

# LETTERS TO THE EDITOR

## Fairness to Students Top Priority

### TO THE EDITOR:

We wish to thank Dr Walling and her colleagues for their recent article in *Family Medicine*, “Do Students Falsify Information in Clinical Notes?”<sup>1</sup> The authors appropriately conclude that all potential sources of error must be excluded before making judgments of falsification of data. For the 15 scored history items for each case in their school-based clinical skills assessment (CSA), the authors conclude that disparities between what was obtained during history-taking and what was recorded in post-encounter notes were mostly explained by flaws in their examination processes: standardized patient error, poorly worded checklists, and data entry error. Accusing students of falsifying data is a serious allegation, and care must be taken to ensure fairness to students.

In 2007, the National Board of Osteopathic Medical Examiners (NBOME) instituted a policy to address the accuracy and integrity of elements of post-encounter notes for the Comprehensive Osteopathic Medical Licensing Examination-USA Level 2-Performance Evaluation (COMLEX-USA Level 2-PE), the high-stakes clinical skills licensing examination for osteopathic medical licensure.<sup>2</sup> The process for failing students due to a consistent pattern of misrepresentation of clinical findings on written post-encounter notes in COMLEX-USA Level 2-PE has been described.<sup>2-5</sup> Between 2007 and 2010, 12,510 candidates took COMLEX-USA Level 2-PE, and 24 students have failed because of clearly documenting medical history that was not elicited or physical examination maneuvers or techniques that were not performed during the encounters.<sup>5</sup> With the high-stakes nature of the COMLEX-USA Level 2-PE, the NBOME takes great care in following strict procedures for flagging, screening, and making final determinations. Each note and corresponding video are reviewed by physician staff and an external panel of physician reviewers to exclude all sources of error, like those identified by Walling et al, before rendering a final decision. This policy was instituted to ensure exam integrity and to emphasize

that overdocumentation practices, if continued in clinical practice, may jeopardize the safety of patients.

Walling et al identify important causes to exclude before alleging “deliberate falsification.”<sup>1</sup> Without understanding or knowing the intent of students when writing post-encounter notes that contain information that was not obtained during the clinical encounter, we agree that this behavior cannot necessarily be considered deliberate. Certainly if the actions are deliberate, then they clearly fall into the category of unprofessional behavior. Even if they are not deliberate, however, the recorded information was not obtained during the patient encounter, and the recorded information may therefore be inaccurate. Deliberate or not, overdocumentation errors still may lead to devastating negative patient outcomes if continued in clinical practice. Therefore, the identification of students who are repeatedly making these types of errors in their documentation on COMLEX-USA Level 2-PE is consistent with the NBOME’s mission to protect the public. Honoring the public trust demands that the medical profession self-regulate and promote the safe and professional practice of medicine.

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### References

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**AUTHORS' REPLY:**

We greatly appreciate the comments from Drs Langenau, Sandella, and Gimpel as our study was prompted by their reports from the National Board of Osteopathic Medical Examiners (NBOME). Our primary concern was that alleged over-reporting in clinical notes would lead to students being falsely accused of serious professional misconduct—a stigma with longstanding implications.

We completely agree that student note fabrication is a rare but serious concern for student professionalism and patient safety. The literature cited by Langenau et al nicely describes procedures to identify such fabrication in a high-stakes national examination. Our experience illustrates that at the medical school level, practical issues with the examination itself were the predominant reason why some students were initially flagged as potential fabricators but were ultimately cleared. We decided to report our experience in a transparent manner to draw attention to the absolute necessity for quality improvement in institutional clinical examinations. Our findings suggest that despite continued refinement of evaluation methods, clinical skills examinations remain

rather blunt instruments and should be interpreted cautiously.

All errors in clinical documentation are potentially serious, regardless of the type of error or motivation of the recorder. Improved ability to recognize true fabricators in our learners is increasingly important, due to the rapid adoption of electronic health records (EHRs). Many EHR systems have features that facilitate inaccurate and potentially dangerous reporting of data that were not obtained in a clinical encounter. These features include automatic population of data fields, default documentation of “normal” clinical findings, and “cut and paste” of prior data. We are concerned that the accuracy of notes will decline substantially and hope more of our colleagues will be stimulated to investigate the accuracy of clinical documentation—a fertile and important area for clinical and educational research.

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