EDITORIAL

Medical Documentation- An Ignored Aspect in Patient Care

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The medical record is the wellspring of data for countless decisions regarding patient care from doctors, paramedical and administrative staff. Even though, during recent years the ancillary activities like audit, research, legal etc which depend on the medical record have received most of the attention. The most frequent problem encountered by administrative and medical authorities is probably as old as the concept of the medical records itself i.e. its completion in time and in accurate manner. An inaccurate or incomplete medical record reflects that the patient care was incomplete. Medical record which contains gaps depicts poor clinical care, demonstrate non-compliance with institutional policies and can be used to support allegations of negligence or fraud. Moreover, an incomplete patients clinical documentation can leads to legal actions, can results in loosing job, contribute to imprecise quality and care information, leading to lost revenue/reimbursement to institution or physician, inappropriate billing and leading to charges of fraud. In addition, incomplete or improper documentation interfere with research, data analysis, patient-related studies and most likely compromises safe patient care.[1,2] That's why every health care provider institution should ensure timely, precise and complete clinical documentation of all patients at any cost.

Keeping in view all this, the proper documentation has become an integral part of patient management and it has evolved into a science of itself. This is the only mode for clinician to prove that a proper treatment was carried out. There is a strong consensus that properly maintained medical record is of immense help in the scientific evaluation and analysis in patient management issues. Its significance for clinicians and medical establishments is for three important reasons. Firstly, it will help them in the scientific evaluation of patient's profile, treatment outcome analysis, and in planning the treatment protocols. Secondly, it is also helpful in planning institutional or governmental strategies for future medical care. In addition, it is also used to inquire the issue of alleged medical negligence during treatment because the legal system relies mainly on documentary evidence. In these scenarios, the documentation is the most important evidence which decide the sentencing or acquittal of the doctor.[2,3,4,5]

It is disheartening to observe that in spite of knowing the significance of proper medical record keeping, this matter is still in a nascent phase in our country. It is wise to remember that “Poor records mean poor defense, no records mean no defense”.[3] Abernethy et al after reviewing the documents has observed that insufficient data availability has hindered the quality assessment. Of the all eligible patients for analysis, only 12.22% patients can be included in the full analysis. They observed that the sex was un identified in 17%, missing data on race or ethnicity in 26%, confirmed diagnosis in 86%, only 38% provided TNM stage, missing histo-pathology in 34% and up to 10% of records did not revealed dates of administration of chemotherapy to the patients. After switching to electronic medical record keeping the reporting has improved significantly but documentation problems persisted. Overall, they concluded that the records containing data sufficient to evaluate conformance to the colorectal cancer metrics, conformance was low as 50% to 70%.[6] Medical records comprises of a variety of information's from patient's history, clinical findings, investigations, treatment planned, pre and post-operative care, operation notes, daily progress notes of a patient, diagnosis, discharge summary and follow up plan etc which can be used for varied evaluations. For example, in case of a surgery, a properly obtained consent will go a long way in proving that the surgical procedures were carried out with the patient's concurrence. Similarly, meticulous or properly endorsed operation notes can protect a surgeon in case of alleged negligence claims. It needs to be the concerted effort of all

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members of team who are involved in patient care in keeping the proper medical record. In this regard, the doctor is the prime person to oversee this documentation process and is primarily responsible for patient's history, clinical examination, investigation plan, treatment prescribed, operation details, consent forms, referral notes, discharge summary and medical certificates. Other than this, proper recording of nursing care, laboratory data, diagnostic evaluations reports, record of pharmacy and billing processes is also crucial which needs to be maintained by paramedical or administrative staff. In order to maintain proper hospital record, doctor, paramedical and nursing staff should be trained properly.[2]

The medical facilities in Pakistan range from smaller clinics to large hospitals and from private sector to public sector medical facilities. Proper medical record keeping is a separate and specialized domain in some of the public sector, teaching and corporate hospitals of urban setup which are having dedicated medical records officers capable of handling these documents. However, it is yet to develop into a proper record keeping process in majority of hospitals and clinics that provide medical facilities to a large section of the people in Pakistan. To conclude, when documentation is complete and accurate in all domains, it works wonders at telling a patient's story and can even improve patient care. To achieve this, the documentation in the medical record needs to be complete and accurate to facilitate effective continuum of care."

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