Review Article

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Medical Record

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Abstract

Medical records are documents of a Health Institution and Medical Records department is the back bone of Health information system. Medical records can be used as a personal or impersonal document. Personal document is confidential and should not be released without the consent of the patient except in some specific situations. The impersonal documents have been used for research purposes as the identity of the patient is not revealed. As medical records form an important part of the management of a patient, so it is important for the doctors and medical establishments to properly maintain the records of patients. As we can see, medical record is an important component of the healthcare information system. As a patient, it is often time-consuming to complete intake forms, but they are very valuable pieces of information to hospital as well as for doctor. As a patient-focused approach, medical record is advantageous to both patients and providers; we must adopt problem oriented medical record (POMR) in present situation.

Keywords: Medical records; POMR.

Introduction

Medical record, health record, and medical chart are used somewhat interchangeably to describe the systematic documentation of history of medical illness and treatment what is given to patient by doctor.

Medical records are documents of a Health Institution and Medical Records department is the back bone of Health information system. Medical Record or health record or medical chart is a systematic documentation of a patient's medical history and treatment. Medical records speak volumes on and about, inception and progress of Hospital, retrospective and prospective statistical analysis, trends of cases admitted to the hospital etc. Medical Records must be meticulously and systematically compiled, preserved and protected for the benefit of hospital, doctor and patients. Good medical Records provide relevant data base of medical and scientific knowledge and help the Government while planning and allocation of budget for health care system of the country. The need of hour is to make uniformity in storing Medical Records by various Acts.

Medical records can be used as a personal or impersonal document. Personal document is confidential and should not be released without the consent of the patient except in some specific situations. Whereas impersonal document loses its identity as a personal document and patient permission is not required. These records could be used for research purposes by institution or by doctor. The hospital is legally bound to maintain the confidentiality of the personal medical records Confidentiality is an important component of the rights of the patient. So patient can claim negligence against the hospital or the doctor for a breach of confidentiality. The significance of documenting patient care accurately, comprehensively, concisely, objectively, contemporaneously or

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within reasonable time, and legibly cannot be overemphasized however; there are certain situations where it is legal for the authorities to give patient information like during referral, when demanded by the court or by the police on a written requisition, or when demanded by insurance companies as provided by the Insurance Act when the patient has relinquished his rights on taking the insurance, and when required for specific provisions of Workmen's Compensation cases, Consumer Protection cases, or for Income tax authorities. As medical records form an important part of the management of a patient, so it is important for the doctors and medical establishments to properly maintain the records of patients[1].

The impersonal documents have been used for research purposes as the identity of the patient is not revealed. Though the identity of the patient is not revealed, but research team must maintain privacy to patient records and a cause of concern about the confidentiality of information. Historically, such research has been exempted from an ethical committee and researchers have not been required to obtain informed consent from patients before using their records. There are no definite legal guidelines in India regarding how long to retain medical records in hospital or clinic. The hospitals follow their own pattern retaining the records for varied periods of time. Under the provisions of the Limitation Act 1963 and Section 24A of the Consumer Protection Act 1986, which dictates the time within which a complaint has to be filed, it is advisable to maintain records for 2 years for outpatient records and 3 years for inpatient and surgical cases

Categories of Medical Records

The different categories of medical records are as follows

- Certain records must be given to the patient as a matter of right and without charging any fee like discharge summary, referral notes, and death summary in case of natural death. Hence, these have to be given to patients who leave against medical advice. The hospital bill cannot be tied up with these sensitive documents that are necessary for continuing patient care. Thus, the above documents cannot be legally refused even by doctor when the hospital bill has not been paid.
- Certain records may be issued after the patient or authorized attendant fulfils the due requirements as fixed by a hospital. This requires a formal application to the hospital requesting for the records and it is necessary that the hospital bills are cleared and the necessary processing fee has been paid. Such documents include copies of inpatient files, records of diagnostic tests, operation notes, videos, medical certificates, and duplicate copies for lost documents. It is important that the duplicate copies should be marked appropriately.
- Certain records cannot be given to patients without the requisition of the Court or legal authority like outpatient file, inpatient file, and files of medico-legal cases including autopsy reports cannot be handed over to the patient or relatives without the direction of the Court. But if these medico-legal cases are being referred to another centre for management, copies of records could be given. However, X-rays are given only after a written undertaking by the patient or relatives that these will be produced in the Court as and when required.

Medical Council of India View on Medical Records

The issue of medical record keeping has been addressed in the Medical Council of India Regulations 2002 guidelines answering many questions regarding medical records. The important issues are as follow….

- Make indoor records in a standard proforma and maintain for 3 years from commencement of investigation and treatment.
- Medical records documents ask by patient or authorized attendant should be issued within 72 hours.
- Maintain a register of certificates with the full details of medical certificates issued with at least one identification mark of the patient and his signature. Efforts should be made to computerize medical records for quick access and issue under hospital information system.

How Long Medical Records should be preserved?

There are no definite legal guidelines in India regarding how long to retain medical records in hospital or clinic. The hospitals follow their own

pattern retaining the records for varied periods of time. Under the provisions of the Limitation Act 1963 and Section 24A of the Consumer Protection Act 1986, which dictates the time within which a complaint has to be filed, it is advisable to maintain records for 2 years for outpatient records and 3 years for inpatient and surgical cases. The Medical Council of India guidelines also insist on preserving the inpatient records in a standard proforma for 3 years from the commencement of investigation and treatment. The records that are the subject of medico-legal cases should be maintained until the final disposal of the case even though only a complaint or notice is received. It is necessary that the Government should frames legal guidelines for the duration for which medical records are preserved by the hospitals so that hospitals are protected from unnecessary litigation in issues of medical records.

The provisions of specific Acts like the Pre Conception Prenatal Diagnostic Test Act, 1994 (PNDT), Environmental Protection Act, etc. necessitate proper maintenance of records that have to be retained for periods as specified in the Act. 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 said 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.

Ownership of Medical Records

An important issue of dispute between the patient and the treating hospital is about the ownership of the medical records. Medical records are the property of the hospitals and it is the responsibility of the hospitals to maintain it properly. The hospitals and the doctors have to be careful with medical records as these can be stolen, manipulated, and misused for malafide reasons by any interested parties. Hence, the records must be kept in safe custody. It is the primary responsibility of the hospital to maintain and produce patient records on demand by the patient or appropriate judicial authority. However, it is the primary duty of the treating doctor to see that all the documents with regard to management are written properly and signed. An unsigned medical record has no legal validity in court. The patient or their legal heirs can ask for copies of the treatment records that have to be provided within 72 hours. The hospitals can charge a reasonable amount for the administrative purposes including photocopying the documents[2]. Failure to provide medical records to patients on proper demand will amount to deficiency in service and negligence on part of hospital.

Whom to Release Medical Record Information

The major consideration bearing upon disclosure and release should be based on the nature of the information requested and the person or agencies requesting the information.

Majority of the request will come from

- The provider and the relatives.
- The member of the medical staff, other physicians and hospitals concerned with the management of illness of patients.
- The third party payers, government and other agencies.

In these cases the confidential information may be released with appropriate authorization. In this, consent generally may be given by the patient himself or by legal authority representatives. In minor, parent or guardian authorised by court can demand for medical record[3]. The consent of the patient is not required when a subpoena or an order of a court directs that records be produced.

Without the consent of the patient, the hospital may allow physicians to consult its medical records for purposes of study, statistical evaluation, research and education. If the records are requested for such purposes by persons other than the hospitals staff or an affiliated organization it is wise to obtain the approval of the administrator or of the medical record committee.

The hospital shall not disclose to an insurance company any patient identifiable medical record information maintained by the hospital unless the request in accompanied by the patients authorization for disclosure of information necessary to process the insurance claim.

Summoning Medical Records by Courts

Medical records are acceptable document as per Section 3 of the Indian Evidence Act, 1872 amended in 1961 in a court of law. These are considered useful evidence by the courts as it is accepted that documentation of facts during the course of treatment of a patient is genuine and unbiased. Medical Records that are written after the discharge or death of a patient do not have any

legal value or erasing of entries is not permitted and is questionable in Court. In the event of correction, the entire line should be mentioned and rewritten with the date and time and put signature after correction.

Medical records are usually summoned in a court of law in the following condition……

- Criminal cases for proving the nature, timing, and gravity of the injuries. It is considered important evidence to corroborate the nature of the weapon used and the cause of death.
- Road traffic accident cases under the motor vehicle act for deciding on the amount of compensation.
- Labour courts in relation to the Workmen's Compensation Act.
- Insurance claims to prove the cause and duration of illness and the cause of death.
- Medical negligence cases these can be in criminal courts when the charge against the doctor is for criminal negligence or under the Consumer Protection Act for deficiency in the doctor's or hospital's services.

It is usual to summon a doctor to appear in court to testify and to bring all the medical documents concern with patient or case. When the court issues summons for medical records, it has to be honoured and respected as it is a constitutional obligation to assist in the administration of justice. The records can also be produced in court by the medical records officer of the hospital. If the doctor is required to be present for giving evidence based on the medical records, he has to be present in the court to give evidence. However, if the records are required for continuation of the medical treatment of the patient, copies can be kept by the hospital.[4]

Legal Issues of Medical Records

There have been many judicial decisions pertaining to medical records from various courts in India and some of the important cases in general are discussed over here …..

Not producing medical records to the patient prevents the complainant from seeking an expert opinion. It is the duty of the person in possession of the medical records to produce it in the court and adverse inference could be drawn for not producing the records. The State Commission held that there was negligence as the case sheet did not contain a proper history, history of prior treatment and investigations, and even the consent papers were missing. The State Commission held that failure to deliver X-ray films is deficient service. The patient and his attendants were deprived of their right to be informed of the nature of injury sustained.

The National Commission had held that there was no question of negligence for failure to supply the medical records to patients unless there is a legal duty on part of hospital to give the records and alleged hospital had provided a detailed discharge summary to the patient. However, the Bombay High Court held that doctors cannot claim confidentiality when the patient or his relatives demand medical records. Under MCI Regulations 2002 bill it has been held without confusion that the patient has a right to claim medical records pertaining to his treatment and the hospitals are under legal obligation to maintain them and provide them to the patient on request.

The allegation of not informing the possibility of vocal cord palsy to patient or guardian was negated by the detailed written medical record showed that it was explained properly and consented before procedure and allegation of the patient regarding negligence of the doctor concern with information was rejected.

The hospital was held vicariously liable for the negligent action of the doctor on the basis of the bill showing the professional fees of the doctor and the discharge certificate under the letterhead of the hospital signed by the doctor. If medical record was manipulated or issuing tampered medical records need detailed examination in a civil as well as criminal court. The National Commission in another case held that the hospital was guilty of negligence on the ground that the name of the surgeon were not mentioned in the operation notes of patient though two surgeon were involved in operation procedure was said by attendant of died patient in court.

Conclusion

As we can see, medical record is an important component of the healthcare information system. As a patient, it is often time-consuming to complete intake forms, but they are very valuable pieces of information. Some are important for record-keeping, some are important for identification, but all can be potentially lifesaving in emergency situations. With the advent of computer technology, medical records can be updated easily and made

available nationwide further increasing their effectiveness. Medical Record will be problem oriented medical record (POMR). As a patient-focused approach, POMR is advantageous to both patients and providers. The problem is that many doctors avoid using it, arguing that it's too cumbersome, has many data synthesis restrictions and requires one to take a lot of notes. But we must adopt problem oriented medical record in present situation.

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