

Medical records and you



The use and storage of medical records is regulated by state government legislation and National Privacy Principles. From a medico-legal perspective you need to be aware of your obligations.

While the purpose of medical records is to assist in the quality and continuity of care, good records will also assist you in supporting your defence in the event of a complaint or claim being made against you. Inadequate and poor medical records are a common factor in claims against doctors being compromised and settled.

When there is a dispute about what happened or what took place during a consultation, the patient's recollection of the events is often considered by a medical board, tribunal or court as being more accurate because of the significance of this event in their life. In contrast, the doctor's recollection of events is usually not patient-specific or is limited because of the number of patients they see and will necessarily be based on their usual practice. It is for this reason that medical records play such a significant role in the defence of a claim.

While courts may well take the view that 'If it's not written down, it didn't happen', contemporaneous written records of the event provide what is generally considered to be a more 'independent' record of the event because they are prepared before the complaint is made.

There is an old axiom: *Good notes; good defence. Poor notes; poor defence. No notes; no defence.*

The value of good medical records cannot be overestimated

What are medical records?

'Medical record' is a general term for many types of health data and includes a patient's progress notes (hand-written or computer generated), appointment books, accounts, consultant reports, hospital discharge summaries, pathology reports, medical imaging reports such as x-rays, videos, photographs and medico-legal reports.

Medical records may be used as evidence in criminal, civil or disciplinary legal proceedings or for coronial inquiries.

Conversations and correspondence between a doctor, their medical indemnity provider and lawyers are not part of a patient's records. These documents should be kept separate

from the patient's clinical file. Correspondence regarding patient complaints should also be kept separate from their clinical file.

Who owns the records?

In solo practice, generally speaking medical files belong to the doctor who prepares them, not the patient. An exception here might be X-rays or investigations paid for by the patient. The question of ownership where doctors practise together or in a shared practice can be unclear. It's useful to clarify ownership of the records when you start work at the practice.

Legislative requirements

Commonwealth legislation and various state and territory legislation set out minimum requirements for medical records. The Commonwealth *Health Insurance Act 1973* for the purposes of compliance with Medicare requirements provides a good example:

HEALTH INSURANCE (PROFESSIONAL SERVICES REVIEW) REGULATIONS 1999 (Cth)- REG 5

An adequate record

For the definition of adequate and contemporaneous records in section 81 of the Act, the standard to be met in order that a record of service rendered or initiated be adequate is that:

- (a) the record clearly identify the name of the patient; and
- (b) the record contain a separate entry for each attendance by the patient for a service and the date on which the service was rendered or initiated; and
- (c) each entry provide clinical information adequate to explain the type of service rendered or initiated; and
- (d) each entry be sufficiently comprehensible that another practitioner, relying on the record, can effectively undertake the patient's ongoing care.

Important details to be included in records

A well-designed questionnaire which patients complete at their first visit should provide data about prior illnesses and operations, family history, allergies, current medications, and smoking and alcohol consumption. But it must be kept up to date.

Also record any significant illness that has been managed elsewhere – particularly any factors that may require special consideration – and any information obtained concerning the patient's mental state.

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The following is a list of risk management strategies to help you manage your records.

We suggest that:

- records are legible, and that any acronyms or abbreviations can be **understood by another doctor**
- records include history and examination findings; the results of any tests performed on the patient, positive and (relevant) negative findings; discussion of possible diagnosis and proposed management plan
- discussions concerning planned procedures and/or treatment options are documented
- any written consent given by a patient to any proposed medical treatment (including any medical or surgical procedure) is kept in the file
- a patient's refusal to consent, undertake tests or comply with treatment is documented
- telephone conversations are documented
- particulars of medication prescribed– i.e. drug name, quantities, frequency of dosage and date prescribed – and repeat prescriptions are recorded
- details of house calls are recorded
- information concerning allergies or other factors that may require special consideration are recorded
- particulars of any clinical opinion reached by the medical practitioner are recorded
- follow-up recommendations are recorded and compliance is monitored
- a computerised system ensures you back up on a daily basis
- security protocols limit unauthorised access to the records
- your staff are aware that privacy legislation covers all the information you hold about the patient – the medical record, reports, x-rays, accounts, appointment books, videos, photographs, test results, as well as the medical notes.

Testing the adequacy of your notes

A simple way to assess the adequacy of your notes is to include everything you would wish your predecessor to have recorded if you were taking over the patient's management for the first time.

Pain deserves a special mention here: the time of onset, its situation, severity, quality, radiation and changes over time must

be recorded. All too often a record contains the statement 'chest pain' without the detail which helps to formulate a diagnosis or diagnoses.

Summarising the content of the consultation, articulating a clear plan for that care, noting therapeutic options and the patient's response are key elements of good notes.

In 1969, Professor Lawrence Weed introduced the Problem Oriented Medical Record using the 'SOAP' acronym:

S = Subjective – the information the patient (or others) provide to you

O = Objective – what you find on examination or on pathology or imaging

A = Assessment – your complete diagnostic formulation

P = Plan – the total management plan

These days, SOAP should be SOAPIF, where:

I = Information – the information you provide to the patient

F = Follow-up – making a specific note of what advice was given to the patient
(e.g. 'return prn', 'ring 3/7', 'Return for review 1/52')

Storage of records

Records should be stored in a manner to:

- preserve the confidentiality of the record
- prevent damage, loss or theft of the records
- be reasonably accessible to ensure continuity of medical treatment
- be secure – take reasonable and prudent steps to protect the security of your patients' medical records. It is unlikely you would be held liable for the theft of records from properly secured surgery premises; theft from the seat of an unlocked or even a locked car may be another matter.

How long should records be kept?

The short answer is 'as long as possible'. This is especially true when dissatisfaction with treatment has been expressed, an adverse outcome has occurred or legal action has been threatened.

The legal requirements for retaining medical records vary depending on the jurisdiction, but generally medical records are retained for seven years from the date of the last consultation.

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In the case of a patient under the age of 18 at the time of their last consultation, medical records are retained until that person reaches (or would have reached) the age of 25. This means the patient who was a minor during the treatment period has seven years from the time they reach the age of majority (when they have legal capacity in their own right) to commence proceedings.

You should consider whether the records should be kept for medico-legal purposes. Avant strongly encourages members to retain medical records indefinitely if they believe that there is a prospect of a claim or complaint.

The following are illustrative circumstances in which a member should retain a clinical record:

- dissatisfaction expressed by the patient or a relative or threatened legal action or complaint
- an adverse outcome of treatment
- a delay in diagnosing or failure to diagnose a medical condition
- a medical report was prepared for the patient when applying for disability or income protection insurance or it has been requested since a medical service was last provided to the patient, indicating a compensation claim in respect of which a member may be required to give evidence.

Once you have confirmed that there is no legal obligation or medico-legal reason to retain a medical record, before destroying it ensure that the patient's name and the period covered, together with the date of deletion or disposal, are recorded in a register kept for the purpose.

Patient access to medical records

Introduction of Commonwealth and state/territory privacy legislation generally provides patients (with limited exceptions) with a statutory right of access to their records; this includes:

- having a copy of the records made and given to them
- having a copy provided to a third party authorised by the patient e.g. a solicitor
- inspecting their records.

Medical records should be more than just notes to assist your memory. Records should be written with the knowledge and expectation that the patient may have access to them. Records should not be written in personal shorthand, use obscure abbreviations or be in writing unable to be read (even by you). In a request for access, a patient can demand that they be 'translated' by the author. Consider providing a detailed case summary report for patients in addition to the medical records requested.

If a patient wishes to transfer to another practitioner at another practice, the new practitioner is entitled to information required for the proper ongoing care of the patient, i.e. preferably a copy of the medical records or a summary of the treatment provided.

There is no obligation to provide original records. Indeed, it is preferable to keep the original records and send copies to the new treating practitioner. A patient should bear the reasonable cost of providing this information (some states have scheduled maximum fees that can be charged), but failure to pay should not be used as a reason to prevent relevant information being provided to the new practitioner.

Patients should provide a written authority to transfer their records to another practitioner. The authority should:

- request that a copy of the records be transferred to the new practitioner
- contain the name and date of birth of the patient whose records are to be transferred
- be signed by the patient
- be dated.

If records are transferred to a new practitioner or if a practitioner is leaving the practice and a significant number of patients wish to follow them, keep a register or record of:

- the names of each of these patients
- the date the authority is received
- the date of transfer of records
- whether the original records have been transferred and if a copy was retained
- the new location of the records and the name of the new practitioner.

Good medical records are essential for good patient care and are essential for a proper defence in the event of a claim or complaint against you. If in doubt, retain medical records and remember that your patients can have access to their health information contained in the records.

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Further reading

Privacy obligations of medical practitioners in regard to patients' records and health information:

- Nationally, the Commonwealth *Privacy Act 1988*
- In New South Wales – *Health Records and Information Privacy Act 2002*
- In Victoria – *Health Records Act 2001*
- In the Australian Capital Territory – *Health Records (Privacy and Access) Act 1997*

National and State authorities

Office of the Privacy Commissioner (Commonwealth)
www.privacy.gov.au

Office of the Victorian Privacy Commissioner
www.privacy.vic.gov.au

Office of the NSW Privacy Commissioner
www.lawlink.nsw.gov.au/lawlink/privacynsw/ll_pnsw.nsf/pages/PNSW_index

Office of the Information Commissioner – Queensland
www.oic.qld.gov.au/privacy-policy

Office of the Information Commissioner – Western Australia
www.foi.wa.gov.au/

Government of South Australia – Department of Health
www.health.sa.gov.au

Office of the Information Commissioner - Northern Territory
www.privacy.nt.gov.au/

Office of the Tasmanian Ombudsman
www.ombudsman.tas.gov.au/

ACT Human Rights Commission
www.hrc.act.gov.au/

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