the REPORTER

2-HOUR CME

CASE CLOSED: UNDERSTANDING DIAGNOSTIC ERRORS

UPDATE: TMLT RISK MANAGEMENT TRENDS

TMLT
Texas Medical Liability Trust

Quarter 4, 2026

2-HOUR CME
CASE CLOSED: UNDERSTANDING DIAGNOSTIC ERRORS

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The closed claim studies published in this article describe how actions or inactions on the part of physicians led to allegations of professional liability, and how risk management practices may have either prevented the outcome or increased the likelihood of a successful defense. Consultant opinions regarding the clinical care delivered in these cases reflect recommendations at the time the incident occurred. These cases are not intended to establish a standard of care. In some cases, clinical guidelines may have changed, but the claim review presents a snapshot of what transpired during treatment.

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OBJECTIVES

At the conclusion of this educational activity, the learner should be able to:

1. review real medical liability cases that involve diagnostic errors;
2. discuss issues associated with allegations of failure to diagnose;
3. explain the importance of effective communication between physicians, patients, and the health care team in diagnostic result management, follow up, and other critical areas; and
4. apply risk management strategies to reduce the risk of diagnostics errors and improve patient safety.

COURSE AUTHORS

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DISCLOSURE

Laura Hale Brockway and Wayne Wenske are employees of TMLT and have no relevant financial relationship(s) with ineligible companies to disclose. TMLT staff, planners, and reviewers have no relevant financial relationship(s) with ineligible companies to disclose.

TARGET AUDIENCE

This 2-hour activity is intended for physicians who are interested in practical ways to increase patient safety and reduce the potential for malpractice liability.

CME CREDIT STATEMENT

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The Texas Medical Liability Trust designates this enduring material for a maximum of 2 *AMA PRA Category 1 Credit(s)™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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This course has been designated by TMLT for 1 credit in medical ethics and/or professional responsibility.

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The following fee will be charged when accessing this CME course online at http://tmlt.inreachce.com.

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CME DISCOUNT

TMLT policyholders who complete this program may earn a 3% discount that will be applied to their next eligible policy period.

RELEASE/REVIEW DATE

This activity is released on November 24, 2025 and will expire on November 24, 2028.

INTRODUCTION

Diagnostic errors generate more medical malpractice payments than any other type of medical error, according to a review of approximately 350,000 paid claims in the National Practitioner Data Bank.[1]

Yet determining the prevalence of diagnostic errors is challenging, particularly outside the fields of pathology and radiology. With the decline in autopsy rates, physicians do not generally receive feedback on their diagnoses. As a result, "diagnostic errors often are unrecognized or under-reported."[2]

ABOUT DIAGNOSTIC ERRORS

According to research from the field of cognitive psychology, the majority of medical errors occur when health care professionals are performing schematic behavior tasks. These tasks are performed reflexively or on autopilot, and "slips" occur due to distractions, fatigue, or lapses in concentration. Interventions such as checklists have been shown to greatly reduce the likelihood of errors involving schematic behavior tasks.[3]

Other types of errors occur when health care professionals are engaged in attentional behavior tasks. These tasks require active planning and problem solving, and errors in attentional behavior are often caused by lack of experience or training. Diagnostic errors are considered errors in attentional behavior and require solutions focused on training, supervision, and decision support rather than standardizing behavior.[4,5]

Yet, diagnostic errors are not simply the result of cognitive errors on the part of caregivers. Diagnostic errors can occur for many reasons, including poor teamwork and communication between physicians; poor communication between patients and physicians or between patients and staff; lack of reliable tracking systems for test results; and patient noncompliance. Underlying health system issues — such as health insurance preauthorization — also contribute to errors in diagnosis.

A study of diagnostic errors in the ambulatory setting published in the *Annals of Internal Medicine* found that very few diagnostic errors were linked to single contributing factors. The study identified the following as main breakdowns in the diagnostic process:

- failure to order appropriate diagnostic tests;
- inappropriate or inadequate follow up;
- failure to obtain an adequate medical history;
- failure to perform an adequate physical exam; and
- incorrect interpretation of diagnostic test results.[6]

The case studies in this course demonstrate that diagnostic failure rarely occurs at a single decision point. In many cases, the outcome reflects a series of missed opportunities: incomplete history taking or examination; failure to order or interpret tests; inadequate communication among members of the health care team; unreliable follow up on results or referrals; and missed opportunities to reassess a patient whose symptoms continue or worsen.

By reviewing these case studies, physicians can identify practical risk management strategies that support more reliable diagnostic processes and reduce the likelihood that abnormal findings or unresolved symptoms will be overlooked.

CASE 1: FAILURE TO DIAGNOSE FRACTURE

Presentation
An eight-year-old boy came with his mother to a local emergency department (ED). He reported pain in his lower left leg ("hamstring pain") from a fall earlier that day.

Physician action
The patient's care in the ED was directed by a physician assistant (PA). An emergency medicine physician was listed as the attending physician, but there was no documentation of his involvement in the case.

The PA examined the patient and noted decreased range of motion (ROM), pain, and tenderness of the left leg. The patient's pain level and degree of loss of ROM were not described. The PA ordered and interpreted a "femur left x-ray" as showing no fracture or dislocation. The patient was prescribed ibuprofen, rest, and crutches. He was discharged from the ED after crutch training and instructed to follow up with his pediatrician in two to three days.

The next morning, a radiologist interpreted the x-ray images as showing no abnormality. Pediatrician A saw the patient five days later and noted that he "continues with pain" and had difficulty walking and putting pressure on the leg, but was "better today." His physical exam described "tender left groin" and "hips okay." He concurred with the previous diagnosis of muscle pain and recommended symptomatic care. The patient was told to return as needed. The patient did not return to Pediatrician A.

Two years passed and the patient saw Pediatrician B for a well-child visit. Pediatrician B found that the patient's right leg was longer than his left leg and referred him to a pediatric orthopedic surgeon.

During the first visit with the pediatric orthopedic surgeon, the patient's mother provided the patient's history of the previous injury and reported that it took two months for him to recover from the pain in his leg. The pediatric orthopedic surgeon found that there was a difference in the height of the patient's femurs, and he had a Trendelenburg gait. X-rays showed a short femoral neck fracture and a high trochanter compared to the right hip.

The pediatric orthopedic surgeon reviewed the x-ray from three years earlier and stated that the patient had a femoral neck fracture that was not recognized by the radiologist. His findings and options for treatment — including leg lengthening surgery or trochanteric transfer — were discussed with the patient's mother. The mother said she would consider the options.

An MRI was performed the next day. It confirmed evidence of a prior femoral neck fracture with subsequent angulation of the metaphysis and epiphysis, causing posterior angulation by 63 degrees.

Two months later, the patient and his mother met with the pediatric orthopedic surgeon to discuss options, including 1) lengthening the left leg via osteotomy and an internal bone lengthening nail; 2) shortening the right leg; and 3) no surgery until the patient experiences pain or difficulty walking.

The surgeon noted, "We reviewed the risks and benefits of each option . . . they would like to monitor and consider surgery in the future if he becomes symptomatic." At this meeting, the patient denied any pain and reported that he was wearing a shoe lift in his left shoe that helped him feel "more level."

During the next year, the patient remained asymptomatic. It was maintained that surgery may become necessary in the future as the patient was still growing and his condition could progress.

Allegations
A lawsuit was filed against the radiologist, alleging misdiagnosis of the patient's injury that resulted in a leg length discrepancy that will require surgery to repair. The plaintiffs also alleged that had the fracture been treated at the time of the injury, "his risk of malunion and avascular necrosis would have been substantially lower."

Legal implications
This was a difficult case to defend. Radiologists consulting for this case reviewed the x-rays that made the basis for this claim and identified the fracture. These original x-rays demonstrated "significant angulation of the left femoral neck, consistent with a poorly visualized fracture." Further, one consultant stated, "The fracture line is not clear because it is a femur study and not a hip study, so positioning is not optimal. The wrong test was ordered. The radiologist should have recommended a hip study be ordered."

Radiologists reviewing this case also noted the patient's injuries "were not appropriately diagnosed and managed by the ED and radiology staff."

Consultants were also critical of Pediatrician A for not setting a more established follow-up date rather than telling the patient to return "as needed." It was also noted that Pediatrician A's patient history and overall documentation were poor and failed to reflect an adequate exam.

Disposition
This case was settled on behalf of the radiologist.

Risk management considerations
Defense radiology consultants were critical of the radiologist for "failing to diagnose the fracture and in failing to report the fracture to the referring physician at the time of interpretation." These opinions were consistent with a study that noted "from a practical point of view once an abnormality on a radiograph is pointed out and becomes so obvious that lay persons sitting as jurors can see it, it is not easy to convince them that a radiologist who is trained and paid for seeing the lesion should be exonerated for missing it."[7]

When these types of errors and discrepancies occur in radiology, contributing factors can include technical errors, system issues, frequent interruptions, and more. For instance, technical errors such as the specific imaging protocols used could influence a radiologist's ability to appropriately identify or interpret abnormalities.[7]

Systems issues may include staff shortages, work overload, inadequate equipment, staff inexperience, or even the reporting environment. Other considerations include limited clinical information, or inappropriate expectations and capabilities of various radiological techniques. Frequent interruptions may also lead to loss of concentration and failure to report identified abnormalities.[7]

CASE 2: FAILURE TO DIAGNOSE APPENDICITIS

Presentation
A 6-year-old boy, accompanied by his mother, came to Pediatrician A for a sick visit on October 21. The child had a five-day history of irritability, sore throat, coughing, vomiting, stomach pain, and fatigue. He had been a patient of Pediatrician A since birth.

Physician action
Pediatrician A examined the patient and documented the exam as normal with an additional comment of "benign" written to describe the abdomen. The patient had a fever of 102.6 degrees. A urinalysis showed 3+ red blood cells, trace protein, and 1+ leukocytes.

Pediatrician A diagnosed the patient with a urinary tract infection (UTI) and prescribed cefixime. A CBC was ordered, but a urine culture was not.

The next day the patient's mother called the office and reported that the patient was having diarrhea. She was instructed to "push fluids," start him on a BRAT (bananas, rice, applesauce, and toast) diet, and call back in the morning. The next day, the mother called the office and spoke to Pediatrician A's triage nurse; she reported that the patient had not improved. She was advised to continue pushing clear liquids.

On October 24, the patient returned with his mother to the pediatric clinic. Pediatrician B, who shared office space with Pediatrician A, examined the child as Pediatrician A was not available.

The previous symptoms were reported: the patient had a temperature of 100.4 degrees, and his weight was down two pounds from the previous appointment. The results from an influenza test were negative. The CBC that was previously ordered had not been completed.

The documentation of the physical exam, including the abdomen, was checked off as "normal."

The diagnosis was fever and UTI. The patient was to continue cefixime. Pediatrician B would later recall that the child was able to jump on the exam table and move around without any restrictions or distress.

On a third visit to the clinic on October 26, the patient came accompanied by both parents. His symptoms were the same and he was still taking cefixime. The child was afebrile, and his weight had increased by one-half pound. Although Pediatrician A ordered a urinalysis, it was not completed because the patient could not provide a specimen. A catheterized specimen was deemed not necessary because the child was afebrile. The abdominal exam was documented as normal, and the final diagnosis was gastroenteritis/viral syndrome.

On November 5, the boy returned to Pediatrician A. The mother reported that the patient's symptoms had continued for "2 weeks on and off." The patient's temperature was 97.4 degrees. His weight had increased by another one-half pound, but still down one pound from his original weight. Documentation from the physical exam noted the abdomen to be soft and non-tender with increased bowel sounds. A urinalysis showed 3+ red blood cells and 2+ protein. The final diagnosis was dysuria and diarrhea. Pediatrician A ordered a gastroenteritis protocol, stool culture, and stool testing for ova/parasites.

The next day, the mother took the patient to a freestanding emergency room. The physical exam showed the patient had a temperature of 102.9 degrees; blood pressure 114/72 mm Hg; a pulse of 120 bpm; and a tender right lower quadrant. The physician suspected appendicitis and transferred the patient to a hospital.

At the hospital, a CT scan of the abdomen showed a large intra-abdominal abscess. The patient was taken to surgery that day and was found to have a perforated appendicitis with an intra-abdominal abscess and compromised vasculature to the terminal ileum. The abdominal abscess was washed out. The surgeon could only partially close the abdomen and a wound vac was placed. The patient was in the ICU and intubated for several days. On postoperative day five, he had return of bowel function in the colostomy bag.

On postoperative day 10, the patient was febrile with increasing abdominal pain. A CBC showed leukocytosis and a CT scan of the abdomen revealed an additional intra-abdominal abscess near the site of the previous abscess. An interventional radiologist placed a drain and IV antibiotics were started again. Eventually the drain produced scant purulent material. He was discharged after 16 days in the hospital.

Nearly three months later, a pediatric surgeon reversed the ileostomy and repaired a mucous fistula. The patient was hospitalized for one week with this procedure.



Allegations
A lawsuit was filed against Pediatrician A. The allegations were failure to recognize the signs and symptoms of appendicitis that led to a ruptured appendix, requiring multiple surgeries and hospitalizations.

Legal implications
The plaintiff's attorney retained a pediatrician who was critical of the defendant for diagnosing a UTI without obtaining a urine culture. He further stated that since the symptoms did not resolve, further work up including an abdominal ultrasound and lab work should have been considered. The second plaintiff's consultant, a pediatric surgeon, agreed and criticized the defendant for failing to consult or refer the patient to a general surgeon to assess the abdomen.

Two pediatricians who reviewed this case for the defense were lukewarm in their support of Pediatrician A's care. The first pediatrician stated that the clinical findings did not suggest appendicitis. He speculated that the antibiotic prescribed for the UTI may have reduced the patient's pain and hidden the symptoms until the appendix became encapsulated. A pediatric surgeon noted that at each visit it was documented that the patient did not have abdominal tenderness. The diagnosis of a UTI was consistent with the patient's symptoms.

However, these physicians criticized Pediatrician A for an inadequate clinical exam and follow up on a patient whose symptoms were not improving over two weeks. The failure to order appropriate labs and treatment led to a delay in diagnosing appendicitis, resulting in the perforation and more involved treatment.

Disposition
The case was settled on behalf of Pediatrician A.

Risk management considerations
In this case, the patient continued to have abdominal and gastrointestinal symptoms over multiple appointments, while UTI remained part of the working diagnosis. Multiple encounters for the same symptoms can be an important clinical signal. Review of past visits prior to examination may reveal patterns that should be explored. Consider using EHR alerts or problem-list documentation that make the history of repeat symptoms apparent to the treating physician and staff. A pattern of unresolved symptoms may warrant an in-person assessment, additional diagnostic testing, or referral.

Documentation can also be important when patients return with unresolved symptoms. Document the pertinent positive and negative findings and any changes from previous examinations. Detailed documentation can help demonstrate the physician's clinical reasoning and help subsequent treaters understand how the patient's condition progressed.

Follow-up was also an issue in this case. A CBC was ordered at the first visit but never completed. There was no documented plan to obtain it later or determine if it was still needed. Practices should have reliable systems — including EHR tracking tools — to track ordered tests and notify the physician when follow up is needed.

CASE 3: FAILURE TO PROPERLY EXAMINE PATIENT

Presentation
Early in the COVID-19 pandemic, a 46-year-old woman came to her internal medicine physician reporting shortness of breath, back pain, burping, and fever. The patient had a history of morbid obesity, heart disease, smoking, alcohol use, and diabetes. She was seen by the physician five times in the last three years. The patient did not have health insurance and was noted as often non-compliant.

The physician diagnosed her with bronchopneumonia, back pain, shortness of breath, and dyspnea and instructed her to take a COVID-19 test.

Physician action
One week later, the patient returned to the clinic with a negative COVID-19 test result. She reported that her backache and burping symptoms had improved, but she was still experiencing shortness of breath and exhaustion from light activity (walking).

The physician increased the dosage of her diuretics and planned to refer her to a cardiologist. There was no record that a detailed medical exam was performed.

The patient was sent home and died later that day on the way to the hospital. The autopsy stated the cause of death to be pulmonary thromboembolism (PE) due to congestive heart failure (CHF) complicated by morbid obesity and hypertensive heart disease.

Allegations
A lawsuit was filed against the internal medicine physician, alleging failure to properly examine, diagnose, and treat the patient. The plaintiffs claimed that the failure to transfer the patient to the hospital led to her death.

Legal implications
Poor documentation was a key element in this case. The lack of a documented physical exam made it difficult to determine whether the patient should have been transferred to a hospital. The patient visited the clinic during the height of the COVID-19 pandemic, and the physician was reasonable in thinking her initial symptoms could have been related to COVID-19. However, both internal medicine consultants felt the physician should have sought an alternative diagnosis once COVID-19 was ruled out.

Cardiology consultants noted that while PE is difficult to diagnose from a clinic visit, the patient's symptoms and pre-existing conditions should have led the physician to order a thorough cardiac evaluation.

An expert for the plaintiff stated the physician breached the standard of care by not performing a proper work up and failing to order necessary testing such as D-dimer, CT angiography, and a ventilation-perfusion scan to rule out PE. He felt that a PE would have been diagnosed and anticoagulation therapy or thrombectomy could have been initiated had the proper testing been completed.

The defense argued that while the patient's pre-existing CHF, obesity, and other co-morbidities put her at a higher risk for PE, her symptoms were vague and not enough to warrant suspicion of PE. The patient did not have swelling in her legs and was hemodynamically stable, making management of CHF exacerbation the most reasonable course of treatment.

Additionally, reviewers felt that even if the patient had been immediately transferred to the hospital, there was a 50 percent chance that a workup would not have been completed in time to prevent the PE from causing sudden death.

The lack of a documented physical exam was a considerable weakness in the defense of this case.

Disposition
The case was settled on behalf of the internal medicine physician.

Risk management considerations
In this case, the physician did not document a physical exam, full patient history, vitals, differential diagnosis once COVID-19 was ruled out, or follow-up instructions. She also did not document whether she completed a referral to a cardiologist.

This patient's co-morbidities and lifestyle choices put her at high risk for several possible cardiac issues, which should have made a thorough exam a priority for the physician. One consultant for the defense suggested that the patient's presenting condition — consistent with both PE and CHF — may have been confusing and a diagnosis hard to determine. This made a thorough, documented exam even more necessary.

This case was further complicated because the patient did not provide an accurate medical history and was noncompliant with medications. She did not divulge her tobacco use, that she had a previous CHF diagnosis, that she had been previously placed in a life vest to prevent sudden death. She also did not reveal that she had been previously hospitalized for weeks due to sepsis, had been intubated, and then admitted to a heart failure clinic.

The physician concluded the patient had CHF from the medications she listed but might have been more insistent on obtaining a detailed patient background. Physicians do not always have complete information about a patient's history, medications, home life, or social activity. As in this case, patients may be poor communicators or historians. This makes a complete and thorough intake, exam, and documentation even more important in high-risk scenarios.

CASE 4: FAILURE TO PROPERLY INTERPRET BRCA RESULTS

Presentation
In December 2018, a 40-year-old woman came to her ob-gyn for a well-woman visit. The results of the pelvic examination were normal with no palpable masses or tenderness. Per the patient's request, breast cancer susceptibility gene (BRCA) testing was scheduled to take place in 10 days.

The patient's history included hospitalization for pulmonary embolism. Her family history included breast cancer (mother, two aunts, first cousin) and ovarian cancer (aunt).

Physician action
The patient's BRCA report was received by the ob-gyn's office in January 2019. The BRCA1 sequencing results indicated "positive for a deleterious mutation." The report also stated that deleterious mutations in BRCA1 may confer as much as 87 percent risk of breast cancer and 44 percent risk of ovarian cancer by age 70.

When the ob-gyn received the report, he initialed it and underlined the phrase, "although the exact risk of breast cancer and ovarian cancer conferred by this specific mutation has not been determined . . ."

The ob-gyn documented that the patient's BRCA testing was negative. There was no documentation that the ob-gyn informed the patient of the test results.

At the patient's next well-woman exam in December 2019, the patient reported left lower abdominal pain, heavy periods, and urinary retention. The pelvic exam was again noted to be within normal limits with no palpable masses or tenderness. The patient was referred to a urologist.

In February 2021, the patient returned to the ob-gyn for another well-woman exam. The results of the exam were noted as unremarkable.

The patient next saw the ob-gyn in September 2021. She reported right-sided abdominal pain, constipation, and urinary tract infection. A week before, an abdominal and pelvic CT revealed multiple bilateral ovarian cysts and free fluid in the pelvic cul-de-sac. Urinalysis was positive for blood. The patient was instructed to call the office if her pain worsened. The ob-gyn documented that he would order a pelvic ultrasound if the patient's pain worsened.

In September 2022, the patient was scheduled for pelvic prolapse repair surgery with a general surgeon. In preparation for surgery, the patient underwent a transvaginal ultrasound that revealed masses on both ovaries that were suspicious for metastatic cancer. Further testing confirmed the diagnosis of high-grade serous ovarian cancer.

One month later, the patient had an exploratory laparotomy, left salpingo-oophorectomy, infracolic omentectomy, and lysis of adhesions. The right ovary could not be removed due to tumor involvement in a previously placed hernia mesh and the extent of the disease in the abdomen. The patient underwent a second surgery for a total hysterectomy and right salpingo-oophorectomy, followed by a course of chemotherapy.

In November, the patient called the ob-gyn's office to provide an update on her health. There was no documentation of a return call in the medical record.

Allegations
The patient filed a lawsuit against the ob-gyn, alleging failure to properly interpret genetic testing results and failure to refer the patient for appropriate genetic counseling and treatment. It was further alleged that these failures led to the patient's diagnosis of metastatic ovarian cancer.

Legal implications
Consultants who reviewed this case were critical of the ob-gyn. One consultant felt the BRCA analysis report clearly stated that the patient tested positive for deleterious mutation and that this finding should have been addressed, especially given the patient's family history of cancer. The consultant stated that if the ob-gyn was uncertain about the report findings, he should have asked for clarification or more information.

Consultant opinions differed on whether the cancer was there during the initial 2019 BRCA testing or if it appeared later. They felt that the timeframe from the BRCA testing to the diagnosis of cancer provided the opportunity for either prophylactic surgery to avoid development of cancer or debulking and chemotherapy to lessen the severity of the cancer.

One consultant stated that had the patient undergone bilateral removal of her fallopian tubes and ovaries, she would have increased her chances of survival by 80-90 percent. This consultant also felt that the ob-gyn failed to interpret the BRCA report correctly.

Disposition
The case was settled on behalf of the ob-gyn.

Risk management considerations
While the BRCA report may have been somewhat misleading or confusing, it did indicate a positive result for deleterious mutation. If uncertain about a test result and its meaning, make inquiries with the testing facility or consult with colleagues. They may provide conclusive information or serve as "another set of eyes" to either confirm or question your interpretation.

It is important to keep track of all tests ordered and received. Once a test result is received, careful interpretation and timely consultation should take place. When notifying patients of test results, explain the results and answer all questions. Educate patients on all treatment options and, if necessary, refer to specialists to discuss further options.

Documentation of the test results, patient notification, education, referrals, and treatment options should all be maintained in the patient's record. In this case, there was no documentation of test result discussions, education, or returned phone calls.

It is also important to obtain, assess, and document your patients' family histories for hereditary risk factors. In this case, proper interpretation, communication, and education of treatment options may have resulted in a better outcome for the patient.

CASE 5: FAILURE TO DIAGNOSE FETOMATERNAL HEMORRHAGE

Presentation
A 24-year-old woman came to Ob-Gyn A in January for confirmation of her first pregnancy. Pregnancy was confirmed with an estimated due date in mid-September. Prenatal profile testing revealed that the patient was Rh-negative.

Physician action
The patient's first two trimesters were uneventful, other than intermittent reports of nausea, vomiting, heartburn, tension headaches, and upper respiratory infection. The patient also had a urinary tract infection that was treated with nitrofurantoin. A 20-week ultrasound revealed a low-lying placenta, and the 28-week ultrasound showed a marginal placenta previa with the baby in the frank breech position.

The first RhoGAM injection was given at 28 weeks' gestation. Repeat antibody screening was negative. A 32-week sonogram revealed a marginally low-lying placenta and estimated fetal weight of 5 pounds. No gross fetal abnormalities were noted.

On July 22, at 33 weeks' gestation, the patient came to the hospital with spotting. She was examined by Ob-Gyn B and admitted to the hospital for observation. Ultrasound revealed slightly enlarged fetal ventricles. Non-stress testing was considered reassuring. The patient experienced occasional contractions with variable decelerations during the night. She was evaluated by Ob-Gyn A the next day. Ob-Gyn A ordered 1 ampule of RhoGAM. Per hospital protocol, the lab performed a Kleihauer-Bekte (K-B) test to determine the RhoGAM dosage required.

That evening, K-B test results indicated that 4.22 percent, or an estimated 212 ml, of the blood within the maternal circulation was fetal in origin. Nursing staff notified Ob-Gyn A at 3 a.m. on July 24 that the fetal screen indicated that she needed 8 ampules of RhoGAM due to significant fetal-maternal bleed. Ob-Gyn A felt that this test result was inconsistent with the patient's clinical picture and asked that the lab supervisor repeat the test.

Repeat test results available the next morning confirmed that 4.24 percent of the maternal blood was fetal and that 8 ampules of RhoGAM were required. Ob-Gyn A asked that the screen be performed a third time, and results confirmed the original findings. Ob-Gyn A doubted the accuracy of the test results because the estimated fetal blood loss was in excess of the baby's estimated entire blood volume of 192 cc.

Ob-Gyn A consulted a perinatologist, who agreed that the results were difficult to believe and suggested that the K-B testing be repeated by an expert. Ob-Gyn A chose to give the patient one ampule of RhoGAM but consulted with a pathologist who agreed to repeat the K-B test at a lab outside the hospital. A hemoglobin electrophoresis was also ordered.

The patient was discharged from the hospital on July 24, with instructions to return to the Ob-Gyn A's office on July 28. The outside lab tests were completed on July 25, and the results confirmed the accuracy of the previous K-B tests. However, these results were not communicated to Ob-Gyn A or entered into the hospital's EHR system.

On July 25, the patient called to report that she was "doing great," and was informed by the staff that they were still researching her condition and had not yet received her test results.

On August 1, the patient reported intermittent light brown spotting, contractions, and decreased fetal movement. She was asked to return to the practice. A repeat non-stress test was reactive. K-B testing showed 4+ fetal cells on maternal circulation, greater than the entire estimated blood volume of the fetus. Ob-Gyn A also mentioned that hemoglobin electrophoresis was pending, unaware that it had been received by the hospital.

The patient returned for lab work on August 6. Ob-Gyn A discussed the case with two outside perinatologists, who suggested that she order indirect Coombs, CBC, and AST testing. The testing was ordered, but results of these tests did not make it into the patient's medical record.

On August 7, the patient called the practice to report decreased fetal movement; she was instructed to go directly to the hospital. She was admitted for a non-stress test that revealed a non-reassuring baseline and minimal fetal heart rate variability. Due to the patient's previous complications, the decision was made to perform a cesarean delivery. Preoperative diagnosis was uterine irritability, non-reassuring fetal heart rate, and questionable fetomaternal hemorrhage.

Ob-Gyn A delivered a 5-pound, 8-ounce girl with Apgar scores of 8 and 8. The baby was tachypneic and was placed in an oxyhood and given oxygen. She was severely anemic with a hemoglobin/hematocrit of 5.1/17. She was given a partial exchange transfusion with packed red blood cells. After 60 ml her hemoglobin/hematocrit increased to 8/25. The placenta appeared abnormal with large cotyledons and possible infarction. The cord pH was 7.396.

The baby was transferred to a children's hospital on August 11. A CT scan of the brain showed diffuse edema, and EEG was abnormal due to the presence of excessive background suppression. During treatment, the baby experienced significant hypertonia, contractures, multiple episodes of apnea and possible seizures. Her condition was complicated by pulmonary edema. Treating physicians felt that a fetomaternal hemorrhage caused the severe anemia and resulting hypoxic brain injury.

The child has spastic quadriparesis, feeding difficulties that require a G-button, developmental delays, and problems with temperature regulation. She is significantly impaired and will require extensive medical care for the rest of her life.

Allegations
The plaintiffs filed a lawsuit alleging that Ob-Gyn A ignored the repeated K-B test results that revealed chronic fetal to maternal blood transfusion. They alleged the results of the testing warranted extensive RhoGAM administration and emergent delivery and argued that the baby sustained global brain injury that could have been avoided. They also claimed that the mother became Rh sensitized due to the administration of inadequate amounts of RhoGAM, which make it a risk for her to attempt pregnancy in the future.

Legal implications
Obstetricians who reviewed this case for the defense stated that it was reasonable for Ob-Gyn A to question the initial K-B test results. The results from the non-stress test did not indicate that immediate delivery was warranted. However, the reviewers expressed mixed opinions about whether it was reasonable for Ob-Gyn A to question the repeat test results. Generally, they agreed that had Ob-Gyn A relied on the test results, she could have delivered the baby earlier or performed an intrauterine blood transfusion.

Ob-Gyn A attempted to have the test results confirmed with additional testing by an outside lab, but the results were not reported to her. One reviewer felt that it was likely that the brain injury occurred long before the mother's hospitalization and felt that the actions of Ob-Gyn A might not have affected the outcome.

The plaintiff's expert stated that Ob-Gyn A was negligent in disregarding the repeat K-B test results and failing to recognize them as evidence of fetomaternal hemorrhage. He felt that Ob-Gyn A's calculations of fetal blood volume failed to consider factors such as placental blood, the potential for fetal red blood cell production compensating for fetomaternal hemorrhage by extramedullary hematopoiesis, and increased bone marrow production of red blood cells. He stated that had Ob-Gyn A correctly assessed the evidence and acted on it, an early delivery could have prevented the outcome.

Disposition
This case was settled on behalf of Ob-Gyn A.

Risk management considerations
Fetomaternal hemorrhage — an extremely rare condition — presented a substantial challenge to Ob-Gyn A. All physicians who reviewed this case felt that questioning the initial K-B test result was reasonable. Taking the clinical

picture into account, the first set of results seemed implausible. Diagnosing a chronic fetomaternal hemorrhage can be extremely challenging, especially in the absence of obvious fetal distress.

Unfortunately, the outside test results that confirmed a substantial fetomaternal hemorrhage were completed on July 25, but Ob-Gyn A was not aware that the results were available. The results were shared with the hospital on August 1, but still not reported to Ob-Gyn A. It was arguable whether acting on the test results at that time would have affected the outcome for the patient, but it may have assisted the physician's defense.

As illustrated in this case, developing, implementing, and consistently following procedures for monitoring and acting on test orders and results can assist physicians and may prevent test results from being overlooked. Such protocols can enhance patient safety and reduce liability for physicians.

CASE 6: DELAY IN DIAGNOSING TESTICULAR CANCER

Presentation
A 17-year-old boy came to the ED after being involved in a motor vehicle accident. The emergency medicine (EM) physician ordered a chest x-ray. The radiologist's impression of the chest film was: "right infrahilar mass-type lesion is noted. Follow-up radiograph and possibly CT scanning suggested for further evaluation."

A CT scan of the abdomen and pelvis was read as normal. The patient was referred to his family physician for further evaluation.

Physician action
On June 23, approximately two months later, the patient came to Family Physician A. The patient had a history of cardiac surgery for pulmonary stenosis and surgery to an undescended right testicle when he was three years old. Family Physician A ordered a CT scan of the chest that revealed a 2.7 x 3.3 cm soft tissue mass in the right lung and a 1 cm mass in the left lung.

Family Physician A referred the patient to Pulmonologist A. Family Physician A also spoke to the radiologist who recommended an upper abdominal CT scan and scrotal ultrasound.

The patient did not keep his appointment with Pulmonologist A on July 11. On July 28, he returned to Family Physician A. She ordered a sonogram of the scrotum that revealed focal calcification of the left testicle. The patient's appointment with Pulmonologist A was rescheduled for August 2. Again, the patient did not keep this appointment.

The patient returned to Family Physician A on August 11. She again advised the patient to see Pulmonologist A. Family Physician A noted in his records "CT scan in three months."

On August 15, Pulmonologist A evaluated the patient. His impression was "the differential is broad. The most likely etiology is a prior fungal infection such as coccidial mycosis or histoplasmosis that is now resolved. Metastatic disease is unlikely. The patient has not had weight loss or progressive symptoms over the past four months." Pulmonologist A's plan was to obtain records from Family Physician A, review lab results, test for tuberculosis, and scrotal ultrasound.

Pulmonologist A ordered a CT scan of the chest, which was completed that day. The conclusion was "lobulated nodular density in right mid lung zone . . . may represent mucoid impaction within an area of underlying bronchiectasis. This may be seen in cases of cystic fibrosis or bronchopulmonary aspirate gelosis. Other entities including neoplasm cannot be excluded, but are considered less likely . . . nodular density in the left mid lung zone has decreased significantly in size since prior examination, and is almost imperceptible on the current exam."

The patient was scheduled for a follow-up visit with Pulmonologist A on August 18, but he did not keep that appointment.

The patient returned to Family Physician A on December 12 reporting chest pain, cough, rhinorrhea, shortness of breath, and fever for two days. Her impression was pleuritic chest pain with bronchitis.

The patient saw Family Physician A on February 12 and February 19 and reported back pain, shortness of breath, cough, sputum, and left nipple swelling for one month. Family Physician A ordered an MRI, and the results were reported as negative. Two more weeks passed. The patient returned to Family Physician A for significant pain, shortness of breath, cough, sputum, and left abdominal pain.

On March 29, the patient saw Family Physician B. This physician ordered a chest x-ray. The impression was "mediastinal lymphadenopathy with bilateral pulmonary nodules." A CT scan revealed "extensive pulmonary metastases and mediastinal adenopathy consistent with metastatic disease, most likely seminoma or other testicular tumor." A sonogram of the scrotum revealed a hyperemic left testicular mass.

The patient was admitted to the hospital by Pulmonologist A on March 30. A CT scan of the abdomen revealed extensive retroperitoneal adenopathy consistent with metastatic tumor. A chest x-ray showed mediastinal and hilar lymphadenopathy and bilateral mass lesions.

A urologist was consulted, and the patient underwent a left radical orchiectomy on April 1. The pathology report indicated "near malignant germ cell neoplasm, equal components of embryonal and yolk sac carcinomas; invasion of mediastinum testis." The patient was started on chemotherapy and was discharged from the hospital on April 9. He continued chemotherapy.

By December 12, the patient's testicular cancer was in clinical remission. However, the patient was noncompliant in keeping follow-up appointments, as documented by the oncologist.

Allegations
A lawsuit was filed against Family Physician A and Pulmonologist A. The allegations were:

- failure to order proper testing;
- failure to follow up on the scrotal ultrasound and CT scans; and
- failure to refer to a urologist.

Legal implications
Defense consultants were not supportive of Family Physician A's actions. On August 11, she indicated she would order a CT scan in three months. When the patient returned on December 12, February 12, February 19, and March 1, it was not addressed. Family Physician A did not question the patient about seeing Pulmonologist A and did not follow up. The urologist was not directly critical of Family Physician A but testified that it would have been reasonable to obtain a urological consult based on the July sonogram.

Family Physician A testified that she thought the pulmonologist was following up on the CT scans. Pulmonologist A testified that he never told Family Physician A he was going to order serial CT scans.

The subsequent treating oncologist testified that it was the standard of care to obtain a urological consult when there is an abnormal testicular sonogram. He also stated that Family Physician A should have ordered a CT scan when the patient returned in December.

Regarding the actions of Pulmonologist A, defense experts were critical of his lack of follow up after the August 18 CT scan. There was no indication in the medical record that Pulmonologist A tried to contact the patient when he failed to show for the appointment.

Disposition
This case was settled on behalf of Family Physician A and Pulmonologist A.

Risk management considerations
This case illustrates how abnormal findings can become lost when patient care extends across multiple visits and physicians. Missed appointments and uncertainty about who is responsible for follow-up can further delay timely care. The following recommendations may help reduce liability related to delayed diagnosis.

- **Use EHR tracking tools to follow abnormal findings.** EHR tracking tools can help practices maintain oversight of outstanding tests and referrals, identify missed appointments, assign follow-up responsibilities, and help confirm that recommended care has been completed.

- **Maintain an active problem or follow-up list** for unresolved issues. Findings that require ongoing evaluation should remain visible in the EHR so they can be addressed at the next encounter/appointment. When patients return for other concerns, review outstanding tests, referrals, and recommendations with them. Do not expect patients to raise outstanding issues.

- **Use EHR alerts to flag missed appointments** that require following up for abnormal findings or potentially serious conditions. Alerts or work queues can identify patients for appropriate outreach and escalation. Document attempts to contact the patient.

- **Clearly establish who is responsible for follow-up.** Do not assume a consultant or referring physician is monitoring an abnormal finding. Communicate and document who is responsible for ordering additional testing, reviewing results, contacting the patient, and providing ongoing surveillance.

- **Communicate the importance of follow-up to the patient.** Explain why additional testing or specialty referral is recommended and the potential consequences of delaying follow-up. Document these discussions, particularly when a patient has missed several appointments or does not complete recommended testing.

CASE 7: FAILURE TO RE-EXCISE A SUSPICIOUS LESION

Presentation
On September 3, a 36-year-old woman came to a plastic surgeon about a "progressively enlarging mole on her right foot." She reported a positive family history for melanoma. Specifically, her grandmother died at age 45 from metastatic melanoma.

Physician action
The plastic surgeon examined the patient and noted that she had blond hair with fair skin. Except for the foot lesion, no other skin abnormalities were found. He described the foot lesion as "suspicious" and performed a 3 mm punch biopsy.

The specimen was sent to a pathology lab. In his report, the pathologist described the tissue as having abnormal cell growth and thickening with proliferation of slightly atypical melanocytes within the epidermal area. The cells were atypical in that there was a visible but not prominent nucleus.

The pathologist believed that the dermis was fibrotic but did not manifest fibroplasias of the dysplastic nevus. The lateral margins of the specimen were involved, and the pathologist recommended conservative re-excision with 0.5 cm margins.

The pathologist also noted that the specimen had a more than expected degree of cytoarchitectural atypia. The final diagnosis was acral compound melanocytic nevus, moderate cyto-architectural atypia, and nevus at peripheral, not deep edges. A second pathologist at the lab reviewed this specimen and concurred with the first pathologist's opinion.

The surgeon saw the patient again on September 11. He concluded that the lesion was a melanocytic nevus and that there was no need for removal. The plastic surgeon recommended biannual follow-up for re-examination of the lesion.

The patient returned one year later on September 9 to discuss removal of the lesion. She said that the lesion was rubbed by her shoe and was tender to touch. The plastic surgeon recommended excision in light of the pathology report, irritation, and recent infection. On September 30, the plastic surgeon saw the patient for a preoperative evaluation. The lesion was "not getting any better" and caused the patient pain when walking. The plastic surgeon obtained a full history and informed consent for the procedure.

On October 1, the plastic surgeon performed an excisional biopsy of this area as planned. The pathologist reported that the lesion represented an invasive malignant melanoma. He described it as Clarks Level III with Breslow thickness of 2.1 mm. The margins were free from lesional tissue, meaning the biopsy had theoretically removed the entire lesion.

The plastic surgeon informed the patient of the results at a follow-up visit. He told her that the specimen would be reviewed for a second opinion, but indicated that she would be referred to a surgical oncologist for treatment. A dermatopathologist agreed with the diagnosis of malignant melanoma.

The patient saw a surgical oncologist who performed a wide excision and lymph node biopsy. The pathology report revealed micrometastatic melanoma of the lymph node.

The patient was referred to an oncologist and underwent adjuvant chemotherapy with interferon. The patient did well until widespread metastasis was revealed nine months later. She died three months later at the age of 38.

Allegations
A lawsuit was filed against the plastic surgeon alleging negligence in performing a punch biopsy on a suspicious lesion and for failing to re-excise the lesion after the pathology report recommended re-excision.

Legal implications
The plaintiffs were able to locate experts supportive of their allegations. They claimed that if the lesion had been re-excised, in all reasonable medical probability, the patient would have been cured.

The biggest hurdle for the defense was that the pathologist recommended re-excision, but the plastic surgeon did not re-excise the lesion. It was clear from the medical records that the plastic surgeon did not read the entire pathology report. He specifically wrote in his notes that there was no reason to re-excise the lesion. In the pathology report, the recommendation to re-excise the lesion was placed in the "Microscopic Description" section instead of the "Diagnosis" section.

Defense consultants were divided on whether the plastic surgeon breached the standard of care. One consultant stated that the plastic surgeon's failure to read the entire pathology report was indeed a breach in the standard of care. Further, even if he did not read the comment on re-excision, certain "red flags" in the report could indicate the need for re-excision. These "red flags" included the fact that the patient had fair skin and a family history of melanoma; that the lesion extended to the margin; and the lesion had moderate atypia.

Other consultants supported the surgeon's decision not to re-excise and stated that follow-up would have been the appropriate way to handle the lesion.

Several defense consultants criticized the format of the pathology report. They commented that the recommendation to re-excise the lesion was "buried" at the end of a long paragraph in the "Microscopic Description" section. One consultant stated that when physicians review pathology reports they generally do not read the microscopic section of a report, but instead focus on the "top line" diagnosis.

Disposition
This case was settled on behalf of the plastic surgeon.

Risk management considerations
When physicians receive reports for tests they have ordered — lab and imaging studies or a specimen sent to pathology — they are accountable for reviewing the content of the report and acting on the information. This case serves as an affirmation that the complete report be reviewed and that there be no assumptions regarding the anticipated "style" of a report.

After the patient's follow-up appointment to review the findings of the report, it was recommended that she return for biannual (twice a year) re-examination of the lesion. If possible, follow-up appointments should be scheduled before a patient leaves the practice. Then, if the patient does not return, action can be taken and documented to reschedule them. Alternatively, physician practices should consider a recall/reminder system when patients leave without a scheduled return appointment.

CASE 8: MISDIRECTED TEST RESULTS

Presentation
A 67-year-old woman came to a walk-in clinic reporting a cough. The cough had persisted for a week; was made worse with exertion; was described as moderate to severe; and was productive and blood tinged. The patient also reported chills, dyspnea, dyspnea on exertion, fatigue, fever, hemoptysis, pleuritic pain, and a sore throat.

The patient was a smoker and had a history of COPD. She was also thin, with a BMI of 16.6.

Physician action
An internal medicine (IM) physician saw the patient and diagnosed COPD with acute exacerbation and acute bronchitis. She ordered a high-resolution CT scan of the thorax, a chest X-ray, and prescribed levofloxacin, dextromethorphan and guaifenesin, and a tiotropium bromide inhaler. This note was signed at 5:30 p.m. on October 17.

The chest CT was performed the next day at a nearby hospital. The indications for the procedure, as noted by the IM physician, were "COPD, smoker, 30 years, cough."

A radiologist read the scan and dictated the following in his report at 10:23 a.m. on October 18: "Suspicious mass in the left lower lobe as above. This lesion would be amenable to CT-guided biopsy. There is a smaller subpleural soft tissue nodule in the posterior aspect of the right lower lobe. A small parapneumonic effusion is present."

The radiology report was faxed to the hospital and to the IM physician's office at 11:35 a.m. on October 18. The IM physician's office did not receive the faxed report. There was no follow-up on the October 18 CT scan, either by the patient or the IM physician.

Eighteen months passed. The patient went to another urgent-care clinic with concerns that she had pneumonia. A CT scan was ordered, and the report noted the lung nodule. The patient was referred to a pulmonologist. A biopsy revealed squamous cell carcinoma of the lung. The patient was diagnosed at Stage IV and was treated with chemotherapy.

Allegations
A lawsuit was filed against the IM physician, the hospital where the CT scan took place, the radiologist who read the CT scan, and his radiology group. The allegations were:

- failure to follow up on the patient's CT scan (IM physician);
- failure to communicate the suspicious findings on the CT to the ordering physician (radiologist);

- failure to have policies and procedures in place to ensure that critical findings are timely and appropriately reported to ordering physicians (radiology group); and
- failure to ensure the critical finding from the CT was reported to the IM physician (hospital).

The plaintiffs further alleged that the delay in the diagnosis and treatment of the patient's lung cancer resulted in limited treatment options and a less favorable outcome.

Legal implications
Physicians who reviewed this case stated that the radiologist appropriately read the scan and timely dictated the report. The report was faxed to the hospital, as required by the contract between the hospital and the radiology group. The report was also faxed to the IM physician at the walk-in clinic. However, during the investigation of this case, it was discovered that the radiology group faxed the CT scan report to the wrong fax number. It was sent to the walk-in clinic's old fax number, so the IM physician did not receive it.

The hospital — which was contractually obligated to forward radiology reports to ordering physicians — did not attempt to forward the report to the walk-in clinic. The reason for this was unclear.

While acknowledging that the IM physician clearly did not receive the report, physician reviewers were critical that he did not follow up on the test that he ordered. The IM physician also believed that he should have followed up on the results of the CT scan.

Patient responsibility was a factor in this case. The patient did not follow up on the CT scan, as she testified that she assumed it was "okay" since she did not hear back from the walk-in clinic.

Regarding causation, the defense oncology expert stated that the patient was likely at stage IV when the October 18 CT scan occurred. Consequently, earlier intervention may not have changed the patient's treatment, prognosis, or outcome. The plaintiff's oncology expert was not definitive about the patient's staging on October 18. He stated there was evidence of metastasis on the October 18 scan, and it appeared the lesion did not grow much over an 18-month period.

Radiologists who reviewed this case expressed concerns about whether the defendant radiologist should have called the IM physician to report the results of the scan. Those who stated the radiologist should have called cited the *American College of Radiology Practice Parameter for the Communication of Diagnostic Imaging Findings*.[8]

Conversely, the defendant radiologist stated that the scan was a non-urgent outpatient study. The findings — in a patient with COPD and a 30-pack year smoking history — were not unexpected. The radiologist did not believe the standard of care required a phone call.

Disposition
This case was settled on behalf of the IM physician. The hospital also settled their case. The case against the radiologist and the radiology group was dropped.

Risk management considerations
Tracking and follow-up of lab/diagnostic imaging is an important risk management strategy and, most importantly, a patient safety issue. General risk management strategies to assist with following up include these recommendations.

- Have written policies and procedures in place to track and follow lab work, testing, and referrals.
- Use a tracking system to ensure test results are received. A tracking system can be enhanced with dedicated personnel who schedule diagnostic testing, monitor tracking logs, make appointment reminder calls, and follow up on patients who do not keep scheduled appointments.
- When ordering a test or procedure, assist the patient with scheduling when needed. Schedule a follow-up appointment with the patient to review results.

- Engage patients in their own care by educating them about needed follow-up labs and testing. Include clear instructions on when to contact you if they do not receive results or hear back from you. It is important to document these conversations and any education in the progress notes.
- Avoid a "no news is good news" approach when it comes to communicating test results to patients. In this case, the patient wrongly assumed that she did not need to follow up on the CT scan and that it was "okay" since she did not hear back from the clinic.
- Communicate any change in your contact information — phone number, fax number, email, website — to all outside vendors and contacts. This includes hospitals, labs, radiology groups, physicians you refer to, etc. You may need to send your new contact information more than once.

While a physician who orders diagnostic testing or imaging is responsible for obtaining the results and acting on them, there is also a shared responsibility of all physicians to ensure results are communicated in a timely manner. According to the American College of Radiology, there are instances when it may be appropriate for the interpreting physician to contact the ordering physician directly.[8]

PREVENTING DIAGNOSTIC ERRORS

Consider the following guidelines to help reduce liability related to errors in diagnosis.

- Stay current with clinical practice standards that are applicable to your specialty. Consider using well-vetted decision support tools or other resources at the point of care. If you use these resources, do not ignore the guidelines, alerts, and reminders these systems employ.

- Foster an accurate diagnosis by asking the right questions, conducting a thorough physical exam, reviewing the medical records, and gathering clinical data.

- When possible, follow up with patients to ensure diagnostic accuracy. Repeated calls or visits from patients with ongoing symptoms provide the opportunity to reassess the patient and identify an issue that may have been overlooked.

- Have a well-defined and consistently followed process to verify that test results have been received, thoroughly reviewed, and acted upon. Processes should be developed for both diagnostic studies and specialist referrals.

- Even if the patient is told to contact the practice within a set time frame, it is beneficial for the physician to have a follow-up system in place.

- When test results or consultant reports are received in the office, do not file the reports in the medical record until the ordering physician has reviewed them.

- When caring for hospitalized patients, maintain open communication with all members of the health care team, including consulting physicians and hospital staff. Thorough patient evaluation and assessment — including reviewing nursing notes and directly communicating with consulting physicians — promotes optimal patient care.

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UPDATE: TMLT RISK MANAGEMENT TRENDS

by Tanya Babitch, Vice President of Risk Management



TMLT's Risk Management team is dedicated to helping you practice medicine safely and reduce your liability risk. To accomplish our goal, we offer continually evolving comprehensive services developed using the first-hand experience we gain by visiting physician practices, responding to your calls and emails, and monitoring what's happening in the regulatory and medical liability environment.

Our team tracks the issues that concern you the most. We receive more than 1,000 phone and email consultation requests each year from physicians and administrators seeking guidance on difficult patient scenarios, laws and regulations, and other concerns. We also keep tabs on the recommendations given during risk management practice reviews. We evaluate this data to identify emerging issues. This information is used to enhance our consultation and practice review services and develop relevant continuing medical education (CME) activities.

PRACTICE REVIEW RECOMMENDATIONS

Recommendations given during our practice reviews span topics such as documentation, office procedures and protocols, and federal and state regulations.

In 2025 and the first half of 2026, top recommendations included:

- **Prescription documentation**
  Documentation of prescribed or refilled medications should include the medication name, dosage, route of administration, instructions, quantity prescribed, and discussion of side effects and potential adverse interactions as appropriate.

  Medication samples should also be documented thoroughly when dispensed by you or your team. While the use of EMRs facilitates this documentation through prompts, systems can be bypassed and prescription information left incomplete.

  Document conversations with patients about medication precautions.

- **Injection documentation**
  Medications administered in the office should be documented in the patient's record with the medication name, dosage, lot number, expiration date, route and location of the injection, and the patient's condition post-injection.

  Patients should be observed to monitor for potential drug reactions. The duration of observation should be consistent with applicable clinical recommendations.

  Please note: When administering vaccines, documentation should include the vaccine information statement (VIS) date. (VIS information is found on the CDC website, link found below in "Sources and links."[1]) Texas physicians and health care providers must also provide a special Texas COVID vaccine information sheet (link below[2]) to patients prior to administering the COVID-19 vaccine and must obtain signed acknowledgment.[3]

- **Advanced Practice Provider (APP) acknowledgement/consent**
  Patients who are seen by an APP should be aware that they are not being treated by a physician. At your discretion, a form including general information about APPs and indicating the patient's acknowledgement that they will be treated by a physician assistant, advanced practice registered nurse, or nurse-midwife may be beneficial.

  In addition, APPs should wear a nametag or identification to indicate their credentials, as required by many state medical and professional boards.

- **Patient history updates**
  A patient's medical history should be updated to reflect their current health status. Patients should be prompted to share information at each visit; medical procedures, social history, new diagnoses, or other changes to health status should be added to the medical record. Updates should be reviewed by the physician or treating provider. Documentation of history review may be helpful in the event of a medical liability claim.

- **Signature of staff**
  Staff should sign any entries they make in the medical record, whether electronic or paper. Staff members should have unique EMR log-in credentials, and their identities/signature should be included in any entries.

- **Policies and procedures**
  Medical practices should maintain policies and procedures to guide patient care and regulatory compliance. Policies may include documentation requirements, communication with patients, management of medication refills, test tracking protocols, emergency plans, and more.

  Policies and procedures should also include HIPAA privacy and security guidance and other compliance elements. Policies and procedures should be signed by physicians and staff members to indicate acknowledgment, include implementation and revision dates, and be reviewed regularly.

- **Review your practice website**
  We recommend regular review of your practice website. Medical practice websites should be up to date, comply with Texas Medical Board Rule 164, Physician Advertising, include the practice's HIPAA Notice of Privacy Practices per federal guidelines, and include disclaimer language if supplying medical information.[4, 5]

- **Telemedicine**
  If offering telemedicine visits, physicians should review applicable laws and develop protocols for the use of telemedicine in their practice. Texas requirements include documentation of patient consent for telemedicine, sharing of HIPAA privacy information, telemedicine-specific fraud and abuse protocols, and more. Some of these elements are addressed in the TMB Rules, Chapter 175. Telemedicine[6] and the Texas Occupations Code, Chapter 111. Telemedicine, Teledentistry, and Telehealth.[7]

  If considering implementing telemedicine services, physicians should contact their medical liability carrier to ensure appropriate coverage.

  If practicing out of Texas, contact your state medical board for further guidance or information.

RISK MANAGEMENT CONSULTATIONS

The most frequently discussed topics in 2025 were:

- termination of the physician-patient relationship;
- regulatory and TMB issues;
- how to leave or close a practice;
- medical records;
- staff issues, including supervision, OSHA, and employment;
- HIPAA;
- patient complaints;
- release of medical records;
- general office, including regulatory and policy questions; and
- patient visits, including appointments, recording of visits, and referrals.

Termination of the physician-patient relationship remains a significant concern for physicians. This is unsurprising, as ending a relationship with a patient may present a new set of circumstances each time and is often uncomfortable for the physician. We can offer guidelines and sample notification wording to assist policyholders during this challenging process.

Additional TMLT resources on physician-patient relationships are found online at www.tmlt.org/topics/physician-patient-relationships.

EMERGING TREND: ARTIFICIAL INTELLIGENCE (AI)

As more physicians adopt AI tools, we have observed an increase in questions about AI use in medical practice. TMLT has not seen significant claims involving the use of AI, but many experts believe that these claims will come. While it is unknown who will bear the burden of medical liability in these cases (the physician or the AI system developer), some software companies may include liability clauses in contractual language to protect themselves. Physicians and practices must know what is in these agreements before adopting new AI systems.

The use of AI in medicine offers both incredible opportunities and potential pitfalls. To protect themselves and their patients, physicians in and out of Texas should comply with their individual state and federal laws and take precautions to ensure appropriate adoption and use of AI systems.

In 2025, Texas passed two laws that address the use of AI in health care.

- **SB1188** requires that the "practitioner reviews all records created with artificial intelligence in a manner that is consistent with medical records standards developed by the Texas Medical Board," and that AI used for diagnostic purposes be disclosed to patients.[8]

- **HB149** requires that if AI is used in health care, the provider of the service must disclose the use to the recipient of the service (patient) no later than the date the service or treatment is first provided. The disclosure must be "clear and conspicuous" and be "written in plain language." We recommend that disclosure and patient consent be documented in the record.[9]

The most widely used AI platforms noted by the Risk Management team are ambient AI scribing systems. These platforms record physician-patient interactions, extract relevant medical information, and draft notes — potentially saving physicians considerable time. However, these AI-generated notes must be reviewed thoroughly before signing off to catch any errors or discrepancies.

External noise, poor communication, or other factors can affect the quality of the data captured by these systems. Scribing systems will not pick up any interaction that doesn't occur out loud; a running exam dialogue by the physician or additional entry post-visit may be required.

Of further concern is that AI-generated documentation errors may be more difficult to detect. AI is trained to *seem* accurate even when inaccurate. Physicians must also be aware of potential privacy issues with the recording and storage of patient data, which should be clarified with the vendor before adoption of any system.

AI resources

- TMLT webinar, *RX for AI- Clinical Advances, Legal Risks, and Regulatory Response*, found at https://tmlt.inreachce.com/details/Information/72495517-dc86-4268-ad9b-f2c18c37ce0c

- TMLT article, *Texas physicians must disclose use of AI under new state rules*, found online at www.tmlt.org/resource/texas-physicians-must-disclose-use-of-ai-under-new-state-rules

- TMLT article, *An introduction to AI-assisted documentation tools*, found online at www.tmlt.org/resource/an-introduction-to-ai-assisted-documentation-tools

- TMLT article, *Using AI medical scribes: Risk management considerations*, found online at www.tmlt.org/resource/using-ai-medical-scribes-risk-management-considerations-2

- The Texas Medical Association (TMA) AI hub is found at www.texmed.org/AI/

CONTINUING MEDICAL EDUCATION (CME)

Our CME team works hard to develop educational activities that meet your needs. We offer webinars, live onsite seminars, and anytime-access to education via our online CME platform at https://tmlt.inreachce.com/. In 2025, our top live program requests included:

- communication;
- Texas Medical Board/legal/legislative;
- cyber risk management;
- physician-patient relationships (including how to end the relationship); and
- safe prescribing of opioids.

Our most popular online courses, all found on our CME platform, included:

- *5 things that get physicians sued*
- *Case Closed: Surgical specialties*
- *Case Closed: Odd cases*
- *Electronic medical records: A practical guide*
- *Supervising advanced practice providers: Definitions, agreements, and delegation*

In 2026, we have seen increased interest in AI use reflected in our requested CME programs, with AI now included in our top five most requested topics.

TMLT's goal is to offer our policyholders the risk management tools, resources and assistance you need to help you practice medicine with peace of mind. We encourage you to reach out to us online at **www.tmlt.org/insurance-services/risk-management-support** with risk management questions, to request a practice review, to find out more about our CME, or to let us know what risk management services or content interests you.

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