

MEDICAL RECORDS LAW IN TEXAS

Deciphering Records: What to Look For and What Should be There

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Deciphering Records: What to Look For and What Should be There

–by Matthew B. E. Hughes¹

Medical records can make or break a case. Witnesses who embrace them generally appeal to juries. Witnesses who don't, don't. This is because the silent records usually are more persuasive than a live witness. One of the most difficult jury arguments for a medical malpractice defense attorney thus is, “My careful client provided good care, but his medical records are filled with contrary information. So ignore what he wrote at the time and focus on what he says now, years after the fact (and after he hired me).” As a plaintiff's lawyer, your mission is to make the records speak against the defendant. As a defense attorney, on the other hand, your mission is to place the records in their proper context.

This paper focuses on the practical side of medical records: getting them; analyzing them; and using them. Because these issues are fact-specific, a number of checklists and case studies are included. These checklists provide a framework for detecting errors or omissions. And these case studies provide examples of how to use, or how not to use, such errors or omissions.

I. Getting the Records

A. Ways to Obtain Records

1. By Notice Letter:

All parties shall be entitled to obtain complete and unaltered copies of the patient's medical records from any other party within 45 days from the date of receipt of a written request for such records; provided, however, that the receipt of a medical authorization in the form required by Section 74.052 executed by the claimant herein shall be considered compliance by the claimant with this subsection.

TEX. CIV. PRAC. & REM. CODE § 74.051(d).

- a. The plaintiff must give notice in writing and send request by CM/RRR to all potential defendants. TEX. CIV. PRAC. & REM. CODE §74.051(a).
- b. The plaintiff's notice must be sent 60 days before suit is filed. *Id.*

¹ I wish to express my gratitude to R. Gregg Byrd, J.D., Deb Parks, R.N., and John Chambers who assisted me in the preparation of this paper and of the Power Point presentation.

2. By Subpoena:

- a. A formal request should cover the “complete” record. For example, America First uses this format in their subpoenas:

Any and All Medical Records, including, but not limited to, any new patient information, medical records, emergency room records, prescriptions, doctor referrals, radiology reports, insurance records, office notes, office memos, reports, photographs, audio tapes, video tapes, and any and all type of correspondence, and anything else reduced to writing in the possession, custody or control of the said witness, and every such record to which the witness may have access pertaining to: [patient’s name] and [patient’s social security number and date of birth].

3. By Another Doctor:

If you suspect that a physician will sanitize the records, then—before a notice letter is sent—consider having the patient request that the physician in question send the records to another physician. This could produce two very different sets of records: those intended for another physician; and those intended for the patient’s attorney.

Several years ago, for instance, I was faced with two sets of my client’s records: the set he contemporaneously sent to another doctor; and the set he sent to his former patient’s lawyer after the suit was initiated. The second set had twice as many office notes. And the second set’s office notes were more detailed. The earlier notes were, shall we say, scant.

B. Overcoming Resistance

1. Pay:

If the physician charges for producing a copy, then the records must be turned over within 15 business days after the receipt of reasonable fees for furnishing the records. 22 TAC § 165.2(b).

2. Avoid Exceptions:

A physician may refuse to release medical records if the physician determines that the information therein would be physically, mentally, or emotionally harmful to the patient. TEX. OCC. CODE §159.006(d)(1).

3. Notice the Custodian’s Deposition:

Noticing the records custodian’s deposition might encourage production of the records. TEX. R. CIV. P. 202.

II. Analyzing the Records

A. Step 1: Analyze the Records for Completeness

1. Check for the components of complete medical records. *See* Appendices A-C.
2. Verify that the written records and radiology films, pathology slides/specimens, and so forth match up.
3. Verify whether the hospital or the physician provided any relevant pager. This is the first step for obtaining pager records.
4. Verify the existence of all billing records.
5. Verify the written versus the electronic records.

B. Step 2: Analyze the Record for Internal Consistency

Compare:

1. radiology films to radiology reports;
2. pathology slides/specimens to pathology reports;
3. lab results to Doctors’ Orders;
4. lab results to doctors’ Progress Notes & Nurses’ Notes;
5. Nursing Interventions to Doctors’ Orders;
6. Nursing Interventions to doctors’ Progress Notes; and
7. Nurses’ Notes to doctors’ Progress Notes and Consults.

C. Step 3: Analyze Charting Patterns

1. Compare the charting on “critical” day(s) to other days.
2. Note all the addendums and late entries.

3. Note any unusual entry styles, such as loosely written notes on most days or densely packed entries on critical day(s).
4. Note any charting in unusual locations. For example, calls might normally be recorded in the Nurses' Notes, but were recorded on the lab sheets on the critical day.
5. Note the communication patterns and whether a communication pattern was different on the critical day. For instance, did the nurses chart that the physician was "unavailable" only as a late entry? Do corroborating pager records exist?
6. Compare the Discharge Summary to the History and Physical. For one thing, did any signs and symptoms "disappear" between admission and discharge?

D. Step 4: Analyze Billing Records

1. Investigate the meaning of all applicable CPT and ICD-9 Codes.
2. Compare the billing records to the History & Physical's diagnosis and the Discharge Summary's diagnosis.
3. Compare the billing records to actions actually taken in the Progress Notes.
4. Compare the billing records to actions performed or omitted in the Nurses' Notes.
5. Compare the billing records to drugs administered in the Medical Administration Record.

III. Using the Records

A. Interpret the Evidence

1. Unless the original charting was ambiguous, juries tend to believe what is charted over subsequent inconsistent testimony.
2. Distinguish between spoliation and a naïve records custodian's:
 - i. failure to copy inconsequential pages;
 - ii. failure to copy back sides of pages; or
 - iii. failure to understand that the request was for the entire chart, not for portions of the entire chart.

Ironically, the “worse” the initial production, the less likely that the error was significant. Poor production typically is fruitful for cross examination only when a critical page or lab—and only that page or lab—was omitted.

B. Establish the Importance of the Record

1. Physicians generally have an obligation to maintain records for 7 years. 22 TAC § 165.1(b)(1).
2. Physicians cannot destroy records if they are part of a criminal, civil, or administrative suit until such proceedings have ended. 22 TAC § 165.1(b)(3).
3. If it is necessary to subsequently amend or supplement a medical record, then the physician must indicate the time and date of the amendment or supplement and clearly indicate that the record has been amended or supplemented. 22 TAC § 165.1(a)(9).
4. Since healthcare providers use the record as part of their care and treatment, establish the importance of the records in day-to-day practice.

C. Have Witness Acknowledge Importance of Amended, Supplemented, or Missing Records

Witnesses who should understand the importance of any amended, supplemented, or missing records should be made to explain the context of them. If the missing pages were not important, additionally, then are any other non-important pages that are missing? Furthermore, what pages are missing, and what information should have been on those missing pages?

IV. Practical Examples

A. 1st Case Study: Missing Records and Unusual Charting Story

1. Facts Pattern: G v. M
2. Issue: Were the nurse’s actions and the Nurses’ Notes inconsistent with her charting pages to a physician on lab results?

B. 2nd Case Study: Ambiguity Creates Opportunity

1. Fact Pattern: H v. L
2. Issue: Did the signature and ambiguous date on a pre-operative lab establish that it was viewed by the surgeon pre-operatively?

C. 3rd Case Study: Impeachment of the Wrong Witness

1. Fact Pattern: S v. P
2. Issue: Did different versions of the chart impeach the doctor or the records custodian?

D. 4th Case Study: When Everyone Is Wrong, Don't Impeach!

1. Fact Pattern: W v. G
2. Issue: Was there any benefit to impeaching a party over an error in the medical records when other medical records contained similar mistakes?

E. 5th Case Study: Poor Charting Equals Poor Care

1. Fact Pattern: H v. S
2. Issue: Was poor charting of pre-operative instructions evidence that the post-operative course was abnormal?

F. 6th Case Study: Look it Up!

1. Fact Pattern: R v. S
2. Issue: Was "close enough" on a consent form sufficient for List A purposes?

G. 7th Case Study: Verify, Don't Trust!

1. Fact Pattern: A v. S
2. Issue: Did a blank record negate a nurse's oral assurance regarding sponge counts?

Conclusion

Medical records are a set of tools for your case. Wielded skillfully, they can cut down acres of obfuscation and excuse-making. But wielded poorly, they can trim the examiner's credibility. The difference in effect is due to whether the set(s) of records actually support the examiner's theory of the case and the extent to which the examiner capitalizes on such support.

Appendix A:
Nursing Home Medical Records Checklist

Nursing Home Medical Records Checklist

Admission data

Minimum data set for Medicaid

Other administrative information (incident reports, financial data)

Correspondence

Consents

Order sheets (admission orders, MD orders)

Physician progress notes

Consultation notes

Nursing notes and care plans

- Admission nursing assessment
- Nursing progress notes – narrative
- Care plans
- Weight charts
- Skin assessment and care charts
- Flow sheets (vital signs, skin, diet, safety, grooming)

Social services notes

Medication administration record

Activity log

Hospitalization records

Appendix B:
Hospital Medical Record Components Checklist

Hospital Medical Record Components

Minimum components:

Administrative data
Consents
Admission history and physical
Physician progress notes (or multidisciplinary)
Physician orders
Nurses' Notes

- Flow sheets (vital signs, assessments)
- Narrative notes
- Case manager notes

Lab studies (including pathology)
Radiologic studies
Medication administration record
Discharge summary

Other items if applicable:

Emergency Room notes
Consultations
Respiratory therapy notes
Physical therapy, occupational therapy notes
Social services notes
EKG studies
EEG studies
Operative and procedure reports
Resuscitation records
Death note

Appendix C:
Hospital Medical Record Components – Cardiac Checklist

Hospital Medical Record Components – Cardiac Checklist

Minimum components:

Administrative data
Consents
Admission history and physical
Physician progress notes (or multidisciplinary)
Physician orders
Consultations (cardiology, cardiovascular surgery, internal medicine)
Operative and procedure reports (including PTCA, bypass, angiogram)
Nurses' Notes

- Flow sheets (vital signs, assessments)
- Narrative notes
- Case manager notes

Lab studies (including pathology)
Radiologic studies
EKG studies (stress tests)
Echocardiogram studies
Medication administration record
Discharge summary

Other items if applicable:

Emergency Room notes
Respiratory therapy notes
Physical therapy, occupational therapy notes
Social services, chaplain notes
EEG studies
Resuscitation records
Death note

Appendix D:
Red Flags Checklist

Red Flags Checklist

MD or RN writes on undesignated areas (lab sheets).

Charting is overly (as in CYA) comprehensive.

Nursing notes have late (as in CYA) entries.

Record has hiatus in documentation (MAR, vital signs) or missing pages.

Health care provider uses terms like “unintentionally, inadvertently, unexplainably, accidentally and unfortunately” (known as hangman’s words)

Health care provider uses subjective rather than objective reporting: “wound ok, appears restless...” rather than (“surgical incision healing without signs of infection, thrashing in bed.”

Appendix E:
Fact Patterns for Case Studies 1-7

Case Study No. 1: G v. M

This case involved a 74-year-old woman who underwent surgery on May 22, 2002. [Defendant-Doctor 3] performed a right hip endoprosthesis. The surgery was apparently uneventful. [The patient] was then transferred to the medical floor. [Defendant-Doctor 3] ordered 10 – 15 mg. of Morphine for postoperative pain as needed. In the recovery room, [the patient] received 3 mg. of Morphine by IV. [The patient]’s blood pressure at 8:00 a.m. was 158/54. [The patient] received 10 mg. of Morphine intramuscularly at 3:00 p.m. and again at 7:15 p.m. on May 22. [The patient]’s urine output from 7:00 p.m. to 3:00 a.m. was approximately 37 cc/hr. [Defendant-Doctor 1] reportedly was paged at 9:30 a.m. and at 10:30 a.m. on May 23 regarding [the patient]’s obtunded condition. These unreturned pages were recorded on the lab results, not on the Nurses’ Notes.

Shifting to [Defendant-Doctor 1]’s perspective, [Defendant-Doctor 2] called him at approximately 8:30 on the morning of May 23, 2002. [Defendant-Doctor 2] asked [Defendant-Doctor 1] to cover his patients, including [the patient] (whom he thought to be a preoperative patient). [Defendant-Doctor 2] was about to undergo a colonoscopy and wanted his patients covered while he was under sedation. [Defendant-Doctor 1] intended to finish seeing his office patients and then check on [Defendant-Doctor 2]’s patients between 2 p.m. and 3 p.m. [Defendant-Doctor 1] testified that he was first notified regarding [the patient]’s obtunded condition at approximately 12:30 p.m. on May 23 when [a nurse] called him at his office. [The nurse] told him that [the patient] was still “drowsy” from the night before, that maybe [the patient] had been given too much morphine, and that [the patient]’s potassium level was elevated at 5.8 (the upper-end of normal is 5.5). In response, [Defendant-Doctor 1] ordered Narcan (to reverse the effects of the Morphine), D50 (sugar, to reverse the potassium), Insulin (to prevent diabetic coma), a stat chest X-ray (to check for lung problems), and a stat CT scan of her head (to check for stroke). [Defendant-Doctor 1] left his office and went to [Defendant-Hospital] immediately after [the nurse]’s 12:30 p.m. phone call.

Case Study No. 2: H v. L

This case involved a then 18-year-old college student who initially presented to [Defendant-Doctor]’s office with a six-month-to-one-year history of increased right cheek swelling, which [Defendant-Doctor] initially suspected was a form of sinusitis. [The patient] admitted having a history of right nasal airway obstruction and nasal congestion. Interestingly, [the patient] had been under the care of another physician, and this mass—or at least portions of it—had been present on a prior MRI. He was diagnosed at that time with chronic sinus disease bilaterally. At the time of his presentation to [Defendant-Doctor]’s office, [Defendant-Doctor] estimated the mass to be 3 X 4 cm in size.

A major factual dispute involved [the patient]’s pre-operative PTT values. [The patient] claimed [Defendant-Doctor] did not review them before surgery. [Defendant-Doctor] testified he did. However, [Defendant-Doctor] signed and dated the PTT lab report on December 30, 2002—thereby allowing [the patient] to argue that he only reviewed them post-operatively.

On December 26, [Defendant-Doctor] removed the mass. The Operative Report noted that [the patient] experienced “brisk post-operative bleeding” as a complication.

Case Study No. 3: S v. P

This case involved a 71-year-old obese, Hispanic male with multiple comorbidities who was seen by [Defendant-Doctor] on 1/15/03 for back pain. [Defendant-Doctor] noted a positive guaiac stool. Based on this finding, [Defendant-Doctor] ordered a CT scan of the abdomen (performed on 2/17/03), which revealed hepatic fatty infiltration and gallstones. Due to [the patient]'s high risk for surgery, [Defendant-Doctor] decided to order a surgical consult if and when the gallstones became symptomatic. On 5/29/03, [gastroenterologist] saw [the patient] for rectal discomfort and bleeding. Endoscopy revealed diverticulosis, hemorrhoids, and melanosis coli secondary to laxative use. Blood work on 6/4/03 revealed ALT 55 (normal 10 - 40), Amylase 126 (normal 30 - 110), Lipase 544 (normal 34 - 350), Cholesterol 226 (normal 131 - 200), Triglycerides 783 (normal 35 - 160), and LDH 244 (normal 100 - 240). [Gastroenterologist] repeated the Amylase and the Lipase on 6/9/03, and the Amylase had dropped to 62 (normal 30 - 110) while the Lipase had dropped to 341 (normal 34 - 350). A gallbladder ultrasound also done on 6/9/03 revealed multiple gallstones, no evidence of inflammatory changes of the gallbladder wall, and no evidence of biliary tree distention. [Gastroenterologist] recommended evaluation by a surgeon of [Defendant-Doctor]'s choice. [The patient] subsequently expired due to sepsis. No autopsy was performed.

[Defendant-Doctor]'s chart did not include any paper work related to [gastroenterologist]'s May 2003 or June 2003 treatment. In [gastroenterologist]'s chart, some of this paper work was stamped as "faxed" to [Defendant-Doctor].

[The patient]'s daughter requested a copy of [Defendant-Doctor]'s chart and received approximately 20 pages and an Affidavit signed by [Defendant-Doctor]'s records custodian. But we subsequently produced [Defendant-Doctor]'s entire chart—consisting of approximately 150 pages—in response to Plaintiff's Request for Disclosure.

Case Study No. 4: W v. G

This case involved a diabetic 79-year-old man who sought foot care from [Defendant-Doctor] over a period of years. [Defendant-Doctor]'s office notes twice referred to the patient as "she."

[The patient] returned to [Defendant-Doctor]'s office on 3/14/02. No palpable pulses were present in the lower extremities. His feet were cold with dependent rubor (redness due to circulatory problems). [Defendant-Doctor] debrided [the patient]'s toe nails and discussed diabetic footwear and care. He scheduled a follow-up visit for 3 weeks later.

[The patient] thereafter developed a non-healing foot wound. But [the patient] never returned to [Defendant-Doctor's] office or contacted [Defendant-Doctor]'s office.

Case Study No. 5: H v. S

This case involved a liposuction surgery. [The patient]'s first visit to [Defendant-Doctor]'s office was on 2/26/96. [Defendant-Doctor] discussed [the patient]'s expectations, surgery, risks, and cost with her during this visit. He noted that she was concerned with lower abdominal fat, with flank fat, and with lateral thigh fat. [The patient] initially came to [Defendant-Doctor]'s office because she talked to a friend, on whom [Defendant-Doctor] previously performed liposuction. [The patient] was impressed with her friend's results. [Defendant-Doctor] did not take any photographs or make any drawings of [the patient] during this visit, except for a minimal picture on the back of a patient self-history sheet. [The patient] came in for another visit before [Defendant-Doctor] performed the procedure, but nothing was documented since it was an informal visit.

[Defendant-Doctor] performed the liposuction on 3/14/96. He administered 4,000 cc of saline with Xylocaine and Epinephrine into the areas that he intended to suction.

At trial, [the patient] testified that her liposuction wounds were leaking fluid so badly that she had to sit on garbage bags during the car ride home.

Case Study No. 6: R v. S

This case involved a cholecystectomy. In his deposition, [Defendant-Doctor] admitted that he did not disclose to [the patient] in writing all of the disclosures required by List A in 1997. [Defendant-Doctor] testified that he discussed all but 1 of the required disclosures with [the patient]. Specifically, [Defendant-Doctor] did not disclose pancreatitis as a potential complication of cholecystectomy. [The patient], on the other hand, did not develop pancreatitis.

Case Study No. 7: A v. S

This case involved a 29-year-old white female, who underwent an exploratory laparotomy with lysis of adhesions, and a left salpingo-oophorectomy (removal of the left ovary) on February 7, 2001. One of the nurses left the operating room close to the very end of the surgery, around the time when the sponge count would have been performed. Ordinarily, [Defendant-Doctor] hears the sponge count, but does not personally count them himself. [Defendant-Doctor] was certain that in this case he was advised that all sponges were accounted for, because he does not close the patient until he has been assured of same. The February 7, 2001 operative report failed to indicate that the sponge count was correct.

[The patient] thereafter experience symptoms consistent with a retained sponge. And a sponge was found during a subsequent exploratory surgery.