## MEDICAL AND DENTAL PROFESSIONS BOARD

### GUIDELINES FOR GOOD PRACTICE IN MEDICINE, DENTISTRY AND THE MEDICAL SCIENCES

# GUIDELINES ON KEEPING OF PATIENT RECORDS

**BOOKLET 11**

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## THE SPIRIT OF PROFESSIONAL GUIDELINES

Medicine, dentistry and the medical sciences are professions based on a relationship of trust with patients. The term "profession" means "a dedication, promise or commitment publicly made".[1] To be a good doctor, dentist or medical scientist requires a life-long commitment to good professional and ethical practices and an overriding dedication to the good of one's fellow humans and society. In essence, the practice of medicine, dentistry and the medical sciences is a moral enterprise. In this spirit the Medical and Dental Professions Board presents the following ethical guidelines.

[1] Pellegrino, ED. Medical professionalism: Can it, should it survive? *J Am Board Fam Pract* 2000; **13**(2):147-149 (quotation on p. 148).

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# GUIDELINES ON KEEPING OF PATIENT RECORDS

These guidelines are applicable to medical practitioners and dentists in private practice (including managed health care organisations), as well as to those in the employ of the public service.

## 1 DEFINITION OF A MEDICAL RECORD

According to de Klerk, the expression a *medical record* may be defined as follows:

"A medical record is constituted by any record made by a medical practitioner at the time of or subsequent to a consultation with, an examination of, or the application of a medical or surgical procedure to his or her patient and which is relevant thereto."[2]

A medical record contains the information about the health of an identifiable individual recorded by a doctor or other health care professional, either personally or at his or her direction.[3]

## 2 WHAT CONSTITUTES A MEDICAL RECORD

2.1 Flowing from the above definition, the following documents are listed as essential components of a medical record, obviously depending on the nature of the individual case:

2.1.1 Hand-written contemporaneous notes taken by the attending doctor or other health care worker.

2.1.2 Notes taken by previous attending doctors or other health care workers, including a typed patient discharge summary or summaries.

2.1.3 Referral letters to and from other health professionals.

2.1.4 Laboratory reports and other laboratory evidence such as histology sections, cytology slides and printouts from automated analysers, X-ray films and reports, ECG traces, etc.

2.1.5 Audiovisual records such as photographs, videos, tape-recordings.

2.1.6 Clinical research forms and clinical trial data.

2.1.7 Other forms completed during the medical interaction such as insurance forms, disability assessments and documentation of injury on duty.

2.1.8 Death certificates and the autopsy report.

2.2 The above records may be archived on microfilm, microfiche or magnetic data files.

## 3 WHY DOCUMENTS OR MATERIALS SHOULD BE RETAINED

Documents and materials are to be retained in order to -

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[2] de Klerk A. The right of patients to have access to their medical records: the position in South African law. *Medical Law*, Vol 12, 1993, pp. 77 - 83

[3] *Making and keeping medical records.* MPS Casebook 13 (International), July 2000, 6-8

- further the diagnosis or ongoing clinical management of the patient;
- conduct clinical audits;
- to promote teaching and research;
- use the data for administrative or other purposes;
- keep as direct evidence in litigation;
- use as research data;
- keep for historical purposes;
- promote good clinical and laboratory practices;
- make case reviews possible;
- serve as the basis for accreditation.[4]

## 4 COMPULSORY KEEPING OF RECORDS

4.1 Medical practitioners and dentists shall enter and maintain at least the following information for each patient consulted:

4.1.1 Personal (identifying) particulars of the patient.
4.1.2 The bio-psychosocial history of the patient, including allergies and idiosyncrasies.
4.1.3 The time, date and place of every consultation.
4.1.4 The assessment of the patient's condition.
4.1.5 The proposed clinical management of the patient.
4.1.6 The medication and dosage prescribed.
4.1.7 Details of referrals to specialists, if any.
4.1..8 The patient's reaction to treatment or medication, including adverse effects.
4.1.9 Test results.
4.1.10 Imaging investigation results.
4.1.11 Information on the times that the patient was booked off from work and the relevant reasons.
4.1.12 Written proof of informed consent, where applicable.

4.2 Records shall be kept in black ink and erasure fluid shall not be used.

4.3 See also the ethical rule on signing of official documents which reads as follows:

*"Rule 14. Any student, intern or practitioner who, in the execution of his or her professional duties, signs official documents relating to patient care such as prescriptions, certificates, patient records, hospital or other reports, shall do so by signing such document next to his or her initials and surname in block letters."*

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[4] Royal College of Pathologists, Marks and Spencer Publications Unit. *The retention and storage of pathological records and Archives, London, Royal College of Pathologists,* 1995

## 5 ALTERATION OF RECORDS

5.1 No information or entry may be removed from a medical record.

5.2 An error or incorrect entry discovered in the record may be corrected by deleting it with black ink and correcting it. The date of change must be entered and the correction must be signed in full. The original record must remain intact and fully legible.

5.3 Additional entries added at a later date must be dated and signed in full.

5.4 The reason for an amendment and/or error shall also be specified on the record.

## 6 RETENTION OF RECORDS

6.1 Records shall be stored in a safe place and if they are in electronic format, safeguarded by passwords. Practitioners should satisfy themselves that they are informed of the Board's guidelines with regard to the retention of patient records on computer compact discs.

6.2 Records shall be stored for a period of not less than six (6) years as from the date they became dormant. In the case of minors and those patients who are *non compos mentis,* medical practitioners and dentists should use their own discretion whether the records concerned should be kept for a longer period.

6.3 Notwithstanding the provisions in paragraph 6.2 hereof, the records kept in a provincial hospital or clinic shall only be destroyed if such destruction is authorised by the Deputy Director-General concerned.

6.4 Apart from the obvious clinical reasons for keeping medical records, there are a number of other factors which may influence the period for which they should be kept. No clear-cut rules exist. The United Kingdom Department of Health specified, for example that -

6.4.1 obstetric records should be kept for twenty-five years;

6.4.2 records relating to children should be kept until the patient's 25$^{th}$ birthday (thus allowing 3 to 4 years after reaching majority to enable the individual to submit a claim, should there exist any grounds for such a plan);

6.4.3 other personal records should be kept for eight years after conclusion of treatment[5];

6.4.4 certain medical conditions take a long period to manifest themselves, such as asbestosis and records of patients who may have been exposed to such conditions, need also to be kept for a sufficient period of time, but not less than 25 years.

6.5 A balance must be reached between the costs of (indefinite) retention of records (in terms of space, equipment, etc.) and the occasional case where the practitioners' defence of a case of negligence is handicapped by the absence of records. The value of the record for academic or research purposes, or the risks resulting from the handling or complications of the case could serve as additional considerations.

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[5] Royal College of Pathologists, Marks and Spencer Publications Unit. *The retention and storage of pathological records and Archives*, London: Royal College of Pathologists, 1995

6.6 Where there were statutory obligations which prescribed the period for which patient records should be kept, a practitioner shall comply with those obligations.

## 7 OWNERSHIP OF RECORDS

7.1 Where records are created, including the original radiographs or ultrasound images, such records remain the property of the medical practitioner, dentist, medical scientist or institution concerned and may be retained by him or her, but a copy thereof should be given to the patient or referring practitioner on request. The patient may be charged the appropriate fee for such copies.

in the case of Government Hospitals, where radiographs were the property of the hospital, such original radiographs/ultrasound images should be retained by the hospital or medical practitioner involved; copies could, however, be made available to the patient or referring practitioner on request for which a fee could be charged;

ii In cases where patients were required to pay for radiographs/ultrasound images (private patients/hospitals) such patients should be allowed to retain such records; unless the practitioner deemed it necessary to retain such records for purposes of monitoring treatment for a given period. Should the patient however require the radiographs/ultrasound images for any reason such as consulting with another practitioner he or she should be allowed to obtain the original images

7.2 As the ownership of records in a multi-disciplinary practice depends on the legal structure of the practice, the governing body of such multi-disciplinary practice should ensure that these guidelines relating to records are being adhered to.

7.3 Should a medical practitioner or dentist in private practice (both in a solus practice and in a partnership) pass away, his or her estate, which includes the records, would be administered by the executor of the estate.

7.4 Should the practice be taken over by another practitioner, the executor shall carry over the records to the new practitioner. The new practitioner is obliged to take reasonable steps to inform all patients regarding the change in ownership and that the patient could remain with the new practitioner or could request that his or her records be transferred to another practitioner of his or her choice.

7.5 Should the practice not be taken over by another practitioner, the executor should inform all patients in writing accordingly and transfer those records to other practitioners as requested by individual patients. The remaining files shall be kept in safe keeping by the executor for a period of at least twelve (12) months with full authority to further deal with the files as he or she may deem appropriate, provided the provisions of the rules on professional confidentiality are observed.

7.6 It should be noted that certain partnership agreements may make specific provision for the management of a deceased partner's share in the partnership which would include the records.

7.7 In the event of a medical practitioner or dentist in private practice who decides on closing his or her practice for whatever reason, the practitioner shall timeously inform in writing all his or her patients of the following, namely –

7.7.1 that the practice is being closed as from a specified date;

7.7.2 that requests could be made that records be transferred to other practitioners of their choice;

7.7.3 that after the date concerned, the records would be kept in safe keeping for a period of at least twelve (12) months by an identified person or institution (an identified person or institution in this sense means a responsible person such as the practitioner's attorney, accountant or bank manager) with full authority to further deal with the files as he or she may deem appropriate, provided the provisions of the rules on professional confidentiality are observed.

## 8 ACCESSIBILITY TO RECORDS

8.1 A medical practitioner or dentist shall provide any person of age 14 years and older with a copy or abstract or direct access to his or her own records on request.

8.2 Where the patient is under the age of 16 years, the parent or legal guardian may make the application for access to the records.

8.3 Information about the termination of pregnancy may not be divulged to any party, except the patient herself, regardless of the age of the patient.

8.4 No medical practitioner or dentist shall make information available to any third party without the written authorisation of the patient or his or her legal representative.

8.5 A medical practitioner or dentist may make available the records to a third party without the written authorisation of the patient or his or her legal representative under the following circumstances:

8.5.1 Where a medical practitioner or dentist is a witness in a trial between a patient and another party or where a patient has instituted action in court against a medical practitioner or dentist and is ordered to testify on the patient's medical condition or to produce the records and he or she should request that such testimony be given *in camera* in accordance with section 153(1) of the *Criminal Procedure Act*, 1977 (Act No. 51 of 1977).

8.5.2 Where a patient sues a medical practitioner or dentist and the latter testifies in his or her own defence.

8.5.3 Where the Medical and Dental Professions Board has instituted disciplinary proceedings and the medical practitioner or dentist has to answer to a charge or defends himself or herself.

8.5.4 Where the medical practitioner or dentist is under a statutory obligation to disclose certain medical facts, e.g. reporting a notifiable disease or in terms of the *Child Care Act,* 1983 (Act No. 74 of 1983), reporting any case of suspected child abuse.

8.5.5 In the event where the ailment of a patient becomes known to a medical practitioner or dentist and the nature thereof is such that the medical practitioner or dentist concerned is of the opinion that the information ought to be divulged, in the interest of the public at large. Before the information is divulged the relevant information shall be given to the patient and voluntary authorisation shall be sought from the patient.

8.6 In provincial hospitals the records shall be kept under the care and control of the superintendent. Access to such records shall be subject to compliance with the requirements of the Access to Information Act and such conditions as may be approved by the superintendent.

## 9 RETENTION OF PATIENT RECORDS ON CD-ROM

9.1 Storage of clinical records on computer compact disc (CD-ROM) would be permissible, provided that protective measures are in place.

9.2 Protective measures referred to in paragraph 9.1 would entail that –

9.2.1 only CD-ROM technology is used, i.e. designed to record a CD once only so that old information cannot be overwritten, but new information can be added;

9.2.2 all clinical records stored on computer compact disc and copies thereof are to be encrypted and protected by a password in order to prevent unauthorised persons to have access to such information;

9.2.3 a copy of the CD-ROM to be used in the practitioner's rooms will be in a read-only format;

9.2.4 a back-up copy of the said compact disc must be kept and be stored in a physically different site in order that the two discs could be compared in the case of any suspicion of tampering;

9.2.5 effective safeguards against unauthorised use or retransmission of confidential patient information to be assured before such information was entered on the computer disc. The right of the patient to privacy, security and confidentiality should be protected at all times.

## 10 CHECKLIST FOR MEDICAL RECORD-KEEPING

The following checklist may serve to guide practitioners in the appropriate keeping of patient records:[6]

- ♦ Good notes imply good practice.
- ♦ Records should be complete, but concise.
- ♦ Records should be consistent.
- ♦ Avoid self-serving or disapproving comments in patient records.
- ♦ Use a standardised format: Notes should contain in order the history, physical findings, investigations, diagnosis, treatment and outcome or disposal.
- ♦ Avoid conclusionary comments, describe the facts, and make conclusions only essential for patient care.
- ♦ If the record needs alteration in the interest of patient care - then show no intent to hide by lining out items, signing in full and dating the changes and, when possible, entering a new note that refers to the correction without altering the initial entry.
- ♦ Release a copy of records only after receiving proper authorisation.
- ♦ Keep billing records separate from patient care records.
- ♦ Always label attached documents such as diagrams, lab results, photographs, charts, etc. Never rely on sheets of paper to remain identifiable by being bound or stapled together.

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[6] Torres, A, Proper S.: Medico-legal developments and the Dermatologist. *Advances in Dermatology*, Vol 12, 1987

## Ethical guidelines for good practice in medicine, dentistry and the medical sciences

The Medical and Dental Professions Board of the Health Professions Council of South Africa has embarked on a project to bring together ethical and professional guidelines for doctors (medical practitioners), dentists, and medical scientists. The following Booklets are separately available:

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| ***Booklet 1:*** | *General ethical guidelines for doctors, dentists and medical scientists* |
| ***Booklet 2:*** | *General ethical guidelines for health researchers* |
| ***Booklet 3:*** | *Ethical and professional rules of the Medical and Dental Professions Board* |
| ***Booklet 4:*** | *Professional self-development* |
| ***Booklet 5:*** | *Guidelines for making professional services known* |
| ***Booklet 6:*** | *Guidelines for the management of health care waste* |
| ***Booklet 7:*** | *Policy statement on perverse incentives* |
| ***Booklet 8:*** | *Guidelines for the management of patients with HIV infection or AIDS* |
| ***Booklet 9:*** | *Guidelines on research and clinical trials involving human subjects* |
| ***Booklet 10*** | *Research, development and use of the chemical, biological and nuclear capabilities of the State* |
| ***Booklet 11*** | *Guidelines on keeping of patient records* |
| ***Booklet 12*** | *Canvassing of patients abroad* |
| ***Booklet 13*** | *National Patients' Rights Charter* |
| ***Booklet 14:*** | *Confidentiality: Protecting and providing information* |
| ***Booklet 15:*** | *Seeking patients' consent: The ethical considerations* |