

THE PHYSICIAN MEDICAL RECORD*

Purpose of Medical Records:

The physician's medical record is a reflection of the interaction between a physician and a patient. For each interaction the record should show why the patient was seen, what was found and what was done. The record may be used:

- a. as a source of information for the physician providing care;
- b. as a source of communication between the physician and other health care providers;
- c. for medical-legal purposes;
- d. as a mechanism for review of the quality of care provided to the patient.

Requirement for Medical Records:

Members of the College are required to keep medical records in accordance with By-Law No. 1 of the College of Physicians and Surgeons of Manitoba.

Content of the Patient's Office Medical Record:

Essentially, the office medical record is comprised of all information obtained in the process of, or arising from, direct patient care. It includes not only the physician's own notes, but also consultation reports, laboratory and x-ray reports, hospital documents and records from previous physicians. It should not include the material referred to below under the heading "Physician's Reference File".

Although the specific contents of an office medical record may vary, the patient's office medical record content must comply with By-Law No. 1, Article 29, which provides:

"Members in practice shall keep:

- (A) Clinical records on every patient which shall include:
 - (a) patient demographic information, including:
 - (i) full name as it appears on the patient's health insurance registration card,
 - (ii) current address,
 - (iii) personal health identification number or other unique identifier,
 - (iv) date of birth,
 - (v) telephone number and any alternate telephone contact numbers, and
 - (vi) next of kin.

* This guideline was developed based on PHIA as it existed in October 2000. Changes to PHIA made since that date may impact upon the requirements of trustees. It is the responsibility of trustees to ensure that the current requirements of PHIA are applied.

- (b) all dates on which the patient was seen and for each visit:
 - (i) an adequate patient history;
 - (ii) particulars of physical examinations, investigation orders and the results of same;
 - (iii) the diagnosis made (if any);
 - (iv) the treatment prescribed; and
 - (v) ancillary medical or psychological investigations.
- (B) Daily diary or appointment sheets showing for each day the names of patients seen or treated or in respect of which some professional service is rendered.”

The office medical record should:

- a. accurately reflect the interaction between physician and patient for each visit;
- b. be as objective as possible;
- c. contain sufficient detail to enable a physician reviewing the record to readily determine or retrieve the presenting complaints, the investigation results, the diagnosis or differential diagnosis, the treatment prescribed, and follow-up recommended;
- d. follow an appropriate format to record each patient visit, such as the **SOAP** format:
 - Subjective complaints
 - Objective findings
 - Assessment of information (diagnosis)
 - Plan of management and treatment

Legibility:

By-Law No. 1 requires that all records shall be typed or legibly written and kept in suitable systematic permanent forms such as files or computer disk.

Electronic Records¹:

Where records are maintained by use of electronic media, the physician must ensure that the system:

- (a) is capable of producing a written record if required;
- (b) maintains an audit trail that,
 - (i) records the date and time of each entry of information for each patient,
 - (ii) indicates and dates any changes in the recorded information,
 - (iii) preserves the original content of the recorded information when changed or updated, and
 - (iv) is capable of being printed separately from the recorded information for each patient;

¹ See Statement 104 respecting computerized medical records 1-G40

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- (c) includes a password or otherwise provides reasonable protection against unauthorized access;
- (d) automatically backs up files and allows the recovery of backed-up files or otherwise provides reasonable protection against loss of, damage to, and inaccessibility of, information.

The Physician's Reference File:

Physicians are advised to maintain a separate file for personal information which is used for the physician's education or which arises from legal issues pertaining to a patient's care. Such material includes communications between the physician and:

- Regional Health Authority, Hospital or Area Standards Committee
- The College of Physicians and Surgeons
- The Canadian Medical Protective Association
- Manitoba Health
- The Medical Review Committee
- The physician's legal counsel or professional liability insurer

Ownership of Records:

- The physical record is usually owned by the physician who prepared it, but there are exceptions. For example, where a physician generates medical records in the course of employment, the employer may own the medical record. A partnership agreement may impact on the issue of ownership. It is important that physicians recognize that no one rule applies to all circumstances. Therefore, physicians are encouraged to seek their own legal advice respecting their own particular circumstances.
- Physicians in group practice or physicians who share office expenses with other physicians are advised to have an agreement respecting ownership of medical records generated during the course of the practice, and the management of records in the event a physician leaves the group or the group dissolves. Such an agreement should also provide for reasonable access to records by former members of the group in the event of a medical-legal issue where the record is relevant.

Transfer of Records to Another Physician:

The patient has the right to demand the transfer of the patient record or information to another physician. When a transfer of a record between physicians is contemplated, the following issues should be considered:

- *Maintaining the Original Record:* The sending physician is legally responsible to maintain the original copy of the patient record. Record transfer must occur

- between two physicians so that responsibility/ accountability is clear. Where a record being transferred is the only extant record, it must be sent by bonded courier or certified mail.
- *Consent:* The patient must give appropriate consent to the transfer. The requesting physician is responsible for obtaining an appropriate written consent signed by the patient, and providing the consent to the sending physician.
- *What Information is Required:* When requesting information, a physician has a responsibility to determine the amount of information needed to be able to treat a new patient appropriately. A blanket request for a complete past record may not be necessary. A synopsis may be sufficient for the receiving physician as it may be easier to use and to incorporate into his/her own records.
- *Transfer of a Large Number of Records:* Where a large number of transferred records are involved, the sending physician should seek legal advice on arrangements:
 - a. to lend the record to the receiving physician to abstract or to copy, or
 - b. to surrender the record to the receiving physician on that physician's undertaking in writing that the record will be securely stored and destroyed only in compliance with College approved guidelines or on the sending physician's written consent.
- *When Physician Leaves a Group Practice:* Group practice members are advised to establish a protocol for notifying current patients of a physician who leaves the group, and for the transfer of records where appropriate. Where a physician leaves a group but continues practice in the same locality, the choice of physicians is that of the patient.
- *Fees:*
 - The requesting physician has a responsibility to inform the patient that there may be a charge assessed by the sending physician.
 - The specific amount which may be charged for a transfer will be affected by the units of work and complexity of the work. Most physicians set up a simple chart of charges to accommodate similar situations rather than trying to calculate a precise charge in each case. [See the MMA Guide to Direct Billing for Uninsured Service.]
 - The physician sending the record should take into consideration the patient's ability to pay. Requiring payment in advance is unacceptable. However, a fee may be collected at the time the information is provided.
- *Continuity of Care:* The transfer of medical information is important to the continuing provision of good patient care. Both the requesting and the sending physician have a responsibility to facilitate the process. Physicians must not delay transfer of necessary information because payment of fees respecting the transfer has not been received.

Occupational Health Records

The Occupational Physician, although employed by a third party, is primarily responsible to the employee and reports to the employer only on matters which may affect the safety of the employee or co-workers. There are therefore special requirements for occupational health records, as follows:

1. Occupational health records must be kept separately from general medical records in order to ensure the integrity of the occupational health record.
2. Occupational health records must continue under the authority of the Occupational Health Physician and must be transferred only to a named successor.
3. Information from an occupational health record must be released to the employer or other third party only with the express consent of the patient, except where the release is necessary to protect the employee or other employees, or pursuant to other exemptions contained in *The Personal Health Information Act*. The Occupational Health Physician is advised to strongly encourage the employer to document and distribute to employees personnel policies describing the circumstances in which information contained in occupational health records will be released to the employer or other third parties without the consent of the employee.
4. Information from an occupational health record may only be transferred to a general medical record with the patient's consent.

Mental Health Records

Physicians should be aware that *The Mental Health Act* sets forth special requirements governing clinical records compiled and maintained in a facility (defined as a place designated in the regulations to the Act as a facility for the observation, assessment, diagnosis and treatment of persons who suffer from mental disorders). Any physician who has such a record, should refer to *The Mental Health Act* to become familiar with these requirements. *The Mental Health Act* takes precedence over PHIA, and the requirements set forth below do not take into account the specific requirements of *The Mental Health Act*.

Disclosure of Medical Records without Consent:

Personal health information concerning a patient may only be disclosed without the express consent of the patient or the patient's representative in very limited circumstances.

1. *Pursuant to Legislation:*

- Physicians may be compelled by legislation to produce medical records or disclose information about their patients. Examples of such legislation are the Acts governing Manitoba Health, the Workers Compensation Board, the College of Physicians and Surgeons of Manitoba, and the Office of the Chief Medical Examiner. Legislation not only may dispense with consent but can override a patient's objection to disclosure. Before providing any information, a physician is responsible to ensure that the legislation in question is applicable and, where appropriate, the physician should take steps to preserve patient confidentiality.
- Pursuant to ss 22(2) of *The Personal Health Information Act* ("PHIA"), personal health information may be disclosed without a patient's consent in limited circumstances, including disclosure:
 - a. to another of the patient's health care providers to the extent necessary to provide health care to that patient
 - b. for specific humanitarian purposes such as contacting the next-of-kin of an injured or deceased person or assisting in identifying a deceased person;
 - c. to prevent or ease a serious and immediate threat to the mental or physical health or safety of a person or the public;
 - d. for peer review or risk management purposes.

PHIA contains several other exceptions and physicians should have regard to the specific provisions of PHIA if a disclosure issue arises.

2. *Pursuant to Subpoena or Court Order:*

- A subpoena or summons is a document issued by a court which requires a physician to attend in court and to produce to the court the documents identified in the subpoena/summons. Service of a subpoena/summons on a physician does **not** give a physician authority to release the record or information from the record to anyone without consent of the patient prior to the physician producing the documents to the court or attending in court to give evidence.
- A court order may compel the production of medical records in accordance with its terms. Typically, notice of the request for the court order is served on the physician in advance of the court date, and, if the order is granted, the signed order is then served upon the physician with a request to produce the record specified in the court order.

Disclosure of Medical Records to a Third Party with Consent:

- When a physician is requested to provide access to, or a copy of, a record to a third party, the physician should ensure that he/she receives a signed consent from the patient which specifically authorizes access to the record and/or a copy of it. If the direction from the patient is not clear, clarification should be obtained from the patient.
- The physician has an obligation to review the consent to ensure that it is the informed consent of the patient.
- The physician has the responsibility to ensure that the disclosure made is specific to the request and to the consent.

Disclosure to the Patient:

PHIA provides that, subject to PHIA, an individual has a right, on request, to examine and receive a copy of his/her personal health information [s. 5(1)]. This does not entitle the patient to the original record and does not entitle the patient to remove the record from the physician's premises.

Pursuant to PHIA:

- a. physicians have an obligation to respond as promptly as the circumstances require, but in any event within 30 days of receiving the individual's request [s. 6(1)]. A failure to respond within this time frame is treated as a refusal of the request [s. 6(3)];
 - b. physicians may require the request to be made in writing [s. 5(3)];
 - c. physicians have a duty to make every reasonable effort to assist an individual making a request and to respond without delay, openly, accurately and completely [s. 6(2)];
 - d. in responding to a request, a physician has three options:
 - (i) make the personal health information available for examination and, if asked, provide a copy [s. 7(1)(a)];
 - (ii) advise in writing if the information does not exist or cannot be found [s. 7(1)(b)];
 - (iii) advise in writing if the request is refused, in whole or in part, for a specified reason described in PHIA, and advise of the person's right to make a complaint under PHIA [s. 7(1)(c)];
 - e. fees for permitting examination and providing a copy must not exceed the fee provided for in the Regulations [s. 10]².
- When granting a patient access to review an original record, it is recommended that the physician
 - or a member of the physician's staff supervise the review.

² If the PHIA Regulation contradicts the MMA rates for uninsured services, the Regulation prevails.

- Prior to granting access to a record, the physician should review the record to ensure that the record does not contain:
 - a. the physician's own personal material;
 - b. information concerning other individuals misfiled on the record;
 - c. material excluded from disclosure pursuant to PHIA.

Consultant Reports:

Consultant reports or records received from other physicians participating in the patient's care are part of the patient's medical record. The physician is not obligated to notify a consultant of the patient's access, but, as a professional courtesy, may do so.

“Confidential” Stamps:

Stamps or typed directives suggesting that the material has special confidential status have no legal significance and do not affect the way the record should be handled.

Third Party Consultants:

Physicians should be aware that there is divided legal opinion on the question of whether a patient has access to a report prepared by a physician retained by a third party, such as an insurer. Physicians are encouraged to seek direct legal advice if this point arises in their practice.

Reasons for Refusing Access:

Pursuant to s. 11 of PHIA, physicians are not required to permit examination or copying of personal health information if:

- a. “knowledge of the information could reasonably be expected to endanger the mental or physical health or the safety of the individual or another person;
- b. disclosure of the information would reveal personal health information about another person who has not consented to the disclosure;
- c. disclosure of the information could reasonably be expected to identify a third party, other than another trustee, who supplied the information in confidence under circumstances in which confidentiality was reasonably expected;
- d. the information was compiled and is used solely
 - i. for the purpose of peer review by health professionals,
 - ii. for the purpose of review by a standards committee established to study or evaluate health care practice in a health care facility or health services agency

- iii. for the purpose of a body with statutory responsibility for the discipline of health professionals or for the quality or standards of professional services provided by health professionals, or
- iv. for the purpose of risk management assessment; or
- e. the information was compiled principally in anticipation of, or for use in, a civil, criminal or quasi-judicial proceeding.”

Physicians are required, to the extent possible, to sever the information which cannot be examined or copied and disclose the balance [s. 11(2)].

The patient has a right to make a complaint where access is denied. The Ombudsman has jurisdiction to investigate a complaint and, if an investigation is undertaken, the physician is given an opportunity to make representations respecting the denial of access [s. 43(1)].

Corrections to the Record:

PHIA permits individuals to request corrections to the medical records “for purposes of accuracy or completeness” [s. 12(1)]. Any such request must be made in writing [s. 12(2)].

Physicians must respond to requests for corrections as promptly as required in the circumstances, but no later than 30 days after receiving the request [s. 12(3)].

A responding physician has four options:

- a. make the requested correction by adding the correcting information to the record of the personal health information in such a manner that it will be read with and form part of the record or be adequately cross-referenced to it [s. 12(3)(a)];
- b. inform the individual that the personal health information no longer exists or cannot be found [s. 12(3)(b)];
- c. inform the individual that the trustee does not maintain the personal health information and provide him or her with the name and address, if known, of the trustee who maintains it [s. 12(3)(c)]; or
- d. inform the individual in writing of the trustee’s refusal to correct the record as requested, the reason for the refusal, and the individual’s right to add a statement of disagreement to the record and to make a complaint about the refusal under PHIA[s. 12(3)(d)].

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Where a physician makes a correction or adds a statement of disagreement, he/she must, when practicable, notify others to whom the personal health information was disclosed in the preceding year [s. 12(5)].

No fee may be charged in connection with a request for a correction [s.12(6)].

Retention of Records:

By-Law No. 1 requires that clinical and psychotherapy records be retained for at least ten years from the date of the last entry recorded, and that clinical and psychotherapy records pertaining to paediatric patients be retained to the date the patient is 18 years old plus ten years.

PHIA requires that physicians establish and comply with a written policy concerning the retention and destruction of personal health information, which policy must comply with the regulations made pursuant to PHIA. When creating the policy, the following points should be considered:

- Original medical records should be retained under the control of the physician who created them.
- Each physician who has contributed to group records should have continued direct access to those records.
- The physician has no right to sell medical records to succeeding physicians.
- The patient has no right to require that the **original** record be transferred to a second physician.

Destruction of Records:

Pursuant to PHIA, physicians must have a written policy concerning destruction of medical records [s. 17(1)].

When records are to be destroyed, destruction must be done in a manner which preserves privacy and is in accordance with the regulations made under PHIA [ss. 17(2) and 17(3)]. The only method of assured destruction appears to be supervised incineration, or alternately, supervised shredding. Shredders can be purchased or leased, or physicians can contract with bonded services for shredding.

Physicians must maintain a record of the individual whose personal health information is destroyed and the time period to which it relates, and the method of destruction and person responsible for supervising the destruction [s. 17(4)].

Termination of Practice:

Surviving spouses or other executors or administrators should not be suddenly faced with the problem of disposing of the deceased physician's medical records. All members should give serious thought to the manner in which their records will be disposed of upon retirement or death. The primary concerns for the physician managing patient records on termination of practice should be:

- a. assuring continuity of patient care;
- b. assuring accessibility to appropriate persons;
- c. security of records (in accordance with PHIA);
- d. destruction of records (in accordance with PHIA).

All physicians planning to leave clinical practice must notify the College of the name, address and telephone number of any custodian of the physician's medical records.

Where a member is leaving practice or leaving the jurisdiction, it may not be convenient to retain the records and it may be difficult to respond to requests for information from these records. The records should not be sold to a second physician, but it may be appropriate to transfer the records to the custody of a second physician. The transfer should be documented in a written agreement. The following factors should be considered and addressed in the agreement:

- a. the agreement should permit free access to these records by the original doctor;
- b. the custodian of the files will take over only the records of those patients who seek professional advice from that custodian and therefore have implied consent to such takeover of the records;
- c. agreement should specify when the records may be ultimately destroyed;
- d. the custodian of the files will abstract relevant facts for a third doctor upon request.

It remains the responsibility of each individual to ensure his/her own compliance with the requirements of PHIA. The foregoing guideline has been developed to assist members in understanding those requirements, and in implementing policies and procedures to comply with those requirements. However, physicians must be aware that this guideline was developed based on PHIA as it existed in October 2000. Changes to PHIA made since that date may impact upon the requirements of trustees. Furthermore, it is the responsibility of trustees to ensure that the requirements of PHIA are applied to their own particular information management systems. Physicians are strongly advised to seek advice specific to their own individual circumstances.

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A guideline is practice generally recommended.