Medical Records: Writing Them (Part two)

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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 use 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, no 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). The retention periods for medical records issued by the Ministry of Health in 1996 is available on the SMA website www.sma.org.sg. Such guidelines would be reasonable for medical clinics to follow as well.

OWNERSHIP OF MEDICAL RECORDS

Medical records may be regarded as aides-memories 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.

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