MMAP NEWS

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Medical Records and Malpractice Litigation – Part Three

By David Karp

The first two articles in this series on medical records discussed some of the recommended components of patients' medical charts. This article reviews documentation deficiencies that result in treatment errors and injury or force malpractice defendants to settle defensible claims.

Blanks on forms or dictation: A blank space on a form does not always signify a negative response. Plaintiffs' attorneys and jurors may regard blank spaces on an examination template as evidence that parts of the exam were not done. On a questionnaire, patients may leave spaces blank because they did not understand or overlooked the question, or did not know how to spell a medical or drug term. Failure by physicians and nurses to fill in spaces on labor and delivery and other operating room forms has had significant consequences in numerous malpractice cases. All spaces for information on forms should be filled in or voided. Ask office staff to review forms patients fill in to ensure the forms are complete. Physicians should not sign operative reports, discharge summaries, or other transcriptions before filling in blanks.

Illegible handwriting: Illegible writing that is misinterpreted, overlooked, or unreadable can cause patient injuries or death and 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 unreadable entries, showy initials or signatures that obscure medical notes, improper corrections, writeovers, and crossouts not only are hazards in patient care, but weaken the credibility of documentation and the defense of a malpractice claim.

Dictated and transcribed medical records are an alternative to handwritten charts, especially for doctors who cannot write legibly. Dictated medical records tend to be more complete and thus more helpful in documenting patient care, and more supportive in the defense of a malpractice claim than are many handwritten charts. The ease of dictating encourages physicians to include more than the usual details of history, examination, their judgment, advice discussions, instructions, and contacts with specialists and referring doctors. Transcribed records are especially recommended in complex cases and in cases in which other physicians rely on the chart. Dictated records also are advisable in cases the doctor reasonably can expect will involve either litigation or liability claims, such as auto accidents, industrial injuries and abuse cases.

Untimely dictation: Operative and procedure reports or discharge summaries dictated too long after an event 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.

“Dictated but not read” rubber stamps: Some busy physicians believe this rubber stamped disclaimer excuses them from errors or omissions on reports or correspondence they sign. In fact, such attempts to limit liability increase it. If unreviewed reports contain errors or omissions that cause patient injury, in addition to claiming negligence, plaintiffs will allege in litigation 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 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.

Crossouts and writeovers: Crossed out or overwritten entries in a medical record are liabilities in litigation. These unexplained changes may obscure both the original entry and correction, and confuse or mislead others who rely on the information. Overwritten, unreadable entries on vital sign charts, medication orders, labor and delivery records and other chart forms contribute to patient injuries, including medication under- or overdoses, and the omission of other intended treatment.

Plaintiffs’ lawyers attempt to cite unexplained crossouts of medical chart entries to suggest the medical records were intentionally altered to conceal a defendant’s negligence. (“Did you change that fetal heart rate *after* you learned the baby had brain damage, doctor?” “Did you change that abnormal blood pressure after the patient’s stroke or before?”) Correct writing errors by drawing a single line through the error without obscuring it. Enter the correction, the date and your initials. Indicate the reason for significant changes or identify their source.

Squeezed in entries: Physicians frequently remember an important detail after they have filled the progress page or after a dictated note has been transcribed. Writing addenda need not be a problem. But when afterthoughts are squeezed in on the page, however innocently, they can have repercussions in litigation. Plaintiffs’ attorneys urge jurors to view squeezed in entries as the defendant’s effort to falsify the record to conceal negligence. Notes important enough to include in the medical record should be written in adequate space. Start a new page if necessary.

Caveat: When amending progress notes, include the date, time and, when the reasons for the addition are not obvious, explain the change. Never amend or correct a medical record after receipt of notice of a potential claim. Obtain advice from a defense attorney if charting errors are discovered following a complication or after a claim is made.

Deliberate alteration of a medical record is illegal and unethical, and may subject the writer to criminal and civil penalties, including possible loss of license to practice. The technology to detect documentation alterations is sophisticated and includes methods that accurately determine if entries on the page were made at the same or different times. Evidence of late entries or of alterations is usually admissible in court and strengthens the plaintiff’s case.

Loose slips of paper: Physicians and their staff should not use small slips of unattached paper in medical charts for notes or phone messages. These notes can be overlooked or lost. They often are made in haste and omit a patient name, the date, or the writer’s identity. Write information that is important enough to be placed in the chart on a standard note form; include sufficient detail and affix the notes to the page.

Ignored ‘Red Flagged’ Progress Notes: A ‘red flag’ progress note is intended to remind the writer of the need for follow-up. For example, a physician may document (red flag) a decision to defer a diagnostic test pending results of a short course of medication. The next progress note should cancel the red flag alert by indicating that: (a) the problem resolved; (b) further observation is planned; or (c) other actions (referral, tests, etc.) will be taken. If the physician neglects to cancel the red flag with a closing note and the same or a similar problem surfaces in the future, it may be difficult to distinguish between a new complaint and the older, apparently untreated one. Ignored red flag notes are serious defense problems in “failure-to-diagnose” claims.

Unclear Return to Work Orders: To avoid injury to a patient, return to work advice should be specific and reflect an understanding of the patient's job requirements. Orders for the patient to return to "light work" or "limited duty" may be misinterpreted by the patient or employer, or disregarded if the job duties cannot be modified as "light" or "limited." The doctor's orders should specify limitations on activities such as lifting, carrying, climbing, standing, or operating equipment. Return to school orders similarly should list activity restrictions.

Unsubstantiated subjective remarks: Medical record entries should be objective. It is risky to refer to a patient as a "malingerer" or "alcoholic" or write that he "abuses drugs" without objective substantiation of these potentially libelous assertions. 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 or an objective explanation for the patient's complaints of pain."

Criticism of other professionals: Comments critical of treatment by other health professionals are inappropriate in the medical record. Too often, criticism is written or expressed by physicians who have not reviewed prior medical records or discussed the case with the previous physician, but instead relied on the patient's account of what occurred. Uninformed criticism of colleagues triggers a high number of unmeritorious law suits. Hospital and medical society peer review or quality assurance committees are more suitable forums than the medical record for physicians to question a colleague's competence, judgment or treatment choices.

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Important Note from MMAP:

In an effort to reduce the turn around time in 2006 for receipt of claim history information, we are circulating the HIPAA compliant release form which the MMAP requires be signed by the insured physician or representative of the insured facility authorizing release of a loss history.

This form should be completed each time loss history information is requested, as the name and address of the recipient may change, and sent via fax with your request using the toll free fax # 888.371.4841 for a prompt response.

You will also find a copy of this form on the MMAP website at www.dfa.state.ms.us. Simply click on the link named 'Physician and Hospital Insurance Information' found on the left hand side of the home page and you will be directed to the location where the release form is found.

We are committed to improving the turn around time for this process with your cooperation.

MISSISSIPPI MEDICAL MALPRACTICE AVAILABILITY PLAN CONFIDENTIALITY AGREEMENT AND RELEASE FORM FOR CLAIM HISTORY

Insured or Policyholder____

Federal Employer ID#____

Insured's Current Address____

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Person and Address for mailing of requested information, if different than above:

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I hereby authorize the release of claims information as designated above. I authorize the Mississippi Medical Malpractice Availability Plan (MMAP) to release information relating to claims and suits against me on record with MMAP as of the date below. I understand that this information is highly confidential and should not be disclosed in any manner that would cause such information to benefit any claimant. If requested or required to disclose the information in a legal proceeding, I and my representatives will immediately notify the Mississippi Medical Malpractice Availability Plan (MMAP).

I understand that neither the Mississippi Medical Malpractice Availability Plan (MMAP) nor its representatives makes any representation or warranty as to the accuracy or completeness of the information, and I hereby release from liability MMAP and all its representatives for their acts performed in good faith.

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Signature of Insured/Policyholder Date