DOCUMENTATION DILEMMAS

OUTLINE

A. Introduction

1. The practice of law is based in paper.
2. The standard legal critique always emphasizes paper over patient.
3. We must strike a balance between efficient patient care and sufficient documentation.

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B. Procedure Notes

1. Scenario #1 – Minor complication, Patient likely to have a good outcome
2. The resulting procedure note may someday become "Exhibit A."
3. Dictating the Note
    a. Honesty and credibility are paramount
    b. Lengthy explanations should generally be avoided
    c. The value of a "textbook" dictation
4. A plaintiff's goal is to show that we failed to properly identify/properly manage the complication.

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5. Scenario #2 – Major Complication, Patient likely to have a bad outcome.
    a. Approach to the dictation is exactly the same.
    b. Textbook care followed by a textbook note.

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6. Scenario #3 – Non-textbook Care

    a. Dictate it just like it occurred.

    b. There are no magic words which can change the reality of what happened.

C. Radiology Reports

1. Scenario #1 - Routine mammogram - Mass suspicious for malignancy.

    a. Emergent or unexpected and potentially serious finding:

        i. Call the ordering physician.

        ii. Inform the patient when appropriate.

        iii. The final report should display the critical findings in a prominent way.

        iv. Recommending the needle biopsy?

            - "Right breast mass, suspicious for malignancy, consider ultrasound-guided needle biopsy after clinical correlation of radiographic findings"

            - Provides assistance without putting ordering physician in a box

2. "Dictated, But Not Read."

    a. What does this phrase actually mean?

    b. Do not use this phrase on the final copy of a report.

3. Proofreading Dictation

    a. If possible, proof the "Conclusion." This is the only section that most clinicians will read.

E. Phone Calls

1. Standard legal advice: Document every phone call

2. Sources of most of telephone-related legal issues:

    a. Calls that we don't return - We must have a system for reliably returning patient calls in timely manner.

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    b. After-hours calls

        i. We should have a very low threshold for seeing these people.

        ii. The patient who does not go to the ER – How do we disprove what he alleges?

        iii. The patient must have a credible story, not just an allegation.

        iv. Documenting after-hours phone call – Whenever/however feasible

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F. Explaining Your Thought Process

1. Scenario #1 – Obvious case of appendicitis

    a. When the patient's condition leads to an obvious course of action, no explanation is needed.

2. Scenario #2 – Less obvious case of appendicitis

    a. The problem of medical necessity and fraudulent billing.

    b. Document your reasoning when it may not be clear why you're doing what you're doing.

3. Scenario #3 – Patient with documented PCN allergy.

    a. Document your reasoning when it looks like you're doing something that's wrong.

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G. Level of Detail in the Medical Record

- "Chest clear"
- "Chest clear to auscultation and percussion"
- "Chest clear to auscultation and percussion, bilaterally"
- "Chest clear to auscultation and percussion bilaterally, no wheezes, rubs, rales or other sound, sign or suggestion of pathology"

1. If you focus on the patient, the documentation will usually take care of itself.

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H. Curbside Consults

1. Situations where we informally ask one another's opinion

2. Legal Aspects of Curbside Consults

   a. Cotton VR, Legal Risks of "Curbside" Consults, Am J Cardiol. 2010; 106(1):135-8. Epub 2010 May 13. victor@lawandmed.com

   b. Liability for medical malpractice is dependent upon a doctor-patient relationship.

   c. In order to form a doctor patient relationship, the doctor must have contact with the patient.

   d. A curbside consultant cannot be successfully sued no matter what he says because he's not the patient's doctor.

3. You cannot create liability for another person simply by writing his/her name in a chart.

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4. The Value of a Curbside Consult

   a. Involving a consultant usually provides a layer of medical-legal protection.

5. "I informally discussed the worsening renal function with Dr. Jones, head of nephrology, and will reduce the antibiotic dose by half."

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6. Documentation of Curbside Consults

   a. The treating physician's protection depends on credibility, so he/she should document that he asked for help.

b. The consulting physician's protection depends on informality, so he/she shouldn't document anything.

I. EMR

1. "Legal Health Record" – "Those records generated at or for a healthcare organization as its business record"

2. "Designated Record Set" – "A group of records maintained by or for a covered entity"

3. "Medical Record" – The term used by CMS and the legal system

4. Everything that a clinician documents is part of the legal health record, the designated record, set and the medical record.

5. "Personal Health Record" - Records that the patient creates and maintains himself. Can be given as much consideration as warranted.

J. Changes and Amendments to the Medical Record

1. The central role of honesty.

2. The most common way that improper alterations of the record are discovered is by copies that were previously made.

3. Ink Analysis – Far from an exact science

K. Conclusion

In evaluating a documentation dilemma, we must find a common-sense balance between the legal profession's desire for paper and the patient's desire for care.