Documentation Dos and Don’ts Can Derail a Lawsuit

BY SHERRY BOSCHERT
San Francisco Bar News

Cabo San Lucas, Mexico — What you put in a patient’s medical record could drive a potential lawsuit to court or away from litigation, Dennis J. Sinclitico, J.D., said. “You want control the labor and delivery. The one thing you can do is control what appears in the medical record,” he said at a conference on obstetrics, gynecology, perinatal medicine, neonatology, and the law.

The biggest problem he said he sees in documentation is incompleteness—charts that fail to offer pertinent information to the physician’s role, decision-making process, and justifications for management.

Many physicians complain that they don’t have time to write sufficient records, said Mr. Sinclitico, a defense attorney in Long Beach, Calif. “Would you rather spend the time in court for 12 weeks, 3 days a week, from 9 a.m. to 5 p.m.?” he asked.

Adequate documentation may be less than physicians imagine. Writing “Matter was discussed with patient” is better than saying you discussed it because you risk leaving something out of the record. Writing “Exam was done” or “Doctor was notified” is better than giving details because these statements free you to add details orally if questioned, he said at the meeting, sponsored by Boston University and the Center for Human Genetics.

Rules concerning medical documentation may differ somewhat from state to state, he said, but the following do’s and don’ts will help create records that should stand up in court.

— Don’t destroy evidence. No matter how bad the fetal monitoring strip looks, resist the urge to make it disappear. In some states, destroying it is a form of tampering, exposing you to additional liability.

— Don’t ever change the record. “It’s simple advice, but I see it happen over and over again,” Mr. Sinclitico said. Sophisticated technology can detect alteration of records. In some states, changing a record is an added offense.

— Do label any addition to the chart as a “late entry.” Late entries are common when even the wisest physician knows why the patient cannot adequately document things as they happen, such as being busy with the patient’s care.

— Do indicate that you reviewed the laboratory data. Most institutions use a report that contains all the data that people want. Many physicians use charts, order laboratory work, and do not connect the dots. In this case, the record is incomplete.

— Do indicate that you reviewed the laboratory data. Many physicians neglect the legal implications of the laboratory data. In a recent trial, an expert testified that the laboratory data would have prevented the patient’s hospitalization. Rules concerning medical documentation may differ somewhat from state to state, but the following do’s and don’ts will help create records that should stand up in court.

— Don’t show the patient data on the chart. That’s the lawyer’s job, not yours.

— Don’t include negative data concerning the patient’s condition, i.e., the patient was a healthy person. If you don’t include negative data, the record will not be complete.

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— Do describe your management plan well. Provide enough detail to support the orders you give.

— Don’t editalize the patient or anyone else. Personal comments are a prescription for legal disaster, he said.

— Don’t add risk management comments as “There weren’t enough beds available.” Many institutions use a report that contains all the data that people want. Many physicians use charts, order laboratory work, and do not connect the dots. In this case, the record is incomplete.

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