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Dispelling Common Myths About Documentation

Excerpted from an interview with John P. Ryan, Esq., a Partner with the Sloane and Walsh law firm in Boston, published in Forum, July 1995.

Q Do risk managers and attorneys exaggerate the value of documentation?

A No. Documentation's obvious value is its reflection of good patient care. But when the patient care is challenged in a malpractice claim, good documentation of good care can convince the prospective plaintiff attorney not to bring a suit. The ability to utilize notes to prove that the doctor is speaking truthfully is critical in the defense of malpractice cases. Documentation also aids the physician's memory. It's not unusual for a physician's care to be challenged many years after it was provided. The notes become critical because they record what occurred and can also be used to refresh the physician's memory as to what took place. It's very comforting to physicians to know they can go back to their notes and corroborate their memory.

Q Is a good note always very detailed and extensive?

A That's a common misconception, that in order to defend a medical malpractice case, doctors somehow have to be clairvoyantly writing notes that would satisfy a lawyer or a congressional hearing. It really isn't true. One illustration is an older case involving an intrauterine device that perforated the patient's uterus. The plaintiff alleged that she had not been adequately informed prior to the insertion of the device of potential complications, most specifically, perforation. The physician had a short form on which he would note his advising the patient. And the note read something like: "patient advised of risks, including infection, sterility, and death." Now notice the word "perforation" was not in the note. But, the doctor was able to testify that although he didn't have a specific memory of this patient and a specific recall of the insertion of this particular IUD, those eight or nine words that were in the note, was his thumbnail way of noting that he had a lengthy discussion with the patient before utilizing the device, and that he always discussed perforation. That case also resulted in a verdict in favor of the physician.

Q What are plaintiffs' attorneys likely to look for in a medical record?

A Four major things: 1) holes, 2) missing pieces, 3) conclusory statements, and 4) contradictory statements.

By holes, I mean that the record is intact, but the plaintiff is looking for a conceptual hole or break in the information something that's not being addressed. They'll try to use any holes they find to develop the fact that perhaps the physician wasn't focused or really wasn't paying attention.

Plaintiffs also try to identify "missing pieces," something such as lab value or lab slip that can't be found; an X-ray report that's missing--things of that nature. Whenever a piece of the record can't be located, that's something they like to work with.

The third thing plaintiffs search for in the record are conclusory comments made by a subsequent physician about a prior event. One illustration involved a pediatric cardiac surgery case, in which questions were raised about whether or not an embolic event had happened during the performance of the surgery resulting in an insult to the child's brain. During the post-operative period in the ICU, an extubation incident occurred spontaneously. The child developed seizure activity that led to a great deal of questioning and wondering what the child's problem was.

Within a week or so after the ICU incident, some-one along the line made a conclusory statement that was something to this effect: "Child seen today for seizure activity and question of brain insult secondary to extubation incident in ICU." As a matter of fact, no detailed investigation had been done. The child was being seen for treatment of the condition, not to be looking back at it historically. Despite those facts, that comment was used to confront the physicians who were responsible for the child in the ICU that there was a conclusion in the record about what had happened.

The fourth area that comes to mind is the contradictory comment among one or more physicians.

Q How can contradictory documentation impact a case?

A Real contradictory comments are fairly rare; apparently contradictory comments are fairly common. Often you'll see that subsequent caregivers in the record will make statements or comments that, on the surface, are contradictory. We try to work through all of those statements to reconcile them. Frequently, the apparent contradiction results from the subsequent caregiver not providing as detailed a note as the prior caregiver did.

A real contradictory note is a little bit more difficult to work with. Fortunately, they are not that common. Most experienced physicians understand the import of their words. But I think that physicians need to understand that when they are making conclusory comments or comments that might be directly contradictory to another care-giver, they ought to go slowly, because they can really be placing someone unfairly in harm's way. Often, the subsequent contradictory note creator doesn't have all of the facts.

If a subsequent caregiver conscientiously disagrees with prior treatment, he or she should confer with his or her colleagues in order to reach a consensus on the appropriate treatment before changing the treatment method. In such a case, good patient care can be achieved without potentially unfair commentary about prior caregivers getting into the record.

Q How damaging is alteration of records?

A First, let's consider the modifier used in front of the word "alteration." Clinicians make many appropriate alterations; in some instances they make inappropriate alterations. An inappropriate alteration would be a conscious practice of altering the record to not reflect the true facts. The only way to handle those, quite frankly, is to confront the physician or caregiver who has apparently altered the record. The defense has to get the correct information because going into negotiations or a trial with a consciously, inappropriately altered record, would be devastating. Sophisticated plaintiffs' attorneys who believe they have inappropriately altered records will have them reviewed by document experts. It's a very risky business not to be aware of it.

With regard to those that have been altered appropriately, or in the so-called gray zone, once again the defense team has to find out from the physician what the reason was for the alteration. A common explanation is that people have gone back after an untoward result to fill in unrecorded events or to more completely fill out the record. This is a problem at a trial; post-event augmentation of the record can be used very effectively by plaintiffs.

Q In general, is concurrent documentation better than information entered after the care occurred?

A The concurrence of the notes in the record has an element of verification that's irreplaceable in a courtroom. Consider the case which involved an issue of whether or not a patient had been mismedicated with theophylline. When the case came to trial, nine years post event, a question was raised about whether or not the plaintiff had taken a correct amount of theophylline and, if so, when she took it. When Miss Smith had come into the clinic, someone had had the presence of mind to record that Miss Smith complained of a fainting incident. At that time, the cause of the fainting (a convulsion or a seizure) could not be determined. However, the triage nurse had written down what the patient had said about how many of the pills she had taken, and recorded that she (the nurse) counted only seven pills. If the patient had followed her physician's orders, eight pills would have remained.

When that case came to trial, the concurrent record taken that day of what the plaintiff said was helpful, because the plaintiff had an entirely different story to account for the missing pill. And we were able to confront her with the record, which of course is admissible in court. The concurrency of the record was the springboard from which the physician had a confidence level that he could testify about what had taken place. You can imagine how much more difficult that would have been (without the note) saying to the jury, "It's nine years after the event, but I remember she told me she took one extra pill more than she should have."