Now Doctor......

I have no doubt that you are a caring and meticulous physician. In fact your examination was quite detailed. Would you please explain to the jury exactly how you examined every one of the cranial nerves from two to twelve that you indicated were normal on your exam? And while you’re at it, please explain the names of each of them.

Gotcha !!!
Always Remember ....

- What we chart is every bit as important as how we treat the patient.
- It shouldn’t be
  - But it is.
- At least in the medical-legal world.

Agenda for Today...

- This talk necessarily will cover only a few of the issues regarding charting.
- We will discuss some actual cases which resulted in litigation.
- And we will review a number of important things to remember about documentation.

Confidentiality Issues

- Obviously, care has been taken to obscure any identifying information.
- No patient names are used
- Sometimes the gender and other non-relevant facts have been changed.
- Most of the cases are real and resulted in litigation.
- Some are illustrative but based on real cases.

Case C-1

0450 hours ICU

Anesthesiologist is called STAT because the emergency physician cannot intubate a post-operative patient with stridor

Anesthesiologist’s Note

- In asystole.
- Multiple attempts by ED physician, unable to intubate
- ETT 7.0 in esophagus and left in place and immediately a Mac 3 blade 7.0 mm ETT into trachea under direct supervision
The Medical Chart
Anticipating the Lawyer’s Review

Course
- Resuscitated
- Prolonged ICU course
- Multi-organ system failure
- Patient eventually died
- This was a semi-elective intubation for a post-operative patient slowly developing mild stridor post extubation.

Question?
> Based on this note, is the emergency physician going to be sued?
> Will he lose the case?

Emergency Physician’s Note
- Multiple attempts made, with Ambu bag use in between to place ETT.
- Anesthesia called.
- Tube placed post several attempts.
- Tube then changed x 3 due to significant airway edema and patient became asystolic.

Medical-Legal Course
- Event - 2004
- Malpractice case filed - 2005
- 4 years of litigation
- Depositions of both physicians, 3 respiratory therapists, 4 nurses, 2 hospital administrators.

> Based on the depositions, the plaintiff’s attorney finally dropped the case
> After 4 years of pain for the emergency physician
> And hundreds of thousands of dollars in expense
> Why did this happen?
**The Medical Chart**
**Anticipating the Lawyer’s Review**

**Medical-Legal Course**

- CYA note by anesthesiologist
- “ETT 7.0 in esophagus and left in place and immediately c Mac 3 blade 7.0 mm ETT into trachea under direct supervision”
- Didn’t lie, but implication is clear

- EP’s note fairly good, but a bit vague
  - “Multiple attempts made, with Ambu bag use in between to place ETT.”
  - Was the ET removed or was the Ambu ventilation through esophageal ET?
  - What were O2 sats between attempts?
  - When did asystole occur?

- After years of litigation, the facts became clear
  - The EP had pulled the ET tube immediately after every failed attempt
  - O2 sats were adequate between attempts
  - Asystole occurred after the anesthesiologist had tried to change to a larger tube
  - Anesthesiologist was never sued!

**Case C-1**

What can we learn from this case?

- Anyone reading your chart a few years from now must be able to “see a movie” of the encounter.
  - Anything you would want your defense attorney and expert witness to know should be apparent from your medical record.

- This also applies to any potential plaintiff’s attorney or prospective plaintiff’s expert.

- Most lawsuits are aborted without our ever knowing we were being considered for litigation.

- Your record should make it clear to the patient’s lawyer and to any expert who reviews your record on behalf of the patient
  - That you gave excellent care
  - That a lawsuit would be a waste of their time and money.
The Medical Chart
Anticipating the Lawyer’s Review

Michael Jay Bresler, M.D., FACEP

Course Notes:

Case C-1
What can we learn from this case?

• Your goal in charting is that your record should “speak” for itself – and for you.
• You should not have to explain your actions or thoughts several years later after being sued.

Case C-1
Outcome

• The plaintiff’s attorney said that if the emergency physician’s note had been more clear, he never would have sued him.

Case C-2
76 year old woman presents to ED with several hours of mild epistaxis
• Bleeding has now stopped
• EP places anterior pack as a precaution
• Blood begins to pour out of nose
• Blood pressure drops to 60.
• Patient becomes unresponsive.

Case C-2

• Airway is full of blood
• RSI by EP with difficulty
• Bleeding eventually controlled
• Patient lives, but with some brain damage.

Case C-2

Who has a problem with the care?

• Should he have placed a pack for only mild bleeding which has now stopped spontaneously?
• That was not the issue in this case.

Would you have looked at the patient’s prior records before deciding whether or not to pack the nose?

1. Yes
2. No
Case C-2
Prior Medical Record...

- History of Osler-Weber-Rendu vascular abnormality
- Prior life-threatening epistaxis requiring 8 units of blood and ICU admission
- Note in chart:
  - “If epistaxis, apply pressure and notify ENT. Do NOT instrument this lady’s nose!”

Case C-2
What can we learn from this case?

- Review the past medical record, ideally before you see the patient.
- You’ll often be surprised at what you can learn!

Case No. 10
Presentation

- History
  - 63 yo female in MVA. c/o neck pain
    - Thinks she hit her forehead on windshield.
    - Was wearing seat belt.
    - Cervical spine immobilized by EMT-P’s.

Case No. 10
Exam

- Alert & oriented.
- Exam normal except moderate palpation tenderness - posterior neck.

Case No. 10
Course

- Cervical spine films read as normal by emergency physician.
- Immobilization discontinued.
- Neck now less tender to palpation.
- Patient can spontaneously move through relatively full range of motion, but with some discomfort.
- Discharged with cervical collar, Rx for pain, and follow-up as needed.

Case No. 10
Additional Information

- Nursing note states:
  - “Patient continues to complain of weakness.”
- RN assisted patient into friend’s car because of weakness.
### Case No. 10

**Course**
- Incomplete C-5-6 paraplegia.
- Cervical spine films were indeed normal.
- Even according to plaintiff’s radiology expert!
- There never was a cervical spine injury.
- Diagnosis was spinal cord contusion and hematoma.

**Issues**
- Was EP ever told by RN of weakness?
- Did EP ever read nursing notes?
- When were nursing notes written?
- If EP was informed, did she re-examine patient?
- Does absence of spinal skeletal injury preclude cord injury?

### Case C-3

**18 month old with fever**
- RN note
- Lethargic child.....
- EP note
  - Ears: nl
  - Chest: nl
  - Heart: nl
  - Imp: Viral

**Returns 3 days later with meningitis**
- What EP testified to in deposition
  - - and wished he would have written!
  - Initially sleepy child, but when fully awake, active, playful, and making good eye contact. Normal muscle tone.....

### Cases 10 & C-3

**What can we learn from these cases?**
- Nursing notes are part of the medical record
  - READ THEM !!!
- Same for paramedic notes!
- Beware of notes completed after patient is discharged.

**Outcome**
- Both cases settled before depositions.
Case C-4

Emergency Physician’s Note

MEDICAL DECISION-MAKING: I was very concerned for possible dissecting aortic aneurysm given her symptoms and history of thoracoabdominal aneurysm diagnosed last week. Other concerns include right lower quadrant pain from appendicitis or ischemic bowel vs obstruction vs abdominal pain and syncope from cardiac causes such as acute coronary syndrome vs seizure vs arrhythmia.

Case C-4

What can we learn from this case?

* Superb charting
* Years of litigation and potentially bad outcome avoided
* Dictation allowed inclusion of full details and timing

Case C-4

Outcome

* Case against emergency physician dropped
* Case against hospital pursued
* Nearly 3 hour delay from MSE to bed in patient with abdominal pain and known aortic aneurysm

Case C-4

What can we learn from this case?

Always consider dictating your chart, at least the “medical decision making” portion.

Explain WHY you sent that chest pain patient home.

Don’t assume the reason is “obvious”.

Juries don’t know what is obvious to doctors.
Case C-5
- 40 year old woman with isolated hand injury
- Deep laceration with documented sensory loss to two fingers
- Hand surgeon requests skin closure & agrees to see patient after the holiday weekend

Case C-5
- Emergency physician's charting documents
  - Full physical exam, including ENT, chest, heart, abdomen
  - Full ROS
- Wound is anesthetized, cleaned, explored, irrigated, closed and splinted.

Case C-5
- The patient followed up as directed with the hand surgeon
- She was left with permanent numbness
- She sued the emergency physician, who was working the holiday weekend
- She did not sue the hand surgeon, who was home having a beer and enjoying his family

Anyone have a problem with this case so far?
- 1 Yes
- 2 No

Case C-5
- At deposition, physician asked to repeat exactly what questions he asked for each of the slash marks on his ROS
- Became obvious that he had not really asked all those questions
Case C-5
What can we learn from this case?

- He was asked why he did a full exam on a healthy young woman with an isolated hand injury
- Attorney’s questions implied that he had done so in order to charge more, and had lied about ROS for same reason

Case C-5
What can we learn from this case?

- While the permanent sensory loss may have been defendable, the physician’s credibility was not
- The case settled prior to trial
- Had the charting been more realistic, this case probably would have been won by the physician -- or perhaps never even filed.

Case C-5
What can we learn from this case?

- Credibility is Crucial!
- If you chart something you cannot back up (like cranial nerves II-XII being normal) -- even if you gave excellent care -- the jury may not believe you about other aspects of your care.

Case C-5
What can we learn from this case?

- Be particularly careful with template charts. Resist the temptation to “slash & burn”.
- Document only what is accurate.
- Place your check marks and slashes very carefully.
- Similar principles apply to electronic medical records.

Some Specific Problems
Clearance for Psychiatry

Case C-6

- 27 year old bipolar male with acute manic episode. Long history of cyclic disease
- Emergency physician is asked to “medically clear” him prior to transfer to a psychiatric hospital.
- Exam and routine lab, including toxology screen, are all negative
- He is “medically cleared” for psychiatry
Case C-6

• 3 days later he is found seizing on the inpatient psychiatry unit
• Status epilepticus is controlled only after a prolonged time
• He is left with permanent neurologic disability
• His serum lithium level was extremely high.

Case C-6

• The emergency physician was sued.
• The defense argued that
  - Their tox screen did not contain lithium
  - The hospital lab could not run a STAT lithium level
  - The patient denied taking any of his meds for the past month
• The case settled after depositions

Do you have to medically “clear” psych patients?

- 1 Yes
- 2 No

How many of you feel comfortable doing so?

Anyone ???

Case C-6

“Medical Clearance” for Psychiatry

• Can a patient really be “medically cleared”?
• What constitutes an adequate evaluation?
• What should your medical record state?

Sample wording:

“At this time there is no evidence of a non-behavioral medical emergency that would preclude transfer of care to the psychiatric service (or another facility) for further psychiatric as well as medical evaluation.”
Some Specific Problems

Temporary Admission
(Holding) Orders

Case C-7

17 year old adolescent in diabetic ketoacidosis
EP orders IV fluids and insulin infusion
Primary MD agrees to admit the patient, but asks the EP to write temporary holding orders as it is now 1 am.
Patient is admitted.

Case C-7

Emergency physician’s Orders
Admit to TCU
Dr. X will revise current orders
The patient sleeps peacefully throughout the night
So peacefully that he cannot be awakened at 0800 when Dr. X makes rounds
His glucose is now 35

WHO’S AT FAULT?

1 Emergency Doc
2 Primary Doc
3 Nurses

Crucial Issue

- Who is in charge of the patient?
- Communication is essential!
  - Between physicians
  - Between physicians and nurses.

What can we learn about temporary (holding) orders?
The Medical Chart
Anticipating the Lawyer’s Review

Case C-7
What can we learn about temporary (holding) orders?

- Must be appropriate - both right now and later
- Must cover contingencies
  - What to look for
  - What to do
  - When to do it
  - Whom to call

Case C-8
36 year old diabetic presents to triage feeling light-headed.
- Took her insulin this morning but too nauseated to eat.
- Bedside glucose 55. RN informs EP
- EP writes an order for
  - 25 gm IV dextrose

Some Specific Problems
Timing of Orders

Case C-7
What can we learn about temporary (holding) orders?

- Must specify
  - Who is in charge.
  - When that M.D. will see the patient.
  - To call that M.D. for questions or problems
  - That physician must agree.

DOCUMENTATION !!!!!

Case C-7
Outcome
- In depositions, who was at fault?
  - "everyone else"
- They all settled...

An hour later, EP picks up the next chart (hers), walks into the room, and finds the patient comatose
- The nurse to whom he gave the D50 order is "on break". The covering nurse knows nothing about the order
- Bedside glucose is now 26
- The EP gives a verbal order for D50.
Case No. C-5

- Patient recovers but claims difficulty with memory ever since the event and sues the physician for delayed care.
- The only time on the order is the 2nd nurse’s acknowledgement an hour after the EP claimed he gave the 1st order.
- The 1st nurse no longer works at this hospital and attempts to reach him are unsuccessful.

Case C-7

What can we learn form this case?

- Time your orders!
- Especially with electronic health records, the only time recorded will be when you communicate with the computer.
- This will be particularly problematic with verbal orders.
- Always indicate the time the orders were given, even if charted later.

Case C-7

Outcome

- The doctor made a good witness at trial.
- The jury decided in favor of the doctor and against the hospital.
- The plaintiff’s attorney said he never would have sued the doctor had the time of his first order been charted.

Case C-7

What can we learn about timing of orders?

Do it!

Some Specific Problems

Signing out Against Medical Advice

Case 24

Presentation - 2 am

- 48 y.o. male hit head on sink
- Repetitive speech. Oriented x 2
- No obvious head trauma
- On methadone maintenance
- Head CT negative
- Tox screen + only for narcotic
- "Admitted" to Trauma Service
Case 24

Course

- No beds available - boarded in E.D.
- Agitated during night, needed restraints
- 5:30 am - haloperidol & lorazepam
- 7 am - Concerned about missing work
- 10 am - Discharged at his request
- Note - “We recommend you stay but recognize you wish to leave.”

Case 24

Course

- 1:30 pm
- Found by side of road
- Confused
- Subdural hematoma
- Bimalleolar ankle fractures
- Incomplete neurologic recovery

Case 24

Issues

- Was patient holdable against his will?
- Would signing an AMA form have sufficed?

Case 24

What can we learn about Leaving Against Medical Advice (AMA)

- Patient must be mentally competent.
- Potential consequences of AMA decision should be explained.
- Option of returning to ED should be offered
- Appropriate follow up should be arranged

Case 24

Outcome

Case settled

Some Specific Issues

Endotracheal Intubation
# The Medical Chart

## Anticipating the Lawyer’s Review

<table>
<thead>
<tr>
<th>Case No. 11</th>
<th>Presentation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>History</strong></td>
<td>47 year old male</td>
</tr>
<tr>
<td></td>
<td>Overdosed on alcohol &amp; “sleeping pills”</td>
</tr>
<tr>
<td></td>
<td>Depressed over recent divorce.</td>
</tr>
<tr>
<td><strong>Exam</strong></td>
<td>Comatose with minimal respiratory effort.</td>
</tr>
<tr>
<td></td>
<td>Cyanotic, vomitus in mouth.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Case No. 11</th>
<th>Course</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Course</strong></td>
<td>No response to naloxone.</td>
</tr>
<tr>
<td></td>
<td>Endotracheal intubation without difficulty.</td>
</tr>
<tr>
<td></td>
<td>Chest x-ray and lab studies ordered.</td>
</tr>
<tr>
<td></td>
<td>Vital signs stable.</td>
</tr>
<tr>
<td></td>
<td>EP leaves to attend other patients.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Case No. 11</th>
<th>Course</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Course</strong></td>
<td>Patient arrests 10 minutes after MD leaves the room, about 5 minutes post chest x-ray.</td>
</tr>
<tr>
<td></td>
<td>Re-examination</td>
</tr>
<tr>
<td></td>
<td>No breath sounds</td>
</tr>
<tr>
<td></td>
<td>Stomach distended</td>
</tr>
<tr>
<td></td>
<td>ET tube removed and replaced -&gt;</td>
</tr>
<tr>
<td></td>
<td>Good breath sounds.</td>
</tr>
<tr>
<td></td>
<td>Cardiac rhythm restored.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Case No. 11</th>
<th>Course</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Course</strong></td>
<td>Brain function is not restored.</td>
</tr>
<tr>
<td></td>
<td>Now in chronic vegetative state.</td>
</tr>
<tr>
<td></td>
<td>Patient is - or rather, was</td>
</tr>
<tr>
<td></td>
<td>A senior partner in city’s biggest law firm.</td>
</tr>
<tr>
<td><strong>Charge</strong></td>
<td>Esophageal intubation.</td>
</tr>
<tr>
<td></td>
<td>Loss of consortium by former wife.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Case No. 11</th>
<th>Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Issues</strong></td>
<td>Was there an esophageal intubation?</td>
</tr>
<tr>
<td></td>
<td>When did it occur?</td>
</tr>
<tr>
<td></td>
<td>Did positioning for x-ray dislodge tube?</td>
</tr>
<tr>
<td></td>
<td>Was tube properly secured?</td>
</tr>
<tr>
<td></td>
<td>Who’s responsible for that?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Case No. 11</th>
<th>Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Issues</strong></td>
<td>What documentation appears in chart demonstrating adequate ET position?</td>
</tr>
<tr>
<td></td>
<td>None</td>
</tr>
</tbody>
</table>
WHO’S AT FAULT?

- 1 Emergency Doc
- 2 Nurse
- 3 Respiratory Therapist

Case No. 11
Outcome

- The jury found
- FOR the doctor
- Against the hospital
- The dislodged due to inadequate securing by RT
- The nurses failed to detect the error in time

Case C-9
Letter to Hospital Administrator from Pain Specialist (excerpt)

- "She presented to the ED with pain, but was discharged, presumably assumed to be a drug seeker.
- "This experience aggravated her post-traumatic stress syndrome.
- "She is now on twice the dose of pain medication after her ED experience.

Case C-9

- "She was told her compression fracture was old and not new, and she was called a drug seeker.
- "She was unable to obtain assistance and was forced to wet herself.
- "She was escorted out of the ED by Security and had to wait on the hard, cold cement until a family member picked her up."
A lawsuit was filed against the hospital and emergency physician for mental cruelty and permanent psychological damage.

**Nurse’s Note (excerpts)**

- "Yelling and cursing, states ‘I want to get out of this fucking place. I’ve never been treated this way.’"
- "Apparently was told that her lumbar spine x-ray was unchanged from her old studies - all three of them…"
- 6 pages of detailed quotes from patient
  - 5 times the patient is asked by nurse to let her know how she can help her.
  - She tells her to get out each time.
  - She says she has to urinate. The nurse says she’ll be right in as soon as she puts down the blood tubes she’s holding. The patient screams that she should come immediately.

**Case C-9**

- The nurse offers to assist her to the bathroom. Is told to "fuck off, I’ll just pee in bed."
- The nurses try to change her wet sheets.
- The patient refuses to move to allow that, then complains they’re letting her lie on her own piss.
- She is offered pain meds several times, and each time tells the doctor and the nurse to “go fuck yourself”.
- She eventually stands up, sits in a wheelchair, and demands to be pushed out of the ED.
- Security complies.
Case C-9

- Outside, she gets out of the wheelchair and sits in the hospital driveway, refusing to get up until her family finally comes and takes her home.

Case C-9

- How did the doctor’s note describe the patient’s behavior?
  - It didn’t.
  - No mention is made of the difficult behavior.

Case C-9

- The nursing notes were submitted as part of the motion for summary judgment.

Case C-9

- The case was dismissed before the first deposition was even taken.

Case C-9

- Chart the patient’s exact words
- Include the profanity and the threats
- If security needs to be called, document why. It’s usually because of fear of violence.
- Call security before the situation escalates.

What have we discussed today?

- Accuracy
  - Don’t chart what you didn’t do
  - Cranial nerves II - XII
  - Detailed review of systems
  - Review the past medical history
- Read nursing and paramedic notes
  - Beware of unfinished or unavailable notes when you do yours

Some Final Thoughts
What have we discussed today?

- Time your orders
- Explain your thought process
- Dictate whenever possible
- "Medical clearance" for psychiatry
- Temporary (holding) orders
- Leaving against medical advice
- Documentation of intubation
- Exact words of hostile patient

What have we NOT discussed today?

- Write legibly
- Even better, DICTATE - at least make your through process clear
- After care instructions
- The progression of the disease process
- It’s all in your syllabus
- Read at your leisure

Some Final Thoughts...

- Everyone of us makes an occasional mistake
- Even when we don’t, the specter of litigation is always there
- We never know which patient may be a potential danger to us

Some Final Thoughts...

- The vast majority of times, what we do for our patients is correct
  - Our chart must make this absolutely clear that we gave good medical care
  - Our chart is our best opportunity to state our case.
  - We should not have to explain ANYTHING later should there be litigation

Some Final Thoughts...

- Our chart should preempt the possibility of litigation.
  - Good plaintiff’s attorneys reject 95% of cases that come to them
  - Reputable emergency medicine expert witnesses reject the majority of plaintiff’s cases they’re asked to review

Some Final Thoughts...

- Investigative reporters’ favorite question
  - What did you know?
  - And when did you know it?
- Your question to yourself re charting
  - What did I do?
  - And why did I do it?
  - Does my chart reflect this?
Some Final Thoughts...

- If our records accurately reflect these questions
- And if we provide good care and have good rapport with our patients
- We will rarely be sued