Standardization of the Medical Record in Plastic Surgery

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ABSTRACT

The objective of the present study is to propose a standardization of the medical record for Plastic Surgery. The record model proposed would work for most plastic surgeons, and could be filled out in an automated and oriented manner by the physician and also allow adaptations according to individual needs. Data on Identification, Chief Complaints, History of Present Illness, Systems Investigation, Personal Background and Family Background could also be filled out alternatively by the patient him/herself, by using language and expressions accessible to the lay public, and in order to support the physician more effectively in the case of legal disputes. The record can be viewed quickly and objectively due to the use of figures and diagrams. It has a simple cataloguing and filing system for photographic documents and registered data are numbered in order, so that they may be computerized, making scientific research easier and minimizing data collecting errors. The record model may be used in hospitals, outpatient clinics and individual medical offices. The resolutions of the medical entities that regulate the utilization of Medical Records or Medical Files are also discussed.
Patient History in aesthetic Plastic Surgery differs from other medical specialties: in general, the patient already comes in with his/her own diagnosis and treatment. It is up to the specialist to confirm or not the “diagnostic hypothesis”, orient the best treatment, perform a clinical evaluation or contra-indicate surgery. Therefore, the psychological factors in these patients and in the physician-patient relationship are unique.

Another specificity of the specialty is that a result that may be considered satisfactory by the surgeon may not be so considered by the patient, or vice-versa.

The result of a surgery may also depend on factors that are not significant in other specialties. There are variables that may influence the quality of results, such as previous prolonged exposure to the sun, obesity, exaggerated and repeated changes in weight, post diet malnutrition in order to undergo plastic surgery, utilization of contraceptives, smoking, racial and age factors that interfere in scarring, and major psychological personality conditions, generally related to self-esteem and self-image.

Plastic Surgery, and more specifically aesthetic surgery, among the various medical specialties, is one that most frequently leaves the professional vulnerable to legal dispute. All these specificities of the specialty make it interesting to have a comprehensive and standardized “Medical Record” or “Medical Observation” that meets the needs of most plastic surgeons.

Integrating a medical record with standardized photographic documents benefits the plastic surgeon who could take better advantage of his routine work. The Medical Record for the Plastic Surgery patient is unique in the association of the Medical Record and photographic documents, therefore being called Clinical-Photographic Record or Photo-Document Set. “The medical record should comprise clearly the identification of the patient; daily medical follow-up (if inpatient); follow-up of nurses and other professionals; laboratory, radiological and other tests; medical reasoning, diagnostic assumptions and definite diagnosis; treatment, medical prescriptions, descriptions of surgeries, anesthetic records, discharge summary, outpatient appointments and/or urgencies, medical observation chart and physician follow-up.”

The Federal Medical Council enacted Resolution 1639 on July 10, 2002, approving the “Technical Standards for Using Computerized Systems for Keeping and Handling Medical Records”(2). It established a minimum of 20 (twenty) years, as of the last recording, for keeping medical records in hard copies. Afterwards, the record may be stored in any magnetic or optical electronic medium and microfilmed, as long as it can be recovered, according to the standards of the Brazilian Society of Information Technology in Health (Sociedade Brasileira de Informática em Saúde - SBIS), in a specific association with the Federal Medical Council, and anticipated in the Brazilian Filing Legislation(2).

“The data that comprise the record belong to the patient and should be available on a permanent basis, so that whenever requested by the patient or proxy, they should allow for authentic copies of the pertinent information”(3). The Regional Medical Council stresses the rights of the patient: “To have access, at any time, to his/her medical record and receive in writing the diagnosis and treatment recommended, bearing identification with the name of the professional and registration number at the agency responsible for regulating and controlling the profession”(2). Moreover, “The physician can not disclose the content of the medical record or file without the patient’s consent, except for legal obligations. If the request is submitted by the family, the patient must give authorization”(2).

The quality of medical care depends on the quality of the information in the record (3). A standard Clinical Chart should order the parts that refer to history, general and special physical exam and subsidiary tests. Registered data should be easy to see in a simple, fast and objective manner. The follow-up of the chart would assist scientific research, because of the possibility of computerization due to the numeric fields for registering data (4,5,6). The record could be adapted for use in offices, outpatient clinics and hospitals. Using the record in a hospital with a busy surgery schedule would minimize the high possibility of errors whenever statistical studies are performed (7,8).

The model for the standardized Medical Record herein proposed allows consistent utilization among plastic surgeons, responding to the needs of most professionals and is flexible enough to allow for individual adaptations. The fields were ordered aiming at following clinical reasoning and the distribution of space is adequate to the content of each item to be filled out. It allows a quick and global view of information due to the utilization of figures and diagrams, and also allows for an easy and orientated way of writing information (Figs. 1-6).
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Fig. 1 – Medical record (page 1).

Fig. 2 – Medical record (page 2).

Fig. 3 – Medical record (page 3).

Fig. 4 – Medical record (page 4).

As the item "Chief Complaints" is characteristically short and objective for most Plastic Surgery patients and because it was intended to optimize questions on the record, the items "History of Present Illness" (HPI) and "Family Background" (FB) were emphasized less, and "Systems Investigation" (SI) and "Personal Background" (PB) were emphasized more.

Bearing in mind a still incipient anthrosophical approach in Plastic Surgery, but with a growing demand due to the needs the specialty requires, a psychiatric SRQ-20 (Self Report Questionnaire) questionnaire was included\(^{10,11}\). It is a tool for assessing non-psychotic psycho-emotional disorders\(^{12}\). Eight or more positive affirmative answers in the assessment ("Yes") indicate that the patient has a significant depression and anxiety profile.

There is a tendency to automate care in centers with high patient loads. The Medical Record model described also allows it to be filled out by the patient in the waiting room for the fields referring to information the individual him/herself would give. In this case, the patient receives only the first part of the record ["Record N_1 (Patient)"], with a questionnaire written in terms and expressions he/she is able to understand.

The information and personal medical background should be dated and acknowledged by the patient with his/her signature on the Medical Record, bearing in mind that many patients, due to their anxiety to undergo plastic surgery, may deliberately or accidentally distort or hide important information. Having the fields filled out in the patient's own handwriting presents the advantage of comprising in the future a tool for the physician in case of a lawsuit. Obviously, each item of the questionnaire needs to be checked by the physician, who should correct and take the notes he/she deems necessary in the open optional fields.

The Informed Consent can currently be considered as a part of the Medical Record or Medical File\(^{18}\). This is why a standardized Medical Record and Informed Consent are necessary in order to guarantee a healthy physician-patient relationship.

**REFERENCES**


