Volume : 2 | Issue : 2 | february 2013 ISSN - 2250-1991

Research Paper Medical Science

Medical Records –Boon Or Bane

* BH.Srinivas Reddy ** Dr.J.N.Rao
*** Dr.B.V.Subrahmanyam

* MBA Hospital Administration Co-ordinator MHM Course, Dept of Hospital Administration Narayana Medical college & Hospital, Nellore, AP, India.

** MD (Hospital Administrator), Professor of Hospital Administration

*** Professor & HOD, Dept of Forensic Medicine

“Memories fail – people lie – witness die – but medical records live forever”1

A Medical record is defined as a clinical, scientific and administrative and the legal document relating to patient care in which sufficient data is written in the sequence of events to justify the diagnosis, treatment and the results[2]

Medical records department has been defined by HAYAT (and) HAYAT as “Mirror of medical achievement in a hospital where errors of omissions and commission are revealed and facts are stored”[3]

Dr. Mac. Eachern, the “father of Modern medical records” has described medical records as “clear, concise and accurate history of the patients’ life and illnesses written from medical point of view and its true from is a complete compilation of scientific data derived from many sources record department and finally filed away for various uses, personal and impersonal”[4]

The need for appropriate, written documentation of facts related to patients’ treatment in the hospitals cannot be brushed asid, because failure to maintain records means failure of duty towards the patient.

Medical records through which hospital statistics are generated serve **as eyes as ears to the hospital administrator**. Medical records are of importance to the hospital for evaluation of its services for better patient care. They also serve as a resource for education and training of physicians and others, also being the basis for clinical research. Research to be effective requires scientifically recorded observations as reflected in the medical record. And, the importance of accurate records for legal purpose is well established.

In short, the necessity for maintaining proper medical records by a hospital can be broadly grouped as follows –

1. Patient needs
2. Physicians needs
3. Institutional Needs
4. Health Authorities Needs[5]

It is also defined as a document of facts, which contains statements by trained, observes of condition found and the application and result of the examination and therapy.

It is also indicates whether or not the efforts of the doctors supplemented by the hospital and related facilities are in accordance with the reasonable expectations of the present days scientific medicine.

The medical records today is a compilation of the patient facts relating to a patient’s health history including past and present illness or illnesses, and treatment prescribed by health professionals contributing to the patients care. The medical records should be compiled chronologically and should contain sufficient data to identify the patient, support the diagnosis or the reason for the treatment, justify the treatment, and accurately document the result.

The medical professional must ensure that it contains all the relevant facts needed for patient care and other uses. The process of ensuring that the medical record is adequate, complete and useful requires a thorough knowledge not only of the content, ownership, value uses of and responsibility for the medical record.

The medical record is assembled after the discharge of the patient so as to facilitate the logical flow of information regarding the patient’s past and present illnesses, diagnosis, treatment and the outcome. The information must be available readily as and when required for several purposes, for example, patient care, legal affairs, research& education, quality review, correspondence and so on.[2]

IMPORTANCE OF MEDICAL RECORDS

Jest as it important and obligatory to dispense all the required care to patients, both indoor and outdoor maintenance of records and proper documentation of all the events and management carried out are even more important. In earlier years when patient care was given mainly by clinical examination and on one to one basis by the treating physician, records were not given much importance. With increase in availability of scientific technology for investigative and therapeutic procedures, and with altered method of practice on modern medicine documentation has become essential.[6]

Importance of Documentation

1. For efficient patient care services
2. Convenience for the treating doctor/team
3. Helpful for performance appraisal of doctor, treating team, department and hospital
4. Useful for planning, starting or stopping certain services
5. Reimbursement of bill by insurance agency or other third party payer.
6. Useful for education and research activities
7. Important and useful in the event of litigations and complains
8. Necessary for understanding epidemiology and the outbreak of certain disease and take appropriate measures.[6]

MEDICAL RECORDS 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.
3. 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 theycould 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 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.
- 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.
- Intra operative 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.[7]

Legal aspect of medical records

The Medical Records serve a secondary and important purpose, and being a legal document, is as such affected by laws, regulations and institutional policies.

The medical record being the property of the hospital, that contains personal data, is considered a confidential communication. It is compiled, preserved and protected from unauthorized inspection in the interest of the patient, his family and health care provider, the doctor, as per the existing laws in some states and by the administrative practices in the other.

As the medical record is maintained to serve the patient, the hospital and his doctor, in accordance with the requirements of legal, accrediting and regulatory authorities, the hospital should have definite procedures for disclosure, access and amendment to health record information, for making it known to the patients on request. It should be released only with proper authorization, except in the following cases.

1. When it is required by law
2. When it is released to another health care provider, currently involved in the care of the patient.
3. For medical care Evaluation.
4. For research and Education.[8]

Medical records are the who, what, why, where and how of the patient care. With the advancement and complexity of medical and surgical treatment in modern health care facilities and reference of the care rendered. The medical record is both personal documents, the record identifies the patient by name and presents physical findings and treatment given. Such information is confidential no one is allowed to access the record.

(Not even next of kin) and no information is released without the written authorization of the patient. As an impersonal document, the patient's record is utilized for research or educational study and the authorization from the patient is not mandated unless the patient will be specifically identified in reports of publications emanating from these scholastic endeavors.9

A court of law has the right to summon patient. Records are not to be handled by anyone except those authorized as determined by the hospital.

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