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CLINICAL STUDY

Management of Medical Records: Facts and Figures for Surgeons

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Abstract Medical records are the document that explains all detail about the patient's history, clinical findings, diagnostic test results, pre and postoperative care, patient's progress and medication. If written correctly, notes will support the doctor about the correctness of treatment. Inspite of knowing the importance of proper record keeping in India, it is still in the initial stages. Medical records are the one of the most important aspect on which practically almost every medico-legal battle is won or lost. This article discusses the various aspect of record maintenance.

Keywords Medical record · Law · Alteration · Maintenance

Introduction

A good medical record serves the interest of the medical practitioner as well as his patients. It is very important for the treating doctor to properly document the management of the patient under his care. Medical record keeping has evolved into a science. The key to dispensability of most of the medical negligence claim rest with the quality of the medical records. Record maintenance is the only way for the doctor to prove that the treatment was carried out properly. Medical records are often the only source of the truth. They are likely to be far more reliable than memory.

The management and preservation of the hospital records in Indian context present a very gloomy picture. Despite the intensive effort at national and international level, the fundamental health care needs of the population of the developing countries are still unmet. The lack of basic health data renders difficulties in formulating and applying a rational for the allocation of limited resources that are available for patient care and disease prevention.

It is recommended that more efforts should be made by the institutions/hospital managements, all clinicians and medical record officer to improve the standard of maintenance and preservation of medical records. In this article, we are discussing the various aspects of the medical record management.

Objectives of Maintaining Medical Records

1. Monitoring of the actual patient
2. Medical research
3. Medical/dental or paramedical education
4. For insurance cases, personal injury suits, workmen's compensation case, criminal cases, and will cases
5. For malpractice suits
6. For medical audit and statistical studies

Altering Medical Records

1. While writing the medical notes, as far as possible do not overwrite. If the change is needed, strike the whole

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sentence. Do not leave ambiguity. Make a habit of signing if change is made. Preferably put the date and time below the signature. Attempting to obliterate the erroneous entry by applying the whitener or scratching through the entry in such a way that the person cannot determine what was written originally written raises the suspicion of someone looking for negligent or inappropriate care [1].
2. Do not alter the notes retrospectively. If something written was inaccurate, misleading or incomplete then insert an additional note as a correction [2].
3. Entries in a medical record should be made on every line. Skipping lines leave the room for tampering with the records [1].
4. Amend on electric record by striking through rather than deleting and overwriting the original entry. After inserting the new note, add date, time and doctor name [3].
5. Correction of the personal identification data of the patient like name, age, father/husband name, and address should only be made on the basis of affidavit attested by notary or 1st class magistrate [3].

Who has Access to Medical Records?

1. Medical records are the property of the hospital or patient's medical practitioner. It is a confidential communication of the patient and cannot be released without his permission [1].
2. All patients have right to access their records and obtain copy of those records [1].
3. Patient's legal representative has the right to those records as long as patient has signed a release of records to accompany any request from the legal representative [4].
4. Other health care providers have the right to the records of the patient, if they are directly involved in the care and treatment of the patient [4].
5. Parents of a minor also have access to patient's medical records [4].
6. Medical records are usually summoned in a court of law in certain cases like-road traffic accident, medical negligence, insurance claim etc. [2].
7. The impersonal documents have been used for research purposes as the identity of the patient is not revealed. Though the identity is not revealed, the research team is privy to patient records and a cause of concern about the confidentiality of the information. Recently a need has been felt to regulate the need of medical research, effectively restricting the manner in which this type of research is conducting. An ethical review is required for using the patient's data [3].

Release of Records

1. Request for medical records by patient or authorized attendant should be acknowledged and documents should be issued within 72 h [3].
2. Maintain the register of certificates with the detail of medical records issued with at least one identification mark of the patient and his signature [5].
3. Effort should be made to computerize the records for quick retrieval [2].
4. Certain document must be given to the patient as a matter of right. Discharge summary, referral notes, or death summary are important document for the patient. Therefore, these documents must be given without any charge for all including patients who discharge themselves against medical advice [3].
5. Doctors are not under any obligation to produce or surrender their medical records to the police in the absence of valid court warrant [6].
6. A subpoena to produce clinical records is a form of court order. Failure to comply is in contempt of court and may be punished. Medical records which are subpoenaed are to be made over to the court and not to the solicitor who sought the subpoena [6].

Care while Issuing certain Medical Records

Prescription

The prescription should be preferably on the OPD slip of the institution or on the letter pad of the doctor. Drug company or chemist prescription pad should never be used. Prescription must contain—patient's name, age, sex, address and institution/hospital name. Prescribed drug should be preferably in capital letter or else clearly visible. One should mention its strength (especially in paediatric age group), its dose frequency, duration in days, and total quantity (number of tablets and capsules). Below the main drug, also mention other instructions of precautions and what to avoid. If any investigation is advised, do not forget to mention it on the prescription slip and call the patient after the investigation. If patient fails to keep follow up date and if then some complication occurs, then patient is also considered negligent (contributory negligence) [1].

Reports

All reports i.e. lab investigation, X-ray reports, ultrasound reports, computed tomography (CT-scan)/magnetic imaging resonance (MRI) reports, and histo-pathological reports should be issued by a qualified person. Biopsy report

should preferably be issued in duplicate so that the referring doctor/hospital can keep the original copy. If the pathologist does not give a duplicate copy the referring doctor should get it xeroxed and should be handed over to the patient.

Referral Notes

Always keep the carbon copy of referral note especially in case of critically ill patient. Referral note should mention the date and time of writing the note. Also write the treatment given.

Discharge Card

Consultant in-charge should himself fill or supervise the discharge card. Condition of the patient on the admission, investigation done, the treatment given and detail advice on discharge should be written on discharge card. Operation notes if mentioned have to be correct otherwise just mention the name of the operation and give separate note in detail if asked for. If any complication is expected after discharge ask the patient to report immediately. Instructions while discharge must be very clear and elaborative. Keep in mind that abbreviations may not be understood by others. Also do not use code messages, sarcasm or poor opinion to the patient.

Certificates

A medical certificate is defined as a document of written evidence vouching for the truth of a fact as determined by the doctor issuing such a document. If medical certificate is admitted in a court of law as evidence and is proved to be false, the issuing doctor is liable for punishment. While issuing a medical certificate following things should be kept in mind,

1. Medical certificate should be on institution/doctor letter pad.
2. Date, time, and place should be mentioned.
3. Issue it only for legitimate purpose and only when necessary.
4. It has to be true and clear without any ambiguity.
5. There should be an identification mark of the patient, preferably a thumb impression.
6. Period of illness should be clearly mentioned.
7. Diagnosis disclosure of the diagnosis should be only after the patient's express consent, unless required by the law
8. Doctor should maintain the duplicate copy of every certificate.

How Long to Maintain the Records

1. Ideally records of adult patient are maintained for 3 year.
2. 21 year for neonatal patient (3 + 18 year).
3. For children 18 year of age + 3 year.
4. For mentally retarded patient forever till hospital/institution is working.
5. From income tax point of view for 7 years.

How to Destroy the Records

1. Public notice of destroying the records in English news paper and in one vernacular paper mentioning the specific date up to which destruction will be sought [1].
2. Give a time limit of 1 month for taking away records for those who want the records with written consent [1].
3. After 1 month destroy the records up to date specified except for following
    a. Where litigation is going on.
    b. Where future trouble is expected.
    c. Mentally ill or retarded patient.
    d. Pre-litigation process of notice exchange is going on.

Hard Copy Only

Computers are now widely used in institution/hospitals for electronic patient records but still hard copy is required for following documents [1]

1. Consent need to be on hard copy.
2. Referral to doctor need hard copy.
3. Police case need hard copy.
4. Certificate of fitness should be on hard copy.

Problem of Record Management

There are many problems faced by institution/hospital for the proper maintenance of the records. 1. Constant revision of the outdated form is needed [2]. 2. Always trained personnel are needed for the maintenance [2]. 3. Inactive records need storage at appropriate place [7]. 4. There must be a need of determination of record retention [7]. 5. Unwanted records must be destroyed [8]. 6. Record storage entail into 2 stages. A. Moving the records from

active to inactive file and from there to storage room. B. Destruction and disposal of the unimportant records [8].

There are various type of damage which may be found in paper documentation like-aged paper may become weak, colour alteration from white to yellow, dirt and dust may be present on the surface, insect and fungus is a big threat for the records, if paper is kept folded, it may become weak at the crease, dampness and water leakage in storage room also destroy the paper.

Proper Preservation of the Medical Records

Collect all the records and classify them according to the different section [7]. Protect the records from insect attack. Spray insecticide or place naphthalene balls over shelves to preserve the records. Plan a periodical checking for the records [3]. Proper care should be observed while handling the records. Fire extinguisher should be available in record room. Protect all records from dampness, water, and from hot and dry climate [8]. Records should be kept in dust free area. Windows and ventilators should be properly covered with frames as safeguard against sabotage. Destroy the records as per the regulation established for retention of records.

Conclusion

Medical records form an important part of a patient management. It is important for the doctor and medical establishment to properly maintain the records of the patient for 2 important reasons. First one is that it helps in proper evaluation of the patient and to plan treatment protocol. Second is that the legal system relies mainly on documentary evidence in cases of medical negligence. Therefore, medical records should be properly written and preserved to serve the interest of doctor as well as his patient.

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