FOJP

Medical Charting

How the Medical Record Can Best Support a Physician in Litigation

BEST PRACTICES

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Introduction

This guide is intended to help physicians create medical records that, in addition to facilitating patient care, will properly document information and actions in the event an adverse outcome results in a claim of malpractice. All physicians should follow their own institutions' and groups' practices and procedures concerning medical records. This guide supplements those practices and procedures. The guidelines here are neither authoritative nor mandatory extensions of the institutional rules; rather they are a resource for physicians seeking to document their professional decisions most effectively.

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What Is a Medical Record?

A medical record is the documentation of a patient's history, evaluation, diagnosis, treatment, and progress as determined by the physician under the circumstances in which he or she saw the patient. The primary purpose of the medical record is to assist in the care and treatment of the patient. Anything done to further the care and treatment of the patient should be included in the record. The record is not just a personal memory aid for the individual physician who creates it, but also a tool for communicating with other medical providers to ensure that they understand the patient's clinical history, current problems and ongoing tests, as well as treatment.

In the courtroom, the medical record informs jurors about the treatment at issue. It is important evidence that will be examined by the court, expert witnesses, and ultimately the jury. The importance of complete medical records in litigation is captured by a simple rule: if it wasn't charted, it wasn't done. The record, therefore, needs to provide insight into the clinician's actions, thought processes, and judgments. When in doubt, always include more details in a note.

General Principles

Clarity

Clear writing denotes clear thinking. Spend a moment to compose your thoughts before beginning a note. Try to find a place and time to prepare your notes where you can be uninterrupted. A review of prior notes will help ensure that your diagnosis and treatment are based on the most complete and accurate information available.

Abbreviations

Use only recognized and accepted abbreviations. Misinterpretation of an abbreviation can lead to administration of the wrong medication or an unintended treatment. Physicians must be familiar with, and use only, abbreviations approved by the institution at which they practice. When in doubt about an abbreviation, don't use it; write out what you mean. Remember, there is no defense in a lawsuit where a medication or treatment was administered as the result of an incorrectly interpreted abbreviation.

Legibility

Notes are valuable only if they can be read and appropriately understood by readers. If you cannot read the notes, neither can anyone else.

Grammar

Spell- and grammar-checking are available in most electronic medical records (EMRs); use them. Proofread notes for transcription and typographical errors. Grammatical and spelling errors could erroneously lead a jury to believe that a physician is not careful.

General Principles *cont'd*

Time, Date, and Signature

Notes should be properly timed, dated, and signed. When a note is written after the fact, the note—particularly in the EMR—should reflect when the note was entered, and specify the time period to which the note refers. Patient care always comes before charting. A note reflecting that "patient X was seen earlier today on rounds and a note is being entered now to memorialize what occurred earlier" could help prevent confusion years later in a courtroom.

In addition, notes should be in proper chronological order. When a note is out of temporal sequence in a chart, plaintiff's lawyer will call its veracity into question. This can lead to arguments that the record was altered and is unreliable. Avoid writing notes in the margin of a document, squeezing them in between other notes, or starting them at the bottom of a page in a manner that requires them to be carried over to another page.

Timelines

A note should not contain an inaccurate or assumed amount of time that a given activity took. The management of a resuscitation from a cardiac arrest is a particularly good example of this caveat. If you know the exact timeline of events, then it is proper to include it. Otherwise, a recitation of what took place without a specific time attribution is the more accurate way to create the record. Once times are included, in a record, it will be very difficult to disavow them if litigation occurs. This admonition is intended primarily to deal with treatment provided in an emergency setting, when assertions of delay in providing timely and proper treatment are alleged. Before preparing notes of this kind, consider huddling with other staff involved in the delivery of care. Certainly in complex and unusual circumstances, this is a good practice.

The Medical Record—Basics

The medical record should contain the following:

General Information

History. Memorialize the complete background, and refer to forms and practices of your hospital. The history must be complete.

Chief complaint. Quoting the patient can be very helpful. Details of the patient's chief complaint are often disputed in litigation. Therefore, quoting the patient that the lump, weakness, pain, etc., started "x hours/days/weeks ago," or other details, as indicated, is helpful in resolving potential disputes.

Examination. Document pertinent positives and negatives. Specifically identify the findings on examination that rule in and/or rule out a particular diagnosis. For example, documentation regarding the presence of peripheral pulses suggests that peripheral vascular disease is not present.

The Medical Record—Basics *cont'd*

General Information *cont'd*

The presence of normal bowel sounds, together with the absence of guarding, rebound, or rigidity are important evidence suggesting that a surgical abdomen is not present. The note should include the details from the examination that will support clinical treatment decisions and impressions. When salient aspects of an examination that was performed are not memorialized, at trial the physician will be forced to reconstruct those findings from memory or custom and practice. Having a note with the relevant details is the better practice.

Impression. Offer your best differential diagnosis, but include all the conditions that need to be ruled out.

Plan and follow-up. Indicate the tests, therapies, and treatments being considered. Often the note is self-explanatory, demonstrating the physician's judgment. If otherwise, a note reflecting the critical thinking is appropriately placed here. For example, if selecting between different modalities of therapy, this is where the chart should reflect the factors that support the decision.

Conversations. Include a brief statement concerning any conversations held with the patient and/or family members present that are relevant to history, plan, expectations, and informed consent. These conversations should be memorialized in an objective and neutral manner. It is not uncommon for a patient or family member not to recall either the details of a conversation, or even that a conversation occurred. Meetings with physicians during times of illness are stressful for patients and their families. A contemporaneous note will let the jury know that you took the time to keep the patient and family members informed and to answer their questions.

Forms and templates. It is important to completely fill out template exam forms or to affirmatively cross out and initial those parts of forms that are not applicable to the examination at hand. When these forms are simply left blank, it can lead to the impression that a proper and complete (under the circumstances) exam was not performed. *A normal exam is not an excuse to leave areas blank.*

Free text in the EMR. Most EMRs have an option for adding free text notes to the record. When necessary, take advantage of this feature. The presence of free text within the record demonstrates independent thought in creating a note, as opposed to just completing boxes.

Informed Consent

Informed consent is an educational process, not merely a piece of paper. Any progress note, or signed consent form, is proof only that some communication took place between the provider and the patient. Therefore, engaging in a thoughtful conversation with the patient is always of paramount importance. Your subsequent note provides some proof that you educated the patient appropriately about the risks, alternatives, and benefits of a proposed course of treatment.

Many physicians use literature to help educate patients about their disease process and treatment options, and this is a reasonable approach. Remember, however, that the literature used by a physician to educate a

The Medical Record—Basics *cont'd*

Informed Consent *cont'd*

patient may also be used in court during cross examination of that physician. This caution is not intended to discourage using these kinds of printed materials. But the physician using them must have a clear understanding of what is in the materials, and must document whether and why parts of the literature may not apply to a particular patient.

The note that a physician writes regarding informed consent need not, and probably never could, list all potential risks of a course of evaluation or treatment. If the patient does have a particularly noteworthy risk, it is advisable to highlight that this was discussed with the patient. The note, however, should generally reflect that a conversation took place; the extent of the detail is a matter of each physician's judgment under the circumstances. If a particular risk is listed, the note should reflect that it was discussed. When dealing with patients who are difficult or have unrealistic expectations, it is good to spend more time with them to properly set expectations.

Ideally, an informed consent note should include details concerning:

- Who was present for the conversation;
- The approximate length of time for the conversation;
- Whether models, drawings, or other resources were used to educate the patient about his or her anatomy, disease process or condition, and/or the treatment at issue; and
- That the risks, benefits, and alternatives to the proposed course of treatment were discussed, and the patient's questions were answered. Another way to express this is to note: "Risks, benefits, and alternatives discussed; patient understands."

The note on informed consent should **not** contain any of the following:

- A guarantee or promise about the outcome of the procedure;
- Statistics or percentages regarding potential complications;
- A list of potential complications; or
- The physician's subjective opinion about whether the patient should have the procedure.

Procedure Notes

Prepare all procedure notes in a timely fashion; most facilities require a note to be prepared within 24 hours of a procedure. Again, be familiar with your institution's policies and procedures. As a routine, document in these notes that consent was obtained and that a time out (if applicable) occurred. Debriefing with the team about the procedure at the end of the case can reduce conflicts in notes that otherwise might end up, unnecessarily, in the record.

The Medical Record—Basics *cont'd*

Procedure Notes *cont'd*

When a complication and/or an adverse outcome occurs, take extra care to prepare procedure notes as expeditiously as possible. These notes should contain factual observations and thoughtful plans. It is not recommended to chart that a patient has developed or suffered an "adverse event" or "complication." These kinds of terms might be misconstrued to suggest that the event was avoidable. Moreover, take care to accurately and clearly describe the morbidity or event that the patient sustained or developed. For example, it is more accurate and appropriate to simply reflect that the patient developed a wound dehiscence, an intestinal leak, a pneumonia, a line infection, a post-operative fever, and the like, without otherwise characterizing the event. Moreover, in circumstances like these, it is best not to delegate preparation of the notes to a resident. Years later these notes may well represent a central piece of evidence for the defense if a malpractice case is brought.

Always review and correct dictated notes carefully before signing them. An uncomfortable and difficult situation arises in litigation when a note that has been signed—but not read for accuracy—is found to contain an error. If this happens, the physician is forced to concede that he or she disagrees in some fashion with a written record that he or she signed.

When more than one service is involved in a procedure, each service should prepare its own notes. In such setting, the physician should communicate clearly about the procedure with the other service before preparing his or her own notes. This practice can reduce conflict and confusion between the services that could otherwise unnecessarily complicate the medical record.

Best practices and The Joint Commission require that a "brief procedure note" be promptly placed into the record upon completion of a procedure, prior to transfer to the next location of care. This note provides essential information to various clinical providers until a full, dictated note is made part of the record. The attending and resident should always discuss the content of this brief procedure note before it is written, and before the formal procedure note is dictated.

Whenever a complication or adverse outcome occurs, the attending should dictate his or her own operative notes—and not delegate this task.

Judgment

The law recognizes that there are often many different acceptable modalities to evaluate or treat a given problem. The law also recognizes that every physician is entitled to exercise reasonable medical judgment. When choosing between diagnostic or treatment alternatives, place a note in the record reflecting the reason for your clinical judgment, which will convey to the reader that you considered the alternatives.

No physician can guarantee a positive outcome. All that can be represented is that you provided care consistent with accepted standards and to the best of your ability. A record should reflect your judgment, and the basis for that judgment, thereby providing the reader with important insight into your decision making. For example, when you elect not to perform a further study—or, conversely, to perform a further study—the basis for the decision should be supported by the record of your reasoning.

The Medical Record—Basics *cont'd*

Test Results

Normal/benign test results. The record should contain some evidence of your appreciation/review of the results of tests and studies ordered. Your initials on these reports can serve as an indication.

Abnormal test results. The record should reflect an acknowledgment of abnormal or unexpected results and a discussion of their significance or non-significance with the patient. If an abnormal result need not be acted on, the record should reflect the clinical thinking to support this decision. Again, document the basis of your judgment.

Test follow-up. If there is a plan for a patient to appear or pursue follow-up tests, the record should indicate the essential elements of the plan, and that the plan was clearly communicated to the patient.

Communication of test results that will require action on the patient's part. The record should indicate that the patient was informed of pertinent test results. Details concerning how and when the patient was informed, as well as efforts taken to contact the patient, are critical. The manner of communication is a matter of judgment and is subject to how critical the test results are. For example, think initially of attempting to contact by telephone. After that, you might try first-class mail or registered mail. Eventually, as warranted, you could consider approaching the police to make contact. In a hospital-based practice, you must be familiar with applicable policies and, when necessary, contact risk management for assistance. Many a lawsuit has been prosecuted because patients alleged that test results either were not communicated or were miscommunicated. This recommendation on communicating test results is all-encompassing—including blood work, radiology studies, biopsy reports, and similar activities.

Prescriptions

Note the indication for the prescriptions you write, along with the dose, duration, and instructions provided. Frequently, the record fails entirely to reflect that prescriptions were dispensed. In addition, the record should reflect whether you expect the patient to follow up after a prescription is dispensed. Although hospital order systems capture these data electronically, individual practice charts often do not. A copy of the actual prescription is not necessary; a progress note regarding the prescription will suffice.

Noncompliance

Always chart episodes of noncompliance. If a patient elects not to pursue a test, referral, follow-up, course of treatment, or admission to the hospital, or seeks premature release from the hospital against medical advice, or similar noncompliance, enter a narrative note in the chart to document both the noncompliance and your efforts to achieve compliance. The note also should reflect that the possible consequences of noncompliance were communicated to the patient.

The Medical Record—Basics *cont'd*

Noncompliance *cont'd*

Issues of patient compliance frequently arise in litigation and become credibility battles between the testimony of the doctor versus that of the patient because no note about the patient's noncompliance was ever entered. When appropriate, consider requesting that a patient sign the chart acknowledging noncompliance, including actions taken by the patient against medical advice. This patient-signing practice may facilitate more dialogue with the patient, encourage the patient to change his or her mind, and/or create a record that establishes the patient's noncompliance.

Telephone Contact

Enter a brief note contemporaneously or at the next available time about telephone contact with a patient, including salient details of the communication. Lawsuits often raise issues of advice provided over the telephone, or assertions of non-responsiveness by physicians to telephone calls.

E-mails and Written Communications with Patients and Third Parties

Patients often e-mail questions and comments to their physicians. Insert all of these communications, along with any responses, in the medical record.

Keep letters from patients, as well as from physicians (including copies of consults, recent examinations, assessments), in the record and initial them to establish receipt and review.

Alterations, Addenda and Late Entries

Altering the medical record is an easy way to compromise your credibility—and your case. If the record contains an error or omission, enter a properly dated addendum in the chart. Notes of this kind should be put into the record only after thoughtful evaluation, as the entry could be construed as self-serving. It is advisable to contact risk management prior to issuing an addendum or correction.

Late entries and addenda must always be properly identified, timed, dated, and signed.

Adverse Events and Complications

Lawsuits generally involve the subset of patient encounters in which an adverse event and/or a complication occurred. When an adverse event and/or a complication occurs, it is best to chart at least the following:

- A factually accurate, non-conclusionary recitation of the process(es) that the patient experienced—such as post-operative fever, pneumonia, wound infection, or fistula—rather than a characterization of the experience as a problem or complication;
- A notation that the patient (and/or family, if appropriate) has been informed of the situation; and
- The treatment plan chosen to promote the patient's recovery.

The Medical Record—Basics *cont'd*

Adverse Events and Complications *cont'd*

Avoid speculation or assumption in the medical record about the cause of all adverse event or complication. Likewise, attributions of blame, finger pointing, or subjective theories as to causation—i.e., comments that do not aid in the treatment of the patient—should not be part of the medical record. Statements of this sort may not be accurate, and do not help the patient's care and recovery. Moreover, the "cause" of the problem often may not be clear immediately after a patient develops a problem. Speculating about the cause without thoughtful deliberation can lead to erroneous conclusions. What's more, it might be difficult, if not impossible, to disavow such recorded speculation at a later date.

Missed Appointments and Follow-Ups

Place a brief note in the record concerning missed appointments and/or missed follow-up obligations. Document all efforts taken to communicate with the patient about the importance of follow-up compliance.

Referrals

Identify the physician or practice to whom the referral is made, along with the purpose of the referral.

Document when a patient has been offered and refused a referral, this being a feature commonly seen in malpractice cases. In these circumstances, it is also important to document that the patient was counseled about the need for the referral and about the consequences of not following through with it.

Transmitting the Record to Third Parties

When a medical record is copied and forwarded to a third party in an office setting, a record should be made of this transmission.

Countersigning Notes

Every physician must read and ensure that he or she knows the content of a note before countersigning it. If you disagree with a recommendation or suggestion in a note, contribute your critical thinking on the issue in a separate signed note.

Translators

It is not uncommon for physicians to use the services of a translator when discussing issues with a non-English-speaking patient. Try to use hospital-approved translators. Do not use members of the patient's family as translators. The record should make clear that a translator was used, and, when possible, should identify the translator by name and affiliation.

Language and Themes to Avoid

Language

Be careful of the language used in and the words chosen for your notes. Avoid terms that imply sloppy, deficient, inattentive or thoughtless patient care. There are many entries in this category of words that are inappropriate for your notes. For example: *Missed*, as in "missed enterotomy;" *failed*, as in "failed to appreciate;" *ripped* and/or *torn* in referring to damage to an adjacent structure. Always think before you write.

Themes

Regarding the patient. Do not make derogatory, disparaging, or inappropriate comments about the patient in the record. Document facts that support problematic or noncompliant behavior, but leave the characterization of these behaviors to others, including a jury.

Regarding other providers and services. Avoid disparaging comments about other providers in the medical record. The record is a communication tool that concerns the patient's health issues. Disparaging or critical comments about other providers do not further the goals of providing the patient with proper care and maximizing the patient's recovery, rehabilitation, and comfort.

Attributing fault to other providers. You must avoid notes that imply, suggest, or state that another provider is responsible for a patient's complication. Notes of this kind are invariably used by a plaintiff's attorney to help prove that a particular provider failed to act appropriately, missed a condition or diagnosis, and/or caused a problem through improper care or treatment. It is imperative that you be fair and thoughtful in any charting that offers critical comment regarding a prior treating physician. Referring to the failure of another physician does nothing to help the patient's care and raises the question of what you did to resolve the patient's medical problems.

Themes to Include

In medical malpractice litigation, the physician should be perceived by the jury as intelligent, well trained, thoughtful, and concerned with helping the patient. Therefore, it is helpful if the medical record demonstrates:

- A commitment to keeping the patient informed, educated, and involved in his or her care; and
- An understanding by the physician of the difficulties a patient encounters.

Notes

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FOJP SERVICE CORPORATION, 28 EAST 28 STREET, NEW YORK, NY 10016 T: 212.891.0700 www.fojp.com