PRESERVATION OF MEDICAL RECORDS- AN ESSENTIAL PART OF HEALTH CARE DELIVERY

Dr Sanju Singh (presenting author), MHA (AIIMS)
Senior Resident, Dept of Hospital Administration, All India Institute of Medical Sciences, New Delhi

Dr U.S. Sinha, Professor & Head
Dept of Forensic Medicine, M.L.N. Medical College, Allahabad, U.P

Mr. N. K. Sharma, Chief Medical Record Officer
All India Institute of Medical Sciences, New Delhi

ABSTRACT:

The diagnostic reports, clinical as well as Para clinical care, medico-legal reports, birth and death certificates are various medical records which are prepared in a hospital in the interest of patient, hospital and law the medical records required to be preserved up to certain length of time and this article discussing the safe methods of preservation of medial record.

Key: Medical Record, Preservation, Micro Filming

INTRODUCTION

Record management is a programme that involves the function of creating, administering, retaining, submitting and destroying the record. Herbert Hoover has rightly mentioned the advantages of proper record keeping when he says, "A business decision is only as good as the facts on which it is based." 5

Records are memory of the Internal as well as external transaction of an organisation. By external transaction we mean the correspondence between the organisation and its client, beneficiaries as well as supporters. By internal transactions, we mean the dealings on external traction by persons in the organisation at all levels. Records contain a written evidence of the activities of an organisation in the form of letters, circulars, reports, contracts, invoices, vouchers, minutes of meeting, books of accounts, etc. it is recommended that more efforts should be made by the hospital management, all clinicians as well as medical record officer should move towards improving the standard of maintenance and preservation of medical records.

The management and preservation of hospital records in the Indian context presents a very gloomy picture. Of course, the private hospitals have been found establishing an edge over the government hospitals even in respect o f records management.1

Despite intensive endeavors at national and international levels the fundamental health care needs of the population in developing countries are still unmet and the underprivileged in these countries scarcely have excess to health services. The lack of basic health data renders difficulties in formulating and applying a rational for the allocation of limited resources that are available for patient care and disease prevention.

Prior to last four decades, the status of medical record administration and technology in developing countries was deplorable. The medical staff only vaguely appreciated the value of the health care record, record completion task and its maintenance remains a low priority. Within last thirty years, significant progress has been occurred in the field of medical records in developing countries. Medical record departments in teaching and research hospital have planned and organized efficacious system for record completion and retention9. Yet by international standards much remains to be done, especially in the vast majority of hospitals where medical record services are sometimes considered as an administrative burden.

Hospital medical records is a documentary evidence as per the Indian Evidence Act, 1872, as amended up to August 1, 1952 & 1961 and medical records are generally summon to the court of law in the following types of cases in our country:

Insurance Cases: Frequent requests come from the life insurance corporations regarding details of the hospitalization of a patient. This is for the purpose of disposing claims that may have arisen for settlement as the patient is insured with the

corporation. With the help of the hospital medical record, various life insurance forms are completed. Though the information made available from the hospital medical record is a privileged communication and the document in this respect is used as a personal document, yet the release of such information without the prior consent of the patient is permissible because the patient had waived his claim of this privilege at the time of taking out a policy with the corporation.

Workmen's Compensation Cases: The workmen's compensation Act of 1923 as amended up to 1942, provides for the payment, by certain classes of employees to their workmen, of compensation for injury caused by accident arising out of and in the course of employment. A commissioner appointed under section 20 of the above Act awards the compensation as prescribed in the Act. A right from the onset is therefore of paramount importance. The medical record in such instances is used as evidence to show the date, the type and severity of the injury, the period of disability and the prognosis.

Personal Injury Suits: In this type of suit, the claim is made by the individual for damages sustained as the result of injuries, which were due to the fault or neglect of another. The patient may show the extent of the injuries, the treatment rendered and the duration of the care required. The medical record is used to obtain the required data for this purpose.

Malpractice Suits: Malpractice is defined as want of reasonable care and skill or willful negligence on the part of a doctor, nurse or other staff of hospital in the treatment of a patient so as to lead to bodily injury or loss of life. An action for malpractice may be brought against the hospital and its employee in a civil or criminal court. The hospital medical record is used to show whether there was negligence and whether the treatment rendered was adequate and proper or otherwise.

Will Case: The patient may have made a will during his hospital stay. After the death of the patient an attempt may be made to set the will aside by seeking to prove that the patient was not competent to make a will at that time.

The Income Tax Act: Request for confidential information concerning a patient is frequently required by the income tax officer from the hospital. This information is available in the medical record. Here, again the medical record is used as a personal document and yet the information has to be made available to the income tax officer by virtue of the power conferred on him under the section 38(5) of the Income Tax Act 1922 and no prior permission from the patient is necessary.

Criminal Cases: Cases which are tried under the Indian Panel Code and related with criminal cases are generally limited to the medico-legal report and postmortem examination report. However in many cases a criminally injured patient receive medical or surgical care as a hospitalized case, in such situation clinical sheets are required to decide the nature of injury in recovered patient.

Human Organs transplant Cases: The transplantation of human organs act, 1994 is meant to "provide for the regulation of removal, storage and transplantation of human organs for therapeutic purposes and for the prevention of commercial dealings in human organs." The central act illegalises the buying and selling of human organs and make cash for kidney transaction a criminal offence. The act details action that amount to direct participation in or abetment of the organ trade: these offences are punishable under section (19) of this act.

The section (20) of this act states that, whoever contravenes any provision of this act or rule made, of any condition of the registration granted, there under for which no separately provide in this Act, shall be punishable with imprisonment for a term which may extend to three years or with fine which may extend to five thousand rupees.

Further the section 22(3) of the Transplantation Of Human Organ Act, 1994 states that, where a complaint has been made under clause (b) or sub-section (1), the court may, on demand by such person, direct the appropriate authority to make available copies of the relevant records in its possession to such person. Thus in such a situation the hospital medical record is used to show whether any malpractice done and would also be required to decide the nature of offence actually committed by the hospital and its employee3.

Other important medico legal issues

(i) Laws in each country very and one must be familiar with the country's laws for dealing with medico legal requests. In the absence of specific statutes and regulations, certain practices should be determined by the hospital administration and MUST be followed by the medical record staff.

(ii) The attending doctor should be responsible for checking legal requests and release of information to ensure that only information relevant to the request is released.

(iii) Except for providing ongoing care and treatment for the patient, all photocopying of the patient's medical records requested by the patient or the patient's authorized nominee should be at the expense of the patient and not the hospital.

(vi) As a general rule, access to medical records should be restricted to health professionals involved in the continuing care of the patient.

(v) Medical records may be used for research and statistics without the patient's consent as long as the patient is NOT identified.

Legal Limit for Preservation of Medical Records

1) Where there is chance of litigation arising for medical purpose of negligence, record should be preserved for at least 25 years, specially because there are rules where the minors have the rights to sue the doctor within three years from the date of majority, for the injuries sustained due to negligence of the doctor during the period of his minority.

2) Other medico legally important records should be preserved upto 10 years after which they can be destroyed after making index and recording summary of the case.

3) Routine cases records may be preserved upto 6years after completion of treatment and upto 3 years after death of the patient.

4) There are certain records in hospital, which are of public interest and are transferred to public records library after 50 years for release to public and those involve confidentiality of the individuals are released only after 100 years2.

Correction of Original Data

The problem of correction of ages, dates, etc., in hospital records is of vital importance. Information contained in the personal and statistical data of a medical record should never be altered. It should only be endorsed after receiving an affidavit from the patient or his/her legal heirs. Correcting an error or oversight in a medical record can be disastrous in a medical negligence case, if the judge believes that the changes were made to cover up improper care or to include something that was never done9.

Destruction or alteration of a medical record by an unauthorized person is known as SPOLIATION. To prevent the appearance of spoliation, health care providers should follow DGHS guidelines, vide letter No. 10-3/68-MH dated 31/8/1968, which are as under:

1. When correcting an error, strike out the incorrect statement with a single line and place your initial and date next to it. Then make the correct entry in the record. Attempting to obliterate the erroneous entry by applying a whitener or scratching through the entry in such a way that a person cannot determine what was originally written raises the suspicion of someone looking for negligent or inappropriate care.

2. Entries in a medical record should be made on every line. Skipping lines leaves room for tampering the record, a practice not in the best interest of the patient or provider.

3. In medico-legal cases, the record should be in the custody of the doctor who examines the patient and finalizes the report. No one else should have access to it.

4. Correcting of personal identification of data of the patient like: name, father/ husband name, age, sex, address should only be done the basis of affidavit by notary or 1st class magistrate.

The relationship between physicians and patients has changed and the concept of personal autonomy has become an important aspect of healthcare delivery, all over the world. The ownership or right to information from medical records has also changed. The current widely accepted theory about medical records is that the caregiver or hospital owns the records, but the patient has the right to the information included in the record except where prohibited by law or by the patient's medical condition did not indicate necessity of procedures. The laws of ownership require that, the records be released to patients upon request8.

ESSENTIALS OF RECORDS MANAGEMENT:

1. **Comprehensive:** The records should be such as can be easily understood when retrieved back for planning, policy making and decision making. The language used should be simple and understandable.

2. **Properly planned:** The records are to be screened at regular intervals of time to weed out the information not required for future. In this way we can reduce the paper work to 25%. This would indirectly help us in locating the desired information quickly.

3. **Economical:** We should manage the records economically so that we may achieve more with minimum efforts.

4. **Accurate:** The records should be accurate otherwise its utility would be doubtful.

5. **Timely:** The time taken in retrieving the information should be as short as possible. Reducing retrieval time is essential for effective material management.

6. **Classification:** Records must be classified to be of practical use. The classification is done either on the basis of subjects or chronology.

It should: -

(a) Serve specific needs

(b) Have specific objectives and purposes.

(c) Be kept to a minimum with respect to number, scope and content.

(d) Be designed for least expensive handling

(e) Be upto date

(f) Be worth their cost

(g) Be related directly to tabulations and reports that will stem from them

(h) Be available when needed

(i) Be considered valuable by supervisors and line management.

Some of the medical records have to be retained for more than 10 years and some of them for even an indefinite period because of the important purposes they serve, namely:

1. To meet the needs of patient;

2. To assist in protecting the legal interest of the patient, the attending staff

3. The hospital and also to serve as proof of work done;

4. To assist in the teaching of medical and paramedical staff and to carry out medical research.

The recent guideline of Indian court and DGHS vide letter No. 10-3/68-MH dated 31.8.1968 states that responsibility of hospital to keep medical records is up to duration of 5years for outpatient department and inpatient medical record (case sheet MLC and Non MLC) is up to 10 years.

Issues and Problems of Records Management and Its Preservation in Hospitals

Based upon observation, discussion and analysis, the main problems faced by hospital authorities in preservation and management of records are as follows: -

a. Use of outdated forms: Need of constant revision

b. Shortage of experienced personnel: Need of trained personnel

c. Lack of planning in storage of in-active records: Need of effective storage and control of in- active records.

d. Lack of determination of records retention period: Need of determination of records retention period. The unwanted records should be destroyed to save the time and resources.

e. Delay in transfer of records: transfer of record entail two stages i.e. (i) Dating of unimportant records for destructions and

ultimate disposal. (ii) Moving the records from active to in-active files and from there to the storage area.

Types of Damages:

There are various types of damages1, which may be found in paper documents, like: -

1. With age it may become weak. Sometimes paper gets so weak that it gets broken into pieces.

2. There may be a colour alteration in it and it may get yellowed.

3. Dust and dirt may be present on the surface.

4. Insects of various types may have damaged the document.

5. Fungi may be actively present, or may have damaged the paper in the past.

6. The document may have got stained by various means e.g.: water stains, fungus stains oil stains, ink stains or simply dirt stains.

7. Water may have affected the paper at some time, and besides staining, it may have made it limp.

8. In prolonged contact with water it may become soggy.

9. The sizing materials may have deteriorated, making the paper loose or soft.

10. The document may not be complete and some part may be missing.

11. If the paper is kept folded, it may become weak or may break at the creases.

These are only examples, and apart from them, there may be some other types of defects also present in the paper.

Deterioration of paper takes place due to various agencies1, which may be grouped as:-

A. Biological: - The most important biological organisms are Fungi, Bacteria, Algae, Yeast, protosova. Insects such as cockroaches, silver fish and bookworms damage the paper materials. The most devastating are the termites', which may damage full stacks of record materials in no time. Other biological agents are rodents like rats.

B. Physical: - It is noticed that with time, paper gets physically weak and brittle. The main causes of physical deterioration are light, heat, moisture and handling. While, light, heat and moisture brings about photochemical changes or oxidative changes in paper, mishandling or neglect may cause mechanical damage.

C. Chemical: - It is very difficult to make a distinction between physical and chemical deterioration of paper. It is only for understanding, the phenomenon that certain types of deterioration, for example caused by light, heat and humidity have been included under physical deterioration. Although it is very well known that these agencies also cause chemical actions like photochemical action, oxidation, hydrolysis, etc. Under the heading Chemical Deterioration are included those actions which are brought about by chemicals present in the paper or in the atmosphere.

Factors of Deterioration:

According to the survey done at the INTACT, Indian conservation Institute, there are a number of factors that have a deteriorating action on record papers and files. Some of the important factors as under7:

1. Climate and environment

2. Light

3. Insects

4. Fungus

5. Atmospheric pollution

6. Mishandling/ neglect

7. Improper storage

The Following Measures Are Recommended In Literature For Proper Preservation Of Medical Records:

1. Selection of paper and ink. 2. Preservation (prevention of decay. 3. Protection from insect attack: Dark and dinghy places, crack, loose joints in floor and walls and presence of edibles in the record room encourage insect breeding. Along with periodical checking of the floors and walls, and attending to minor defects, insecticidal powers or spray insecticides can be used and naphthalene balls placed on shelves to preserve the records. 4. Protecting all documents including patient's files, registers, index cards, etc from water and dampness. 5. Preventing documents from being exposed to hot and dry climate. 6. Safety measures against fire: Smoking, lighting of matchsticks. 7. Care in handling: All efforts for proper preservation and storage will however be in vain if care is not observed in handling the record. 8. Filing records in a dust free areas. 9. Prohibiting of storing of chemicals near the records. 10. Providing and maintaining adequate fire extinguishers at all required places. 11. Covering with wire net (as frames) the windows and ventilators as safeguards against sabotage or pilferage. 12. Regulating the temperature and humidity in the range between 22-25 degree centigrade (72-780F) and 45-58 % humidity respectively. 13. Taking good care in handling the records. 14. Microfilming control register: certain medical records including patient files may be preserved and microfilmed as a long-term measure6.

Maintenance of Old Records:

1. Collection of old register, records and index cards of the medical record department and other departments of the hospital.

2. Classifying them according to the different sections.

3. Allocating an old record in a place designated for the purpose for a prescribed period.

4. Filing all old records in a place designated for the purpose for a prescribed period.

5. Destroying the records as per the regulations established for retention of records.

6. Enter in a destruction register, the records destroyed

7. Keeping a note of the records destroyed, of the records for which microfilm copies (or microfiches) are available.

Micro Filming of Records:

1. Microfilm documents including patient's file, index cards, etc. as per the record retention schedule or the standing instructions issued by the hospital, the ministry, the state or federal government.

2. Refer to guidelines for microfilmed records in the pre- hospital number register.

3. Enter the identification data of microfilmed records in the pre- hospital number register.

In a complex organisation, we can make use of microfilms. Microfilms can help in space saving, safe preservation, clean and easy handling. Besides, these reduce the risk of fire hazards and chances of loosing documents5.

CONCLUSION

The medical record is the property of the hospital. The chief value of medical records as evidence is that they contain unbrased statements in as much as the doctors, nurses and other concerned in making the medical record at the time of the patient's hospitalization had no interest in any subsequent litigation. The hospital medical record is not merely a collection of papers recounting the tale of patients sojourn under the care of his physician in a hospital. It is an inpatient document and is frequently used in the court.

In order to balance the health care provider (doctor & hospitals) and the receiver / consumer (patients) there is a need to legalize the importance of maintaining and scientific preservation of patient records in all the healthcare facilities including private practitioner clinics, nursing homes, PHCs and small and big hospitals.

The code of medical ethics adopted on the basis of Medical Council of India circular letter no 11/3/02 MCI-221 (2) 2001-Regn/2373 also states that the medical profession has a long subscribed to a body of ethical stament developed primarily for the benefit of the patients. Further it goes on to state that every doctor registered with Medical Council of India 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 Performa laid down by Medical Council of India. If any request is made for medical records either by the patients/ authorized attendants or a legal authorities involved, the same may be duly acknowledged and documents shall be issued within the period of 72 hours. Even while issuing a medical certificate the registered medical practitioner shall maintain a register of medical certificates giving full details of certificates issued. It has also suggested that efforts shall be made to computerize medical records for quick retrieval6.

Thus the record management and preservation is concerned with the retaining, submitting and destroying of records. The proper preservation and maintenance of these records in right quantity and quality is the essence of record management. The success of this record keeping would be reflected in the timely availability of all the records. In the context of medical records, Dr. M. C. Gibony had said, “Chronicle of the pageantry of medical and scientific progress is found in the hospital records.” There may be found a running story, disconnected it is true, of the drama, the comedy, the mystery, miracle of medicines and hospitals of the 20th centaury4.

REFERENCE

1. Agarwal OP, Barkeshli M, Conservation of books, Manuscrprits and paper documents, INTACT, Lucknow, 1997, pp. 25-48

2. Basu R.N, Bose T.K: Medico legal aspect of clinical & hospital practice, English edition publishers, Mumbai, India, pp 86-89; 2005

3. The Transplantation Of Human Organs Act, 1994, [Act No. 42 Of 1994 Dated 8th July, 1994] http://www.indialawinfo.com/bareacts/_Toc498337733 accessed on 05- 05-2006.

4. Mc. Giboney, John, R: Principles of hospital administration, GP Putnam and sons, 1952, pp. 223-230

5. Mogli GD: Organisation and management, Jaypee brothers medical publishers (p) ltd, New Delhi, India, 2001, pp. 348-61

6. Notification No. MCI 211(2) 2001- Regn., dated 11th March, 2002, published in the Gazette of India, Pt. III. Sec 4, dated 6/4/02

7. Paper conservation news, No.79, pp. 10-11

8. Stetler CJ, Mortiz AR. Doctor and patient and the law. St Louis:C. V. Mosby; YEAR:pp. 133-72.

9. World health organisation study group on hospital medical records: WHO/HS/NAT.COM/70/752