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Guest Editorial

Samantha Walker

"I think we are faced in medicine with the reality that we have to be willing to talk about our failures and think hard about them, even despite the malpractice system. I mean, there are things that we can do to make that system better."

- Atul Gawande

Welcome to the October 2020 edition of the Future Leaders Communiqué. In this issue we discuss the theme of clinical documentation and handover. We explore what the quality of clinical documentation and handover reveals about the treating team, and how improving it will reflect better on our professionalism, in addition to helping our patients.

In this issue we present an inquest into the death of a six-year-old boy from a readily treatable illness due to inadequate documentation, poor communication, and sub-standard care.

The health care system is a complex maze of examinations, procedures, medications and people. The usual hospital inpatient will see 18 different health professionals during their admission1. Although the health system is a collective hub, we each work with relative autonomy. The cornerstone of communication between each health professional is the medical record and handover.

In each hospital or clinic, the medical record may be a hard copy, electronic file, or a combination of both. As the current difficulties with the My Health Record demonstrate, these systems have varying levels of security and efficiency and are subject to user error. Deficiency in clinical documentation and handover is known to lead to errors in care, misdiagnosis, increased morbidity and mortality. Documentation is inherently important in medical practice; so much so that it is imbued in the good medical practice guidelines and national standards for quality and safety.

All that being said, clinical documentation is considered a dry and unrewarding task. Most people get into medicine to care for patients and for interesting cases and procedures; not to write the perfect review or ward round note.

Medical teams contain consultants, registrars, residents, and interns. Despite this it is often the most junior team member left to write notes. Clinical documentation should be a snapshot of the patient's journey up to the point of review. It should clearly delineate specific issues and progress made, an impression of the patient's current status as well as a plan for the rest of the team to follow. However, if time is limited or the author does not understand the clinical scenario and plan, documentation can be lacking or incorrect. Take for example, an all too familiar note, *"Pt X, 50yo, day 3 with query pneumonia; vitals stable and afebrile; continue current management"*.

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FEEDBACK

The editorial team is keen to receive feedback about this communication especially in relation to changes in practice. Please contact us at: **flc@thecommuniques.com**

Guest Editorial (continued)

This note reflects an underinformed author, an uncertain plan or a very cursory review. It does not provide any direction to other members of the multidisciplinary team that will influence the patient's outcome, and it can seriously misguide future management.

Whether you realise it or not, you analyse the quality of each interaction, written or otherwise. All health professionals do. You can look at a patient note and recognise the handwriting of a registrar or resident and think either "this will be thorough and useful" or "I might as well start from scratch myself". If you do not have professional standards of documentation, the rest of the team cannot function efficiently, and patients suffer.

As the case presented in this issue demonstrates, our documentation and interprofessional communication that occurs in daily practice will be scrutinised with a fine-tooth comb at a coronial inquest. Not just by one person. In this case, events were examined by two coroners, multiple legal representatives and five expert witnesses, as well as the public when the case findings are reported. Think about what you last wrote in the patient record. Would it stand up to such scrutiny?

Think of your documentation and handover as a reflection of your professionalism. Your competency may be more clearly and reliably demonstrated in your written and verbal handovers if you routinely utilise a reproducible system such as SOAP (subjective, objective, assessment and plan) or the better validated ISBAR (identification, situation, background, assessment and request). Ask for more time on ward rounds to write your note or make a list of files to return to complete. Read colleagues' notes critically to pick up phrasing that you like, as well as recognise paucity of notes.

Clinical documentation may be a chore for medical practitioners, but it reflects the writer's professionalism and is integral to good patient care. So, the next time you write in a patient's file you should consider whether it's a note that will positively contribute to the treating team and the patient's safety.

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Editorial

by Dr Brendan Morrissey

Welcome to the fourth edition of the Future Leaders Communiqué for 2020. This year continues to challenge us all both personally and professionally. What has been required of us in 2020 is constant change. Borne from necessity, our practice has evolved at a fantastic rate to meet the demands of the pandemic. The rapid evolution of our clinical practice over such a short period has been made possible by examining our patient care, and sharing the lessons learned openly, with the explicit aim of improvement. This speaks to a core conviction of the Future Leaders Communiqué – that sharing lessons learned in the course of clinical practice can improve patient safety and care. It is with this in mind that we are very proud to bring you our latest edition.

In this edition our guest editor, Dr Samantha Walker, will be discussing a coroner's investigation into the tragic death of a 6-year-old boy following delays in the diagnosis and management of bacterial sepsis. This case allows us to reflect on the importance of clinical handover and documentation in our everyday practice. These are both cornerstones of safe patient care, but too often are underserved – left wanting as the demands on our time and attention are drawn elsewhere.

Dr Samantha Walker is a 3rd year medical officer working at Melbourne Health. Samantha studied in a regional hospital medical school and after graduation worked across both metropolitan and large regional centres. Her professional interests include the specialty of paediatrics. We are amazed by how our guest editors manage to balance a plethora of commitments, both at work and home, and still bring their experience and enthusiasm to each edition of the Future Leaders Communiqué. This has undoubtedly been even more of a challenge in these extraordinary times – congratulations to Samantha on this achievement.

The two expert commentaries in this edition focus on the themes of documentation and communication. Samantha has drawn on the expertise of Dr Nick Thies, Paediatrician, Warnambool Hospital, who provides a thoughtful piece on the importance of the medical record. Dr Susan Hertzberg, Senior Medical Adviser, Avant Mutual and Rocky Ruperto, Legal and Policy Officer, Avant Mutual, contribute a second commentary to this edition, offering a reflection on the art of clinical communication and record-keeping.

On a final note, we are excited to be able to share the Future Leader Communiqué, along with all of the Communiqués, in a new format. Visit our website to find details on how to download and listen to our new podcast series!

Write as though a person's life depends on it

Case Number 7048/2010 WA
Author **Dr Samantha Walker,**
BBiomedSc MBBS
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Melbourne Health

i. Clinical Summary

SP was a fit and healthy 6-year-old boy; he was close with his sister and particularly enjoyed video games and movies. SP was living between the homes of his parents who had recently separated.

SP became unwell with mild flu symptoms while in the care of his mother. On the third day of illness his mother transferred care to SP's father, with the information that SP was unwell with a flu and requested he take SP to see a doctor. SP's father (a registered nurse at the regional hospital) believed his son had a virus and kept him home.

'The consultation took place without a formal triage process, and no record or documentation of the assessment was made.'

The following day, SP's father attended the emergency department (ED) on a social visit with SP who had developed a bright rash on his body. At his colleagues' encouragement, SP's father brought SP to the doctor on duty for a review. This doctor was an experienced locum, Dr C.

The consultation took place without a formal triage process, and no record or documentation of the assessment was made. Dr C diagnosed a viral illness, with a differential diagnosis of scarlet fever or tonsillitis. Dr C prescribed penicillin to be used if SP became more unwell and sent SP home with his father.

SP returned to the care of his mother (also a registered nurse at the regional hospital) the next day, along with the information of a viral illness and the 'as required' script. SP's mother was concerned about his condition and returned to the ED with him. SP was seen by Dr R, who considered SP's symptoms to be that of a virus but arranged a chest x-ray to rule out pneumonia. Dr R handed over to Dr C (who had consulted on SP earlier), who reviewed the x-ray, considered it normal and discharged SP home.

That same evening SP's condition worsened, he developed a fever and vomiting. The next morning his mother took him to the general practitioner (GP). The GP diagnosed scarlet fever and referred SP to the ED with a letter requesting admission for management. At the ED, SP was seen by paediatrician Dr I, who diagnosed scarlet fever along with a possible chest infection.

SP was given intravenous (IV) antibiotics and admitted to the high dependency unit (HDU).

Over the course of the afternoon SP's heart rate and respiratory rate remained very high, 190 beats per minute and 60 breaths a minute respectively. At Dr I's instructions SP received IV fluids at a maintenance rate.

At an evening ward round, Dr I reviewed SP, noted the ongoing rapid heart and respiratory rates and made no changes to management. Just after midnight, SP deteriorated, and while being reviewed stopped breathing. Resuscitation attempts were unsuccessful, and SP was pronounced dead at 2am.

ii. Pathology

At autopsy the cause of death was Influenza A H1N1, complicated by Streptococcus pyogenes group A bacterial pneumonia associated with scarlet fever, empyema and sepsis, the latter of which caused death.

iii. Investigation

SP's death was referred by SP's mother to the regional Coroner. After a protracted police investigation, the regional Coroner transferred the investigation to the State Coroner with a recommendation that an inquest be held.

A paediatrician completed an initial review of the case and deemed the management of SP to be acceptable, and an inquest was not held. SP's mother contested this approach, and further reviews by two paediatricians and an emergency physician found that the care received by SP was below acceptable standard.

An inquest was held four years after SP's death. The treating doctors were called to give oral evidence. Also called to the inquest were: SP's parents; representatives of the health service; representatives on behalf of the nursing staff; and expert witnesses (specialists in infectious diseases, emergency medicine and paediatric medicine).

The general practitioner who saw SP and diagnosed scarlet fever gave video evidence. The regional health service was asked to provide documented evidence regarding the conditions of Dr I's registration and practice as a doctor.

'Opinion was requested of the expert witnesses regarding the lack of documentation by Dr C'

The coronial investigation into the management of SP focused on:

- the unrecorded consultation with Dr C, and widespread failures of note-making
- the 'as required' penicillin prescription by Dr C, otherwise known as delayed prescribing
- The delay in the reporting of the x-ray
- Dr I's failure to recognise and treat compensated septic shock

The informal consult of SP by Dr C was shown to be a product of many factors.

SP's father worked in the ED and Dr C felt obliged to see SP despite the lack of a formal triage process. Dr C was an experienced doctor who had worked in EDs in rural and remote Australia, however it was her first day working in the regional health service and she was pressured by her colleagues to see SP. It was acknowledged that it was a difficult position for Dr C to have been put in, as informal consultations were at that time not uncommon.

Opinion was requested of the expert witnesses regarding the lack of documentation by Dr C, in addition to the quality of documentation throughout SP's treatment at the regional health service. Although there was an obvious deviation from expected standards when Dr C did not document any of her consultation of SP, there were also more subtle deficiencies that followed such as illegible writing and non-contemporaneous notes. The investigation found that although Dr C did not document the consultation, her testimony demonstrated that they likely conducted a thorough examination and had relative foresight to suspect scarlet fever. Dr C admitted that not recording the consultation was below the expected standard and not her usual practice.

It was the unanimous opinion of the experts that clinical documentation is of the utmost importance when seeing a patient, and throughout SP's care there were significant deficits in documentation and communication.

The expert witnesses acknowledged that giving 'as required' scripts is common practice but noted that there was no formal guidance as to whether this is an acceptable practice.

Dr C submitted NICE (National Institute for Health and Care Excellence) guidelines that 'as required' scripts are considered safe and responsible prescribing. The witnesses were generally critical however, of the 'as required' script. Their opinion was that either the script should be given with clear directions for use, or instructions to return for review if the patient's condition worsens.

'At the time of inquest there was no formal guidance from the Department of Health as to their recommendations on "as required" scripts.'

At the time of inquest there was no formal guidance from the Department of Health as to their recommendations on 'as required' scripts. The handover between Dr C and Dr R was scrutinised in detail, as it was a key point in SP's care where the early pneumonic changes could have led to delivery of antibiotics 24 hours earlier. Dr C and Dr R differed in their recollection of the handover and expected actions afterwards. Dr R said that he had asked Dr C to check the x-ray of SP and then reassess him before deciding whether he required antibiotics or hospitalisation. Whereas Dr C interpreted the handover as she only needed to review the x-ray and if nothing significant was seen, discharge the patient.

At the time of SP's treatment at the regional health service there was a trial for handover with the ISBAR system, which Dr C was not aware of and Dr R was not proficient in. If this system had been used, Dr C would have been less likely to have misinterpreted Dr R's instructions.

The reporting of the x-ray taken during SP's second emergency department presentation was reviewed during the inquest. There was a delay of 18 hours between the x-ray and the formal report that stated, "likely early changes of pneumonia". It is unclear whether Dr C or Dr R were notified of the report, or whether they had checked it of their own accord. Dr C considered that the x-ray did not appear to have any significant infective changes, so she did not instigate antibiotics at that time, and discharged SP to home.

While SP was not given antibiotics on the basis of the x-ray, the Royal Children's Hospital guideline recommends that x-rays and blood tests are not required for clinically suspected pneumonia. Thus, there were two missed opportunities for SP to have been commenced antibiotics, the first being Dr C's consultation, which did not occur, and the second being on review of the x-ray.

There was unanimous consensus between the expert paediatricians and emergency physicians that SP had demonstrated signs of systemic inflammatory response syndrome (SIRS), which developed into compensated septic shock due to scarlet fever. Dr I's failure to respond to SP's persistently high heart rate and fevers was criticised by the expert witnesses.

They found this to be below the expected standard of a paediatrician. Dr I did not escalate his treatment accordingly, which meant that SP's illness naturally progressed to decompensation and cardiorespiratory arrest.

'It was likely that with earlier intervention SP could have survived.'

Unfortunately, Dr I was unable to complete his testimony as he had a severe stress reaction after the first day of giving evidence. He was therefore not able to explain his actions during SP's treatment or answer to the criticisms. Dr C was no longer registered to practice as a paediatrician by the time of the inquest.

iv. Coroner's Findings

The coroner found evidence of a series of missed opportunities and errors that allowed a minor illness to turn into a serious condition, undiagnosed until SP was gravely ill. It was likely that with earlier intervention SP could have survived. A clinical misjudgement in the form of unrecognised sepsis deprived SP of that chance.

Following SP's death, the health service instituted a mandatory triage process for any patient being seen in the ED, including staff and family members. They also introduced standardised observation charts with stipulated parameters for escalation based on age, for clinical review and emergency response.

The coroner made two recommendations:

1. The Department of Health determine whether doctors in the public health system should employ the strategy of 'as required' antibiotic prescriptions and provide guidance accordingly.

2. The regional health service consider implementing a procedure to ensure that, where appropriate, radiologists' reports of x-rays of children with potentially serious illnesses are provided to requesting clinicians with the least possible delay.

v. Author's Comments

Reading this case is very difficult due to it being about the death of a small boy, and because we see moments where the outcome could have changed.

'The intention of this publication is to help junior clinicians develop their critical evaluation of their own work and others.'

It is important to reflect on this case to think about what you could do in your own practice to avoid a similar circumstance and take the opportunity to learn from this tragedy.

Consider the dangers of any informal consultations, the importance of accurate note-keeping, following up laboratory or imaging results, the benefits of a thorough handover, and responding to early signs of clinical deterioration. The intention of this publication is to help junior clinicians develop their critical evaluation of their own work and others. To continually develop as health professionals, you need to be open to criticism and look for ways to improve your response.

Multiple checkpoints failed SP along his health care journey resulting in deterioration and ultimately death. It is easy with the power of hindsight to wonder how each of these deviations from accepted practice happened, but when surrounded by the chaotic working environment of the health care system, mistakes can happen. That is why it is important to conscientiously document and follow guidelines. It isn't exciting, but it is safer for our patients. You need to be consistent with these aspects of clinical practice because you do not know if you might be one of the broken links in a chain that fails a patient.

The coroner's first recommendation has been responded to by the Department of Health under their recommendations for antimicrobial stewardship in general practice. The information provided in antimicrobial stewardship guidelines detail studies that show delayed prescribing can decrease the amount of antibiotics taken by patients without a difference in outcomes. The caveat to that information is that the prescription needs to be explained to the patient or guardian, and explicit instructions given regarding when to take the antibiotics. An alternative proposed to delayed prescribing is to arrange further review in the event the patient does not improve. In the case presented, Dr C prescribed the penicillin as required if SP became "more unwell".

In this case the non-specific instructions may have presumed professional knowledge that SP's father had as a nurse.

Given all patients have varying levels of health literacy, it is important to discuss all treatment decisions to ensure understanding and improve adherence to advice.

The second recommendation was for the health service to develop an early reporting system for direct feedback of significant imaging findings in children. The difficulty with reporting scans in a timely manner seems to be a widespread one. The use of offsite radiology reporting after hours can help to improve the timeframes. It is also essential to have sufficient information on referral forms to enable the radiologist to interpret the imaging within the correct clinical context. If a clinician orders a test, they need to either follow-up the test themselves (preferable) or give clear instructions at handover for their colleague taking over that role. Another initiative that is useful in safeguarding the timely review of results in urgent care and emergency departments, is having all significant investigations pending results be flagged and checked by senior staff members.

Some of the differences in practice between when these events unfolded in 2011, and now, are the development of clinical review and MET (medical emergency teams) call criteria observation charts, which have been shown to increase earlier intervention and avoid serious deterioration. The importance of these charts is to enable the escalation of concerns by medical and nursing staff.

Additionally, clinical guidelines are more readily available in the form of therapeutic guidelines and, pertinent to the case presented, the Royal Children's Hospital (Melbourne) clinical guidelines.

The out-of-hours reporting of radiological investigations is supported by better computer systems and online reporting platforms (such as 'Everlight' and 'VRC'), which enable access to after-hours radiologists for timely interventions.

Lastly, I feel it important to finish by echoing the coroner's statement regarding SP's family, particularly his mother in advocating for the inquest. At first an inquest was not going to be held, but SP's mother persevered in reaching out for expert reviews and further investigation of her son's case. It is due to her determination that SP's story was heard, examined, and given opportunity for changes in practice to occur at individual, organisational and government levels. SP's mother should be commended for her dedication in the face of such heartbreak.

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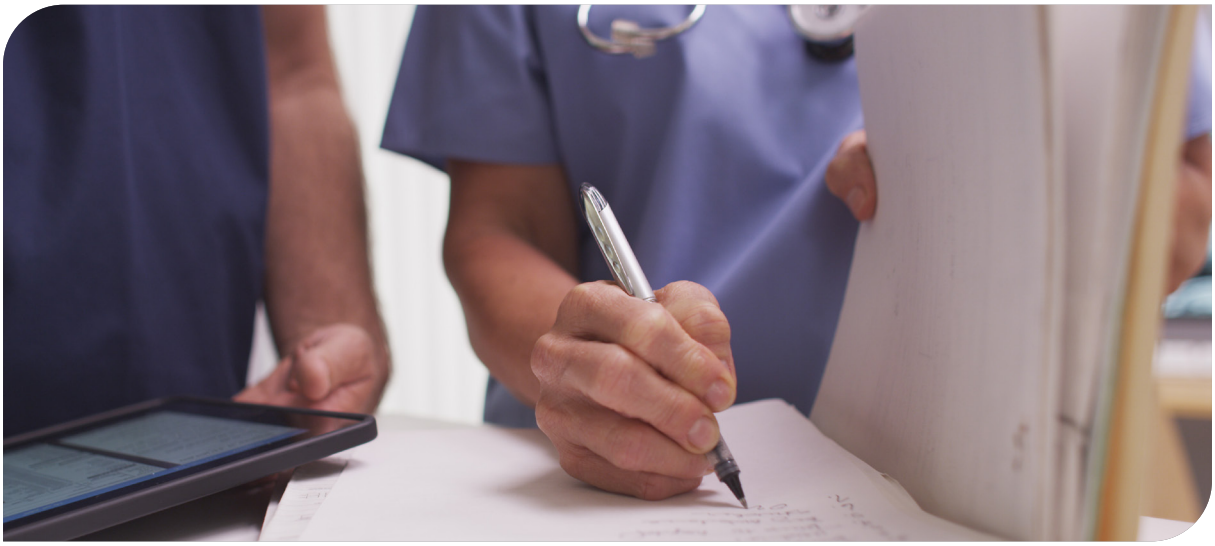
vii. Keywords

Clinical documentation, handover, paediatric, delayed prescribing, scarlet fever, sepsis



Medical record writing is an art which can enhance knowledge and experience and contribute to efficient and safe patient care

Nick Thies
Paediatrician
Warrnambool, Australia

The coronial enquiry into the tragic death of SP has revealed several significant contributing issues, which unfortunately are recurring themes - the treatment of children of health professionals, the virulence of Streptococcus pyogenes, and the importance of a systemic approach to writing in the medical record. This commentary will focus on the medical record.

As a medical student, I was not taught how to write medical notes. However, I was fortunate in being introduced to a very structured system of record keeping in my early years as a registrar at the Royal Children's Hospital in the 1970s, using the relatively "new" problem orientated medical record and SOAP (subjective, objective, assessment, plan) system.

'One quickly realises the value or otherwise of record entries.'

This was obviously paper-based, the front page listed individual problems, the date they developed, and were numbered, and these numbers used as references in the body of the ongoing medical record where entries were written using the SOAP format.

This provides an elegant structure and ensures that the review of progress is relatively easy, but this value for providing information is only as good as the quality of the information placed into it.

The "S" and "O" provide information over time, but the "A"-assessment, is the most valuable entry each day, being the opinion of the author using all their knowledge and experience and committing it to writing. The "P"-plan, will follow logically.

For comprehensive medical record keeping, the "system" needs to have a unified structure, such as that mentioned above, which everybody follows. One can learn the value of such a system if given the task of reviewing medical records for writing a summary, or for the purpose of doing an audit or research project. One quickly realises the value or otherwise of record entries. Unfortunately, poor systems are identified during an audit process resulting from a coronial inquest which occurs after a significant mishap.

Let's get back to the quality of what goes into the notes. In emergency departments there seems to have developed a habit of writing notes at the end of the shift, a sure recipe for omitting vital information. I recognise that an ED doctor may be juggling a few patients at a time, but with the initial contact with the patient, the doctor should give all their undivided attention to the interview and examination. They should make notes at the time, ignoring any distractions, and should formulate a written assessment and plan on the spot.

'The practice of medicine involves writing notes many times each day so one should develop good habits early, and continually reflect on the quality of what is written.'

This ensures that if something untoward occurs in the next short period of time and another doctor or nurse has to be involved, they will have all the information on which to base further care.

Recording a complete SOAP entry also acts as a great learning exercise for junior doctors. Often, I have been asked to review a patient in ED, and no notes have been written by the referring junior doctor. They have lost an opportunity to use their knowledge to provide their own assessment/opinion and put it in writing. It doesn't matter if it is not the same as the consultant. Maybe it might even help the senior doctor to think outside the box.

The junior doctor can also add to their knowledge by looking up references online for possible differentials, helping them come to a more confident assessment and plan.

The practice of medicine involves writing notes many times each day so one should develop good habits early, and continually reflect on the quality of what is written. Writing down assessments is probably the most difficult part of SOAP for junior doctors, but by doing so one will gain greater experience quickly, and also enhance patient safety.

The art of describing the case: Communication and clinical record-keeping

Rocky Ruperto,
Legal and Policy Officer,
Avant Mutual

And

Dr Susan Hertzberg
Senior Medical Adviser,
Avant Mutual

A tragic case such as the death of SP highlights the importance of good communication in enabling health care teams and systems to work together to provide good patient care. As is often the case when reviewing an adverse event in hindsight, it is all too easy to see places where a mistake could have been avoided if only someone had asked the right question or had critical information at the time. Good clinical records are an essential part of communication between healthcare providers[1].

In our experience poor clinical records are often part of a more complex picture of errors, as this case illustrates.

Record-keeping as a medico-legal issue

When Avant analysed recent claims where medical records were a factor, a number of issues stood out2. Records were found to be below standard in 11% or one out of every nine claims. However, it was rare for documentation issues to be the primary basis of the claim (less than 1% of matters).

Problems with record-keeping were much more common where the doctor's care was ultimately assessed as below the expected standard on other grounds. Most commonly these claims involved diagnosis or medication issues.

High quality records illustrate a doctor's clinical reasoning and, provided the care was reasonable, claims are more easily defended because the record is a valuable source of evidence.

Records should enable handover of care

Unfortunately, as medical defence lawyers, we may be looking at clinical records in the aftermath of a complaint or adverse event to try to work out what went wrong. Many years after the event, the contemporaneous record is essential in trying to reconstruct what happened. However, thinking about the lawyers or regulators scrutinizing your record with a fine-tooth comb may be confronting and overwhelming.

It may feel as if lawyers hold doctors to unrealistically high standards of documentation.

However, as a recent New South Wales decision illustrates, regulators acknowledge records are produced in a less-than-ideal environment with competing distractions and demands[3].

'Note your clinical reasoning and your rationale for reaching a diagnosis, performing a test or prescribing medication.'

The challenges and limitation of producing some objectively perfect record are recognised. However, the aim is always to ensure important details about the patient's health are recorded for the benefit of those who may need to take over care[1]. The case of SP illustrates the way in which missing or incomplete notes can deprive another practitioner of the full picture of care up to that point. When making notes, think about what you would want to know if you were taking over care and hadn't spoken to the previous doctor. Your aim should be:

1. To show your thinking in relation to the particular patient
2. To document the current clinical state of the patient including relevant vital signs.
3. To communicate your thinking to all the people who will be looking after the patient, including a differential diagnosis, a list of problems or concerns related to the patient.
4. To communicate clear instructions and a management plan for the patient to all the people who will be looking after the patient.

Note your clinical reasoning and your rationale for reaching a diagnosis, performing a test or prescribing medication. Keeping a record of any significant differentials you considered or excluded is also important. Mnemonics such as SOAPIF (a common variation of the 'SOAP' mnemonic – subjective, objective, assessment, plan, information, follow-up) can be useful as a prompt to record key details[4].

The pitfalls of the informal consultation

Providing care for family or friends is also a scenario that can lead to adverse outcomes. As in this case, it may not be seen as a 'proper consultation' requiring contemporaneous record-keeping or handover. The Code of Conduct[5] states in most cases, providing care to close friends, those you work with, and family members is inappropriate because of the lack of objectivity, possible discontinuity of care and risks to doctor and patient. Where it cannot be avoided, it is important to be particularly vigilant about ensuring professional boundaries and objectivity. Try to avoid 'corridor consultations' and ensure records are complete and up-to-date[6].

Communication between care teams

The coroner in this case also raised concerns about communication between ED and Radiology teams. It was noted that clinicians requesting scans did not normally explain the concerns behind the requests, and it was often up to the radiologist's discretion to decide whether to treat particular images as urgent.

It is important to document relevant history on a radiology request form. Avant's analysis of claims has also highlighted that breakdown in communications between diagnostic specialists, primary care practitioners, and patients can lead to diagnostic error[7]. As the NSW Clinical Excellence Commission suggests, one important step in reducing such errors is direct communication between primary care practitioners and diagnostic practitioners[8].

Telling the story of the patient

Atul Gawande[9] has also said medical records should be fundamentally about communication with everyone on the team. He suggests one problem, particularly with electronic record keeping, is that "the story of the patient has disappeared from our notes … this is this person, this is what I know about them, this is what I'm worried about in this person, here is what's exceptional about them and here is what's routine. I think that art of describing the case and making sure that everybody knows about it is fading."[9]

Medical record keeping in a modern hospital environment is challenging, but the electronic medical record can provide a clear time frame of contemporaneous events which is invaluable to clinicians caring for the patient.

Thinking about the records as a way of communicating between all those caring for the patient, rather than something for the lawyers, could be a useful strategy to ensure that medical teams keep better records.

Expert Commentary (continued)

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Comments From Our Peers

"Good documentation is never formally taught or discussed in medical school but its importance in both clinical care and medicolegal safety only escalates as we continue practicing and growing as professionals. Learning and practicing to document well should be a high priority for junior doctors."

"A huge challenge in the acute medical setting is prioritising clinically urgent tasks alongside thorough and timely documentation. This case serves as a good reminder that ultimately, they are one and the same."

"The further along in training I go, the clearer it is that good documentation saves time and lives. I try to think, who is going to be reading this note and what do I want them to know about this patient."

"This is a great reminder of the importance of a task that junior doctors perform on a daily basis, which is often perceived as obligatory yet frivolous. Medical students and the most junior doctors should be given formal opportunities to develop their own style of medical documentation that meets appropriate communication and legal obligations"

"Informal consultations have many issues for both patient and doctor. In order to minimise risk to patients and to myself I now avoid informal consultations where possible while directing the person for an objective consultation with a different doctor and if unavoidable, I offer minimal safety-based advice and document contemporaneously."

"The value of clear succinct notes has never been more evident than at 2AM in the morning as the covering doctor for a MET Call."

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