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Medical Records

Contents

What are medical records?

"Medical records" is a broad term, encompassing a range of data and information storage mediums containing patient information. Whether paper based or electronic, the term "medical records" applies to:

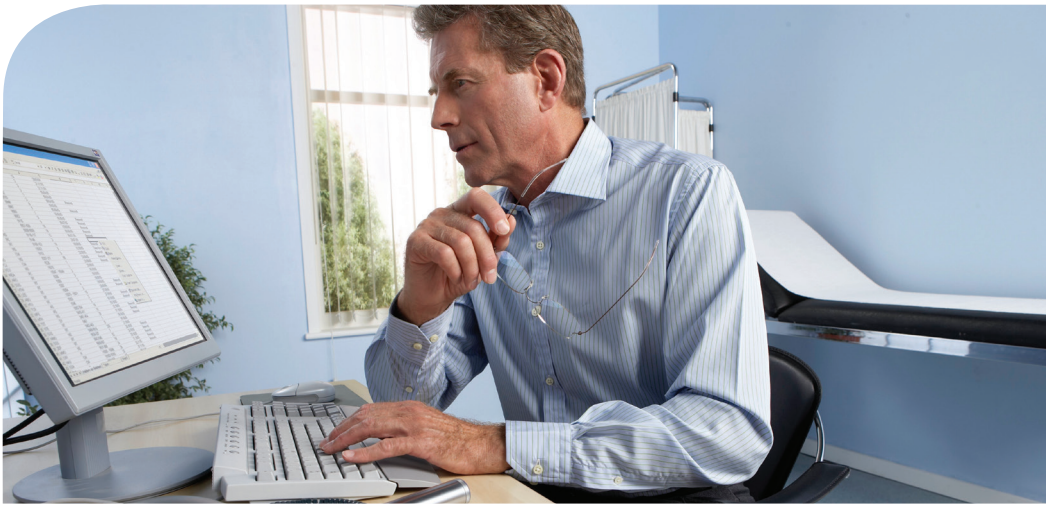
- clinical notes
- investigations
- letters from other doctors and healthcare providers
- photographs
- video footage.

However, information exchanges (such as correspondence, email and file notes of discussions) between a medical practitioner and their medical indemnity insurer or solicitor should not be stored in the medical record. For this reason, it is recommended that you keep a separate medico-legal file in which to store these documents.

What is the purpose of the medical record?

Medical records are an integral part of good quality patient care. The primary purpose of the medical record is to facilitate patient care and allow you or another practitioner to continue the management of the patient. Clinical observations, decision making and treatment recommendations or plans should be recorded contemporaneously. This reduces the possibility of an error occurring and is an important risk management tool.

Good medical records can also significantly improve the defensibility of a claim or complaint, particularly when a conflict exists between the patient and the practitioner's recollection of events.



What should my medical records contain?

While professional regulations for medical records differ from state to state, the Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors in Australia* (the Code) provides specific guidance regarding making, storing and accessing medical records.[1] The provisions of the Code are comparable with the *Health Practitioner (New South Wales) Regulation 2010*,[2] which is considered to be an appropriate reference point for all practitioners.

On the basis of the Code and regulations, a medical record should include:

- information relevant to diagnosis and treatment, e.g. history, physical examination (including relevant negative findings), mental state, results of any tests, allergies
- clinical opinion
- plan of treatment
- any medication prescribed
- information, warnings or advice given to the patient in relation to any proposed medical treatment
- any follow up instructions given to the patient
- details of any medical treatment, including any medical or surgical procedure
    - date of the treatment
    - nature of the treatment
    - name of any person who gave or performed the treatment
    - type of anaesthetic, if any
    - any tissues sent to pathology
    - results or findings made in relation to the treatment
    - copy of any written consent provided to the patient for the treatment.

General requirements as to content and form of records:

- A record must include sufficient information concerning a patient's treatment to allow another medical practitioner to continue to appropriately manage the patient's care.
- All entries must be accurate statements of fact or statements of clinical judgement. Personal (non-medical) opinions should not be included.
- Include details of significant discussions or correspondence including telephone calls with the patient or other health professionals and copies of referral letters, reports and test results.
- Only abbreviations or expressions which are generally understood in the medical community should be used. All records need to be legible.
- Each entry must identify the person who made the entry and the time and date it was made.
- Keep up-to-date records. Enter information at the time of the event or as soon as possible after.[1]
- A record may be made and kept in a computer database or other electronic form but only if it is capable of being reproduced, e.g. printed on paper.
- A medical practitioner or medical corporation must not alter a record in a way that obliterates, obscures or renders illegible information that is already contained in the record.[1]
- Ensure records show respect for patients, e.g. do not include demeaning or derogatory remarks.[1]

Remember, a record needs to be sufficient to ensure continuity of patient care.

Comprehensive and accurate medical records are an integral component of a defence to investigations, claims or complaints.

Why are medical records important medico-legally?

Medical records may be used as evidence in legal proceedings, including medical negligence claims, disciplinary hearings, criminal proceedings or Coronial Inquests.

As medical negligence claims often involve a factual dispute, comprehensive and accurate medical records are an integral component of a defence to investigations, claims or complaints. By the time proceedings have commenced, the practitioner may no longer recall the relevant consultation or event, leaving the patient's recollection of events as the only evidence of what actually occurred. Even where the practitioner does remember what occurred, if that recollection conflicts with the patient's, the patient's version of events will often be preferred by the arbiter. A contemporaneous medical record, however, is likely to be more persuasive than either party's memory.

How long should I keep medical records?

From a medico-legal perspective, medical records should be kept until such time as there is little or no risk of litigation arising from the patient's treatment. This will depend upon the statutory limitation period within the relevant jurisdiction, and any applicable state or territory legislation governing medical records.

Unfortunately, it is difficult to be definitive about the applicable limitation period, as courts generally have a discretion to extend it in certain circumstances.

Where there has been a patient complaint or an adverse outcome, or legal proceedings have been foreshadowed, the medical records should be kept indefinitely (or advice sought from MDA National prior to disposal).

Medical records for a patient who has a current claim for damages or who is subject to a guardianship or other court or tribunal order should also be kept indefinitely, or until seven years after the patient's death.

The Australian Capital Territory (ACT),[3] New South Wales (NSW)[4,5] and Victoria[6] have legislation which outlines the minimum period of time which medical records should be kept, namely for:

- an adult – seven years from the date of last entry
- a child – until the age of 25 years.

MDA National considers these requirements to be appropriate in all Australian contexts.

How should I dispose of medical records?

You must dispose of the medical records in a manner that preserves the confidentiality of your patients. This involves taking reasonable steps to destroy or permanently de-identify the personal health information of your patients.

In the ACT,[7] NSW[8] and Victoria,[9] when disposing of records, practitioners are required to keep a register identifying the:

- name of the individual to whom the health information related
- period of time over which the health record extends
- date on which the record was deleted or disposed.

It may also be helpful to publish a notice in the local newspaper advising of your intention to destroy the records of patients last seen on a particular date, and suggesting that patients who wish to transfer or retain their records contact the practice to advise of their preference. Any such notice would also need to include a timeframe in which to respond and a date on which it is proposed that the records will be destroyed.

If you use a commercial company to dispose of the records, the company should provide certification to confirm confidential destruction. Practitioners should retain copies of any certificates of destruction and any public notices or advertisements which have been placed.

Make reasonable efforts to ensure that you provide continuity of care for your patients when closing a practice.

What is required when transferring medical records?

If you transfer medical records to another practitioner or medical practice, you should record the name of the individual or practice to whom a copy of the records have been transferred and their address, together with the date of transfer, preferably in a register.[7,10,11]

What should I do if the practice is permanently closing?

If you are closing the practice, the most important responsibility you have is to make reasonable efforts to ensure that you provide continuity of care for your patients. You should notify patients as soon as practicable that the practice is closing and of the manner in which you propose to deal with their health information.

The Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors in Australia* provides specific guidance about closing your practice.[1] According to the Code, when closing or relocating your practice, good medical practice involves:

- giving advance notice where this is possible
- facilitating arrangements for the continuing medical care of all your current patients, including the transfer or appropriate management of patient records. You must follow the law governing health records in your jurisdiction.

In the ACT and Victoria, you are required to publish a notice about the closing of the practice in the local newspaper and take other practicable steps to inform patients of the practice's closure, such as placing signage in the practice, sending letters to patients, or advising patients when they next attend for a consultation.[12,13]

For practices located in the ACT, NSW or Victoria, your options with regard to patients' medical records are to:[14-16]

- transfer the records to the patient's nominated treating practitioner
- provide the medical records directly to the patient concerned
- advise patients as to how their medical records can be accessed in the future if you propose to retain/store their health information.

Any patient records which have not been passed onto another medical practitioner or the patient must be stored securely for the statutory period.

MDA National considers the above requirements to be appropriate in all Australian contexts.

It is up to the health professional and healthcare institution to determine how data security is maintained.

What are my obligations regarding the storage of medical records?

Australian Privacy Principle (APP) 11 – contained in an amendment to the *Privacy Act* – imposes a statutory duty upon practices/practitioners to ensure that there are safeguards in place to protect a patient's health information.[17] This applies to all forms of recording a patient's personal information, whether it is held in paper, electronic format, x-rays, photographs, audio or video (which includes telemedicine). Reasonable security measures must be taken to ensure the security of the patient's health information. Although the Australian Privacy Principles provide some guidance, it is up to the health professional and healthcare institution to determine how data security is maintained.

Examples include:

- implementing computer system safeguards, such as firewalls, virus protection, and password protection with frequent password updates
- regular backups of all electronic information (preferably held offsite)
- ensuring that there is lockable physical security for paper records
- monitoring information systems to check and evaluate the data security.

The overriding duty is to ensure that patient confidentiality is maintained and that records are not lost, stolen, damaged or altered.

Who owns the medical records?

Unless there are specific contractual arrangements, medical records generally belong to the medical practice or hospital in which they were created.

Can patients access their records?

Australian Privacy Principle 12 grants patients the right to access their medical records on request. The holder of the records must verify that the request was made by the individual concerned, and must give access to the records in the manner requested by the individual (e.g. by email, in person, hard copy), if it is reasonable and practicable to do so.

How much time do I have to process a request for medical record access?

As a guide, the Office of the Australian Information Commisssioner (OAIC) recommends that the total time for processing an access request should not exceed 30 days.

Should a request for medical records access be made in writing?

MDA National recommends that patients are asked to provide a written and signed request to access their medical records. However, you cannot force them to do so. Any requests for access from a third party must be in writing and include a signed authority from the patient; however, a patient authority is not required in certain situations such as being served with a valid subpoena or search warrant.

If you provide access to the medical records, you should record details in the patient's record of when and to whom you provided access.

Can I refuse to provide a patient access to their medical records?

Access to a patient's medical records can only be denied to the patient (or their nominated representative) in exceptional circumstances, such as:

- a serious threat to the life, health or safety of any individual, or to public health or public safety
- unreasonable impact on the privacy of other individuals.

If access is denied, the patient must be advised in writing why the request was declined and the complaint mechanisms available to them. The reasons for refusing access should also be noted in the patient's records.

We recommend you obtain advice from MDA National if you intend to refuse a person access to their medical records.

Can I charge for providing a patient or third party with a copy of the medical records?

A fee may be charged to cover the cost of providing access to the medical records (e.g. photocopying, printing and administrative costs), as long as the fee is not excessive[18] and does not discourage a patient from accessing their records. The Office of the Australian Information Commissioner suggests that a patient's individual circumstances and capacity to pay for access should be taken into account when considering what fees may apply.

Can I provide access to specialists' letters which are contained in the medical records?

The patient's right of access to their medical records includes specialists' reports and letters. This is regardless of whether or not the specialist's letter states that it is not to be released to a third party without the permission of the author.

Who can access a deceased patient's medical records?

A patient's right to confidentiality does not end when they are deceased. In circumstances where the patient is deceased, consent to access their medical records should be provided by the executor or administrator of their estate. If you practise in the ACT or Victoria, only the executor of the will (where probate has been granted) or the administrator of the patient's estate has a right of access to a deceased patient's records.[19,20] In NSW, Western Australia, South Australia, Northern Territory, Queensland and Tasmania, in the absence of any apparent dispute or clear inconsistency with the deceased's wishes, we recommend access to the medical record should be given to a person who makes a written request accompanied by a certified copy of the will proving their appointment as executor.

A request for access should:

- state the name and address of the individual requesting access, and their relationship to the deceased
- identify the health information which is sought
- specify the way in which the individual is seeking access, e.g. provision of copies or review of the notes in person
- state the basis on which the request is being made, e.g. as the executor, with the permission of the executor, or for bereavement purposes.

If a request for medical records is in the context of a will dispute, further advice should be obtained from MDA National.

When access is provided to a deceased patient's health information/medical record, a note should be made in the record indicating who was given access, the grounds for allowing access, and the extent of the information which was supplied.

Can a practitioner erase or alter a medical record relating to a specific incident?

After receiving a claim or complaint, you may feel tempted to change the medical records or to document all of your recollections of the event in the notes. Although poor medical records may make a claim difficult to defend, altered medical records will make a claim virtually impossible to defend. As soon as you are aware of a claim or complaint, no changes of any sort should be made to the patient's medical records.

If, in the normal course of patient management, you become aware that personal information is incorrect, you are required to correct it. It is quite acceptable either to add a contemporaneously dated electronic note, or to rule across the mistaken entry (without deleting it), initialling the correction, including the date that the correction was made. If information relating to a particular incident is received at a later date, insert an entry but clearly mark it "additional" and include the date and time it was made (if adding it to a paper record).

Note that in the normal course of care, APP 13 requires personal information found to be incorrect to be corrected.

Can I scan records into an electronic form and destroy the paper based records?

Medical practitioners are often required to manage the medico-legal and practical issues associated with keeping a mix of paper and electronic patient records.

Whilst current legislation does not specify the format in which a patient's medical records must be kept, in some instances, an original paper document may be of forensic importance.

However, if retention of the original paper documents is not possible for some reason, e.g. due to storage limitations, the original, complete documentation should be promptly scanned and saved into the patient's electronic medical record. The original paper documents may then be destroyed in a secure manner.

Scanning should be of sufficient quality to allow a complete and legible hard copy to be reproduced from the electronic copy.

Can I summarise the records into an electronic form and then destroy the paper based records?

MDA National strongly advises against the practice of summarising original paper documentation to facilitate destruction of the original paper records. The practice of summarising documents in an electronic medical record may lead to relevant information being omitted, altered in context and/or misinterpreted.

What needs to be done if medical records (electronic or paper based) are lost, stolen or damaged?

If electronic records are lost they can hopefully be restored from your most recent backup. If your backup is damaged, third party technical assistance may be required to try and rebuild the records. This is expensive and time consuming and it may only be possible to partially recover the lost data, requiring manual re-entry of the data.

If paper records are lost they will need to be recreated as best they can be.

Contact MDA National as we may be able to assist you under your Policy to retrieve the records. Note that loss of electronic documents may not be covered unless there is an appropriate backup, protocols for access to the documents and current security software installed.

If there has been a breach of patients' privacy, notify the affected patients. If there is a risk of serious harm as a result of the privacy breach, notify the Office of the Australian Information Commissioner. MDA National may be able to assist you with these actions.

Australian Privacy Principles, your privacy policy and medical record management

The 13 APPs[21,22] detail requirements for how you collect, use, store and transfer medical information.

Under APP 1 you are required to have a clearly expressed and current policy (an *APP privacy policy*) that details how you manage personal information. Personal information includes medical information you hold about patients. You must make your privacy policy available to patients in any reasonable form they request, e.g. as an electronic document or in printed form. Your privacy policy must cover:

- the kinds of personal information you collect and hold
- how and for what purpose personal information is collected, held and used
- for what purposes you will disclose personal information to other persons or agencies, what information you will disclose and to whom
- the process for a patient to access and seek correction of their personal information
- your complaint process in the event that a patient makes a complaint related to breaches of privacy or confidentiality
- whether personal information may be disclosed to overseas recipients and, if so, the countries in which such recipients are likely to be located if it is practicable to specify in the policy.

Although not required under privacy law, MDA National recommends that the practice's privacy policy also addresses:[23]

- staff training and confidentiality agreements
- policy review timeframes
- processes for dealing with unauthorised access to individuals' health information, including who must be notified in the event of a breach.

The ways in which you collect, store, transfer and destroy your medical records must be in line with your own written privacy policy, as well as the relevant national and state/territory legislation. If you transfer records overseas (e.g. to an off-shore transcription service) you must take steps as are reasonable in the circumstances to ensure that the overseas recipient does not breach the APPs in relation to the information.

Also note that where an individual requests access to their records, the organisation must give access to personal information in the manner requested by the individual if it is reasonable and practicable to do so (APP 12).

Australian Privacy Principle 12 does not stipulate formal requirements for patients making a request to access their medical record or require that a request be made in writing. If your practice requires an individual to follow a particular procedure in requesting access to their medical information, you should display that procedure and draw attention to it, for example, by displaying it in reception or by providing a link in your APP privacy policy and on your website.

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Find Out More

Where can I get help if I still have questions regarding medical records?

Please contact MDA National for further information and advice regarding medical records, and indeed any risk management or medico-legal matter.

For advice call our Medico-legal Advisory Service on **1800 011 255.**

MDA National's experienced medico-legal advisers provide accurate, empathetic and timely medico-legal advice, with access to our 24/7 service for urgent matters.

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