Good Medical Records: Standards and Challenges

Text by Dr Gerald Chua and Sophie Chua

Gone are the days of handwriting paper notes and the arduous, time-consuming task of deciphering the illegible doctor scrawl. We now practise in the era of electronic medical records, a tool that has undeniably transformed and improved the way clinical information is documented, accessed and used in modern healthcare.

Despite technological advancements, the fundamental pillars underpinning medical practice and professionalism remain unchanged. These pillars – competence, altruism and a commitment to ethical practice – continue to guide our work. Likewise, our core professional duties – to diagnose, to advise and to treat – persist. Together, these principles are reflected in the actions we perform instinctively on a daily basis, acting as cogwheels in a coordinated manner. These might be described as the three Ts: to think, to talk, and to type. We **think** through our differentials, the advice we intend to give to our patients and our treatment plans; we then **talk** with our patients, and sometimes with their next-of-kin as well, to communicate the details of our management plan; and finally, we **type** (or write) into our records to create a visible, durable footprint of our findings, thought processes and discussions with our patients.

Medical records as a footprint of our care must extend beyond the account of what is found, said and done. They must convey our delineation of the clinical facts, the weighing up of the options, and the thought process underpinning our clinical decision-making. Our records must also serve as a clear and accurate guide for the next healthcare professional attending to the patient to aid the quality of continuing care, especially when team-based care is provided.

The aspects of a good medical record can be summarised under the following seven Cs.

Content

The SOAP (subjective, objective, assessment, plan) note for recording our ward rounds and clinic encounters is a tried-and-tested method of documentation. It serves its purpose for most routine encounters. However, on occasions when the clinical interactions and decision-making is non-routine and more complex, the simplicity of the SOAP note may be inadequate. An alternative method to record the content of our patient interaction is **FOR-DEC**, a structured decision-making framework that originated in the aviation industry in the 1990s.

Facts: What is known about the patient?

Options: What are the diagnostic and/or treatment choices ahead?

Risks: What goes for and against the application of the different options?

Decision: After weighing the above with the patient, what is the plan?

Execute: The plan – to be executed by whom and when by?

Check: How will the patient's progress be monitored?

This documentation framework is particularly applicable when the clinical plan entails a necessary deviation from the usual practice, there is clinical equipoise, or existing practice evidence and/or guidelines are not extrapolatable to a set of unique clinical circumstances. Documenting the content of our clinical plans in this manner promotes clarity, states uncertainty and complexity where it exists, and enhances continuity of care.

Context

In any narrative, viewing and interpreting the content within the context it sits is important. Particularly in situations filled with complexity (see the below section), documenting both clinical and situational contextual facts enables subsequent healthcare professionals to accurately interpret the note and understand the rationale for decisions made.

Contextualised records enhance clinical reasoning transparency, medico-legal defensibility and patient-centred care by demonstrating that decisions were informed by the full clinical situation rather than isolated data points.

Complexity

The acronym VUCA was first used by the US Army to refer to volatile, uncertain, complex and ambiguous state of the world in a post-Cold War era. Robert Johansen, a leadership consultant, built upon this in his proposed behavioural leadership model **VUCA Prime** – vision, understanding, clarity and agility, as a way of counteracting the challenges of VUCA.

The lack of **VUCA Prime** attributes can alert us to the potential complexity of a patient interaction.

- Lacking **vision**:
  The patient is unable to appreciate the management path and/or longer-term goals ahead beyond the immediate next steps.
- Lacking **understanding**:
  The patient is unable to fully comprehend the plans.
- Lacking **clarity**:
  The current plans, because of disease-/patient-related factors, are necessarily not fully determined.
- Lacking **agility**:
  The patient has rather rigid ideas of how clinical management is to be executed.

Even the most health literate of our patients can find themselves mired in complexity, beset by the conditions as described above. This is more commonly encountered when a multitude of treatment options exist, or there are many stakeholders involved in the care. Under such circumstances, good record-keeping becomes all the more crucial.

Concision

With the rise of content-importing technology in electronic medical records, a new phenomenon of "note bloat" has emerged. The ease of being able to copy-paste, import templates and autofill speeds up documentation, but inadvertently often results in the accumulation of redundant information.

Critical changes in symptoms, assessment or plan can be buried beneath copied text. This increases the risk of errors and miscommunication, and compromises patient safety. Over time, note bloat impairs the usefulness of the medical record as a clear and concise clinical communication tool to the next provider, turning it into a repository of recycled text rather than an accurate reflection of the patient's present state and care.

To remedy this habit, the notion of **SOAP v2.0** is proposed – the idea that every clinical note should be **succinct**, **original**, **accurate** and **problem-oriented**.

Clinical entries, particularly one read at 3 am by the junior doctor on-call or the night-shift nurses encountering the patient for the first time, must convey with clarity and efficiency the patient's key problems and critical facts. Well-constructed notes allow all team members to rapidly achieve shared situational awareness, ensuring that any patient care in the moment or planned for the future is effective and unhindered. To support problem-oriented documentation, most electronic medical record systems include a "Problem List" tab, enabling clinicians to encode problems as they arise and organise their notes around the patient's active clinical issues.

Check

In our increasingly fast-paced practice, we are reminded of the need to pause and check that our clinical documentation is accurate. If records are made on our behalf by team members, we must take reasonable steps to ensure that the quality of the records meets the required standard.

A reasonable attempt to check the clinical facts contained in a patient's existing medical records should also be made at each encounter, and more thorough attempts at checking made when complexity is anticipated/encountered, or when pivotal clinical decisions need to be made.

Conversation

The C of conversation is a reminder that even amid the needed attention paid to clinical documentation, we need to be present for and engage with our patients. Taking a good history involves conversing with our patients, not just a careful perusal of the content of the existing medical records.

The Four-Box Method for ethical analysis (medical indications, patient preference, quality of life, contextual issues) developed by Jonsen, Siegler and Winslade can also be used as a framework to guide our conversations with our patients.

Consent

The final C of good medical records revolves around specific records of the consenting process. Once the conversation with our patients on what matters (materially) to them has taken place and its elements clearly documented, meeting the standards of giving medical advice (for informed consent) as laid out in the Civil Law Act Section 37 will not be difficult.

Taking a step back, we remind ourselves of the three pillars of informed consent: capacity, voluntariness and disclosure. A record of how the three pillars are present/upheld should be made.

In conclusion

Accurate and thorough medical records are the backbone of high-quality healthcare. We keep good clinical records not just for medico-legal purposes, but because they aid sound clinical decision-making, promote continuity of care and facilitate good team-based care.

Ultimately, a well-kept record ensures that our patients' health stories are clear, accessible and readily actionable, which directly improves our care and their clinical outcomes. ◆

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