

(2004) 01 KL CK 0023
In the High Court Of Kerala
Case No : Writ Petition (C) No. 40121 of 2003

Rajappan

APPELLANT

Vs

Sree Chitra Tirunal Institute for Medical Science and
Technology

RESPONDENT

Date of Decision : 14-01-2004

Acts Referred:

Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002
— Regulation 1.3.1, 1.3.2

Citation : (2004) 2 ILR (Ker) 150 : (2004) 2 KLT 157 : (2004) 3 RCR(Civil)
304 : (2004) 3 RCR(Criminal) 253

Hon'ble Judges : C.N. Ramachandran Nair, J

Bench : Single Bench

Advocate : P. Ramakrishnan and A.K. Preetha, for the Appellant; T.R. Ravi, for the Respondent

Judgement

C.N. Ramachandran Nair, J.—The petitioner is the father of a patient who died in the course of treatment in the respondent-Medical Institution which is a statutory corporation created by the Government of Kerala for Medical Research and Treatment. The petitioner's daughter was admitted in the hospital for epilepsy. The patient was admitted on 3.4.2003 and died on 17.4.2003. After the death of petitioner's daughter, the petitioner applied for medical records pertaining to the treatment of his daughter. The husband of the deceased however was given case summary and discharge record and investigation report by the respondent-Hospital. Therefore the petitioner's request for copies of medical records was declined.

2. I heard counsel for the petitioner and standing counsel appearing for the respondents. While the petitioner maintains the stand that petitioner is entitled to a statement from the doctor concerned in the form of Appendix 3 under Regulation 1.3.1 of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 together with copies of the medical records maintained by the hospital, the standing counsel for the respondent-Hospital

submitted that records referred under regulation 1.3.1 is only the certificate in the form of Appendix 3 which contains all the details. According to him the Institution has already issued the details covering the data referred to in Appendix 3 and so much so no more details can be given. Counsel for the petitioner contended that documents referred to in Regulation 1.3.2 are copies of the originals maintained by the Hospital and not a summary to be given in Appendix 3.

3. The relevant Regulations are extracted hereunder for easy reference:

Maintenance of Medical Records:

1.3.1. Every physician shall maintain the medical records pertaining to his/her indoor patients for a period of three years from the date of commencement of the treatment in a standard proforma laid down by the Medical Council of India and attached as Appendix 3.

1.3.2. If any request is made for medical records either by the patients/ authorised attendant or legal authorities involved, the same may be duly acknowledged and documents shall be issued within the period of 72 hours.

Appendix 3 referred to in regulation 1.3.1 provides for information, among other things, pertaining to diagnosis, investigations advised with reports, diagnosis after investigation, and advice. Therefore it is obvious from the appendix that what is to be given is the full details about the patient, namely, the findings pertaining to the deceased. That is the diagnosis and the periodical advice for treatment. As and when diagnosis is made the treatment will be advised by the doctor to the nursing staff in the case sheet itself. Therefore the case sheet will show the progressive testing, diagnosis and treatment given to the patient. The details to be furnished in Appendix 3 are of comprehensive in nature and should contain the diagnosis and treatment given to the patient during the period, the patient was under treatment. Regulation 1.3.1 has to be read with regulation 1.3.2 which makes it mandatory that any patient requesting for medical records should be furnished copies of "documents" within 72 hours from the date of demand. In other words, the patient's right to receive documents pertaining to his/her treatment is recognised by the Regulations. The documents referred to in Regulation 1.3.2 necessarily have to be the entire case sheet maintained in the hospital which contains the result of diagnosis and treatment administered, the summary of which is provided in Appendix 3. Therefore the petitioner is entitled to photocopies of the entire case sheet and the respondents cannot decline to give the same by stating that the details are available in Appendix 3 furnished, which they are willing to furnish.

4. It is also to be noticed that Regulations do not provide any immunity for any medical record to be retained by any medical practitioner of the hospital from being given to the patient. On the other hand it is expressly provided that a patient should be given medical records in Appendix 3 with supporting documents. Therefore in the absence of any immunity either under the

Regulations or under any other law, the respondent-Hospital is bound to give photocopies of the entire documents of the patient. Standing counsel for the respondent-Hospital submitted that the documents once furnished will be used as evidence against the hospital and against the doctors concerned. I do not think this apprehension will justify for claiming immunity against furnishing the documents. If proper service was rendered in the course of treatment, I see no reason why the hospital, or staff, or doctors should be apprehensive of any litigation. A patient or victim's relative is entitled to know whether proper medical care was rendered to the patient entrusted with the hospital, which will be revealed from case sheet and medical records. There should be absolute transparency with regard to the treatment of a patient and a patient or victim's relative is entitled to get copies of medical records. This is recognised by the Medical Council Regulations and therefore petitioner is entitled to have copies of the entire medical records of his daughter which should be furnished in full. The respondent Hospital is entitled to retain the original for their purpose and need furnish only the true certified copy of the originals. W.P. is therefore disposed of directing the respondents to give photocopies of the entire case records of the deceased to the petitioner, within three weeks from the date of production of a copy of this judgment by the petitioner. If there is no provision for issuing photocopies at the cost of the Hospital, the petitioner will remit the photocopying charges.