WHAT'S YOUR STORY?
Have you ever watched CSI, Dateline or Unsolved Mysteries? It's amazing how the discovery of evidence such as DNA, fabric fibers, bullet analysis and polygraphs are all used to create a story about the characters involved in and around the crime. These various fragments of evidence are like the pieces of a puzzle, and when correctly assimilated together, a complete picture or story unravels. This is exactly how criminal litigation works.

However, in a medical malpractice case, which is considered civil litigation, usually the only piece of evidence that is responsible for telling the unabridged, exhaustive story of what happened to a patient is….you guessed it: the medical record. The very chart that you created along with other health care providers is going to either help you or hurt you in litigation. Without a complete, accurate and legible medical record, you may be unable to defend yourself against allegations of improper care.

Solid, defensive and concise documentation may not absolve you from an unexpected legal experience, but it will provide a strong foundation on which to stand should the care you provide ever come under legal scrutiny. The medical record must reflect an accurate chronology of events and tell your story with out any gaps, holes or incongruities.

WHAT IS MEDICAL MALPRACTICE LITIGATION?
Most lawsuits involving physicians or healthcare providers are civil cases that attempt to prove that negligent care resulted in an injury to a patient. The law defines negligence as a failure to provide a patient with the standard of care that a reasonably prudent healthcare provider would exercise in the same or similar circumstances. To prove that a healthcare provider was negligent, the patient’s attorney must prove all four of the following elements:

- The healthcare provider had a duty to provide care to the patient and to follow an acceptable standard of care.
- The healthcare provider failed to adhere to the standard of care.
- The healthcare provider’s failure to adhere to the standard of care caused the patient’s injuries.
- The patient suffered damages as a result of the healthcare provider’s negligent actions.

It is not sufficient if only 3 of the 4 elements are proven. The only way for a patient to win a claim of medical negligence is to prove the existence of all four elements. This is typically done by way of the medical record. Interestingly, the number one reason why healthcare providers lose lawsuits is because of poor documentation.

PURPOSE AND VALUE OF DOCUMENTATION
If you face an allegation of negligence or improper conduct, your documentation can make or break your case. Your assertion that you provided appropriate care is significantly weakened if you do not document or if your documentation does not clearly show that you met the standard of care. The old adage “If it’s not documented, it wasn’t done” has proven impossible to refute most of the time in trial. Without evidence in black and white, as written in the medical record, you must rely on your ability as a witness to convince a judge or jury that you gave appropriate care, despite your failure to document the care you provided.

No matter how articulate, confident and knowledgeable you are, more likely than not, you will NOT make a good witness on your behalf when trying to justify inadequate or missing documentation. Those of you who have given your deposition are nodding your head in agreement. Here are the reasons why… Most plaintiffs’ attorneys are not interested in the truth. Remember how we likened the medical record to a story earlier. If there are gaps, holes or inconsistencies in the story (the medical record), the plaintiff’s attorney will attempt to create their own version of your story. Most likely, it will not be an accurate depiction of how you recall
Not only does falsification of medical records make lawsuit defense more difficult, it is actually considered professional misconduct and constitutes criminal activity. In addition, it may cause the entire medical record to be inadmissible as evidence in court.

- Communication is more difficult by telephone than in person because nonverbal cues that enhance communication are eliminated. Therefore, when communicating via telephone, you must communicate information in a logical, organized way that creates a “word picture.”

**ELECTRONIC HEALTH RECORD – Application, Documentation and Risk in Litigation**

On February 17, 2009, as part of the American Recovery and Reinvestment Act of 2009, President Obama signed the Health Information Technology for Economic and Clinical Health (HITECH) Act, providing over $19 billion, to entice the widespread adoption of Electronic Health Record (EHR) usage in the US healthcare system. The anticipated goal of this bill is to foster EHR adoption across the country, improve the coordination of healthcare, maximize revenues to healthcare providers, and allow focused quality care. In keeping in line with my “story theory”, I liken the use of EHRs to the transformation of the paperback novel to the “Kindle”. It is supposed to be the “new way to read”, to be more convenient, to be more affordable to buy books online than in stores, and to be user-friendly allowing many different application and note-taking capabilities simultaneously.

Interestingly, just like the slow cautious move from a paperback novel to an electronic version, few US physicians or hospitals - approximately 17% and 10% respectively- have even basic EHRs. Health policy advocates suggest a myriad of potential benefits that should result from the widespread implementation of EHRs, to include safe storage of health information to electronic sharing of clinical information. Experts claim the knowledge shared through this access to patient’s medical data promises to improve patient safety and reduce costs associated with duplicate and/or unnecessary tests and treatments. Electronic prescribing assures reduction in medication errors ranging from drug interactions to misinterpreted handwriting.

However, currently there are some major setbacks that exist with current EHR systems. There are multiple challenges related specifically to the data-entry characteristics of the electronic history and physical (H&P) with existing EHRs. There are coding engines that fail to consider medical necessity, fail to provide compliant evaluation and management (E/M) documentation and coding, and fail to provide protections for over- and under- coding. Many EHRs allow the copying of near identical documentation into large numbers of multiple patients’ records. There has been a discrepancy with incorporating protections for EHRs to ensure correct usage of many of the tools intended as shortcuts.

**DOCUMENTATION IN AN EHR**

Considering that eventually, EHRs will be more prevalent in hospitals and physicians offices, there are a few notable items that should be considered when documenting in an EHR. A medical record should capture the patient’s story as well as the clinician’s thought processes.

---

**The number 1 reason why healthcare providers lose lawsuits is because of poor documentation.**

the facts, or representative of the care you provided. When the plaintiff’s attorney is rewriting your story, he will attempt to add variances and inconsistencies that will portray you as either a bad or a dishonest doctor.

Unfortunately, a deposition is not a good place to attempt to justify your actions, especially if your documentation is less than complete. The very best place to tell your story is in the medical record.

**PRACTICAL DOCUMENTATION TIPS FOR PHYSICIANS**

- Avoid using slang or euphemisms, as they may be misinterpreted and leave a poor impression on the reader. Referring to patients as “frequent fliers” or making observations such as “ETOH on board” speaks poorly of the writer and can be damaging in a lawsuit.
- Writing notes that point fingers at other providers or institutions is unprofessional, inappropriate and potentially damaging. The medical record is not a forum for criticism of personality conflicts, and such entries create a poor impression of the writer. Disputes and judgments have no place in the chart.
- Make corrections, addenda, continued notes, and late entries as per institutional policy. Scribbles, scratches, correction fluid or alterations may appear as falsification. Once litigation has begun you should never add information to a patient’s medical record.
Unfortunately, most EHRs tend to discourage such detailed charting by limiting the physician to “yes” or “no” questions, resulting in computer notes that are missing useful clinical information.

Documentation shortcuts are extremely tempting for busy clinicians with an EHR. The innovation of the EHR, which allows for easier movement of information, has made it easier to reuse previous documentation with a single click. From the standpoint of litigation, this is very dangerous and can actually be construed as fraud. Once copy and paste finds its way into a medical record, even if done so accidentally, the credibility and authenticity of the medical record is compromised.

In some instances, scribing or authenticating notes made by another person, can be considered a fraudulent act if not properly acknowledged. For example, a medical assistant may complete a comprehensive history and physical on a patient. Subsequently, the supervising physician may log into the record, evaluate any proof of positives or negatives, confirm the findings and assessment and electronically sign the documentation in such a way that overwrites the presence of the medical assistant. Though the actions appear completely harmless, there is an enormous potential that this type of documentation will be construed as deceitful or intentionally misleading.

Many EHRs were initially designed to maximize the billable elements of an exam and the templates they include may commonly document additional things that were not actually done for the patient. Templates must be customized so as to capture relevant exam findings. At the end of the day, ensure that the EHR you have implemented is capable of capturing and assimilating clinical data to be used to promote and facilitate the best quality of care for your patient, without the possibility of being misused by technological shortcuts.

IS YOUR STORY COMPLETE?

Multiple discrete factors influence every jury trial and verdict. However, the key to achieving a medical malpractice defense verdict is to provide the jury with an authentic, complete and irrefutable story of the care that was rendered in a way that makes more sense and is more persuasive than the interpretation provided by the plaintiff. The best most efficient and predictable way to do this is by detailed documentation in the medical record. Do everything in your power whether using EHR or documenting by hand to ensure accuracy and inclusiveness.

Remember, the medical record is your concise, accurate and credible story of the appropriate and comprehensive care you provided to your patient. Do not allow anyone the opportunity to rewrite your story.

Gallagher Healthcare, a subsidiary of Arthur J. Gallagher & Co. the 5th largest broker in the world, provides insurance and risk management solutions exclusively to healthcare providers and organizations. We offer the expertise and personal attention of a boutique firm, combined with the resources of a large international organization to solve all of your insurance and risk management needs.

Michelle M. Samadany, BSN, RN, JD has dedicated her entire career to healthcare in a variety of different capacities. She practiced as a nurse for 6 years, followed by the defense of physicians and hospitals in litigation throughout Texas courtrooms for the next 10 years. She worked for Western Litigation, Inc, a national third party healthcare claims administrator for large insurance companies and hospital systems before joining Gallagher Healthcare as a broker, providing insurance and risk management services exclusively to healthcare facilities. For more information e-mail Michelle_Samadany@ajg.com.