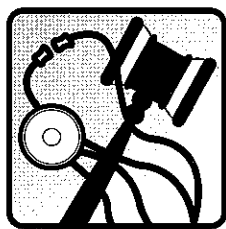


CAPSULES

A Risk Management Publication from Cooperative of American Physicians, Inc.

FIXING THE RECORD AFTER THE FACT: DON'T EVEN BE TEMPTED!

by Catherine Miller, RN, JD
CAP-MPT Risk Management



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Alteration of the Medical Record is Always a Bad Idea!

A reference to "medical record alteration" conjures up images of obfuscation or deliberate falsehood, such as rewritten medical records or fabricated accounts of care. In truth, however, *alteration need not involve a physician's intent to deceive*. Actually, physician intent plays no part in determining if a record has been "altered." Many well-meaning physicians learn the hard way that the simple act of making an inappropriate modification to the medical record may be enough to raise suspicions of alteration. These actions may jeopardize one's credibility and thereby imperil both legal defenses and professional liability coverage.

How It Happens

As evidence at trial, the written record plays a critical role in answering questions relating to the standard of care. Often, the physician-defendant is legitimately concerned about both the quality and accuracy of medical record documentation. In reviewing the record, the physician probably will discover at least *some* element of care that could have been better documented. He might find that: (a) documentation is misleading or unclear, (b) important information

was left out, or (c) a particular entry would benefit from elaboration. Whatever the case, the physician may be tempted to "set the record straight" by changing the original entry. In the words of a physician whose MPT coverage was in peril for yielding to this temptation: "*I only wrote what I wish I'd written the first time.*"

It Will Destroy Your Credibility and Your Defense

Although wanting to set the record straight is readily understandable, altering the medical record is *a sure way to lose credibility* in front of jurors or arbitrators. At trial, the patient's attorney will take every opportunity to discredit the physician. Pointing to an alteration of the record could persuade jurors and arbitrators that the physician is "untrustworthy" and "dishonest."

Once the physician's credibility is irreparably harmed by proof of alteration, little else will be believed. With one's defense so severely compromised, the physician and his attorney will be faced with choosing

between two undesirable options: settling the case or taking the risk of losing at trial.

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It Will Be Discovered

Often, a physician will be tempted to augment the medical record after receiving first notice of a lawsuit. But, that same physician may not realize that the patient's

**MEDICAL LICENSE
FEES BOOSTED: TIME
TO UP YOUR LEVEL
OF PROTECTION?**

by Dan Groszkruger, Esq.
CAPsules Consulting Editor



On January 1, 2006, physicians will be paying substantially higher license fees to the Medical Board of California (MBC). Under a 2005 state law, both initial and biennial renewal medical license fees for practicing physicians will increase from **\$600 to \$790**. This **31.67% increase** will allow the MBC to hire more investigators and prosecutors to go after bad doctors.

Senate Bill 231, sponsored by Senator Liz Figueroa (D-Fremont, CA) authorizes 28 separate changes, all to take effect on January 1st. The increase in the licensing fee is probably the most important. It will increase the MBC's budget by \$10 million, annually. The bill deletes a provision that required the MBC to fix license fees, applying a formula, at a sum not to exceed \$610. The legislature passed this bill largely in response to criticism directed at the perceived inefficiency of the MBC's disciplinary program.

Senator Figueroa, the author of the bill, characterized the MBC, before these new reforms, as ". . . more of a lap dog than a watchdog." According to Figueroa, "This bill will save lives for generations to come. . . . Patients have been waiting for a board that was fully funded, fair and tough."

The additional money will allow the MBC to more aggressively prosecute bad doctors, and to do so quicker. Prior to the advent of SB 231, the MBC depended upon physician license fees to fund its entire \$41 million annual budget. "We couldn't do much but keep our head above water," according to David Thornton, Executive Director of the MBC. There had been no increase in the amount of physician license fees in 12 years, while the number of licensed physicians has grown to about 127,000.

Unfortunately, some very good doctors get swept up in the MBC's efforts to rid the profession of "bad doctors." The MBC's increased budget (i.e., more investigations and more accusations of unprofessional conduct) seems to make the risk of becoming a target just that much higher.

As a benefit of membership, every CAP-MPT member-physician already enjoys protection under the *MEDefense* coverage. This program offers coverage up to \$25,000, to pay defense costs if a member is targeted for discipline by the MBC. However, the complexity and legal issues inherent in MBC actions against your license (similar to alleged Medicare or MediCal fraud and abuse, violation of the EMTALA anti-dumping law), continue to escalate. The cost to defend yourself could exceed current limits.

Additional *MEDefense* coverage, such as higher limits of \$40,000, \$55,000 or \$110,000, is available at a very reasonable additional cost. **Contact Matt Shaklee at *Medical Risk Management Insurance (MRMi) Services*, telephone (877) 898-6764, FAX (888) 745-6764, or e-mail: mshaklee@cap-mpt.com, for additional information or to obtain a quote.**

**CALLING THE
PATIENT WITH LAB
RESULTS: A SECOND
CHANCE TO REFLECT**

by Gordon Ownby



A physician's personal telephone call to the patient, to convey the results of a laboratory test, is one way to cement the physician-patient relationship. Not only is this a key step in involving the patient in managing his own health. But, merely thinking about and making the call helps the physician to focus on the importance of the test, itself.

After a six-year hiatus, a 61-year-old gentleman visited Dr. GP complaining of nausea after meals, as well as cramping and diarrhea. Dr. GP took a history of urinary frequency and nocturia, and learned that the patient's father had died at age 85 of stomach cancer. Dr. GP ordered labs, advised a complete physical, and referred the patient to a gastroenterologist for his GI complaints.

Three months later, blood work showed a glucose level of 399, (normal 70-110) with 4+ glucose and 1+ ketones in the urine (both abnormal). Although it was Dr. GP's office protocol to personally call patients with lab results, **there was no record that Dr. GP made such a call**, in this case.

Four months later, the patient returned for complete physical exam, following a sigmoidoscopy that was normal. Dr. GP's impression at the time was hyperglycemia. He planned to have the patient do another fasting blood sugar and hemoglobin A1C test. Dr. GP gave the patient lab requisition slips, told him to watch his diet and to avoid sugar, and asked him to keep in touch.

Six months later, the patient fell, striking his head. An orthopedic surgeon ordered x-rays. When the patient returned to see Dr. GP, the patient was scheduled to see an ophthalmologist (who found some frontal nerve damage). Dr. GP's records failed to note that **the patient still had not undergone the lab tests recommended six months earlier**. Next, Dr. GP examined the patient prior to prostate surgery. Again, the records made no mention of current labs showing abnormal glucose level (386) and abnormal glucose and ketones in the urine.

Three months later, Dr. GP performed another work-up. This time, lab results showed the patient's glucose at 451 and the AC1 at 11.5 (normal 4.6-6.5). Dr. GP's attempt to reach the patient by phone was unsuccessful because he was out of town. When the patient called back, one of Dr. GP's partner's prescribed insulin and Glucovance over the phone. At his last visit to Dr. GP's office, the patient saw another partner, and reported blurry vision for the past several months. As it turned out, the patient had developed diabetic retinopathy, as well as bilateral lower extremity diabetic neuropathy. He filed a claim against Dr. GP for failure to diagnose and treat diabetes, that was resolved prior to an arbitration hearing.

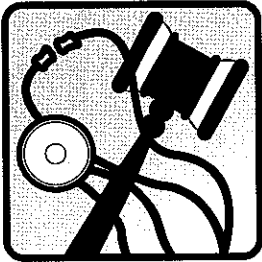
A personal call by Dr. GP to the patient after the initial labs would have given the patient the benefit of the physician's thinking on the results, even if those tests did not yet confirm diabetes. But one can also wonder if making the call could also have benefited the physician: Might the mere acts of sitting down to consider the report, translating its meaning into layman's English, and preparing for the patient's questions, have prompted the physician to adopt a more aggressive plan?

CASE-OF-THE-MONTH
is a regular feature of
CAPSULES, the
Bulletin, and the
Members Only section
of the
CAP-MPT website
www.cap-mpt.com

Comments on
Case of the Month
may be sent to
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attorney subpoenaed a complete copy of the medical record, months earlier. Any discrepancy between the original and the copy will, by itself, establish that the record was altered. If suspicion warrants further investigation, the alteration may be discovered through the sophisticated methods utilized by document examiners. In addition to handwriting analysis, these professionals are able to analyze ink to determine: (a) the timing of an entry, (b) whether the same writing instrument was used, and (c) if pages were removed from the medical record.

It is Excluded from Coverage Under the CAP-MPT Trust Agreement

Importantly, all members need to understand that, under the MPT trust agreement, *alteration need not be committed with the intent to defraud*. Any inappropriate modification of the medical record may be enough to bring coverage into question.

The Do's and Don'ts of Modifying the Medical Record For Physicians and Staff

With coverage and credibility at stake, it is important that *all individuals in your practice who enter information in the medical record* understand the correct way of modifying the medical record. The following examples are offered to clarify these situations. We encourage you to share this information with staff and include it in the orientation of any new staff member.

• If I Make an Error While Charting, How Do I Correct the Information?

The correct way to modify an entry is to draw a single line through the original incorrect entry **while leaving it legible**. Write "error" above the original entry and initial it. Using white out or crossing out information is inappropriate and suggests that the original information was in some way damaging and needed to be "covered-up."

• If I Forget to Chart Information, or am Delayed in Charting, How do I Add Information Later?

Late entries must include the date on which the late entry is actually written and should be labeled as "**Late Entry**." If the late entry is an addition to a previous note, then it should specifically reference the note by date: "**addendum to note from 10/11/05**."

• What If I Forget to Document Information That Might Be Important to My Defense?

Even if you believe that certain information will be crucial to your defense, resist making changes to the record until you contact the

CAP-MPT HOTLINE (800-252-0555)

or your appointed claims representative or attorney. Entries written in anticipation of litigation often *do more harm than good* by appearing desperate and self-serving. Be assured that you will have the opportunity to tell your version of events. For now, defer to your attorney and claims representative.

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