

**ON THE RELATIONSHIP**  
**AMONG THE QUALITY OF MEDICAL RECORD,**  
**MEDICAL ETHICS AND THE LEGAL PROTECTION OF RIGHTS**

NONG Leban LU Xiang (Youjiang Medical College for Nationalities,  
Baise ,Guangxi,China 53300) Telephone: 0776-2834108, 2836599 13707768998  
email: Youyiwj@163.Com

Abstract:

Quality of Medical Record has become one of core evidence in handling of medal disputes. Quality of medical record, medical ethics and legal protection of rights are key elements in improving quality of medical record, manifesting the sense of responsibility of medical professionals from which the patients' right will not be violated and the legal rights of the medical professionals can be protected. In fact, many medical dissensions are caused from medical record-based evidence by patients or their family members in blaming doctors' mistakes and suing compensation. Although the behavior of the patient or their family members shows some sense of one-sidedness, it still shows the importance of the medical record, medical ethics and legal protection of rights. The paper analyzes ways to improve the quality of medical record from medical ethics and legal protection of rights including standardization of issuing record, timing of medical cases, medical professionals who issue the record, diagnosis basis, informed record, layout of the record. It tells us how much sense of responsibility the medical professionals show and points they have to pay attention and how to protect the legal rights of the doctors and the patients.

[Key words]: Quality of medical record, medical ethics legal protection of right

In China, medical laws and regulations clearly states that medical establishments and medical personnel should assure the legal rights and interests of both medical workers and patients. In the last few years, with the enhancement of people's legal consciousness, health consciousness and self-protection consciousness, people begin to have higher demand on medical service, leading to a tendency of escalation in medicine related lawsuits. [ 1 ]. In the processing of medical service dispute, medical record has become one of its core evidence. Undoubtedly, it is very important to improve the quality of medical records, so as to protect the patients' benefit from being violated, and to protect medical personnel's legitimate rights and interests. This article will research into the problem to be addressed of the improving medical record quality as viewed from legal protection and the medical ethics.

First, standardization in the form of medical record writing is not only a manifestation of medical personnel's sense of responsibility, but also a guarantee of medical personnel's legitimate rights and interests in medical disputes.

There are special requirements in writing medical records. The first is the form standardization; the second is the content standardization, one of the main aspects in medical record quality. In the course of treating patients, medical practitioners should write medical records thoroughly, honestly, reliably, in a focused and structured style, missing no important information, so that diagnosis and treatment programs and their courses are accurately reflected in the medical record, and the rationality and legitimacy of diagnosis and treatment, as well as medical workers' sense of responsibility, is also reflected. Unfortunately, it is not infrequent to find that medical records are ignored in reality. Second, the time when medical record is formed is a crucial factor of inherent quality.

Time is an important factor affecting medical record quality. Whether medical workers have a strong sense of "time is life" could be seen as a reflection of their ethical level. They are expected to race against time. If treatment opportunity is missed, it will lead to delay of patients' recovery, or cripple, or even worse, death. [ 2 ]. In the medical record forming process, the time recorded should accurate, time flow ought to be able to reflect changes of patients' condition, this kind of process conforms to the medicine logic [ 3 ]. In practice, doctors are often busy dealing with other daily activities, and medical records are not written in time. They have to make them up afterwards, unavoidably leading to inaccuracy of the records. Some patients of chronic condition are not recorded even for 1 or 2 weeks. Once the condition aggravate within a short time, medical records will be sealed up, and this situation will obviously be bad to medical workers.

Third, medical record writing quality manifests medical personnel's legal liability and their occupational ethics.

Medical records are texts with legal function, once formed they are imparted with legal significance. Therefore, each steps and aspect should be accomplished strictly according to the Medical Record Writing Basic Standard. According to the requirement, doctors of different ranks write corresponding medical document and sign their names, showing that they take responsibility for what they have done, and imparting legal significance to what they have recorded.

Fourth, rationality and legitimacy should be reflected in medical document.

The diagnosis and the course of treatment is the main content of medical record. Any diagnosis and treatment must be performed on sufficient and rational basis. Diagnosis and treatment results should be analyzed and evaluated carefully to testify their treating program.

Fifth, record of informing is a special requirement of medical practitioners' occupational ethics.

According to the law, it is the legal duty of the medical establishment and its practitioners

to inform patients about their condition. Being informed is the right of patients. Doctors must make the patients understand their condition, medical measures to be used, and the potential risks. Surgical operations and special examinations and treatments must be authorized by patients and their families. There are some basic principles to follow when making conversation with patients or their families: 1) Doctors should stick to the key points to make their language apprehensible and acceptable. 2) Conversation before operation should be able to reflect both condition of specialty and whole situation to rule out factors that may affect the operation. 3) When talking about the possible side effect and risks, abstract medical terms difficult to understand should be avoided.

Sixth, the terms and layout of medical record must be standardized and legalized.

The integrity of medical record is the manifestation of the medical workers' commitment and responsibility in their work. Medical documents should not be written without medical terms. Possibility of misunderstanding must be avoided. The language should be logical, clear, accurate, and grammatically correct. The layout should be neat and easy to identify. Alteration of words must be avoided. Any flaw in the writing of the documents could become unfavorable evident in the court.

Seventh, file clerks should have strong legal consciousness and occupational ethics. Attention should be paid to the following issues: 1) Adhere to related laws and regulations. 2) Love the file management work as a life long career. Refresh their knowledge and skills regularly. 3) Be extremely strict in the job. 4) Be objective and neutral.

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#### About the Author:

NONG Leban (1953-) Medicine ethics associate professor, assistant director committee member of Guangxi medicine ethics association, director for Guangxi health law association, director of humanities and social science department of Youjiang Medical College for Nationalities.

LU Xiang (1973-) doctor in charge, medical record room, Affiliated hospital of Youjiang Medical College for Nationalities.