Documentation in Medical Practice

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ABSTRACT:

Many Doctors do not follow proper documentation of medical Records. In fact many of them do not realize the importance of documenting their records thoroughly, thereby exposing them to frivolous charges of malpractice. This paper seeks to impress upon the importance of proper medical documentation and its medico legal significance. The materials are collected by reviewing medical records of KMC hospitals and Govt. Wenlock hospital, Mangalore, India along with medical registers of medical record departments of above-mentioned hospitals. For additional information the listed references were consulted.

Key Words: Medical Records; Documentation; Documentary Evidence

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INTRODUCTION:

A Record can be defined as a Documentary Evidence of any fact or an event. In case of medical records it pertains to documents containing the patient's history, clinical findings, investigations, operation notes and day wise progress.

Presently with medical care getting more complicated, voluminous investigations and data entry is the norm. This has necessitated proper maintenance of patient's records.[1] Because of the increasing cases of litigations against doctors, there is also the overriding need of the legal systems which now makes it imperative for every physician to keep detailed records of his patients.

Records have multiple uses for the modern physician.

1. It helps to document the patient's past and present history of illness.
2. It helps in following up patient's progress and response to treatment.
3. It helps in predicting future risks to the patient's health during treatment and after discharge.
4. It helps the community to maintain epidemiological data thereby assists in improving the health prospects of future generations.
5. Medical records also serve the purpose of medical audit as well as hospital statistics.
6. They help in educating medical personnel and are also useful for clinical research and can help in formulating treatment procedures, policies and guidelines.
7. Documentation is the backbone of any clinical research and advancement.
8. Finally, proper records form a mirror in the court of law, of a physician's actions.

Courts are able to judge the correctness of the treatment only by the available documentary evidence. Thus medico legally speaking, properly maintained case notes are vitally important to the defense of the doctor in any case against him. The Medical record itself can sometime, determine whether or not a malpractice claim will survive beyond counsel's initial review of case. [2]

In our country, many doctors have not realized the importance of maintaining proper case papers and it is common to come across perfunctorily written case notes even in cases of major surgeries. The medical record must speak for itself and accurately reflect the care that patient has received. [2] There have been instances where the doctors have been held liable because they were unable to produce the patient's case papers before the court.

For the purpose of present study the materials are collected by reviewing medical records of KMC hospitals and Govt. Wenlock hospital, Mangalore, India along with medical registers of medical record departments of above-mentioned hospitals. For additional information the listed references were consulted.

Records and Documents

Hospitals records should contain the following data.

1. Registration and administrative data
    i) Name, age, sex, occupation, income, address.
    ii) Date and time of admission and discharge/death.
    iii) Identification (in case of certificates)
2. Medical parts of records.
    i) Case history, clinical notes, investigations requested, surgical notes, progress sheets.
    ii) Final diagnosis and Condition on discharge.

iii) Cause of death, date and time of death.

iv) Discharge summary giving details of clinical history, progress, investigations done, treatment given and referral notes.

This part of the medical record is included in case sheets. In addition there are:

v) Investigation reports.

vi) Consent forms.

vii) Referral notes.

Hospitals are supposed to maintain the following registers in addition to case sheets:

1. Out Patient Register.
2. In patient register.
3. Operation theatre register.
4. Delivery register.
5. Births and Deaths register.
6. Laboratory register.
7. Radiology register.
8. Nurses register and night report.
9. MLC register.
10. MTP register.
11. Family planning device register.
12. Equipment Register.

Various certificates issued by the doctor also form part of medical records. They are to be documented in their prescribed formats.

Modernization has added new forms of documentation like computerized records, videotapes of various operations, electronic pulse, B.P. and Oxygen saturation records, F.H.R. Monitoring record charts, E.C.G. monitoring records etc.

Case papers can be indoor or outdoor. **Outdoor case papers** are usually left with the patients. Sometimes only the prescriptions form the record, which is entirely an incorrect practice. For example, if a patient develops severe allergic reaction to the prescribed drug, even if the doctor had enquired about drug reactions but does not document the fact, in a court of law it will be deemed that he had not enquired about the condition, as it was not documented. It is also very important for the general physician who makes home visits to maintain records of such visits after coming back by noting the findings and the treatment given in the patient's case sheets.

Indoor case papers are documented at the place of treatment, for example the hospital. In such cases it is necessary to record a detailed history, complaints and examination findings of the patient. Some important points that should never be forgotten are the history of allergies, previous surgeries and previous ongoing medications. In indoor case papers, the notes should be contemporary i.e. written as the thing happens. Records that are made up later may be made out by the judges as having been made up as per the convenience, and this can go against the doctor's defense in the court of law.

Day to day updating of indoor case papers is also equally important. For example if a doctor had visited a seriously ill patient and the fact was not documented, there would be no way to prove the contrary in a court of law.

Operation notes form an important part of any case record. If postoperative complications do occur, the court will always look at the correctness of steps having been taken during the procedure. Sometimes, properly written notes of difficult surgeries can protect the surgeon in case of postoperative complications. In a case decided by the State Consumer Forum, the formation of a Recto-Vaginal fistula after

hysterectomy was considered as a pardonable complication as the patient was documented to have multiple adhesions.

The Consent form is a legal and written documentation of consent. Consent form is only a proof of the patient agreeing to undergo the legitimate and proper treatment. Some doctors obtain what could be described as a blanket one line consent from their patients which usually states that the doctor may carry out any operation under any anesthesia to which a patient has agreed presumably. This type of consent has no value in the eyes of the law.

Prescriptions are the instructions to the patient given by the doctor. It should contain the name of the patient as well as date. It should be legible and properly signed. Before writing a prescription a doctor should confirm that the patient is not allergic to the prescribed drugs. The side effects and interactions with other drugs should be considered and in case of a female patient, the possibility of conception should always be thought of. Undated prescriptions could be misused and can get the doctor in trouble in a medico legal situation.

Certificates given by doctors sometimes come under the scrutiny of law as doctors face pressure from their patients to give false certificates, a common example being sickness leave certificates. But it is important to remember that giving a false certificate can be a criminal offence. There is a famous case of a surgeon, who gave a predated certificate for a patient who had undergone an appendicectomy and unwittingly provided an alibi in case of a murder.

The various certificates issued by the doctor in his professional capacity are:

1. Admission & discharge certificate.
2. Emergency admission certificate.
3. Birth record certificate.

4. Death Certificate.
5. Medical termination of pregnancy certificate.
6. Maternity certificate.
7. Leave certificate.
8. Injury certificate.
9. Disability certificate.
10. Sickness Certificate.
11. Fitness Certificate.
12. Medico legal case certificate
13. Unsoundness of mind certificate.
14. Vaccination certificate.
15. Insurance certificate.
16. Drunkenness Certificate.
17. Potency Certificate.
18. Post Mortem Certificate.

Death Certificates should be very carefully given. One should be very sure of the diagnosis before giving a death certificate. In case of a doubt, it is always better to ask for a post mortem examination. Death certificates are extremely important documents and while issuing a death certificate certain precautions have to be taken. A doctor should not issue a death certificate unless he has attended the deceased at least once during the seven days preceding death. A doctor is not entitled to charge fees for writing a death certificate. He also cannot delay or refuse on the grounds of non-receipt of professional fees.

A doctor can refuse to give death certificate if

1. He is not sure of the cause of death.

2. It is a sudden and unexpected death.
3. There is suspicion of foul play.
4. The death is caused by a violent or unnatural cause, drug, medicine or poison.
5. There is suspicion of starvation, exposure or neglect.

In such situations one has to report to the police authorities before the body is removed for cremation. Signing of blank death certificate in anticipation of death is not only illegal but is also in violation of medical ethics.

While giving a certificate it is important to identify the person concerned and to note the identification marks on the certificate. The certificate should also contain day, date, diagnosis, advice given, signature, name and registration number of the doctor with the signature or thumb impression of the patient. It is advisable to keep a duplicate copy of any certificate issued.

Investigation reports form an important part of patient records. Proper preoperative investigation can also help in proving duty of care on part of the doctor. Investigations help in proving the diagnosis and soundness of the treatment. X-rays, ultra sound, E.C.G. records and histopathological reports are irrefutable proof of proper diagnosis and treatment and hence are extremely important medico legally.

Discharge cards are kept by patients. It is important that the discharge summary should always co-relate and mirror the case notes of the patient. The discharge cards should always include the instructions to be followed by the patient after his discharge. It should also include the instructions regarding follow up visits and the circumstances in which the patient should report to the doctor earlier than the routine follow-up.

A case is reported where a patient's hand was put in a plaster by an orthopedic surgeon; the fingers became edematous and blue due to swelling and consequent reduction of circulation. The patient did not report to the doctor as he was told to come back only after three weeks. Since no clear instructions were given to come earlier in such circumstances, the case went against the doctor.

Referral notes are an important aspect of the patient's records. The referral note should always include date and time of issue of patient's general condition, cause of reference and expected course of action to be followed. It is always wise to keep duplicate copy of the referral note with patient's signature on the same.

Citing an example, a general practitioner refers a patient with jaundice to a better-equipped general hospital. The patient goes there only after three days when his condition had deteriorated considerably. When the patient died, the relative's alleged that the doctor was late in referring the patient. This highlights the importance of the duplicate referral note preserved by the doctor.

Equipment receipts are considered as legitimate records by the courts. In a case of injection abscess, the doctor could defend himself by showing the purchase receipts of disposable syringes and needles, thus proving to the court that he was using disposable syringes and needles and hence could not be held negligent of causing an abscess. Similarly, oxygen filling receipts, ECG monitor and pulse oxymeter receipts could help the doctors in proving the presence of such equipments.

Reactions after blood transfusion have led to many mishaps. Hence, preserving blood bank receipts as well as blood bottle labels have helped doctors. In cases where serum hepatitis was alleged to have been caused due to blood transfusions,

it could be proved by the blood bottle labels that the blood was checked and was free of serum hepatitis antigen.

In modern times, high-tech records like computerized records can form a proper record document. However, they need to be initialized by the doctor to prove their authenticity. Videotapes of endoscopic surgeries, electronic fetal heart monitor charts, continuous ECG and pulse oxy meter charts become important evidential documents in the court of law.

Legal Aspects of Medical Records

Hospital records are the property of the hospital or the doctor[3]. It is a confidential record of the patient and cannot be released without the doctor's permission or the patient's consent. Any information from the patient's medical records should be released only on the written request by the patient, for example to the employer or to insurance companies. They cannot be released directly to employer or insurance companies except in cases where public interest is at stake. It can be released only to the concerned authorities and cannot be made public. Police authorities and courts can summon medical records under due process of law. The Mumbai High Court has recently ruled that a doctor must provide copies of the patient's case papers to the patients on request.

If the records are in the written format, they must be legible and any alterations in the records must be initialed. If a correction is made, merely a single line should be drawn through the incorrect entry with an initialed notation in the margin[1,4]. Tampering with medical records can be both costly to the reputation of the physician and hospital resulting in large malpractice awards even when there has been no negligence. [4]

How long to preserve the case papers

This has always remained a controversial point. Limitation period for filing a case is up to 3 years under the limitation act (2 years according to Consumer Protection Act). However, this limitation period starts only after the patient comes to know the effect of the alleged negligence by the doctor. It starts after the patient becomes capable of understanding that the damage caused was due to negligence, i.e. excluding the period of any mental illness as well as the period during which the person was a minor.

An extreme example can be given of the obstetrician who was sued by a child who was delivered by him and suffered a birth related injury, 21 years after birth, i.e. within 3 years of the child becoming a major according to the law.

The Maharashtra Government had issued a resolution (referred G.R. No. JJH-29 66/49733) which states that OPD papers should be kept for 3 years, indoor case papers for 5 years and MLC records for 30 years. This may form a guideline, but in a given case, discovery of negligence as mentioned above will always be crucial.

CONCLUSION:

Records are documentary evidence of any fact or an event. Therefore medical records pertain to events in the treatment of a patient.

In the olden days, medical practice evolved by the systematic documentation of diseases and their treatment. Charaka Sahmita is a great example of an ancient system of medicine, which was compiled by the famous practitioner of Ayurveda, Charaka, which is even now referred to by students of Ayurveda. Siddha, Unani and the Chinese system of medicine are other examples which have survived for generations simply because they were well documented. If not for proper

documentation, these systems of medicine would simply have vanished from the face of the Earth.

Allopathy is a relatively new system of medicine which has evolved considerably into various specialities and superspecialities, and also involves complicated diagnostic and treatment procedures which carry inherent risks. Modernization has also brought about increasing cases of litigation by patients, some genuine, and some frivolous. Hospitals are striving for excellence by adhering to ISO standards and getting accredited by the National Accredition Council, all of which has increased the role of documentation.

But most importantly, when a doctor is confronted by a charge of negligence, the Courts are able to judge the correctness of the treatment only by the availability of documentary evidence. Therefore, these records reflect on the doctor in a court of law. 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.

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