Errors in Patient History in Hospital Records

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Abstract: A patient died of renal failure related to treatment of a hand contusion with ibuprofen and valdecoxib. Her hospital records revealed several incorrect and mutually conflicting statements about seven historical items in the Initial Evaluation Reports authored by five treating physicians. There were errors of commission (relying on imperfect memory, acquiescing erroneous information), and errors of omission (failure to proofread transcribed reports, question and resolve contradictory statements in sister reports, obtain correct history, and review prior medical records). Such errors wrongly implied that patient had preexisting conditions (advanced renal failure, diabetes mellitus, hypertension, asthma and alcoholism) which caused her death, and negatively impacted her workers' compensation claim. Incorrect allergy history was also noted. Preventive measures are suggested.

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INTRODUCTION

The value of medical records for patients' continuing care is well-known, but less recognized is their importance in adjudicating medico-legal claims that clinicians sometimes encounter. Information about preexisting conditions, symptoms, smoking, alcohol, injuries or occupation can be crucially helpful in determining causation and apportionment of disability in workers' compensation and personal injury claims. Prior medical records are usually considered sacrosanct because of their preinjury creation, and consequent impunity from litigation-related tainting. However "To Err Is Human". Conceivably therefore, sometimes records may themselves contain errors that can hinder justice. Yet our PubMed search for "Errors in Medical, Hospital or Physician Records" identified articles only about medical errors (preventable adverse effects of care),[1-5] and errors in death certificates or autopsy reports;[6] and nothing about errors in *medical records*. An identical Google search, though, did reveal several lay items about incorrect medical histories (e.g. "Healthy patients wrongly branded drunks, heavy smokers, and Alzheimer's victims").[7-8] We submit this report to fill the current vacuum in the *scientific* literature, to highlight potential ramifications of such errors, and to offer preventive suggestions.

Background: A previously asymptomatic 28-years-old patient sustained an occupational hand contusion on day-0. Her treatment included 2400 mg ibuprofen daily during days 0–19, valdecoxib 10 mg daily during days 76–139, and extensive ancillary care. She required three hospitalizations: day-19 for severe new-onset hypertension; days 37–40 for newly-diagnosed small kidneys and end-stage renal disease, and days 139–149 for *coma,* hypertensive cerebral hemorrhage and renal failure. She died on day-149. Her workers' compensation claim alleged death from renal failure caused by ibuprofen and valdecoxib.

Review of Hospital Records: We reviewed patient's medical records, and one of us (G.L.) interviewed her friend to learn about patient's pre- and post-injury health and activities. We encountered several erroneous and conflicting statements involving seven historical items in the Initial Evaluation reports of five (1 Admitting, 4 Consulting) physicians who treated the patient during days 139–149. For each questionable item, we quote first the chief incorrect statement followed by subsequent statements, provide relevant evidence-based facts, and analyze probable causes of the errors and their potential medico-legal ramifications.

ERROR #1: INCORRECT HISTORY OF PRIOR RENAL FAILURE.

Nephrologist (N): "She has been told in the past by other nephrologists that she had renal failure and would require hemodialysis treatment."

Admitting physician (A): No mention of prior renal disease.

Infectious disease specialist (I): Blank.

Pulmonologist (P): "Known case of chronic renal failure."

Surgeon (S): "Past medical history is remarkable for chronic renal failure."

Fact: Before day-37, patient had no diagnosis, symptom or knowledge of small kidneys or kidney failure. On day-

37, blood and urine tests first revealed end-stage renal disease. On day-37, a nephrologist (same Dr. N, who saw her again on day-139) had written, "She has no knowledge of having hypertension or renal insufficiency in the past… Recent use of high doses of NSAIDs may have exacerbated her renal insufficiency." On day-38, an ultrasonogram revealed small echogenic kidneys.

Analysis: Dr. N's day-139 statement conflicted with his own day-37 statement. Records disclosed no evidence that this patient had seen a nephrologist before or after her day-37 hospitalization. Moreover, if this patient had no symptoms of renal insufficiency until day-37, why would she have seen any nephrologist before then? On day-139, Dr. N was relying on memory as he noted elsewhere in his report, and his recollection was clearly imperfect. He had neither seen the patient during days 40–138, nor reviewed her prior medical records. Drs. P and S apparently acquiesced the incorrect information from Dr N's report. Patient's kidney failure was probably caused or precipitated by the NSAIDs (non-steroidal anti-inflammatory drugs).

ERROR #2: INCORRECT HISTORY OF CURRENT MEDICATIONS:

A: "None. She was reported to not be taking any medicines."

I: "Zosyn (piperacillin-tazobactam) as per medication list".

N, P, S: None.

Fact: On day-139, patient was taking valdecoxib 10 mg once daily. Outpatient records revealed that on days 76, 106 and 134, patient's orthopedist had documented ongoing pain, ordered physical therapy and temporary total disability, and prescribed valdecoxib 10 mg #30.

Analysis: In patients with renal disease (e.g. small kidneys), cyclooxygenase-II (COX-2) becomes essential for maintaining normal kidney circulation and function. COX-2 inhibition by valdecoxib probably precipitated renal failure in this patient with subclinical small kidneys.

ERROR #3: INCORRECT HISTORY OF PREINJURY DIABETES MELLITUS.

S: "Past medical history is remarkable for diabetes diagnosed about six months ago."

A: "Past history: The patient was reported to have a history of diabetes."

I: Blank.

N: "She does not have any chronic illnesses, such as diabetes mellitus."

P: "She is a known case of diabetes mellitus."

Fact: Patient had no symptoms, diagnosis or knowledge of diabetes mellitus. Before day-139, patient's blood glucose was tested only during her day 37–40 hospitalization and was normal. It was subsequently checked on day-139 when it was 147 (reference: 60-110) mg/dl.

Analysis: Dr. S was unaware of absence of diabetes mellitus on days-37–40, and mistook the day-139 hyperglycemia for preexisting diabetes mellitus. Drs P and A acquiesced the incorrect information from Dr. S. Note Dr. N's conflicting statement. New diabetes on day-139 was probably induced by coma-related endocrinologic dysfunction.

ERROR #4: INCORRECT HISTORY OF HYPERTENSION.

A: "The patient was reported to have a history of hypertension."

N: "She has no history of hypertension."

I, P, S: Blank.

Fact: Patient had no symptoms, diagnosis or knowledge of hypertension till day-10. Patient's blood pressure was normal on days 1–6, and was not rechecked on days 7–9. Hypertension was first noted on day-10.

Analysis: Patient did not have preinjury hypertension. On day-139, patient did have a "past" history of hypertension, but that hypertension had developed after the injury and was caused by renal failure precipitated by ibuprofen treatment on days 0-10. Dr. A was unaware that patient had been normotensive on days 1–6. Note Dr. N's incorrect and conflicting statement.

ERROR #5: INCORRECT HISTORY OF ALCOHOL ABUSE:

I: "There is history of alcohol abuse."

A: "Patient is reported to consume alcohol however there was no alcoholic problem reported."

N: Blank.

P: "Patient drinks alcohol mildly."

S: "Patient does not have a history of alcoholism."

Fact: Patient did not abuse alcohol. She occasionally had a drink.

Analysis: Dr. I's incorrect statement probably represents a typo. Dr. I. probably meant "There is *no* history of alcohol abuse" or "There is history of alcohol *use*". The words "abuse" and "use" may sound phonetically similar especially with suboptimal dictation quality or unique accents. Note the contradictory statements of Drs A, P and S.

ERROR #6: INCORRECT HISTORY OF DRUG ALLERGY:

I: "No known drug allergies, per report of chart."

A: "She is reported to be allergic to some medication which was given for her right arm injury in the past."

N: "She is sensitive to Flexeril (cyclobenzaprine), given for her right wrist pain."

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