A H R M N Y

RISK MANAGEMENT JOURNAL

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Editor's Corner

AHRMNY's Risk Management Journal (RMJ) is the official journal of The Association for Healthcare Risk Management of New York, Inc. (AHRMNY) and is published several times a year.

RMJ's Mission Statement: To enhance the quality of healthcare delivery through education, research, professional practice, and analysis specific to risk management issues.

This journal contains articles on a wide variety of subjects related to risk management, patient safety, insurance, quality improvement, medicine, healthcare law, government regulation, as well as other relevant information of interest to risk managers. The articles are usually written by AHRMNY members, so the journal serves as an opportunity for members to showcase their writing talents.

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Article Requirements: Maximum article length 3,500 words. Photos should be high-resolution JPEGs (at least 300 dpi). AHRMNY will not publish articles promoting products or services.

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Questions or comments to editors may be sent to ahrmny@gmail.com

In this Edition

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President's Message

Stephanie Campbell

President

July 1, 2026 - June 30, 2027

Greetings!

What an exciting time to begin my term as President of AHRMNY. The country has just celebrated its 250th anniversary (so many fireworks!), and World Cup fever is sweeping the nation. It's been thrilling to watch the games, even with the heartbreaking losses of late. My "5¾-year-old" son Lloyd was particularly heartbroken over Cabo Verde's loss. A few days later, when the USA was playing Belgium, I braced myself for more tears as I told him the USA was down 1-0.To my surprise, he slowly leaned back on the couch, placed his hands behind his head, and with a sly, devilish grin, said "Toughen up, boys… toughen up."

The confidence with which he said this, as if he has coached a thousand World Cup matches, was amusing. But it was also a wonderful reminder that even when we have bad days, a new day brings new hope! We just have to give ourselves the grace and permission to experience the bad days without guilt, but also the patience and time to allow ourselves a few moments before we take on the next challenge.

That message resonated with me as I reflected on AHRMNY's Annual Full-Day Conference, held on June 5, 2026, at City Winery. This year's theme explored the vital connection between human capital and patient-centered care—a topic that couldn't be more timely. The conference offered thoughtful discussions on how clinician burnout, moral distress, and psychological safety directly impact patient safety and organizational risk.

I want to give a special thank you to Janelle Arnao, one of our morning speakers and a member of the Education Committee, for proposing this year's theme. It sparked meaningful conversations that I believe were long overdue. My sincere thanks also go to our outstanding Education Committee—especially Gina Kittek, our President-Elect, and Cynthia Robinson, one of our newest board members, for their tremendous work planning the conference and assembling an exceptional lineup of keynote speakers and presenters.

Likewise, no AHRMNY event would be complete without recognizing our Executive Director, Kisha Wright. As always, she worked tirelessly behind the scenes and throughout the conference to make sure every detail came together and that the day ran smoothly. We are fortunate to have her and deeply appreciate everything she does for our chapter.

Finally, I would be remiss if I didn't acknowledge my predecessor, Wilhemina Nyarko ("Willie") and her amazing contributions to AHRMNY over these past few years. Taking the reins from her is a little intimidating. She has been an incredible advocate for our chapter and its members, and she'll be an extremely difficult act to follow. I'm deeply grateful for her leadership and for the strong foundation she has built, and I hope I can continue the momentum she has created.

Following the annual conference, we hosted a half-day webinar on June 24th which explored careers in healthcare risk management. Once again, my thanks go to Cynthia and Gina for organizing another successful educational program.

Looking ahead, our next major event is the ASHRM Annual Conference in Phoenix, October 4-6. For those of you planning to attend the conference, we are expecting to host a chapter event near the conference center, details to follow. I actually lived

in Arizona when I first moved to the U.S. from Canada nearly 30 years ago. Come find me at our event in Phoenix and I'll tell you a wild story about how, in my early 20s, I lived with a boyfriend who thought it would be a good idea to keep two black widow spiders ("both females!", he assured me), as pets in a homemade terrarium and the fun that ensued when an egg sac (which he proclaimed was "definitely empty", but was indeed, quite full) erupted with hundreds of baby black widows all over the kitchen. That's it. That's the whole story. But come find me to chat anyway!

Following ASHRM, we will host our Upstate Educational Conference in Syracuse on October 19, 2026, from 8:00 a.m. to 4:00 p.m., with a cocktail reception on the evening of October 18 at the Museum of Science and Technology (MOST). I have never been to this museum but I believe there is a giant model of a human nose somewhere in the museum that should provide some amusement.

In the meantime, if you've ever thought about becoming more involved with AHRMNY, we'd love to have you. Our committees are always looking for enthusiastic members—and there's truly a place for everyone. Are you the kind of person who throws a party people actually want to attend? We'd love to have you on the Events Committee. Have a knack for finding great speakers or know someone with a story worth sharing? Join the Education Committee. Comfortable asking people for money? Fantastic - I'm terrible at it! Our Fundraising Committee would be delighted to welcome you.

Whatever your talents or interests, there's a place for you in AHRMNY, and we'd love to have you join us.

Until then, enjoy the rest of your summer, cheer on your favorite World Cup team, and I look forward to seeing you at one of our upcoming events.

Cheers!
Steph

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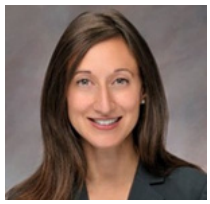

Sharon Scheuermann

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Selling Health Products: Easy Money or Risky Business?

By Laura Cascella

The sale of nonprescription health products — such as dietary supplements, vitamins, essential oils, skin care products, and nutraceuticals — is big business in the United States and abroad. In fact, the global market for dietary supplements was valued at $192.65 billion in 2024, and it is expected to expand at a compound annual growth rate of 8.9 percent from 2025 to 2033.[1]

Many physicians, chiropractors, acupuncturists, physical therapists, dentists, and other licensed healthcare professionals have incorporated the sale of health products into their practices as a way to meet patient expectations, increase convenience, and add new revenue streams — particularly as insurance reimbursements have declined and overhead has increased.

What may seem like an easy way to boost profits, though, can have serious legal and ethical implications. Numerous professional associations have issued guidance warning providers to avoid or use caution when selling health products directly from the office setting or through third parties that give providers a portion of the proceeds.

The perception of elevating profits over patient care can raise questions about financial conflicts of interest, potential patient coercion and exploitation, and negligence. The American Medical Association also warns that these sales can "erode patient trust, undermine the primary obligation of physicians to serve the interests of their patients before their own, and demean the profession of medicine."[2]

Healthcare professionals who wish to pursue the sale of health products, or who currently are recommending or selling specific products, should implement strategies that reduce ethical and legal risks and prioritize optimal patient outcomes and well-being. Examples of such strategies include the following:

- Carefully consider whether the health products you are selling, or considering selling, create a real or perceived conflict of interest or a concern about ethical practice.

- Determine whether the direct sale of products or the way in which you receive remuneration potentially violates state or federal fraud and abuse laws, such as kickback or fee-splitting statutes.

- Perform due diligence and consult legal counsel before entering into license agreements or sponsorships with wellness or diet clinics. These arrangements can expose healthcare providers to legal and professional risks.

- Review your state's laws on patient exploitation to ensure that selling products does not potentially violate these laws. Be particularly cognizant of sales to vulnerable patient populations, such as geriatric patients.

- Do not enter into exclusive distributorship or custom branding agreements with product manufacturers; doing so might trigger allegations of patient exploitation.

- Contact your state licensing board to determine whether it has any guidance or regulations related to the sale of health products to patients.

- Review state laws for in-office ancillary services as they relate to the sale of health products to determine any limitations or restrictions.

- Provide written and verbal disclosure of any financial interests you have in the sale of health products. Some state laws might require this disclosure, but it is prudent to disclose the information regardless.

- Ensure that patients know that they are not obligated to purchase products from the practice, and tell them where they can find similar or alternative products for purchase. Review sales and marketing tactics to verify that they are not coercive or place undue pressure on patients.

- Make sure any communication with patients about health products — including verbal and written communication — is objective, truthful, and devoid of misleading or deceptive claims.

- Only offer products that have undergone reliable and credible scientific review to prove their benefits. Selling or promoting products that make dubious claims with no scientific validity raises significant legal and ethical concerns.

- Make decisions about which products to sell based on patients' immediate needs, the clinical relevance to the patient population served, the availability of dependable evidence to support using the products, and potential barriers patients might encounter trying to obtain the products through other methods (e.g., time or geographic limitations).

- Provide patients with written and verbal information about the risks, benefits, and limitations of products so they can make informed decisions about their care. Make sure information is clear and understandable, and document the provision of information and education in patients' health records.

- Monitor patients who purchase health products to ensure safety and address any issues that might arise with toxicity, adverse events, or lack of improvement in their symptoms or conditions.

- Pay careful attention to any patient complaints — to office staff, on satisfaction surveys, or online — about feeling coerced into buying products or uncomfortable with sales/marketing efforts meant to facilitate product purchases.[3]

Although many healthcare professionals sell nonprescription health products (either in their offices or through manufacturers/suppliers), they should not approach this practice merely from the standpoint of generating revenue. Providers must be vigilant in ensuring these sales do not create conflicts of interest, violate legal statutes, raise questions about ethical behavior, or supersede acting in the best interests of patients.

Approaching the sale of health products with caution and careful consideration can help ensure a legal and ethical approach to product sales.

Article References on page 31

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Laura M. Cascella, MA, CPHRM, is the medical writing and publication management lead at MedPro Group. She has more than 20 years of experience in health communications and content development and has authored and contributed to numerous print and digital publications and health education programs.

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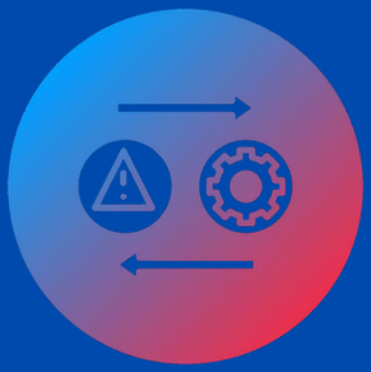
Harnessing AI in Healthcare Risk Transfer: Opportunities, Challenges, and Next Steps



By Meghan Anzelc

INTRODUCTION: WHY AI MATTERS FOR HEALTHCARE RISK TRANSFER

Artificial intelligence (AI) has been informing healthcare decisions for decades and its impact on healthcare and risk management is only growing. From predictive analytics to generative models, AI today is reshaping how insurers, brokers, and healthcare organizations assess, price, and transfer risk.

For healthcare risk managers, brokers, and attorneys, the key is learning how best to leverage the potential of AI. Underwriting, claims, and financing decisions are all being transformed, creating both opportunities and obligations. This article explores how AI is applied across the insurance ecosystem, what it means for healthcare risk managers, and practical steps to navigate this evolving landscape.

THE EVOLVING LANDSCAPE: HOW AI IS RESHAPING RISK TRANSFER

AI is being embedded in the core processes of risk transfer, driving a fundamental shift in how risk is evaluated and managed. Here's how insurers, brokers, and healthcare organizations are making use of AI today:

Insurers: Precision Underwriting and Smarter Claims

Carriers are using AI to overhaul underwriting from a manual, rules-based process into a powerful, data-backed discipline. Machine learning models were deployed at insurers starting decades ago, as carriers began integrating algorithms in high-volume data workflows and processes.

Underwriting models analyze thousands of variables across a vast range of data sources, from clinical data to demographic trends and historical claims data, to more accurately predict loss ratios and better segment customers and clients. In one insurer, supplying underwriters with stronger guidance backed by rich insights from a range of internal and external data sources enabled better decision making both at the individual risk level and the portfolio level.

In claims, AI-powered solutions can help automate the claims process, more quickly and accurately identify claims that need expert adjuster involvement, and identify outliers that could signal fraud or errors in billing. For years, natural-language processing (NLP) tools have been used to extract insights from adjuster notes and medical records, reducing cycle time and improving consistency. AI-based insights from adjuster notes

at one insurer exceeded outcomes of prior methods to direct more complex claims to more experienced adjusters, with the new approach effective months earlier in the life of the claim. Recent AI advancements open opportunities for additional sophistication and the systematic use of more complex and varied data sources to further streamline operations and improve healthcare outcomes.

Organizations are also deploying AI capabilities to help optimize and manage portfolios, quickly highlighting areas of exposure concentration or opportunities for profitable growth. These same tools identify potential emerging risks quickly and automatically, whether from shifts in the prevalence of chronic disease or changes in regulatory environments and jurisdictions, allowing more proactive adjustments portfolios, reserves, and underwriting and pricing strategies.

Brokers: Data-Driven Advisory and Negotiation

Over the past few years, as AI capabilities have improved – particularly in analyzing unstructured data – and costs to deploy AI have dropped, brokers have expanded their use of AI to craft better solutions for clients and enable their clients to make better decisions.

Advising clients on options for risk financing can be enhanced by modeling multiple scenarios tailored to the specific client. Varying scenarios to include stop-loss layers, captive structures, and aggregate coverage can be crafted specific to the client's health data and delivered in moments. Aon's Health Risk Analyzer is one such solution that provides clients with detailed insights and scenario planning to aid in their decision making.

Benchmarking and market analysis can be enriched, helping brokers predict costs across different scenarios and providing data-backed evidence in negotiations with clients and carriers – helping brokers come up with solutions that best meet the needs of all involved. Advising clients on complex risk topics becomes easier with the support of AI to synthesize and simplify communications, increasing awareness and understanding and fostering a stronger, trust-based relationship.

Healthcare Organizations: Smarter Risk Financing Decisions

Risk managers in hospitals and health systems are increasingly using AI to guide strategic decisions, expanding beyond traditional actuarial methods to deliver more sophisticated insights capturing an ever-increasingly complex landscape.

Catastrophic claim scenarios can be simulated quickly and easily, using historical claims data to predict the likelihood of a catastrophic claim. A large health system knowing where high-cost specialty drug claims could spike can help lead to better decisions on whether to retain risk through captives or transfer via stop-loss coverage, balancing premium costs with risk retention and managing volatility.

Forecasts of cost trends and utilization patterns can lend another lens through which to consider more innovative approaches, such as blending traditional insurance with alternative risk financing. Predicting claim trends for chronic conditions and projecting the impact of wellness programs on future costs can influence decisions, enable proactive planning, and provide negotiation leverage with carriers. Simulations comparing captive retention strategies against traditional insurance under different utilization patterns and regulatory changes could be used to help identify whether to form or expand a captive.

Beyond insurance, AI can help identify and manage clinical and operational risks, from readmission likelihood to staffing shortages, helping healthcare organizations better manage their risks and improve efficiency and effectiveness. Monitoring compliance with regulatory requirements and detecting anomalies in billing or coding practices can reduce legal exposure and support enterprise risk management strategies, reinforcing the link between operational integrity and financial resilience.

Why this matters: For healthcare risk managers, understanding these uses isn't optional, it's essential. AI is influencing negotiations, pricing decisions, and risk financing strategies. Those who embrace its potential will gain a competitive edge; those who ignore it risk falling behind in a rapidly evolving market.

OPPORTUNITIES CREATED BY AI

Opportunities Created by AI

When used well, AI becomes a strategic enabler for healthcare risk professionals. Its ability to process vast datasets and uncover actionable insights creates opportunities that were previously out of reach. Here are the most significant benefits:

1. Data-Driven Decision-Making

AI shifts decision-making from reactive to proactive. Predictive models analyze historical claims, demographic trends, and clinical data to forecast future risk with greater accuracy. Anticipating high-cost claims and proactively adjusting coverage strategies gives risk managers greater confidence in financial planning and risk retention strategies.

2. Enhanced Risk Identification and Quantification

Traditional methods often struggle to capture the inequities or geographic concentrations, and solutions should be evaluated to ensure any bias in the underlying data is not encoded or amplified. complexity of healthcare risk. AI excels at identifying patterns and correlations that humans might miss, analyzing and synthesizing vast amounts of data from a wide range of sources. Detecting early indicators of catastrophic claims, clusters of chronic conditions in patient populations, and highlighting opportunities for proactive and targeted interventions are all possible today.

3. Innovative Risk Financing Strategies

AI opens the door to alternative risk transfer solutions beyond conventional insurance. Simulating choices and hybrid models that combine e.g. stop-loss coverage with captive arrangements offer tailored, relevant, and actionable solutions that best meet the balance of volatility, risk retention, and cost management.

4. Customized Coverage and Product Innovation

Carriers can use AI to design products that reflect the unique risk profile of each client. Insurers can offer coverage terms that adjust based on real-time health data and utilization patterns identified by dynamic underwriting models, leading to more personalized insurance solutions and identification of potential cost savings for healthcare organizations.

5. Operational Efficiency and Strategic Insight

AI also enhances operational performance by streamlining workflows and reducing

administrative burden. Automating the claims process can free up expert resources for higher-value work where expertise is essential, improving efficiency, claims outcomes, and talent engagement and retention. Many carriers are effectively using automation to reduce manual effort and streamline processes, lowering costs and improving operational results.

Prediction: Leading organizations taking a strategic view to stronger risk management and more robust decision-making are creating competitive advantage by moving beyond traditional risk transfer models toward a more predictive and personalized approach.

CHALLENGES AND CONCERNS

While AI offers transformative potential, it also introduces new complexities that healthcare risk professionals must navigate carefully. These challenges span legal, ethical, operational, and cultural dimensions.

1. Regulatory and Legal Risks

Decisions in underwriting, claims, and risk financing that make use of AI raise questions about compliance and liability. While the insurance industry has a long history of these capabilities in their businesses, the regulatory landscape is shifting with the increase in prevalence of AI and healthcare organizations must proactively monitor developments in regulations and standards.

2. Data Privacy and Security

Healthcare data is among the most sensitive information in any industry and care must be taken to protect patient privacy and other sensitive data. Development and deployment of AI solutions, whether built internally or via vendor tools, should follow best practices in information security and limit access to sensitive data.

3. Bias and Transparency in Algorithms

Assessing potential bias in historical data should be part of the model training process. Bias can arise in unintended ways, whether due to systematic Transparency and explainability are essential in some use cases and nice to have for others; identifying where "black box" approaches cannot be employed and aligning selection criteria accordingly is an essential step to furthering trust.

4. Change Management and Cultural Adoption

Integrating AI into risk transfer workflows is not just a technical challenge, it's a human one. Experts may feel their value is threatened with the introduction of an AI solution, staff may fear job loss, or poorly-designed change management approaches may leave users distrusting outputs and recommendations. Establishing cross-functional governance and engaging end users in solution development from the outset can go a long way to reducing hurdles in adoption.

Bottom line: Thoughtfully designing and implementing AI is critical to success. Healthcare risk professionals must balance innovation with compliance, ethics, and stakeholder engagement to realize AI's full potential.

PRACTICAL RECOMMENDATIONS FOR HEALTHCARE RISK PROFESSIONALS

While attention is often on the technology, best practice is to align to strategy, ensure operational and talent implications are considered, and put in place appropriate governance and oversight. Here's how different stakeholders can take practical steps to deploy AI responsibly and effectively:

For Risk Managers

- Evaluate AI Tools Critically:
  - Ask vendors and internal build teams: What data sources were used to build and test the model? How is bias tested? How often are models updated?

- Integrate AI into Risk Assessment:
  - Proactively identify high-cost claim drivers and recommend retention vs. transfer decisions.
  - Apply scenario modeling to stress-test stop-loss and captive strategies under varying conditions.

- Build Governance Frameworks:
  - Establish internal policies for AI use, including data privacy, ethical standards, and validation protocols.

For Brokers

- Leverage AI for Advisory and Negotiation:
  - Apply benchmarks and predictive cost models to strengthen option assessment and carrier negotiations.
  - Incorporate AI insights into client presentations to more clearly illustrate complex risk concepts.

- Stay Ahead of Regulatory Trends:
  - Monitor developments in regulation and compliance spheres and ensure recommendations align with emerging standards.

- Collaborate with Clients on Education:
  - Help clients understand how AI informs and supports better program design, aided by expert judgment.

For All Stakeholders

- Build Cross-Functional Teams:
  - Include representation such as risk managers, IT, compliance, HR, operations, and legal in AI adoption discussions.

- Foster a Culture of Ethical AI Use:
  - Train staff on interpreting AI outputs and utilizing them responsibly; highlight examples of appropriate use.

- Plan for Continuous Learning:
  - Commit to ongoing education and governance updates, staying agile and
  - adaptive as capabilities evolve.

Food for thought: Incorporating collaboration, transparency, and a proactive approach to governance are hallmarks of companies succeeding and leading in this space. Where is your organization ahead of the curve? Which recommendations should be included among your next steps?

LOOKING AHEAD: THE FUTURE OF AI IN HEALTHCARE RISK TRANSFER

AI's role in healthcare risk transfer is rapidly expanding. The next wave of innovation will move beyond predictive analytics toward more high-powered, real-time applications that fundamentally change how risk is managed and financed.

1. Generative AI for Scenario Modeling and Dynamic Pricing

Simulating thousands of risk scenarios in seconds, carriers and brokers can model catastrophic events, regulatory changes, or utilization spikes

with unprecedented speed. This means real-time pricing adjustments and tailored contract terms to meet evolving risk profiles are within reach. Healthcare organizations can negotiate more flexible arrangements and anticipate financial exposure with greater precision, leading to improved outcomes for their organizations.

2. Real-Time Data Integration

Integrating live data streams, from electronic health records, IoT devices, and operational dashboards, into risk models means continuous monitoring of risk factors and immediate recalibration of coverage strategies is possible, allowing risk managers to move from annual renewals to data-based risk transfer decisions.

3. Automated Contracting and Compliance

Drafting policy language, validating compliance, and flagging regulatory changes automatically can help streamline administrative processes and reduce workflow risks. This can reduce burdens on legal teams and expedite implementation of coverage changes, allowing attorneys to shift focus from manual review to strategic oversight.

4. Skills and Governance for the AI Era

Training risk managers, brokers, and attorneys to interpret AI outputs and use them responsibly is key, as is cultivating adaptability and agility as AI capabilities and applications continue to evolve. Organizations should establish ethical frameworks and audit protocols to ensure transparency and fairness and strengthen governance and oversight mechanisms to appropriately balance speed of adoption and risk.

Considerations for today:

The next era of healthcare risk transfer will be defined by real-time insights, sophisticated analytics, and cross-disciplinary collaboration. Organizations that act decisively – investing in advanced AI tools and establishing robust governance today – will set the standard for effective, adaptive risk management.

CONCLUSION AND KEY TAKEAWAYS

Bring together leading capabilities, streamlined operations, and an empowered workforce to unlock better decision-making, increase resilience, and deliver greater value to clients and patients. Those investing in increasing AI fluency and more robust governance, with technology investments aligned to business strategy, are leading the next chapter for the industry. By aligning your AI journey to your organization's long-term vision, you can blend the best of expert judgment and advanced analytics to drive a more adaptive, competitive, and relevant risk management environment.

About the Author

Meghan Anzelc, Ph.D., is the Global Leader of Transformation Solutions for Aon STG. The Transformation Solutions Center of Excellence helps clients succeed in their transformation efforts, combining talent, operations, and technology lenses. Focus areas include: transformation strategy, AI / data / technology, talent and organizational strategy, operations, and M&A advisory. She serves on the Advisory Board of Athena Alliance and was awarded Diligent's 2023 Compliance and Ethics Leader, Modern Governance 100.

The Radiologist's Use of Artificial Intelligence and Legal Implications

By Thomas A. Mobilia, Daniel L. Freidlin, and Aryeh S. Klonsky

Artificial intelligence (AI) is transforming industries and aspects of daily life. AI is designed to mimic human intelligence by allowing a machine to solve problems using a set of predetermined rules. AI is slowly (or perhaps not so slowly depending on perspective) being integrated into various sectors, including healthcare. Perceived benefits of the use of AI in healthcare include increased efficiency and enhanced diagnosis.

In the field of radiology, AI is being integrated into radiology practices to assist radiologists in detecting subtle abnormalities. AI algorithms are being promoted as being able to analyze imaging studies including x-rays, mammograms, ultrasounds, CT scans and MRIs. In addition to increased diagnostic accuracy, AI's objective is to enhance workflow efficiency and increase the speed of image interpretation. Further, the AI algorithm will learn over time to recognize patterns associated with specific diseases, leading to earlier and more accurate diagnosis.

One area in radiological imaging where the use of AI is expected to expand over time is in the interpretation of breast imaging studies such as mammograms. There is a reported false negative rate in mammography of approximately 15%.[1] Dense breast tissue is known to obscure subtle densities and microcalcifications associated with breast cancers. Computer-aided detection (CAD) has been used as an adjunct to mammography for years, but it can be unreliable, nonspecific

and overly sensitive. CAD can miss suspicious findings yet highlight findings that are ultimately found to be benign. AI programs are currently being promoted to bypass the unreliable nature of CAD. These programs include Clarity Breast, Mammoscreen, Hologic Genius AI Detection, Profound Detection and others. The AI software will compare the current mammogram to other imaging studies in its database to highlight findings or lesions on imaging for evaluation by the radiologist.

In the typical medical malpractice action involving a failure to diagnose breast cancer on mammography, at the very least the radiologist and radiology facility will be sued. In these cases, the plaintiff must prove that the radiologist departed from the standard of care in failing to identify and report a suspicious finding on mammogram and make appropriate recommendations for further management. The plaintiff will rely on expert testimony to prove that a similarly situated radiologist in the community would have identified and reported the finding with the appropriate recommendation for further management. Defenses to these allegations may include that the finding rep resents normal-appearing fibroglandular breast tissue, that the finding has been present and stable on breast imaging studies over time, or that the finding is so subtle that no reasonable radiologist would be expected to identify it – all of which would ultimately be evaluated by a lay jury at trial.

With continued integration of AI models, a question may arise as to whether it is the radiologist or the AI software developer that should be held liable to the patient. This issue has not yet been evaluated by the courts; if we assume, however, that the radiologist is still rendering the interpretation of the imaging study using AI as an adjunct tool then the plaintiff's lawyer could argue that there exists a physician-patient relationship and that the radiologist owes a duty to the patient. As such, we can expect the law will hold that the radiologist owns the interpretation (and the liability). Whether the radiologist and the defense attorney can use the AI program's findings to convince a jury that the radiologist did not depart from the standard of care in a situation where the program did not identify a suspicious finding will likely depend on how society perceives and learns to accept AI's effectiveness and accuracy.

The more interesting question to be answered is whether the AI software developer will bear any responsibility for a missed cancer. Two issues come to mind: (1) whether the patient can sue the AI developer when this technology is used; and (2) can the radiologist or radiology facility initiate a third-par ty lawsuit against the developer if the software fails to identify a cancer. We can expect that licensing agreements between the radiology facility and the software developer will include clauses to protect the software company from impleaders, but whether the patient can sue remains to be seen. The answer to this question will likely hinge on whether the courts determine that the AI software developer owes a duty to the patient, and in the situation where the radiologist renders his or her own interpretation, the answer to the question is likely

to be no. Historically, we have not seen cases where a CAD developer has been sued where the CAD misses a finding. Although AI is not expected to completely replace the radiologist in the near future, this area of medicine is still evolving, and the analysis may change. As a result, the courts may be compelled to provide the allegedly injured patient with some avenue of recovery.

With the integration of AI into breast imaging, there will likely be an in increase in breast biopsies or callbacks for further diagnostic studies. We can expect that the radiologist will be overly cautious with findings identified by the AI program, even if the radiologist suspects that the same has benign features, for fear of litigation. If a radiologist elects to override an AI finding, and we assume that the AI interpretation is stored and discoverable, radiologists should likely address their analysis of the AI finding in their radiology report so that they can defend themselves years later when litigation arises.

As with any new technology, the integration of AI into medicine is evolving, and the extent of its impact is yet to be known. Novel issues will certainly arise over time with respect to whether the AI software or images are discoverable in the course of litigation and whether use of AI will alter the standard of care for the radiologist utilizing AI as an adjunct tool in the interpretation of imaging studies. We anticipate that for now, radiologists will continue rendering final interpretations with AI as has been the case for years with the use of CAD and therefore will bear the exposure if litigation arises. However, some believe that AI software will have the capability to replace the human radiologist entirely. If this occurs, the courts will have to reinvent how the duty to the patient and physician-patient relationship is evaluated to provide the patient with a cause of action where a cancer or significant finding is missed on imaging.

<u>About the Authors</u>

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Senior Care Risk: Inadequate Staff in Quantity, Quality, Experience, and Training

By Susan Lucot

One of the most influential contributing factors in senior care medical malpractice claims is inadequate staffing — and not only in quantity of staff but also in dedication, knowledge, experience, and skills. Competent, committed, and compassionate staff members are invaluable. Simply hiring someone to fill a position is not sufficient. The role of the direct caregiver requires delivery of high-quality and consistent care rooted in evidence-based practice along with empathetic customer service. Having these well-rounded skills is critical when working in senior care because of the types of medical and other needs of the residents.

For example, when caring for residents with dementia, having a "one-size-fits-all" approach to staff training and education does not truly address resident needs. For example, dementia has several forms (i.e., Lewy body, vascular, frontotemporal, and Alzheimer's disease) and several levels within each form. Understanding the different forms and levels enables a caregiver to select appropriate tools and approaches if they are confronted with an angry, distrustful, isolated, or fearful resident.

Similarly, when caring for residents with behavioral health disorders, understanding the characteristics of each disorder and the potential triggers for negative behavior is essential. Training needs for staff include effective communication skills and de-escalation techniques. Like any other care skill, these must be learned and rehearsed through role playing, group discussions, and simulation scenarios. Having staff simply do a computer-based module on behavior management is counterintuitive. Just like with dementia care, having a variety of tools and strategies to apply in behavioral health situations can affect the outcome for both the resident acting out and the staff member de-escalating the event. It is important to consider and understand these aspects of senior care during the hiring process so that the staff hired have the acumen and other skills needed to meet the residents' needs.

Hiring well-rounded staff and managing the risks associated with staffing requires ongoing diligence and a commitment to workforce development. The following strategies can help senior care organizations assess and improve their approaches to staffing:

- When recruiting new staff, be sure to:
  - Confirm credentials (i.e., education, licensure, certifications).

  - Verify past work experience (including references from previous employers).
  - Assess soft skills (e.g., communication, teamwork, empathy, adaptability, critical thinking, problem solving, professionalism, self-motivation, emotional intelligence, and conflict resolution).
  - Review prior on-the-job training and professional duties, including confirming capabilities and competence.
  - Conduct state and federal criminal background checks as well as national sex offender registry checks.
  - Screen for red flags associated with substance abuse (including drug testing in accordance with organizational policy).

- Develop comprehensive onboarding and orientation programs, or review existing programs to determine areas for improvement.

- Offer thorough skills training for nursing care and activities of daily living.

- Incorporate role playing and simulation activities to improve skills related to communication, behavioral management, and de-escalation.

- Establish an interorganizational behavioral health and dementia care program that is overseen by psychiatric and psychology professionals. Ensure the program has the capacity to provide guidance at every senior care and senior living center within the organization, regardless of geographic location.

- Include robust guidance on topics such as prospective resident admission reviews and placement recommendations, continuous monitoring of resident behaviors in relation to prescribed therapies and treatments, issues and strategies associated with transferring residents, and approaches for managing resident behaviors to ensure continuity of care.

Using these techniques and considerations during the hiring process will help assess the ability of the candidates to meet the needs of senior care residents and in turn, this will enhance the quality of the staff while pursuing the quantity needed.

For additional insights on providing care for residents who have behavioral health disorders and/or dementia in senior care settings, click here.

About the Author

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Case Study: Credentialing Calamity

By Kathleen Harth, Donnaline Richman, and Marilyn Schatz

The patient in this case was a 50-year-old married female who was employed at the medical facility where she was initially treated. She expressed an interest in excess fat removal, breast implants, a revision to her belly button, and abdominoplasty. The practice owner, a MLMIC-insured anesthesiologist, referred the patient to a plastic surgeon at the practice.

The patient presented to the medical facility where she worked and was noted to have a history of smoking two packs of cigarettes per day, five pregnancies, left-knee surgery, and a previous abdominoplasty, and to have lost 150 lbs. during the previous year.

A consent form was obtained for mastopexy with breast implants, a repeat abdominoplasty, and a umbilicoplasty. The non-MLMIC policyholders provided anesthesia and performed the surgical procedures. The pre-operative diagnosis was bilateral breast hypoplasia with ptosis and residual abdominal elastosis. Over the course of seven hours, the procedures were accomplished and saline implants inserted in both breasts with no complications.

Post-operatively, a Jackson-Pratt drain was put in place, and the patient was instructed to use a compression garment for 72 hours. She was noted to be awake, alert, and stable during recovery, with minimal pain, and was discharged home later that day with instructions on changing her dressings and taking oral antibiotics.

The plastic surgeon left for a four-week vacation the day after the surgery.

The patient did not report any open wounds when she changed her own dressings three days

post-operatively. One week post operatively, however, the patient noted that her abdominal wound was completely open with fluid discharge. She sent text messages to the plastic surgeon and the anesthesiologist and was advised to see the anesthesiologist in the office. She presented to the office and was seen that day by the anesthesiologist along with the gastroenterologist who initially performed the patient's pre-op exam, who observed the dressing change and suggested wound irrigation. The patient was instructed in wound care and advised to see the plastic surgeon upon his return to the office.

The patient later returned for a second post-operative visit, and the anesthesiologist became alarmed at the significant discharge and progression of the wounds. He instructed the patient to discuss further wound care with the gastroenterologist, who reviewed photographs of the patient's wounds but failed to examine the patient or refer the patient to a specialist.

Upon his return from vacation, the plastic surgeon resumed treatment of the patient, during which time he performed three surgical repairs and debridement. However, the patient continued to text the anesthesiologist and plastic surgeon, stating that the wounds were not healing.

The patient subsequently presented to the local hospital emergency room with complaints of wound dehiscence, which was noted on bilateral breasts and the patient's abdomen, along with erythema and yellow discharge. Upon admission, she was also noted to have cellulitis and infected incision lines. She complained of pain and was placed on IV antibiotics.

A non-party plastic surgeon at the hospital performed debridement of all wounds with placement of a wound VAC and diagnosed necrotizing fasciitis of the breasts and abdomen, with pathology confirming infected necrotic tissue. The patient was hospitalized for two weeks with a course of pain management, medication, and wound treatment. She was discharged with the wound VAC and home health nurses for daily dressing changes.

Several months later, the patient was seen at the hospital for outpatient replacement of the abdominal skin graft, with her thigh as the donor site, due to a non-healing abdominal wound, which was confirmed to be necrotizing fasciitis.

Four months later, the wounds were noted to be healed by the non-party plastic surgeon. The patient kept in touch with the MLMIC-insured anesthesiologist throughout the pendency of her recovery and later returned to work at this policyholder's medical facility.

One year later, the patient brought a lawsuit against the plastic surgeon and the anesthesiologist who had performed the surgery, along with the facility and our insured anesthesiologist, alleging improper care following breast and abdominal reconstruction, resulting in necrotizing fasciitis that required multiple surgical debridements that left severe scarring.

MLMIC's experts in anesthesia and general surgery found this to be a case with a poor outcome, and although our insured anesthesiologist was not involved directly with the patient's care, she received multiple text messages from the patient without offering

treatment to the patient or referringher to a wound care specialist. She was also criticized for allowing the plastic surgeon, who had licensing issues, to work at the facility without insurance. In addition, following the procedure, the patient's chart could not be found, and there was speculation that the patient or the plastic surgeon may have removedthe record from the facility. The plaintiff's counsel argued that he would request a missing records charge at trial.

The defense for the anesthesiologist, the practice's owner, was that she had a minorrole in this case. However, due to issues with the missing chart, poor credentialing, and allowing an uninsured physician to work at the facility, a decision was made to settle the case on behalf of the practice's owner.

A Risk Management and Legal Analysis

The facts in this case illustrate why it is crucial to ensure that all professionals in a surgical center or practice have current New York State licensure and medical professional liability (MPL) insurance with the appropriate limits of at least $1/3 million.

Was the patient in this case a suitable surgical risk? The surgeon and the anesthesiologist should have been very concerned that she was 50 years old with a history of obesity and that she smoked two packs of cigarettes a day, which can lead to poor healing. There is no indication that she was required to obtain pre-operative clearance from her medical physician, which should have occurred.

Additionally, no one at the surgery center the licensure, current MPL insurance status, and other credentials of the plastics surgeon to make certain that he was eligible to work at that center. The only conclusion that can be drawn is that the practice was so intent on having him work there that it did not bother to obtain these items, which is an essential aspect of every credentialing process. It was determined later that the plastic surgeon lacked MPL insurance coverage and that he had licensure issues and should therefore not have been permitted to operate on any patient at the facility.

Unfortunately, the surgery center paid dearly for its failure to ensure that the physician had essential credentials, licensure, and medical malpractice insurance, as well as the appropriate skills to properly care for this patient. In addition, it is very possible that because the patient was a long-time employee of the surgical center, many of the items that would normally be requested of patients were glossed over.

Since the plastic surgeon lacked MPL insurance, the patient's attorney had to focus on other personnel for whatever assets or insurance the surgery center and anesthesiologist had. Although the medical record may well have shown that the patient was appropriately cared for in the center, the defense was compromised by the fact that the surgeon was not properly credentialed by the center, which did not even verify whether he was licensed in this state. An additional concerning factor was that the patient's medical record was inexplicably missing from the surgery center.

Credentialing Overview

Complete and thorough credentialing of healthcare professionals is a crucial process to

confirm qualifications and ensure competency to appropriately treat patients. Verification of a provider's education, residency training, board certifications, and state licensure is a vital prerequisite to determine whether individuals are qualified to provide qualityhealthcare. A comprehensive background check will reveal the existence of any malpractice claims, disciplinary actions, and/or criminalactivity. Systematic and periodic credentialing assists in assessing whether individuals are qualified professionals who meet required standardsbased on education, training, and experience. If executed properly, credentialing has a positiveimpact on malpractice risks by confirming competency to perform quality healthcare responsibilities.

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Candello
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Illuminating Risks

Understanding the Human Factors in Diagnosis Cases

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Diagnosis-related Cases with Patient Factors

> *A 60-year-old patient without a primary care physician relied solely on urgent care for medical needs. After an elevated PSA was noted, the physician claimed to have called the patient, but no documentation supported this, and the patient denied receiving the call or viewing results online. The patient failed to return or follow up, and subsequent urgent care visits missed the abnormal result. Two years later, metastatic prostate cancer was diagnosed; the case settled for over $2.5M.*

Whether a provider-patient interaction devolves into a medical malpractice case or not, diagnosis-related cases involving patient factors illuminate a considerably complex intersection in patient safety: the space where human behavior, system design, and clinical decision-making meet. Missed follow-up appointments, delayed testing, and broken communication are often not a reflection of neglect, but rather the realities of living within fragmented systems, which can be difficult to navigate even for the most motivated patients.

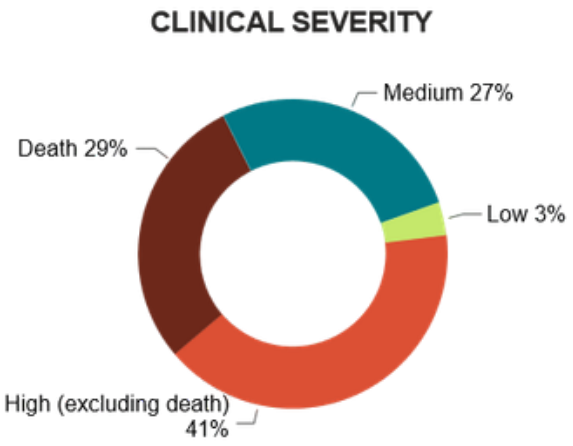
In this report, data from more than 3,500 closed medical malpractice cases involving both a diagnosis-related allegation (missed, delayed, or incorrect) and a patient-related factor reveal the tangible consequences of those breakdowns. The findings emphasize that diagnostic reliability depends not only on clinical accuracy but also on how effectively health care systems support patients in completing the diagnostic journey—scheduling tests, attending appointments, and understanding the urgency of follow-up. When patient factors like non-adherence emerge, they often point to missed opportunities for communication, coordination, and patient education.

For malpractice insurers and health care leaders, these cases highlight both the financial and human costs of gaps in the diagnostic process and the potential for prevention. Strengthening patient engagement systems, such as ambulatory safety nets, can reduce risk by ensuring that abnormal results or missed appointments trigger proactive outreach. Addressing patient-related factors with empathy and structure reframes non-adherence not as patient failure, but as a shared responsibility within the care continuum. Reducing diagnostic risk, then, begins with closing the distance between patient intentions and system reliability.

What Our Data Show

Candello examined **3,633 MPL cases** involving both a patient-related factor and a diagnosis-related allegation that closed between 2015-2024. Among these cases, **70% resulted in high-severity or death**, underscoring the serious outcomes associated with diagnostic process breakdowns. After diving even deeper, we found:

- **Nearly half of cases** involve a cancer diagnosis
- **42% of cases** closed with an indemnity payment averaging over **$550K** plus nearly **$100K** in expenses
- **Patient assessment issues and communication failures** are the most common co-occurring contributing factors
- The most common patient factor, **non-adherence with follow-up calls or appointments**, points directly to opportunities for safety net interventions



Major Allegation Detail Description	% Cases	% All Candello
Diagnosis-Related (Failure, Delay, Wrong)	100%	20%

Final Diagnosis Category	% Cases	% All Candello
Neoplasms	48%	36%
Diseases Of The Circulatory System	19%	14%
Injury, Poisoning, Other Consequences External Causes	17%	13%
Diseases Of The Digestive System	8%	6%
Diseases Of The Nervous System	7%	6%

Primary Responsible Service Rollup Description	% Cases	% All Candello
Medicine	51%	46%
Surgery	19%	17%
Emergency	15%	13%
Radiology	10%	9%
Obstetrics/Gynecology	5%	5%

Why It Goes Wrong: Contributing Factors

Diagnosis-related cases that involve patient factors highlight the deeply human side of diagnostic safety—where communication gaps, access barriers, and system complexity intersect with individual behavior. The most common patient-related issue—non-adherence with follow-up calls or appointments (32%)—is particularly concerning in cases where timeliness can determine outcomes. Yet non-adherence is rarely simple neglect. Patients may face logistical barriers such as transportation difficulties, competing work or family demands, financial constraints, or limited understanding of the medical urgency. Similarly, non-adherence with treatment or testing (25% and 7%) may reflect uncertainty, fear, or dissatisfaction rather than defiance. The finding that nearly one in five patients sought care elsewhere due to dissatisfaction underscores the importance of trust and communication in provider-patient relationships.

While patient factors are, for the most part, beyond a provider's direct control, they often coexist with other contributing elements such as assessment issues (81%), delays in consultation or referral (22%), and communication breakdowns between providers and patients or families (25%). These patterns suggest that what may appear as "nonadherence" can, in many cases, reflect missed opportunities for shared understanding, coordination, or support.

Top Patient-related Contributing Factors

Contributing Factor Detail Description	% Cases
Non-adherence with follow-up call/appointment	32%
Non-adherence with treatment regimen	25%
Other*	23%
Seeking other providers due to dissatisfaction with care	19%
Non-adherence with diagnostic test procedure	7%
Non-adherence with medication/biologic	7%
Family-related behavioral issues	5%

Top Concurrent Contributing Factors

Contributing Factor Subcategory Description	% Cases
Patient assessment issues	81%
Communication between patient/family and providers	25%
Failure/delay in obtaining consult or referral	22%
Communication among providers	22%
Selection and management of therapy	22%
Insufficient/lack of documentation	18%
Non-insured influence*	14%
Lack of/Failure in patient follow-up system	12%
Shift/off hours conditions	11%
Failure or delay in reporting findings/revised findings	9%

***Patient-related factors defined as "Other" in the Candello taxonomy include unrealistic expectations held by the patient, or situations in which the physical characteristics of a patient lead to a delay in care, for example, when a patient who cannot have an MRI because the machine cannot accommodate the patient's size.**
****Non-insured influences marks cases where, for example, a non-insured provider contributed to the event or one of the coded locations is not an insured site.**

Interpreting Trends in Final Diagnoses

The predominance of **neoplasms (48%)** among diagnosis-related cases with patient-related factors underscores the enduring challenge of timely and accurate cancer diagnosis. Many such cases hinge on effective follow-up, communication, and coordination—areas frequently compromised by both patient and system factors. For instance, non-adherence with scheduled appointments or diagnostic testing can delay cancer detection, while inadequate communication or documentation by providers can compound those delays. Similarly, **circulatory system diseases (19%)**, such as myocardial infarction and stroke, often demand rapid recognition and coordination across multiple care settings, conditions particularly vulnerable to assessment lapses or fragmented information exchange.

The co-occurrence of patient assessment issues (81%), delays in consultation or referral (22%), and communication breakdowns between the patient and provider (25%) suggests that diagnostic performance is highly dependent on clarity, follow-through, and shared understanding. These same vulnerabilities appear across the smaller yet significant portions of cases involving digestive (8%) and nervous system (7%) diseases, where non-specific symptoms require both patient engagement and precise clinical reasoning. When patients fail to adhere to follow-up or testing, regardless of the reason, diagnostic uncertainty may persist despite appropriate clinical suspicion. Thus, the distribution of diagnoses in these cases reflects the inherent complexity of certain conditions as well as the points at which patient factors, communication gaps, and coordination failures intersect to hinder timely diagnosis.

Vulnerabilities among Services

The finding that **medicine services accounted for over half (51%)** of these diagnosis-related cases reflects their central role in managing undifferentiated symptoms, longitudinal care, and coordination among specialties. Within this broad category, internal and family medicine services alone make up 55% of cases as they often manage undifferentiated symptoms and coordinate across specialties. The frequent presence of assessment issues (81%), communication failures (both patientprovider and provider-provider, 25% and 22%), and insufficient documentation (18%) underscores the systemic and relational complexity embedded in the diagnostic process, especially in primary and hospital-based medicine.

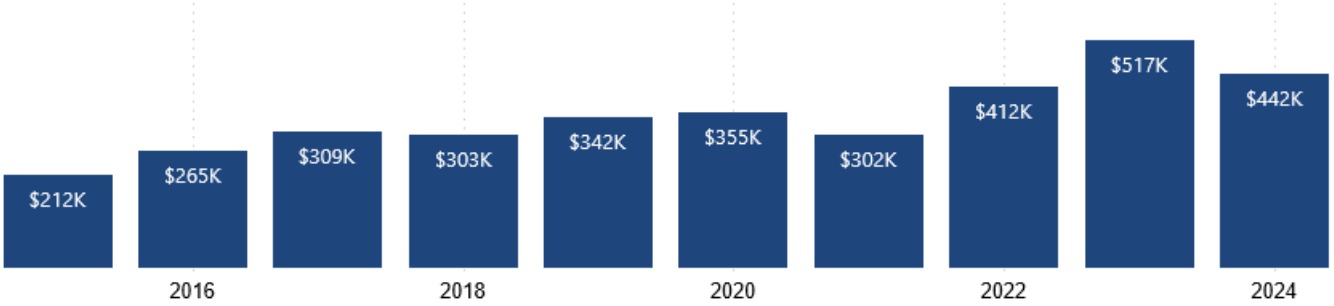
Emergency services's 15% share of cases highlights the pressures of high-volume, episodic care, where diagnostic continuity depends heavily on accurate handoffs and patient adherence to post-discharge instructions. **Radiology's involvement (10%)**, meanwhile, often reflects interpretive or reporting delays, which can be compounded when patients do not act on follow-up imaging recommendations or when results are not clearly communicated across teams. The representation of **Surgery and OB/Gyn services (19% and 5%)** reveal that diagnostic missteps can occur even in procedural specialties, for example when preoperative or perinatal findings are not revisited or clarified.

Across all services, the pattern of concurrent contributing factors, particularly within the realm of communication and follow-up failures, suggests that diagnostic safety is as dependent on relational continuity as on clinical acumen. The interplay between patient factors and care systems shows that diagnostic reliability depends on both accurate clinical assessment and effective patient engagement, coordination, and feedback throughout the care continuum.

Financials

Diagnosis-related malpractice cases involving patient factors represent a costly and persistent area of risk. As shown in the accompanying figures, 42% of these cases closed with an indemnity payment, with an average indemnity of $551,222 and average expenses of nearly $100K. These values reflect the complexity and severity of diagnostic allegations—particularly when delays or missed diagnoses involve serious conditions such as cancer or circulatory disease. Finally, the trend in average total payments by close year shows a steady rise over the past decade, peaking in 2023 before a slight decline in 2024. This upward trajectory indicates both increasing claim severity and the growing recognition of diagnostic error as a key driver of malpractice costs. Together, these data illustrate that diagnosis-related cases involving patient factors are not only clinically significant but also financially consequential—reinforcing the importance of interventions that strengthen communication, follow-up systems, and patient engagement to mitigate risk.

AVERAGE TOTAL PAID BY CLOSE YEAR



Major Allegation Detail Description	% Indemnity Paid	Avg. Indemnity	Avg Expenses
Diagnosis-Related (Failure, Delay, Wrong)	42%	$551,222	$98,523

Primary Responsible Service Detail Description	% Indemnity Paid	Avg. Indemnity	Avg Expenses
Emergency	34%	$595,128	$89,007
Internal Medicine	44%	$577,265	$89,793
Family Medicine	46%	$501,188	$96,827

Final Diagnosis	% Indemnity Paid	Avg. Indemnity	Avg. Expenses
Malignant Neoplasm-Prostate	50%	$801,571	$98,640
Malignant Neoplasm-Breast	48%	$690,219	$92,323
Malignant Neoplasm-Bronchus/Lung	41%	$498,159	$103,497

Across services, the financial impact varies but remains consistently high. Family medicine and internal medicine show the highest indemnity rates (46% and 44%), consistent with their role in ongoing diagnostic management and coordination. Emergency medicine, while somewhat lower at 34%, still carries the highest average indemnity ($595,128) among the core clinical services, underscoring the financial exposure associated with acute, time-sensitive decision-making.

By diagnosis, malignant neoplasms of the prostate, breast, and lung dominate the costliest categories, each with indemnity rates near or above 50%. Prostate cancer cases, in particular, show the highest average indemnity ($801,571), aligning with the serious consequences of delayed detection. Procedural data reflect similar trends: MRI spinal canal cases average over $1 million in indemnity, suggesting that diagnostic challenges involving complex imaging and neurological outcomes are especially high risk.

Recommendations

Improving diagnostic safety in cases involving patient factors requires interventions that address both the clinical process and the human realities of care. The data presented in this report show that patient-related factors—such as non-adherence with follow-up, treatment, or testing—often coexist with provider assessment issues, communication breakdowns, and gaps in system reliability. While these cases can appear to stem from individual patient behavior, the evidence consistently shows that they reflect broader system challenges in coordination, communication, and patient engagement.

The following recommendations are drawn from peer-reviewed research and evidence-based safety initiatives aimed at reducing diagnostic error and improving continuity of care. Each focuses on strengthening the points in the diagnostic process most vulnerable to breakdown: patient assessment, communication between patients and providers, and follow-up management. Collectively, they offer practical, system-level strategies to reduce malpractice risk while advancing safer, more equitable diagnostic care.

- **Enhance patient education through clear, health-literate communication.** Tailored materials that explain diagnostic steps, test significance, and follow-up expectations using plain language, teach-back methods, and culturally responsive tools.[1]

- **Implement ambulatory safety nets (ASNs) for diagnostic follow-up.** Establish dedicated trackingregistries, automated alerts,and patient navigation workflows to close the loop on missed or abnormal test results. Evidence from academic settings shows that ASNs reduce delayed cancer diagnoses by flagging patients overdue for follow-up and actively outreaching to them.[2]

- **Standardize handoff and interprovider communication protocols.** Introduce clear escalation criteria, documentation templates, and checklists to reduce ambiguity when transferring diagnostic responsibility—especially across departments or specialty boundaries. Structured communication tools, such as I-PASS, can help reduce errors in care transitions.[3]

- **Monitor and audit diagnostic delays linked to patient non-adherence as system safety events.** Instead of attributing non-adherence solely to individual behavior, treat missed follow-ups in diagnosis pathways, e.g., cancer or acute workups ,as reportable signals. This allows root-cause review of how system, provider, and patient factors converged, which aligns with the broader framework of diagnostic excellence and system accountability.[4]

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