

5. MEDICAL RECORDS

One of the most contentious matter the medical profession is facing in the recent past all across the world is access to medical records. Though the access may not be the most relevant issue pertaining to medical records as far as the profession is concerned. Developed societies like the United States Of America, United Kingdom and Australia seem to have come up with some legislation making medical records more accessible.

As far as Malaysia is concerned we have not kept pace with the changing trends allowing the confusion as to access to medical records to continue. Medical legislation is very slow though it may be hastened on an issue the government of the day deems fit.

In our law there is no right of access to medical records, unless it becomes a litigious issue and only in the process of a court case a legal demand can be made for access to the medical records. Even then only a medical report from the records is rendered and not the record itself. In the public sector medical records are covered by O.S.A and probably will require a specific court order for the revelation of the same.

This though may be protective of the profession, seems often to deprive patients of their rights. Medical records which started of as 'Aids memoirs' has matured into legal document, extensively used for medical auditing within the profession. In recognition of this the medical profession and the law in developed countries have taken a step forward by legislating on various issues pertaining to medical records.

The Americans apparently had taken a free for all stand and seem to be facing some problems with such a stand. The British and Australian approach which appears to be more of a middle of the road stand, providing fair justice to patient rights.

Probably the Australian guidelines are more appropriate to the current Malaysian scenario and it should also be our guidelines to medical records.

TERMINOLOGY

Medical records

The term "medical records" have been defined in various ways.

While some states define the term. Others merely specify what information such a record must contain. Colorado, for instances, defines a medical record as "the written or graphic documentation, sound recording, or computer record of physicians, dentists, nurses, technicians or other healthcare personnel. "Medical record" includes such as diagnostic documentation as X-rays, electrocardiograms and other test results.

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. Tittle or the right of possession, and full control over it.

MEDICAL RECORDS, MEDICAL CERTIFICATES AND CONFIDENTIALITY

It is fundamental to a proper doctor-patient relationship that patients who disclose intimate details to treating doctors know that they will observe strict confidentiality about such personal matters. Patients must not be afraid to seek the advice of doctors, who in turn must be free to ask patients any questions necessary for proper diagnosis and treatment. The basis of this trust lies in one of the oldest concepts of medical practice and was stated in the Hippocratic Oath as follows:

whatsoever I shall see or hear in the course of my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets.

Virtually the same obligation of professional secrecy has since been repeated in the Declaration of Geneva, in the Declaration of Lisbon and in the International Code of Medical Ethics. The simple injunction for a doctor to "observe absolute secrecy on all which has been confided to him or which he knows because of the confidence entrusted in him", unless the patient permits or asks for its disclosure, has come under increasing strain in modern times.

Medical care has become more complex, particularly in hospitals, and relies on an enlarging "patient care team" with access to patient records. In addition, requests for information about patients from insurers, employers, police, lawyers and Government agencies, for statutory, legal, financial or other reasons have increased and doctors may face several decisions everyday in relation to the release of confidential information.

Doctors frequently exchange confidential information regarding patients either in person, by telephone or by letter. Nearly all of this exchange is necessary and has the implied consent of patients because it is part of the care of the patient, as for example when a general practitioner refers a patient to a consultant specialist. In releasing information regarding patients, especially by telephone, a doctor needs to be confident of the identity of the person to whom the information is being released. At times, reasonable and quite justified reluctance to give information over the telephone can be interpreted as lack of cooperation on the part of the doctor. This is a particular issue for work-related illness and injury and is discussed later in this chapter.

It is essential that all doctors appreciate the ethical principles and relevant laws relating to confidentiality and to the closely related topic of medical record keeping.

MEDICAL RECORDS

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.

Medical Records and Privacy

Medical records are a major repository of personal information. They include records held in private doctors' surgeries, in private and public hospitals, in medical clinics in industry, in community health centres and in a variety of State and Federal governmental departments including those of Health and Community Services, Veterans Affairs, Education, Defence and the Health Insurance Commission. These records are generated in a vast variety of places and circumstances and increasing numbers are becoming computerized and centralized. Often the information is readily available at remote terminals.

Shielding medical records of sick patients in hospitals from all unauthorized eyes is virtually impossible. Invariably their care involves several or many doctors, the handling and exchange of confidential information between doctors, nursing staff, technicians, dietitians, physiotherapists, social workers and others who need access to the medical records in order to provide appropriate care and treatment for the patient. Administrative staff, filing clerks and hospital porters are in a position to read such records if they are so inclined. In teaching hospitals, students of various disciplines also have access to medical records. Most patients nowadays who are treated in hospitals realize that any confidential information given to an attending doctor will probably be seen by other doctors and health professionals, and consent by patients for such access is usually implied.

Doctors who have themselves been patients in hospitals, public or private, will realise how readily information, at the very least about their diagnosis, is disseminated amongst their medical colleagues. Indeed in this area many doctors can be justifiably accused of practising double standards in relation to confidentiality. Practical difficulties exist even in smaller private hospitals in protecting the confidentiality of the individual patient. Again, as most doctors will acknowledge, the name of a public figure appearing on a list of current in-patients or an operating list, will immediately attract attention and nearly always lead to breaches of confidentiality. Some medical practitioners appear to believe that so long as these breaches are restricted to discussion amongst colleagues (ie. non-treating colleagues) that no harm is done, a belief which in the opinion of the editors of this book is quite wrong.

Access to Patient Records

Access by patients to the contents of medical records concerning them has long been a contentious issue. Various hospitals will allow patients to read their own case notes. In others the security may be lax, and patients and visitors may, without permission, easily pick up and read confidential case notes and letters containing confidential material. The issue of whether patients should have access to their own medical records is controversial and varies from country to country. A recent Canadian higher court decision established the right of patients to see and make copies of any part of medical records concerning them. Denmark has also introduced legislation which will have this same result.

The following "Guidelines on patients' access to records concerning their medical treatment" were issued by the AMA Federal Council in March 1994:

In the Australian Medical Association's view, unrestricted access to records concerning their medical treatment may not always be in patients' best interests. Access to records concerning their medical treatment by patients is a matter for individual negotiation between patients and their attending medical practitioners.

Where a doctor agrees to provide information to a patient from the contents of records concerning the patient's medical treatment, the following guidelines apply:

The patient should be informed of all relevant factual information contained in the record;

However, the doctor's opinions and conclusions recorded in the medical record will be released only at the discretion of the doctor concerned.

Where the doctor or doctors concerned have agreed to release information from records concerning a patient's medical treatment, the patient should be informed, as relevant, of any or all content of the following sections of the medical record:

- History
- Findings on physical examination
- Results of investigations
- Diagnosis or diagnoses
- Treatment plan proposed

Reports by specialists are prepared for the purpose of communication between doctors. Consequently, patients wishing to obtain a copy of the report from a specialist should either approach the specialist concerned directly, or obtain his/her permission for any other doctor holding such a report to release it.

Reports prepared for third parties, such as those prepared for medico-legal or insurance purposes, are the property of the party for whom they were prepared. Doctors who hold copies of such reports have no right to release them to patients without express permission from their owners.

Where records concerning patients' medical treatment are maintained

by a hospital or other organisation, identical principles as for an individual doctor should apply concerning the release to patients of information contained in the records.

Information concerning patients contained in medical records will normally be released, on request, only to the patient concerned. Third parties requesting access to such information will normally be required to produce a written consent from the patient. All other cases of a third party seeking access will be treated on their individual merits. In particular, instances are acknowledged where disclosure of information concerning patients is required by law. Otherwise, the normal principles of medical confidentiality apply when information contained in medical records is released for any purpose.

Reasonable charges, sufficient to meet the costs of researching and documenting information sought, may be charged to patients or their legally authorised agents for the provision of information contained in records concerning patients' medical condition and treatment.

Retention of Medical Records

The following statement concerning the "Retention of Medical Records" was adopted by the AMA Federal Executive Council in December 1993:

In the view of the Australian Medical Association, from January 1994 medical practitioners should retain records concerning their patients for a minimum period of 10 years following each patient's last attendance. In the case of minors, there is an additional responsibility to retain records until 10 years after the patient's attainment of legal responsibility (usually at the age of 18) regardless of the date of last attendance.

The AMA recognises that there are particular circumstances in which it may be desirable to retain medical records for longer periods. This might apply to particular fields of specialist practice where there is a tendency to deal with chronic disease or to specific patients with chronic disease when it may be important for either general or specialist practitioner to retain records for the lifetime of the patient or even, in the case of genetic diseases, beyond. Under circumstances where a practitioner has a routine policy of culling records after a specific interval, it is recommended that the records of such patients be marked so that they can either be retained long term in a separate storage system or alternatively offered, if necessary in abridged form, to the patient or the patient's family for safekeeping.

Retention of Medical Records when a Doctor Dies

When a solo medical practitioner dies, records of his or her patients become the property of the estate. When the executor is able to sell the practice to another medical practitioner, the care and retention of those records becomes the responsibility of the purchase and problems do not arise. However if the practice is not sold, the executor will need to take steps to care for the records, for leaving aside the interests of the patients, the estate may need the protection of those records should civil action for negligence or damages arise.

There is no single correct manner to handle this situation and neither is there a clear legal obligation upon the executor. Approaches which may be taken include:

- obtaining the assistance of another medical practitioner who agrees to take care of the records, and notifying the patients by letter of this arrangement.
- inviting patients to nominate another medical practitioner to whom the records may be forwarded, and
- inviting patients to accept their own records and make use of them as they choose.

Destruction of Medical Records

The following statement concerning the "Destruction of Medical Records" was adopted by the AMA Executive Council in December 1993:

The Australian Medical Association considers that confidentiality of the contents of medical records is of fundamental importance to the doctor-patient relationship. When medical records are no longer required, whether stored as hard copy or in electronic media, they should be destroyed by means which ensure that no identifiable contents are retrievable. Conventional incineration or shredding may not achieve this purpose.

The medical practitioner's responsibility for maintaining the confidentiality of the medical record's physical contents ceases only at the time of the record's destruction. Accordingly, medical practitioners should either personally oversee the destruction of their medical records or contract for such destruction with an ethical operator.

MEDICAL RECORDS AND THE FREEDOM OF INFORMATION ACT 1982

The preface of the above Act states that it is "an Act to give the members of public rights of access to official documents of the Government of Victoria and of its agencies..." Subsections (1), (3) and (4) of section 33 of the Act provide as follows concerning a "document affecting personal privacy":

- (1) A document is an exempt document if its disclosure under this Act would involve the unreasonable disclosure of information relating to the personal affairs of any person (including a deceased person).
- (3) Where ... the agency or Minister decides to grant access to the document, the agency or Minister (as the case may be) shall if practicable notify the person who is the subject of that information (or in the case of a deceased person, that person's next-of-kin) of the decision and of the right of appeal against the decision provided by section 50 (2) (e) to the person or, in the case of a deceased person, to the person's next-of-kin.
- (4) Where a request is made to an agency or Minister for

access to a document of the agency, or an official document of the Minister, that contains information of a medical or psychiatric nature concerning the person making the request and it appears to the principal officer of the agency or to the Minister, as the case may be, that the disclosure of the information to that person might be prejudicial to the physical or mental health or well-being of that person, the principal officer or Minister may direct that access to the document, so far as it contains that information, that would otherwise be given to that person is not to be given to him but is to be given instead to a legally qualified medical practitioner to be nominated by him and approved by the principal officer.

MEDICAL RECORDS IN PRIVATE HOSPITALS

The Freedom of Information Act 1982 does not apply to Private Hospitals. Copies of medical records need not be released without a Court Order. Where the treating medical practitioner or Director of Medical Services has reasons to believe that the direct release of reports of special investigations to a patient may not be in the best interest of the patient, then such reports should only be released to a medical practitioner nominated by the patient.

MEDICAL RECORDS AND THE COURTS

The important role of adequate medical records in protecting a doctor against unfounded allegations or complaints cannot be overstressed. Where oral evidence of two parties is in conflict, a clear contemporaneous record made by the doctor of his or her clinical findings, or of treatment or advice given carries great weight in court.

The availability of adequate detailed medical records is most important in medical negligence litigation. A persistent theme in advice given to doctors by medical defence associations is the importance of keeping thorough and accurate contemporaneous clinical notes. The courts will always, other things being equal, prefer oral evidence which is reinforced by contemporaneous notes to evidence which relies on unaided recollection of distant events. If the notes are made reasonably soon after the events to which they refer - and reasonably soon should be a matter of hours, not days - the court will allow the witness who made the notes to refresh his or her memory from them when giving evidence. All or part of a patient's medical record may become court exhibits. Poorly kept records can very easily be used in court to throw doubt on a doctor's professional ability, competence, responsibility and dedication.

The following eight points are important guidelines for the keeping of good medical records:

- Do them promptly.
- Make them objective and accurate.
- Write legibly the first time.
- Date and note the time of each entry.
- Write the notes yourself.
- Do not edit the notations, even for legibility.
- If errors occur, cross out the inaccuracies and initial

and date them. Enter a marginal note as to the reason for the correction. Then enter the corrections in proper chronological order.

Do not make thoughtless or unnecessary disparaging remarks about colleagues or their treatment. Such remarks may prompt subsequent litigation.

OWNERSHIP OF MEDICAL RECORDS

The following is an extract from the advice given by the Medical Board of Victoria in its Bulletin of July 1993:

"From time to time the Board receives inquiries and complaints relating to access to medical records. The most common issues are as follows:

- Access to medical records where a patient changes from one practice to another.

The Medical Board restates that the past treating medical practitioner has a clear obligation to convey to the new treating medical practitioner sufficient information to ensure adequate continuity of care. As a minimum this should be a summary of the key details of the records held, together with an offer of further information if requested. In many instances, photocopies of most or all of the records are an appropriate way to respond. The original records are the property of the patient's medical practitioner(s) who created them.

- Should a fee be charged for forwarding copies or a summary of a record to another practice?
Most practitioners will not charge for this service, an attitude the Board encourages. If a fee is charged, it should only cover the genuine cost of performing this task.
- How long should private medical records be held?
There is no statutory requirement or legal directive as to how long your private medical records should be maintained. Medical indemnity organisations recommend a minimum of 7 years (or 21 plus 7 years for minors) to cover the possibility of legal action i.e. you are advised to maintain your records for this minimum period for your own protection.
- Who owns medical records where a private practitioner is employed by a clinic owned by non-medically qualified persons?
This question is currently before the Supreme Court of Victoria and it is inappropriate for the Medical Board to comment.
- Is there an obligation to provide a medical report on a patient for their legal representative if by providing that report you believe that legal action against you may ensue? This question was addressed by the Medical Board in the last two years. Advice from the Government Solicitor indicates that in this situation there is no obligation for medical practitioners to provide reports. Their medical records are however disclosable to the

courts, upon summons.

What should happen to medical records when a medical practitioner dies? This is a difficult question. If the practice is sold, it is usual for the records to be passed to the incoming medical practitioner, who will care for the records as if they were his/her own. Where the practice is not sold, the person in charge of the estate has a dilemma. The best advice the Medical Board can give is that where possible the records should be stored for a minimum of 7 years and made available to patients upon request."

THE MEDICAL RECORD AND RESEARCH

The use for medical research of medical records that contain identifying information about, and without the consent of, their subjects is open to some fundamental legal and ethical objections. In law, these objections arise from duties of confidentiality and concepts of privacy while in ethics, objections are based upon principles of respect for autonomy (and its expression in the need for consent), justice and beneficence.

The enactment of the Privacy Act 1988 by the Commonwealth and recommendations of law reform bodies highlighted the ethical and legal issue of access, for research purposes, to medical records without consent of the subject of those records. This Act, State legislation and law reform recommendations led to reliance on Institutional Ethics Committees (IEC) to approve access that may infringe privacy or confidentiality.

It is clear that some medical research cannot be done unless identifying information is obtained about subjects. Examples are: the identification of all cases of a disease occurring in a group of people exposed to a particular agent, living in a defined geographical area or time period, attending a particular health service or exposed to a defined treatment or therapy. In such research, identity of subjects is essential and where the relevant information has already been recorded it will be access to the medical records that will be sought. While consent is normally necessary before such access is granted there are situations where researchers advance arguments for access without such consent. Such arguments include:

- Seeking consent would cause the subject "unnecessary anxiety" and the breach "will not be to the disadvantage" of the subject.
- Non-consensual access to the medical records is justified if the processes of gaining consent "are likely to prejudice the scientific value of the research".
- A requirement for consent may result in a skewed subject sample.
- Non-consensual access is a cost that is justly balanced by the benefits of medical research or that it is a cost that is part of living in a community in which

contribution to the overall good includes costs such as the occasional loss of autonomy.²

Section 95 of the Privacy Act 1988 empowers the Privacy Commissioner to approve the establishment of guidelines for the protection of privacy in the conduct of medical research. The effect of Section 95 is that disclosure or use of information, that would otherwise be unlawful, would, if made in accordance with the guidelines, now be lawful. Section 95 prescribes:

- (1) The National health and Medical Research Council may, with the approval of the Commissioner, issue guidelines for the protection of privacy in the conduct of medical research.
- (2) The Commissioner shall not approve the issue of guidelines unless he or she is satisfied that the public interest in the promotion of research of the kind to which the guidelines relate outweighs to a substantial degree the public interest in maintaining adherence to the Information Privacy Principles.
- (3) Guidelines shall be issued by being published in the Gazette.
- (4) Where:
 - (a) but for this subsection, an act done by an agency would breach an Information Privacy Principle; and
 - (b) the act is done in the course of medical research and in accordance with guidelines under subsection (1); the act shall be regarded as not breaching that Information Privacy Principle.

Section 95 in essence provides that the use or disclosure of information for the purpose of medical research will be lawful if an IEC has determined that the public interest in the research outweighs to a substantial degree the public interest in privacy. IECs are charged with the onerous responsibility of forming an opinion as to whether proposed research described in protocols, is or is not, acceptable on ethical grounds. Guidance for IECs is provided by the NHMRC in its Statement on Human Experimentation and Supplementary Notes 1992 which is published in full in Appendix II of this book.