http://jmscr.igmpublication.org/home/
ISSN (e)-2347-176x ISSN (p) 2455-0450
crossref DOI: https://dx.doi.org/10.18535/jmscr/v7i12.28

IGM Publication
Journal Of Medical Science And Clinical Research
An Official Publication Of IGM Publication

Original Research Article

Death Audit – 2014 to 2018 as an activity of Medical Education Technology

Authors
Dr Vivek Pande[1], Dr Nalini Humanay[2*], Dr Ravindra Kshirsagar[3]
[1]Associate Professor, [2]Professor & amp; HOD Medicine, [3]Assistant Professor
Department of Medicine, NKP Salve Institute of Medical Sciences & amp; Research Centre, Nagpur
*Corresponding Author
Dr Nalini Humaney
Professor & amp; HOD Medicine, NKP Salve Institute of Medical Sciences & Research Centre, Nagpur-440019, India

Abstract
Background: *Death Audit needs to be conducted frequently in all hospitals to check IPD (Indoor Patient Department) files for qualitative and quantitative adequacy.*
Various parameters used to check Death files are (a) correctness of diagnosis (b) Adequacy of Investigations (c) Promptness & Adequacy of treatment in comparison to normal standard (d) Correctness and completeness of documentation.
Aims and Objectives: *To study impact of conduct of monthly Death Audit in Medicine Department in improving standard of documentation by doctors.*
Methodology: *The present study was a Record based, Interventional study covering 5 calendar years. After obtaining permission of institutional ethics committee, documentation errors in 1198 Death files [87.38% of total death files between 2014 to 2018], were studied. Data obtained was analyzed by Chisquare Test.*
Results: *Errors rates were reduced in most of 18 parameters used to check Death Files and in many parameters reduction is statistically significant.*
Discussion: *Tenure of junior residency is best phase of doctors, to develop habit of correct and complete documentation in all IPD files. In a teaching hospital monthly Death Audit meets can be used as a tool of Medical Education Technology (MET), to teach JRs (Junior Residents) about need and method of documentation, so that they are competent to avoid legal problems in their careers.*
Conclusions: *Meticulous record keeping is required to avoid observations from various courts, insurance and empanelment agencies, Government Health officials and NABH inspectors.*
Keywords: *Death Audit, Error Rates, Documentation, Legal Issue.*

Introduction

Death Audit is qualitative and quantitative analysis of clinical records [Death files] and collection of data about professional care given to patient during hospitalization and analysis of such collected data. It also includes death file evaluation and tabulation of evaluation and it's presentation during Death Audit meetings[1].

In 18th century, in England, for first time, system of medical and death audit came into existence. In India however process is slow[1].

At present in India, meetings of maternal mortality, infant mortality are being conducted frequently by Government Health officials. Apart from this, Death Audit meetings are infrequently conducted in Hospitals.[2]

Death Audit [Synonem:-Death Review] includes checking of all deaths occurring 48 hrs after hospitalization with objectives of analyzing (a) Diagnosis& it"s correctness (b) delay in Investigations & initiating treatment (c) Circumstance which resulted in death of patients [d] types of consultations obtained & recorded [e] adequacy of investigations & treatment in comparison to normal standards (f) daily monitoring of progress [g] prompt change in treatment depending upon reports of investigations [h] various consents & procedure notes (i) Measures needed to prevent recurrence of errors.[2] Data on different indicators should be prepared unit wise on monthly basis. Deviation from standard norms should be informed to concerned unit for prevention of recurrences, of errors, if any.[2&3]

As per section 2 (f) of RTI Act 2005, Hospital Records must be provided on demand for legal and claims and other purposes. Hospital records (both IPD and others) can be demanded by patients or their next of kin or relatives of patients, empanelment and insurance agencies, various courts, police officials, Government Health officials and NABH authorities. On demand, hospital records must be given within 3days[4] .

Time gap between date of Death or Discharge and date of demand of Hospital records may vary from weeks to years, because case can be filed, usually, anytime, upto,2yrs after treatment of patients [4] After such a gap treating doctor may be asked to justify diagnosis made and treatment given to a patient and after such intervening gap treating doctor may not remember details of case. Therefore correct and complete documentation is must.

Court of Law follows a principle that "If it's not written in medical record it has not been done".[5]

Number of malpractices suits against Doctors are increasing in India. Hence, doctors should be made aware of laws, which govern patient care and follow code of Medical ethics as laid down by Medical Council of India (5)

Legal notice to a clinician from court of Law, results in stress to treating doctor.

To promptly draft reply to such legal notice within time limit specified, correct and complete documentation in Hospital Records, is helpful. Therefore, many courts including Supreme Court of India have advised all practicing doctors to maintain comprehensive documentation of diagnosis and treatment in all cases (6–10).

Retention of medical records & Correct and complete documentation has gained importance due to inclusion of medical services under Consumer Protection Act(11&12).

First patient based record was preserved in 1907. In 1965, Turn Bridge was first to standardize records and derive information from such record: In 1968, Weed proposed that, medical records should be based more on patients problem and not entirely on disease and daily update of record was also proposed(13).

Handwritten records and electronically computer based records are two types of medical records available. Poor quality of handwriting may make interpretation of handwritten record difficult. Computer based electronic records avoids problem of not readable handwriting, but suitably trained staff is difficult to find and increases expenses of hospital(11&13).

Health Care professionals needs to be educated to abide by all record keeping practice guidelines decided by institution(14). Detailed documentation is cumbersome and boring for doctors, therefore simple methods of medical education technology are required to develop habit of good documentation amongst JRs. One such simple technique has been used during conduct of death audit & discussed in this study.

Frequent Audits need to be conducted to check quality of record keeping and to rectify errors (15).

Documentation and record keeping are crucial for safety of clinicians, because courts consider documents as most important witness during deliberations in hearings & final ruling by courts depends on witnesses provided to courts by various parties. [16].

Aims and Objectives

To study impact of conduct of monthly Death Audit in Medicine department in improving documentation by JRs in 1198 death files of patients of Medicine wards between calendar years 2014 to 2018.

(II) To find out statistical significance of data made available by study.

Inclusion Criteria: All death files belonging to medicine wards & made available by Medical Record Department, for Audit for 5 consecutive years with effect from 1/1/2014.

Exclusion Criteria: (i) Death in casualty (ii) Brought in Dead cases

Material & Method: This was a, record based, interventional study conducted in Medicine Department of N.K.P. Salve Institute of Medical Sciences, [NKPSIMS], Hingna Road, Nagpur [MS]. Death Audit meetings are being conducted regularly, once a month, in our department since 1st January 2014, to discuss deaths occurred in previous month. Record of errors by JRs in death files of Medicine ward is available in Department of Medicine. Since 1/1/2014, during each death Audit meeting, whole department was given presentation about errors in (i) Documentation (ii) Diagnosis (iii) Investigations (iv)Treatment recorded& other points , in Death files of previous months. All teachers, who are present in Death Audit Meet, actively participate in discussion about each death case.

During each Death Audit meeting, JRs were given typed reports of errors in Death files of their respective unit and they were instructed to correct correctable errors in Death files, which are preserved in medical record department [MRD]. Frequently pictures of the errors were taken on mobile, and errors were displayed during presentation in Death Audit meet. Whenever Death Audit meet could not be held, errors were posted on What's App Group of Medicine Department and JRs were instructed to correct correctable errors.

Monthly listening to documentation errors during Death Audit meet and monthly visit to MRD by JRs to correct errors, was planned to develop habit of correct documentation amongst JRs. Checklist of 18 parameters, which were used to check Death file were prevalidated and informed to JRs during their departmental orientation programme on joining and during monthly Death Audit meetings. The study was conducted after obtaining permission of Ethics Committee of NKPSIMS.

Sample Size and Selection

Total 1198 Death files of patients of Medicine wards were checked between 1/1/2014 to 31/12/2018. Total 1371 Deaths occurred during this period in Medicine & TB & Chest wards and therefore 87.38% of Total Death Files were included in this study. Total 59451 continuation sheets and records of 5730 hospital days were checked during study.

Each Death file was checked using 18pre-validatedfollowing parameters:-

1. Patients Name and IPD number on all sheets
2. Signatures of Doctors below notes and their name& registration number , below their signature
3. Admission notes inadequacy and provisional diagnosis
4. Daily progress and revised treatment notes
5. Blood Transfusion Notes
6. Procedure Notes
7. Consent for Indoor care treatment
8. High Risk Information
9. Consent for procedures
10. Date and Time in daily notes
11. Entry of reports with dates in investigation charts
12. Death Notes and Death Certificate or Death Report
13. Missed Diagnosis

14. Death Summary
15. Outside investigations reports and discharge card with Name of Hospital
16. Intake, Output, Temperature, Pulse, Respiration, Blood pressure and other charts
17. Dead Body handing over certificate with signature, Name and Relation of Recipient & time & date of handing over dead body.
18. Numbering of all sheets

These 18 parameters were split into 28 parameters for describing results in better manner.

Results

During period of 5 years, Total 1371 Deaths occurred in Medicine wards, between 1/1/2014 to 31/12/2018. Total of 1198 Death Files have been checked in this study [87.38% of total death files]. Percentage of errors in 28 parameters, in calendar year 2014 and 2018 are tabulated in Table No. 1

Table No. one shows statistically and significant reduction of errors in

(a) Patient's Name on sheet and IPD Number on sheet
(b) Signature under Notes and Name of Doctor& their registration number under their sign.
(c) Provisional Diagnosis
(d) Procedure notes
(e) Consents for indoor treatment
(f) Missed Diagnosis
(g) Signature of senior residents and teachers on Death summary
(h) Numbering of pages and
(i) Dead body handing over certificate.

In other parameters improvement was not statistically significant.

The percentage of errors increased marginally in 2018 in revised treatment and it was due to fact that doctors took some time to get used to rules of NABH documentation.

During period of study 15.78 % patient died within 24 hours of hospitalization & 29.69% patient died within 48 hours of Hospitalization in our Hospital.

Frequently when death occurs during hospital stay < 24 hours, & complete evaluation may not be possible in each case due to shortage of time. In such a scenario, retention of previous hospital records helps to give Diagnosis in death certificate & death summary & avoids clinical autopsy. Errors in retention of old records reduced from 4.05 in 2014 to 3.97 in 2018.

Table No. 1

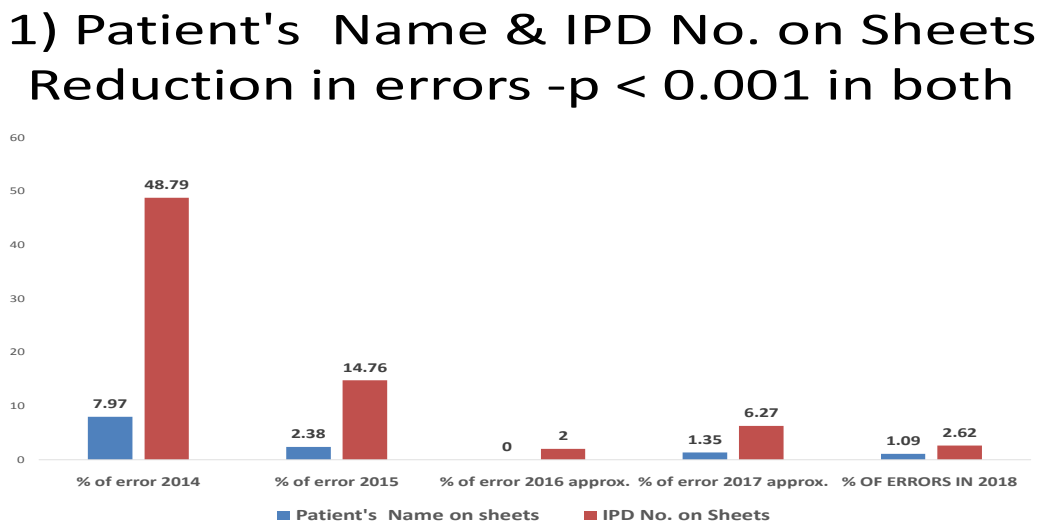
Sr.No.	Documentation Errors	% of errors in 2014	% of errors in 2018	P value
1.	Patient's name on sheet	7.97	1.35	<0.001
2.	IPD Number on sheets	48.79	3.18	<0.001
3	Signature under notes	6.62	2.3	<0.001
4	Name of doctor under signature& registration number	31.69	7.8	<0.001
5	Admission notes inadequacy	15.32	5.9	N.S
6	Provisional Diagnosis	22.5	5.7	<0.001
7	Revised Daily treatment notes	4.87	6.14	N.S
8	Daily progress notes	0.2	0.05	N.S
9	Blood Transfusion Notes	0.4	0.24	<0.001
10	Procedure Notes	3.15	0.21	<0.001
11	Consent for Indoor Treatment	22.1	2.53	<0.001
12	High Risk Informed consent	4.5	2.17	N.S
13	Consent for procedure	2.25	1.34	N.S
14	Date and Time in Daily notes	5.46	1.3	N.S
15	Reports of all investigations in chart	19.8	1.22	N.S
16	Death notes/ Death certificate	1.35	1.81	<0.001
17	Missed Diagnosis	25.6	5.93	<0.001
18	Death Summary	0.45	0.36	N.S
19	Outside Hospital Records	4.05	3.97	N.S
20	Signature of SR / Teacher on Death summary	66.6	0.72	<0.001
21	Intake output chart	0.45	0.01	N.S

22	TPR BP charts	1.8	0.11	N.S
23	D/B H/o certificates, sign of relatives	0.1	1.44	N.S
24	Name of Recipient of Dead Body	42.7	3.25	<0.001
25	Relation of Recipient with Dead person	50	4.33	<0.001
26	Date of H/o of Dead body	40.9	3.61	<0.001
27	Time of H/o of Dead Body	86.4	3.97	<0.001
28	Numbering of all sheets	74.3	1.81	<0.001

Table-2 Details of Parameters studied, which helped in calculating P value.

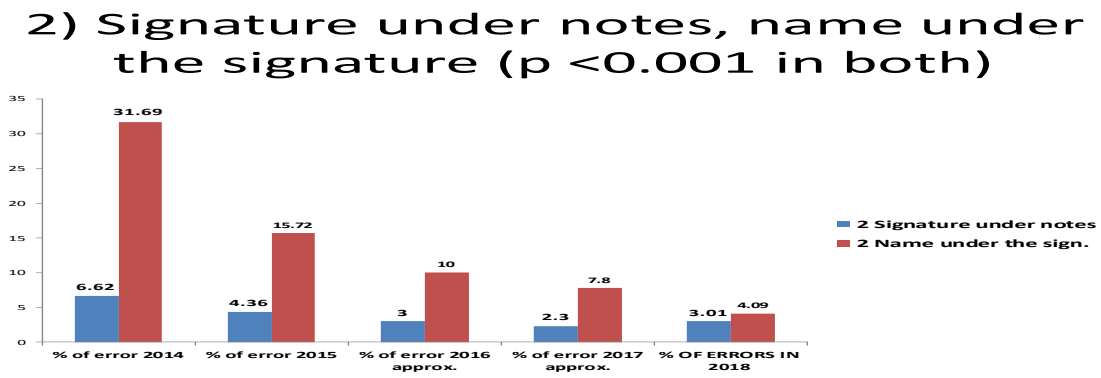
Year	Total Death files studied	Total pages studied	Total IPD days	Total procedure & consents	Total Notes by Drs./ JRs	Total Diagnosis	Total investigations
2014	222	7368	1223	864	8049	1221	2662
2015	260	12854	1260	922	8756	1452	2783
2016	242	12824	1080	968	8640	1166	2712
2017	217	13837	1012	852	8242	1346	2582
2018	277	18200	1211	1092	9866	1484	3378

Bar Diagram No. 1



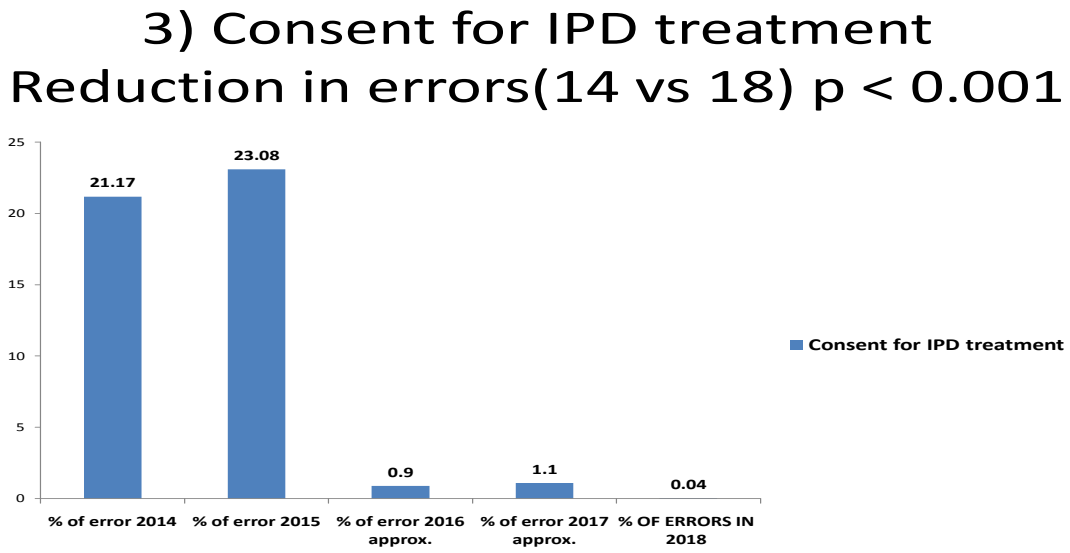
This Bar Diagram depicts reduction in errors about patient's Name and IPD Number on sheets [2014vs 2018], which is statistically significant.

Bar Diagram No. 2



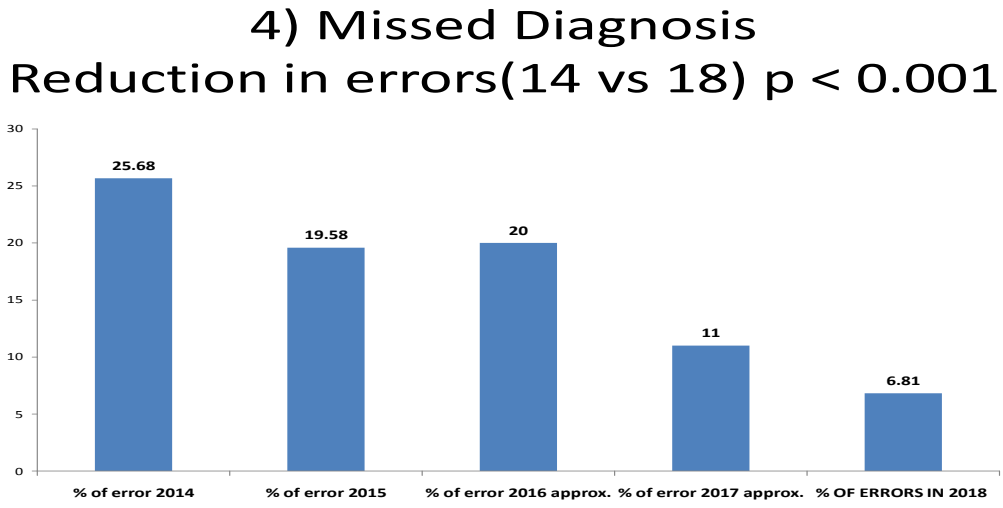
This Bar Diagram shows reduction of errors [2014 vs2018] about signature of doctors below notes and name of doctors with their registration – Number below their signatures,& this reduction is statistically significant.

Bar Diagram No. 3



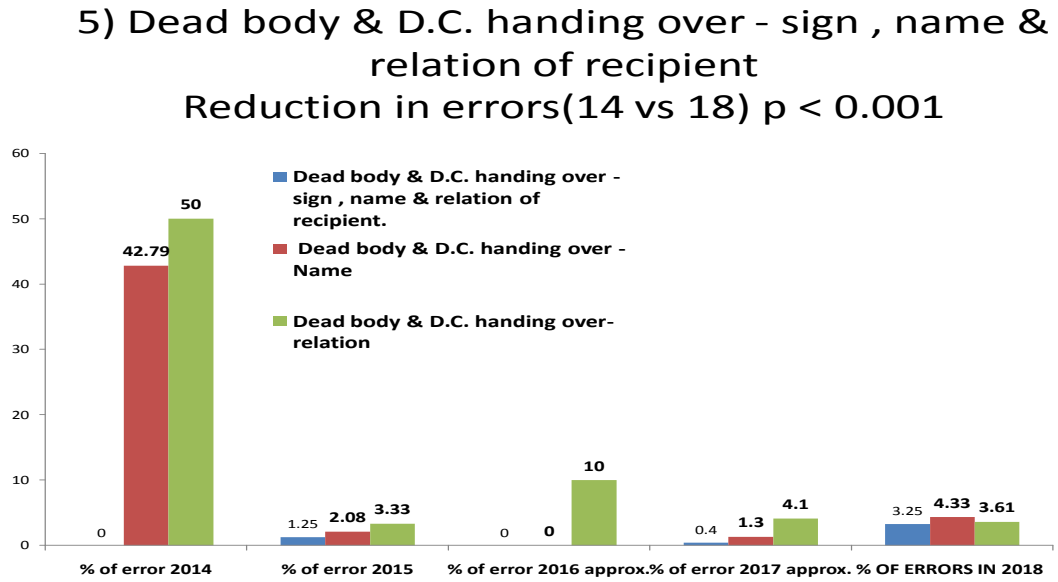
This Bar Diagram shows reduction of errors in obtaining consent for IPD treatment on admission and this reduction is statistically significant.

Bar Diagram No. 4



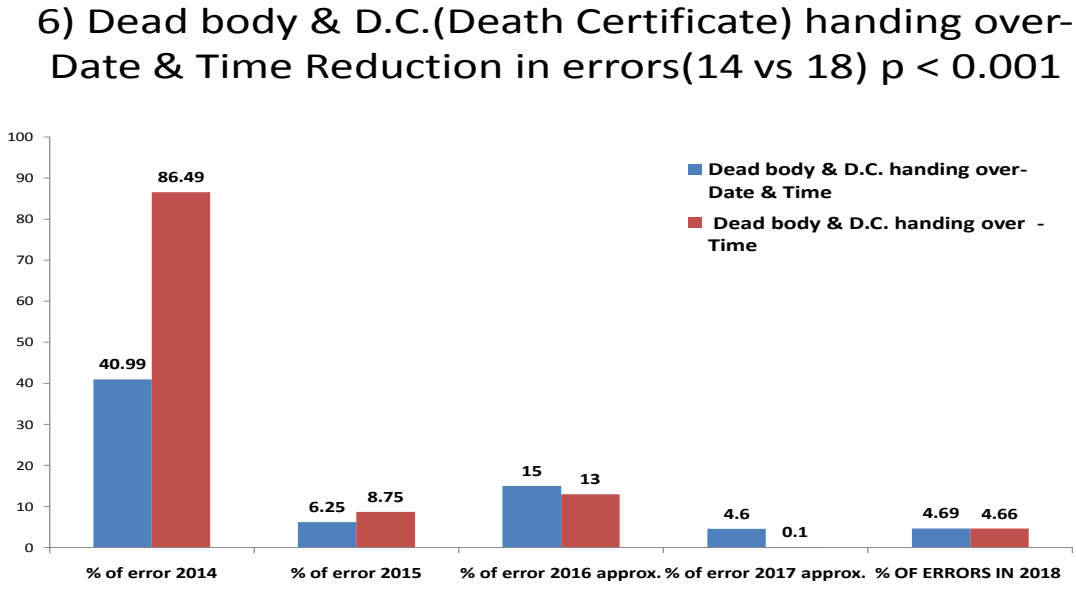
This Bar Diagram shows reduction of errors in missed diagnosis, which is statistically significant.

Bar Diagram No. 5



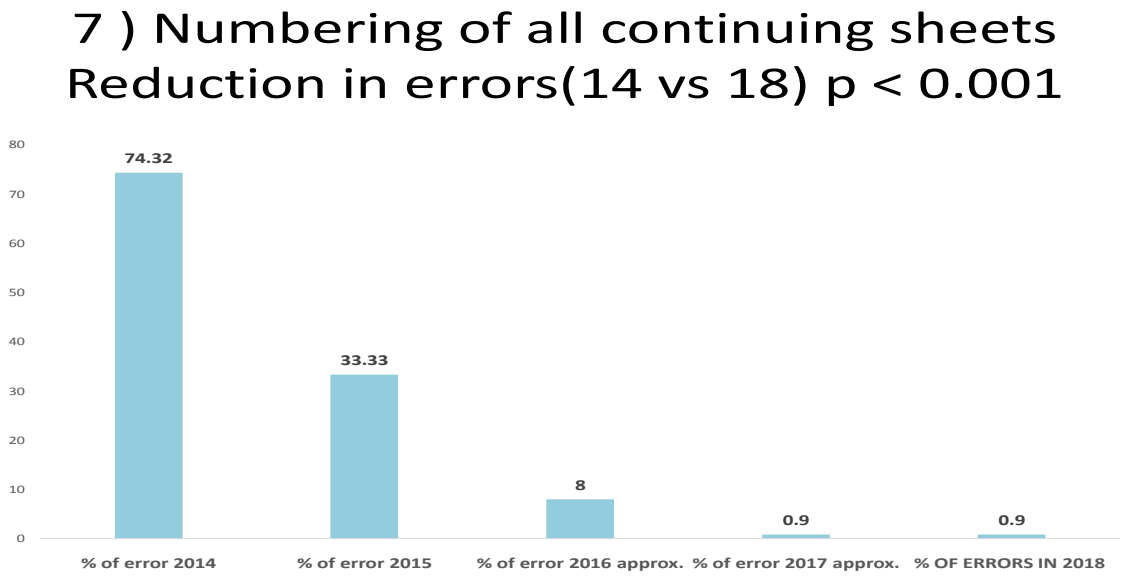
This Bar Diagram shows reduction in errors about documentation of Name of person receiving dead body and relation with died patient. This reduction is statistically significant.

Bar Diagram No. 6



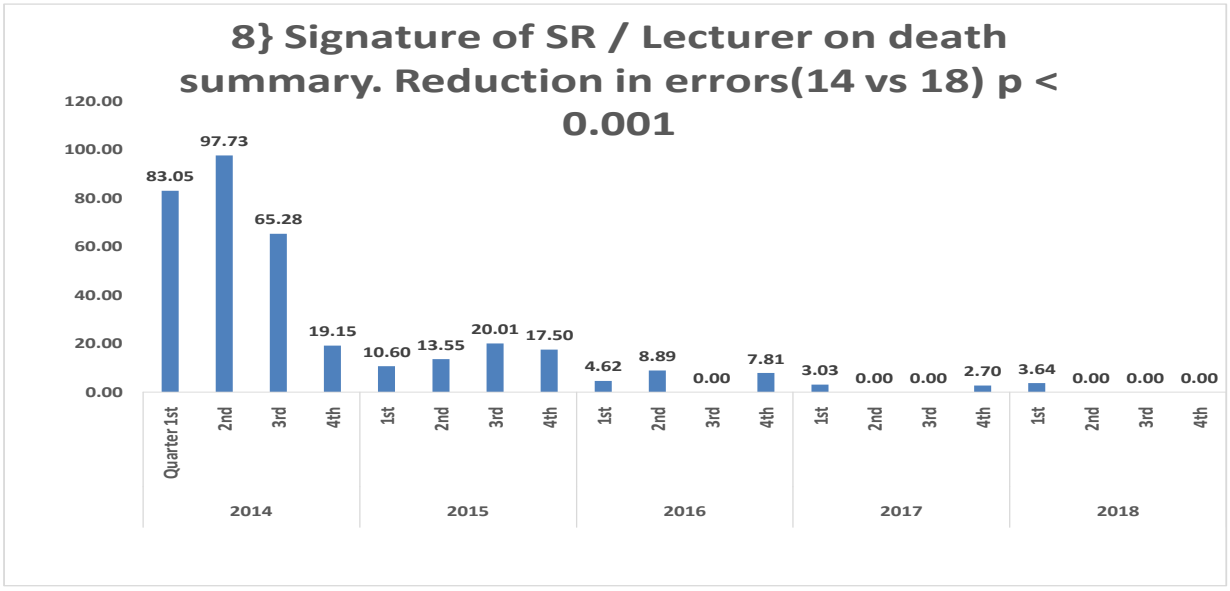
This Diagram shows reduction of errors in noting Date & Time of Handing over of Dead Body. This reduction is statistically significant.

Bar Diagram No. 7



This Bar Diagram shows reduction of errors about serial numbering of pages in Death File. This reduction is statistically significant.

Bar Diagram No. 8



This Diagram shows reduction of errors about signature of SR/ Lecturer on Death summary. This reduction is statistically significant.

Discussion

All Hospital Records including death files are Legal documents, if relatives of patients approach consumer forum or other courts. Complete and correct documentation helps doctors to defend themselves in court of Law.

Various courts have stressed the importance of documentation of diagnosis, treatment, consents

etc and preservation and maintenance of hospital records[6-9]. Documentation by clinicians must include admission notes, daily progress notes, provisional and final diagnosis, investigations advised and done, consent for Indoor treatment, consent for other procedure, procedure notes, High Risk informed consent, summary of reports of all investigations, daily progress notes, daily revised treatment plan and improvement or deterioration of patient etc [11].

Discharge or death summary must be written in detail and saved in IPD file in MRD, & these must justify diagnosis made and treatment given .

In surgical cases pre-operative assessment, Pre Anaesthetic checkup (as per checklist), operation notes, postoperative care records and separate consents for both diagnostic and therapeutic procedure should be recorded.[11].

In Samira Kohli V. Dr Prabha Manchanda, Supreme Court ruled that treatment without informed consents may amount to negligence and separate consents needed for diagnostic and therapeutic procedures [7].

Gayatri Gupta et al reported about partial lack of knowledge of informed consent amongst doctors. Total 413 doctors participated in study (consultants 60% & Residents 40%) and their speciality was 49.9 % from General Medicine, 38.5% from Surgery and 11.6% from Anaesthesia dept.[17]

(a) 6.3 % participant were not knowing about Legal age, at which, valid consents can be taken.

(b) 17.4% participants gave wrong answer to question" when consent need to be taken in Elective Procedure".

(c) 25.4 % participants gave wrong answer to question" when consent is to be taken for emergency procedure".

(d) 31.3 % Respondents were not knowing "weather consent taken for major procedure can be used for minor procedure".

(e) 11.9% Respondents gave wrong answer to question" weather consent taken for Diagnostic Procedure is valid for therapeutic procedure".

(f) 40.4% Respondents were not knowing about fact that patient needing three procedures in casualty, need 3 separate consents for 3 separate procedures.

(g) 40.9% respondents were not knowing about fact that consent for invasive procedure of 17 year old patient is to be taken from Legal Guardian.

(h) 6.8% respondents were not knowing correct answer to question:- " when can diagnostic & therapeutic procedure can be carried out without consent".

(i) 42.6% respondents were not aware about what to do if, Attendants refuse Cardio Pulmonary Resuscitation.

(j) 20.6 % respondents were not knowing about consequences of invalid consents or no consents.

[i] 50.4% respondents were not aware about, who is required to take valid consent for intervention .[17]. This study indicates need of efforts to increase awareness of knowledge about various consents amongst doctors.

In our study errors in [a] consents for indoor treatment reduced from 22.1% in 2014 to 2.53% in 2018, which is statistically significant (P value < 0.001): [b] Errors about consents for procedure reduced from 2.25% [in 2014] to 1.34 % [in 2018] [c] high risk information reduced from 4.5 % [in 2014] to 2.17% [in 2018] .

As per Times of India Newspaper, Nagpur, News article, published in May 2019, a lady , in early 20, admitted in Nursing Home, Sadar, Nagpur on 9/6/2007. Her father approached consumer forum against medical deficiency on 6/6/2008 and consumer forum awarded penalty of Rs.13 lakhs against doctor and complainant approached consumer forum after gap of almost 11 months, After such a gap, it is difficult for doctors to remember details of case and in such a case correct and complete documentation and it"s safe preservation helps to fight Legal battle.[18]

A Gallegos stated that mistakes and casual approach to details in patient records can offer wealth of material for plaintiff. &Attorneys and Lawyers look for what is missing.[19] Section 304 A, of IPC states that medical negligence occurs

when (a) Doctor deviates from accepted standard of care, & (b) wrong diagnosis (c) Delayed treatment. In our study no patient had recieved delayed treatment or was given wrong diagnosis. However 25.6% diagnosis were missed in Death certificates in 2014 and these errors reduced to 5.98% in 2018, which is statistically significant [P <0.001].

In Dr. Shyamvs vs Ramesh Bhai Kachhiya Case no. 4-1 (2006) [C-P] 16 [N C] court blamed Doctor because (a) informed consent was improper and (b) Hospital records were not given[20].

In SamurajVsMeenakshi mission Hospital case – S-1 [2005] [CP] 33 {NC} Hospital were blamed because (a) Name of Anaesthetist was not written in operation notes &(b) Failure to keep and produce Hospital Records created doubt during Legal proceedings [21] . In our study, errors in Name of Doctor below their sign were 31/69% in 2014 and 7.8% in 2018 and this reduction of errors was statistically significant (P value <0.001).

Shreeji Hospital, Surat was blamed for death of 1st year MBBS student, because Hospital documents cannot be produced in Court and penalty of Rs. 19.5 lakh was ordered on 25/5/2019.

In Vijay Vs AIIMS New Delhi case [complaint 240/2008], an MBBS student of AIIMS New Delhi admitted in 2006 with Dengue Fever. AIIMS New Delhi contested that student was not a consumer and no charges were paidby patient, so hospital is not under consumer Act. But on 10/5/2019 court ordered AIIMS New Delhi to pay Rs. 50 lakh fine due to delay in treatment. In this case also consumer forum was approached after about 1 ½ years of Death.[22]

In our study 18 Risk factors [errors] of documentation were studied. Name and IPD number on each page is needed to establish that page belong to a particular patient. Signature below notes and Name of Doctor below sign with Registration Number is a requirement of NABH and survival of many Hospitals now depend upon NABH Accreditation. Admission notes indicate condition of patient on admission and provisional diagnosis is a component of Admission notes.

Daily progress notes establish improvement or deterioration of condition of patient and also establishes that treating doctors have been repeatedly evaluating patients. Daily revised treatment establishes that reports of all recent investigations are kept in mind, and treatment has been changed accordingly and this is also a NABH requirement. Blood transfusion notes and procedure notes indicates that (a) all standard protocols have been followed during these procedures and (b) It rules out or establishes complications during procedure (c) it helps in early identification of complications of procedure and early start of its treatment.

Consent of indoor treatment, all procedures and High Risk information are Legal requirement[7&17]. Investigations chart is backup of investigations, if original reports are lost, and reports of investigations are needed to justify diagnosis and treatment. Death summary and frequently whole death file can be demanded by police, court, insurance and empanelment agencies for Legal andclaim purpose. Intake output, TPR, BP/ RBS & other charts help in establishing deterioration or improvement and guide changes in treatment plan.

Complete documentation in dead body handing over certificate including date, time, name and sign of Recipient have legal implications [23].

There are more chances of patients or their relatives going to consumer forum against alleged negligence by doctors due to ease with which a consumer case can be filed. Whenever patients or their relative approach courts, they need to prove their charges against doctors. Therefore, in courts a complete and correct documentation of accepted standard norms of treatment [which courts expects doctors to follow] protects a doctor. Whenever a legal notice is served to a doctor, a nicely drafted reply within time frame stipulated in notice, must be sent. To prepare such a reply, documentation helps and in many cases such a reply is sufficient

to close the case [M.S. Pandit & Shobha Pandit] [24]

Frequently adequate treatment is given but doctors forget to document full extent of treatment and obtain inform consent. Such errors are exploited by lawyers, because Law say "If it is not documented, it is not done" (12,25,26,27,28).

Conclusion

Maintenance of comprehensive and accurate hospital record is need of hour because these must be provided on demand for claim and legal purpose. Junior Residency is best phase of career to learn habit of complete and correct documentation. In our study we have used one simple &uncommon method of teaching and learning. Teaching Learning method (TLM) is a planned way of providing a teaching learning experience.

Monthly Death Audit can be made more effective by this uncommon, simple, TLM, in which junior residents are taught about correct method of documentation using 18 parameters. We recommend each teaching hospital should conduct monthly death audit.

Acknowledgment

We acknowledge help received from scholars whose articles are cited and included in references of this manuscript.

Conflict of interest & financial grants: None.

References

1. Somanath et.al – J. Indian ACAD. Forensic Med. 32(4) [Med wd. nic. in 7 JAL, ISSN 0971-0973]
2. Times of India 2004-J . Indian ACAD Forensic Med. 32 (4) [med wd. Nic.in 7 JAL Issn 0971-0973]
3. Audit of death cases –Retrieved from htpps://www.google.com/se
4. Correct data key for doctors in medical negligence cases by Chaitanya Deshpande @timesgroup.com , nov-19
5. KK Agrawal et al, Journal of Mahatma Gandhi Institute of Medical Sciences 2016, Volume 21 Issue 2 Page 94-100, Guest Editorial.
6. Jacob Mathew Vs State of Punjab (2005) 6 SEC (I) downloaded from https://www.casemne.com>Search and www.jmgims.co.in>article.
7. Samira KohliVs Dr. PrabhaManchanda I (2008) CPJ 56 (SC) downloaded from http://www.Ncbi.nim.gov>pmc and Indian Journal of Urology, 2009.July- Sept: 25(3) 372-378.
8. Martin F. D'Souza Vs Mohammad Ishfaq (2009) 3 SCC I, Retrieved from http://www.Ncbi.Nim.gov>PMC
9. V. KishanRaoVs Nikhil super-speciality hospital (2010) 5, SSC 513 downloaded from http://www.ncbi.nim.gov>PMC.
10. Malay Kumar Ganguly Vs Sukumar Mukherjee (2209) 9 SSC 2', Retrieved from http://www.ncbi.nim.gov>PMC.
11. Tiwari S. Recordkeeping in Text Book of medico-legal issue related to various medical specialities, editor Nilofer Mujawar, Jaypee Brothers, Medical Publisher, New Delhi 2012, 49-52
12. CG2- Record keeping Guidelines, Retrieved from http://www nhs professional nhs.UK. download /comms/cg 21. 20% - C/- 20 Record % 20 keeping % clinical % 20 guidelines, PDF
13 Nursing Documentation, Record keeping and written communication Elsevier health retrieved from http://www.us.elsevier.health.com/media/us/sample chapters / 9780 443097 991 / 9780 4430 73991, PDF.
14 Statement of consistency of Health Care, Diagnostic and procedural coding " AHIMA" position statement, retrieved from www.Aahima. Org.
15 "Developing a coding compliance policy documents" Journal of Ahima, Retrieved from www.ahima.org.

16 Diamond B et al:- Legal aspects of documentation, Exploring common deficiencies that occur in record keeping. British Journal of Nursing 2008-14 (10) 568-71.
17 "Knowledge about legal consents amongst Doctors, Gayatri Gupta et al " JAPI Oct 2018, Volume 66, Issue 10, Page 57 – 62
18 Sarfaraz. Ahemed @ times group.com May 2019.
19 A Gallegos et al:- AmedN ews .com. published by American Medical Association, March 29, 2013.
20 Dr. ShyamVs Ramesh Bhai :- Case -1 (2008) (CP) 16 (NC) retrieved from http://www.ncbi.nim.gov>pmc
21 L. SamurajVsMeenakshi Mission Hospital Case -1 (2005) CPJ (NC) retrieved from http://www.n.c.bi .nim. gov>PMC.
22 Vijay Vs AIIMS New Delhi complaint No. 240/2008: downloaded from http://www.n.c.bi.nim.gov.PMC
23 Bodek H.et al :- Basic standards for clinical documentation and record keeping. The New York state society for clinical social work, INC, downloaded from http://www.clinical s.w.org/basic_ standard.html.
24 M.S. Pandit et al:- " Medical Negligence : coverage of profession duties, and ethics" Indian J. UROL.2009 Julu-Sept: 25(3), 372-378.
25 Bargaje C. " Good documentation practice in Clinical Research" Persp clin.RES.2011; 2 (2). 59-63
26 "Health Care Records – Documentation and Management", Retrieved from http://www.health, NSW, gov,Au, Policies / pd/2012/pdf/PD2012_069PDF
27 "Legal Medical Record standard", retrieved from http:/11/policy.ucop.edu/doc/110168/legal medical record.
28 "A Guide to better physician documentation" Retrieved from http://www.health.gov.on.ca/transformation/providers./information/pdf/guide_6pd:pdf.