The Doctors Company
TDC GROUP

Detecting and Addressing Incidental Findings: Medical Malpractice Claims Analysis

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Using current imaging technology, it has become more common to find abnormalities not associated with the reason the imaging was ordered. These unrelated abnormalities are considered incidental findings. If not followed up, incidental findings may lead to patient harm that can result in medical malpractice claims and lawsuits.

The Doctors Company studied medical malpractice claims closed from 2007 through 2022 with incidental findings. We defined an incidental finding as a result discovered during medical imaging that was unrelated to the reason the testing was ordered and deemed to be "actionable," meaning that it required further action or investigation by the ordering practitioner. Our study includes instances in which no follow up was completed because the practitioner in charge of the patient's care was either unaware of the finding, did not document it, or did not inform the patient of the finding. The study also includes data on whether the knowledge of the incidental finding would have changed the patient's outcome.

Some imaging tests had a higher frequency of incidental findings than others: cardiac magnetic resonance imaging (MRI), chest computed tomography (CT), and CT colonoscopy.[1] While the majority of incidental findings tend not to be life threatening, the rate of cancer discovered from incidental findings ranged from 2.3 to 4.5 percent.[2] A meta-analyses review showed that incidental findings in the breast had the highest percentage of malignancy, followed by renal, thyroid, and ovarian.[1] However, evidence around incidental findings in medical malpractice claims is lacking.

In evaluating the occurrence of incidental findings in medical malpractice claims, our goals were to:

1. Examine the outcome severity and outline the top incidental findings.
2. Describe the primary services responsible and, where possible, the roles involved.
3. Define other contributing factors involved.
4. Highlight the locations where incidental findings frequently occurred.

Method

We used an evidence-based taxonomy from Candello[3] to analyze claims from 2007 through 2022 with a contributing factor that identified an incidental finding. The inclusion criteria contained the following elements: injury severity, major allegation, location of the event, primary and secondary services, the role involved, diagnostic test completed, and any other contributing factors. Additionally, we searched clinical narratives for the word "incidental" in other claims during the same time period that did not list an incidental finding as a contributing factor.

We read each clinical summary to ensure that each claim met our established definition for an incidental finding. We recorded each specific imaging test performed, the incidental finding discovered, and whether earlier treatment would have made a difference according to medical experts.

Claim Characteristics

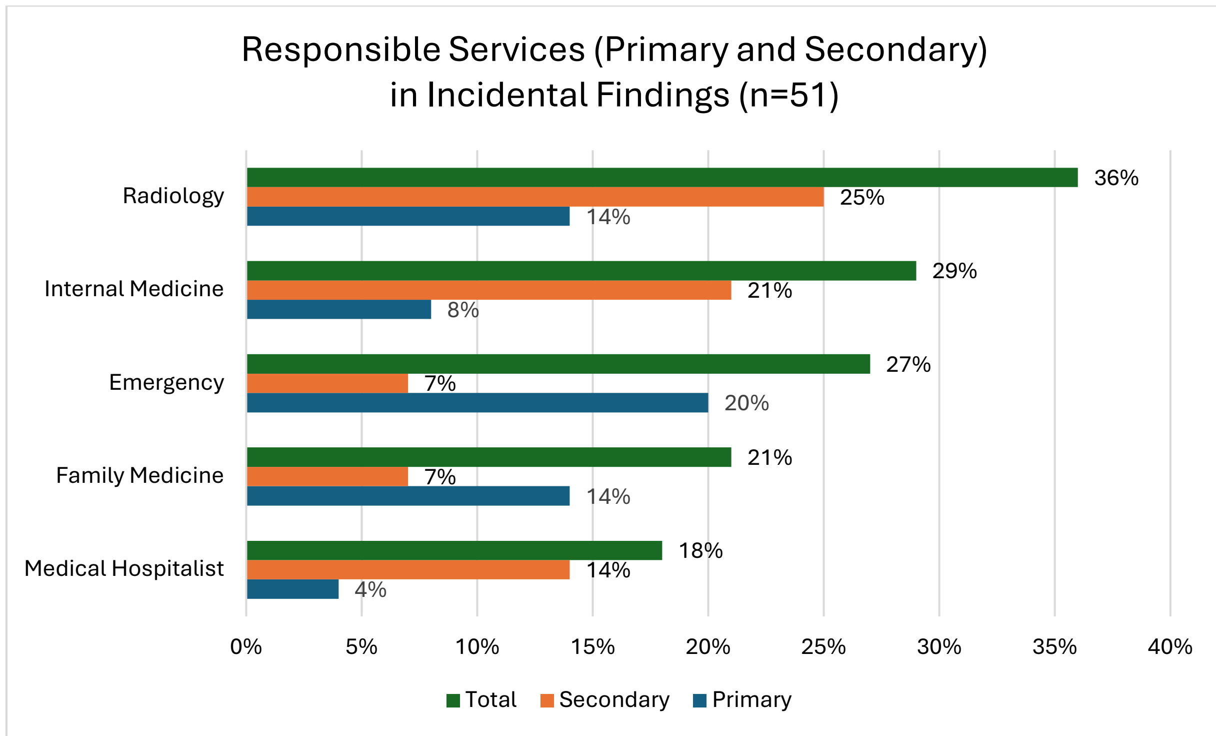
We found 51 claims involving an incidental finding. More than 41 percent of the claims had an indemnity payment. The average claimant age was 57 years old. As shown in Table 1, the injury severity tended to be high or disabling, with many claims involving death (n=21; 41 percent). The top primary responsible services included emergency, radiology, and primary medicine (family and internal medicine).

Table1. Incidental Finding Claims 2007–2022

Data Point	Case Count (Percentage)
Severity	
Death/Fetal Death (n=21)	41%
High (n=19)	37%
Medium (n=8)	16%
Low (n=3)	6%
Claims With Indemnity Paid (n=21)	41%
Top Location	
Office/Clinic (n=22)	43%
Patient Room (n=11)	22%
Emergency Department (n=8)	16%
Radiology (n=6)	12%
Imaging (n=3)	6%
Top Primary Responsible Service	
Emergency (n=10)	20%
Radiology (n=7)	14%
Family Medicine (n=7)	14%
Internal Medicine (n=4)	8%
Top Primary Roles*	
Attending/Consulting Physician (n=48)	94%
Physician Assistant (PA) (n=7)	14%
Organizational Leadership (n=4)	8%
Clerical Staff (n=4)	8%
**May have more than one Primary Role (totals exceed 100%)*	

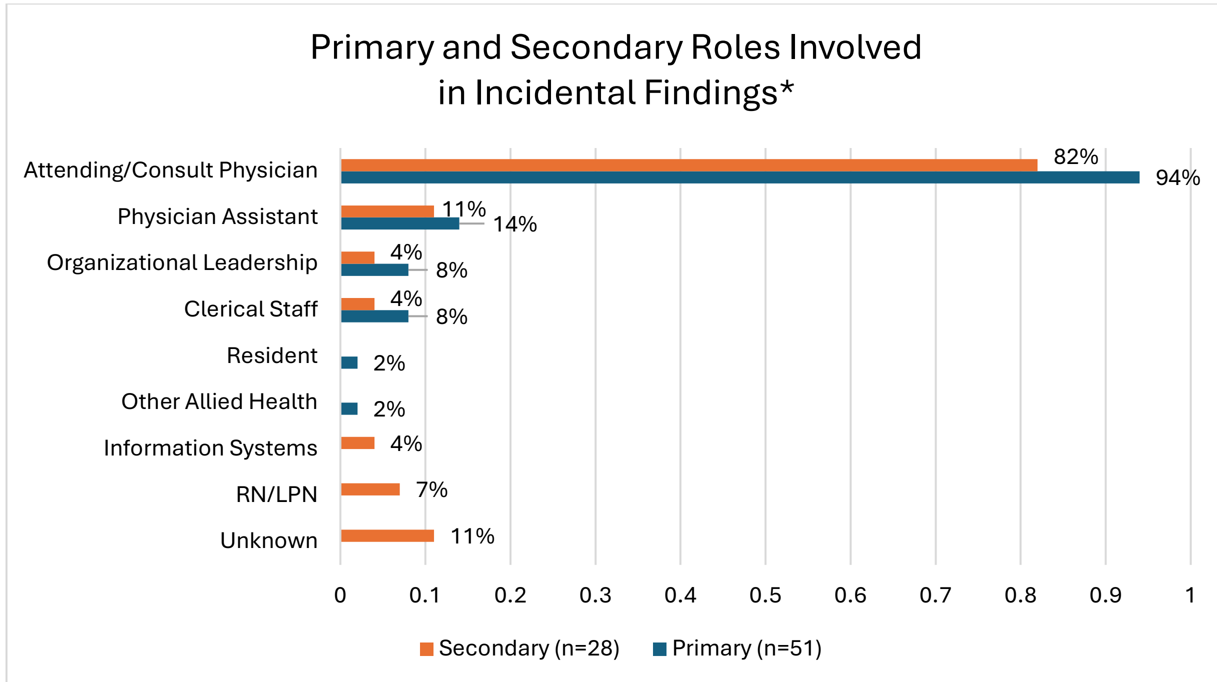
Responsible Service. Responsible service is defined as the team of practitioners providing care at the time of the event who contributed in some way to the event or to the claim filing. Each claim has one *primary* service identified as the service most responsible for the event. Claims may also have additional—or *secondary*—responsible services, identified as also contributing to the event. Over 54 percent of claims (n=28) had two or more responsible services involved in the claim. With that combination, radiology service was the top responsible service, followed by primary medicine (family medicine and internal medicine).

Figure 1. Top Responsible Services Involved in Incidental Finding Claims 2007–2022



Roles. Our analysis also investigated the service roles included in incidental finding claims. The attending or consulting physician was the most common role in the primary and secondary responsible areas, comprising 94 percent and 82 percent of claims, respectively. Other roles, such as physician assistants, clerical staff, and organizational leadership, had a percentage of both primary and secondary involvement.

Figure 2. Primary and Secondary Roles Involved in Incidental Finding Claims 2007–2022



*Claims can have more than one role.

Body Location of Incidental Finding. Our analysis found lung masses or nodules (n=13; 25 percent) to be the most common location of the incidental findings. Kidney lesions (n=6; 12 percent) and masses or nodules in the liver (n=3; 6 percent) and thyroid (n=3; 6 percent) were the next most common sites.

Contributing Factors

We also examined contributing factors. Beyond the major factor of a failure or delay in reporting the incidental finding, we found that the top two contributing factors involved a systems issue (that is, the patient did not receive an initial or revised test result) and a patient assessment issue (which is the failure to appreciate and reconcile relevant signs, symptoms, and test results). Communication issues (between providers and failure to read the patient record) were also top contributing factors. Table 2 illustrates the contributing factors category and subcategory involving incidental findings claims.

Table 2. Contributing Factors Involved in Incidental Finding Claims 2007–2022

Contributing Factors*	Number of Claims*	Percentage of Claims*
Failure/Delay Reporting Findings/Revised Findings	**51**	**100%**
Failure/delay in reporting incidental test finding	51	100%
Patient did not receive initial or revised test results	23	45%
Clinician did not receive test result—other	4	8%
Patient Assessment Issues	**41**	**80%**
Failure to appreciate and reconcile relevant sign/symptom/test result	23	45%
Narrow diagnosis focus: failure to establish differential diagnosis	17	33%
Failure/delay in ordering diagnostic test	16	31%
Misinterpretation of diagnostic studies (x-rays, slides, fetal monitoring)	8	16%
Narrow diagnosis focus: chronic/previous diagnosis assumed	6	12%
Narrow diagnosis focus: atypical presentation	4	8%
Narrow diagnosis focus—other	4	8%
Communication Among Providers	**31**	**61%**
Failure to read medical record	22	43%
Failure to communicate regarding patient's condition	10	20%
Failure with closed-loop communication	7	14%
Communication Between Patient/Family and Providers	**14**	**27%**
Communication between patient/family and providers—other	9	18%
Patient/family education—follow-up instructions	3	6%
Failure/Delay in Obtaining Consult/Referral	**13**	**25%**
Failure/Delay in obtaining consult/referral	13	25%
Insufficient/Lack of Documentation	**12**	**24%**
Clinical Findings	4	8%
Insufficient/Lack of documentation—other	4	8%
Patient Factors	**8**	**16%**
Nonadherence with follow-up call or appointment	6	12%
Nonadherence with diagnostic test or procedure	3	6%
Nonadherence with treatment regimen	3	6%
Shift/Off Hours Conditions	**7**	**14%**
Weekend/Holiday	5	10%
Night Shift (11:30 PM–7:30 AM)	3	6%
Policy/Protocol	**6**	**12%**
Need for Policy/Protocol	4	8%

*Claims have more than one contributing factor. Numbers will exceed total. Percentages will exceed 100%.

Our analysis examined whether earlier treatment would have made a difference. In 17 of the claims (33 percent), the outcome would have been different if the patient had been informed of the incidental finding earlier. In over 45 percent of the claims (n=23), the clinical experts were uncertain whether it would have made a difference. In only 11 of the claims (22 percent), experts opined that the incidental findings made no difference in the outcome for the patient.

Discussion

As our analysis highlights, missed incidental findings do not occur in isolation or from a single missed opportunity. We found that more than one service and role were often involved in overlooking the incidental findings. For example, although the emergency service had the highest primary responsibility for incidental findings, with combined responsibility, the radiology service had 36 percent. The role of attending/consulting physician was the most prominent role involved, but other roles—such as physician assistant, clerical staff, and organizational leadership—were also implicated as having responsibility for failing to address incidental findings. Additionally, the error consisted of various contributing factors that included issues with systems, communication, documentation, shift work, and a lack of policies and procedures.

Earlier studies found that chest CTs had the highest percentage for incidental findings.[1] Our analysis differed slightly. CTs involving the abdomen and pelvis had a higher percentage in our study (n=22; 43 percent) and chest CTs (n=7; 14 percent) were lower. Chest x-rays (n=8; 16 percent) had a high percentage of incidental findings in our study of malpractice claims.

Risk Mitigation Strategies

By examining the contributing factors in these claims, we can determine several strategies to help mitigate risk and improve the follow-up for incidental findings:

Establishing protocols and tracking systems. Develop and implement clear protocols for identifying and managing incidental findings. Although protocols will vary among specialties and organizations, they should focus on identifying and communicating incidental findings, along with follow-up and tracking to ensure that findings are appropriately addressed.

Clinicians and organizational leaders can use guidelines recommended by the American College of Radiology (ACR) to develop policies and systems for tracking follow-up. Systems may initiate alerts to inform practitioners about incidental findings and track communication and patient follow-up.[4]

Communication among providers. Effective communication among providers is vital to ensuring that incidental findings are seen and acted upon by the ordering practitioner. As noted in "Managing Incidental Findings" in *Applied Radiology*, strategies for radiologists include listing the incidental finding and making clear recommendations in the Impressions section of the radiology report. Clear recommendations are specific and include identifying and measuring (if applicable) the finding in question, the modality for follow-up, and the timeframe in which the follow-up should be completed. Radiologists should also verbally communicate critical findings to the ordering practitioner. Likewise, it is essential for ordering practitioners to read the entire radiology report to ensure an incidental finding is not overlooked. Incidental findings should be added to the patient's problem list to ensure that the finding is addressed.

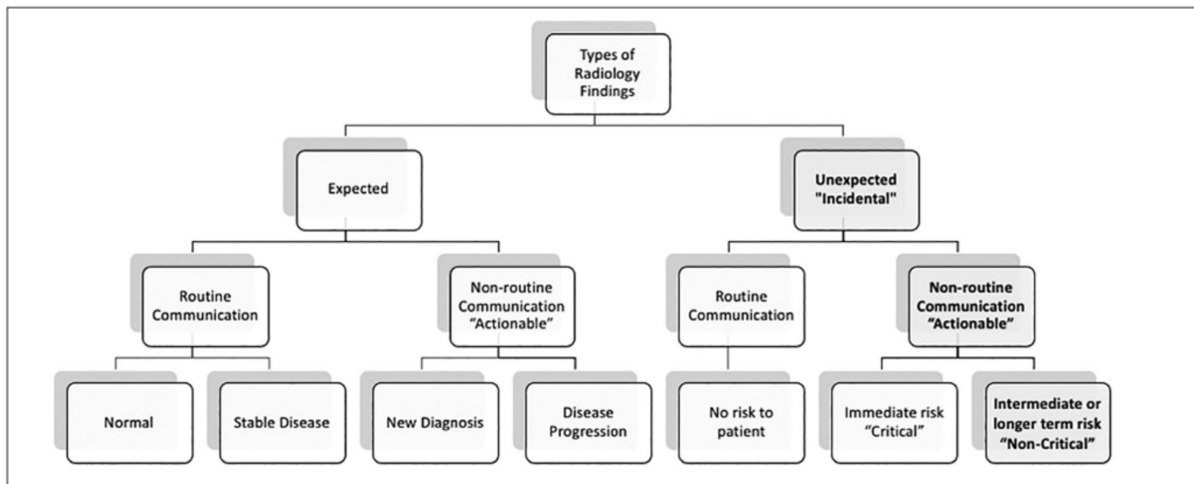
In its Quick Safety Issue 52, The Joint Commission discusses the importance of closed-loop communication when an incidental finding is discovered. The goal of closed-loop communication with

incidental findings is to ensure that the recipient receives, acknowledges, and acts upon the test result. The process also involves the sender and recipient working together to accomplish this task.

Closed-loop communication can be done verbally via a phone call or through electronic means, and it should be documented. Additionally, technologies are available that can confirm test results were received, eliminating some of the burden with certain test results.[2]

Figure 3, Terminology Used for Various Imaging Findings, demonstrates terminology related to incidental findings. This terminology can be used to start a discussion among members from various departments to define "critical" and "noncritical" risks, then the team can develop a system to communicate and document how to handle incidental findings within their organization.[2]

Figure 3. Terminology Used for Various Imaging Findings



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The American College of Radiology is another source for this information. ACR's Incidental Findings Committee has published multiple white papers on the management of various incidental findings. Radiologists can insert a message, such as an Information Reporting and Data Systems (Info-RADS), in the radiology report to inform the patient about the need for a follow-up.[2] There has been some call for mandating direct-to-patient reporting, such as requiring radiologists to report suspicious mammography findings directly to patients. This type of reporting is not, however, currently required. It is up to individual practitioners and administrators to develop reliable systems.

Patient Communication. With the increased availability and use of advanced imaging technologies, the risk of incidental findings has also increased. To alert patients and families and alleviate the potential for anxiety, outline the possibility of incidental findings prior to the imaging test.[1] Preparing patients for this possibility will also aid in initiating a discussion in the event of an incidental finding discovery.

If an incidental finding is detected, notify the patient promptly. Develop and use standardized methods (both written and verbal) to communicate incidental findings to the patient. Discuss the significance of the incidental findings and outline the next steps required for further evaluation.

If possible, in inpatient situations, discuss incidental findings in person. In many situations, however, the results may not be available until after a patient has been discharged. In these situations, encourage patient engagement. In accordance with the Cure's Act Final Rule, inform the patient that a test result is outstanding. Suggest checking the EHR for the report and following up with the practitioner who ordered the test to discuss the findings and any need for additional testing.

Many practitioner offices and healthcare organizations use patient portals to deliver patient information, including diagnostic test results, in a timely manner. Patient portals are, however, the last safety net if a practitioner inadvertently does not communicate incidental findings to the patient. It is, therefore, recommended that the report use patient-friendly language as much as possible.

Documentation. Documenting the receipt and review of an incidental finding and any discussions with the patient about the finding is crucial for several reasons. It provides a clear record that the practitioner was aware of the finding *and* that the discovery was discussed with the patient along with a follow-up plan. The documentation will ensure that the incidental finding is not overlooked and will aid in continuity of care between practitioners. Importantly, contemporaneous documentation provides strong evidence in the event of a claim that the incidental finding was addressed and the patient was aware of the finding.

Limitations

This analysis was limited to one large national professional liability insurer. Additionally, we included only malpractice claims and suits. We did not evaluate cases with incidental findings that did not lead to a claim or suit.

Conclusion

With the number of incidental findings on the rise, it is imperative for practitioners to be aware of potential problems and establish systems to avoid overlooking new findings. Communication among healthcare services can be beneficial in establishing effective systems. Some imaging tests have a higher incidence of incidental findings, so informing patients of the potential can alleviate anxiety and increase patient engagement. Ensuring safe patient care remains a top priority.

If you have questions, contact the Department of Patient Safety and Risk Management at (800) 421-2368 or by email.

References

1. O'Sullivan JW, Muntinga T, Grigg S, Ioannidis JPA. Prevalence and outcomes of incidental imaging findings: umbrella review. *BMJ*. 2018:361:k2387. doi:10.1136/bmj.k2387
2. Makeeva V, Schofield K, Davis M, Kadom N. Managing incidental findings. *Appl Radiol*. November 6, 2021. https://appliedradiology.com/articles/managing-incidental-findings
3. CRICO-Candello. Copyrighted by and used with permission of Candello a division of The Risk Management Foundation of the Harvard Medical Institutions Incorporated, all rights reserved. As a member of the Candello community, The Doctors Company participates in its national medical malpractice data collaborative.

4. Moore CL, Baskin A, Chang AM, et al. White paper: best practices in the communication and management of actionable incidental findings in emergency department imaging. *J Am Coll Radiol*. 2023 Apr;20(4):422-430. doi:10.1016/j.jacr.2023.01.001

The guidelines suggested here are not rules, do not constitute legal advice, and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any treatment must be made by each healthcare provider considering the circumstances of the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

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