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CRITICAL REVIEW

Documentation of Medical Record in Day-to-Day Medical Practice

Mahanta Putul[1], Yadav Mukesh[2]

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ABSTRACT

Proper documentation of medical records promote patients' and physicians' best interests for many reasons. Recording all relevant data of a patient's care helps physicians monitor what's been done, and curtails the risk of mistakes scrambling into the treatment process. Systematic medical records document basic facts about the patient's health care delivery system, including who did what, and what results occurred. Improper documentation on the other hand may invite medical litigation at any point of time. Sound record keeping also plays a role in quality assurance practices; hence medical litigation can be avoided.

***Keywords**: Medical record, medical litigation, documentation*

Address for correspondence and reprint:
[1]Associate Professor of Forensic Medicine
Tezpur Medical College, Tezpur, Assam, India
Email: drpmahanta@gmail.com
Mobile: 09435017802
[2]Editor, Journal of Indian Academy of Forensic Medicine
Professor & Head
Rama Medical College, Hapur, UP
Email: drmukesh65@yahoo.co.in

INTRODUCTION

The terms medical record, health record, and medical chart are used somewhat interchangeably to describe the systematic documentation of a patient's medical history and care, time to time within one particular health care provider's jurisdiction.[1] Medical records include a variety of type of 'notes' entered over time to time by health care providers, recording observations, administration of drugs, surgical interventions, orders for the administration of drugs and test results, etc. The maintenance of complete and accurate medical records is a requirement of health care providers and is generally enforced as a licensing prerequisite.

Nothing is more devastating to an innocent physician's defense against the allegations of medical malpractice than an inaccurate, illegible or skimpy record, except for a record that has been changed after the fact, and therefore inevitably compromises the otherwise defensible case.[2] The medical record is the basic legal document in medical malpractice litigation. A well-organized, well-written record is the best defense for the competent health care provider. A poorly written, disorganized record is a strong evidence of an incompetent health care provider. The poorly kept record is not, in itself, proof of negligence on the part of the health care provider, but it is proof of substandard care.[3]

Medical malpractice litigation is built around the medical record, which provides the only objective record of the patient's condition and the care provided. Records are particularly important for a physician's defense. It is the physician's responsibility to keep the medical record. The patient has injuries to show the court; the physician or

other health care provider has only the medical records to prove that the injuries were not due to negligence. If the record is incomplete, illegible, or incompetently kept, this is the physician's failure.

SIGNING ON MEDICAL RECORDS

Special attention has to be given while signing on medical records. Signing on a fake medical certificate can invite medical litigation (**Case Report-1 & 2)**.

Case Report-1

The police have zeroed in on a group of government doctors allegedly running a racket in collusion with private hospitals to falsely implicate people in criminal cases by "inflicting" injuries on persons wanting to settle scores with their rivals. Based on the "doctored" injuries, a medico-legal report would be issued for the "victim," which would be used to get a case of attempt to murder registered against one's rival.[4]

Case Report-2

A woman government doctor was sentenced to one year rigorous imprisonment by a special Central Bureau of Investigation (CBI) court for issuing fake medical certificates. The doctor, Asha Kiran, was caught red-handed by the CBI along with her husband Vinod Kumar while issuing a fake medical certificate to a woman for money here in 2001. Joginder Kaur, who got a fake medical certificate from Kiran, was working with the Chandigarh health department and presented the medical certificate in the Punjab and Haryana High Court to get bail on medical grounds in a murder case. The complainant in the murder case got a whiff of the fake medical certificate and sent a decoy patient to Kiran. The patient was asked to pay Rs. 6,000 for a fake certificate. The CBI then laid a trap and nabbed Kiran.[5]

RECORD OF MEDICAL CERTIFICATES

While the health care provider records a medical certificate or other, they should follow the following three basics: (i) The doctor should keep a copy of medical certificate issued, (ii) maintain a register containing full details of medical certificate issued and (iii) it should be issued on an approved proforma.

The medical officers shall not omit to record the signature and/or thumb mark, address and at least one-identification mark of the patient on the medical certificate or report.[6]

USERS OF MEDICAL RECORDS

One can hypothesize that initially the records may have been kept more for the physician's interest rather than anything else. Just as advances in modern medicine are progressing in leaps and bounds, the needs for a good hospital records is also increasing.[7] There are many meaningful users of health information for different purposes as follows (**Table 1**).

Table 1 Different users of Medical Records

Primary users	Secondary users	Third party users
– Attending physician (themselves) – By other physicians (for consultation)	– Nursing/ paramedical staff – Patient (during consultation or referral/for future) – Hospital administrators – Students teaching – Clinical Research – Epidemiology, Statistics – Insurance companies – Tool for training of medical staff – Anticipate future health problems – Serve basic for standard preventive measures	– Social worker – Occupational therapist – Audit purpose – Accreditation purpose – MCI/CEA purpose – Government agencies (Statutory bodies: PCPNDT Act, MTP Act, etc., Blood bank licencing) – Court of law (during trial) – Investigating agencies (police, internal enquiry, criminal negligence enquiry)

CONTENTS OF MEDICAL RECORD

A patient's individual medical record identifies the patient and contains information regarding the his medical history. The health record as well as any electronically stored variant of the traditional paper files contain proper identification of the patient.[8] However a complete medical record for inpatients should show the followings:

- Demographic data
- Para clinical data
- Clinical data
- Therapeutic data
- Documentary items
- **Ancillary diagnostic media**: X-Ray/CT/MRI Scans, pathology specimens/documents, ECG/EEG and photographs, etc.
- **Miscellaneous**: Consent form, MTP forms, insurance records, legal documents and correspondence (referral form/consultation advise), etc.

The bedhead ticket should also reveal the bed allotment, ward number and others. Details of procedures performed on the patient should mentioned including dietary supplements, dressings including self-medication if any.

TYPES OF MEDICAL RECORDS

Broadly, medical records are of two types, viz., (i) personal and (ii) impersonal used for research or statistics. They can also be further divided as: (i) paper records (hard copies) and (ii) computerized records. [7]

IMPORTANCE OF MEDICAL RECORDS

A medical record documents a member's medical treatment, past and current health status, and treatment plans for future health care and is an integral component in the delivery of quality health care. Besides individual interest it has some other purposes as follows:

- Quality of patient care/continuity of medical care
- Medical education
- Research
- Efficient administration
- Communication devise between multidisciplinary team/ group practice
- Medical audit
- Medical tourism (transmission)

PROBLEMS OF MEDICAL RECORDS

While physicians acknowledge the importance of the medical record to both patient care and medical education, there is increasing awareness that the record along with our current system of processing medical information is seriously deficient. The extent of these deficiencies has serious implications for the usefulness of current practices of medical record audit. Followings are the main problems:

- Legibility (hand writing, typed, computer generated)
- Retention and preservation
- Confidentiality
- Privileged communication
- Storage (space)
- Uniformity
- Utility
- Quality
- RTI
- Terminology/Abbreviations
- Retrieval (timing)
- Medico-legal reporting

One of the biggest problems of medical records amongst those is the illegible handwriting. To find a cure for this problem, the hon'ble Punjab and Haryana High-Court has reminded the doctors that they should not scrawl on documents for self consumption; and has even asked the directors of health services in Punjab, Haryana and Chandigarh to ensure that the element of legibility is injected into their handwriting.[9] It turns out that all those jokes about doctors' scrawl are not funny at all. Doctors' illegible handwriting causes 7,000 deaths in the US every year and another 1.5 million Americans report minor adverse reactions—be it diarrhea or rashes—or even death. A movement has begun in Mumbai asking the medical fraternity to write prescriptions in "separate, capital letters". The brainchild of an NGO called the Forum for Enhancement of Quality in Healthcare (FEQH) and the Quality Council of India (a semi-government organization accrediting services), the first meeting on the issue held last week was attended by representatives of medical associations and NGOs. The campaign borrows from QCI's hospital accreditation system called the National Accreditation Board for Hospitals (NABH), which requires prescriptions to be written in capital letters.[10]

EASE OF RETRIEVING MEDICAL RECORDS AND CONFIDENTIALITY

Medical records should be organized and stored in a manner that allows easy retrieval and are to be made available as and when required. Computerization of medical record can help by easy and fast retrieval and reduced space requirement.

Medical records are stored in a secure manner that allows access to authorized personnel only and is protected against unauthorized or inadvertent disclosure. The handling staff should receive periodic training in confidentiality of member information. Medical records are safeguarded against loss or destruction and are maintained according to state requirements.

PRESERVATION OF MEDICAL RECORD

The records should be kept under lock and key, in the custody of the doctor concerned or may be kept in a Central Record Room, in hospitals where such facility is available; as per the institution's rules. Most hospitals have a policy of maintaining all medico-legal records for variable periods. However, as per law, there is no specified time limit after which the MLR's can be destroyed. Hence, they have to be preserved permanently. In view of the

multitude of cases against the doctors under the Consumer Protection Act, it is advisable to preserve all the in-patient records for a period of at least 5 years and OPD records for 3 years.[6]

As per the MCI provisions under Regulations, 2002, every physician shall maintain the medical records pertaining to his/her indoor patients for a period of 3 years from the date of commencement of treatment in a standard performa laid down by MCI. If any request is made for medical records either by the patients/authorized attendants or legal authorities involved, the same may be duly acknowledged and documents shall be issued within the period of 72 hours.[11]

PNDT ACT AND MEDICAL RECORD

Section 29 of the PNDT Act, 1994 requires that all the documents be maintained for a period of 2 years or until the disposal of the proceedings. The PNDT Rules, 1996 requires that when the records are maintained on a computer, a printed copy of the record should be preserved after authentication by the person responsible for such record.[12,13]

PROVISIONS UNDER THE RTI ACT, 2005

Under this Act every citizen has got the right to obtain a copy of medical records. Section 3 of the RTI Act confers right to information to all the citizens and corresponding obligation under Section 4 on every public authority to maintain record so that the information sought for, be provided.[14]

In the case of T.S.R, Subramanyam[14], their lordships of Hon'ble Supreme Court settled that nothing should be done by oral instructions and the practice of giving oral directions by administrative superiors and public executives, would defeat the object and purpose of RTI Act and shall give room for favouritism and corruption. Division Bench clarified that in view of the above, every decision taken for the purpose of treatment of a patient or instruction issued by the doctors to their subordinates, must be converted in writing indicating the name of doctors. [Para 26][12,13]

Court further added that "But, all these rights generally declared either in favour of citizens of this country or parties to the prosecution or litigation are only subject to certain reasonable restrictions either imposed by law or even by rules, conventions, precedents, etc. One such restriction that is imposed regarding the issuance of a copy of the post mortem certificate, which is the subject matter of the above petition, Rule 591 of the Madras Police Standing Orders which is positive to the effect that 'originally the post mortem certificate has to be sent by the medical officer direct to the magistrate concerned in a sealed cover, the police being given a copy of it immediately after the examination is over' thus setting the procedure as to the issuance of the post mortem certificate and therefore revoking such procedures established by law. This court or any other court for the matter is not entitled to order to issue the copy of the post mortem certificate particularly when the investigation into the case registered regarding the death in encounter by the respondent police is still pending finality of decision by the police themselves and since the field is occupied entirely by the respondent, as it is held on the part of the Honourable Apex Court in general regarding any criminal case registered which is under investigation that the courts are of little or no chance to order such applications, citing the general provisions of law or even the constitutional provision which would set the outer line without specifying anything which has to be decided in the manner provided under the law on the specific subject and the propositions held by the upper forums of law do not help the case of the petitioner".[15]

IMPROVED OUTCOMES

Keeping proper medical records improves patients' clinical outcomes once they leave the hospital, according to a November 2006 report by the Ontario Ministry of Health and Long-term Care. About 20 percent of patients experience adverse events after discharge, including drug reactions, infections and procedural complications. Many of these problems result from delayed or incomplete information given to subsequent health care providers. The ministry's report also cited a 2003 study that found patients with significant gaps in their health records spent an average of 1.2 hours longer in emergency rooms. [16]

MALPRACTICE DEFENSE

It is indeed necessary for doctors to remember that their ignorance can't be the defense in the court. Therefore, there is a need to make a culture to keep medical records systematically. Proper documentation is the best defense against a negligence claim. For court, if a procedure

doesn't appear on a chart, it hasn't been done.

Physicians must ensure that all X-rays and other lab work are done, and followed up with the patient. This step minimizes the risk of a missed diagnosis. Good record keeping is also vital in dealing with patients who are abusive, decline to follow advice, or present the same complaint without improvement.

Case Report-3

The Supreme Court ordered one of the highest compensations so far in the country in a case of medical negligence Rs 1.8 crore. The Tamil Nadu government had to pay the sum to a 18-year-old girl who lost her vision at birth due to medical negligence at a government-run hospital. The girl, who is now 18 years old, was born prematurely at the government hospital in Chennai's Egmore. But, she was discharged from the hospital without a retinopathy test, a must for preemies. By the time the family discovered the lapse, the girl had lost her vision. Her father then approached the National Consumer Forum, which awarded Rs. 5 lakh. Unhappy with the compensation, the family then approached the top court.[17] In this case no record of referral to ophthalmologist was found during the time of her birth.[18]

CONCLUSION

Therefore clinical record should be structured around the patient's problem rather than medical problems and updated in detail on a daily basis as suggested by Weed.[19] It is also important for the clinician to maintain a proper doctor patient relationship, besides maintaining a good medical record. The patient doctor relationship is a vital concept in health care. A good relationship increases adherence to treatment recommendations, enhances continuing care and promotes patient satisfaction and can reduce the medical litigation.[20]

In conclusion, it can be suggested that the members of the legal profession, our law courts and everyone concerned should also keep in mind that a man in the medical profession should not be unnecessarily harassed for purposes of interrogation or any other formality. He/she should not be dragged during investigations at the police station which should also be avoided as far as possible.

REFERENCES

1. Personal Health Records. CMS. April 2011. [cited 2015 September 22].
2. Karp David, Huerta JM, Dobbs Claudia A, Dukes Dorothy l, Kenady Kathy. Medical Record Documentation for Patient Safety..MIEC. [cited 2015 Sept 21]; Available from: URL:http://www.miec.com/Portals/0/pubs/MedicalRec.pdf
3. Law and Physician Homepage. Medical Records in Litigation. [cited 2015 Sept 21]; Available from: URL:http://biotech.law.lsu.edu/Books/lbb/x187.htm
4. Deepender Deswal, TNN. The Times of India. Haryana doctors doctor 'legal' reports 2010 Dec 6; [cited 2015 September 23]; Available from: URL:http://timesofindia.indiatimes.com/india/Haryana-doctors-doctor-legal-reports/articleshow/7050516.cms
5. Thaindian News. Doctor jailed for issuing fake medical certificates. 2008 December 6 by IANS [cited 2015 July 4]; Available from: URL:http://www.thaindian.com/newsportal/uncategorized/doctor-jailed-for-issuing-fake-medical-certificates_100127982.html
6. Medico-legal helpline [24X7 helpline]. Maintenance of Medical records. 2008 June 15; [cited 2015 September 22]; Available from: URL:http://medicolegalhelpline.blogspot.in/2008/06/maintenance-of-medical-records.html
7. Tiwari Satish, Baldwa Mahesh, Tiwari Mukul, Kuthe Alka. Textbook on Medicolegal Issue. 1st ed. New Delhi: Jaypee Brothers Medical Publishers (P) Ltd; 2012. p. 49-52.
8. A Sample Health Record. Nlm.nih.gov. 2012-04-14. [cited 2015 September 22]; Available from: URL:https://en.wikipedia.org/wiki/Medical_record#cite_note-7
9. HC Division Bench of Justice, Satish Kumar Mittal and Justice, M. Jeyapaul, P & H High Court.
10. Malathy Iyer. The Times of India. Write all prescriptions in capital letters, Mumbai citizens tell doctors. 2012 May 20, 01.26AM IST. [cited 2015 July 4]; Available from: URL:http://timesofindia.indiatimes.com/city/mumbai/Write-all-prescriptions-in-capital-letters-Mumbai-citizens-tell-doctors/articleshow/13308546.cms
11. Mahanta Putul. Medical Law and Ethics. In: Modern Textbook of Forensic Medicine and Toxicology. 1st ed. New Delhi; Jaypee Brothers Medical Publishers (P) Ltd; 2014. p. 34.
12. Devi Prasad Singh, J Arvind Kumar Tripathi (II), J. Sameer Kumar vs. State of UP Thr. Prin. Secy. Medical Health Deptt. & Others, Misc. Bench No.11289 of 2013,

Date of Judgment: 12th September 2014, High Court of Judicature at Allahabad Lucknow Bench Lucknow. [cited 2015 July 4]; Available from: URL:http://updgme.in/docs/93Order%20Dated%2012-09-2014.pdf

13. Devi Prasad Singh, J Arvind Kumar Tripathi (II), J Smt Vimla Dvi vs. State of UP Thr. Prin. Secy. Medical Health Deptt. & Others, Misc. Bench No.7157 of 2014, Date of Judgment: 12th September 2014, High Court of Judicature at Allahabad Lucknow Bench Lucknow. [cited 2015 July 4]; Available from: URL:http://updgme.in/docs/93Order%20Dated%2012-09-2014.pdf
14. T.S.R. Subramanyam and Others. vs. Union of India and others, AIR 2014 SC 263. [cited: 2015 Oct 11]. Available from: URL:http://judis.nic.in/supremecourt/imgs1.aspx?filename=40943
15. Yadav Mukesh. Editorial: RTI and Medicolegal Cases. J Indian Acad Forensic Med 2013 Jan-March;35(1):4-6.
16. Ralph Heibutzki. Importance of Medical Documentation. Demand media. [cited 2015 July 4]; Available from: URL:http://work.chron.com/importance-medical-documentation-6966.html
17. A Vaidyanathan. NDTV. Supreme Court Orders Compensation of Rs. 1.8 Crore to Chennai Girl in Medical Negligence Case. 2015 July 02. [cited 2015 July 4]; Available from: URL:http://www.ndtv.com/india-news/supreme-court-orders-compensation-of-rs-1-8-crore-to-chennai-girl-in-medical-negligence-case-777238
18. SA Bobde, JV Krishnakumar vs. State of Tamil Nadu and Ors., Civil Appeal No. 8065 of 2009, with Civil Appeal No. 5402 of 2010. 1st July 2015 [cited 2015 July 2]. Available from: URL:http://judis.nic.in/supremecourt/imgst.aspx?filename=42745
19. Weed IL. Medical Records that guide and teach-N-Engl J Medicine 1968;278:652-7.
20. Verma Sunil. Patient Doctor Relationship: Changing Paradigm, Challenges and Strategies. International J of Health Research and Medico Legal Practice 2015;1(2):8-13.

Academic Excellence of Founder Member of IJHRMLP

Dr. Putul Mahanta MD FIAMLE is presently working as Associate Professor of Forensic Medicine and Toxicology in Tezpur Medical College, Tezpur, Assam and is a founder member cum chief editor of IJHRMLP.

Recently he has presented a guest lecture on the topic of "**Medical Ethics in Present Day Scenario**" at ICFMT 2015, XIVTH Annual National Conference of Indian Congress of Forensic Medicine & Toxicology held at Gurgoan SGT University held in 13th to 14th November, 2015 where he was awarded Fellow of "Indian Congress of Forensic Medicine & Toxicology". He is also a Fellow of "***Indian Association of Medico legal Expert***".