WORLD JOURNAL OF PHARMACEUTICAL RESEARCH
SJIF Impact Factor 8.084
Volume 10, Issue 6, 1832-1838. Review Article ISSN 2277– 7105

# MEDICAL RECORDS

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Article Received on
18 April 2021,

Revised on 8 May 2021,
Accepted on 27 May 2021

DOI: 10.20959/wjpr20216-20695

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## ABSTRACT

Medical records are the document which records, documents and chronicles patient history, medical examination, diagnostic test results, treatment advised, pre and post operative care. It also supports doctors about correctness of treatment. Medical records are most important aspect in medico legal cases which determines the outcome of the medico legal cases. In India maintaining and preserving medical records is in initial stages so it is important to know all the aspects about medical records. This article focuses on various aspects of medical records their importance, maintenances, preservance and disposal.

**KEYWORDS**: Disposal, Medical records, maintainance, medico legal.

## INTRODUCTION

A proper and well equipped medical record is beneficial for both practitioners as well as patients. it is also very important for doctor to maintain the proper documentation of management of patient under his care.[1]

Maintaining proper medical records has now evolved a lot and has been given a lot of

importance as well. It helps medical practioners to prove that the treatment carried was appropriate and properly managed in medico legal battle or medical negligence. Maintaining proper record is the only way to prove .Medical records provide valuable information and are the source to know the facts and truth.

The management and preservation of hospital records in India needs to be updated.[1]The inadequate data regarding basic health brings difficulties in formulating and providing of resources that are available for patients care and prevention of disease. It is very much recommended to improve the efforts made by institution, hospitals, and all practicing clinicians to upgrade and improve the standard of maintenance and preservation of medical records.

In this article we will discuss and focus on various aspects of medical records management.

**Objectives**

**Medical**

1) To maintain the record of patients and care and management given to them.
2) To maintain continuity in the evaluation of patient's treatment.[5]
3) Evaluation of drug therapy and cost accounting for follow up patients.[5,7]
4) Provide data for use in medical education and clinical research.

**Legal**

1) Assist in protecting legal interest of patient, Hospital, and practitioner responsible for patient
2) To document communication between patient, doctor and any other health care professional who contributes in patient's care
3) Documentation for reimbursement.
4) Required in professional negligence, third party claims under health and accident insurance
5) Required in workmen's compensation Act.[5,7]

**Administration**

1) For cost accounting
2) To reply t RTI queries (right to information)[7]

**Maintainance of Medical Records**

Following guidelines have been given to maintain the records.

- Medical records for indoor patients should be maintained for a period of 5 years from the date of commencement of treatment.
- Medical Records for outdoor patients should be maintained for 3 years from the date of commencement of treament.[1,4,7]
- For income tax purpose for 7 years.[1]
- for mentally retarded patients record should be maintained till hospital or institution is working
- Record for MLC cases should be maintained for 30 years
- MTP records for 5 calendar years.[9]
- USG records for 2 years
- 21 years for neonatal patient.
- records given to patient on request should be given within 72 hours
- efforts should be made to computerize the medical records for easy and quick retrival.
- Medico legal records till supreme court decision is given.[4,6]
- Pediatric major surgery records for 25 years
- Medical documents can be published after 50 years and routine documents after 6 years.
- Non MLC x-ray films opd-upto 2years.[6,8]
- Ipd upto-5years.[6,8]

**Certificate Issuance**

When issuing a medical certification identification marks should be mentioned (at least one mark) one certificate.

- One copy should be given to him.
- Maintain a register of medical certificates.
- Signature/thumb impression of patient on both copies.[1]
- Full address.[7]
- Period of illness should be mentioned.
- It should be on institution or doctor letter pad.[1]

**Prescription**

Prescription should be on OPD paper or institution or hospital letter pad of doctor.

It must contain-patient's Name, age, sex, full address and hospital or doctors name.

Drug should be written properly with dose frequency, duration in days, total quantity.

Also prescription should have signature, name, date an time at which it is issued.[1]

**Discharge Card**

Consultant in charge should fill or supervise the discharge card all the necessity information like admission date, investigation, treatment given in detail and advice should be written.

Discharge card is many of the times incomplete or not in detailed so it is important to fill it completely.[1,4]

**Corrections and alteration of records**

1) Medical notes as far as possible should not e overwritten.
2) If changes are needed cancel the whole statement.
3) Sign should be made below the if changes are made and also date and time should be mentioned.
4) Retrospective notes should not be altered. Additional note should be mentioned near it.
5) More room or skipping lines should not be done while writing notes as it can lead to tampering or adding anything to it.
6) Personal identification correction has to be made with affidavit attested or 1st class magistrate.[1,4]

**ACCESSIBILITY AND ISSUING OF RECORDS**

1) Medical records belong to hospital and medical practitioner.[1,4,10]
2) Records of patient are confidential and cannot be submitted without prior permission of patients.(except for eg. medico legal case).[1,4]
3) Patients and their legal authority can have access to their own records
4) Other medical practitioners have the right to access the records if they are involved in the treatment or care of patients
5) Medical records are summoned in courts in cases like accidents, medical negligence, crimes.[1,4]
6) Doctors are allowed not to produce medical records to police if warrant is not issued.[1]

**MEDICAL AND MEDICOLEGAL DOCUMENTS**

- Medical Certificate.
- Fitness Certificate.
- Birth certificate.
- Death certificate.
- MLC report.
- MLC register.
- Injury report.
- MTP Form c.
- USG form F.
- Disability certificate.
- Operative notes.
- Lab reports.
- Referral notes.[5,6,7]

**Discarding or Disposing Medical Records**

1) Public notice should be given of destroying the records in national newspaper and in one local newspaper mentioning specific date and up to which destruction will be done.
2) Time period of 1 month is given to take away records for those who want the records with written consent.[1]
3) Following records are not destroyed like.

1) In case of litigation.
2) Future trouble is involved.
3) Mentally retarded patient.
4) Paper records are to be destroyed by burning, shredding, pulping and pulverizing.[3,6,8]
5) Microfilms are to be destroyed by recycling or pulverizing.
6) CD's and DVD's are to be destroyed by shredding or cutting.[3]

**Manual or hard copy of records**

1) Consent document should be maintained in hard copy.
2) Referral to doctor also needs hard copy.
3) In case of police or legal complaint hard copy is required.
4) Fitness certificate should be on hard copy.[1]

**Storage and Preservation of Medical Records**

1) The medical records storage needs lot space and room to keep it properly.
2) Damage to documents of records can happen like paper gets torn, dirty, weak, discoloration.
3) Loss of records can happen during shifting.[1]
4) Damage due to external weather conditions or insects.
5) Records should be kept properly in classified manner in different section.
6) Record should be handled with proper care while shifting.[1]

**HIPPA (Health Insurance Portability And Accountability Act 1996)**

1) HIPPA was introduced in U.S.A. to improve portability and continuity of health insurance coverage in group and individual markets to fight waste, abuse and fraud in health insurance on 21/08/1996.[2]

**Aim's of Hippa**

1) To make easier for people to keep insurance policy.
2) To protect the confidentiality of health care information and control of administrative cost.
3) HIPPA provides privacy rules to protect Individuals identifiable health information which also affects day to day business operation of organizations that provide medical care and maintain personal health information.
4) HIPPA protects an individual's health information. This is called "protected Health Information"(PHI)[2]

**Benefits**

1) Covers only for accident.
2) Disability income coverage.
3) Liability insurance, including general liability insurance and automobile liability insurance.
4) Worker's compensation or similar coverage.[2]

**Hippa For India**

1) If HIPPA is in India there could be more business flowing from countries like U.S.A.
2) HIPPA compliant means added health care data protection and it adds value addition to country.

3) Rights of patients will be well guaranted.[2]

## OBSERVATION AND CONCLUSION

1) Medical records play very important role in hospital and patient management.
2) Medical records help medical professional to evaluate treatment and care and progress of patient.
3) It also helps in legal disputes and in medico legal cases.
4) Also medical records also help in giving useful data in medical research and education
5) It helps in the innovation and up gradation of treatment protocol.
6) Hence proper maintenance and completion of all medical records should be done in all hospitals/institution and medical practitioners.
7) Also training regarding maintenance and updating of medical records should be given as they are the only document which play vital role in medico legal cases and which can avoid any queries regarding.[1,7]
8) Medical records should be properly written and preserved to serve the intrest of doctors as well as their patient.
9) Also India might need acts like HIPPA which means added data protection and also guarantees right of patients.

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