Deficiencies in Documentation Make Malpractice Allegations Indefensible

Theodore Passineau, JD, HRM, RPLU, CPHRM, FASHRM

Introduction

The rendering of medical care — especially in the acute care setting — can involve various practitioners treating a patient at different times. Failure to maintain thorough and timely documentation of the patient’s care can compromise patient safety and potentially increase liability risks, as demonstrated in this interesting case from the Southwest.

Facts

The patient was a 22-year-old male who suffered a severe tibia and fibula fracture while riding his motorcycle. He was transported to Hospital X, and Dr. A (an orthopaedic surgeon) was contacted. The following morning, Dr. A performed an open reduction and fixation of the fracture. On Postoperative Day 1, the patient experienced some trouble breathing. This symptom was attributed to a small fat embolism, which was successfully treated. On Postoperative Day 3, the patient indicated he wished to go home (against medical advice). At his insistence, the patient was discharged on Day 3 and returned to his residence. During the time of his initial hospitalization, the patient never showed any signs of compartment syndrome.

The morning after the patient’s discharge, his wife contacted Dr. A. She indicated that the patient was experiencing increasing pain and had a fever. Doctor A did not document this phone conversation. The patient was transported to Hospital Y because it was closer to his residence than Hospital X. At Hospital Y, he came under the care of Dr. B, another orthopaedic surgeon.

The records from Hospital Y indicate that the patient was there for 13 days; however, during the first 3 days of his hospitalization, he was not evaluated for compartment syndrome. On his fourth day at Hospital Y, compartment syndrome was identified, and the surgical site was operated on to relieve the pressure. Several subsequent surgeries occurred after this, including a re-fixation of the fracture. (The original fixation had failed, presumably due to the compartment syndrome.)
On Day 10 of the patient’s hospitalization at Hospital Y, the facility’s plastic surgeons concluded they were not prepared to deal with the severity of the surgical wound, which remained open and in need of significant grafting. For that reason, the patient was sent to a major academic medical center, where he underwent an additional 22 days of hospitalization while the wound was successfully treated. When he left the academic center, the wound had been successfully closed. However, he had considerable residual scarring, as well as a foot drop that required bracing.

After the patient’s discharge from the academic medical center, he was not able to continue his apprenticeship in HVAC; instead, he took a maintenance position at a local hotel. Rather than pursuing physical therapy and pain management (as recommended for his injury), he began using medical marijuana in excess of what his physicians recommended. (The patient was acquiring as much medical marijuana as he could get legally and supplementing it with additional amounts from illicit sources.) Ultimately, he was not able to return to his apprenticeship, and he suffered personal issues, including a divorce.

The patient sued Dr. A and Hospital X, alleging failure to diagnose compartment syndrome. However, he did not sue Dr. B or Hospital Y. Because of the significant medical expenses associated with this case, combined with the patient’s limited potential for full employment in the future, the case was settled on Dr. A’s behalf in the midrange, with defense costs in the high range.

Discussion

From a defense standpoint, the outcome of this case was disappointing, given the patient’s noncompliance with medical advice and his excessive use of marijuana. However, the outcome can be explained.

In any type of litigation, including medical malpractice litigation, an element of “artificiality” is always present. This means that a difference exists between knowledge of facts and proof of facts. A jury verdict ultimately should be based on the proof that has been presented for the jury’s consideration. The proof may deviate to some degree from what one or more of the parties may know actually occurred. However, in the end, the proof that is presented normally controls the outcome of the case. This is one of several reasons why the documentation of medical care is so important.

Let’s begin the analysis of this case with what is known. Sometime after the patient’s initial surgery, compartment syndrome developed, and it significantly affected the outcome of the surgery — both from a functional and an aesthetic standpoint.

The compartment syndrome could have developed any time during a 6-day period (from Postsurgical Day 1 until the third day of treatment at Hospital Y). No evidence indicates that compartment syndrome had or was developing during treatment at Hospital X. In fact, based on what is known of the case, it is more likely that the condition developed during the first 3 days at Hospital Y.
However, some weaknesses in Dr. A’s documentation of the patient’s care significantly impaired the defense of this case. First, although the patient was discharged from Hospital X on Postsurgical Day 3, the discharge summary was not dictated until 3 weeks later. This point is important because, just as the history and physical tell us the patient’s condition at the commencement of treatment, the discharge summary tells us the patient’s condition at the conclusion of treatment. From an evidentiary standpoint, the more contemporaneous that documentation is with the actual provision of care, the more credibility that documentation possesses.

Documentation completed 3 weeks after the fact suffers from at least two weaknesses. First, the doctor may potentially forget the “fine points” of the case because of the passage of time. Second, in a situation such as this, the plaintiff’s counsel might portray documentation that occurs 3 weeks after care is rendered as a self-serving attempt to “cover one’s tracks.” Although Dr. A was resolute in his assertion to his defense counsel that he had not manipulated the facts in any way, a jury might not be convinced.

A second deficiency in Dr. A’s documentation was that he had no record or recollection of his phone conversation with the plaintiff’s wife on Postoperative Day 4. Phone records show that the conversation took place, but Dr. A did not document the conversation in any way. During this phone call, Dr. A may have asked questions aimed at identifying whether compartment syndrome was developing; however, with no record or independent recollection of the call, the defense counsel could not prove that Dr. A was appropriately vigilant in watching for this potentially dangerous development.

The failure to document clinically significant telephone conversations has been an issue among physicians for many years (especially when these conversations occur while the doctor is not in the office). This particular case is a prime example of how problematic the lack of documentation can be in the defense of a subsequent malpractice case.

An interesting aspect of this case is the fact that Dr. B and Hospital Y were not sued. This is surprising given that, based on the facts as we know them, it is highly likely that the compartment syndrome developed and went undetected while the patient was being treated at Hospital Y.

Also noteworthy is the fact that Dr. B served as a standard of care expert witness for the plaintiff, and he was highly critical of the care Dr. A provided. This situation is somewhat unusual because expert witnesses for either the plaintiff or the defense typically come from outside the immediate area and are not involved in the plaintiff’s treatment. It isn’t known why the plaintiff’s counsel chose to not include Dr. B and Hospital Y as defendants in this litigation or why Dr. B consented to serving as one of the plaintiff’s standard of care experts.

Acting as a standard of care expert, Dr. B was in a very strong position to criticize Dr. A’s care and place blame on him, because Dr. B
saw the patient shortly after his admission to Hospital Y. It seems likely that Dr. B’s willingness to serve as a standard of care expert for the plaintiff (especially when his deposition testimony was very critical of Dr. A) was a significant factor in Dr. A’s decision to settle the case rather than let it go forward to a jury trial.

Summary Suggestions

The following suggestions might help healthcare providers better document the provision of patient care in the acute care setting:

- When monitoring a patient for a potential complication following treatment, documenting symptoms (or lack thereof) in the patient’s record is extremely valuable.
- Documenting clinically significant conversations with the patient (or other people who have information regarding the patient) in the patient’s record is important. This includes conversations that take place by phone, either during or outside of office hours. If such a conversation takes place through email, the email should be copied to the patient’s chart.

• When a patient is discharged from care (either hospital care or office care), a discharge summary should be completed as soon as possible after the discharge. Delays in completing the discharge summary increase the likelihood of inaccuracy and decrease the usefulness of the discharge summary as evidence if needed in subsequent litigation.
• At the time a patient is discharged from care, the attending physician should review the chart to ensure that all necessary components of documentation are present and complete.

Conclusion

Documenting patient care is not the most enjoyable part of the job for most physicians. However, documentation can be critically important for coordinating care among providers, contributing to an accurate and complete medical history, and, as in this case, defending a medical malpractice lawsuit. The time invested in accurate and complete documentation will, at the end of the day, prove to be time well spent.

The information provided in this document should not be construed as medical or legal advice. Because the facts applicable to your situation may vary, or the regulations applicable in your jurisdiction may be different, please contact your attorney or other professional advisors if you have any questions related to your legal or medical obligations or rights, state or federal statutes, contract interpretation, or legal questions.


©2015 MedPro Group.® All Rights Reserved.