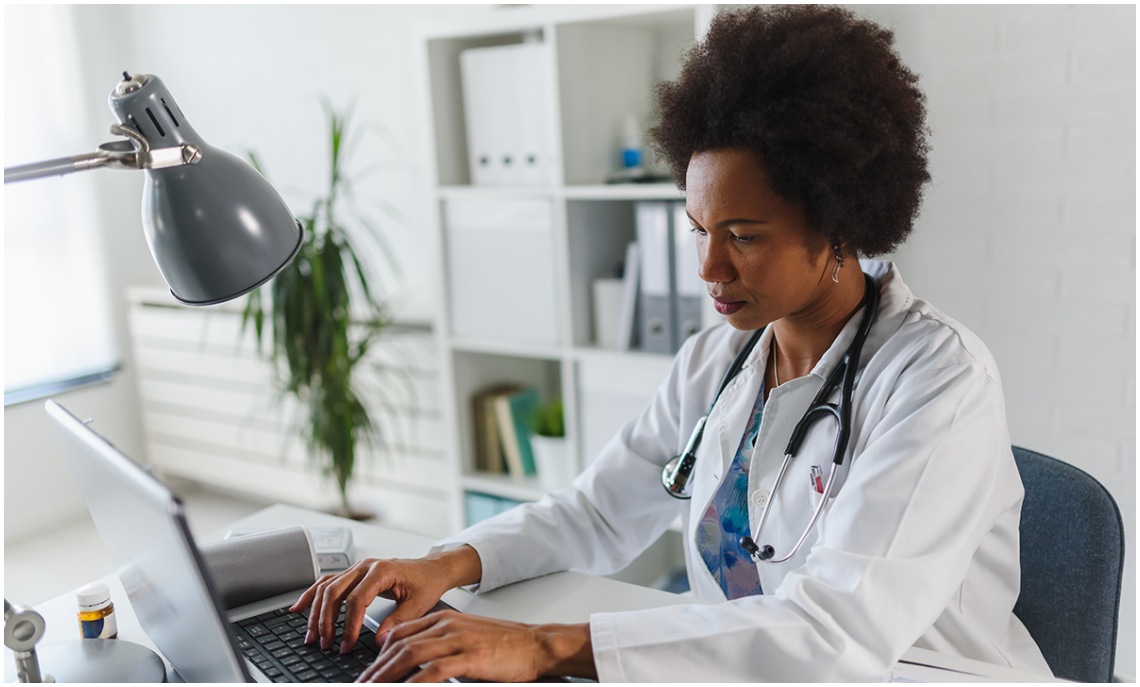
Medical Records: An Essential Element of the Defense



By Kathleen W. Smith, JD

Medical records are essential to the practice of medicine. Among several uses, medical records ensure continuity of care; facilitate effective communication among providers; serve as evidence of all pertinent facts related to the diagnosis and treatment of a patient; and serve as a basis for reimbursement. Medical records are also a critical component in the defense of a malpractice lawsuit. This closed claim shows just how important they are to a malpractice claim because this lawsuit probably never would have been filed but for the deficiencies in the record.

On September 6, 2015, new patient Jennifer Jones[1], who was then 35 years old, presented to an OB-GYN clinic for her well-woman exam. During the visit, she also reported that she recently found a lump in her right breast. Ms. Jones was seen by nurse practitioner Meredith Matthews. In addition to performing the well-woman examination, Ms. Matthews confirmed the breast lump first found by the patient. In her note for the visit, Ms. Matthews documented that the lump was a 2-3 cm mass, mobile and non-tender, in

the two o'clock position of the right breast. However, the note is completely silent as to what Ms. Matthews planned to do next. Approximately one year later, Ms. Jones, who had since moved to another state, was diagnosed with breast cancer. She underwent chemotherapy, bilateral mastectomy, and radiation. What happened during the interim between Ms. Jones' appointment with Ms. Matthews and her cancer diagnosis? This, as it turned out, became the basis for Ms. Jones' lawsuit against Ms. Matthews, her supervising physician, and her employer, the OB-GYN practice.

Ms. Jones claimed that Ms. Matthews dismissed her concerns about the breast lump during the visit, telling her that it was "just" a fibroadenoma and "not to worry about it." Ms. Jones alleged that Ms. Matthews breached the standard of care by failing to further investigate the mass, thus causing a delay in the diagnosis and treatment of breast cancer. She also claimed that Ms. Matthews "refused" to order a mammogram.

Ms. Matthews maintained that, while she advised Ms. Jones that the mass was likely only a fibroadenoma, she still recommended ordering a breast ultrasound to further investigate the mass. Then, if indicated by the results of the breast ultrasound, a mammogram would be ordered. Unfortunately, the visit note is completely silent as to this plan. Ms. Matthews believed that she was called away to assist another patient, and she just did not return to complete the dictation. The dictation ends mid-sentence, which is consistent with her explanation of being called quickly away.

Although the visit note does not document the treatment plan for the mass, other records corroborate the plan. There are numerous phone notes and messages documenting communications between the clinic staff and Ms. Jones discussing breast ultrasound vs. mammogram and Ms. Matthews' recommendation for ultrasound first, then mammogram if indicated. During discovery in the lawsuit, the phone records for both the clinic's phone and Ms. Jones' phone were obtained, and those phone records were consistent with the phone notes and messages documented in the chart. This supplemental supporting evidence was essential to the defense of the case, since it directly refuted Ms. Jones' primary claim that Ms. Matthews dismissed the significance of the breast mass and did nothing to follow up on it.

Additional corroboration was the fact that the OB-GYN clinic scheduled Ms. Jones for the breast ultrasound at the local breast imaging center. Ms. Jones did not keep the ultrasound appointment, and she never returned or followed up with the clinic. After making the ultrasound appointment, the clinic never followed up with her either.

There are several important points to learn from this case.

- Do establish a workable, reliable internal process for those times when you are unable to complete your documentation in one sitting. Determine what is workable and reliable for you and your practice. It could be anything from utilizing an internal workflow in your EHR system to writing a sticky note and putting it on your desk or computer. Plan ahead for how you will return to the work after being interrupted, because the interruptions will certainly occur. Additionally, encounters cannot be

billed until the note is completed.

- Do not simply sign off on the note. Doing so may be the reason you are included in the lawsuit. Although it was not discussed above, Ms. Matthews' supervising physician signed off on the note for Ms. Jones' visit. If you are a physician supervising an advanced practice provider, do pay attention to the note that you are asked to review. Check it like you would check your own work. If something is missing from the note that you would expect to see there, follow up with the provider.
- Do establish a workable, reliable internal process for following up with patients for whom you have ordered outside testing and follow-up appointments. What is important is that it is workable and reliable for you and your practice. The process should enable you to see who has not had the outside testing you ordered and who has not returned to the clinic in follow-up. If you need some ideas for implementing this type of process in your office, see "Tracking Procedures" for a helpful informational resource discussing this topic.
- Although this point was also not discussed earlier in the article, Ms. Jones and/or her attorney requested a copy of the clinic's chart prior to filing the lawsuit. The clinic provided most of the chart but not the phone notes. After the lawsuit was filed, the complete record was produced. When a practice is asked for a copy of a patient's record, do read the request carefully and provide copies of all documents requested. Commonly, a request for medical records asks for "each and every" document contained therein. Sometimes, providers interpret their "record" to mean only visit notes that they have created, not copies of phone notes, correspondence, or records received from outside providers. As this closed claim shows, this is a mistake that can re-surface during a lawsuit. If you ever have a question about whether or how to respond to a request for medical records, contact SVMIC and one of the attorneys in the Claims Department will be glad to assist you. We can be reached at ContactSVMIC@svmic.com or 800.342.2239.
- Finally, do take the time to document phone and other communications with patients, and make sure that your staff does the same. Although these interactions may not seem as important as the visit itself, all patient communication is important and should be documented. Without the phone notes here, this lawsuit probably would have had a much different ending.

How did this case end? After some time and discovery, Ms. Jones dismissed her lawsuit. By the time of the lawsuit, Ms. Jones was in remission from her breast cancer, and her health was otherwise stable. Her move to a new state probably made pursuing the lawsuit more difficult that she originally anticipated. Further, her lawyer likely explained just how damaging the phone notes and corroborating phone records were to her case. That evidence made it very unlikely that a jury would believe her version of events over Ms. Matthews' explanation of what happened.

[1] Names and dates have been altered.

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