MEDICAL RECORDS, DOCUMENTATION, CONFIDENTIALITY AND OBLIGATIONS

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Introduction

Patient medical records represent a lifetime history that describes the healthcare experience of the patient. Generally, providers must be cognizant about potential invasion of privacy and breach of confidentiality suits for inappropriate use and/or disclosure of medical information. Also, providers should be aware of government regulations on medical privacy that may also result in significant penalties if their tenets are not adhered to. These issues and related concerns are reviewed below. In this article, we focus on the USA; however, the themes and concepts are similar in other western industrialized countries and we provide some information thereon when relevant.

General Considerations

It is important to note that medical record-keeping is not merely a legal construct to follow, but serves the purpose for allowing an adequate medical assessment and appropriate clinical intervention for use and interpretation by others involved in patient care. Comprehensive, quality medical records are a necessity for clear communications between healthcare professionals. Clinical documentation standards from medical organizations, accreditation groups, and provider entities thus emphasize the need to provide complete and accurate records to allow a reader other than the author to review the patient's history, care provided, and care plan to render the best care for the patient at hand. Indeed, facilities around the world have emphasized such a need in response to care that has been found suboptimal as a direct result of poor documentation in a wide and highly diverse array of clinical circumstances, such as psychiatric care in Singapore and Finland, nursing care in Taiwan, wound ostomy care in the USA, alcohol treatment in Canada, and critical care in Norway.

In most medical facilities, each test, procedure, provider visit, treatment consent, and medical impression is recorded in a patient's medical record. Further, sensitive information describing a patient's psychological state, personal beliefs, human immunodeficiency virus (HIV) status, financial status, and other important, but private, information is also collected in the medical record. As such, both private accrediting organizations and public law mandate patient record standards. For example, in the USA, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), a private accreditation entity, requires that the medical record be accurate; include information regarding physical exam, admitting diagnosis, results of all medical evaluations, complications, orders and notes as well as other reports, discharge summary without outcome and disposition of treatment, and final diagnosis; be documented in a timely manner with its information readily available and accessible for prompt retrieval; and be stored in a manner to maintain confidentiality and security. Substantively, JCAHO's standards are similar to those of federal regulations for hospitals serving the government Medicare and Medicaid programs and other sites for care. State requirements range from the very general to the very detailed and once again reiterate the need to assess local conditions to determine legal obligations. Generally, a complete record of the care provided and relevant supporting activities and discussions must be documented within the medical record. If care is not documented in the medical record, the provider and/or organization will often have to rebut the presumption that the specific event did not occur and may be held liable thereon. Indeed, this can extend to "criminal" liability if the omission from the medical record was committed to falsify business records or medical records to hide an event that should have been recorded.

Although there are standards relating to the form and substance of the medical record and information contained therein, the critical considerations for legal purposes are the confidentiality of medical information and when this confidentiality may be breached.

Confidentiality of Medical Records and Information

For the purposes of literal ownership, medical records are the property of the entity that created them, e.g., individual provider, hospital, managed-care organization, and group practice. However, the patient is generally considered to have some ownership interest in the information contained in these records. Physicians and other medical providers are under an affirmative duty to keep the information within these medical records confidential, as indicated by professional ethics pronouncements, formal court decisions, as well as legislation. The policy is to encourage the patient to indicate all relevant information to the provider so that the provider can make a full clinical determination and then provide medically appropriate care. Without an assurance of confidentiality, the patient may not reveal such information and the therapeutic process could be hindered.

Under the common law, two general tort theories have been used for breach of medical record confidentiality. Under the first, the unauthorized disclosure of patient information by a provider constitutes an invasion of privacy. Such an invasion generally consists of an unauthorized release of medical records that constitutes an unwarranted appropriation or exploitation of the patient's personality, publicizing the patient's private affairs with which the public has no legitimate concern, or wrongful intrusion into the patient's private activities which would cause outrage or mental suffering, shame, or humiliation to a person of ordinary sensibilities.

The second theory by which courts hold providers liable for unauthorized release of medical records is through a common-law rule of confidentiality in the physician–patient relationship. If a medical provider discloses to a third party personal information learned about the patient during the course of treatment, the provider may be liable for breach of confidentiality between provider and patient, unless such disclosure is justified when there is a danger to the patient or another person. Thus, under this rule, all physicians have an obligation to keep confidential any information obtained during the physician–patient relationship and within the medical record; if they breach this rule, they may be liable for damages.

Other Issues Regarding Confidentiality of Medical Records

Altering, Appending, and Correcting Medical Records

Medical records can be altered and corrected for valid purposes, e.g., to correct transcribing errors or note new information relevant to the patient's care. These changes should be clearly indicated by making a single line through the portion of the record to be altered, corrected, or appended, with the date of the change and the person's signature or legible initials noted conspicuously. Further, an explanation as to why the record is being altered, corrected, or appended should be placed in the chart. The exact form by which these changes are made in the medical record is dictated by government regulation, medical bylaws, or both.

However, alterations that allow for view of previous notes will assist in avoiding any charges that the record was altered for self-serving purposes. Changes to a medical record that are made for purposes such as fraud or intent to deceive are, in some locations, subject to criminal and civil penalties (including punitive damages), and medical board or association sanctions for unprofessional conduct, and may result in loss of licensure and malpractice insurance.

Similarly, in England and Wales, the Data Protection Act of 1998 requires amendments to a record to be made in a way that clearly indicates why the alteration was made, to ensure the records are not tampered with for any underhand reason. The Act also authorizes patients either to petition the court to have inaccurate records amended, or to seek the assistance of the Information Commissioner.

Disclosure of Identity

The scope of the confidentiality is broad. The patient's identity, even to his or her own kin, is also within this right under the physician–patient relationship. Thus, a physician who delivered a patient's daughter was held to be answerable to the patient after the physician assisted the daughter in finding out her mother's identity after the child had been put up for adoption. Another concern is when patient information/likeness is used as materials in a book. This use is also within the scope of the confidentiality relationship and if a provider utilizes such materials without patient consent, the provider may once again be liable for damages in tort even if the patient's name is not disclosed.

Drug and Alcohol Information

There are strict requirements to maintain confidentiality of patient records regarding alcohol and drug treatment for patients who are participating in drug or alcohol rehabilitation programs. In the USA, government regulations for these facilities preempt any local laws that allow for purported disclosure of this information, although local government entities may pass valid laws that are more stringent than the national requirements. The consent for disclosure of this information will be valid only if the patient consents to disclosure to a particular party in writing; and the facility provides in writing to the patient-approved party: the facility's name or program name, the name/title of the person to receive the information, the patient's name, the purpose/need for the disclosure, the extent/nature of the information to be disclosed, a declaration that the consent may be revoked and the time when the consent will expire automatically, the patient's signature, and the date of the signature.

HIV Status

Generally, HIV status is strictly confidential. Many local governments have passed statutes that specifically apply to disclosure of medical information regarding HIV and impose both criminal and civil penalties (including punitive damages) against providers who violate these rules. Thus, whenever records or other information that includes any mention of a patient's HIV status is requested, the provider would be prudent to remove HIV information from the report unless specifically authorized in writing by the patient. Courts have stringently attempted to minimize identification of persons with HIV or acquired immunodeficiency syndrome (AIDS), although sometimes allowing for limited disclosure.

The law in the UK is even more strict. It prevents the disclosure of any identifying information about a patient examined or treated for a sexually transmitted disease beyond only HIV. However, like the USA, disclosure is allowed to a medical practitioner, or to a person employed under the direction of a medical practitioner, for valid diagnostic and treatment purposes.

Medical Malpractice

Breach of confidential information may also be brought as a malpractice claim in some jurisdictions. Because the provider has a duty to maintain appropriate confidences under a professional standard, a breach of that standard can be negligence and therefore malpractice.

Other Causes of Action

Beyond the standard tort causes of actions indicated above, patients have brought actions for breaches of medical record confidentiality under intentional infliction of emotional distress and breach of implied contract suits. Of importance is that the former requires extreme and outrageous conduct and the latter is amenable to the generally longer statute of limitations for breach of contract actions as opposed to general tort claims such as malpractice. However, as in the standard breach of confidentiality or privacy, the plaintiff must still show inappropriate disclosure of confidential information.

Physician–Patient Privilege

Some jurisdictions in the USA have laws that provide for a physician–patient privilege, which allows the provider not to disclose information in circumstances where the provider is compelled to testify, including testimony at trial, depositions, or administrative hearings. These statutes apply where the patient may not be suing and/or has not placed his or her condition at issue. This privilege is held by the patient, and

therefore only he/she may waive it to allow the provider to testify. Note, however, that this privilege does not apply when the patient is putting his/her medical condition at issue or has waived his/her right in some other manner.

Localities without such statutes generally do not have a physician–patient privilege because the common law does not generally recognize this form of privilege, and thus the provider must testify in these circumstances. However, some of these jurisdictions are adopting a psychiatrist–patient privilege and a psychologist–patient privilege due to the sensitive nature of mental health therapy and communications. The privilege extends only to circumstances where there is a true provider–patient relationship and only to communications between the parties; hence, there is some question as to whether third parties, such as nurses, are included within it. This latter concern requires careful assessment of the laws to determine if and when the privilege applies.

Other common-law jurisdictions also have a tendency to reject the physician–patient privilege. For example, an early English case, Duchess of Kingston's Trial in 1776, rejected such privilege. The court reasoned that "even absent a privilege, a patient's self-interest would ensure that he/she would reveal all necessary information to his or her physician" and held that "while a physician must generally protect a patient's confidences, to reveal such information in court was not a breach of duty to the patient." England and its former colonies, such as Singapore and Australia, still follow this common-law rule and reject the physician–patient privilege.

Allowable Disclosures

Certain situations exist where the medical provider can disclose potentially embarrassing or private information without the patient's consent. However, these disclosures are very circumscribed and thus quite limited in scope.

Waiver

The first method by which a provider may validly disclose medical record information is through patient waiver. Waiver generally relates to providers giving their opinion about the patient in a dispute that directly relates to the condition of the patient, i.e., the patient is putting his or her very medical status in question in the dispute. Under these circumstances, when the focus of the conflict is upon the patient's medical status, generally the provider who discloses such information is not liable for invasion of privacy or breach of confidentiality.

Public Duty

The second basis for allowed disclosure stems from some official public duty. Generally, if providers are asked to give an official opinion for a court or provide information pursuant to an official government requirement or law, reporting the relevant information therein to the appropriate authority is not a violation of the patient's right to privacy or confidentiality.

Public Welfare

Disclosure without the patient's permission is also permitted when the disclosure is necessary to protect the public interest. Public interest in this context generally includes warning of a foreseeable danger or circumstances of possible death.

Beyond simply addressing acute dangers, Denmark and England allow disclosure of patient information for broader general welfare and public interest. Both have governmental registries of birth parents and adoptees, as well as records of patients (and their names) who have genetic disorders. Government possession of such information is presumed to be beneficial for the citizens' healthcare and social services and thus is presumptively disclosed to the relevant government databases.

Other Issues Regarding Allowable Disclosures

Disclosure of Information to Employer

Generally, it has been held that information disclosure by a provider to an employer is not in violation of a patient's right to confidentiality or privacy if that information is of direct and legitimate interest to the employer. These circumstances are akin to workers' compensation cases; courts will often hold that employers have a right to this information and thus providers who supply the information are not liable. However, it is important to note that, once again, the information that can be legitimately disclosed is limited to that directly relevant to the employer with respect to the employee; other information disclosure, even if relevant to the present work-related injury or circumstance (such as a previous history of a similar injury), may be a violation of the patient's confidentiality and privacy if disclosed without authorization. Further, if providers obtain information regarding HIV-positive status that is not directly relevant to the patient's workers' compensation claim, it has been held that liability may attach to the provider if this information is disclosed to employers, since the disclosure by the provider in these circumstances is not privileged.

Duty to Warn in the Public Interest – Variations

Information on foreseeable harm obtained through the special relationship between providers and patients usually creates some duty to warn. While some courts require that a specific individual be identified, others impose a more general duty. Providers may also be liable if they merely warn instead of implementing other precautions, including confinement. This liability may extend to providers not warning their patients of potential risks and harms of their medical conditions, including a duty to warn children regarding ramifications of their genetic disease transmissibility. In addition, this requirement to warn may be applicable to warning family members of a contagious or sexually transmissible disease including, in some localities, HIV. Of course, if the warning is provided under appropriate circumstances, there will be no liability of the provider for such disclosures.

Other duties to warn are also extant. For example, in Australia, Brazil, Denmark, Italy, and Norway, disclosure of a Huntington's disease diagnosis is routine and permitted. Australia, Brazil, and Denmark also permit disclosure of a hemophilia A diagnosis. In England, the Abortion Regulations of 1991 require that medical practitioners, who carry out termination of pregnancy, notify the Chief Medical Officer and provide detailed information about the patient. The Chief Medical Officer may then disclose that information under provisions of the Regulations.

HIV Status

Prohibitions against reporting do not apply to circumstances when the provider is required by law to report information regarding AIDS incidence (as compared with HIV infection) and other epidemiological factors to specific authorities "as specifically delineated by law." Sexual partners, spouses, and/or needle partners in some jurisdictions may also be allowed knowledge of the HIV status of a patient and, under specific circumstances, are allowed access to that information regardless of patient authorization.

Disclosure may also be allowed to other specified third parties, including coroners and funeral directors, epidemiologists, facilities which procure transplant organs, semen for artificial insemination, or blood products, quality assurance and accreditation committees, parents of minors who have been diagnosed with HIV infection, researchers, and victims of sexual offenses. Further, disclosure of a physician's HIV status by hospitals to individuals who may have been treated by the physician has been allowed. However, beyond these narrow circumstances, providers should not release HIV information to any entity without the express consent of the patient or before checking with legal counsel. Finally, many laws either require or rely on voluntary reporting and disclosure of providers who are HIV-positive.

Other countries, however, have very different approaches to the HIV disclosure problem. France requires mandatory reporting, which was used to develop epidemiological information within the context of a universal healthcare system that provides 100% coverage for AIDS patients and their healthcare needs. Japan imposes no legal restriction or requirement concerning disclosure, and scholars have criticized the Japanese society for not recognizing patients' rights. However, a recent court ruling found the dismissal of an HIV-infected worker based upon his HIV status illegal and an infringement on the worker's human rights. In addition, the court found the disclosure of the worker's HIV status by his employer to third parties to be an infringement upon his right to privacy. For Japanese society, that has traditionally viewed employers and physicians as paternal guardians, this ruling signifies deviation from this traditional value. Australia takes an intermediate position on this issue. Legislation in New South Wales, Victoria, South Australia, and Queensland imposes duties of nondisclosure of HIV status and other medical information acquired during the course of employment of health professionals employed in public hospitals and other government-funded facilities. However, statutory restrictions are not applicable to private clinics and hospitals.

Other Public Policy Exceptions

In addition to circumstances of a foreseeable harm to others, additional circumstances have been held to be within the purview of allowable disclosures. Two major circumstances include when formal legal authorities such as the police pursuant to a valid court order request the information; and when another's life is being threatened. Note again, however, that it is important to limit the disclosure to that requested and directly relevant to the circumstance; additional information that is beyond this scope may subject the provider to liability under a breach of privacy or confidentiality.

Other Legal Disclosures

Practical disclosures are also generally allowed. For example, medical records may be released when transferring the patient to another facility or when requested by medical or forensic examiners. Other areas of permitted disclosure include suspected child abuse, wounds that are inflicted by sharp instruments that could cause death and all gunshot wounds, or

simply all wounds that were a result of a criminal act. These laws are consistent with protection of the public welfare.

Patient Consent and Minors/Incompetents

If a patient consents to have his/her records released to a particular party, then the provider must release the specific records to that party, and no liability should result for such disclosure. What this implies in law is that patients have a right of access to their records. With regard to minor patients, parents generally have the right of access to a minor child's medical records, but in specific circumstances the parent may not have complete access if a provider determines that access is detrimental to the child.

Similarly, guardians of mentally incompetent patients generally have access to medical records, but again, there may be a limit on the disclosure if the information sought contains sensitive family information or if full disclosure would be detrimental to the patient's well-being. Disclosure of psychologically sensitive information that may harm the patient has been decided differently in different countries. For example, physicians in Switzerland favor the disclosure of Down syndrome carrier status, while physicians in Japan are generally against such disclosure as it may threaten marriages and other social institutions.

International Comparative Perspectives on Patient Record Access

Privacy appears to be a concept often seen native to the USA. For example, the Danish Council of Ethics began a study of medical privacy only in 1992. In other countries, the general focus of medical records is generally the access to one's own records. Physicians are given wide discretion in handling medical information and patients' access may be restricted for reasons such as lack of medical knowledge to understand their content. While Canada, the Netherlands, China, and Norway recognize patients' right specifically to medical records, Germany and Austria have only recognized such right of access through the individual citizen's right to self-determination.

In the UK, access has been a hotly contested issue. Under the universal healthcare system, physicians maintain a lifelong medical record for each patient. If the patient applies for life insurance, it is the physician who supplies the patient's medical information to the insurer. In a well-publicized High Court decision, a patient was denied access to her own records held by her plastic surgeon, which she sought for the purpose of legal action against a breast implants manufacturer. The Royal College of Physicians forbade its members to provide any such information to lay persons. Addressing this issue, under the Data Protection Act of 1998, competent patients in England and Wales may now apply for access to their own records; Scotland is now implementing access to immediate discharge of documents under the 1998 Act. Authorized third parties, such as attorneys and parents, may also gain access under the 1998 Act. However, disclosure of any third-party identities is prohibited, unless the third party consents, or it is reasonable to dispense with that third party's consent. In addition, the 1998 Act also requires important explanations: the Act mandates the patient's record to be accompanied by an explanation of any terms that are or may be unintelligible. It should be noted that the law still requires the decisions about disclosure be made by the appropriate health professional, who is usually the patient's primary care physician. Courts under the law are authorized to order disclosure or nondisclosure, especially regarding information as to the physical or mental health condition of the patient. However, the 1998 Act specifically restricts the disclosure about the keeping or use of gametes or embryos, but genetic information is not covered by the Act.

In Australia, where the English common-law tradition is often followed, patients have very limited access to their own records, especially those held by private clinics. The Commonwealth Freedom of Information Act of Australia only enforces access to records in the public sector, and hence only these patients are afforded access rights. The six judges of the High Court unanimously rejected the notion that patients should have a right of access to medical records held by private physicians. Only the Australian Capital Territory and New South Wales have legislated for patients to access records in private healthcare facilities. The New Zealand legislature enacted the Health Information Privacy Code in 1993 to ensure patients' access to records, which generally grants broad access by patients for medical records and information.

The US Health Insurance Portability and Accountability Act (HIPAA)

In response to possible inappropriate use of private medical information, attention has resulted in national US laws to address the growing concern. HIPAA rules in this area cover all identifiable patient healthcare information in any form – oral, written, or electronic – maintained or transmitted by a wide array of "covered entities," including providers, healthcare clearinghouses, contractors, subcontractors, and health plans.

This extensive rule requires significant administrative policies, physical safeguards, technical security services, and mechanisms to be put into place by the covered entities. These entities must designate a privacy official or contact person to address complaints and provide privacy information, develop employee privacy training programs, implement "appropriate" systems against unauthorized access and mistaken misuse, create a mechanism of complaint for the entity's privacy practices, and develop employee sanctions for violations of the rule and the covered entity's privacy policies.

In addition, business associates of all of these entities are subject to the privacy regulations, including those who provide legal, actuarial, accounting, consulting, management, accreditation, and data aggregation, and financial services and any other entity that receives protected health information from or performs a function or activity for the covered entity. Contracts between the parties must limit business associate use and disclosure of patient information to parties specified and must require particular security, inspection, and reporting mechanisms by the business associates, and their subcontractors; internal records must be made available to the US Secretary of the Department of Health and Human Services, and all protected information must be returned or destroyed at the end of the contract period if practicable. The healthcare entity may be held responsible for rule violations of its business associates if it has knowledge thereof.

Patients have the right to inspect their healthcare information, copy and amend it, authorize (or not authorize) its use, and receive formal accounting of how their information is used. When patients request access, copying, inspection, and amendments to their medical records, covered entities have time limits to respond to these requests.

When disclosure and use of medical information are allowed, disclosure is limited to that "minimum necessary," with limited exception for treatment-related disclosures to providers. This standard requires that only the information necessary to accomplish the purpose for which the information is used or disclosed be released. The rule provides significant incentives for providers to err on the side of too little information use or disclosure: criminal and civil sanctions. Civil monetary penalties of up to $25 000 and criminal penalties of imprisonment of up to 10 years and a fine of up to $250 000 for each standard violation may be imposed, with providers subject to both for the same violation. The law represents a floor of protection for privacy; stricter local laws are not preempted. The rule also encourages providers to make a good-faith effort to obtain patients' written acknowledgment that they have received notice of their privacy rights and the entity's privacy practices.

There are exceptions to the patient authorization requirements. Authorization exceptions include information use for health oversight activities, public health activities, and research; in addition, law enforcement, legal proceedings, marketing, public safety and welfare circumstances, and listing in facility patient directories require no or limited patient approval.

See Also

Consent: Confidentiality and Disclosure; **Medical Malpractice:** General Practice

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