Medical Law and Ethics
Handout 2.5
The Medical Record Part I

by Kevin M. Chevalier

Introduction

In this handout, we will look at an important part of one's medical history--the medical record. A **medical record** (often referred to as "medical chart") is written documentation containing information on a patient's past medical history, current diagnosis and treatment, signed confidentiality agreements and waivers, and any additional information provided by healthcare professionals pertaining to the patient's care. Information can include vital signs, progress notes, prescription history, operative reports, and fluid intake and output (I & O).

A medical record is considered a legal document. Therefore, ensuring that the information contained in the record is accurate and complete is crucial. In the event that the court will require medical records for a case (e.g. negligence or malpractice), the court may subpoena the records. A **subpoena** refers to a court order requiring an individual to appear in court or for documentation to be submitted to the court. Medical records may be used by patients and healthcare professionals for court cases.

Since medical records provide objective and factual information regarding the patient's health status and treatment, it should only contain documented evidence related to the patient's care. Irrelevant information and opinions such as a healthcare professional's feelings about a patient (e.g. "the patient was unpleasant and irritating") should not be a part of the record.

A Patient's Medical History

Medical records allow physicians and other healthcare professionals to examine a patient's health over the course of their lifetime. Relevant information from past diagnoses and treatments can assist the current physician with evaluating his/her current patient so that he/she may create an appropriate treatment plan.

Medical records also serve to provide statistics and data on the current health trends of the population. Recall in Handout 2.3 when we discussed the physician's role in notifying the Health and Vital Statistics Department regarding births and deaths. Additionally, physicians and healthcare professionals must notify their state departments regarding any outbreaks of communicable diseases affecting the population. All of this information pertaining to the patient will be included in the record.

In a healthcare setting, the medical record is used as a form of communication among healthcare personnel involved in the patient's care. A physician may write orders for the administration of a drug or instructions regarding the aftercare of a procedure which will then be handled by the attending nurse. It is also important to notify the physician, nurse, or other healthcare professional when encountering unclear instructions in order to verify the procedures that he or she must perform. **Failing to do so can lead to a patient's harm or death**.

In the case of *Norton v. Argonaut Insurance Company* 144 So.2d 249 (1962), a miscommunication between the cardiologist Dr. John Stotler and the nurse Mrs. Florence Evans regarding the administration of Lanoxin led to the overdose and death of three month old Robyn Bernice Norton.

Two months after Robyn's birth, her pediatrician Dr. Charles Bombet consulted with Dr. Stotler and a heart surgery specialist Dr. Charles Beskin when he noticed loud heart murmurs upon examination. The three agreed that heart surgery was required to treat the child's congenital heart defect.

Upon Robyn's admittance to Baton Rouge General Hospital Dr. Stotler provided instructions on the physician's order sheet for "*Elixir Pediatric Lanoxin 2.5 cc (0.125 mg) q6h x 3 then once daily*" (2.5 cc of Pediatric Lanoxin Elixir to be administered every six hours for three doses then once daily).

When the nursing staff did not administer one of the doses in a timely manner, Dr. Stotler allowed Robyn's mother, Mrs. Anne Norton to administer the maintenance dose (2.5 cc) of the drug using a calibrated dropper after she had voiced her concern regarding the administration issue. Robyn was then discharged from the hospital.

A few weeks later, Dr. Bombet noticed that Robyn's condition was getting worse and had her admitted to the hospital. Dr. Bombet noted on the admission order that Mrs. Norton was administering the Pediatric Lanoxin Elixir. This was then placed into the hospital chart.

Before administering the drug, Nurse Evans checked with the nursing staff and consulted with the physicians who were familiar with the drug. Despite taking the necessary precautions and steps to verify whether Robyn was given the dose of the drug, Nurse Evans still failed to verify with the attending physician. In addition, she had

limited knowledge of the drug. She was not aware that Lanoxin was available in elixir form and thought that injection was the only route of administration.

Dr. Stotler testified that on the day of Robyn's death he failed to document that Robyn's mother administered or was going to administer the daily dose (one dose) of 3 c.cs. of the drug on the order sheet. Without his documentation of Robyn's mother being given authorization to administer the medication on that day, it would have been the obligation of the nursing staff to administer the medication on the order sheet.

To read the full case, please refer to Norton v. Argonaut Insurance Company under the reference section for this handout.

From this case, Dr. Stotler's omission on the order sheet in regards to providing permission to Mrs. Norton to administer the dose of Lanoxin resulted in Robyn's overdose. The head nurse, Nurse Evans, subsequently administered the Lanoxin dose as a result of this miscommunication.

From this major case we can see the importance of clarity and communication pertaining to a patient's medical records. If there is ambiguity with an order, the nurse or other healthcare professional should consult with the physician. Dr. Stotler and Nurse Evans should have discussed the proper route of administration (i.e. should it have been oral or parenteral [i.e. via injection]) and dosage of the Lanoxin before giving the injection.

Medical Record Information

As we had discussed earlier in this handout, the medical record contains factual evidence of an individual's medical history.

Personal information

Information that fall under this category includes the patient's name, address, date of birth, social security number, contact information, and insurance information. A patient may also fill out a medical history along with their personal information form so that the physician may examine any relevant health issues before meeting with the patient.

Accreditation requirements

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as well as Medicare has established a set of standards for medical records. Since medical records are considered legal documents in the United States, individual states have passed laws stating the requirements of what must be included in the medical record.

In general, the following information is required:

- Admitting diagnosis
- Any consent forms with the patient's signature for procedures and testing
- Examination notes by the attending physician with completed health history and physical examination (the requirements depend on the state, but generally they must be completed within 24-48 hours of a patient's admission or no more than a specified amount of time prior to the patient's arrival--for example, they cannot be filled out more than a week prior to the patient's admission)
- Consultations from physicians involved with the patient's care
- Adverse reactions from medications or any infections developed from the hospital/facility
- All documented reports and treatment performed by the healthcare staff in the facility; these include lab tests, clinical notes related to a patient's care (written by physicians, nurses, physical therapists, nutritionists, behavioral health staff, etc.), radiology reports, and medication history
- Documentation of the time and date of appointments (including missed appointments) related to the patient's care
- Discharge summary and follow-up/aftercare instructions

In addition to the information we discussed above, other information such as a patient's advance directives and correspondences related to the patient's care (recipients of the copies of the patient's medical record such as insurance companies or other facilities and professionals involved in the patient's care) are also included in the medical chart.

Charting Guidelines

Proper charting habits serve several purposes. One is to facilitate the care of the patient. This will allow the healthcare team to properly delegate roles and communicate with each professional involved in the patient's care. Additionally, it provides factual evidence which can be used in court cases in the event of a malpractice suit.

Poor charting methods can lead to errors and potential liability suits (as we had seen from the Norton case earlier in this handout). Incorrect or missing information may bring serious harm or death to a patient.

These are general guidelines when charting in the United States. Each individual state and medical facility will have their own specific rules and regulations pertaining to the documentation and maintenance of medical records.

Identification

The first thing to check is that the right patient's chart is where the note is being written. Verify the patient's identifying information such as name, date of birth, and ID number to make sure they match with the record.

Language and Content
Ensure that the note is written in clear and understandable language. If medical abbreviations and notations are used, they must be the standard acceptable abbreviations known by healthcare professionals.

Notes should be specific (i.e. detailing the patient's condition and progress or noting any issues the patient discussed about the procedure or a new medication). Using vague observations (e.g. the patient is okay) can cause a problem during reimbursement when insurance companies or government agencies will question whether the office visit was necessary.

For paper charts, ensure that the note is written legibly and in permanent dark ink (usually black or blue).

Whether the documentation is done electronically or by hand, healthcare professionals must ensure that the notes are detailed and accurate. "Detailed" does not necessarily mean writing a novel. Notes can be brief yet include all of the necessary information regarding the session with the patient.

Incomplete medical records can become an issue when healthcare providers involved in malpractice litigation cannot defend themselves as a result of the lack of evidence. Without documenting the procedures they performed, they cannot present their case to the court. (**We will discuss this more in a later section called "Medical Record Credibility"**)

Revisions and Corrections
For electronic charting, revisions will be noted by the system (i.e. putting a date/timestamp and specifying the name of the individual writing the note), but the record of the original chart's note will still be available for review (i.e. the original note will not be erased). In this case, refer to the record that you are making a correction (or addition) to and write the correction/addition.

For example, in the event that the patient is unsure about the specific dosage of the tablets when meeting with the physician, he can quickly verify with a family member or the pharmacist to look up the dose on the medicine bottle after the session. The nurse can then note the specific dosage later that day to be placed in the patient's record.

"Addition to 4:15 pm entry on November 10 regarding metformin dosage. Patient spoke with his wife and verified that he's taking two 500 mg generic Metformin tablets orally twice a day after meals (total daily dose of 2000 mg)."

or for a correction:

"*Correction to 10:17 am entry on March 25. Patient is taking 75 mg of amitriptyline. Incorrect entry specified 50 mg*."

For paper charts, healthcare staff should not erase any errors since it may look like the record was altered. If a mistake was made, they should cross out the error and write the correction. Next to the correction, they should include their initials and the time and date of the correction. They should then note that it was a correction of an error on the chart record.

Double check information and proofread the entry before submitting (if performed electronically). For paper charting, review the information for accuracy and sign and date the entry upon completion.

Timeliness

Notes should be written in a timely manner. **Timeliness of documentation** refers to the fact that all charting entries must be written upon completion of an event or as soon as possible after the event. If a professional is handling several patients or tasks, he or she must ensure that the notes are written as soon as he/she is able to. It is easier to recall the information regarding the session with the patient the sooner the note is written. It may also become a problem if the professional incorrectly recalls what had occurred and subsequently documents it as a fact.

Federal and state reimbursement guidelines provide a timeline in which entries are to be completed and submitted. When submitting clinical records to claims departments for reimbursement, providers and facilities must provide the information within the specified timeframe. Inaccurate records or records containing omissions may have payment delayed or rejected.

Communication

Any form of communication pertaining to the patient's care should be documented. These can include speaking with the insurance company regarding the approval or denial of a procedure, receipt of clinical notes from a facility or physician who cared for the patient, or verifying appointments with the patient. Instructions or education given to a family member or caretaker should also be documented.

In addition, communication among all professionals involved in the patient's treatment is crucial so that a patient can be given the highest standards of care. This may involve meetings with the staff and/or providing relevant and up-to-date information in the patient's record (which can be reviewed by the staff member). Referrals and consultations to specialists should be documented on the chart.

Signatures

Chart entries must be initialed or signed by the individual writing the record. In addition, the individual's credentials should follow their name.

If a record is dictated and then transcribed by an approved transcriptionist, the physician must validate the documentation and provide his/her signature noting that he/she has reviewed it.

(Please read "Medical charting errors can drive patient liability suits" under References)

Access and Security

Medical records are considered protected and confidential (contain sensitive information such as social security numbers and the patient's entire medical history). Therefore, healthcare staff should ensure the confidentiality of its contents. (**We will cover HIPAA and patient confidentiality in a separate chapter.**)

Charts or information on the computer monitor should not be left out where the public or unauthorized personnel can access it. For electronic medical records, healthcare staff should always log out after charting.

Patient information should not be discussed in public areas or shared with unauthorized individuals.

Paperwork no longer needed should be shredded or disposed of promptly. For electronic records, the supervisor of the Information Technology Department can assist with deleting electronic data from computers or discs. Note that different states have requirements regarding the time period to hold medical records before they can be discarded.

In the case of providers or facilities who may request the patient's information (e.g. patient goes for a second opinion or to a specialist), the staff member handling the records should verify the identification of the requester by asking for specific information pertaining to the patient (e.g. date of birth or last four digits of the social security number). The provider or facility requesting the record should be able to answer the questions. Patient information should only be released with their consent.

Falsification of Medical Records

Falsification of medical records can result in felony charges for all of the parties involved.

There are several issues pertaining to the falsification of records:

- False records can create problems related to reimbursement

- As we had discussed in previous handouts, there are healthcare providers and facilities who bill for services which they have not performed. They may note on the chart that the services were performed on the patient even though they weren't.
- This is a major issue for cases involving Medicaid or Medicare fraud

- Treatment and procedures related to a patient's care may seem incoherent. (We will discuss this more under "Medical Record Credibility" in the next section)
  - In medical institutions and facilities, there will be several healthcare professionals documenting information related to the patient's care. Inconsistencies and falsified information will be more obvious to catch. If one healthcare professional falsifies or omits information, there will be other professionals who will document defensively with consistent notes. If all of their notes match while the other healthcare professional's doesn't, it will be obvious that the information was made up or tried to be hidden.

  - Additionally, the patient's record should flow with each healthcare professional's subsequent note. If a physician notes that he/she ordered for the patient to attend physical therapy on a specific day and there were no notes from the physical therapist that he/she met with the patient, there may be questions as to what had happened to the patient on that day.

- If there are suspicions of falsified information, forensic experts will examine and analyze medical records to find evidence that they were altered or tampered with. If lawyers or legal experts want to review medical records, they must first request permission from the patient and those directly involved and authorized to speak on behalf of the patient's care.

  After the patient and his/her caretakers receive the copy of the medical record, a request can be made by the lawyers and legal experts for a certified copy of the records. The patient's copy and the certified copy will then be reviewed for omissions or changes.

If there are issues with missing information related to a case, the healthcare professional will have to explain it in court. It will give greater leverage to the plaintiff (e.g. the patient) during a malpractice case. We will read about it in *Thor v. Boska* in the next section.

(Please refer to Seven Reasons Why Falsification of Records Does Not Pose a Major Problem In Medical Malpractice Litigations under References)

Medical Record Credibility

Since medical records are legal documents, the court will verify that the information contained in the record are reliable and trustworthy. A **credibility gap** refers to an apparent disparity between what is said or written and the actual facts. The court may question whether the motive of the individual testifying is truly what he or she intended regarding their action or inaction. For example, the medical chart states that a confused patient injured herself by slipping on the bathroom floor. The lawyers will review the chart and read a note that a nurse's aide/assistant was monitoring and attending to the patient the entire time. The court may be skeptical about whether the patient was fully attended to at the time of the incident.

Under criminal law, **motive** refers to why one committed the crime, the inducement, reason or willful desire and purpose behind the commission of an offense (thelawdictionary.org).

Note that courts do not need proof of the motive of the crime (the "why" or reasoning behind the party's action) to determine whether the parties involved are guilty. The court just needs to prove that the parties involved **committed** the crime.

However, the prosecution team must prove intent. **Intent** refers to the defendant's state of mind in committing the act. For example, the physician gives the patient a placebo instead of the oxycodone tablet (so that he/she can acquire it personally). The physician then notes that the patient took the oxycodone tablet on the chart. The prosecution has to prove that the physician **intended** to administer the placebo in order to keep the oxycodone for him/herself.

If there are missing progress notes or lab tests, the lawyers may question whether it was done on purpose to conceal any improper actions. **Even when the findings are normal, they should be noted in the medical record.** If a test or procedure was performed and the results came back normal, failing to document it can create issues later. The court may question whether or not the procedure was actually performed in the first place. Only noting abnormal findings is not enough. Regardless of any testimony given by the physician or healthcare professional involved in the procedure, the court may assume that it was not done due to the lack of evidence. This is why it is important to document both abnormal and normal findings.

Additionally, if entries are written after a lawsuit is initiated, it may raise suspicions as to why the entries were not included in the original chart.

In the case of *Thor v Boska*, 38, Cal. App. 3d 558, 113 Cal Rptr. 296 (1974), Dr. David Boska was taken to court for malpractice by the plaintiff Jean Thor when he failed to perform tests and diagnose a lump on her left breast (which was later on revealed to be breast cancer). Dr. Boska was unable to submit the original clinical notes pertaining to Jean Thor's treatment and assumed that they were destroyed after being recopied into a more legible format.

The California Appellate Court concluded that his inability to present the original clinical notes "created a strong inference of consciousness of guilt".

Initially the court found in favor of Dr. Boska as a result of an issue regarding the interpretation of the defendant admitting negligence. The original judgment was then reversed by the appeals court.

Although this case is a bit more complex, the main point to focus on is that Dr. Boska could not provide the evidence (Jean Thor's clinical information) that he treated her. Whether or not he may have been at fault cannot be verified without this information. As a result of this lack of information, he lost his case.

(To read the full case, please refer to Thor v. Boska under the reference section for this handout.)

Even if a healthcare professional is not at fault, careless charting practices can result in legal consequences such as punitive damages or inability to defend his/her actions in court.

References

Norton v. Argonaut Insurance Company (from Leagle)

Medical Charting Errors Can Drive Patient Liability Suits (please see the main site on LCDK Mathsci)

Seven Reasons Why Falsification of Medical Records Does Not Pose a Major Problem in Medical Malpractice Litigations by John J. Ratkowitz, Esq.

Thor v. Boska (from Leagle)