

PRESENTATION OF THE MEDICAL RECORD IN COURT

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Pleura*

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The presentation of a medical record as legal evidence is a courtesy that every hospital will extend to any court or properly constituted commission. For the protection of the hospital and its personnel, the physician and the patient, the medical records librarian as a representative of the hospital is not obliged to present the medical record in court, or before any commission except upon a proper court order or subpoena.

The subpoena is usually addressed to "The Custodian of Records" and directs that person to appear in a given court, before a named judge, on a date and at an hour designated in the subpoena, and to bring on that date the records designated for the patient named in the subpoena. After acceptance of the subpoena all records specifically enumerated in it must be produced in court at the time and place designated, or the party subpoenaed is liable for contempt of court.

In accident cases the injured party and eye witnesses are more apt to tell the truth about the circumstances at the time of entrance of the patient to the hospital as they are at that time unprejudiced by thoughts of liability. The chief value of a medical record is that it is an unbiased statement inasmuch as the doctors, interns, nurses, and others concerned in making the record at the time of the patient's hospitalization have no interest in any subsequent litigation.

Because each hospital case is a potential court case careful recordings of the medical findings are of primary importance. Notation of the complete findings upon examination and the exact status of the case on admission should be set forth, together with a report of the patient's progress while in the hospital. Therefore an analysis of the individual record by the medical records librarian is of utmost importance. Entries that have been erased and not initialed or signed according to the rules of the hospital should be rejected. The position of the medical records librarian is one of especial trust, therefore it is her duty to ascertain that the record is properly completed so that the hospital may be in a position to clear its responsibility in court proceedings.

Before taking the medical record from the hospital to court each page should be numbered in ink, the total number of pages recorded on the folder, and a record of this total left at the hospital. An itemized list of the sheets comprising the medical record should be made in duplicate, the original kept with the record and the duplicate left at the hospital.

RELEASE OF INFORMATION

A hospital will receive many legitimate inquiries from welfare organizations, veterans' bureaus and other organizations. Such inquiries are legitimate and are solely for the benefit of the patient, therefore it would seem that the release of information without the written authorization of the patient would not meet with criticism, but the medical records librarian for her own protection should always require proper authorization from the patient for release of information.