Know Your Medical Record

By Tim Behan, JD

Know your medical record. It's an obvious statement. It's a simple statement. On the face of it, it shouldn't even be a necessary topic of discussion because it is presumed that we in fact do know our records. But that presumption is rebutted each and every day by reality. The reality of a steady stream of patients, many with complicated and extensive histories. The reality of procedures taking longer than expected, leaving little time for preview or review. The reality of peripheral business and insurance issues that can slow the practice of medicine to a crawl. And lastly, the reality of electronic medical records that have been known at times to make accessing and obtaining correct medical information more difficult. All of these considerations and stresses can leave little time to know the critical bits of information in a patient's chart. Most of the time it is not a problem. But when it does become a problem, the results can be catastrophic. The following three cases illuminate this point.

An expectant 34-year-old mother of one of our insured obstetricians underwent routine screening for Group B Streptococcus, as ordered by the doctor. The OB physician assumed that the test result was transmitted to the hospital. The result was positive and scanned into the patient's EHR, maintained by the doctor, since he ordered the test. The result went unread. On the day of delivery, the vaginal delivery was performed as though the result was negative because they did not have instructions to the contrary. The doctor assumed the result was negative because the hospital scheduled it as a routine vaginal delivery. The chart, with the positive test result, was readily accessible in the hospital prior to the birth. The chart was again not reviewed by the doctor or hospital staff. Mom had an uneventful delivery of a male baby, and both were discharged home in due course. However, the mom returned the day after discharge when her baby began suffering seizures. It was then that the doctor saw mom's positive Group B Strep test, and the male baby was diagnosed with sepsis and meningitis. After a prolonged hospital course, he was discharged to return home. A lawsuit was then filed against the obstetrician and the hospital. Litigation took some time, however, as the extent of the damage to the child could not be determined until more time passed. The child had some fairly severe neurological deficits from the untreated Group B Strep, and a settlement was reached by all defendants prior to trial.

A 29-year-old male patient presented to a gastroenterologist with a laundry list of abdominal issues including diverticulosis and irritable bowel syndrome. The patient was new to the area and was establishing care. At this visit, the patient noted on his new patient questionnaire that he had Ehlers-Danlos syndrome, a connective tissue disorder. He had some mild complaints, which were treated conservatively. The patient returned less than

five months later, this time complaining of more severe abdominal problems, including bloody diarrhea. Due to the patient's extensive history, the doctor scheduled an immediate EGD and colonoscopy. On the pre-procedure form, the patient failed to note that he had Ehlers-Danlos. The procedures went well and the patient was sent home. Later that evening, the patient called the office stating that he was vomiting and had some abdominal pain. The doctor prescribed Phenergan and set up an appointment for the next day. Before the patient could be seen, he went into cardiac arrest and suffered brain damage. It was later determined the patient's duodenum had been perforated during the procedure. The lawsuit that soon followed alleged that the doctor should have been more aggressive in treating the patient's post-procedure complaints since the initial intake form mentioned the connective tissue disorder. The gastroenterologist relied on the patient-completed questionnaire and failed to review his own record, which included the history of Ehlers-Danlos Syndrome. The defense countered that the patient failed to note the syndrome on the pre-procedure form, but a jury agreed with the patient's contention and rendered a significant verdict against the doctor.

A pediatrician referred his young male patient to a local ENT due to continuing issues with upper respiratory tract infections. At the initial visit, the parents noted that their son also suffered from frequent restless and noisy breathing while sleeping. The ENT sent the child for a study to determine if he had sleep apnea, which would dictate the best place for him to have his surgery. In the meantime, surgery to remove his tonsils and adenoids was scheduled at the ambulatory surgery center. If the study confirmed sleep apnea, the surgery was going to be moved to the nearby hospital. The study did confirm that the young boy had sleep apnea. This finding was placed, unread, in the doctor's chart. A few weeks later, the adenotonsillectomy took place at the ambulatory surgery center. After the ENT completed what appeared to be a routine procedure, he left the patient with the anesthesia team to awaken the boy and discharge him home. The problem was, the child did not awaken easily. The anesthesia team administered oxygen via an ambu bag and a mask. Eventually, they administered Narcan. Everyone involved was still unaware of the sleep study finding of apnea. No thought was given to transferring the child to the hospital. Finally, the patient was stable enough to send home. Later that night, the parents found their son with a bluish color and in respiratory distress. The child was rushed to the ED and resuscitated. He was admitted for an extended stay but passed away. An attorney for the family alleged that the procedure should have never taken place in an ambulatory surgery center based on the sleep apnea. It was difficult to refute that contention based on the fact that was the exact purpose of obtaining the sleep study. An out-of-court settlement was reached.

The specialties and procedures involved in the above cases are all very different. But there is a common theme running through all of them: information was obtained and placed in the medical records, whether it was test results or a questionnaire. In all three cases the information was critical to the rendered treatment. In all three cases the information was not reviewed, leading to devastating consequences. Had there been stronger systems in place to ensure that test results had been received and reviewed, communicated to the patient and follow-up treatment decisions made, the outcomes for these three patients

would most likely have been much different.

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