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The Devil is in the Details

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I have written many times about the importance of thorough documentation. As much as it does not serve to beat the proverbial dead horse, I have reason to visit that topic again. I was recently called to give my opinions on standard of care in a deposition for a malpractice case. While on vacation the patient had seen another practitioner – this individual called her regular provider back home and got a slew of treatment notes. He then rendered care he felt was very similar to what was reflected in the provided records – however the patient felt the care was different. Different enough that she didn't like the care provided and sued for bad treatment that caused her pain. I was asked to review the notes provided and give my opinion as to whether or not the provider seen while on vacation acted within a reasonable standard of care or negligently.

What became apparent during the file review process was that the vacation provider (in my opinion) did act responsibly – he requested previous treatment records and narrative reports. He took the time to review the records, and compared those findings to his own quick patient assessment. He relied heavily on the provided records to establish a baseline rationale for his treatment. The bigger problem was that the "back home" provider kept pretty poor notes, and the records sent did not give a good representation of the patient's condition, including an old spinous fracture at C7.

During my deposition, I was asked a number of questions by both sides. These questions give a very good insight into how the legal realm looks at your records, and what they expect to see.

One of the first questions posed was: "Is it fair to say that good record keeping is essential to being able to provide good patient care, and to prevent injury to the patient?" Realize what is being said there – good documentation is integral to good care. The corollary to that is then that good documentation is necessary to keep a patient from being harmed. If you are not keeping good records, you are legally viewed as not providing good care, and potentially jeopardizing the well-being of your patient.

At a point in the interview, the provider noted that he had recently changed his office practice and started using electronic records. The attorney allowed him to explain that this had become necessary due to insurance billing requirements, and also the changing healthcare laws. At this time the attorney again postulated that these rule changes were to ensure good documentation and show good care – and that not providing good documentation could potentially harm the patient.

At several points in the record, another practitioner noted that "previous medical records will be requested for review." This sounds good at face value, but the follow up question posed by the attorney was: "Well, how do you know these records were ever requested or reviewed." Unfortunately, there was no good answer to the question. The provider had recorded that he intended to request the notes – but it was not recorded that he had requested them, if or when they were received, or if they had been referenced or reviewed. The lesson here is that when you make a note about other treatment records, follow through – get those notes, include them in your file, and reference that you have received and reviewed them in your own records.

The next issue that was brought up was technique. The records provided only stated that "traditional full body treatment was provided." Again, that is simple and general, and sounds good, but is not adequate. Questions that were asked at this point included: "What specific points were used in the lower cervical spine?" "How do you know?" "What treatments were used, how were the needles manipulated?" The general umbrella comment that "full body care was provided" did not answer any of those questions. There was no credible way for the provider to recollect those minute specifics. Since that information was not well documented, the care provided was considered questionable at best.

Many other questions were debated during the course of this interview, but I hope I have shared how the medical-legal realm looks at our documentation. The attorney in this case made it very clear that appropriate documentation must be complete. The omission of small details can become a big issue. When caring for a patient, it is your responsibility to accurately document all components of the care you provide. Here are some basic steps to follow:

- Your consultation must be relevant. Comments like "good" or "worse" are inadequate. What has changed since they were last in? How have they felt better? More active? Less medication? These are minor details that make a big difference in how accurate your records are. If the patient has not been in for awhile, make sure you discuss what has changed in the interim. Take the time to document the changes since the last visit.
- Your findings must be current. During your evaluation, note if muscle tone has changed – better or worse. How is the patient's condition different? Is range of motion better or worse? You do not need to do a full exam every visit – but it is reasonable to expect that there would be some progressive changes in the patient's status with the care you provide. Make sure that is clearly documented on each visit.
- Don't trust someone else's notes. As in the case I discussed above, clinical judgment was made using someone else's poor records, and the provider that tried to provide good care ended up getting sued. Is it your responsibility to fully assess any patient you see before you provide them care.
- Based on the subjective comments of the patient, and your objective review – make sure you give a straightforward rationale for the treatments you provide on that date.
- Your treatment notes must be specific. Don't fall back on generalities. "Full body care" is not appropriate. When you provide therapies, make sure you state what therapies, and to what body part they were provided. Note what soft tissue treatments were provided, and name the tissues treated. Name the points treated – not just general body regions. If you recommend rehabilitation, define the exercises performed. Also, when you list the procedures you provide on a given date, I would recommend you itemize them in the order performed – this shows a flow of care, not just a list of procedures.

At a point this may seem like a lot of information to manage, and it is, but all of this data is relevant and important as part of the care you provide. Thorough documentation is part of good patient care. Think of these notes like a fire extinguisher - you don't want to have to deal with it, but when you need it, you are happy to have it there. During a deposition an attorney can ask you just about anything about your care of that patient, whether or not you wrote it down. What you "think" or "remember" is not credible – if it is not written down, it is not part of the record! If you are ever called upon to justify the care you provided a patient, the notes in your file will be the only tool you have at your disposal. Make sure you take the time to complete your documentation – it's good practice and good patient care!

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