MEDICOLEGAL DOCUMENTATION
SUMMARY HANDOUT

Malpractice Information

Errors in diagnosis and procedural complications are two of the leading causes of error contributing to medical malpractice cases. Missed diagnoses are common complaints alleged against physicians, often as a result of no or limited differential diagnosis, error in testing due to delays or incorrect testing, as well as premature discharge and inadequate assessment. According to malpractice trends, an undiagnosed condition is riskier that an incorrect diagnosis. Another contributing factor to error, and therefore malpractice claims, is a breakdown in communication between other team members and the physician.[1,2]
The natural course of ED care has inherent risk, particularly during transitions of care, as do efficiencies we as physicians have built into the system, such as the use of dictation.[3,4,5]
When comparing the types of errors that occur in an emergency department, one study found that 13% of all errors were related to documentation, such as documenting in incorrect patient's charts, inaccurate documentation, as well as incomplete documentation.[6]
Documentation is a vital part of the provision of care, and a sound chart can facilitate defensibility should a medicolegal issue arise.

Purpose of Documentation

Documentation serves multiple purposes. Communication to other providers and preservation of information is critical. Documentation, especially structured paper or electronic records with built-in prompts, is also key to maximizing billing and reimbursement. It serves an important role in quality assurance, as well as facilitating data collection and research. And finally, good documentation can serve the purpose of providing medicolegal protection.

Electronic Medical Record (EMR)

Aalthough built to facilitate care, the presence of an EMR can contribute to error. Wrong orders or documentation may occur on the wrong patient chart. Unidentified patients (i.e., "Doe" patients) can be difficult to discern if more than one is present in the department at a given time. It may decrease communication between team members if one is isolated to a computer at a specific location, or communication is occurring only via electronic means and not in person. Most physicians can probably think of nursing notes they missed or didn't read until after the fact, whereas in-person communication is more likely to keep and maintain a physician's attention. Similar to electronic communications, alerts can be useful and serve a purpose, but when the number of alerts rise, the risk of alert fatigue also rises. EMR systems are not always developed by physicians, so displays are not always compatible with how information is taught in medical school. For example, EMRs may list data (labs, vital signs, etc.) in table format, but in a different order (i.e., alphabetical, chronological) than how we were taught to interpret them, such as labs in the traditional "stick" diagram. Similar to alert fatigue, it can become too easy to acknowledge results in the EMR without actually mentally processing the data and then addressing it.[10]

However, EMRs have some genuine advantages over traditional paper charts as it pertains to medicolegal documentation. The electronic record eliminates issues with illegibility and minimizes non-standard abbreviations. An electronic record can typically be accessed by multiple providers across multiple sites within a health system, often simultaneously, and may facilitate the transfer of information. Additionally, EMRs can record tasks completed by a physician without a physician having to provide detailed commentary on it. Each time labs are viewed, a consult is ordered, or the time the first order is placed, is readily searchable within the EMR. In addition to these advantages, EMRs are often semi-customizable. In order to prioritize how information looks, health systems, individual practices, or individual providers can often select personalized elements according to their priorities in viewing information and application of filters.[10,11]

Electronic records often have complaint-driven templates, which may minimize the amount of free text necessary. Clinical guidelines and clinical decision tools may minimize excess testing, as well as provide protection by prompting adherence to a regional or national standard of care.[8,12-14] Electronic records also have the advantage of having previous information ready available. If a patient has a complex medical history, it can be advantageous to perform a brief "chart dive" prior to seeing the patient, or soon after. But having an EMR is a double-edged sword, because if information is readily available but was not reviewed, and there is ultimately a bad outcome, that physician could potentially be held accountable.[15,16]

How To Document

A medical document, particularly an ED note where there is a limited timeframe, should read in a relative chronological order, like a story. There is a beginning (the patient's chief complaint and associated symptoms, followed by the review of systems, medical history, and exam). The history of present illness is more subjective, and is usually presented in lay terminology, and the most appropriate location for patient quotations. The review of systems, medical history, and exam findings are more objective, utilize medical terminology over lay terminology, and have little utility for patient quotes. Following the introduction of the case, the middle is more about case evolution (medical decision making, tests and test results, and initial treatment). This evolution can be as short or long as needed, especially if circumstances change in response to or despite treatment. The end of the story is the ultimate disposition, followed by any future plans for follow-up.[17]

Some EMRs may have a location for medical decision making after the HPI, ROS, medical history, and exam; areas for reassessment and disposition often follow afterward. Other EMRs may place this information near the physical end of the document, as an overall assessment and plan, with room for reassessments and disposition. The location for the medical decision making may physically be in different locations of a specific EMR, but the purpose remains the same. This area should not be a reiteration of the chief complaint, but more of what the physician is doing to address the chief complaint. The medical decision making should explain the differential diagnosis and what can be ruled in or ruled out based on history, exam, or testing. Not everything on the differential needs to be tested for if it can be explained out other ways, *as long as there is an explanation*.[16-18]

Documentation Pitfalls

Too much/too little

There are two universal rules related to documentation: 1) don't document something you didn't do and 2) if it isn't documented, it didn't happen. It can be too easy, especially with an "all normal" or similar option, to select that option even if everything under that section was not addressed. If there is a skeleton for portions of the physical exam, it is much safer to expand that section and only note what was actually performed. Physicians can also accidentally miss portions of the document, even if the events occurred. Elements of the chart, especially skeletonized electronic charts, can be easy to skip over, but unfortunately "but I did it…" is not adequate defense if the evidence is missing.[16,17,19]

Macros

Macros are often used for the sake of efficiency. Similar to selecting "all normal" for a feature on a chart template, problems arise when too much information is contained in a macro, and the macro is not changed specific to a patient encounter. Some recommend putting the least amount of information in a macro to make it more broadly applicable to patients or building multiple macros so that there are simple and complex options available to select for each case.[4,16]

Discrepancies

It is not uncommon to find discrepancies or outright contradictions in the chart, but the physician is ultimately still responsible for everything in the document. We can all think of the child triaged as "lethargic" who is running around the room, playing on our exam. Registration information should be briefly reviewed, as well as nursing notes and EMS notes (if available). Discrepancies should be addressed prior to the note being finalized. The medical decision making is probably the best spot for this. It is also imperative to add in additional information obtained after the fact (i.e., after family arrival, after calling nursing home for more information), noting whether it support your working diagnosis or changes your care plan altogether.[16,19]

Timestamps

A key thing to remember is that timestamps in the EMR reflect when you are entering data, not when you are doing something. So if you are in a room resuscitating a patient or performing a procedure and documenting it afterward, either have someone else record the accurate time or document approximate times.[4,16,19]

Consultants

"Bob from Ortho" doesn't have a great ring to it. If you talk with a consultant, either in person or over the phone, it is very important to document their name, the time of the conversation, and any recommendations they give at that time or after patient evaluation.[19] If there is a disagreement in care plan, find a politically correct way to document it without further context or inflection. The documentation has no room for "chart wars" and opens avenues for malpractice attorneys.[19]

Transitions of Care

Everyone knows that sign-out is an inherently risky time in patient care. There are two key elements of transition. When giving/receiving sign out with a colleague in the ED, it is important to try and standardize the process. The actual transition of care should be denoted in time, as well as what information was shared during the exchange. This becomes especially important if there is a change in plan or change in patient status. The ideal situation should involve an evaluation of the patient by both providers around the time of transition. Treat admissions like a transition of care as well. Document the conversation with a timestamp, the name of the person you spoke with and what service they represent, as well as what information was given to them. It may also be pertinent to note any mutually agreed-upon time for patient evaluation, especially for those sicker patients.[16]

Discharge

Patients need to be informed of relevant and incidental findings. It is good practice to document that the patient was given this information, as well as any other witnesses to this discussion. The diagnosis should be explained, or if a lack of formal diagnosis remains, the follow-up plans. Some EMRs require the use of prefabricated discharge instructions and return precautions, but it is also good practice to individualize these precautions to the specific patient encounter.[16]

Special Circumstances

Abnormal vital signs should be reassessed to see if they normalized or improved; if they have not normalized, they should at least be explained (i.e., tachycardia due to multiple albuterol treatments). The "PO challenge" is especially important at the extremes of age, as infants and toddlers as well as the elderly are more susceptible to dehydration and may have difficulty in remaining hydrated. Finally the "road test" is also key to document. If a patient was previously ambulatory, they should be assessed for ambulatory status prior to discharge, and this should be documented.[16]

Summary

When documenting, it is important for the chart to read like a story. You want to be able to remember the patient encounter, well after the fact. Malpractice cases often occur after some time has lapsed from the initial encounter, so you want to ensure a clear clinical picture is painted for any subsequent readers. Anticipate difficult encounters or elements of the chart and ensure they are documented well. Finally, do not leave opportunities for elements of your chart to be used against you.

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