

## ALTERED STATES

by Judith Fine, RN, MSN, TMLT Risk Management Representative

Alteration of medical records can make it impossible to defend a case. Consider the 1998 Alabama “medical malpractice case in which a patient died from lack of oxygen during surgery. At trial, an anesthesiologist testified that the critical period of oxygen deprivation was only about three minutes; however, evidence was presented that the decedent’s medical records had been altered, and a jury awarded her family \$22.5 million.<sup>1</sup>”

TMLT is seeing an alarming increase in the number of cases involving alteration of records. Most physicians acknowledge that it is unacceptable to alter medical records. Nevertheless, there have been several situations where a physician caught in a dilemma yielded to panic and destroyed or changed a medical record entry, hoping that it would not be noticed. Not only was it noticed, but it fatally damaged otherwise defensible cases.

High technology has entered the arena of forensic records analysis. If a record is changed 20 minutes after it has been written, in the same handwriting and using the same pen, this can now be detected through Mylar transfer and other new analysis techniques. No secret will bear today’s technology. A change will surely be detected.

Looking for alteration of records is often a routine procedure for plaintiffs’ attorneys. Commonly, a patient may seek the services of an attorney to help make a decision about filing a claim. The attorney instructs the

patient to request records from the physician without mentioning the potential claim and to deliver the records to the attorney for review. If the attorney believes that the case has sufficient merit to proceed, he or she requests a second set of records directly from the physician. A quick side-by-side scan of the two sets of records is all that is needed for the attorney to detect possible alteration of records. If an alteration has been made, it will surely be noticed.

Intentionally evasive alteration of records is not common. The increase in altered records cases

entries written as part of a previous note — has been observed repeatedly by TMLT Risk Managers in the course of Risk Management Practice Reviews.

A late entry should bear the date on which it is written, and it should say, “LATE ENTRY.” The relationship to a previous note should be explained, e.g., “addendum to note of 2/26/99” or “see 2/26/99 note.” Also the reason for the late entry should be explained. Why wasn’t this information in the previous note? A late entry should appear in



being noted by the TMLT Claims Department may be due, in part, to additions and comments made by well-meaning physicians who are attempting to clarify or elaborate on previous notes. Anything that is being added to a previous note is properly a late entry, regardless of whether or not the note was signed by the physician. This type of alteration — late

its normal chronological position in the chart, not squeezed into space near the previous note to which it relates.

What about the not-so-late entries? TMLT Risk managers are often asked, “How late is late enough to be a late entry?” Once a note is finished, anything else is a late entry.

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## Altered States (continued)

When in doubt, a late entry, clearly identified and properly referenced to the original note, is always preferable to adding anything to an existing note.

TMLT Risk Managers have also observed a bizarre form of shorthand being employed by some physicians that results in alteration of the record. A physician may write an order, e.g., "Tell her to stop taking (drug)," and then, after talking to the patient, changes it to

"I Tell her to stop taking (drug)." In this example, a new note should have been written to document the phone call. Having to write a few more words is a minor effort, especially considering the risk of allegation of altered records.

Blank lines or large blank spaces in the medical record may constitute for some individuals an invitation to make changes or additions to a note. It is wise to protect your medical documenta-

tion from such alteration by not leaving blank lines or by marking through spaces in a manner that prevents alteration.

<sup>1</sup> Medical Malpractice Law & Strategy, Vol. 16, No. 3, Leader Publications, January, 1999

## 1999 TMA/TMLT Risk Management CME

As part of its liability premium discount program, TMLT teams up with Texas Medical Association each year to offer risk management education seminars for physicians.

A copy of each certificate of completion will be forwarded to TMLT by TMA. A five percent premium discount for TMLT-insured physicians will be applied following the receipt by TMLT of each certificate of completion. Two five percent TMLT Risk Management discounts (not to exceed \$1,000 per program), for a total of 10 percent (maximum \$10,000) may be applied per policy period.

### **Before You Sign on the Dotted Line . . . What Doctors Should Know About Contracts and Practice Structuring**

**Time** — 6:30-9:30 p.m.

**Cost** — \$85 TMA member or employee;

\$65 for TMLT insured

**Date/Place** — April 28 — Austin

May 12 — Houston

May 19 — Fort Worth

June 2 — Amarillo

September 22 — San Antonio

October 14 — Dallas

October 28 — Corpus Christi

November 11 — Houston

**To register** — Call (800) 880-1300, ext. 1411

This 1999 series covers two very important areas of liability that are often misunderstood — managed care contracting and structuring a medical practice. Speaker Michael Z. Stern, a certified public accountant and experienced attorney, reviews hundreds of managed care contracts each year through a special arrangement with TMA.

Mr. Stern will share knowledge gained through this experience in the form of a managed care contract checklist. He will also cover financial and liability risks associated with various business structures available for physicians such as: sole proprietorships, partnerships, professional associations and nonprofit health corporations.

### **Was It Something I Said? The Underlying Psychology of Medical Malpractice Litigation**

**Time** — 6:30-9:30 p.m.

**Cost** — \$85 TMA member or employee;

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June 8 — Houston

September 18 — Austin

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For years, the greatest question pervading medical malpractice circles has been, "What makes one physician a more likely target for a malpractice action than the next? Likewise, why does one patient sue, whereas another patient — having experienced an identical result — does not?"

Speaker M. Beth Krugler, a defense attorney, mediator and licensed professional counselor, recently conducted a survey of leading defense and plaintiff attorneys. Of those polled, 82 percent said they believe that a minimum of three out of every 10 cases could be eliminated entirely by improved communication between doctors and patients. This program will look at the results of studies on the effects of communication on the physician/patient relationship.

This is the first in a 3-part series on Y2K compliance for the medical office

# Y2K: Getting a Grip

Every day we read and hear more about Y2K, and everything we read and hear makes the task of preparing for the year 2000 seem more daunting. What to do? Where to begin? Is it too late? If these questions sound familiar to you, it's time to get a grip on Y2K. Your efforts even now, if thoughtfully executed and thoroughly documented, may assist your defense in potential allegations of negligence related to Y2K problems. The way to begin is by identifying the potential Y2K problems that could impact your practice.

First, inventory the software used by your office computers for billing, appointments, and other patient data. Make a list of all software programs, including software used by the operating system of the computers.

Next, inventory all the medical equipment and devices that you use which could possibly contain a computer or a computer chip. Most of your electrical medical equipment should be on your list. Include direct patient care equipment and devices as well as other medical equipment. Now sort the list into three categories, as follows:

- High Risk — Equipment or supplies used for life support, resuscitation, or critical monitor equipment that could cause serious harm to a patient if it failed.
- Medium Risk — Equipment that would have a significant impact on patient care if it failed, but would do no immediate harm.
- Low Risk — Equipment that would have no serious impact on patient care or safety if it failed. Equipment slated for replacement before 2000. Equipment that does not perform any of the following functions: calculate age or time

or elapsed time; track data or events; interface with other devices or computers or computer systems; allow the user to input a two-digit year.

Please refer to the appendix of the TMLT publication, "TMLT Physicians and the Year 2000 Problem" for a starter list of devices that are likely to be in each category. The list is not comprehensive and should be compared with the reality of your actual use of the equipment in your practice.

Having made two inventory lists, one for software and one for equipment, the next step is to determine what information you have regarding Y2K compliance for the items on your list. Examine any warranties or contracts related to the items on your lists. If the software or equipment is more than one year old, there probably will be no mention of Y2K compliance. You may wish to consult with an attorney in evaluating the language in these warranties or contracts for

request a certificate of Y2K compliance. If the contract or warranty makes no mention of Y2K or if the contract or warranty specifically excludes Y2K compliance, write the manufacturer or vendor to request that either the contractual language be changed to indicate Y2K compliance or that a certificate of Y2K compliance be provided.

If you lease equipment or use hospital equipment, submit in writing a request for verification that the person responsible for equipment maintenance has taken these same measures. Also request that a copy of the certificate of Y2K compliance be sent to you when it becomes available.

The TMLT publication, "TMLT Physicians and the Year 2000 Problem" includes a sample letter to equipment and device manufacturers. Also included is a sample letter to suppliers of goods and services. This publication was mailed to all TMLT-insured physicians with an "Important

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direct or indirect references to Y2K. Note that contracts may contain exclusions that relate to Y2K.

When you identify an item that is Y2K compliant according to an applicable contract or warranty, place a copy of the contract or warranty in a newly created "Y2K Compliance" file, and note on your inventory that the item has been indicated to be Y2K compliant by certification.

If there is no applicable contract or warranty or if the contract or warranty has expired, write the manufacturer or vendor to

Announcement Concerning the Year 2000 Problem." For an additional copy, please call Shanna Homann at (800) 580-8658, extension 5910.

By inventorying vulnerable software and medical equipment and by attempting to verify Y2K compliance, you have made a good start. If you preserve all related documentation, you will, if necessary, be able to demonstrate that you made an effort in good faith to protect your patients from the possible perils of Y2K computer mishaps.

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## Inside INSURANCE

### Do you know how to read an insurance policy?

by Theo van Eeten, Consultant

You've heard about the so-called "fine print" in insurance policies or contracts. Do you believe that the "fine print" is used to spring an unpleasant surprise on you — one that may leave you feeling a little cheated? There is really no such thing as "fine print" if you know how to read an insurance policy!

Most policies start with an "insuring agreement" or "coverage agreement." This is where the policy spells out what the insurer will pay for. In this part of the policy, some of the terms used may be subject to interpretation, and they may be explained in a section called "definitions." For example, if a policy says that it will pay if you become liable as a result of causing "injury" to someone, does that mean that you are protected if someone acquires a disease because

of your negligence or if someone dies? The answer depends on the definition of "injury."

"Exclusions" will remove some coverage given in the "insuring agreement." There may also be "exceptions to the exclusions," which reinstate some of the coverage. For example, TMLT policies for physicians exclude coverage for commercial laboratories, but they also state that laboratories used for testing of patients as part of a physician's practice are not considered commercial laboratories.

Now, take a look at any "endorsements" that may be attached to the policy. Endorsements can cover a variety of issues, but one purpose is to provide, remove or change coverage. Endorsements clarify and amend the policy to which they are attached.

After you figure out what coverage you were provided by the "insuring agreement," subject to the "definitions," changed by the "exclusions," changed again by the "exceptions to the exclusions" and finally clarified and modified by endorsements, you still need to consider that all of this is contingent upon other parts of the policy. For example, the part called "conditions" requires certain things of you, such as the fact that you must be helpful in settling claims or your coverage may be void. Last but not least, a court of law may have its own interpretation of what you and the insurance company agreed to in the insurance policy.

Insurance policies are not always easy to read or interpret, but taking the time to do so will keep you from being surprised by "fine print."