Proper Documentation and Good Medical Record Keeping: An Essential Part of Patient care

V. Ramachandiran
Senior Medical Records Officer.
Sri Venkateshwaraa Medical College Hospital & Research Centre,
Puducherry-605102

Abstract: In this communication, the author illustrates the importance of proper case documentation and medical record keeping through a partly fictional case study. A patient had undergone laparoscopic cholecystectomy. Post-operatively, he developed pain and distension of abdomen for which he underwent re-exploration. After discharge, his son requested compensation for the re-operation and prolonged hospital stay. The appropriate committee investigated the matter and imposed fine to the concerned clinical staffs for the lack of proper case documentation and in part due to certain negligent attitude. The medical records should be properly documented, including the clinical case details, details of procedure performed and name of the surgeon who actually performed it and the occurrence and details of postoperative complications, as the records can be used in medico-legal litigation to prove or disprove the claims. The importance of medical record keeping and its confidentiality are also emphasized.

Key words: Medical Record, Documentation, Confidentiality.

Introduction:
In this communication, the author illustrates the importance of proper case documentation and medical record keeping through a partly fictional case study as narrated below:

History:
A 58-year-old man had attended the medical outpatient department (of a secondary care facility) with the complaint of pain abdomen on 14th July 2009. After physical examination that revealed skin petechiae, he had been admitted for further evaluation on the same day. During the ward rounds, ultrasonography of abdomen was ordered and surgical referral was also made on 15th July. He was booked for ultrasonography on 16 July. In the meanwhile, the surgeon examined the patient and advised transfer of patient to the surgical facility. On 16th July, ultrasonography of abdomen was performed and the report was sent to the medical ward. Since the patient was not in medical ward, the report was retransmitted to the medical records department (MRD). Filing clerk of MRD handed over the report to the surgical ward nurse on 18 July. The sonographic impression was cholelithiasis. The patient underwent laparoscopic cholecystectomy on 20 July.

He was operated by:
Surgeon: Dr. X
Assistant: Dr. Y
Start time: 9.00 hrs.
End time: 13.25 hrs.

Postoperatively, patient developed pain and distension of abdomen, which did not resolve with support measures. Hence, patient was taken up for surgical re-exploration that revealed an artery was damaged during the initial surgery. Hence, Roux-en-Y procedure was performed. The post-operative period was smooth and the patient was discharged on 28 July.

On 29th July, the patient's son wrote a complaint to the Health Directorate mentioning that his father was not treated properly and also asked the reason for re-operation. Moreover, he also requested for compensation for the reoperation and prolonged stay that caused his father mental agony and loss of wages.

The Health Directorate forwarded the complaint to the Medico-Legal Committee (MLC) and requested the committee to investigate the case. The MLC demanded the case sheet of the patient for medical audit. From the medical record, the committee raised the following issues:
1. Delay in referring the case to surgeon,
2. Delay in getting the sonogram report, and
3. Prolonged period of Laparoscopic cholecystectomy.

Resolution:
The physician was called for his explanation for the delay in referring the case to surgeon, as petechia was noted during physical examination. In other words, why he did not refer the patient on the same day of admission? Moreover, the plan of care was not properly documented. As the committee was not satisfied with his explanation,

he was asked to pay a fine.

The Radio-diagnosis department was questioned for the delay in issuing the report, as the impression of the sonogram report was "cholelithiasis". The Committee felt the radiologist should have at least informed the result (positive findings) over telephone. This would have helped the team to speed up their line of management. The Radiologist was also asked to pay a fine.

The Principal Surgeon was questioned for the prolonged period of surgery (for about 4 hours and 25 minutes). The Principal surgeon replied that he did not perform the surgery, but he assisted. His assistant willingly performed the surgery.

As per the document, the principle surgeon was the operating surgeon, although in practice, it was he who assisted the surgery and the assistant actually performed the surgery. This was confirmed by the witnesses of theatre staff. The committee counseled him and imposed penalty.

The Committee also interrogated the assistant (surgeon). He replied that he had performed the laparoscopic cholecystectomy under the supervision of the unit chief. However, the committee warned him and advised him to follow the ethical norms meticulously. The committee also imposed penalty and also issued warning letters to both surgeons. The committee also paid the monetary compensation to the patient.

From the above case, it is evident that proper documentation and good medical record keeping are essential part of patient care.

Discussion:

Medical record keeping started in India in the nineteen sixties and has grown tremendously, parallel to modern medicine: It has evolved from the paper medical record, unit medical record, paperless medical record and presently it is becoming electronic medical record. The medical records are used for the following purposes:

i. to document the course of medical illness and treatment,
ii. to communicate between physicians and other professionals contributing to patient care,
iii. to provide continuity of patient care during the subsequent visit of the patient,
iv. to review, study and evaluate patient care by hospital medical staff committees,
v. to provide data to the third party concerned with the patient upon proper requisition and ensuring confidentiality,
vi. to provide data in protecting the legal interest of the patient, the hospital and the medical staff,
vii. to provide the clinical data for research, study and education.

It should be remembered that the confidentiality of the medical record is maintained, while using medical record either as a personal document or impersonal document.

The medical record today is a compilation of pertinent facts of patient's life and health history, including past and present illness (es) and treatment(s), written by the health professionals contributing to that patient's care. The medical record must be compiled in a timely manner and should contain sufficient data to identify the patient, support the diagnosis or reason for health care encounter, justify the treatment and accurately document the results[1].

In 1995, after the Hon'ble Supreme Court gave the decision that doctors also come under the purview of the Consumer Protection Act, 1986 and the medical records have become an important aspect of the written evidence. Records and documents properly kept can become defense shields for the doctors in the court of law. Hence, proper maintenance of such records should form an essential element of good practice. Therefore, the doctor should take every precaution to preserve the medical records of a patient for the stipulated period. It will act as a passport to prove his or her innocence in any alleged medical negligence[2].

Medical records are used in medico-legal litigation to prove or disprove it. Hence, medical records are to be kept for a prescribed period, as per the retention policy of the hospital or State. The confidentiality of medical records should be maintained during the retention period.

Medical records are owned by the institution or individuals providing care for the clients. Owners are responsible for safeguarding the medical record contents against loss, tampering and unauthorized access to information. Despite the medical record's source, its purposes, contents and governing legal requirements are essentially the same.

Institutional/provider is responsible for ensuring the confidentiality of medical information contained in the medical record including unauthorized disclosure to personnel, unauthorized disclosure to outsiders, and accidental or malicious errors. The medical record is the primary source of evidence in malpractice and other professional negligence lawsuits. It is also used in criminal, personal injury, worker's compensation, and insurance and probate cases.

The hospital compiles and keeps medical records primarily for the benefit of the patient and the protection of the hospital and health care team. However, the personal data contained therein, considered as confidential communication, is the property of the patient. They are being kept for the benefit of the patient and medical records are also kept as a guide for health care professionals in the education of undergraduates and postgraduates, for the training of the nurses, medical research, for compiling statistical information and the protection of the care providers against unjust criticism.

When the hospital admits a patient, it enters into an implied contract to render service necessary in the care and treatment of the patient. This necessitates keeping a chronological record of the care and treatment rendered by the medical personnel.

Before a medical record may be used as evidence in litigation, the following must be established[3]:-

i. The record is that of the patient in question,
ii. the record has been compiled in the ordinary course of patient encounter and consultation
iii. The record has been prepared by person who has knowledge of the events being recorded.
iv. The record has been prepared before litigation begins; and
v. The record is legible.

Conclusion:

Medical records are important documents in general and more so in the event of litigation in particular. They are used in a number of ways. They are also used in legal affairs, as they provide ample healthcare information and also help in protecting the legal interests of patient and health care providers.

Please remember that[4]:

1. What is written and followed actually happened.
2. What is written and not followed may not have happened.
3. What is not written never happened.

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Corresponding Author:

V. Ramachandiran,
Senior Medical Records Officer.
Sri Venkateshwaraa Medical College Hospital & Research Centre,
Puducherry-605102.
Email: rvaradarassou@yahoo.co.uk.