
— DIAGNOSTIC ERROR LITIGATION

The Test Result Nobody Owned

Following a Finding Through the Record in Delayed Diagnosis Cases

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A test gets ordered. The result is abnormal. It's sitting right there in the chart. And the next step never happens. A year later the patient is diagnosed with exactly what that earlier result was pointing to.

At first glance these cases look simple: an abnormal finding, a later diagnosis, and a gap between them. The real work is inside the gap. You need to know how the information moved, what it meant at the time, who was supposed to act on it, and whether acting on it would probably have changed anything.

WHY THIS KEEPS HAPPENING

Test result follow-up is a well-known safety problem. The federal government's 2025 SAFER Guides, the self-assessment tools for safe EHR use from ASTP/ONC, include a whole guide on test results reporting and follow-up. The Joint Commission's National Patient Safety Goal NPSG.02.03.01 requires accredited organizations to report critical results on a timely basis. The fact that regulators keep coming back to this tells you something: a result showing up in the computer and someone actually acting on it are two very different things.

Incidental findings are especially easy to lose. They turn up while everyone is focused on something else, often in an ER or hospital where the team will never see the patient again, and the follow-up usually lands on someone who was never told about it.

A FICTIONAL CASE

A patient goes to the ER after a fall. A CT rules out the injury everyone was worried about. The radiology report also mentions an incidental lung nodule and recommends follow-up imaging. The patient goes home with instructions to "follow up with primary care." The discharge

paperwork doesn't mention the nodule. More than a year later, during a different episode of care, the patient is diagnosed with lung cancer.

START WITH THE FINDING ITSELF

It's tempting to focus only on the radiologist's recommendation. It matters, but it's one piece.

First, when was the report finalized? ERs often discharge on a preliminary read. If the nodule only appeared in the final report, after the patient left, that raises a different set of questions about who was responsible for acting on it.

Second, what did the report actually say? Routine surveillance and "needs prompt evaluation" are very different recommendations. For incidental lung nodules, the Fleischner Society's 2017 guidelines tie follow-up to the nodule's size, number, and appearance and to the patient's risk. Many small nodules in low-risk patients need no routine follow-up at all, while others call for a CT within months. The American College of Radiology's incidental findings papers do the same job for other organs. The right interval depends on the actual finding and the actual patient, and a bad outcome later doesn't turn every earlier incidental finding into an emergency.

Third, where did the report go? To the ER doctor, to a primary care doctor listed in the chart, to a results inbox nobody checks after discharge, or nowhere in particular?

Fourth, what was the patient told? "Follow up with your doctor" and "you have a spot on your lung that needs a repeat CT in three months" produce very different behavior.

Now add one fact: a phone note showing a nurse called the patient, explained the nodule and the recommended scan, and got the patient's agreement to schedule it. That changes the picture. It may not answer everything, but it keeps an incomplete set of records from driving the conclusion.

"FOLLOW-UP" IS REALLY SIX STEPS

The most useful thing you can do in these cases is break follow-up into its parts, because each one can fail on its own and each leaves different evidence.

The result is **produced**: the report is finalized, and the timestamps, addenda, and preliminary-versus-final reads show when. It's **transmitted** to someone, which routing logs, inbox delivery records, or fax confirmations can show. It's **reviewed** by a responsible clinician, as shown by acknowledgment timestamps, audit trail views, or a result note. The **patient is told**, through a phone note, portal message, letter, or discharge instructions. Follow-up is **scheduled**, with an order, a referral, an appointment. And follow-up is **completed**: the scan or visit actually happens.

A transmission log proves a message was sent, not that anyone read it. An acknowledgment proves someone saw the result, not that the patient heard about it. So be wary of the phrase “closed loop.” Ask what counted as closing it. When the message left the hospital? When the patient picked up the phone? When the scan was done? Without that answer, two witnesses can describe the same system in completely different terms.

WHEN SEVERAL ORGANIZATIONS ARE INVOLVED

Ownership gets murky fast. The ER reasonably expects primary care to handle it. The primary care office may not consider this person its patient, or may never have gotten the report. The specialist gets a half-complete referral and waits for more. The patient reasonably assumes someone will call.

Don’t assume any of that just because there was a delay. Referral records, rejected or returned referrals, appointment messages, and the receiving office’s own chart can show what each party actually knew. Policies matter too: many hospitals have written procedures for results that come back after discharge, and whether one existed and was followed is often central.

THE IMAGING ITSELF

This is one reason Imaging Analysis is the third pillar of the Lexcura Clinical Intelligence Model. A finding has to be read in context: the report, any addendum, earlier studies, and whether comparison images were available.

There’s also a line to respect. Reading a radiology report isn’t the same as reading the images. If the case turns on what the scan actually showed, such as the nodule’s true size or whether it was visible on an earlier study, you may need a radiologist. A clinical analyst should say so rather than imply a summary settles it.

Earlier imaging deserves a close look. Did the radiologist compare to prior studies? Were those images even available? A finding that looks brand new in a fragmented record may have a long history, and an assumption that something was “stable” should be checked against the actual comparison.

DON’T TAKE “NONCOMPLIANT” AT FACE VALUE

“Patient noncompliant” or “failed to follow up” often shows up in a chart as if it explains everything. Treat it as a starting point. What was the patient actually told? Was it specific enough to act on? Did they understand it? Could they act on it, given insurance, transportation, and appointment availability? What happened when the first try failed?

Suppose the patient called the specialist and was told there was no referral on file, then called primary care and was offered an appointment six weeks out. That’s a very different story from a chart that just says they didn’t follow up, and it helps show whether anyone knew the plan had

stalled.

Fairness runs the other way too. Patients sometimes decline testing after a clear conversation. A documented informed refusal, with the discussion and date in the record, is a very different thing from an appointment that simply never happened. How patient conduct affects the claim varies by state and is a legal question, but the record should make clear which situation you're actually dealing with. And if the record doesn't show why follow-up failed, say so. An honest "here's exactly what we don't know yet" is far more useful to an attorney than a confident label that falls apart later.

DID THE DELAY MATTER?

Once you've found the gap, you have to address its clinical consequence. How long was the delay? What would probably have happened if the follow-up had been done? Would earlier evaluation have changed the stage, the treatment options, how hard treatment was, or the outcome?

The later diagnosis can't answer that by itself. The tumor's biology, the patient's baseline health, the findings at each point, and the likely diagnostic path all matter, and answering usually takes an oncologist or pulmonologist. Be especially careful with claims that earlier testing "would have" prevented the outcome when the evidence supports only a range of possibilities. The causation standard, including whether your state recognizes loss of chance, varies, so frame the clinical analysis in a way counsel can apply to the governing law.

A helpful exercise is to write two versions side by side. One is what actually happened, with dates. The other is what should have happened, with the clinical support for each step. If the second version needs the referral to be accepted promptly, the follow-up CT to show growth, the biopsy to confirm cancer, and treatment to then be curative, every one of those links needs support. The conclusion is only as strong as the weakest of those links, so put that link where everyone can see it.

WHAT AN EARLY REVIEW SHOULD GIVE YOU

An early clinical review should tell you what's already supported and what still needs digging. It might show that an actionable finding existed and that nothing in the records shows completed follow-up. It might also turn up a missing office chart or referral file that could change everything.

That's valuable before any final opinion. It focuses your next records request, tells you which specialist questions are worth paying for, and keeps you from investing in a theory built on a misread finding. Ask your reviewer for the earliest point at which further action was reasonably

indicated, the next documented action and the time between them in actual dates, the patient's condition during that gap, every record that could still change the picture, and why the gap matters clinically, not just that it was long.

Timing matters legally as well. When the patient knew or should have known about the missed finding can bear on limitations periods and discovery rules, which vary by state. The clinical timeline is usually the foundation for that analysis.

IT'S NOT JUST CANCER

The same approach applies to a blood culture that turns positive after the patient goes home, a lab value that comes back after discharge, a pathology report routed to a resident who's left, or a repeat-imaging recommendation buried in an addendum. The urgency differs. The need to follow the information from start to finish doesn't.

SOURCES

- ASTP/ONC, *2025 SAFER Guide: Test Results Reporting and Follow-Up*
- The Joint Commission, National Patient Safety Goal NPSG.02.03.01
- MacMahon H, et al., *Guidelines for Management of Incidental Pulmonary Nodules Detected on CT Images: From the Fleischner Society 2017*, *Radiology* 2017;284(1):228–243
- American College of Radiology, Incidental Findings Committee white papers

This newsletter is for education only and isn't medical or legal advice. The case is fictional.

ABOUT LEXCURA CLINICAL INTELLIGENCE

Lexcura Clinical Intelligence provides integrated clinical and regulatory analysis for attorneys handling healthcare litigation. If you have a delayed diagnosis case and want the finding traced from report to follow-up, the ownership gaps identified, and the causal chain tested link by link, we'd welcome the conversation.

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