

SPECIAL REPORT

MIEC Claims Alert

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Altered medical records and other charting hazards

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*Few medical-legal topics have generated as much discussion as has the subject of medical record documentation. Many medically defensible malpractice claims result in a victory for the plaintiff because of the poor quality of medical records, even in cases in which appropriate medical care was provided. Liability insurers, defense attorneys and third-party payers such as managed care plans, remind physicians and other health professionals that the safety of patients, the outcome of litigation and the promptness of reimbursement depend on the adequacy, legibility, completeness, timeliness and accuracy of medical records. "Nothing is more devastating to an innocent physician's defense against the allegations of medical malpractice than an inaccurate, illegible or skimpy record, **except for a record which has been changed after the fact**, and therefore inevitably compromises the otherwise defensible case." (Brad Cohn, MD, Chairman, MIEC Board of Governors) This Claims Alert Special Report re-visits the subject of medical records and litigation, and underscores one of the most serious problems for the defense: an altered medical record.*

Costly record alterations

Within the last few years, MIEC settled at least three lawsuits in which the physicians altered the patients' medical records, cases defense experts believed were managed appropriately.

In one of the lawsuits, the physician denied under oath during his deposition that he had changed the record.

After a certified document examiner proved that the doctor had altered the chart, the physician agreed to contribute a substantial sum of his own money to settle the case. Had the case gone to trial, it is likely that the changed medical record would have become a central focus in the case, over-shadowing the clinical issues. Moreover, it was very likely that the plaintiff would have asked for and been awarded punitive damages once the alteration and the doctor's denial under oath were disclosed.

In a second case, the patient's medical records had been requested on two separate occasions, the second request made after the patient was diagnosed with cancer. The records included a notation recommending a surgical procedure a few years before the patient's cancer was diagnosed. At the time of his deposition, the physician testified that he wrote the note on the date indicated; however, the plaintiff's attorney compared the two available copies of the patient's records and noted that this significant entry *was not* in the first requested copy. Later it was determined that the physician added the information after the patient's cancer was discovered during surgery.

The incidence of medical records that are altered with the intent to deceive is infrequent, but as these examples show, they are costly mistakes. **Each of these cases was settled for policy limits.**

Statutes and case law governing claims of medical record alterations vary from state to state, and determine whether

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criminal or disciplinary action is taken. In California, *“Altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct. In addition to any other disciplinary action, the Division of Medical Quality [Medical Board of California]... may impose a civil penalty of five hundred dollars (\$500) for a violation of this section.”* [Business & Professions Code §2262.] California Penal Code §471.5 states: *“Any person who alters or modifies the medical record of any person, with fraudulent intent, or who, with fraudulent intent, creates any false medical record, is guilty of a misdemeanor.”*

Alaska law does not specifically address the topic of altered records; however, the Medical Board may impose a sanction if it finds, after a hearing, that a licensee, *“... (2) engaged in deceit, fraud, or intentional misrepresentation while providing professional services or engaging in professional activities...”* [AS 08.64.326] In addition, in *Sweet v. Sisters of Providence in Washington* [895 P.2d 484], the Alaska Supreme Court held that spoliation of medical records (i.e., in this case, the loss of pertinent nursing notes) relevant to a medical malpractice claim impairs the plaintiff’s ability to prove that the treating physician or hospital staff was negligent and caused the patient’s injury. As a result, the burden of proof must shift to the doctor or health care provider who altered or lost the medical record to demonstrate that medical negligence did not cause the patient’s injury. If records are intentionally altered or destroyed, a separate allegation for spoliation of evidence may be brought against the provider and could include

punitive damages not covered by liability insurance.

According to defense counsel in Idaho, there are no statutory provisions for altered medical records. However, alteration of medical records in Idaho may extend the statute of limitations if a professional has altered medical records in a manner that would constitute some form of “fraudulent concealment.” Also the limit on recovery for noneconomic damages may be waived if the physician is guilty of “willful or wanton misconduct” or if the fact finder determines, beyond a reasonable doubt, that the conduct would constitute a felony under state or federal law.

Hawaii does not have a cause of action for spoliation of evidence; however, according to defense counsel, if it is discovered that a medical provider altered the records, the plaintiff can request monetary sanctions to compensate for the harm that was caused. In some cases, the discovery of altered or lost records can mean that the defendant is automatically found negligent. The only issues that remain to be litigated are the plaintiff’s comparative negligence and damages. At other times, the trial judge can strike certain defenses that would have relied upon the medical records. The plaintiff can also file a claim for fraud, intentional misrepresentation, and punitive damages. Finally, the medical provider could face criminal penalties for fraud that would include both imprisonment and monetary sanctions.

Changes easily detected

Detecting medical record alterations and out-of-sequence additions is relatively easy for an expert. An experienced certified document examiner is able to distinguish between entries that were written

at different times, even though the same pen and ink, word processor, or printer were used for all of the notes. Using sophisticated electronic equipment, experts can determine the age of the ink used for all entries on a page. Inks from many manufacturers contain chemical markers that indicate their source and date of production. Paper age also can be accurately determined. In several cases, experts were able to show that the ink used or the paper on which questionable dated notes were written were manufactured long after the date of the notes. Changes of medical records kept on computer disks and tapes also can be easily detected by experts. The forensic expertise of certified document examiners is recognized by the courts in most jurisdictions.

Changes can be made

Appropriate and timely changes to a medical record aren’t a significant problem in litigation, but unexplained alterations or additions attract attention. In a complex case that might otherwise be defensible, the suspicion that entries were intentionally altered has great weight. In a difficult case, if a jury is unable to determine whether or not the defendants should be held liable for malpractice, suggestions that the medical record may have been altered to protect the guilty benefits the plaintiff. Changes can be made, safely and properly, to any medical record — and it is appropriate to correct errors, or sometimes to clarify a prior note. To ensure that such changes are not misinterpreted or viewed as efforts to conceal or deceive, any changes or additions to a medical chart should: (a) be accurate and true; (b) include the date they are made; (c) include the writer’s initials or signature; and (d) indicate what prompted the change or addition.

When a new entry significantly changes information previously recorded, the old entry should not be removed. Rather than squeeze in a change, cross out the erroneous entry with a single line, being careful not to obscure what is written, and add a cross-reference to call attention to the correction where it appears later in the chart.

To avoid the appearance of impropriety, anyone who makes entries in a medical record should avoid:

- **write-overs** — This is a common documentation error found mainly in entries that include numbers, such as vital signs or medication amounts. The writer, discovering that the first entry was an error, writes the corrected entry over the original, thus obliterating both: “Demerol ~~200~~ mg.” Rather than write over an entry, draw a single line through the error, write in the correction, the date, and initial the entry. Don’t use liquid paper to cover errors.

- **late additions** — Unexplained notes added after the main body of the record was completed raise questions and suspicions. Rather than squeeze such notes between original entries, write the addition in a clear space and include the date and time. When appropriate, explain why an entry is out of sequence or context, or what prompted the addendum. (e.g., “Although patient denied medication use, at discharge, patient’s husband recalled patient takes Prozac daily. This does not change discharge meds. *MJN, MD*”)

- **detailed addenda** — MIEC and other insurers have reviewed a number of charts in which physicians apparently felt compelled to write detailed addenda to the medical record *after* they learned a patient was injured or was considering a malpractice claim. Most of

these notes were accurate and legitimate, but appeared suspicious and self-serving because they included more examination details, lengthier notes about treatment, discussions with the patient, and post-treatment advice not found anywhere else in the same medical record. Claims managers call them “panic notes,” because they are almost always written by a doctor or nurse after they learn there might be litigation. In many instances, the original notes would have been sufficient. If the notes were made weeks or months after treatment or surgery, a jury in a malpractice case may have difficulty believing that defendants could recall so many details long after an event. The fact that they were written after notice of potential litigation also creates suspicion.

There may be occasions when an addendum, even a lengthy one, is appropriate, but MIEC’s defense attorneys stress that physicians should consult legal counsel before making a significant change to a medical record. “It is easier to defend a case in which the documentation is not ideal, but adequate,” says a malpractice defense attorney, “than it is to explain to a jury what the doctor had in mind when he or she wrote a lengthy apologetic addendum.”

- **re-written chart notes** — Insurers report they were forced to settle a number of medically-defensible cases because physicians completely re-wrote a medical record after learning of potential litigation. In most instances, the reasons for the re-writes appeared plausible. For example, in one case a physician reconstructed several pages of progress notes in a hospital chart because his original entries were illegible and several were out of sequence. However, the potential litigant’s attorney had already re-

quested and received a copy of the original hospital chart; the rewritten version was therefore viewed as a fraudulent medical record. In another case that resulted in a huge settlement, a physician re-wrote several key entries more than a year after a surgery. The physician was unaware that the hospital form on which he re-wrote the altered notes had been reprinted and bore a revision date one year later than the date of the surgery. Re-writing the record might be acceptable in limited circumstances, provided that the original is retained and attached to the corrected version to show that the new entries were not intended to conceal or deceive. No such re-writing should be done before discussion with legal counsel.

More hazards to avoid

Accurate, timely and complete medical records protect patients from injury, and are the foundation for defending physicians in malpractice litigation. Attention is needed to avoid other documentation problems that jeopardize the defense of malpractice claims, such as:

- **sparse or ambiguous progress notes:** Plaintiffs’ attorneys use sparse progress notes to demonstrate for jurors or arbitrators that office visits were too brief, or that examinations were superficial, just as the patient “remembers” and alleges. Phrases in progress notes like “OK,” “looks fine;” “normal neurological exam;” “headaches;” “ROS WNL [review of systems within normal limits];” or “some numbness,” are too ambiguous for defense experts to evaluate, and provide ammunition for the plaintiffs’ experts to question and criticize the defendant’s care and treatment. These types of notes imply inattention or haste and have

influenced the outcome of many “failure to diagnose” malpractice suits that physicians were forced to settle or which were lost at trial.

■ **illegible handwriting:** Illegible writing that is misinterpreted, overlooked, or unreadable can cause patient injuries or death and in turn lead to malpractice litigation. In both office and hospital charts, a carelessly written decimal point in a drug order, an unclear number on a laboratory report or vital signs chart, or medical orders that even their author cannot decipher are charting deficiencies malpractice carriers say result in some of their most expensive and difficult-to-defend lawsuits.

■ **squeezed-in entries:** Squeezed-in, unreadable entries, and initials or signatures that obscure medical notes, weaken the credibility of documentation and the defense of a malpractice claim. Start a new page, rather than squeeze in notes at the bottom or the sides of a full page. In litigation, such notes may appear to have been added with the intent to falsify the record after an adverse event occurred or after litigation was threatened.

■ **untimely, missing dictation:** Operative and procedure reports or discharge summaries dictated too long after an event may handicap other physicians who care for hospitalized patients or who are on call for another physician. Serious diagnostic and treatment errors have resulted in injury and litigation because these reports were not available. Reports dictated too long after a complication is identified lack credibility, whether or not the complication resulted from negligence.

■ **uncorrected errors in transcribed reports:** Busy physicians may not always take time to review transcribed dictation to ensure its

accuracy. Some doctors ask a transcriptionist to stamp “Dictated but not read,” in the belief that this disclaimer excuses them from finding and correcting errors or omissions on transcribed documents. In fact, such a disclaimer may increase liability. If unreviewed reports contain errors or omissions that cause patient injury, in addition to claiming negligence, litigants will allege that the doctor was “too busy” or “too unconcerned” to ensure the accuracy of an operative, history and physical, or consultation report. Juries have not been sympathetic to the excuse that a doctor was too busy to protect patients from injury by reviewing these important documents. It is difficult to correct errors or fill in blanks months or years after a report was signed. It is even more difficult for doctors to convince jurors they meant to say something other than what appears on the report they dictated and signed without reading.

■ **subjective remarks:** Medical record entries should be objective. For example, do not refer to a patient as a “malingerer” or “alcoholic” or write that he “abuses drugs” without objective substantiation of these potentially harmful assertions. When making reference to alcohol, tobacco, or street drug use, include specific amounts; terms such as “heavy,” “moderate,” or “occasional” are subject to broad interpretation. The physician should document objectively what the patient did or said that led the doctor to conclude the patient demonstrated “drug seeking behavior.” When a physical exam fails to explain a patient’s subjective complaints, it is best to say so, using professional language; e.g., “I am unable to find the source of an objective explanation for the patient’s complaints of pain.”

■ **criticism of other health**

professionals: Comments critical of treatment by other health professionals are inappropriate in patients’ medical records. Uninformed criticism of colleagues could trigger a lawsuit. Physicians should not use a patient’s office or hospital medical record to criticize nurses or to comment on the quality of services others provided or failed to provide. This is not to say that physicians or other health professionals should suppress their legitimate concerns about patient care or about the responsiveness of others involved in the patient’s care. However, hospital and medical society peer review or quality assurance committees, not the medical record, are the appropriate forums for physicians and others to address issues related to a colleague’s competence, judgment or treatment choices.

For patient-specific questions, physicians may contact MIEC’s Claims Department, or they may call the Loss Prevention Department for answers to general professional liability questions.

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