Journal of Clinical and Biomedical Sciences

Review Article

Medical Records- a Legal Perspective

Abinandana R[1], Srinivasa Reddy P[2]*
1. Assistant Professor, Department of Forensic Medicine and Toxicology.
2. Professor and Head, Department of Forensic Medicine and Toxicology,
Sri Devaraj Urs Medical College, SDUAHER, Tamaka, Kolar.

Abstract

A medical record is a document containing chronologically written account of a patient's examination and treatment. A medical record apart from case sheet includes investigatory reports, investigatory samples, referral letter, discharge summary etc. Every registered medical practitioner is supposed to maintain the proper medical report of his / her patient. The Indian government has laid down certain guidelines as to properly preserve the records. As a component of good medical practice it is necessary to maintain the medical records anticipating the litigation anytime.

Key words: Medical records, Documentation, Electronic medical records, Medico legal report.

Introduction

A medical record is a document containing chronologically written account of a patient's examination and treatment. [1] A medical record is information about the health of an identifiable individual recorded by a doctor or other healthcare professional, either personally or at his or her instructions. [2] A medical record is a prime important part of any medical care. A medical record should give the seeker all the necessary information pertaining to that patient starting from the identity of that patient, his / her chief complaints until treatment given with discharge advice. A medical record at times is needed by many sectors of the society to name a few, it is needed by the health care sector for further expert treatment or to obtain history of that patient, it is required by the police and law sectors to gain information of accused, victim including the treatment provider, it is required by the consumer protection courts, insurance companies, local administrating bodies (municipalities) for registration and etcetera to name a few.

Hence a health care provider apart from treating a patient should also be able to document, prepare and retain the medical records. A medical record is not just a hospital case sheet, instead it includes the outpatient department slip, prescription slip, inpatient department case sheet, laboratory investigation reports, radiological investigatory films, histopathological slide and tissue blocks, operative notes, wound certificates, autopsy reports, sickness certificates, fitness certificates, clinical trial forms, clinical research data etc. Any paper or any documents that are part of a patient doctor relationship should be considered as a medical record.

The prime purpose of a medical record is to provide good continuity of care. The next purpose is to provide evidence of care given to the patients.[2] Legally all medical records should document the event of patient care right from first meet till the discharge and advice including every event happened, no matter how trivial the event or care is, it must be

***Corresponding Author**
Dr. Srinivasa Reddy P
Professor and Head Department of Forensic Medicine and Toxicology. Sri Devaraj Urs Medical College, SDUAHER, Tamaka, Kolar
Mob No: 9449677567
E-mail: drsrinivasareddyp@gmail.com
Conflict of Interest: None
Financial Aid: Nil

recorded. A medical record should include history, examination of the patient including both positive and negative points, consent of both acceptance and denial, diagnosis, management plan, discharge summary, advice at discharge, follow-up, referral quoting the reason and to whom was the patient referred.[3] The clinical establishments (Registration and Regulations) act 2010 in its minimum standards (Annexure 7) prescribes the following content (Table 1) at the least to be present in a medical record. [4]

A medical record includes the data of a patient and it is held in custody of the treating doctor or the particular institute or establishment. This does not allow the custodian to freely access the patient record or publish or provide access to any third person of interest. The doctors are bound to keep secret all the data learnt from the patient while in treatment. This simply means the medical records are owned by the doctors but the information in it is a right and property of that particular patient. The doctor is liable for the proper maintenance, custody and storage of the record for the required statutory period. [5] When the patient or competent authority asks for a medical record the doctor should be able to produce the same. In a government institute where the cost of treating and diagnosis are all provided by the government, the original records can be retained by the treating doctor and the copies of the same may be issued on request to the competent authority with minimal fees. In a private institute or establishment, where the cost of patient care is provided by the patient, the patients have right for the original documents and the same may be issued to them at discharge, while all the necessary precautions are taken to keep a copy of the same for the future legal and healthcare needs.[6,7,8] A medical record can only be issued to the patient or his legal relative except under "Privileged communication" a doctor can and must issue the necessary medical records to the concerned authority upon interest of socie-

Table 1 (Content of medical record)

Content
Name & Registration number of treating doctor
Name, demographic details & contact number of patient
Relevant Clinical history, Assessment and re-assessment findings, nursing notes and Diagnosis
Investigation reports
Details of medical treatment, invasive procedures, surgery and other care provided
Applicable consents
Discharge summary
Cause-of-death certificate & Death Summary (where applicable)

The clinical establishments Registration and Regulations) act 2010 also provides guidelines [4] as to maintenance of the medical records as in table 2

Table 2 (Record maintenance and reporting guidelines)

9.1	The minimum medical records to be maintained and nature of information to be provided by the Hospitals shall be as prescribed in CG 2 Annex as per Section 12 (1) (iii) of this Act
9.2	Medical Records may be maintained in physical or digital format.
9.3	Confidentiality, security and integrity of records shall be ensured at all times
9.4	The medical records of IPD patients shall be maintained in consonance with National or local law, MCI guidelines, and court orders.
9.5	Every Hospital shall maintain health information and statistics in respect of national programs, notifiable diseases and emergencies/disasters/ epidemics and furnish the same to the district authorities in the prescribed formats and frequency.

ty like detection of communicable diseases, when required by the police and legal authorities for the safe guard of public, the detection of sexually transferrable diseases shall be communicated to the wife / husband. [9] however section 8 (1) (i) of the RTI (Right To Information act) exempts from disclosure of information and data that is personnel and if it has no relationship with the interest of the public activity.[10]

It is the responsibility of the medical records department in a healthcare institute or establishment for the proper maintenance and preservation of medical records. Medical records should be kept under proper security and shall only be removed from the section upon proper receipt of a subpoena, statutory authority or court order. [4] The medico legal reports always belong to the requestor i.e., the police. The person who got examined also has no authority to ask for a copy of the examination report, if that examination was done on request by the police. The doctor is supposed to provide the original report to the requestor, and only upon request the report can be issued as a attested photo copy to the affected party or the next of kin, after receiving the request letter and photo ID proof stating the relationship with the deceased, the reason for obtaining the report and the number of copies required, then the same shall be issued after collecting a prescribed fee.

The Indian law does not state the minimum period up to which the medical reports should be kept or when to destroy the same. However the DGHS (Director general for health services) and MCI (Medical council of India) and various courts have given some guidelines for the same, but there may be occasions in which the medico legal reports are need to be kept for longer periods as the court case may ask to be finalized. There is no time limit in the Indian courts as when a case to be opened and when to be closed, especially for the criminal cases.[11] As per the regulation 1.3.1 of the Medical Council of India, a registered medical practitioner should maintain an inpatient medical report for a minimum period of 3 years.[12]

The Director general for health services in India prescribed in its regulations that all the government hospitals are supposed to maintain the medical reports for a minimum of 5 years if it is an outpatient report and for inpatient medical reports, be it a medico legal or not are supposed to be preserved for not less than 10 years. [13] The Consumer Protection Act 1986 gives a time period of 2 years until a case can be filed in it from the date of medical negligence or the first day of notifying the negligence by the consumer, however the section 24 (A) of the act provides extension of this time limit upon discretion of court. [14] With the above it is learnt that there is no definite prescribed time period until which a medical report shall be preserved by the doctors. Hence it will be a good practice to keep a track of medico legal reports until it is finalized with a verdict in the court or to obtain a no objection certificate from the concerned police station before destroying the reports. World Health Organization in its medical records manual – A guide for developing countries lays down certain standards to be maintained before destruction of medical reports. It asks the concerned authority to keep a log book for destruction and the following entries shall be made in the same. [8] (Table 3)

Table 3 (Entries to be made in medical record destruction log)

Particulars of the patient including hospital number
Admission and discharge dates
Names of the attending doctors
Diagnosis and operations performed
Discharge summary for each admission
Date of destruction of the record
Signatures of the individuals witnessing the destruction
Method of destruction

It is even wiser to keep an electronic scanned copy of the reports before destroying. In recent years the electronic medical reports are replacing the traditional paper reports owing to their ease of preparation, tracking, maintenance and custody.[15] The Information Technology Act 2000. and The Indian Evidence Act (Amendment 2002) gives the provision of ad-

mission of these electronic records as evidence in the court of law. [16,17]

Conclusion

Medical records are a vital part of doctor patient relationship. Every registered medical practitioner, hospitals, healthcare institutes and establishments should take due responsibility in preparing and maintaining these records as when a need for these arises in the court of law arises cannot be predicted. Also a properly maintained medical record would help a patient for further and higher treatments in different parts of the country and world. Whilst a proper prescription of guidelines for maintenance and destruction of medical records is to be made by the government. Through the years the gradual shift from traditional paper records to electronic records are evident but there is always a threat of data theft, mishandling and destruction is to be anticipated and taken care of.

References

1. Medical record. Wikipedia.(online).2019.(Cited 2019 May 15); Available from https://en.wikipedia.org/wiki/Medical_record
2. Medical Records: Making and Retaining Them. Singapore medical association.(online).2000. (Cited 2019 May 15); available from https://www.sma.org.sg/UploadedImg/files/Positions%20Statements/medical_records.pdf
3. Medicolegal Aspect of Medical Records. Scribd. (online).2015.(Cited 2019 May 15); Available from https://www.scribd.com/presentation/140300472/Medicolegal-Aspect-of-Medical-Records
4. Clinical Establishment Act Standards for Hospital (LEVEL 3). Clinical establishments act. (online).2012.(Cited 2019 May 15); Available from http://clinicalestablishments.gov.in/WriteReadData/776.pdf
5. Biswas G. Legal and ethical issues of medical records. Recent advances in forensic medicine and toxicology. 1st ed. Vol 1. New Delhi: Jaypee publishers;2015; p.140-159.
6. Medical record. ICFMT.(online).2011.(Cited 2019 May 15); Available from http://www.icfmt.net/iijfmt/vol3no4/preservation_%20of_medical_%20records.html
7. Guidelines for good practice in the healthcare professions. Health professions council of south africa.(online).2014.(Cited 2019 May 15); Available from https://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/Booklet%2010.pdf
8. Medical records manual : a guide for developing countries. WHO.(online).2002.(Cited 2019 May 15); Available from https://iris.wpro.who.int/handle/10665.1/10404
9. Reddy KSN. Medical law and ethics. The essentials of forensic medicine and toxicology. 33rd ed. Hyderabad: Jaypee publishers;2014; p. 24-56.
10. Right to information act 2005. Ministry of law and justice.(online).2005.(Cited 2019 May 15); Available from https://rti.gov.in/rti-act.pdf
11. Fixing a time limit for criminal cases. The Hindu.(online).2016.(Cited 2019 May 15); Available from https://www.thehindu.com/news/national/tamil-nadu/fixing-a-time-limit-for-criminal-cases/article6451106.ece
12. Professional Conduct, Etiquette and Ethics) Regulations, 2002. Medical council of India. (online).2002.(Cited 2019 May 15); Available from https://www.mciindia.org/documents/rulesAndRegulations/Ethics%20Regulations-2002.pdf
13. Directorate general of health services guidelines vide DGHS letter no. 13-3/68-MH dated 31.8.68
14. Consumer protection act 1986. Ministry of law and justice.(online).1986.(Cited 2019 May 15); Available from http://ncdrc.nic.in/bare_acts/Consumer%20Protection%20Act-1986.html#_Hlk149662073
15. Rustagi N, Singh R. Electronic medical record: Time to migrate?. Perspect Clin Res. 2012 Oct-Dec; 3(4): 143–145.
16. The Information Technology Act 2000. Ministry of law and justice.(online).2000.(Cited 2019 May 15); Available from https://indiacode.nic.in/bitstream/123456789/1999/3/A2000-21.pdf
17. Indian Evidence Act (Amended 2002). Ministry of law and justice.(online).2002.(Cited 2019 May 15); Available from https://indiankanoon.org/doc/1555515/