GUIDELINE OF
THE MALAYSIAN MEDICAL COUNCIL

MMC GUIDELINE 002/2006

MEDICAL RECORDS AND MEDICAL REPORTS

Malaysian Medical Council

PRELUDE

The main substance of this Guideline on Medical Records and Medical Reports is the consensus reached in a workshop/symposium on the topic, conducted by the Malaysian Medical Council (MMC) on 11-12 August 2003, attended by representatives of the medical, legal profession and consumer bodies. The initial draft was prepared by the organising committe comprising Dato Dr. Abdul Hamid Abdul Kadir (chairman) and Dr. Milton Lum Siew Wah and Dr. Ravindran Jegasothy (members). The draft is extensively reviewed by all stakeholders to obtain this final guideline.

In this Guideline, the words "doctor", "physician", "medical practitioner" and "practitioner" are used interchangebly, and refer to any person registered as a medical practitioner under the Medical Act 1971. The words "hospital" and "healthcare facility and service" are used interchangeably and refer to any premises in which members of the public receive healthcare services. Words denoting one gender shall include the other gender. Words denoting a singular number shall include the plural and vice versa.

Adopted by the Malaysian Medical Council on 14 November 2006

FOREWORD

The Malaysian Medical Council, with the objective of ensuring that registered medical practitioners are fully aware of the codes of professional medical practice, issues directives and guidelines from time to time. The purpose of these codes, guidelines and directives is to safeguard the patient and members of the public, to ensure propriety in professional practice and to prevent abuse of professional privileges.

The Guidelines are designed to complement, and should be read in conjunction with, the Medical Act and Regulations, Code of Professional Conduct of the Malaysian Medical Council and other Guidelines issued by the Council or any related organisations, as well as any statute or statutory provisions in force and all related statutory instruments or orders made pursuant thereto.

This Guideline on the **Medical Records and Medical Reports** has been prepared with careful attention to details, cognisant of the current international stand on the subject. The draft has been reviewed numerous times by the Malaysian Medical Council and includes valuable responses from individuals, organisations and professional bodies in the country, before formal adoption by the Council.

The Guideline is available in the printed form as well as in the MMC website. Registered medical practitioners are advised to familiarise themselves with the contents, as they will serve as documents to refer to or to seek clarifications from, when they need guidance on matters of professional ethics, codes of professional conduct and medical practice in general.

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1. MEDICAL RECORDS

1.1. Introduction

A medical record is documented information about the health of an identifiable individual recorded by a practitioner or other healthcare professional, either personally or at his or her instructions. It should contain sufficient information to identify the patient, support the diagnosis based on history, physical examination and investigations, justify the professional management given, record the course and results thereof, and ensure the continuity of care provided by practitioners and other healthcare workers to that particular patient.

Medical records were historically regarded as ***aide memoirs*** for physicians treating patients and as essential components to patient care. They contained information about the patient, on one part, and the physician's opinion and clinical judgment which brought to bear on the patient's management, on the other part.

The understanding that the notes were essential tools in patient care became well established and evolved to establish the concept that medical records were documents which belonged to the physician and were therefore retained by him in his place of practice.

Based on these concepts, the medical records were considered "confidential" documents in testimony to good medical practice and the information therein contained considered "private" in observance of ethical doctor-patient relationship.

Certain aspects of these concepts have to some extent undergone changes in recent times, but have not materially altered the fundamental historical principles relating to medical records.

With advances in technology, and the development of Electronic Medical Records new vistas in patient record keeping having emerged, particularly in reducing the volume of printed clinical materials, but with inevitable challenges regarding their security, accessibility and assurance of patient confidentiality.

In preparing Medical Records, the practitioner must keep in mind that he is generating a document which, while reflecting his personal findings and management of a patient's illness in the best of times, can be demanded by the patient and the courts of law in matters of litigation.

There is a need to exercise caution in the manner and form of putting words on paper (or in the electronic media) in the course of management of a patient. It is imperative that the doctor is at all times aware that the Medical Record is a valuable document in patient care which may be read or disclosed subsequently, and therefore must be complete, objective and comprehensive.

1.2. Contents of a Patient's Medical Record

The following intellectual and physical items may, in whole or in part, make up the contents of a patient's Medical Record:

- Doctor's clinical notes
- Recording of Discussion with patient /next of kin regards disease/ management (with witness) / Possible use of tape recording for such discussions
- Referral Notes to other specialist(s) for consultation/co-management
- Laboratory & Histopathological reports
- Imaging records and reports
- Clinical Photographs
- Drug Prescriptions

- Nurses' Reports
- Consent Forms, At-Own-Risk Discharge Forms
- Operation Notes/Anaesthetic Notes
- Video Recordings
- Printouts from monitoring equipment (e.g. Electro-cardiogram, Electro-encephalogram)
- Letters to and from other health professionals
- Computerized/electronic records
- Recordings of telephone consultations/instructions relevant to the care of the patient.

1.3. Manner of Making Medical Records

The use of Integrated Clinical Notes is encouraged. This means that the medical practitioner, the nursing staff, the physiotherapist and occupational therapist, dietician and any other person involved in the management of the patient will all make contemporaneous entries on the same Continuation Sheet in the Medical Records. This would enable each and every member of the management team (Doctor, Nurse, Physiotherapist, Dietician, etc) to keep direct track of the daily management procedures of a patient, without having to refer to other records in the folder.

The entry in the Continuation Sheet should be precise and legible and record the Date, Time and the Procedure or Treatment, in chronological sequence, and should be signed by the person making the entry. The name of the person should be clearly written below the signature, or the name rubber-stamped, so that the person making the entry can be traced later without difficulty, if such need arises.

1.4. Use of Abbreviations and Short Forms

Abbreviations (e.g. CBD) and short forms should generally be avoided when making entries in the Clinical Notes and Continuation Sheets. The

use of unfamiliar or unconventional abbreviations and short forms may lead to untoward incidents in the management of the patient.

When used at all, these abbreviations and short forms should be those traditionally accepted and recognised by healthcare personnel. Institutions and healthcare facilities may provide a list of such traditionally accepted and recognised abbreviations for use and reference by their staff, but should be aware of possible limitations in their usage and interpretation and are expected to defend them when required.

It is well to realize that the same abbreviation or short form may mean different things to different medical disciplines and specialties (E.g. "PID" could mean 'Pelvic Inflammatory Disease' or 'Prolapsed Intervertebral Disc'), and the confusion that may arise in the use of such short forms should be kept in mind.

1.5. Entries to be avoided

It is imperative that the practitioner, nursing staff or any ancillary staff should strictly avoid entering irrelevant, disparaging, derogatory and offensive personal remarks about the patient, or other colleagues and healthcare workers, in the patient's Clinical Notes.

Practitioners and nursing and ancillary staff should avoid leaving blank spaces in between entries in the Continuation Sheet so that no person may be able to make late or retrospective notes in such space. Such entries will probably not be in chronological sequence and may be interpreted as false and as an attempt to cover up errors.

All entries should be objective in nature and relevant to the management of the patient.

1.6. Corrections to Notes

Erasure or "blacking out" of entries already made in the Continuation Sheet should be avoided. If there are reasons for some corrections, the erroneous statement should be neatly crossed out, but still be readable. The correction should then be entered in space available next to the deleted statement, and signed clearly by the person making the correction.

The tampering of clinical notes should be avoided as this may be interpreted as a member of the management team making alterations to cover up some mistakes in the management of the patient.

1.7. Patient's Expectations and Rights to Medical Records

It is generally accepted that the patient should:

- have access to records containing information about his/her medical condition for legitimate purpose and in good faith;
- know what personal information is recorded,
- expect the records are accurate, and
- know who has access to his/her personal information.

There is evidence that increased access to Medical Records has provided patients with better understanding of their illness as well as having a positive impact on patient-doctor relationship.

While patients have right of such access to their Medical Records, they may be permitted to inform the practitioner of any factual errors in the personal patient information. They should not seek to change any entries made by the practitioner in the course of consultation, diagnosis and management as these are made by the practitioner based on his clinical judgement.

1.8. Legal Status of Medical Records and Medical Reports

Medical Records, while not strictly classified legal documents, may be considered legally supportive documents in a court hearing. This is because medical practice must operate within broadly understood legal rules, such as those embodied in the common law.

1.9. Status of Medical Records within the Healthcare Facility

Medical Records are to be classified "Confidential" for administrative purposes within a healthcare facility. It is acceptable to label the Medical Record on the cover "Not to be handled by the Patient".

1.10. Handling of Medical Records by Nursing and Ancillary Staff

It is normal for various grades of medical and ancillary staff to handle Medical Records in the course of their duty in a healthcare facility. These staff must appreciate, and be impressed upon, the confidential nature of the Medical Records, and must at all times ensure that the contents and information are closely guarded and protected.

While it is accepted that some grades of nursing and ancillary staff have their own Codes of Conduct to cover such matters, the ultimate responsibility in this context rests with the Person in Charge (Chief Executive Officer / or Director) of the healthcare facility.

1.11. Security of Medical Records

The security and safekeeping of Medical Records is the responsibility of the Person in Charge, Chief Executive Officer (CEO) or the Medical Director of the healthcare facility or service.

Medical Records must be stored in safe and secure rooms at all times when not in use. They must be protected from the weather and vermin. They must be easily accessible and retrievable when required and returned in a complete form after use.

As a general rule, Medical Records must not be taken out of the healthcare facility. When such is demanded by a court order, a copy of the records shall be retained by the private healthcare facility or service and the original records shall be returned to the private healthcare facility or service at the end of the proceedings for which the records were directed to be procured.

Medical Records are often required to accompany an in-patient to the Imaging Department, Rehabilitation Department, Operation Theatre, etc, within the healthcare facility or service. Their safekeeping in transit and in the aforementioned departments must be ensured by the Person in Charge (CEO/Medical Director).

1.12. The Ownership of Medical Records

A patient's medical record is the property of the medical practitioner and the healthcare facility and services, who hold all rights associated with ownership. It is important to appreciate the confidential nature of the Medical Records and though the practitioner and the healthcare facilities and services have rights of ownership, they should still obtain consent from the patient or next of kin before any release of information from the medical records to any third person.

Medical records are also the intellectual property of the medical practitioner who has written them, and also belong morally and ethically to the practitioner and the patient.

The personal information (name, address, identification data, etc.) that the medical practitioner has recorded belongs to the patient. This is based on the premise that the notes are made in the first place because the patient has voluntarily sought the consultation.

The results of investigations (blood tests, tests on secretions, imaging and scans) belong to the patient, and these may be released to him/her when requested.

Information obtained by the practitioner from a third party (relative mainly) about the patient is not part of the patient's information, as such information may have been revealed on strict instructions of confidentiality. Such information may be crucial in the care of the patient. The practitioner may be obliged to reveal such information in providing a Medical Report to the patient. The practitioner, however, should not reveal the source of the information in view of the instructions of confidentiality by the third party informant.

1.13. Imaging and Laboratory Reports

Unless imaging records (e.g. X-ray, ultrasound) have to be retained by the practitioner or the healthcare facility or service for medico-legal reasons, or for continuing patient care, patients should generally be given their X-rays or copies of the X-rays for their retention.

Photo-copies of Laboratory Test Results may be given to the patient if requested.

Specimens obtained for histopathological examination and slides made of such specimens should generally be retained by the practitioner or healthcare facility or service, though copies of the reports may be given to the patient on request.

1.14. Transfer of Patient to another Hospital

When a patient is transferred to a second healthcare facility or service for whatever reason, the primary practitioner (and the primary healthcare facility) is expected to provide a full Clinical Summary of the patient's management during his/her stay in the first facility, with the object of the patient being able to receive continuing further management in the second healthcare facility, without undue delay and with full knowledge of his/her previous treatment.

The primary practitioner is to provide photo-copies, or full details, of all relevant results of investigations, and copies of all important recordings (electro-cardiogram, intensive care monitoring) and radiographs, Magnetic Resonance Imaging, Computer Tomogram Scans, Ultrasounds, etc.

The original whole Medical Record shall be retained physically with the primary medical practitioner (and the primary healthcare facility or service) and should be accessible to the referred second facility or service if needed for continuing management of the patient.

At no time must the continuing management of the patient in the second healthcare facility be compromised or delayed by lack of information provided by the primary practitioner or the first healthcare facility.

1.15. Access to Medical Records

The patient may be entitled to access Medical records as part of the contract between him/her and the medical practitioner, for various purposes, ranging from need to seek second opinion, to seek further treatment elsewhere, or for litigation. This privilege is also extended with the patient's consent to the patient's appointed agents.

Normally, medical practitioners and persons in charge of healthcare facilities and services should not object to the release of results and reports of the patient's laboratory investigations, X-rays and scans, and other such diagnostic tools, which the patient would have paid for personally or through insurance.

Medical practitioners and persons in charge of healthcare facilities and services are generally expected to cooperate and release all parts of the medical records, or certified true copies of the records, when so requested by the patient.

If the patient's or agents' request for access is refused after all other avenues have been explored, a patient may then resort to civil action. Legal proceedings are commenced by issuing a writ to permit the process of 'order of discovery' to proceed after which documents may be subpoenaed.

When Medical records are taken out from the private healthcare facility or service whether by a court order, or mutual consent, a copy of the records shall be retained by the private healthcare facility or service and the original records shall be returned to the private healthcare facility or service at the end of the proceedings for which the records were directed to be procured.

The patient, and/or his appointed agent/officer, on written request, is entitled to a written Report on the care given to the patient as recorded in the Medical Record, and relevant copies of their Medical Records. The healthcare facility is not liable for any interpretation or analysis of the Medical Record made by a third party.

The withholding of information of the care, diagnosis, treatment and advice given to the patient, and relevant copies of the Medical Records, is unethical.

1.16. Disclosure to Third Party Payers and MCOs

Medical Records of patients who are employees of corporate bodies, or who are under healthcare insurance cover, belong physically and, as stated above, intellectually to the practitioner (and the healthcare facility or services) and ethically to the patient. Release of information from the Medical Records to Third Party Payers and Managed Care Organisations, and through them to the employers, should only be made with the informed consent of the employee/patient.

Employees may be compelled to sign a blanket document of consent by the corporate employers giving the Third Party Payers or Managed Care Organisations the right to obtain confidential information from the healthcare providers.

Such blanket consent, without reference to specifics, is not to be encouraged. Informed consent for disclosure must be on a case-by-case basis and should be obtained by the practitioner personally from the patient. This is to safeguard the patient's right as some points in the disclosure may adversely affect or influence the patient's employment status.

1.17. Denial of Disclosure

The practitioner may deny disclosure of the contents of the Medical Record, if in his considered opinion, the contents if released may be detrimental or disparaging to the patient, or any other individual, or liable to cause serious harm to the patient's mental or physical health or endanger his life. The practitioner may also deny disclosure particularly if the patient is deceased. In such instances, the practitioner should be able to justify his decision to deny disclosure.

The practitioner may deny disclosure if there is no written consent from the patient, or his legal next-of-kin or guardian, for release of the contents of the Medical Record to a third party.

2. MEDICAL REPORTS

2.1. Introduction

Medical Reports are documents prepared by a practitioner on a patient based on Medical Records. Opinion by an Expert may also be part of a Medical Report.

Practitioners are obliged to provide comprehensive medical reports when requested by patients or by the next of kin, in the case of children or minors, or by the employer with the patient's specific consent. Any refusal or undue delay in providing such reports is unethical.

2.2. Contents of a Medical Report

A Medical Report may begin with the following preamble:

- A brief statement of who the practitioner is and his specialty and appointment.
- Whether the practitioner has the authority to write the Report
- A statement of which medical records were available when writing the report.
- Any special circumstances.

The Medical Report may contain, in whole or part, the following:

- Patient identification data
- Dates and time of admission or treatment,

- Brief history
- Significant examination findings
- Results of relevant investigations
- Diagnosis
- Treatment
- Management plan

The Medical Report should only contain facts. When an opinion is requested, with regards employment, disability, further management, etc., this should be separated from the facts of the Report and identified as Opinion or Recommendation.

Certified true copies of results of relevant investigations, or other data records, may be included as a part of the Medical Report.

2.3. Legal Status of Medical Reports

Medical Reports, like Medical Records, can be demanded and produced as legally supportive documents. The Court has the right to call the practitioner who generated the Medical Report to appear before the presiding judge or magistrate to explain or clarify the contents of such Report as may be required. It is in the interests of the practitioner and for the course of justice that the practitioner should not refuse to attend court when so required.

Where the practitioner anticipates a medico-legal problem arising out of a Medical Report, he may be advised to obtain the opinion of legal counsel and/or the person in charge/ CEO/Medical Director of the healthcare facility.

2.4. Time Limit for Providing a Medical Report

Patients or their authorized agents request for a Medical Report for various purposes, amongst which are: insurance claims and rebates, disability assessment, SOCSO Board, etc.

Patients, or next of kin, may also request for a Medical Report for their retention, for second opinion or litigation purposes.

There is obviously some urgency for the Medical Reports to be prepared and ready for collection by the patient, next of kin or authorized agents.

It is to be noted that undue delay is not proper and a **time frame of six (6) weeks** from the time that the Records Officer, having processed the request, submits the medical records and related documents, along with the request and consent forms duly signed by the patient, to the practitioner for his personal attention. The Records Officer must maintain a book, properly dated and signed, to show that the practitioner has indeed received the request and that he will prepare the Report without undue delay so that the Report can be handed to the patient within the stipulated six weeks.

It is normal for fees to be charged for the Medical Report and this may be obtained from the patient (or his/her appointed agents) in advance and before the records are sent to the practitioner for his action.

If the practitioner, for some reason, is unable to meet the six-week deadline, he should convey his reasons to the Records Officer who will accordingly inform the applicant about the delay, and set a new early deadline. At all times the applicant making the request for the Medical Report should be kept informed about any delay.

2.5. Refusal to Provide Medical Report

It is unethical for a practitioner to refuse to provide a Medical Report and the patient has every right to complain to the Medical Council of any such refusal or undue delay. If, in his considered opinion, the practitioner has strong reasons to deny such a report, he should be able to justify his decision and inform the patient.

The withholding of Medical Reports because of failure of the patient to settle professional and healthcare facility and services fees and bills is unethical.

2.6. Fees for Medical Report

A reasonable quantum of fees may be charged for a Medical Report and this may vary according to the details and length of the report. The amount of the fees charged must be communicated to the patient or the authorized agent requesting the report for their agreement to pay. It is reasonable to obtain the fees in advance.

2.7. Medical Report when Practitioner is Deceased

Occasions may arise when a medical report is requested by a patient after the untimely death of the practitioner who had been treating or managing him/her. In such instances, the person in charge of the healthcare facility or service where the patient had been treated must obtain permission from the next of kin or legal representative of the deceased practitioner for release of information. If agreed, the person in charge must seek a practitioner of the same specialty, preferably but not necessarily from the same healthcare facility or service, and such a practitioner being acceptable to the patient and the deceased practitioner's next of kin or legal representative, to write the Medical report.

The practitioner willing to write the medical report must then write the report factually as recorded in the Medical Record of the patient without any interpretations or opinions on statements or findings recorded in the patient's notes by the deceased practitioner. These steps are necessary as there may be litigation matters raised against the deceased practitioner.

3. SECOND AND EXPERT OPINION

When Second Opinion is sought from another practitioner at the request of the patient or next of kin, the primary practitioner should provide a comprehensive summary with relevant details of investigations and management of the patient. The Medical Record, if requested for perusal by the practitioner giving the second opinion, should also be made available.

When a practitioner is required to give an Expert Opinion, the entire Medical Record should be made available for the doctor to study or peruse in the course of preparing his expert opinion.

A practitioner involved in the management of the patient or working in the same healthcare facility or Ministry as the doctor in the inquiry, should not appear as expert witness in such inquiry.

The doctor/specialist giving the report as a second opinion may charge a reasonable quantum of fees, which may be obtained in advance.

A list, or a pool, of Expert Medical Witnesses, willing to give expert opinion in legal proceedings, may be held by specialist professional organisations and any request for an expert witness from legal councel may then be appropriately processed by such specialist organisations.

4. PROCEEDINGS OF IN-HOUSE INQUIRIES

In-House Enquiries may be conducted by Committees appointed by Private Hospitals on assessable deaths (Mortality Assessment) as required by the Private Healthcare Facilities & Services Act 1998 (Sections 67, 68 and 69).

The primary objective of these In-House Inquiries is to improve on the standards of care provided to patients.

It is a proviso that the information obtained by the Committee in the course of the enquiry is confidential (Section 70), and the Committee in performing its functions shall not allocate any blame to any medical or dental practitioner or to any other person.

The proceedings of such inquiries are to be considered confidential and the privacy of the doctors involved in the inquiry and in the management of the patient should be safeguarded. In New Zealand, the law prevents the proceedings of these Inquiries being brought before a court.

DISCLAIMER

While every attempt is made to provide comprehensive guidelines for medical practitioners, patients, and any other interested parties, with regards Medical Records and Medical Reports, there may inevitably be areas of doubt and controversy. In such instances, further directions may be sought from the Malaysian Medical Council or through due judicial process.

REFERENCES

1. Seminar-Workshop on Medical Records and Reports: MMC 11-12 August 2003
2. Private Healthcare Facilities & Services Act 1998 and Regulations 2006
3. Code of Professional Conduct MMC
4. Good Medical Practice MMC 2001
5. Confidentiality MMC 2001

The initial draft of this Guideline on *Medical Records and Medical Reports* was prepared by Dr. Abdul Hamid Abdul Kadir MBBS (S'pore) FRCSEd., MChOrth (Liverpool), Dr. Milton Lum MBBS (Mal), FRCOG (London), Dr. Ravindran Jegasothy MBBS (Mal), FRCOG (London), FAMM at the conclusion of the Workshop/Symposium on the topic conducted by the Malaysian Medical Council on 11-12 August, 2003.

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