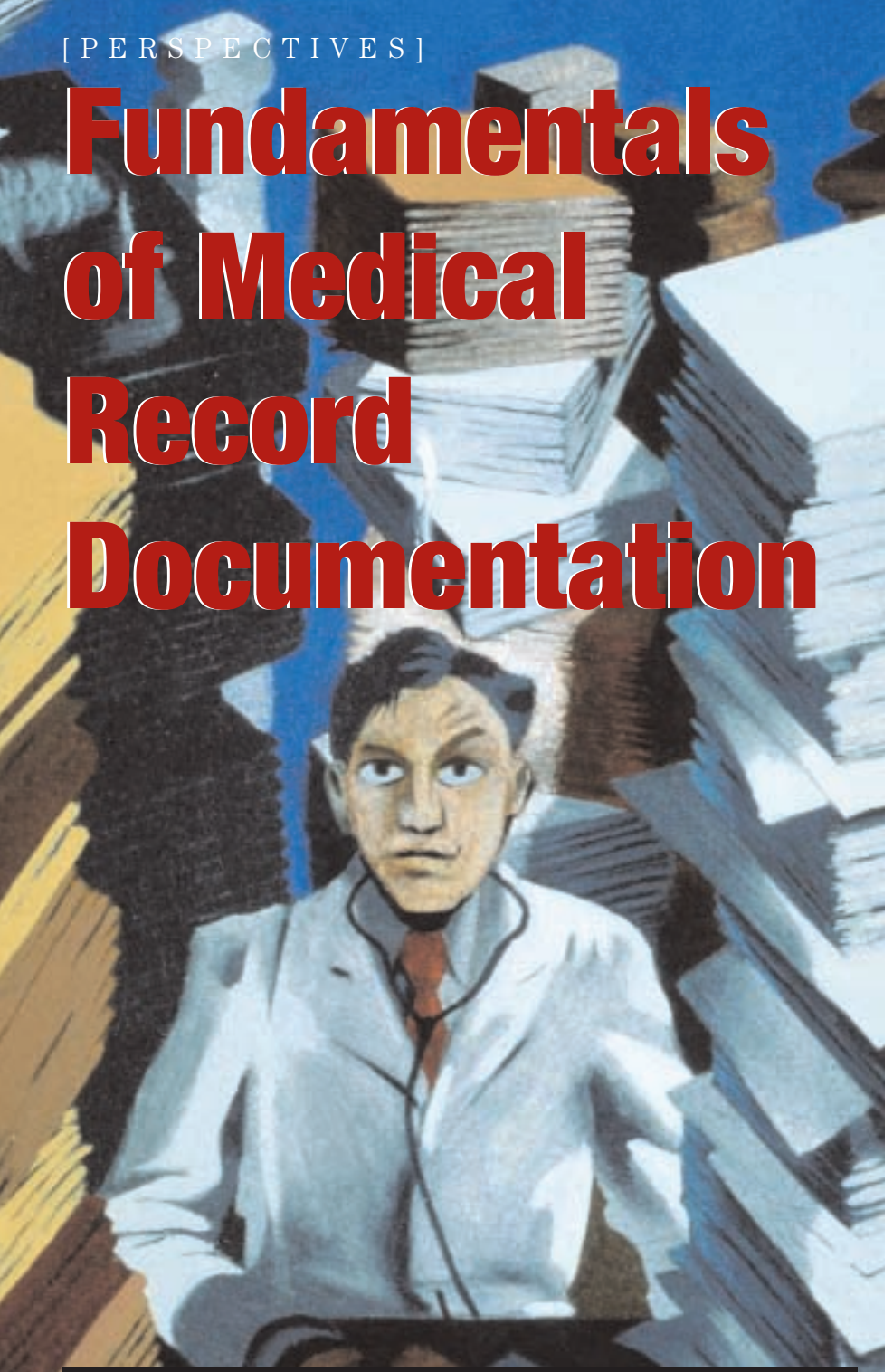
Fundamentals of Medical Record Documentation



DOCUMENTATION OF MEDICAL RECORDS may not be all that exciting, but it only takes a moment on the witness stand in a malpractice case with a patient's chart on display as the subject of discussion for boredom to vanish and terror to take its place. There are some basic principles of sound documentation that psychiatrists should know.

By Thomas G. Gutheil, MD

In the legal system, documentation is regarded as an essential element. Extending the risk management dimension, failure to document relevant data is itself considered a significant breach of and deviation from the standard of care.[1–3] Of course, protection from legal jeopardy is far from the only reason for documentation in clinical care. The patient's record provides the only enduring version of the care as it evolves over time and a reference work of value in emergency care, research, and quality assurance. This discussion will outline some basic principles of sound documentation with an emphasis on those aspects that serve the goals of risk management and liability prevention.

BASIC PRINCIPLES OF DOCUMENTATION

A significant portion of risk management advice regarding documentation unfortunately boils down to the injunction, "You physicians ought to write more." From my years in the medicolegal field, I have found that this advice not only fails to be useful, but is actually counter-productive: faced with excessive demands for documentation, many clinicians dig in their heels and refrain from writing at all or from writing down even relevant data.

Writing more is not the solution; simply writing with greater efficiency will cut down on time spent in documentation. The key to this approach is to keep in mind the three sovereign principles of documentation, which also closely resemble the three principles of medical decision analysis.

First, record the risk-benefit analysis of important decisions in the clinical care of the patient. This risk-benefit analysis should include even obvious or "given" benefits. This is a point where many clinicians fall short because, in being risk-aversive, they tend to focus mostly on the risk side without equal attention to the benefit side of a decision. For exam-

ple, prescribing a particular medication carries a certain risk of side effects, such as allergic reactions or other undesirable outcomes. Clinicians tend to focus on these possible risks and address them in particular in their record progress notes. However, the *benefits* of these medications are often stinted, and the risks of *not receiving* the medications are often omitted entirely. When the discussion of a decision, such as whether to medicate, includes both the risks *and* benefits of each path (prescribe or don't prescribe), the clinician's reasoning is viewed as far more reasonable than if only one of these elements was cited.

One way to visualize this issue is to consider a decision tree in which the tree's two branches represent both options: "medicate" inhabits one branch and "don't medicate" inhabits the other. Each branch then sprouts two twigs: one for risks, and one for benefits. Thus, there are both risks and benefits of prescribing and risks and benefits in not prescribing in a given case. A physician who has even briefly noted the pros and cons in each branch of this decision may be portrayed by a fact-finder or perceived by a jury later as having been wrong in the conclusion at which he or she arrived, but a jury will not see that physician as negligent since the decision was, as supported by the physician's documentation, the result of a well-thought out process.

Thus, if the patient does in fact suffer an ill effect from medication, it is all too easy for a plaintiff's attorney to portray the physician as having cavalierly prescribed this dangerous substance to the patient; however, if the physician has noted that the goal of this medication is to prevent or improve a condition, the sense of a balanced and reasoned decision becomes much clearer to a lay audience.

The second essential point of documentation is the use of clinical judgment at critical decision points. There are many possible definitions of clinical judgment, but a useful one for our purposes is "an assessment of the clinical situation and a response congruent to that assessment."

There are several reasons why this essential element of documentation is useful in liability prevention. First, clinical judgment is itself the polar opposite of negligence, one of the critical elements of malpractice. In addition, the exercise of clinical judgment is based on both objective and subjective clinician factors that emerge from the actual encounter with the patient; no one else had that direct experience with the patient. To derive a benefit from the immediacy of these observations, it is critical to identify the decision-making process that goes into this treatment decision.

Obviously, the response to this assessment must be congruent to the clinical needs defined by the patient's assessment. For example, a clinical judgment and response that reads, "Patient still extremely suicidal, discharge today" would clearly fail the test of the congruence of the response to the assessment.

One of the subtextual elements in a malpractice situation that is a factor in the determination of standard of care is known as the "primacy of the on-site observer."[4] This is a principle used by expert witnesses in determining whether the standard of care was met, while giving the benefit of the doubt to the individual who was on the scene at the time, since the latter has access to ephemeral details and subjective clinical data that may never be contained in the record. However, this benefit of the doubt is lost when the clinical judgment is not recorded.

The last sovereign principle of documentation relates to the patient's capacity to participate in his or her own care. Examples of this include the patient's ability to understand the purposes of the various medications being prescribed, the patient's awareness of what symptoms to look for regarding exacerbation of the condition, and the patient's knowledge of what symptoms or states of mind constitute an emergency.

Additionally, the patient should know who to call in the event of an emergency. Many readers will note that these elements closely resemble a competency assessment; indeed, that is the point at hand. If the physician asks the patient the questions implied above, and records the patient's responses, monitoring of changes in the patient's condition may be delegated to that patient.

On the other hand, a patient who demonstrates no ability to manage these basic details of participation in the medical care plan should have alternative resources made available. This may be as simple as giving the prescribed medications to a spouse, parent, partner, or child to issue to the patient, or as complex as encouraging family members to undertake full guardianship proceedings.

By focusing on these three principles of documentation, a short, concise note may effectively take the place of pages of excessive verbiage and thus bring greater efficiency to the burden of record-keeping, while simultaneously achieving the goal of addressing critical risk management factors.

AUDIENCES FOR THE RECORD

While writing the record, the clinician should keep in mind the possible reader audiences for the record, because this will help achieve sufficient clarity, avoid cryptic communication styles, and achieve the goals of the record in both patient care and liability prevention. Within the clinical realm, the audiences for the record will include other members of the treatment team: on-call physicians, emergency physicians, and those colleagues covering one's practice when the clinician is on vacation or off shift. A more expanded audience will include utilization reviewers,

members of professional standards review organization (PSRO) committees, insurers, quality assurance reviewers and similar review organizations, and procedures. In a worst case scenario, a plaintiff's attorney could be another potential audience for the record. Finally, recall that in most jurisdictions, patients themselves are considered a possible audience for the record. Most of the 50 states allow some processes whereby patients are permitted to view their own records.

This last point places an additional burden on documentation, because, with the possibility of the patient viewing the record, it should not only reflect skilled professional care, but should also convey tact in its observations. For example, when referring to an individual with a lengthy psychopathic history, rather than describing the patient in disparaging language such as, "The patient is the typical social deviant with a long history of failed stints," use more diplomatic phrasing such as, "The patient has a history of antisocial activity and incarcerations." One of the greatest contributors to maintaining a tactful tone is the use of the most objective language possible, since even relatively stigmatizing information sounds less judgmental when stated in an objective manner.

PITFALLS AND POINTERS IN DOCUMENTATION

The primary pitfall in documentation is attempted alteration. The most critical advice in documentation is that one should never attempt to change an existing record. Do not insert, use little arrows, add inter-lineations, etc. Should a particular record entry need changing for accuracy purposes, to comport with the facts, or to correct an accidental notation in the wrong chart or record, the key principle to remember is the principle of transparency. Transparency refers to the quality of documentation whereby the original and the correction or addition are both clearly marked so that viewers know when the original was written and when corrections or additions were made. No attempt is made to mislead the reader or to "fudge" the record content. There are several ways to achieve transparency. The most obvious way of correcting a pre-existing entry is to begin a new entry, write the current date and current time, and then describe the correction:

"[Current date and time]: Review of previous day's entry reveals omission of father's visit, which most likely caused the patient's decompensation shortly afterwards."

While the above emendation does not undo the oversight of omission of this important piece of information, the correction does make clear that the clinician is reading his or her own chart and that he or she understands what is clinically significant by recognizing the relevance of the omission and consequently recording it in the record.

For smaller errors, such as typographical errors, misspellings, wrong terms, etc., a single line drawn through the error and a correction out in the margin that does not block the existing entry will suffice; the correction should also be dated and initialed. If time is critical, supply the time of the correction as well.

The second general pitfall of documentation can be described as one of tone. As a record of professional activities, the record should maintain a professional tone. This means that sarcasm, demeaning terminology, attempted joking, or even too casual a tone may reflect badly on the clinician. No joking that may have been humorous in the nursing station is ever funny when read aloud from the witness box at a trial during cross-examination. Recall that the average jury understands very little about psychiatric care, and may project their fear and distaste for the mentally ill onto the clinician. If the clinician appears to act out this image through the negative tone of the record entries, it is difficult for the jury to support the notion of careful, professional, objective care devoted to the patient's welfare.

When referring to patient A in the chart of patient B, remember to use the other patient's initials, hospital number, or first name and last initial. This limited information will supply sufficient evidence to guide the care of the contemporary treatment team, while preserving the confidentiality of patient A if patient B's chart must be revealed for some legitimate purpose.

It is important to identify the clinicians in question in medical records. When recording staff names, give a staff member's name and discipline. For example, "The patient was medicated by R. Smithers, RN." This completes the clear, concise format necessary to provide the relevant information in a given case.

CONCLUSION

Within the nightmare of a malpractice suit brought against a physician, a solid documented chart in one's hand is universally recognized as one of the critical elements of the best defense. The principles of documentation outlined above should serve as useful guidance to maintaining successful patient care and effective liability prevention.

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