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Perspectives on clinical risk management

THE WHOLE STORY: *The Importance of a Comprehensive Patient History* Goals, Objectives, and Disclosures

A comprehensive patient history is often the key to a correct and timely diagnosis. This activity, an update of a *Perspectives* article first published in 1999, examines some of the issues that may arise when physicians try to address a patient's medical concern or problem without having a complete patient history. Case studies from ProMutual Group's closed files are used to illustrate the potentially grievous impact that an incomplete history can have upon the health or life of a patient. Risk management principles designed to help physicians increase patient safety through the use of full and complete patient histories are presented throughout the activity.

For successful completion of this activity, physicians will read the provided article and answer supplied questions at www.pmgcme.com for a maximum of 1 AMA PRA Category 1 Credit™.

Learning Objectives: At the completion of this activity, participants will be able to:

- Use a form in such a way that it maximizes the opportunity for patient care.
- Take six specific steps to identify spousal abuse.
- Maximize the security of electronically held confidential patient information through the implementation of at least six specific steps.

Author: Linda Greenwald, MS, RN, Editor, Physician Education Publications, ProMutual Group

Advisor: Maureen Mondor, Vice President, Physician Education, ProMutual Group

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Target Audience: Physicians, all specialties

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ProMutualGroup®

Physician Education Department

101 Arch Street
P.O. Box 55178
Boston, MA 02205-5178

800/225-6168
617/330-1755
Fax: 617/330-6995

www.pmgcme.com

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Linda Greenwald, MS, RN
Research and Writing

Jennifer Werner
Layout

THE WHOLE STORY

The technological and scientific advances that have brought American medicine to the cutting edge of health-care can lull one into believing that in patient care, only state of the art equipment is important, only sophisticated tests lead to correct diagnoses, and only expensive drug therapies cure. Technology and science have their place in medicine, to be sure. However, when the basic, time-tested elements of patient care are sacrificed to sophistication and complexity, both patient and physician may suffer.

There is perhaps no art in medicine that is more basic and, as the cases that follow indicate, more important than the gathering of a comprehensive patient history. In all too many instances, however, the histories taken—and given—in physician offices today are curt, not comprehensive. Some physicians, pressured by the demands of a busy practice, limit their history-taking to asking the history of the patient’s present illness. Others, conscious of the time it takes to take a truly complete history, ask patients to fill in a preprinted form during the first visit and then fail to use it. Another group, acting on their personal (and sometimes erroneous) assumptions, may refrain from asking portions of the history they consider irrelevant. Yet others, uncomfortable with or unsure about how to elicit a history about issues such as spousal abuse, simply avoid that part of the history.

Some patients may not divulge information they find embarrassing or consider unnecessary; others may choose to lie or deliberately withhold information. The physician who suspects these tactics may pick up (and then act on) telltale cues from the patient: evasiveness, hesitation, contradiction, too long a story, or too few words. In the absence of such signs, it is not the physician’s responsibility to uncover lies or to probe unreasonably. It is, however, up to him/her to ask all the questions appropriate to a comprehensive history, to document the patient’s responses,

to elicit additional information as necessary, and to weigh the patient’s history when making medical decisions on the patient’s behalf.

CASE STUDIES

In many instances, a thorough history can be a better diagnostic tool than sophisticated testing and extensive laboratory workups. Unfortunately, the histories included in many medical records are sketchy at best, absent at worst. Sometimes they reflect only what the physician has asked. In other instances, they reflect merely what the patient has chosen to offer. It is the gaps between the asking and the offering that are likely to lead to litigation. Consider the following:

Incomplete Family History

Case 1: *A 57-year-old man who had been under the care of an internist for hypertension for eight years reported blood in his stool for two weeks. His medical history was significant for a melanoma in-situ and a basal cell carcinoma, both successfully removed. The family history in the record was a written note documenting only an absence of familial hypertension and cardiac disease. No complete physical examinations were recorded. The gastroenterologist to whom the patient was subsequently referred learned from the patient that both his father and grandmother had died of colon cancer. Flexible sigmoidoscopy revealed a sessile polypoid adenocarcinoma which was surgically removed. However, the cancer had metastasized, and the patient succumbed within months. The family brought suit, alleging failure to diagnose cancer.*

Commentary

The defense experts who reviewed this case faulted the physician for the absence of three factors: a complete family history, cancer screening, and physical examination.

An incomplete family history is implicated in a significant number of ProMutual

Group's cases alleging failure to diagnose, and particularly those alleging failure to diagnose cancer. A positive family history of cancer, heart disease, or other disease entity may help raise

should have a documented family history in his/her medical record. In many practices, the patient fills out a preprinted history at the time of the first visit. However, in some

helpful if they are used, not merely filled out and then filed. The history form that serves merely as a prop given to patients may jeopardize the safety of the patient and provide a point of entry into litigation for the physician. Consider the case that follows:

“The history form that serves merely as a prop may provide a point of entry into litigation for the physician.”

the suspicion of a physician who might otherwise not consider the problem as part of his/her differential diagnosis.

Positive family history may alert the physician to the need to be particularly focused and up-to-date with cancer screening. By virtue of his age alone, the patient in Case 1 was a candidate for colon cancer screening. His family history of colon cancer would have reinforced the advisability of discussing and, it is hoped, scheduling a colonoscopy for this at-risk patient.

In some cases, a positive family history triggers early, and potentially life-saving cancer screening. In one instance that resulted in gratitude rather than litigation on the part of the patient, an asymptomatic woman in her early thirties went to a new internist for a routine annual visit. When the internist learned that the patient's family history included an aunt and a grandmother who had been diagnosed with breast cancer, he suggested a baseline mammogram “just to be safe.” The patient was diagnosed with ductal carcinoma in-situ and chose to have a mastectomy. Today, over 10 years later, she is healthy and well and grateful to a physician who based a treatment plan, in large measure, on family history.

Risk Management Principles

- 1. Document a family history for every patient.** Every patient

cases, patients who present only for episodic care are asked for no family history or, in some cases, a family history relating only to the issue at hand.

- 2. Consider expanding the definition of family.** Ideally, for purposes of the history, “family” should extend beyond parents and siblings. As the woman with DCIS noted above can attest, it is the extended family whose stories may prove life-saving. In many offices, a form that is filled out at the time of the first visit asks the patient to check off the illnesses that a parent or sibling may have had. If the form cannot be modified to ask for information about any family members' illnesses, a discussion between physician and patient should include that information, which is then documented.
- 3. Update family history as needed.** Families are not static. Their stories, like the patient's, need to be updated to reflect changes that have the potential for impacting the patient and, in some cases, the treatment options offered by the physician.

Misuse of Forms

Asking the patient to fill out a history form is the practice of many medical offices. These forms, like others that are included in the medical record, can be

Case 2: *A 47-year-old female went to a physician for a routine physical. The woman was asked to fill out a history form before being examined. On that form, in a space marked “other,” she wrote, “Pain in...” and never finished the thought. The patient allegedly made no reference to the unidentified pain when she met with the physician, and the physician did not ask her what she had planned to write. All parts of the physical exam were documented as “WNL.” Eight months later the patient complained of a painful breast mass she stated she had had at the time of the earlier visit. Diagnosed with an adenocarcinoma with metastases, she subsequently expired. The family charged the physician with negligence, alleging failure to diagnose cancer.*

Commentary

Defense experts were critical of this physician's failure to follow up with the patient and elicit more information about the pain she mentioned but did not detail on the form. The absence of follow-up led the physician experts reviewing the case for the defense to question whether the defendant physician had seen or read the form at all.

History forms are most helpful when they are used either as a supplement to obtained information or as a basis for discussion with the patient. The form in this case was an end in and of itself. In addition, its importance appears to have been discounted by the physician, who overlooked the incomplete information on it.

Forms are not a necessity in medical practice. However, they can be a helpful way of keeping and comparing data and information. The physician who chooses to use medication and/or problem lists, patient history, physical examination, and/or cancer screening forms, and other flow sheets must make sure they are complete and current. Unanswered questions, half-written answers, and blank spaces may both compromise patient safety and open the door to medical malpractice litigation.

A final note recorded by defense experts concerned the physician's use of the abbreviation "WNL" on the preprinted physical examination form. Writing "WNL" is a commonly accepted way of indicating a negative finding. Others include making a checkmark, drawing a horizontal line, or drawing a circle with a line through it. None is preferred. However, good risk management dictates that a symbol or set of letters written once at the top of a page and then continued through a long list with a single vertical line is not acceptable. In the case of litigation, one might question whether individual attention was given to each question, body part, or system. It is better to make one distinct mark for each entry on the form.

No matter the abbreviation or symbol used on any form, flow sheet, or, for that matter, anywhere in the medical record, it should be accompanied by a written key of explanation that is kept on file in the office. In the case above, no such key existed and it was difficult, in retrospect, for the experts to determine the extent or details of the breast examination that was documented simply as "WNL."

Risk Management Principles

- 1. Consider using a form to supplement, not replace, the patient's verbal history.**

- 2. Make sure a history form that is used by the patient leaves space for narrative.** Checkmarks are easier to read, but they may not tell the entire story. Invite questions on the form or include two or three printed lines at the end for the patient to "add any information that you think is important for the doctor to know."
- 3. Review with the patient any history form or questionnaire he/she has filled out and clarify any questions or blanks.**
- 4. Keep forms current and complete.**
- 5. Discard from the record any forms that are completely unused.** Forms that are only partially used may be kept in the record. However, on these forms there should be a note explaining, for example, "form discontinued on [date]," "form replaced by [name and location of new form]." The note should be dated and initialed.
- 6. Initial a form after reviewing it with the patient and before it is filed in the medical record.**
- 7. Use a written key to define the meaning of each symbol or abbreviation used on a form, flow sheet, or other record.**

Assumption, Not History

In some cases, patient histories are left incomplete. The problem may be mechanical. That is, the history form may be too abbreviated or the patient may not have had time to finish filling it out before being called into an examining room. More likely, the patient may fail either to remember important information or to recognize certain information as important. Sometimes the physician

makes assumptions that exclude a necessary question or line of questioning. Consider the following:

Case 3: *A 24-year-old woman with a decidedly Irish name presented to her obstetrician at seven weeks gestation. The physician obtained a medical, family, and social history. All were benign and considered non-contributory to the pregnancy, which proceeded uneventfully until at 39 weeks, the woman gave birth to an apparently healthy female with Apgar scores of 8 and 9. At five months of age, however, the child began exhibiting neuromuscular symptoms that were found to be consistent with Tay-Sachs disease. The patient sued the physician for negligence, citing his failure to perform the prenatal genetic testing that would have revealed the presence of the Tay-Sachs gene and enabled the patient and her husband to determine whether or not to continue the pregnancy.*

Commentary

Defense experts in this case noted that the physician had relied on his erroneous assumption that at least some of the patient's history could be found in her name. In fact, it was her husband who was Irish; she was an Ashkenazi Jew. The physician's failure to elicit an ethnic history and to act on fact rather than assumption led to his subsequent failure to discuss with her the potential implications of her heritage on the fetus.

Many of the obstetric history forms that have been revised since this case was filed now include genetic information, including ethnic heritage. However, ProMutual Group's cases indicate that some physicians are still likely to make and to act on quick and erroneous assumptions that not only prevent the gathering of an accurate and complete patient history but also delay or preclude an accurate diagnosis.

In some cases, needed screening or diagnostic testing is not ordered because the patient may be too young, too old, or the wrong gender. In other cases, presenting symptoms may not fit the textbook presentation of a potentially fatal illness and the physician, assuming something less benign, begins an inappropriate treatment regimen. What these physicians learn in the litigation process that follows is that assumptions have no place in clinical practice. In the case below, physician assumption was joined by naiveté to deny the patient a timely and correct diagnosis.

Case 4: *An internist in private practice had as a patient a woman who first presented in his office when she was 48. For 12 years thereafter, she visited the physician regularly with a myriad of non-specific complaints but no identifiable illness. Diagnostic studies were all negative and the patient declined referrals to specialists. The internist eventually gave up private practice to devote time to working in an ED. One evening, his ex-patient presented to him in the ED complaining of chest pain and acute anxiety. She attributed her symptoms to her son-in-law's violence toward her daughter. With further discussion, the patient admitted that her daughter's situation duplicated her own. She admitted that she had been being abused throughout all the years she had been a patient of the physician—and well before.*

Commentary

If one believes the stereotype about spousal abuse, all of its victims are poor, uneducated females. In truth, spousal abuse does affect primarily women. However, it crosses all cultural and socioeconomic boundaries. Despite the fact that spousal abuse is an issue of growing national (and medical) concern, many physicians remain uncomfortable with or unknowledgeable about the topic.

Believing, or wanting to believe spousal abuse does not affect their patient population, they retreat into denial and silence and risk depriving their patients of a correct diagnosis. Until it is ruled out, domestic violence should be considered whenever a patient presents with facial injuries, fractures, bruises, burns, and/or a spectrum of unspecified complaints.

In all but the rarest cases, the initiative in uncovering an instance or pattern of spousal abuse must be the physician's. To do justice to all his/her patients, every patient history should include a question about the patient's relationship with her/his partner. Each patient, whether homeless drug addict or wife of a prominent clergyman, should be asked, sensitively and in the absence of the partner, "Are you comfortable in your relationship with your partner?" "Has your partner ever hit you or hurt you or frightened you?" If the answer to the latter is positive, options, including hot lines, local shelters, and advocacy groups, should be discussed. In many cases, the physician will be able to do no more than offer emotional support until the patient actively seeks help.

There are currently few malpractice claims dealing with spousal abuse, and many people see the issue as a social, not a medical, concern. However, as more abused women present in physicians' offices and EDs, it is reasonable to foresee future claims and suits filed by women or the families of women whose death or permanent emotional incapacitation and/or physical impairment might have been prevented if the physician had recognized the signs of spousal abuse and counseled the patient early about her options.

Risk Management Principles

1. **Include in every patient history a question about the patient's relationship with his/her partner.**

2. **Suspect denial on the part of the patient** if details of her/his account of what happened seem vague or incomplete.

3. **Be aware of your own denial** if you find it difficult to approach the topic of domestic abuse with a patient. For the good of the patient, try to separate personal feelings from professional responsibilities and to the best of your ability, try to elicit information from the patient about possible abuse.

4. **Take care not to communicate disinterest or judgment** by failing to raise the topic of spousal abuse.

5. **Have a list of resources** available for the patient who admits being a victim of spousal abuse. This list should include, at a minimum, the telephone numbers of a local crisis center, counseling service, shelter, and hot line. You may also wish to consider posting these numbers in a waiting room, patient bathroom, or other areas readily accessible.

6. **Know state laws concerning the reporting to authorities of domestic abuse.** In many states, including a number of those where physicians are mandated reporters of the abuse of an elder, disabled adult, or child, domestic abuse is *not* reportable.

Privacy and Security Concerns

Despite the physician's best attempts to elicit a comprehensive patient history, his/her efforts may be foiled by patients who choose to pepper the history with half-truths or to completely withhold vital information. A study conducted by WebMD indicates this group represents a substantial minority. In that overview of 1,500 respondents, 13 percent admitted lying to their physicians, while an

additional 32 percent owned up to “stretching the truth.”¹ The topics that tend to lend themselves to such activity are diet, exercise, smoking, sex, alcohol use, the use of recreational drugs, alternative and over-the-counter therapies and supplements, and failure to follow a prescribed treatment regimen.

Fear is the underlying reason that most patients embellish—or withhold—the history they share with their physician(s). Some fear being seen as a “bad patient,” while others fear incurring their physician’s anger or judgment. A greater fear for many is the fear that their insurance coverage will be cancelled or denied when an insurer learns, from physician records or billing information, the details of a genetic, family, or medical history. A growing fear on the part of many is a breach of privacy as electronic medical records and other patient files are moved between healthcare providers.

At one point, secrets too personal to be revealed even to family members were considered safe in the hand of one’s physician. In this electronic age, with security leaks commonplace, identity theft a growing reality, and stories about personal snooping available simply for the asking, many patients censor what they tell the physician. Some withhold, some lie, and some walk tentatively, offering to divulge what may be life-saving information only by first trying to extract from the physician a promise not to document it anywhere. What they fail to realize is that at a critical moment, however, this strategy may not only jeopardize their own health but also compromise the professional integrity of the physician.

To obtain a patient’s whole story while still respecting his/her right to privacy and his/her fear of any breach of that right, physicians might take some or all

of the following steps to secure the privacy of the patient information in their offices.

- 1. Make sure that the office is fully compliant with the HIPAA Privacy and Security Rules.**
- 2. Require that every staff member sign a confidentiality agreement** before beginning work with patient information.
- 3. Consider requiring a separate agreement for those who are given access to the computer system.** Included in this agreement might be a statement concerning disciplinary action(s) that may follow the unauthorized accessing of confidential information.
- 4. Use a system of passwords** to allow different levels of access to electronic data.
- 5. Monitor the use of passwords and access codes** to identify employees who try to gain access to data beyond their level of security.
- 6. Consider coding sensitive information,** for example, information about HIV status, psychiatric history, or substance abuse history, in a way that makes it inaccessible to all except those with a need to know. One approach is the assignment of a designated password to those who are given unrestricted access to the system.
- 7. Consider encrypting data** that is transmitted to or from a remote location.
- 8. Conduct random audits** to make sure that data integrity and security are maintained.

9. Maximize the security of the system with the use of anti-virus, anti-spyware, and anti-adware software in addition to firewalls and intrusion detection software.

10. Consider locking computers, particularly laptop computers and other equipment containing personal health information. Alternatively, keep such equipment in a locked area when unattended.

To help patients feel safe in the revealing of personal information, physicians may wish to consider the following:

- 1. In a written statement that is included on the history form a patient is given, make the patient aware of the importance of a thorough and documented history in his/her ongoing care.** Many practices ask patients to initial that statement.
- 2. Give the patient the opportunity to tell his/her story,** not merely to check off a series of boxes.
- 3. Share with the patient the practice’s confidentiality policies** and assure him/her that, although no absolute guarantees about privacy can be made, the practice (a) is sensitive to every patients’ right to privacy and (b) has taken every possible step to ensure that right.
- 4. Try to bolster the trust of patients** who ask that certain information not be documented. Affirm their privacy concerns but explain to them the potential negative consequence of excluding from the medical record data that at some future time may prove key in helping the physician make a correct and timely diagnosis or select an appropriate treatment.

5. **Document all discussions** about any patient's reluctance to offer a full history.

Conclusion

The importance of a comprehensive and regularly updated patient history cannot be minimized, either from a clinical or a risk management perspective. As the case studies in this activity indicate, clinical decisions made in the absence of a complete history may prove incorrect and the failure to diagnose a serious condition because of an unawareness of familial tendency, a failure to elicit a vital part of the medical or surgical history, and inattention to a detail in the social history may lead to malpractice litigation.

The patient history is not a document but a process, one that requires interchange between physician and patient. Attempts to shorten the process may save time in the present but cost a life in the future. The physician who reduces a patient history to a series of checkmarks deprives himself/herself of the opportunity to learn the patient's whole story. The physician who elicits only a selective history from the patient risks basing a clinical judgment on a half-truth. And the physician who omits a history deprives himself/herself of the opportunity to understand the patient as a person rather than as a medical problem, illness, or disease.

In this age of gadgets, gizmos, and extremely sophisticated technology, the patient history is often considered one of the lesser tools in the physician's armamentarium. As the point of entry into the patient's thinking and feeling and hurting and hoping and fearing, it should be valued as one of the greatest.

Reference

1. Raymond J. Little White-Coat Lies. *Newsweek*. 8 Jan 2009. Available at <http://www.newsweek.com/id/178493>.

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