

Medical Records

Proper record-keeping and maintaining medical records properly have gained immense importance in today's medical practice.

Whenever there is interaction of a patient with a doctor or hospital, a new medical record is generated. It may be in the form of an outpatient department (OPD) paper, emergency services, inpatient department notes, or any laboratory or radiological reports. A medical record is a legal document of the care provided. All relevant information about the patient during his hospital stay is recorded, and it is essential for proper clinical communication. These records are essential for recognizing the disease pattern, assessing the quality of treatment, and evaluating the outcome of treatment.

Well-maintained medical records are the only evidence for guarding the interest of hospitals and physicians in case any medico-legal issue arises. Hence, it is most essential for the clinicians to ensure that clinical notes are complete, legible, and updated from time to time. These notes should be precise, specific, and must not be manipulated. Clinicians should clearly mention the clinical diagnosis, differential diagnosis, and any other associated ailments in clear, understandable words.

Clinical notes should provide a clear idea about clinical symptoms, findings, diagnosis, tests to be ordered, care provided, and further advice to the patient. If there is any clinical complication, it should be mentioned whether it was before admission or on or after admission, due to treatment or any other procedure.

Healthy medical records are the key to your safety. As they say, good records are good defense; poor record is poor defense; and no record is no defense.

The purpose of choosing this topic is that we find a lot of incomplete files in the medical record departments. Many doctors have suffered losses because of improper documentation. Proper documentation is a vital component of safe and efficient practice, as it provides evidence of professional judgment and care provided. It reflects the application of knowledge and judgments. Good documentation reflects accountability and is legal record of events and source of evidence.

If records are clearly written, retrospective analysis of the records helps clinicians to clarify doubts, find missing links, and also helpful to recollect care provided in case any medicolegal issue arises. Proper documentation acts as a communication bridge between the health-care providers and different specialties.

Documentation should be done in such a manner that it should meet professional and legislative requirement.

Proper documentation starts from the OPD/emergency departments and ends at discharge summary.

Proper notes should contain a heading mentioning who is writing the notes; professor/consultant/JR/SR. Patients age/sex, date, and time of examination should be mentioned clearly. Notes should be duly signed with name and designation.

Content of notes should start describing subjective and objective manner; assessment and plan of treatment should be clearly mentioned in the systematic way. If the patient is to be referred or second opinion needs to be taken, that should be documented.

Medical professionals are poor in communication and documentation; also doctors are not aware of what is required by law.

Proper documentation is also essential while maintaining nursing sheets and allied services and while taking consents. Informed consent forms should be filled fully. Just a signature by the patient is not sufficient to protect the medical practitioner. Informed consent forms should reflect about the communication of risks involved and consequences. Informed consent form should be patient specific and content of consent form should be specific for the procedure to be performed.

Medical practitioners have common bad habits of forgetting to document things in emergency situations and later if they are presented in front of court, tend to give explanations. Hon Judges require evidence on paper, any emotional appeal from Doctors side is not acceptable in court of law. Even if a doctor takes a precautionary measure and fails to document it, then just verbal information is not sufficient, if doctor has documented that particular precautionary measures were taken, then and then only it is considered as valid evidence. Your deeds should be supported by documentary evidence. Every physician's duty is to take care, and care provided should be documented. The outcome or cure of the patient is not in the physician's hand, but care should be provided professionally.

Case 1

A female underwent a cesarean section to deliver a child. As complication later developed ureterovesical fistula. Family sued doctors in court claiming that cesarean section was performed unnecessarily which led to the complication. Defendant argued in court that fetal non stress test was done and fetal distress was the reason for performing the cesarean section. Unfortunately, this was not documented in noted and the medical practitioner lost the case.

Case 2

An 8-year-old child was admitted in the hospital with fever, responded well initially to the treatment. The child deteriorated after the 8th day. Clinician overheard the relatives discussing about some liquid given to the child from a local Baba or saint. He documented this and also preserved a sample of that liquid. Unfortunately, the child succumbed. Medicolegal suit was raised. Defendant brought up the issue of some liquid given to child by the parents and that liquid was sent for the chemical analysis. Later, it was found that child died because of that liquid formulation.

In this case, proper documentation formed a good defense for the clinician.

Wise to remember “Failure to document is failure to provide evidence.”

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