

How LNCs Can Spot AI Hallucinations in Medical Records

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AI is becoming a powerful tool in healthcare, but it brings a new responsibility for anyone who works with medical records, especially Legal Nurse Consultants. One of the biggest risks is hallucinations: when an AI confidently produces information that is not actually in the chart.

If you have ever caught a stray page from the wrong patient slipped into a paper chart, you already understand the pattern. The clinical logic breaks. The timeline collapses. Details stop matching the patient's story.

AI hallucinations look like that too. They occur when the model fills gaps, misreads context, or tries to complete a narrative instead of staying anchored to the record.

Why this matters legally: AI generated errors can distort timelines, introduce nonexistent diagnoses, or misrepresent the sequence of care. In a medical legal case, that can affect causation analysis, liability arguments, and settlement strategy. If the AI adds something that never occurred, the downstream impact is real.

Common signs include:

- **Broken timelines:** procedures before non-emergency admissions, vitals at impossible times, or events that contradict the flow of care.
- **Mismatched identifiers:** names, ages, or diagnoses from a different encounter.
- **Invented clinical events:** medications, consults, or diagnoses that never appear in the record.
- **Nonexistent page references:** citations to pages or sections that do not exist.
- **Overconfident conclusions:** the model fills in gaps instead of staying anchored to documentation.
- **Omitted details:** the AI fails to mention information that *is* in the record, creating gaps that distort the timeline or context.
- **Formatting quirks:** for example, a bracketed reference appearing where other citations use parentheses. This often signals the model is inventing information rather than pulling it from a real source.

A quick example: an AI might confidently state that the patient received naloxone even though there was no indication for it and the medication never appears in the MAR or any other chart location.

The safeguard is the same one LNCs already use: **traceability**. If a statement cannot be tied to a specific page in the record, it is not defensible, and it is not real. Another safeguard is confirming that every document referenced by the AI actually exists. If the tool cites a record that was never produced, that's a red flag for missing or phantom data.

AI can accelerate review, but it cannot replace clinical judgment. LNCs are uniquely positioned to catch these errors because we already know what a defensible record looks like. AI does not replace that skill. It increases the need for it.

AI HALLUCINATIONS: WHEN THE RECORD DOESN'T ADD UP



MEDICAL RECORD

Patient: **Jane Smith**
DOB: **04/12/1962**

ADMISSION
Date/Time: 05/14/2024 09:12
Reason: Chest pain

PROGRESS NOTE
Date/Time: 05/14/2024 10:30
Patient reports chest pain radiating to left arm.
No shortness of breath.
PCI planned.

VITAL SIGNS
Date/Time: 05/14/2024 10:30
BP 128/76 HR 72 RR 16 O2 98%

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MEDICAL RECORD

Patient: **Janet Smith**
DOB: **1981**

ADMISSION
Date/Time: 05/14/2024 09:12
Reason: Chest pain

PROCEDURE NOTE
Date/Time: **05/13/2024 14:20**
Procedure: Coronary angioplasty with stent placement

CONSULT
Date/Time: 05/14/2024 14:15
Consultant: Cardiology
Reason: Evaluation for PCI

PLAN
Start Clopidogrel 75 mg daily

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IDENTIFIER?
Different patient name and DOB

TIMELINE?
Events dated before admission

SOURCE?
Page 347 doesn't exist



TRACE IT. **VERIFY IT.** DEFEND IT.

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