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ND Insights℠

Compelling scenarios and risk management tips for the naturopathic profession

Why Healthcare Records Should Never Be "Doctored"

By Carol Romano, Esq.

You are served with legal documents stating that a former patient is suing you for malpractice, or perhaps you receive a letter from the patient's attorney, advising you that a claim is being made against you (and instructing you to put your carrier on notice).

The allegation may be that a botanical you prescribed caused acute liver injury. Or the allegation might be that a nutritional regimen you recommended failed to prevent a stroke. There may be assertions that you did not obtain the patient's informed consent.

You have never been sued before; it is startling or perhaps even frightening. The first thing you naturally do is to pull the patient's chart, either a hard copy or on your computer. You realize that your documentation is inadequate. It appears only fair in your mind that you add things you recall about the patient, or something that you always do as a matter of course, but you simply did not include it in the chart.

There are situations when adding or deleting information to a chart is legitimate. However, no matter how innocent your intention, any change, if not done properly, can be seen as a self-serving attempt to cover a misdeed.

Say, a week after a visit, you're reviewing your records and remember a detail you left out. Never backdate an entry. Date your annotation truthfully, and specify that you're adding it after the fact (a "late entry"). If possible, write why you needed to add new information.

One inviolate rule: Never alter records in any way after they've been subpoenaed. That situation is every plaintiff's lawyer's dream and every defense lawyer's nightmare.

How Are Alterations Detected?

Handwritten alterations are extremely easy for a forensic document examiner to detect. Experts can point out variations in handwriting, chemical content of inks, types of pens or types of forms. The example that follows shows how obvious detection can be. To the naked eye, the first blood pressure reading appears to be 120/80. However, infrared luminescence provided proof that a different writing instrument was used to change the entry, which was originally 170/90.

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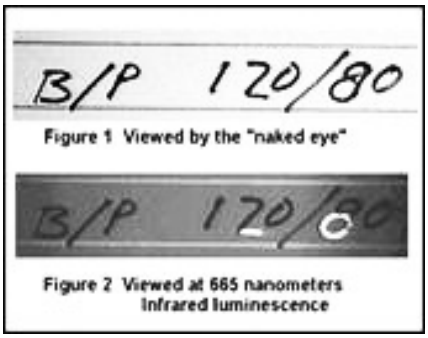
The black ink of the altering pen glows white, showing where the original entry was changed.



In addition, document examiners can do a handwriting examination to determine if the sequence of the documents was altered or to determine who wrote the entry. These experts can determine if any pages were inserted or removed, and by examining folds, creases, and staple or punch holes, they can determine the handling and history of the document.

What About Electronic Records?

Alterations to electronic records are a bit more difficult to detect because the doctor's server or hard drive must be examined by a forensic computer analyst. They can determine the procedures for making entries into the computer, when the entries were made, whether an entry was made during the office visit, after the office visit, days later or at some other point in time. In fact, a forensic computer analyst with specific computer operating systems and software/coding systems can determine whether there had been changes made. This would include reformatting and deletions from any record or records entered into that computer with respect to a given patient. However, this can be quite expensive for some plaintiffs. There are, however, more common ways in which alterations in both handwritten and electronic records are "caught."

Often, copies of records are supplied to other providers in the ordinary course of treatment, long before a problem or an attorney appears on the scene. The plaintiff's attorney does not assume that the records supplied by you in discovery are identical to the ones supplied to others before a problem manifested itself. Records from all providers for the patient will be obtained, and different charting may be found. Attorneys compare records written by physicians when they are found in more than one set of records.

More often, however, a set of records is obtained by the plaintiff prior to litigation, sometimes without you knowing it (e.g., if you have staff who provide patients with their records without telling you every time) or without you giving it a second thought. If you alter the records after a suit is filed or a claim is made, the records you provide during litigation will be different from those previously obtained. The plaintiff's attorney will look for new entries added to later copies of the records, pages that are missing from the first set of records or additional pages that were in the first set of records.

The Penalty for Altering Records

Improperly changing clinical documents can invite a world of trouble, in addition to jeopardizing a malpractice defense. In some states, you could face criminal charges for fraud and perjury, or you could lose your license. Authorities/state boards may consider an alteration serious professional misconduct.

While it is wise to heed the foregoing precautionary advice, if you are an NCMIC insured, you will have an experienced defense team to fight for you in the event of a claim. They will guide you through the process and protect your interests in all respects.

Carol Romano, Esq., is a partner at Gust Rosenfeld Law in Phoenix, Arizona. She has 30 years of experience defending chiropractors and other healthcare providers in complex malpractice and wrongful death cases, and has achieved numerous defense verdicts in cases with multimillion dollar exposure.

Any change to the record, particularly deletions or the removal of documents, is called spoliation. Plaintiffs' attorneys know that evidence of spoliation of records in healthcare negligence actions can strengthen their clients' cases. They apply the mantra "assume nothing," and believe that record tampering is far too common to think that it does not happen in a malpractice case.

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