TALE AS OLD AS TIME: AVOIDING THE PITFALLS OF MEDICAL RECORD DOCUMENTATION IN THE AGE OF TECHNOLOGY

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It's the *tale as old as time, song as old as rhyme* – documentation is a *beast*. We live in the 21st century where news can travel around the world in a matter of seconds, food can be seen in a refrigerator without opening a door, and automobiles can navigate the freeways without human input. However, despite living in the age of technology, hospitals continue to struggle with maintaining complete and accurate documentation of medical records. The transition to electronic medical records has proved to be a grueling evolution, and while electronic records have improved some of the pitfalls, it has also created new ones. Currently, many healthcare facilities are stuck in a hybrid system where some records are stored electronically, while other records continue to be filed away in hard copy. During this transition, focusing on keeping accurate and well-documented medical records is more important than ever. Accurate and thorough medical record documentation is crucial for professionals in all areas: lawyers and risk managers need to adequately defend physicians and their records; physicians and medical professionals need to keep thorough documentation to provide quality care; and insurance adjustors need the ability to use documentation when evaluating claims.

TUNE AS OLD AS SONG: THE EVOLUTION OF MEDICAL RECORD DOCUMENTATION

Due to the emergence of electronic medical records (EMRs) and continuous speech recognition (CSR) technologies that allow the spoken voice to be translated into computerized text, many forget that medical record documentation and the corresponding issues are not an invention of modern times. The earliest semblance of medical record documentation can be traced back to cave paintings – depicting procedures such as spine manipulation to relieve pain – that date back to 17,500 B.C. From there, the Egyptians progressed and began to record anatomical research and supernatural healing techniques by sketching hieroglyphics on papyrus and stone tablets. After centuries of discovery spent on herbal medicine, blood-letting, and rudimentary surgical procedures, modern medical records came to the forefront in the 17th century with the increased curiosity of the pathology of diseases and the advent of case books and annotated medical experiments.

By the early 20th century, medical records were kept by modern transcription. To begin, transcription was completed in shorthand with the assistance of nurses and secretaries. Eventually, typewriters took over as the predominate method of transcription, and in due course, tape recorders became the easiest way of recording the physician's orders. In the 1960s, "problem-oriented" medical records became the standard in record-keeping. Rather than simply documenting a diagnosis and treatment plan, physicians were now using medical records to safeguard a collection of patient data capable of aiding other health providers in continuous healthcare.

With the advancement of technology, the "problem-oriented" records morphed into what is now known as EMRs. Electronic medical records

were developed with the goal of creating an easily accessible, streamlined method of providing quality care among various health care providers. However, despite compelling intentions, EMRs and the hope of creating an idealistic system of documentation has fallen short. For instance, most hospitals in the United States are stuck in a hybrid system consisting of both electronic and paper medical records. According to HIMSS Analytics, as of the last quarter in 2016, less than 5% of hospitals in the United States were completely electronic in their record-keeping. Moreover, the consequences of poor record-keeping continue to plague healthcare facilities around the country.

LEARNING YOU WERE WRONG: CONSEQUENCES OF POOR RECORDKEEPING

Most lawsuits that arise in the context of healthcare are civil cases that revolve around alleged medical negligence. For instance, take this basic example: Patient sues physician for negligent care which patient claims resulted in an injury. In this simple scenario of a medical malpractice case, there is one piece of evidence that has the power to make-or-break the physician's case: the medical record. Unlike other types of evidence, the medical record is the only type that can be prepared fully and accurately before a lawsuit comes to fruition. By the time the lawsuit is filed, healthcare providers can have a solid and defensive piece of evidence ready to protect both their license and reputation; however, there is a Catch-22.

Well-documented medical records can be a physician/defendant's best defense, but illegible, inaccurate, or incomplete records can weaken or even destroy the chances of defensibility. Poor documentation, including contradictory statements, missing data, and incoherent plans of treatment are just a few examples of the problems that have afflicted medical records for centuries. Some of the most often cited consequences of poor documentation include:

- Increased value of the lawsuit for the plaintiffs
- Incentive to pursue cases against healthcare providers
- Break in the continuum of patient care
- Miscommunication between physicians, staff, and patients
- Duplicative, omitted, or inaccurate insurance billing

These examples, among many others, illustrate how poor medical records can make it difficult for attorneys, expert witnesses, and risk managers to evaluate whether a claim is meritorious or frivolous. In fact, poor documentation in medical records is one of the deciding factors in many malpractice cases which ultimately are decided in the plaintiff's favor. The reason for this is simple – people are more apt to believe what is written rather than what is not.

For years, patients and their attorneys have abided by the old adage: "If it's not written in the medical record, then it didn't happen." While probably erroneous in its entirety, this adage sadly rings true in many cases where the healthcare provider's documentation is sloppy or sparse. However, the solution to this problem is not necessarily writing more, but writing objectively, accurately, and efficiently. Overall, record-keeping does not require an exorbitant endeavor – rather, it only takes a little change to make a transformation with lasting impact.

JUST A LITTLE CHANGE, SMALL TO SAY THE LEAST: REMEDIES TO FACILITATE CHANGE

When given the choice, juries are more likely to trust a healthcare provider whose documentation supports their testimony. Regardless of a physician's education, experience, or resume, no one wants to see a medical record that includes contradictory complaints, missing allergies, or illegible handwriting. Further, not only are medical records critical in the defensibility of a medical malpractice lawsuit, but also in providing quality, thorough, and continuous healthcare to patients. Unlike the disjointed, jargon-filled EMRs of today, medical records should read like a book. Ideally, individuals should be able to pick up a medical record and be able to visualize the patient depicted in records: *his age, his appearance, his past medical history, his current health status*, and so forth. From a multidisciplinary standpoint, this allows all members of the healthcare chain to function efficiently. For instance, the importance of quality documentation transcends the four walls of a hospital:

- *Attorneys* utilize medical records as a defense mechanism in a wide variety of areas such as medical malpractice, long-term care facility litigation, employment law, and products liability litigation.
- *Risk Managers* rely on medical records when identifying risks and formulating plans on how to combat these uncertainties.
- *Insurance Executives* for commercial insurance providers and malpractice insurance companies use medical records when evaluating potential clients who wish to be insured.
- *Claims Adjustors and Managers* for commercial insurance providers and malpractice insurance companies review medical records when investigating claims, evaluating liability, and negotiating settlement values.
- *Human Resources Personnel* for hospitals and healthcare facilities review medical records when hiring, credentialing, and evaluating employees for raises, promotions, and privileging.

Changing old habits can be difficult, and with the sweeping force of EMRs, modifying the robotic nature of medical records can be daunting – but it doesn't have to be. Here are three tips that will instantly improve all record-keeping: (1) Resist the Temptations of EMRs – do not simply checkmark boxes, do not copy and paste; and do not forget to add narrative; (2) Tell the Story – document objective observations; document patient conversations in quotations; and document accurately, thoroughly, and efficiently; and (3) Get Back to Basics – double check the simple aspects that are often overlooked – are the records organized, dated and signed, legible, complete? Abiding by these three tips will not guarantee perfection, but they will improve the overall quality of the record.

BITTER SWEET AND STRANGE, FINDING YOU CAN CHANGE: MOVING FORWARD

Ultimately, despite the fact that medical records have existed in some form or another for thousands of years, our society continues to struggle with medical documentation. However, documentation is just as critical as the medical care itself. Individuals from all disciplines rely on medical records in their everyday work, and with the ongoing transition to EMRs, ensuring that records are organized and well-documented is more important than ever. Poor medical record-keeping may be the *tale as old as time, song as old as rhyme* – but with *just a little change, small to say the least*, documentation can be a *beauty* and not a *beast*.*

**Céline Dion and Peabo Bryson, Beauty and the Beast (Walt Disney Records 1991).*

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