Medical Malpractice Matters: Medical Record M & Ms

John M. Lyons, III, MD, Jorge A. Martinez, MD, JD,† and J. Patrick O'Leary, MD*‡*

*Department of Surgery and †Department of Emergency Medicine, Louisiana State University, Health Sciences Center, New Orleans, Louisiana, and ‡Florida International University, Miami, Florida

Accurate and thorough chart documentation is extremely important not only for patient continuity of care but also for medical legal risk reduction. It is common knowledge that a large percentage of court cases involving health care practitioners rely substantially on the chart documentation to determine outcomes. In this article, the authors have outlined particular court cases that illustrate the dramatic influence medical documentation has had in case law. (J Surg 66:113-117. © 2009 Association of Program Directors in Surgery. Published by Elsevier Inc. All rights reserved.)

KEYWORDS: medical malpractice, medical record

CASE 1: *SCHWARTZ V BOARD OF REGENTS*[1]

Dr Schwartz, who is a physician licensed to practice medicine in New York State, performed 4 abortions. After this action, he was charged by the New York State Board for Professional Medical Conduct with 5 specifications of professional misconduct regarding the treatment of these 4 patients. Among these specifications was the charge of unprofessional conduct for the failure to keep patient records as required under New York Code *8 NYCRR § 29.2*.[2] After Dr Schwartz was eventually found guilty by the Board and his medical license was suspended, he appealed to the New York courts. He contended that the finding of unprofessional conduct is not supported by substantial evidence and that the measure of discipline imposed was disproportionate and excessive.

However, the court's review of Schwartz's documentation for these 4 patients revealed only sparse information. The charts lacked notations concerning blood pressure, body weight, laboratory results, and physical examination findings. Schwartz testified that it was his policy to note "only unusual and exceptional matters" in these records, and that if a patient's record contains nothing about the patient's history, physical examination, abnormalities, or the procedure, this indicates that all these matters were "normal."

He argued that his records are accurate reflections of his evaluation and treatment of each patient. He felt that according to the New York Code,[2] medical records must be accurate but not necessarily adequate. In other words, he contended that, according to New York law, medical records are satisfactory as long as the treating physician can interpret them accurately even if they are clearly inadequate records.

The court felt that "this contention is clearly without merit" stating that "the purpose of the record-keeping requirement is, at least in part, to provide meaningful medical information to other practitioners should the patient transfer to a new physician."

Dr Schwartz's records clearly did not meet this standard, and his own witness testified that if he were just to look at one of these records, without any other explanation: "I don't think I'd get too much information from it."

Thus, the court felt that a patient record that is so sparse as to be accurate and meaningful only to the recording physician fails to meet the intent of the requirement to maintain a record that "accurately reflects the evaluation and treatment of the patient" under New York Code.[2] They upheld the determination of unprofessional conduct citing other examples, which included *Matter of Jay v Board of Regents*[3] and *Matter of Snyder v Board of Regents.*[4]

CASE 2: *YOUNES V NOLAN*[5]

Dr Younes, who is a licensed physician, began treating a 62-year-old woman. Her course with Dr Younes was relatively unremarkable until 1 year into their relationship when she was found to have metastatic carcinoma. After this diagnosis, she filed a complaint against Dr Younes with Dr Nolan of the Rhode Island Board of Medical Licensure and Discipline.

After reviewing the case, the Board ruled that Dr Younes was guilty of unprofessional conduct by reason of negligence in his diagnosis, evaluation, and treatment of the patient. It also recommended disciplinary sanctions pursuant to the Rhode Island Code Unprofessional Conduct (§ 5-37-5.1[19]) based on

Correspondence: Inquiries to John M. Lyons, III, MD, Department of Surgery, Louisiana State University Health Sciences Center School of Medicine, 533 Bolivar St, 5th Floor, New Orleans, Louisiana 70112; fax: (504) 568-4633; e-mail: cmelhl@lsuhsc.edu

Younes' failure to record and document needed clinical findings.

Challenging the Board's ruling, Dr Younes filed a hearing in Rhode Island Superior Court. At the hearing, the patient's son testified that the patient specifically complained to the doctor of a pressure or soreness surrounding a lump in her neck. The patient's son reported that this neck mass was "a very large lump" and "it was very bumpy." He also testified that despite being informed, the doctor did not touch his mother's neck.

Although nurses notes indicated that the patient had complained of cervical pain, Dr Younes admitted that he had not documented whether the patient had complained of cervical pain. Dr Younes conceded that nothing was in the patient's records to indicate that an examination of the head, face, or neck was performed. He then stated that he did not remember whether he palpated her neck on this day. However, he suggested that if it was not mentioned to him, it would not be documented because he did not usually record negative findings.

Testimony for the Board was given by Dr Agatiello, who is a board-certified internist. After reviewing the office and progress notes of Dr Younes, Dr Agatiello went into detail describing the inadequate documentation on the part of Dr Younes with respect to this patient's treatment. He stated that, regarding documentation, physicians are taught in medical school that if it is not written, it is not done. In support of this, Dr Agatiello presented a page from Harrison's Principles of *Internal Medicine,* 10th edition, pertaining to the "history" and "physical" stating that the written history of an illness should embody all the facts of medical significance in the life of the patient. Dr Agatiello testified that based on a review of the patient's records, her head, face, or neck had not been examined. If it had been done, then it had not been documented in the record.

The Court found that the Board's decision to discipline Dr Younes for unprofessional conduct was consistent with the plain and ordinary language of the Rhode Island statute and that this decision was supported by substantial evidence in the medical record.

Courts in several other jurisdictions have also held similar opinions. For example, in *Halter v State of Alaska,*[6] the Supreme Court of Alaska held that the failure to chart and document in specific patient files were grounds to sanction a physician for professional incompetence, although no specific regulations were available about record keeping in the State of Alaska at the time of the physician's conduct.

Similarly in *Bogdan v New York State Board for Professional Medical Conduct,*[7] the Court held that where a relationship between inadequate record keeping and patient treatment is observed, the failure to keep adequate records may constitute negligence.

CASE 3: *ZUTTAH V WING*[8]

In this case, the court found that the Dr Zuttah's medical charts failed to disclose fully the medical necessity regarding services and tests for which he had billed. Because of the lack of documentation, several medical services ordered by Dr Zuttah were deemed medically unnecessary. The doctor could not refute this assumption because no documentation was available. Furthermore, because Dr Zuttah had allegedly ordered unnecessary tests, he was also charged with the submission of false claims. The court upheld a determination made by the Commissioner of the New York State Department of Social Services that excluded Zuttah from participation in the Medicaid program for 2 years and sought recovery of overpayments from him.

In addition, the court reminded the medical community that the failure to document the need for services billed and ordered is considered unacceptable record keeping, as it reflects a failure to maintain records necessary to disclose fully the medical necessity for such services.[9] The lack of documentation also supports a finding of submitting false claims because, without proper documentation, medical services or supplies ordered or prescribed are considered excessive or not medically necessary.[10] Furthermore, it is a provider's burden to show that all costs claimed were allowable.[11]

CASE 4: *WATERS V US*[12]

Mr. Waters had been suffering with mental illness since the late 1950s. He was medically discharged from the U.S. Air Force because of this, and by the early 1980s, he was determined to be 100% disabled by the Veterans Administration. His psychiatric history included many hospitalizations and 1 attempted suicide.

In December 1982, Waters was admitted to the hospital and was found to have schizoaffective disorder depressed type. The treating physician, Dr Neil Price, started Mr Waters on 15 mg per day of Stelazine (GlaxoSmithKline, Philadelphia, Pennsylvania), an antipsychotic medication, and Cogentin (Merck & Co., Inc., Whitehouse Station, New Jersey).

When discharged from the Veteran's Affairs Medical Center (VAMC) in January 1983, Waters followed up with a different psychiatrist, Dr Hassan. When Hassan saw Waters in February 1983, he noted improvements in Waters' condition and decreased his Stelazine level from 15 mg to 10 mg.

One month later when Dr Hassan saw Waters again, he decreased the Stelazine from 10 mg to 5 mg and discontinued the Cogentin altogether. In late May of 1983, Waters began to experience antipsychotic symptoms once again. After unsuccessfully attempting to reach Dr Hassan, Waters telephoned Dr Price, with whom he still maintained occasional contact. Dr Price and Mr. Waters discussed Waters' condition, and Dr Price made a "mental status examination" over the phone. Based on his telephone examination, Dr Price increased Waters' Stelazine dosage to 30 mg per day (increased from 5-mg per day) and restarted his Cogentin.

In June 1983, Waters returned to see Dr Hassan again who found the patient to be delusional and psychotic. After his examination, Hassan increased Waters' Stelazine to 40 mg/day. On July 2, 1983, Waters and his family went to a shopping mall