Clinician Reviews®

Good Notes Can Deter Litigation

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At 11:15 PM on August 31, 2014, a 19-year-old surgical technician with the United States Air Force presented to the emergency department (ED) of a hospital with lacerations to his right hand and fingers. At about 10:30 PM, he reported, he and his girlfriend had been sitting in the car, waiting for a late-night screening at the movie theater, when an unknown assailant reached through the open window of the driver's side and slashed him with a knife. He said that he raised his right hand over his face to protect himself and ended up with lacerations to his pinky, ring, middle, and index fingers. (The police were subsequently notified and interviewed the patient and his girlfriend at the hospital. No arrests were ever made.)

While in the ED, the patient was examined and treated by a PA. At approximately 12:13 AM, the patient underwent an x-ray of his right hand. The PA personally reviewed the x-ray that he had ordered and saw no abnormalities. The x-ray was later interpreted by a physician as exhibiting no significant arthropathy or acute abnormality of the bones, no visible soft-tissue swelling, and no fracture or dislocation.

Given the lack of any positive pertinent findings, the PA irrigated the patient's wounds and applied 1% lidocaine to all affected fingers so that pain would not mask any potential physical exam findings. He also used single-layer absorbable sutures to repair the injured digits. In addition, the PA tested the plaintiff for both distal interphalangeal (DIP) and proximal interphalangeal (PIP) flexion function and recorded normal results.

The PA discharged the patient from the ED at 5:56 AM on September 1, 2014. The patient was instructed to follow up with his primary care provider within 2 to 3 days for a wound check. He was also prescribed bacitracin to be applied 3 times a day, 500 mg of Keflex, 600 mg of ibuprofen, and hydrocodone/acetaminophen.

The PA provided no further care or treatment to the patient following the visit to the hospital's ED. However, the patient contended that he suffered an injury to the tendons of his right hand, which ultimately required several surgical procedures. He sued the hospital, the PA, the PA's medical office, his supervising physician, and the physician who performed the later surgical procedures. The supervising physician and the surgeon were ultimately let out of the case by summary judgment motions. The hospital, which was named as a defendant under a *respondeat superior* theory, was also dismissed from the case when it was established that the PA was employed by his medical office and not by the hospital directly. The PA stipulated that he was within his course and scope of employment at the time he treated the plaintiff.

Plaintiff's counsel contended that the defendant PA was negligent in his examination and evaluation of the plaintiff's digit lacerations and that he was negligent for failing to splint the plaintiff's hand. Counsel also contended that the defendant was negligent for failing to refer the plaintiff to a hand surgeon (either directly or through the plaintiff's primary care provider) and/or for failing to seek the assistance of his supervising physician, who was on site at the hospital's ED and available for consultation.

Defense counsel argued that the defendant met the applicable standard of care at all times, in all aspects of his visit with the plaintiff in the early morning hours of September 1, 2014, and that there was nothing that he either did or did not do that was a substantial factor in causing the plaintiff's alleged injuries and damages. The defendant claimed that upon his arrival at the patient's bedside, the plaintiff verbally indicated to him that he could move his fingers (extension and flexion). He also claimed that he visualized the plaintiff moving his fingers while they were wrapped in the dressing that the plaintiff had placed on himself after the injury-producing event. However, the plaintiff disputed the defendant's claim, denying ever being asked to extend and flex his fingers. The plaintiff also claimed that he never was able to make a full fist with his fingers on the night in question while in the ED, either by way of passive or active flexion.

Defense counsel noted that the defendant's dictated ED note stated that the range of motion of all the plaintiff's phalanges were normal, with no deficits, at all times while in the ED. The defendant testified about

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how he tested and evaluated the plaintiff's DIP function. He also testified that he had the plaintiff lay his hand on the table, palm side up, and then laid his own hand across the plaintiff's hand so as to isolate the DIP joint on each finger. He explained that he then had the plaintiff flex his fingers, which allowed him to determine whether there had been any kind of injury to the flexor digitorum profundus tendon (responsible for DIP function in the hand). The defendant claimed that he did the test for all the lacerated fingers and characterized them as active (as opposed to passive) flexion. Thus, he claimed that his physical exam findings were that the plaintiff had full range of motion (ROM) intact following the DIP function testing, which helped him conclude that the plaintiff did not have completely lacerated tendons as of that visit.

The defendant further explained that if the tendons were completely lacerated, the plaintiff would have had nonexistent DIP functioning on examination. The defendant testified that if he suspected a tendon laceration in a patient such as the plaintiff, his practice would be to notify his supervising physician in the ED and then either refer the patient to a primary care provider for an orthopedic hand surgeon referral or directly refer the patient to an orthopedic hand surgeon. He claimed that he took no such actions because there was no indication, from his perspective, that the plaintiff had suffered any tendon damage based on his physical exam findings, the plaintiff's ability to make a fist, and the x-ray results.

VERDICT

After a 5-day trial and 7 hours of deliberation, the jury found in favor of the defendants.

COMMENTARY

As human beings, we do a lot with our hands. They are vulnerable to injury, and misdiagnosis may result in life-altering debility. The impact is even greater when one's livelihood requires fine dexterity. Thus, tendon lacerations are relatively common and must be managed properly.

In this case, we are told that the PA documented in his notes that the plaintiff had range of motion in all phalanges and no deficits. We are also told the defendant testified regarding his procedure for hand examination. But we are *not* told that his note included the details of his exam—and by inference, we have reason to suspect it did not.

You might think, "The jury found in favor of the defense, so why does this matter?" Because a well-documented chart may *prevent* liability.

If you wish to avoid lawsuits, it is helpful to understand how they originate: An aggrieved patient contacts a plaintiff's lawyer, insists he or she has been wronged, and asks the lawyer to take the case. Often faced with the ticking clock of statute of limitations (the absolute deadline to file), plaintiff's counsel will review whatever records are available (which may not be all of them), looking for perceived deficiencies of care. The case may also be reviewed by a medical professional (generally a physician) prior to filing; some states require an affidavit of merit—an attestation that there is just cause to bring the action.

Whether reviewed only by plaintiff's counsel or with the aid of an expert, a well-documented medical record may prevent a case from being filed. Medical malpractice cases are a huge gamble for plaintiff firms: They are expensive, time consuming, difficult to litigate, document heavy, and technically complex—falling outside the experience of most lawyers. They are also less likely than other cases to be settled, thanks to National Practitioner Data Bank recording requirements and (in several states) automatic medical board inquiry for potential adverse action against a medical or nursing professional following settlement. Clinicians will often fight tooth and nail to avoid an adverse recording, hospital credentialing woes, and state investigation. A medical malpractice case can be a trap for both the clinician and the plaintiff's attorney stuck with a bad case.

In the early stages of potential litigation, before a case is filed in court, do yourself a favor: Help plaintiff's counsel realize it will be a losing case. You actually start the process much earlier, by conducting the proper exam and documenting lavishly. This is particularly important with specialty exams, such as the hand exam in this case.

Here, simply noting "positive ROM and distal CSM [circulation, sensation, and motion] intact" is inadequate. Why? Because it is a conclusion, not evidence of the specialty examination that was diligently performed. The mechanism of injury and initial presentation roused the clinician's suspicions sufficiently to conduct a thorough hand examination—but the mechanics of the exam were not included, only conclusions. The trouble is, those conclusions may have been based on sound medical evidence or they may have

been hastily and improvidently drawn. A plaintiff's firm deciding whether to take this case doesn't know but will bet on the latter.

The clinician testified he performed a detailed and thorough examination of the plaintiff's hand. Had plaintiff's counsel been confronted with the full details of the exam—which showed the defendant PA tested all the PIPs and DIPs by isolating each finger—early on, this case may never have been filed. *Thus, conduct and document specialty exams fully.* If you need a cheat sheet for exams you don't do often, use one—that is still solid practice. If you don't do many pelvic exams or mental status exams, make sure you aren't missing anything. Practicing medicine is an open-book exam; if you need materials, use them.

Good documentation leads to good defense, and any good defense lawyer will recommend the *Jerry Maguire* rule: "Help me help you." Solid records make a case easier to defend and win at all phases of litigation. Of course, this is not a universal cure that will prevent all lawsuits. But even if the case is filed, the strength of your records may have convinced stronger, more capable medical malpractice firms to turn it down. This is something of value: It is "you helping you" and potent proof that your human head weighs more than 8 lb.

IN SUMMARY

A well-documented chart may prevent liability by showcasing the strength of your care and preventing no-win lawsuits from being filed. Help the plaintiff's attorney realize, early on, that he or she is facing a costly uphill battle. The key word is *early*, when the medical records are first reviewed—not 18 months later, when the attorney hears your testimony at deposition and realizes that he or she has invested time and sweat in a case only to learn that your care was fabulous. Showcase that fabulous care early and short circuit the whole process by detailing the substance of a key exam (not just conclusions) in the record. Detailed notes may spare you from a visit by a sheriff you don't know holding papers you don't want. **CR**