clinical audits and the state of record keeping in india

There is no legislative framework in India at the moment, which would enable collating data from hospitals on standard indicators of quality of patient care. It is only such data on patient care processes and outcomes, which would enable any meaningful audit of medical services with a view to making these services patient oriented. Hospital services should be such as to facilitate better patient outcomes and should be consistent with current professional knowledge. But without any data on quality of care indicators, there is no way to identify areas which need improvement and which could indeed enable patients to be better served. It is structured data on large numbers of patients from any specific institution over a reasonable period of time and also across institutions and adjusted for risk, which would enable care providers to identify and address lacunae. But without any law which says this should be done, it is only data which managements consider important which is captured. Many individual doctors also record data regarding their own patients but unless they have access to structured data about a larger patient set, it would be difficult to see why some patients in similar circumstances get better and others don't.

We routinely hear discussions about bed occupancy rates and the cost of medical services because data is readily available about these parameters. But patient oriented data whether it be about mortality and post-operative complications or about medications or about infection rates is rarely available; so it is rarely discussed.

It is as a result of lack of legal requirements that clinical audits to improve the quality of care for in-patients in Indian hospitals, come up repeatedly against the poor quality of medical records. The majority of hospitals do not even record patient history in detail and information about treatment provided is sometimes as scanty. Recently when asked to provide Operation Theatre notes for some complicated case in a health insurance scheme, one doctor wanted to know why it was necessary to record any notes; was it not sufficient to record the name of the surgical procedure conducted. Such naivete is a telling comment on the state of medical records in India.

Surgery volumes for different procedures, mortality rates both procedure wise and disease wise, post-operative complications and infection rates are good indicators of the quality of in-patient care, provided that such data is recorded in structured formats. Currently such data is hardly captured in centralized databases within patient care provider institutions.

Information about health care services in medical institutions collected over a period of time can be a goldmine for doctors and care providers, provided that the information is collected systematically and in standardized, computer readable formats. Unfortunately the health care system in India has been so overloaded with providing of services that collection of information comes way down on the list of priorities. Quality managers in hospitals are harried human beings; the eternal question they contend with is should the doctor concentrate on treating a patient or filling up a form.

But without those forms, it is almost impossible to make sense of the vast numbers of patients who get treated in Indian hospitals. The private sector hospitals are better equipped in terms of money and men to do the needful as compared to public hospitals. But in the absence of any government regulations, which require regular submission of information, there is no incentive to collect this data. And public hospitals are overloaded with patients. The basic issue remains that collating patient related information requires time and effort. If there is no over arching legal requirement to do so, that effort does not get made.

Nor is any structure for recording data set up. This is almost entirely left to individual initiative. So medicines are rarely coded according to a standard drug list, infections are seldom categorized across institutions; diagnoses do not follow standard algorithms.

In the past few years there has been some interest in the subject of hospital acquired infections and how these can be brought down but in the absence of data, efforts remain a sporadic affair. The majority of hospitals, public or private, simply record any incidence of hospital acquired infection on the case papers of individual patients; there is no centralized register to track infections throughout the hospital so there is no database. It is only a few institutions like the PGIMER where there is some effort made to track infections and to take remedial measures.

Even data about death, the most significant adverse outcome, is not recorded such that risk adjusted mortality rates could be worked out. There is simply no information available. Actually the way to do this would be to computerize the mandatory certificate of cause of death by building in ICD codes for procedure and disease. Just this simple change could provide a lot of information to doctors about treatment outcomes.

Currently, in the absence of systematic recording of data about death in a thirty-day period after the procedure, there is no way that mortality rates could be benchmarked over time or adjusted for risk. Such kind of information on outcomes requires effort to collect; discharged patients have to be tracked down and interviewed. And families who lost a family member are hardly willing to talk about what happened. Perhaps this is the reason that patient outcome oriented hospital indicators, whether on mortality or complications, hardly ever get recorded.

Process oriented indicators like infections, are easier to track. But apart from a very few hospitals, such indicators are given little importance by hospital managements. Each hospital does have some key performance indicators but they rarely include infections or Ventilator associated pneumonias. Formal discussions in hospitals might discuss how they compare with each other in terms of services provided, prices and rates of profit; rarely if ever do they discuss how they compare in terms of incidence of hospital acquired infections.If there is little institutional backing, doctors are left to record patient information at their own levels. But individuals are ill placed to shoulder such responsibilities; it is the management which needs to deploy people to manage data.

The reality that the majority of individual care-givers are quite helpless in the face of institutional indifference, is not so visible to the public.

Any assessment of outcomes should be seen in the context of health care processes and the extent to which these adhere to standard protocols. But it is only the use of well-defined formats whether in the physician's clinic or in the operation theatre which would yield data amenable to analysis. Maharashtra has made a beginning by developing simple sets of 5-6 questions for diagnosing some common clinical indications and the system has yielded a huge data set. Some departments of PGIMER had also participated actively in this exercise along with faculty members of the most prestigious medical institutes in the country. Being able to look at structured data for large numbers of patients gives an entirely different perspective on patient care.

The key lies in being able to develop brief and easy to fill computer readable formats for collecting information at the point of care. Without systematic information of this variety, it would not be possible to conduct any meaningful audit of healthcare services.

Actually the very requirement to record information in a pre-defined format encourages compliance with guidelines. We found that by asking a question whether a Pre Anaesthesia check had been conducted a day before the surgery, the incidence of such checks went up. The requirement to grade anginas in different classes encouraged the use of stress tests. Questions about the use of Surgical Safety checklists and adverse events involving retained surgical items, evoked a similar response. We often tend to forget that pre Anaesthesia checks are commonly conducted on the operating table in many hospitals.

Here we need to note that the present structure of the healthcare industry in India does not encourage any record-keeping that requires men and money. Another major problem in record keeping comes from the idea that it is doctors who must fill out all these formats. Nurses can be trained for a large number of such routine tasks also.

Above all, keeping patient records systematically in structured formats and following standard clinical guidelines are in the interests of doctors and patients so we wonder why is it that such record keeping systems are not maintained rigorously.

Possibly there could be a perception that such information could harm the profession. But Quality of care indicators and clinical audits cannot be used to target individuals; rather they should be used to improve institutional mechanisms to provide care.

Any move to follow standard formats and to compile these would yield a great deal of information on the delivery of health care services and would show ways to improve it.

In Maharashtra, the government has already made a beginning by asking nearly 300 hospitals participating in a health scheme to send regular reports on roughly 50 indicators of hospital activity. This initiative was accompanied by extensive training sessions of the hospital staff to familiarize them with the activity and the results have been good so far.

Today we have the men, materials and money, which is needed for this exercise. But somehow the will and the legislative framework is lacking. The interesting thing is that a very large number of doctors accept this point and pursue good practices at a personal level. However good will cannot be the basis for large-scale systems to survive. Good will needs institutional backing and legislative support.

Editor Comments

1. Conferences could be completely funded by Govt for both organizational expenses as well as travelling of doctors thus reducing the chances of companies influencing the physicians
2. Branded drugs could be replaced by Generic medicines, procured from govt pharmacies, atleast for certain medicines, subject to QC checks The govt labs conducting investigations should be increased to avoid referrals outside institutions, especially in case of public hospitals.
3. Cost audit of treatments by way of analysing hospital (and pharma company) revenues lost to outsourced centers (in the form of investigations and prescriptions) could be used to curb unnecessary tests, prescriptions and investigations

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