CHAPTER 13

Medical records and patient access to information

Robert Stevens is an Auckland barrister and a consultant in the management of personal information and privacy.


Purpose and content of the record 122
Legal and ethical obligations 123
Electronic records 123
The rules of the Health Information Privacy Code 123
Health research 126
Other requested disclosures 126
Certain protected disclosures 127
Transfer of patient records to another doctor 127
Dr D’s documentation in relation to the consultation on 21 June was inadequate and, accordingly, he breached Right 4(2) of the Code.

Health and Disability Commissioner’s Decision 10HDC00753.

Purpose and content of the record

An all too common finding of bodies with statutory rights to investigate doctors is that of inadequate clinical records. The clinical note 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. A good medical record 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.

There are some useful principles that apply to clinical notes:

- 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.

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 47.5 mg 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.
With modern computer systems in both primary and secondary care, test results such as bloods and imaging are an important part of the clinical record. Although the principles of management of tests will be discussed in chapter 14, it is useful to think of such results as part of the record.

**Legal and ethical obligations**

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). It has the force of law. 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.

**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.

**The rules of the Health Information Privacy Code**

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 HIPC. 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.

**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 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.

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. 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.

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.
It sometimes happens that a doctor is given information about a patient by someone else, and the source of the information may ask that the patient is not to be told that the doctor has the information or who gave it. However, no matter what the doctor promises, the right of access under the Privacy Act still exists, so doctors should never give unqualified promises of confidentiality if they receive information about a patient from third parties.

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.

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.

Rule 10 — Limits on use

Health information obtained for one purpose cannot be used for another purpose. There are some exceptions to this rule.
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 allow 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. The rule against disclosure applies to health information about individuals until twenty years after their deaths.

Rule 12 — Unique identifiers
You can use another agency’s unique identifier only where your use of it 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 your agency is for the purpose of making the claims and reports which are required to be indexed by that common identifier.

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.

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. In those cases the legislation allowing or requiring the disclosure will protect the doctor who made the disclosure in good faith from any legal or disciplinary action being taken against the doctor on account of that disclosure.

Transfer of patient records to another doctor

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.