6. ACCESS TO MEDICAL RECORDS

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Definition

The term 'medical records' have been defined in various ways. One definition of a medical record is "written or graphic documentation, sound recording, or computer record of physicians, dentists, nurses, technicians or other healthcare personnel. "Medial record" includes such as diagnostic documentation as X-rays, electrocardiograms and other test results.

Medical records were originally regarded as "aide memoires" for treating doctors – hence the concept that the records belonged to the doctor and not to the patient. This situation is progressively altering, under the influence of factors such as Freedom of Information legislation, concepts of openness and accountability, quality assurance, the involvement of patients more closely in understanding their illnesses and being fully informed before decisions are taken about treatment, and in some parts of the world, allowing the patient to be the holder of the record. The accuracy and objectivity of the medical record has therefore assumed greater importance.

The importance of keeping adequate medical records in order to maintain a high standard of patient care is particularly obvious in situations such as in public hospitals where resident medical cover is arranged in shifts; in group practices where patients see different doctors; and in after hours deputizing services (locums) where the only communication between the locum and the treating doctor is in writing.

Ownership

From the legal point of view, "ownership" is broad term that derives its meaning according to the context and circumstances. As court cases and state laws have not defined specifically the term "ownership", therefore, with respect to medical records, the usual connotation needs to be taken into consideration. That is, one who "owns" something has dominion, title or the right of possession, and full control over it.

Access to information is still a privilege more than a right, even in nations such as the United States which prides in believing that it has an open system. No government can function with open access to information considered as secrets, neither can commercial companies, or even individuals. However, there is now a debate in Malaysia, as in many other countries with enough wealth to look beyond the acquisition of resources just necessary for basic survival, on just where the boundary between free flow of information lies, and where secrecy is to remain.

Patients in such diverse nations as Britain, Canada, China, Norway and parts of Africa as well as an increasing number of states within America routinely have access to their medical records. In contrast, in 1978, only seven American states had statutes that granted patient access to records held by both doctors and hospitals. Now half of all states have statutes providing for such access and an additional six provide access to hospital records only. In addition, 27 states and the District of Columbia currently have laws allowing direct access for mental health records. However, having legal access to medical records is not necessarily the same as being able to access them with ease, or that roadblocks cannot be created.

Malaysian doctors in government hospital practice enjoy a high degree of protection against disclosure of medical records or either patients or outside professionals such as lawyers. It is one bad thing already to have a tragedy befall a family member in a hospital that is the result of

malpractice, but it is another thing to prove such malpractice did take place. Not having direct access to unedited medical records that will give day-by-day account (or, even in the case of Intensive Care patients, a minute-by-minute account) of treatment makes proving malpractices difficult at best.

Under the current system of information release, any lawsuit against a government hospital in Malaysia will result in a knee-jerk reaction from the Deputy Public Prosecutor to deny the release of medical records, offering instead a medical report to be filled in by the departmental head or specialist involved in the case to be given to the plaintiff's lawyers.

Often, in serious cases involving more than one department, many such reports will be commissioned, and no outside third party specialist will be allowed access to the medical records to comment on any omissions or inaccuracies that may be present in the medical reports so written.

The situation in the private sector in Malaysia is freer, with doctors choosing personally whether to turn over their personal medical records to patients or not. This has resulted in threatened lawsuits being dropped, as patients realize that the treatment given was in accordance with accepted norms. This is not unexpected; in Scotland, one tradition is for the defendants and the plaintiffs to attend a pre-trial conference with all information at hand, so that matters arising from the case can be discussed and areas of agreement resolved, so that only points of conflict are brought into open court. This has the effect of settling some cases out of court, and also allowing the plaintiffs to understand certain finer points of the case so that so called "silly questions" are not asked during cross-examination, thus saving on precious court time.

The debate over release of medical records must center around the following points:

1. Is it in Patient's Interest?

While many patients can be helped by release of records, it is not always in patients' interest that they can gain access to records. American laws allow doctors' records to be disclosed to some parties and not to others; it can be deemed against the patients' interests to know exactly what was in his files.

In the United Kingdom, information held on citizens by government bodies (including medical records) can be accessed under the Code of Practice on Access to Government Information (also known as the 'Open Government' Code of Practice), which came into force in April 1994. This further widened rights already granted under the Access to Health Records Act 1990 which allows people to see information about their physical or mental health which has been recorded manually by or on behalf of a 'health professional' who has treated them. It applies both to NHS and private records. The Act only applies to information recorded after November 1999. However, it too has exemptions where records may not be released.

Disclosures which would be "an unwarranted invasion of privacy" are exempt. This protects personal information about the patient: it also means patients will not be able to see private information about someone else which might form part of the patient's file. Information likely to cause serious harm to the patient's or someone else's physical or mental health is also exempt. There is a long list of other exemptions. These include information harmful to national security, defence, and foreign relations; information which would prejudice law enforcement, legal or other formal proceedings, public safety, and public order, etc.

2. Is Release In the Doctor's Interest?

It is always in doctors' interests to settle the minds of patients and those of their relatives, and to see that the right and just thing is done, and is seen to be done. If that is not so, it is time for that doctor to throw in the towel and change professions. If medical records be can be released by law, it will mean that care provided by doctors will be under greater scrutiny, and certainly the standard of record keeping will have to rise too, or that doctor will be savaged by the lawyers. It will add another level of scrutiny, over and above that provided by the Ministry of Health, the Malaysian Medical Council, and the relevant hospital authorities (where applicable). Whether this will improve medical practice or lead to frustration remains to be seen.

Ironically, the focus on the medical record as a legal document has reduced both its legal and its medical effectiveness. Medical personnel, told that "the good medical record is the best defense", miss the point that the good medical record is valuable only to the extent that it documents the actual rendering of good medical care. A medical record can be disastrous if it demonstrates the incompetence of the underlying medical care. Poor documentation is actually the advantage to an incompetent defendant whose best defense is obfuscation. A poor record may prevent the medical care providers from establishing the good care they gave the patient, but a good record is not a substitute for good care.

3. Will it Increase Litigation?

The likelihood is that it undoubtedly will but slowly (see below). Easier access to medical records will make people rather more curious as to what has been written, and some will take offence over the contents. In the United States, there exists law firms, which widely advertise their services, with medically-trained personnel who will spend time to pore over a minute-by-minute account of your treatment in hospital, if the records are available, to detect mistakes. However, access to medical records does not make a litigious population.

UK patients do have access to their records, perhaps to an even greater extent than their American counterparts. However, the litigation rates there are much lower, as are monetary settlements. Conversely, Americans will sue their doctors even without complete medical records as their disposal.

What does this mean for Malaysian health services? I believe that if medical records were made freely available, rates of litigation will not increase by much, and any increase will be slow. This is because while most Malaysians are meant to be literate, most do not read much, if at all, and I think many trust lawyers even less than they trust doctors. Lawyers are not allowed to advertise, and certainly not to offer a "find a malpractice" service. The problem getting local expert witnesses will remain. And lawyers are not allowed to sue people while assuring as much as half of all malpractice payment ends up in the pockets of lawyers due to this 'bounty' system, and this benefits nobody but lawyers.

Conclusion

It is fair to say that the general trend worldwide is for access to medical records to be liberalised. Apart from government-run institutions, many private practitioners in Malaysia will disclose all or part of a patient's medical notes, if asked. In many countries, an appropriate fee is charged; this should not be a problem in Malaysia. It is not a question of whether medical records can be released to patients, it is really a question of by when such a law can be enacted, and of establishing the appropriate safeguards and exemptions to such release. If the MMA acts

appropriately, it will be able to dictate the rate of change of this policy. It is unlikely that Malaysia will go from non-disclosure to full disclosure overnight; indeed, from the British and American experience, access has been given under a series of evolutionary laws rather than in one giant step that changes all previous norms. It will be a series of laws that makes compulsory the breadth and depth of the disclosure, rather than relying on the generosity of the DPP and of individual practitioners, as now. The DPP, for all his power, cannot sometimes prevent the leakage of medical records anyway in all cases, as there are a variety of ways in which they can be copied and spirited out of the hospitals; some malpractice trials and out-of-court settlement talks have become Trials By Ambush, where neither side knows how much information the other side has.

In view of a rather tame population where litigiousness is concerned, the effect of such laws will be to nudge the litigation rate to nearer the British rather than the American model. Healthcare costs will rise, as they have done year on year for every nation on earth; it will be more due to inflation and new method of practice than due an increasing flurry of defensive medicine. This will help to weed out hopeless doctors, for hospital will find them a liability to employ; it may hopefully lead to more thought as to which treatments and investigations are necessary, rather than those memorized by note. Hopefully will lead to some doctors being more conscientious, and to medical universities giving more attention to quality training, in the fear that their graduates will quickly become lawyer fodder.

While there may be patients who may be harmed by seeing their records, there are also many who find relief in finally knowing about diagnoses which have been reached years ago, but which they were not privy to. No doubt, some information in medical records is plain wrong or outdated; it is necessary and desirable that this be corrected.

Recommendations

1. The MMA should state that it supports the compulsory release of all unedited medical records should this be requested by the patient either to himself or to third parties approved by the patient, unless the medical practitioner has strong grounds to believe that harm will come to the patient by doing so. This should come into force by 1st January 2005.
2. This compulsory release should be extended to cover all notes made on or after 1st January 2002; all notes made previously should be at the doctor's discretion.
3. A commensurate fee should be levied for administrative charges incurred in duplicating the records.
4. Exemptions to full disclosure of medical reports should include:

- Private information about someone else which might form part of the patient's file.
- Information likely to cause serious harm to the patient's or someone else's physical or mental health.
- Information harmful to national security, defence, and foreign relations and information which would prejudice law enforcement, legal or other formal proceedings, public sector or public order.

The MMA must draft guidelines to educate medical practitioners on what information should or must appear on medical records, in preparation for the consequences that release of medical records may bring.

Medical students should be educated on the importance of proper record keeping during their training.