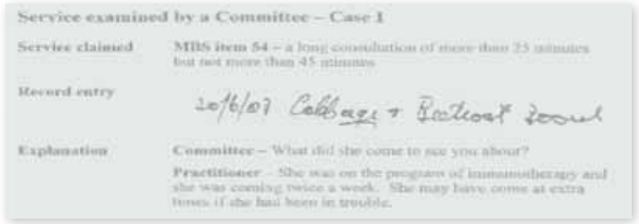
Note Worthy

Keeping good patient records is a vital component of running an efficient medical practice, writes **Margaret Faux**.

Medical records can make for riveting reading but the opposite is also true. One doctor, obviously not given to expansive description, claimed an item number with the accompanying words "cabbage and beetroot" in his medical notes.


Service examined by a Committee – Case 1

Service claimed: MBS item 54 – a long consultation of more than 25 minutes but not more than 45 minutes

Record entry: 20/6/07 Cabbage + Beetroot soup

Explanation: **Committee** – What did she come to see you about?

Practitioner – She was on the program of immunotherapy and she was coming twice a week. She may have come at extra times if she had been in trouble.

The Professional Services Review committee cited this example in its annual report to illustrate what is unacceptable for Medicare reporting requirements. While there may be a place for such laconic communication, the clinical recording of patient consultations is not one of them.

Another common, and equally unacceptable, example is the use of ISQ, or 'in status quo'. Incredibly, there are doctors who have felt that these initials, along with + or – signs and "etc, etc, etc", are sufficient to stand in for a record of consultation because that's all that appears in their notes; nothing else.

MAINTAINING CLARITY

Given that Medicare foots much of the medical bill on behalf of taxpayers, it is entitled to expect a clear and comprehensive explanation of the services being provided.

Under the *Health Insurance Act 1973*, all Australian medical practitioners must provide adequate and contemporaneous records. Section 82 (3) of the Act says that whether or not a practitioner has kept **adequate** and **contemporaneous** records will be considered in determining "whether a practitioner's conduct in connection with rendering or initiating services was inappropriate practice".

When the term 'adequate' is defined for the purposes of a medical record, it must:

- Clearly identify the patient.
- Contain a separate entry for each attendance.
- Provide clinical information to explain the services rendered or initiated.
- Be sufficiently comprehensive so another practitioner can undertake ongoing care of the patient.

All these requirements seem reasonable and, indeed, practical. No-one can doubt that there will be times when a doctor, for whatever reason, is not available the next time their patient seeks subsequent assistance. The doctor who steps in has to be able to identify the records of the patient they now have to follow-up and clearly understand what symptoms they have presented with in the past and the courses of treatment they have received. Otherwise, it's back to square one. Worse, in fact, because the new doctor may be revisiting unsuccessful treatments or exacerbating existing conditions.

While the definition refers to 'another practitioner', even if it is the very same doctor seeing their own patient, a review of the medical records will be needed to refresh their memory of the case. No matter how vivid you believe an exchange has been in your consulting rooms, just a few days later the details will have blurred. As memories are not reliable, good record keeping is in the interest of all doctors so they can ensure the best patient care.

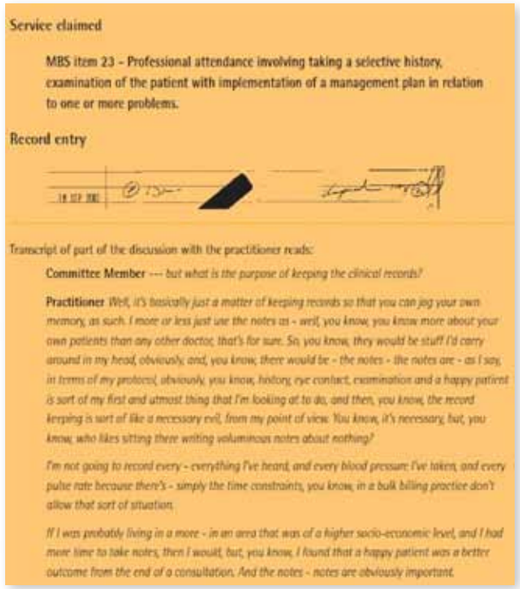
SATISFYING MEDICARE

Disgruntled doctors who complain about the Medicare record-keeping requirements might be surprised to learn that they are far less onerous than the requirements made of them under the various state and territory Acts and Regulations pertaining to medical practice.

The relevant NSW regulation – which can be viewed at **http://www.austlii.edu.au/au/legis/nsw/consol_reg/hprswr2010580/sch2.html** – devotes two pages to the records it requires doctors to keep for the privilege of practicing. So, doctors are obliged to provide much more detailed records than Medicare expects of them, every time they see a patient. If doctors are following the guidelines of their own professional regulatory body, they will well and truly be satisfying Medicare rules.

Of course the burden of keeping medical records is the time it takes to prepare them. In circumstances where a doctor is seeing a very complex patient, it might take half an hour or more to write up the notes, in which time he or she could have seen a couple more patients waiting at reception.

Because we speak on average seven times faster than we can write, and four to five times faster than we can type, the clever way to deal with medical records is to dictate them, even if they are simply quick clinical notes. These notes can be transcribed by someone else and then put back in the file – as long as they are dictated at the time of the consultation or shortly afterwards, the records will satisfy the requirement that they be contemporaneous.


Service claimed

MBS item 23 – Professional attendance involving taking a selective history, examination of the patient with implementation of a management plan in relation to one or more problems.

Record entry

Transcript of part of the discussion with the practitioner reads:

Committee Member — *but what is the purpose of keeping the clinical records?*

Practitioner *Well, it's basically just a matter of keeping records so that you can jog your own memory, as such. I more or less just use the notes as – well, you know, you know more about your own patients than any other doctor, that's for sure. So, you know, they would be stuff I'd carry around in my head, obviously, and, you know, there would be – the notes – the notes are – as I say, in terms of my protocol, obviously, you know, history, eye contact, examination and a happy patient is sort of my first and utmost thing that I'm looking at to do, and then, you know, the record keeping is sort of like a necessary evil, from my point of view. You know, it's necessary, but, you know, who likes sitting there writing voluminous notes about nothing?*

I'm not going to record every – everything I've heard, and every blood pressure I've taken, and every pulse rate because there's – simply the time constraints, you know, in a bulk billing practice don't allow that sort of situation.

If I was probably living in a more – in an area that was of a higher socio-economic level, and I had more time to take notes, then I would, but, you know, I found that a happy patient was a better outcome from the end of a consultation. And the notes – notes are obviously important.

ON THE RECORD

When it comes to record keeping, it is often GPs that come unstuck. Because specialists have their patients referred to them, the very nature of their work requires them to send a letter back to the referring doctor explaining what has transpired during their consultation and what course of treatment is being pursued. This letter forms part of the medical record and, in preparing it, the specialist is maintaining the requirement of adequate record keeping.

GPs, on the other hand, are non-referred and, as the medical notes appear to be only for their own purposes, it is easy to feel no obligation to complete them. However, GPs have more and more item numbers in the MBS that have specific record requirements attached to them and, as a result, it is no longer the exclusive domain of specialists to have their records transcribed.

More and more GPs are seeing the value of dictating their records, particularly in the context of the team-care arrangements and management-plan services they provide.

Apart from the clear value of accurate and adequate records for the treatment of individual patients, the records maintained across a practice allow the doctor to interrogate them in a way that captures the nature of patients seen, the incidence of illness, prescribing patterns and other valuable demographic information.

Well-maintained medical records are a significant asset to your practice. They support your daily work, help you form longer-term strategies in running your practice and allow potential partners to gain a snapshot of the practice – all this as well as ensuring you meet your Medicare obligations. Ⓟ

Margaret Faux is Managing Director of Synapse Medical Services.