MIEC

Write On!

MIEC'S DOCUMENTATION NEWSLETTER

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Telephone communication: Did you hear what I heard?

INSIDE

Write on!

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"I have been involved with the defense of physicians in professional liability claims since 1976. One common thread that has existed in all claims seen over the years is that the ***medical record is the physician's greatest asset*** *in defending him or her against allegations of negligence. If more physicians realized that clear, legible medical records are their best defense and they documented accordingly, most claims would never be brought, and many claims that are contemplated would not be pursued."*

Stephen D. Stimel,
Former VP of Claims, MIEC

For years, MIEC's Loss Prevention specialists and defense counsel have talked to policyholders about the importance of prudent record-keeping practices—documentation that: illustrates the quality of patient care; provides evidence of physician decision-making and judgment; justifies fees for services rendered; and helps in a physician's defense if sued for professional negligence. A number of claims reported in the Physician Insurers Association of America (PIAA) Data Sharing Project cite "problems with records" as an "Associated Medical and Legal Issue" that directly affected the defense of a lawsuit. MIEC's claims experience likewise reflects the impact of poor record-keeping on a physician's defense.

Some policyholders respond, "Prove it. I'm too busy to spend my time documenting. Show me how poor documentation can directly impact the outcome of my case!" We hope to do just that. This newsletter, and future issues, will present some of MIEC's closed suits/claims, the outcomes of which were directly affected by the contents of the medical record (either by failure to document significant information, or because information was prudently noted). The names and some details of the cases have been changed to protect the identities of both plaintiffs and defendant physicians.

MIEC's Loss Prevention staff has spoken with numerous policyholders who honestly declare, "I rarely document telephone calls and I certainly never document phone calls from my patients, or my colleagues' patients, when I'm on-call. If I have to start writing down those phone messages, I'll just stop taking call after hours, or I'll direct patients to go to the ED." We understand and empathize with physicians who find this type of documentation burdensome, but warn policyholders that the failure to document telephone calls, especially when on-call, could be dangerous and costly.

David W. Shapiro, MD, JD, Editor of *Professional Liability Newsletter*, reviewed a case in which the patient alleged failure to diagnose retinal tears resulting in retinal detachment, diplopia and cataracts. Dr. Shapiro concluded:

"The quality of one's notes is one of the few things in medicine that a physician can effectively control. After the trial, jurors told the defense lawyer that, because the defendant's [second office visit] note did not contain the four words, 'complete retinal exam performed,' they concluded he had not done such an exam. Everyone knows good documentation is valuable, but this is the first time I've been able to put a dollar value on it: $1,163,750 a word. Avoiding being sued in the first place: priceless." *Professional Liability Newsletter, May/June 2006*

Case 1: Dr. Brown (non-MIEC) was the treating pediatrician of Baby Joel Smith, born on August 3, at 38-weeks gestation. On August 4, Dr. Brown noted that the infant was stable and breast-feeding well, but was slightly jaundiced, although his skin appeared normal. The doctor did not obtain a baseline bilirubin and discharged the newborn.

According to the baby's chart, the parents called Dr. Brown on August 5th and 6th. The details of the calls were documented only cursorily. Dr. Brown testified at his deposition that Mrs. Smith said that Baby Smith was fussy, and that Dr. Brown told the mother to take her child to the emergency department if his fussiness increased. **This advice was not documented**. Mrs. Smith testified that she told Dr. Brown's receptionist that the baby was not nursing well, was jaundiced and was arching his back; she further said that Dr. Brown did not return her call.

On August 7th, Dr. Johnson was on-call for Dr. Brown. Dr. Johnson testified that he received two calls from the Smiths, **but he did not document the calls**. He recalled that Mr. Smith said the baby did not have a fever, was fussy and hungry, and was not breast-feeding well; Dr. Johnson testified that Mr. Smith did not mention the jaundice. The doctor reassured the father, offered appropriate advice based upon what the father said, and told him to call again if there was no improvement.

Dr. Johnson said that Mrs. Smith called later in the day to ask if it she could administer Mylecon drops for colic, which Dr. Johnson approved. He recalled that Mrs. Smith said the baby was sleeping. Contrary to Dr. Johnson's testimony, Mrs. Smith testified that she called and told Dr. Johnson that the baby was fussy, was born jaundiced, had stopped nursing, was moaning and arching his back, and was holding his fists to his side. She recalled that Dr. Johnson advised her that the baby had colic, and recommended Mylecon drops and Tylenol.

By 11:00 p.m. on August 7th, Baby Smith was arching, moaning, "turning red," and had a rectal temperature of 100°F. Mrs. Smith took the infant to a local ED.

Baby Joel was diagnosed with hyperbilirubinemia. Despite treatment, the infant suffered significant permanent injuries. The obstetrician/gynecologist was dismissed from the subsequent lawsuit. The delivering hospital and Dr. Brown settled before trial. The matter was taken to trial based upon the defense's position that Dr. Johnson's advice was appropriate and nothing he said or did caused the injury. However, the jury returned a multimillion dollar plaintiff's verdict against Dr. Johnson, the sole remaining defendant. Post-trial the case was settled.

Bottom line: Documentation can prevent a credibility battle.

Recollection of the events, specifically what was communicated between the parents and Dr. Johnson during the two phone calls, *changed* as the number of plaintiff depositions taken *increased*. According to the MIEC Claims Representative who handled this matter, "Dr. Johnson's deposition testimony remained unchanged and was substantiated by the parents' actions. The Smiths' testimony changed from little to no memory of the events on August 7th to almost textbook recitation of symptoms of jaundice and kernicterus [by plaintiffs' deposition #3], which they claimed were ignored by our insured."

Why did the jury believe the parents? Dr. Johnson took care of hundreds of patients over time. How could he possibly recall two discussions that he never documented? The Smith family had one child with one crisis. In the minds of the jury, the parents' recollection was more credible and accurate.

Case 2: Case 2 took over ten years to resolve and included two trials, two appeals, and more than $500,000 in legal and related defense expenses. Allegation: "Delay in treatment of abdominal pain; malrotated bowel; neurological deficits." The plaintiff alleged that the defendant failed to inform her during a phone call that her condition could be life threatening.

The case involved a 53-year-old female, Ms. Wilson, who had a history of a vertical banded gastroplasty performed when she was approximately 42 years old. When general surgeon, Dr. Mitchell, first saw the patient, she had gone from 310 pounds to 100 pounds, was malnourished, and at risk of starving to death. Dr. Mitchell recommended that the stomach pouch be taken down in an effort to restore gastrointestinal continuity *after* the patient gained 30 pounds with the assistance of a feeding tube.

Ms. Wilson gained the recommended weight and Dr. Mitchell performed the stomach surgery. Approximately three months post-surgery, at 10:30 p.m., Ms. Wilson called Dr. Mitchell and complained of abdominal pain, nausea and an inability to burp. Dr. Mitchell advised the patient that he could not evaluate her condition over the phone, and that she should go to the emergency department. **Dr. Mitchell did not document the phone call nor the advice he gave the patient.** Ms. Wilson told Dr. Mitchell that she would *not* go to the ED and he did not inquire why she was disregarding his recommendation. Ms. Wilson testified at her deposition that Dr. Mitchell did not advise her of the risks if she failed to go to the ED for examination; however, she admitted that she couldn't recall anything that he told her on the phone that evening. At 1:00 a.m. the following morning, Dr. Mitchell received a telephone call from the ED and was informed that the patient's family found her unconscious at her home. She was admitted to the hospital where Dr. Mitchell took her to surgery. He dictated the phone call into his operative report. Ultimately the patient was discharged to a long-term care facility with irreversible brain damage and later returned to her home.

Dr. Mitchell's care and treatment were found to be within the standard of care during both trials. The phone communication (specifically, whether or not Dr. Mitchell breached his duty of care because he did not specifically warn the patient that she could suffer a significant injury if she did not go to the ED) was one of the focal points of this ten-year-long litigation.

Bottom line: Clearly documented communication differentiates between the physician's and the patient's responsibilities—in this case, the patient's decision to ignore Dr. Mitchell's advice versus his responsibility to inform her of the risks for possible injury. The patient admitted that Dr. Mitchell told her to go to the ED for evaluation, but contended that he did not specifically warn her of the potential for significant harm by failing to do so. Dr. Mitchell's case would have been much easier to defend if he documented what he discussed with the patient, the advice he gave, and the patient's response.

When asked what he might have done differently in this case, Dr. Mitchell said, "When the patient said she was not going to the ED, I should have asked, '*Why not?'* The question would have allowed me to try to convince her to go despite any excuses she might have come up with. Physicians have to be able to use their phones as a way to effectively communicate with patients. Seeing them is obviously better, but when we're unable to do that, communication by phone (including advice we give) should not expose us to increased liability."

Recommendations

Documentation of telephone communication between patients and physicians or physicians' staff members is an important component of medical charting. Failure to memorialize this type of communication creates significant gaps in the documentation of patients' care and treatment. Physicians who are on-call after normal business hours for their own patients or for their colleagues' patients also need an effective method for documenting patient contacts to ensure patient safety and to decrease the physicians' liability risks.

General telephone advice:

(1) Document significant phone calls in patients' charts. Include both what patients communicated (e.g., reaction to medication, new symptoms, significant medical history, and more) *and* what advice was given. Documentation should include the date and time of the call, who called, contents of the communication, and the author's initials.

(2) Be specific in chart entries that memorialize advice given to patients. Include: risks discussed, changes in medications and why, recommendations to be seen in the office and when, recommendations to go to the ED, referrals to specialists and the reason for the referral, urgency, etc. Document patients' responses to the advice you give (including excuses they may communicate). If staff is directed to call a patient on your behalf, that person's chart note should likewise be *specific* and include, "Per Dr. XX , advised patient…"

Of note: When patients refuse your advice, we recommend that you discuss with them the potential risks for injury and document same. Clearly document that patients give all indications that they *understand* the decision they are making to refuse treatment.

(3) Document telephone calls in which medical decisions are made (i.e., colleague to colleague, physician to patient's parents, physicians to adult child of dependent parent, etc.).

On-call advice:

(1) Document calls received when on-call. Develop a system to note the calls and to report patient contacts to off-call

colleagues. MIEC's On-Call Physician's Report Form on page 6 (also available on our website at www.miec.com **under Loss Prevention, Online Publications**) is a helpful tool that policyholders are welcome to download and adapt to their practices. Some physicians dictate calls received, have them transcribed, and file the transcription in their charts or mailed/faxed to the patients' primary physicians. Others keep a notepad in their pockets or on their nightstands to document calls and bring them to the office for inclusion in the chart. Leaving messages in office voicemail for staff to transcribe is another means of memorializing phone calls. Ask that on-call colleagues reciprocate when they see your patients.

(2) Establish a prescription refill policy. Avoid refilling narcotics, or authorize only enough medication to cover patients until their primary care physician returns to the office.

(3) Make certain your on-call colleagues have professional liability coverage.

(4) Ensure that you and your on-call colleagues have staff privileges at the same hospitals.

(5) Review "high risk" patients with your on-call colleagues prior to going off-call.

(6) Consider allowing your answering service to call you (if at all possible) when a patient dies while you are off-call and the family is trying to contact you. Death is not the time when family members should have to discuss your patient with an on-call physician.

MIEC's newsletter, "Communication between physicians and other health care providers," *Managing Your Practice*, Advisory Number 12, is another resource for policyholders. Download a copy or request the publication by contacting Loss Prevention.

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Doing it Write!

(MIEC's salute to policyholders doing the Write thing)

John Muffoletto, Board-certified General Surgeon, Anchorage, AK, shares call with three surgeons in the community. He and his colleagues have established an on-call documentation protocol. Prior to requesting on-call coverage, they communicate the status of certain patients (e.g., hospitalized patients) with the doctor who is scheduled to be on-call. This is usually done by phone and Dr. Muffoletto takes extensive notes about patients he is to follow on any particular on-call weekend. Whenever he and his colleagues telephonically communicate with or treat one another's patients, the physicians send a written report to each other. Dr. Muffoletto dictates/ transcribes the on-call discussions or examinations, sends the reports to the appropriate physicians, and retains a copy for his files.

On-Call Physician's Report Form

Practice Information

DATE: _____

TO: _____ , M.D.

RE: Patient _____

This patient phoned on _____ at _____ o'clock.

I saw this patient ☐ office / ☐ Emergency Department / ☐ _____

_____ at _____ o'clock.

Chief Complaint/History (and historian)/Allergies/Medication:

Examination:

Impression:

Action/Advice: Admitted to: _____

Patient advised to call you in _____ days. Patient advised to go to ED _____

Other: _____

Medication prescribed: (Drug, dose, #, sig) _____

☐ Phoned to _____ ☐ Prescription written

☐ **Attachments**: