Author's response to reviews

Title: What they fill in today, may not be useful tomorrow: Lessons learned from a study of medical records at the Women hospital in Tabriz, Iran

Authors:

Faramarz Pourasghar (Faramarz.pourasghar@ki.se)
Hossein Malekafzali (afzali@hbi.ir)
Alireza Kazemi (dr_alireza_kazemi@yahoo.com)
Johan Ellenius (Johan.Ellenius@ki.se)
Uno GH Fors (Uno.Fors@ki.se)

Version: 2 Date: 4 February 2008

Author's response to reviews: see over
Comments to the reviewers

Title: What they fill in today, may not be useful tomorrow: Lessens learned from studying of Medical Records at the Women hospital in Tabriz, Iran

Authors: Faramarz Pourasghar, Hossein Malekafzali, Alireza Kazemi, Johan Ellenius & Uno Fors.

We would like to thank you for reviewing our manuscript and for the constructive comments. We have revised the manuscript based on both reviewers’ comments. Here are details of the changes:

Reviewer: Petra Knaup

Comment:
Abstract: Add some consequences and perspectives to the conclusion part of the abstract

Changes:
The following text was added to the abstract section:

Missing of information or lack of documentation usually lead to repeat medical or laboratory exams, delay in providing medical care, and increase financial burden on patients and hospitals.

Comment:
Introduction: Second last sentence - in the medical records (not on).

Changes:
The following text was changed in the introduction section:

However they often report a lack of information in the Medical Records they have evaluated from hospital records [8].

Comment:
Objective: Add the information, why these aims are important to reach. What is the motivation for the research? What to you intend to change/plan on basis of the results?

Changes:
The following text was added to the objective section:

Since it earlier had been indicated that some of the Medical Records were incomplete, but there was no exact figures of completeness/incompleteness of Medical Records at the university hospitals, this study focused on to draw a general picture of the quality of Medical Records system at the university hospital, then to measure the completeness/incompleteness of Medical Records and finally to find out the probable reasons of shortcomings in Medical Records.
On the other hand, the quality of Medical Records had never been seen from the physicians and nurses view points. This study also aimed to evaluate opinions of medical staff on the quality of Medical Records system as the main providers and consumers of the medical information.

Comment:
Methods: I do not understand the sentence "... and by considering confidence interval of....” What Confidence Interval do they mean? Why is it necessary? Which question does the CI answer? Is it really necessary?

Changes:
The content of that section was reorganized and the CI section deleted.

Comment:
The information in the two paragraphs "The sheets were categorized in two groups..." and "The next group is those sheets..." should be placed before 3.1 and 3.2

Changes:
The content of that section was reorganized.

Comment:
Is availability checked for both of the mentioned groups?

Explanation:
We did check for availability of both essential and optional sheets. The first two columns of Table1 summarize the result of availability test of the sheets.

Comment:
How did the checklists look like? What was the content of the checklists? Were the checklists validated? What is the Gold standard? Did you perform a quality control for filling out the checklists?

Changes:
The following text was added to clarify the checklist:

The checklists were based on the standard Medical Records at the university hospitals in Iran. In these checklists, there was a place for every requested item on every medical record sheet. If the requested information was registered in the sheets correctly, a check mark was consequently placed in the checklist for that specific item.
Generally the requested information on each sheet are included identification information of patient, physician and ward, the result of medical or surgical
interventions and/or laboratory and radiological tests and finally date, time and signature of the care provider. Since it is expected that the Medical Records hold all clinical information of the patient, the golden standard was to document all requested information elements in the records. Before collecting data and in order to perform a quality control on the checklists, a limited pilot test was carried out on the Medical Records to verify that the checklists covered all essential information.

**Comment:**
3.3 usability. Delete first sentence. I did not find any results referring to this sentence. If I am wrong, please refer to this sentence in the results.

**Changes:**
That line was removed from the text.

**Comment:**
Results, 4.1 Medical records: The explanation of the categories belongs to the methods section.

**Changes:**
The text block moved to the method section and was reorganized.

**Comment:**
4.1.1 Refer to table 1 in the first sentence.

**Changes:**
The “Table1” was added to the text.
Almost all records contained the essential sheets (Table1).

**Comment:**
It was predictable that not all records might contain... Delete last sentence, it is redundant

**Changes:**
That text line was removed form the text.

**Comment:**
4.2.1 Daily working hours?

**Changes:**
The following text was added to the manuscript:
The average of time that physicians had spent on documentation was 1 hour and 45 minutes of a working shift (8 hours).
Comment:
Please shorten chapter 4.2 considerably. Maybe it is helpful to better integrate the results of the physicians and nurses, so that they are better comparable for the reader.

Changes:
The “result of interview” section was revised. The result of interview of physicians and nurses was merged to make it easier for comparing the result.

Comment:
Please explain: "...almost all physicians had requested.... and in most cases they had failed." Is this only true if the patient was in another hospital before?

Changes:
Some text was added in order to clarify the situation:
Almost all physicians had requested their patients’ previous Medical Records, when they had a patient with previous history of hospitalization. If the patient had been hospitalized at the same hospital and/or if she holds a record unit number, it would be easy to retrieve the previous records and in most cases they had access to her previous Medical Records, but if she had been hospitalized at other hospitals, or referred from out patient clinics the chance of getting access to previous records was very limited.

Comment:
Please shorten discussion considerably.

Changes:
The discussion section was completely revised.

Comments:
Is it severe that 10% of progress reports are missing?

Changes:
The following text was added to the manuscript:
It is possible that a patient be visited by different residents during afternoon and night shifts if the patient’s clinical condition required it. The residents usually do search in the Medical Records for some information (for instance progress report sheets) for evaluating effectiveness of the current treatment, in that situations missing sheets might affect their decision on continuation or termination of the treatment.
Comments: 
"... Paid more attention to legal aspects of documentation", than... (Please add)

Changes:
The following lines were added to the text:

It indicates that physicians and nurses have paid more attention to legal aspect of documentation in order to protect themselves if some jurisdiction issues might occur.

Comments:
In my understanding it is unusual, that the medical record department care for the completeness of the records. How should the get the missing information? Better explain these concepts, which may be different in different countries of the world.

Explanation:
A part of the responsibility of the medical records department is to review medical records in terms of existing all sheets, completeness of documentation of all requested information, immediately before the patient is discharged from the hospital. In our study, we found that some the records have been archived without being reviewed by medical records experts.

Comments:
Which degrees of completeness are reported by other studies?

Explanation:
This is the first study of this kind in Iran. There was no previous measurement on the quality of medical records in term of availability, completeness and ease of use.

Comments:
Author's contribution: Who performed the data recording for the quality control? (Who filled in the checklists?)

Changes:
The following text was added to the manuscript:

Faramarz Pourasghar contributed to conception and design of study, design of checklists and interview guidelines, interview with physicians and nurses, quality control of data, analysis and interpretation of data, and drafting of the manuscript.
Comment:
References:
Do not cite the months of publication
5. Author is missing
6. Authors are Dick, Steen, publishing company: National academy press
8. Title is missing

Changes:
The references section was reorganized and some references were replaced with new references.

Comment:
Table 1: Add availability and completeness in the title of the legend. Explain N/A
In the legend

Changes:
The following line was added to the legend of the table 1.
- (N/A) It is not required to document identification information of care providers on these sheets.

Comment:
Results: Were all records of the random sample immediately available? Or did they increase the sample, when a record could not be found.

Changes:
The all selected Medical Records were available immediately. We didn’t increase the sample size.

To Reviewer: Arild Faxvaag
Comment:
1.1. To improve readability and understandability,…

Changes:
The following text was added to the manuscript:

In the Iran medical care system, there are several hospitals, including public hospitals which are run by the Ministry of Health and Medical Education of Iran (MOHME) through universities, private hospitals which are run by private sector physicians and social insurance hospitals which are run by social insurance organization. The university hospitals are dominant in terms of number of the hospitals, number of beds, verity of specialties and services they provide. The university hospitals are public hospitals and available for all people. Patients are usually admitted through the hospitals’ clinics or are referred from other health centers and/or private sector physicians.
The patients are required to pay the hospitalization expenses, and if the patients have contract with insurance companies, this companies cover the expenses. Several insurance companies are active in the Iran medical care system.

**Extra explanation:**
The University hospitals are all public hospitals, which it means they are available for all people regardless of their financial status. More than 90% of people admitted are under the coverage of an insurance system.

**Comment:**
1.2. The choice of methods only partly suits the purpose of the study. Are other documentation systems in use at the department?

**Changes:**
The following text was added to the manuscript:

The PBMR system is the only available documentation system at the hospital. No extra records are kept at the wards. There is an index book at the Medical Records department for recording the identification information of patient, record unit number and the diagnosis after discharge. This book is used to retrieve patient’s Medical Records.

**And also:**
The Medical Records are not only used for treatment purposes, but are also considered as a source of information for research and education. At the university hospitals, physicians are also responsible for conducting research, and sometimes the Medical Records are the only source of information, and incomplete Medical Records could affect the results of the researches.

**Comment:**
1.3. I miss a more thorough discussion

**Explanation:**
The discussion section was revised completely.

**Comment:**
“….. The possible implications (of the results) for the forthcoming EMR system at the hospital should be discussed.”

**Changes:**
The following text was added to the discussion section:
The authors are planning to conduct a study on the quality of Medical Records after introducing of the EMR system at the hospital and compare the results to find out the impact of the EMR system on the quality of Medical Records.

*Faramarz Pourasghar*