Significance of signing medical chart on legal liability

Key words: Employment, medical records, negligence.

Even though medical charts are commonly found in healthcare, there seems to be confusion about their impact on legal liability. The AANA Standards of Practice provide that there be “complete, accurate and timely documentation of pertinent information on the patient’s medical record” (AANA Standards of Practice, Standard VI). The interpretive provision states that the CRNA should document all anesthetic interventions and patient responses. “Accurate documentation facilitates comprehensive patient care, provides information for retrospective review and research data and establishes a medical-legal record.” Some physicians have expressed concern that their signature on the medical chart creates liability for anything that is reported on the chart. Such concerns may have been justified when the law followed the simplistic “Captain of the Ship” doctrine. But modern decisions view the complex reality of the operating room and impose liability only where there is responsibility. What responsibility relates to signing the medical chart?

The medical chart is a convenient and well-established method to collect data concerning patients, their physical condition and health, and the care that they received or failed to receive within a healthcare facility. Like so many healthcare concepts, the medical chart has various interpretations and meanings that can vary from hospital to hospital and even site to site. Medical charts may be associated with liability because of the responsibilities they evidence, not because of any magical significance occurring on the signing of the chart.

Legal responsibilities

The case of Fischer v Canario is a good introduction to the legal significance of the medical chart and what is expected of the person who signs it. Mrs Fischer was treated in an emergency room by an orthopedic surgeon for a broken shoulder suffered in a fall. The surgeon examined an x-ray of her shoulder, diagnosed her injury as a fracture, administered medication for pain, and told her she could go home. Mrs Fischer, however, did not want to go home because there was no one at home to take care of her. The surgeon reluctantly agreed to permit her to stay at the hospital. (This occurred in 1984, when physicians could sometimes take pity on patients who might need hospital care for non-medical reasons.) The surgeon was listed as attending physician on the hospital records although he did not treat her after her admission.

Hospital policies required that all patients being admitted have chest x-rays, and Mrs Fischer was no exception. The radiologist’s report attached to the x-ray showed a probable lung tumor, but the surgeon was unaware of it. At some point, the x-ray, with the radiologist’s report, was placed in the patient’s hospital chart, but it is not clear when. Approximately 1 week after the patient was discharged from the hospital, the surgeon signed her chart. The surgeon testified that he did not see the x-ray or the radiological report revealing that Mrs Fischer had a tumor.

Two and one-half years after Mrs Fischer’s
treatment for the broken shoulder, she was diagnosed as suffering from metastatic lung cancer. By the time she was diagnosed, little could be done for her, and she died within a year after being diagnosed. Had she been diagnosed in 1984, testimony indicated that she would have had a 50% chance of a cure. Her estate sued both the surgeon and the radiologist for failing to notify her of the existence of the tumor. A jury found that the surgeon was negligent even though he had been unaware of the tumor and had admitted Mrs Fischer only as an accommodation. The radiologist, who was aware of the tumor, was not found to be negligent.

The surgeon appealed the ruling. The appellate court relied on expert testimony that a patient's attending physician was required to know what tests were performed on his patient and what the results were before he signed the chart. Therefore, whether or not the radiologist's report was in the chart, the surgeon was liable under either possibility. If the report was present when he signed the chart, the surgeon was negligent in overlooking the x-ray report and failing to advise the patient of the existence of the tumor. If the report was not attached to the chart, then the surgeon should have known that the x-ray was taken and was negligent in failing to obtain a copy of the report before signing the chart. The Supreme Court of New Jersey reversed the case and returned the matter to the trial court for a new trial on the issue of damages (143 N.J. 235, 670 A.2d 516, 1996). A harsh result for a surgeon who felt sorry for a woman living alone.

The Fischer case is one of the clearest explanations of the relationship between signing the medical chart and liability. An attending physician has certain obligations, including the obligation to review the results of all tests performed. If damage results because this burden is not carried out, the surgeon faces liability.

A physician signing a medical chart was not liable in Nieto v State of Colorado (952 P.2d 834, Colo., 1997). The plaintiff was a prisoner in the Colorado prison system who sought treatment at the prison's medical clinic. He was given cold and flu medication by a nurse employed by the state. Three days later he returned and was told to continue using the medication already given to him. Several days later he appeared again, complaining of continuing pain and a swollen right eye. This time he was told to leave the clinic, and that if he returned again he would be disciplined. Ultimately, he was found unconscious in his cell, suffering from such a severe sinus infection that he underwent eye surgery, two sinus surgeries, three brain surgeries, and suffered a stroke. He became permanently paralyzed on his left side.

He sued the state of Colorado and the Department of Corrections. A jury award of $1,440,000 was reduced to $150,000. The state defended on the grounds that the nurse and prison guard who had provided improper care were under the supervision of a physician, and since the physician was an independent contractor, the physician, not the state of Colorado, should be held liable for their negligence. The court did not accept the state's argument that the physician was responsible. The physician had supervised a physician's assistant who authorized the prescription of an antibiotic pursuant to telephone instructions. The same physician had also signed the patient's medical chart several days later. However, the physician had never seen the patient and had no independent knowledge of the patient's condition. Moreover, the jury had not determined that the nurse was being supervised by the physician. The court refused to impose liability on the physician merely because he signed the patient's chart.

Thus, the mere fact of signing the chart does not automatically create liability or responsibility. Signing the chart can be an acknowledgment of certain responsibilities as it was in the Fischer case. While the court in the Nieto case does not reveal why the physician signed the chart, the court indicates that whatever the purpose, the physician had no responsibility for the injuries. These cases demonstrate that liability is based on the physician's responsibility, not signing the medical chart.

**JCAHO requirements**

Like many other healthcare terms, medical records are analyzed and described in the Accreditation Manual for Hospitals, published by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). In addition to requirements on the administration of records by the medical record department, JCAHO has 3 requirements about medical records. First, they must be documented accurately and timely, and they must be readily accessible. Second, they must contain sufficient information to identify the patient, support the diagnosis, justify the treatment, and accurately document the course and results of treatment. Third, they must be confidential, authenticated, legible, and complete.

**Need for accuracy**

Most litigation involving charts arises out of the need for accurate charts. In the United States v Sims-Robertson (16 F.3d 1223, U.S. Court of Appeals, 6th Circuit, 1994), 2 physicians and 4 pharmacists
were convicted of being part of a drug distribution, mail fraud, and Medicaid fraud conspiracy. Testimony indicated that although the physicians were supposedly hired to supervise the practice of medicine, their duties were actually limited to signing charts for 15 minutes to a few hours per week and allowing the medical clinic to use their Drug Enforcement Agency (DEA) and Medicaid numbers to carry out its fraudulent activities. A physician's assistant testified that the supervising doctors did not review patient charts until long after the patients were examined, controlled drugs were prescribed, and tests were ordered. One of the physicians revealed her participation in the conspiracy when she told a physician's assistant to add information to patients' charts so that the charts would "look better" in case of an investigation.

In *Quintal v Laurel Grove Hospital* (62 Cal. 2d 154, 397 P. 2d 161, California, 1965), a 6-year-old patient undergoing an operation to correct the inward deviation of his eyes suffered severe brain damage as the result of a cardiac arrest. The jury returned a verdict of $400,000 in favor of the patient and against the hospital, the ophthalmologist, and the anesthesiologist. During the administration of the anesthetic, the patient suffered respiratory arrest followed by a cardiac arrest. The ophthalmologist did not feel competent to administer a manual massage of the heart. In the few minutes it took to locate another surgeon, the patient suffered irreversible brain damage.

After the evidence was presented at the trial, the defendants moved for directed verdicts in their favor, which the judge denied. The judge permitted the case to go to the jury, which rendered verdicts in favor of the plaintiff. Nonetheless, the judge set the jury verdicts aside and ordered judgment for the defendants. (Sometimes, judges think there is not enough evidence of negligence but let the jury decide in the hope that the judge will not have to rule. When the jury fails to do the "right thing," the judge orders judgment for the defendant, notwithstanding the verdict.)

The appellate court considered the evidence and found that there were sufficient inferences to support the jury verdict. One of the chief contentions was that the arrest might have been related to the patient's high temperature when he arrived at the hospital. Administering an anesthetic to a patient in the child's agitated condition, with a high temperature, could result in cardiac arrest. The hospital's records showed that the patient's temperature just before the operation was normal. However, expert testimony was presented that there had been a correction and erasure to the medical record. Even though there was no direct evidence of negligence, the need for an accurate medical record is so great that the appellate court accepted whatever inferences the jury might choose to make, including the ultimate inference that the patient's temperature was high at the time of the operation and the erasure was done to conceal the fact.

Legally, this was a rather complicated case because the trial court had refused to instruct the jury on *res ipsa loquitur* and had ordered a new trial as an alternative to judgment notwithstanding the jury verdict. *Res ipsa loquitur* (which translates as "the thing speaks for itself") is a legal doctrine that permits a plaintiff, otherwise unable to prove negligence, to pursue a lawsuit if the injury is caused by something under the control of the defendant that does not cause injury unless someone is negligent. It is often applied to cases of anesthesia mishap when the plaintiff is either asleep or unable to understand what is occurring. Trial courts are given substantial discretion by appellate courts in ruling on the adequacy of factual evidence. Even though the appellate court ruled that the judge was wrong to order judgments in favor of the defendants, the appellate court was unwilling to reverse the trial court's decision that there should be a new trial. Therefore, the appellate court permitted the case to be sent back for a new trial, although this one will presumably include instructions on *res ipsa loquitur*.

One of the interesting things about the *Quintal* case for nurse anesthetists is the court's discussion of the role of the surgeon in working with an anesthesiology provider. As indicated, there was no nurse anesthetist involved in this case. The only health-care providers were an ophthalmologist and the anesthesiologist. When the patient went into cardiac arrest, the evidence showed that the proper treatment was cardiac massage. The ophthalmologist did not feel competent to provide cardiac massage. The appellate court agreed that the jury could have found him negligent because if the ophthalmologist did not feel competent to provide cardiac massage, he should have made arrangements to make sure that there was someone else available who would.

In *United States v Custodio* (39 F. 3d 1121 (United States Court of Appeals, 10th Circuit, 1994)), a physician convicted of filing false claims with the government appealed his conviction. The physician was an obstetrician/gynecologist providing service at a local military base. In order to bill the federal government, the physician had to sign the patient's chart as well as submit a claim form signed by the patient. The government claimed that the defendant was submitting claims by signing charts of patients treated by physicians who were direct em-
ployees of the government and, therefore, unable to bill for their services. Signing a chart means that one has at least read the chart and become familiar with it. The defendant was terminated as a participant in the government insurance program when he asked an obstetric patient, who turned out to be a nurse lieutenant, to fill out a claim form. The nurse asked what had happened to the claim form she filled out when she was admitted to the hospital, and the physician told her that “the pediatrician must have picked it up for the circumcision of your baby.” The nurse responded “I thought you had reviewed my chart. I had a girl.”

Charting and employment termination

Hospitals’ responsibilities for accurate charting are so important that hospitals are given substantial leeway in terminating employees for improper charting.

In Layfield v Beebe Medical Center (1997 W.L. 817994 (Del. Super.)), the plaintiff was a nurse, terminated for failure to follow hospital policy. The nurse claimed that she was fired for following oral directions of a surgeon that the surgeon wrongly refused to acknowledge. The nurse and the surgeon were busy with a patient when a woman returned to the emergency room. The nurse spoke to the woman and the surgeon about the woman’s care. The surgeon said that he would not do anything more than was done the last time the woman was in the emergency room. The nurse asked if she should try an enema solution and the surgeon responded “whatever.”

The nurse mixed the solution and gave it to the patient, who then left. A clerk asked the nurse to indicate a diagnosis of the patient’s condition on the chart for accounting purposes. That night, the surgeon refused to sign the chart because he had never examined the patient. The next morning the patient’s daughter filed a complaint about the patient’s treatment at the hospital. The patient’s treatment was a “late” entry, and the failure to note that it was late violated hospital policy.

As a result of the incident, the hospital reviewed a number of charts in which the nurse had made entries and discovered that she had made many documentation entries that violated various hospital policies. The nurse was terminated; she sued the hospital and surgeon. She claimed her termination violated an implied covenant of good faith and fair dealing because the surgeon would not acknowledge his participation in the patient’s care. In 2 appeals to the Superior Court of Delaware, the nurse was unable to get the court to support her position. In both appeals, the nurse’s charting errors and specifically the nurse’s entry of a diagnosis on the chart and failure to indicate she was making a late entry were major factors in the court’s upholding of the nurse’s termination.

Finally, the case of Maxey v United States (1989 W.L. 56497 (W.D.Ark.)), is an example of how not to chart. Dr Maxey, an employee of the Veteran’s Administration (VA), was having a dispute with administration as to whether, as a surgeon, he could refuse to accept responsibility for “medical” patients. Dr Maxey maintained that his refusal to treat medical patients was justified by the hospital’s bylaws, because the bylaws referred to the American Medical Association’s “Code of Ethics,” which requires that physicians be competent and free to choose whom to serve. Dr Maxey argued that, as a surgeon, he was competent only to see surgical patients and the VA should hire more internists to see “medical” patients. In the view of administration, there was a shortage of physicians available and Dr Maxey failed to distinguish internal medicine, which is a specialty, from general medicine, which any physician, even a surgeon, can treat. The prime evidence of Dr Maxey’s lack of cooperation was an entry on a patient’s chart that read, “Trans. to med. or reassign as Dr Maxey can treat. The prime evidence of Dr Maxey’s lack of cooperation as evidenced by his statement in the chart was sufficient to justify his termination. Charts record patient care. They are not the place for healthcare workers to carry out their battles with hospital administration.

Conclusion

It is thus apparent, even from these few cases, that the chart or medical record is not a magic document which in and of itself confers liability or responsibility. It is a record, to be kept accurately, of a patient’s care. It has such importance as a contemporaneous document that it should not be altered. It is not a place to conduct one’s battles with hospital administration, nor is it a place to attempt to improve your position in the face of possible claims or challenges. While liability may be attached to signing the chart, the liability relates either to the patient’s care or lack of care. The chart may create liability for those who fail to keep it accurately and correctly. The chart does not create responsibility for patient care; responsibility for patient care carries with it the obligation to chart.
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