

# Facts of Medical Record Keeping - The Integral Part of Medical and Medico Legal Practice.

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## Abstract

Proper handling and maintenance of patient's / deceased person's medical records is an integral part of medical and medico legal practice. This is the least bothered and most neglected section in medical practice, especially in developing countries like India. Medical records have proven of great help in medico legal matters and in cases of negligence suits filed against the medical practitioner. Properly kept medical records can save the doctor from many unpleasant situations. Indian law is not very clear about the facts of medical records. There are some guidelines issued by recognised professional bodies regarding them. So it is must for a medical and medico legal practitioners to know about the facts of medical and legal aspects of maintaining the patient's records for their own benefits, as ignorance is not always bliss.

**Key words:** Medical records, medical practitioner, medico legal expert, record keeping, patient

## Introduction

All written material is documentary evidence in the eyes of courts of law. Preparation and maintenance of these records is the integral part of every profession. Same principle applies to the medical profession too. The technical, medical and legal knowledge of preparing, keeping and maintaining medical records is an essential art to be known to every medical practitioner. Medical records are documentary evidences, which are of immense help not only in medico legal cases but also in defending the doctor in cases of negligence suits or allegations against him/her. There are many cases / instances which are decided in favor of doctors only on the grounds of well kept and well reproduced records in consumer courts. Medical records have assumed more importance and significance because of application of Consumer Protection Act to medical profession. However, doctors because of their busy schedule, either don't maintain records or records are kept very brief, incomplete, cryptic records which are of no use in court matters.<sup>1</sup>

## Reasons for knowing about them

India is slowly becoming a litigant society. The doctors are being sued by the patients or by the patient's relatives on regular basis for trivial matters. In the present days of medical practice, it is very important & essential to know about this most neglected but important aspect of medical profession. In many of the occasions the allegations are either proved or disproved only on the basis of the well kept or ill kept medical records. It is high time that the medical professional should take a serious look at the facts of the physical and legal details of medical records. Just imagine the situation, you approaching a patient or a research project without any prior history or records, it is like few blind men describing an elephant. Medical records are not only of great help in medico-legal matters, but also they form an essential data of patient's history, illness, treatment, prognosis etc. which are essential in research and advancement of medicine. They also act as statistical data used for formulating public health guidelines and health policies of a nation.

## Essential ingredients of a good medical record

Medical records should be maintained serially in a chronological order with dates and they

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should preferably contain the following entries in them.<sup>2</sup>

1. General particulars of the patient eg; Name, age, sex, address, emergency contact no, who brought him / her [with details]. etc.
2. Consent form duly filled and signed.
3. Dates and timings of examination / admission and discharge – in patients.
4. Dates and timings of all visits and consultation.
5. Details of the complaints – in a chronological order
6. Personal and past history.
7. Physical and laboratory / investigation findings (reports enclosed).
8. Treatment given / surgical procedures in detail.[immediate entry not later]
9. Day to day prognosis.
10. In case of death; precise cause of death, date and time of death.
11. Details of consultation by other doctors and their opinion.
12. In medico legal cases police need to be informed both at the time of admission as well at the time of discharge.
13. In patients; details of discharge, cause of discharge – cured / referred to other centre /discharge on request or against medical advice [DAMA]etc.
14. Any other special findings which you feel noteworthy.

### **How the records are to be prepared and maintained**

All medical practitioners must maintain different registers for specific purposes in their office or place of practice. Doctor must maintain a separate register for the medical certificates issued, where in all details must be entered. Every certificate must include two identification marks ,if not at least one identification mark of patient, his signature /left thumb impression should taken in the space meant for that. Certificates are to be prepared in duplicate and one copy must be kept in the records as office copy which should contain the receipt signature of the patient or the legal representative. The

certificates must be prepared in a prescribed performa.<sup>3</sup> All these documents should be written in a legible way or type written Eg; writing diagnosis or prescription in capital letters is a better way. Scribbling must be avoided. The medical records must be accurate, up to date, placed in order and complete in all respects. Incomplete or altered records create room for suspicion.

Any alterations made must be initiated without obliterating the original entry. Eg : drawing a single line over the sentence / word.<sup>4</sup> It just not sufficient to diagnose and treat a patient properly .The doctor must take some time / spend some time to prepare the patient's details in documentary form or get them prepared by a trained competent assistant [in western countries trained medical clerks are used by the doctors]. India is a global hub for computer and information technology. Medical fraternity must make use of the talents available in these fields. Where ever possible sincere efforts are to be made to computerize the data, so that we can minimize the errors and the paper work can be brought down. Important and wonderful part of these computerized data is that they can be easily retrieved with a click of a button by the authorised user with basic computer knowledge, as they are well protected by passwords.

Ideally if you are keeping the records with you then keep them under lock and key or in the record room specifically meant for that , if such facilities are available with the hospital or institution. Make very sure that they are accessible only to the authorized persons of the institution.

### **Discussion**

#### **Ownership of medical records**

Who owns these records?, Treating doctor or hospital or the patient or the legal representative of the patient. This question is raised frequently in various situations / forums by both doctors and patients. Due to many reasons the custody of records varies from country to country. In some they are the property of the concerned doctor who is treating the patient. In that case the patient can have the copy of records whenever the necessity arises. In India it is very

common practice that the patient keeps all the records with him or her especially in private practice. In Government offered health services, the records are with the respective hospitals, only the treatment summary is given to the patient during discharge or need arises. India is becoming the most preferred destination for health tourism .The benefits of this influx are being reaped by the mushrooming private or corporate hospitals. In most of these corporate hospitals the patient's records are with the hospital and only the copies [may be in the form of treatment summary or photocopies of the entire case file] are given to the patient. In many parts of rural India or for that matter any developing countries the word of preparing or maintaining medical records is almost unheard. Every one have developed and adopted their own methods suitable for their setups. Likewise there are several methods which are adapted presently due to lack of proper legal guidelines in India with this respect.

### **Legal status in India and abroad**

As such there are no legal guidelines for keeping or maintaining the medical records in India. Law do not specify any period beyond which the records can be destroyed. With so many negligence cases which are being filed against the doctors under consumer protection act, it has become essential to have some legal stipulations for preparation, maintenance and discarding the medical records. The consumer protection act advises to preserve the in patient records for five years and out patient records for three years. Even though the records need not be kept beyond 2 years, as the limitation period for filing a case in consumer court is 2 years. Cases can be filed beyond 2 years period, provided the delay can be explained to the satisfaction of the consumer court.<sup>5</sup>

The Medical Council of India has given few guidelines/ recommendations with reference to the maintenance of the medical records. Doctor must keep the medical records of an indoor patient for at least period of 3 years from the date of commencement of treatment in the standard performa which has been laid down by the Medical Council of India in 2002.<sup>6</sup> Medico-legal records to be kept for at least period of 30 years or up till the cases are decided in the court of law

whichever is earlier ,even though it is so difficult to keep them for such along period. The need to maintain the records properly and produce them when asked by the courts of law itself is may detour many doctors from entertaining medico legal cases in their day to day practice. There is an urgent need to do something about this matter by the authorities.

If any request is made for medical records either by patient/authorized attendant or legal authorities involved, the same may be duly acknowledged and documents shall be issued with in 72 hrs. If the doctor refuses to give the details / copies when requested by an authorized person, he shall be charged for professional misconduct. Doctor will be held liable if he/she discloses the records or the contents to any unauthorized person or without the consent of the patient. At present the medical records are not covered under Right to Information act. No one can force a doctor to disclose the details of the patient other than the clauses given under the doctrine of Privileged communications. According to the Access to medical records act 1988, the patient's records cannot be shown to the insurance agency or to the employer until the patient has consented for its disclosure.<sup>7</sup> Patient's records cannot be used for any purpose except for statistical data or for quality care determination even without his/her consent. If used with consent for presentations at conferences, CME's etc identity of the person should not be revealed either in text or in photographs. A discharged patient should be given discharge summary even when he is Discharged Against Medical Advice (DAMA) and death summary should be issued to the next of kin. Under Sec 104 of Cr.P.C. [power to impound document etc. produced] Courts have power to summon any medical record.<sup>8</sup>

U S congress passed (1996) the health insurance portability and accountability act (HIPAA) and more stringent privacy rules went in to effect in 2003. It included -

- National standards for medical records.
- Patient's right to see his own medical records.
- Right to know how his records are used and disclosed.<sup>9</sup>

There is an urgent need to bring an act to have uniformity in preparing and maintaining the medical records in our country. Enacting and implementation of such act will have positive effects on the health care sector as well on the national health policies and programmes.

### **Conclusion**

Medical records are the integral part of medical practice/ medical profession. These records are important documents for the doctor, to the patient and to the society in general, more so in situations like medical emergencies, negligence suits, medical researches etc. In the present days of consumer awareness and litigation suites, they help the treating physician to prove that he / she has used proper care and skill while treating the patient. Maintaining and preserving them in a proper and methodical way is the responsibility of the concerned doctor. They also form medical database of the region in particular and country in general useful while tabling health policies. Data can be made available instantly to the treating doctor, which can be life saving in critical medical conditions like drug hypersensitivity, comatose patients etc.

Lastly in the present digital era every effort shall be made to computerize the medical

records, which are fairly well protected for the purpose of safety and easy retrieval. It will save space and labour by eliminating paper based records. Remember that honest and best maintained records will save you from crisis and claims not just once but all the times.

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