MEDICAL DOCUMENTATION Part II (Continued from 2/2008)
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Amongst the contents of a comprehensive medical record will be the identity of the patient, his admission records, his continuation sheets, requests for investigations, results of investigations, records of treatment and procedures carried out, medications given, records of other attending healthcare personnel, consent forms, referral forms, and any other related documents pertaining to the treatment given.

A proper medical record must support the diagnosis of a patient based on a medical history taken, detailed and meticulous physical examination and appropriate and relevant investigations instituted based on the diagnosis or at least a provisional one. It must justify the professional management given, record the course and result thereof. It must evidentially support the continuity of care provided by the practitioner and other healthcare personnel without any break in the chain of care provided.

Practitioners are reminded of the far reaching tragic implication of a scanty medical report in issues related to medical litigations which may takes years to be disposed of. Not only detailed chronologically written medical records which support your actions or inactions will become indispensable in such instances, the safety of these records are equally important. It is the paramount duty of the practitioner himself, or at least the authorities in charge of the various institutions to ensure the safe custody of relevant documents related to the treatment of patients which can be easily retrieved as and when required. The more complex or the more controversial a particular case, the more precaution is to be taken to safeguard the documents. With the continuous movement of people whether in a private or public setting, the possibility of the documents falling into the hands of unscrupulous people leading to disastrous results, must be avoided at all cost. The storage of documents based on the period of legal requirements currently in force, is to be adhered to scrupulously so as to not to fall foul of the required limitation periods and to ensure the ability of the documents as and when necessary.

A practitioner or any other healthcare personnel will not be able to remember the details of every patient that he or she attended to. Neither will they be able to recall the exact details of the treatment regime instituted to a particular patient. The only source that will remember for posterity is the documents that you generate throughout the whole period care is rendered to the patient. Thus it will not be an understatement to emphasise here that the safety and availability of all documents pertaining to a patient must be ensured at all times.

A civil litigation for tort of negligence, trespass to person or assault and battery (any of the civil suits a disgruntled patient can bring against a practitioner or healthcare personnel) can be filed at any time within 6 years of the incident or knowledge of it. However, if the practitioner is a government servant, a suit can only be brought against him within a period of three years of the incident under the Public Authorities Protection Act 1948. Besides civil suits, a practitioner can also be charged for the criminal offence of manslaughter which is becoming apparent in recent years in the western countries, for acts of gross negligence where cogent evidence will be required to save a practitioner from grave consequences. In the above two instances, the terminology “incident” has been used. To understand an actual situation, a particular scenario can be enacted to clarify the meaning. Let us assume a

patient is brought into the emergency department of an institution today with a fractured femur. He is attended to, first by paramedics, followed by the doctor who immobilise him and admit him to the ward. He is put on traction and seen by the specialist who decides to fix up his fracture by plating. Subsequent to his discharge he has several follow up sessions and maybe one year hence he realises that he has a shortening of his limb which he feels is due to the negligence of the attending doctors. Limitation period only starts running from the time he realises his defect, i.e. about one year from the time he attends at the emergency department.

Under the law of tort this particular patient has another 6 years (for government servants another 3 years) from this instance of the realisation of his defect, to sue the doctors. Given the clogged up civil courts which has hundreds of thousands of cases, it is anybody's guess when the actual case will be disposed of, maybe in another 10 years time. In the case of *Foo Fio Na vs Dr Soo Fook Mun & Hospital Assunta* the accident to the appellant took place on 11 July 1982 but it was finally disposed off at the Federal Court only on 29 December 2006, devouring an exasperating period of 24 years, far beyond the imagination of anyone. As such the information in the documents and records that are generated from day one of the treatment of the patient will become relevant facts when the case is litigated in the far distant future. Practitioners are also reminded that the documents you generate today may not be handled by you alone in the future, you may not be there and someone else may give evidence on your behalf, thus clarity in the information that is provided is paramount so as to assist anyone who will be presenting the evidence at that time.

(To be continued ...)