Risk Management and Liability Prevention: 
The Importance of Proper Medical Documentation

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General Medical Records Requirements

• A physician shall maintain medical records for patients which accurately, legibly and completely reflect the evaluation and treatment of the patient. The components of the records are not required to be maintained at a single location. Entries in the medical record shall be made in a timely manner.

• The medical record shall contain information sufficient to clearly identify the patient, the person making the entry if the person is not the physician—such as a physician assistant or a certified registered nurse practitioner—the date of the medical record entry and patient complaints and symptoms.

• Clinical information pertaining to the patient which has been accumulated by the physician, either by himself or through his agents, shall be incorporated in the patient’s medical record.

PA Code, Title 49, Chapter 16, Subchapter F § 16.95. Medical records.
Specific Medical Records Requirements

Medical records. Accurate and complete medical records must document the evaluation and care received by patients.

(i) On the initial occasion when a drug is prescribed, administered or dispensed to a patient, the medical record must include the following:

(A) A specification of the symptoms observed by the licensed health care provider and reported by the patient.
(B) The diagnosis of the condition for which the drug is being given.
(C) The directions given to the patient for the use of the drug.
(D) The name, strength and quantity of the drug and the date on which the drug was prescribed, administered or dispensed.

What is a “Medical Record”

• Records pertinent facts, enables planning and evaluation of treatment
• Enhances communication between professionals:
  ✓ assuring continuity of care
  ✓ decrease medical error
  ✓ increasing patient safety
• Assists communication with third parties (legal, regulatory, research)

Patient’s Medical Record

• Like a police report in an auto accident case, your patient’s chart will be the center of attention in a medical liability case. Well kept records will act as an effective SHIELD to liability. They will protect you and show you met the standard of care.

• However, poorly kept records are likely to be used as a SWORD or weapon against you as evidence of your failure to comply with the minimum standard of care.
Medical Record as a “SHIELD”

• Well maintained medical records will shield you from liability and provide key evidence that you met the applicable standard of medical care.
• Hopefully, your patient’s chart will be “Exhibit A” used by your defense attorney to keep you out of trouble.

EXAMPLES
1. Allergic reaction — a detailed patient history with documentation of known allergies and reactions will shield you from allegations you gave a drug to which the patient had an allergy.
2. Failure to order diagnostic test — documentation of diagnostic testing recommended to the patient by you will protect you from allegations you failed to order same. (If you feel an MRI is needed and patient is unwilling, document that fact.)

Other “SHIELDS”

• Written policies and procedures
• Documented protocols
• Self-assessment/audit and internal monitoring
• Staff and provider education related to medical record documentation

Medical Record as a “SWORD”

• Poorly kept records can be used as a weapon against you in a medical liability claim.
• The last thing you want to see is your own records listed by the Plaintiff’s attorney as “Exhibit A” in their case against you.

EXAMPLES
1. Failure to diagnose breast cancer — issue of whether breast exam was done (not charted = not done).
2. Failure to notify patient of lab results — issue of whether patient was made aware of significant lab results (not charted = not done).
Other “SWORMS”

- No policies/procedures/protocols
- Documentation that lacks an assessment or an incomplete assessment
- Incomplete notes
- Unrelated treatment ordered/prescribed
- Utilizing the same list of diagnoses for every patient

2 Types of “Medical Records”

Designated Record Set

HIPAA Privacy Rule defined the Designated Record Set (DRS) as a group of records maintained by or for a covered entity that is:

- The Medical Records & Billing Records of a patient/individuals for a covered entity
- Enrollment, payment, claims adjudication, and case or medical management records systems maintained by a Health Plan
- Used by the covered entity to make decisions about patients/individuals, in whole or in part

Legal Health Record
Legal Health Record

• The legal health record serves to:
  ✓ Support the decisions made in a patient's care
  ✓ Support the revenue sought from third-party payers
  ✓ Document the services provided as legal testimony regarding the patient's illness or injury, response to treatment, and caregiver decisions
  ✓ Serve as the organization’s business and legal record

• The legal health record is typically used when responding to formal requests for information for evidentiary purposes. It does not affect the discoverability of other information held by the organization.

How to Avoid Red Flags (BE ABLE TO DEMONSTRATE ON DEMAND)

Clinical
- Minimum content
- Strong Provider Involvement

Administrative
- Medical Record Organization
- Ease of Retrieving Records

Regulatory
- Coordination of Care
- Handling of Confidential Information

Minimum Documentation

Each Patient Encounter should include:
• The reason for the encounter
• Office Visit
  • Relevant history – include med REVIEW and appropriate health risk factors
  • Physical exam findings (BMI?)
  • Prior diagnostic test results
  • Assessment / clinical impressions/diagnosis
  • Plan for care
  • Date/Time/ legible identity of observer
• Hospital visit
  • Patient's progress, response to and changes in treatment (revised diagnosis?)
• CPT and ICD9-CM codes on health insurance claim form should be supported by this documentation
Documentation Standards

- Additional Standards for Primary Care Physicians
  - Vital Signs at every encounter, including BMI
  - Problem list
  - Complete medical information/medication reconciliation
  - Ongoing tracking (of condition, of meds, etc.)
  - Consultation review
  - Immunization
  - Preventive Health

- RED = must be done by provider

Procedural Reports

- Full note written immediately after... or
- Dictated immediately after procedure with a short handwritten note immediately
  - Names of procedural provider & any assistant
  - Name of the procedure(s) performed
  - Description of the procedures (steps)
    - The only element not required on the short note
  - Findings at surgery
  - Estimated blood loss
  - Specimens removed (and disposition)
  - Post procedure diagnosis & patient condition
How to Avoid Red Flags (BE ABLE TO DEMONSTRATE ON DEMAND)

Clinical
- Minimum content
- Required Provider Involvement

Administrative
- Medical Record Organization
- Ease of Retrieving Records

Regulatory
- Coordination of Care
- Handling of Confidential Information

Documentation Standards

• Medical Record Organization
  • Patient identification
  • Separate records for each patient (NOT FAMILIES)
  • Dated/timed
  • Clear identification for every treating practitioner (legible signature) on every entry

• Data Integrity
  • Legibility

Documentation Standards

• Ease of Retrieving Medical Records
  • Identification
    ✓ retrieved in a timely manner
  • Systematic Storage
    ✓ NOT IN CAR TRUNK
How to Avoid Red Flags
(BE ABLE TO DEMONSTRATE ON DEMAND)

Clinical
- Minimum Content
- Strong Provider Involvement

Administrative
- Medical Record Organization
- Ease of Retrieving Records

Regulatory
- Coordination of Care
- Handling of Confidential Information

Documentation Standards
- Information Filed in Medical Records
  - Coordination of care
  - Continuity of Care
- Confidential Patient Information
  - Treat as confidential (training?)
  - Safeguards
  - Release and Tracking
  - Advance Directives

Documentation Pitfalls

RED FLAGS FOR AUDITORS
Red Flags for Auditors

• Not legible
• Late entries
  • Date and time it as the current date, not the date for which it is being corrected
• Different handwriting in the same entry (scribe or other staff) without authentication
• NO CHART for patients to whom you’ve prescribed medications – especially controlled substances
• Abbreviations that are not readily acceptable or understood

Legible????

Red Flags for Auditors

• Documentation does not comply with guidelines, regulations or statutes.
• Lack of specificity or clarity
• Pre-printed forms and check boxes
  ✓ Still must add patient specific information
• Dictation Templates
  ✓ Be cautious if always using the default
• Inaccurate gender use
• Non-professional tone
Clear and Understandable???

E.M.R. Red Flags for Auditors

- Copy and paste
  - Leaves electronic tag, implies no patient specificity
- E.M.R. macro’s
  - Patient specific information
- “Tailgating”
- Lack of training/lack of updated education
- Delay in documentation

E.H.R. Red Flags for Auditors

- Incorrect selection of templates (i.e., selection of “New Patient” template for an established patient or vice-versa)
- Selection of a “follow-up” exam without specifically indicating the true “chief complaint”
- Contradictory documentation between areas such as: HPI, ROS, exam components
- Typographical or “nonsensical” documentation
EHR Copy and Pasting (CLONING)

The potential risks associated include:

- Incorrect information may impact patient care
- Documentation of services provided when in fact they were not - upcoding
- Discrepancies in information leading to confusion
- Patient's condition not updated
- Decline in accuracy if careful review and update of information is not performed
- Incorrect information/treatment protocols could result in injury to the patient (even death)
- Pertinent aspect of patient safety

Documentation Opportunities

RISK REDUCTION

- Organize charts
- Avoid sticky notes
- Use a running problem list – update it / review it / resolution
- Do not use "dictated but not read" stamp; Don’t use STAMPS at all
- Initial or sign outside documents as evidence of your review
  - not part of your legal record unless you review
- Provide detailed management/treatment plan
**Risk Reduction Practices**

- Fill in or void spaces on forms
- Avoid cross outs, write-overs
- Corrections
  - ✓ Draw a single line, write "error" above the entry with date and initial
  - ✓ Do not obliterate entry / scratch out/ white out
- Dispense education materials and document, especially drug education
- Provide the REASON for the test, med, etc........
- Avoid risk management comments

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**Risk Reduction Practices**

- Late Entry
  - ✓ Written as "addendum" and reflect date and time the entry was made, not when it was supposed to be made, (explain why it was late)
- Use a medication reconciliation process
  - ✓ All prescriptions and dates of refills/discontinued medications
  - ✓ Even list drugs that you are not prescribing
  - ✓ Avoid global statements like "renew meds"
- Resolve medical problems reported on prior visits, keep a running list with dates and initials of who reviewed the problem on that date
  - ✓ To be able to bill for it, the provider must review it

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**Risk Reduction Practices**

- Supplement narrative text with line drawings, diagrams
- Document informed refusal discussion as well as informed consent discussions
- Document patient non-compliance in progress record
- Include positive and negatives from patient’s H&P
- Document return visit advice and did not keep appointments
- Avoid criticism of other professionals in chart notes
Risk Reduction Practices

• Use a medication control record
  • All prescriptions and dates of refills
  • Even list drugs that you are not prescribing
  • Avoid global statements like "renew meds"

• Resolve medical problems reported on prior visits, keep a running list with
dates and initials of who reviewed the problem on that date
  • To be able to bill for it, the provider must review it

Risk Reduction Practices

SCREES

• Physician must be physically with them, must be clinically appropriate to
use scribe
• Their entry should include notation that:
  "<name of scribe> is working for, and in the presence of <physician name>
  " with the scribe's signature date and time
• Physician should sign each entry with:
  "I, <physician name> personally performed the services describe in this
documentation as scribed by <name of scribe>, and it is both accurate and
complete" with physician signature, date and time

Risk Reduction Practices

POLICIES AND PROCEDURES

• Ensure that all policies and procedures are consistent with your
  practice
• Review annual and update as needed
• Document updates and archive old policies
• Maintain old policies electronically for legal purposes
Risk Reduction Practices

GUIDELINES, STANDARDS, LAWS AND STATUTES

• Be informed of all information pertaining to medical records documentation
  ✓ Ignorance is not a defense
• Educate other providers and staff related documentation obligations and requirements
  ✓ Document the education as well – may be a life-saver at some point

Who is Watching You?

Audit Risks - Who is Watching!

• Federal (CMS) – conditions of participation
  • MACs, RACs, ZPICs
• State (WC, Medicaid)
• Third party – e.g. Highmark, BC – med necessity
  • ASK FOR THEIR BILLING MANUAL
• Accrediting agencies
• Organizational Bylaws
  • Rules about how soon a medical record must be completed, what constitutes a post op note
Others Who are watching

- Office of Inspector General
  ✓ improves HHS programs and protects them against fraud, waste, and abuse
- Licensing boards
- State Attorney Generals
- Health Departments
- Med Mal carriers
- Payers

Conclusions

If it is **NOT** documented, then it did **NOT** happen

If it **CANNOT** be understood, then it did **NOT** happen

If it **CANNOT** be read, then it did **NOT** happen

Questions and Answers

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Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Medical Documentation Issues in Administrative Proceedings

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September 14, 2019
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Pennsylvania Board of Medicine

Regulations - Medical Documentation

- 49 Pa. Code § 16.95. Medical records

A physician shall maintain medical records for patients which accurately, legibly and completely reflect the evaluation and treatment of the patient. The components of the records are not required to be maintained at a single location. Entries in the medical record shall be made in a timely manner.


A medical record shall be maintained for each patient, identifying the patient, the person making the entry, the date of each contact, pertinent clinical information, diagnoses, findings, laboratory results and other diagnostic, corrective or therapeutic procedures, including prescription drug orders, arising out of the licensee’s care of the patient.

(b) The medical record shall contain information sufficient to clearly identify the patient, the person making the entry if the person is not the physician—such as a physician assistant or a certified registered nurse practitioner—the date of the medical record entry and patient complaints and symptoms.

(c) Clinical information pertaining to the patient which has been accumulated by the physician, either by himself or through his agents, shall be incorporated in the patient's medical record.

(d) The medical record shall also include diagnoses, the findings and results of pathologic or clinical laboratory examination, radiology examination, medical and surgical treatment and other diagnostic, corrective or therapeutic procedures.

49 Pa. Code § 16.95(b), (c), and (d).


(b) When prescribing, administering or dispensing drugs regulated under this section, a person licensed to practice medicine and surgery in this Commonwealth or otherwise licensed or regulated by the Board shall carry out, or cause to be carried out, the following minimum standards:

(1) Initial medical history and physical examination. An initial medical history shall be taken and an initial physical examination shall be conducted unless emergency circumstances justify otherwise...

(2) Reevaluations. Reevaluations of the patient's condition and efficacy of the drug therapy shall be made consistent with the condition diagnosed, the drug or drugs involved, expected results and possible side effects.

(4) Medical records. Accurate and complete medical records must document the evaluation and care received by patients.

(i) On the initial occasion when a drug is prescribed, administered or dispensed to a patient, the medical record must include the following:

(A) A specification of the symptoms observed by the licensed health care provider and reported by the patient.

(B) The diagnosis of the condition for which the drug is being given.

(C) The directions given to the patient for the use of the drug.

(D) The name, strength and quantity of the drug and the date on which the drug was prescribed, administered or dispensed.

(ii) After the initial occasion when a drug is prescribed, administered or dispensed, the medical record must include the information required in subsection (b)(4)(i)(D) and changes or additions to the information recorded under subsection (b)(4)(i)(A)—(C).

Being guilty of immoral or unprofessional conduct. Unprofessional conduct shall include any departure from, or the failure to conform to, the standards of acceptable and prevailing osteopathic medical practice. Actual injury to a patient need not be established.

63 P.S. § 271.15(a)(8).

Section 41(8)(ii) – Further defines deviating from quality standard

A practitioner departs from, or fails to conform to, a quality standard of the profession when the practitioner provides a medical service at a level beneath the accepted standard of care. The board may promulgate regulations which define the accepted standard of care.

In the event the board has not promulgated an applicable regulation, the accepted standard of care for a practitioner is that which would be normally exercised by the average professional of the same kind in this Commonwealth under the circumstances, including locality and whether the practitioner is or purports to be a specialist in the area.

63 P.S. § 422.41(8)(ii).
Board of Medicine

- Violating a lawful regulation
- Failing to conform to the profession's ethical or quality standards
- Being guilty of immoral or unprofessional conduct

63 P.S. § 422-4(6), (8).

Board of Osteopathic Medicine

- Violating a regulation
- Being guilty of immoral or unprofessional conduct
- Failing to conform to the standards of acceptable and prevailing osteopathic medical practice

63 P.S. § 271.15(a)(6), (8).

Department of State/Prosecutor

1. Professional Compliance Office receives a tip, complaint or other.
2. Investigation by BEI investigator.
3. Prosecutor obtains medical records at issue.
4. Prosecutor sends medical records to an expert for review.
5. Prosecutor prepares Order to Show Cause, if warranted OR prepares Consent Agreement OR both.
Physician

1. Receives Order to Show Cause in mail*
2. Possibly panics, confused, upset or not sure what to do.
3. Possibly calls an attorney.
4. Decides how to respond.

*In some cases, physician or attorney for physician would receive a Consent Agreement to try to settle before OTSC issued.

Order to Show Cause

2. Provides Notice to physician.
3. Outlines factual allegations.
4. Outlines alleged violations.
5. Advises of possible penalties.
6. Outlines procedures.
Order to Show Cause:

Factual Allegations

Respondent did not document any pill counts in the medical record for patient ZZ.

Respondent did not document any urine drug screens in the medical record for patient ZZ.

Respondent's medical record prepared for patient ZZ did not document why Respondent added or changed medications for the patient.

Physical examinations and interim history noted by Respondent in the treatment record for patient ZZ were repeatedly scant in terms of questioning the patient on the level of pain.

Order to Show Cause

Factual Allegation Examples

1. Patient ZZ presented to Respondent early for opioid medication renewal on a regular basis.
3. Respondent never noted in the treatment record for patient ZZ that he had questioned the patient regarding the actions referenced in paragraphs 1 and 2.

Although so documented in the ED records for the treatment/services Patient received on May 25, 2012, Respondent avers that he questioned Patient twice while Patient was in the ED regarding statements that he was having suicidal/homicidal thoughts and was not safe. Specifically, Respondent avers he asked Patient twice if he was still having suicidal/homicidal thoughts, and Patient stated “no” on each occasion.

The ED records for the treatment/services Patient received on May 25, 2012 do not identify that Respondent: performed any psychiatric examination on Patient, requested a psychiatric consult of Patient, referred Patient for a psychiatric evaluation by another health professional, and/or instructed Patient to seek counseling after his discharge.

Respondent's treatment of Patient departed from and/or failed to conform to a quality standard of the profession by providing a medical service at a level below the accepted standard of care, namely, less performed in a negligent manner in that:
1. Respondent failed to ensure that Patient's medical chart was accurate and complete;
2. Respondent failed to appropriately evaluate Patient regarding suicidal and homicidal statements, request a psychiatric consult of Patient, refer Patient for a psychiatric evaluation by another health professional, and/or instruct Patient to seek counseling after his discharge.
21. At 0745, there was a change in LTV, new with diminished LTV, the contraction pattern represents a high-frequency low amplitude pattern.

22. At 0835, the baseline changed to 150 BPM, with continued decreased LTV.

23. At 0900, a spontaneous decaeration was noted.

24. At 0955, a baseline change was noted, now at 160 BPM, with continued decreased LTV and the contraction pattern continued to be irregular.
Risk Management and Liability Prevention: The Importance of Proper Medical Documentation

Order to Show Cause
Alleged Violated Example

Based upon the foregoing Factual Allegations, the Board is authorized to suspend or revoke, or otherwise restrict Respondent’s license under Sections 41 and 42 of the Act, 63 P.S. §§ 422.41 & 422.42; or impose a civil penalty under Sections 59 through 62 of the Act, 63 P.S. §§ 422.39-422.42 and/or Section 50(x)(4) of Act 66, 63 P.S. §2501.404; and/or impose the costs of investigation under Section 50(x)(5) of Act 66, 63 P.S. §2501.406. Furthermore, Respondent violated Section 41(a) of the Act, 63 P.S. §2501.401(b) in that Respondent dispensed, used, or failed to conform to a standard of care in which actual injury to a patient may not be established.

Osteopathic Medical Board

Order to Show Cause
Alleged Violated Example

Based upon the foregoing Factual Allegations, the Board is authorized to suspend or revoke, or otherwise restrict Respondent’s license, or impose a civil penalty under 63 P.S. §2501.404 and/or impose the costs of investigation under Section 50(x)(4) of Act 66, 63 P.S. §2501.406. In that Respondent violated Board regulations requiring medical records at ¶ Pa. Code §25.211(a) by failing to maintain pertinent clinical information in a patient’s medical record.
Risk Management and Liability Prevention:
The Importance of Proper Medical Documentation

Order to Show Cause
Alleged Violation Example

44. Based upon the foregoing factual allegations, the Board is authorized to suspend or revoke, or otherwise restrict Respondent’s license, or impose a civil penalty under 63 P.S. § 2205(b)(4), and/or impose the costs of investigation under Section 59.6 of Act 68, 63 P.S. § 2205(b)(4), in that Respondent violated Board regulations regarding medical records as PP As, Code (22-231) by failure to maintain pertinent clinical information in a patient’s medical record.

Penalties / Corrective Action

1. Public Reprimand
2. Probation of License
3. Suspension of License
4. Revocation of License
5. Civil Penalty up to $10,000 per violation
6. Submit to care, counseling or treatment of physician or psychologist
7. Refresher education courses
8. Cost of investigation
9. Voluntary surrender (not in statute)

63 P.S. § 422.39(b); 63 P.S. § 422.42(a); 63 P.S. § 2205(b)(4), (5) (ACT 48)
The Importance of Proper Medical Documentation

**Example**

**SUMMARY:** ER Doctor saw a patient in ER. ER doctor did not make proper notations of Patient’s suicidal thoughts or refer Patient for further assessment. Patient was admitted to hospital and was treated with anti-depressants. ER doctor was charged in order to show cause for reporting from standard of care for failing to ensure that Patient’s suicidal chart was accurate and complete and for failing to appropriately account Patient regarding his suicidal and homicidal statements. Request a psychiatric consult of patient, refer Patient for a psychiatric evaluation to another mental health professional and instruct Patient to seek counseling after his discharge.

**OUTCOME:** Consent Agreement and Order (Settled with Prosecution). Within sixty (60) days of date of agreement, Respondent shall attend and successfully complete ten (10) hours of remedial education – 1 hours on topic of documentation and record keeping and 9 hours on topic of evaluation and treatment of patients who present with a mental health symptomology.

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**Example**

**SUMMARY:** Physician practices medicine in the specialty of internal medicine. Male patient was initially prescribed 60 tablets of Hydrocodone/Acetaminophen 7.5/325 mg. Shortly thereafter, physician prescribed Oxycodone to patient. Then, physician prescribed Morphine extended-release to patient. Physician increased Oxycodone dose to 30 mg tablets. Physician then prescribed Oxycodone ER 40 mg twice daily. Physician prescribed a few other medications. Physician did not document any urine drug screens or pill counts or acknowledge added risk of Zolpidem to medication regimen of patient. Patient with only showed mild degenerative disease as well as opiate dependency. Physician continued to prescribe controlled substances to patient in number, frequency and potency that was inappropriate in the clinical circumstance. Patient presented to physician with opiod withdrawal. Physician did not document that he diagnosed Substance Use Disorder as a medical diagnosis for Patient.

**OUTCOME:** Consent Agreement and Order (Settled with Prosecution) $4,000 civil penalty and remedial education (24.5 credits) at Case Western Reserve University School of Medicine titled "Intensive Course in Controlled Substance Prescribing."

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**Example**

**SUMMARY:** Physician practiced osteopathic medicine as a specialist in family medicine. Physician treated 1 patient between January 2007 through June 2008 with large quantities of various controlled substances. Physician failed to perform physical examination of several patients who were given a prescription for controlled substances. Physician failed to document justification on medical record of many patients of why he prescribed the controlled substances. Patients consistently renewed prescriptions prior to end of current prescription. Physician increased doses of controlled substances for patients and did not document pill counts. A narcotic agreement, as to whether some drug screens were provided: 

**OUTCOME:** Initial – Consent Agreement & Order, 2012 (Settled with Prosecution): $2,500 civil penalty and 11 hours of continuing education at Case Western Reserve University School of Medicine titled “Intensive Course in Controlled Substance Management.” Then, ensuing occurred related to another OTC with other patients - case dismissed. Current: Order of Temporary Suspension issued on December 27, 2017. Grand jury issued indictment in criminal matter in U.S. District Court, Middle District of PA, on or about December 20, 2017.
Summary

Physician practiced osteopathic medicine as a specialist in obstetrics-gynecology. Patient presented to hospital when approximately 37 weeks pregnant. Patient placed on fetal monitor with baseline at 135 beats per minute (BPM). Appeared irregular contraction pattern. Baseline changed at different intervals to 150 BPM, 160 BPM, 170 BPM, 180 BPM. During that period of time, contraction pattern clear and every 2 minutes. Accelerations, long-term variability, decelerations noted in records. Anticipated order for GAB. Pitocin ordered to expedite delivery. Delivery occurred. Child found to have significant delays in speech. Alleged that physician failed to 1) identify a non-reassuring fetal heart rate tracing; 2) provide the requisite interventions to manage the non-reassuring fetal heart rate tracing; 3) identify chorioamnionitis as a possible etiology for fetal tachycardia; 4) empirically treat patient AB for presumed chorioamnionitis; 5) determine if Pitocin should have been utilized to expedite delivery despite a non-reassuring fetal heart pattern; and 6) properly manage the Pitocin by not adjusting the dose or discontinuing the drug despite tachystole and loss of short-term variability. Also alleged that physician failed to create an entry in the medical record for patient AB reflecting a differential diagnosis for fetal tachycardia in violation of Board regulations at 49 Pa. Code § 25.213 (a). Underlying civil action in matter.

Outcome

Order to Show Cause dismissed. In Proposed Adjudication, 297 findings of fact. Physician documented fetal tachycardia and addressed it, identified chorioamnionitis as a possible etiology for fetal tachycardia, and managed the Pitocin properly, and conformed to the standard of acceptable and prevailing osteopathic medicine by an OB/GYN to an obstetric patient in providing care to patient AB.

Thank you!

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Questions & Answers