Through the Eyes of An Expert Witness:

COGNITIVE BIASES

CHARTING SNAFUS

PROCEDURAL CONUNDRUMS

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Objectives of this Presentation:

- 1. Define cognitive biases and how these can lead to poor outcomes in correctional health care
- 2. List at least three charting snafus that can undermine defensibility in a lawsuit
- 3. Describe at least two correctional health care administrative procedures or processes that can lead to legal quandaries and what can be done to mitigate negative legal impact

Cognitive Biases

The human brain is a complex organ with the wonderful power of enabling man to find reasons for continuing to believe whatever it is that he wants to believe.

– Voltaire

Thinking About Thinking:*

System 1

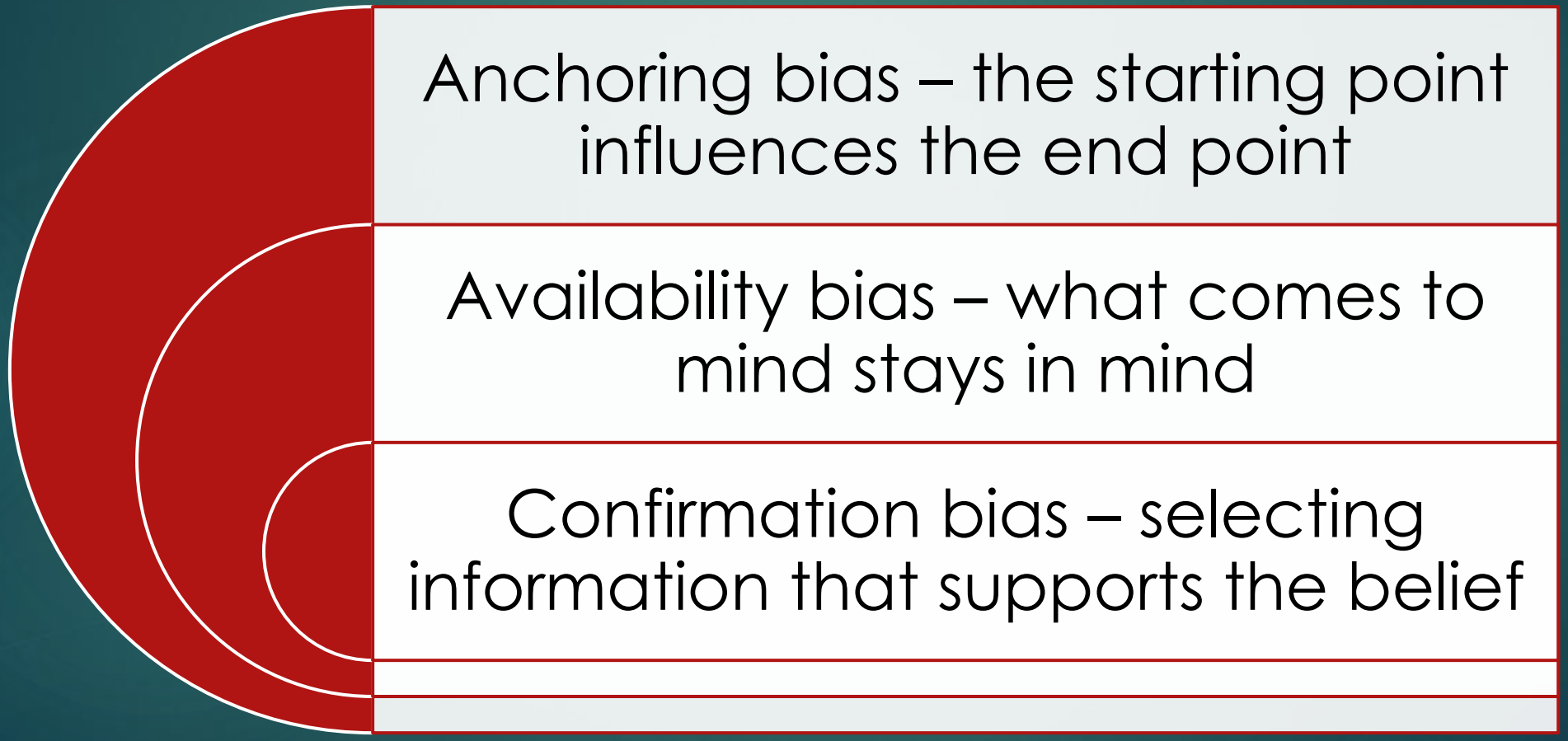
- Heuristic-based "Rules of Thumb"
- Gets us through the day
- Quick and generally effortless
- Based on experiences and immediate knowledge
- Fraught with errors and biases

System 2

- Requires effortful thinking and computation
- May kick in automatically when we recognize a difficult situation
- We often must force ourselves into System 2 when System 1 is not meeting the needs of the situation

*See Kahneman, D. (2011). Thinking, fast and slow. New York: Farrar, Straus and Giroux

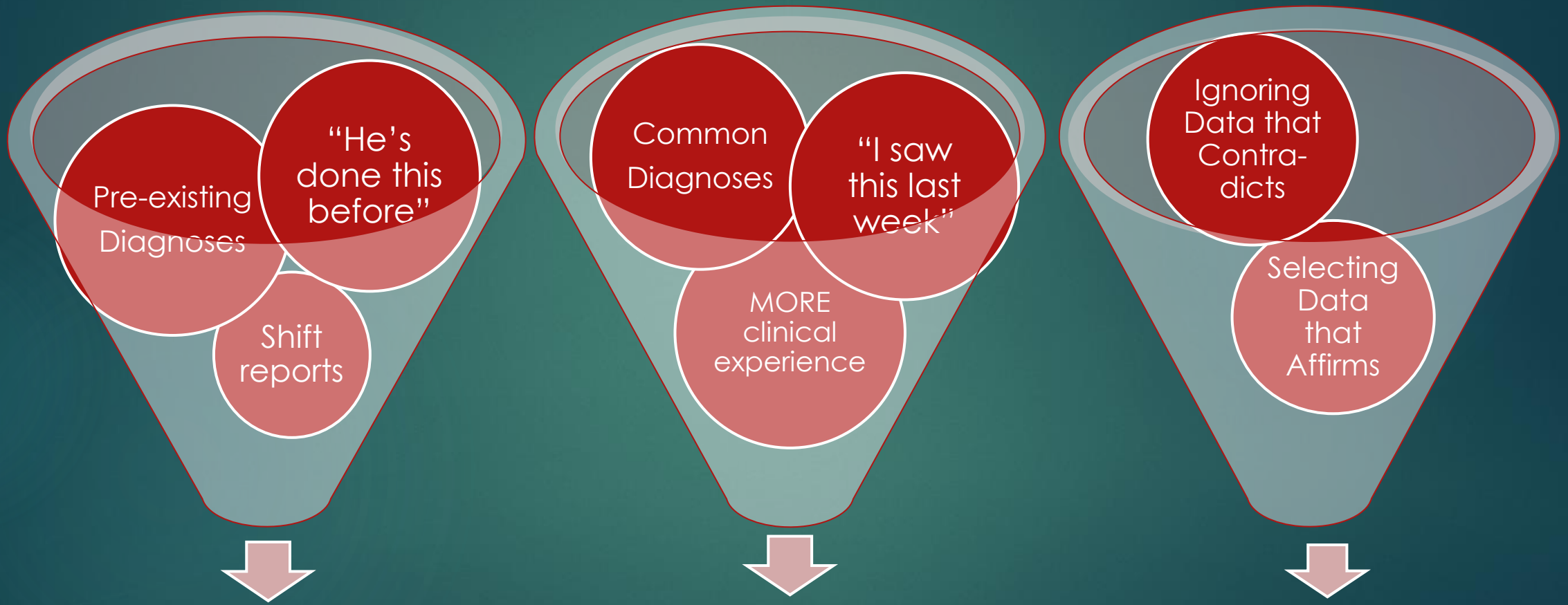
Cognitive Biases – Inherent in System 1 Thinking:



Examples of System 1, Heuristic-based, Bias-prone Situations

- Abdominal Pain
- Hematuria
- Blurry Vision

Abdominal Pain:



Anchoring Bias

Availability Bias

Confirmation Bias

Hematuria:

Anchoring Bias

- Age and Gender
- Previous Diagnoses

Availability Bias

- What we see every day
- The information we receive from others

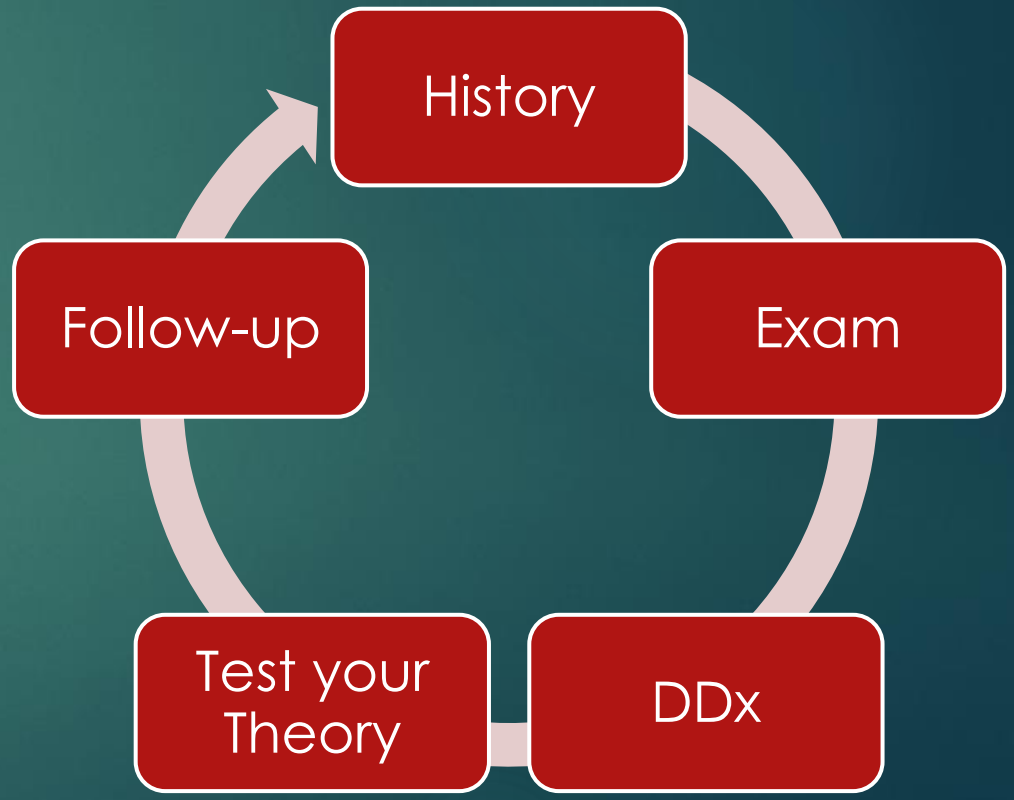
Confirmation Bias

- Trace leukocyte esterase = cystitis
- Small solitary stone on KUB = urolithiasis
- Negative KUB = “must be one of the 20%”

Burry Vision: Exercising System 2

System 1:

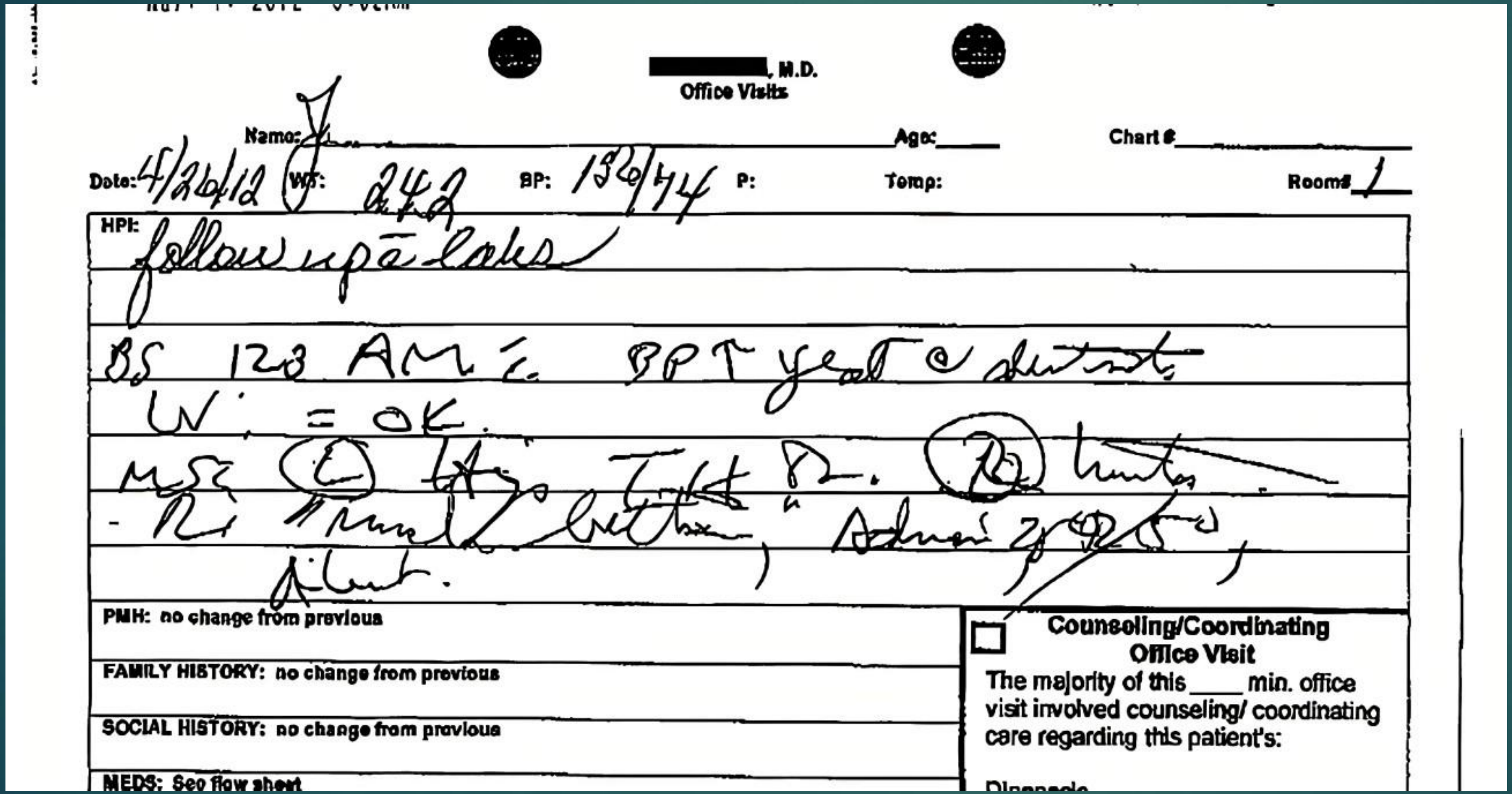
System 2:



Charting Snafus

The chart is a legal document and WILL be read in court!

Charting Badly:



[redacted], M.D.
Office Visits

Name: | Age: | Chart #
Date: 4/26/12 Wt: 242 BP: 136/74 P: Temp: Room# 1

HPI: follow up ā labs

PMH: no change from previous

FAMILY HISTORY: no change from previous

SOCIAL HISTORY: no change from previous

MEDS: See flow sheet

Counseling/Coordinating Office Visit
The majority of this ____ min. office visit involved counseling/ coordinating care regarding this patient's:

If your institution is still using paper charting, learn how to convert your paper forms to type-able, editable forms for printing off and putting in the chart.

Charting Too Little -- Everyday Notes:

S: I/M states chest pain starting about an hour ago

O: VSS, NAD
Lungs clear
Heart RRR without murmur
Sternum tender to pressure

A: Costochondritis

P: IBP 600mg BID PRN x 10 days

E: F/U PRN if getting worse

I/M has a ***NAME* – use it**

If you read this to a jury two years from now, would it make sense? Could you explain it?

Does your **SO** support your **AP**?

Charting Too Little -- Refusals:

Just like having an *informed consent*, you must have an **INFORMED** REFUSAL!

Every Time!

*What is being refused
*Why it is being refused (fill out by patient)
What may happen as a result of the refusal – *in detail

Charting Too Much – ROS copy and paste:

Denies Constitutional: lack of energy, unexplained weight loss or gain, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer.
Denies HEENT: difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in the ears, blurry vision, changes in vision, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness.
Denies CV: irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking.
Denies Resp: shortness of breath, prolonged cough, wheezing, sputum production, prior TB, pleurisy, history of abnormal chest x-ray.
Denies GI: heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting.
Denies GU: painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence.
Denies MS: joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain.
Denies Skin: persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase.

Charting Too Much – Exam copy and paste:

Head: normocephalic, atraumatic; unremarkable to visual inspection; non-tender to palpation.
Eyes: PERRL; RR present bilaterally; conjunctiva and sclera are clear; fundi unremarkable with flat discs and normal vessels.
Ears: Clear ear canals; TM's grey and translucent; TM's mobile.
Mouth: Oral mucosa moist and without lesions; pharynx unremarkable; dentition unremarkable.
Neck: Supple without TM or LAD.
Chest: Grossly normal to inspection with normal respiratory effort.
Lungs: Clear in all fields with good air movement throughout; no rales, wheezing or rhonchi; no vocal fremitus.
Heart: RRR without murmur or extra sounds; S1 and S2 are normal; no S3 or S4; no bruits; precordial is non-hyperdynamic.
Abdomen: soft, NT, no masses, no organomegaly, normal bowel sounds all four quadrants.
Neuro: normal movement all four extremities; normal strength all four extremities; DTR's normal throughout; CN 2 through 12 intact; gait normal; toe-to-heel walking intact.
Skin: clear throughout; no rash, cyanosis, or jaundice.

Chart Wars - Just Don't:

Don't blame another provider for your current predicament – "Since Dr. Jones neglected to order the MRI that was recommended by the specialist…"	• *Instead,* "MRI that was recommended by the specialist appears not to have been ordered, so I will do that today."
Don't argue with another provider in absentia – "I don't agree with Dr. Barberi about her assessment of this case…"	• *Instead,* "Although the previous provider's assessment is appreciated, an alternative viewpoint in this case might be…"
Don't advise the next provider not to change your orders – "Do NOT restart this patient on Atorvastatin…"	• *Instead,* "Statins are currently contraindicated during treatment for HCV…"

Effective Story Telling:

Avoid using the term "I/M" – it is pejorative and dehumanizing.	• All inmates have a name, and it takes an extra second to spell it out, but sounds humanizing in front of a jury.
Absolutely NEVER use the term *malingering* in a note.	• Anchoring bias. Sets a poor tone for the ultimate outcome. • Malingering is a mental health diagnosis found on page 726 of the most current DSM. It should be de-emphasized in our minds as well.
Be honest and complete – don't overstate nor understate the encounter.	• Your encounter documentation should tell an accurate, organized and believable story.
Do not copy and paste large portions of previous notes into your current notes	• Makes it difficult to distinguish today's findings from old news • It is okay – and encouraged – to guide the reader to previous notes that are germane to the issue at hand (i.e. "see encounter dated 1/1/22 for complete history")

Procedural Conundrums

Medication Administration – Unavailable Medications:

- Unavailable medications can lead to stroke, MI, worsening CHF, worsening infection, glaucoma exacerbation, etc.
- "Sorry. No meds for you today…" is not acceptable – insist that missing medications be located in real time, or go to back-up
- Someone MUST be responsible for locating or researching the whereabouts of unavailable medications
- Educate inmates if medications are available as stock until their cards arrive
- In general, all cardiac, respiratory, immunologic and ophthalmic medications should be considered critical

Medication Administration – MAR Documentation and Revocation of KOP's:

- "Blanks" mean the medication did not get administered, regardless of the reality.
- If you have an alternative paper KOP documentation system, make sure it covers all of the pertinent information – date, time, medication, # dispensed, and signature of inmate.
- KOP revocation should be done selectively and only by a provider who actually counsels the inmate about the reason for revocation.
- Revisit involuntary revocation monthly – just like a special needs case – and document the encounter.
- Consider trial of KOP reinstatement periodically in select cases.

Consultation and Referrals:

Delays

- Requested timeline is critical – urgent, routine or 2-weeks, 1-month, 3-months, etc.
- If necessary, call the specialist office. Don't wait for an appointment call if out of range.

Denials

- Appeal, appeal, appeal! If no appeal, have the provider document why not.

Specialist Recommendations

- Unless clearly unreasonable, specialist "recommendations" should be ordered.
- If a recommendation is not being considered, documentation to that effect is necessary.

Laboratory Tests:

"There's no one to draw labs" is…

NO Excuse!

Sick Call Referrals – What's Appropriate and What's Not:

Nurse Sick Call

- Truly acute and unprecedented issues – "I have a cold"; "I hurt my back playing basketball"
- Nursing procedures – ear lavage, toenail maintenance, diabetic foot exam, wound care.
- NOT: repeated complaints of the same issue; chronic issues

Provider F/U and Referrals

- If a patient has a chronic issue (not necessarily CCC) for which they are receiving medications, this needs to be referred straight to provider; inmates should not be stuck in a NSC loop.
- Providers should initiate a F/U for any inmate receiving a long-term medication

“Medicine is a science of uncertainty and an art of probability.” ~ Sir William Osler

“The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head.”

~ Sir William Osler

REFERENCES

- Kahneman, D. (2011). Thinking fast and slow. New York: Farrar, Straus, and Giroux.
- Saposnik, G., Redelmeier, D., Ruff, C.C., & Tobler, P.N. (2016). Cognitive biases associated with medical decisions: A systematic review. *BMC Medical Informatics and Decision Making, 2016,16*(138). DOI: 10.1186/s12911-016-0377-1
- O'Sullivan, E.D., & Schofield, S.J. (2018). Cognitive bias in clinical medicine. *Journal of the Royal College of Physicians of Edinburgh, September 2018, 48*(3), 225-232.

QUESTIONS?