How to Create and Maintain a Legally Defensible Medical Record to Protect Your Clinic

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In today’s litigious society, it is more important than ever for veterinarians to practice defensive medicine. Equine practitioners have several unique issues that make it particularly problematic for them to practice defensive medicine. These issues include but are not limited to practicing ambulatory medicine, which may necessitate using owners and trainers for animal restraint, as well as having a direct relationship with trainers and farm managers but often not with the owners themselves. Other issues include horses with multiple owners—each with their own insurance company and their own financial and emotional interests—and the high monetary value of some of our patients.

The primary step in practicing preventative medicine is to prevent misunderstandings with owners and agents. This is achieved largely through clear communication. The responsible party must understand all the procedures that are going to be performed on their horses—or the horses in their care—as well as the associated risks, costs, and prognosis. Many lawsuits arise when what the veterinarian thinks they said is different from what the owners think they heard. The best way to avoid this issue is to make sure the owners and agents understand what is said, giving the owner time to ask questions and having a description and estimate of a given procedure in written form so that a responsible party can read, understand, and sign the document once they are satisfied with the discussion.

Medical records are your first line of defense. Every time you write in a medical record, you are writing a legal document that could be read in court and could potentially affect, or possibly end, your career. One procedural mistake in a medical record could put the entire record in question as to its accuracy or validity. It must be noted that many complaints made to the State Boards of Veterinary Medicine are dismissed after the state board reads a complete and accurate medical record. A quick review of the proper guidelines for medical records are as follows:

1) Write everything in blue or black ink and not in pencil or red ink. All entries should have the date and time noted and should be signed (or initialed) as they are put in the record. The record should be legible and should not contain any abbreviations that are not universally known, understood, and accepted.

2) There should not be any blank lines. If you skip a line, a lawyer may claim that you left a blank area in the medical record and then went back later to fill it in and did not use up all the space left blank. Additionally, one should not write in margins or
below and above the lined areas. Again, this may encourage a lawyer to claim that entries were added to the medical record at a later time.

3) Anything that is changed should have a single line drawn through it. The reader should be able to read what has been crossed out. There should be a date, time, and signature along with an explanation as to why the item was crossed out. An example of this would be with “2/19/2012 written in wrong chart” written next to it and then signed or initialed.

4) Do not go back and add anything to the record on a previous line. If you forgot something put it on the next available line and write “addendum” at the beginning of that line and state the time that the item was performed.

5) Everything that is discussed with the owner, trainer, insurance company, referring veterinarian, consulting veterinarian, and so on, should be written in the chart. Even conversations that occur in remote locations should be added into the chart as soon as possible.

6) Additionally, all treatments and observations throughout the day should be listed. Mundane observations such as fecal production and water consumption can become important if a hospitalized horse has development of colic. Even in the absence of disease, these observations are evidence of your continued monitoring and care of your hospitalized patients. Certainly, all procedures and all physical exam findings should be placed in the record. Normal findings are important to record because they may protect you in the future. For example, if you do not record a horse’s normal temperature, you cannot prove that it did not have a fever or that you even checked its temperature.

7) If consent is needed you should have the owner or agent sign the consent form. If this is not possible and consent is given over the phone, you should consider having two people gain consent from the owner. Both people should record it in the medical record. A faxed, signed consent from the owner can be added to the record until an original can be obtained.

8) On field calls, your physical examination should be recorded. An example is that when you look at a foal with contracted tendons you should not just record “bandages applied.” You should explain why you are doing any procedure. In this case, for example, for treatment of bilateral front fetlock contracture. Detailed information is important. In this case, for example, if tetracycline was given, then record the amount that was given and if it was diluted in a liter of saline and given through a catheter.

9) If multiple treatment options are given to an owner, be sure to record each option, with all pertinent information such as projected costs and prognosis. You should record which option the owner chooses and, if possible, why the owner chose that option. This is particularly true if the owner or trainer declines referral. Make sure that you record that referral to a specialty center was recommended or offered. If you consult with a specialty clinic about any case, record the communications with that clinician.

10) We recommend having the owner/agent sign the farm call invoices to acknowledge that the treatment was administered.

Confidentiality is paramount in any medical profession. A simple way to anger a client is to disclose private medical information concerning their animal(s) to a third party. As a referral hospital, we routinely have performance animals in our barn. When a client is in the barn, he or she may recognize the animal and ask questions regarding its condition. Disclosing information could greatly affect an animal’s value, result in significant problems with an owner, and potentially cause a lawsuit. We cover any names on halters with white tape. Records are kept in an area where only employees have access. It is very important to emphasize to your lay and professional staff that they should not disclose any medical information about a client’s horse to anyone—this includes even confirming that the animal is present at the hospital. In high-profile cases, the client is consulted and dictates the amount of information that we can release, if any. Additionally, all employees have a confidentiality clause in their contract, and lay staff members sign a confidentiality agreement.

The most important thing to remember with regard to communication is to be honest with owners. Mistakes will occur, but that is not equivalent to malpractice. Open communication and explanation are critical. An example of this comes from orthopedic surgery cases: on occasion, drill bits or screws can break, and these issues should not be hidden from owners. Communication must be initiated, including prognosis, treatment necessity, and options. We referred a yearling Thoroughbred horse back to its original surgeon to remove a transphyseal screw that he had placed. There were issues with the placement of the screw, and we believed that the surgeon who placed the screw would be better prepared to remove it. After surgery, the horse was returned to the farm, with no problems reported. Four months later, while taking survey radiographs for the yearling sales repository, it was discovered that the screw had broken off, and half remained in the leg. This information could have been better handled if we had known about it before the sale.

Another example seen frequently involves the intra-arterial injection. As long as you have used normal accepted procedures when giving an intravenous injection, recognized the problem when it occurred, and treated it appropriately, malpractice is not an issue. This is a known complication and accepted risk. I often hear owners being told that their horse had an allergic reaction to a particular drug—not to an intra-arterial injection. This is an unnecessary lie that makes things more difficult.
later and results in bad feelings with the owner when they eventually learn the truth.

In our hospital, we take a photograph of every horse both when it arrives and when it is discharged from the hospital. Any lesions or cuts that may be present are photographed. These photographs are date- and time-stamped and are added to the medical record. Digital photography is increasingly accessible with the advent of camera phones. It is relatively inexpensive as well. Photographing lesions and problems allows for objective evaluation of the progress of a case without relying on subjective memories, and the images are easily shared with owners who may not be the animal’s primary caretaker.

We weigh each horse on admission and discharge. This allows for more accurate drug dosing and protects the hospital from owner complaints about lost weight while the horse was hospitalized. We use a digital scale, although a weight tape and calculation can be used. Additionally, body score and condition is noted on the admission physical examination.

With business and case communications being increasingly conducted through text messaging, text messages are becoming part of the legal and/or case record. There are several ways to print text messages with the dates, sender, and recipient recorded in the printout. Such methods include specific software programs that transfer data from a phone, to forwarding messages to an e-mail, or even taking photographs of the text messages. Phone calls are summarized in the records and are often followed up with an e-mail stating “to reiterate our conversation of such date and time...” followed by a synopsis of the conversation, which is also printed and added to the medical record. This practice is also beneficial in that it gives the client the opportunity to better understand what was discussed during the conversation and for disputing the validity of the conversation.

On occasion, communications by phone, text, or fax are disputed by the client. When a document is faxed to a client, we record the date and time the item was faxed. We also keep a binder with the printed logs from our fax machine showing all incoming and outgoing faxes. This prevented, in one case, a judgment being vacated because the client claimed we never faxed a letter to them. We were able to prove, in a matter if moments, that we, in fact, did fax the client and that the fax was received. In addition, phone bills can be used to prove a phone call or text message was made or received, although the content of the message cannot be proven.

Communications through the United States Postal Service are also often disputed by our clientele in legal cases. When important documents are mailed by United States Post Office First-Class Service, you can ask for a certificate of first-class mailing. This is simply a receipt with the recipient’s name and address and the date that it was mailed. This costs less than a dollar and is significantly less expensive than sending certified mail. It is legal proof of mailing, although obviously it does not prove content. In the rare instance that proof of content is required, we have our office staff mail the document and then write a sworn statement stating the content of the mailed document. This statement is then notarized.

In some instances, owners will make complaints to the state board or file for malpractice when they are compelled to pay a bill. Often, they threaten to do so first; therefore these cases are not a surprise. At this time, you must decide if the benefit of bill collection is worth the time defending yourself to a court or state board. We always pursue payment in these cases. Although this may not always be a good financial decision, it is our business policy because we believe that it is important to defend our reputation and support any associate veterinarians who are named in the complaint.

It is important to know all the individual state laws and rules governing the practice of veterinary medicine. There are variations in laws even in neighboring states. For example, in Massachusetts, an owner must give informed written and witnessed consent before tranquilization of any animal. Therefore, before you sedate a horse for a dental or other procedure, you must have the owner sign a consent form and have it witnessed. A signed invoice after a procedure or the fact that the owner gave verbal consent and held the horse for the tranquilizer injection is not sufficient. They can still claim they did not give prior consent. This is different from the laws in neighboring New York State.

In today’s world, social media outlets such as Facebook and list servers are becoming more and more prevalent. Remember: Anything that you put on the Internet can always come back to haunt you. Nothing should be written that cannot be viewed by clients or defended in court, even on a personal Facebook page. A list server recently featured a thread regarding the necessity of wearing sterile gloves for castrations. Several veterinarians commented that this practice was not necessary and was an unnecessary expense. Individual veterinarians may agree or disagree with this statement, and it should be noted that a percentage of castrations will become infected despite precautions. Additionally, owners and/or trainers should be told both in verbal and written form of the possibility of complications from castration, including infection, with each procedure. It would be counterproductive to a defense if an owner brought you to court for an infected castration and could provide written documentation that you did not wear gloves because of the expense.

With owner ability to research on the Internet, the idea of regional standard of care is becoming less prevalent to almost nonexistent. It is difficult to support a claim that you had no knowledge or understanding of a treatment being performed on the other side of the country. Internet searches and
list servers make information readily available to all clinicians, no matter where they are located. Additionally, common surgery such as umbilical herniorraphy in a young foal is often safely performed in the field. If no hospital is readily available in the geographical area, complications are easier to defend because regional standards of care would dictate a field procedure. However, if a hospital is available and a complication occurs (even a commonly accepted complication), you may have to defend your decision not to offer referral for the surgery. If you offered and the owner declined and you can provide documentation, no defense is needed. A certain percentage of horses will have a complication such as an infection or dehiscence; therefore, this issue may arise. This does not mean that every surgery must be referred—just that documentation is necessary.

If you have any suspicion that a malpractice suit or complaint may be filed, it is imperative that you notify your malpractice carrier immediately. Failure to inform a malpractice carrier in a timely manner may void your coverage. Even more importantly, they may have suggestions on how to proceed. The malpractice carriers and their attorneys have much more experience and the legal knowledge to better handle the case. They may instruct you to cease communications with the client and let the attorney handle all ongoing issues. They will also provide you guidelines for the information you should start gathering to provide the most successful outcome.