Medical Records: Making Them (Part one of a two-part series)

By A/Prof Goh Lee Gan

WHAT IS A MEDICAL RECORD?

A medical record is information about the health of an identifiable individual recorded by a doctor or other healthcare professional, either personally or at his or her instructions. It should contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among healthcare providers.

A good medical record should therefore provide a newcomer to the care team with all the information about a patient and his/her treatment plan that he/she would need for continuity of care. The items that may constitute part of the patient's medical record include one or more items of the following list: hand-written clinical notes; computerised/ electronic records; letters to and from other health professionals; laboratory reports; radiographs and other imaging records; printouts from monitoring equipment; photographs; videos and tape-recordings of telephone consultations.

COMPUTERISED AND ELECTRONIC RECORDS

From a legal viewpoint, the evidential value of records held only on computer depends very much upon the audit trail that can be demonstrated. Systems that record the author and the dates on which entries and other amendments to them are made will be of high evidential value.

PRINTOUTS FROM MONITORING EQUIPMENT

These are particularly important in emergency situations – such as during cardiac arrest or difficulties during anaesthesia, where it is difficult or impossible to keep contemporaneous written records. Printouts from monitoring devices are also an important part of the obstetric record. Thermal printouts (using heat-sensitive paper) fade over time so they should be photocopied for inclusion in the record. Printouts must be attached securely to handwritten records, and monitoring artefacts identified clearly.

GOOD CONTEMPORANEOUS NOTES

Good contemporaneous notes should be made in each medical consultation. The primary purpose is to provide good continuity of care. The secondary purpose is to provide evidence of care given to the patients. In court, medical records may undergo detailed scrutiny. Their quality tends to be seen as a reflection of the standard of medical care provided by the writer.

Furthermore, in a factual dispute where the patient alleges one thing and the doctor another, the patient's recollection will usually be preferred to that of the doctor, unless the doctor can produce a clinical entry supporting his/ her version that was written at the end, or very soon after the particular incident in dispute.

HOW TO WRITE A GOOD MEDICAL RECORD

Notes should be written during the consultation or immediately afterwards, as soon as possible after the event has occurred. Write your notes in a straightforward, purposeful and factual style. Avoid remarks of sarcasm, wit or cryptic remarks. Write also such that it cannot be erased. Use clear handwriting that is large enough to be readable on photocopying and ensure that you can be identified as the author (i.e. initialise at the end of what you have written).

WHAT TO LEAVE OUT

Do not write critical comments about care given to the patient by others. You may not have all the information then to make a balanced judgment. Record facts rather than personal opinion of the patient's character, particularly if derogatory. For example, record in a factual manner the amount of exercise a patient takes rather than writing in your notes 'couch potato'.

WHAT TO INCLUDE

You should:

- State the history, including answers to relevant direct questions.
- Record all the systems you examined, note all positive findings, important negative finding and objective measurements such as blood pressure.
- State your opinion (avoiding vague and obsolete diagnostic terms) - remember that a reader should be able to understand from your notes why you reached that conclusion.
- Include a careful record of investigations, so that results can be reviewed by others if necessary; make a clear distinction between investigations you have actually ordered and those that you are contemplating.
- List the drugs and dosages you have prescribed, and other treatments you have organised.
- Record, in a prominent place, any drug allergies or adverse reactions.
- Record arrangements for follow-up and referrals made.
- Summarise the information you have given the patient about his or her condition, including, where appropriate, warnings about the risk/ benefits of proposed treatments.
- Record prominently any advance directives made by the patient prohibiting certain treatment options.

If you have been given the patient's history by a person other than the patient (e.g. a relative, police officer, translator or friend), record that person's name and status. ■

Look out for Part 2 on Medical Records: Retaining Them.