8 Medical records, reports and certificates

Keeping good medical records, preparing timely medical reports and providing accurate medical certificates are essential components of good medical practice. As tangible evidence of standards of medical practice readily visible to others, these three components are a frequent basis of complaints made against doctors and for this reason alone deserve to be dealt with conscientiously. In this chapter, we discuss why each component is so important and give advice about how to meet one's professional responsibilities adequately. Issues arising from electronic records and electronic communication are also discussed.

8.1 The importance of medical records

Accurate and sufficiently detailed medical records are an essential component of good patient care. Their main purpose is to store clinical data for use in patient management and as a means of communication with other doctors and health professionals. Thus, the medical record should contain sufficient information to enable another doctor to carry on the management of the patient. This is essential in situations such as public hospitals, where resident medical cover and nursing cover is arranged in shifts; in group practices where patients may see different doctors; and in after-hours deputising locum services where the only communication between the locum and the treating doctor is in writing.

Medical records are a major store of personal information. They include records held in private doctors' surgeries, in private and public hospitals, in medical clinics in industry and in community health centres. Medical or health information is also held in a variety of federal government departments including those of health, human services (which holds Medicare information), Veterans Affairs, Education and Defence. Similar information is also held by state health departments.

Medical records can be important also for clinical and epidemiological research, teaching and health administration, and in litigation. Requests for information about patients come not only from other doctors, but also from insurers, employers, police, lawyers and government agencies, for legal, financial or other reasons—accurate medical records are essential for all of these.

Incomplete, inadequate or illegible records create dangers for patients and may lead to severe criticism by a coroner or medical board, and are likely to hinder a doctor's ability to defend allegations of negligence (see 8.13 below and Chapter 9). Tardiness in providing such items as consultants' reports to referring doctors and discharge summaries can also interfere with good patient care. Illegibility of doctors' handwriting is so common as to be part of community folklore; unfortunately, research has shown that this is not a myth. In one study, 20% of doctors' medication orders and 78% of doctors' signatures were illegible [1]. Poor handwriting is unprofessional, dangerous and disrespectful of patients and professional colleagues but is surprisingly still tolerated by many in the profession [2].

A professional responsibility closely related to good medical record keeping is the need to keep them confidential, a requirement based originally on ethics and common law, and now reinforced by privacy legislation. Doctors make daily decisions about the release of confidential information and should appreciate the ethical principles and laws related to the release of any information from the medical record. Confidentiality and privacy are discussed in Chapter 7.

8.2 What is a medical record?

A patient's medical record includes information recorded about the medical history, findings on physical examination, possible diagnoses, investigations, treatment provided and follow-up advice. The record also includes correspondence from other doctors. Information usually kept separately—such as images from X-rays, ultrasounds or other techniques, and clinical photographs—also form part of the medical record.

Medical record remains a convenient term that includes all the information about a patient to which the doctor's ethical and legal duties of confidentiality apply, but neither the concept nor the term is used in privacy law. The key terms there are *personal information* and *health information*. The Commonwealth *Privacy Act 1988* and health privacy acts in New South Wales and Victoria use similar definitions of *health information*, which indicates what a medical record would normally contain. For example, Victoria's *Health Records Act 2001* defines *health information* as:

> a) information or an opinion about —
>
> (i) the physical, mental or psychological health (at any time) of an individual; or