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Case of the Month

The Hidden Costs of Delayed Diagnoses

by Jane Mock, CPHRM
Senior Risk Management and Patient Safety Specialist

Diagnostic errors—delays and misses—are a perennial driver of medical professional liability claims. Candello, a national organization that collects and analyzes malpractice claims data, reviewed 6,544 general medicine cases closed between 2014 and 2023. In 46 percent of these cases, diagnostic failure was the primary allegation, with missed or delayed diagnosis of cancer cited most frequently. This study found that a series of problems—rather than one dramatic event—contributed to the ultimate delay in or failure to diagnose cancer, including failure to appreciate concerning symptoms; failure to appreciate the significance of test results; follow-up deficiencies; poor communication; and inadequate documentation.[1]

The following example illustrates how a combination of factors can delay diagnosis and treatment.

Delayed Diagnosis of Laryngeal Cancer

A 45-year-old female patient with a history of reflux disease (GERD) presented to her primary care physician (PCP) in February of 2023 with complaints of recent hoarseness, dysphagia, sore throat, and weight loss. She saw a gastroenterologist the year before for workup of GERD and possible esophagitis. At that time, an upper endoscopy (EGD) showed reflux changes, and the gastroenterologist prescribed a proton pump inhibitor (PPI). When the patient saw her PCP, she reported that she had not found relief from the medication and had stopped taking it. The PCP referred the patient to an otolaryngologist (ENT), and an appointment was scheduled.

When the patient saw the ENT in April of 2023, she relayed her history of GERD. The ENT indicated he had reviewed the gastroenterologist's notes and proceeded with examination. A flexible laryngoscopy was performed and right vocal cord paralysis and some inflammation were noted; no biopsy was performed. The ENT ordered a CT scan and performed a videostroboscopy. The CT scan report described soft tissue "thickness," and the videostroboscopy showed an area of inflammation. The ENT diagnosed laryngopharyngeal reflux and recommended the patient resume taking the PPI.

Over the next three months, the patient continued to experience worsening vocal changes, labored breathing, and dysphagia. She returned to the ENT in July and underwent a repeat laryngoscopy, which showed the right vocal cord remained paralyzed. The ENT added albuterol for relief of symptoms attributed to asthma. Although a follow-up visit with the ENT was scheduled for one month later, the patient cancelled the appointment without rescheduling.

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In December of 2023, the patient established care with a new ENT. She complained of persistent hoarseness, tiredness, and shortness of breath. The ENT performed a flexible laryngoscopy and ordered a biopsy and imaging, which revealed Stage III laryngeal squamous cell carcinoma. The new ENT also reviewed the patient's prior records and noted that the inflammation on the videostroboscopy from April was suggestive of a mass. The patient underwent a laryngectomy, chemotherapy, and radiation, and required a permanent tracheostomy. She sued the first ENT and radiologist, alleging delayed diagnosis of cancer resulting in loss of her natural voice and reduced life expectancy.

The patient/plaintiff's case centered on failure to adequately investigate and follow up on red flags: hoarseness, dysphagia, vocal cord paralysis, weight loss, and progressive respiratory symptoms. Experts felt that the patient's history of GERD created an "anchoring bias" that traveled with the patient over subsequent evaluations. Experts were critical that the first ENT did not biopsy or otherwise definitively evaluate suspicious laryngeal findings. The ENT also failed to document why a biopsy was not indicated. They also opined that the videostroboscope and CT results were underappreciated. The first radiologist minimized the CT findings as soft tissue thickness and did not note a suspicion of cancer. This radiology report, in turn, influenced how the ENT approached the case and contributed to his not pursuing an explanation for the patient's symptoms.

Risk Management Opportunities

This scenario presents several high-risk failure points involving diagnostic anchoring, inadequate follow-up of persistent symptoms, communication gaps, and inadequate documentation.

Be Aware of Cognitive Biases

"Anchoring" is a common cognitive bias. It occurs when clinicians focus on a particular piece of information early in the patient workup and fail to incorporate subsequent information or impressions. When a patient presents with a particular complaint or working diagnosis, it can lead physicians to a premature conclusion that such initial findings explain symptoms.[2,3,4] Taking this narrow path can, unfortunately, lead nowhere—until it's too late. Here are some recommendations to manage risk:

- Establish a differential diagnosis. Ask yourself, "What else could this be?" "What is the worst thing it could be?"
- Consider taking a diagnostic "timeout"; run through a checklist before finalizing benign diagnoses. Your electronic health record (EHR) might offer some support with diagnosis templates or prompts for persistent, unresolved symptoms. As with any template, be sure to review and tailor it to the specific patient before finalizing a note.
- Consider that the patient could have concurrent conditions.
- Solicit colleague feedback in exploring alternative diagnoses for persistent symptoms.[5]
- Remember that rushing to judgment can lead to a missed abnormality. Try deliberately slowing down to consider alternative diagnoses.[5]
- Review the medical record with a fresh eye to catch and track unresolved abnormal findings.

Documentation

Documentation should support patient care and, in the event of an adverse outcome, demonstrate the defensibility of that care. Elements of strong documentation include:

- The physician's analysis and thought process (e.g., why malignancy is or is not suspected; reason for deferring biopsy)
- Discussion of differential diagnoses
- Follow-up instructions

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- Advice about what symptoms the patient should look for and action to take (e.g., immediate return if hoarseness persists)
- Planned reassessment timeline

For Radiology

The CT interpretation by the first radiologist described soft tissue "thickness," which was deemed ambiguous. Appreciate the importance of:

- Using clear language when malignancy cannot be excluded
- Including actionable recommendations, such as:
  - "Direct visualization/biopsy recommended"
  - "Correlation with laryngoscopy advised"
  - "Short-interval follow-up suggested"
- Documenting whom you notified; date/time of communication; and clinical urgency

Coordination of Care

The PCP appropriately referred the patient to an ENT, but there may have been a missed opportunity for coordination of care and addressing the patient's persistent symptoms. Specialists should ensure that the patient's PCP receives specialist reports promptly, and the PCP should track unresolved referrals.

Follow-Up

When patients cancel appointments without rescheduling:

- Ensure physician review of cancellations and no-shows to determine urgency of outreach for follow-up. Instruct staff to contact patients with a phone call and to document results of call attempts.
- If there is no response, send a letter by certified and regular mail to communicate the need for follow-up, the recommended timeframe, and the potential consequences of not following up.

In cases of persistent, unresolved symptoms, implementing risk management strategies early, and along the continuum care, can improve outcomes and reduce liability for physicians.

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RISK MANAGEMENT
AND
PATIENT SAFETY NEWS

Reducing Risk Through Clarity: Patients' Rights and Responsibilities

by Tanha Ahmed, MPH
Senior Risk Management and Patient Safety Specialist

In contemporary healthcare, the concept of patients' rights has become firmly embedded in clinical, legal, and ethical frameworks. Rooted in principles of autonomy, informed consent, and dignity, these rights are essential to promoting trust within the physician-patient relationship.

While physicians are held to well-defined professional and legal standards, patients are increasingly recognized as active participants in their own care. Adherence to treatment plans, accurate disclosure of medical history, and engagement in shared decision-making are integral components of effective healthcare delivery.

Patients' Rights at the Point of Care: Moving From Principle to Practice

Patients' rights, while often framed as abstract concepts, are most impactful in high-stakes clinical decision-making. They shape diagnostic, treatment, and documentation practices and are clearly defined in California law (Title 22, CCR §70707) and the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (42 CFR §482.13), which require hospitals to protect patients' rights to informed consent, participation in care decisions, and the ability to accept or refuse treatment. These requirements must be consistently operationalized despite clinical pressures.[1,2]

National standards emphasize that patient engagement is foundational to safe care, with The Joint Commission underscoring the importance of effective communication and patient understanding.[3]

In practice, this means practitioners have a responsibility to:

- Verify the patient's understanding of risks of declining care
- Offer alternatives to help mitigate further deterioration
- Adapt recommendations to patient preferences

The Right To Refuse Care: Clinical and Legal Boundaries

The right to refuse care is a direct extension of patient autonomy and is well-established in both ethical and legal frameworks.[4,5] Even when refusal places the patient at substantial risk, competent adults retain the right to decline medical intervention.

Clinically, physicians must balance autonomy with beneficence and nonmaleficence. A structured approach includes:

- Assessing decision-making capacity
- Ensuring the patient is adequately informed
- Exploring underlying reasons for refusal
- Documenting the discussion and associated risks

Courts and regulatory bodies consistently evaluate not the outcome of refusal, but whether the physician fulfilled the duty to inform and document appropriately.[4]

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Health Literacy and the Limits of "Informed" Decision-Making

A critical limitation in applying patients' rights is the assumption that information provided is equivalent to information understood. Health literacy gaps, language barriers, and cognitive limitations frequently undermine true informed consent.

Joint Commission standards explicitly require that communication be delivered "in a way the patient understands," including the use of interpreters and accommodations for cognitive or sensory impairments.[3]

When Patient Responsibilities Directly Impact Care

The practical significance of patient responsibilities becomes most apparent in day-to-day clinical encounters, where lapses in engagement or adherence can materially affect outcomes. The following scenarios illustrate how patient behavior intersects with physician duties, often shaping both clinical trajectories and medicolegal exposure.

Incomplete or Inaccurate Disclosure

A patient presenting with nonspecific gastrointestinal symptoms denies recent medication use. Subsequent evaluation reveals complications related to undisclosed nonsteroidal anti-inflammatory drug (NSAID) overuse. In such cases, even thorough clinical evaluation may be undermined by incomplete patient disclosure.

From a risk management perspective, documentation should reflect that a comprehensive history was requested and that the patient denied relevant exposures.

Nonadherence to Treatment Plans

A patient with hypertension is prescribed antihypertensive therapy and advised on lifestyle modifications but returns months later with persistently elevated blood pressure and evidence of end-organ effects. Upon further inquiry, the patient reports inconsistent medication use.

While nonadherence is common, failure to address and document it can blur accountability. To ensure patient accountability, physicians should document:

- Counseling on risks of nonadherence
- Assessment of barriers (e.g., cost, side effects)
- The patient's stated level of adherence

Clear records demonstrating patient education and follow-up recommendations are essential in mitigating liability.

Refusal of Recommended Care

A patient with chest pain declines emergency department evaluation despite counseling regarding the risk of myocardial infarction. In such high-stakes scenarios, respecting autonomy does not eliminate physician responsibility.

Best practices include:

- A detailed informed refusal discussion
- Documentation of the risks explained
- Assessment of decision-making capacity
- When possible, obtaining a signed refusal form

Failure To Follow Up

A patient is advised to obtain repeat imaging for a spot on the lung, but does not return for follow-up despite outreach attempts. Delayed diagnosis of malignancy may result. Courts often scrutinize whether the physician took reasonable steps to ensure continuity of care.

Documentation demonstrating that the physician fulfilled their duty, even when the patient did not meet their responsibility to engage should include:

- Clear follow-up instructions
- Multiple efforts to contact the patient
- Escalation protocols (e.g., certified letters)

Disruptive or Noncooperative Behavior

In behavioral health and primary care settings alike, patients may exhibit hostility, refuse examinations, or decline to participate meaningfully in care planning.

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Such behaviors can limit diagnostic accuracy and treatment effectiveness.

Physicians should document:

- The impact of these behaviors on care delivery
- Clear boundaries

When appropriate, follow formal processes for termination of the physician–patient relationship in accordance with legal and ethical guidelines.

Your Responsibilities:

From a risk management perspective, physician documentation should reflect:

- The content and quality of the discussion
- The patient's level of understanding
- The patient's decisions, including refusal or nonadherence

Example:

"Discussed concern for possible acute coronary syndrome and recommended transfer to the ED for further evaluation. Reviewed risks, including myocardial infarction, arrhythmia, and death. The patient verbalized understanding and accurately repeated the risks in their own words. Decision-making capacity was assessed and found intact. The patient declined transfer, stating a preference to go home and follow up with their PCP. Advised the patient to seek immediate care if symptoms worsen. The patient signed an informed refusal form."

Ethical and legal analyses emphasize that liability is mitigated when the record clearly demonstrates that the patient was **informed** and made a **voluntary decision**.[4]

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[2] *Code of Federal Regulations*, 42 C.F.R. § 482.13.

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Your Voice at the Capitol: A Year of Stronger Advocacy

by Gabriela Villanueva

In 2026, the Public Affairs program at the Cooperative of American Physicians (CAP) expanded its presence one lawmaker at a time in the California legislature. Backed by a strong collaborative team, including CAP staff, state and federal lobbyists, and a coalition-building political consultant, we have sharpened our approach to advocacy and deepened our engagement with state legislators on the issues that matter most to independent physicians.

Over the years, CAP has advanced its advocacy work through the commitment of physician members serving on state and federal political action committees who represent their colleagues before lawmakers in Sacramento and Washington, DC.

These physicians have been more active than ever, weighing in on key assembly and senate races across California and connecting directly with legislators at various events throughout the state.

Since March, the Public Affairs team has also met with various state legislators in Sacramento to discuss the growing challenges facing independent medical practices, including administrative burdens, reimbursement pressures, and workforce shortages that are threatening access to quality patient care. These conversations have emphasized an often-overlooked reality: independent practices are small businesses and employers whose financial viability directly affects community health and local economies. By sharing these perspectives, CAP is helping to ensure that the voices of independent physicians, their patients, and the communities they serve remain part of the policymaking process.

With the legislative session set to conclude on August 31, 2026, CAP's Public Affairs team is focused on providing lawmakers on both sides of the aisle with firsthand insights into the challenges impacting California's independent physicians. These efforts are central to our mission to build stronger relationships and continue to create meaningful opportunities for deeper engagement between CAP members and their state legislators.

Gabriela Villanueva is CAP's Government and External Affairs Analyst. Questions or comments related to this article should be directed to GVillanueva@CAPphysicians.com.

Travel Insurance Tailored for Physicians Who Plan Ahead

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Trip Delay	$3,000 ($250/day)	Baggage Damage/Loss	$2,500
Optional Enhanced Trip Delay	$7,000 ($500/day)	Baggage Delay	$600
Trip Cancellation	100% up to $200,000/person	Accidental Death & Dismemberment (AD&D) - 24/7	$25,000
Optional Cancel for Any Reason	75% of Trip Cost	AD&D - Common Carrier	$50,000

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