LAW & MEDICINE

What Every Physician Should Know

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BETTER DOCUMENTATION

The medical record is powerful document that is usually the focal point when there is a question about previous medical care. And, unless the record is riddled with blatant contradictions or alterations, it is always believed. Although we often view the medical record as something that is used against us, the overall positioning of the document is actually very much to the clinician's advantage.

Unless the medical record is riddled with blatant contradictions or alterations, it is always believed

In simple terms, the medical record is the main piece of evidence in most medical-legal proceedings; it is universally believed; and, we have the privilege of creating it. From a legal perspective, that is a nearly ideal situation. In contrast, the patient and his attorney have to prove that we did something wrong, yet have no input on the medical record. As such, one could make a good case that a clinician who knew how to document properly would be very difficult to beat in a medical malpractice lawsuit. The purpose of this article is to ensure that every clinician is in just such a position.

DOCUMENT. DOCUMENT. DOCUMENT.

"Document. Document. Document" is one of the least helpful and most irritating phrases in all of medicine. Unfortunately, there are many people who believe that the phrase is the solution to every medical-legal dilemma. Although there is no question that documentation is valuable from both a clinical and a legal perspective, it cannot solve problems and it is not why we practice medicine.

The patient is always more important than the chart.

The primary focus of both the practice of medicine and the accompanying legal system is proper patient care. Everything else, including documentation, is secondary. From both a medical and a medical-legal perspective, the patient is always more important than the chart. Therefore, the solution to every medical and/or legal dilemma begins with the proper care of the patient. And, any approach which does not have that as the focus is incorrect.

THE MYTHS

Although focusing our efforts on patient care seems both obvious and uncontroversial, there are a number of medical-legal myths which fail to recognize this principle.

MYTH #1

Lawsuits are caused by poor documentation.

The reality is poor documentation never caused a lawsuit.

Although physicians spend an ever increasing amount of time with the medical record, patients do not care about the condition of their chart. They are unconcerned with whether the notes are complete, accurate or even legible. Patients desire a good result and a pleasant bedside manner. And, when these expectations are not met, they will sometimes seek the services of an attorney. However, a patient's decision to seek an attorney, which is the critical step in creating a lawsuit, has nothing to do with the medical record.

No physician has ever been sued by a chart.

Unfortunately, the chart is the first place that many of us go when faced with a difficult situation. Despite the temptation, it is important to keep in mind that no physician has ever been sued by a chart. So, rather than spending added time with the medical record, we would be much better off from both a medical and medical-legal perspective to spend any additional time that might be available with the patient himself. Although the chart is important and should be properly managed, it is never more important than the patient.

MYTH #2

Physicians frequently lose malpractice cases because of inadequate documentation.

Putting aside the shortcomings of juries and expert witnesses, the reality is that the leading reason physicians lose malpractice cases is inadequate patient care. Although many of us can cite a medical malpractice case that was lost simply because of poor documentation, this is a misperception. Most of these cases were actually lost because of shortcomings in patient care.

Case #1

A 35 year old woman presented to the emergency room with abdominal pain. She also had nausea, vomiting and a low grade fever. She was otherwise well and took no medications. Several members of her family had been suffering from the same symptoms.

Her temperature was 100.4 degrees, she did not look seriously ill, and her abdomen was soft, with moderate diffuse tenderness. Her bowel sounds were normal.

She was diagnosed with a viral syndrome, treated with supportive measures and given instructions to see her family doctor if she did not improve. The emergency room physician recorded all the above findings along with his assessment and plan in the patient's record.

Unfortunately, over the next two days the patient worsened. She presented to her family physician with a temperature of 103 degrees, severe abdominal pain and vaginal bleeding. She was diagnosed as having pelvic inflammatory disease and was also eight weeks pregnant. She was hospitalized, suffered a miscarriage, and subsequently sued the emergency room physician, alleging that he failed to manage her condition properly.

The chart from her emergency room visit contained no record of the patient's last menstrual period. There was no notation of whether she was asked if she was pregnant. There was no record as to whether she had vaginal discharge, or the results of a pelvic examination or pregnancy test.

The defense attorney recommended that the physician settle the case, and a financial payment was made to the patient.

Analysis

It would be easy to attribute this outcome to a documentation problem. In other words, if the physician had simply documented some of the missing facts, the case would have been defensible. Although that conclusion is commonly drawn, it is completely incorrect. In fact, no amount of documentation could have saved this case because the problem had nothing to do with documentation.

The medical-legal problem was that the patient's symptoms were not properly evaluated and she received substandard treatment. When a 35 year old woman presents with abdominal pain, gynecologic disease must be included in the differential diagnosis and evaluated accordingly. This patient should have been asked about her last period and whether she might have been pregnant. A pregnancy test should have been done and a pelvic exam should have been performed.

This patient did not have a viral illness. She had PID and she was pregnant. She received an inadequate evaluation, was given the wrong diagnosis, received the wrong treatment and experienced a bad outcome. None of that has anything to do with documentation. It is entirely a patient care issue.

Of course, despite the substantial shortcomings in the patient's care, it might be argued that the case would have more defensible with better documentation. Although that is a widely held belief, it is difficult to envision what type of documentation could have made a difference here.

Documentation must ultimately be based on reality.

If the physician had recorded the patient's last menstrual period, it would only hurt his case by showing that she was probably pregnant. And, it would have been difficult to record that her pelvic exam was normal and her pregnancy test was negative, given that they were not even done.

Of course, it could be argued that these items were done, but simply not included in the chart. Unfortunately, that position is completely incompatible with reality, given the fact that the patient was discharged with the diagnosis of viral illness. In other words, had the patient been fully evaluated, she would have been found to have PID and the diagnosis of "viral illness" would never have been made. The problem here is not the documentation; it is the fact that she was not properly evaluated.

And, because she was not properly evaluated, no amount of documentation can "cover" the errors that were made. Documentation must ultimately be based on reality and the care that was provided. It cannot operate on its own, independently of what actually occurred. Although it is certainly important to document what happened, documentation itself is worth nothing. Proper patient care must actually be provided. And, if it is not provided, no amount of documentation can rectify the situation.

Most things that are not done are also not documented.

"Not documented, not done" is a widely quoted expression. The inference is that if something is not in the chart, then it did not occur. The phrase is not entirely correct, but it can be restated in a manner that better explains many malpractice cases. Rather than saying, "not documented, not done," a better approach is to say, "not done, not documented." In other words, if something was not done, then it is unlikely to be documented in the chart. And, any legal problems that arise will be because the evaluation or treatment in question was not done.

MYTH #3

When bad things happen, extra documentation can save you.

The reality is that when bad things happen, extra documentation will usually hang you.

Case #2

A 24 year old woman is diagnosed as having an uncomplicated urinary tract infection. She is otherwise well. She has no known allergies, takes no medications and is not pregnant.

She is treated with an appropriate dose of TMP/SMX. She takes the medication as prescribed, but experiences a severe skin reaction.

Analysis

In accordance with the myth, the physician would respond to the adverse outcome with additional documentation in the patient's chart. The goal of the note is to "tie up" any loose ends, restate the case for using TMP/SMX, and generally make it known that no mistakes were made. These supplemental entries are often titled an "Addendum," a "New note," or a "Clarification of previous note." But, no matter what they are called, they are a mistake.

Even if the entry is made in a completely honest manner with the best of intentions, it often contradicts another entry made at an earlier time, or it might not be consistent with a lab, study or X-ray result. And, unfortunately, contradictions are never helpful as they give the appearance that someone is not being honest.

The second problem with the extra documentation is that it starts to "wall in" the clinician. If this patient does decide to sue for malpractice, she might make any number of allegations, from wrong diagnosis to wrong medication to inadequate follow-up. And, depending on what she alleges, the defense strategy will be to highlight certain aspects of her care and downplay others.

This is not to say that attorneys alter the facts to suit the case, but they do emphasize those facts that are most favorable to their client. And, so that the defense attorney can do that to the maximum extent possible, we should not state our defense strategy in the chart before the plaintiff even makes an allegation. Instead, it is better to save the explanations and clarifications for a time when we might need them.

Explanations and clarifications should be saved for when they are needed.

The final reason that extra documentation is a dangerous endeavor is the "heat of the moment" phenomenon. In

the immediate aftermath of a bad result, it is often difficult to see things as objectively or clearly as we otherwise might. In the heat of the moment, it can feel like we are entirely to blame, but that might not be the case. The problem is that statements written or recorded in such a situation, with the emotional burden of guilt, often unnecessarily damage our position. And, there is no medical or legal reason to do so.

Although it is tempting to summarize what happened or restate the case with a magical set of words, the temptation must be resisted. Instead of attending to the chart, the better approach is to attend to the patient. Then, afterwards, the events should be documented in a manner that objectively describes the situation, just as we would with any other patient.

A good approach to handling patient care, communication and documentation in the wake of a bad outcome is to react, behave and document as if we just became involved with the case. In other words, we had nothing to do with the disaster that just occurred. We have nothing to clarify or explain. We have no reason to try to bolster a previous note. We are simply there to fix the problem and care for the patient accordingly. If a bad situation is approached from that mindset, the resulting documentation will be appropriate.

MYTH #4

You can cover yourself by blaming someone else.

The reality is that it is never helpful to point fingers at one another.

Case #3

An elderly patient is receiving IV fluids. At 6 PM, the physician writes an order stating, "D/C IV fluids and cap IV." Unfortunately, the order is not executed and the patient receives IV fluids all night.

The next morning, the patient is volume overloaded and short of breath. The physician then writes a note stating, "IV fluids ran all night despite order to stop, pt now in CHF."

Analysis

The note is factually correct, but unnecessarily critical. And, from a medical-legal perspective, it is a disservice to everyone involved. What the note implicitly states is: "This patient is in CHF because somebody did not follow my order. It is not my fault." Although that might seem like a good way to cover himself, this physician needs to be careful about pointing fingers.

Although he believes that the patient's predicament is someone else's fault, he should not be overly confident. It is possible that he wrote the order incorrectly; perhaps he wrote it in the wrong chart; perhaps she was already volume overloaded by the time he wrote the order; or, perhaps she should have never been receiving IV fluids in the first place.

Because we all live in a medical-legal glass house, we need to be careful about casting stones.

When something like this happens, the situation is rarely "black-and-white." And, that means that everyone who is involved has a degree of vulnerability. Regardless of who may be primarily at fault, we are all at risk of scrutiny. And, being under the microscope is never desirable.

As such, we need to be careful about expressing criticism of others in the chart, even if someone did make a mistake. Of course, we are permitted to express our opinion fully and directly to the involved individual, to his or her supervisor, or to the hospital quality assurance committee. But, it does not help anyone, including the patient, to express dissatisfaction with one another in the medical record.

In this case, a better approach would have been first to take care of the patient. Stop her IV fluids and treat her symptoms. Then, the accompanying record entry could state, "Appears to be volume overloaded, fluids stopped, diuretics started." Such a note serves the patient's interest and tells the truth without pointing fingers. Once the patient's need was met, the physician could then address the shortcomings of the preceding night directly with the involved persons.

HOW TO DOCUMENT

Because the medical record is such an important document, it must be created in a legible manner that gives the appearance of an unemotional, professional approach. Unfortunately, there are a number of ways in which we regularly violate this simple principle.

First, we allow emotion to enter into our notes. For example, we express frustration by writing, "STOP HEPARIN NOW" in the chart. Although the use of big, block letters might motivate the person who reads them, it needlessly draws attention to the fact that the patient's care is less than ideal.

Medical record entries should be devoid of exclamation points and question marks.

Another sign of emotion is the use of any punctuation mark other than a period. Almost every sentence should end with a period, yet we use explanation points and question marks on a regular basis. These also draw unneeded attention to problematic issues, especially when multiple punctuation marks are run together. For example, a note stating, "What's going on here????" is far from helpful.

If there is a question, it should usually be answered before we write the note. And, if there is excitement, it should be allowed it to pass. Doing so would allow us to document in the preferred, unemotional and professional manner.

The next mistake is treating the medical record as if it were one's diary. This occurs when a clinician writes things about himself in the chart, and it is never a good idea. For example, a note that reads, "I was not able to view the CT yesterday, will check it today" seems benign.

An entry that is not about the patient does not belong in the chart.

But, that entry is not about the patient and it does not belong in the chart. The entry is actually about the doctor and it indicates that he did not look at the CT scan yesterday. And, that is a problem if the CT happens to show something that needed immediate attention. Every medical record entry must pertain to the patient, not the physician. This mistake can be easily avoided by limiting the use of the pronoun "I".

The last point regarding how to document is the use of templates, preprinted sheets and outlines, for certain symptoms or diagnoses. These are available in both electronic and paper formats and allow the clinician to check a box instead of writing everything longhand.

Templates save time and provide a framework that reduces the risk of forgetting something. And, they are an excellent way to document. Although some people worry that checking a box is not as good as writing longhand, the two methods are identical from a medical-legal perspective, which makes templates a very valuable tool.

Templates save time and provide a framework that reduces the risk of forgetting something.

Of course, there is a way to get into trouble with templates, and that is to check every box on every patient. In other words, document that everything was done, every time. On the surface, the approach seems to reflect thoroughness. But, the reality is that it is not believable. In fact, documenting that everything was always done on every patient, casts doubt on whether the clinician even did anything. The end result is that templates are a valuable, so long as they are used in a manner that truthfully reflects reality.

What to Document

Complete documentation must include five fundamental elements:

1. **Every fact that is needed to convert the patient's complaints into the physician's assessment and plan.**

One of the most common documentation questions is: "How much detail should I include?" The answer is that there must be enough detail so that a clinician who did not see the patient can read the chart and arrive at the same assessment and plan as the treating physician. If another clinician can look at the chart and do that, then the amount of detail is sufficient.

Case #4

A 30 year old man presents with headaches. He has no other medical problems. After a full evaluation, a diagnosis of tension headaches is made and the clinician prescribes an appropriate treatment.

<u>Analysis</u>

The accompanying note should contain enough information to allow a clinician who did not see the patient to read the chart and arrive at a diagnosis of tension headache. The easiest way to do this is to start with the chief complaint and mentally construct a differential diagnosis. In this case, the patient's problem might have been the result of tension headaches, migraine headaches, cluster headaches, trauma, a brain tumor or high blood pressure. There are undoubtedly a few more possibilities, but this short list will keep the analysis simple.

Once the differential diagnosis is constructed, the next step is to document in a way that works through the differential diagnosis. This would include noting:

- The characteristics of the headache: onset, duration, location, and associated symptoms. These help the reader distinguish between tension, migraine and cluster headache;

- That there was no history of trauma;
- That his blood pressure was normal; and,
- That his neurologic and fundoscopic exams were normal; and,
- That the patient has no significant Past Medical History, Social History, Family History, takes no medications and has no known drug allergies.

Those facts allow a clinician to read the chart and confidently arrive at the diagnosis of tension headache. And, in order to tie up any "loose ends," it is important to also note that the patient has "no other complaints." Doing so assures the reader that the clinician has been thorough, and also that there are no other complicating conditions. The phrase is so valuable that it should be included in virtually every note.

The phrase, "No other complaints" should appear somewhere in almost every note.

Persons who are just starting their career in medicine often mindlessly document everything. The end result is a lengthy note that does not lead anywhere. And, somewhere buried in the entry are the facts that are actually relevant. This is the classic medical student note and it not the type of documentation to which any seasoned clinician should aspire.

Good documentation is inseparable from good clinical reasoning.

A better approach is to think first and document second. If a fact is relevant to the clinician's thought process and reasoning, then is should be documented. Otherwise, it is neither relevant nor helpful and should not be included.

Once a working diagnosis is established, the note should finish by mapping out the assessment and plan. This includes noting any studies, referrals or tests that are ordered/planned, any prescriptions or sample medications that are given, the details of any procedures that were done, and the plan for follow-up. Unless there is something atypical or unusual about the treatment plan, the clinician's thought process and justification should not be recorded.

2. The reason why we are executing Plan B instead of Plan A.

Case #5

A patient needs an MRI to rule out a brain tumor. His physician requests authorization for the MRI from the patient's insurance company, but the request is denied. Instead, the insurer states that it will pay for a CT scan.

However, the physician is concerned that a tumor may not be visible on a CT. The physician asks the patient if he can pay for the MRI himself, and the patient responds that he cannot. Because the CT scan is better than nothing, the physician orders the CT.

Analysis

It does not take a seasoned malpractice attorney to see what might happen next. If the CT misses a tumor, the patient's diagnosis will be delayed, and his condition and/or prognosis could suffer as a result. The risk is that he or his family may then blame the physician with a lawsuit alleging that he should have ordered an MRI.

Of course, the failure to perform the MRI initially was not the physician's fault. He tried to secure the test, but could not obtain payment or authorization. And, there was no means by which the physician could obtain an MRI for free. So, he did the next best thing, which was a CT. In short, he made the best of a bad situation. And, that is exactly what the accompanying note should state: "Neither patient nor insurance company willing to pay for MRI, will do CT."

Any time a clinician moves from Plan A to Plan B, a note must be written which gives the explanation.

Any time a clinician moves from Plan A to Plan B, a note must be written which gives the explanation. The reason might be insurance coverage, patient finances, patient noncompliance, an allergy or a contraindication.

But, regardless of the reason, a clinician who executes Plan B must be prepared for the possibility that someone will say, "It's your fault, you should have been on Plan A." As such, anytime we abandon Plan A in favor of Plan B, we must document the reason. Otherwise, people might mistakenly conclude that we are the reason.

3. Our justification for doing something that looks, or perhaps even is, unconventional.

Case #6

An elderly patient's blood pressure is repeatedly documented to be in the range of 176/84. Despite the increased risk of stroke, her physician follows her for over a year without initiating any anti-hypertensive treatment. Eventually, the patient suffers a stroke.

Analysis

From a medical-legal perspective, this case is concerning. The failure to treat hypertension in this situation is certainly unconventional. And if a plaintiff attorney is asked to review the chart, it will not take her long to conclude that she has a very promising case.

The patient also had severe orthostatic hypotension. When she rose from sitting to standing, her blood pressure fell from 176/84 to 90/60, and she became lightheaded. She was also 84 years old and lived alone.

The physician's notes stated that because of the great risk of fall and her frail condition, he believed that it was best to withhold anti-hypertensive treatment even though there was an increased risk of stroke.

This explanation changes the case entirely. It goes from a glaring case of malpractice to a well-reasoned clinical decision. And a plaintiff attorney who reads the chart is going to conclude the same thing. By putting the reasons for a seemingly unconventional approach in the record, what looked like a serious mistake suddenly goes away.

On the other hand, if the reasoning is not in the record, and the basis for the decision is unclear, then it looks like malpractice. Although the facts might eventually come out at the physician's deposition or at trial, the goal is to avoid being blamed in the first place.

When taking an unconventional approach, explain yourself in the chart. It may save the trouble of explaining things later.

As a general rule, we do not need to put our thought process and reasoning in the chart. But, when we are engaged in something that looks unconventional, we want to document why the approach is actually a sound one.

4. ANY WARNINGS THAT WE ISSUE TO THE PATIENT.

From a legal perspective, a warning downloads the risks of a product or a situation to the consumer/patient. A warning is thus appropriate anytime a patient makes a decision which carries risks that he may not fully appreciate. From a practical perspective, that is almost every patient.

Case #6

A 55 year old woman refuses a screening mammogram.

Analysis

This patient has made a decision which carries risks that she may not fully appreciate. She should be warned. The verbal statement, "I want you to understand that your decision may prevent us from detecting breast cancer, and that might mean that you could die of breast cancer" is sufficient.

The statement is a warning, and it effectively downloads the liability to the patient. The physician cannot force her to have a mammogram. All that he can do is recommend it and warn her of what might happen if she refuses. Ultimately both the choice and the consequences belong to the patient.

The accompanying record entry should state, "Refuses mammogram, risks discussed." The note does not need to be more specific, nor is it required to record the exact words that were said. The risks of refusing a mammogram are widely known to every clinician and do not need to be listed here. Although specific risks should be listed as part of "informed consent," that process is not applicable here.

Anyone who refuses a recommendation must be warned.

Most physicians recognize the importance of documenting the above events, but many of us do so in a less-than-ideal manner. For example, many physicians would document the above series of events by simply writing, "Mammogram refused" in the chart. Although the patient did refuse a mammogram, the entry does not reflect that she was warned of the risks of doing so. In short, that entry is not enough; it is not a warning.

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In addition to warning patients who refuse our recommendations, we should also warn patients who follow our advice.

Case #7

A 44 year old man who has chest pain is referred to a cardiologist by his family doctor.

Analysis

The patient should be warned. Although he has, for the moment, not expressed disagreement with the physician's plan, he should be cautioned of the risk of changing his mind. Saying,

"Sir, I don't want to alarm you, but you could be at risk

of having a heart attack. I'm going to make an appointment for you to see a cardiologist. If you can't keep that appointment please call me."

is sufficient. And, in the chart the note should state, "Referred to cardiology, Importance discussed." If the patient does not keep the appointment, that is his choice. But, he must bear the consequences of doing so. Because he was properly warned, the risks associated with any other course of action are now his own.

A proper warning shifts the responsibility to the patient.

These discussions and the associated documentation all have the same pattern.

"Risks discussed."

"Importance discussed."

"Ongoing treatment plan discussed."

There are a number of ways to express the warning and, in most cases, any one of them can be used.

5. Anything that is needed to satisfy the various coding and billing requirements.

It is against the law to submit a claim for services rendered unless the chart supports that those services were actually performed. Because the coding and billing requirements are somewhat technical, this adds another layer of complexity to every note that we write.

In fact, every note has to satisfy at least three purposes:

- Patient care and communication,
- The medical-legal/medical malpractice system, and
- The billing and coding requirements.

Fortunately, there is a fair amount of overlap. But, it is important that each entry covers the necessary elements of all three.

Documentation Dilemmas

Chart Revisions and Alterations

Case #8

A physician writes a progress note. Sometime later, he realizes that the note is incorrect and desires to change it.

Analysis

Whether it happens while we are still writing the note or not until the next time we see the patient, we all encounter the need to modify a chart entry. Fortunately, correcting a mistaken entry is not a serious issue, so long as it is done in a manner that does not create confusion or give the appearance that something is being hidden.

The best technique is to cross out the incorrect items with a single horizontal line, and then sign (or initial) and date the changes. The reason for using a single line is so that the incorrect entry can still be read. Because, if it cannot be read, it gives the appearance that something is being hidden, and that is undesirable. So, the goal is to make the correction without making it look like a "cover-up."

Revisions and corrections should be executed in a manner that does not create confusion or give the appearance that something is being hidden.

Although corrections can be made at any time, the longer we wait, the more suspicious the correction becomes. But, as long as the correction is made within a few days or weeks, it is generally not a problem. However, corrections should never be made after a bad event occurs.

In the wake of a bad outcome, it is tempting to look back at our recent notes and add a few things or make a correction. But, even if this is done in good faith, it looks suspicious. Therefore, entries should never be amended or altered after a patient suffers a bad outcome.

Entries should never be amended or altered after a patient suffers a bad outcome.

The last time limit on amending a note is the act of being sued for malpractice. Once a lawsuit is filed, no record should be amended in any way. In addition to creating suspicion, this situation faces the added danger that the patient's attorney undoubtedly already has a copy of the chart. And, we then face a situation where there are several versions of the same chart. From a legal perspective, that type of case is nearly indefensible.

Medical Errors

Handling a documentation error is easy. We simply correct the chart in a manner that makes it obvious we are not trying to hide anything. However, handling documentation in the wake of a medical error is more challenging.

Case #9

A patient is admitted with pneumonia. To keep the case simple, we will assume that erythromycin is the drug of choice for the patient's infection. Unfortunately, the physician is fatigued and loses his focus. He inadvertently writes for the patient to receive gentamicin, instead of erythromycin.

The patient begins receiving gentamicin, and not surprisingly, he does not improve. Two days later, he is still febrile and feels much worse. And, it is at this time that the physician realizes that he is not receiving the correct antibiotic.

Analysis

An obvious error was made and it resulted in patient suffering. The first priority, as always, is to take care of the patient. As such, his antibiotic should be changed to something more appropriate as soon as is feasible. After the patient's antibiotics are rectified, what should be written in the chart? What are the magic words that can be used to "cover" a situation like this?

In simple terms, there are no magic words. The reality is that the patient received the wrong antibiotic for two days. And, no amount of documentation can change it.

Documentation cannot change reality.

Many clinicians believe that when an error like this occurs, ingenious documentation can salvage the medical-legal situation. But, documentation is no more able to salvage the medical-legal situation than it is capable of salvaging the patient himself. No matter what is written in the chart, it cannot change the fact that the patient received the wrong antibiotic for two days.

Unfortunately, many clinicians respond to the discovery of an error by trying to explain what happened or clarify the events in hope of "covering" themselves. But, this is never successful. Instead, it draws attention to the matter and invariably damages whatever defense might exist by introducing inaccuracies and contradictions.

Instead of trying in vain to "cover" himself, the physician's note should simply state, "Patient not responding to gentamicin, will change to erythromycin." The entry is accurate, truthful and fairly represents the patient's condition. It does not attempt to explain anything, as there is nothing to explain; it does not "cover" anything, for it is impossible to do so; and, it does not attempt to "hide" anything, as that is unethical.

We are not required to incriminate ourselves and should generally avoid doing so.

One possible concern that some clinicians might raise is that the above note does not "tell the whole story." But, the entire story is already in the chart for all to read. The patient received the wrong antibiotic for two days because the physician made a mistake. Those facts are already in the chart. They should not be covered-up; but, there is no purpose in restating them. In short, we are not required to incriminate ourselves and should generally avoid doing so.

DISAGREEMENT WITH ANOTHER PROVIDER

The next dilemma that we sometimes face is disagreement with another provider. It could be a difference of opinion between two doctors, a doctor and a nurse, or a doctor and a pharmacist. Regardless of who the two people are, there is a good chance that the disagreement will eventually be reflected in the chart.

Case #10

A patient develops post-operative fevers and the surgeon consults infectious diseases. The infectious diseases consultant writes a note stating, "Patient's overall condition has deteriorated, recommend starting broad spectrum antibiotics."

The surgeon reads the note, but disagrees. He writes a note that states, "Temp lower this afternoon, no antibiotics for now." The next day the infectious disease consultant writes, "Continued fever, again recommend antibiotics."

Analysis

The chart can be an excellent communication tool. But, it should not be used in the manner displayed in this example. Although the physicians' notes are collegial and far from inflammatory, the problem is that the two clinicians are expressing disagreement as to a critical aspect of the patient's care. Collegial or not, that is very concerning.

When clinicians work together, the goal of both patient care and its accompanying documentation is to discuss the options, explore the alternatives, and then proceed in a mutually agreeable manner. That approach is best for the patient and it provides us with a unified line of defense in the event that we are accused of wrongdoing.

But, if our opinions diverge, that line of defense is com-

promised. This is not to imply that we must robotically agree with one another. But, it does mean that we should always be working toward agreement.

Clinical disagreement is both inevitable and invaluable; but, we should always be working toward agreement.

For example, when the surgeon disagreed with the consultant's recommendation for antibiotics, he could have called the infectious diseases doctor. The two of them could have discussed the matter and then proceeded in an agreed manner. If they decided to not start antibiotics, the surgeon could have written, "After discussion with ID, will hold on antibiotics for now."

Unfortunately, in this case, the surgeon simply wrote his note and left without making the phone call. Although less than ideal, this is not a legal disaster. However, the onus of resolution then shifts to the infectious disease consultant. When he reads the surgeon's note, he needs to make the phone call. Temporary differences of opinion are not a problem. In fact, they are an expected and valuable part of the practice of medicine. However, we need to resolve diligently any such disagreement in a timely manner.

Collegial debate is important, but it should not take place in the patient's chart.

If the disagreement is allowed to go back and forth in the chart, everyone is vulnerable. Therefore, the process of resolution must begin as soon as the disagreement becomes apparent. Thereafter, both the patient's treatment and our documentation can reflect a unified approach.

The Attorney-Client Privilege

The last documentation issue pertains to a common and very damaging mistake that many of us unfortunately make.

Case #11

A patient suffers a number of complications after elective surgery and spends months recuperating. Eventually, she informs her physician that she plans to sue and contacts an attorney.

As most of us would, her physician thoroughly examines the medical record in order to ascertain the strengths and weaknesses of the situation. He finds a few notes that are in need of clarification and has some thoughts as to how the situation can be best defended.

But, he is aware that he should not make any additions or deletions to the chart at this point. So, he does not make an entry in the medical record. Nonetheless, he wishes to record his thoughts while they are still fresh in his mind.

Analysis

The physician's observations and thoughts about the case are important to the defense of his position, and it would be valuable to have them recorded somewhere for later reference. But, placing them in the chart is a bad idea that will invariably do more harm than good.

Faced with this dilemma, physicians use a variety of different methods to record their thoughts. Some use a "Personal file" or "Personal record," that is kept separate from the medical record. Some use a ledger that they keep off-site, perhaps in their desk drawer at home. Some use their home computer. Unfortunately, every one of these methods is a mistake.

In the course of a lawsuit, the plaintiff attorney will demand that the physician produce "all records, files, films, tapes, discs, photos and documents that are related to the patient's care." It does not matter where the files are kept, what they are called or who has them. The plaintiff demands them and will usually be successful in obtaining them.

Many physicians believe that information can be protected from discovery by keeping it out of the "official" medical record, but that is not correct. The plaintiff has a right to the diary in your nightstand if you made notes about the case in it.

However, there is one way to record information so that no other party can ever obtain it. And, that is by use of the attorney-client privilege. Made famous in the movie "The Firm," confidential communication between an attorney and a client cannot be obtained by another party. The theory is that the attorney and client, just like the doctor and patient, must be allowed to communicate freely, so as to explore the case fully and develop the best possible strategy. Thus, all such communication is strictly protected.

Our thoughts as to the strengths and weaknesses of our situation should not be expressed outside of the attorney-client privilege.

Therefore, what this physician should do is take a piece of paper and write across the top, "Confidential Attorney-Client Privilege" and then write, "To my attorney:" as if he is writing a letter. At that point, he can write whatever he desires. He should then keep the letter in his posses-

sion and give it to his attorney at their first meeting.

Once he declares the attorney-client privilege, the document is un-discoverable. The other side cannot obtain it and the physician's attorney can never share it. And, it is thus the ideal place to express one's thoughts, feelings and strategy about a medical-legal situation.

Conclusion

The medical record is a powerful legal document and it deserves a fair amount of our attention. But, most of us spend too much time with the record and some of what we document is not helpful. Rather than worrying about the record, and trying to document everything, a better strategy is to spend our time focused on the patient. If we do that, most of the documentation will take care of itself.

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