Access to Medical Records

\*\*\*Remember that at common law there is no right to access

\*\*\* Note that wherever there are children with parents wanting access that Gillick’s (In competency notes) may be relevant

1. Introduction
   1. The general principle is that they are owned by the person who created them (i.e. doctor) or the institution which prepared them (i.e. hospitals).(Breen v Williams)
      1. This can be contrasted to the Canadian position where they do have access
         1. ***McEniery v Macdonald*** case
            1. ***Relied on fiduciary relationship and***
   2. Shifts in patient autonomy and recognition of the fiduciary relationship bw doctors and patients allows patients the right to look at their records and obtain copies (Rogers v Whitaker)

***Breen v Williams***

* *Woman who was trying to access her medical records she had implants put in and they got infected and she was in a class action in the US and she sought medical records*
* *She was asserting that she had an independent right to access the records*
* *The appellant argued that there was a prop right to the stuff itself (Documents etc)*
* *She conceded that the Dr. had OWNERSHIP of the records*
  + *But is there an implied term to get access*
  + *No – and that was said in both cases*
* *They said its information so there is no proprietary right because you can not limit it to one owner*
* *They all denied that there was an independent right and where not happy with the Canadian approach*
* *They argued that the info as held on trust but that was shot down*
* *Is the entire relationship bw Dr. and patient fiduciary?*
* *How does this sit with copyright?* 
  + *Remember that if you have ownership of something then you have the right to reproduce it* 
    1. *The court said that this should be a matter for parliament.*

1. **Policy reasons for providing access** 
   1. Checking accuracy of records being held
   2. If you already know it all then why not have it
   3. Benefit in getting access to records so that you can bring it to your new health care professional if it change
   4. Might just help your own management and treatment of your condition because you have the most accurate information
   5. You want to make sure that they have not stuffed up

**BUT**

* 1. Well be indecipherable to a patient
  2. You don’t want them to be so worried about what they write down that they are so careful that some things get left out

1. **Competing interests with respect to release** 
   1. Is it in the patients best interests to release
   2. What if it contains information about speculative illnesses that may be detrimental to the patients well being
   3. Dr’s may hold back on information important to the patients later care if they do not wish for the patient to see it

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| --- |
| 1. What are Medical Records?  * Include any:   + Records, files, documents, or other written material   + Concerning the patients medical, health or social history, diagnosis, condition, treatment or assessment,   + Created or maintained by a doctor, other health care professional, hospital * Records held by DOCTORS   + Doctors notes re patients background, family history, condition   + Doctors notes re observations, speculations   + Referral letters from specialists   + Investigation reports (Xrays etc)   + Photographs, correspondence with patient. * Records held by HOSPITAL   + Admission/discharge forms   + Letters/referral information   + Progress notes   + Operation and anaesthetic notes   + Investigation and diagnostic reports   + Drug order/administration charts |

1. Ownership of Records
   1. Generally the person who made the record
   2. This position can be somewhat complicated where the doctor is employed by others as part of a corporation or business, however it has been held that it is the corporation/business that owns the documents and not the doctor (*Health Services for Men v D’Souza*).
   3. At common law, ownership rights therefore vest with doctor/corporation and entitle them to dispose of the records like any other assets subject to the requirement of confidentiality.
   4. Where the patient moves to another district and doctor, the original doctor is not required to hand the documents to the patient, however if so requested the original doctor must forward to the new doctor as soon as practicable.
   5. **If payment provided:** Arguments as to a limited exception re x-rays or pathology reports, the ownership of which a patient may be able to claim (*Breen v Williams*) on the basis they have provided payment for them.
2. Patient’s right to access
   1. Historically- patients had no right to access
   2. Today all Australian jurisdictions have implemented freedom of information legislation which allows patients to access medical records held by government agencies and public medical institutions (Freedom of Information Act (Qld) and (Cth), Privacy Act (Cth)).
      1. Note the new Right to Information Act in Qld 2009 s40
         1. National Privacy Principle (NPP) number 6 is what is required for access
            1. This states that information must be provided unless it poses a serious threat to the life of the individual

This is a higher threshold

* 1. Note that the legislation does not extend to cover records held by private doctors and hospitals
     1. Private practitioners are subject to the Privacy Act (Cth) and the NPP’s which govern the handling of personal information
        1. Must grant access to records if requested
           1. Note the operation of the new Qld Information privacy Act 2009 which encompasses the NPP’s
  2. Does this operate at a high or low threshold?
     1. Potentially low
     2. Little case consideration of this term

1. Queensland Right to Access
   1. At statute access is granted under:
      1. PUBLIC HEALTH
         1. Information privacy Act 2009
            1. Health department must comply with national privacy principles s31; Sch 4 IPA
            2. Individuals can apply for their own medical records under s40 and s43
         2. Right to information Act 2009
      2. PRIVATE HEALTH/FEDERAL HEALTH
         1. Privacy Act 1988
         2. Freedom of Information Act 1982
2. **IF ACCESS IS DENIED**

***Private Health:***

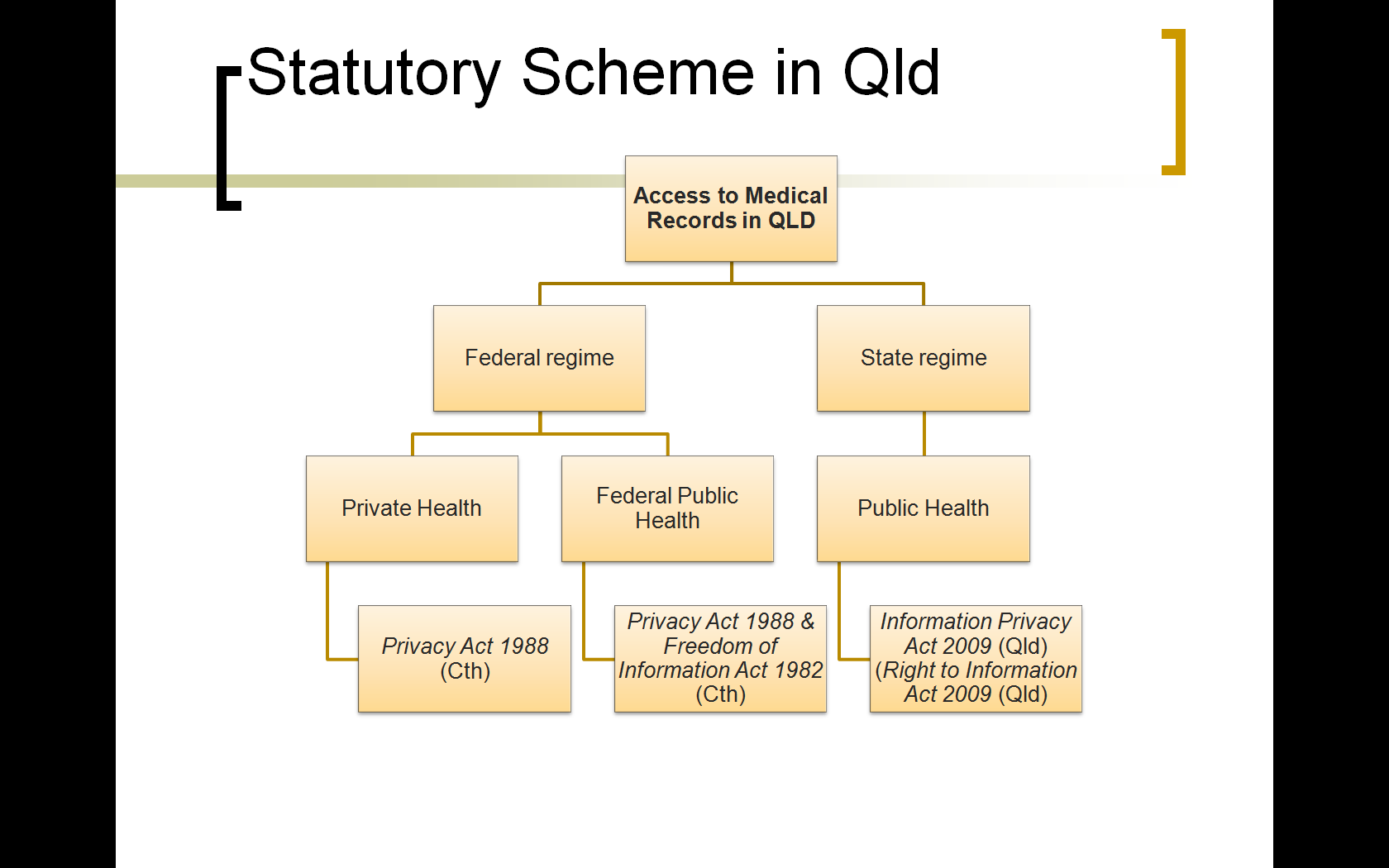
[Patient] can make a complaint to the Privacy commissioner pursuant to **s 36(1)** of the **Privacy Act.**

* On finding the complaint substantiated (which in this case is likely/unlikely), the commissioner may make a declaration about what should occur or the [patient] is entitled to compensation: **s 52(1)(b) and (3B) Privacy Act.**
* Compensation may be awarded for hurt feelings, humiliation and expenses in bringing the complaint (**s 52(1A),(3).**
* Commissioner may order materials be corrected

The Commissioners determination is not binding, but the complainant or the commissioner may apply to FCA or Fed Mags Ct to enforce the determination **(s55A(1)).**

***Public Health:***

* Section 80 of RTI Act (Qld) provides for the internal review of a decision not to give access
* Part 9 provides for the external review of the decision by the Commissioner
  1. Queensland Health has, in addition to the avenues already mentioned, in place an ‘Administrative Access to Health Records Policy’ under which a patient can make a written application to a hospital or other health service for access to his or her health record.
  2. Exceptions and limitations
     1. E.g. In relation to deceased persons or where it would involve a breach of confidence.



1. AMA Code of Ethics re Right to Access
   1. The AMA has published guidelines for doctors on providing patients access to their medical records. These guidelines acknowledge that the doctor is the lawful owner of the record but also recognizes that patients have a right to be informed of all factual information contained in the medical record relating to their care.
   2. However, this right is not said to be absolute and is subject to disclosure being in the best interests of the patient
   3. The AMA guidelines suggest that the Dr give a summary so that there is no misinterpretation

**OR**

* 1. That the Dr be there to explain the content of any copies made

1. Exemptions to granting access

Exempt information is defined in schedule 3 and s48

* 1. Public hospitals
     1. Legal professional privilege
        1. Public hospitals do not have to grant access where the documents would be subject to legal professional privilege
     2. Unreasonable disclosure of personal information
        1. Access will not be granted if it would involve the unreasonable disclosure of information relating to the personal affairs of any person
     3. Contrary to the public interest
     4. Where disclosure would divulge any information disclosed in confidence that would be contrary to the public interest because it would be reasonably likely to impair an agency/Minister to obtain similar information in the future
     5. Contrary to the patient’s health
        1. Where disclosure would be detrimental to the patients health, public hospitals have a right to refuse
        2. Can refuse if not in the patients best interests
           1. Parliament considers it would… be contrary to the public interest to give access …to the extent it comprises relevant healthcare information of the applicant if the disclosure …***might be prejudicial to the physical or mental health or wellbeing o f the applicant***.

S 67 IPA and s51 RTIA

* + - 1. Specifically, documents containing information of a medical or psychiatric nature which might have an adverse effect on the physical/mental heath of the applicant
      2. E.g. for suicidal/mentally ill patients
    1. Children and mentally disabled
       1. Children may obtain access before they are 18 years provided they are able to understand the nature of the request (*Haines v Leves; Wallace v Health Commission of Victoria*)
       2. Can be refused if contrary to a child’s best interests
          1. S67 IPA and s50 RTIA
          2. May result in only limited access being granted

IPA can suggest that the information be given by a healthcare professional – s92 IPA

This would allow for the professional to explain what terms meant etc.

* + - 1. NOTE: the AMA recognises that there may not be an automatic right for a parent to see medical information relating to their child
         1. See the Gillick Test

Outline on page 7 of Consent notes

* 1. Private hospitals/practitioners

Private run institutions include:

* Nursing homes
* Private institutions
* Dentists
* Radiology services etc.
  + 1. Private practices and hospitals my refuse to grant access to information where:
       1. it would pose a serious threat to the life or health of any individual: Sch 3 NPP 6.1(b)
       2. it would have an unreasonable impact on the privacy of others: Sch3 NPP 6.1 (c)
       3. the information relates to existing/anticipated legal proceedings between the organisation and the individual: Sch 3 NPP 6.1 (e)
       4. it would be unlawful: Sch 3 NPP 6.1 (g), (h)
       5. providing access would likely prejudice an investigation of possible unlawful activity or cause damage to the security of australia: Sch 3 NPP 6.1 (i), (k)

1. Complaint procedures where access is denied
   1. Where access to information is refused under the Privacy Act, the person can complain to the Privacy Commissioner under s36(1) where they can establish an interference with their privacy.
   2. Although a refusal to grant access to information may not be an interference with privacy in the ordinary sense of the term however when read in conjunction with NPP’s 6 and 7 it is clearly intended to be so interpreted.
   3. The Privacy Commissioner may then declare that
      1. There was an interference with privacy which should not be repeated or continued (s52(1)(b)(i)(B));
      2. The respondent should perform any reasonable act to redress any loss/damage suffered by the complainant (s52(1)(b)(ii)); or
      3. The complainant is entitled to compensation (s52(1)(b)(iii)

***Health Services for Men Pty Ltd v D’Souza* [1999] NSWSC 969:**

* A company employed doctors on contract to provide treatment for sexual dysfunction in men. The company leased, equipped and staffed premises; engaged 10 doctors to work in its 21 clinics; and advertised its services extensively (this cost $30,000/week). Doctors moved between clinics as allocated by the company. Patients often saw more than one doctor in follow-up consultations and each doctor wrote notes in the patient’s records. Fees were collected through Medicare in NSW and by billings in Victoria. Moneys received were paid into a joint account and the doctors were then paid. Three doctors withdrew from their agreement with the company and took patient files with them. The company sought orders restraining the doctors from soliciting or approaching any patient and from using confidential information, and a declaration that the company owned the files and that they should be returned to it.
* **The Court of Appeal held that, in these circumstances, the files were owned by the company and not the doctors. The intention in the relationship was that the clinic provided the treatment, not the individual doctors. The examination sheets that the doctors completed for each patient were provided by the company and there was:***…no basis upon which it could be inferred that the [parties] intended that [they would]…become the property of the doctors.* ***Nor could any such intention be implied as a matter of contract*** (@458).

Sheller JA @ 460 said:

*…it may be that when [a pathology report] was sent to and received by a practitioner in a private practice, who had requested the report, it became the property of that practitioner* (emphasis added)

***Breen v Williams* (1996) 186 CLR 71**

* Mrs B had breast implants which were subsequently found to have leaked.
* In order to participate in a class action against the US manufacturers, Mrs B req’d copies of her medical records.
* She sought from Dr W (respondent) her records and he refused.
* Later he wrote a letter saying he would be willing to provide her with a medical report of things like her history, diagnosis, investigation results, advice and treatment but not his handwritten notes. She refused this offer.
* Mrs B went on to the Cts to seek a declaration that she had a right to examine and access her medical records.
* High Court dismissed.
* Mrs B argued that her right to access her medical records arose from four sources:
* \* A patient’s proprietary right/interest in the information contained in the records;
* \* An implied term of the K between doctor-patient;
* \* A fiduciary relationship between doctor-patient; and
* \* A general “right to know”

**Proprietary right/interest**

Brennan CJ, Dawson, Toohey, Gaudron, McHugh and Gummow JJ

* Documents prepared by a professional person to assist the professional to perform his/her duty are not property of the lay client; they remain the property of the professional.
* That property right entitles the doctor to refuse other person access to the records.

**Implied term in K**

Brennan CJ

* In the absence of a special K between doctor-patient, doctor undertakes by the contract between them to advise and treat the patient with reasonable care and skill.
* No term implied that doctor act in “best interests” of patient 🡪 terms limited to subject matter of K, that is, benefiting health of patient.
* No term implied if K effective without it.

Dawson and Toohey JJ

* Primary obligation under K was to use reasonable skill and care in treating and advising Mrs B.
* Not necessary for reasonable/effective performance of that obligation to give Mrs B access to medical records.

Gaudron and McHugh JJ

* Distinction between terms implied in fact and in law.
* Mrs B argued an implication by law that doctor act in “best interests” of patient however although a relevant consideration, doctor’s primary duty owed is to exercise reasonable skill and care in provision of professional advice and treatment.

**Fiduciary relationship**

Brennan CJ, Dawson, Toohey, Gaudron, McHugh and Gummow JJ

* No definitive answer to what is a fiduciary relationship 🡪 depends on nature of relationship and facts of the case
* Although duties of fiduciary nature may be imposed on doctor, doesn’t cover entire relationship.
* No fiduciary relationship with respect to access to medical records
* Generally relationship not fiduciary in nature

**Access to factual information**

- Brennan CJ highlighted that information with respect to a patient’s history, condition or treatment etc, must be disclosed by the doctor when:

**(i)** refusal to make the disclosure requested might prejudice the general health of the patient;

**(ii)** the refusal for disclosure is reasonable having regard to all circumstances; and

**(iii)** reasonable reward for the service of disclosure is tendered or assured

* But the Canadian position as stated by La Forest J in ***McInerney v MacDonald*** in the Canadian Supreme Ct differs.
* Canadian position holds that a patient is entitled to reasonable access to examine and copy the doctors records.
* This was founded on the grounds of a fiduciary relationship between doctor-patient in that it was the duty of the doctor to act with “utmost good faith and loyalty.”
* **La Forest J** in ***McInerney v MacDonald*** reached the following conclusion:

**“**Information about oneself revealed to a doctor in a professional capacity remains, in a fundamental sense, one’s own. The doctor’s position is one of trust and confidence. The information conveyed is held in a fashion somewhat akin to a trust. While the doctor is the owner of the actual record, the information is to be used by the physician for the benefit of the patient. The confiding of the information to the physician for medical purposes fives rise to an expectations that the patient’s interests in and control of the information will continue.”

* However the Australian High Ct in ***Breen v Williams*** emphatically rejected this proposition as not being the law of Australia.
* Dawson and Toohey JJ stated that “there is no foundation in either principle or authority in this country” as such a duty of utmost good faith and loyalty “hardly fits with the undoubted duty of a doctor in this country.”

Gaudron and McHugh JJ said that in Australia “it is not possible to regard the doctor-

***McInerney v MacDonald* (1992) 93 DLR (4th) 415**

* The respondent patient was treated by various physicians over a period of years before being treated by the appellant physician. **On the appellant's advice, the respondent ceased taking thyroid pills that had been previously prescribed by other physicians**.
* **She requested the contents of her complete medical file from the appellant. The appellant delivered copies of all notes and reports that she had prepared herself but refused to produce copies of the reports and records that she had received from other physicians.**
* An application to the courts for an order directing the appellant to provide a copy of the entire medical file was granted. An appeal to the Court of Appeal was dismissed.

On appeal, held, the appeal should be **dismissed**.

* The physician, institution or clinic compiling the medical records owns the physical records. However, a patient has a vital interest in the information contained in his or her medical records. While a patient may, in the past, have relied primarily upon one physician, the trend is now to favour referrals to a number of professionals. As the number and use of specialists increase, it becomes more difficult for the patient to gain access to the full medical picture. If the patient is only entitled to obtain particular information from each health care provider, the number of contacts he or she may be required to make may become enormous.
* At least in part, medical records contain information about the patient revealed by the patient and the information is acquired and recorded on behalf of the patient. The records consist of information that is highly private and personal to the individual. It is information that goes to the personal integrity and autonomy of the patient. This information remains, in a fundamental sense, the patient's own for the patient to communicate or retain as he or she sees fit. Thus, the patient has a basic and continuing interest in what happens to the information and in controlling access to it.
* The relationship between physician and patient is one in which trust and confidence must be placed in the physician. The physician-patient relationship is a fiduciary relationship. Certain duties arise from that special relationship of trust and confidence between physician and patient. Among these are the duty of the doctor to act with utmost good faith and loyalty and to hold information received from or about a patient in confidence. When a patient releases personal information in the context of the doctor-patient relationship, he or she does so with the legitimate expectation that these duties will be respected. The relationship also gives rise to the physician's duty to make proper disclosure of information to the patient. The fiduciary duty to provide access to medical records is ultimately grounded in the nature of the patient's interest in his or her records. The information conveyed to the doctor is held in a fashion somewhat like that of a trust. While the doctor is the owner of the actual record, the information is to be used by the doctor for the benefit of the patient. The confiding of the information to the physician for medical purposes gives rise to an expectation that the patient's interest in and control of the information will continue.
* The trust-like beneficial interest of the patient in the information indicates that, as a general rule, he or she should have a right of access to the information and that the physician should have a corresponding obligation to provide it. The patient's interest being in the information, it follows that the interest continues when that information is conveyed to another doctor who then becomes subject to the duty to afford the patient access to that information.
* If a patient is denied access to his or her records, it may not be possible for the patient to establish that the duty of the doctor to act with utmost good faith and loyalty has been fulfilled. It is important that the patient have access to the records to ensure the proper functioning of the relationship and to protect the well-being of the patient.The trust reposed in the physician by the patient mandates that the flow of information operate both ways.
* The onus lies on the doctor to justify an exception to the general rule of access. The burden of proof should fall on the party who is in the best position to obtain the facts. If a physician objects to the patient's general right of access, he or she must have reasonable grounds for doing so.
* Equity works in the circumstances to enforce the duty to disclose. The foundation in equity gives the court the discretion to refuse access to the records where non-disclosure is appropriate.

Tangible records belong to the physician and the physician must have continued access to the records to provide proper diagnosis and treatment. Such access would be disrupted if the patient was able to remove the records from the premises. Accordingly, the patient is entitled to reasonable access to examine and copy the records, provided the patient pays a legitimate fee for the preparation and reproduction of the information. Access is limited to the information the physician obtained in providing treatment. It does not extend to information arising outside the doctor-patient relationship. The patient is entitled upon request to inspect and copy all information in the patient's medical file which the physician considered in administering advice or treatment. Considering the equitable base of the patient's entitlement, this general rule of access is subject to the superintending jurisdiction of the court. The onus is on the physician to justify denial of access.