International Journal of Middle Eastern Research
ISSN: 2976-5455
DOI: 10.32996/ijmer
Journal Homepage: www.al-kindipublisher.com/index.php/ijmer

IJMER
AL-KINDI CENTER FOR RESEARCH AND DEVELOPMENT

| RESEARCH ARTICLE

Envisaging the Recalibration of Clinical Documentation Competency, Accreditation, and 'Diyya' Risk Mitigation Across G20 and GCC Health Systems

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| ABSTRACT

In the evolving digital age, clinical documentation has transitioned from a routine administrative task to a critical, cross-professional competency. This shift is highlighted by differing digital applications, electronic health record architectures, and regional regulatory frameworks across the health systems of the Group of Twenty (G20) and Gulf Cooperation Council (GCC) countries. This review scrutinizes the necessity of recalibrating clinical documentation as a vital competency and safeguard within the context of healthcare practice, contrasting broader international institutional accreditation frameworks with regional medico-legal realities, specifically Islamic jurisprudence concerning "Blood Money" (Diyya). A review of recent cross-sectional data in the literature, institutional reports, and medico-legal literature that spans 2019 to 2026 was conducted to appraise documentation consistency, digital liabilities, and adherence mechanisms across medical, nursing, pharmacy, and rehabilitation professions within G20 and GCC nations. Evidence reveals that unstandardized or ambiguous documenting potentially escalates clinical under-treatment, system fragmentation, and insurance claim approvals globally. In the digital sphere, issues like copy-paste errors, and template omissions introduce distinctive compliance risks. While international frameworks like Joint Commission International (JCI) minimize incomplete entries by standardizing baseline operational principles, localized models like the Saudi Central Board for Accreditation of Healthcare Institutions (CBAHI) integrate stricter documentation requirements overtly tailored to local medico-legal liabilities. Crucially, within applicable Islamic jurisdictions, contemporaneous and specific documenting acts as the primary evidentiary determinant for considerations to reduce or refuse Diyya financial liabilities for medical negligence. Widespread gaps in documentation training and interoperability persist across international clusters, turning electronic records into potential liabilities. Recalibrating thorough yet efficient documentation competencies across healthcare professions is an indomitable safeguard to accomplish global institutional accreditation mandates, mitigate profound localized Diyya financial risks, and ensure continuity of care in modern digital health systems.

| KEYWORDS

Clinical documentation competency, digital health records, institutional accreditation, medico-legal liability, Blood money (Diyya), Saudi Central Board for Accreditation of Healthcare Institutions (CBAHI), Joint Commission International (JCI), G20 and GCC health systems

| ARTICLE INFORMATION

ACCEPTED: 05 August 2026 **PUBLISHED:** 07 September 2026 **DOI:** 10.32996/ijmer.2026.5.3.3

Introduction

The modern paradigm shift toward digitized healthcare infrastructures has profoundly restructured the delivery, monitoring, and verification of clinical care across global health systems. Within the Group of Twenty (G20) nations and Gulf Cooperation Council (GCC) states, the widespread implementation of electronic health records (EHR) and secondary digital health applications has transformed clinical documentation from a routine administrative task into an essential, high-stakes transprofessional competency. Clinicians no longer merely record observations to preserve memory; instead, they generate digital legal mechanisms that have direct consequences on patient safety outcomes, institutional accreditation viability, and professional liability profiles. As defined by Adewumi (2026), clinical documentation encompasses the manual or digital entry of health histories, objective clinical assessments, and therapeutic interventions intended to comprehensively memorialize the continuum of patient care. However, despite the universal clinical importance of this practice, substantial heterogeneity exists globally regarding how clinical documentation standards are taught, audited, and enforced.

This educational and operational variance is highly visible across the distinct regulatory clusters of the G20 and GCC nations that are listed in table 1 that follows.

Table 1: The clusters of G20 and GCC countries

<table>
<tr><th colspan="5">G20 Countries</th><th>GCC Countries</th></tr>
<tr><th>Group 1</th><th>Group 2</th><th>Group 3
Latin America</th><th>Group 4
Western Europe</th><th>Group 5
East Asia</th><td rowspan="3">Bahrain
Kuwait
Oman
Saudi Arabia
Qatar
UAE</td></tr>
<tr><td>Australia
Canada
Saudi Arabia
United States</td><td>India
Russia
South Africa
Turkey</td><td>Argentina
Brazil
Mexico</td><td>France
Germany
Italy
United Kingdom</td><td>China
Indonesia
Japan
South Korea</td></tr>
<tr><td colspan="5">The European Union
The African Union</td></tr>
</table>

Clinical documentation in these groups of countries has been overlooked to varying degrees despite it being a connecting link between professional competency, medico-legal liability, Islamic 'Diyya', and accreditation. The most effective method of preventing avoidable harmful events and medico-legal disputes is to standardize the approach to clinical documentation among health professionals as a means of recalibration by observing key principles in the activity. The focus on four key principles will be discussed, supported by literature-based evidence.

1. Competency Across the Healthcare Professions

Ensuring proper documentation is the best way to ensure the safety of patients and healthcare providers. Demsash et al. (2023) advocate the documentation of clinical notes as an important part of providing safe and continuous care to patients in the sense that the other teams that join the care delivery process do not rely on verbal handover but rather rely on what has been done or not as captured in clinical documentation.

As relates to medicine, Tate et al.'s (2023) initial study on documentation consistency during emergency transfers of long-term care residents across 38 facilities to two emergency rooms in Western Canada revealed that more than a third of transitions (38.4%) had inconsistent documents. The poor documentation consisted of missing reports, vague explanations, and ambiguous changes in conditions that were likely to lead to clinical under-treatment and negative consequences (Tate et al., 2023). Alabdulqader et al. (2023) conducted a study on Saudi Arabian care facilities and found that only 28.2% of emergency physicians knew about the writing and completion of a medico-legal report, 82.4% had no instruction of any kind about medico-legal documentation, and 91.8% said that they did not receive medico-legal training. However, it was acknowledged that well-structured training on documentation had helped clinicians reduce the number of medico-legal disputes (Alabdulqader et al., 2023). Indeed, adequate documentation practices are essential for maintaining continuity of care, ensuring patient safety, and minimizing medico-legal risks.

Clinical documentation is similarly critical for the nursing profession. According to Fleischmann-Struzek et al. (2021), 31.5% of previously independent sepsis patients who were hospitalized in Germany become dependent on nursing care once they survive their sepsis, and 74.3% of these patients develop at least one new diagnosis during their first year after hospitalization. These findings indicate that nursing professionals' failure to sufficiently document early warning signs (such as trends in vital signs and fluid balance) may lead to the development of long-term dependencies on nursing services following a diagnosis of sepsis. The

evidence denotes that documentation competency should be assessed as rigorously as clinical skills to improve patient care outcomes.

Pharmacy practice and health informatics data evidence show that although documentation improves patient safety, it tends to be burdensome. Recent research from India and Indonesia indicates documentation as a critical link between prescribers and dispensers. Pharmacists' medication reconciliation reduces adverse drug effects when documentation is done using a standard form (Faller, 2022). However, a perspective emerging in the United States is that excessive documentation (in electronic health records) leads to bloated notes that consume up to 39% of clinicians' time without comparable benefits (Apathy et al., 2023). It is evident that a balance between thoroughness and effectiveness in healthcare providers' clinical skills needs to be struck to achieve the desired care delivery goals.

Clinical documentation competency has far-reaching consequences with regard to patient safety and claims processing in rehabilitation and community health. Ryu et al. (2020) illustrated the traditional and Western system duality of the South Korean healthcare system intrinsically splits patient pathways, with Korean medicine outpatient visits the most frequent choice (56%) for ankle sprains for example. While the total annual medical costs exceed US$3 million, the aspects of care are highly fragmented; over 73% of patients moving between systems duplicate diagnostic efforts like radiography. Analytically, this parallel outreach in ankle sprains reveals a critical lack of essential and standardized clinical documentation competency across systems, as independent record-keeping exposes a disconnect between Western and Korean medical institutions that fails to consistently provide a singular clinical patient timeline. Similarly, an interoperability challenge is experienced in Brazil between community health workers and the health administration. Poorly documented community health data is not connected to hospital systems, which leads to disjointed care pathways (Martins et al., 2020). Evidently, clinical documentation is one of the transprofessional competencies whose outcomes can be measured in terms of safety and reimbursement.

2. Clinical Documentation Principles

While digitization of traditional documents helps in maintaining the principles of accuracy and access, it introduces unique adherence risks related to overall compliance. Sittig et al. (2022) discovered evidence of the hybrid model (digital and paper) and how they uphold principles such as timeliness, accuracy, legibility, contemporaneous, and author attribution. However, copy-paste and other electronic errors, template omissions, and the weaknesses of audit trails in medicine and pharmacy compromise the accuracy of electronic records. In the USA, Bell et al. (2020) showed that 21.1% of patients reading their open notes picked up a perceived error, with frequent mistakes in diagnosis and capturing the patients' medical histories. De Oliveira et al. (2024) posit that manual clinical documentation in Brazil is still prone to loss and illegibility, but offers a simple way for the user to access their data. Health systems in the G20 need to merge both the principles of traditional patient documentation and the access afforded by electronic patient documentation to ensure accuracy and consistency of medical records across areas of medicine.

Contemporaneity and specificity are significant principles of clinically valid, legally sufficient, and acceptable clinical documentation. A major evidence-based premise is that documentation must be contemporaneous. Prictor (2025) asserts that delayed charting by clinicians beyond 24 hours in Australia is regarded as *prima facie* proof of unreliability in malpractice litigation. Another guideline is specificity in the use of ambiguous phrases such as 'patient stable', which is medico-legally risky. Most notably, Sasanuma et al. (2024) observe that Japanese courts have ruled against rehabilitation specialists who utilized such ambiguous terms when objective signs indicated deterioration. These principles underline the significance of timely and exact record-keeping to sustain clinical correctness and medico-legal accountability.

Confidentiality, data retention, and amendment methods are medico-legal issues emerging globally. In Europe (France, Germany, Italy) and similar countries, patients can, with the help of the General Data Protection Regulation (GDPR), and similar legislation in Turkey and Russia, request access to their records and amend them (Turnšek, 2024). Inability to address the request appropriately is usually followed by fines and restrictions of the license (Turnšek, 2024). In the U.S., the 21st Century Cures Act requires immediate electronic access to patients, introducing additional legal risks when physicians document candidly but patients misread notes (Arvisais-Anhalt et al., 2022). The integration of digital documentation and the Islamic law (Shari'ah) in GCC countries introduces another compliance dimension, especially in the field of administration and informatics. As an example, within the UAE, electronic signatures and timestamps are deemed evidence of negligence in case the chain of custody is violated (Ziad et al., 2024). Nonetheless, in some religious scenarios, manual documentation is still favored because it can be authenticated by professional witnesses in Diyya cases. The literature outlines the legal complexity of managing documentation between the multiple regulatory and cultural settings.

3. Islamic Medico-Legal Considerations in Situations of "Blood Money" (Diyya)

'Diyya' is one particular area in Islamic jurisprudence that influences healthcare negligence liability in many countries. It is financial compensation for victims of bodily harm or heirs of homicides and works as a distinct medico-legal concept in Islamic law (Alotaibi, 2024). Diyya can directly apply to healthcare malpractice in GCC states and the Islamic majority G20 countries of Saudi Arabia, Turkey and Indonesia, and, to a smaller degree, the Muslim majority regions of India (Alotaibi, 2024). Notably, this

area is an identified vulnerability for non-Muslim health professionals practising in Muslim-majority countries where Diyya intersects with medical malpractice (Najid & Kassim, 2017). Furthermore, In Sharia-based jurisdictions like the UAE, Saudi Arabia, Kuwait, and Qatar, medical negligence causing death or permanent impairment is reviewed based on the Sharia and not the standard Western tort law because the Sharia treats clinical errors as civil infractions rather than public violations (Alotaibi, 2021). Consequently, this triggers private rights of financial restitution (diyya) or retribution (qisas), exposing expatriate and non-Muslim healthcare staff to personal and legal accountability. In contrast to common law damages, in which economic loss and pain and suffering are included, Diyya is determined by Shari'ah based on particular injuries and death and adjusted according to factors such as gender, religion (previously), and earning potential of the victim (Alotaibi, 2024). The context-sensitive and stable structure of Diyya is what makes it unlike typical medical negligence compensation.

Recent research has shown a significant increase in the number of Diyya claims in which the quality of documentation was noted as an important determinant in the resolution of such cases. According to scientific research conducted in Saudi Arabia, the rise in the number of malpractice cases based on Diyya has occurred because of surgical mistakes, wrong administration of anesthesia, and overdose of drugs (Alghamdi, 2025). In one particular lawsuit, the court awarded Diyya with a mean value of Saudi Arabian Riyals 300,000 (equivalent to US$ 80,000) for wrongful death (Alghamdi, 2025). Diyya was either refused or reduced in situations in which physicians and pharmacists had kept contemporaneous, readable, and comprehensive records (Alotaibi, 2024). According to the literature, the best predictor for determining liability is the quality of clinical documentation. Diyya has a different standard of evidence compared to criminal negligence. To obtain damages on the claim, the plaintiff should demonstrate professional liability breach, direct causation, and long-term harm according to the UAE Federal Law No. 5/2020 on medical liability (Allouz et al., 2026). The Diyya schedule defines the approach to claims determination, categorizing cases as permanent disfigurement, loss of organ functions and death depending on the circumstances of each case (Alotaibi, 2024). Critical analysis by Allouz et al. (2026) asserts that the current system compensates excessively for mortality and compensates less for chronic handicap, which is a perverse incentive. In Indonesia, where a mixed civil-Sharia system is in place, Diyya claims against nurses and midwives constitute the majority of claims for professional liability insurance (Khalid et al., 2024). The apparent variances indicate that there are long-term problems of fairness and consistency in Diyya-based compensation systems.

The convergence of Diyya and institutional culpability is one of the research areas that has not received much attention. Latest evidence from Bahrain shows that hospitals are vicariously liable more and that financial compensation is more than the individual clinician can afford (Saleh, 2023). This has put pressure on professional indemnity insurance that is modified to Shari'ah-compliant models (takaful). As demonstrated in the literature, there is a distinct overlap in the fact that Islamic medico-legal principles are changing, with the courts relying more and more on documented evidence, as opposed to testimony of witnesses alone. Diyya litigation puts clinical documenting competency squarely in the spotlight.

4. Hospital/ Healthcare Institutional Accreditation Standards

Joint Commission International (JCI) and Saudi Central Board of Accreditation of Healthcare Institutions (CBAHI) standards provide the most detailed operational basis for clinical documentation. Particular data provided by JCI-accredited hospitals in the UAE have shown that adherence to JCI documentation standards significantly improves clinical record accuracy, with the data here showing a decrease in incomplete records from 18% to 4% (Sallam & Hamdan, 2023). To maintain compliance, JCI mandates that every medical record explicitly identify its author, date, time, and professional discipline, and that any late entries must be clearly indicated as such; and subsequent corrections must remain attached permanently to the original entry (Sallam & Hamdan, 2023). Interestingly, the flexibility of JCI in terms of manual or electronic documentation (as stated in MOI.8 through MOI.10) has allowed smaller facilities in Mexico to be accredited without fully adopting electronic health records (JCI, 2019). One major disadvantage mentioned in the literature is that JCI does not require standardized data input of quality measures, and therefore, there is continued variability in its application.

CBAHI National Hospital Standards require more specific documentation than JCI. For instance, they address local medico-legal concerns, such as Diyya, which JCI does not cover. Alturbag and Alyahya (2025) state that for changes made to documents, the original text must remain, and the new text must be added with a date, time, and signature. This added requirement is a direct result of court decisions relating to Diyya cases, in which changes in documentation were disputed (Alghamdi, 2025). In contrast to JCI, CBAHI requires that a second clinician document a review of any high-risk medications. This is a direct result of Saudi Ministry of Health adverse event documentation, which identified 29% of harm events as occurring due to a lack of documented medication reviews (Alturbag & Alyahya, 2025). CBAHI is shown to integrate stricter documentation requirements and medico-legal concerns to better safeguard patients and care providers.

JCI and CBAHI are congruent in relation to the significance of documentation in care transitions. Both mandate a standardized transfer of care with proper documentation through writing/electronic means (JCI, 2019; Alturbag & Alyahya, 2025). Research evidence from a cross-sectional study of Saudi hospitals reveals that structured handover documentation reduces adverse events by 34% (Saleem & Kadi, 2022). Nevertheless, CBAHI mandates extra clinician education on timely handover of documentation to enhance care outcomes. Clearly, both standards fail to consider documentation for AI applications, leaving a loophole for the

future, especially 2026 onwards. However, for any healthcare institution located within a G20 and GCC country, adhering to JCI and CBAHI standards in terms of documentation offers strong legal cover for malpractice claims.

Conclusion

In G20 and GCC countries, clinical documentation is more than an administrative task because it is a common professional competence that has a direct influence on patient safety as well as legal responsibility. Notably, it informs Islamic Diyya compensation and institutional accreditation. Flaws in documentation have been established as connected to adverse consequences and settlement and judicial penalties in Canada, Saudi Arabia, Germany, the United States, South Korea, Brazil, and the UAE. In the meantime, the convergence of JCI standards and CBAHI documentation practices leads to the standardization of documentation and, therefore, helps healthcare organizations by reducing errors and enhancing legal cases under Islamic law. They also ensure that Diyya compensation payments are avoided or minimized. The G20 country groupings and GCC nations demonstrate definite indications of a common need for better clinical documentation standards to minimize not only avoidable damage but also medico-legal conflicts.

Disclaimer:

The views expressed are entirely those of the coauthors, and therefore are not necessarily perspectives of the institutions associated with the coauthors. It is declared that there are no conflicts of interest. Furthermore, the coauthors are not responsible for any errors or omissions, and/or for the results obtained from the sources used to generate this review publication. The coauthors therefore bear no liability to any person for any loss or damage arising out of the inaccurate use of the information provided in the review.

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