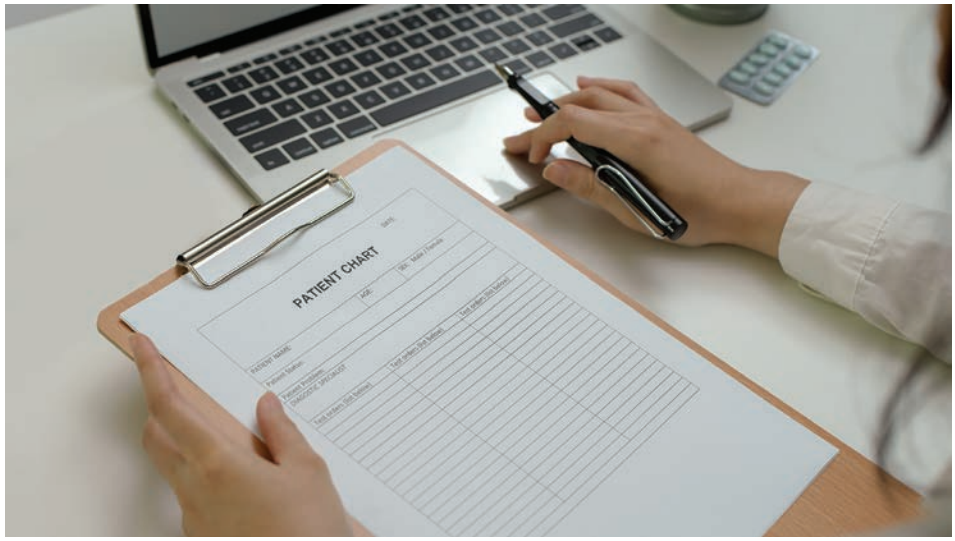
BY JARROD SHAPIRO, DPM

Documentation: Boring But Important

Complete and accurate records are your best defense.



Practice Perfect is a continuing every-issue column in which Dr. Shapiro offers his unique personal perspective on the ins and outs of running a podiatric practice.

At the risk of scaring all of our readers away, let's talk a bit about charting and documentation today. Now you're thinking, "Could there be a more boring topic?" Maybe not, but the importance of documentation is inversely proportional to how boring it is. First, remember that the chart note is your medical-legal shield. The note has to be of excellent quality, and the better the note, the better the shield. If you were a knight of the Round Table, would you have wanted your shield to be weak so your opponent could skewer you with their sword? Of course not. Similarly, maintain a strong medical shield so the lawyers can't hurt you as easily.

Before we get to it, let's point out, this article is not being written by a lawyer, and the advice given here does not constitute formal legal advice from either me personally, the folks from PRESENT e-Learning Systems, or the folks at *Podiatry Management* Magazine. Additionally, state laws vary, and it behooves every doctor to be as knowledgeable as they can about the laws in their state.

When a patient tells you how much they love you or how happy they are with the care you've given or if they bring you a gift, state so in the subjective section. This establishes that the patient was satisfied. If they later sue you.

How Does One Keep a Strong Shield? Here Are Some Ideas.

1) Include Patient Compliments in the History of Present Illness—When a patient tells you how much they love you or how happy they are with the care you've given or if they bring you a gift, state so in the subjective section. This establishes that the patient was satisfied. If they later sue you, that note may contradict comments about poor service, or how they were unhappy with how they were treated.

2) Include Complications as Soon as Possible—For some people this may sound counterintuitive. First, you should never hide a complication or poor result from a patient. That's not in the patient's best interest. It may be bruising to your ego and a difficult conversation to have, but it's better to suck it up, tell the patient you are not happy with the result, or something untoward is going on, and fix the problem. Most patients will appreciate your honesty. From a charting standpoint, stating that a complication occurred often starts the clock on the statute of limitations. If the statute runs out and then the patient wants to sue you, the case may be dismissed.

3) Keep Your Objectivity—Don't include judgmental comments or

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opinions in the physical examination. For instance, stating a patient is obese is okay (though it's technically a diagnosis), but it's not specific enough. Use descriptors such as "central adiposity" or include a BMI. Also, don't include diagnostic terms in your physical exam. For example, if a patient has a bunion, describe what it looks like without saying it's a bunion. One option could be something like "medially prominent 1st metatarsal head with valgus rotation of the hallux abutting the 2nd toe." This keeps it professional.

Don't include judgmental comments or opinions in the physical examination.

4) Include Images—Just about all common electronic medical record systems allow importation of clinical pictures into chart notes. Remember, a picture is worth a thousand words. It also makes a note more comprehensive and informative and lets others know better what is going on.

5) Show Your Thought Process—Part 1—We're all taught that the chart note should consistently, from start to finish, justify the diagnosis leading to a reasonable treatment plan, and this remains true. For example, if your diagnosis is right foot cellulitis, then the history and physical sections had better say something about signs of infection (fever, chills, malaise, nausea, erythema, edema, drainage, malodor, etc.).

6) Show Your Thought Process—Part 2—This recommendation had to have its own number. For those of you doing surgery, if you don't already do it, it is strongly suggested to add a section in the assessment or plan for your rationale for picking whatever procedure you're planning. First, it's just good charting to clearly state what you're going to do and why. Second, for those of you pending board certification, this will clearly explain your choices, making it more likely you'll pass the case submission portion.

As a final bonus recommendation, include in the plan details about any counseling and education. Risks, benefits, and complications of surgery should be stated in your note, not only that you discussed them but what they actually might be. If you prescribe a drug, it is your legal responsibility to counsel patients on potential side-effects, but don't forget to list those potential side-effects and what to do if they occur. Include in the note if the patient has been non-adherent or non-compliant. If you told a patient at the last visit to be non-weight-bearing at all times after a bunionectomy, and they walked all over it, enter that in the chart. If they sued you after, say, for a non-union, your documentation may establish *comparative negligence* in which the plaintiff is responsible for some part or all of their injury.

Risks, benefits, and complications of surgery should be stated in your note, not only that you discussed them but what they actually might be.

These suggestions can easily create longer chart notes, but most EMR systems allow templates to be created that you can use and modify as necessary without too much extra wasted time. Build up that shield with your excellent charting and avoid the sword. **PM**

Dr. Shapiro is editor of PRESENT Practice Perfect. He joined the faculty of Western University of Health Sciences, College of Podiatric Medicine, Pomona, CA in 2010.