Introduction:

The medical record is central to the defense of many, if not most, medical malpractice cases. At its best, the medical record is comprehensible, complete and up to date. It prominently displays the patient’s allergies; it contains a comparatively recent history and physical; it records age- and gender-appropriate cancer screening; and it includes both a problem list and a medication list. Too often, however, the medical record also includes more than the objective data needed to successfully defend a malpractice case. It may also contain entries that are detrimental to or destructive of a case. This article looks at the ways in which tampering with a medical record can cast a negative reflection upon physicians, their medical care, their professional practice, and, ultimately, the defense of their malpractice case.

Learning Objectives:

At the end of this course participants will be able to:
1. Describe at least four prohibitions involving medical records
2. Follow risk management guidelines when documenting
3. Differentiate between tampering with and amending a record

Accreditation: Coverys designates this enduring material for a maximum of 1 AMA PRA Category 1 Credit(s). Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This activity meets the criteria of the Massachusetts Board of Registration Medicine for risk management study.

Coverys is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Medium and Method of Participation: For successful completion of this online activity, physicians will read the provided article and complete an online assessment with a score of 80% or higher for a maximum of 1 AMA PRA Category 1 Credit(s). The assessment that accompanies this newsletter is available for a fee online at www.coveryseducation.com. Physicians who do not have Internet access may call 800.225.6168 ext. 5322 for assistance.

Author: Chad P. Brouillard, Esq., & Linda Greenwald, RN

Advisor: Geri Amori, PhD, ARM, CPHRM, DFASHRM

Faculty Disclosure Statement: The course advisor, authors and planning committee members have no relevant financial relationships to disclose.

Target Audience: Physicians, all specialties

Estimated Completion Time: The estimated time to complete this activity is one hour.

Date of Release & Term of Approval: This activity was released on June 10, 2014, is reviewed annually and will expire on January 1, 2017.
One problem stands above all others in its ability to negatively impact the course of a malpractice case: tampering with the medical record. A case that is considered defensible on the basis of the medical care provided may be rendered indefensible by a record that has been changed after the fact.

The case studies included in this article reflect medical malpractice cases with risk management implications. Names have been omitted and some details have been changed for confidentiality purposes.

INTRODUCTION

The medical record is central to the defense of many, if not most, medical malpractice cases. At its best, the medical record is comprehensible, complete and up to date. It prominently displays the patient’s allergies; it contains a comparatively recent history and physical; it records age- and gender-appropriate cancer screening; and it includes both a problem list and a medication list. It also:

- Describes and systematically documents all of the clinical care the physician provided
- Outlines the decision-making processes that led to the choice of one treatment course rather than another
- Shows that the physician offered—and the patient signed—an informed consent form for all invasive procedures, the administration of psychotropic medications, and the administration of blood and blood products
- Reflects comprehensive and consistent follow-up, both clinical and administrative
- Documents telephone conversations and electronic communications with the patient both during and after office hours

Too often, however, the medical record also includes more than the objective data needed to successfully defend a malpractice case. It may also contain entries that are detrimental to or destructive of a case. Examples include subjective epithets or personal opinions that have no bearing on the patient’s medical care; statements of explanation that assume the role of personal incident reports or other attempts at face-saving; and the blaming or demeaning of another practitioner’s care.

One problem stands above all others in its ability to negatively impact the course of a malpractice case: tampering with the medical record. A case that is considered defensible on the basis of the medical care provided may be rendered indefensible by a record that has been changed after the fact. Whether the amendment is a valid correction of erroneously entered information, the obliteration of documentation entered in the wrong record, the addition of new information, an embellishment of already recorded facts, or changing objective data to reflect “facts” that never existed, the effect is the same. “Once the accuracy of the record is challenged, the integrity of the entire record becomes suspect.”

Many of these cases are settled only because of the specter of impropriety or a cover-up.

This article looks at the ways in which tampering with a medical record can cast a negative reflection upon physicians, their medical care, their professional practice, and, ultimately, the defense of their malpractice case.

TAMPERING WITH AN ELECTRONIC RECORD

Allegations that practitioners tampered with documentation in electronic medical records (EMRs) are becoming increasingly more common as part of underlying medical malpractice cases. Plaintiff’s attorneys and their experts are writing books and holding seminars with pointers for
detecting medical record alterations. One of the reasons that EMR tampering is such a hot topic is that, to someone who is not technically savvy, tampering with an electronic record may appear easier than changing a paper document. After all, when you delete a sentence from an EMR, it disappears from the screen and is thought to be gone forever. In reality, simply hitting the delete key does not mean that data cannot be retrieved or reconstructed. Just as there are experts who analyze paper records, there are experts who specialize in computer forensics and EMRs. These computer forensic and EMR experts are able to objectively demonstrate that the record has been altered, often by analyzing the system’s audit trails.

Claims of EMR tampering also grow out of a plaintiff attorney’s own unfamiliarity with electronic record functionality. For instance, an EMR can have dynamic lists, such as problem lists, which continuously change as time progresses. Thus to an uninformed attorney, it may appear as if someone changed the problem list. Additionally, the system may have been upgraded and the format of the documentation simply looks different. Because the technology is so new, plaintiff attorneys have a fair amount of suspicion about alterations in EMRs. Allegations of record tampering may be unfounded and can often be explained by qualified clinicians or experts.

Another reason allegations of EMR tampering are becoming more common is the advent of formal eDiscovery rules which impose harsh sanctions if a party can demonstrate that the evidence has been spoliated. In the legal context, “spoliation” can be either the intentional or, in some cases, the inadvertent but careless destruction or modification of potentially relevant evidence. The consequences for such tampering can range from financial penalties to legal penalties. Penalties may include a judicial finding on negligence or allowing the jury to know that the defendant engaged in a cover up. Tampering with records can also be considered a criminal violation in some jurisdictions. From a practical point of view, evidence of spoliation is disastrous to the defense of the case.

Example: In one notable federal case, an LPN failed to properly administer a reduced dose of anticoagulation therapy. After the patient suffered an adverse outcome, the LPN went back and changed her notations to indicate she had administered the proper dosage and that she had transcribed the physician’s order correctly. In a later legal proceeding, a federal prosecutor learned of this and proceeded against the nurse with criminal charges of falsification of medical records for a federal benefit program under HIPAA.

Even if the later modification of a medical record is not deemed to be spoliation, it may still be used as evidence of an admission of negligence (why would one engage in a cover up if he/she provided good care?) and may provide grounds for a separate tort action.

THE AUDIT TRAIL

Most EMR systems are designed so that they in fact track and record all changes and deletions made to the medical record. One fundamental tool designed for this purpose is built into EMRs — the system’s audit trail. The audit trail is designed to track users and usually also keeps track of note creations, deletions and changes made by identified users. The audit trail is increasingly taking center stage in medical malpractice discovery. It can serve as the provenance of the record, ensuring its authenticity and integrity so that it may be relied upon during legal proceedings. In the case of a tampered medical record, an audit trail is often the key piece of evidence. EMR specialists, and very often the attorneys, will be able to discern almost immediately who logged on to the EMR, viewed portions of the chart, and made changes to the record. As a result, many medical malpractice attorneys requesting the audit trail as a matter of course for the record sets which are at issue in the litigation. Many more will request the audit trail if they have any suggestion that the EMRs were changed in any manner.

Example: A patient dies at a teaching hospital following respiratory depression leading to hypoxia and neurologic injury. Three days after the event, the attending emergency room doctor instructs a fellow in his program to add a “Difficult Airway” tag to the patient’s record, thus altering the record. Reviewing the audit trail, the plaintiff attorney detects the subtle change and brings it to the judge’s attention. The judge in the case then orders the fellow to be deposed by the plaintiff attorney to explore the issue of medical records tampering. The defense claimed the fellow’s coding in the medical record was for peer review purposes, but the case, which was thought to be otherwise defensible, was settled for an undisclosed amount.

Finally, plaintiff attorneys are also routinely making the argument that if you access and modify a patient’s record after the fact, you are violating the patient’s HIPAA rights. If you have stopped treating the patient, there...
may be no valid legal ground for you
to access that patient’s chart, outside
of passively reviewing it for purposes
of preparing your defense. If plaintiff
attorneys request an audit trial, they
can easily detect if the record was
accessed after treatment of the
patient was stopped.

WHEN IS IT TAMPERING?

Many risk managers have long
advised physicians to never change a
medical record after the fact. That may
be sound advice for most situations.
The reality, however, is that there are
rare circumstances in which leaving
erroneous information in the record is
dangerous to the patient. This may be
particularly true in electronic
documentation environments in which
incorrect data may be carried forward,
exchanged, cloned and/or otherwise
propagated throughout the record.
The danger is that subsequent
clinicians may then rely on the
erroneous information that has been
disseminated throughout the EMR.

From time to time, there may be a
legitimate need to amend a record. In
those instances, physicians need to
be careful not to make their
amendment appear to be an attempt
at a cover-up. This is a serious
situation which requires the attention
of the risk manager and may require
technical input, as most EMR systems
employ safeguards which prevent or
detect any modification of records.

First, if the EMR system allows,
clinicians should use an amendment
or addendum as opposed to deleting
existing information. In systems that
permit amendments or addendums to
old notes, typically the new material is
clearly marked as such and contains
the date of the amendment on its
face, making it clear when and why
the clinician is adding the updated
information to an old note. Amendments and addendums also do
not change the old content, so there
can be no claim of tampering with
previously existing records.

Some systems contain features which
allow errors to be stricken or otherwise
noted. Such functionality is ideal, as it
adequately resolves the issue of
need to remove erroneous material
without removing the evidence of the
erroneous material for legal purposes.

If a note contains an error which is too
risky to keep in the EMR at all, clinicians
must rely on their technical experts
and vendors to advise them how to
safely purge such data. In such
circumstances, the physician should
consider obtaining advice from both
the risk manager and legal counsel. If
a deletion must be made, and there is
no other adequate alternative, it is
best practice to add an amendment or
note into the medical record explaining
what has been removed, on what
date, and why. A copy of what was
deleted from the record should be
preserved for legal purposes. Thus, if
a question ever arises in a legal
proceeding, a transparent and clear
answer as to what was removed and
why will be available.

There is no general advice on how to
safely amend an EMR in this current
environment, as there are a myriad of
electronic documentation systems on
the market that handle this in different
ways. It is important to assume that
someone will be able to detect an
alteration to a record was tampering
and you may be placed in the position
of needing to prove otherwise.
Alterations made for clinical purposes
need to be well-documented.

LOCKING NOTES

Many software systems reduce the
risk of record tampering by locking
notes after a certain date or after the
documents are electronically signed.
In such systems, it becomes imperative
to lock or sign the notes in a timely
fashion. Forgetting to electronically
sign or lock in notes may prove to be
a costly oversight. Failure to do so
might draw criticism if documentation
takes place well after it is known that
an adverse event occurred.

Example: A primary care provider is
following a patient for routine care. He
is swamped with work and well behind
on his documentation. One notable
area included finalizing and locking his
notes. One of his patients dies one
week after a routine primary care visit.
He does not finalize the note for the
last encounter until four months later,
after receiving notice of the patient’s
death. He is then sued for medical
malpractice/wrongful death for failing
to diagnose the plaintiff’s condition.
The plaintiff’s attorney reviewed the
documentation, which plainly indicates
that it was locked only after the patient’s
death. The plaintiff then alleges the
documentation for the last visit is a
fraud and written only after the physician
knew he was going to be sued. This
final note now becomes the focus of
the litigation.

Not only is this type of oversight
dangerous, but it may undermine the
ability to use the note as evidence.
Notations in medical records are
typically allowed into evidence
because of their inherent
trustworthiness as contemporaneous
professional notations for the purpose of patient care. If notes are not locked in for months or years, it may be difficult to establish that the notes are trustworthy, as opposed to being motivated by litigation.

CORRECTING TYPOS

If months or years pass after an EMR entry is made and then a clinician logs in to change the entry a month after being sued, there is likely to be a very big problem. Such a case may be indefensible, regardless of why the clinician went back in to change the record. When some clinicians learn of the potential for a lawsuit, they have an impulse to make sure the notes read perfectly. Even if the changes they make are benign, such as correcting typos, these clinicians open the door to the argument that litigation-motivated changes were made.

Example: A clinician is sued for medical malpractice. She immediately logs into the EMR to check her notes regarding the care she provided. She notes several typos made by her dictation service. The typos are irrelevant to the case against her. She corrects the typos. Noting differences in the medical records that are produced, the plaintiff attorney requests an audit trail which confirms that the notes were changed after the clinician was served with the lawsuit. Proving that the changes made were harmless will be an uphill battle.

Record tampering is rarely, if ever, the principal allegation in a case. In most instances, the tampering is not even detected until the discovery phase of a case is well underway. In a few cases, however, the tampering becomes apparent early on and becomes a central focus of the plaintiff’s case.

Claim 1. When a compression spot film revealed a highly suspicious area in the upper inner aspect of the 42-year-old patient’s right breast, the radiologist recommended needle localization and removal. The surgeon to whom the patient was referred reported that the patient was reluctant to undergo needle localization. A biopsy without localization was performed on the upper outer quadrant of the right breast. The pathology report indicated no malignancy. Several months later, the patient complained to her primary care physician of a firm mass in the right upper mid breast, medial to the scar from the breast biopsy. A subsequent biopsy revealed infiltrating ductal carcinoma of the breast. Upon further work-up, the patient was found to have metastases to the liver.

The patient and her family sued the surgeon, alleging a failure to diagnose cancer. The main focus of the suit was the fact that the defendant surgeon had biopsied the wrong area of the breast. The formal allegations also included repeated mention of the fact that the physician had amended the record in an attempt to conceal the error. Where the original record had noted “thickened area R U I,” the amended record changed the “I” to “Br.” It was alleged that such tampering:

- “constitutes a gross violation of [the defendant’s] privileges to practice medicine in [this state],”
- “constitutes a violation of the fundamental standards of ethics and decency in the medical profession,” and
- “represents extreme and outrageous conduct.”

This claim may not have been defensible, even without the record tampering. However, with the defense agreeing that “the alteration of records is the most inflammatory part of this case,” the claim was settled with a payment of almost $1 million.

Fear is one of the primary inducements for record tampering, with the fear of a malpractice lawsuit perhaps the predominant motivator. As the case above indicates, it is folly to tamper with a record. The act of tampering is likely to either cause a suit to be filed, as is hinted at in Claim

COPYRIGHTED
1, or cause a case to be lost, as shown in Claim 2.

**Claim 2.** A one-year-old girl was brought to the pediatrician’s office with what the mother described as “fussiness,” one episode of vomiting, and an axillary temperature of 101°F. Physical examination revealed a normal chest, heart and abdomen and a supple neck. Rectal temperature was 103.6°F. The pediatrician documented two to three “small pink slightly elevated bite-like spots” on the child’s chest. They were considered non-specific and attributed to the fever. A urinalysis and throat culture were ordered and the child was sent home with Tylenol and instructions to the mother to call if the child became worse.

That night, the mother called the on-call pediatrician and was instructed to take her daughter to the emergency department, where a purpuric rash led physicians to believe the child was suffering from meningococcemia. The child was treated and then transferred to a tertiary center, where she ultimately developed extensive disseminated intravascular coagulation and gangrene of the fingers and toes. The child survived her illness, but underwent below-the-knee amputations of both legs and the amputation of nine fingers. She also suffers from cortical blindness.

The defense experts who reviewed this case were all totally supportive of the medical care provided by the pediatrician and the case went to trial. During trial, however, a question was raised about whether the pediatrician had added the word “pink” to the description of the child’s rash after the fact. With the question raised but unanswered, the jury deadlocked and a mistrial was declared.

The defense attorney opined, “The jury changed their position at the end, probably due to the issue of changed records.”

In this particular case, the practice used a combination of electronic and paper records — called a “hybrid record.” The pediatricians were still using paper forms to document exams during the practice’s transition to a complete EMR. Before a new trial could be scheduled, a handwriting expert and a forensic chemist examined the paper medical record and determined that, indeed, “pink” was a late addition to the record, as were two other entries.

With the credibility of the defendant physician in question, this claim was settled for $1 million.

Meningitis is notorious in its ability to present as an apparently benign condition and then, within only hours, to completely ravage an individual, often a child. The physician in this case had conducted a thorough physical examination of the child, including checking for signs of meningitis. The late addition of the word “pink,” which clearly differentiated the spots on the child’s body from the purplish red of petichiae, may have been written in a fearful attempt to ensure freedom from responsibility for a misdiagnosis. Instead, it became an accusation.

Fear is not the motivating factor behind all record tampering. Anger is another reason that medical records are occasionally changed. On more than one labor and delivery record, the Apgar scores given by a nurse have been crossed out and higher scores assigned by an obstetrician.

Some tampering occurs because practitioners want to save face. Laboratory data may indicate a problem that might—or perhaps should—have been picked up on physical examination.

Some tampering occurs because physicians do not know the correct way to make needed changes. A supervising physician, for example, might change the history and physical recorded by a resident in a well-meaning attempt to clarify facts or include information known or learned by the attending.

Tampering is invariably suspected when all or part of a questionable
Some tampering occurs because physicians do not know the correct way to make needed changes. A supervising physician, for example, might change the history and physical recorded by a resident in a well-meaning attempt to clarify facts or include information known or learned by the attending.

OTHER PROHIBITIONS
Tampering with a record is perhaps the most serious, but certainly not the only prohibition involving the medical record. Others include:

Self-justification
- A physician wrote a lengthy note in the medical record justifying all the steps he took during what he called a “completely disorganized code” because the patient did not survive.

The blame game
- The second orthopedist to treat a patient who suffered disabling cervical and lumbar pain following a motor vehicle accident wrote in the record that the injury was attributable to a discogram performed by the orthopedist who first treated the patient.
- A neonatologist documented that an infant’s injuries were due to “trauma secondary to forceps.” Forceps had not been used in the birth.

Frustration
- Following a telephone call to the physician, a PACU nurse became enraged that the concerns she expressed about a patient’s pain were dismissed by the physician. She documented in the record that the physician said, “I’m not going to do anything, I’m not going to change the medication, and I do not want you to call me again.” This is finger pointing, not problem solving. It does not belong in the medical record.

Disagreement with another practitioner
- Two physicians alternated providing care to a hospitalized patient. Every other day for more than a week, the physician on duty cancelled the medication ordered by the other physician and re-ordered his own medication of choice.

RISK MANAGEMENT GUIDELINES
Medical record tampering can be devastating to the defense of a lawsuit and has even lead to criminal charges. Even when your motivations are benign, it is best not to change imperfections in the record after the fact. In those rare cases in which the presence of erroneous information is truly a patient safety issue, work with your administrators, technical support people, risk manager and legal counsel to determine the safe and proper way to correct the record.

The following are additional risk management suggestions to help ensure your medical record documentation will serve you well.

1. **Use the medical record for its intended purpose only**, namely, to objectively document the patient’s healthcare information.

2. **Do not use the medical record to justify anything you did or did not do.** Attempts at self-justification often appear to be acknowledgements of wrong-doing and may work against you.
In those rare cases in which the presence of erroneous information is truly a patient safety issue, work with your administrators, technical support people, risk manager and legal counsel to determine the safe and proper way to correct the record.

3. **Do not make accusations or advance opinions that implicate another.** Subjective opinions can and often are proven incorrect when objective data become available. To malign another in medical record documentation does not serve the purpose of the medical record, may open the accuser to charges of libel, and may unnecessarily involve both parties in a malpractice suit.

4. **Do not blame another practitioner or department.** Casting blame on another, either directly by impugning another practitioner or indirectly by assigning diagnoses that fall within the purview of another specialty, may serve little more than to involve you in the very malpractice suit you were trying to avoid.

5. **Do not vent emotions in the medical record.** Anger, frustration, sadness and other emotions should be addressed some place other than the medical record.

6. **Do not engage in a personal or professional battle with another practitioner in the medical record.** It will likely be the patient who suffers. Disagreements with another practitioner need to be settled with that person directly. They should not be reflected in the medical record.

**SUMMARY**

It has often been said that the medical record serves as a witness in medical malpractice claims. Ensure your records will be a good witness for you should you need them, resist the urge to tamper with records. Use caution and appropriate guidance when making additions or corrections to the record. Finally ensure all of your record entries are objective, professional and patient related.

**REFERENCES**


3. Janet Sweet, individually and as Administratrix of Samuel Sweet, v. UPMC Presbyterian Hospital, et al., Court of Common Pleas Alleghany County, Pennsylvania, No. 09-019407.