REVIEW

Medical Ethics III
Medical Record

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Five cases of medical litigation are pending in the courts of Bahrain (1988-89), the average amount of compensation requested is BD 80,000. We used to think that the practice of medicine in Bahrain is different, but the year '88 and '89 proved otherwise.

Medical litigation has started to spread, and if it is not controlled, it might affect many practitioners. On one hand it will make the physicians more careful, but on the other, it will push some to practice a defensive medicine with its accompanying drawbacks of excessive investigation and withholding of some medication for the remote possibility of side effects. It is time for the physicians to think seriously to protect themselves against litigation, which can be done through:

A – Good medical records.

B – Good patient's rapport.
This will avoid lawsuit in most instances.

C – Good bedside manners.
A physician who spends enough time with his patients, caring about them will hardly be taken to court.

D – Treat patients as human.
A physician should realise that patients are human, and not "cases" to be discussed as interesting and to be reported to conferences and journals.

E – Refer patients whenever necessary.
It is better to have a second opinion than to make the patient suffer and end up in court.

F – You should certainly avoid in your practice unjudicious comments or nasty remarks about prior treating physicians.

G – Don't forget that the patient has a right even in a cut throat society.

H – You should seriously think to become a member of medical protection organisation in order to prepare yourself for the inevitable.

To practice good medicine is to have good medical records which are the keys to avoid medical litigations, and they are the keys for good and successful management of the patients, not only that, good medical records are excellent tools for research, future predictions and health planning.

Keeping and maintaining accurate medical records is one of the most important and effective aspect of human communication.

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Medical records can either be your best friend or your legal enemy. Some patients may have amazing memory, they can sometimes remember what they had for breakfast eleven years ago before going in for the operation. Doctors see many patients and may not remember them. If you have the records to help, you can be better off than saying I do not remember too much about this patient.

Do's and Don'ts[1]

1. Have your records dated and timed. Time becomes important in a legal context in the court room.
2. Handwriting should be clean so as not to stumble years later while reading.
3. When documenting the history of the patient be specific.

Medical record is not a script for the next issue of your local medical journal. Do not write medical records as if you are using all your creative ability in writing. They should be medically legible. Do not venture rage against the nurse or somebody who did not do exactly as you wanted. Be judicious in your comments against the care of others in the chart because it will eventually come back to haunt you in other settings. Never be tempted to alter or change the records after the fact. The shortest way to lose is to have altered records. Cases will be tried on the records that were altered. If you are using abbreviations or symbols for terminology, make sure they are common and acceptable.

The first to document is the history, which includes: history of current illness, history of past illness and medication, social history and habits. Next, is the examination of the patient, which should be detailed, every observation should be recorded. It is difficult to defend something which has been done but not recorded. Every investigation requested or suggested should be recorded. Recommendation, and treatment should be put under separate heading in the medical records.

Your handwriting in the medical records should be clear, concise and precise, you should be able to read your own handwriting after five years. It is difficult to defend a handwriting which cannot be read by the writer.

A physician is obliged to inform the patient of those alternatives, risks and complications which may occur during or after the course of the proposed medical treatment or surgery. This is supposed to be done by every physician before he expects a reasonable patient to decide. The information and the conversation should be documented.

Not every risk or complication should be relayed to the patient, but if the risk or complication is 1% or more, a reasonable patient would want to know about and which you have a legal obligation to tell.

Patients' expectation should be discussed at length, the patient might have a very high expectation, and may think that you have a miraculous cure. This phenomenon is usually observed among the uneducated, ignorant, and rich. These groups are difficult, and expect the physicians to make them new and free of diseases for ever by one course of treatment or surgery, they do not understand the limitations of the physicians, for they are not creators.

A case is still pending in the court of a patient with disfigured face who by design found himself rich beyond his limit of expenditure, therefore decided to make himself good looking and hired several general and plastic surgeons to work on his face, he was not knowing that a plastic surgeon can change the ugly face to acceptable and the acceptable to beautiful, therefore when his face was changed to acceptable, he was not satisfied and he dragged the surgeons to the court, asking for compensation.

It is important to discuss with the patient his expectations and to record these in his medical records and to explain to the patient all the possibilities regarding his illness whatever he/she is going to achieve:

1. Short term cure.
   Common cold, acute bronchitis, gastroenteritis ... etc. These illnesses can be treated at a time, but cannot be prevented from recurring.
2. Long term cure.
   Smallpox, measles ... etc. These illnesses can be prevented for long time by proper vaccination.

3. Live on maintenance treatment but no cure. Diabetes mellitus, hypertension ... etc. These patients can live normally with medication, but to this day, they cannot be cured by one course of treatment or surgery.
4. Alleviate the suffering of a terminal patient but no cure is expected.
   Patients with stage IV breast carcinoma and metastasis ... etc. These patients may live on analgesic and sedative to the end of their lives.
5. Short term cure but short life expectancy.
   Heart transplant patients ... etc. These patients are expected to live near normal life for one to five years.
6. Miraculous cure, this is something which you should not pose to be able to do.

Remember that the consent is the meeting of the minds that occurs between you and your patient – what you said and what the patient understood.

How to protect yourself during the signing of the consent form?

1. Have an adequate form.
2. Supplement the form with a specific written note if necessary.
3. Supplement even further by documenting the informed consent conversation.

It is important that the physician speaks in a language which is understood by the patient because he has the obligation to give the information in that language, he must build trust which requires the truth to be told and if possible the whole truth.[1] If you are speaking through an interpreter, make sure that he/she knows your language and the patient's language equally well. Very often the interpreter has very little command of the physician's language and it is unfortunate that most expatriate physicians do not have a command of Arabic, and worse, they are not willing to learn. It is unfortunate to see a physician who worked for 15 or 20 years in Bahrain, yet he is not able to speak the language of the country.

It is important that the patient understnds every single detail you explain, otherwise the signing of the consent legally is not binding.

Do not delegate taking the consent to your resident or any other of your junior staff. In teaching institutions it is often the practice to have the resident discuss the procedure with the patient, but the operating surgeon has the legal duty to obtain the consent. It does not look good in the court that you did not explain the procedure but someone else did.

Do not give the consent form to the patient for signing when he is already premedicated, because legally it is not binding.

While discussing the management proposed have a witness to the fact that you have discussed the consent with the patient. The witness can be a nurse, the resident or a relative and have them sign the consent. Next, write in his medical records the discussion.

Preparing for the inevitable i.e. when you are dragged into a litigation case[2].

a. Be comfortable with your lawyer. If you are not, select somebody else.
b. Take time to prepare yourself. You are in a different setting. You are no longer the king of the ward round where no one dare contradict you. There is very little respect for you in a court room and the rules are different than your hospital or clinic. Doctors who do not want to get kicked around should stay out of the court.
c. Educate your lawyer to become the best medical person in order for him to be able to defend you. If he is unwilling to do so then get another lawyer.
d. Help your lawyer to get suitable experts to use in your defense.
e. You should have no fear of going to court, if you have been practicing honest medicine and scientifically following the proper procedure, if

you are educating yourself by reading recent publication in your field and attending conferences, if you believe in yourself, and if you have got a good lawyer, you will definitely win the case.

My final advise is to be careful because in one of the GCC countries and specifically in October 1987 a consultant surgeon was shot dead by an angry father who was promised by the surgeon to operate on his child. Postoperatively, the child developed a mild transient complication and due to that the influential angry father managed to gain an access to the medical records where he discovered that his child was operated upon by the senior resident of the department rather than the consultant.

REFERENCES

1. Markus AC. "Good morning, Doctor, How are you?" Annals of the New York Academy of Sciences. The New York Academy of Sciences 1988;530:46-53.
2. Starr AH. Preparing for the inevitable. Audio-Digest. Otolaryngology – Head and Neck Surgery 1989;22:08.