Altering Record Compounds Deadly Mistake

A 17-year-old girl underwent a routine tonsillectomy without complications at a surgical center. Following the procedure, she was taken to the recovery room and administered fentanyl for pain.

The recovery room nurse assigned to monitor the patient spent 20 minutes treating another patient and then went on break, signing out to a second recovery room nurse. On receiving the signout, the second recovery room nurse discovered that the patient was in respiratory distress and began resuscitation efforts. The patient was resuscitated but died 15 days later.

The plaintiff claimed that the girl was left unmonitored by nurses assigned to the unit and that the monitoring equipment was not used, not set properly, or muted.

During her deposition, the second recovery room nurse admitted under oath that the first recovery room nurse falsified the patient's chart; the first nurse claimed that she had assessed the patient during an important time period when she had not.

OUTCOME

The case was settled for $6 million: $1 million against the surgical center's primary policy and $5 million against its excess policy.

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COMMENT

Cases such as this one are unfortunate and avoidable—and tragically, too common. On any medical malpractice lawyer's desk is a teetering stack of potential cases; much of that stack involves narcotics. This case raises two important areas to discuss: the dangers of parenteral narcotics and the perils of falsifying medical records.

First, when parenteral narcotics are given, proper monitoring safeguards must be in place. Malpractice cases frequently involve a scenario in which patients are given parenteral narcotics and left alone, out of sight, and unmonitored. This simply can't be done. Close supervision and monitoring—with both equipment and eyes—are required to safeguard your patients *and* avoid malpractice risk.

Other malpractice scenarios involve the ambulatory patient who is given parenteral narcotics in a clinic setting and discharged after a 10-minute "observation" period—a period during which peak drug effect is probably not realized. The patient is unsafely discharged before that peak is reached and suffers potentially fatal adverse effects. Even when direct fatal effects are not realized, the patient is discharged with impaired motor coordination and cognitive judgment, placing the patient at risk in his/her surroundings.

If a clinician commits to giving parenteral narcotics, he or she commits to providing "real-time" monitoring until the narcotic effects have safely diminished and the patient's condition is thoroughly documented in the record. Generally speaking, the patient must be reasonably clear of the effects of narcotics before discharge. (Remember the special case of naloxone, administered for opiate excesses, in which naloxone is metabolized before the opiate; the patient can relapse into a coma/apnea if the naloxone fully metabolizes before the opiate.)

Here, this young woman was probably opiate naïve. While the amount she was given was certain, her response to the drug was not. She was left alone for at least 20 minutes and did not have a functioning SaO_2 monitor. Close monitoring of this patient was required but not provided.

As a result of this case, the surgical center changed several policies: Nurses must be on a one-to-one ratio with patients who have received narcotics during anesthesia. Furthermore, nurses must have line-of-sight to see patients at all times and, importantly, may not mute monitors (eg, oximetry monitors).

The second salient point of this case is never, ever alter or falsify patient records! It *will* be discovered, and your credibility will be irretrievably damaged. Plaintiff lawyers live for this, and yet clinicians continue to do it. *Don't.*

When altered medical records are discovered, the plaintiff's theory of the case will be "cover up," and jurors will be invited to pun-

ish the clinician for it. The jurors will do so.

Also problematic is an otherwise defensible case that becomes much more difficult to defend because a clinician has altered the records. Remember, the plaintiff must prove *all* aspects of negligence, including causation and damages. In some cases, the clinician knows an obvious mistake was made but does not know that the eventual damages may be minimal or attributable to another cause. By altering the medical record, the clinician may enhance the damages value of a case by introducing a punitive element. Altering records may result in a lawsuit being filed when it otherwise wouldn't have, or maintained when it would have been dropped before trial. In sum, don't create a case against yourself by altering the medical records.

Here, the falsification of records came to light during the deposition of the second nurse—who, being under oath, probably had little choice but to testify that the first nurse falsified the records. No doubt, this falsification made a bad case worse and gave the plaintiff leverage in securing more favorable settlement terms.

You can't make it right by rewriting history, but you can make it right by showing concern for the patient in your actions following a problem. You can also make it right by troubleshooting problems in a closed-door, formal peer review conference. Peer review conferences are designed for full and frank communication between clinicians and staff to solve problems, and as such they are protected from plaintiff disclosure.

This is an unfortunate case and a tragic loss of life. As clinicians, we must respect the potential life-ending power of parenteral narcotics. **—DML** **CR**