

13 The medical record

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Purpose and content of the record

An important part of a good doctor patient relationship is the keeping of a proper medical record. It is a tool for management, for communicating with other doctors and health professionals, and has become the primary tool for continuity of care in many practices as well as in hospitals. To fulfil these tasks, the record must be comprehensive and accurate. Time constraints and different styles of consultation may result in records that are not as comprehensive as is desirable. A good medical record, however, is important for the health care for a patient and can also be helpful for the doctor if there is any question or complaint about the care of the patient.

There is a long established tradition in medicine that the “notes” that form the main part of the record contain something about the patient’s symptoms, signs, diagnosis and treatment plans. It is useful to differentiate between what is reported, what is observed, and what is diagnosed. These different features of a record entry are often abbreviated as (S) subjective, (O) objective, (Dx) diagnosis and (P) plan. It is also important that the notes can be ascribed to the appropriate patient (so the name, date of birth or other identifying details must be recorded accurately), at an identifiable time and by a recognisable author.

Lillenthal suggested 11 “commandments” of medical record keeping, which, if observed, would improve practice and protect the doctor in the event of a complaint¹

- write legibly
- write the date and time
- sign legibly
- do not use ambiguous abbreviations
- do not alter notes or disguise additions
- do not use offensive or humorous comments
- check what you have written
- look at and deal with, and initial/date reports
- remember the patient may need your notes
- understand how patients can get access to your notes
- if in doubt consult your defence organisation

Consider the difference between a record on one day which says “Repeat meds Metoprolol 47.5 daily 3/12” and one which says “Repeat meds, well, 130/80,

pulse reg 64/min, Metoprolol 47.5mg daily 3/12, buying Cartia”. Although not a lot longer, the second form shows considerably more of the process the doctor is going through and records important findings for monitoring the patient’s health and the results of the doctor’s interventions.

Sometimes, on reviewing an earlier record entry, a doctor may feel that it is inaccurate, incomplete or potentially misleading. It is appropriate to augment a record in such cases, making it clear when and by whom the augmentation or annotation was added. The earlier entry should never be deleted, obliterated or changed, if only because such amendments might later raise suspicion of covering up an error in treatment or diagnosis.

Legal and ethical obligations

The legal and ethical duties around medical records have nothing to do with ownership of documents.

The management of all personal information is covered in New Zealand by the Privacy Act 1993. Where health information is concerned, a special code of practice issued under the Privacy Act adapts the usual rules at the centre of the Privacy Act to health care. It is called the Health Information Privacy Code 1994 (HIPC).² It has the force of law. A copy should be readily available in every medical practice and any other organisation involved in health care in New Zealand.

The HIPC provides rules for health agencies, including doctors working on their own account or for others, on their handling of health information that is about identifiable individuals. “Health information” covers everything from consultation notes through to medical test results, and also includes the incidental information used in conducting the business side of health care such as address and billing details. A brief outline of the twelve rules at the heart of the HIPC is given in this chapter, but in case of any doubt doctors should refer to the words of the HIPC itself, or obtain advice from someone else who is more familiar with the Code. The HIPC is published with accompanying commentary by the Privacy Commissioner; the commentary is not legally binding, but contains a wealth of practical pointers and observations which will answer many a query.

The rules of the HIPC are designed to ensure that people retain a degree of autonomy when others are dealing with health information about them. A good rule of thumb is that there should be no surprises for the individual in how information about them is collected, is used, and is passed to others. The rules generally reflect good ethical medical practice.

Some other laws are also applicable to medical records. Among the more important of these is the Health Act 1956, and regulations issued under that Act on the retention of medical records. The published version of the HIPC has an appendix containing extracts from several other applicable statutes.

Electronic records

The obligations around medical records exist regardless of the form in which they are kept. Medical records are very often made and held in electronic form, and existing paper records converted to electronic media. To the extent that an electronic record captures everything which was in the original paper version, there is no need to retain that original. However, if scanned copies of images

would miss detail of potential significance, the original films should not be destroyed inside of the normal minimum retention period.

Whilst they are immensely convenient, electronic records do require some special care simply because they are easy to access, copy and transmit. Thus, when sending off certain information in an electronic record, the practitioner must be alert to the possibility that the transmission will send more of the record than was required or intended.

The Rules of the Health Information Privacy Code

Rule 1 – Purpose of collection

You must collect health information only where the information is needed for a lawful purpose, and the collection is necessary for that purpose. You will usually be collecting it for care and treatment, including the administrative aspects of those activities. You may be asked to justify having collected individual items of health information.

Rule 2 – Source of the information

Wherever practicable, you should collect health information directly from the individual concerned. One exception is where the individual has authorised you to collect the information from someone else. It is good practice to record the source from which you have obtained health information, especially if it has come from someone other than the individual concerned.

Rule 3 – Collection of health information

When you collect health information directly from the individual concerned, you must take all reasonable steps to ensure that the individual is aware that the collection is taking place, is aware of who is doing the collection, for what purpose, and with what intentions of passing the information to others. You should also see that the individual is told the name and address of the agency which will be keeping the information, and that they have a right of access to it. If it is practicable to do so, these steps should be taken before the health information is collected. Many health care agencies find it convenient to communicate these matters by the use of leaflets, and by notices on the forms which the individual uses to give the information.

Rule 4 – Means of collecting health information

You must collect health information by means which are lawful, fair, and do not intrude unduly on the individual's personal affairs. This means that information should not be collected by, for instance, giving a misleading impression of the purpose, or by offering inappropriate inducements or threats to obtain it. Medical professionals become used to dealing with very sensitive personal information, but must remain mindful of its importance to the individual concerned.

Rule 5 – Storage and security

Anyone holding health information must take the steps which are reasonable in the circumstances to ensure that it is guarded against loss or unauthorised access and use. Amongst other precautions, this means that the more personal information

should not be voiced where others can hear it if those others have no business to know it. Similarly, care must be taken when transmitting health information by fax or computer transfers to ensure that it goes only to the appropriate recipients. As with several other rules of the HIPC, the test of what steps are “reasonable in the circumstances” calls for a proportional approach – the more sensitive the information, the greater should be the safeguards applied. Transfers, archive storage, or destruction of medical records, all require particular care as to confidentiality. Computers should have passwords, and records should be accessible only in areas where access is limited to staff.

Rule 6 – Right of access

Individuals have the right to have access, on request, to health information about them. Access should usually be given without charge, and in the form that the individual prefers. A request for access must be responded to promptly, and certainly within twenty working days. The health agency should verify the individual’s identity before giving the information to them. There are circumstances in which the request for access may be refused, but these are exceptional cases and the only valid reasons for refusal are those set out in the Privacy Act. Any doctor making records should do so on the assumption that they may be seen by the individual concerned.

A private sector health agency may make a (reasonable) charge for providing copies of X-Ray or similar images; see Clause 6 of the HIPC. Similarly it may require the payment of a reasonable charge for access by an individual to any health information about herself where substantially the same access has already been given in the previous 12 months. In any case where a charge is proposed and it would exceed \$30, the requesting individual must be advised of the likely charge before it is incurred. The Privacy Commissioner has power to investigate complaints about charges being made where they should not be made, or charges which are more than is “reasonable”, and she can make binding rulings on the amount of those charges in any such complaint.

Rule 7 – Correction of health information

Every individual has the right to request correction of health information about them if they believe it to be wrong. The agency keeping this information may refuse to make the correction if the agency feels that it would not be appropriate to do so, but in such a case the agency must if so requested attach a note to the contested information showing the patient’s assertion of the error. Quite apart from any request, if you become aware of an error in health information held you should yourself take steps to correct it. Any corrections made should be communicated, if practicable, to every other person or agency to which the erroneous information has been previously passed. Questions of correction are kept to a minimum if the record clearly shows what items of information are opinions rather than facts.

Rule 8 – Check before use

You must not use health information without first taking reasonable steps to ensure that it is accurate and not misleading. The steps taken will depend on the use to which the information is to be put: the more important that item of

information is in the proposed action, the more rigorous should be the steps to ensure that it is accurate, up to date, complete, relevant and not misleading.

Rule 9 – Retention of medical records

This HIPC rule states that health information is not to be kept for longer than it is required for those purposes for which it may lawfully be used. Given that health information is normally kept for purposes which include future diagnoses and care, the rule itself will not often impose a limit on retention. Furthermore, there are specific regulations – the Health (Retention of Records) Regulations 1996 – requiring that health information relating to an identifiable individual must be retained for a minimum of ten years from the day after the last treatment or care of that individual by the agency holding the information. Unless the accuracy of certain health information is being questioned, the most likely form of complaint in relation to retention is that it has not been retained for long enough. The Medical Council’s guideline, and the advice of several colleges, is that records are retained for more than ten years.

Medical records can be, and usually are, passed on to another doctor as a patient moves from one to another. The question often arises as to what to do with health records relating to a patient who has not been seen for very many years, particularly when a sole general practitioner has died or retired. Doctors in sole practice would do well to make arrangements in advance for their records to be transferred in bulk to another doctor for safe keeping should they cease practice suddenly.

Rule 10 – Limits on use

Health information obtained for one purpose cannot be used for another purpose unless one of the exceptions to this rule applies. The most commonly encountered exceptions are where the new use is directly related to the original purpose, or where the individual has authorised the other use. Another permitted exception applies in the area of health research, of which more will be said below.

Rule 11 – Limits on disclosure

Disclosures which were anticipated and intended when the information was obtained can proceed as planned. Other disclosures can be made with the authorisation of the individual. A further group of exceptions applies to permit other disclosures where it is not desirable or practicable to obtain the individual’s authorisation, and the situation fits into one of the limited exceptions set out in the full rule. Examples of this group are where the disclosure is directly related to the purpose for which the information was obtained, where the disclosure is for a professionally recognised accreditation or quality assurance programme, or where the disclosure is for statistical or approved research programmes (of which more is said below). The rule against disclosure of health information applies to individuals until twenty years after their deaths.

Rule 12 – Unique identifiers

Unique identifiers can be used where these are assigned by the agency itself and are necessary for the agency’s own purposes. Some external body’s unique identifier can be used where the use is part of the purpose for which that identifier

was assigned. A case in point is the National Health Index number, where its recording and use by the agency is for the purpose of making the claims and reports which are indexed by that common identifier. The rule does prohibit a health agency using the same identifier (e.g. a driver licence number) given by another body for an unrelated purpose.

Health research

Most health research in New Zealand has to be approved by an official ethics committee, which will inquire into any privacy issues apparent in the scope and conduct of the proposed programme and may set limits in those areas. Health information can then be used in, and disclosed for, a research programme which has received ethics committee approval, but even so any disclosure for the purpose of such a research programme can only go ahead in the absence of the individual's authorisation if it is not practicable or not desirable to obtain that authorisation.

It should be noted that there is no prohibition on the use or disclosure of statistical information which is not identifiably about any individual. Where information about an identifiable individual is to be disclosed for use in statistical surveys, but nothing will be published in a form that could be expected to identify the individuals covered, this can proceed without the individual's authorisation if it is not desirable or practicable to obtain that authorisation.

Disclosures under other legislation

Disclosure to other health professionals

Where another health care professional makes a request for health information in order to provide health or disability services to the individual, this is permitted by section 22F of the Health Act, and there are only limited circumstances in which the request for information may be refused. It is not necessary for the doctor acting on such a request to get the individual's authorisation to make the requested disclosure, although one of the few grounds on which disclosure of the information can be refused is if the doctor has reasonable grounds to believe that the individual does not want it so disclosed. Refusal to provide requested information to another health professional, where that disclosure seems to be required under section 22F, can be referred as a complaint to the Privacy Commissioner, who will treat it as if it were a refusal to give access requested by the individuals concerned. Section 22F applies to requests; it does not cover volunteered or routine disclosures, such as a report to the individual's normal general practitioner, where the matter ought to be dealt with in the usual way under rules 3 and 11 of the HIPC.

Disclosures to representatives

Section 22F also allows the doctor to meet requests for information from the individual's "representative" where the individual is under the age of sixteen or is for any other reason unable to exercise their own rights. If the individual is dead, their "representative" is their executor or administrator; if the individual is a child under the age of 16, it means their parent or guardian; in any other case it means a person appearing to be lawfully acting on the individual's behalf or in their interests (including a welfare guardian or attorney). The request may still be refused if the doctor has good reason to believe that the individual would not want that information to be disclosed to that representative.

Other requested disclosures

There are a number of other provisions in legislation under which information can be requested from, and supplied by, a doctor. The bodies which make such requests should make it clear what statutory authority they are relying on. A doctor can and should ask the requesting body to clarify in writing exactly what information is sought, the reason for the request, and the statutory provision which might permit or require the doctor to provide that information.

Certain protected disclosures

There are provisions under the Children Young Persons and their Families Act 1989 which allow and protect the reporting to Police or to a social worker of suspected neglect or abuse of a young person. There is a duty on a doctor under the Land Transport Act 1998 to report to the Director of Land Transport Safety any person they know of who is likely to drive a vehicle but whose mental or physical condition makes it unsafe for them to do so.

Transfer of patient records to another doctor

Partnerships of doctors operate as single agencies under the HIPC, and their obligations under the Code apply to all the health information held by the partnership. Locum doctors may work in, and as employees of, that partnership. A doctor leaving a partnership has no automatic right to remove any records, and legal advice should be sought where the partners do not agree on what should happen to the records.

When a patient's medical records are to be transferred to another doctor, medical defence organisations strongly recommend the doctor keeps a copy, especially if there has been any suggestion of complaint. Such transfers must be made at the request of the patient, either received directly or through the request of the new doctor. Transfers should be made promptly on request, and the existence of outstanding accounts is no excuse for refusal or delay. The record to be transferred would usually be the whole folder of notes or print out of the electronic file, but at the minimum should consist of a brief factual summary of what records the doctor has along with a note of the present state of the patient's health. The agency holding the record should generally wait for a request by the patient or by the new health care provider before transferring the records; this allows for agreement on what records are to be transferred and by what means.

References

1. Lillenthal C, Medical Records – the eleven commandments. *Journal of the Medical Defence Union*, January 1997.
2. *Health Information Privacy Code 1994* (reprinted with amendments September 1998), obtainable from the Office of the Privacy Commissioner, or at www.privacy.org.nz.
3. The Privacy Commissioner's enquiry line on 0800 803909.
4. *Maintenance and retention of patient records*. Medical Council, 2001.