Review

Medico-Legal Aspects of Medical Records & Documentation

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Article History
Received Nov 13, 2017
Received in revised form Nov 28, 2017
Accepted on Dec 8, 2017

Abstract
Medical records of the patients are medico-legal documents and a doctor can be cross- examined against the same. However, it is a strong evidence of the proof of administration of standard medical care provided the medical record is properly maintained and the documentation is complete. Incomplete medical records spell deficiency in service and the complainant patients are entitled for compensation under law.

Key Words:- Medical Record, Personal Health Record, Dossier, Bioethics, Electronic Health Record, Legal Liability, Malpractice, Interoperability.

Introduction

The terms medical record, health record, and medical chart are used somewhat interchangeably to describe the systematic documentation of a single patient's medical and care across time within one particular health care provider's jurisdiction [1]. The medical record includes a variety of types of "notes" entered over time by health care professionals, recording observations and administration of drugs and therapies, orders for the administration of drugs and therapies, test results, x-rays, reports, etc. The maintenance of complete and accurate medical records is a requirement of health care providers and is generally enforced as a licensing or certification prerequisite.

Medical records have traditionally been compiled and maintained by health care providers, but advances in online data storage have led to the development of personal health records (PHR) that are maintained by patients themselves, often on third-party websites. This concept is supported by US national health administration entities [2] and by AHIMA, the American Health Information Management Association [3].

Because many consider the information in medical records to be sensitive personal information covered by expectations of privacy, many ethical and legal issues are implicated in their maintenance, such as third-party access and appropriate storage and disposal. Although the storage equipment for medical records generally is the property of the health care provider, the actual record is considered in most jurisdictions to be the property of the patient, who may obtain copies upon request.

Some of the medical and legal issues concerning maintenance of the medical records are being discussed here for the knowledge of and as the guidelines for the medical professionals dealing with patients to sensitize them for the day to day ethical and legal challenges from different quarters:-

a. **The Use:**
   - The information contained in the medical record allows health care providers to determine the patient's

medical history and provide informed care.

- The medical record serves as the central repository for planning patient care and documenting communication among patient and health care provider and professionals contributing to the patient's care.
- An increasing purpose of the medical record is to ensure documentation of compliance with institutional, professional or government regulation.

b. **The Media:**

- Traditionally, medical records were written on paper and maintained in folders often divided into sections for each type of note (progress note, order, test results), with new information added to each section chronologically. Active records are usually housed at the clinical site, but older records are often archived offsite.
- The advent of electronic medical records has not only changed the format of medical records but has increased accessibility of files. The use of an individual dossier style medical record, where records are kept on each patient by name and illness type originated at the Mayo Clinic out of a desire to simplify patient tracking and to allow for medical research.
- Maintenance of medical records requires security measures to prevent from unauthorized access or tampering with the records.

c. Bio-Medical Ethics:

- **Bioethics** is the study of the typically controversial ethical issues emerging from new situations and possibilities brought about by advances in biology and medicine. It is also moral discernment as it relates to medical policy and practice. Bioethicists are concerned with the ethical questions that arise in the relationships among life sciences, biotechnology, medicine, politics, law and philosophy. It also includes the study of the more commonplace questions of values which arise in primary care and other branches of medicine.
- Medical ethics is the study of moral values and judgments as they apply to medicine. The four main moral commitments are respect for autonomy, beneficence, normaleficence, and justice. Using these four principles and thinking about what the physicians' specific concern is for their scope of practice can help physicians make moral decisions [4].

d. **Electronic Health Record:**

An **electronic health record** (**EHR**), or **electronic medical record** (**EMR**), refers to the systematized collection of patient and population electronically-stored health information in a digital format [5]. These records can be shared across different health care settings. Records are shared through network-connected, enterprise-wide information systems or other information networks and exchanges. EHRs may include a range of data, including demographics, medical history, medication and allergies, immunization status, laboratory test results, radiology images, vital signs, personal statistics like age and weight, and billing information [6].

EHR systems are designed to store data accurately and to capture the state of a patient across time. It eliminates the need to track down a patient's previous paper medical records and assists in ensuring data is accurate and legible. It can reduce risk of data replication as there is only one modifiable file, which means the file is more likely up to date, and decreases risk of lost paperwork. Due to the digital information being searchable and in a single file, EMR's are more effective when

extracting medical data for the examination of possible trends and long term changes in a patient. Population-based studies of medical records may also be facilitated by the widespread adoption of EHR's and EMR's. The legal issues related to HER systems include:

i. **Liability**: - Legal liability in all aspects of healthcare was an increasing problem in the 1990s and 2000s. Failure or damages caused during installation or utilization of an EHR system has been feared as a threat in lawsuits. [7]. Similarly, it is important to recognize that the implementation of electronic health records carries with it significant legal risks [8].

While there is no argument that electronic documentation of patient visits and data brings improved patient care, there is increasing concern that such documentation could open physicians to an increased incidence of malpractice suits. Disabling physician alerts, selecting from dropdown menus, and the use of templates can encourage physicians to skip a complete review of past patient history and medications, and thus miss important data.

Another potential problem is electronic time stamps. Many physicians are unaware that EHR systems produce an electronic time stamp every time the patient record is updated. If a malpractice claim goes to court, through the process of discovery, the prosecution can request a detailed record of all entries made in a patient's electronic record. Waiting to chart patient notes until the end of the day and making addendums to records well after the patient visit can be problematic, in that this practice could result in less than accurate patient data or indicate possible intent to illegally alter the patient's record [9].

ii. **Legal interoperability**: - In cross-border use cases of EHR implementations, the additional issue of legal interoperability arises. Different countries may have diverging legal requirements for the content or usage of electronic health records, which can require radical changes to the technical makeup of the EHR implementation in question especially when fundamental legal incompatibilities are involved. Exploring these issues is therefore often necessary when implementing cross-border EHR solutions [10].

e. **Hospital Information System:-**

A hospital information system (HIS) is an element of health informatics that focuses mainly on the administrational needs of hospitals. In many implementations, a HIS is a comprehensive, integrated information system designed to manage all the aspects of a hospital's operation, such as medical, administrative, financial, and legal issues and the corresponding processing of services. There is no standardization, except for data formats and for data interchange, as with the HL7 initiative supported by ISO:

- Efficient and accurate administration of finance, diet of patient, engineering, and distribution of medical aid. It helps to view a broad picture of hospital growth.
- Improved monitoring of drug usage, and study of effectiveness. This leads to the reduction of adverse drug interactions while promoting more appropriate pharmaceutical utilization.
- Enhances information integrity, reduces transcription errors, and reduces duplication of information entries [11].
- Hospital software is easy to use and eliminates error caused by handwriting. New technology computer systems give perfect performance to pull up information from server or cloud servers.

f. **Physician-Patient-Privilege:**

Physician–patient privilege is a legal concept, related to confidentiality that

protects communications between a patient and his or her doctor from being used against the patient in court. It is a part of the rules of evidence in many common law jurisdictions. Almost every jurisdiction that recognizes physician–patient privilege not to testify in court, either by statute or through case law, limits the privilege to knowledge acquired during the course of providing medical services. In some jurisdictions, conversations between a patient and physician may be privileged in both criminal and civil courts.

The privilege may cover the situation where a patient confesses to a psychiatrist that he or she committed a particular crime. It may also cover normal inquiries regarding matters such as injuries that may result in civil action.

The rationale behind the rule is that a level of trust must exist between a physician and the patient so that the physician can properly treat the patient. If the patient were fearful of telling the truth to the physician because he or she believed the physician would report such behavior to the authorities, the treatment process could be rendered far more difficult, or the physician could make an incorrect diagnosis.

In some jurisdictions, the doctor cannot be forced to reveal the information revealed by his patient to anyone except to particular organizations, as specified by law, and they too are required to keep that information confidential. If, in the case, the police become aware of such information, they are not allowed to use it in court as proof of the sexual conduct, except as provided by express intent of the legislative body and formalized into law [12]. The law in Ontario, Canada, requires that physicians report patients who, in the opinion of the physician, may be unfit to drive for medical reasons as per Section 203 of the Highway Traffic Act Ontario [13]. The law in New Hampshire places physician–patient communications on the same basis as attorney–client communications, except in cases where law enforcement officers seek blood or urine test samples and test results taken from a patient who is being investigated for driving while intoxicated [14].

g. **Maintenance of Medical Records: As per Indian Medical Council Act [15] rules:**
   - 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.
   - If any request is made for medical records either by the patient / authorized attendant to the authorities, the same may be duly acknowledged and documents shall be issued within the period of 72 hours.
   - A registered medical practioner 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 certificate or report.
   - Efforts shall be made to computerize medical records for quick retrieval.

Conclusion:

Complete documentation and maintenance of the medical record of the patients is the mandatory legal requirement under Indian Medical Council Act and the Consumer Disputes

Redressal Commission. The information in medical records is considered to be sensitive personal information covered by expectations of privacy and many ethical and legal issues are implicated in their maintenance. Although stored in the custody of the health care provider, the medical records are in fact property of the patient. Respect for autonomy, beneficence, normal-eficence and justice to the patients are the four main commitments and the principles of the medical ethics which can facilitate the physicians to make moral decisions for their patients. Physician–patient privilege is a legal concept related to confidentiality and the rationale behind the rule is that a level of trust must exist between a physician and the patient so that the physician can properly treat the patient.

Conflict of Interest None

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