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Policy: Interested Parties Meeting March 21, 2024

Policy:
Interested Parties Meeting

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In accordance with the Open Public Meetings Act, this meeting notice was sent to individuals requesting notification of the Department of Health, Washington Medical Commission (WMC) meetings. This agenda is subject to change. The WMC will take public comment at the Policy: Interested Parties meeting. To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

The WMC is providing a virtual option for this meeting.

Virtual via Teams Webinar: Registration link can be found below.
Physical location: 111 Israel Rd SE, TC2 Room 153, Tumwater, WA 98501

Thursday, March 21, 2024

Open Session

10:00 am	Agenda
To attend virtually, please **register** here: WMC Policy: Interested Parties	
The purpose of this meeting is to allow anyone to comment on and suggest changes to the WMC's policies, guidance documents, procedures, and interpretive statements. The WMC encourages open discussion on the items on this agenda.	
Organizer: Pam Kohlmeier, MD, JD, Staff Attorney	
1	**Guidance Document: Medical Records: Documentation, Access, Retention, Storage, Disposal, and Closing a Practice** *Review and discussion of current document and proposed revisions.* Current document on pages 3-17 Revised draft on pages 18-33
2	**Procedure: Compensation and Reimbursement for Commission Duties** *Review and discussion of current document and proposed revisions.* Current document on pages 34-35 Revised draft on pages 36-37
3	**Procedure: Processing Complaints Against Medical Students, Residents, and Fellows** *Review and discussion of current document and proposed revisions.* Current document on pages 38-39 Revised draft on pages 40-43
4	**Open Forum** Interested parties may provide ideas for new policies or suggestions to reform an existing policy. The comment period for each speaker will be limited to two minutes. We also welcome written comments, see below.
Public Comment *The public will have an opportunity to provide comments on any topic. If you would like to comment, please use the Raise Hand function, or add your comments to the chat. Please identify yourself and who you represent, if applicable. If you would prefer to submit written comments, please email medical.policy@wmc.wa.gov by 5 pm on March 20, 2024.*	

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Guidance Document

WASHINGTON Medical Commission
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Medical Records: Documentation, Access, Retention, Storage, Disposal, and Closing a Practice

Observe, record, tabulate, communicate.
-Sir William Osler (1849-1919)

Introduction

The Washington Medical Commission provides this guidance document to physicians and physician assistants (practitioners) on the appropriate documentation of a medical record; special considerations for maintaining an electronic health record; providing access to medical records; the retention, storage and disposal of medical records; and handling records when closing a practice. The Commission recognizes that in some practice settings, practitioners may not have control over the records and may not be able to fully implement the recommendations made below. The Commission appreciates the variety of medical practices and urges practitioners to exercise reasonable judgment which may vary by specialty in the application of the guidance document. An appendix contains a history of the medical record, illustrative examples of complaints regarding medical records made to the Commission, and additional information on the implementation of electronic health records.

Guidance

I. Documentation

A. Purpose of the Medical Record

As part of delivering high-quality, safe, and integrated medical care, it is critically important that each practitioner maintains accurate, clinically useful, timely, and consistent medical records. A practitioner should maintain a medical record for each patient for whom he or she provides care. Notes, either handwritten, typed or dictated, must be legible. Dictation must be transcribed, reviewed, and signed within a reasonable time. The practitioner must ensure that the transcription of notes is accurate, particularly when using dictation or voice-recognition software.

The medical record is a chronological document that:

1. Records pertinent facts about an individual's health and wellness;
2. Enables the treating care provider to plan and evaluate treatments or interventions, making clear the rationale for diagnoses, plans and interventions;
3. Enhances communication between professionals, assuring the patient optimum continuity of care;

4. Assists both patient and practitioner in communication with third party participants;
5. Facilitates the practitioner's development of an ongoing quality assurance program;
6. Provides a legal document for verification and/or audit of the delivery of care; and
7. Is available as a source of clinical data for research and education.

B. The Essential Elements of a Medical Record

The practitioner should include the following elements in all medical records:

1. The purpose of each patient encounter and appropriate information about the patient's history and examination, the patient's perspective and preferences, plan for any treatment, and the care and treatment provided;
2. The patient's pertinent medical history including serious accidents, operations, significant illnesses, and other appropriate information;
3. Prominent notation of medication and other significant allergies, or a statement of their absence;
4. Known or suspected reactions including allergy warnings;
5. Clearly documented informed consent obtained from the patient or from a person authorized to consent on behalf of the patient. In some emergency situations, the reason for a lack of informed consent should be clearly documented; and
6. The date of each entry, and the time as appropriate.

C. Additional Elements of a Medical Record

The following additional elements reflect commonly accepted standards for medical record documentation:

1. Each page in the medical record contains the patient's name or ID number.
2. Personal biographical information such as home address, employer, marital status, emergency contact information and all telephone numbers, including home, work, and mobile phone numbers.
3. Each entry in the medical record contains the author's identification. Author identification may be a handwritten signature, initials, or a unique electronic identifier.
4. All drug therapies are listed, including dosage instructions and, when appropriate, indication of refill limits. Prescription refills should be recorded.
5. Encounter notes should include appropriate arrangements and specified times for follow-up care.
6. All consultation, laboratory, and imaging reports should be entered into the patient's record, reviewed, and the review documented by the practitioner who ordered them. Abnormal reports should be noted in the record, along with corresponding follow-up plans and actions taken.
7. An appropriate immunization record is kept up to date by the primary care provider and, ideally, readily accessible by all clinicians caring for the patient, as technology permits.
8. Documentation of appropriate preventive screening and services being offered in accordance with accepted practice guidelines, as relevant to the visit and/or the specific provider's role in caring for the patient.
9. Documentation of other persons present during the encounter.

Where possible, the practitioner should avoid judgmental language in the medical record. The practitioner should consider that patients increasingly have access to and will read their own medical record. The practitioner should also be aware that a patient has a statutory right to submit a concise statement describing a correction or amendment for inclusion in the medical record. RCW 70.02.110. For a history of the medical record, see Appendix, Part I.

D. Special Considerations When Using an Electronic Health Record

An electronic health record (EHR), a digital version of the traditional paper-based medical record, documents health care that took place within a practitioner's office, single health care facility or health care system as well as all other communications (records of phone calls, emails, etc.) between the health care team and the patient. [1] The ideal EHR is designed to contain and share information among all involved providers, patients, and their designated caretakers.

The EHR offers a number of potential benefits over the paper medical record. However, as with any innovation, there are challenges and potential hazards in its meaningful use. The Commission recognizes several problematic documentation practices while using an EHR that in some instances interfere with delivery of high-quality, safe, and integrated medical care; impede medico-legal or regulatory investigation; or are fraudulent.

1. Recommendations for Practitioners

The following recommendations, which are not necessarily exhaustive, are intended to inform practitioners of the appropriate use of an EHR, and to indicate how the Commission will evaluate a medical record, including records that are the product of an electronic system.

The patient record in an EHR should reflect the same or improved content and functionality as that produced in traditional formats, and will be held to essentially the same standard.

a. A practitioner using an EHR must ensure:

   i. authorized use and compliance with state and federal privacy and security legal requirements, law, and with institutional privacy and security policies;
   ii. a timely, accurate, succinct, and readable entry;
   iii. consistency and accuracy between various aspects of a record; and
   iv. assumption of ultimate responsibility for trainees' and scribes' documentation.

b. Retention or re-entry of inaccurate, inconsistent, or outdated information in the EHR from historic entries should be avoided. Original information needs to be retrievable from a separate location in the EHR via a secure and permanent audit trail.

c. A practitioner's actions and decision-making should be accurately reflected in the documentation. The record will include a description of any shared decision-making process, when appropriate.[1]

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[1] EHRs have the potential to support shared decision-making. Studies show that EHRs that have incorporated shared decision-making tools result in improved clinical outcomes. *The Promise of Electronic Health Records to Promote Shared Decision Making: A Narrative Review and a Look Ahead*, Medical Decision Making, Vol. 38(8) 1040-1045 (2018). For more information on shared decision making, see the Washington State Health Care Authority web site on shared decision making, and the Bree Collaborative web site describing its work on this topic.

d. Documenting aspects of a practitioner-patient interaction that did not transpire, such as indicating that components of a physical examination were performed when they were not, even when it occurs inadvertently because of EHR design or function, may be considered fraud. Similarly, when documentation about a significant aspect of the practitioner-patient interaction is not present, the assumption is that it did not occur.

e. It is important to distinguish those portions of the history that were obtained by the note writer from those that were copied or carried forward from another practitioner's note. [2] The practitioner must recognize that "carry forward" or "cut-and-paste" functions, even when done automatically by the EHR software, represent significant risks to patient safety. Concerns about "clinical plagiarism" or fraudulent billing may arise when appropriate and accurate attribution of copy-paste or carry-forward information is missing from an EHR note. Practitioners should carefully review and edit any EHR-generated note to assure its accuracy prior to authenticating it.

f. Laboratory and imaging data should only be brought into the practitioner's note when pertinent to the decision making process for the patient. Wholesale importation of laboratory data and imaging data that is already documented elsewhere in the chart is to be avoided as such practice can make interpretation of medical records by subsequent caregivers extremely difficult.

g. The practitioner should assure that problem lists and medication lists are kept current, and that they are not cluttered with outdated information.

Examples of complaints received by the Commission relating to EHRs can be found in Appendix, Part II.

2. Suggestions for EHR Software Developers and Healthcare Institutions

The fruitful evolution of the EHR will require collaboration between entities that develop and purchase EHR systems and practitioners who use the EHR. The primary goal of the EHR is to promote high-quality, safe, and integrated health care. Other roles, such as documentation to support coding and billing, are secondary. It is unfortunate that, in general, these roles seem reversed in current EHR systems. With this in mind, the Commission offers suggestions about potential EHR improvements for software developers and health care institutions, and believes that practitioners should be involved in collaborative efforts with those entities to improve the EHR.

a. Practitioners and clinical information specialists have an important role to play in development, decision-making, evaluation and improvement of EHR systems.

b. EHR systems should result in a patient record that is organized, concise, and easily-readable. Lengthy and redundant information in the EHR, a source of common practitioner complaint, makes it difficult for other practitioners to identify data within the EHR that is relevant to actual patient care.[3]

c. EHR systems should also include tools to support the clinician to use best practices when available as well as shared decision-making.

d. An ultimate goal of the EHR universe should be widely compatible systems allowing seamless transfer and sharing of electronic medical information within and among practitioners, medical offices and clinics, hospitals and other health care institutions, as well as patients and their caregivers.

e. It is essential to have capacity within EHR systems to correct errors as soon as they come to light, and thereby prevent their perpetuation. The original documentation must be retrievable in the EHR via secure and permanent audit trail.

f. As patients increasingly have access to their EHR, they will undoubtedly find information within the medical record that is erroneous or with which they disagree. There should be a mechanism in place within healthcare institutions to respond to patients' questions and concerns that arise from review of their EHR, and to allow patients to submit a correction or amendment for inclusion in the medical records. RCW 70.02.110.

g. Software supporting EHR clinical documentation should be designed and constructed for the type of provider who will use it (e.g., specialty, training) and the context in which it will be employed (e.g., admitting, consulting, ambulatory). It should automatically attribute information to each author.[4]

h. The medical record serves many audiences who need to be considered in the design and implementation of EHR systems. To meet their potential, EHRs should incorporate comprehensive decision support that:

   i. leads to improved patient outcomes;
   ii. ensures safe transitions of patients from one practitioner, facility, or office to another;
   iii. allows easy tracking and reporting of patient care metrics and outcomes; and
   iv. promotes patient-centered communication between patients and the health care system.[3]

i. Health care institutions should consider having mechanisms in place to monitor documentation quality and practitioner satisfaction with the EHR, and to identify changes to support improved usability, validation, integrity, and quality of data within the EHR.[4]

j. The EHR should be designed for maximum portability and interoperability of information to benefit the patient and the public health. Full integration into the Washington State Health Information Exchange provides benefit to the patient requiring treatment when away from their medical home and provides meaningful data to assess population health. Technology vendors should design their systems with these functions as standards and institutions should mandate these functionalities as standard requirements for their implemented systems.

k. The EHR should support rapid, minimally complicated integration with the state's prescription monitoring program to facilitate inquiry in those systems.

For additional information on the implementation of an EHR, see the Appendix, Part III.

II. Access to Medical Records

A practitioner's practices relating to medical records under his or her control should be designed to benefit the health and welfare of patients, whether current or past, and should facilitate the transfer of clear and reliable information about a patient's care. The Commission recognizes that electronic health records systems may not be compatible, making it challenging to send records to a practitioner in another electronic health record system. Practitioners should do the best they can to get medical records to patients and subsequent providers in a usable format.

A. Per RCW 70.02.080, a practitioner is legally obligated to make medical records available to a patient to examine or copy within 15 days of the request. A practitioner may deny the request under circumstances specified in RCW 70.02.090.

B. Except for patients appealing the denial of social security benefits, the practitioner may charge a reasonable fee for making records available to a patient, another provider, or a third party and is not required to honor the request until the fee is paid. RCW 70.02.030(2). What constitutes a reasonable fee is defined in WAC 246-08-400. The practitioner cannot, however, withhold the records because an account is overdue or a bill is owed.

C. To prevent misunderstandings, the practitioner's policies about providing copies or summaries of medical records and about completing forms should comply with appropriate laws and should be made available in writing to patients when the practitioner-patient relationship begins.

D. The failure to provide medical records to patients in violation of RCW 70.02 can result in disciplinary action by the Commission.

III. Retention of Medical Records

A. There is no general law in Washington requiring a practitioner to retain a patient's medical record for a specific period of time.[2] The Commission appreciates the variety of medical practices and urges practitioners to exercise reasonable judgment which may vary by specialty for the retention of medical records. When appropriate, the Commission concurs with the Washington State Medical Association recommendation that practitioners should retain medical records and x-rays for at least:
   1. ten years from the date of a patient's last visit, prescription refill, telephone contact, test or other patient contact;
   2. 21 years from the date of a minor patient's birth;
   3. six years from the date of a patient's death; or
   4. indefinitely, if the practitioner has reason to believe:
      a. the patient is incompetent;
      b. there are any problems with a patient's care, or
      c. the patient may be involved in litigation.

B. A practitioner should consider whether it is feasible to retain patients' medical records indefinitely.

C. A practitioner should verify the retention time required by their medical malpractice insurer.

D. A practitioner should inform patients how long the practitioner will retain medical records.

IV. Storage of Records

A. A practitioner is responsible for safeguarding and protecting the medical record, whether in electronic or paper format, and for providing adequate security measures.

B. A practitioner may contract with a third party to act as custodian of the medical records. The responsible person, corporation, or legal entity acting as custodian of the records must comply with federal and or state confidentiality laws and regulations.

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[2] RCW 70.02.160 requires a health care provider to maintain a record of existing health care information for at least one year following receipt of an authorization to disclose that health care information and during the pendency of a patient's request either to examine or copy the record or to correct or amend the record. For hospital medical record retention requirements, see RCW 70.41.190.

V. Disposing of Records

A. When retention is no longer required, records should be destroyed by secure means. The Privacy Rule in the Health Insurance Portability and Accountability Act (HIPAA) prohibits digital and paper records containing confidential information from being thrown away in a public dumpster or recycling bin until they have been rendered unreadable or indecipherable by shredding, burning or other destruction.

B. A practitioner should give patients an opportunity to claim records or have them sent to another provider before records are destroyed. For some practitioners, the nature of their specialty will make notifying patients impractical.

VI. Handling Medical Records When Closing a Medical Practice

A. The obligation to make medical records available to patients and other providers continues even after a practitioner closes a medical practice.

B. The recommendations in this section do not apply to:

1. A practitioner who leaves a multi-practitioner practice. In that instance, the remaining practitioners in the practice typically assume care of the patients and retain the medical records.
2. A specialist or other practitioner who does not have ongoing relationships with patients. These practitioners typically provide patient records to the referring practitioner, the patient's primary care provider, or directly to the patient.

C. Prior to closing a practice, a practitioner should notify active patients and patients seen within the previous three years.

D. The notice should be given at least 30 days in advance, with 90 days being the best practice.

E. The notice should be given by:

1. individual letter to the last known patient address;
2. electronically, if this is a normal method of clinical communication with the patient; or
3. placing a notice on the practitioner's web site, if the practitioner has a web site.

F. The notice should include:

1. the name, telephone number and mailing address of the responsible entity or agent to contact to obtain records or request transfer of records;
2. how the records can be obtained or transferred;
3. the format of the records, whether hard copy or electronic;
4. how long the records will be maintained before they are destroyed; and
5. the cost of recovering records or transferring records as defined in Chapter 70.02 RCW.

G. The practitioner is encouraged to provide notice to the local medical society, whether the practitioner is a member or not.

H. If the practitioner practices as part of an institution, the institution may provide the notice of the closing of the practice.

I. If the practice closes due to the practitioner's death, the practitioner's estate becomes the owner of the medical records and is encouraged to provide this notification to patients.

J. Disciplinary action by the Commission, including suspension, surrender or revocation of the practitioner's license, does not diminish or eliminate the obligation to provide medical records to patients.

There is no more difficult art to acquire than the art of observation, and for some it is quite as difficult to record an observation in brief and plain language.

-Sir William Osler (1849-1919)

Number:	GUI2020-01
Date of Adoption:	January 17, 2020
Reaffirmed:	N/A
Supersedes:	Retention of Medical Records GUI2017-02; and Physician and Physician Assistants' Use of the Electronic Medical Record MD2015-09

Appendix

I. History of the Medical Record

The medical record, as an entity documenting an encounter between a patient and a practitioner, is a relatively new concept. Prior to the turn of the 20th century, patient case reports were written retrospectively, primarily for the purpose of teaching [5], with less emphasis on continuity of care. In the early 1900's, real-time documentation describing patient history and treatment was an emerging format, but patient care data were scattered and disorganized. A first step towards improving the quality and utility of medical documentation occurred in 1907 when assigning a unique number to each patient and consolidating all data for that patient into a single record was introduced. [5]

As medical education and the medical profession progressed following the Flexner Report in 1910 [2], it became necessary to document a patient's history for continuity of care and to accommodate growing involvement of medical and surgical specialists. In 1918, the American College of Surgery initiated a requirement that hospitals maintain records on all patients so that their content could be used for quality improvement. [5]

Throughout the 20th century, standards for formatting of the medical record continued to evolve. The Problem Oriented Medical Record (POMR) was introduced by Dr. Lawrence Weed in 1968. [5] The initial intent of the POMR was as an educational tool to help trainees organize their decision-making and treatment plan around each of a patient's separate medical problems. [6] [7] However, the POMR gained widespread acceptance among practitioners at all levels as did the SOAP (Subjective-Objective-Assessment-Plan) note format, which was derived from the POMR. [8] Additionally, within health care institutions and specialties, standards have emerged for documenting various types of encounters between practitioners and patients (e.g., History and Physical, Operative Note, Ambulatory New and Return Patient Notes, Interim and Discharge Summaries).

Requirements for clinical documentation were dramatically altered by release of the Evaluation and Management (E&M) guidelines by the Centers for Medicare & Medicaid Services (CMS) in 1995 and 1997. [8] Intended as a measure of cognitive (as opposed to procedural) services, the E&M guidelines specified the format and necessary components to be included in the medical record to support specific CPT codes for billing. The complexity of these requirements led many practitioners to rely on medical record templates, which were designed to promote compliance with E&M guidelines.

Until the late 20th century, the medical record was largely recorded on paper, either written longhand, or dictated and then subsequently transcribed. In part driven by approximately $30 billion of federal incentive payments over the last five years, the rate of EHR adoption has since risen quickly, [9] such that practitioners and health care institutions not currently using EHR are now outliers. The EHR has specific goals (Table 1) and serves the needs of a variety of audiences (Table 2).

Table 1: Goals of the Medical Record[1] (as informed largely by Shoolin, et al [4])

- Tell the patient's unique story as it relates to the patient's concerns ("the patient voice")
- Demonstrate diagnostic thinking and decision-making process undertaken by the practitioner.
- Provide clinical information to allow covering or consulting colleagues to maintain care and make informed decisions regarding further care
- Support coordinated longitudinal plans of care and care transitions within and across organizations
- Provide a clear and easily understood summary of the encounter, including findings and recommendations, to the patient or the patient's designated representative
- Provide clinical information to drive accurate Clinical Decision Support
- Support and identify the quality of care provided to patients
- Satisfy reasonable documentation requirements from payers
- Create the legal business record of the patient care facility
- Support population data collection and research
- Create the legal record of a patient's medical and surgical care
- Meet legal, accreditation, and regulatory criteria

[1] These goals are similar to the intentions of "Meaningful Use." For additional background, refer to: http://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives

Table 2: Medical Record Audiences

➢ Patients and their designated representatives.[2]
➢ Fellow practitioners
➢ Other members of the health care team
➢ Researchers
➢ Public health systems
➢ Payers
➢ Legal counsel
➢ Courts, juries and medical review/regulatory bodies

II. Examples of Complaints Received by the Commission Relating to EHRs

After reviewing many complaints about EHRs, the Commission is concerned about problematic features of EHR implementation and use and offers the following examples of EHR-related problems, which are based on cases reviewed by the Commission:

- A patient complains a practitioner documented a complete physical examination in the EHR when only a focused examination of a patient's rash had been performed.
- Under the physical examination section of a patient's EHR, "tympanic membranes within normal limits" is explicitly stated, but in the assessment, the patient is described as having a "right acute otitis media."
- An error in a CT report about a mass in the right kidney is subsequently corrected to indicate that the mass is in the left kidney. The original diagnosis of right kidney mass is carried forward in the EHR problem list, leading to a wrong-site surgery.
- A primary care practitioner forgets to include a patient's bleeding disorder in the EHR problem list following his first appointment with the patient. The incomplete problem list is carried forward without review or update for inclusion in numerous other documents. During major surgery two months later, the patient suffers a massive hemorrhage. The surgeon was unaware the patient had a bleeding disorder.
- A practitioner complains that her colleague copies and pastes the assessment portion of patients' EHR, including detailed medical decision-making, from other practitioners' notes and then bills at a higher level than his actual work would support.
- A patient files a medical malpractice claim after delay in diagnosis of a brain tumor. The practitioner says that she performed a complete neurologic examination, which was normal, but the EHR documentation for the neurologic portion of the examination only states "Patellar reflexes 2+ bilaterally."

[2] With implementation and expansion of the EHR and EHR, patients either already have or soon will have greater access to their own health information.

- A judge in a medical malpractice case found the EHR inadmissible because it contained so much redundant and irrelevant information.

III. Current EHR Implementation

Potential benefits and advantages of the EHR. There are potential benefits of the EHR, particularly as compared to paper medical records. Certain capabilities of the EHR may present both the potential for improving and for interfering with optimal documentation and patient care, which reinforces the importance of thoughtful and careful EHR planning, implementation, and use.

- Legibility: Handwritten notes could be illegible.
- Potentially greater efficiency for practitioners who, under increasing time pressures and facing large volumes of data, need ways to streamline their record keeping.
- Reviewing and documenting in the EHR can be done remotely.
- Within an EHR, there is the capability to transfer important information about a patient from one note to another, reducing the need to rewrite information that has not changed.
- EHR templates save time by displaying information in a standard format and relieving the practitioner of reestablishing a format each time a similar note is needed.
- More efficient computer entry, "real-time," i.e., during a patient encounter, could save time and reduce the need to recall details about the patient visit at a later time, potentially leading to greater accuracy.
- Better system efficiency including data retrieval, remote access, and transfer of information. Electronic access eliminates the cost and time needed to request and locate the hard chart. It also diminishes the chance of lost records, physical space required to store charts, and the need for personnel to assemble, store, and retrieve paper records.
- EHR systems allow multiple providers to simultaneously enter data during a patient encounter. This saves time tracking down and waiting to document in the hard chart.
- The EHR is more readily searched than the hard chart, which often existed in multiple volumes. The EHR is typically indexed by type of record, author, and date.
- EHRs integrate different types of information that at one time were maintained in separate paper files in the inpatient setting (e.g., practitioner orders, nurses and other ancillary staff documentation, prescription and medication administration records, allergies, vital signs, laboratory and radiographic studies, problem lists, and demographic information), into a single system and allow such information to be imported into electronic clinical notes.
- Real-time reminders and alerts can be incorporated into an EHR system including:
    - reminders about health care maintenance (e.g., immunization timing),
    - education (e.g., link to evidence-based guidelines), and
    - error checks (e.g., alerts about allergies or potential drug interaction or incorrect medication dosing).
- Improved regulatory and security monitoring the EHR includes "meta-data" (such as date and time stamps) and audit trail information that didn't exist in the legal paper record.

- Ease of quality improvement and research studies electronic data are more readily accessible for quality improvement, public health, and research studies.

Potential challenges with current EHR implementation. The EHR theoretically promises to improve efficiency and communication, reduce errors, and improve quality of care. Yet, every advance brings with it the potential for new problems, and the EHR is no exception. There are serious negative implications to poorly designed EHR systems, suboptimal EHR implementation, or careless EHR use by practitioners. A poor quality medical record, which could be inaccurate, inconsistent, incomplete, or obscure important information among unneeded or redundant detail, may adversely impact current or future care, transfers of care, and/or medico-legal investigations. Problematic aspects of current EHRs include:

- **Increased work load:** Data entry into the EHR can be time-consuming, particularly for practitioners who do not type well.[3]
- **Copy-paste:** Electronically carrying forward or copying portions of previously written notes and pasting them into a currently drafted note is problematic when it is either:
  - Copying the work of others without attribution ("clinical plagiarism") or without independent confirmation.[4]
  - Introducing unnecessary redundancy (see next point—"note-bloat.").
- **"Note-bloat":** Note bloat refers to unnecessary and redundant expansion of a note's length and complexity. With electronic documentation, it is easy to incorporate large volumes of data into clinical documentation. Inappropriate copy-paste, carry-forward, and computer-aided data entry (auto-filling) increases the risk of lengthy but information-poor notes. Such redundant content detracts from readability, makes it more difficult to interpret and identify pertinent content, and jeopardizes the communication for which clinical notes are intended.
- **"Boilerplate":** Despite the appeal of using templates, "boilerplate" text may add unnecessary detail that detracts from more important information. Furthermore, busy practitioners may carelessly retain parts of a normal review of systems or examination from the template rather than correctly indicating abnormal reports or findings from their interaction with the patient, resulting in inconsistent and erroneous information within the medical record.
- **Differences between the electronic version and paper copy of the EHR:** The printed copy of the EHR may look very different from the electronic version. Specifically, the paper copy of the EHR may differ from the electronic version either by including auto-populated redundant or extraneous information or excluding data that could not be readily printed. Currently, however, when copies of records are requested for patient care, investigative, or discovery purposes; they are typically provided as paper copies, often at a considerable cost to the requesting party, which may be difficult to read or incompletely reflect patient care.

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[3] Some practitioners rely on scribes or speech recognition software. Ultimately, the practitioner is responsible for ensuring that the medical record is accurate.

[4] The US Department of Health and Human Services and the Office of the Attorney General have expressed concern for fraud resulting from liberal copying-pasting within the EHR and subsequent upcoding, citing "possible abuses including 'cloning' of medical records, where information about one patient is repeated in other records, to inflate reimbursement In 2012, the Obama administration warned against such practice: "There are troubling indications that some providers are using this technology to game the system, possibly to obtain payments to which they are not entitled. False documentation of care is not just bad patient care; it is fraud." (Abelson and Creswell, 2012)

- **"Pseudo-history" and "pseudo-examination"*:*** Some EHRs convert checked symptom boxes into sentences and paragraphs that are then imported into the EHR such that they appear to recount the verbatim report of the patient. However, the generated history is not derived from the patient's actual words; it only represents binary (YES/NO) data processed into standardized phrases. A similar process with checkbox-to-sentence physical examination findings is available. Such technology potentially undermines consideration of each patient as an individual and conceals the nuances of his/her unique history and needs.
- **Errors in the EHR can be perpetuated and difficult to correct:** Some of these errors have serious undesirable implications for subsequent care and patients' health. Providers and patients complain that when an error occurs in the EHR, it can be very difficult to correct. These errors in documentation can be perpetuated over time and may lead to actual medical errors and adverse patient outcomes.
- **Interference with provider-patient relationship:** Real-time EHR entry during a patient visit may interfere with face-to-face contact with the patient, which may reduce active listening, conceal important diagnostic clues, and damage patient-practitioner rapport.
- **Overemphasis on documentation to meet billing specifications:** This issue largely dates back to E&M regulatory efforts, initiated when paper medical records still predominated. However, EHR systems have also incorporated E&M elements into their electronic templates leading to concern that documentation whose major design objective is to support coding and billing may subvert the true goal of the EHR, which is to promote high-quality, safe, and integrated health care.

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Guidance Document

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Medical Records: Documentation, Access, Retention, Storage, Disposal, and Closing a Practice

Observe, record, tabulate, communicate.

-Sir William Osler (1849-1919)

Introduction

The Washington Medical Commission (Commission) provides this guidance document to physicians and physician assistants (practitioners) on the appropriate documentation of a medical record; special considerations for maintaining an electronic health record (EHR); legal requirements involving ~~retention~~access, retention, storage and disposal of medical records; and the handling of records ~~when~~ if a practitioner is under discipline or closing a practice. The Commission recognizes that in some practice settings, practitioners may not have control over the records and may not be able to fully implement the recommendations made below. The Commission appreciates the variety of medical practices and urges practitioners to exercise reasonable judgment ~~which may vary by specialty~~ in the application of the guidance document. An appendix contains a history of the medical record, illustrative examples of complaints made to the Commission regarding medical records ~~made to the Commission~~, and additional information on the implementation and management of ~~electronic health records~~EHRs.

Guidance

I. Documentation

A. Purpose of the Medical Record

As part of delivering high-quality, safe, and integrated medical care, it is critically important that each practitioner maintains accurate, clinically useful, timely, and consistent medical records. A practitioner should maintain a medical record for each patient for whom ~~he or she provides~~they provide care. Notes, either handwritten, typed or dictated, must be legible. Dictation must be transcribed, reviewed, and signed within a reasonable time. The practitioner must ensure that the transcription of notes is accurate, particularly when using dictation or voice-recognition software.

The medical record is a chronological document that:

1. Records pertinent facts about an individual's health and wellness;

2. Enables the treating ~~care provider~~practitioner to plan and evaluate treatments or interventions, making clear the rationale for diagnoses, plans and interventions;
3. Enhances communication between professionals, ~~assuring the patient optimum~~to help optimize a patient's continuity of care;
4. Assists both patient and practitioner in communication with third party participants;
5. ~~-~~Facilitates the practitioner's development of an ongoing quality assurance program;
6. Provides a legal document for verification and/or audit of the delivery of care; and
7. Is available as a source of clinical data for research and education.

B. The Essential Elements of a Medical Record

The practitioner should include the following elements in all medical records:

1. The purpose of each patient encounter and appropriate information about the patient's history and examination, the patient's perspective and preferences, the plan for any treatment, and the care and treatment provided;
2. The patient's pertinent medical history including serious accidents, operations, significant illnesses, and other appropriate information;
3. Prominent notation of medications ~~and other significant allergies~~, or a statement of their absence;
4. ~~Known or suspected reactions including allergy warnings~~Prominent notation of any known allergies to medications and other allergens including the severity of the reaction (e.g., aspirin (hives), bee stings (anaphylaxis)), or a statement of their absence;
5. Clearly documented informed consent obtained from the patient or from a person authorized to consent on behalf of the patient. In some emergency situations, the reason for a lack of informed consent should be clearly documented; and
6. The date of each entry, and the time as appropriate.

C. Additional Elements of a Medical Record

The following additional elements reflect commonly accepted standards for medical record documentation:

1. Each page in the medical record contains the patient's name or ID number~~;~~
2. Personal biographical information such as home address, employer, marital status, emergency contact information and all telephone numbers, including home, work, and mobile phone numbers~~;~~
3. Each entry in the medical record contains the author's identification. Author identification may be a handwritten signature, initials, or a unique electronic identifier~~;~~
4. All drug therapies are listed, including dosage instructions and, when appropriate, indication of refill limits. Prescription refills should be recorded~~;~~
5. Encounter notes should include appropriate arrangements and specified times for follow-up care~~;~~

6. All consultation, laboratory, and imaging reports should be entered into the patient's record, reviewed, and the review documented by the practitioner who ordered them. Abnormal reports should be noted in the record, along with corresponding follow-up plans and actions taken;~~.~~
7. An appropriate immunization record is kept up to date by the primary care provider and, ideally, readily accessible by all clinicians caring for the patient, as technology permits;~~.~~
8. Documentation of appropriate preventive screening and services being offered in accordance with accepted practice guidelines, as relevant to the visit and/or the specific provider's role in caring for the patient; and~~.~~
9. Documentation of any other person(s) present during the encounter.

Where possible, the practitioner should avoid judgmental language in the medical record. The practitioner should consider that patients increasingly have access to and will read their own medical record. The practitioner should also be aware that a patient has a statutory right to submit a concise statement describing a correction or amendment for inclusion in the medical record. RCW 70.02.110. For a history of the medical record, see Appendix, Part I.

D. Special Considerations When Using an ~~Electronic Health Record~~EHR

The ~~An electronic health record (~~EHR~~)~~ is~~,~~ a digital version of the traditional paper-based medical record that~~,~~ documents health care that took place within a practitioner's office, single health care facility or health care system as well as all other communications (records of phone calls, emails, etc.) between the health care team and the patient. [1] The ideal EHR is designed to contain and share information among all involved ~~providers~~practitioners, patients, and their designated caretakers.

The EHR offers a number of potential benefits over the paper medical record. However, as with any innovation, there are challenges and potential hazards in its meaningful use. The Commission recognizes several problematic documentation practices while using an EHR that in some instances interfere with delivery of high-quality, safe, and integrated medical care; impede medico-legal or regulatory investigation; or are fraudulent.

1. Recommendations for Practitioners

The patient record in an EHR should reflect the same, or improved content and functionality, as that produced in traditional formats. The following recommendations, which are not necessarily exhaustive, are intended to inform practitioners of the appropriate use of an EHR, and to indicate how the Commission will evaluate a medical record, including records that are the product of an electronic system.

~~The patient record in an EHR should reflect the same or improved content and functionality as that produced in traditional formats, and will be held to essentially the same standard.~~

a. A practitioner using an EHR must ensure the following:

~~i.~~• A~~a~~uthorized use and compliance with state and federal privacy and security legal requirements, ~~law,~~ and with institutional privacy and security policies;
~~ii.~~• A~~a~~ timely, accurate, succinct, and readable entry;
~~iii.~~• C~~c~~onsistency and accuracy between various aspects of a record; and
~~iv.~~• A~~a~~ssumption of ultimate responsibility for trainees' and scribes' documentation.

~~a.~~ b. Retention or re-entry of inaccurate, inconsistent, or outdated information in the EHR from historic entries should be avoided. Original information needs to be retrievable from a separate location in the EHR via a secure and permanent audit trail.

c. A practitioner's actions and decision-making should be accurately reflected in the documentation and~~. The record will~~ include a description of any shared decision-making process that was utilized~~, when appropriate~~.[1]

d. Documenting aspects of a practitioner-patient interaction that did not transpire, such as indicating that components of a physical examination were performed when they were not, even when it occurs inadvertently because of EHR design or function, may be considered fraud.

e. W~~Similarly, w~~hen documentation about a significant aspect of the practitioner-patient interaction is not present, the assumption is that it did not occur.

f~~e~~. It is important to distinguish those portions of the history that were obtained by the note writer from those that were copied or carried forward from another practitioner's note. [2] The practitioner must recognize that "carry forward" or "cut-and-paste" functions, even when done automatically by the EHR software, ~~represent~~ create significant risks to patient safety. Concerns about "clinical plagiarism" or fraudulent billing may arise when appropriate and accurate attribution of copy-paste or carry-forward information is missing from an EHR note. Practitioners should carefully review and edit any EHR-generated note to assure its accuracy prior to authenticating it.

g~~f~~. Laboratory and imaging data should only be brought into the practitioner's note when pertinent to the decision-~~-~~making process for the patient. Wholesale importation of laboratory data and imaging data that is already documented elsewhere in the chart is to be avoided as such practice can make interpretation of medical records by subsequent caregivers extremely difficult.

h~~g~~. The practitioner should ~~assure~~ensure that problem lists, and medication lists, are kept current~~,~~ and that they are not cluttered with outdated information.

Examples of complaints received by the Commission relating to EHRs can be found in Appendix, Part II.

2. Suggestions for EHR Software Developers and Healthcare Institutions

The fruitful evolution of the EHR will require collaboration between entities that develop and purchase EHR systems and practitioners who use the EHR. The primary goal of the EHR is to promote high-quality, safe, and integrated health care. Other roles, such as documentation to support coding and billing, are secondary. It is unfortunate that, in general, these roles seem reversed in current EHR systems. With this in mind, the Commission offers suggestions about potential EHR improvements for software developers and health care

[1] EHRs have the potential to support shared decision-making. Studies show that EHRs that have incorporated shared decision-making tools result in improved clinical outcomes. *The Promise of Electronic Health Records to Promote Shared Decision Making: A Narrative Review and a Look Ahead*, Medical Decision Making, Vol. 38(8) 1040-1045 (2018). For more information on shared decision making, see the Washington State Health Care Authority web site on shared decision making, and the Bree Collaborative web site describing its work on this topic.

institutions~~,~~ and believes that practitioners should be involved in collaborative efforts with those entities to improve the EHR.

a. Practitioners and clinical information specialists have an important role to play in the development, decision-making, evaluation and improvement of EHR systems.

b. EHR systems should result in a patient record that is organized, concise, and easily readable. Lengthy and redundant information in the EHR, a source of common practitioner complaints, makes it difficult for other practitioners to identify data within the EHR that is relevant to actual patient care.[3]

c. EHR systems should also include tools to support the ~~clinician~~ practitioner to use best practices when available as well as shared decision-making.

d. An ultimate goal of the EHR universe should be widely compatible systems allowing seamless transfer and sharing of electronic medical information within and among practitioners, medical offices and clinics, hospitals and other health care institutions, as well as patients and their caregivers.

e. It is essential to have capacity within EHR systems to correct errors as soon as they come to light, and thereby prevent their perpetuation. The original documentation must be retrievable in the EHR via secure and permanent audit trail.

f. As patients increasingly have access to their EHRs, they will undoubtedly find information within the medical record that is erroneous or with which they disagree. There should be a mechanism in place within healthcare institutions to respond to patients' questions and concerns that arise from review of their EHR, and to allow patients to submit a correction or amendment for inclusion in the medical records. RCW 70.02.110.

g. Software supporting EHR clinical documentation should be designed and constructed for the type of ~~provider~~ practitioner ~~who will use it~~ (e.g., pediatrician, surgeon, ~~specialty~~cardiologist, ~~training~~) who will use it and the context in which it will be employed (e.g., training, admitting, consulting, ambulatory). It should automatically attribute information to each author.[4]

h. ~~The medical record serves~~Medical records serve many audiences who need to be considered in the design and implementation of EHR systems. To meet their potential, EHRs should incorporate comprehensive decision support that do the following:

~~a.~~• L~~l~~eads to improved patient outcomes;
~~b.~~• E~~e~~nsures safe transitions of patients from one practitioner, facility, or office to another;
~~c.~~• A~~a~~llows easy tracking and reporting of patient care metrics and outcomes; and
~~d.~~• P~~p~~romotes patient-centered communication between patients and the health care system.[3]

i. Health care institutions should consider having mechanisms in place to monitor documentation quality and practitioner satisfaction with the EHR, and to identify changes to support improved usability, validation, integrity, and quality of data within the EHR.[4]

j. The EHR should be designed for maximum portability and interoperability of information to benefit the patient and the public's health. Full integration into the Washington State Health Information Exchange provides benefit to the patient requiring treatment when away from

their medical home and provides meaningful data to assess population health. Technology vendors should design their systems with these functions as standards and institutions should mandate these functionalities as standard requirements for their implemented systems.

k. The EHR should support rapid, minimally complicated integration with the state's prescription monitoring program to facilitate inquiry in thatose systems.

For additional information on the implementation of an EHR, see the Appendix, Part III.

II. ~~Acces~~Handling, Accessing, and Amendings ~~to~~ Medical Records

A practitioner's ~~practices relating to~~handling of medical records under ~~his or her~~their control should be designed to protect patient privacy, to benefit the health and welfare of patients~~, whether current or past~~, and to ~~should~~ facilitate the transfer of clear and reliable information about a patient's care. The Commission recognizes that ~~electronic health records~~EHR systems may not be compatible, ~~making~~ which often makes ~~it challenging to~~that last goal challenging when sending records to a practitioner in another ~~electronic health record~~EHR system. Practitioners should do the best they can to protect privacy and to ~~get~~ provide medical records to patients, and ~~subsequent~~ other practitioners as indicated, ~~oviders~~ in a usable format. Practitioners should be aware of the following recommendations, statutes, and regulations as they address the authority of patients[2] to access, and potentially amend, their medical records.

A. To prevent misunderstandings, the Commission recommends that practitioners ensure that their offices or practices have policies regarding how patients may obtain copies or summaries of medical records. These policies must comply with the law and should be made available in writing to patients when the practitioner-patient relationship begins.

~~A.~~B. Per RCW 70.02.080, a practitioner is legally obligated to make medical records available to a patient to examine or copy within 15 days of the request. A practitioner may deny the request under circumstances specified in RCW 70.02.090.

~~B.~~C. Except for patients appealing the denial of social security benefits, the practitioner may charge a reasonable fee for making records available to a patient, another provider, or a third party and is not required to honor the request until the fee is paid. RCW 70.02.030(2). What constitutes a reasonable fee is defined in WAC 246-08-400. The practitioner cannot, however, withhold the records because an account is ~~overdue~~overdue, or a bill is owed.

~~To prevent misunderstandings, the practitioner's policies about providing copies or summaries of medical records and about completing forms should comply with appropriate laws and should be made available in writing to patients when the practitioner-patient relationship begins.~~

~~C.~~D. A patient has a statutory right to submit a concise statement describing a correction or amendment for inclusion in the medical record. RCW 70.02.110~~RCW 70.02.110~~.

E. The failure to provide medical records to patients in violation of RCW 70.02 can result in disciplinary action by the Commission.

Commented [KPS(1]: [just note that I moved this up as it is an overarching recommendation and the other sections have statutes attached so I think this was the flow seems a bit more natural, thoughts?]

[2] Legal protections of patients to access or amend their medical records include authorized patient representative(s) acting on the patient's behalf as permitted by law.

~~D.~~E. The Commission recommends that practitioners review and comply with all federal laws that address accessing or amending medical records including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 45 CFR Section 164.526.

III. Retention of Medical Records

~~There is no general law in Washington requiring a practitioner to retain a patient's medical record for a specific period of time.[3]~~ The Commission appreciates the variety of medical practices and urges practitioners to exercise reasonable judgment ~~which may vary by specialty for the~~ as they apply t~~retention of medical records.~~ he following recommendations to their retention of medical records.

A. There is no general law in Washington requiring a practitioner to retain a patient's medical record for a specific period of time.[4]

~~A.~~B. When appropriate, the Commission concurs with the Washington State Medical Association recommendation that practitioners should retain medical records and x-rays for at least:

- ~~1.~~ Tten years from the date of a patient's last visit, prescription refill, telephone contact, test or other patient contact;
- ~~2.~~ Twenty-one (21) years from the date of a minor patient's birth;
- ~~3.~~ Six years from the date of a patient's death; or
- ~~4.~~ Iindefinitely, if the practitioner has reason to believe:
  - ~~a.~~ Tthe patient is, or was, incompetent;
  - ~~b.~~ Tthere are, or were, ~~any~~ significant ~~problems with~~ concerns involving a patient's care; ~~,~~ or
  - Tthe patient is, or is likely to~~may~~ become, involved in litigation.
  - ~~c.~~

B. A practitioner should consider whether it is feasible to retain patients' medical records indefinitely.

C. A practitioner should verify the retention time required by their medical malpractice insurer.

D. A practitioner should inform patients how long the practitioner will retain medical records.

IV. Storage of Records

A. A practitioner is responsible for safeguarding and protecting the medical record, whether in electronic or paper format, and for providing adequate security measures.

~~[3] RCW 70.02.160 requires a health care provider to maintain a record of existing health care information for at least one year following receipt of an authorization to disclose that health care information and during the pendency of a patient's request either to examine or copy the record or to correct or amend the record. For hospital medical record retention requirements, see RCW 70.41.190.~~

[4] RCW 70.02.160 requires a health care provider to maintain a record of existing health care information for at least one year following receipt of an authorization to disclose that health care information and during the pendency of a patient's request either to examine or copy the record or to correct or amend the record. For hospital medical record retention requirements, see RCW 70.41.190.

Commented [KPS(2]: [add hyperlink if approved to Pub. L 104-191]

Commented [KPS(3]: [hyper link will be added if approved]

Commented [PK4]: [note that this number will update to 3, with the following footnotes all being updated in number once we accept moving this]

Commented [KPS(5]: [note that in these sub-bullet points I added present and past tense verbs, does that help address what is intended?]

B. A practitioner may contract with a third party to act as custodian of the medical records. The responsible person, corporation, or legal entity acting as custodian of the records must comply with federal and or state confidentiality laws and regulations.

V. Disposing of Records

When retention is no longer required, records should be destroyed by a secure means.

A. The Privacy Rule in ~~the Health Insurance Portability and Accountability Act (~~HIPAA~~)~~ prohibits digital and paper records containing confidential information from being thrown away in a public dumpster or recycling bin until they have been rendered unreadable or indecipherable by shredding, burning or other destruction.

B. A practitioner should give patients an opportunity to claim their records or have them sent to another ~~provider~~ practitioner before the records are destroyed. For some practitioners, the nature of their specialty ~~will~~ may make notifying patients impractical.

Commented [KPS(6]: [HIPAA is already now spelled out as to what it is in a new/earlier section, so I did not re-spell out what HIPAA is here]

VI. Handling Medical Records if a Practitioner Is Involved in Disciplinary Action

Disciplinary action by the Commission, including suspension, surrender or revocation of the practitioner's license, does not diminish or eliminate the obligation to provide medical records to patients.

Commented [KPS(7]: [note that I just moved this to be its own section as it was buried in the closing a medical practice subsections, but it really isn't closing a practice so I put it in its own category, even though it is quite short]

VII. Handling Medical Records When Closing a Medical Practice

~~A. The obligation to make medical records available to patients and other providers continues even after a practitioner closes a medical practice.~~

~~B.~~A. The recommendations in this section ~~do~~ may not apply to:

1. A practitioner who leaves a multi-practitioner practice~~. In that instance,~~ and the remaining practitioners in the practice ~~typically~~ assume care of the patients and retain the medical records~~;~~ or~~.~~
2. A ~~specialist or other~~ practitioner who has not had ~~does not have~~ ongoing relationships with patients and their ~~. These practitioners typically provide~~ patients' records have been provided to their referring practitioners, the patient~~'s~~' primary care providers, or directly to the patients.

~~C.~~B. Prior to closing a practice, a practitioner should notify active patients and patients seen within the previous three years.

~~D.~~ ~~The notice~~Notice should be given at least 30 days in advance, with 90 days being the best practice.

~~E.~~ ~~The n~~Notice should be given by at least one, but preferably all, of the following:
~~1.~~ ○ ~~I~~individual letter to the last known patient address;
~~2.~~ ○ E~~e~~lectronically, if this is a normal method of clinical communication with the patient; or
~~3.~~ ○ P~~p~~lacing a notice on the practitioner's web site, if the practitioner has a web site.

- If the practitioner is part of an institution or multi-practitioner practice, the institution or practice may provide notice of the closing of the practice, but it is the practitioner's responsibility to ensure those arrangements have been made.

~~F.~~• N~~The n~~otice should include:
  1. ○ the name, telephone number and mailing address of the responsible entity or agent to contact to obtain records or request transfer of records;
  2. ○ how the records can be obtained or transferred;
  3. ○ the format of the records, whether hard copy or electronic;
  4. ○ how long the records will be maintained before they are destroyed; and
  5. ○ the cost of recovering records or transferring records as defined in Chapter 70.02 RCW.

~~G.~~C. The practitioner is encouraged to provide notice to the local medical society, whether the practitioner is a member or not.

~~H. If the practitioner practices as part of an institution, the institution may provide the notice of the closing of the practice.~~

D. If the practice closes due to the practitioner's death, the practitioner's estate becomes the owner of the medical records and is encouraged to provide this notification to patients.

~~I.~~E. The obligation to make medical records available to patients and other practitioners continues even after a practitioner closes a medical practice.

~~J.~~A. ~~Disciplinary action by the Commission, including suspension, surrender or revocation of the practitioner's license, does not diminish or eliminate the obligation to provide medical records to patients.~~

There is no more difficult art to acquire than the art of observation, and for some it is quite as difficult to record an observation in brief and plain language.

-Sir William Osler (1849-1919)

Number:	GUI2020-01
Date of Adoption:	January 17, 2020
Reaffirmed:	N/A
Supersedes:	Retention of Medical Records GUI2017-02; and Physician and Physician Assistants' Use of the Electronic Medical Record MD2015-09

Appendix

I. History of the Medical Record

The medical record, as an entity documenting an encounter between a patient and a practitioner, is a relatively new concept. Prior to the turn of the 20th century, patient case reports were written retrospectively, primarily for the purpose of teaching [5], with less emphasis on continuity of care. In the early 1900's, real-time documentation describing patient history and treatment was an emerging format, but patient care data were scattered and disorganized. A first step towards improving the quality and utility of medical documentation occurred in 1907 when assigning a unique number to each patient and consolidating all data for that patient into a single record was introduced. [5]

As medical education and the medical profession progressed following the Flexner Report in 1910 [2], it became necessary to document a patient's history for continuity of care and to accommodate growing involvement of medical and surgical specialists. In 1918, the American College of Surgery initiated a requirement that hospitals maintain records on all patients so that their content could be used for quality improvement. [5]

Throughout the 20th century, standards for formatting of the medical record continued to evolve. The Problem Oriented Medical Record (POMR) was introduced by Dr. Lawrence Weed in 1968. [5] The initial intent of the POMR was as an educational tool to help trainees organize their decision-making and treatment plan around each of a patient's separate medical problems. [6] [7] However, the POMR gained widespread acceptance among practitioners at all levels as did the SOAP (Subjective-Objective-Assessment-Plan) note format, which was derived from the POMR. [8] Additionally, within health care institutions and specialties, standards have emerged for documenting various types of encounters between practitioners and patients (e.g., History and Physical, Operative Note, Ambulatory New and Return Patient Notes, Interim and Discharge Summaries).

Requirements for clinical documentation were dramatically altered by release of the Evaluation and Management (E&M) guidelines by the Centers for Medicare & Medicaid Services (CMS) in 1995 and 1997. [8] Intended as a measure of cognitive (as opposed to procedural) services, the E&M guidelines specified the format and necessary components to be included in the medical record to support specific CPT codes for billing. The complexity of these requirements led many practitioners to rely on medical record templates, which were designed to promote compliance with E&M guidelines.

Until the late 20th century, the medical record was largely recorded on paper, either written longhand, or dictated and then subsequently transcribed. In part driven by approximately $30 billion of federal incentive payments over the last five years, the rate of EHR adoption has since risen quickly, [9] such that practitioners and health care institutions not currently using EHR are now outliers. The EHR has specific goals (Table 1) and serves the needs of a variety of audiences (Table 2).

Table 1: Goals of the Medical Record[5] (as informed largely by Shoolin, et al [4])

- Tell the patient's unique story as it relates to the patient's concerns ("the patient voice");
- Document the pertinent history and physical exam findings,~~Demonstrate diagnostic thinking~~ in addition to~~and~~ the pertinent diagnostic testing results and decision-making processes undertaken by the practitioner, for each patient encounter;~~.~~
- Provide other pertinent clinical information to allow covering or consulting colleagues to maintain care and make informed decisions regarding further care;
- Support coordinated longitudinal plans of care and care transitions within and across organizations;
- Provide a clear and easily understood summary of the encounter, including ~~findings and recommendations~~the practitioner's assessment and plan;
- Document ~~, to the patient or the patient's designated representative~~conversations that occur with the patient or the designated caretaker including but not limited to the risks, benefits and alternatives discussed involving informed consent or shared decision-making;
  - ~~Provide clinical information to drive accurate Clinical Decision Support~~
- ~~Support and identify the quality of care provided to patients~~
- ~~Satisfy reasonable documentation requirements from payers~~
- ~~Create the legal business record of the patient care facility~~
- ~~Support population data collection and research~~
- Create the legal record of a patient's medical and surgical care;
- Create the legal business record of the practitioner's practice or institution;
- ~~Meet legal, accreditation, and regulatory criteria~~Satisfy reasonable documentation requirements from insurers or payers; and
- Support population health data collection and research.

[5] These goals are similar to the intentions of "Meaningful Use." For additional background, refer to: http://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives

Table 2: Medical Record Audiences

- Patients and their designated representatives;[6]
- Fellow practitioners;
- Other members of the health care team;
- ~~Researchers~~
- ~~Public h~~Health care systems or institutions;
- State agencies/regulatory bodies including but not limited to the Commission
- Workers' compensation programs or Social Security;
- ~~Payers~~
- Legal counsels, courts, and juries;
- ~~Courts, juries and medical review/regulatory bodies~~Insurers or payers; and
- Researchers.

Commented [PK8]: [can we get someone with IT skills to move this to the previous page, it would be visually ideal if we can have both tables on the same page, as that would allow starting this page with the next section (II. Examples of Complaints…, which seems a bit cleaner)]

II. Examples of Complaints Received by the Commission Relating to EHRs

After reviewing many complaints about EHRs, the Commission is concerned about problematic features of EHR implementation and use and offers the following examples of EHR-related problems, which are based on cases reviewed by the Commission:

- A patient complains that a practitioner documented a complete physical examination in the EHR when only a focused examination of a patient's rash had been performed.
- Under the physical examination section of a patient's EHR, "tympanic membranes within normal limits" is explicitly stated, but in the assessment, the patient is described as having a "right acute otitis media."
- An error in a CT report about a mass in the right kidney is subsequently corrected to indicate that the mass is in the left kidney. The original diagnosis of right kidney mass is carried forward in the EHR problem list, leading to a wrong-site surgery.
- A primary care practitioner forgets to include a patient's bleeding disorder in the EHR problem list following his first appointment with the patient. The incomplete problem list is carried forward without review or update for inclusion in numerous other documents. During major surgery two months later, the patient suffers a massive hemorrhage. The surgeon was unaware the patient had a bleeding disorder.

[6] With implementation and expansion of the EHR ~~and EHR~~, patients either already have or soon will have greater access to their own health information.

- A practitioner complains that her colleague copies and pastes the assessment portion of patients' EHR, including detailed medical decision-making, from other practitioners' notes and then bills at a higher level than his actual work would support.
- A patient files a medical malpractice claim after a delay in diagnosis of a brain tumor. The practitioner says that she performed a complete neurologic examination, which was normal, but the EHR documentation for the neurologic portion of the examination only states "Patellar reflexes 2+ bilaterally."
- A judge in a medical malpractice case found the EHR inadmissible because it contained so much redundant and irrelevant information.

III. ~~Current~~ EHR Implementation Benefits and Challenges

Potential benefits and advantages of the EHR. There are potential benefits of the EHR, particularly as compared to paper medical records. Certain capabilities of the EHR may present both the potential for improving and for interfering with optimal documentation and patient care, which reinforces the importance of thoughtful and careful EHR planning, implementation, and use.

- Legibility: Handwritten notes could be illegible.
- Potentially greater efficiency for practitioners who, under increasing time pressures and facing large volumes of data, need ways to streamline their record keeping.
- Reviewing and documenting in the EHR can be done remotely.
- Within an EHR, there is the capability to transfer important information about a patient from one note to another, reducing the need to rewrite information that has not changed.
- EHR templates save time by displaying information in a standard format and relieving the practitioner of reestablishing a format each time a similar note is needed.
- More efficient computer entry, "real-time," i.e., during a patient encounter, could save time and reduce the need to recall details about the patient visit at a later time, potentially leading to greater accuracy.
- Better system efficiency including data retrieval, remote access, and transfer of information. Electronic access eliminates the cost and time needed to request and locate the hard chart. It also diminishes the chance of lost records, physical space required to store charts, and the need for personnel to assemble, store, and retrieve paper records.
- EHR systems allow multiple providers to simultaneously enter data during a patient encounter. This saves time tracking down and waiting to document in the hard chart.
- The EHR is more readily searched than the hard chart, which often existed in multiple volumes. The EHR is typically indexed by type of record, author, and date.
- EHRs integrate different types of information that at one time were maintained in separate paper files in the inpatient setting (e.g., practitioner orders, nurses and other ancillary staff documentation, prescription and medication administration records, allergies, vital signs, laboratory and radiographic studies, problem lists, and demographic information), into a single system and allow such information to be imported into electronic clinical notes.

- Real-time reminders and alerts can be incorporated into an EHR system including:
  - reminders about health care maintenance (e.g., immunization timing),
  - education (e.g., link to evidence-based guidelines), and
  - error checks (e.g., alerts about allergies or potential drug interaction or incorrect medication dosing).
- Improved regulatory and security ~~monitoring~~monitoring of the EHR includes "meta-data" (such as date and time stamps) and audit trail information that didn't exist in the legal paper record.
- Ease of quality improvement and research studies electronic data are more readily accessible for quality improvement, public health, and research studies.

Potential challenges with ~~current~~ EHR implementation. The EHR theoretically promises to improve efficiency and communication, reduce errors, and improve quality of care. Yet, every advance brings with it the potential for new problems, and the EHR is no exception. There are serious negative implications to poorly designed EHR systems, suboptimal EHR implementation, or careless EHR use by practitioners. A ~~poor-quality~~poor-quality medical record, which could be inaccurate, inconsistent, incomplete, or obscure important information among unneeded or redundant detail, may adversely impact current or future care, transfers of care, and/or medico-legal investigations. Problematic aspects of current EHRs include:

- **Distraction during patient encounters:** Data entry by practitioners during patient encounters may be distracting to the patients and the practitioners. The main benefits of typing data into the EHR real-time are accuracy and efficiency. However, unintended consequences of typing while trying to converse may be the perception of not being "fully present" with each other which may hinder connection.
- **Increased ~~work load~~workload:** Data entry into the EHR can be time-consuming, particularly for practitioners who do not type well.[7]
-
- **Copy-paste:** Electronically carrying forward or copying portions of previously written notes and pasting them into a currently drafted note is problematic when it is either:
  - Copying the work of others without attribution ("clinical plagiarism") or without independent confirmation.[8]
  - Introducing unnecessary redundancy (see the next bullet-point, ~~—~~"note-bloat.").
- **"Note-bloat":** Note bloat refers to unnecessary and redundant expansion of a note's length and complexity. With electronic documentation, it is easy to incorporate large volumes of data into clinical documentation. Inappropriate copy-paste, carry-forward, and computer-aided data entry (auto-filling) increases the risk of lengthy but information-poor notes. Such redundant content

[7] Some practitioners rely on scribes or speech recognition software. Ultimately, the practitioner is responsible for ensuring that the medical record is accurate.

[8] The US Department of Health and Human Services and the Office of the Attorney General have expressed concern for fraud resulting from liberal copying-pasting within the EHR and subsequent upcoding, citing "possible abuses including 'cloning' of medical records, where information about one patient is repeated in other records, to inflate reimbursement In 2012, the Obama administration warned against such practice: "There are troubling indications that some providers are using this technology to game the system, possibly to obtain payments to which they are not entitled. False documentation of care is not just bad patient care; it is fraud." (Abelson and Creswell, 2012)

detracts from readability, makes it more difficult to interpret and identify pertinent content, and jeopardizes the communication for which clinical notes are intended.

- **"Boilerplate":** Despite the appeal of using templates, "boilerplate" text may add unnecessary detail that detracts from more important information. Furthermore, busy practitioners may carelessly retain parts of a normal review of systems or examination from the template rather than correctly indicating abnormal reports or findings from their interaction with the patient, resulting in inconsistent and erroneous information within the medical record.
- **Differences between the electronic version and paper copy of the EHR:** The printed copy of the EHR may look very different from the electronic version. Specifically, the paper copy of the EHR may differ from the electronic version either by including auto-populated redundant or extraneous information or excluding data that could not be readily printed. Currently, however, when copies of records are requested for patient care, investigative, or discovery purposes; they are typically provided as paper copies, often at a considerable cost to the requesting party, which may be difficult to read or incompletely reflect patient care.
- **"Pseudo-history" and "pseudo-examination":** Some EHRs convert checked symptom boxes into sentences and paragraphs that are then imported into the EHR such that they appear to recount the verbatim report of the patient. However, the generated history is not derived from the patient's actual words; it only represents binary (YES/NO) data processed into standardized phrases. A similar process with checkbox-to-sentence physical examination findings is available. Such technology potentially undermines consideration of each patient as an individual and conceals the nuances of his/her unique history and needs.
- **Errors in the EHR can be perpetuated and difficult to correct:** Some of these errors have serious undesirable implications for subsequent care and patients' health. Providers and patients complain that when an error occurs in the EHR, it can be very difficult to correct. These errors in documentation can be perpetuated over time and may lead to actual medical errors and adverse patient outcomes.
- **Interference with provider-patient relationship:** Real-time EHR entry during a patient visit may interfere with face-to-face contact with the patient, which may reduce active listening, conceal important diagnostic clues, and damage patient-practitioner rapport.
- **Overemphasis on documentation to meet billing specifications:** This issue largely dates back to E&M regulatory efforts, initiated when paper medical records still predominated. However, EHR systems have also incorporated E&M elements into their electronic templates leading to concern that documentation whose major design objective is to support coding and billing may subvert the true goal of the EHR, which is to promote high-quality, safe, and integrated health care.

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Compensation and Reimbursement for Commission Duties

Introduction

The Washington Medical Commission (Commission) will compensate its members for performing the duties of the Commission in accordance with RCW 43.03.265 and will reimburse its members for travel expenses in accordance with RCW 43.03.050 and RCW 43.03.060.

Compensation

1. Under RCW 43.03.265, the Commission will compensate its members a maximum amount of $250 for performing the duties of the Commission for eight hours or more in a single day. The Commission will compensate its members at the prorated hourly rate of $31.25 for performing the duties of the Commission for less than eight hours in a single day. The Commission will compensate its members for time spent on Commission-related work, including, but not limited to:
    a. Attending Commission meetings;
    b. Traveling to and from official meetings;
    c. Reviewing case files and preparing for case presentation, including journals and other research documents;
    d. Participating in telephone calls and telephone conferences;
    e. Reviewing complaints for the case management team meetings
    f. Reading the business meeting packet, the compliance packet, and other documents necessary to actively participate in Commission meetings;
    g. Preparing for and participating in settlement conferences;
    h. Participating on a hearing panel that does not occur at a regular Commission meeting;
    i. Reviewing agreed orders, stipulations to informal disposition, final orders, and other legal documents;
    j. Administrative and organizational duties requested by the Commission Chair and by members designated by the Chair.
    k. Administrative work by any commission member, including but not limited to e-mail or telephone correspondence
    l. Other duties expected of commissioners in the performance of their Commission role, including commission approved talks and educational conferences.
2. Reading journals or articles, or conducting research that is not directly related to case reviews, are to be done on the Commission member's own time and will not be compensated.
3. Only Commission members appointed to specific regular and ad hoc committees will be compensated for attendance at those committee meetings.

4. A pro-tem member may be compensated only for time spent on duties stated in the appointment letter from the Commission's Executive Director.

Reimbursement

1. Under RCW 43.03.050, expenses for lodging and meals will be compensated with a per diem rate in accordance with the Office of Financial Management (OFM) regulations.
2. Under RCW 43.03.060, automobile mileage will be compensated at the rate set by the Director of OFM, pursuant to RCW 43.03.060.
3. Other transportation costs will be compensated in accordance with OFM regulations. All airplane flights must be arranged through Commission staff.

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    c. Reviewing case files and preparing for case presentation, including journals and other research documents;
    d. Participating in telephone calls and telephone conferences;
    e. Reviewing complaints for the case management team meetings;
    f. Reading the business meeting packet, the compliance packet, the Panel L packet, and other documents necessary to actively participate in Commission meetings;
    g. Preparing for and participating in settlement conferences;
    h. Participating on a hearing panel that does not occur at a regular Commission meeting;
    i. Reviewing agreed orders, stipulations to informal disposition, final orders, notices of required examinations or denials, and other legal documents;
    j. Administrative and organizational duties requested by the Commission Chair and by members designated by the Chair;
    k. Administrative work by any commission member, including but not limited to e-mail or telephone correspondence; and
    l. Other duties expected of commissioners in the performance of their Commission role, including Ccommission approved talks and educational conferences.
2. Reading journals or articles, or conducting research that is not directly related to case reviews may, are to be done on the Commission member's own time and will not be compensated.

3. Only Commission members appointed to specific regular and ad hoc committees will be compensated for attendance at those committee meetings.
4. A pro-tem member may be compensated only for their time spent on duties stated in the appointment letter from the Commission's Executive Director.
5. All requests for compensation should be submitted to Commission staff within 30 calendar days. Any requests for compensation made after 90 calendar days following an otherwise eligible occurrence will be denied.

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1. UnderPursuant to RCW 43.03.050, expenses for lodging and meals will be compensated with a per diem rate in accordance with the Office of Financial Management (OFM) regulations.
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3. Other transportation costs will be compensated in accordance with OFM regulations.
4. To be eligible for reimbursement, All airplane flights must be arranged through Commission staff, and hotel arrangements must not be made through a third-party vendor.
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Procedure

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Processing Complaints Against Medical Students, Residents, and Fellows

Introduction

In carrying out its disciplinary role to protect the public, the Washington Medical Commission (WMC) occasionally receives complaints[1] against medical students, residents and fellows. Because of the highly-supervised environment in which they practice, the WMC creates this procedure for processing complaints against medical students, residents and fellows.[2]

Medical students are not required to have a license to practice medicine. They are legally permitted to practice medicine in an accredited school of medicine so long as the practice is pursuant to a regular course of instruction or assignments from an instructor, or performed under the supervision or control of a licensed physician.[3] Since medical students are in the early stages of learning in a highly structured and supervised environment, the dean of the medical school is often better equipped to address a concern than the WMC

Residents and fellows, who may or may not possess a license to practice medicine,[4] do not practice independently. Rather, they practice in a learning environment with continuous evaluation and feedback designed to develop the skills to be a competent physician. An attending physician is responsible for training residents and fellows as to the proper standards of care and appropriate behavior. The attending physician is therefore in a better position to manage concerns than the WMC. If, however, a resident or fellow practices outside the program and independent of the supervision of the attending physician, such as in a moonlighting setting, the WMC is the appropriate entity to address concerns and take action if necessary.

If a complaint alleges that a resident or fellow engaged in reckless behavior or gross misconduct, the WMC may investigate the complaint against the resident or fellow, and may choose to open an investigation on the attending physician as well.

Procedure

A. Complaints against medical students

1. A panel of the WMC reviews a complaint against a medical student.

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[1] For the purpose of this procedure, the term "complaint" includes a mandatory report under RCW 18.130.070 and 18.130.080.
[2] A fellow is a physician who has completed a residency and is pursuing further training in a medical specialty.
[3] Both residents and fellows are exempt from the license requirement under RCW 18.71.030(8) if they are in a program of clinical medical training sponsored by a college or university or hospital in this state and the performance of medical services are pursuant to their duties as residents and fellows. Although not required, many residents and fellows obtain a full license or a limited license under RCW 18.71.095(3) or (4)(b).
[4] RCW 18.71.030(8).

2. The panel may close the case and refer the matter to the dean of the medical school in which the medical student is enrolled, unless the panel believes that the medical student may have engaged in reckless behavior or gross misconduct. In such a case, the panel may choose to investigate the complaint.

B. Complaints against residents and fellows

1. A panel of the WMC reviews a complaint against a resident or fellow.
2. If the panel believes there was a breach of the standard of care, but there was no gross negligence or other reckless behavior, the panel will change the name of the case from the resident or fellow to the name of the attending physician.
3. If the panel believes that the resident or fellow engaged in reckless behavior or gross misconduct, the panel may decide to investigate the resident or fellow, and may open a new case and investigate the attending physician as well.
4. If the panel believes that the resident or fellow was practicing without the supervision of a license supervisor in an approved training program, such as in a moonlighting environment, the panel will treat the resident or fellow as it would any other licensed physician. The panel may decide to investigate the resident or fellow and will not hold the attending physician responsible for actions of the resident or fellow.
5. If the WMC takes disciplinary action against the attending physician, the WMC may consider restricting the attending physician from the training of residents or fellows, though the WMC is not limited to this particular sanction.

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WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Processing Complaints Against Medical Students, Residents, and Fellows

Introduction

In carrying out its disciplinary role to protect the public, the Washington Medical Commission (~~WMC~~Commission) occasionally receives complaints[1] against medical students, residents and fellows. Because of the highly ~~-~~supervised environment in which they practice, the ~~WMC~~ Commission provides~~creates~~ this procedure for processing complaints against medical students, residents and fellows.[2]

Medical Students

Medical students are not required to have a license to practice medicine. They are legally permitted to practice medicine in an accredited school of medicine so long as the practice is pursuant to a regular course of instruction or assignments from an instructor, or performed under the supervision or control of a licensed physician.[3] Since medical students are in the early stages of practicing medicine, and monitored ~~learning~~ in a highly structured~~, and~~ supervised environment, ~~the dean of the~~ medical school deans are~~is~~ often better equipped to address ~~a~~ concern~~s~~ than the ~~WMC~~ Commission.

However, if the Commission receives a complaint involving reckless behavior or gross misconduct by a medical student, the Commission may choose to investigate the complaint.

Residents and Fellows

[1] For the purpose of this procedure, the term "complaint" includes a mandatory report under RCW 18.130.070 and 18.130.080.
[2] A fellow is a physician who has completed a residency and is pursuing further training in a medical specialty.
[3] RCW 18.71.030(8). ~~Both residents and fellows are exempt from the license requirement under RCW 18.71.030(8) if they are in a program of clinical medical training sponsored by a college or university or hospital in this state and the performance of medical services are pursuant to their duties as residents and fellows. Although not required, many residents and fellows obtain a full license or a limited license under RCW 18.71.095(3) or (4)(b)~~.

PoResidents and fellows, who may or may not possess a license to practice medicine,[4]stgraduate clinical training programs generally require each of their residents and fellows to obtain a limited license which permits them to practice medicine in connection with their duties as a resident or fellow. do not practice independently. Rather, theBy design within their program, their practice of medicine occurs practice in a learning environment with continuous evaluation and feedback designed processes toto cultivatedevelop the skills necessary to be a competent physician. AAn attending physicians areis responsible for training their residents and fellowsresidents and fellows onas to the proper standards of care and appropriate behaviorprofessional conduct involving the practice of medicine. Due to established supervisory roles within training programs, a program director isThe attending physician is generally therefore in a a better positions than the Commission to manage concerns involving one of their residents or fellows than the WMC.

However, a limited license does not shield a resident, fellow or their supervising attending physician from possible discipline by the Commission involving reckless behavior or gross misconduct; additionally, a limited license does not authorize a resident or fellow to engage in any practice of medicine outside of their program. If , however, a resident or fellow practicess medicine outside of their program and independent of the supervision of the attending physician, such as in a moonlighting setting, the WMC Commission is the appropriate entity to address concernscomplaints, and to take action if necessary. Additionally,

iIf a complaint alleges that a resident or fellow engaged in reckless behavior or gross misconduct, the CommissionWMC may open an investigatione the complaint against the resident or fellow, and may choose to open an investigation on the attending physician as well.

Procedure

A. Complaints against medical students will be handled in the following manner.

1. A panel of the CommissionWMC reviews a complaint against a medical student.
2. The panel may close the case and refer the matter to the dean of the medical school in which the medical student is enrolled, unless the panel believes that the medical student may have engaged in reckless behavior or gross misconduct. In such a case, the panel may choose to investigate the complaint.

B. Complaints against residents and fellows will be handled in the following manner.

1. A panel of the WMC Commission reviews a complaint against a resident or fellow.
2. If the panel believes there was a breach of the standard of care, but there was no gross negligence misconduct or other reckless behavior, the panel will change the name of the case from the resident or fellow to the name of the attending physician.

[4] RCW 18.71.030(8). Both residents and fellows are exempt from the license requirement under RCW 18.71.030(8) if they are in a program of clinical medical training sponsored by a college or university or hospital in this state and the performance of medical services are pursuant to their duties as residents and fellows. Although not required, many residents and fellows obtain a full license or a limited license under RCW 18.71.095(3) or (4)(b).

3. If the panel believes that the resident or fellow engaged in reckless behavior or gross misconduct, the panel may decide to ~~investigate~~ open an investigation on the resident or fellow, and may choose to ~~open a new case and investigate~~ open an investigation on the attending physician as well.

~~3.~~ If the panel receives a complaint that the resident or fellow is impaired or potentially impaired as the result of a health condition, the panel may open an investigation and consider making a simultaneous referral to the Washington Physicians Health Program (WPHP). If WPHP determines that a resident or fellow may be unable to practice with reasonable skill and safety and that the resident or fellow is not following the requirements of the program, WPHP will make a report to the Commission pursuant to its statutory reporting obligations (RCW 18.71.320 and RCW 18.130.175). The Commission may choose to weigh WPHP's experience and expertise, the trust it places in WPHP as the Commission's approved physician health program, and WPHP's statutory reporting obligations, in evaluating the credibility and seriousness of the report.

~~4.~~

~~4.~~ If the panel believes that a~~the~~ resident or fellow was practicing independently outside of their program and without the supervision of an attending physician~~a license supervisor in an approved training program~~, such as in a moonlighting environment, the panel ~~will treat the resident or fellow as it would any other licensed physician. The panel~~ may decide to investigate the resident or fellow but~~and~~ will not hold an~~the~~ attending physician or program director responsible for actions of the resident or fellow.

~~5.~~

6. If the Commission takes disciplinary action against an attending physician, the Commission may consider restricting them from the training of residents or fellows, though the Commission is not limited to this particular sanction.

~~If the WMC takes disciplinary action against the attending physician, the WMC may consider restricting the attending physician from the training of residents or fellows, though the WMC is not limited to this particular sanction.~~

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