INSTRUCTOR'S GUIDE
MEDICO-LEGAL DOCUMENTATION

BACKGROUND:
Learners in medicine are often instructed on the logistics of how to document patient encounters, but not always the "why," especially as it pertains to medico-legal documentation. Learners may also get mixed or conflicting messages depending on the purposed of documentation (i.e., communication to other providers/preservation of the record, medico-legal defensibility, or for revenue generation/billing and coding). Those responsible for teaching documentation may have limited personal medico-legal experience or ready access to legal counsel for advice and recommendations. Input from legal experts may also come with a cost. It is not uncommon for those physicians with the most clinical experience to take the lead on this topic; those who may have previously been involved in a medico-legal case and willing to share their experience and what they learned from the case may also take lead on this topic.

There is not abundant evidence as to what makes a sound medico-legal document, especially specific to Emergency Medicine. Literature review of this topic demonstrates malpractice data (including payouts, diagnoses, etc.), common errors made in patient care even if these errors did not directly result in malpractice claims, and elements that contribute to errors in care. More information is available on this topic from organizational viewpoints and expert or consensus opinion. Essentially, there is gestalt as to what makes a "good" chart, but often not much supporting evidence.

A sound medico-legal document is just as much about what *is* in the chart as what *is not* in the chart. A common adage in medicine is, "If it's not documented, then it didn't happen." This is especially true in the field of Emergency Medicine, where the spectrum of acuity and pathology can present in close temporal proximity, providers are task-switching probably more than any other medical specialty, and any number of other staff or providers may be involved in a given patient's care, confounded by cumbersome electronic health records, frequent interruptions, limited ability to document live, and pressures from a multitude of sources to improve efficiency and provider volume.

PURPOSE & GOALS:
To provide a brief overview of the various reasons why healthcare providers must document their care, and better delineate elements of what makes a sound medico-legal document. Learners can then practice elements of chart review in different settings to improve performance regarding this important aspect of patient care.

EDUCATIONAL OBJECTIVES:

- Understand areas of medico-legal risk pertaining to documentation of patient encounters specific to Emergency Medicine, as well as all fields of medicine
- Discuss elements that are imperative to include in medical documentation, as well as necessary elements to exclude, that make a chart more legally sound

- Evaluate real documentation for medico-legal appropriateness and cohesiveness
- Practice revision of problematic charts

RESOURCE FILES:

1. **Medico-legal Documentation** Didactic (filename: documentation.cts.pptx)
   - This didactic provides a combination of literature and expert consensus describing details of malpractice data in Emergency Medicine, common sources of error, elements to improve electronic medical records (if applicable), and tips and tricks for general documentation purposes as well as special circumstances
   - Estimated time: Adaptable to 20-60 minute range (see below)
2. **Documentation Rubric** (filename: chart.review.tool.pdf)
   - This document is a worksheet/rubric used to review charts in a systematic manner to assess for quality, consistency and exposure to liability
3. **Summary Handout** (filename: documentation.summary.handout.pdf)
   - This document provides a summary of the teaching points for the module

TOTAL MODULE DURATION: 2 hours

REQUIRED RESOURCES:

- Computer with capability of running PowerPoint
- Sample Charts:
  - Sample charts should be pulled directly from resident cases, ideally preliminary notes prior to faculty edits and addenda. De-identified patient data as appropriate. Depending on the setting of use, there could be consideration as to maintaining confidentiality of the resident authors for each case reviewed.

DESCRIPTION OF MODULE:

Intended Audience

- Emergency medicine residents at any level of seniority

Pre-Reading

- Learners should read the article and watch the brief video prior to the initial presentation.
  - Top 10 Principles on How to Avoid Getting Sued
    - Grassie C, Nauss M, Schmitz G, et al., ACEP Medical Legal Committee. Top 10 principles on how to avoid getting sued in emergency medicine: an information paper. American College of Emergency Physicians. October 2013.
  - Top Ten Docucmentation Mistakes
    - Video presentation of Dr. Greg Henry and Dr. Gillian Schmitz discussing the top ten documentation mistakes. American College of Emergency Physicians. April 2017.

Recommended Implementation/Timeline

- Pre-module

    - Prior to the day of the module, the pre-reading should be provided to the learners to familiarize themselves with the content. This will allow more time for focusing on more advanced defensive documentation concepts.
- During the module
    - Goals and objectives of the module are introduced by the presenter *(5 minutes)*
    - **Medico-legal Documentation** didactic presented by a senior resident or faculty member
        - The presentation can be abbreviated to as little as *15-20 minutes* with limited discussion, or up to *60 minutes* with presenter-facilitated group discussion of examples pertinent to the topic
    - **Documentation Rubric** is distributed to each audience member, and reviewed briefly by presenter (5 minutes)
    - Sample charts reviewed using **Documentation Rubric**
        - Allotted time can vary according to the needs of the program and the format in which it is being used. Potential considerations:
            - During regularly scheduled QI/M&M, use rubric to evaluate the chart(s) in question. Charts (appropriately de-identified as needed) may be sent out in advance for learners to familiarize themselves with the case, so that group discussion of documentation performance occurs during conference *(45 min)*
            - Learners can be assigned any number of their peers' charts for comparison according to the documentation rubric. Feedback to the original chart author can be given in a written format (submitted rubric) or in individual, small group or larger group discussion. Faculty mentors can facilitate these discussions. *(asynchronous)*
            - Learners can be assigned a number of their own charts for personal review. Discussion of performance can be held with faculty advisors or other faculty mentors. *(asynchronous)*
        - Audience participates in large-group, collaborative revision of sample charts using areas for improvement identified using **Documentation Rubric** during sample chart review. *(15 minutes)*
            - Additionally applicable to peer review, and personal chart review *(asynchronouos)*

CONCLUSIONS:

Documentation from a medico-legal perspective is an acquired skill, and one that is variably incorporated into didactics for Emergency Medicine learners, often by non-experts. It is applicable to medical students, residents and fellows, advanced practice providers, and even faculty. It is unfair to criticize learners about their documentation if they are not given appropriate education initially and constructive feedback regularly regarding their documentation practices. Ideally this curriculum introduces the importance and necessary elements of a cohesive chart from a medico-legal perspective, and provides an opportunity

for residents to learn from their peers as well as self- in order to improve their documentation practice.