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Use of a mock deposition program to improve resident understanding of the importance of documentation

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ABSTRACT

Introduction: It has been estimated that the probability of a physician being involved in a medical litigation by 65 years of age ranges from 76 to 98% depending on specialty. We hypothesized that a mock deposition held by a medico-legal expert attorney could effectively increase awareness of the importance of accurate and complete medical documentation.

Methods: Pre and post-lecture and mock deposition surveys were analyzed and the contents evaluated. Residents and attendings from the surgical, medical and OB-GYN departments participated. Results were analyzed through frequency distribution.

Results: A total of 62 participants attended, 42 completed the pre-survey, while 24 completed the post-survey. Majority had no prior experience in malpractice lawsuits. After the post-survey, 95.8% believed that incorporating the mock deposition may reduce documentation error.

Conclusion: Based on the results of the surveys we concluded that a mock deposition exercise provides a means for education residents regarding the importance of medical documentation.

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Introduction

It has been estimated, that the probability of a physician being involved in a medical litigation by 65 years of age ranges from 76 to 98%, depending on specialty.[1] In 2014 alone, total amount of medical malpractice paid, according to the National Practitioner Data Bank, was nearly $3.2 trillion.[2] Not only do physicians have to face monetary repercussions, but as shown by the Medscape Malpractice Report of 2015, it was estimated that greater than 40 h were spent on defense preparation and more than 50 h on court and trial related meetings.[3]

Also, illustrated by the Medscape Malpractice Report of 2015, of those involved in a medical litigation, the most common change of practice included "better chart documentation".[3] A survey done by Evans et al., in 2007 revealed that the extent of medico-legal education that residents received was inadequate and that concentrated legal education could improve physicians' knowledge base regarding medicolegal interactions.[4] In consideration, we have hypothesized that a mock deposition held by a medicolegal expert attorney, involving resident physicians, could effectively increase awareness of the importance of documentation and potentially reduce the incidence of malpractice claims.

Methods

Prior to initiation of the study, Institutional Review Board approval was obtained. A survey analysis was conducted, in which the survey was given prior to and after a mock deposition and lecture. Both surveys were anonymous and were distributed to residents from several specialties including surgery, obstetrics-gynecology, and internal medicine. The pre-survey was created to assess the knowledge base of the residents, prior to any formal training, in regards to documentation and medicolegal repercussions. The contents of the pre-survey can be seen in Table 1.

The session consisted of a mock deposition and a lecture, held once, after the pre-survey and prior to the post-survey. The mock deposition consisted of one case selected at random. A selected resident and an attorney from our institution independently reviewed the case prior to the deposition. During the deposition, the case was deliberated and weakness of the documentation were revealed to the audience. After the mock deposition, a lecture followed which again highlighted potential weaknesses in the documentation and how changes and detail could have further

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Table 1
Pre-survey assessment of knowledge.

1. Demographics: age, type of residency program, postgraduate year in training
2. Prior involvement in a malpractice lawsuit
3. If he/she has been named a defendant in a lawsuit
4. If he/she has ever initiated a malpractice claim against a physician, other medical professional, or health institution
5. If he/she has ever been deposed for a malpractice lawsuit
6. If he/she has ever testified in court for a malpractice lawsuit
7. His/her understanding of the process of a deposition
8. To state their level of knowledge regarding the steps involved in bringing a malpractice lawsuit to trial
9. His/her perception of the importance of accurate documentation in the medical record
10. Rated opinion of the quality of documentation done by the attending physicians with whom he/she currently work with? With residents with whom he/she currently work with?
11. How does he/she feel about the amount of resources offered for documentation, coding, billing, and medicolegal education
12. Has he/she received or are expected to receive any training in documentation, coding, and billing
13. His/her perception of the importance of accurate documentation in the medical record
14. Rate the importance of documentation in the medical record, as compared to the importance of direct patient care
15. Rate his/her own documentation in the medical record
16. Which items he/she feels are important to include in the medical record to protect himself/herself in the event of a lawsuit? How often does he/she include these items?
17. How concerned he/she is with being involved in a lawsuit or deposition

protected the defendant in the case. Additionally, the medicolegal aspects of a malpractice lawsuit were outlined.

After the session, residents were given an anonymous post-survey which assessed knowledge learned during the deposition and lecture. Further, it assessed how their documentation habits had changed. The post-survey contents can be found in Table 2.

Results

A total of 62 participants attended, of which 45.0% were internal medicine resident physicians, 27.5% general surgery resident physicians, 20.0% obstetrics-gynecology resident physicians, and 7.5% were attending physicians. 43 completed the pre-survey, while 24 completed the post-survey. Average age was 26–35 years (76.7%).

From the pre-deposition survey, in regards to prior malpractice lawsuit experience, the majority lacked prior experience, this included: no prior involvement in a malpractice lawsuit (78.6%), never a defendant in a lawsuit (88.4%), never initiating a malpractice claim (100.0%), never being deposed for a malpractice lawsuit (86.1%), and has never testified in court for a malpractice lawsuit (97.6%). Similarly, when asked to rate their level of knowledge in regards to malpractice lawsuits, the majority of respondents felt as though they were a novice (61.0%), while the remaining (39.0%) felt somewhat knowledgeable.

Although subjects felt they had a lack in knowledge regarding medicolegal litigations and documentation, the majority (90.2%) recognized the importance of accurate medical documentation, and 70.7% believed that accurate documentation is equally important to direct patient care. In terms of the perception of their own documentation, answers were split between “accurate but not complete” (48.8%) and “detailed and accurate” (51.2%). Conversely, when asked to rate their colleagues' documentation, most deemed it “accurate but not complete” (43.9%), while some stated it was “inadequate” (31.7%). Finally, regarding attending physicians with whom they work, 61.0% of respondents felt that it was also “accurate but not complete”.

Of the respondents, 48.8% stated that they “often” include the four key components of changes in plan of care, radiological results, clinical status change, and medication changes. The remaining “always” (34.2%) or “sometimes” (17.1%) include these four key items. While the majority (70.7%) felt that they have received some training regarding the importance of documentation, most felt that they were “somewhat satisfied” (46.3%) or “not satisfied” (36.6%) with the quantity and quality of medicolegal litigation and documentation training.

In the post-survey, almost all attendees (79.2%) agreed that accurate documentation was “very important”. Importance of the key components in the medical record increased in all four areas including: change in plan of care (87.5%), radiographic results (70.8%), clinical status change (95.8%), and medication change (70.8%). Interestingly, only 33.3% responded that they “always” include these four components; the remaining participants stated to “often” (58.3%) and “sometimes” (8.3%). 70.8% of respondents have changed their clinical practice to have more complete/accurate documentation and 97.5% of total participants felt as though they have an increased understanding of the importance of documentation after the mock deposition and lecture.

Nearly all respondents (95.8%) believed that incorporating such mock depositions into a residency program may reduce documentation errors. Additionally, 91.7% stated they would be interested in participating in another mock deposition in the future.

Discussion

As stated before, medical malpractice is a significant burden to practicing physicians. Documentation is one key factor that can be

Table 2
Post-survey assessment of knowledge.

1	After the mock deposition, his/her perception of the importance of accurate documentation in the medical record
2	After the mock deposition, which items he/she feels are important to include in the medical record? How often does he/she now include these?
3	Has he/she had a change in clinical practice by having more complete and accurate documentation after participating in the mock deposition
4	If participation in the mock deposition improved his/her understanding of the importance of documentation in the medical record
5	If he/she believes incorporating similar exercises and lectures into a residency program may ultimately reduce errors in medical documentation
6	His/her interest in participating in another mock deposition in the future

Final results were analyzed through frequency distribution.

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