VIMS HEALTH SCIENCE JOURNAL

March – 2014, Volume 1, Issue 1

ISSN No : 2348 – 523X www.vimshsj.edu.in

REVIEW ARTICLE

MEDICAL RECORDS : THE BEST DEFENCE OF DOCTORS

Dr. Shrikant Asawa - Professor and HOD, Department of Forensic Medicine.

Correspodance Address :

Peoples College of Medical Sciences and Research Centre, Bhopal.

Medical record is an important compilation of facts about a patient's life & health. It includes documented data on past & present illnesses and treatment by health care professionals i.e. doctors, nurses, paramedical staff etc caring for the patient.

The medical record is everything of patient care in the hospital. It is defined as an orderly written document encompassing the patient's identification data, health history, physical examination findings, laboratory reports, diagnosis, treatment and surgical procedures and hospital course.

The medical record **"must contain sufficient data to identify the patient, support the diagnosis or reason for attendance at the health care facility, justify the treatment & accurately document the results of that treatment."** (Huffman 1990)

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.

Every document authored by a doctor in his/ her professional capacity has some or the other medico legal significance at some time or the other. 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/ Dental / Nursing records have become an important aspect of the written evidence.

Categorizing , some documents as medical and some as medico legal is a myth. Each & every document has a medico- legal significance, so it is incorrect to label some as medical & some as medico -legal. As regards medical / Dental documents even an OPD slip, prescription, indoor case papers operative, anesthetic , nursing notes, Intake- Output and TPR – BP charts ,Informed consent or refusal forms, high risk consent, leave against medical advice , medical bill , referral slips, call sent to consultants, notes in transit, various certificates issued in professional capacity , various forms and hospital registers, investigation reports , ECG strips, Kardex, flow sheets, nurse progress notes, etc have medico legal significance, so all are medico legal documents.

A significant number of medical/ dental mal practice suites are rendered indefensible due to problems with medical records. Although doctors claim to be expert witness and medico legal experts advocates are becoming medical record experts.

Let's accept medical/ dental/ nursing record keeping and documentation is one of the most ill understood and poorly implemented areas of medical/ dental/ nursing practice in our country. One may add it is also an area to which there is an inexplicable resistance to improvement and willingness to change current practices The principal reasons for this are

1. Not much importance is given to the significance of record keeping in the medical/ dental/ nursing curriculum hence it does not get inculcated in budding health care professionals.
2. Only when one is required to face medico legal problem we realize its importance.

The Purpose Of The Medical Record -

- To record the facts about a patients health with emphasis on events affecting the patient during the current admission or attendance at the health care facility.
- For the continuing care of the patient when they require the health care in future.
- To furnish documentary evidence of care provided.
- Assist in quality review of patient care.
- To protect everybody involved including patient, in the eventuality of litigation.
- To help in managerial aspects of finance and service improvement, planning, review, medical education and research.

A patient's medical record should provide accurate information on:

- Who the patient is and who provided health care;
- What, when, why and how services were provided; and
- The outcome of care and complete treatment given to the patient
- The medical records have four major sections:
- Administrative, which includes demographic and socioeconomic data such as the name of the patient(identification), sex, date of birth, place of birth, patient's permanent address and medical record number;
- Legal data including a signed consent for treatment by appointed doctors and authorization for release of information;
- Financial data relating to the payment of fees for medical services and hospital accommodation; and
- Clinical data on the patient whether admitted to the hospital or treated as an outpatient or an emergency patient.

The importance of medical records can be simply divided into 4 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 carry out 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.

For the consultant -

1. 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.
2. OPERATIVE NOTES - To consult the operative events and treat the patient accordingly. To plan for the next operation. To know any anaesthetic problems met with.
3. 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.
4. DATA - The medical records are, of course, the most important of al 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 cannot be ignored

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.
- Whole of the medication prescribed by him.
- What were his findings?

For the Nursing staff -

The Nursing 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.

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 / Dental / Nursing Ethical & Legal Aspects Of Medical Records -

The code of medical ethics [Indian medical council (professional conduct Etiquette &Ethics) regulations, 2002 serve as a guide line to a physician in the responsible discharge of his/ her duties.

One of the many important matters that a physician has to take care of is maintenance and issue of medical records and certificates.

CHAPTER 1 section C - states that it is the responsibility of every physician to properly maintain, in accordance to standard proforma laid

down by the Medical Council of India , all medical records relating to his or her indoor patients for a period of 3 years from the date that the treatment was started . In case patients or authorized attendants or legal authorities involved make a request for medical records, it should be duly acknowledged and that relevant documents must be made available within a period of 72 hours.

A physician should maintain a register of Medical Certificates containing full details of all certificates issued. While issuing a medical certificate he or she should always take care to keep a copy with him or her .The physician must not omit to record the signature and /or thumb mark, address, and at least one identification mark of the patient on the certificate on report. Every effort should be made to computerize medical records so that they can be quickly retrieved.

CHAPTER 7 speaks of those violations that shall constitute professional misconduct and make a physician liable for disciplinary action. Section (A), if a physician does not maintain the medical records of his or her indoor patients for a period of three years and provide the relevant records within 72 hours to the patient or his or her authorized representatives when a request is made for them (Regulation 1.C) , it will be treated as misconduct. Section (E) deals with the signing of professional certificates , reports and other documents. It states that physicians are in some cases bound by law to give, or, in some other cases, may be called upon to give, certificates, reports and other such documents signed by them in their professional capacity, to be used later in courts, for administrative purpose etc. Such documents include those issued under, for, or in connection with various envisaged Statutes.

Dentist code of ethics regulations 1976 clause 6 d unethical practices also clearly mentions that

Signing under his name and authority any certificate which is untrue, misleading or improper or giving false certificates or testimonials directly or indirectly concerning supposed virtues of secret therapeutic agents or medicines will call for action by state dental council.

Medical record as evidence -

Hospital records are primary evidence as per Indian Evidence Act 1872. They can hardly be challenged unless proved otherwise.

They are subpoenaed in court in following circumstances and wherever there is a question of compensation.

- Workman's compensation Act.
- Personal injury suits.
- Malpractice suits.
- Negligence under consumer protection act.
- Will cases.
- Income tax act.

The length of period for which medical records are required to be preserved depends upon the relevant and applicable legal principle. There is no general / comprehensive legislative guideline mandating for how long the medical records are required to be preserved, of late in certain subject matter specific legislations appropriate provisions are being incorporated.

Limitation period for filing a case paper is maximum up to 3 years under the Limitation Act.

OPD paper --- 3 yrs

Indoor case records --- 5 yrs

Medico legal case records --- 30 yrs[1]

Recommendations -

IPD records should be preserved for 10 years.

Hospital OPD records for 5 year

Obstetric records.—21 YRS

PNDT records for 2 yrs.

MTP records for 7 yrs.

All sundry registers 2 yrs.

In case you want to destroy the records it is necessary to give a public notice of the same. The patients can come and take away their record before destroying them.

Electronic records are now valid in the court of law but can be easily discredited as changes can easily be made any time in future. Since the softwares are

now tamper proof and changes are not easily possible, the court can get convinced that the records are genuine.[2]

If you are able to show a recent backup and the records match each other, they are accepted easily.

Any subsequent changes made in the records to appear them in favour of hospital and consultant amounts to fabrication of evidence.

Fabrication of evidence - section 192 IPC.

Giving or fabricating false evidence -section 194 and 195 IPC.

Issuing or signing false certificates -section 197 of IPC.

Causing disappearance of evidence of offence-section 201 IPC.

Destruction of document to prevent its production as evidence – 204 IPC.

Doctors feel smart enough and change the records accordingly however tampering with the records can be easily detected by forensic labs and then they go against the consultant as evidence.

There is nothing that can be called as ideal record but whatever pattern of records is maintained by that particular hospital must reflect the working pattern and transparency in the delivery of services. The records must be in legible handwriting, written in chronological order.

To scanty documentation is dangerous and reflects carelessness of the consultant and hospital whereas excessive record keeping can be equally disastrous as it might be taken as doctored record and it amounts to fabrication of evidence.

A satisfactory documentation is one which is Chronological, Comprehensive, Complete, Concise,

Discriptive, Factual, Legally aware , Legible, Relevant, With use of standard Abbreviations, Symbols and Terms ,Through and Timely.

Effective Documentation Principles[3]

- Correct client record
- Identifying information on every page
- Immediate documentation
- Date and time of each entry
- Sign each entry with name, designation as per policy
- No space between entries, write on every line
- Avoid errors
- Avoid erasing, crossing out or using correction fluids
- Don't change other persons entry
- Use quotation marks to record direct clientale response
- Document in chronology
- Legible entries
- Use permanent ink pens
- Complete and conscise documentation
- Document all telephone calls you make or receive
- Document reasons for deviation from original treatment plan
- Document referral to or consultation with fellow colleagues
- Comments about cost of treatment and patients payment history
- Document lost records and x rays.

Carry Home Message -

As far as the courts are concerned , whatever is not documented in your notes, never happened regardless of whatever you may have actually done. Therefore it is always important to remember that in your medical, dental, nursing career, profession, practice medical documentation is a very good defense that you can always have in this litigative era.

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