The Importance of Documentation:
The Medical and Legal Issues

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Goals

- Review the Importance of Medical Documentation
- Discuss the Improved SOAP note and how its documentation can reduce malpractice risk
- Do's and Don'ts of Documentation
- Review 5 High Risk Diagnoses for Malpractice
- How Documentation affects Billings
- Review Specific Cases of Poor Documentation and their Legal Implications

Disclaimer

I have NO personal financial relationship with any manufacturer of products or services that will be discussed in this lecture.

“Excellence in medical documentation reflects and creates excellence in medical care.”

Teichman, PG; Documentation Tips for Reducing Malpractice Risk, 2000 American Academy of Family Physicians.

Importance of Medical Documentation

- **Function of Medical Documentation**
  - Provides all the information about a specific patient that any doctor looking at the record would need to know to treat that patient.
- **Significance of Medical Documentation**
  - Essential for standards of care to be met.
- **Medical Billing and Coding**
- **Standards of Care**
  - Neglecting to document important details can lead to adverse patient outcomes and malpractice suits. Documentation is legal protection for both patient and physician in the event of disagreement over care.
- **Ethics**
  - Adequate medical documentation assures patient confidentiality and ensures that standards of care are met. Failure to treat illnesses to the best of a physician's ability based on the documented patient's medical record compromises medical ethics and professional conduct.

Improved SOAP note

- "At its best, the medical record forms a clear and complete plan that legibly communicates pertinent information, credits competent care and forms a tight defense against allegations of malpractice by aligning patient and provider expectations."

- **OLD:** SOAP (Subjective, Objective, Assessment, Plan)

- **NEW:**

S O O O A AP

(Subjective, Objective, Opinion, Options, Advice, Agreed Plan)

Teichman, PG; Documentation Tips for Reducing Malpractice Risk, 2000 American Academy of Family Physicians.

S O O O A AP

Subjective, Objective, Opinion, Options, Advice, Agreed Plan

Subjective:

- **Use direct patient quotes**
  - Demonstrates your attention to patients
  - Highlights main areas of concern
  - Builds credibility into the record
  - Accurately documents a patient's competency, affect, and attitude.
  - **FOR EXAMPLE**: *" I've been to 20 doctors and no one can help me."*

- **Complete Review of Systems with an inquiry**
  - **FOR EXAMPLE**: *"Do you have any other concerns?"*
  - Documenting all concerns addressed demonstrates your thoroughness in obtaining the patient's history, and
  - Avoids later charges that the patient brought an important symptom to your attention that you ignored or neglected.

S O O O A AP

Subjective, Objective, Opinion, Options, Advice, Agreed Plan

Objective:

- **Provides a list of measurable, reproducible data:** Vitals, Labs, Imaging
- **Perform sensitive exams (breast or genital) with a qualified assistant present:**
  - Document such: **FOR EXAMPLE:** *"Chaperoned exam of ..."*
- **Avoid judgmental or potentially anger provoking descriptors:**
  - **FOR EXAMPLE:** Replace *"Needs a bath"* with *"Hair oily. Scent of body sweat present."*
- **Include descriptors that lend insight but exclude your interpretation:**
  - **FOR EXAMPLE:** *"Two inch black swastika tattoo present on left biceps."*
- **Avoid embarrassing or easily misunderstood descriptors:**
  - **FOR EXAMPLE:** **SOB** may be misinterpreted, and the patient may respond to such a label with anger. Remember, the **medical record belongs to the patient**!

S O O O A AP

Subjective, Objective, Opinion, Options, Advice, Agreed Plan

Opinion:

- Communicate the limitations of medical diagnosis
- Should preclude absolutism
- Strive to provide an impressive record of your comprehensive care
- Avoid false certainties in diagnoses

- Reduce burden of unmet expectations
- Document your thought process and differential diagnosis
  - **FOR EXAMPLE:** *" likely gastroenteritis, appendicitis possible."*

- To patients, their families and jurors, unmet expectations are the emotional equivalent of broken promises.
- Disappointment provokes anger.
- Anger precipitates malpractice claims

- Clearly explain that the assessment is an opinion that may change as new findings develop and additional treatments may then be needed.

S O O O A AP

Subjective, Objective, Opinion, Options, Advice, Agreed Plan

Options:

- Supplies evidence of INFORMED CONSENT or INFORMED REFUSAL
  - Consent and Refusal are CHOICES
  - To choose, requires ALTERNATIVES
  - Discuss Alternatives, risks and benefits of evaluations and treatments
  - Review likely outcomes if treatment is withheld or refused and
  - DOCUMENT the patient's ability to understand the repercussions of the refusal
  - FOR EXAMPLE: *" Consistent with the patient's informed choice."*
  - Consider dictating during your patient encounter.

S O O O A AP

Subjective, Objective, Opinion, Options, Advice, Agreed Plan

Advice:

- Share your expertise and encouragement
- Document your reinforcement of the principle that the physician advises and the patient chooses
- Confront unreasonable expectations
- Open disagreement is acceptable
- Document encouragement of health maintenance and wellness
  - **FOR EXAMPLE:** *"Urged smoking cessation and offered assistance."*

S O O O A AP

Subjective, Objective, Opinion, Options, Advice, Agreed Plan

Agreed Plan:

- **Document goals or expected outcomes and specify a time frame**
  - **FOR EXAMPLE:** *" Recheck if not better in 5 days, sooner if worse."*
- **Anticipate possible serious adverse events and teach your patients to notify you if they occur and document that you have done so.**
  - **FOR EXAMPLE:** *" Patient knows to call any time if an emergency arises."*
- **Document statement of agreed plan which seals patient's accepted responsibility into the medical record.**
  - **FOR EXAMPLE:** *"Patient understands and agrees."*
    "Patient agrees to follow up."
    "Patient states he will keep appointment."

A sample SOOOAAP note

S**ubjective:** 41-year-old white female states, "I felt a lump on my right breast yesterday." Lump is nontender without pruritus, bleeding or nipple discharge. No associated fevers, chills, fatigue, weight change, hot flashes, back or joint pains. No personal or family history of breast cancer. Menarche at age 13, mother of three, first born at age 22, all breast fed to age 1 without problems. Normal LMP three weeks ago, contraception via condoms, infrequently performs BSE, drinks three to five cups of coffee daily, nonsmoker. No other concerns today.

Objective: Chaperoned exam by nurse A.C. BP, 120/70; P=66; RR=14; T=99.2 oral; weight=138 lbs. Lungs clear bilaterally, Heart RRR, no palpable vertebral tenderness or spinal deformity. Breast without skin color or texture change, no retractions. Left breast without nodularity or expressed discharge. Right breast with 1.5 cm, mobile, smooth-bordered, rubbery, nontender lesion at 10 o'clock. No other lesions. No nipple discharge. No axillary lymphadenopathy bilaterally.

Opinion: Right breast lump. Specific diagnosis unclear. History and exam favor fibrocystic change. Rule out malignant involvement.

Options: Reviewed observation with re-examination through full menstrual cycle vs. ultrasound with possible biopsy. Symptomatic treatments reviewed including caffeine reduction and hormonal stabilization with OCPs.

Advice: Advised ultrasound characterization now with possible follow-up investigations including biopsy and/or excision. Tripartite nature of breast cancer reviewed. Encouraged annual screening mammography and reviewed its diagnostic limitations. Instructed BSE. Reminded patient she is due for lipid profile.

Agreed Plan: Patient chooses ultrasound now. Radiology appointment scheduled. She understands need for close follow up and states she'll keep appointments. Recheck in one week. Dictated in patient's presence.

Many physicians complain that they do not have the time to write sufficient records!

"Would you rather spend the time in court for 12 weeks, 5 days a week, from 9am to 5pm?"

Boschert, Sherry; Documentation dos and don'ts can derail a lawsuit, 2005 OB/GYN News.

Do's and Don'ts of Medical Documentation

- **Don't Destroy Evidence**
  - In some states, destroying a record is an added offense.
- **Don't Ever Change the Record**
  - Sophisticated technology can detect alteration of records. Again, in some states this is an added offense.
- **Do Label any addition to the chart as a "late entry"**
  - If it is self serving late addition, lawyers will hammer you with it
  - If it attempts to be objective about what occurred and the its timing, then it is appropriate.
- **Do Time and Date your entries in the record**
  - Chronicity is very important to reconstruct what happened.
  - Don't rely on memory – recall is faulty
- **Do include significant positives and negatives from the patient's history and physical exam**
  - Many records lack any mention of history, or references to history are illegible.

Do's and Don'ts of Medical Documentation

- **Do Make your notes legible.**
  - You will not look credible in court if an unreadable squiggle has meaning to you and no one else.
- **Do indicate that you reviewed the laboratory data etc**
  - Physicians frequently neglect to note these things in the record.
- **Do Describe your Management Plan well**
  - Provide detail and rationale as to your plan.
- **Don't Editorialize about your patient or anyone else**
  - Personal comments are recipe for legal disaster!
- **Don't Add Risk Management Comments**
  - *"There were not enough beds available."*
- **Don't include Peer-Review Comments**
  - *"Dr. Smith failed to arrive in a timely fashion."*
  - Use the appropriate hospital committee to take the matter up, NOT the chart.

5 High Risk Diagnoses for Malpractice

- Myocardial Infarction
- Breast Cancer
- Appendicitis
- Lung Cancer
- Colon Cancer

5 High Risk Diagnoses for Malpractice

- **Myocardial Infarction**
  - Typical claim involves allegation of misdiagnosis or mismanagement of tests.
  - Common pitfall is **POOR DOCUMENTATION** of characteristics and precipitating factors for chest pain.

- **Breast Cancer**
  - Most common allegation is that doctor's actions or lack of action led to delay in diagnosis with subsequent injury to the patient.
  - Common pitfall is **failure to document** a clear followup plan, failure to followup on abnormal mammograms, and failure to order diagnostic tests.

- **Appendicitis**
  - Allegations concentrate on **failure to document** an adequate examination and failure to provide proper followup care.
  - Common pitfall is **failure to document** a reasonable effort to rule out appendicitis and **failure to clearly document** and elucidate a followup plan should the patient's symptoms change or worsen.

5 High Risk Diagnoses for Malpractice

- **Lung Cancer**
  - Typical allegation claims that physician did not recognize the importance of a symptom in enough time for early diagnosis and curative therapy.
  - Common pitfall is failure to order chest films in patients whose symptoms might indicate lung cancer.

- **Colon Caner**
  - Typical claim is that physician did not intervene with diagnostic tests when symptoms indicated.
  - Common pitfall is physician **fails to document** the recommendation for a test and if the patient refuses the test, **failure to document** that the patient is made aware of the risks of refusal.
  - *"If I had known why my doctor ordered that sigmoidoscopy, I would have done it. He just did not explain it to me."*

“The palest ink is better than the strongest memory.”

Legal Ramifications of Medical Documentation

- A Fully Documented record can forestall a suit.
- A Poorly Documented record can lead an attorney to aggressively pursue the claim.
- Benefits of Full Documentation
  - It provides Proof that you indeed did the right thing.
    - Not writing it down affects the weight of your testimony
    - All things being equal, a jury is much more likely to believe your testimony if it is supported by a good chart.
  - It support the idea that you are a careful, caring physician who gave adequate thought and consideration to the case.

Billing Ramifications of Medical Documentation

- **Billing Guidelines**
  - **The service(s) must be medically necessary.**
    - This is by Medicare's definition, NOT yours.
  - **The service(s) must be performed.**
    - If you bill for a service that you did not perform, then the service was NOT performed.
    - If you bill for a service and you performed a different service, the service you billed for was NOT performed either.
  - **The service(s) performed must be sufficiently documented to show medical necessity.**
    - This is the most important.
    - It all comes down to DOCUMENTATION.
    - You can be a highly credentialed physician who does great work and you are honest and bill exactly what you perform. However, if you don't document sufficiently for the services rendered, it is as if you did NOT perform the work at all.

Billing Ramifications of Medical Documentation

- **Medicare's specific stand on Documentation:**
  - If it is NOT documented → then it did NOT happen
  - If it cannot be understood → then it did NOT happen
  - If it cannot be read → then it did NOT happen
  - If it did NOT happen → then it should NOT have been paid
  - If it was paid → then they will ask for the money back (usually with a "tip" attached)

CASES

FACTS:

The patient, a 51-year-old, self-employed truck driver with a history of heavy smoking and alcohol use, sought treatment from Dr. M (an internist) for arthritis. At his initial visit, the patient refused a complete physical. He said that he didn't have health insurance and couldn't afford it.

Dr. M saw the patient for arthritis treatments nine times over the next 11 months. At his 10th visit (although the patient had no complaints of chest pain) Dr. M convinced him to undergo a baseline EKG, which revealed some abnormalities. Dr. M recommended a referral to a cardiologist, which the patient refused and stated he couldn't afford. Dr. M did not document the fact that the patient refused both of his recommendations - to undergo a complete physical and to consult with a cardiologist about the EKG results.

Ten days after his last appointment with Dr. M, the patient was found dead in the sleeper portion of his semi-truck. An autopsy identified the cause of death as atherosclerotic cardiovascular disease with a myocardial infarction.

The patient's wife filed suit alleging failure to: properly diagnose and treat the patient; obtain timely cardiac consultation; and conduct follow-up EKGs.

ISSUES:

The issues in this case included:

failure to inform patient of the possible consequences of delaying the detection of potential cardiac disease

failure to document non-compliance

lack of informed refusal

OUTCOME:

The case resulted in a settlement on behalf of the physician.

RISK MANAGEMENT LESSONS:

Courts have established that it is the physician's responsibility not only to inform patients of recommended treatment, but also the consequences of not following the physician's recommendations. In this case, Dr. M breached his duty of care by failing to inform the patient of the potentially serious consequences of not consulting with a cardiologist.

The lack of documentation indicating that Dr. M discussed cardiac risks with the patient or that the patient refused to see a cardiologist made this case impossible to defend.

FACTS:

The patient, a 34-year-old man with a ten-year history of poorly controlled diabetes, sought treatment from an internist who prescribed Lisinopril 5mg/day. Over the next year, the patient's creatinine levels fluctuated within the normal ranges. During the second year of taking the medication, at two consecutive office visits that were four months apart, the patient's creatinine levels varied between the abnormal ranges of 4.7 and 7.4 mg/dL, respectively. The internist referred the patient to his choice of three different nephrologists; however, the patient never made an appointment to see one of them.

Nearly a year after the nephrology referral, the patient was involved in a car accident and admitted to the hospital. During his hospital stay, it was discovered that the patient had a creatinine level of 12.6 mg/dL and was in renal failure. The patient underwent dialysis treatments and a kidney transplant. He also filed a lawsuit against the internist alleging failure to properly manage his diabetes and creatinine levels.

Upon receiving notice of the lawsuit, the internist reviewed the patient's medical record and realized that he had not recorded everything he told the patient regarding the risk of kidney failure, the importance of adhering to a diabetes regimen, and the importance of seeing a nephrologist. Based on his recollection of conversations with the patient, the internist added this information to the medical record prior to releasing it to the plaintiff's attorney.

During trial, the plaintiff attorney was able to prove, via forensic experts, that the internist added to the existing medical record entries. This had an extremely negative affect on his credibility in the eyes of the jurors, effectively sabotaging the physician's defense.

ISSUES:

The issues in this case included:

inadequate medical record documentation

failure to track whether the patient followed through on the referral to a nephrologist

failure to document non-compliance

lack of informed refusal

alteration of the patient's medical record after the fact - this critical issue made the case extremely difficult to successfully defend

OUTCOME:

Prior to a verdict being rendered, the case was settled on behalf of the plaintiff for a significant sum of money.

RISK MANAGEMENT LESSONS:

As this case clearly demonstrates, it is never acceptable to alter a medical record, even if the reason appears to be harmless or is an attempt to document what the physician remembers to have occurred. Altering the record after the fact greatly increases the likelihood of a plaintiff verdict in a malpractice claim. It also can subject the physician to disciplinary hearings and sanctions by state licensing boards and hospitals at which the physician has staff privileges. Fines, attorney fees and other costs resulting from these hearings are not covered under American Physicians' policy. And, in many states, alteration of a medical record could result in criminal prosecution.

Upon receiving notice of a lawsuit, it is recommended that the patient's medical record be locked in a secure cabinet with limited access. In the case of electronic medical records, the physician should check with their software vendor to see if they can prohibit access to the patient's file. It is important for physicians and staff members to understand that medical records should never be altered, amended, or revised after receiving notice of a lawsuit. Altering a medical record includes adding and/or removing information from the chart.

FACTS:

A medical assistant, who had been employed at a health clinic for approximately six months, asked one of the physicians to look at his eye so he would not have to leave work to see his family physician. He said he had been raking leaves and thought something had gotten in his eye because it was irritated, watery, and pink.

The physician took him to an examination room and shined a light on the eye. In deposition, the physician stated that there appeared to be a slight abnormality on the cornea, which she felt could have been a small foreign body or an abrasion. She did not think it looked like "pink eye," but was not sure. The physician claimed she explained to the employee that, because she did not have a slit lamp and was not sure what was causing the problem, the employee should see an ophthalmologist soon to determine if there was a foreign body in the eye. The physician also wrote him a prescription for Cortisporin eye drops.

The employee filled the prescription, but did not go to an ophthalmologist. In deposition, the employee claimed he was not instructed to see an ophthalmologist. He also said that when he came to work the next day and told the physician his eye was still watery, she told him to keep using the eye drops. He also admitted in deposition that he did not know what a slit lamp was or why it might be used.

Approximately a week and a half later, the employee went to an urgent care center complaining that his eye felt like it was being poked by needles. The urgent care center arranged for him to see a specialist, who diagnosed Herpes Simplex Keratitis. This ultimately resulted in structural damage to the cornea and likely permanent loss of vision.

ISSUES:

Allegations in this case included: 1) failure to timely and properly diagnose the herpes simplex virus; 2) failure to refer the employee to a qualified healthcare provider in a timely manner; and 3) improperly prescribing a topical steroid, which caused the keratitis to rapidly worsen. (The plaintiff expert asserted that antiviral agents should have been ordered instead.)

OUTCOME:

The case went to trial, but was settled prior to a verdict being rendered.

RISK MANAGEMENT LESSONS:

Because there was no medical record documenting the treatment given or the advice provided, this case revolved around the physician's recollections of events versus the employee's. During trial, the plaintiff's attorney strived to create ambiguity in the minds of jurors as to time frames for referral and treatment. This appeared to be effective with the jurors, resulting in the defendant physician settling the claim.

This case demonstrates the need to document all care provided, even when the patient is an employee. Everyone treated in a physician's practice should have a medical record documenting the treatment provided, prescriptions provided, and recommendations for follow-up.

Unfortunately, this physician "thought" the employee had a better understanding of the treatment and recommendations. It is common for doctors to assume that employees and other medical personnel know more about their medical condition than they really do. As this case demonstrates, such assumptions can lead to dire consequences for the physician.

FACTS:

The patient, a 50-year-old woman, began treatment with her primary care physician in 1995 for persistent difficulty with hot flashes and mood swings related to menopause. The physician performed a complete gynecologic physical, including a bilateral breast examination. He specifically noted that the breast examination showed no gross lesions, dominant masses, tenderness or discharge. He ordered a screening mammogram, and placed the patient on Hormone Replacement Therapy (HRT) to relieve her menopausal symptoms. The mammogram was performed later the same year and read as normal. However, it noted that the patient had unusually dense and fibrocystic breast tissue.

Three years later, in September 1998, the patient returned to her primary care physician complaining of a possible lump or cyst in her right breast. Upon examination, the physician noted a "fibrocystic like irregularity" in the area of the upper outer quadrant of the right breast. In response to the patient's concerns, he referred her for a diagnostic mammogram and breast ultrasound of the right breast.

The medical record demonstrated that the physician spoke with the patient via telephone when the test results were returned. Documentation of this discussion showed that he informed the patient her mammogram results identified very dense breast tissue with architectural distortion due to scarring from previous breast reduction surgery and a shadowing in the area behind the right nipple. In addition, the patient was told that the mammogram report stated there was no suspicion of a mass. Regardless, the physician advised her to have an ultrasound, which was performed a month later. The physician informed the patient that the results of the ultrasound report were normal without any indication of a tumor, mass or cyst. This discussion was also thoroughly documented in the medical record.

The patient was instructed to return in nine months for a complete physical examination, including an annual gynecologic examination. The physician also documented that he had an extensive conversation with the patient concerning the current approach to HRT. The patient stated she wanted to continue HRT because she could not function without some hormone treatment.

Eight months after the patient's last discussion with her primary care physician, she saw a gynecologist with complaints of pain in her right breast. The gynecologist performed an examination and noted a "visible prominence" in the upper outer quadrant of the right breast. Further studies showed a density suspicious for malignancy and a subsequent needle biopsy was positive for an invasive carcinoma, which was mixed ductile and lobular type, Grade II.

The patient then filed suit alleging that the primary care physician was negligent in his examinations and failed to refer her to a breast surgeon, resulting in a delayed diagnosis of her breast cancer.

OUTCOME:

The case went to trial where a verdict in favor of the physician was rendered.

RISK MANAGEMENT LESSONS:

This case prevailed at trial for several reasons. While it was vital that defense experts were able to support the care rendered, it was the well documented medical record that really helped this physician. The physician recorded his thought processes and provided clear evidence of discussions regarding the patient's care plan and possible outcomes. According to jurors who were polled following the trial, it was the concurrent documentation of findings, thought processes and plans for care that won the case.

Medical records often are the most objective evidence offered in the defense against a malpractice claim. As demonstrated in this case, complete, accurate, and objective medical records lend credibility to the physician and provide an excellent defense against claims of negligence.

FACTS:

In January of 2002, a 22-year-old woman saw her primary care physician with complaints of nausea and fatigue. The physician noted that the patient had abnormally high rates of protein in her urine and referred her to a urologist for an ultrasound and a 24-hour urinalysis. The patient saw the urologist in February 2002. The urologist ordered a kidney ultrasound, which showed cysts on both kidneys consistent with polycystic kidney disease. The urologist referred the patient to a nephrologist. The nephrologist's office scheduled an initial appointment with the patient for April 16, 2002.

Early in March 2002, the patient's legs began swelling. She returned to her primary care physician who described her condition as 3+ edema to her thighs with 4+ protein in her urine. The physician did not attempt to change the patient's appointment with the nephrologist to an earlier date. Three days later, the patient's swelling had extended to her abdomen and buttocks and she sought treatment at a local hospital. Laboratory work from the emergency room visit was faxed to the nephrologist. He reviewed the lab results and put the patient on diuretics. No attempt was made by the nephrologist to reschedule her April 16 appointment to an earlier date.

Throughout the month of March, the patient became more ill with malaise, fatigue, nausea and lower abdominal discomfort. As her symptoms increased, both the patient and her mother called the nephrologist's office several times to describe her worsening condition. None of these phone calls were documented in the patient's medical record. The only documentation found was a note on March 30 indicating that the appointment of April 16 was moved up to April 7. There was no documentation as to why the appointment had been rescheduled or to record any discussions between the patient and the physician. During deposition, the nephrologist claimed that he had never been notified of the telephone calls and did not recall why the appointment had been changed.

On April 4, 2002, three days before the patient was scheduled to see the nephrologist, she collapsed at home. It was determined that she was dehydrated with severe nephrotic syndrome and exertional dyspnea. The patient was hospitalized for a prolonged period of time.

ISSUES:

The patient sued the nephrologist for delay in diagnosis, failure to respond to telephoned symptoms, and delay of treatment.

OUTCOME:

The case was settled out of court.

RISK MANAGEMENT LESSONS:

Although there were questions regarding whether the primary care physician should have contacted the nephrologist to request an urgent appointment, the main issue in this case was the lack of documentation of the telephone calls made by the patient and mother to the nephrologist. The calls were not returned or given to the specialist.

Telephone communication is a critical part of the overall care and management of patients and also presents a significant area of liability exposure. Poor documentation, or a lack of documentation, frequently impacts the defense of a medical malpractice claim. In these instances, the defense often has to rely on the memory of the physician and/or staff to recall the telephone call. The physician or staff recall often conflicts with that of the patient. Juries know that medical practices receive several hundred calls a year, but the patient only has to remember one or a few calls. Therefore, juries often believe the patient rather than the physician.

Telephone triage requires accurate assessment without the benefit of a face-to-face encounter. For this reason, only professional staff with appropriate training should provide telephone assessments. Qualifications and training should be clearly defined in each staff member's job description.

FACTS:

The patient, a 56-year-old female, was admitted to the hospital with gallbladder complaints and jaundice. She was scheduled for a laparoscopic cholecystectomy to take place in three days. In anticipation of the surgery, and as part of the preoperative workup, the surgeon ordered a chest x-ray. The film was obtained on the day the patient was admitted to the hospital (three days before the surgery).

One day before the surgery, a CRNA performed a pre-anesthesia evaluation and noticed that the patient's chart did not contain the chest x-ray report. The CRNA wrote an order in large, legible handwriting to have the report of the chest x-ray put into the chart prior to the surgery scheduled for the next morning.

The film was read by a radiologist early in the morning on the day of the surgery. The radiologist quickly dictated and transcribed a report that noted a suspicious right apical pulmonary mass posteriorly located over the thoracic spine and measuring 3 ½ centimeters in diameter. She recommended the patient undergo a follow-up CT scan. The radiologist did not telephone or speak to anyone involved in the surgery about the abnormal finding.

A laparoscopic cholecystectomy was performed as scheduled. The surgical progress notes and discharge summary made no mention of the radiology report. The patient was discharged without being informed about the results of her chest x-ray.

Evaluation and treatment of the mass did not occur until 19 months later, at which time the patient's lung cancer was diagnosed as a Stage IIIB. The mass was inoperable because it had spread into the pleura. The patient underwent extensive chemotherapy but eventually died from the cancer. A lawsuit was brought against the radiologist, surgeon and hospital.

ISSUE:

The primary issue in this case is a delay in the diagnosis of lung cancer due to: (1) failure of the radiologist to read the x-ray and produce a report in a timely manner; (2) failure of the radiologist to appropriately communicate results of the x-ray; (3) failure of the surgeon to review the results of the preoperative x-ray; and (4) failure of the surgeon to inform the patient of the abnormal finding and recommended follow-up.

OUTCOME:

The surgeon and hospital settled out of court. A jury returned a verdict in favor of the plaintiff and against the radiologist.

RISK MANAGEMENT LESSONS:

Following are recommended steps that could have prevented this delay in diagnosis:

1) Abnormal findings arising from a preoperative evaluation should be verbally communicated to the appropriate caregiver.

Although the radiologist did not read the chest film and write her report until the morning of the surgery (almost three days after the x-ray was taken) she did not consider it necessary to directly contact the surgeon regarding the abnormal finding. In deposition, she indicated that her report was available to the surgeon since any physician can listen to dictated reports on the hospital's voice dictation service. In addition, it was hospital policy that preoperative radiology reports are sent to the patient's floor immediately after transcription as well as a copy sent to the ordering physician. The radiologist admitted in testimony that she could not have been certain that the report could be transcribed and added to the chart prior to the start of the surgery. In fact, the chest x-ray report did not get placed in the medical record prior to the start of surgery.

2) Surgeons must review all pre-operative tests to be sure the patient is cleared for surgery.

Despite the large note placed by the CRNA in the patient's chart, the surgeon and operating room nurses failed to read and adhere to the note, and failed to communicate with one another to determine if the x-ray report had in fact been obtained and read prior to the start of surgery. Had this been a more significant respiratory problem, the patient could have died on the table.

3) Prior to discharge, physicians must ensure the results of all labs, diagnostic tests and vital signs are known and recorded in the medical record, and that the patient is adequately informed.

The surgeon made no effort to obtain and read the radiology report either before or after surgery. He remained unaware of the abnormal finding and the need for a follow-up CT scan throughout the patient's hospitalization.

FACTS

The patient, a 52-year-old woman, had been treated by an internal medicine physician for approximately 12 years. During this time, the physician determined that the patient had iron-deficiency anemia and advised her on several occasions to have an endoscopic evaluation. He even sent a letter of referral to a gastroenterologist, a copy of which was placed in the patient's medical record. However, the physician did not mention the possibility of cancer to the patient or the importance of the test in identifying certain types of cancer. Despite the physician's repeated advice, the patient did not follow through with the testing.

The patient changed physicians and had a copy of her medical record forwarded to her new internist. While being treated by the new internist, the patient had an endoscopy that revealed colon cancer. The patient had curative surgery but was left with a colostomy. The patient then sued the original internist for delay in diagnosis and failure to diagnose the colon cancer.

After receiving a request for a copy of the medical record from a malpractice plaintiff attorney, the original internist discovered that there were no notations in the chart documenting the referral to the gastroenterologist, the repeated instructions to the patient to see the gastroenterologist, or the importance of having the endoscopic evaluation. The physician remembered the patient and his repeated discussions with her about the need to have the endoscopy. He was concerned about the lack of documentation and, prior to providing a copy of the record to the attorney, he altered the medical record to add documentation of his discussions with the patient, as well as his referral to the gastroenterologist. The new documentation was made to appear as if the notations had been made at the time of the patient visits. The physician reasoned that he was merely documenting what had actually occurred and therefore he was not really altering the medical record. In addition, he was concerned that his malpractice insurer would have a difficult time defending the case without the added documentation and he wanted to assist the insurer in providing a strong defense.

ISSUES

The issues in this case involved delay in diagnosis, failure to diagnose, inadequate documentation, and alteration of the medical record.

OUTCOME

The jury awarded the plaintiff compensatory and punitive damages. The punitive damages resulted from the alteration of the medical record. In addition, the state licensing board imposed sanctions against the physician, including a large fine that was not covered by his insurance policy. Hearings conducted by two hospitals at which the physician had staff privileges resulted in a six month suspension of his privileges. Fortunately, the district attorney elected not to bring felony charges even though, technically, altering the record did constitute a criminal act.

RISK MANAGEMENT LESSONS

Two of the most frequent malpractice allegations arising from physician office practices are delay in diagnosis and failure to diagnose. These allegations often result from:

inadequate communication between the physician and patient - such as the reason for and importance of recommended tests or procedures; and/or

the absence of important office processes - such as follow-up systems, tracking systems, documentation protocols.

When allegations involve communication issues, documentation of all conversations between the physician and patient becomes critical.

When the physician was unable to convince the patient to schedule the endoscopy, he should have discussed the reason(s) for recommending it, and the potential consequences of non-compliance, with the patient. By discussing the reason(s) for a test or procedure, or by better explaining its importance, physicians often are able to convince the patient to agree to have it done. In this case, the subsequent treating internist was able to convince the patient to have the endoscopy.

It is important to remember that lack of documentation in the medical record about discussions with patients makes defense of a case much more difficult, calls into question the thoroughness of the care provided, and requires the physician to rely solely on his/her memory regarding the patient's treatment. This not only can be detrimental to continuity of patient care but also allows serious questions to be raised in the minds of jurors. Lack of contemporaneous documentation makes it difficult to prove what was actually discussed or actually occurred. It establishes a "he said, she said situation," which often proves to be a major disadvantage for the physician.

RISK MANAGEMENT LESSONS

As this case clearly demonstrates, it is never acceptable to alter a medical record, even if the reason appears to be harmless or is an attempt to document what the physician remembers to have occurred. Altering the medical record is an indefensible action in the eyes of a jury, and can harm the credibility and veracity of the physician. If a physician believes that additions or revisions to a medical record have to be made, the changes must be done properly.

Altering a medical record increases the likelihood of a plaintiff verdict in a malpractice claim. It also can subject the physician to disciplinary hearings and sanctions by state licensing boards and hospitals at which the physician has staff privileges. Fines and costs resulting from these hearings often are not covered by professional liability policies. And, in many states, alteration of a medical record could result in criminal prosecution.

FACTS

The patient, a 44-year-old man, was involved in a motor vehicle accident and sustained burns to more than 25% of his body. He was admitted to the hospital's intensive care unit and intubated to assist with his breathing. The patient often became agitated, making it difficult to maintain a secure airway. After the patient's thrashing caused the endotrachael tube to become displaced, his nurse contacted the on-call resident for assistance. After examining the patient, the resident charted the following in the hospital record:

"Asked to evaluate patient because of desaturation and difficulty with airway management. Evaluation of patient revealed ET (endotracheal tube) malpositioned and not adequately ventilating patient, with pulse oximeter reading 40s %. I removed ET, masked patient until anesthesiology arrived to re-intubate. ***Of concern were the actions of the patient's nurse. She appeared preoccupied with the patient's dressing change instead of the urgent matter of establishing an airway.*** [Emphasis added] The patient was re-intubated. Follow-up chest x-ray shows worsening infiltrates. We will bronch patient. Need better control of pulmonary status. ***Per advice of attending physician, I will complete an incident report on the nurse's actions***." [Emphasis added]

Attempts to adequately control and maintain the patient's airway were unsuccessful and he died the following day.

ISSUES

This case demonstrates that some types of documentation are not appropriate in the medical record. The specific issues in this case involve two inappropriate entries (as emphasized above) recorded by the resident in the medical record:

1) His subjective opinion of the nurse's actions; and
2) His intention to complete an incident report

OUTCOME

The case was settled by the hospital and two physicians named in the lawsuit.

RISK MANAGEMENT LESSONS

The purpose of the medical record is to record the patient's health care story, and it should contain only clinically pertinent information. According to the Joint Commission's Hospital Accreditation Standards, "**the medical record contains sufficient information to identify the patient, support the diagnosis, justify the treatment, document the medical course and results, and promote continuity among healthcare providers.**"

Finger pointing, blame, and conflicts or arguments with other caregivers do not belong in the medical record. The use of subjective accusatory terms represents a "red flag" to plaintiff attorneys and can not only spark a lawsuit, but in many cases create a winning case for the plaintiff. Words such as "mistake," "error," "fault," "blunder," or "accidental oversight" should never appear in the record. Physicians must be careful not to let their anger and frustration with another caregiver - or their unverified subjective opinions - be used as ammunition in a lawsuit.

If a physician has concerns with a hospital's staff, facilities or equipment, he/she should address it with the hospital's administration or department head and, if necessary, complete an incident report. It is important to remember that incident reports should never be filed or referred to in the patient's record.

Most states have adopted legislation protecting incident reports from discovery if they are part of a hospital's peer review process. However, this protection can be, and often is, challenged by plaintiff attorneys when they become aware that an incident report exists. This information often is discovered through a review of the medical record.

In addition, conversations with your insurance carrier, attorney, or the hospital's risk manager should not be documented in the medical record. If you feel the need to document those conversations, it should be done on separate paper. Keep in mind, however, that plaintiff attorneys frequently ask if you have any other documentation regarding the incident. This additional documentation is not protected under peer review statutes.

FACTS

The patient, a 60-year-old man, was being treated by an internist for management of post-stroke hypertension and occasional chest pain. During a workup, the internist diagnosed an aneurysm described in the medical record as an "abdominal aortic aneurysm dilated to approximately 4 cm." The internist informed the patient that the aneurysm should be rechecked in one year.

Approximately 14 months later, the patient returned to the internist complaining of left upper quadrant pain. The internist ordered an ultrasound which showed the aortic aneurysm had increased in size to 6.3 cm, extending above the renal arteries. A CT scan performed three weeks later showed a thoracic aneurysm that had increased to 8 cm. The internist informed the patient that he should be evaluated by a general surgeon and gave him the surgeon's telephone number. No effort was made by the internist to contact the general surgeon or to have his office schedule an appointment for the patient.

The patient scheduled an appointment and was seen by the general surgeon three weeks later. A note in the medical record for this visit stated "no problem." The general surgeon informed the patient that surgery was needed but that he did not perform surgery on thoracic aneurysms. The patient was given the name and telephone number of a thoracic surgeon and told to make an appointment. The patient did not schedule an appointment. No effort was made by the general surgeon to contact the thoracic surgeon, have his office schedule an appointment for the patient or communicate with the internist.

In the four months following the patient's visit to the general surgeon, the patient saw the internist twice for management of hypertension. There was no documentation in the medical record that either the aneurysm or the patient's treatment with the general surgeon was discussed.

Approximately three months after the patient's last visit to the internist, he went to the emergency room complaining of abdominal pain. A CT scan revealed the aneurysm had increased to 9.6 cm. Surgery to repair the aneurysm was performed. The patient suffered bilateral lower extremity paralysis and mental deterioration immediately following the surgery, and was hospitalized for eight months.

ISSUES

Lack of documentation in the medical records maintained by both the internist and general surgeon made it difficult to defend this case. In addition, this case demonstrates the problems that can arise if follow-up and communication do not occur between referring and consulting physicians, as well as between physician and patient.

OUTCOME

The case was settled on behalf of the internist and general surgeon. The thoracic surgeon was dismissed from the case.

RISK MANAGEMENT LESSON

To ensure proper communication and follow-up, it is important to have a system in place to verify that: 1) patients who are referred to a consulting physician actually follow through with the appointment; 2) a report of the consultant's findings and treatment is received by the referring physician; and 3) there is a clear understanding regarding who will contact and follow-up with the patient. These responsibilities exist for both referring and consulting physicians. In addition, it is recommended that referring physicians have their office staff contact the consultant to schedule an appointment for the patient, particularly in urgent situations. This helps ensure that appropriate information is communicated to the consultant.

When documenting in the medical record, it is vital to include enough detail to enable someone reading the notes (even years later) to understand the thought process and actions taken. Cryptic notes and generalizations frequently leave doubt regarding the intent of the physician or the care provided to the patient. When referring a patient for a consultation, the reason for the referral should be documented in the medical record and provided to the consultant. The documentation should indicate that the patient was informed of their medical condition and the reason/importance for the consultation. If the patient is non-compliant in keeping the appointment with the consultant, this should be shared with the referring physician. It also should be noted in the medical record.

FACTS

The patient, a 22-year-old pregnant female was living with her parents. She and her family had been under the care of a family practitioner; however, the patient had not seen the physician since she was 18 years of age.

At approximately 9:00 p.m. on the night of the incident the patient's mother called the family practitioner and told him that her daughter was five to eight weeks pregnant and had been experiencing abdominal pain. The mother testified the physician told her to bring the patient to his office the next day, but never mentioned the possibility of an ectopic pregnancy or that the patient should be taken to an emergency room if the pain increased.

The physician testified he told the mother that abdominal pain is not abnormal during pregnancy, but to take her daughter to the emergency room if she got any worse. He said he also told the mother to have the patient see a doctor the next day.

The next morning the mother drove the patient to the hospital, where she was admitted into the emergency room. She was rushed to surgery and a ruptured fallopian tube, resulting from an ectopic pregnancy, was discovered. She went into cardiac arrest and died after a period on life support.

The physician did not document the telephone call or his advice in the patient's medical record.

ISSUES

Because telephone advice/consultation occurs without the benefit of actually observing or examining the patient, there are significant liability risks. This case demonstrates the importance of documenting all telephone calls.

OUTCOME

The jury awarded wrongful death damages against the physician and the hospital.

RISK MANAGEMENT LESSONS

Patients, and others calling on their behalf, may give an inaccurate assessment of the severity and/or location of physical complaints. Providing telephone advice can be tricky and frequently places the physician at risk of a claim if something goes wrong. If the telephone call is not documented, the evidence amounts to the physician's word against the patient's. To reduce risks:

Have a standard reply, such as "I cannot diagnose your problem over the telephone." Advise patients each time they call about the limitations of dispensing medical advice by telephone. Callers with urgent problems should be directed to an emergency department.

Document every after-hours telephone exchange. Include the name of the patient or person calling on their behalf, date, time, specific complaint, advice provided, final disposition of the call, and referral to other providers or facilities.

If you use dictation in your office, dictate a note as soon as possible while the conversation is still fresh in your mind.

Inform patients in writing about your policies and procedures for handling after-hours calls. Include information regarding the types of complaints that can be handled in after-hours calls.

If you use an answering machine, the message should state that calls will not be returned until the next day and that patients should go to the emergency room if they have an urgent problem.

If you use an answering service, maintain logs of telephone calls for future reference.

FACTS

A patient presented to a general surgeon with an acute onset of pelvic pain and heavy vaginal bleeding. An ultrasound confirmed an ectopic pregnancy on the right side, which the surgeon removed laparoscopically. A laparoscopic exam of the patient's left tube revealed a complete hydrosalpinx, so the surgeon removed it as well.

ISSUES

The patient alleged unnecessary removal of the right tube, and alleged that the left tube was removed without informed consent. Experts reviewing the case expressed concerns over the surgeon's qualifications to conduct the surgery, and were critical regarding the removal of the tube on the left side without informed consent.

OUTCOME

The case was settled.

RISK MANAGEMENT LESSONS

Consent and informed consent are two separate and distinct concepts. Consent is generally recognized as a patient signing a name to a form, or verbally agreeing to a treatment plan or a procedure. Informed consent is a communication process that leads to shared decision-making by the physician and patient. Informed consent accommodates both patient autonomy and the physician's responsibility for assisting the patient in developing and maintaining treatment plans. Physicians are required to obtain informed consent from patients prior to treatment.

Research shows that most patients want both information and advice from their physicians. The communication process should be a conversation in which the patient obtains information, asks questions and gives information back to the physician. Once the patient and physician agree on a treatment plan, procedure or medication regime, the physician is duty-bound to carry out the patient's wishes in instances other than emergency situations. If the medical conditions or circumstances change in any way, the physician must again review and discuss the plan with the patient.

<u>Medical record documentation should reflect the following</u>:

A summary of informed consent conversations with the patient

The diagnostic or therapeutic treatment of procedure recommended

The benefits of treatment

Potential significant side effects and complications of treatment

Alternative forms of treatment, including risks and benefits, and

The risk of non-treatment

FACTS

The patient came to a general practitioner with a history of a left lung resection for cancer years prior. As part of his initial work-up, the physician obtained a chest x-ray, which was interpreted by the co-defendant radiologist as positive for chronic obstructive pulmonary disease and bilateral interstitial fibrosis. The general practitioner later maintained that the patient had refused a CT scan, which he recommended at that time. The charting did not clearly support this position. A year later, a repeat chest x-ray was positive for a nodular density in the right lung apex. Although the physician again maintained that he discussed further work-up and the patient again refused, there was no documentation in the chart of such a discussion or refusal. Several months later, the patient sought treatment with another physician and was diagnosed with an inoperable lung lesion on the right side.

ISSUES

The patient alleged that the delay in following up on the positive X-ray findings allowed the tumor to grow and become unresectable. Although experts differed on whether the delay actually resulted in a worsened prognosis, the physician's lack of clear charting made the case difficult to defend on liability grounds.

OUTCOME

The case was settled.

RISK MANAGEMENT LESSONS

No jury can ever know what actually happened during a medical event. The medical record provides the best evidence of contemporaneous events. If the patient's record appears to require some action to protect the patient and that action is not taken, the record can assist the plaintiff in efforts to establish negligence.

Informing the patient of further diagnostic testing accommodates patient autonomy and the clinician's responsibility to the patient in maintaining treatment plans. The medical record should detail the content of the clinician's communication and recommendations to the patient. The patient always has the right to reject the clinician's recommendations. However, the patient's refusal is a "red flag" which warrants the clinician's attention to both further communication and documentation practices.

The clinician has a duty to adequately disclose to the patient the potential risks and consequences of refusing further testing recommendations. Once again, the medical record must reflect the content of the discussion. The clinician should also send the patient a letter reiterating concerns about the treatment plan. A copy of the letter should be attached to the patient's record. It is a good idea to send such letters registered, return receipt requested, and to have the returned receipt placed in the patient's record. this can serve as evidence of receipt of the letter by the patient and further indicate the effort and concern of the physician for the patient.

The clinician's later description of unrecorded factors that actually determined actions, and the patient's inaction, may be viewed by the jury (or experts) as a purely defensive action, with no credible supporting evidence. In a credibility contest, judges and juries will often believe the patient or family member over the health care provider.