Maintenance and Preservation of Medical Record

KK AGGARWAL*, IRA GUPTA†

Hon'ble Member Dr. S. M. Kantikar, of Hon'ble National Consumer Disputes Redressal Commission in the case "Sri Ramachandra Hospital versus Suryanarayana & Others" vide judgement dated 17.12.2015 has stated:

"So, unsurprisingly, the content of medical records may be fundamental to the success of potential medical negligence case. A trained, experienced vigilant person is necessary to ensure this, which although it may be a time-consuming and costly process. Ultimately, the Patient records can help or tarnish a doctor in medical negligence cases....!!"

INTRODUCTION

Medical records are documentary evidences, which are of immense help not only in medicolegal cases but also in defending the doctor in cases of negligence suits or allegations against him/her. There are many cases/instances which are decided in favor of doctors only on the grounds of well-kept and well-reproduced records in consumer courts. However, doctors because of their busy schedule, either don't maintain records or records are kept very brief, incomplete, cryptic records which are of no use in court matters.

Hon'ble Supreme Court and the National Consumer Commission in various judgments have held the hospitals/doctors are liable for medical negligence for non-production of medical record and for non-maintenance of medical records.

DUTY OF THE DOCTOR TO MAINTAIN MEDICAL RECORD

It is the duty of doctor or hospital to preserve, maintain the medical record for certain specified period under different laws like Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, Limitation Act, Consumer Protection Act, the Directorate General of Health Service (DGHS), Prenatal Diagnostic Test Act, 1994, the Clinical Establishments (Registration and Regulation) Act, 2010 (Central Act No.23 of 2010). These records are required in medical negligence, accident, insurance claims and in criminal cases also in the Labor Courts.

The **Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002** (hereinafter MCI Code of Ethics) provides that

"Duties and responsibilities of the Physician in General:

1.3 Maintenance of medical records:

1.3.1. 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 the treatment in a standard proforma laid down by the Medical Council of India (MCI) and attached as Appendix 3.

1.3.2. If any request is made for medical records either by the patients/authorized attendant or legal authorities involved, the same may be duly acknowledged and documents shall be issued within the period of 72 hours.

1.3.3. A Registered medical practitioner shall maintain a Register of Medical Certificates giving full details of certificates issued. When issuing a medical certificate, he/she shall always enter the identification marks of the patient and keep a copy of the certificate. He/She shall not omit to record the signature and/or thumb mark, address and at least one identification mark of the patient on the medical certificates or report. The medical certificate shall be prepared as in Appendix 2.

1.3.4. Efforts shall be made to computerize medical records for quick retrieval."

NONMAINTENANCE OF MEDICAL RECORD IS A PROFESSIONAL MISCONDUCT

If the doctor does not comply with the provisions of MCI Code of Ethics, then the doctor is liable for disciplinary action. One of the act or omission on the part of doctor which can invite disciplinary action against the doctor is nonmaintenance of medical record. The provisions of MCI Code of Ethics are as follows:

"7. Misconduct: The following acts of commission or omission on the part of the physician shall constitute professional misconduct rendering him/her liable for disciplinary action:

7.2 If he/she does not maintain the medical records of his/her indoor patients for a period of 3 years as per

*Group Editor-in-Chief, IJCP Group
†Advocate and Legal Advisor, HCFI

regulation 1.3 and refuses to provide the same within 72 hours when the patient or his/her authorized representative makes a request for it as per the regulation 1.3.2."

Whether it is Government hospital or private, under whatsoever name may be, or the clinical establishments covered by Section 2 (c) of 2010 Act or the MCI Act, shall be liable to maintain the medical record and provide to patient or their attendants. Regulation 1.3 of the Regulations framed by the MCI (supra) requires that medical record shall be provided within 72 hours as and when demanded. The provision contained in Regulation 1.3 is applicable equally to all clinical establishments, private or State sponsored like individual medical professionals, hospitals, medical colleges, nursing homes, universities etc. Even if 2010 Act has not been applied, the definition of clinical establishment contained in 2010 Act, may be borrowed for the purpose of implementation of Regulation 1.3 framed by the MCI. **(Judgement dated 12.09.2014 Hon'ble High Court of Allahabad Lucknow Bench in the matter "Sameer Kumar versus State, Misc. Bench No. 11289 of 2013)**

IMPORTANCE OF MAINTAINING GOOD MEDICAL RECORD

- Communicates vital information about a patient's history and health status.
- Act as basis of planning and continuing medical treatment.
- Serve as source of information about the quality of care rendered to patient.
- Records consents, refusal, referrals, etc.
- Serve as a source of information for Mediclaim (insurance) related cases.
- Serve as a source of research and education.
- Provides evidence on whether care rendered met the professional standard of care.

ESSENTIAL INGREDIENTS OF A GOOD MEDICAL RECORD

Medical records should be maintained serially in a chronological order with dates and they should preferably contain the following entries in them:

- General particulars of the patient e.g.; Name, age, sex, address, emergency contact no, who brought him/her (with details). etc.
- Consent form duly filled and signed and thumb impression taken.
- Dates and timings of examination/admission and discharge – inpatients.
- Dates and timings of all visits and consultation.
- Details of the complaints – in a chronological order
- Personal and past history.
- Physical and laboratory/investigation findings (reports enclosed).
- Treatment given/surgical procedures in detail. (immediate entry not later)
- Day-to-day prognosis.
- In case of death; precise cause of death, date and time of death.
- Details of consultation by other doctors and their opinion.
- In medicolegal cases police need to be informed both at the time of admission as well at the time of discharge.
- Inpatients - details of discharge, cause of discharge – cured/referred to other centre/discharge on request or against medical advice (DMMA), etc.
- Any other special findings which you feel noteworthy

GUIDELINES FOR PREPARATION AND MAINTENANCE OF MEDICAL RECORD

Doctors should prepare and maintain medical records in the following manner:

- Maintain different registers for specific purposes in their office or place of practice.
- Maintain a separate register for the medical certificates issued, wherein all details must be entered. Every certificate must include two identification marks, if not at least one identification mark of patient, his signature/left thumb impression should take in the space meant for that. Certificates are to be prepared in duplicate and one copy must be kept in the records as office copy which should contain the receipt signature of the patient or the legal representative.
- All medical records including certificates must be prepared in a prescribed performa.
- All medical records should be written in a legible way or type written e.g., writing diagnosis or prescription in capital letters is a better way. Scribbling must be avoided.
- Medical records must be accurate, up to date, placed in order and complete in all respects. Incomplete or altered records create room for suspicion.
- Any alterations in the medical record made must be initialled without obliterating the original entry. E.g., drawing a single line over the sentence/word.

- The doctor must take some time/spend some time to prepare the patient's details in documentary form or get them prepared by a trained competent assistant (in western countries trained medical clerks are used by the doctors).
- Sincere efforts should be made to computerize the data, so that we can minimize the errors and the paper work can be brought down. (Facts of Medical Record Keeping - The Integral Part of Medical and Medicolegal Practice. *Gurudatta. S. Pawar, **Jayashree .G. Pawar)

PATIENT'S RIGHT TO OBTAIN MEDICAL RECORD

The Hon'ble National Consumer Disputes Redressal Commission in the matter titled as **Dr. Paramjit Singh Grewal vs Charanjit Singh Chawla vide judgment dated 19 October, 2006 held that**

> *"It is high time that Doctors write correct notes in the operation record and discharge summary. These documents should be made available to the patient at any time without any hue and cry. When information is given orally, it becomes a matter of debate as to who is telling the truth. It is patients right to know how his case has been dealt with by the treating Doctor. It will also enable him to follow the treatment prescribed for future and, if required, sometimes, even to take a second opinion of an expert. It is the duty of the Doctor to state in the record all the details of the treatment given, medicines which are prescribed and the follow-up advice, if any, and give it to the patient for his reference. Patient has a right to get the medical record pertaining to him and he cannot be denied the same when he paid the Doctor/Hospital for his treatment and hired the services."*

Even as per Clause 1.3.2 of the **MCI Code of Ethics**, it is the duty of the doctor to provide the medical record to the patient or his/her authorised representative. The provision is reproduced hereunder:

"Duties and responsibilities of the Physician in General:

> *1.3.2. If any request is made for medical records either by the patients/authorized attendant or legal authorities involved, the same may be duly acknowledged and documents shall be issued within the period of 72 hours.*

If the patient or any of his/her authorized representatives makes a request for the medical record and the doctor refuses to provide the medical record to the patient within a period of 72 hours (i.e. 3 days) then the doctor is liable for professional misconduct. The provisions of MCI Code of Ethics are as follows:

> *"7. Misconduct: The following acts of commission or omission on the part of the physician shall constitute professional misconduct rendering him/her liable for disciplinary action:*
>
> *7.2 If he/she does not maintain the medical records of his/her indoor patients for a period of 3 years as per regulation 1.3 and refuses to provide the same within 72 hours when the patient or his/her authorized representative makes a request for it as per the regulation 1.3.2."*

In case of **Dr. Shyam Kumar v Rameshbhai, Harmanbhai Kachiya I (2006) CPJ 16 (NC), the Hon'ble National Commission of Consumer Disputes Redressal** said that not producing medical records to the patient prevents the complainant from seeking an expert opinion and it is the duty of the person in possession of the medical records to produce it in the court and adverse inference could be drawn for not producing the records.

The **Hon'ble Central Information Commission** in the matter titled as "**Mrs Anita Singh vs Gnctd,** CIC/SA/A/2015/001894 order dated **16 March, 2016** observed that three enactments RTI Act, Consumer Protection Act and Medical Council Act, provided the appellant a strong and undeniable right to information to the patient of his/her own medical record.The Right of patient to Information to his/her own medical record is not only guaranteed under above three legislations but also rooted in Article 19 and 21 of the Constitution of India, 1950. This right is not limited to records held by public authorities alone but extends to all hospitals including private or corporate hospitals also to individual doctors, who treat patients.

CONCLUSION

Medical records are an integral part of medical practice as these records are important for the doctor, hospital, patient, patient's relative and society in general. These records are useful in situations like medical emergencies, medical negligence cases, medical researches, etc. Maintaining and preserving the good medical record is the responsibility of the doctor/hospital. The medical record should not only be maintained and preserved, it should be complete as well as incomplete medical record illustrates that care was incomplete, noncompliance of standards, organizational policies, supports allegations of negligence, etc. Honest, best and well-maintained medical records will always save the doctor and also the hospital from all types of crises and claims at all times.