Journal of Population Therapeutics & Clinical Pharmacology

RESEARCH ARTICLE
DOI: 10.53555/aqvpkf37

KNOWLEDGE, ATTITUDE AND PERCEPTION OF INTERNS AND JUNIOR RESIDENTS TOWARDS THE IMPORTANCE AND PROCEDURE OF MEDICAL DOCUMENTATION AND MAINTENANCE OF HEALTH RECORDS

Dr. D. Madhu Sudhana Reddy[1*], Dr. S. Lokanadham[2]

[1*]Principal researcher, Assistant Professor, Dept of Forensic Medicine, ACSR Govt. Medical College SPSR Nellore
[2]Assistant Professor, Dept of Anatomy, Government Medical College, Adhoni

***Corresponding Author:** Dr. D. Madhu Sudhana Reddy
*Assistant Professor, Dept of Forensic Medicine, ACSR Govt. Medical College SPSR Nellore,
Email ID: drmaddyforensic376@gmail.com

ABSTRACT

INTRODUCTION

Accurate Medical documentation helps in providing better health care to the patient and indirectly helps in protecting the doctor from negligence cases that arise due to improper medical records

AIMS & objectives

1. To assess the Knowledge, Attitude and Perception of Interns & Junior Residents towards Importance of Medical Documentation and Health Records.
2. To obtain perception of interns and junior residents regarding the implementation of medical documentation in the curriculum during Phase III part I of MBBS

METHODOLOGY:

The present study was carried out on interns and junior residents at Kurnool medical colleges and GGH after obtaining institutional ethic committee approval and written informed consent from the participants

A set of 20 questions on knowledge 10 on attitude and perception were given to the students who participated in the study, feedback was also obtained using a Likert's scale.

The pre-test and post test results obtained were subjected too statistically analysis

RESULTS:

241 students out of 325 (200 and 125) participated in the present study, of which 146 (interns) and 95 (Junior Resident) The present study has shown improvement in knowledge of medical documentation after the seminar. The perception and attitude of both interns and junior residents was good.

DISCUSSION:

Junior residents have better knowledge, perception and attitude when compared with the interns due to their experience. While interns without any training have gained sufficient knowledge on medical documentation after seminar

CONCLUSION

The participants in the present study has stated that teaching medical documentation will benefit the medical students during 3 mbbs phase 1 instead of foundation course

KEY WORDS: Medical documentation/ hospital records/ medico legal documentation.

INTRODUCTION:

The basic principle of medical documentation is writing it simple. Medical Documentation is a part of medical profession which was hidden in the curriculum till 2018 and in the year 2019 National medical council has introduced Medical Documentation in to undergraduate curriculum, as a part in foundation course[1,2]. Nothing is more devastating to an innocent physician's defence against the allegations of medical malpractice than an inaccurate, illegible or skimpy record, except for a record that has been changed after the fact, and therefore inevitably compromises the otherwise defensible case[3]

AIMS & OBJECTIVES:

- To assess the Knowledge, Attitude and Perception of Interns & Junior Residents towards Importance of Medical Documentation and Health Records.
- To obtain perception of interns and junior residents regarding the implementation of medical documentation in the curriculum during Phase III part I of MBBS

METHODOLOGY

An observational study was conducted to interns and junior residents, at Kurnool medical college Kurnool. During the month of May 2022, the students who had attended the seminar to impart knowledge and wareness of medical records and medical documentation to both interns and junior residents, prior to the seminar a set of 20 questions on knowledge were given for assessing the knowledge as pretest after obtaining written informed consent and those who gave written informed consent were included in the study and who were absent on that particular day were excluded from the study, was given to students as pre-test, in the form of Google forms, which was followed by seminar on medical documentation and maintain hospital records and same set of questions were given as post-test to students by Google forms.

Regarding perception of participants an open end questionnaire was given along with post test

A questionnaire containing 10 questions on attitude was handed over to the interns and junior residents toward procedure of medical documentation and maintenance of hospital records with Likert"s scale rating from 1 to 5. after one week

(1.strongly disagree, 2. disagree, 3. neutral 4. agree and 5. strongly agree).

A Feedback was also taken by using a Likert's scale.

- Pre-test and Post-test questions answered by the participants was subjected to statistical analysis.

RESULTS:

-241 students of 325 (200 and 125) participated in the study of which 146 (interns) and 95 (Junior Resident) The above data has been entered inmicro soft excel and analyzed with SPSS version 20 statistical software(IBM, Chicago, USA) and chi square and p valve for both pre-test and post-test of interns and junior residents respectively, p valve of <0.00005 as significant.

The present study has definitely shown an improvement of knowledge and change in attitude towards medical documentation of medical records after the seminar in both interns and junior residents, Perception of both interns and junior residents was good,

Attitude of the both interns and junior residents was good

DISCUSSION:

- Results of this study conveyed that junior residents have better knowledge on documentation of medical records than interns, it is due to their experience gained by them during their internship, were as interns, who didn't had any sort of knowledge or training on medical documentation

showed us were lagging behind on the knowledge aspect, but has gained the knowledge sufficiently.

- The perception of participants towards medical documentation showed that majority of the participants have good perception towards the study
- Attitude wise the majority of the participants have agreed that documenting the medical records accurately protects them from negligence suits that arise in future and also it will be helpful for them for giving proper care to patients as it helps them to keep the track of the patient prognosis.
- Majority of the participants suggested that documenting the medical records should be the duty of treating doctor.
- About: 4 Interns and 16 junior residents had opined that they would prefer only in treating the patients than learning the procedure of medical documentation.

Tola kasu et al in a study stated that intervention done has increased the overall inpatient medical record completeness by 11% from 73% to 84% (P value < 0.05)[4].
Siamian H et al in a study stated that students and interns have poor knowledge on medical documentation, were as in our study also showed similar results -–interns has less knowledge than junior residents.
on perception and attitude wise stated that student had good knowledge, in our study both interns and junior residents have good perception[5].
Belay A and Rao Y.N in a study done on medical documentation stated that health professionals at hospitals have somewhat poor documentation practice and unfavorable attitude towards medical documentation practice. Similarly in our study also 4 interns and 16 junior residents have stated that they more interested in treating the patient than documenting the records of the patient they are treating, this attitude of present day young doctors confirms the importance of work setting guidelines, documenting for all patients using documentation standard tools and necessary steps to be taken to change the attitude of young doctors towards medical documentations

More over the majority of the participants were interested in learning the art of medical documentation and has given some of the comments to open question on there learning experience, some of the comments are listed below

- ❖ Presentation with specific examples
- ❖ Learning and recalling about medical documentation
- ❖ Examples you gave and all doubts got clarified
- ❖ Concise and crisp nature of lecture
- ❖ Came to know lot of new things
- ❖ Importance of documentation
- ❖ High lighting the importance of documents
- ❖ Learnt the things that i didn't know
- ❖ Useful information
- ❖ Real life examples
- ❖ Learnt basics
- ❖ Would have been helpful if this was taught during 3rd MBBS or before start of internship
- ❖ More examples of wrongly maintained records
- ❖ If it was taught earlier
- ❖ implementing this to curriculum
- ❖ Conducting workshop before internship will be helpful

Conclusion:

Medical documentation of medical records and treating the patient should be carried out at same time simultaneously, if done it will benefit both doctor and patient – About the prognosis of the patient and what treatment or medication that has been prescribed to the patient and more over it

will also protect the doctors from negligence claims. The present day medical students are not being properly trained or monitored during their training in internship, with implementation of medical documentation in foundation course, it has gained the importance, but being taught in foundation alone may not be any helpful to the medical students, as many students have suggested that it will be helpful if it is taught during phase III part I or before the commencement of internship,

SUGGESTIONS AND RECOMMENDATIONS

1. Should be included in the curriculum during phase III part I MBBS and proper assessment should be done on medical documentation by keeping a checklist so that it facilitates the students in better in documentation .
2. Conduction of continuous medical education / medical records documentation / work shop for medical students should be organised periodically every year.
3. Evaluation of clinical skill along with medical records documentation should be carried out at the end clinical postings.
4. A committee should be formed and promote medical records documentation by taking lecture/seminar to the faculty or to the students.

LIMITATIONS OF THE PRESENT STUDY

- As the study was done in a small group does not through much insight.

Request to carry out similar type of studies, as it brings different insights to the KAP of the students

DRAWBACKS:

1. Responses was delayed and constant reminders has to be forwarded
2. Retention test : No responses, had left the institution and were preoccupied with work

TAKE HOME MESSAGE:

Present day doctors should be made aware of documentation of medical records as these are the only one which are going to defend and safe guard the doctor in the court of law

REFERENCES

1. Gutheil TG. Fundamentals of medical record documentation. Psychiatry (Edgmont). 2004 Nov;1(3):26-8. PMID: 21191523; PMCID: PMC3010959.
2. Thomas J. Medical records and issues in negligence. Indian J Urol. 2009 Jul;25(3):384-8. doi: 10.4103/0970-1591.56208.PMID: 19881136; PMCID: PMC2779965.
3. SutiIsmawati ND, Supriyanto S, Haksama S, Hadi C. The influence of knowledge and perceptions of doctors on the quality of medical records. J Public Health Res. 2021 Apr 14;10(2):2228. doi: 10.4081/jphr.2021.2228. PMID: 33855413; PMCID: PMC8129755.
4. Biswas. G "Recent Advances in Forensic Medicine and Toxicology Text book" 1st edition: Jaypee Brothers Medical Publisher:2015: Chapter-8: 140 -162
5. Tola. K et al, "Improving Completeness of Inpatient Medical Records in Menelik II Referral Hospital, Addis Ababa, Ethiopia" Hindawi Advances in Public Health: Volume 2017: Article ID 8389414, 5 pages
6. Siamian. H et al "Study on Rate of Knowledge, Attitude and Practice of Medical Students towards Method of Medical Records Documentation" © IDOSI Publications, 2008: World Journal of Medical Sciences 3 (1): 24-27, 2008: ISSN 1817-3055
7. Putul. M, Yadav. M: "Documentation of Medical records in Day-to-day Medical Practice": IJHRMLP, vol-02, no-1: January 2016: page-29-33: ISSN -2454 5139
8. Dr. Phyllis J. Watson "Medical Records Manual A Guide for Developing countries' World Health Organization Western Pacific Region: 2006.
9. Thomas G. Gutheil " Perspective fundamentals of medical documentation" November: Psychiatry 2004

10. Ajemigbitse. A. A et al "Assessment of the Knowledge and Attitudes of Intern Doctors to Medication Prescribing Errors in a Nigeria Tertiary Hospital" Journal of Basic and Clinical Pharmacy: Vol. 5: Issue 1: December-February 2014: Page- 7 -14:
11. Saravi B.M et al "Documentation of Medical Records in Hospitals of Mazandaran University of Medical Sciences in 2014: a Quantitative Study: ACTA INFORM MED. 2016 JUN; 24(3): page -202-206.

Table:1 showing results of interns and junior residents – pre-test and post-test

• **Results**								
Pre -test interns Total – 146 out of 200			**Post - test interns Total – 146 out of 200**		**Pre - test Junior residents total – 95 out of 125**		**Post - test Junior residents total – 95 out of 125**	
Question	YES	NO	YES	NO	YES	NO	YES	NO
1	48	98	87	59	23	72	82	14
2	52	94	98	48	19	76	86	10
3	48	98	128	18	17	79	73	22
4	56	90	81	65	30	65	76	19
5	56	90	96	50	47	48	83	13
6	40	106	117	29	25	75	76	19
7	46	100	106	40	39	56	73	22
8	50	96	90	56	28	67	68	27
9	42	104	103	43	21	74	84	11
10	67	79	113	30	6	89	93	2
11	36	110	112	31	34	61	64	31
12	26	120	121	25	59	36	76	19
13	58	88	99	47	17	78	72	23
14	56	90	130	16	17	78	63	32
15	35	111	109	37	28	67	80	15
16	72	74	116	30	16	79	71	24
17	36	110	97	49	28	67	77	18
18	44	102	119	27	34	61	88	07
19	33	113	120	26	21	74	79	16
20	58	88	135	11	39	56	92	03

Table:2 showing results of P valve and chi square test for both inerns and junior residents

Statistical analysis by using SPSS 2022 software : P valve and chi square				
Interns			**Junior Residents**	
Question	**p- value**	**Chi Square test**	**p- value**	**Chi Square Test**
1	<0.00001	29.5	<0.00001	72.26
2	<0.00001	29.0	<0.00001	93.4
3	<0.00001	91.53	<0.00001	67.0
4	<0.003	38.59	<0.00001	45.15
5	<0.00001	21.95	<0.00001	30.04

6	<0.00001	81.68	<0.00001	59.02
7	<0.00001	49.36	<0.00001	25.14
8	<0.00001	50.95	<0.00001	33.68
9	<0.00001	50.97	<0.00001	84.49
10	<0.00001	33.75	<0.00001	159.63
11	<0.00001	83.26	<0.00001	18.96
12	<0.00001	123/63	<0.00001	7.39
13	<0.00001	23.15	<0.00001	63.96
14	<0.00001	81.1	<0.00001	45.68
15	<0.00001	75.02	<0.00001	58.01
16	<0.00001	28.91	<0.00001	71.83
17	<0.00001	51.38	<0.00001	51.11
18	<0.00001	78.11	<0.00001	66.78
19	<0.00001	103.92	<0.00001	71.01
20	<0.00001	90.6	<0.00001	69.05

Table:3 showing the response on attitude of interns on medical documentation

Attitude: Interns		
Question	Agree strongly agree	Disagree, strongly disagree
1	101	45
2	126	20
3	96	50
4	23	122
5	116	30
6	136	10
7	128	18
8	48	98
9	4	142
10	16	130

Table:4 showing the response on perception of interns on medical documentation

Perception – interns 146		
Question	Agree strongly agree	Disagree, strongly disagree
1	72	72
2	58	88
3	83	63
4	80	86
5	70	76
6	82	64
7	75	71
8	42	104
9	88	58
10	60	86

Table:5 showing the response on attitude of junior residents medical documentation

Attitude: Junior residents 95		
Question	Agree strongly agree	Disagree, strongly disagree
1	62	33
2	79	16
3	59	36
4	71	24
5	91	4
6	88	7
7	11	84
8	14	91
9	16	89
10	3	92

Table:5 showing the response on perception of junior residents medical documentation

Perception – Junior residents 95		
Question	Agree strongly agree	Disagree, strongly disagree
1	63	32
2	78	17
3	67	28
4	73	22
5	54	41
6	71	24
7	68	27
8	22	73
9	31	64
10	54	41

Table 8- interns feedback on medical documentation

Feedback – interns			
	Skill full	Advanced skill	No skill
1	60	4	82
2	64	5	77
3	41	28	77
4	39	32	75
5	75	67	4

Table- 9 junior residents feed back on medical documentation

Feedback – JUNIOR RESIDENTS			
	Skill full	Advanced skill	No skill
1	90	5	-----
2	91	4	------
3	67	28	-----
4	70	25	------
5	43	53	------

Annexure -1 pre- test and post questioner

Annexure-1 Knowledge

1. According to Medical council of India code of conduct 2012, all the medical records of inpatient should be stored for?

A. 2 years from the date of the last entry.
B. 3 years from the date of the last entry.
C. 5 years from the date of the last entry.
D. 7 years from the date of the last entry.

2. An incomplete record may?

A. Not be a problem, as the reminder of the data entry could be discussed with judge/ lawyer during a court hearing
B. Make it impossible for the healthcare provider to defend allegations against him in the court of law.
C. Allow only part of a bill to be paid by the patient.
D. Not able to be subpoenaed to court of law.

3. For the court's purpose, if documentation does not appear in the medical record

A. It did not occur.
B. It can be documented at a later date without harm.
C. The court will not use the medical record against the healthcare provider
D. Allow only a part of a bill to be paid by the patient to the doctor.

4. To protect patient confidentiality, medical records can be released

A. To employer
B. To the Judge.
C. On request by patient's family members
D. Only with the patient's written consent

5. When preparing a copy of a medical record for a third party,

A. Keep the copy and send the original
B. Make two copies and send the original
C. Keep the original and send a copy
D. Make a copy of the complete record and send it even when one part is requested

6. The accepted method of correcting medical errors is

A. Erase and write the correction
B. Draw a line through the error and write the correction underneath
C. Draw a line through the error and write the correction above with the date and initials of the person making the correction
D. Erase and write the correction, adding the date and initials of the person making the correction,

7. Among the following which are considered as health records of an individual?

A. Outpatient card
B. Patient admission records
C. Investigation records
D. Discharge Summary

8. Purpose of documenting health records?

A. Communication.

B. To remember patient details and diagnosis.

C. Helps as an education and research.

D. In auditing of the quality of health service provided.

9. What is the common method of disposal of health records/ medical records of patients at your hospital?

A. Burning

B. Shredding

C. Trammeling

D. Pulping

10. By when the patient can have his treatment records?

A. 12 HOURS

B. 18 HOURS

C. 48 HOURS

D. 72 HOURS

11. Among the following which are the components of effective documentation?

A. Illegible and accurate.

B. legible and incomplete

C. illegible and incomplete

D. legible and accurate

12. Why medical records should be stored in a safe place?

A. To maintain confidentiality of the patient.

B. To avoid excess bill charged to the patient

C. To prevent negligence claims

D. To avoid easy access to the third party**.**

13. Among the following what is the most common error in medical documentation?

A. Incomplete record

B. Over correcting the mistakes with authentication

C. Following the sequence of events during the course of treatment and documenting.

D. Using common language

14. What should be done to the medical records, which are being destroyed after certain period preservation?

A. Make a Xerox copy of those and destroy.

B. Hand over to the concerned patient

C. Maintain a log book with patient details

D. Hand over to third party for destruction**.**

15. Does unique patient identification method being followed in your hospital, if so what is it?

A. Only patient name and date of birth

B. Only patient name with surname

C. Unique hospital identification number with name if the patient

D. Patient name and address

16. Who is responsible for the medical records management in your hospital?

A. Treating doctor
B. Medical superintendent
C. RMO
D. Head of the department of medical records

17. According to Directorate general of health services the medical records should be preserved for how long?

A. Out Patient: 2 years, Inpatient: 5 years
B. Out Patient: 5 years, Inpatient: 10 years
C. Out Patient: 3 years, Inpatient: 5 years
D. Out Patient: 5 years, Inpatient: 5 years

18. Under what circumstance can a doctor reveal the medical records of a patient to the public/third party without patient consent?

A. Patient relatives request
B. Employer request
C. Court order
D. Research purpose

19. Missing date or missing data of health progress of a patient in the medical records suggest?

A. Treating doctor wontedly missed the dates or date to avoid complications.
B. Nothing has been done to the patient.
C. Patient gets the chance so that can pay fewer fees to the doctor.
D. Both patient and doctor are liable for fine under the court of law.

20. Ownership of medical records usually remains with whom?

A. Doctor
B. Patient
C. Court
D. Insurance company

Annexure – 2

Attitude (Likert scale)

1. In order to be a good clinician, I must learn to properly document the medical records correctly?

a) Strongly disagree
b) Disagree
c) Neutral
d) Agree
e) Strongly agree

2. Documentation of medical records in a correct method is as important as treating the patient?

a) Strongly disagree
b) Disagree
c) Neutral
d) Agree

e) Strongly agree

3. Learning the skill of proper documentation of medical records during the MBBS course would have helped me better than learning it during internship?

a) Strongly disagree
b) Disagree
c) Neutral
d) Agree
e) Strongly agree

4. Learning the skill of proper documentation of medical record is not going to help me in giving a good care to the patient?

a) Strongly disagree
b) Disagree
c) Neutral
d) Agree
e) Strongly agree

5. Nobody is going to file a case on the doctors for not learning proper documentation of medical records?

a) Strongly disagree
b) Disagree
c) Neutral
d) Agree
e) Strongly agree

6. I find it difficult to document the details given by the patient in medical records?

a) Strongly disagree
b) Disagree
c) Neutral
d) Agree
e) Strongly agree

7. If documentation of medical records is correctly done, there is less chance of filing a negligence cases against me?

a) Strongly disagree
b) Disagree
c) Neutral
d) Agree
e) Strongly agree

8. It is waste of time for learning the ways of documenting a medical records in a proper way during MBBS course or internship?

a) Strongly disagree
b) Disagree
c) Neutral
d) Agree
e) Strongly agree

9. I haven't got enough time to learn the proper way of documenting the medical records during my under graduate course?

a) Strongly disagree
b) Disagree
c) Neutral
d) Agree
e) Strongly agree

10. I don't need good documentation skills in order to be a good physician?

a) Strongly disagree
b) Disagree
c) Neutral
d) Agree
e) Strongly agree

PERCEPTION

1. What is your opinion on medical documentation being implemented in undergraduate curriculum?

a) Strongly disagree
b) Disagree
c) Neutral
d) Agree
e) Strongly agree

2. Will the MBBS student be able to learn the proper way of documenting the medical records, just by lecture on medical documentation during the foundation course?

a) Strongly disagree
b) Disagree
c) Neutral
d) Agree
e) Strongly agree

3. If medical documentation was part of the curriculum during your MBBS course, does it would have helped you?

a) Strongly disagree
b) Disagree
c) Neutral
d) Agree
e) Strongly agree

4. Documenting Medical Records In A Standard Way Helps In Reducing Negligence Cases Filed Against Doctor?

a) Strongly disagree
b) Disagree
c) Neutral
d) Agree
e) Strongly agree

5. MBBS students should be able to learn the proper way of medical documentation by the end of III phase part II MBBS?

a) Strongly disagree
b) Disagree
c) Neutral
d) Agree
e) Strongly agree

6. Accurate medical records has benefits like proper patient care, less chances of negligence cases against doctors, helps in research and better communication with other health personnel?

a) Strongly disagree
b) Disagree
c) Neutral
d) Agree
e) Strongly agree

7. Documentation in medical records help in better communicating with the patient and his relatives regarding the care given to the patient?

a) Strongly disagree
b) Disagree
c) Neutral
d) Agree
e) Strongly agree

8. Due to emergency, you have failed to document in the medical records of a patient, on a later date, you remembered of it, and you think it is correct time to document?

a) Strongly disagree
b) Disagree
c) Neutral
d) Agree
e) Strongly agree

9. Documenting the details of the patient in the medical records usually results in loss of privacy and confidentiality of the patient?

a) Strongly disagree
b) Disagree
c) Neutral
d) Agree
e) Strongly agree

10. There are no any laws or legal provisions for preserving the medical records of a patient, do you think there should there be any specific law for preserving the medical records of a patient?

a) Strongly disagree
b) Disagree
c) Neutral
d) Agree
e) Strongly agree

Feedback (Likert scale)

1. How knowledgeable you are prior to this session?

A. No Knowledge
B. Basic Knowledge
C. Sufficient Knowledge
D. Advanced Knowledge
E. Highly Knowledge

2. How skill full you are prior to this session?

A. No Skill
B. Basic Skill
C. Sufficient Skill
D. Advanced Skill
E. Highly Skill

3. How knowledgeable you after this session?

A. No Knowledge
B. Basic Knowledge
C. Sufficient Knowledge
D. Advanced Knowledge
E. Highly Knowledge

4. **How skilful you are after this session**?

A. No Skill
B. Basic Skill
C. Sufficient Skill
D. Advanced Skill
E. Highly Skill

Open End Questions

5. How important this session was?

6. What went well in this teaching session?

7. **What could have been done better**?