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By doctors for doctors

Doctor's medical records sub-optimal but not significantly below standard

Key messages from the case

Medical records may be created under pressure of time and when doctors are managing competing distractions and demands. While doctors are not expected to produce objectively perfect records, they must ensure that important details of the patient's health are captured for the benefit of those who may need to take over care, as this case illustrates.

Details of the decision

Standard of care

A 78 year old patient Mr A died in a regional hospital.

He had presented to the Emergency Department at 4.27am, complaining of left shoulder pain radiating to the side of the chest. He was known to the hospital and had multiple pre-existing conditions including ischaemic heart disease. He had had a repair of an extensor tendon in the left wrist five weeks earlier. He was on opiate medications for chronic back pain. Mr A said that the pain had commenced when he was hanging out washing.

Mr A was admitted under a medical team after the ED doctor spoke with Dr C, a specialist physician. Dr C reviewed Mr A at approximately 10:30am. At the time Mr A was in pain but lucid and conversing. His blood results showed a raised white cell and neutrophil count.

Dr C concluded the cause of the shoulder pain was most likely septic arthritis. Dr C prescribed antibiotics and referred Mr A to the orthopaedic department. Antibiotics were administered mid-afternoon, after a delay to allow testing to identify the source of presumed infection.

The notes of Dr C's assessment were completed by the resident medical officer (RMO). Based on the hospital records, it was alleged that Dr C's care was significantly below the required standard in terms of her history-taking, examination, diagnosis, management plan, pain relief, medication and handover.

Dr C agreed that with the benefit of hindsight, it would have been better to commence antibiotic treatment sooner. Nevertheless, the regulatory committee deciding the matter concluded that Dr C's assessment had been adequate, and that her provisional diagnosis and referral to the orthopaedic team was reasonable and appropriate in the circumstances. It found no fault with her care.

Record-keeping

Concerns were raised about the lack of information documented in the record relating to Dr C's observations, blood test findings, management plan, the decision-making process informing the plan and the handover process.

While Dr C delegated the task of documenting the management plan in the hospital records to the RMO, she acknowledged that she remained responsible for the accuracy of the records.

The committee acknowledged the competing demands on clinical teams and stated that while "good documentation is extremely important, unfortunately it does not always occur in the real world at the level expected by regulators."

The committee took a pragmatic view that record-keeping should ensure important details of the patient's health are included. It noted that Dr C's records formed part of the hospital record and should be seen in that context. While she had not separately documented information such as test results, these were available to other treating doctors in other parts of the record.

Outcome

While Dr C's record-keeping was below the standard reasonably expected, it was not significantly below that standard and so did not constitute unsatisfactory professional conduct.

Key lessons

While you may delegate your record keeping obligations to a colleague or junior doctor, you remain responsible for the contents and accuracy of any records made on your behalf. This includes making sure the medical records identify the patient and include enough information to allow another medical practitioner to continue management and care of the patient.

Additionally, the level of detail required of your medical records must be tailored to the patient's case and include:

- relevant details of clinical history
- clinical findings
- investigations including their outcomes and results
- information given to patients
- medication
- all other management.

In hospitals, some patient care systems connect patient records to test results. However, it's recommended to always record all investigations, along with their outcomes and results, in the patient notes. Don't rely on other healthcare providers having access to the links.

References and further reading

Avant factsheet – Medical records: the essentials

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