Medical Records:
Best Friend or Worst Enemy?

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Physicians are legally obligated to maintain adequate and accurate patient medical records, whether they practice in a hospital or ambulatory setting. A permanent legal document, the medical record often serves as a critically important means of communication among healthcare providers concerning a patient’s medical history and course of treatment. The medical record also provides information that supports the need for a particular diagnostic test or type of treatment in the event of a reimbursement or utilization dispute. From a risk management perspective, the medical record is a crucial factor in preventing and minimizing potentially adverse medical consequences. It is also a key element in defending malpractice claims and lawsuits since it documents the patient’s history with which the physician began, the physician’s critical thinking in evaluating the current situation, the basis for the diagnosis and treatment the physician offered and prescribed, the sequence in which care was provided, the patient’s response to treatment, and any reluctance or failure by the patient to heed the physician’s advice. In contrast, a poorly maintained or improperly modified or altered record will be used to attack and undermine not only the physician’s diagnostic acumen and the appropriateness of the care that was provided, but also the physician’s credibility regarding what was discussed with the patient, including the patient’s reluctance or refusal to heed the physician’s advice. As such, the medical record has sometimes been referred to as the “witness whose memory is never lost.”

Common Pitfalls in Malpractice Litigation

Unclear, incomplete, or inaccurate record entries

It is critical to document contemporaneously the care offered, provided, or rejected as completely as possible, including the date, time and signature of the healthcare provider who is making the entry. Without dates and times, it becomes very difficult to establish timelines of care, either for reference by other healthcare providers or for use in malpractice litigation.

Beyond that, the absence of timely and accurate documentation provides the obviously dissatisfied plaintiff with the means to challenge the quality of care the physician provided during their relationship, including disputing the history that was given, potential diagnoses that were discussed, tests that were either ordered or suggested, referrals that were recommended or declined, etc. Leaving the documentation door open enables the unhappy plaintiff with a selective memory to retrospectively create issues and scenarios that never existed but which a creative lawyer and his willing expert can use to suggest that the physician did not, in fact, provide the care required under the circumstances.

In short, untimely, poorly maintained, incomplete, illegible or improperly altered medical records can be, and often are, used to suggest not only that the physician provided inadequate medical care, but also that he/she subsequently attempted to “doctor” the treatment record to conceal that fact. Conversely, a timely, contemporaneously created and well-documented record can serve as the physician’s first line of defense in such claims.

Spoliation

The term “spoliation” generally refers to the destruction or concealment of evidence. In the context of a malpractice case, the concept can be a potent weapon used not only to compromise the defense of the medical case, but also to inflame the jury’s passions against the defendant physician.

The law requires physicians to ensure that medical treatment records accurately reflect the treatment or services provided. The law further specifies that corrections or changes to entries in such records may be made only where the change is clearly identified as such and then simultaneously dated and initialed by the person making the change.
It is illegal for a person to alter medical records with the intent to deceive or mislead anyone. The liability resulting from such an act may be civil, or in some cases, criminal. In a civil malpractice action, for example, the court may instruct the jury that if they conclude that the alteration was intentionally done to deceive or mislead anyone, they may infer that the physician altered the record because he/she believed the original would have been unfavorable to him/her in the trial of the case. Evidence of such alteration may also serve as the basis for the plaintiff asserting a separate and independent claim for fraudulent concealment against the physician seeking to recover both compensatory and punitive damages.

Spoliation may take the form of destroying the original record, of rewriting the original record, or creating a new and different record. It may also consist of erasing, obliterating or adding information to the original record after the original note was made. Although there may be times when a non-contemporaneous entry in a medical record is appropriate, the physician making such an entry should be certain to follow the rules whenever making such an addition or change.

The Impact Extends Beyond Patient Care and Litigation Concerns

The failure to maintain adequate and accurate records may not only jeopardize the welfare of the patient, but also constitutes unlawful and unprofessional conduct. In addition, it may affect the availability of insurance for a malpractice claim in which improper record keeping is involved.

- Insurance companies may deny coverage if the insured fraudulently destroys, rewrites, creates, alters or modifies a medical record.
- In New Jersey, the purposeful destruction, alteration or falsification of records relating to the care of medical, surgical or podiatric patients in order to deceive or mislead is a crime of the fourth degree (N.J.A.C.2C:21-4.1).
- The NJ Board of Medical Examiners considers unlawful alteration to be an act of professional misconduct, and can therefore levy sanctions and fines against offending license holders.

Spoliation Detection

Experts such as forensic chemists, ink-dating, fingerprint and DNA specialists employ a number of techniques to detect record alterations. For example, the ink-dating technique can detect an alteration made with a different pen, as well as determine the age of the document or a particular ink. The ink specialist may also utilize an infrared image converter or special lasers to confirm that ink of the same color was used at different times.

Obviously, such expert testimony confirming that an alteration has occurred will be used to undermine the credibility of the healthcare provider involved in the spoliation. It may also serve to inflame the jury’s view of what justice requires to “set things right,” thereby increasing the amount of compensatory damages that the jury may award to the aggrieved patient, as well as fueling a separate and additional punitive damages award.

Correcting a Record

Obviously, the most troubling record change cases are those in which records have been intentionally altered to cover up diagnostic, treatment or charting deficiencies or errors. However, even legitimate, well-intended modifications to records can give rise to suspicion of improper intent if not correctly done.

So what should one do if he/she discovers a mistake or omission? How should one correct an error in charting? To begin with, charting errors should be corrected as soon as they are detected. Equally important, the correction should be open, transparent and clear, leaving no room for any suggestion that it was made surreptitiously or for any reason other than ensuring that the patient’s record is accurate and complete.

If the error consists of incorrect information, the best way to make the correction is simply to draw a single line through the incorrect information without obliterating it, making sure that what has been stricken out can still be read. Then enter the correct information either above, below or next to the lined-out entry. Lastly, the person making the correction should write his/her initials and the date the change is being made next to the corrected entry.

If the error consists of a failure to include information that should have been included in the record but was inadvertently omitted, the best approach is to simply write a note captioned “Addendum” or “Late Entry,” noting that the information being supplied was inadvertently omitted when it had first been obtained, e.g., when a particular complaint had been received, when a specific finding had been made, when a particular test, treatment or referral had been discussed and recommended, when the patient had agreed with or rejected proposed testing, referral or treatment, etc. Again, all such notes should be initialed and dated on the date they are entered.

Adding or correcting a note to ensure that the patient’s record is accurate and complete is important to maintaining the integrity of the medical record and to advancing proper patient care. It may also be of benefit in later defending the physician accused of not having provided the patient with proper medical care.

Obviously, the best practice is always to complete the records correctly the first time. But where that doesn’t occur, it is imperative that any addition or correction be made in a clear, open manner so that the belated entry does not become the basis for a colorable claim of spoliation or cover-up.

In summary, altering an original medical record for any reason other than safeguarding the patient or documenting the care actually provided is not only wrong, it is also fraught with risk. There are many ways for external reviewers to detect record alteration, and even the most “clever” attempts will likely be discovered. Furthermore, electronic medical records make alterations even easier to spot with time-stamping, metadata, and the potential existence of multiple versions.

Perception can be, and often is, interpreted as reality. As a famous Greek philosopher once observed, “We judge the present by looking at the past.” The medical record we analyze today should provide an accurate picture of what occurred during the physician-patient relationship. Diligence and honesty in documentation will go a long way toward enabling the innocent physician to successfully defend a future malpractice claim challenging the quality of the care he/she provided.

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