Medical Documentation

By: **C. Perumal**, Legal Officer MMC

A medical record is documented information about the health of an identifiable individual recorded by a practitioner or healthcare professional, either personally or at his or her instructions. It should contain sufficient information to identify the patient, support the diagnosis based on history, physical examination and investigations, justify the professional management given, record the course and results thereof and ensure the continuity of care provide by practitioners and other healthcare workers to that particular patient. Excerpts from "**Medical Records and Medical Reports**" a guidebook endorsed by the Malaysia Medical Council in January 2007.

From the above summary, it can be clearly concluded that every aspect of healthcare provided to a particular patient, including the identity of the patient must be meticulously and laboriously recorded to ensure that anytime in the future these records can be completely relied upon to provide a comprehensive and satisfactory explanation to what happened at that material time. Records of patients can be sought for various reasons such as follow up treatment, referred to other facilities, litigation purposes, for research, for mortality or morbidity studies, for planning purposes or for the personal interest of the patient himself. Proper and appropriate Medical Documentation is the hallmark of good medical practice.

The Council as the custodian of the medical profession in the country is entrusted to ensure not only that practitioners provide competent, safe, appropriate, cost effective, warranted and evidence based medical care, it has also the additional responsibility to adjudicate fairly on to all complaints received related to ethics in medical practice. In disposing off such complaints the Council not only has to meet out justice to both parties, it also has the onerous duty to ascertain that justice is seen to be done. Time and again accusations of unfairness had been unfurled against the Council by discontented parties on the outcome of inquiries carried out.

On many occasions the Council had been handicapped or restricted in its deliberation due to the acutely sparse medical documentation by practitioners which does not portray an actual picture of the situation. However, unfortunately having to other options, decisions have to be given, much to the chagrin of the disadvantaged parties.

It is well to remember that issues related to medical documentation will not come into play in the near future but will be called into questions years later when the practitioner or members of the healthcare team that provided the care will no longer be at the scene, or even if they are there they will not be able to recollect exactly what happened to that particular patient, having attended to hundreds, if not thousands of patients subsequently. Only the actual medical records will be there to tell the story and pathetic record keeping will definitely be detrimental to the party relying on the records.

As Malaysia is often quoted by the World Health Organization as a shining example of a nation that provides excellent healthcare services to its population amongst third world countries, every aspect of attaining this status, including proper medical documentation must be maintained, if not enhanced, to deserve the accolade given. It is more important, given the efforts by the government to promote health tourism and make our country a competitive medical hub in this region.

As we take pride in having a highly literate society, we must also be prepared to face a progressively litigatious population. With the advent of information technology and a bigger and bigger cross section of our community becoming computer savvy, compounded with the consumer movements becoming more and more apparent in educating the public of their rights, more and more practitioners are going to be sued by disgruntled patients. It cannot be denied that there definitely is an upward trend and cascading sense of litigation consciousness amongst the various sectors of the population which was not apparent even as back as 10 years ago.

Thus, in order to avoid such occurrences or at least to put up an effective defense, it is definitely prudent and advisable for practitioners to steer away from their lackadaisical attitude of paying scant attention to providing details of treatment provided to their patients and instead pay serious attention by spending more time in keeping proper clinical notes, bearing in mind that you are the ones going to face the brunt of any litigations in future.

To be continued.

Management of Case brought in dead (BID)