



Human Doctors vs. AI Advisor

Reciprocal MD-AI Interaction Failures and Lessons Learned

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Uncompressed Thinking

Case in Point: An OB Near-Miss

Preamble

I am writing about this case because it moved me deeply, not only as a medical story, but as a human story about time, attention, and responsibility. A young woman carrying twins came close to a catastrophic outcome, and the difference between tragedy and recovery appears to have depended on one physician's ability to recognize a dangerous pattern before the system lost the time she did not have.

At the same time, this is not only a story of one doctor's intuition. It is a technical lesson in how modern medical teams construct a case, how they communicate uncertainty, and how AI can only assist when physicians first assemble the facts honestly and completely. The case is therefore personal, but its lesson is procedural: in high-risk obstetrics, scattered symptoms must be gathered before reassurance becomes delay.

When the Facts Are Present but Not Yet a Diagnosis

There are moments in medicine when the diagnosis is not missed because nobody knows it, but because nobody has yet gathered the scattered signs into one picture. The facts may all be present, or nearly present, but they sit in different corners of the clinical room. One person hears about the contractions. Another hears about the headache. Someone notices nausea and vomiting, but pregnancy has a way of making those symptoms sound ordinary. Someone records the blood pressure and is reassured because it is not dramatic. Someone remembers that the urine was negative for protein. Someone else recalls that blood tests were normal four days earlier. A patient says she feels foggy, speaks strangely, becomes anxious and disoriented, and the team sees distress, but not yet the pattern.

That is where this story begins, not with ignorance, but with fragmentation.

The clinical story itself began quietly, almost deceptively so. The danger was not written in one dramatic number or one unmistakable sign. It had to be assembled from fragments, and for a period of time those fragments were not assembled fast enough.

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The Case Enters Under the Wrong Frame

The patient was a 28-year-old woman with a twin pregnancy at 34 weeks. Until then, the pregnancy had been described as uneventful. She was being evaluated because of the possibility of preterm birth, and at first the situation seemed to sit inside a familiar obstetric frame. Her blood pressure was 136/82. Her pulse was 74. There was no protein in the urine. She had no major complaint except irregular contractions. Blood tests four days earlier had been normal. Nothing in that first outline sounded calm exactly, because a twin pregnancy at 34 weeks always deserves attention, but nothing in it yet seemed to force the team into emergency recognition.

There was, however, one fact that did not fit easily into the ordinary clinical frame, and it was not a laboratory value. The doctor had communicated with this patient for quite a while before her hospitalization. He knew her not as a generic patient, but as a particular person: extremely bright, analytical, composed, and almost religiously modest and private. That prior knowledge mattered. It gave him a baseline that no chart number could provide.

Then the patient changed. She began to complain of brain fog, started talking in a way that did not make sense, and became slightly disoriented and anxious. For someone who did not know her, this could have sounded like nonspecific confusion, stress, or the emotional strain of late pregnancy. For this doctor, it was something else entirely. The content and character of her speech were so sharply out of alignment with the woman he knew that it was beyond surprising; it was shocking. This was not simply “talking nonsense” in the abstract. It was a jarring break from her intellectual and moral baseline, a break so strange that it would not leave him alone.

The missing step was not brilliance. It was assembly.

The Red-Flag Bundle Appears

Additional symptoms were later recognized as part of the same story. She had right-upper abdominal pain. She had nausea and some vomiting. She had a headache that was not responding to medication. She had some visual changes. Once those signs are placed beside the neurologic change, the case no longer feels like an ambiguous late-pregnancy episode with anxiety and contractions. It becomes a much more specific

obstetric emergency: preeclampsia with severe features, HELLP-spectrum disease, possible cerebral involvement, possible PRES, and impending eclampsia until proven otherwise.

This is the central lesson of the case. The diagnosis did not require exotic technology. It required the medical team to stop treating symptoms as separate complaints and begin treating them as a cluster. In late pregnancy, especially in a twin pregnancy, the combination of refractory headache, visual symptoms, right-upper-quadrant or epigastric pain, nausea or vomiting, and altered mental status should not be allowed to drift through the chart as unrelated observations. It is a red-flag bundle. It may not yet prove HELLP or severe preeclampsia, but it should immediately move those diagnoses to the center of the room.

The Physician Who Turned Around

In the actual course of events, the decisive recognition came from a physician with direct hands-on experience with HELLP syndrome, including training with a world-known specialist in the field. But the trigger was not textbook memory alone. The trigger was the collision between what he heard from the patient and what he knew of her as a person. He had known her as unusually bright, analytical, modest, and private. The sudden change in her speech and behavior was so out of character that it disturbed him deeply. It was not merely a symptom recorded in the mind; it was a human contradiction he could not explain.

While already on the way away from the hospital, he apparently could not think about anything else. What was happening? What had triggered such a change in this particular woman? Why would someone with her clarity and self-command speak in a way so unlike herself? His confusion ended only when the case connected in his mind with what he had learned from his mentor about HELLP syndrome and its complex bucket of symptoms, not only physiological but also neurologic and mental. Twin pregnancy. Late gestation. Strange speech. Disorientation. Headache not relieved by medication. Visual changes. Right-upper abdominal pain. Nausea and vomiting. The pattern became too serious to leave behind. That was the U-turn moment. He turned the car around, returned to the hospital, and moved the case toward the urgent intervention it required.

After further discussion with the team, I would no longer describe this only as a possible catastrophe avoided. The doctor's intervention saved the patient's life. That is a strong statement, but in this case it is justified. The alternative path appears to have involved additional neurologic investigation, including brain imaging, and in that particular hospital after 6 p.m. such imaging could have taken a significant amount of time. In ordinary circumstances, imaging can be exactly the right thing to do when a pregnant patient develops acute neurologic symptoms. But in this case, the dangerous obstetric pattern was already present. The time that would have been spent waiting for imaging was not neutral time. It was time during which severe preeclampsia or HELLP-spectrum disease could continue to progress. In that sense, the doctor did not simply make a better diagnosis. He did not simply make a better diagnosis. He interrupted a fatal delay.

From Recognition to Delivery: The Real Outcome

After returning to the hospital and reframing the case as a suspected HELLP or severe preeclampsia-spectrum emergency, the doctor started an induced labor protocol. In this setting, induction was not simply a routine attempt to start labor; it belonged inside a high-risk obstetric pathway in which the mother would typically be managed with close blood pressure surveillance, seizure precautions, repeat platelet and liver-enzyme testing, kidney-function and hemolysis assessment, fetal monitoring for both twins, anesthesia involvement, preparation for hemorrhage or transfusion if needed, and magnesium sulfate when severe preeclampsia or impending eclampsia was considered clinically plausible. The details would depend on the bedside findings and local protocol, but the practical shift was clear: the case moved from watchful obstetric management into urgent maternal stabilization and delivery planning.

The key point is not that brain imaging would have been wrong in every similar case. The key point is sequence. In a pregnant patient with sudden neurologic symptoms, imaging may be necessary if stroke, hemorrhage, cerebral venous thrombosis, or another neurologic emergency remains plausible. But when the obstetric pattern of right-upper abdominal pain, vomiting, refractory headache, visual changes, and altered mental status is already visible, delay becomes dangerous. The doctor recognized that this was not a case in which the team could calmly spend the evening completing one diagnostic branch before acting on the obstetric emergency. He moved the case into the pathway where time mattered most.

The delivery that followed was intense and involved surgery. That real outcome matters because the clinical recognition did not remain theoretical; it changed the action path. The doctor started the induced labor protocol, the situation escalated into a demanding delivery with surgical involvement, and after that urgent process the patient and both babies were fine. That is the emotional center of the story. The good ending should not soften the danger that came before it. It should make the danger more visible. A mother and two babies were fine because the delay was broken in time.

Why This Was More Than a Near-Miss

This is why the case deserves to be examined. It was not merely an interesting diagnostic puzzle, and not merely a near-miss in the casual sense. It was a fatality averted. The purpose of saying this directly is not to accuse the team personally or to turn a complicated clinical situation into melodrama. The purpose is to preserve the seriousness of the lesson. Obstetrics is unforgiving because severe disease can hide behind symptoms that are common, soft, and easy to normalize. In this case, the danger was real, and delay would not have been a harmless detour. The doctor's decisive return changed the outcome.

The most important failure in this story was a failure of diagnostic framing. The patient entered the system under one concern, possible preterm birth, and the frame did not change fast enough when the clinical facts changed. Once altered mental status appeared, the frame should have widened immediately. Once the associated symptoms were recognized, the frame should have narrowed again, sharply, toward severe preeclampsia and HELLP-spectrum disease. This movement from broad danger to specific danger is one of the central skills of emergency medicine. First, the team must recognize that the patient has crossed into an emergency category. Then it must identify which emergency pattern best fits the available facts. Delay at either step can be costly.

The Reassuring Numbers That Were Not Reassuring Enough

Blood pressure played a particularly misleading role. A reading of 136/82 is not a severe-range blood pressure, and in isolation it can falsely calm the room. But a single non-severe reading cannot neutralize neurologic symptoms, refractory headache, visual changes, right-upper abdominal pain, and vomiting in late pregnancy. The patient's baseline blood pressure also matters. A pressure that looks modest on paper may represent a meaningful rise for a particular woman. More importantly, severe preeclampsia and HELLP-spectrum disease are not diagnosed by one number alone when the body is already sending organ-system warnings. The blood pressure should be trended, repeated, and interpreted inside the whole clinical picture, not used as a sedative for clinical concern.

The old lab results created a second layer of reassurance. Normal blood tests four days earlier were useful historical information, but they were not present-tense safety data. In an evolving obstetric emergency, four days can be a long time. Platelets can fall. Liver enzymes can rise. Hemolysis can develop. Renal function can change. A patient's current symptoms must outrank yesterday's normality. The appropriate response is not to remember the old labs with relief, but to repeat the relevant labs urgently and interpret them against the patient standing in front of the team now.

The negative urine protein also had the potential to mislead. It may have lowered suspicion in the minds of clinicians trained on the classic preeclampsia formula of hypertension plus proteinuria. Yet the dangerous forms of preeclampsia are often recognized through severe features and organ involvement. Proteinuria is important, but it is not a permission slip to ignore severe headache, visual symptoms, right-upper-quadrant pain, vomiting, and altered mental status. A team that waits for every classic sign to appear in textbook order may wait too long.

In retrospect, the most dangerous reassurance was not any single number. It was the accumulation of almost-reassuring facts: blood pressure not severe, urine protein negative, old labs normal, symptoms explainable one by one. Each could calm the room just enough to postpone the right action. But severe obstetric disease does not always announce itself in the order physicians prefer. The body may speak first in discomfort, confusion, nausea, pain, and visual disturbance, and the laboratory confirmation may arrive only after the clinical danger has already become urgent.

The Neurologic Warning

The neurologic symptoms were perhaps the most important warning of all. Brain fog, nonsensical speech, anxiety, and mild disorientation can be softened by language. They may sound subjective, emotional, or nonspecific. But in a pregnant woman at 34 weeks, they should trigger a disciplined neurologic and obstetric emergency response. The bedside team should be asking whether this is confusion, aphasia, postictal state, cerebral edema, PRES, stroke, venous thrombosis, hypoglycemia, medication effect, infection, or impending eclampsia. These possibilities should not be handled sequentially over many hours if the patient is actively changing. The evaluation must proceed in parallel, because the dangerous causes overlap in time and presentation.

The new information about after-hours imaging makes this point even sharper. A sequential approach, first imaging and only later obstetric intervention, could have cost the patient the window in which rescue was still straightforward. The physician who returned did not reject neurologic thinking. He prevented neurologic workup from becoming a time-consuming substitute for recognizing the obstetric emergency already in front of the team.

AI as a Mirror, Not the Center of the Story

This is where the role of AI enters the story, but only as a mirror of the medical process rather than the center of the lesson. An AI advisor can only respond to the case it is given. If the initial description includes twin pregnancy, irregular contractions, normal blood pressure, no urine protein, normal recent labs, and new confusion, the AI may reasonably produce a broad differential that includes atypical preeclampsia, PRES, stroke, seizure, and metabolic causes. That answer may be technically correct and still not force the bedside team to the correct urgent center. Once the missing symptoms are added, right-upper abdominal pain, vomiting, refractory headache, and visual changes, the diagnostic gravity changes immediately.

There was also a dimension of the case that AI could not have generated on its own unless the doctor supplied it: the patient's personal baseline. A language model can process symptoms, probabilities, and patterns, but it does not know what it means for this particular woman, known to this physician as intensely analytical, modest, and private, to suddenly speak in a way that violated everything he knew about her. That recognition was not only medical. It was relational. It came from memory, continuity, and human familiarity. In this case, the shock of the mismatch became part of the diagnosis.

The lesson for physicians is therefore not that AI should have been smarter. The lesson is that doctors must not use AI, or any consultant, human or digital, as a substitute for disciplined case construction. If the

team does not assemble the essential facts before asking for a second opinion, the second opinion will reflect the same fragmentation. The problem begins at the bedside, not in the software. In that sense, the AI interaction is useful mainly because it exposes the quality of the clinical handoff. A weak prompt is often a weak medical summary. A missing symptom in the prompt may mean a missing symptom in the team's shared understanding.

Case Construction Before Consultation

A strong protocol for physician use of AI in emergency obstetrics should therefore begin with physician behavior, not AI behavior. The team should have a habit of packaging high-risk cases in a structured way before seeking any outside interpretation. For late pregnancy with neurologic change or upper abdominal pain, the summary should not be a loose narrative. It should automatically include gestational age, fetal number, blood pressure trend, baseline pressure if known, urine protein status, headache character and response to medication, visual symptoms, right-upper-quadrant or epigastric pain, nausea and vomiting, neurologic status, seizure signs, reflexes and clonus, platelet count, liver enzymes, creatinine, hemolysis markers, glucose, electrolytes, medications, fetal status, and the exact timeline of change. This does not need to be recited as a bureaucratic checklist in the essay, but in the clinical room it should function exactly that way. Before diagnosis comes the disciplined gathering of the dangerous facts.

The proposed lesson is simple but not small: in high-risk obstetrics, the red-flag bundle must be assembled before the team allows itself to be reassured. A patient at 34 weeks with twins, neurologic change, refractory headache, visual symptoms, right-upper abdominal pain, and vomiting is not a patient for relaxed observation while the team waits for the picture to become obvious. She is a patient for urgent maternal stabilization, repeat current labs, magnesium consideration when severe preeclampsia or impending eclampsia is plausible, fetal monitoring, anesthesia and MFM involvement, neurologic evaluation when indicated, and early delivery planning if severe disease is confirmed or strongly suspected. The exact treatment decisions belong to the responsible physicians at the bedside, but the diagnostic posture should be urgent from the moment the pattern is recognized.

Trained Intuition and the Limits of System Memory

The physician who turned his car around represents the best part of medicine. He did not simply process data. He remained mentally attached to the patient after leaving the room. He allowed uneasiness to continue working. He recognized that the case had not been safely explained. He trusted a pattern learned through experience and returned before the system had fully declared the emergency in formal terms. That kind of judgment is not easily reduced to an algorithm, and it should not be dismissed as intuition in the shallow sense. It is trained intuition, which is another name for experience disciplined by memory.

This is the part of the story that moved me most. The doctor was not standing at the bedside when the pattern finally struck him with full force. He was already on the way out. Yet the case kept working inside him, not only as a list of symptoms, but as the voice and behavior of a woman he knew. Her words did not match her. Her manner did not match her. The contrast was too jarring to dismiss. He did not surrender to the comfort of having left the hospital. He allowed the uneasiness to keep pressing until it found the pattern his mentor had taught him to recognize. He turned around. In the language of systems, this was escalation. In human language, it was responsibility. In the life of that patient, it was rescue.

But the fact that the case depended on that one returning physician is also the weakness the system must confront. A safe system should not require the right doctor to remember the right training while driving away from the hospital. It should make the red-flag cluster difficult to miss for any competent team. It should force the case to be reframed when new symptoms appear. It should treat normal old labs as history rather than

reassurance. It should prevent mild blood pressure elevation from overshadowing severe-feature symptoms. It should require that neurologic change in late pregnancy be treated as an emergency until proven otherwise.

Lessons Learned

For Physicians

For physicians, the central lesson is that diagnosis begins before the differential diagnosis is written. It begins with disciplined case construction. In this near-miss, the danger was not hidden in a rare laboratory value or an obscure theory. It was hidden in the separation of symptoms that belonged together. A neurologic change, a refractory headache, visual symptoms, right-upper abdominal pain, nausea and vomiting, late twin pregnancy, and an old normal lab report should not have coexisted in a reassuring frame. The frame should have changed.

The second lesson is that old reassurance must not outrank new deterioration. A normal lab panel four days earlier, a single non-severe blood pressure reading, and a negative urine protein test may all be true and still be insufficient to explain the patient now. In severe obstetric disease, the present clinical pattern deserves priority over yesterday's normal data. When the patient changes, the diagnosis must be rebuilt.

The third lesson is that AI, like any consultant, is only as good as the handoff it receives. If the physician gives AI an incomplete case, the physician may receive an incomplete answer. The medical responsibility remains at the bedside. AI can assist, organize, challenge, and remind, but the doctor's first duty is to notice the facts, gather them honestly, and pass them forward without selective reassurance. In uncertain cases, the best prompt to AI is not a polished story that hides ambiguity, but a complete clinical picture that includes the uncomfortable details.

The fourth lesson is that time is part of the diagnosis. In a hospital where brain imaging after hours may take significant time, the team must recognize when waiting for another diagnostic step becomes dangerous in itself. In suspected severe preeclampsia or HELLP-spectrum disease at 34 weeks, especially with neurologic symptoms and liver-area pain, the question is not only "What else could this be?" but also "What delay can this patient safely tolerate?" In this case, the answer appears to have been: very little.

The fifth lesson is that the patient's personal baseline is clinical information. When a physician knows a patient as clear, precise, analytical, restrained, modest, or private, a sudden break from that pattern should not be dismissed as personality, anxiety, or emotional noise. It may be neurologic information. It may be the first sign that the brain is being pulled into the disease process. In this case, the doctor's knowledge of who the patient was helped him recognize the danger in what she suddenly became.

For Patients and Expecting Mothers

For patients, and especially for expecting mothers, the lesson is simple and important: talk to the doctors. Tell them every problem, sensation, or change that feels different, even if it seems small, unique, embarrassing, vague, or probably unrelated. A patient should not have to decide whether a symptom is medically important before reporting it. That is the clinician's job. Medicine often depends on patterns, and a symptom that means little by itself may become crucial when placed beside another symptom and understood by a trained team, and, when needed, by an AI advisor assisting that team.

A future mother might say, "I had a headache, and the normal medicine did not work too well." She might add, "I felt some pain on the right-top side of my abdomen, but I thought it was the baby pushing too hard."

She might mention, "I felt nauseous, but I did not eat anything unusual, and my general condition just felt off, I guess." None of these symptoms, offered separately, may feel to her like an emergency-level situation. Together, they may become the exact pattern that allows her doctors to recognize danger early.

Patients should not worry about overloading doctors with information. Doctors are trained to sort through symptoms quickly, to separate ordinary discomfort from danger, and to recognize when a small detail changes the entire diagnosis. In modern care, where AI may be available at the side of doctors as a 24/7 supporting advisor, completeness of the patient's story matters even more. The doctor cannot pass to AI what the doctor has not heard, and AI cannot help assemble facts that were never placed on the table.

For expecting women, the practical habit is gentle but powerful: take notes of changes in how you feel and how your body functions. Write down unusual headaches, vision changes, nausea or vomiting, abdominal pain, shortness of breath, confusion, swelling, weakness, reduced fetal movement, bleeding, or simply the sense that something is not right. This is not anxiety, and it is not self-diagnosis. It is partnership. A healthy and safe birth experience is built by experienced physicians, attentive nurses, appropriate technology, and the mother's own voice becoming part of the medical record at the right time.

The reassurance is this: the patient is not responsible for making the diagnosis. She is responsible only for telling the story as completely as she can. With doctors at the bedside and AI increasingly available as a supporting advisor when uncertainty arises, the safest future is not one where machines replace human care, but one where the mother's observations, the physician's judgment, and the AI-assisted second look all meet before the danger is missed.

Conclusion: Not AI Against Doctors, but Medicine Against Fragmentation

The forward-looking conclusion, then, is not that AI will save obstetrics, nor that doctors should surrender judgment to software. It is the opposite. Doctors must become more disciplined in how they construct the case, especially before they ask anyone or anything else to comment on it. AI may be useful as a second-opinion tool, but only after physicians have done the first and most human part of diagnosis: noticing, collecting, connecting, and refusing to be reassured too early.

This case should be remembered not as a contest between human doctors and an AI advisor, but as a warning about fragmentation, delay, and the false comfort of incomplete reassurance. The doctor who returned to the hospital saved the patient's life because he reassembled the fragments into a pattern, but also because he recognized a human rupture that no isolated chart entry could fully describe: this woman was no longer speaking or behaving like herself. He acted before the system lost the time the patient did not have. The next goal is to make that reassembly less dependent on one doctor's private moment of recognition. In a well-designed medical process, the team itself should turn around earlier.

That is the lesson of this OB near-miss. In medicine, and especially in obstetrics, facts do not always arrive in order. The discipline of the team is to gather them before the patient pays the price.

I was moved by this story because it ended well, but also because it came close enough to ending differently. A mother survived. Two babies were fine. A doctor's memory, training, uneasiness, and decision to return changed the path of the evening. That is not a small footnote to the case. It is the case. The future of medicine should not make such moments less human. It should make them less lonely, less accidental, and less dependent on one physician having to turn his car around in time.