Medical Record Documentation for Patient Safety and Physician Defensibility is a publication of the MIEC Loss Prevention Department. The authors have conducted hundreds of medical practice surveys and have reviewed thousands of medical records maintained by physicians in all medical specialties. Each of the authors has extensive experience in medical malpractice claims management and loss prevention activities on behalf of physicians and other health professionals. Recommendations for defensible medical records are based on the authors' analyses of medical records and malpractice litigation files, and include documentation advice from malpractice defense attorneys, claims experts and physicians whose involvement in peer review activities gives them a unique understanding of the importance of sound medical record documentation.

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This publication was developed and updated under the direction of the Loss Prevention Committee of the MIEC Board of Governors.
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“Nothing is more devastating to an innocent physician’s defense against the allegations of medical malpractice than an inaccurate, illegible or skimpy record, except for a record which has been changed after the fact, and therefore inevitably compromises the otherwise defensible case.”

Brad Cohn, MD, Pediatrician
Chairman, MIEC Board of Governors
Oakland, California
A Handbook for Physicians and Medical Office Staff

Few medical-legal topics have generated as much discussion as the subject of medical record documentation. Liability insurers, defense attorneys, and third-party payers remind physicians and other health professionals that the safety of patients, the outcome of litigation and the promptness of reimbursement depend on the adequacy, legibility, completeness, timeliness and accuracy of medical records.

Many malpractice claims result in a victory for the plaintiff because of the poor quality of medical records, even in cases in which appropriate medical care was provided. Maintaining adequate, defensible medical records need not be a chore. Ensuring that medical records are well-organized and reasonably complete may add a few minutes per chart to the physician’s day. But, physicians whose inadequate records were partly responsible for their involvement in litigation can attest to the fact that the amount of time spent in deposition, meeting with legal counsel, worrying about the case and its effect on their personal life and professional reputation, or preparing for and attending trial far exceeds the time it takes to maintain adequate medical records.

This handbook is a companion to MIEC’s sample forms, templates and letters — shortcuts to facilitate charting and maintain defensible medical records.

“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 Claims Manager
Medical Insurance Exchange of California
Weak medical records — an invitation to litigation

Medical records often are the most important objective evidence physicians and hospitals can offer in their defense against a malpractice claim. When jurors, arbitrators, pre-litigation screening panels or other triers of the facts must choose between conflicting, undocumented versions of events told by opposing parties, the documentation that was made at the time care was rendered is a defendant’s most decisive confirmation that he or she met accepted standards of medical practice. Weak medical records invariably handicap litigation defense. Liability experts are convinced that poor medical records are a leading reason so many questionable malpractice claims are filed and pursued, and why some of these cases ultimately are decided in the plaintiff’s favor. Poor medical records make it difficult to determine whether an adverse outcome resulted from factors beyond the physician’s control or from negligent medical care.

Aside from medical-legal considerations, the most important reason for physicians to maintain accurate, credible medical records is that good documentation protects patients. Medical records contain information required to inform physicians of past and present treatment decisions, and to provide evidence that such care was appropriate in all respects. Weaknesses in the charting increase the margin for error that could result in patient injury, or be an impediment to a physician’s defense.

Complete, timely records offer physicians a strong defense

Good documentation protects physicians and other health professionals against claims of negligence. Typically, when a patient asks an attorney to file a malpractice claim against a physician, hospital or other health professional, most attorneys obtain copies of the pertinent medical records for review by an independent medical consultant. The reviewer is asked to determine, based on the documentation, if the treating physician(s) provided appropriate care — and whether the physician was negligent.

Similarly, when a doctor reports a potential claim to MIEC’s Claims Department, the doctor’s defense attorney obtains and submits the medical records to independent medical reviewers, a medical society peer review committee and, where applicable, to a state-mandated pre-litigation screening panel. Each consultant or review panel is asked to consider the same question the plaintiffs’ consultants consider: Based on the documentation, did the physician provide appropriate medical care? The strength of the documentation often is the deciding factor in whether a plaintiff pursues a claim and in how effectively defendants and their insurers can mount a solid defense against the allegations.
Recommendations for Defensible Medical Records

Organize charts

Well-organized, neatly-maintained patient charts facilitate making new entries and locating previously-recorded information. Secure loose pages to the chart cover with two-pronged clips. In larger charts, use dividers to separate progress notes from lab reports, correspondence, copies of hospital reports, and other materials. Include the patient’s name or other identifier on each page in the medical record.

Avoid the use of sticky notes

Avoid the use of sticky notes or unattached slips of paper, which can become separated from the chart. MIEC’s office practice surveyors find that most notes written on loose slips of paper or Post-It® notes do not include the patient’s name, the full date of the note, other essential details or the writer’s initials. Sticky notes are meant to be temporary and lack space for the essentials of meaningful and permanent chart entries.

Note the reasons for visit

Begin each progress note with information about the reason for a patient’s office visit. The absence of this data handicaps the defense against allegations that the doctor failed to diagnose a problem the patient reported. As part of the intake or “triage” process, the doctor or an assistant should document the patient’s chief complaint using quotes, when applicable, to indicate the patient’s own words, and include the onset and duration of symptoms. Office staff should not translate the patient’s comments into a medical diagnosis or medical terminology. A sample complaint might read: “Pt. states: ‘Stomach pain, diarrhea, headaches for two days. Has taken aspirin three times.’” A rubber-stamp-template such as that in Figure 1 facilitates this documentation.

**Figure 1: Triage Template**

<table>
<thead>
<tr>
<th>Date</th>
<th>Weight</th>
<th>BP</th>
<th>LNMP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Sitting / Lying</td>
</tr>
<tr>
<td>Complaint(s)</td>
<td>(Onset/duration)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td>Meds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient’s other physicians:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

__________
Initials
Anyone who obtains this information should note clearly who the historian is, if it is not the patient. If the patient does not speak English or is hearing-impaired, include the name of the interpreter.

Chart allergies, current medications, names of other physicians

Ask patients on their first visit about drug or other allergies; periodically update this information. MIEC’s claims data reveals that the second most common category of medication-related claims involves the prescription of a contraindicated drug due to an unknown and/or overlooked allergy. To avoid overlooking patient allergies, physicians should document this significant information on a brightly-colored sticker placed on the cover of each patient’s chart or on a triage template (see Figure 2). When patients report “No-known-drug-allergies” (NKDA), document “NKDA” on the sticker or in the chart as evidence that the question was asked and allergies were denied.

Document the names of other treating physicians and note the conditions and/or medications they are managing. Ask patients about medications other doctors have prescribed since the previous visit, over-the-counter drugs, complementary and alternative supplements, and illicit drug use; document the information completely. Ask patients to bring all of their current medication vials to each appointment, so that the doctor can review them.

Consider a “Problem List” in group practice charts

When more than one physician in an office or clinic treats a patient and makes entries in a unified medical record, communication among the co-treaters can be facilitated by a problem list that identifies serious medical conditions and includes the dates of onset and resolution. The problem list entries alert co-treaters to review their colleagues’ progress notes and correlate their own treatment or follow-up advice. Caveat: Problem lists must be current and complete or they could mislead. You
may wish to assign an assistant the responsibility to ensure that significant current visit information is added to the problem list.

Sign or initial all chart entries

Physicians and their staff should initial or sign their chart entries. Author identification gives chart entries credibility and limits the number of people a plaintiff’s attorney could question about an unattributed entry. Phone messages in which important information is received from or given to patients by the staff on the doctor’s behalf should be initialed (or signed) and dated. Medication refill notes should confirm that a physician approved the order (e.g., “per Dr. Jones”) and be initialed by the employee who relayed approval to a pharmacy. Staff notes should similarly indicate that medical advice relayed to patients came from the doctor.

In multi-specialty group practices, precede progress notes with the treating physician’s name and specialty or department. Medical assistants can imprint this data and the visit date with a rubber stamp.

Write legibly!

Everyone who writes in the medical record must ensure that entries are legible. Unreadable entries in a medical record usually are not a problem if only one physician relies on the chart — although poor handwriting has subjected many physicians to time-consuming depositions or court appearances just to decipher their writing. When more than one person has to read and interpret the records, including office staff or other physicians, the potential liabilities of poor handwriting increase dramatically. In both office and hospital charts, a carelessly written decimal point in a drug order, an unclear number on a laboratory report or vital signs note, or medical orders that even their author cannot decipher, are charting deficiencies that can result in expensive and difficult-to-defend lawsuits. Squeezed-in unreadable entries, initials or signatures that obscure medical notes,
improper corrections, writeovers, and crossouts are not only hazards in patient care, but weaken the credibility of documentation and the defense of a malpractice claim.

**Dictated your records**

Dictated and transcribed medical records are an alternative to illegible handwriting. Dictated progress notes tend to be more complete and thus more helpful in documenting patient care, and more supportive in the defense of a malpractice claim than are many handwritten charts. Their most important feature may be that the ease of dictation enables the physician to include extensive details of history, examination, educational and instructional discussions, and contacts with specialists and referring doctors. Writing fatigue and time constraints make some doctors handwrite less information than they are likely to include in a dictated note. Transcribed records are recommended in complex cases, and in cases in which more than one physician provides care. Dictated records are advisable in cases the doctor reasonably can expect will involve either litigation or liability claims, such as auto accidents, industrial injuries, and reportable abuse. In these cases, the treating physician may be called as a witness. The quality of his or her medical record could become the focus of the litigation or proceeding if medical information has not been accurately, legibly and consistently documented.

**Consider an electronic medical record**

An increasing number of software programs and complete documentation systems are available for physicians who want to computerize their medical records. When choosing an electronic medical record (EMR) system, physicians should first assess their practice management and documentation needs, and spend some time evaluating the EMR product and the company’s stability. Computerized medical records should include the essentials of good documentation as outlined in this text. Specifically, the EMR should offer (among other features): default fields that cannot be skipped (e.g., allergies, medications); reminders for health maintenance diagnostic testing; pop-up warnings about contraindicated medications due to allergies or prescribed drugs; safeguards against undetected alterations; an automatic backup system; and more. *(See the EMR Supplement to this text.)*

**Avoid untimely dictation**

Operative and procedure reports or discharge summaries dictated too long after an event may handicap physicians who care for hospitalized patients or who are on-call for another physician. Serious diagnostic and treatment errors have resulted in injury and litigation because these reports were not available. Reports dictated too long after a complication lack credibility, whether or not the complication resulted from negligence.
Do not use a “Dictated but not read” stamp or note on transcription

Some busy physicians believe this rubber stamped disclaimer excuses them from errors or omissions on reports or correspondence they sign. In fact, such attempts to limit liability actually increase it. If unreviewed reports contain errors or omissions that result in patient injury, in addition to claiming negligence, plaintiffs could allege in litigation that the doctor was “too busy” or “too unconcerned” to ensure the accuracy of an operative, History and Physical, or consultation report. Juries have not been sympathetic to the excuse that a doctor was too busy to protect patients by reviewing these important documents. It is difficult to correct errors or fill in blanks months or years after a report was dictated. It is even more difficult for doctors to convince jurors they meant to say something other than what appears on the report they dictated and sent without reading.

Initial or sign questionnaires as evidence of your review

Many medical practices ask patients to complete a questionnaire that documents information about past medical and surgical history, family medical history, and personal habits. These can be helpful forms as they provide the physician with useful information. As evidence that the physician has reviewed questionnaires and history forms, the doctor should initial the forms and, in the case of significant patient responses to questions, make a note next to these items (or refer to them in the progress notes) to indicate the patient’s responses were discussed and considered.

Fill in or void spaces on forms and transcription

A blank space on a form does not always signify a negative response. Plaintiffs’ attorneys and jurors may regard blank spaces on an examination template as evidence that parts of an exam were not done. On a questionnaire, patients may leave spaces blank because they did not understand or overlooked the question, are functionally illiterate, or did not know how to spell a medical or drug term. Fill in or void all spaces for information on forms. Ask office staff to review forms patients fill in to ensure the forms are complete. Physicians should not sign operative reports, discharge summaries, or other transcription before filling in blanks.

Initial or sign lab, X-ray, consultants’ reports as evidence of your review

A number of patient injuries and malpractice cases are traced to physicians’ failure to review and act upon positive laboratory and X-ray reports or treatment recommended in correspondence from consultants before these items are filed in the medical record. It is not fail-safe to file these reports in the chart with the expectation the doctor will review them the next time the
patient is seen; if the patient does not return, as some patients who became malpractice plaintiffs did not, the doctor may not discover significant findings that require action until the patient suffers an injury. Another unsafe but common practice is to assume that a report was reviewed because it is in the doctor’s “out” basket. Every liability insurer has had cases in which unreviewed reports somehow managed to get into the out basket and were filed, but were never reviewed by a physician. A safer approach is to require physicians to initial all reports as an indication to the staff that each item has been reviewed and can be filed; the staff would file such reports only if evidence of the physician’s review was clearly visible.

The template shown in Figure 4, which can be made into a rubber stamp, has space to note the physician’s review, and documentation that the patient was advised of the results.

**Avoid unexplained crossouts, writeovers or squeezed-in entries**

Crossouts or other unexplained changes or writeovers obscure both the original entry and correction. These changes often are cited by a plaintiff’s attorney to suggest that the medical record was intentionally altered. Correct writing errors by drawing a single line through the incorrect entry so that it can still be read. Write in the correction (legibly) and initial it. Avoid writing over any entry, especially digits (for vital signs, medication doses and amounts, etc.). Start a new page, rather than squeeze in notes at the bottom or the sides of a full page. In litigation, such notes may appear to have been added with the intent to falsify the record after an adverse event occurred or after litigation was threatened.

**Caveat:** When amending progress notes, include the date, time and, if the reasons for the amendment are not obvious, explain the change. Never amend or correct a medical record after receipt of notice of a potential claim. Obtain advice from MIEC’s Claims Department if charting errors are discovered following a complication or after a claim is threatened or filed.

**Caveat:** Deliberate alteration of a medical record is illegal and unethical, and may subject the writer to criminal and civil penalties, including possible loss of the doctor’s medical license. The technology to detect documentation alterations is sophisticated and includes methods that accurately determine if entries on the page were made at the same or different times. Evidence of questionable late entries or alterations is usually admissible in court and strengthens the plaintiff’s case.
Chart medication prescriptions and renewals completely

As many malpractice claims involve medication problems, physicians should have a good system to ensure that they do not err in prescribing new drugs or granting renewals because they overlooked earlier prescriptions that were noted in the chart, but were not easily visible upon cursory review. Review of MIEC’s medication-related malpractice claims found that a large number of errors resulted when the prescribing physician overlooked earlier notations about prescriptions, particularly in offices in which more than one physician prescribed or renewed medications for the same patient. Some cases resulted when a physician prescribed a drug which was contraindicated because of an earlier prescription; the earlier prescription was appropriately documented, but the documentation was “buried” in the depths of the patient’s chart and apparently overlooked. In a number of cases involving allegations that too much medication was prescribed, the error was traced to the physician’s failure to notice that renewals were being ordered in increasingly shorter time spans. Again, the problem occurred because the medication information was buried in the body of the chart.

Use a Medication Control Record

The risks of harmful errors are reduced by maintaining a Medication Control Record (MCR) that lists all prescriptions and refills and is easily accessible for review. (Contact the Loss Prevention Department for a copy of an MCR or download one from the Loss Prevention section of MIEC’s website at www.miec.com.) Physicians who choose to record medications in progress notes rather than on a medication control form should make certain that all entries are complete. Each entry should include the full name of the medication, dose, number dispensed and instructions. Medication renewal notes should be similarly complete. Notes that read, “Renew meds” are ambiguous — and may be misleading if the patient is

Figure 5: Confusing writeovers and crossouts

Figure 6: Sample MCR
taking several medications and not all of them are due to be refilled at the same time the note was written.

**Dispense drug education materials and document the details**

Studies by the National Council on Patient Information and Education say that more than half of the prescriptions doctors order each year for patients of all ages are taken improperly or are not taken at all. According to the National Pharmaceutical Council, patients not taking medications as directed result in 125,000 deaths per year, 10% of all hospital admissions, 25% of all hospital admissions among the elderly, and 23% of all nursing home admissions.

These data underscore the importance of giving patients information about the drugs they are advised to take, and clear instructions for taking them. The studies also emphasize the need to take and periodically update an adequate medication use history, and to document the fact that information about drug side-effects was dispensed to the patient.

To increase patient understanding, promote patient compliance with medication instructions, and to reduce liability exposure, dispense written instructions for prescribed medications. Some commercial materials and some from medical specialty organizations are designed to familiarize patients with the drugs they are taking and to alert them to drug-related problems that they should call to the physician’s attention. Doctors who do not like pre-printed forms should consider writing their own drug information sheets.

When written materials are dispensed, a note should be made in the patient’s medical record. Medication information sheets may be numbered, so that documentation could consist of a note that says, for example: “PMI #007,” which means patient medication instruction sheet #007 was dispensed, and the patient was told to read it and let the doctor know if he or she had any questions. MIEC’s Medication Control Records have a space to indicate that printed information was dispensed.

Physicians who prefer to rely on oral advice should document in the progress notes that they have explained to patients each drug’s use, the directions for use, significant side effects and what to do if the patient experiences them, and other significant and/or educational information.
Document significant phone conversations with dates, names, and content

Document in patient charts phone calls in which a physician receives or imparts important medical information. Documenting the calls in a separate log is risky, because: (1) co-treating physicians in the practice may not seek out and review logged messages about symptoms, medication changes or advice that might affect their own diagnostic or treatment decisions; and (2) as phone logs are not included when a pre-litigation copy of the patient’s chart is provided, the patient’s attorney may be unaware of telephoned information essential to understanding the case. Keep phone message pads at home and carry one on hospital rounds to facilitate documenting out-of-office phone calls. Many physicians dictate details of phone conversations into a small pocket recorder and have the notes transcribed when they return to the office or call their dictation service and record the details of a phone call. On-call physicians should document significant after-hours phone calls with their colleagues’ patients and remember to inform the colleague. The form shown in Figure 7 on page 14 can be used to document contacts with a colleague’s patients.

Office staff who receive phone calls from patients should document these calls in a consistent manner. An effective telephone message slip, similar to the example in Figure 8 on page 15, should have space for the physician or staff person to document actions taken (or directed by the doctor) in response to the patient’s call.

Document referral notes unambiguously

Document referral recommendations in unambiguous terms. Rather than note, for example, “to see GYN,” write, “Pt urged to see her GYN promptly for vaginal bleeding; patient understands urgency.” Instead of, “back pain—needs ortho,” write, “Pt says she will call today for an appt with orthopedist for back pain.” In place of “ENT for nasal polyp,” write, “Made appt for pt on 10/6/06 with Dr. Nohs for nasal polyp.”

Include sufficient details of exam findings in progress notes

In litigation, progress notes can be the strongest or weakest parts of the defendant’s medical record. Because of inadequate chart notes, hundreds of defendant-physicians have had only their recollections on which to base testimony about details of physical exams, postoperative bedside visits, advice they gave to patients, and medications they prescribed and renewed. In litigation, patient-plaintiffs often convincingly dispute their doctors’ undocumented recollections. Plaintiffs’ attorneys cite sparse progress notes to argue to jurors or arbitrators that office visits were too brief, or that examinations were perfunctory, just as the patient “remembers” and alleges. Phrases in progress notes like “OK;” “looks fine;” “normal neuro exam;” “headaches;” “ROS WNL (review of systems within normal limits);” or “some numbness,” are too ambiguous for defense experts to evaluate, and provide
Date: ______________________

To: ______________________________________________________________, M.D.

Re: Patient _____________________________________________________

☐ This patient phoned on ________________________ at ____________________ o’clock.

☐ I saw this patient in  ☐ Office  ☐ Emergency Department

☐ _____________________________________ at __________________________ o’clock.

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

Examination:

Impression:

Action/Advice: Admitted to ____________________________________________

☐ Patient advised to call you in ________ days.

☐ Patient advised to go to ______________________ Emergency Department

☐ Other: ____________________________________________________________

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

☐ Phoned to _____________________________  ☐ Prescription written

☐ Attachment: __________________________________________________________
ammunition for the plaintiffs’ experts to question and criticize. These types of notes imply inattention or haste and have influenced the outcome of many “failure-to-diagnose” malpractice suits that physicians were forced to settle or which were lost at trial. More physicians are now dictating hospital progress notes in complex cases to ensure adequate documentation of their bedside evaluations and discussions with patients or their families. Haste is not an affirmative defense for inadequate documentation or resultant errors.

Patient-safe (and defensible) progress notes include sufficient information about: (1) reasons for the current visit; (2) the scope of examination; (3) positive and pertinent negative exam findings; (4) diagnosis or impression; (5) treatment details and future treatment recommendations; (6) medication administered, prescribed or renewed; (7) written (or oral) instructions and/or educational information to the patient; and (8) recommended return visit date.

Supplement narrative text with line drawings, diagrams and templates

These charting tools expand on narrative descriptions of the location of an injury or lesion, such as lacerations, burns, breast lumps, painful or erythematous areas, foreign body puncture sites, and neurological deficits. They add substance to indefinite phrases such as: “lump in upper outer quadrant left breast;” “laceration on plantar surface;” “facial acne;” “4 mm melanoma on back.” A simple line drawing supplements narrative descriptions of size, depth, scope or severity.
Document informed consent discussions carefully

Although a signed consent form technically is evidence of a patient’s consent to a surgery or invasive procedure, litigants often claim — and juries believe — they did not read or understand the lengthy form they signed, or that they signed it because they were told the procedure would be canceled if they did not. Even in states in which a signed consent form is *prima facie* evidence that a patient gave an informed consent, a consent form alone may lack credibility unless it is backed up by a physician’s handwritten or dictated note in the office or hospital record that verifies informed consent was obtained. Defense attorneys recommend that physicians document their informed consent discussions with a note similar to this: “The patient was advised of the purpose, benefits and significant risks of this procedure, including but not limited to bleeding, infection, (damage to adjacent structures or organs) (other specific, common risks). Alternative treatments and their risks, and the risks of non-treatment also were discussed. The patient’s questions were answered. (S)he appears to understand the risks of the procedure and gives his/her informed consent.” Defense attorneys further suggest that physicians indicate in the note who else (spouse, relative) was present during the informed consent discussion with the patient.

**Important Note:** Physicians should document informed consent discussions with patients in their office progress note, a History and Physical report, or a consultation report, **but not in an operative or procedure report**, which are dictated after the surgery or procedure. If problems occur, notes about pre-operative discussions of complications or potentially adverse outcomes in these after-the-fact reports appear self-serving and may lack credibility in court.

Physicians are encouraged to ask patients to sign a plain-language consent form for elective and non-emergency office surgery at the time the procedure is discussed. Include statements on the form for the patient to validate, such as: “Dr. (name) has explained to my satisfaction the purpose, benefits and alternatives to this procedure, the significant risks, and the consequences of not having the procedure. The doctor answered my questions and I wish to proceed.”

Document “informed refusal” discussions

Several states require physicians to inform patients who refuse medically essential surgery or diagnostic tests if there are potentially deleterious consequences to their decision. Informed refusal, if it is properly documented, protects physicians from liability for decisions the patient has made after being informed of the risks. A brief chart note such as: “Patient refuses test [or procedure]; explained risks of refusing treatment and degree of urgency, and patient understands,” generally suffices.
Contact MIEC’s Loss Prevention Department for a *Claims Alert* with state-specific information on informed consent and informed refusal.

**Document patients’ noncompliance in the progress record**

Physicians should document a patient’s failure to follow advice, take medication, obtain requested diagnostic studies, keep an appointment with a consultant, or other actions the patient takes or fails to take that could cause or contribute to an injury or delay in resolution of a medical problem. Countless physicians have testified, without benefit of documented proof, that a patient’s claimed injury did not result from the physician’s negligence, but from the patient’s own action or inaction. In such cases, denials by patients or by survivors of deceased patients may appear believable when medical records do not support the defendant’s assertions of the patient’s carelessness. Sometimes documentation does exist, but it is too equivocal to resolve a dispute about what was said or done.

Each of the following notes from actual cases helped somewhat in their writers’ defense, but would have been more convincing had the italicized text been included: “patient and husband refuse internal fetal monitor; *limitation on our ability to identify fetal distress emphasized*;” “patient refuses hospitalization and surgery; *patient and wife informed of risks of surgery delay, including sudden death*;” “patient continues to use alcohol and tobacco during pregnancy; *again urged her to stop and stressed risks to fetus*;” “patient has not kept cast dry as instructed; *advised of possible delay in healing and risk of deformity; applied new cast; re-instructed pt in mother’s presence*;” “patient says he often forgets to take HTN meds; *gave him written time/dose schedule for all drugs and discussed dangers of not taking all as ordered*;” “patient refuses breast exam, says her GYN will do it next month; *I stressed urgency of prompt evaluation of lump she said she felt*."

**Chart evidence that patient education information was dispensed**

Patients can sustain an injury when they misunderstand or cannot remember a physician’s oral advice. Patients who are not educated about the scope and limits of medical care and/or about their own responsibilities for self care, keeping appointments, or taking medication, often have unrealistic expectations of their physicians, and may sue when the outcome of treatment is not optimal. Increasingly, physicians are becoming convinced that *second only to never making a mistake or never having a bad result, the most effective deterrent to patient injury and litigation is patient education*. Written information on numbered handouts that supplements oral advice and instructions helps to inform patients of their condition, medication, or treatment; transfers responsibilities to patients; and reduces the physician’s liability.
Documenting that written (or oral) medical information and advice were dispensed is essential. Some litigants claim they did not receive written material; others do not accurately recall the doctor’s oral advice or deny any was given. Documentation strengthens a physician’s defense against such claims. A note such as “PI #7” can be used to mean that the patient: (a) received Patient Information sheet #7; (b) was told to follow the written advice; and (c) was encouraged to ask questions about the material. Document oral advice with a note such as: “Discussed hypertension in detail. Pt understands med use and need for BP test every X weeks.”

**Document return visit advice in each progress note**

Conclude office visit progress notes by indicating when the patient was advised to return. Such notes help defend a physician in a malpractice case brought by a patient whose injury resulted from his or her own failure to return for follow-up. The documentation also prevents a patient whose failure to keep appointments resulted in injury from claiming the doctor was negligent for not suggesting a return visit. When no specific follow-up is required, a “return if any problems” or “return if (cite problems) occur” note means the doctor gave the patient the responsibility to decide when to return.

**Document failed and canceled appointments in the progress record**

Patients who consistently miss or frequently cancel appointments may place themselves at risk; some try to blame the doctor for injuries caused by their own negligence. Failed appointments documented in the patient’s chart are likely to be noticed by the attorney who obtains a pre-litigation copy of the medical chart to determine if a patient’s claim has merit. Few attorneys relish representing an injured patient who failed to heed a physician’s advice to return for further care. Failed or canceled appointments may be recorded in an appointment log or a computer scheduling program, but because the suing attorney does not have access to the log or scheduling system, he or she may not find out how often the patient failed to keep appointments until the lawsuit is filed and the doctor’s deposition is taken — unless the information is in the chart. The template shown in Figure 9 can be made into a rubber stamp.
Resolve medical problems from previous visit in the chart

Medical problems reported on prior visits that were not resolved should be “red-flagged” to remind the writer of the need for follow-up on a subsequent visit. For example, a physician may document (i.e., red-flag) a decision to defer a diagnostic test pending results of a short course of medication. The next progress note should cancel the red-flag alert by indicating that: (a) the problem resolved; (b) further observation is planned; or (c) other actions (referral, tests, etc.) will be taken. If the physician neglects to cancel the red-flag with a closing note and the same or a similar problem surfaces in the future, it may be difficult to distinguish between a new complaint and the older, apparently untreated one. Ignored red-flag notes are serious defense problems in “failure-to-diagnose” claims.

Brightly-colored highlighter markers can be used to flag these important notes.

Write unambiguous return-to-work or school orders

To avoid injury to a patient, return to work advice should be specific and reflect an understanding of the patient’s job requirements. Orders for the patient to return to “light work” or “limited duty” may be misinterpreted by the patient or employer, or disregarded if the job duties cannot be modified as “light” or “limited.” The doctor’s orders should specify limitations on activities such as lifting, carrying, climbing, standing, or operating equipment. Return-to-school orders similarly should list specific activity restrictions.

Avoid unsubstantiated subjective remarks in the progress record

Medical record entries should be objective. For example, it is risky to refer to a patient as a “malingering” or “alcoholic” or write that he “abuses drugs” without objective substantiation of these potentially harmful assertions. When a physical exam fails to explain a patient’s subjective complaints, it is best to say so, using professional language; e.g., “I am unable to find an objective explanation for the patient’s complaints of pain.” When making reference to alcohol, tobacco, or street drug use, include specific amounts reported by the patient. Terms such as “moderate,” “heavy,” or “occasional” are subject to broad interpretation. The physician should document objectively what the patient did or said that led the doctor to conclude the patient demonstrated “drug-seeking behavior.”

Avoid criticism of other professionals in chart notes

Comments critical of treatment by other health professionals are inappropriate in patients’ medical records. Too often, criticism is expressed by physicians who have not reviewed prior medical records or discussed the case with the previous physician, but instead relied on the patient’s
Our legal system is oriented to documents. Medical records are central documents in the defense of any malpractice case. The medical record usually is the most definitive piece of evidence presented at trial.

Charles Bond, Esq.
Appellate and Medical Law Attorney
Charles Bond & Associates

account of what occurred. Uninformed criticism of colleagues triggers a high number of unmeritorious law suits. Physicians should not use a patient’s office or hospital medical record to criticize nurses or to comment on the quality of services others provided or failed to provide. This is not to say that physicians or other healthcare professionals should suppress their legitimate concerns about patient care or about the responsiveness of others involved in the patient’s care. However, hospital and medical society peer review or quality assurance committees, not the medical record, are the appropriate forums for physicians and others to address issues related to a colleague’s competence, judgment or treatment choices.

Use prenatal forms with adequate space for data; complete forms legibly

Many prenatal forms provide minimal space for narrative notes about prenatal visits. OB-GYNs are advised to consider using a supplemental sheet for progress notes if their prenatal forms do not provide enough space to describe the patient’s complaints or lack of them, the results of physical examinations, and the substance of the doctor’s discussion and advice. A consistent finding in studies done of obstetrical injury malpractice cases was that the reviewers often were unable to piece together a patient’s prenatal course because of the scant progress notes, and therefore could not determine if the care was appropriate. The American College of Obstetricians and Gynecologists (ACOG) publishes the Antepartum Record, forms that assist physicians in their management of obstetrical patients and offer adequate space to document prenatal care. For information on ordering forms, contact: ACOG, 409 12th Street, SW, Washington, DC 20090-6920; 202/638-5577; website: www.acog.org.

Physicians should carefully review documentation in labor and delivery records prepared by hospital personnel. In these records, spaces for significant information should be filled in or voided, not left blank.

Document prenatal risk evaluation

The American Academy of Pediatrics (AAP) and ACOG’s Guidelines for Perinatal Care, as well as comments by expert obstetricians, indicate that physicians should adopt and document a formal risk evaluation system. ACOG’s Antepartum Record encourages obstetricians and their staffs to document risk factors, vital lab test results, ultrasound results, and more.
Frequently Asked Questions About Medical Records

The following are general answers to common questions about medical records. These answers are not intended as legal advice. Individual situations may require a more specific response. To the best of our knowledge, these answers are compatible with the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). State laws prevail when contrary and more stringent than HIPAA. If an answer below conflicts with your interpretation of HIPAA as it applies to your practice, please consult your HIPAA resource. If your questions are more complex than those presented below and you would like to discuss the specific details, or if you have other general questions about medical records or their release, please contact MIEC’s Loss Prevention Department. For patient-specific inquiries related to medical records or their release, call MIEC’s Claims Department.
1. Are patients entitled to a copy of their medical records?

The physician (or the medical corporation if the practice is incorporated) owns the medical records generated by the practice. A physician is not obligated to relinquish original records, but must produce them for inspection and/or copying under certain circumstances.

Upon written request, a patient, former patient, parent or guardian of a minor patient, guardian or conservator of an incompetent patient, or legal representative of a deceased patient may be entitled to inspect and make copies of a patient’s medical records. However, some states allow physicians to withhold information if, in the physician’s medical judgment, release of the information could cause serious harm or be detrimental to a patient’s mental or emotional well-being. For information about your state’s laws concerning patients’ access to their medical records, please contact the Loss Prevention Department at 800/227-4527.

2. Can the doctor send a summary of the chart rather than a copy of the complete chart?

Each state has its own requirements if a physician elects to provide a summary of a patient’s chart rather than a complete copy of a record. Physicians are encouraged to call MIEC’s Claims Department if they are considering a written summary to comply with a request for a specific patient’s medical record. The Loss Prevention Department can provide general information for the content of a summary provided in lieu of a copy of the medical records.

3. Can we charge patients, lawyers, other physicians and insurance companies for copies of the medical chart? for copies of X-rays? How much can we charge?

Generally, yes, physicians can charge patients, lawyers, other physicians and insurance companies for copies of medical charts and X-rays. However, MIEC recommends that physicians use discretion and consider community practices when charging for medical information. For example, doctors usually do not charge a co-treating physician for copies of patient records, and many do not charge patients whose chart contains only a few pages. It also is not customary to ask the insurance company that is paying for the patient’s medical care to pay for a copy of the medical records. Physicians do generally pass on the cost of copying X-rays, and are entitled to charge for copies of medical records requested by an attorney or other physicians who are not involved in the patient’s care. The amount to charge per page varies from state to state. For information about HIPAA’s and your state’s laws concerning copying charges, please contact the Loss Prevention Department.
Contact your county or state medical association for information about community practices.

Of note: Medical ethics and state and federal laws forbid physicians from withholding a copy of the medical record because a patient has an outstanding balance or cannot pay the copying fee. A patient’s continuity of medical care cannot be interrupted because of monies owed. See Question #10.

4. If our chart includes records received from another doctor, should we include the other doctor’s records when we respond to a subpoena that requests our chart? Should we include the other doctor’s records when we respond to a patient’s or attorney’s request for a copy of the chart?

Attorneys are divided on whether copies of another doctor’s records that are in your chart should be considered part of your chart, and therefore released in response to a subpoena or request for your records. Some states define “medical records” as information in the possession and control of the physician relating to any diagnosis, treatment, prognosis or history kept in connection with the treatment of a patient. Some attorneys advise that when asked to provide a copy of the patient’s medical record, a physician is required to include all of the information in a patient’s chart. Still others recommend that physicians provide only the information they have generated in their office; in such cases, the requesting party should be advised that the chart also contains partial or complete copies of medical records from other sources, and that these materials are not included in the copy. (Suggesting that requesters obtain copies of medical records from their original source is often a prudent approach, especially if you are not certain that the other doctor’s records are complete.) When you are uncertain about how to respond to a request for a copy of a specific patient’s medical records, contact the MIEC Claims Department for assistance.

5. Are law enforcement, state and federal agencies entitled to a copy of a patient’s chart upon request?

It depends on the circumstances of the request. In California, the California Medical Association warns physicians to consult with an attorney immediately upon receipt of a request for records from a law enforcement agency. In a criminal investigation, medical records may be obtained pursuant to a valid search warrant. State and federal authorities (e.g., the state medical board and Medicare) have a right of access to medical records in connection with an investigation by the entity.
Physicians may be required to release medical records to law enforcement, state and federal agencies in connection with a reportable event such as child abuse, elder and dependent adult abuse, maternal substance abuse, sexual assault/rape, domestic violence and more. If you are unsure about whether to release a patient’s chart to a law enforcement agency, contact MIEC’s Claims Department for advice.

6. **How long should we retain medical records? X-rays? Billing information?**

Defense attorneys recommend that medical records, X-rays and billing information be retained “forever.” Because of possible exceptions to the statute of limitations (how long a patient has to bring a law suit), claims conceivably can be filed many years after the incident in question. The physician’s medical record is needed in every malpractice case. Patients may require a copy of their medical record for continuity of care, for answers to medical questions years after the conclusion of treatment, and for legal or medical needs in the future.

If “forever” is impractical in your practice, consider thinning records by removing the records of: (1) patients deceased for five years or more, when death was unrelated to treatment; and (2) patients not seen for at least eight years, when the care rendered was routine and/or short-term.

Other records should be kept for a longer period of time: records of (1) patients treated for serious or chronic illness particularly when treatment involved serious injury or complications; (2) patients treated for or during pregnancy; and (3) minors (until beyond their age of majority).

When a physician moves or retires and transfers custody of original records to another physician, the records should be maintained for a minimum of ten years by the custodial physician, who promises to make the records available to the patient upon appropriate request, and to the physician-owner of the chart. Additionally, the custodian of records promises not to destroy the charts without the physician-owner’s permission.

**Hawaii:** After eight years, physicians in Hawaii can destroy the medical records; however, they are required to retain “basic information” for 25 years after the last chart entry. “Basic information” includes the patient’s name and birth date, a list of dated diagnoses and intrusive treatments, and a record of all drugs prescribed or given. X-ray interpretations or separate reports must all be retained for 25 years. Medical records for minors must be retained for seven years after the minor’s eighteenth birthday; “basic information” must be retained 25 years after the minor’s eighteenth birthday.
7. **What type of information requires special authorization to release?**

Many states have special confidentiality laws for the release of HIV test results, drug and alcohol abuse treatment, and in-patient mental health records. Federal laws also restrict the release of certain drug or alcohol treatment programs’ medical records. HIPAA privacy rules may be more permissive, but are superseded by contrary and more stringent state law. When in doubt, contact the MIEC Claims or Loss Prevention Departments, or your local medical society.

8. **Can patients prohibit us from releasing parts of their charts in response to a subpoena or other request for the medical record?**

If the subpoena or other request is accompanied by a general authorization, the physician must withhold information that is protected by special confidentiality laws (e.g. HIV test results, in-patient mental health records, and some drug and alcohol records). He/she should notify the requesting party that the chart contains state and federally protected data that cannot be released without a special authorization signed by the patient, and occasionally, by the treating physician.

However, when a patient requests that information not specifically protected be withheld from a requesting party, which is a patient’s right under HIPAA and many state laws, the physician should consider whether the omission is medically-significant and if its exclusion could mislead the recipient or result in injury. The physician should notify the recipient of the copy that information has been omitted at the request of the patient. The patient and the requesting party will then negotiate how to proceed.

For advice related to subpoenas, patients’ requests for records, or patients’ requests that information be omitted when records are released, call MIEC’s Claims Department.

9. **Do we have to send the original chart in response to a subpoena duces tecum?**

It depends on the state in which the physician practices. A *subpoena duces tecum* is the legal document used to compel production of medical records. Some states require that a physician or custodian of records make a personal appearance in court and bring the original chart. In other states, a physician can send a certified copy of the chart to the requesting party, accompanied by the custodian’s original declaration. We recommend that policyholders call MIEC’s Claims...
Department for state-specific advice and for answers to questions about how to respond to a *subpoena duces tecum*.

10. **If a patient has not paid the doctor for services rendered, can we refuse to send a copy of the patient’s medical record to another physician? to an insurance company? to the patient?**

   No. There are no exceptions for withholding records until outstanding bills are paid. The American Medical Association’s Principles of Medical Ethics state “...medical reports should not be withheld because of an unpaid bill for medical services.” A patient may have a cause of action against a physician if the withholding of the medical records results in a harmful delay of treatment or the wrong medical care.

11. **Can our original charts be turned over to the doctor who purchases the medical practice?**

   A physician who sells his/her practice may designate the purchaser as the custodian of records. The doctor may not, however, sell the records. Similarly, a physician cannot “transfer” patients to the purchasing physician’s practice. The seller may make recommendations to his/her patients that they continue their treatment with the new physician, but patients have the right to select any physician they choose.

   It is prudent to specify in the purchase contract that the buyer will: (1) be custodian of the records; (2) maintain the records in a safe place; (3) make a copy available for transfer to any doctor to whom the patient requests such a transfer be made; and (4) make the records available to the selling physician in the event that they are needed in connection with litigation. The purchase agreement also should specify that the records will be held by the custodian for at least ten years, and that the records may not be destroyed prior to that time without the selling physician’s consent.

   Some physicians, whether they sell their practice, simply retire or make a geographical move, make arrangements with a trusted colleague or partner to become the custodian of records upon the closing of a practice. A simple written agreement stating the previous four commitments and signed by the departing physician and the willing custodian of records should suffice to memorialize the understanding.

12. **What should we do if a patient asks the doctor to delete information from his or her medical record, or asks the doctor not to document certain sensitive information?**

   We recommend that physicians never delete or omit any information
they believe is pertinent to diagnosing and treating a patient. In some circumstances, improper deletion of medical information may even constitute unprofessional conduct by a physician.

Physicians should explain to patients the importance of documenting relevant information in the medical chart and how its omission may mislead others, including other physicians, who legally obtain a copy of the patient’s chart. Patients should be assured that all information in their medical chart is confidential and will not be released without the patient’s written authorization, except when the release is required by law.

HIPAA rules allow patients to request that their records be amended to correct incomplete or erroneous information by delivering a request to their physicians. (For HIPAA rules to apply, the physicians must be “covered entities” as defined by the federal regulations.) The requested amendment may be denied if: (1) the information was not created by the custodial physicians; (2) the information is not part of the health information maintained by the physicians; (3) the patient is not permitted to inspect or copy the information; or, (4) the information is accurate and complete. If the patient’s request for an amendment is denied, he/she must be informed of the reason for the denial and have the opportunity to submit a statement of disagreement to be kept in the chart, along with the original request.

13. Can we send copies of medical records by fax?

Yes, generally speaking, medical records can be sent by fax to the extent that their release has been appropriately authorized according to state law and/or HIPAA regulations. When physicians or hospitals send medical information by fax, they should take steps to ensure that the information is transmitted properly. To ensure confidentiality of faxed information:

A. Ask patients for authorization to send records by fax.

B. Establish policies governing emergency transmittals when patient authorization cannot be obtained.

C. Handle medical records transmitted by fax with the confidentiality required for any other medical records and medical information.

D. Place fax machines in areas where confidentiality is ensured.

E. Include a statement on the face sheet that: identifies the intended recipient; states that the content of the fax is confidential medical information; directs the recipient of a misdirected fax to call the sender and destroy the fax; and lists the sender’s name, fax number and telephone number.
F. Confirm the fax number before transmittal.

G. Call to confirm the fax is received by the intended party.

H. Dial fax numbers carefully. If the fax number is misdialed and the information is transmitted, obtain the misdialed number from your fax machine’s internal log and refax a request to the unintended recipient asking that the transmitted information be destroyed.

I. Do not transmit prescriptions for controlled substances to patients or pharmacies by fax.

14. How can we thin out our medical records to reduce storage space? (See Question #6)

15. What should we do if, on review of a medical record, we discover significant errors in the charting or in dictated and transcribed reports?

Changes can be made to any medical records and it can be appropriate to correct errors, and sometimes to clarify a prior note. However, to ensure that such changes are not misinterpreted or viewed as efforts to falsify the record or to conceal or deceive, all changes or additions to a medical chart should: (a) be accurate and true; (b) include the date they are made; (c) include the writer’s initials or signature; and (d) when it is not clear why a change is being made, indicate what prompted the change or addition. When a new entry significantly changes information previously recorded, the old entry should not be removed. Rather than squeeze in a change, cross out the erroneous entry with a single line, being careful not to obscure what is written, and add an asterisk to call attention to the correction written in an available space on the dictated note or on a separate piece of paper.

If the error is the omission of information that should have been included in the entry, rather than squeeze such notes between original entries, write the addition in clear space and include the date, time and initials of the person adding the information. When appropriate, explain why an entry is out of sequence or context, or what prompted the addendum. Cross-reference the new entry to alert readers of its existence.

MIEC defense attorneys stress that physicians should consult legal counsel before making a significant change to a medical record. If the notes are written weeks or months after treatment or surgery, a jury in a malpractice case may have difficulty believing that defendants could recall so many details so long after an event. Do not alter a chart note after you learn that a patient intends to sue you; notes written after notice of potential litigation may decrease your credibility. “It is
easier to defend a case in which the documentation is not ideal, but adequate,” says a malpractice defense attorney, “than it is to explain to a jury what the doctor had in mind when he or she wrote a lengthy, apologetic addendum.”

16. Do we need the patient’s permission to permit other physicians who practice in our office to see the patient’s medical records?

No. The law (including HIPAA's Privacy Act) generally permits physicians to share medical information for treatment and billing purposes with members of the same medical practice and other co-treaters. However, in a multi-specialty or large practice, physicians who are not involved in treating a patient of the practice should respect the confidentiality of each patient’s chart and follow the “need-to-know” rule, as should all employees.

17. What is the best way to destroy unneeded medical records?

Shredding or burning records are the safest ways to destroy medical records. Bonded commercial records destruction companies can be found in the Yellow Pages under “Business Records Destruction” or a similar heading. In some communities, hospitals may offer document-destruction services to members of the medical staff. Your local medical society may have the names of document destruction services.

18. Should we document in the patient’s chart incidents in which the patient was abusive to the physicians or staff?

Yes, but be objective in descriptions of the encounter. Chart entries should be specific. Physicians and their staff should objectively document what occurred, the patient’s demeanor during the encounter, and quote examples of the patient’s verbal attacks.

We also encourage physicians to establish a “zero tolerance” office policy for physically-violent or verbally-abusive patients. When a patient verbally assaults a staff member, a physician should be notified to come and speak with the patient. The doctor should decide whether such behavior warrants discharging the patient from the practice. Notify the local police immediately when a patient threatens or attempts to physically harm a physician or staff person. Call MIEC for advice about responding to specific non-emergent situations.
19. Does the doctor have to enter his or her full signature after every progress note in the chart?

No. A physician is not required to enter his or her full signature after every progress note in the chart. (Some managed care credentialing agencies, and some hospitals, insist on a full signature for each progress note; others accept initials.) MIEC recommends that physicians, nurses, medical assistants, technicians, and other staff initial or sign every entry they make in the medical record, and that a signature/initial list of all employees (including physicians) be maintained by the practice manager. Notes are more credible when their author is identified.

20. What do we do if a medical record is lost?

Notify MIEC’s Claims Department or Loss Prevention Department for assistance. In some cases, a physician may be able to recreate the chart from memory, the billing records and from discussions with the patient.

21. Should we keep duplicates of hospital reports in the patient’s office chart?

Duplicates of some hospital reports may be helpful to the treating physicians and to colleagues in the same office who co-treat the patient. However, it is not necessary to retain copies of all hospital reports, since the original reports are available in the hospital record. If you rely on information contained in the hospital record to provide treatment in the office, it is prudent to retain the copies.

22. If we send a letter discharging a patient from the practice, should a copy be kept in the patient’s chart?

Yes. Remember to send discharge letters by certified mail. The green receipt, certifying that the patient received the withdrawal letter, should also be filed in the patient’s medical record. If the certified letter is returned to your office, file it in the patient’s chart and send a copy by regular mail.
Documentation Review Self-Assessment

Instructions:
Physicians are encouraged to periodically review a selection of their own medical records to assess and maintain the quality of their documentation. The Documentation Review Self-Assessment form can be photocopied and used to document these reviews. Depending on the size of the practice and the quality of the medical record documentation, it may be appropriate to use a separate form for each provider in the practice. Or, one form may be used and the reviewer may enter pertinent notes about the habits of individual providers in the “comments” section. In some medical practices, an initial screening of the charts can be done by a qualified assistant; the assistant sets aside the charts that do not meet the listed criteria so that they can be reviewed by a physician. The results of the periodic reviews can be tracked over time and discussed at formal or informal meetings of the practice’s physicians.
### Documentation Review Self-Assessment

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<td>Allergies or “NKDA” are noted</td>
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<tr>
<td>Medication orders include the indications for use, drug name, dose, amount, directions, and number of refills authorized; renewals are clearly charted</td>
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<td>Medication renewals include all of the above, plus who authorized the renewal and the initials of the person who “called in” the renewal</td>
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<tr>
<td>Evidence of dispensed written patient education materials is charted</td>
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<tr>
<td>Failed, canceled, rescheduled appointments are documented in chart</td>
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<tr>
<td>Significant phone calls are documented (content, advice, decisions, etc.), dated, signed</td>
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<tr>
<td>No unsubstantiated, subjective remarks are seen</td>
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<tr>
<td>Criteria</td>
<td>+</td>
<td>-</td>
<td>N/A</td>
<td>Comments</td>
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<td>------------------------------------------------------------------------</td>
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<tr>
<td>Providers (including nonphysician clinicians)</td>
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<tr>
<td>Handwriting is legible throughout</td>
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<tr>
<td>Dictation is timely, and bears evidence of physician review and correction</td>
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<tr>
<td>No “Dictated but not read” stamps seen</td>
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<tr>
<td>Patient questionnaires are initialed by providers as evidence of review</td>
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<tr>
<td>Significant phone calls (including those taken while on-call) are documented (content, advice, decisions, etc.), dated, signed</td>
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<tr>
<td>Progress notes adequately detail scope of exam, findings, history, treatment, recommendations, and include:</td>
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<tr>
<td>Medical history</td>
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<tr>
<td>SOAP (or similar) format</td>
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<td>Pertinent positive and negative exam results</td>
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<td>Impression or diagnosis; rule-out list</td>
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<td>Treatment rendered in office and/or recommended for future visits</td>
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<tr>
<td>Why diagnostic tests were ordered or deferred; information reviewed by MD</td>
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<tr>
<td>Diagrams, when appropriate</td>
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<tr>
<td>Informed consent discussions</td>
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<tr>
<td>Informed refusal discussions</td>
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<tr>
<td>Documentation of noncompliance</td>
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<tr>
<td>Evidence of oral and written patient education dispensed</td>
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<tr>
<td>Unresolved medical problems are flagged, addressed and resolved</td>
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<tr>
<td>Follow-up advice given to patients</td>
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<tr>
<td>Patient-specific, unambiguous return-to-work/school orders, including limitations</td>
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<td>Return visit date or timeframe for follow-up</td>
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<tr>
<td>Specific, unambiguous referral notes including indications, urgency, and patient understanding</td>
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</table>
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