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Medical Records: Making and Retaining Them

What Is A Medical Record?

A medical record is information about the health of an identifiable individual recorded by a doctor or other healthcare professional, either personally or at his or her instructions. It should contain sufficient information to 'identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among healthcare providers'.

A good medical record should therefore provide a newcomer to the care team with all the information about a patient and his/her treatment plan that he/she would need for continuity of care. The items that may constitute part of the patient's medical record include one or more items of the following list: hand-written clinical notes; computerized/electronic records; letters to and from other health professionals; laboratory reports; radiographs and other imaging records; printouts from monitoring equipment; photographs; videos; and tape-recordings of telephone consultations.

Computerised and electronic records.

From a legal viewpoint, the evidential value of records held only on computer depends very much upon the audit trail that can be demonstrated. Systems that record the author and the dates on which entries and other amendments to them are made will be of high evidential value.

Printouts from monitoring equipment

These are particularly important in emergency situations - such as during cardiac arrest or difficulties during anaesthesia where it is difficult or impossible to keep contemporaneous written records. Printouts from monitoring devices are also an important part of the obstetric record. Thermal printouts (using heat-sensitive paper) fade over time so they should be photocopied for inclusion in the record. Printouts must be attached securely to handwritten records, and monitoring artefacts identified clearly.

Good contemporaneous notes

Good contemporaneous notes should be made in each medical consultation. The primary purpose is to provide good continuity of care. The secondary purpose is to provide evidence of care given to the patients. In court, medical records may undergo detailed scrutiny. Their quality tends to be seen as a reflection of the standard of medical care provided by the writer.

Furthermore, in a factual dispute where the patient alleges one thing and the doctor another, the patient's recollection will usually be preferred to that of the doctor, unless the doctor can produce a clinical entry supporting his/her version that was written at the end, or very soon after the particular incident in dispute.

How To Write A Good Medical Record

Notes should be written during the consultation or immediately afterwards, as soon as possible after the event has occurred. Write your notes in a straightforward, purposeful and factual style. Avoid remarks of sarcasm, wit or cryptic remarks. Write also such that it cannot be erased. Use clear handwriting that is large enough to be readable on photocopying and ensure that you can be identified as the author (i.e., initialize at the end of what you have written).

What to leave out

Do not write critical comments about care given to the patient by others. You may not have all the information then to make a balanced judgment. Record facts rather than personal opinion of the patient's character, particularly if derogatory. For example, record in a factual manner the amount of exercise a patient takes rather than writing in your notes 'couch potato'.

What to include

You should:

- State the history, including answers to relevant direct questions.
- Record all the systems you examined, note all positive findings, important negative finding and objective measurements such as blood pressure.
- State your opinion (avoiding vague and obsolete diagnostic terms) - remember that a reader should be able to understand from your notes why you reached that conclusion.
- Include a careful record of investigations, so that results can be reviewed by others if necessary; make a clear distinction between investigations you have actually ordered and those that you are contemplating.
- List the drugs and dosages you have prescribed, and other treatments you have organised.
- Record, in a prominent place, any drug allergies or adverse reactions.
- Record arrangements for follow-up and referrals made.
- Summarise the information you have given the patient about his or her condition, including, where appropriate, warnings about the risk/benefits of proposed treatments.
- Record prominently any advance directives made by the patient prohibiting certain treatment options.

If you have been given the patient's history by a person other than the patient (e.g. a relative, police officer, translator or friends), record that person's name and status.

Therefore, a good medical record serves the interests of the medical practitioner as well as his patients. The key to defensibility of at least 40% of all medical negligence claims rests with the quality of the medical records. Illegibility, inadequacy or absence dooms almost half of medical negligence cases. Medical records are often the only source of truth. They are likely to be far more reliable than memory.

Abbreviations

Keep in mind that abbreviations may not be understood by others. Also do not used coded messages to express exasperation, sarcasm or your poor opinion of the patient.

Altering Medical Records

Please take note that you:

- Do not alter notes retrospectively. The courts would view very seriously any attempt to rewrite notes that will be used as evidence in legal proceedings. If you later discover that something you have written was inaccurate, misleading or incomplete, insert an additional note as a correction.
- Make sure that it is clear to the reader that the new note is a later amendment, and that you are not attempting to tamper with the original record – date and sign it.
- Amend an electronic record by striking through rather than deleting and over-writing the original entry. After inserting the new, add the date and your name.

Retention Of Records

Statutory limitation periods for an action in negligence to be brought up for hearing after the alleged negligence occurred vary from country to country. Generally, it is between 3 and 7 years. They do not however, apply to plaintiffs with brain damage; they can bring a negligence claim at any time because in legal terms they are considered to be minors, not matter what their chronological age.

As a rule of thumb, most medical records can be safely destroyed when 10 years have elapsed since the patient was last treated, or since the patient's death. However, if the records related to a minor, or are maternity records, they should be kept until the patient reaches 25 unless he or she is brain-damaged, in which case the records should be kept until 10 years after his or her death.

In Singapore, the Ministry of Health has defined guidelines for retention of medical records in hospitals. These were issued in February 1996 and further clarified in the circular of March 1996. The retention period for primary medical record of all adult hospital surgical patients is 3 years which is the same as that for adult medical patients. The legal requirement for retention of medical records is 15 years. To comply with this requirement, the Guideline requires hospitals to retain secondary medical records for these patients for a further minimum of 17 years. The legal requirements for the retention of medical records are laid out in the Limitation Act (22/92). Annex 1 shows the retention period for medical records in Singapore (issued by Ministry of Health, Singapore, in Feb 1996) as well as explanatory notes on what are primary and secondary records. Such guidelines would be reasonable for medical clinics to follow as well.

Ownership of Medical Records

Medical records may be regarded as aides-memoires created by the medical practitioner to assist him in the management of patient care. As such they are and remain the doctor's own property. By the same argument, hospital records belong to the hospital.

GPs are often asked for the medical records of patients either by the patients themselves or by another GP. Doctors should co-operate fully by providing a comprehensive and detailed clinical report for the patients' new GP. Where the patient is not satisfied with the arrangement, it is sometimes appropriate to send a photocopy of the records to the new practitioner.

The second form of request by a patient for his medical records is more ominous. It is usually made on his behalf by solicitors in search of a cause of action in negligence. Even if the solicitor's letter is accompanied by a signed release authority from the patient, the medical practitioner is under no obligation whatsoever to accede to this request. Under such circumstances, the GP concerned should act through his medical adviser / medical defence lawyer.

Release of Records To Other Parties

Although the patient does not own the medical records, he owns the information contained in them to the extent that he can insist that the information is kept secret. Medical practitioners are under no obligation to produce or surrender their medical records to the police in the absence of a valid search warrant.

A subpoena to produce clinical records is a form of court order and the medical practitioner who fails to comply is in contempt of court and may be punished. Medical records which are subpoenaed are to be made over to the court and not to the solicitors who sought the subpoena. Whether or not the records are to be admitted as evidence is a matter for the discretion of the court.

41ST SMA Council

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ANNEX 1 - REVISED RETENTION PERIODS FOR MEDICAL RECORDS (1 FEBRUARY 1996)

Type of Medical Records	Retention Period /1		Remarks
	Primary Medical Records /2	Secondary Medical Records /3	
(A) HOSPITAL RECORDS			
(i) Adult Medical			
• Inpatient	3 years	17 years	] Exception:
• Specialist Outpatient	3 years	17 years	] Where hospital is aware that legal
			] action has been initiated, complete
(ii) Adult Surgical			] medical records of patient should
• Inpatient	3 years	17 years	] be retained until completion of
• Specialist Outpatient	3 years	17 years	] legal proceedings.
			]
(iii) Paediatric Medical			] Hospital to stamp "Medico-Legal
• Inpatient	5 years	17 years	] case" prominently on the case
• Specialist Outpatient	5 years	17 years	] folder of these cases.
			]
(iv) Paediatric Surgical			]
• Inpatient	5 years	17 years	]
• Specialist Outpatient	5 years	17 years	]
			]
(v) Cancer Records			]
• Inpatient	till death	indefinitely	]
• Specialist Outpatient	till death	indefinitely	]
			]
(vi) Psychiatric Records			]
• Inpatient	7 years after death of patient	NA	]
• Specialist Outpatient	7 years after death of patient	NA	]
			]
(vii) Accident & Emergency Records			]
• Accident/Police cases	5 years	NA	Hospital A&E Departments to highlight all accident/police cases records by stamping "Accident/Police Case" prominently on all the records.
• Medical cases	3 years	NA	
(B) PRIMARY HEALTH CARE (PHC) RECORDS			] Exception above regarding
• Outpatient records	5 years*	NA	] retention of complete records of
• School Health Records	3 years	Up to age 21 years	] patient for Medico- Legal case
			] also applies to PHC and Dental
			] records.
			]
(C) DENTAL RECORDS	3 years	NA	]
(D) PATIENT REGISTERS (Eg. Admission Register, Outpatient Attendances Register, A&E Attendance Register, Operation Record Book, X-ray Register, Ward Register, etc)	3 years	NA	3-year retention period applies to paper records, including their computer-generated hard copies.
(E) COMPUTERISED PATIENT RECORDS / DATABASES	Indefinitely	NA	

/1]
/2] Please see explanatory notes attached
/3]

- Records to be retained for 3 years at the clinic and a further 2 years at another location

/RE312(RETENTN.DOC) [source: MOH circular 1/96]

NOTES:

1. Retention Period

Retention period refers to the period following the date of last discharge from hospital or last attendance at the Outpatient Clinic.

2. Primary Medical Records

2.1 Primary Medical Records refer to all the original inpatient and outpatient records generated at the time of admission or outpatient attendance.

2.2 After the specified period of retention, primary records must be culled by extracting the forms listed in para 3 below, which will be assembled to form the Secondary Medical Records

3. Secondary Medical Records

Secondary Medical Records include the following documents of patients:

- Inpatient / Outpatient Discharge Summary
- Operation Report Form
- Consent for Operation Form
- X-ray Report Form
- Histopathology Investigation and Report Form
- Maternity Record Form
- Labour Record Form
- Neonatal records which are enclosed in the mother's casenotes
- Workmen's Compensation Reports, Insurance, Medical and other Medico-Legal Reports

4. Microfilmed Records

Original paper secondary medical records of patients which have been microfilmed may be destroyed. Before destruction of the original documents, hospitals/institutions must first ensure that the microfilmed records are properly kept and that the microfilms are clearly catalogued for easy retrieval.

Minimum retention period for microfilmed secondary records of patients is 17 years.

/RE312(RETENTN.DOC) [source: MOH circular 1/96]