures, and a careful investigation should pinpoint where the diagnostic process broke down rather than assume one person was responsible. The table below shows where each provider fits in the process.

Provider	Role in the Scan	Where a Breakdown Can Happen
Ordering physician	Orders the study and supplies the clinical history	Incomplete history, or no action taken on the result
Radiologist	Interprets the images and writes the report	A missed or mischaracterized finding, or no comparison with prior studies

Provider	Role in the Scan	Where a Breakdown Can Happen
Hospital or imaging center	Delivers reports and tracks urgent findings	An urgent or changed result never reaches the care team
Specialist	Receives the referral for further workup	A referral that is delayed or never completed

How Can a Preliminary Read Lead to a Missed Diagnosis?

Some scans are read twice. A preliminary report may guide immediate care in the emergency department, and a final report follows later.

The American College of Radiology (ACR) practice parameter on communicating imaging findings says a significant change between the two readings should be reported in a way that reasonably ensures the treating physician receives it. It also says that communication should be documented.

Imagine a patient who goes to a Palm Beach County emergency room after a fall. The preliminary CT reading shows no bleeding, and the patient goes home. The next morning, the final report notes a small brain bleed, but nobody calls the patient or the emergency physician.

If the patient's condition worsens before anyone acts, the claim may focus less on the original reading and more on why the corrected finding never reached the people who could respond. Records showing when the final report was signed, who viewed it, and whether anyone was notified can become central evidence.

What Evidence Matters in a Missed Radiology Case?

The radiology report matters, but the original images are often central because an independent radiologist can review what was actually visible at the time. Later scans can make an earlier abnormality easier to spot, so the expert still has to judge the earlier study by what a reasonably prudent radiologist should have recognized then.

Other useful records may include:

- **The Original Study and Reports** – The actual X-ray, CT, or MRI images, along with the radiologist's preliminary and final reports for the study.
- **The Imaging Order** – The physician's order and the clinical history showing why the study was requested in the first place.
- **Prior Imaging** – Earlier studies that were available for comparison and may show when an abnormality first became visible.
- **Treatment Records** – Emergency room, hospital, and specialist records documenting symptoms, history, and how the delay changed the patient's care.
- **Electronic Record Timestamps** – Audit data showing when the report was finalized, when it was viewed, and whether it was communicated to anyone.

- **Later Imaging** – The study that finally identified the missed condition, which can show how far the problem progressed.

The strength of a claim depends on that evidence and on what qualified experts conclude about both the standard of care and causation. Mr. Shomo's medical malpractice case results include a $1,851,000 outcome for a failure to diagnose and treat a pulmonary embolism that resulted in death, although every case turns on its own facts.

Does a Bad Radiology Result Automatically Prove Negligence?

No. Florida law states that the existence of a medical injury does not create any inference or presumption of negligence. The patient still has to prove both a breach of the prevailing professional standard of care and causation.

Radiology also involves judgment. Some abnormalities are subtle, some studies are limited by patient motion or other technical factors, and some findings reasonably permit more than one interpretation. A viable claim generally requires evidence that the original interpretation fell below the accepted standard of care and that the error caused additional harm.

How Long Do You Have to File a Radiology Malpractice Claim in Florida?

Under Florida Statutes Section 95.11(5)(c), a medical malpractice action generally must be filed within two years of the incident or within two years of when the incident was discovered, or should have been discovered with due diligence. A four-year statute of repose sets an outer limit measured from the incident itself.

Exceptions exist. The four-year limit does not bar a claim brought for a minor on or before the child's eighth birthday, and when fraud, concealment, or intentional misrepresentation prevented discovery, the deadline can extend two years from discovery, up to seven years after the incident.

Timing is especially tricky with imaging errors because a patient may not learn about the earlier miss until another scan is performed months or years later. The pre-suit notice has to be served within the limitations period, although mailing it tolls the statute of limitations during the 90-day screening period.

Waiting can also make it harder to obtain complete records, including the original images, and to identify every provider involved.

Florida also requires a presuit investigation before a medical malpractice lawsuit can proceed. That process generally includes obtaining a verified written opinion from a qualified medical expert supporting the claim.

Taking Action After a Missed Radiology Finding

A radiology malpractice investigation reconstructs the diagnostic timeline. That means obtaining the original images rather than relying only on written reports, identifying what clinical information the radiologist received, comparing prior and later studies, and determining when treating providers learned of the result.

Mr. Shomo represents patients in communities throughout Florida, and he handles medical malpractice cases on a contingency fee basis. There is no attorney's fee unless compensation is recovered for you.

If an X-ray, CT scan, MRI, or other imaging study failed to identify a serious medical condition and your health worsened while treatment was delayed, contact us for a free consultation. We can review the details of your situation and explain your legal options.