NEW!
Malpractice Rx

Tips to make documentation easier, faster, and more satisfying

Douglas Mossman, MD

Current Psychiatry's malpractice column is evolving. Previously, "Malpractice Verdicts," used case decisions to initiate discussions of clinical situations that can generate lawsuits. The verdicts remain as "Malpractice Minute" (page 86), but Current Psychiatry has invited me to contribute a new column, "Malpractice Rx," that will solicit questions and address practicing clinicians' concerns about malpractice risk.

To start this dialogue, I'll begin with a question that often comes up in discussions with colleagues, and especially when I teach psychiatry residents: "What should I document?" In this article, we will review why proper documentation is essential. We'll also look at some ideas that might make documentation easier, more efficient, and more satisfying.

Purposes of documentation

When I was in medical school, my professors said the primary reason for accurate charting was to communicate with the rest of the treatment team. This is still true. But in these sadder-but-wiser days, when I ask psychiatry residents "What is the purpose of documentation?" they always answer, "to create a legal record."

Documentation plays many roles (*Table 1*). From the standpoint of preventing a malpractice judgment, the clinical record can accomplish 3 important things:

Lawsuit deterrence. Records are a key source—and often the only source—of information an attorney uses when deciding whether to file a lawsuit. An attorney won't risk time and money on a malpractice case if the clinical record suggests that a psychiatrist was conscientious and met the standard of care.[1]

Impression management. The patient's chart is what plaintiffs' and defendants' experts use when forming their initial opinions about the quality of care delivered.

Credibility. Clinical records are the most believable source of information about what you observed, what you thought, what you did, why you did it, and when you did it. The adage "if it wasn't written, it didn't happen" is not always applicable,[2] but if an adverse event occurs,

Table 1

Purposes of medical record documentation

- **Communicate** clinical information to current and future caregivers
- **Remind** you of what happened and what you did
- **Justify** care to third-party payers
- **Inform** professional standards review organizations
- **Satisfy** accrediting agencies
- **Create** a basis for defense in a malpractice action

Do you have a question about possible liability?

- If so, please submit your malpractice-related questions to Dr. Mossman at douglas.mossman@dowdenhealth.com.
- Include your name, address, and practice location. If your question is chosen for publication, your name can be withheld by request.
- All readers who submit questions will be included in quarterly drawings for a $50 gift certificate for Professional Risk Management Services, Inc's online marketplace of risk management publications and resources (www.prms.com).

Dr. Mossman is professor and director, division of forensic psychiatry, Wright State University Boonshoft School of Medicine, Dayton, OH, and administrative director, Glenn M. Weaver Institute of Law and Psychiatry, University of Cincinnati College of Law.

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a defendant doctor's verbal testimony about delivering good care will be more convincing when backed up by documentation created before the event.

Improving documentation

Because it is impossible to describe everything you see, hear, say, do, and think during clinical encounters with patients, you must make choices about what to include in the record. The components of good documentation depend on the clinical context, but the following general principles may avert some malpractice actions.

1 **More is better.** Psychiatric practice often requires you to be discreet about patients' personal information. Within appropriate bounds, however, the more information the record contains about objective findings, patients' statements, clinical judgments, and your decision making, the better the portrayal of competent care.

2 **Record the time and date.** When attorneys and experts try to reconstruct what happened before an adverse occurrence, knowing the exact time you saw the patient, recorded findings, wrote orders, followed up on lab tests, or discussed problems with others—including family and treatment team members—can make a big difference.

3 **Sooner is better.** The most credible charting is done during or just after a service is rendered. Charting completed after an adverse event is vulnerable to accusations of fabrication.

4 **Describe your thinking.** Most aspects of clinical medicine are far from certain. Documenting the reasoning behind your diagnosis and treatment selection—what you've ruled out, what still seems tentative, and what risks and benefits you've weighed—helps emphasize this reality.[3] After some-

Table 2

6 more ideas about improving your documentation

Idea	Comment
Use speech recognition software	You speak faster than you write. Transcription software accuracy has improved in the last few years.
Use handouts and medication instructions	Patients often do not remember or understand much of what doctors tell them,[7,8] so handouts may be more useful than verbal instructions. Good handouts about medications are available on the Internet. Note in the chart that you gave the patient the document.
Seek anonymous consultations with colleagues	Documenting consultations shows you are prudent and a colleague agreed with your treatment.
Ask patients to rate their own symptoms and progress	This practice may improve your information gathering and help document what the patient told you.
Use standard rating scales	Rating scales can help you record more information in a scientifically validated format.
Use macros and templates	Macros can reduce time needed for documentation. Your memory isn't perfect, but templates can help you include everything you need to cover.

thing bad happens, people retrospectively regard the event as more probable than it really was.[4] Documenting your uncertainty and ways of addressing it may help counter this "hindsight bias." It also shows that you were thoughtful and took therapeutic steps prudently.

5 Collaborate with the patient. In some circumstances, it is appropriate to draft documents in a patient's presence. Examples might include information sent to third-party payers or referrals to other clinicians. Noting that you've done this demonstrates the patient's awareness and implicit concurrence. Also, collaborative documentation reinforces the "working together" aspects of a doctor-patient relationship and can be therapeutic.[5]

6 Clarify capacity. Jurors may believe that all psychiatric patients are incompetent, and plaintiff's attorneys sometimes try to create the impression that patients are completely controlled by weird whims and aberrant thoughts. To counter this, when appropriate indicate in the chart that the patient can handle responsibilities such as reporting side effects, seeking emergency attention, or notifying you about changes in thought or mood.[3,5]

7 Manage appearance and content. Under Health Insurance Portability and Accountability Act (HIPAA) regulations, patients have the right to review their medical records.[6] If a lawsuit occurs, the records might be read out loud in court. Documentation will make a better impression if it is clear, legible, and free of gratuitous comments.

8 Include quotations. Documenting verbatim statements from a patient, such as "I've never considered suicide," can quickly convey key information that you considered when making a therapeutic decision.

Technical approaches

Table 2[7,8] lists several techniques and technologies that might improve documentation. For example, computer users can create templates or customize software to quickly produce thorough documentation for frequently encountered procedures or

Clinical Point

Good documentation depends on the clinical context, but following some general principles may avert successful malpractice actions

Malpractice minute

We give you facts of an actual malpractice case. Submit your verdict at CurrentPsychiatry.com and see how your colleagues voted.

Was the patient still suicidal?

THE PATIENT. A 30-year-old police officer reports thoughts of suicide. He was under investigation for illegal work-related activities and feared he would have to report his coworkers' involvement in these activities and lose his job.

CASE FACTS. The patient was voluntarily hospitalized for 4 days and received medication and inpatient psychotherapy. When he was discharged, a psychiatrist prescribed follow-up outpatient psychotherapy and antidepressant and antipsychotic medications. The next day, the officer fatally shot himself.

THE PATIENT'S FAMILY'S CLAIM. The psychiatrist did not adequately weigh the patient's depression and stressors, including possibly losing his job, and did not properly assess suicidal ideation. Also, the patient's mother claims she attended the discharge meeting with the psychiatrist and that her son expressed suicidal intentions at that time.

THE DOCTOR'S DEFENSE. The patient believed he could get another job if necessary and was no longer contemplating suicide. Also, he was a voluntary patient and could not be hospitalized any longer without consent.

YOUR VERDICT ❑ LIABLE ❑ NOT LIABLE

Submit your verdict and find out how the court ruled at CurrentPsychiatry.com. Click on "Have more to say about this topic?" to comment.

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clinical events. Whether these approaches are useful and appropriate will depend on your work setting, but all aim to improve the speed and quality of clinical documentation.

Think creatively about improving documentation. Even if you're never sued, better documentation helps you and your patients. For example, several years ago a colleague[9] designed an emergency room form that allowed clinicians to complete in a few seconds a Brief Psychiatric Rating Scale on every patient we evaluated. This innovation shortened the time needed to document a systematic, comprehensive assessment and increased the quantity, quality, and reliability of information in patients' records.

References

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