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Editorial

Importance of Documentation in Surgical Practice

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Modern surgical practice is centered on super specialization and corporate mentality of investigating and treating surgical disease both in private and government hospitals. Due to increased awareness of patient's party and availability of online information there is high incidence of legal cases of negligence. A vast majority of ethical doctors along with small numbers of erring doctors suffer as they are accused of different cases of negligence. Incidence of such types of cases are increasing day by day, deteriorating the doctor – patient relationship.[1]So this is the prime time for medical professionals particularly surgeons to know legally valid correct ways of documentation and record keeping and practice it thus saving ethical doctors from unnecessary and avoidable litigation.

The Collins English dictionary (2003) defines documentation as documents supplied as proof of evidence of something' and record is defined as "a document or other thing that preserves information."

The surgical documentation includes SOAP notes, Consent, Operation note, Post-operative instructions, post-operative note, discharge notes and blood transfusion note. It has been established that poor operative documentation has made the investigation of incidents leading to claims difficult and has prevented the defense of good clinical practice[2]. Although the majority of information will be included in the operation notes, the information could be contained elsewhere in the patient record including assessment in Accident & Emergency Department, ward round entries, a separate WHO Surgical Safety Checklist and drug charts. It is preferable where possible that the operation record is typed. The documentation where appropriate may be made by other members of the surgical team apart from the operating surgeon. However, it is the operating surgeon's responsibility to ensure that appropriate documentation has occurred.[2]

Beside legal protection, Documentation can communicate with other health care personal, serve as a hospital quality indicators and ensures appropriate reimbursement. Further correctly recorded documents are used as a research tool to improve patient care service.

Every aspect of documentation in surgical practice is equally important but emphasis should be given on informed consent, operation note, postoperative instructions and discharge note.

Informed consent means that the patient and the patient's family understand what is going to take place, including the potential risks and complications of both proceeding and not proceeding and have given permission for a course of action. A quiet venue for discussion should be found written material in the patient's preferred language should be provided to supplement verbal communication, with diagrams where appropriate avoiding complex technical language. The provision of translators for the patient who do not understand other than his local language. The person obtaining the consent should ideally be the surgeon who will carry out the treatment rather than a junior member of staff. It should be a choice made free from coercion. If a person is too ill to give consent (for example, if unconscious) and their

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condition will not allow further delay, you should proceed, without formal consent, acting in the best interest of the patient. If the minor is not capable of giving consent, i.e., does not understand, is incompetent or is unconscious, the parent or guardian may generally provide consent. The consent form containing all the pros and cons of service provided to the patient including alternatives should be signed by the patients or appropriate legal guardian in presence of witness.

An operation note is essential to ensure continuity of care between the operating team and other colleagues and provides a medico legal record of a patient's care. "An operation note is close to being a legal document. It is contemporaneous record of a licensed assault."[3]. All surgical trainees should know what needs to be detailed in an operation note. Notes must be completed immediately after an operation by a member of the operating team preferably operating surgeon. They can be handwritten or, preferably typed, in line with current guidance made by the practicing hospital that mitigate the legal need of this state or country. There has been a move towards template-based operation notes to standardize layout and the post-operative instructions, making them easier to understand. The operation note should accompany the patient into recovery and to the ward and should give enough detail to enable continuity of care by another doctor. The operation note can be broken down into the following main parts. Incision and approach – This should indicate the type of incision or portals used (for example, midline, paramedian and posterior) and approach used. This is particularly helpful should revision surgery be needed. Findings – All operative findings should be documented here, including the pathology encountered, specifying if it was as expected and anatomical variations. Procedure should be a step-by-step account of the operation from incision to closure, starting with any major anatomical structures encountered, then techniques used, tissue excised, prostheses implanted, assisting devices used (image intensifier, gamma probe and tourniquet time), and finally any unexpected complications of the procedure, such as significant blood loss or iatrogenic nerve injury. Closure: This should cover any structures or layers closed in order (fascia, fat and skin) and the method of closure, including the suture material and technique.

Documentation by anesthesiologists covering all the corners of anesthesia procedure should be clearly documented and recorded along with operation notes.[2]

Some exceptional situation may be encountered by surgeon while performing surgery which may arise medicolegal issues. Document if there are any intra-operative complications or unexpected findings and if part of the original planned procedure is not performed and the rationale for this. Ensure that any intra-operative decision making is communicated to the patient and clinical team with an explanation behind the change in procedure performed and document that this was communicated to the patient and any questions have been answered.

Delay in surgery with failure to inform patient of the risks related to conservative and surgical management may be an issue of litigation. So, every aspects of change and alternate procedure should be explained documented and signed with date and time.

Post-operative instructions are specific instructions to ensure good post-operative care. It is good practice to include things such as venous thromboembolism prophylaxis, samples that have been sent for pathology or microbiology, further antibiotics if required, any instructions to multidisciplinary team members (physiotherapists, for example), specify conditions for discharge in day case procedures. It is important to ensure that any intraoperative images taken are attached to the note (or saved to a picture archiving and communication system, together with a record of serial numbers of prostheses implanted).[2] The document should then be signed, with the signing doctor also documenting his or her name, grade, and Registration number. Observation and follow up frequency, possible complications and required actions, specific treatment, for example, intravenous fluids, timeline for normal recovery, when to mobilize, when to resume oral intake, physiotherapy, dressing changes and instructions for suture removal, cast and stents care should be clearly noted .

Post-operative notes can be organized in the "SOAP" format, **S**ubjective: How the patient feels, **O**bjective: Findings on physical examination, vital signs and laboratory results, Assessment: What the practitioner thinks and Plan: Management plan, which may also include directives which can be written in a specific location as "orders".

Discharge note is a very important record handed over to the patients which may be the possible source for any initiation of legal action. Hence, this has to be

carefully prepared. It should include admitting and definitive diagnoses, summary of patient's course in hospital, instructions about further management as an outpatient, including any medication and the length of follow-up plan.

A good surgical documentation should be factual, timely recorded, legible, sequential, complete, concise and duely signed by care provider. The usual errors seen in record keeping include illegible handwriting, delays in completing the patient record, completed by someone who has not delivered the care, lack of signature, inaccuracies in dates and times, inaccuracies in patient identification information such as wrong date of birth, misspelling of names, inappropriate language, ambiguous abbreviations, opinion mixed with facts and subjective, not objective observations.[1]Excellence in medical documentation reflects and creates excellence in medical care.[4] Documentation can either be done by conventional manual method or electronic medical record (EMR) method. Manual record is legally more acceptable than EMR but needs more space for storage. Currently EMR is the preferred method for surgical documentation. [5]

Many surgeons are loaded with practice and reluctant to record their performance. So, during medical audit or legal requirements the performance indicator becomes very poor. For ethical and quality practice we should remember that "If it is not documented, it did not happen" .There is a Chinese proverb "The palest ink is better than the strongest memory."[6] So, we should not rely on our memory rather we must record our activities in time. Documentation skill of a surgeon can be improved by standard note taking guideline, regular review, Peer support and continued education. [7,8]

It is high time, for every junior and senior surgeon, irrespective of their post and position, to develop habit of legal and valid documentation in their daily surgical practice. Method of proper surgical documentation and patient counselling should be more highlighted and included in undergraduate and postgraduate curriculum. Definitely it will help to improve doctor-patient relationship, mitigates sue effectively, reduce the tendency of our patient going abroad and improve quality care to the patient.

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