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Medical records: what you absolutely must know

Detailed medical records are essential to ensure that the ongoing care of patients is efficient and safe. Be aware that there is a range of statutory and ethical considerations which govern the creation, maintenance, retention, and use of medical records.

What are medical records?

'Medical record' is a general term for many types of health data and includes a patient's progress notes (hand written or computer-generated), appointment books, accounts, consultant reports, hospital discharge summaries, pathology reports and medical imaging reports, X-rays, videos, photographs and medico-legal reports.

Medical records may be used as evidence, for example in legal proceedings (criminal, civil or disciplinary), and inquiries.

Conversations and correspondence between a doctor, their medical indemnity provider and lawyers are NOT part of the patient's record. These documents should be kept separate from the patient's clinical file. Correspondence regarding patient complaints should also be kept separate from the clinical file.

What should medical records include?

Good records are not only essential for patient care, they also assist in the defence of any claim or complaint. Records should include the following:

- Sufficient information to identify the patient and allow another medical practitioner to continue management of the patient
- Any information known to the doctor who provides the medical treatment or other medical services to the patient that are relevant to their diagnosis or treatment, such as:
  - Information concerning the patient's medical history
  - The results of any physical examination of the patient
  - Information obtained concerning the patient's mental state
  - The results of any tests performed on the patient
  - Information concerning allergies or other factors that may require special consideration
  - Particulars of any clinical opinion reached by the medical practitioner
  - Any plan of treatment for the patient
  - Particulars of any medication prescribed for the patient
  - Notes about information or advice given to the patient in relation to any medical treatment proposed by the treating practitioner.

The records should also include the following particulars of any medical treatment (including any medical or surgical procedure):

- The date of the treatment
- The nature of the treatment
- The name(s) of the person(s) who gave or performed the treatment
- The type of anaesthetic given to the patient (if any)
- The tissues (if any) sent to pathology
- The results or findings made in relation to the treatment
- Any written consent given by a patient to any medical treatment (including any medical or surgical procedure) proposed by the treating practitioner.

Storage of records

The main issues relating to storage of records are:

- Preserving the confidentiality of the medical record
- Preventing damage, loss, or theft of the records
- Keeping records in a reasonably accessible manner to ensure continuity of medical treatment

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- Storage must be secure: in broad terms you must take all reasonable and prudent steps to protect the security of your medical records. It is unlikely you would be held liable for the theft of records from a properly secured surgery premises. However, you might be held liable for a theft from the seat of an unlocked car in a shopping centre car park.

Who owns the records?

In solo practice the medical file belongs to the doctor who prepares them, not the patient. An exception here might be X-rays or investigations paid for by the patient. The question of ownership where doctors practise together or in shared premises can become complicated without an express agreement. It is useful to clarify these matters when you start work in your practice.

How long records must be kept?

It is recommended that medical records be kept for as long as possible. This is especially true where there has been dissatisfaction expressed regarding treatment, where there has been an adverse outcome, or there has been threatened legal action.

Some states and territories have legislation mandating that records be kept for minimum periods. Such periods vary between jurisdictions.

At a minimum it is recommended that records in relation to health information are kept, in the case of a child, until they are 25 years, and for adults for at least seven years after the last consultation.

Patient access to medical records

Introduction of Commonwealth and state/territory privacy legislation now generally provides patients (with limited exceptions) with a statutory right of access to their records, including:

- having a copy of the records
- inspecting their records
- having a copy provided to a third party authorised by the patient, e.g. a solicitor.

Given this access it is advisable that medical records should be more than just notes to assist your memory. They should not be written in personal shorthand or obscure abbreviations. In this form they can be misinterpreted unless translated by the author.

Disposal of medical records

If a patient wishes to transfer to another practitioner at different practice, the new practitioner is entitled to information required for the proper ongoing care of the patient, by way of:

- a treatment summary, or
- preferably, a copy of the medical records.

There is no obligation to provide original records. The patient should bear the reasonable cost of providing this information, but failure to pay should not be used as a reason to prevent relevant information being provided to the new practitioner.

Patients must sign an authority to transfer their care and records to another practitioner. The authority should:

- request that a copy of the records be transferred to the new practitioner
- contain the name and date of birth of the patient whose records are to be transferred
- be signed by the patient (or parent/guardian where applicable)
- be dated.

If records are transferred to a new practitioner, and in particular when a practitioner is leaving a practice and a significant number of patients wish to follow them to their new practice, the practice should keep a register or record of:

- the patients
- the date the authority is received
- the date of transfer of records
- whether the original record has been transferred and a copy made
- the location of the records and the name of the 'new' practitioner.

Take home messages

- Good medical records are essential for good patient care
- Good medical records are essential for a proper defence in the event of a claim or complaint against you
- If in doubt retain medical records
- Remember that your patients can have access to their records.

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