College of Physicians and Surgeons of British Columbia

Professional Standards and Guidelines

Medical Records in Private Physicians' Offices

Preamble

This document is a guideline of the Board of the College of Physicians and Surgeons of British Columbia.

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Medical Records In Private Physicians' Offices

The following is intended to summarize the directions conveyed from time-to-time by the board of the College with regard to medical records. This document also reflects advice from and policy of the Canadian Medical Protective Association (CMPA), the Canadian Medical Association (CMA), the Supreme Court of British Columbia, in its decision in *Swirsky vs. Hachey* and the Supreme Court of Canada, in its decision in *McInerney vs. MacDonald* all of which should be carefully considered in the application of the following.

This summary may not fully address all situations or requests. Where clarification seems necessary, such input should be sought from the Registrar Staff of the College, or from legal resources, including those of the CMPA.

This document is focussed on a discussion of records held by physicians in non-institutional settings such as private clinics and offices but most of the principles enunciated here extend to all sites where medical care is provided. The management of medical records in hospitals and other public facilities is governed by legislation pertinent to those settings (*BC Hospital Act, FOIPPA,* etc.)

I. GENERAL PRINCIPLES

A. Definition

The extent of, and limitations to, what constitutes a patient's medical record can be drawn from the decision of the Supreme Court of Canada in *McInerney vs. MacDonald*, which states that the record includes:

*"**All** information in his/her medical record which the physician **considered in administering advice or treatment**, including records prepared by other physicians that the physician may have received…*

*"Access does not extend to the information **arising outside the doctor-patient relationship**."*
(emphasis added)

From that, a **unified medical record** must be maintained for every patient in the care of a physician in which all components (clinical notes, laboratory and imaging reports, hospital summaries and surgical reports, consultations, etc.) are gathered into one file, in one location, so far as possible.

The above judgment similarly defines the extent of the obligations held by a physician in responding to a valid request/demand for a **complete** medical record of a patient, or for a copy of it.

B. Purpose

Medical records are intended to document:

- The physician's understanding of the patient's "medical burdens", as voiced by the patient or as otherwise known, and whether valid in the physician's view or not *(the presenting complaint)*.
- How all of that information has been conveyed to the physician *(the source of information)*.
- The physician's enquiries, especially those relevant to the presenting complaint, but also to other issues, regarding social, family and personal medical histories, and a system review *(history of present illness and functional enquiry)*.
- Relevant physical findings, as well as any laboratory and imaging data available *(positive and negative physical findings and laboratory data)*.
- Diagnostic speculations and conclusions *(differential diagnosis or tentative diagnosis)*.
- A management (diagnostic and therapeutic) plan, including recommended procedures, prescribed treatment, medication dosage, and number and length of treatment *(treatment plan)*.
- Information conveyed to and understood by the patient, including the patient's obligations for facilitating any further interventions *(follow-up requirements)*.

This information should be recorded in a form that will enable any succeeding physician to continue care of that patient seamlessly, even when no disruption in that care is anticipated.

1. Statutory Requirements

The statutory requirements for medical records are defined in sections 3-5 to 3-8 of the Bylaws made under the *Health Professions Act.*

Requirements for medical practice records

3-5 (1) A registrant must

(a) keep records in English,

(b) keep a clinical record on each patient containing

(i) the patient's name, gender, personal health number, date of birth, address and dates of attendance,

(ii) sufficient information to clearly explain why the patient came to see the registrant and what the registrant learned from both the medical history and the physical examination,

(iii) a clear record of what investigations the registrant ordered,

(iv) a clear record of either the provisional diagnosis or diagnosis made, and

(v) a clear record of the specifics of any treatment, recommendation, medication and follow-up plan,

(c) keep a paper or electronic record with respect to each patient containing the date of the service rendered, type of service and charge made,

(d) for each day, keep a day book, daily diary, appointment sheets or equivalent containing the names of patients seen or treated or in respect of whom professional services are rendered,

(e) keep a record, separate from the patient's medical record, of all narcotics and controlled drugs purchased or obtained for the registrant's practice and a record of all such narcotics and controlled drugs administered or furnished to a patient in or out of the registrant's office, containing

(i) the name, strength, dose and quantity of the drug purchased or obtained,

(ii) the name, strength, dose and quantity of the drug administered or furnished,

(iii) the name and address of the person to whom the drug was administered or furnished, and, if applicable, the name and address of the person who took delivery of the drug, and

(iv) the date on which the drug was obtained and the date on which the drug was administered, furnished or otherwise disposed of, and

(f) keep all records either,

(i) typed or legibly written in ink and filed in suitable systematic permanent form such as books, binders, files, cards, or folders, or

(ii) in electronic form, compliant with the policies and guidelines of the board with respect to the creation, maintenance, security, disposition and recovery of electronic medical records.

(2) The information kept in the records must be capable of being reproduced promptly in written form and the material so reproduced, either by itself or in conjunction with other records, must constitute an orderly and legible permanent record that would provide, without delay, the information required under sections 3-5(1)(b), (c) and (d), and the record keeping system must audit or record any subsequent changes made.

(3) A registrant attending a patient in hospital must promptly complete the medical records for which the registrant or other health care facility is responsible.

(4) A registrant must make all records and all other relevant practice records, documents and writings, available at reasonable hours for inspection by the board, any committee of the board, or any person or body acting on behalf of or under the direction of the College, the board or any committee of the

College, and must permit any such body or person to make copies or remove records temporarily for the purpose of making copies.

(5) A registrant must keep all records in accordance with all Federal and British Columbia statutes applicable to the practice of medicine including, without limitation,

(a) the *Personal Information Protection Act* of British Columbia,

(b) the *Freedom of Information and Protection of Privacy Act* of British Columbia,

(c) the *Personal Information Protection and Electronic Documents Act* of Canada,

(d) the *Privacy Act* and

(e) the *Access to Information Act* of Canada.

Storage and retention of medical practice records

3-6 (1) A registrant must ensure the safe and secure storage of all records

(2) Records are required to be retained for a minimum period of sixteen years from either the date of last entry or from the age of majority, whichever is later, except as otherwise required by law.

Transfer, destruction or disposition of medical practice records

3-7 (1) A registrant must dispose of records only by

(a) transferring the record to another registrant or, with the consent of the patient, to another health care agency or health care practitioner, or to a person or organization retained by the registrant to act on his or her behalf,

(b) effectively destroying a physical record by shredding or incinerating in a controlled environment, or

(c) erasing information recorded or stored by electronic means in a manner that ensures all traces of the original data are destroyed and that the information cannot be reconstructed.

Registrant ceasing to practise

3-8 (1) A registrant who ceases to practise for any reason must dispose of all records described in section 3-5 in accordance with section 3-7, and provide the College with a written summary of the steps the registrant has taken to dispose of the information or promptly inform the College of the location of the records.

(2) A registrant must make appropriate arrangements to ensure that, in the event the registrant dies or becomes unable to practise for any reason and is unable to dispose of the personal information, the information will be safely and securely stored or transferred to another registrant.

2. Essential Elements

The medical record is a comprehensive compilation of all patient-physician encounters, together with all documentation related to those encounters. For patients who attend the physician on an ongoing basis, the record is a single file containing all material related to the patient. For isolated single encounters, such as for episodic care, or single visits to "no-appointment" clinics, the record may be limited to that visit and filed chronologically. However, as described below, repeated visits by a patient to such clinics may be considered as continuous care requiring the creation of a comprehensive patient record. The record should include:

- The patient's demographic information such as name, date of birth, address, telephone numbers, personal health number, family contacts and other information pertinent to the patient.
- A summary sheet (cumulative patient profile), usually detailed on a facesheet, that lists significant:
    - Medical problems (current and relevant past),
    - Therapeutic interventions (including surgeries and current medications with dosage schedules),
    - Known allergies and drug sensitivities / interactions.
- For every *patient contact*:
    - Relevant complaints, systemic review, and physical findings (present or absent).
    - A provisional diagnosis or working diagnoses.
    - A management plan, including investigations, consultations, and therapeutic interventions, implemented or under consideration, and the specifics of plans for follow-up or patient return.

      (Many physicians find that the SOAP format [**S**ubjective, **O**bjective, **A**ssessment and **P**lan] facilitates systematic documentation.)
- Past medical history, family history, social history, personal habits (cigarette smoking, alcohol use, athletic activity, etc.).

(N.B. The statutory requirement for **legibility** can have, and has had, the effect of obliging physicians holding illegible records to have those records transcribed for third parties, the cost of that transcription being borne by the physician.)

These expectations may be reasonably modified for encounters for minor or trivial complaints, so long as that document can stand alone for others to understand that part of the patient's story. For brief visits for minor conditions, recording of extensive information may be neither appropriate nor necessary. When patients are attending at a facility for intermittent or sporadic care, a comprehensive, unified document must be maintained, consolidating all documents from each encounter with that patient.

If a patient has been seen for care on *three* consecutive occasions at a single site, there should be an assumption drawn that *continuous care* is being provided by physicians at that

site, with an expectation that all the essential elements of a conventional medical record will be put in place.

When a physician agrees to provide continuity of care to a new patient, particularly one with complex and chronic problems, it is acceptable to plan a sequential accumulation of the requisite data over a series of encounters.

(The regulations to the *Alberta Hospitals Act* include the valid statement that the office record ought to contain sufficient data "that justify the diagnosis and warrant the treatment given".)

3. Medical Services Commission (MSC) of British Columbia Criteria vs. Requirements of the College of Physicians and Surgeons of BC

The criteria used by the College and the MSC for determining the adequacy of medical records differ, primarily because of the role differences between the two bodies.

The College, in its peer-review function, often carried out through the activities of the Committee on Medical Practice Assessment (COMPA), judges the adequacy of medical records on the basis of a general review of those records, to determine if the records show why the patient came to see the physician, what was found, and what was done. These criteria apply to the course of a patient's illness in general, or may apply to a specific visit. The College's review is based on the subjective application of the bylaws made under the *Health Professions Act.* A College review would not generally be focussed on the appropriateness of billing.

The MSC's role, through the Medical Services Plan (MSP) audit section, is to ensure that all services billed to MSP were medically necessary, were actually rendered, were insured under MSP, and were billed using the correct listing(s) in the Payment Schedule and in accordance with the preambles in that Schedule. "Medical necessity" in this context also requires that the frequency of services be justifiable. Accordingly, during an audit, a claim-by-claim review of a representative sample of patient records is undertaken to determine if the claims made to MSP have the support of the medical records. Depending upon the services rendered and claimed, this support may be adequately found through the record as a whole, or may require date-specific detail.

Thus, it is very possible that a clinical record may not have significant deficiencies overall as far as the College is concerned, but at the same time may not support, nor contain, sufficient detail to justify payment for specific claims, relative to Payment Schedule criteria (Complete Examinations and Prolonged Counselling are examples of services for which records frequently are found to be lacking required detail to comply with the Schedule). Accordingly, such a record may have been found satisfactory from the College's perspective, but could still be found inadequate for billing purposes by the MSC.

C. Confidentiality

1. Ethical Requirements

The Oath of Hippocrates contains a statement of the physician's ethical obligation with respect to confidentiality. It reads:

"All that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and never reveal."

This ethical principle has always been maintained by physicians and is enshrined in current ethical standards and in law.

CMA *Code of Ethics*

31. Protect the personal health information of your patients.
32. Provide information reasonable in the circumstances to patients about the reasons for the collections, use and disclosure of their personal health information.
33. Be aware of your patient's rights with respect to the collection, use, disclosure and access to their personal health information; ensure that such information is recorded accurately.
34. Avoid public discussions or comments about patients that could reasonably be seen as revealing confidential or identifying information.
35. Disclose your patients' personal health information to third parties only with their consent, or as provided for by law, such as when the maintenance of confidentiality would result in a significant risk of substantial harm to others or, in the case of incompetent patients, to the patients themselves. In such cases take all reasonable steps to inform the patients that the usual requirements for confidentiality will be breached.
36. When acting on behalf of a third party, take reasonable steps to ensure that the patient understands the nature and extent of your responsibility to the third party.
37. Upon a patient's request, provide the patient or a third party with a copy of his or her medical record, unless there is a compelling reason to believe that information contained in the record will result in substantial harm to the patient or others.

2. Legal Requirements

The confidentiality of the patient-physician relationship and interactions has been recognized legally by statute and by court decisions.

Provincial and Federal Privacy legislation (PIPEDA, FOIPPA & PIPA) fully recognize the privacy of personal health information and define the terms under which it may be released. Similarly, high profile court decisions (e.g. *McInerney v. MacDonald*) underscore the unique quality of personal medical information and the confidentiality that must be maintained.

D. Retention and Alteration of the Medical Record

1. Retention of Medical Records

Section 3-6 (1) and (2) of the Bylaws requires that a physician must retain a patient's personal medical record for at least sixteen years from the date of the last entry. Where the patient is a minor, records must be kept for at least sixteen years from the age of majority, which is currently 19 years of age.

Registrants should be mindful that the stipulation for minors (infants) includes those birth records held on the mother's medical record.

The CMPA considers that a more prudent interval for retention is ten years. Some defence lawyers have conveyed their view that, were they physicians, they would keep medical records in perpetuity.

In considering the retention of medical records, physicians should be aware of the provisions of the *Limitation Act* (RSBC 1996 c 266) which specifies the limitation periods for various civil actions.

Details of certain procedures, e.g., *ophthalmic surgical procedures,* may be critical to future surgical interventions, so those records should be retained at least to the time of the patient's passing. Recent elucidation of certain *occupational diseases* (e.g., asbestosis, berylliosis) have created a standard for retention of occupational health records of 30 years.

A physician retaining a record in trust (c.f. Ownership) is obliged to do so in a manner that ensures the *confidentiality*, *security* and *accessibility* of its content. The actual custody of the record and the mechanics of retrieval may be delegated to an appropriate third party. However, the physician remains obligated in those same spheres. Those obligations may only be transferred to another physician, and only then by mutual agreement, clearly documented in a contract, that includes a provision whereby the patient can trace the records for retrieval.

All physicians do have an obligation to ensure that the College is aware, at all times, of the location of, and means for accessing, all medical records that exist for a practitioner's patient within the specific time period.

Physicians who do not provide appropriate custody of their medical records, or physicians failing to retain or secure original medical records, are at risk of being found in a professional breach and, more particularly, place themselves in legal peril. That jeopardy increases when original medical records are entrusted to patients for their transfer, given the risks that entails for loss of the records and for "editorial change" from additions or deletions by the patient.

2. Omission of Information from Medical Records

Patients will sometimes take deliberate steps to avoid having information included in their family practitioner's medical record. In their own best interests, patients should be reminded that the obligations of confidentiality allow for safe disclosure of sensitive information to their physician.

3. Alteration of Medical Records

Medical records must not be altered or tampered with, other than to revise incorrect or misleading information. It is inadvisable to remove medically relevant information from a patient's record. Generally, when information recorded in the file, including that entered by prior medical care providers, is inaccurate, that inaccurate content should be struck with a single line that does not obscure the wording, and an amendment made in a manner that it will be recognized as such, containing an explanation for the annotated amendment, along with the date and a signature.

Patients may seek to have "social" information deleted from the medical record on the grounds that it is not relevant to their health and ought not to have been recorded. The

College does not object to such deletions providing that both parties agree (being mindful that not all social information is irrelevant) and that the deletion is done in a way that makes clear that the record has not been inappropriately changed. This also highlights the need for discretion when considering the inclusion of irrelevant information in a medical record.

When patients are motivated by insurance or employment interests in seeking alterations (additions or deletions) to their records, they need to be reminded that, in complying, physicians would expose themselves to allegations of fraud and unprofessional conduct.

In all circumstances, when a physician deems it inappropriate to make an alteration sought by the patient, he/she is obliged to:

- Notify the patient of that refusal and the reasons for the refusal.
- Note the patient's request for an alteration on the record.
- Attach to the record any written opinion that the patient provides to oppose that entry.

This matter is addressed in section 24 of PIPA.

II. OWNERSHIP AND DISCLOSURE OF MEDICAL RECORDS

A. Ownership

1. Principles

Medical records (the actual documents) are not owned by patients but by the physicians who created them. However, the information contained in the record is the patient's and must be provided upon the patient's request, with some exceptions as outlined below. That matter is particularized in the decision of the Supreme Court of Canada in the case of *McInerney v. MacDonald:*

The legal definitions of medical records, their ownership and disclosure are defined in British Columbia by *McInerney vs. MacDonald* and by the *Personal Information Protection Act* (PIPA).

Points from that Supreme Court decision deserve the following emphasis:

- The physician's obligation to maintain confidentiality is a fiduciary one.
- While ownership of the records rests with the physician who created it, he/she has a general duty to disclose the content to the patient concerned. The patient's general right of access to medical records is not absolute and the physician may have an overriding duty to prevent access to certain information (especially that carrying significant likelihood of substantial harm to the patient or to another individual).
- A patient may apply to the court for protection for an improper exercise of the physician's discretion. (The initiative for that challenge rests with the patient; the onus lies on the physician to justify a denial of access.)

It should be noted that:

- The courts make no provision for ownership of office-based medical records being held by anyone other than a designated physician (and certainly none for the "ownership" by clinics or other institutions).
- The previously-stated advice of the College that records prepared for third parties (including those prepared by other physicians), and generated outside of the conventional patient-physician relationship should be severed from the documents disclosed (that then in keeping with the direction of *McInerney vs. MacDonald*), appears to have been overridden by provisions in recent privacy legislation. It would now seem that, assuming authority to disclose, all documents containing healthcare information are producible. Those would include reports to insurance companies, to the Superintendent of Motor Vehicles, to other physicians (or from them) and to lawyers (unless a *privileged* communication). See further under B.1.a. PIPA.

2. Physicians Leaving a Practice

a. Principals Leaving a Practice

In all circumstances, physicians leaving a practice are legally obliged to *advise the College* as to specific means for accessing the medical records they own and by identifying their location.

Physicians leaving a practice and holding ownership of the medical records of that practice, along with the obligations of security, confidentiality, accessibility, and retention of these records attached to that ownership, do not avoid these obligations by their leaving. The obligations must be met by the departing physician, or by a clearly-defined designate (see below), whether that departure is on the basis of relocation, retirement, career-change, disability, or death.

Physicians may, when their departure is planned, ***delegate*** their ownership of records through mutual agreements, written and signed by both parties. Otherwise, their obligations persist.

Unanticipated departures (through disability or death, including that of family members) deserve prior planning by each physician, so that family members, estates and associates are not burdened with those obligations. Without the contractual relationship described above, it may be unreasonable to expect that colleagues will assume the responsibilities even in those events.

Physicians changing venue, and particularly moving to other jurisdictions, foreign or otherwise, without providing to the College knowledge of a system for accessing their records, not only imperil their patients, but may affect that physician's standing with the College and other regulatory bodies.

b. Locum Tenens, or Associates, Leaving a Practice

It is critical, in the context of ownership of medical records and of legitimate efforts to notify patients of changes of a physician's venue, to separate the status of *locum* and of *associate*.

A locum, or locum tenens, is a physician standing in for another physician who has stood aside from all or part of his practice for a finite interval and has an intent to return to that practice, at which time that locum is to be terminated.

Physicians are practising as ***associates*** when they engage themselves in a clinic or practice owned by others, (and typically compensated through recovery of an agreed percentage of billings) or in a setting where two or more physicians simply share an office space and expenses.

For ***locums***, the absent physician retains the integrity of his professional relationship with all patients that existed on departure, along with all patients who joined the practice during his absence. The ownership of the medical records of all of those patients remains with the absent physician. A locum, leaving a practice on return of the principal physician, therefore, has no ownership of those records and would be considered unprofessional (i.e. "poaching") if attempts were made to encourage or entice patients to follow the locum.

Absent a written contract to the contrary, an ***associate***, seeing a patient more or less consecutively, and likely regarded by the patient as his "preferred or designated physician", carries the fiduciary and ethical obligations to that patient as part of the conventional patient-physician relationship, including the ownership of that patient's medical record. While a departing associate is entitled to those records or copies, in the patient's best interest, the transfer of the records to the departing physician's new practice is contingent on the patient's written consent. Patients undoubtedly may object to their records being moved otherwise and should not be assumed to be following the departing physician to a new location. Principals in the practice that the associate is leaving may retain original records or copies of the same, but may encumber neither the departing associate nor the patient with any consequent costs. Where differences exist between physicians regarding ownership of a record, the determination of that rests with the patient and his/her "choice" of physician. Similarly, if the associate leaves a practice to re-establish practice at another site, patients should be offered the option to follow the physician to the new location. Therefore, records should not be moved *en masse*, but rather the transfer of the record should await the patient's decision to follow the departing associate.

There is no ownership of patients. Ultimately, the decision of whether to follow the departing associate, or to remain at the practice site, is the patient's. The departing associate is entitled to, and indeed obliged to, advise patients of that departure. That physician has a right to expect that the patients not so advised will be made clearly aware of the fact that they have an option to move, and to know how they might accomplish that.

2. Patients Leaving a Practice

a. Inadvertent Transfer of Care

Patients should be made aware that the integrity of their relationship with their primary care physician is dependent, at least to a degree, on their awareness of their own obligations to help to sustain *trust* within that relationship.

Patients do have moral obligations, especially to promise-keeping and to truth-telling. Particularly, if they access medical care from others (e.g. in walk-in clinics, or from complementary/alternative medicine practitioners) without disclosing that to their primary care physician, they are at risk of being seen as violating their trust within the

patient-physician relationship and, as a consequence, of having their access to care with the primary care physician terminated.

Therefore, patients have a further obligation to urge those practitioners secondarily involved in their care to communicate the circumstances of that with their primary care physicians. Similarly, physicians providing care ancillary to that of the primary care physician have an obligation to communicate the substance of that care with the latter, barring any explicit (written) instruction to the contrary from the patient.

Primary care physicians, in providing competent and safe comprehensive care, must be made aware of interventions by others that could impact their own decisions. They do have an obligation to maintain a comprehensive medical record and that must be recognized by all, including their patients.

b. Deliberate Transfer of Care

When transfer of care from one physician to another has occurred, regardless of the reasons for that transfer, patients have a right to expect, and their former physicians have a duty to provide, a transfer of relevant information in a timely manner (generally within 30 working days, or sooner if circumstances demand). With that patient's explicit request and consent, all information must be transferred to the succeeding physician which is necessary to enable the latter to reasonably offer informed continuity of care to the patient.

That information may be provided in the form of selected *copies* of relevant documentation from the patient's medical record, and/or an adequately comprehensive summary of the patient's care.

The provision of this information is, at present, a non-insured service, so that a reasonable fee for that may be charged to the patient at the physician's discretion. However, given the potential of harm that could otherwise occur, provision of that information may not be made contingent on pre-payment of the legitimate fee.

Patients seeking copies from their medical record for reasons other than insuring informed continuity of care should be provided with those copies. Provision of those photocopies, also an uninsured service, may, however, be made contingent on pre-payment of a reasonable fee.

When patients seek to personally review their medical records, as is their legal right, either for purposes of selecting content for photocopying or otherwise, that must be facilitated. However, such reviews of files by patients should be done under the direct scrutiny of the physician, or a designate from the office staff. Otherwise, there are risks of the patient misunderstanding content, particularly that of reports from others, and of surreptitious "editing" of documents by the patient. In general, it may be more efficient to simply provide the patient with copies.

Original medical records must not be transferred, *under any circumstances*, to the custody of the patient, not only because of the "editing" risk (which is substantial), but because of the further risk of these documents being misplaced. In both circumstances, the physician is left in jeopardy, especially legally. Original medical records must only be transferred to the succeeding physician if that transfer is unequivocally secured and if the succeeding physician has explicitly consented to accept ownership and the defined obligations that flow from that. Furthermore, the receiving physician must provide

unencumbered future access to the file to the physician surrendering those documents. The physician transferring the original file must retain documentation of that transfer and of the second physician's consent. A list of patient files and where they have been transferred for ongoing custody and potential retrieval should be part of that retained document.

Physicians, having responded to one such patient request for transfer, have no obligation to respond to subsequent such requests from that patient or from subsequent successor physicians. Any such requests should be directed, instead, to the succeeding physician who has already received the information.

It will be evident from the above that the common practice of physicians forwarding original records to their successors with their stated expectation that the succeeding physician will summarize, or cull and copy, the contents, and then return the file, is unreasonable and unacceptable.

Physicians accepting new patients are cautioned that any attempts to charge a fee to new patients for summarizing their earlier medical records will likely not be viewed favourably by the Medical Services Commission, that service being viewed by MSC as an insured one, as part of the patient assessment process.

In all instances, when assigning a fee to a patient for an uninsured service, the physician should be mindful of the patient's ability to pay. That mindfulness need not extend to providing irrelevant documentation merely because the patient has demanded it.

B. DISCLOSURE OF CONFIDENTIAL HEALTH CARE INFORMATION

1. General Obligations and Constraints

Personal Information Protection Act

Section 23 of PIPA requires physicians, on the written request of a patient, to provide the patient with:

a. his or her personal information;

b. information about the ways in which the patient personal information has been and is being used; and

c. names of the individuals and organizations to whom the personal information has been disclosed by the physician or physician's clinic.

Under section 29 of PIPA, a physician must respond to a patient's request not later than 30 days after receiving the patient's request, unless the time to respond is extended in accordance with the provisions of section 31 of the PIPA.

PIPA gives a patient a general right of access to his or her personal information under the custody and control of a private physician's office or of health facilities. This access includes records prepared by other physicians and those generated outside of the conventional physician-patient relationship.

On the other hand, PIPA also protects from disclosure certain categories of information. In particular, section 23(3) allows physicians to *withhold* records which:

- are subject to solicitor-client privilege;

- contain confidential commercial information;
- contain investigative information on a matter still under investigation;
- contain information obtained in the conduct of a mediation or arbitration;
- through disclosure, could threaten the safety or physical or mental health of the patient or another individual; or
- contain personal information about another person.

Otherwise, annotations made on correspondence by physicians seeking to preclude disclosure are trumped by PIPA and must be ignored.

With respect to the disclosure of records generated outside of the patient-physician relationship, such as reports to insurance companies, WCB, or ICBC, physicians must determine whether the organization which paid for the creation of the report has any concerns regarding its disclosure to the patient. If there are no concerns from the sponsoring organization, the report may be disclosed along with other patient medical records. If the organization objects to the release of the information, the patient should be asked to contact the sponsoring organization directly for access to the report.

2. Disclosure to Patients and Families

Family members should not be provided with a patient's medical information without, given a competent patient, the patient's explicit consent.

When a patient cannot give consent, through temporary or permanent incapacity, family members may receive information according to their status as surrogate decision-makers. Physicians may impose, within those guidelines, an obligation on families to appoint a single family member to hear information (and to participate in decision-making).

Deceased Patients

Physicians are obliged to disclose confidential medical information on their deceased patient to the *executor* of that patient's estate upon request. Absent a named executor, that access falls, successively to:

1. Spouse (including partners in a same-sex relationship in which the couple has been cohabitating)
2. Adult child
3. Parent
4. Adult brother or sister
5. Other adult relation by birth or adoption (to determine the nearest relative, please consult Reg. 4 of PIPA Regulations).

3. Disclosure to Third Parties

a. Other Treating Healthcare Professionals

Where two or more physicians are caring for the same patient, including consultants, consent to share or provide information is implicit to that sharing of care. That implicit consent to transfer relevant medical information includes documents arising from

consultations with laboratory and radiology consultants, and from the services of rehabilitation, mental health, social work, nursing and dietary practitioners and other regulated healthcare professionals. When registrants have concerns about sharing information with providers of complementary/alternative care, and particularly considering that endorsement of that care that might wrongly be inferred by the patient through such sharing, guidance from Registrar Staff should be sought.

By involving other healthcare professionals in the care of their patient, physicians should be mindful of the implicit endorsement of that other care that such a request involves, and the persistence of their fiduciary responsibility to their patient. Transfer of medical information could be seen as a similar endorsement of any other category of provision of healthcare.

b. Non-Treating Third Parties

i. Disclosure to Patient's Legal Counsel

Lawyers, having declared and demonstrated their status as counsel to a patient, as the patient's "agent", have legitimate unfettered access to, and so should be provided with, copies of medical records, upon request, subject to confirmation of that status by the patient, preferably, though not necessarily, through a signed statement/consent.

ii. Release to Other Third Parties

In some situations, patients may provide a consent allowing for the release of their medical record to others (opposing lawyers, insurance companies, etc.). It is not unusual for patients unwittingly to sign a consent for the release of all of their medical record, even when only a portion of the record is relevant to the issue at hand. If the record contains other sensitive information unrelated to the focus of the request, physicians would be prudent to seek further direction from the patient as to what they perceive the consent to extend, with a view to consideration of a more limited consent.

iii. Medical-Legal Reports & Opinions

Physicians have an ethical obligation, at least, to provide, in a timely manner (usually 30 working days), a *medical-legal report*, on request, that includes a comprehensive account of the physician's care of that patient, including his/her diagnosis, prognosis and opinion as to causation of the medical problem(s) at issue.

An independent *medical-legal opinion* cannot be sought from a treating physician, but only from a non-treating physician. That non-treating physician would provide that opinion to a third party on the basis of an independent medical assessment, based on a review of medical information from others pertinent to the issue at hand, with or without (as should be documented) that non-treating physician's direct clinical encounter with that patient.

In both instances, either in providing a medical-legal report or a medical-legal opinion, registrants are advised, before preparing and submitting any documentation, to advise the third party seeking the report of the anticipated fee for that. Physicians may not withhold any report that supports their patients' realization of benefits pending payment. If the report is prepared and payment is

not forthcoming, redress for that should be sought by the physician either through the Law Society of BC or through the Medical-Legal Liaison Committee (the latter accessible through the College or the BC Medical Association).

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