

An Ounce of Prevention Is Worth a Pound of Cure



By Matthew Bauer, JD

Medical offices routinely receive medical records requests, and medical offices should have established policies and procedures for the proper handling of medical records requests in order to promote patient care and to comply with state law and HIPAA. While such factors are important, a frequently overlooked fact is that the proper handling of medical records requests can also potentially prevent a medical malpractice lawsuit from being filed.

A plaintiff's attorney will typically review their client's medical records before filing a medical malpractice lawsuit. If a plaintiff's attorney is not provided with a copy of their client's complete medical chart when requested, then the plaintiff's attorney may be under the misconception that a health care provider committed medical negligence due to missing medical records and may file a medical malpractice lawsuit based upon such

misconception. This is exactly what happened in the following closed claim case.

A forty-year-old female patient with GERD, dysphagia, and esophageal stricture had a consultation with Dr. Orton^[i] and decided to undergo esophagogastroduodenoscopy (EGD) with dilation. During the consultation, Dr. Orton reviewed the risks and known complications of the procedure with the patient and had the patient sign an informed consent form. Unfortunately, the patient suffered an esophageal perforation during the procedure and required extensive post-procedure treatment.

Dr. Orton's medical office subsequently received a request from the patient's attorney for a copy of the complete medical chart. However, when Dr. Orton's office processed this request, some of the patient's medical records, including the informed consent form signed by the patient, were inadvertently not sent to the patient's attorney. The patient's attorney subsequently filed a medical malpractice lawsuit against Dr. Orton alleging medical negligence and lack of informed consent.

During the discovery phase of litigation, Dr. Orton's defense attorney realized the error and promptly sent a copy of the patient's complete medical chart, including the informed consent form, to the patient's attorney. The informed consent form enumerated the risks and known complications of an EGD procedure, including the risk of a perforation or tear in the esophagus. Shortly after receiving the informed consent form signed by the patient, the patient's attorney withdrew from representation of the case. The patient was unable to find another attorney to take her case, and approximately two years after the lawsuit was filed, the case was dismissed for lack of prosecution. While the case was eventually dismissed, Dr. Orton had to expend a significant amount of time and effort to defend a medical malpractice lawsuit that potentially could have been avoided in the first place by properly handling the original medical records request from the patient's attorney.

As demonstrated by this closed claim case, there are proactive steps that medical offices can take to reduce professional liability exposure. SVMIC has valuable informational and educational resources for policyholders (<https://www.svmic.com/resources>) that can help medical offices take these proactive steps, which not only improve patient care and legal compliance, but which could also potentially prevent a medical malpractice lawsuit from being filed.

[i] The physician's name has been changed.

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