Medical Records - its Importance and the Relevant Law

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Abstract

Medical Records is an important document meant basically for recording the treatment procedure for a patient. It is important both for the patient, as well as, for the doctor. In 1995, after the Honourable Supreme Court gave the decision that Doctors also come under the purview of the Consumer Protection Act, 1986 the medical records have become an important aspect of the written evidence.

It is important for doctors to realize that Medical Records have become the single, crucial and effective weapon in their hands to counter the false claims of the consumers, when they file a case for compensation.

Outpatient treatment and inpatient management should be documented completely by the consultant. All preoperative instructions, prescriptions and consent for invasive procedures and surgery should be recorded carefully.

Introduction

Medical Records are basically the daily orders related to the indoor patients including the few outdoor sheets. These include the findings on the patient, who have visited the doctor on that day and drug prescription which have been continued or changed. Dosage and the drugs used must be legibly written.

What is the importance of the Medical Records ?

The answer can be simply divided into four parts:

1. For the consultant himself
2. For those consultants who get referrals or who have been attending the patient at the request of the family or general physician's.
3. For the nursing staff to carryout the daily instructions regarding the administration of Medicines.
4. For the legal purpose, making the health personnel in charge responsible for the negligence if anything goes wrong.

1. For the consultant

a. *Daily notes*: Medical Records are the daily orders, which the consultant has to refer time and again during the course of the treatment until the patient is completely cured of the disease. Even afterwards it serves as an important document for further treatment and follow-up.

b. *Operative notes*: To consult the operative events and treat the patient accordingly. To plan for the next operation. To know any anesthesia problems met with. To plan for the operation of the next eye.

c. *Follow up*: Even after the treatment part is completed for the follow up of the patient as and when the patient comes for the treatment. Even more relevant when the patient is examined by another doctor.

d. *Data*: The Medical Records are, of course, the most important of all the documents a patient is having, despite in this age of computerization where the data is stored in the computers itself the need of the hard copy can not be ignored.

2. Other Consultants

According to the medical ethics if a patient is to be referred to other consultant, the original one (consultant) should

- Write down the original history in detail.
- His whole of the medication.
- What were his findings?

To help the next doctor in reaching to a conclusive diagnosis and further to treat the patient accordingly.

3. For the Staff

The staff members get their instructions from the

daily orders regarding which drugs are to be given and the frequency of each of them. They are directed by the orders from the Medical Records.

4. For the Law

Law requires proper maintenance of case sheets. These are the single most important document that can be used in medico legal cases. In few cases these documents may serve as effective alibi for the patients.

Medical Ethics

Law is very clear regarding the Medical Records and the value of it. But let us first see the guidelines of the ethics of our medical council.

1. Medical Records are the single most important document to prove the innocence of the doctor concerned and that the consultant under the medical ethics are supposed to give the case report to the patient on demand. All the details regarding the management of the patient should be documented correctly in the Medical Records.
2. Accusation of malpractice and unethical code of conduct can be made against the concerned consultant if he fails to provide the patient with all the details and the case sheets of his admission, operation and the postoperative medication along with the dosage. All the prescriptions should have the date and signature of the physician.

Also according to the Consumer Protection Act, 1986 and its amendment in 1993 which brought the doctors also under its purview following the landmark decision of the Honourable Supreme Court, the Medical Records have become very important. Because every time the patient goes to the ***consumer forum*** asking for compensation on the ground of medical negligence, Medical Records are the crucial documents to refute the allegations.

In view of this, every doctor has to maintain Medical Records of every patient, otherwise they could not prove their innocence in the court of law. Few Examples,

1. Ragunath Raheja V/S. Maharastra Medical Council

Bombay High Court held that when a patient or his near relatives demand copies of the Medical Records from the hospital or the doctor, it is necessary for the hospital authorities and the doctors concerned to furnish copies of such Medical Records to the patients or to his near relatives. The hospitals and the doctors cannot claim any secrecy or confidentiality in the matter of the copiers of the Medical Records.

2. The mysterious death of Union Power Minister Shri P.R.Kumaramangalam at a young age of 48 has made medical science a center of the media attention. As per newspaper reports a wrong diagnosis at a hospital had resulted in the tragic death of the young Union Minister.
3. A patient had endophthalmitis following the surgery. Here the ophthalmologist has to prove:

- Asepsis of the Operation theatre.
- By the reports of the daily swabs, reports of the culture, if negative. Whether there is a microbiologist working or not.
- Details of the asepsis. What methods are being followed and whether they are approved by national bodies or not.
- The autoclaving facility of the hospital. The records of the autoclaving, the batch numbers etc.
- Preoperative assessment of the patients. All the records, hand written or otherwise, even the note made by the residents ultimately make the senior surgeon responsible for that, as it is his duty to supervise and the residents are there for the training.
- Intraoperative events. The procedure in proper detail. Any complication on table and the management of the complication, in detail. Batch number of the drugs used during the surgery.
- Postoperative care and the treatment. name and dose and concentration of the drug together with the frequency of the drug to be used during the day.

4. Patient has got operated and complains of bad vision one has to prove

- Preoperative notes.
- Explanation of the prognosis to the patients.
- Consent of the patient after the explanation of the prognosis.

If the case is a medico legal case the doctor is under a duty to furnish copies of the Medical Records and

the certificate to the police investigating the case on their demand.

Even otherwise if a patient demands for the Medical Records and the chronology of the treatment given during his stay or even during the period when he was under treatment as an outdoor patient, the doctor has to furnish all the details or else he could be suspected of playing a foul play. It becomes necessary therefore for the doctor to keep the records update, if he has kept the papers with himself.

In case of a government hospital, the daily orders and the treatment is written by the resident doctors. The unit head bears all the responsibility for the treatment orders that have been written in the case paper and hence is answerable to law for the same. It is indeed, taken for granted that the orders are as such from the unit head himself. But he is not responsible for the faulty procedure if done by a resident doctor.

Legal aspect of medical records

Hospital record is the property of the hospital or the doctor. It is a confidential information and could not be released without doctor's permission. Any information from the patient's medical records should be released on written request from the patient e.g. to employer or to insurance company.

Police authorities and court can summon medical records under the due process of law.

The Mumbai High Court has recently ruled that a doctor must provide copies of the patient's Medical Records to the patients on request and this should be remembered by all the doctors.

How long to preserve the medical records?

This has always remained a controversial point. Limitation period for filing a case paper is maximum up to 3 years under the Limitation Act (2 years according to the Consumer Protection Act). However, this limitation period starts only after the patient comes to know the effect of the alleged negligence on the part of the doctor. An extreme example can be given of the obstetrician who was sued by the child who was delivered by him and suffered birth injury after 21 years i.e within the 3 years the child becoming the major according to the law.

Maharashtra government has issued a resolution (referred G.R. No. JJH-29 66/49733) which states that OPD paper should be kept for 3 years, indoor case for a period of 5 years and in case of a medicolegal case for 30 years. This may form a guideline, but in a given case, discovery of negligence as mentioned above will always be crucial.(2)

Following the binding legal regulations, the tools (forms and application software) for evaluating the quality of documentation by regional specialists has been developed.

Kacprzak E, Michalak J, Wagrowska-Koski E et al described the results of three successive controls carried out in three voivodships during the third term of 1996 showed improved quality parameters (transparency and input of appropriate data) due to new pattern of medical documentation. Nevertheless, the key role in quality assurance of medical documentation is played by a regional specialists, equipped with suitable tools facilitating assessment of documentation kept by individual doctors.(3)

Conclusion

Records and documents properly kept can become defense shields for the doctors in the court of law. Hence proper maintenance of such records should form an essential element of good practice.

Therefore, the doctor should take every precaution to preserve the Medical Records of a patient. It will act as a passport to prove his or her innocence in any alleged medical negligence.

References

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