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DOCUMENTATION OF MEDICAL RECORDS IN CONTEXT TO MEDICAL PRACTICE

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ABSTRACT

Proper documentation of medical record promotes patients' and physicians' best interests for many reasons. Recording all relevant data of a patient's care helps physicians monitor what's been done, and curtails the risk of mistakes scrambling into the treatment process. Systematic medical records document basic facts about the patient's health care delivery system, including who did what, and what results occurred. Improper documentation on the other hand may invite medical litigation at any point of time. Sound record keeping also plays a role in quality assurance practices; hence medical litigation can be avoided.

KEYWORDS: Medical record, medical litigation, Documentation.

INTRODUCTION

The terms medical record, health record, and medical chart is used somewhat interchangeably to describe the systematic documentation of a patient's medical history and care, time to time within one particular health care provider's jurisdiction.[1] The medical record includes a variety of types of 'notes' entered over time to time by health care providers, recording observations, administration of drugs, surgical interventions, orders for the administration of drugs and test results, etc. The maintenance of complete and accurate medical records is a requirement of health care providers and is generally enforced as a licensing prerequisite.

Medical records comprise of various documentary reference of the care and treatment particulars provided to the patient.[2,3] It is the only valid data available regarding the patient treated by the health care professional, either as a general practitioner or as a hospital-based medical officer, irrespective of whether private or government origin. It is mandatory that all health care professional should maintain the medical records of the patient examined/and treated by them on outpatient basis or as an inpatient case admitted in the hospital. Such records not only are obligatory in the interest of adequate medical care, but they may also be called upon in the court of law, later on for evidence. Thus, the medical records encompass routinely the *who, what, where* and *when* of the patient care in the hospital. Customarily, there is a separate department in most of the hospitals with trained/qualified personnel maintaining these formalities. Such department is called *Medical Record Department*, often referred to as MRD.

Medical malpractice litigation is built around the medical record, which provides the only objective record of the patient's condition and the care provided. Records are particularly important for a physician's defence. It is the physician's responsibility to keep the medical record. The patient has injuries to show the court; the physician or other health care provider has only the medical records to prove that the injuries were not due to negligence. If the record is incomplete, illegible, or incompetently kept, this is the physician's failure.

Literature Review

Types of Medical Records

Broadly, medical records are of two types, viz., (i) personal and (ii) impersonal used for research or statistics.

They can also be further divided as: (i) paper records (hard copies) and (ii) computerized records.[6]

Importance of Medical Records

A medical record documents a member's medical treatment, past and current health status, and treatment plans for future health care and is an integral component in the delivery of quality health care. Besides individual interest it has some other purposes as follows:

- Quality of patient care/continuity of medical care.
- Medical education.
- Research.

- Efficient administration.
- Communication devise between multidisciplinary team/ group practice.
- Medical audit.
- Medical tourism (transmission).

Contents of Medical Records

The medical records should contain the following[2-5]

- Particulars of the patient, e.g. name, age, sex, address brought by (name of the person who has brought him to the hospital), referred by, etc.
- Date and time of arrival and examination in hospital.
- Date and time of admission and discharge from hospital.
- The present complaints by the patient at the time of arrival.
- Relevant past history.
- Relevant family history.
- Relevant personal history.
- Details of physical examination done by the physician and the findings.
- Laboratory examinations and other investigations advised for and their reports, e.g. blood sugar, blood urea, X-ray, etc.
- Treatment given.
- Duly completed consent form for each and every procedure/s and operation/s performed.
- Prognosis chart.
- Details on cross consultations/references to other specialist doctor/s and his/their opinions and reports.
- In case of discharge from hospital—the condition at the time of discharge.
- Maintain discharge card with discharge summary providing brief information on admission particulars, investigations done, treatment given and follow-up advices given at the time of discharge to the patient. If the patient is referred by a *family* physician a *copy* of the same may better be marked to him as well with all instruction to be carried out by him on discharge from the hospital.
- If the discharge is *against medical advice* (AMA), then record accordingly, and take signatures of patient and/or his/her guardian/relative with whom patient leaves the hospital). Copy of *Police Intimation Letter* with all details of information given to the

police in every medicolegal case (at admission and/discharge on recovery/on death of the patient).

- In the case of death, note down the cause, date and time of death.
- Name and signature, address, medical council registration number/license of doctor.

In Medical Cases

In addition to routine contents mentioned above, certain additional precautionary measures are to be observed in all medical cases and they are.[2-5]

- The casualty MO must ensure that all the registers are numbered and duly certified.
- All pages of the record should be serially numbered.
- On all pages, laboratory reports and X-ray plates, word MLC should be marked. It should be so even on requisition for laboratory investigations and X-ray.
- All the entries should be correct and in detail and in sequential order.
- Abbreviations should be avoided.
- All corrections done should be initialled.
- All medicolegal documents should be prepared in duplicate.
- All communications with police should be in writing only and copy of all such correspondence should be attached to the case papers/file.
- There is no time limit as to when the medicolegal case records can be destroyed by the hospital.
- All records should be kept under lock and key.
- All entries in hospital papers should carry the signature and name of the doctor concerned.

Property Rights of Medical Records

The medical records and also X-ray plates are property of the hospital. The patient buys the expertise and the treatment rather than the hospital records and the X-ray films. All records are kept in the hospital for the benefit of the patient, doctor and the hospital. In no situation does a patient own his/her records, though he/she has a legal right to the use of the information contained therein.[3,4]

Patient's Rights

Usually, the patient is given a copy of the investigation reports, treatment advised and the discharge summary. Patient has the right to know the details in his/her records and is entitled

to get a copy of his/her hospital record on discharge, on payment of cost of reproduction. In case of death of the patient the next of kin can have the hospital records. However, if in the opinion of the doctor, making the records available to the patient would be harmful or dangerous to patient (professional or therapeutic discretion); he/ she may avoid issuing the records to the patient. The records cannot be used by the hospital or the doctor, for publication, without the patient's consent.

Medical Records in Court

When the hospital/doctor have been summoned by the court, requesting for production of the case records, they have to be produced before the court without failure.1,4 The court may require the medical records in all alleged *criminal cases* such as assault, burns, criminal abortion, dowry deaths, injury, murder, poisoning, rape, suicide, and vehicle accidents, etc. In some of the *civil cases* also medical records may have to be procured by the court. Workman's compensation cases, insurance claims cases, malpractice/negligence suits, cases of "contested Will", disputed paternity cases, etc. constitute some of the examples of civil cases required by the court.[5] Information about the health of a patient given to the law courts is covered under *privileged communication* and the doctor in *immune* to the charges of breaking professional secrecy under such circumstances.[2,3] However, hospital should arrange for photocopying every page of the case file prior to taking them to the court, as the court usually retains the records.[2,5] Whenever court needs the document to be retained, hospital doctor should demand a receipt from the court specifying clearly the total number of pages withheld by the court.

Submission of Records to Government and Other Agencies

On several occasions' government and other agencies such as LIC place a request to supply the information about a patient treated in the hospital. As per law, they are not entitled to this information without the written consent of the patient and hence the hospital should not comply with such requests. However, information about name, age, sex, date of admission and date of discharge, etc. can be given as these are not confidential.

Storage and Disposal of Medical Records

Storage and disposal of medical records is an essential matter for every hospital. Ever since computerisation, medical records have become simple. Data can be fed into the computers and preserved easily in computer files or on CDs and using CD writer. Such documents can be preserved for any length of time as CDs require minimum space for preservation unlike

hard copies/ printed or typed documents of a case. However, following scheme is usually adopted in different types of cases

- Non medicolegal Cases (Non-MLC)

– The OPD records have to be preserved for a minimum
of 3 years, when they can be destroyed.

– The IPD records have to be preserved for a minimum of 5 years.

- Medicolegal Cases (MLC)

– There is no specified time limit and hence they cannot be destroyed and must be made available as and when needed.

Medical Records and Research

It must be remembered here that no medical records can be prearranged or provided to any of the research workers without prior written consent of the patient and an approval of hospital ethical committee.

Problems of Medical Records

While physicians acknowledge the importance of the medical record to both patient care and medical education, there is increasing awareness that the record along with our current system of processing medical information is seriously deficient. The extent of these deficiencies has serious implications for the usefulness of current practices of medical record audit. Followings are the main problems.

- Legibility (hand writing, typed, computer generated)
- Retention and preservation
- Confidentiality
- Privileged communication
- Storage (space)
- Uniformity
- Utility
- Quality
- RTI
- Terminology/Abbreviations
- Retrieval (timing)
- Medico-legal reporting

One of the biggest problems of medical records amongst those is the illegible handwriting. To find a cure for this problem, the hon'ble Punjab and Haryana High-Court has reminded the doctors that they should not scrawl on documents for self-consumption; and has even asked the directors of health services in Punjab, Haryana and Chandigarh to ensure that the element of legibility is injected into their handwriting.[7] It turns out that all those jokes about doctors' scrawl are not funny at all. Doctors' illegible handwriting causes 7,000 deaths in the US every year and another 1.5 million Americans report minor adverse reactions—be it diarrhoea or rashes—or even death. A movement has begun in Mumbai asking the medical fraternity to write prescriptions in "separate, capital letters". The brainchild of an NGO called the Forum for Enhancement of Quality in Healthcare (FEQH) and the Quality Council of India (a semi-government organization accrediting services), the first meeting on the issue held last week was attended by representatives of medical associations and NGOs. The campaign borrows from QCI's hospital accreditation system called the National Accreditation Board for Hospitals (NABH), which requires prescriptions to be written in capital letters.[8]

Ease of Retrieving Medical Records and Confidentiality

Medical records should be organized and stored in a manner that allows easy retrieval and are to be made available as and when required. Computerization of medical record can help by easy and fast retrieval and reduced space requirement. Medical records are stored in a secure manner that allows access to authorized personnel only and is protected against unauthorized or inadvertent disclosure. The handling staff should receive periodic training in confidentiality of member information. Medical records are safeguarded against loss or destruction and are maintained according to state requirements.

Preservation of Medical Record

The records should be kept under lock and key, in the custody of the doctor concerned or may be kept in a Central Record Room, in hospitals where such facility is available; as per the institution's rules. Most hospitals have a policy of maintaining all medico-legal records for variable periods. However, as per law, there is no specified time limit after which the MLR's can be destroyed. Hence, they have to be preserved permanently. In view of the multitude of cases against the doctors under the Consumer Protection Act, it is advisable to preserve all the inpatient records for a period of at least 5 years and OPD records for 3 years. As per the MCI provisions under Regulations, 2002, every physician shall maintain the medical records

pertaining to his/her indoor patients for a period of 3 years from the date of commencement of treatment in a standard Performa laid down by MCI. If any request is made for medical records either by the patients/authorized attendants or legal authorities involved, the same may be duly acknowledged and documents shall be issued within the period of 72 hours.[9]

Pndt Act and Medical Record

Section 29 of the PNDT Act, 1994 requires that all the documents be maintained for a period of 2 years or until the disposal of the proceedings. The PNDT Rules, 1996 requires that when the records are maintained on a computer, a printed copy of the record should be preserved after authentication by the person responsible for such record.[10]

Provisions Under the Rti Act, 2005

Under this Act every citizen has got the right to obtain a copy of medical records. Section 3 of the RTI Act confers right to information to all the citizens and corresponding obligation under Section 4 on every pubic authority to maintain record so that the information sought for, be provided.[11] In the case of T.S.R, Subramanyam, their lordships of Hon'ble Supreme Court settled that nothing should be done by oral instructions and the practice of giving oral directions and directions by administrative superiors and public executives, would defeat the object and purpose of RTI Act and shall give room for favouritism and corruption. Division Bench clarified that in view of the above, every decision taken for the purpose of treatment of a patient or instruction issued by the doctors to their subordinates, must be converted in writing indicating the name of doctors. Court further added that "But, all these rights generally declared either in favour of citizens of this country or parties to the prosecution or litigation are only subject to certain reasonable restrictions either imposed by law or even by Rules, conventions, precedents, etc. and one such restriction that is imposed regarding the issuance of a copy of the Post Mortem Certificate, which is the subject matter of the above petition, is Rule 591 of the Madras Police Standing Orders which is positive to the effect that 'originally the Post Mortem Certificate has to be sent by the Medical Officer direct to the Magistrate concerned in a sealed cover, the police being given a copy of it immediately after the examination is over' thus setting the procedure as to the issuance of the Post Mortem Certificate and therefore revoking such procedures established by law, this Court or any other court for the matter is not entitled to order to issue the copy of the Post Mortem Certificate particularly when the investigation into the case registered regarding the death in encounter by the respondent Police is still pending finality of decision by the police themselves and

since the field is occupied entirely by the respondent, as it is held on the part of the Honourable Apex Court in general regarding any criminal case registered which is under investigation that the Courts are little or no chance to order such applications, citing the general provisions of law or even the Constitutional provision which would set the outer line without specifying anything which has to be decided in the manner provided under the law on the specific subject and the propositions held by the upper forums of law do not help the case of the petitioner".[12]

Improved Outcomes

Keeping proper medical records improves patients' clinical outcomes once they leave the hospital, according to a November 2006 report by the Ontario Ministry of Health and Long-term Care. About 20 percent of patients experience adverse events after discharge, including drug reactions, infections and procedural complications. Many of these problems result from delayed or incomplete information given to subsequent health care providers. The ministry's report also cited a 2003 study that found patients with significant gaps in their health records spent an average of 1.2 hours longer in emergency rooms.[13]

Malpractice Defence

It is indeed necessary for doctors to remember that their ignorance can't be the defence in the court. Therefore, there is a need to make a culture to keep medical records systematically. Proper documentation is the best defence against a negligence claim. For court, if a procedure doesn't appear on a chart, it hasn't been done. Physicians must ensure that all X-rays and other lab work are done, and followed up with the patient. This step minimizes the risk of a missed diagnosis. Good record keeping is also vital in dealing with patients who are abusive, decline to follow advice, or present the same complaint without improvement.

CONCLUSION

In conclusion, it can be suggested that the members of the legal profession, our law courts and everyone concerned should also keep in mind that a man in the medical profession should not be unnecessarily harassed for purposes of interrogation or any other formality. He/she should not be dragged during investigations at the police station which should also be avoided as far as possible.

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