2.1.1 Access to Medical Records

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Learning Objectives

1. To appreciate the basis, in ethics and law, of patients' right of access to their medical records
2. To appreciate the limits of patients' right of access to their medical records

Case

Mr. Henry is a 42-year-old longtime patient of Dr. John, a family practitioner in Timmins, Ontario. Mr. Henry is a construction foreman with a wife and two teenage children. He has a long history of vague upper gastrointestinal complaints. An upper gastroesophageal endoscopy performed two years previously revealed gastritis and mild gastroesophageal reflux. He was treated with dietary modification and a proton pump blocker to good effect. Six weeks ago Mr. Henry presented to Dr. John with painless jaundice. In-hospital investigation revealed a 5-cm adenocarcinoma in the head of his pancreas with local lymph node involvement. Three weeks after learning of his diagnosis, Mr. Henry books an appointment with Dr. John and requests a copy of his complete medical records.

Mr. Henry's medical records contain consultation reports from two gastroenterologists seen in previous years, a report from the radiologist who performed the CT scan and CT guided fine needle aspiration of the pancreatic tumour, a report from the pathologist confirming the diagnosis of adenocarcinoma and a report from the medical oncologist.

Dr. John is aware of the emotional distress that Mr. Henry has suffered over the past weeks, especially since the diagnosis of pancreatic cancer was confirmed. Mr. Henry, very understandably, is profoundly saddened and worried about being able to provide for his family. The medical oncologist's report contains a very frank discussion. It speaks of the "dismal nature of the diagnosis" and the "low probability that, even with treatment, the patient will survive more than 12 months."

The medical oncologist's report goes on to express concern regarding the amount of clonazepam that Mr. Henry is taking. Two weeks prior to seeing the oncologist, Mr. Henry filled a prescription for 60 doses of clonazepam 0.5 mg, to be taken twice a day as required. At the consultation he indicated that he was "almost out" and requested another prescription. The oncologist remarked on the "well-known addictive potential of benzodiazepines, especially when, as admitted to me by the patient, they are combined with daily alcohol consumption."

The consultation report from the radiologist who performed the CT scan and CT-guided fine needle biopsy of the tumour contains an unfortunate offhand remark about the patient. The radiologist describes some initial difficulty with the biopsy because the patient was being a "bit of a wimp."

In perusing his own notes in Mr. Henry's record, Dr. John comes across a note from a visit four years earlier in which Mr. Henry had discussed marital difficulties. In his note he states: "Mr. and Mrs. Henry are going through an extremely difficult period in their marriage. I remain concerned that Mrs. Henry refuses to disclose to her husband the ongoing sexual affair between herself and Mr. Henry's business partner. Plan: Continue to support Mr. Henry and meet again with Mrs. Henry in private." He recalls that the affair was never disclosed to Mr. Henry.

Questions

1. Does Mr. Henry have a right of access to his medical records, and if so, what is its basis?
2. If Mr. Henry has a right of access to his medical records, does it extend to records generated by other physicians or health professionals?
3. If Mr. Henry has a right of access to his medical records, to what extent, if at all, is it qualified by Dr. John's concern over the distress that disclosure may cause him?
4. If Mr. Henry has a right of access to his medical records, to what extent, if at all, is it qualified by the presence of the potentially inflammatory but medically relevant remarks of the medical oncologist?
5. If Mr. Henry has a right of access to his medical records, to what extent, if at all, is it qualified by the
Discussion

Q1. Does Mr. Henry have a right of access to his medical records, and if so, what is its basis?

The question of whether patients ought to have a legally recognized general right of access to their medical records has been the subject of considerable debate. Such a right is recognized in Canada at common law and in various provinces under legislation governing the collection, use and disclosure of personal health information. The common-law right of access to records was established by the Supreme Court of Canada in *McInerney v. MacDonald*, where an obligation of disclosure upon physicians was said to follow from the fiduciary nature of the physician-patient relationship. The moral basis of patients’ right of access to their records is found in the moral requirement of respect of autonomy. In order to effectively exercise their right to make decisions concerning personal matters relating to their health and well-being, it is argued, patients must have access to information material to these decisions contained within their medical records. The moral imperative of disclosure is arguably greater in the context of the physician-patient relationship, given that it is a relationship of trust characterized by higher than normal levels of inequality of power and dependence.

While the right of access is well established in Canada, readers should be aware that the debate remains alive internationally. Courts in other countries, notably Australia and England, have denied that physicians operate under a fiduciary obligation to disclose medical records to patients. Denial of a general right of access has most often been based on the finding that physicians have a property interest in patient records that ought not to be interfered with. Some have questioned whether this interest, if it exists, should extend to all information contained in patient records (i.e., including information disclosed by patients), or only to information generated by physicians in the course of providing patient care (i.e., to their work product). In any event, the Supreme Court of Canada in *McInerney* did not deny that physicians have a property interest in patient records. Rather, it held that patients have an enforceable right of access to information contained in their records. This right of access is realized through provision of copies of records.

Q2. If Mr. Henry has a right of access to his medical records, does it extend to records generated by other physicians or health professionals?

The question of whether patients' right of access to medical records extends to records generated by other physicians or health professionals was at the heart of the case in *McInerney*. The physician in that case was unwilling to disclose the parts of the patient's record that were generated by other physicians, on the grounds that this information was the property of those other physicians, requiring the patient to obtain their consent to its release. The position of the physician was based on Canadian Medical Association (CMA) policy existing at the time. The Supreme Court ruled against the physician and overruled the CMA policy, holding that patients' right of access does extend to parts of records generated by other physicians or health professionals.

Q3. If Mr. Henry has a right of access to his medical records, to what extent, if at all, is it qualified by Dr. John's concern over the distress that disclosure may cause him?

While patients' right of access to their medical records is powerful, it is not unlimited. Bioethicists have long criticized claims of "therapeutic privilege" offered by physicians in justification of withholding information from patients. However, the Supreme Court in *McInerney* allowed such claims some latitude. It recognized that physicians do retain the discretion to withhold information on grounds of therapeutic privilege, subject to important limitations. First, the decision must be based on the physician's judgment that disclosure poses a real risk of substantial physical or psychological harm to the patient. The Court suggested that these cases would be very rare. Second, the privilege of withholding information applies only to the parts of the record that pose the risk of harm to the patient.

Q4/5. If Mr. Henry has a right of access to his medical records, to what extent, if at all, is it qualified by the presence of the potentially inflammatory but medically relevant remarks of the medical oncologist? To what extent, if at all, is it qualified by the presence of potentially inflammatory but medically irrelevant remarks by the radiologist?

The law is unclear on these questions. The purpose of the right of access to medical records is to enable patients to
make informed decisions. Generally speaking, only information material to the medical interests of the patient is pertinent to their making informed decisions. Accordingly, it would seem that potentially inflammatory but medically irrelevant information falls outside the purview of the right of access, in light of its generally agreed purpose. Such information may simply be severed from the rest of the record. Potentially inflammatory but medically relevant information, on the other hand, falls within the purview of the right of access. That being allowed, depending on the nature of the information and the circumstances of the patient, highly inflammatory but medically relevant information may be withheld on the basis of therapeutic privilege (see above). Interesting, if unresolved, is the question of whether the claim of therapeutic privilege may be based not only on harm that may directly be caused to the patient by disclosure, but also on the potential harm that may be caused to the patient by eventual further disclosure to third parties (e.g., to employers or insurers).

**Q6. If Mr. Henry has a right of access to his medical records, does it extend to sensitive information about other persons? Does it matter that the information pertains to him?**

Another important and morally intuitive limit to patients' right of access to their medical records is found in the privacy interests of others in information subject to the right of access. Mr. Henry's wife and business partner have a clear privacy interest in Dr. John's notation about their undisclosed extramarital affair. It is, however, unclear that these interests are protected at law. The law has, to date, failed to recognize a general tort of invasion of privacy, which might be invoked in order to protect the privacy interests of both parties. If Mrs. Henry has established a physician-patient relationship of her own with Dr. John, his duty of confidence to her would prevent him from disclosing comments about the affair to Mr. Henry. The comments pertaining to the affair would have to be severed from copies of records released to Mr. Henry. Otherwise, disclosure of the comments would be required, subject to two possible exceptions. The first is the possible applicability of the therapeutic privilege. For therapeutic privilege to apply, Dr. John must find that disclosure of the comments would be inimical to the interests of Mr. Henry, as explained above. His concern to protect the privacy interests of Mrs. Henry or Mr. Henry's business partner would not support invocation of therapeutic privilege. The second is an exception expressly allowed for in *McInerney*, whereby information can be withheld where the physician judges that disclosure poses a real risk of substantial physical or psychological harm to someone other than the patient (e.g., Mrs. Henry or Mr. Henry's business partner).

**References**


**Resources**