STATE OF VERMONT
BOARD OF CHIROPRACTIC

In re Jennifer B. Peet, D.C. } Docket No. CH03-0198

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

The Board of Chiropractic (Board) held a hearing in the above-referenced matter on October 2, 2001, at the Office of the Secretary of State, 26 Terrace Street, Montpelier, Vermont. Board Hearing Panel Members Julia McDaniel, D.C. (Chair), Sean Mahoney, D.C., Philippa Maloney, and Denise Natale, D.C., participated in the decision. Assistant Attorney General Michael McShane appeared for the State. Respondent Jennifer B. Peet, D.C., was present and represented herself pro se at the hearing.

Findings of Fact

1. Respondent Jennifer B. Peet, D.C., is a chiropractor licensed by the Board. She holds license number 6-720.

2. On four occasions in the spring of 1997, Patient C.P. visited Peet's office. The first visit was a consultation. Peet examined and treated C.P. during the three subsequent visits.

3. Peet adjusted C.P. during at least two of the four visits. The adjustments were limited in scope, because C.P. refused to be x-rayed more than once.

4. Peet kept very limited written records of her examination and treatment of C.P.

5. The general standard of care for chiropractic record keeping is (a) that written patient records should be kept, (b) that the written records should be legible, (c) that the chiropractor has an ethical responsibility to keep written patient records, and (d) that the written patient records should provide a subsequent treating chiropractor or other third party the ability to understand the patient's care and outcome.

6. More specifically, the standard of care for chiropractic record keeping requires, among other things, (a) that the chiropractor and patient be identified on each record, (b) that patient demographics, including family, social, and occupational histories, be included in the record, (c) that the onset of injury be documented, (d) that a review of symptoms be included in the record, (e) that any patient self-care be documented, (f) that examination findings be included in the record, and (g) that any special studies undertaken be documented in the record.

7. In addition, the chiropractor's progress notes for the patient should contain the elements of a SOAP note: (a) the patient's subjective complaints, (b) the chiropractor's objective findings, (c) the chiropractor's assessment of what is happening with the patient, and (d) the

chiropractor's plan of treatment for the patient.

8. The statutory provision governing chiropractic record keeping requirements need not list all elements of the professional standard of care, because the statute would be too cumbersome to draft and apply.

9. Legibility and clarity are specifically listed as necessary attributes of chiropractic health care records in the recommended clinical protocols and guidelines for the practice of chiropractic, published by the International Chiropractors Association (ICA). Both parties relied upon the ICA guidelines in this case and cited them as authoritative.

10. The ICA guidelines were published in 2000, but the standard of care for chiropractic health care records in 1997, when Peet treated C.P., was not substantially different.

11. Peet's health care records for C.P. fell below the standard of care because (a) they were not legible, (b) a reader could not tell what happened to the patient, why she was seen, or what she was treated for, (c) the records did not support a diagnosis, (d) the records did not clearly reflect what was done to the patient, and (d) the records did not indicate what technique was used.

12. More specifically, Peet's records for C.P. failed to address C.P.'s complaints of left abdominal pain, left hand numbness, pain in the upper right arm, and sleeping problems. Peet failed to put her own name on every page of the records, so that each page could be tracked and identified. Peet made diagnoses of neuritis (nerve pain) and ridiculitis (radiating pain) but did not perform tests to support these diagnoses, or, if she did perform the tests, she did not note them in her records, so that her records did not support her diagnoses. Peet's records did not indicate which of C.P.'s complaints were past history and which were current. Peet circled items C.P. mentioned in her health history but then failed to follow up on all of these items.

13. Availability or use of a key to decipher Peet's records for C.P. would not have raised the records up to standard, because the records were illegible to begin with.

Conclusions of Law

The ICA Recommended Clinical Protocols and Guidelines for the Practice of Chiropractic (2000), designated as authoritative by both parties in this case, clearly state how important good record keeping is in patient care and bear repeating here at length:

> The health care record serves many important functions and is one of the critical components of the health care delivery system. The most important function is in the immediate care and care of the patient. The record also permits different members of a health care team, or successive health care providers, to have access to relevant data concerning the patient to see what procedures have been performed and with what results. The health care record is important for documenting the specific services received by the patient so that the provider can be reimbursed for them. Records should be maintained in

a manner that makes them suitable for utilization review. The health record is helpful in the evaluation of practitioners, provides data for public health purposes, and may be used for the purpose of teaching and research. It is critical in a variety of legal contexts, including litigation by patients and malpractice claims.

Id. at 105.

The ICA guidelines on both chart/file organization and maintenance of records rate legibility and clarity as necessary components of chiropractic patient records:

> Health records should be neat, organized and complete. Entries in charts should be written in ink. Entries must not be erased or altered with correction fluid (whiteout) or tape or adhesive labels, etc. If the contents of any document are changed, the practitioner should initial and date such changes in the corresponding margin.

Id. at 109, 110.

In the increasingly complex modern health care environment, it is no longer sufficient for a chiropractor to keep patient records that are understandable to the chiropractor but that are not clear and legible to others who may need to consult the records for any of the reasons outlined in the ICA guidelines. Peet's record keeping system may have served her own needs in the past, but her methods cannot withstand scrutiny under standards current in 1997 and today.

In the specification of charges, the State requests that Peet's license be conditioned or otherwise disciplined. The Board declines to place conditions on Peet's license, because it believes that the guidelines set forth in Board Rule 6.1 (minimal record keeping standards), effective June 1, 2001, should be sufficient to put Peet on notice of what she needs to do to bring her record keeping up to standard. At this time, the Board is of the opinion that a reprimand is the appropriate disciplinary action for Peet's failure to uphold the standard of care in keeping health care records for Patient C.P.

Order

On the basis of the Findings of Fact and Conclusions of Law, IT IS HEREBY ORDERED by the Board of Chiropractic of the State of Vermont that:

1. Jennifer B. Peet, D.C., is REPRIMANDED

2. Pursuant to 3 V.S.A. § 129(a)(7) and 131(c)(2)(C), this document is a public record and may be provided to other licensing authorities.

3. This order takes effect as of the date of entry shown below.

Appeal Rights

This is a final administrative determination. A party (the State or respondent) may appeal by filing a written notice of appeal with the Director of the Office of Professional Regulation, Office of the Secretary of State, within 30 days of the effective date (the date of entry shown below) of this order. The filing of a notice of appeal does not automatically stay the Board's order.

Dated: November 26, 2001

VERMONT BOARD OF CHIROPRACTIC

By: Julia McDaniel D.C.
Julia McDaniel, D.C., Chair

Date of entry: 11/26/01