ED Legal Letter™

The Essential Monthly Guide to Emergency Medicine Malpractice Prevention and Risk Management

From the publishers of *Emergency Medicine Reports* and *ED Management*

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Appropriate documentation: Your first (and best) defense

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Editor's note: *Documentation requirements for every patient encounter have increased, leaving less time for the actual practice of medicine. While documentation is a burden to physicians and nurses, it does have unlimited value. Documentation allows for appropriate billing for the time and efforts of the physician, nurse, and other medical specialists. Thorough documentation allows for maximum reimbursement without fear of subsequent legal retribution from various government programs. Furthermore, the medical record is an essential historical document of the patient's previous medical encounters. Documentation of the patient encounter and treatment will provide a defense to potential subsequent litigation that may ensue. The emergency physician may be unaware that a medical expert is reading a case of a previous patient encounter right now. The documentation of the care provided may preclude the plaintiff's expert from making assumptions and opinions adverse to the physician. This month's issue will detail the importance of documentation and outline strategies for reducing risk.*

Introduction

Medical professionals universally despise paperwork. Charting obligations do not rank high on their lists of priorities, and they continually grumble about the number of forms they must complete. Some practitioners even claim that documentation requirements have begun to interfere with their provision of care. Medical record keeping has grown so time-consuming that it now detracts from the process of examination and treatment.[1]

Tiresome or not, documentation has become an essential element of medical practice. Health care providers must keep a thorough, accurate record of care for every patient. Failure to do so can result in license suspension,[2] loss of hospital accreditation,[3] government fines,[4] and exclusion from federal reimbursement

programs such as Medicare and Medicaid.[5] More significantly, inadequate documentation exposes the hospital and its staff to unnecessary malpractice liability.[6]

Compliance with today's complex documentation requirements has proven especially difficult in the hospital emergency department (ED). There, as in any critical care environment, one erroneous notation in a medical record can produce a chain of deadly treatment decisions. Because emergency patients come and go so quickly, however, ED personnel often have a tough time keeping up with the required paperwork. In the ED, creating a record of treatment often takes longer than the treatment itself.

All too often, the frantic pace of the ED causes emergency physicians and nurses to document patient encounters inadequately, improperly, or not at all. One expert in health law has suggested that failure to obtain and record all of a patient's vital information is "probably the greatest sin committed by ED staffs everywhere."[7] The goal of this article is to impress upon ED practitioners the importance of complete and accurate documentation, no matter *how* busy the ED becomes. After a brief review of contemporary documentation roles and standards, the article will examine a number of situations in which documentation practices have made a difference between good and bad legal outcomes for various health care providers.

The Role of Documentation

Hospital documentation exists primarily to facilitate treatment. The medical record serves as a method of communication among practitioners and allied health personnel, which in turn promotes continuity of care.[8] In essence, the medical record tells the patient's life story. It familiarizes the health care provider with the patient's medical status, including past diagnoses and interventions, plans for future care, and consent the patient already has given.[9] Often the medical record must speak for the patient, and as a result, it may prove invaluable when a patient arrives in the ED unconscious or otherwise unable to communicate. Some courts have held that the failure of a hospital to maintain records essential to the provision of care constitutes institutional malpractice.[10]

Information contained in a medical record dictates more than the care of one patient, however. Together, the records of many patients may be used to compile statistics that support clinical and epidemiological research and education.[11] Hospital administrators rely on patient information to conduct utilization review,[12] evaluate quality control,[13] and develop risk management strategies.[14] Without medical records, hospitals would have no way to measure the effects of the care they provide.[15]

Practitioners must not forget that hospital records also constitute legal documents.[16] The law presumes that a medical record accurately reflects the patient's condition and treatment.[17] Prosecutors, therefore, rely heavily upon medical records as a source of evidence in criminal proceedings. With record numbers of Americans bringing lawsuits for personal injury, the outcome of civil litigation, too, often hinges on the information contained within medical records. One scholar estimates that medical records now play a role in 75% of America's civil proceedings and 25% of the nation's criminal proceedings.[18]

Today, with health care insurers processing more than 5 billion claims for payment each year, medical records also double as financial records.[19] A third-party

ED Legal Letter™, ISSN 1087-7341, is published monthly by Thomson American Health Consultants, 3525 Piedmont Road N.E., Bldg. 6, Suite 400, Atlanta, GA 30305.

Vice President/Publisher: Brenda Mooney
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GST Registration Number: R128870672.
Periodicals postage paid at Atlanta GA 30304.
POSTMASTER: Send address changes to ***ED Legal Letter,*** P.O. Box 740059, Atlanta, GA 30374.

Back issues: $82. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.

Opinions expressed are not necessarily those of this publication, the executive editor, or the editorial board. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought in specific situations.

This CME activity is intended for emergency physicians. It is in effect for 36 months from the date of the publication.

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Customer Service: (800) 688-2421
Customer Service E-Mail Address: customerservice@ahcpub.com
Editorial E-Mail Address: allison.mechem@thomson.com
World Wide Web: http://www.ahcpub.com

Subscription Prices

United States: $489 per year
Multiple Copies:
2-9 additional copies: $391 each.
10+ copies: $293 each.
Canada: $519 per year plus GST
Elsewhere: $519 per year

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This continuing education program is sponsored by Thomson American Health Consultants, which is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing for approximately 18 contact hours. Provider #CEP10864.

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This publication does not receive commercial support.

payer has the right to withhold reimbursement if the hospital's documentation does not support its claim.[20] Thus, a physician or nurse who fails to document ED care risks loss of revenue by the hospital. Moreover, submitting a claim to Medicare, Medicaid, or any other government health care program based on a falsified medical record constitutes a felony, punishable by a fine of up to $25,000 and five years of imprisonment.[21]

No discussion of ED documentation would be complete without consideration of mandatory reporting. In most jurisdictions, physicians and other practitioners must report evidence of trauma,[22] child or elder abuse or neglect,[23] communicable disease,[24] birth,[25] and death[26] to designated authorities. Nearly all states require this notification to occur immediately by telephone, and in writing within a specified time thereafter.[27] These reports do not take the form of a medical record, yet their thoroughness and accuracy are equally important as a means of reducing liability exposure.

Documentation Standards

Hospitals enjoy some latitude when establishing documentation procedures. ED personnel must comply with certain standards, however, to meet fiscal, licensure, and accreditation objectives.[28] For example, to qualify for Medicare reimbursement the hospital must create for each patient a medical record that complies with regulations promulgated by the Centers for Medicare & Medicaid Services (CMS).[29] The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has established its own documentation requirements,[30] as have the licensing authorities of many states.[31] **(See Table 1, above right, and Table 2, p. 52.)**

The most controversial of these standards are CMS' Documentation Guidelines for Evaluation and Management Services. Adopted in 1995 by CMS' predecessor, the Health Care Financing Administration, and intended for use in conjunction with the American Medical Association's Evaluation and Management (E&M) reimbursement coding system, these guidelines immediately came under attack as unduly burdensome.[32] Specialists, in particular, complained that the guidelines prevented them from qualifying for higher-paying reimbursement codes unless they performed "comprehensive examinations" that extended beyond their areas of expertise.[33] The guidelines underwent revision once, in 1997, but the objections of no fewer than 39 medical specialty societies have blocked subsequent amendments.[34] Thus, for now, at least, these guidelines remain in effect where E&M coding determines reimbursement.[35]

Some documentation practices, while not required formally, have proven useful in minimizing treatment errors and associated litigation. For example, virtually all authorities agree that the use of commonly accepted abbreviations reduces the likelihood of misinterpretation by the reader.[36] Entries must be legible and never "vague or ambiguous."[37] Errors never should be obliterated, and pages containing erroneous information should not be removed or destroyed. Rather, the incorrect portion of the entry should be stricken with a single line, and the proper information should be inserted at the closest available space, along with the initials of the person making the entry, and the date and time of the correction. Adhering to this simple procedure eliminates any claim that mistakes have been concealed. This may prove crucial in the event of subsequent legal proceedings, for, as one expert has observed, "Alterations are absolutely deadly in court."[38]

Table 1

Medicare Documentation Requirements[41]

Federal law imposes the following documentation requirements on hospitals as a condition of participating in the Medicare program:

1. A medical record must be kept for every patient.
2. All records must document the following, as appropriate:
   - Evidence of a physical examination, including a health history, performed no more than seven days prior to admission or within 48 hours after admission
   - Admitting diagnosis
   - Findings by staff involved in the care of the patient
   - Consent to procedures and treatments
   - Orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, vital signs, and other information necessary to monitor the patient's condition
   - Response to treatment
   - Complications
   - Discharge summary, including provisions for follow-up care
   - Final diagnosis
3. All entries must be legible and complete, and must be authenticated and dated promptly. Authentication may be accomplished through signature, written initials, or computer entry.
4. Documentation must be completed within 30 days following discharge.

Table 2

JCAHO Documentation Requirements[42]

JCAHO requires EDs to document the following information on each patient as a condition of hospital accreditation:

- ✔ Patient's name, address, and date of birth
- ✔ Name of legally authorized representative
- ✔ Legal status of any patient receiving mental health services
- ✔ Emergency care prior to arrival
- ✔ History and physical examination
- ✔ Diagnosis
- ✔ Reason for treatment or admission
- ✔ Goal of treatment
- ✔ Evidence of advance directives and informed consents
- ✔ Diagnostic and therapeutic orders and results
- ✔ Operative and invasive procedures
- ✔ Progress notes
- ✔ Revisions to treatment plan
- ✔ Medication orders and prescriptions, including dose
- ✔ Adverse drug reactions
- ✔ Referral to, or communications with, other health care or service providers
- ✔ Discharge conclusion, instructions, and summary

ED practitioners should become familiar, too, with the regulations promulgated by CMS under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.[39] These regulations limit the manner in which health care providers may store, transmit, and disseminate the personal health information of their patients.[40] Much has been written about HIPAA recently, and a full treatment of CMS' privacy and security regulations falls beyond the scope of this article.

Effects of Inadequate Documentation

Proper documentation can save the career of an ED practitioner. Conversely, poor documentation can ruin a health care provider, both personally and professionally. The transgression need not be malicious, nor must it involve complex treatment issues. As the following case illustrates, failing to document patient care may, by itself, bring the livelihood of a doctor or nurse to a premature end.

Case #1. ***Schwarz v. Board of Regents of the University of the State of New York.***[43]

Herbert Schwarz, a physician licensed by the state of New York, performed abortions on four women during 1977 and 1978. Dr. Schwarz kept only sparse records on these patients. He documented no blood pressures, no physical examination findings, and no laboratory test results.

Acting on a complaint, the State Board for Professional Medical Conduct convened a disciplinary hearing. The board found that Dr. Schwarz had, among other things, engaged in "unprofessional conduct" by documenting patient encounters improperly. Under New York state law, physicians must "keep patient records which accurately reflect evaluation and treatment."[44]

Dr. Schwarz testified at the hearing that it was his policy to note only "unusual and exceptional matters." If the medical record described no complications, the reader could infer that the patient's treatment and recovery had been normal. According to Dr. Schwarz, this approach satisfied New York law. His documentation was accurate, he argued, and "accuracy, not adequacy" was required by state regulations.

The board, a review committee, and the New York Supreme Court all rejected this contention. One purpose of medical documentation, the court said in its opinion, is to "provide meaningful medical information to other practitioners." By documenting only abnormalities, Dr. Schwarz had not met this standard. In fact, Dr. Schwarz's own expert witness, when asked if the documentation in question accurately reflected evaluation and treatment, replied, "I don't think I'd get too much information from it." On this basis, the court upheld the two-year license suspension imposed by the board.

An old medical adage says, "If it isn't documented, it wasn't done." Dr. Schwarz learned the hard way that health care providers have an obligation to document patient encounters comprehensively. ED practitioners should remember this when describing physical examinations, procedures, and tests. Sometimes, documenting what *didn't* happen can be as important as documenting what *did* happen.

Suppose, for example, that a patient enters an ED complaining of nausea. The physician performs a thorough examination and discharges the patient with a diagnosis of viral gastroenteritis. As long as the doctor fully describes the examination in the patient's record, he will have no difficulty justifying his conclusion, even if it later proves incorrect.

What happens, though, if the physician documents only the portion of the examination that pertains to the gastrointestinal system? What if the nausea turns out to be a symptom of stroke or myocardial infarction?

Should the physician later face a claim of negligent misdiagnosis, his failure to document neurological and cardiac findings will create the appearance of an incomplete examination. The physician will have a difficult time demonstrating that he even *considered* neurological or cardiac etiologies, much less that the misdiagnosis was a reasonable one.

The same holds true of responses to treatment. Practitioners should not simply write that they performed a certain procedure; they also should specify whether any complications arose. This documentation will prove invaluable should the patient later claim that the procedure was performed incorrectly. Consider the following case, in which a patient and a nurse gave very different accounts of the same common procedure.

Case #2. *Daley v. Brotman Medical Center.*[45] On Aug. 22, 1997, Lionel Daley entered the ED of Brotman Medical Center in Culver City, CA, complaining of lower right abdominal pain. There, a nurse, Nicitas Villapando, started an intravenous (IV) infusion. According to Mr. Daley, Ms. Villapando thrust the needle perpendicularly into the back of his hand, eliciting severe pain and causing blood to "gush from the site." The IV remained in place until the next day. According to Mr. Daley, the procedure left his forearm numb, and his elbow and forearm swollen.

Mr. Daley did not seek attention for these problems immediately. Despite pain and weakness that allegedly kept him from sleeping and using a computer keyboard normally, Mr. Daley waited a full year before consulting with a physician. The doctor who finally examined Mr. Daley found no weakness in the hand or arm, but he did find reduced sensation and slowed nerve conduction. The doctor attributed these findings to an ulnar nerve injury.

Mr. Daley brought a medical malpractice action against Ms. Villapando and the hospital, claiming that the nurse had injured his hand and arm by inserting the IV needle incorrectly. At trial, Ms. Villapando testified that she had started the IV without difficulty. If she had failed in her initial IV attempt, she said, she would have documented this fact in Mr. Daley's chart. A nurse who appeared for the defense testified that she had reviewed the ED record, and that she could find no evidence of difficulty with the IV. She also pointed out that Mr. Daley's chart contained no mention of a hematoma when he was admitted to the floor.

Likewise, a physician who appeared for the defense testified that "none of the doctors or nurses tending Mr. Daley indicated any problem with the IV, nor was it noted in the charts." This evidence, combined with testimony suggesting other causes of Mr. Daley's symptoms, convinced the court that Ms. Villapando had not inserted the IV negligently. A jury found for the defendants, and the appellate court affirmed.

Unlike the defendant in *Schwarz*, the defendants in this case kept comprehensive records of treatment. These records did not establish conclusively that the provider had performed properly, for they did not expressly state that the nurse had encountered no difficulties in starting the IV. The ED records were thorough enough, however, that they caused several expert witnesses to conclude that problems would have been documented, had any problems actually occurred. In this regard, Ms. Villipando was fortunate. Specifying that a procedure took place without complications represents a far better course of action than leaving the door open for speculation.

Health care providers do not necessarily meet their documentation obligations by simply compiling a mass of information about their patients. Each patient presents with unique medical issues, and as a result, each medical record is a unique document. Some elements, such as vital signs, should appear in every medical record. The patient's condition ultimately will dictate the nature of the information to be entered, however, and practitioners must determine, on a case-by-case basis, whether a particular set of information warrants documentation.

The following cases illustrate each of these principles.

Case #3. *Kearl v. Board of Medical Quality Assurance.*[46] Thirty-seven-year-old Janet Halverson suffered from degenerative disc disease. She entered White Memorial Hospital in Los Angeles on June 5, 1975, for a discectomy, laminectomy, and lumbar fusion. Dr. Sherman Kearl administered general anesthesia at approximately 8 p.m., and the operation began at 8:15.

During surgery, Ms. Halverson's heart rate and blood pressure dropped. The surgical team resuscitated her, but she remained unconscious and apneic. An electroencephalogram (EEG) performed after the operation revealed no brain activity. Ms. Halverson died 12 days later.

California's Board of Medical Quality Assurance launched an investigation into Dr. Kearl's practices. The board found that he had acted with gross negligence in recording Ms. Halverson's vital signs every

15 minutes during the first 90 minutes of the operation, rather than every five minutes as the standard of care dictated. The Board suspended Dr. Kearl's license for one year, and Dr. Kearl appealed to the Los Angeles County Superior Court.

At trial, Dr. Kearl tried to portray his failure to record vital signs every five minutes as a technical departure from the standard of care. He defended his actions by testifying that an anesthesia record "shows trends in the course of the patient's treatment, but is of marginal value to the anesthesiologist during treatment." An anesthesiologist, who appeared as an expert for Dr. Kearl, testified "it is acceptable to record vital signs every 10-15 minutes as long as the anesthesiologist takes the patient's blood pressure more frequently than that and monitors the pulse continuously."

The court flatly rejected Dr. Kearl's contentions. Vital signs must be recorded at five-minute intervals, the court noted, because irreversible brain damage can occur within three to four minutes, and physicians must respond to such changes quickly. Describing vital sign documentation as "necessary to patient care and hospital administration," and distinguishing Dr. Kearl's inadequate documentation practice from a "technical lapse such as failing to dot or cross all the 'i's or 't's," the court found Dr. Kearl grossly negligent and upheld the license suspension.

Case #4. *Nold v. Binyon.*[47] In February 1990, Bonnie Nold became pregnant. Her primary care physician, Dr. Kernie Binyon, referred her to an obstetrician-gynecologist, Dr. Michael Brown, for prenatal care. Dr. Brown ordered a series of blood tests, which were drawn by the staff at Dr. Binyon's office and sent to an outside laboratory. On Feb. 20, the laboratory notified Dr. Binyon's office that the samples had tested positive for hepatitis B. This information was forwarded to Dr. Brown's office, but neither Dr. Brown nor Dr. Binyon communicated this information to Ms. Nold.

A short time later, a disagreement between Dr. Binyon and Dr. Brown over the need for a sonogram caused Ms. Nold to seek the care of new physicians. Dr. James Donnell became Ms. Nold's primary care physician, and Dr. Scott Moser took over her obstetrical care. The original primary care physician, Dr. Binyon, forwarded Ms. Nold's records to Dr. Donnell's office. Dr. Donnell reviewed these records, but never saw the hepatitis B result.

With Ms. Nold's due date approaching, Dr. Donnell sent the records to Wesley Medical Center, the facility where Ms. Nold would deliver. At the same time, Dr. Moser requested Ms. Nold's records from his predecessor, Dr. Brown. Dr. Moser noted the positive hepatitis test and recorded it in Ms. Nold's obstetrical chart. He later testified that he routinely places such information in "a prominent place in the medical record" to ensure that anyone involved in the mother's care will provide appropriate treatment to the neonate.

In September, Ms. Nold entered Wesley's Labor, Delivery, and Recovery Unit. Dr. Eric Pekarski completed the hospital's standard Resident Admission Note. He did not personally review Ms. Nold's prenatal records when writing the note. Dr. Pekarski consulted with Dr. Katie Mroz, the physician who was on call for Dr. Moser, and Dr. Mroz did not mention anything about hepatitis. As a result, Dr. Pekarski did not learn about Ms. Nold's positive hepatitis test, and he could not describe it in his admission note.

By the time Dr. Moser arrived, Bonnie already had begun to deliver, and the baby's heart tones had dropped to a dangerously low level. Dr. Moser performed an emergency cesarean section to save the baby. With his attention focused on the infant's distress, Dr. Moser did not have time to review Ms. Nold's records. Nobody thought to administer a gamma globulin injection or hepatitis B vaccine to the infant. As a result, the infant became a chronic carrier of the disease.

The resident, Dr. Pekarski, handled Ms. Nold's discharge. Later, he reviewed Ms. Nold's chart in its entirety and dictated a discharge summary that made no mention of Ms. Nold's hepatitis status. Two years later, Ms. Nold underwent a hysterectomy. During the procedure, a nurse received a needlestick. Ms. Nold submitted to a blood test, which revealed hepatitis B antigens. On the advice of hospital personnel, Ms. Nold had her daughter tested, and the daughter was found to have hepatitis B antigens as well.

Ms. Nold brought a medical malpractice action on behalf of her daughter against the hospital and all of the doctors who had participated in her prenatal and delivery care. At trial, Dr. Moser testified that he had informed Ms. Nold of her hepatitis status during one of her prenatal visits. Ms. Nold disputed this. An expert for the plaintiffs testified that the nursing staff had violated their own policies by failing to note Ms. Nold's hepatitis status and failing to forward this information to the nursery. A jury found for the

plaintiff. Damages totaling $800,000 were apportioned among Dr. Moser (90%), Dr. Donnell (6%), Dr. Brown (2%), and Dr. Binyon (2%). The court dismissed claims against the medical center, Dr. Pekarski, Dr. Mroz, and the pediatrician who cared for the infant after delivery. The appeals court held that the district court had erred in excluding certain testimony, however, and the case was remanded for further proceedings.

Kearl demonstrates that certain elements, such as vital signs, belong in every ED record of care. Practitioners must include all of the information required by CMS and JCAHO, not only to maintain certification, but because the record otherwise will be incomplete. *Nold* stands for the proposition that each patient presents to the ED with unique problems. Practitioners must take care to seek and document all of the facts relevant to those problems. Failure to do so invites a claim of malpractice.

Documentation inevitably proves crucial in defending against claims of abandonment. Patients probably leave hospitals against medical advice more commonly from EDs than from any other type of unit. JCAHO's requirement that EDs document circumstances under which a patient left the ED against medical advice reflects this fact.

In the following case, the defendant physician avoided liability for abandonment by proving, through appropriate documentation, that he had terminated his professional relationship with a patient in an appropriate manner.

Case #5. *Sparks v. Hicks.*[48] Betty Sparks went to an orthopedic surgeon, Dr. David Hicks, with a complaint of hip and leg pain. Dr. Hicks ordered a series of diagnostic tests, including magnetic resonance imaging (MRI). The MRI suggested a herniated disc. Before performing surgery, Dr. Hicks wanted to confirm the diagnosis with a myelogram. He also wanted an internist to clear Ms. Sparks for surgery, since she had a number of risk factors, including hypertension, coronary artery disease, and chronic obstructive pulmonary disease.

Dr. Hicks documented his plan in this manner:

> "I discussed with the patient and her son my feelings regarding her medical care. I would like to obtain a myelogram and perhaps a post-myelogram computerized axial tomographic scan, if it seems appropriate. I would like to obtain medical consultation prior to proceeding with surgical intervention to insure that it is as safe as possible, prior to proceeding with surgery, if in fact it seems surgery is most appropriate. I have asked Dr. James Bailey to see Ms. Sparks in medical consultation, and he will see her after the myelogram and proceed with those studies felt to be consistent with good medical care."

When the time arrived for the surgery, Dr. Hicks still had not received Dr. Bailey's report. Feeling that he could not proceed safely, Dr. Hicks made plans to discharge Ms. Sparks from the hospital and to reschedule the surgery for the following week. When Ms. Sparks's son learned about this, he confronted a nurse and threatened to call an attorney. Dr. Hicks decided that these actions had destroyed the mutual trust necessary for a professional relationship, and he resolved not to treat Ms. Sparks any further. Dr. Hicks provided Ms. Sparks with the names of four other surgeons. He called two of them personally and received assurances that they would meet with Ms. Sparks concerning the operation. He documented this activity in the medical record. The relevant nursing notes corroborated Dr. Hicks's version of these events.

Some time later, Ms. Sparks called an attorney. She reported that Dr. Hicks had become upset after a conversation with her son, and that he had ordered a nurse to discharge her without discussing the reason. Ms. Sparks brought an action against Dr. Hicks for abandonment.

Based on the information contained in the medical record, the trial court granted summary judgment to Dr. Hicks. The Oklahoma Supreme Court upheld this decision, saying, "This documentation shows that Dr. Hicks gave reasonable notice of his termination of the patient-physician relationship to [Ms.] Sparks and that she had ample opportunity to procure the services of other physicians. There is no indication that [Ms.] Sparks was in a critical stage of treatment or that her condition was life-threatening."

The kind of confrontation that flared up between Dr. Hicks and the Sparks family occurs in the ED with regularity. ED practitioners routinely deal with patients and family members who arrive intoxicated, under the influence of drugs, or in a volatile emotional state. These individuals often make unreasonable demands, and they frequently harbor unrealistic expectations about the nature of the treatment available in the ED. If they leave the ED dissatisfied, they may later attempt to portray their premature departure from the hospital as a denial of care. Appropriate documentation can defeat such a claim.

Just as practitioners may run into trouble by insufficiently documenting patient histories, examinations, and treatment, so, too, they may invite legal problems by documenting too hastily. Adding information to a medical record without first ensuring the accuracy of that information may prove disastrous.

Under no circumstances should a practitioner document unsubstantiated conclusions. Filling a medical record with inaccuracies can prove as troublesome from a liability standpoint as failing to document altogether.

Practitioners must exercise a similar level of care when placing electrocardiograms, laboratory test results, specialists' reports, and other records into a patient's chart. In *Johnson v. Hillcrest Health Center*, a man named Henry Johnson entered an ED complaining of chest pain. A blood test drawn in the hospital revealed elevated isoenzyme levels, suggesting myocardial infarction. Laboratory personnel posted the raw laboratory data on the hospital's computer, but a pathologist's report interpreting the results was placed in the chart of another patient, and a physician who had seen only the medical record discharged Mr. Johnson. He died, and his wife brought a negligence action against the hospital. The Oklahoma Supreme Court ordered the case to trial, on grounds that "reasonable people might conclude that because the tests were placed in the wrong chart, the hospital did not exercise appropriate care given Mr. Johnson's medical condition, and that the hospital's actions caused or contributed to his death."[49]

Health care providers also must take care to document facts as specifically as possible.[50] This concept applies not only to observations about the patient, but also to orders. In *Griffin v. Kinberger*, a physician wrote in a premature infant's chart that nurses should provide oxygen "PRN." The infant went blind in one eye, and family members brought a malpractice action against the hospital and its doctors, claiming that excessive oxygen administration had caused retrolental fibroplasia and glaucoma. The trial court ultimately found in favor of the defendants, but this case should remind practitioners about the dangers of ambiguity.[51]

Consent, in particular, has posed a documentation problem for many health care providers. In *Valcin v. Public Health Trust of Dade County*, a patient who nearly died from a ruptured ectopic pregnancy brought actions for negligence, breach of warranty, and failure to inform against the hospital in which she previously had undergone a tubal ligation. She claimed that a member of the hospital staff had assured her that the sterilization "would be 100% effective," and that she had received no warning about the risk of ectopic pregnancy. The hospital produced consent forms signed by the patient in which she had acknowledged, among other things, that the surgeon had "fully explained" the possible complications and that sterility was "not guaranteed." The trial court granted summary judgment to the hospital, but the Florida District Court of Appeal reversed this decision after finding that the surgeon might have made false assurances about the procedure that had rendered the consent forms invalid.[52] Practitioners should remember, then, that they must do more than obtain a signature on a standard consent form. The prudent health care provider should discuss the details of each procedure to be performed and summarize this discussion in the patient's medical record.[53]

Alterations of Documentation

Falsifying or destroying medical records obviously constitutes a far more serious breach of duty than documenting inadequately.[54] Where the medical record amounts to material evidence, and that record would prove favorable to an adverse party, its destruction may provide sufficient foundation for an inference of guilt or negligence.[55] In *May v. Moore*, an Alabama jury awarded damages to a mother whose infant had died of respiratory infection after the defendant physician mismanaged premature membrane rupture and left the mother to deliver unattended. A number of physicians testified on behalf of the plaintiff, but some of the most damning testimony came from the hospital administrator, who stated that the infant's chart had disappeared, and that the chart introduced by the defendant at trial differed from the original. This created an inference that the physician had tampered with the original chart in an effort to conceal his negligence. The defendant objected to the administrator's testimony, but the state Supreme Court deemed it relevant and affirmed the judgment.[56]

Altering a medical record after the fact may constitute falsification. To see what a profound effect this may have on subsequent litigation, consider the following example.

Case #6. *Gabaldoni v. Board of Physician Quality Assurance.*[57] On July 8, 1995, a Maryland woman delivered a healthy infant at Hagerstown's Washington County Hospital. The mother, who had suffered from anemia even before pregnancy, hemorrhaged as

a result of uterine atony and retention of placental fragments. A little more than two hours postpartum, the mother expelled a large clot, and her blood pressure fell to 67/42. The hospital's nursing staff called the obstetrician, Dr. Louis Gabaldoni, at home, but he elected not to come to the hospital. Instead, he instructed the nurses to run a complete blood count (CBC) in the morning.

The CBC performed at 8:30 a.m. on July 9 revealed a hemoglobin level of 5.4 and a hematocrit of 14.8. Dr. Gabaldoni ordered another CBC for noon. He also ordered a type and cross-match for blood, and regular orthostatic checks by the nurses.

By noon, the patient's hematocrit had dropped to 14. Dr. Gabaldoni visited the patient at some point during the day, but he did not order a transfusion.

On July 10, a nurse again called Dr. Gabaldoni at home. She reported that the patient was complaining of nausea, shortness of breath, and blurred vision. The patient's heart rate had climbed to 124 beats per minute, and rales could be heard in the lower portions of her lungs. Dr. Gabaldoni described his patient's condition to an infectious disease and internal medicine specialist and asked whether the patient might have a pulmonary embolism. The specialist told Dr. Gabaldoni that anemia had caused the change in the patient's condition, not pulmonary embolism. He also impressed upon Dr. Gabaldoni the need for a transfusion as soon as possible. Still, no transfusion was ordered.

During the evening of July 10, on the order of Dr. Gabaldoni, a nurse explained the risks and benefits of transfusion to the patient and her spouse. After capitulating, the patient finally consented, and the nursing staff administered the first of two transfusions at 9:25 p.m.

After the transfusions, the patient's condition continued to deteriorate. A nurse called Dr. Gabaldoni at 4:05 a.m. on July 11 to say that she could hear rales throughout the patient's lung fields. Less than an hour later, the nurse called back and pleaded with Dr. Gabaldoni to come to the hospital. By the time Dr. Gabaldoni arrived, the patient had gone into respiratory arrest. Hospital personnel had inserted an endotracheal tube into the patient's esophagus, depriving her of oxygen for 13 minutes. The patient was transferred to Washington County's intensive care unit, and later to the University of Maryland Hospital, where she died on July 13.

In the weeks that followed, the records kept on this patient by Dr. Gabaldoni came under the scrutiny of the Office of the Chief Medical Examiner. Originally, Dr. Gabaldoni had made the following entries to the patient's hospital record:

- *July 7, 1995*. Vital signs stable. Afebrile. Hematocrit 14.5. Vagina dry (no bleeding). Feels dizzy. Plan: CBC, orthostatics, consider transfusion.
- *July 10, 1995*. Vital signs stable. Afebrile. Hematocrit 14.5. Vagina dry. No dizziness now. Refuses transfusion. Continue hemoglobin and hematocrit.[58]

Two days after the patient's death, Dr. Gabaldoni changed these notes. Under the entry for July 7, he wrote "1:00 p.m.," and added the words "No orthostatic changes in blood pressure or pulse. The patient still refused transfusion. Will continue with hemoglobin and hematocrits, iron, and regular orthostatic checks." Under the entry for July 10, Dr. Gabaldoni wrote "A.M." in the margin, and added the words "Feels much better. Consider transfusion at a later date." Dr. Gabaldoni made these changes in the same color ink as the original notes — blue ink for the July 7 entry and black ink for the July 10 entry.

Four months later, the Maryland Board of Physician Quality Assurance charged Dr. Gabaldoni with several violations of the state's Medical Practice Act. The administrative law judge (ALJ) who first heard the case determined that Dr. Gabaldoni had committed documentation errors. The ALJ ruled, however, that the Board of Physician Quality Assurance would have ordered Dr. Gabaldoni to attend continuing medical education courses pertaining to documentation, and that since Dr. Gabaldoni already had taken these courses on his own initiative, the imposition of sanctions would prove duplicative.

The Board of Physician Quality Assurance reached an altogether different conclusion. Finding that Dr. Gabaldoni had changed his patient's records "in such a manner that the alterations would not be readily apparent," the Board issued a reprimand. The Washington Court of Appeals later described the Board's decision like this:

> The Board has consistently held that the creation of an accurate medical record is a part of the standard of care required of all physicians. The records, which Dr. Gabaldoni created with respect to July 9th and July 10th, violate this standard of care. The records were inaccurate in that they recorded an incorrect hematocrit level, because the time ("A.M.") was inaccurately recorded for July 10th, because

the record for both dates incorrectly reported that continued [hematocrit and hemoglobin] testing had been ordered, and because the record of July 9th incorrectly stated that [the patient] refused a transfusion.

The creation of these records also violated the standard of care because Dr. Gabaldoni added notations to these records two days after [the patient]'s death in a way which did not indicate that these additions were added later. The standard of care requires that later additions be dated as to when made, and clearly shown as later additions.

Dr. Gabaldoni not only failed to mention that the additions were added later; he also used two different pens, a blue pen which matched the blue ink on the original note concerning July 9th and a black pen which matched the original note concerning July 10th. In addition, for July 10th, Dr. Gabaldoni's additions were interspersed throughout the note, from beginning to end, in such a way that it would be natural to mistake the record as one which had been written all at one time. This type of record keeping violates both the letter and the spirit of the standard of care enumerated above. And the changes made are obviously of critical significance.

Dr. Gabaldoni petitioned for judicial review of the Board's decision. At trial, Dr. Gabaldoni offered testimony that contrasted sharply with that of the patient's spouse and Washington County Hospital's nurses, particularly with regard to his efforts to obtain consent for a transfusion. The trial judge held the Board had not abused its discretion in overruling the ALJ, and the Washington Court of Appeals affirmed.

To avoid liability, ED practitioners must not only document their activities properly; they must utilize that documentation appropriately. Providers have run into legal difficulties for failing to send medical records along with a transferred patient, thereby causing a delay in treatment while the receiving facility repeated tests;[59] failing to send x-rays and other diagnostic aids along with a transferred patient's medical records;[60] administering medications to patients despite warnings in the medical record that indicated allergies to those substances;[61] administering a blood transfusion (along with acquired immunodeficiency syndrome) to a patient whose record indicated that he had refused blood products on religious grounds;[62] discharging an unstable patient after reading the chart of another patient;[63] and allowing laypersons to make treatment decisions on the basis of laboratory test results.[64] Not all of these actions resulted in judgments against the health care provider. Still, the defendant in every one of these cases spent a significant amount of money fighting lawsuits, and each paid a heavy emotional toll.

Summary

Practitioners might not enjoy documenting their activities, but approaching this task with a cavalier attitude eventually will lead to disaster. There can be no doubt that a standard of care exists with regard to the keeping of medical records, and that a breach of this duty constitutes malpractice. ED personnel face the additional challenge of documenting quickly, under chaotic conditions. To avoid civil penalties, loss of licensure or certification, expulsion from government reimbursement programs, and lawsuits by patients, they must adhere to the standards established by JCAHO, various entities of the government, and common law.

Endnotes

1. Williams R. Medical record documentation in 1999: Let's not cooperate. *Arch Neurol* 2000; 57:131.
2. *See*, e.g., *Schwarz v. Board of Regents of the University of the State of New York,* 453 N.Y.S.2d 836 (N.Y. App. Div. 1982); *Weber v. Colorado State Bd. of Nursing,* 830 P.2d 1128 (Colo. Ct. App. 1992).
3. Waller A, et al. "Medical Records: Current Issues and Emerging Trends." In: Grosfeld AG, ed. *Health Law Handbook.* New York City: Thomson Legal Publishing; 1992. *See* generally Joint Commission on Accreditation of Healthcare Organizations, *Accreditation Manual for Hospitals*. Oakbrook Terrace, IL; 2003, p. 271.
4. N.Y. Comp. *Rules & Regs.* tit. 8 § 6511 (imposing up to $10,000 fine for professional misconduct, which may encompass repeated failure to maintain medical records). *See* also *Schwarz*, *supra* note 2.
5. *See,* e.g., *Koh v. Perales*, 570 N.Y.S.2d 98 (N.Y. App. Div. 1991).
6. George J. "Considerations in Medicolegal Aspects of Emergency Care: General Principles and Definitions." In: Schwartz GR, et al., eds. *Principles of Emergency Medicine.* Philadelphia: Lippincott, Williams & Wilkins; 1992, p. 3313.
7. *Id.*
8. *Nold v. Binyon,* No. 94,292 (Kan. Ct. App. 2001). *See* also Centers for Medicare & Medicaid Services, *1997 Documentation Guidelines for Evaluation and Management Services.* Baltimore; 1997, p. 2. Joint Commission on Accreditation of

Health Care Orgs. *Proposed Standards for Hospitals.*Oakbrook Terrace, IL; 2003, p. 16.
9. Busis N. Medical record documentation in 1999: Let's cooperate. *Arch Neurol* 2000; 57:130. *See Id*. at 16 n.26.
10. *Thomas v. United States,* 660 F.Supp. 216 (D.D.C. 1987); Schwarz, *supra* note 2.
11. Joint Commission on Accreditation of Health Care Organizations, *supra* note 8, at 16 n.26.
12. *See id.* at 16; Centers for Medicare & Medicaid Servs., *supra* note 8, at 2.
13. Busis, *supra* note 9; Joint Commission on Accreditation of Health Care Orgs., *supra* note 7; Centers for Medicare & Medicaid Servs., *supra* note 8, at 2.
14. Joint Commission on Accreditation of Health Care Organizations., *supra* note 8, at 12.
15. See *id.* at 16 n.26.
16. Centers for Medicare & Medicaid Servs., *supra* note 8, at 2.
17. George J. "Medicolegal Issues in Emergency Medicine." In: Schwartz GR, et al., eds. *Principles of Emergency Medicine* Philadelphia: Lippincott, Williams & Wilkins; 1999, p. 1870.
18. Matte PJ. "Legal Implications of the Patient's Medical Records." In: Wecht CH, ed. *Legal Medicine Annual.* New York City: Appleton-Century-Crofts; 1971, p. 345.
19. Centers for Medicare & Medicaid Servs., *Procedures for Coding and Payment Determinations for Clinical Laboratory Tests and for Durable Medical Equipment.* Baltimore; 2003, p. 1.
20. Centers for Medicare & Medicaid Servs., *supra* note 8, at 2-3.
21. 42 U.S.C. § 1320a-7b(a). *See* Bucy P. *Crimes by Health Care Providers,* 1996 U. Ill. L. Rev. 589 (1996).
22. *See*, i.e., Iowa Code § 147.111.
23. *See* Mass. Gen. L. ch. 119 § 51A (child abuse or neglect); Mass. Gen. L. ch. 19A § 15 (elder abuse or neglect).
24. *See*, i.e., 27 Pa. Code § 27.21a.
25. *See*, i.e., Fla. Stat. Ch. 382.013.
26. *See*, i.e., Fla. Stat. Ch. 382.008.
27. *See*, i.e., Mass. Gen. L. ch. 119 § 51A (written report of child abuse or neglect must follow oral communication within 48 hours).
28. *See* Waller, *supra* note 3.
29. See 42 C.F.R. § 482.24(b).
30. *See* generally Joint Commission on Accreditation of Healthcare Orgs., *supra* note 3.
31. *See,* e.g., Cal. Health & Safety Code § 1457; N.Y. Pub. Health Law § 4165.
32. American Academy of Orthopedic Surgeons, History of E&M Documentation Guidelines, AAOS Bulletin (Oct. 2001). Accessed at: www.aaos.org/wordhtml/bulletin/oct01/fine1.htm.
33. Reinke TW. "Coding Evaluation and Management." *Physician's News Digest* (Aug. 1997) www.physicians news.com/business/897reinke.html>; American Academy of Orthopedic Surgeons, *supra* note 32.
34. American Academy of Orthopedic Surgeons, *supra* note 32.
35. *Id.*
36. Calfee BE. Abbreviations that cause injury, complicate communication, and may kill! *Director* 1997; 5:128.
37. Hirsh HL. "Medical Records." In: Sanbar SS, et al., eds. *Legal Medicine*. 4th ed. St. Louis: Mosby; 1998, p. 280.
38. Hirsh HL. Tampering with medical records. *Med Trial Techniques Q* 1978; 24:450.
39. 42 U.S.C. §§ 1320d to 1320d-8.
40. *See* 45 C.F.R. pts. 160, 164; Security and Electronic Signature Standards, 63 *Fed. Reg.* 43,241-80 (to be codified at 45 C.F.R. pt. 142) (proposed Aug. 12, 1998).
41. 42 C.F.R. § 482.24.
42. Joint Commission on Accreditation of Healthcare Organizatons, *2003 Comprehensive Accreditation Manual for Hospitals: The Official Handbook.* Oakbrook Terrace, IL; 2003, Standard IM.7.2, at IM-12.
43. 453 N.Y.S.2d 836 (N.Y. App. Div. 1982).
44. *See* N.Y. Comp. Codes, R. & Regs. tit. 8, § 6509.
45. No. B143668 (Cal. Ct. App. 2002).
46. 236 Cal. Rptr. 526 (Cal. Ct. App. 1986).
47. No. 94,292 (Kan. Ct. App. 2001).
48. No. 82,203 (Okla. 1996).
49. *Johnson v. Hillcrest Health Ctr. Inc.,* No. 97076 (Okla. 2003).
50. Hirsh, *supra* note 37.
51. *Griffin v. Kinberger,* 647 So. 2d 1270 (La. Ct. App. 1994).
52. *Valcin v. Public Health Trust of Dade County,* 473 So. 2d 1297 (Fla. Dist. Ct. App. 1984).
53. *Winters v. Podzamsky,* 621 N.E.2d 72 (Ill. App. Ct. 1993).
54. *May v. Moore,* 424 So. 2d 596 (Ala. 1982); *Powell v. St. John Hosp.,* 614 N.W.2d 666 (Mich. Ct. App. 2000). *See*

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also *Franz v. Board of Med. Quality Assurance,* 642 P.2d 792 (Cal. 1982).

55. *May, supra* note 54; *Southern Home Ins. Co. of the Carolinas v. Boatwright,* 164 So. 102 (Ala. 1935).
56. *May, supra* note 54.
57. No. 241 Sept. Term (Md. Ct. Spec. App. 2000).
58. Grammar and abbreviations used in Dr. Gabaldoni's notes have been altered for the reader's convenience.
59. *Rahilly v. North Adams Reg'l Hosp.,* 636 N.E.2d 280 (Mass. 1994).
60. *Dickey v. Baptist Mem'l Hosp.* North Mississippi, 146 F.3d 262 (5th Cir. 1998).
61. *Hutchinson v. Sacred Heart Med. Ctr.,* 102 Wash. App. 1042 (2000).
62. *Clark v. Perry,* 442 S.E.2d 57 (N.C. Ct. App. 1994).
63. *Trahan v. McManus,* No. 94-167 (La. Ct. App. 1995). *See* also *Jefferis v. Marzano,* 696 P.2d 1087 (Or. 1985).
64. *Jefferis*, *supra* note 63.

CE/CME Questions

17. What is the proper procedure for correcting or amending a medical record entry?

A. Strike the entry with a single line, initial the change, and add the date and time of amendment.
B. Obliterate the incorrect entry to prevent subsequent confusion.
C. Remove the entire page from the record and add a fresh, signed page.
D. Add the new entry in such a way that it does not interfere with the original entry.

18. In *Kearl v. Board of Medical Quality Assurance*, the court described the documentation of vital signs as:

A. a technicality.
B. necessary to patient care and hospital administration.
C. essential to prevent lawsuits.
D. a routine practice.

19. Though it might be a good idea, JCAHO does *not* expressly require which of the following when documenting patient care?

A. Description of adverse medication reactions
B. Emergency care rendered in the field
C. Physical findings, including vital signs and results of tests and procedures
D. Efforts to contact the patient's family

20. Which of the following represents the best approach to the documentation of treatment?

A. Describe the reason for each procedure and the patient's response to care.
B. Describe the date, time, and result of each procedure.
C. Describe all that was done, and all that resulted, in as much detail as possible.
D. Describe in detail all complications arising from care.

Answers: 17-A; 18-B; 19-D; 20-C.

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In Future Issues:

Failure to Disclose Subarachnoid Hemorrhage