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REVIEW ARTICLE

Legal Aspects of Medical Records

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Abstract

A medical record is a confidential compilation of pertinent facts of an individual's health history, including all past and present medical conditions, illnesses and treatment, with emphasis on the specific events affecting the patient during the current episode of care. The information documented in the health record is created by all healthcare professionals providing care and is used for continuity of care. It reflects and creates excellence in medical care and of Standards of Care. Documentation is legal protection for both patient and physician in the dispute over care. Failure to document important details can lead to adverse patient outcomes and malpractice suits.

Keywords: Confidentiality; consent; documentation

Introduction

The legal health record is the documentation of healthcare services provided to an individual during any aspect of health care delivery in any type of healthcare organization. It is consumer or patient-centric. The legal health record contains individually identifiable data, stored on any medium and collected and directly used in documenting healthcare or health status.

Components of medical records

a. Front sheet or identification summary sheet
b. Consent for treatment
c. Legal documents like referral letter
d. Discharge summary
e. Admission notes, clinical progress notes, nurse progress note
f. Operation notes
g. Investigation reports like x- ray, histopathology reports
h. Orders for treatment & the modification forms listing daily medications ordered
i. Given with signature of doctors & nurse administrations.

Definition of MLC

Cases wherever attending doctor after taking history and clinical examination of the patient thinks that some investigation by law enforcing agencies are essential so as to fix the responsibility regarding the case in accordance with the law of land.

Examples of MLC

1. Injuries due to Accidents and Assault.
2. Suspected or evident cases of suicides or homicides (even attempted cases).
3. Confirmed or suspected cases of Poisoning.
4. Burns.
5. Cases of injuries with likelihood of death.
6. Sexual Offences.
7. Suspected or evident Criminal Abortion.
8. All patients brought to the hospital in suspicious circumstances/ improper history (ex: found dead on road).
9. Unconscious patients where cause of unconsciousness is not clear.
10. Child Abuse
11. Domestic Violence.
12. Person under Police Custody or Judicial Custody.
13. Patients dying suddenly on operation table or after parenteral administration of a drug or medication.
14. Case of Drunkenness.
15. Brought Dead.
16. Natural Disaster.

The Police intimation

The police should be informed under Section 39 of Criminal Procedure.Code, the attending MO is legally bound to inform the police about the arrival of a MLC. Any failure to report the occurrence of a MLC may invite prosecution under Sections 176 and / or 202 of I.P.C

Importance of medical records

Courts rely heavily on Medical Records for evidence and they are summoned for following cases:-

- Criminal cases
- Personal injury cases
- Cases relating to workmen's compensation
- Malpractice suits
- Insurance cases
- Will cases

Legal aspects

- Police authorities and court can summon medical records under the due process of law.
- Limitation period for filing a case paper is maximum up to 3 years under limitation Act.
- According to the consumer protection act it is up to 2 years.

Release of information

The following points may be kept in mind while releasing the information from medical record.

- Name of Institute or individual that is to release and receive the information.
- Mention the Purpose, take Patient consent, Extent or nature, need and take the authorization from the competent authority for the information to be released.
- The patient can appoint the legal representative to receive the information.

Medical record law/ act

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 Honorable 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.

Law requires proper maintenance of case sheets. These are the single most important document that can used in medico legal cases. In few cases these documents may serve as effective alibi for the patients.

Law is very clear regarding the medical records and the valve of it. The medical records serve as legal document in pursuing the cases in the court for any kind incident happens to the patient.

Medical council of India Regulations 2022 Guideline on Maintaining Medical Records

- In a standard prescribed form for 3 years from commencement of treatment (Section 1.3.1 and Appendix 3).
- Request for MRs by patient or authorized attendance – to be acknowledgment and documents issued within 72 hours (section 1.3.2)
- Maintain a register of certificates with the full details of medical certificates issued with at least one identification mark of the patient and his signature (section 1.3.3).

- Efforts should be made to computerize medical records for quick retrieval (section 1.3.4).
- Medico- legal cases should be maintained until the final disposal of the case even though only.

Prenatal Diagnostic Test (PNDT) Act

- The provisions of specific Acts like the pre–Conception Prenatal Diagnostic Test (PNDT) Act, 1994 (PNDT), Environmental Protection Act Etc. necessitate records how have to be retained for periods as specific in this Act.
- 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 records should be preserved after authentication by the person responsible for such record.

Consent and informed consent

- Both are separated and distinct concept.
- Consent is generally recognized as a patient signing a name to a form, or verbally agreeing to a treatment plan or a procedure.
- Informed consent is a communication process that leads to shared decision – making by the physician and patient.
- Physicians are required to obtain informed consent from patients prior to treatment.

Informed consent accommodates both patient autonomy and the physician's responsibility

- Benefits of treatment
- Risks of treatment
- Alternatives (other treatment options)
- No treatment (risks of)
- Documentation + Signature (Pt+Dr+Wints)
- To examine, treat a patient without consent is assault in law even if it is beneficial and done in good faith [(1)].

Release of information

It is the duty of the doctor to keep all the medical records confidential that has originated during treatment. They can be made public only by the written permission of the patient. However, if directed by court of law, they can be produced. Police has the power to seize medical records of some negligence is suspected.

In the absence of agreement to the contrary X-ray plates are the property of the treating doctor as part of his case record. Intact buys the skills and treatment rather than X-ray films [(1)]

Methods to release the medical records

- Direct access to, Photocopying all or a portion and abstracting information from medical records.
- Verbal release of information in the court of law.

Conclusion

Records of the organization come in a variety of formats and needs in various aspects; the storage of records can vary throughout the organization. Good maintenance of medical records is in the interest of patient, doctors and society. When procedure done is not documented means it is not done. Medical records should be neat, legible, timely, and accurate with professional tone. File maintenance may be carried out by the owner, designee, a records repository, or clerk. Records may be managed in a centralized location, such as a records center or repository, or the control of records may be decentralized across various departments and locations within the entity. Records may be formally and discretely identified by coding and housed in folders specifically designed for optimum protection and storage capacity, or they may be casually identified and filed with no apparent indexing. Organizations that manage records casually find it difficult to access and retrieve information when needed. The inefficiency of filing maintenance and storage systems can prove to be costly in terms of wasted space and resources expended searching for records may not cause any hurdle to transform any kind of information to patient and hospital.

References

1) Reddy KN. Essentials of FMT 2017 . 2017.