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DOCTORS Rx

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A Letter from the Chair of the Board

Dear Colleague:

We are using this issue of the Doctor's Rx newsletter to remind you of a topic that is of utmost importance to your practice: medical record documentation. While we are aware that this is an area of risk management that we spend a great deal of time focusing on, it is also an area where we have some of our greatest concern. Too often we see medical malpractice lawsuits come in the door that have elements of inadequate or non-existent documentation that make the defensibility of many of these cases problematic.

Please take a few moments to reacquaint yourself with these principles of good documentation and see how they can help liability-proof your practice.

D. Ted Lewers, M.D.
Chair of the Board
Medical Mutual Liability Insurance Society of Maryland

Documentation Pitfalls: Ways To Avoid Them

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Introduction

Through technology, plaintiff attorneys have found new ways to use documentation, or the lack thereof, against physicians. Physicians have heard time and again about the importance of complete and accurate documentation to reduce liability risk. In the current liability environment, it is, however, more important than ever to revisit this topic and to take documentation to the next level. Not typically or necessarily more, but better.

Computer technology and animation are powerful evidentiary tools when placed before jurors. Plaintiff's attorneys use these tools looking for the factual issue in medical records documentation that can inflame

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Continued on next page

a jury. For example, plaintiff attorneys can place on a large screen before the jurors a medical record focusing on one line that is incomplete, illegible, or inconsistent with other portions of the chart. They then use it to show discrepancies, lack of information, and errors, but in a way never done before. What comes as a result of this changing litigation climate is a greater impact on frequency and severity; that is, the number of claims pursued and the cost per claim.

To counter the above, it is not necessarily more documentation that needs to occur, but better documentation by better means. Let's go on the offensive, particularly where we know we're being hurt. Documentation provides the evidence to show what you have done, what you have said and provides the foundation upon which you will be judged. There are several common documentation pitfalls that physicians often face. Many are described below along with some simple and practical documentation methods for reducing risk. The following focuses on issues that happen in everyday practice and attempts to give you, relatively speaking, simple tools to address them.

Common Documentation Pitfalls and Ways to Avoid Them.

Telephone Calls/Triage. One of the weakest areas of documentation involves the telephone. So often, clinical information is exchanged and actually used by the clinician to make certain treatment decisions and yet the clinical information is not documented. That is, both the symptoms relayed by the patient to the physician and the treatment recommended by the physician to the patient are nowhere to be found

Doctors RX

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Claims Department Fax	410-785-1670
Web Site	www.weinsuredocs.com

in the chart. When a problem arises, a "swearing contest" gets played out in the courtroom. These "he said, she said" contests are very often won by the patient. It may be easier for a jury (a group of patients) to believe a patient's "story" where the patient has seen only this one physician whereas the physician over the years has seen hundreds of patients, or more. It can be hard for a juror to believe that a physician who has not completed documentation regarding a phone call can remember the patient and can remember the particulars of the phone call as well, when there has been no documentation and several years have passed. This all too often looks like merely self-serving comments on their part. Often, what the physician has to rely on is, "I know if she told me that, I would have asked her to come in promptly….that's what I always do."

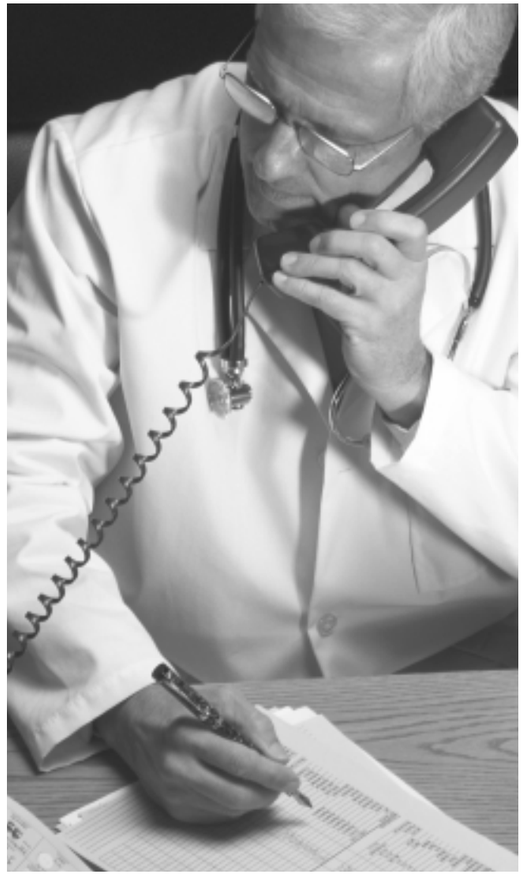
Take for example a lawsuit alleging permanent injury to a child that could have been avoided had a physician examined the child or given proper instructions to a mother who had telephoned the clinic to complain that the child was continuing with headaches after being seen in the ER the day prior. The clinic is closed, but a nurse takes the initial call and relays to a clinic physician the child's symptoms, including that the child was no worse than the day before, and the ER diagnosis made the day prior. Neither the nurse nor the physician ever notes that the child's condition had not worsened, and now in a lawsuit, the claimant alleges that the child's condition was worse when the mother spoke with the nurse. This places the physician in a challenging position from a legal standpoint, a situation that could have been avoided with proper documentation. In addition, the note does not reflect that the physician's instructions were to bring the child to the ER if the child's condition became worse or if the mother were concerned, but otherwise could be seen in the clinic the next day. Again, since the note does not accurately reflect the instructions, a "swearing contest" ensues.

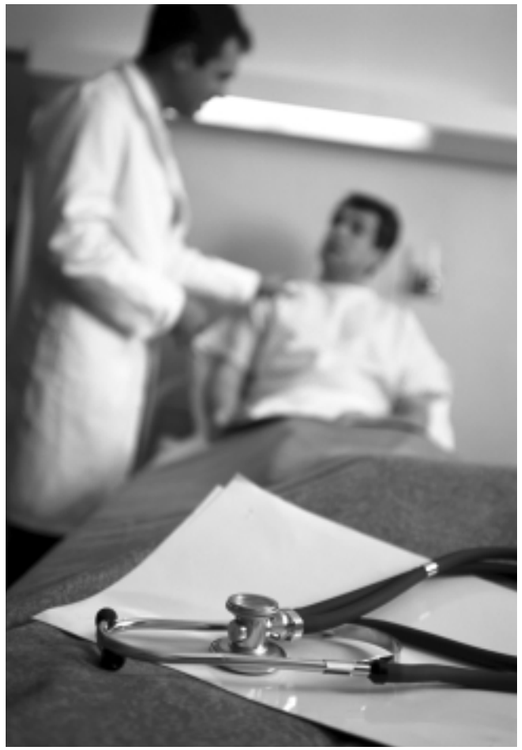
To decrease risk with telephone calls where patients seek medical advice, physicians should have in place a telephone policy. All calls should be accurately documented using for instance a telephone note pad, which documents:

- Name of caller
- Name of healthcare provider taking call
- Content of information relayed by caller, including all symptoms expressed (use a symptoms check list)
- Content of "advice" provided by physician or staff
- Note the time of the call
- Note the caller's expectations (for example, is a return call expected from the physician by the end of the day?)
- When a caller is not satisfied with advice given or it appears to be an emergency, direct the patient to the ER, and document the instructions given to the caller

Forms. Physicians are at risk not only for negligence claims, but also for lack of informed consent claims. Generally, informed consent requires that a patient be informed of the risks and alternatives to a surgical procedure or treatment modality. Often times, physicians use a template in which they must fill in the risks and alternatives. However, with the use of procedure-specific forms along with an attestation by the patient, the risk of informed consent claims can be reduced. At the beginning of the form, the patient must verify that he or she understands the procedure, its risks, its alternatives, and the risks to the alternatives as well as he or she has had all their questions answered. At the end of the form, the patient verifies that they have read the form, understand the form contents, and have no further questions.

In addition, physicians may find themselves in a quandary when a patient refuses a recommended medical treatment or procedure. Without documentation of the refusal, the patient can later file a negligence lawsuit which alleges that they were not adequately informed of the importance and benefits of the treatment or procedure and otherwise would have had it done. By incorporating an informed refusal document into a practice, the risk of such an allegation can be reduced. The form puts the responsibility on the patient and states the benefits of the treatment or procedure as well as the risks or complications of the refusal and that the patient, despite the physician's recommendation, has refused the treatment or procedure. It is then signed by the patient and witnessed and placed in the patient's medical chart.



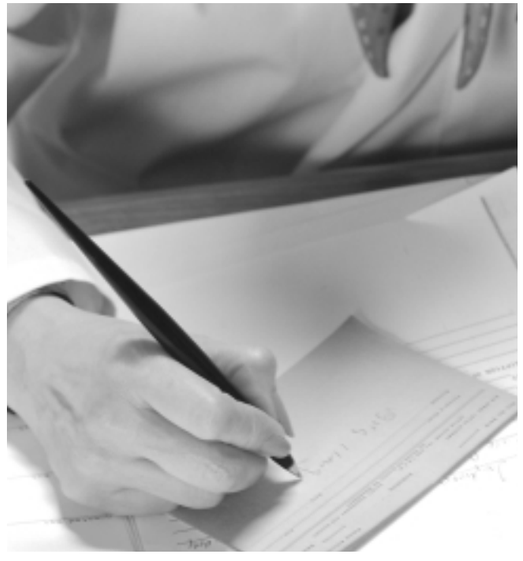


Similarly, non-compliant patients may later file a negligence lawsuit alleging that they were unaware of medical treatment that was recommended. However, with the use of an at-risk letter, physicians can both document that a patient was aware of the importance of following certain medical treatments and also attempt, for the benefit of the patient, to bring the patient back on course with the medical regime. In one recent situation, a patient had missed 9 obstetrical appointments. The physician sent the patient an at-risk letter explaining the importance of keeping obstetrical appointments for the health of the mother and the baby. The patient kept her next appointment and thanked the physician for sending her the letter because she was unaware of how important it was to keep her appointments. She has not missed one since! However, these letters also document that the patient knows not only that the patient is being non-compliant, but also the consequences of the same.

Consider as well the situation where a patient refuses medical treatment or a procedure against medical advice. Again, without proper documentation, this can result in the "swearing contest." Particularly worse is the situation typically seen in this scenario where a patient dies and the family subsequently learns that if the patient had had a certain treatment or procedure, the patient would have lived. Loved ones often do not believe that the patient would have refused a treatment or procedure that could have saved or extended the patient's life. Of course, the patient is not available to set the record straight. When a patient refuses such a treatment or procedure, a document, an informed refusal form, could be used, setting forth the recommended treatment or procedure, the benefits of the recommendation, and the consequences of not having the recommended treatment or procedure. This document then provides the evidence that clearly shows that the patient was informed and that the patient chose not to move forward with the recommended treatment or procedure.

Inadequate history taking is an oft-cited reason for delay in diagnosis and failure to diagnose cases. In a number of circumstances, an inadequate history is not the fault of the physician who has attempted to elicit the information, but rather the inaccurate memory of a patient or a patient not aware of the importance of such information. With the addition of an attestation to the end of history form that is signed by the patient, it places the responsibility on the patient. This simply means placing a statement under the signature line such as: "The above is true and correct to the best of my belief." After incorporating this section onto a history questionnaire, practices have seen patients take this responsibility more seriously, taking the form home with them to complete or refusing to sign until they are certain it is accurate. The form should also start with a statement such as "The following information is very important to your health. Please take the time to fully and accurately fill out this form." This statement drives home the point that the patient's medical history is important and that it is the patient's responsibility to provide it.

Handwriting. Jurors will penalize physicians for illegible handwriting.[2] With the addition of technology in the courtroom as well as states enacting prescription legibility laws requiring legible print or type, this issue has greater significance from a liability perspective.



[2] See Prager, L.O. "Jury Blames Doctor's Bad Penmanship for Patient's Death." Am. Med. News 1999, Nov. 22/29 (accessible at http://www.ama-assn.org/amednews/1999/pick_99/prl12.122.htm) (discussing Texas jury award of $225,000 against a physician).

Jurors are not forgiving of a physician who does not write legibly so that a colleague or staff person cannot read the writing. It is unsafe behavior.

Alterations. A medical record should unequivocally never be altered. No record should be destroyed or whited-out. Physicians are often tempted to "right" a medical chart in retrospect recalling something that was not noted, after litigation has ensued. While it may be accurate, it will most likely not appear that way to a jury, as it looks like the physician is trying to cover something up. Alterations affect a physician's credibility in the courtroom and may force settlement when in fact no negligence occurred.

In one case, a physician failed to fill out the physical exam sheet after a physical examination was performed on a patient. The physical examination was normal. The patient later was diagnosed with metastatic cancer and died. Before the patient's death, she was very angry and there continues to be a potential for a claim of delay of diagnosis and negligence for failure to perform a physical examination. The physician, after notification of the patient's diagnosis, was perplexed and went back through the medical chart. The physician noticed that the form had not been completed and then did so – years later. The physician did not realize that plaintiff's attorneys often employ handwriting experts to review paper, print, and ink – all to verify the integrity of the record. In this particular case, a subsequent review of the record made the case indefensible!

If done properly, an addition, or late entry, can be appropriate. Nothing in the record should be altered; instead, the addition should be in the form of an addendum, with the reason for the late entry noted. The addendum should accurately indicate the date and time the addendum was done and what entry it is in reference to. Any addendum to the medical chart should be made as soon as possible after a discrepancy, error, or omission has been discovered. When in doubt, seek advice.

Abbreviations. Abbreviations often can be misinterpreted. JCAHO recently added a "do not use" list of abbreviations to its 2004 National Patient Safety Goals. When misinterpreted or misunderstood, certain abbreviations can lead to harmful errors, especially involving medications. By January 2005, the abbreviations cannot appear in any patient-related documentation. For example, never use a zero by itself after a decimal point (X.0) and always use a zero before a decimal point (0.X). For other examples and more information concerning this important area of risk, see JCAHO's website: www.jcaho.org.

Brochures. Patients often receive brochures from a practice that provide recommendations and educational information. In one case, a diabetic patient alleged that she was not made aware that she was to notify her obstetrician of swelling and other symptoms indicative of pre-eclampsia. It was alleged in the lawsuit that the physicians failed to inform the diabetic patient that she must inform the obstetrician. It became important as to whether she was given any practice brochures. An educational materials log can be incorporated into a patient's medical chart listing the various practice brochures and when a brochure is given to a patient it can be checked off and dated.

Referrals. Failing to document a referral and the reason for the referral appears all too often in litigation. Not only must physicians be cognizant of documenting what they are doing, but also why they are doing it. For example, is a referral being made to a specialist to rule out a suspected disease process or is it for further evaluation of an unknown etiology? The issue in litigation can become - who had the responsibility for evaluation and treatment - the treating physician or the referral physician? By documenting not only the referral but also the reason for it, one can create evidence for oneself. Patients often have not followed through in making a referral appointment or keeping a referral appointment, often times unbeknownst to the treating physician. Document the referral; document the referral appointment; and document review of letters from a referral physician. In addition, particularly in the high-risk practice areas or with high-risk referrals, document follow-up on whether an appointment was made and kept. Many cases have been filed in which it is alleged that a life or death referral was never made by the physician.

Conclusion.

Again, plaintiff's attorneys are reviewing medical records, looking for that documentation pitfall that can help them prove their case and even inflame a jury. Of course, having good documentation can go a long way in preventing a claim in the first place – either because the lawyer will not invest in the case or might not be able to find a suitable expert. Therefore, it is important to start now to take documentation to the next level.

As a first step, recognize where you are at risk. This may involve auditing. Once it is determined where risk lies, work on a Documentation To Do List. Incorporate forms and procedures into your daily practice as recommended above. By taking the recommendations above and incorporating the documentation tools and procedures into your practice you can reduce your risk of a lawsuit in the first place and secondarily reduce the severity of a claim or lawsuit should one arise.

Risk Management Program "Needs Assessment Survey" on MEDICAL MUTUAL Web site

Let us know how we can better meet your educational needs! MEDICAL MUTUAL's Risk Management Department is offering a needs assessment survey on our web site. This survey asks you to name the "top risk management concerns that you would like to see addressed through an educational activity" along with related questions in a brief, five-question format. Please take a few moments to give us your feedback so that we can design even better educational programs for you and your medical office staff.

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CME Test Questions

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Instructions—to receive credit, please follow these instructions:

1. Read the articles contained in the newsletter and then answer the test questions.
2. Mail or fax your completed answers for grading:

   Med•Lantic Management Services, Inc. Fax: 410-785-2631
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3. One of our goals is to assess the continuing educational needs of our readers so we may enhance the educational effectiveness of the Doctors RX. To achieve this goal, we need your help. You must complete the CME evaluation form to receive credit.
4. Completion Deadline: January 7, 2005
5. Upon completion of the test and evaluation form, a certificate of credit will be mailed to you. Please allow three weeks to receive your certificate.

1. As long as a physician is completely sure about what he/she told a patient, that should be sufficient to prove that the conversation took place.

   A. True B. False

2. Late additions to the record can be problematic but are ok if you can squeeze them in so that they look to be in chronological order.

   A. True B. False

3. One of the weakest areas of documentation occurs from telephone calls.

   A. True B. False

4. Jurors tend to believe patients in "he said/she said" scenarios.

   A. True B. False

5. An attestation statement drives home the point that a patient's medical history is important and that it is the physician's responsibility to provide it.

   A. True B. False

6. "At-risk" letters advise patients of the fact that they have been non-compliant and the consequences of their actions.

   A. True B. False

7. Jurors forgive physicians for writing illegibly because everyone knows that you can't read a physician's handwriting anyway.

   A. True B. False

8. JCAHO has added a "do not use" list of abbreviations to its 2004 National Patient Safety Goals.

   A. True B. False

9. Once you've referred a patient on to a specialist, you're home free!

   A. True B. False

10. Retrospective "righting" of a medical record by whiting out the incorrect information will help your case in the long run.

    A. True B. False

CME Evaluation Form

Statement of Educational Purpose

"Doctors RX" is a newsletter sent twice each year to the insured physicians of MEDICAL MUTUAL/Professionals Advocate. Its mission and educational purpose is to identify current health care related risk management issues and provide physicians with educational information that will enable them to reduce their malpractice liability risk.

Readers of the newsletter should be able to obtain the following educational objectives:
1) gain information on topics of particular importance to them as physicians,
2) assess the newsletter's value to them as practicing physicians, and
3) assess how this information may influence their own practices.

CME Objectives for Documentation Pitfalls: Ways to Avoid Them

Educational Objective: Participants should be able to:
1) Identify areas of risk in the documentation context
2) Gain an understanding of the need for documentation risk reduction strategies
3) Incorporate simple tools into day-to-day practice policies

	Strongly Agree				Strongly Disagree
Part I. Educational Value:	5	4	3	2	1
I learned something new that was important.	❑	❑	❑	❑	❑
I verified some important information.	❑	❑	❑	❑	❑
I plan to seek more information on this topic.	❑	❑	❑	❑	❑
This information is likely to have an impact on my practice.	❑	❑	❑	❑	❑

Part 2. Commitment to Change: What change(s) (if any) do you plan to make in your practice as a result of reading this newsletter?

_____

_____

_____

Part 3. Statement of Completion: I attest to having completed the CME activity.

Signature: _____ Date: _____

Part 4. Identifying Information: Please PRINT legibly or type the following:

Name: _____ Telephone Number: _____

Address: _____

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_____

_____