



College of Physicians and Surgeons of British Columbia

Practice Standard

Medical Records, Data Stewardship and Confidentiality of Personal Health Information

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Related topic(s):	Medical Certificates and Other Third Party Reports , Photographic, Video and Audio Recording of Patients , Leaving Practice , Primary Care Provision in Walk-in, Urgent Care and Multi-physician Clinics , Referral-Consultation Process

A **practice standard** reflects the minimum standard of professional behaviour and ethical conduct on a specific topic or issue expected by the College of its registrants (all physicians and surgeons who practise medicine in British Columbia). Standards also reflect relevant legal requirements and are enforceable under the [Health Professions Act](#), RSBC 1996, c.183 (*HPA*) and College [Bylaws](#) under the *HPA*.

Registrants may seek advice on these issues by contacting the College and asking to speak with a member of the registrar staff, or by seeking medical legal advice from the CMPA or other entity.

PREAMBLE

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

The purpose of this standard is to outline a registrant's professional and legal obligations regarding medical records, data stewardship and confidentiality of personal health information.

BACKGROUND

Registrants must practice in accordance with applicable legislation. Sections 3-5, 3-6, and 3-7 of the Bylaws made under the *Health Professions Act*, RSBC 1996, c.183, outline the following requirements:

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,
 - (e) the Access to Information Act of Canada, and
 - (f) the E-Health (Personal Health Information Access and Protection of Privacy) Act of British Columbia.

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.

The Canadian Medical Association's *Code of Ethics and Professionalism* (sections 18 to 21) requires the protection of patient's personal health information:

Patient privacy and the duty of confidentiality

18. Fulfil your duty of confidentiality to the patient by keeping identifiable patient information confidential, collecting, using, and disclosing only as much health information as necessary to benefit the patient; and sharing information only to benefit the patient and within the patient's circle of care. Exceptions include situations where the informed consent of the patient has been obtained for disclosure or as provided for by law.
19. Provide the patient or a third party with a copy of their medical record upon the patient's request, unless there is a compelling reason to believe that information contained in the record will result in a substantial harm to the patients or others.
20. Recognize and manage privacy requirements within training and practice environments and quality improvement initiatives, in the context of secondary uses of data for health system management, and when using new technologies in clinical settings.
21. Avoid health care discussions, including in personal, public, or virtual conversations, that could reasonably be seen as revealing confidential or identifying information or as being disrespectful to patients, their families, or caregivers.

COLLEGE'S POSITION

Registrants must ensure that the content of a patient's medical record meets the requirements as set out in section 3-5 of the Bylaws. The medical record must contain comprehensive documentation of the clinical care provided to the patient, including

- documentation of patient history, complaints and symptoms, examinations, and laboratory and imaging reports,
- copies of emails, text messages, or other communication with the patient, related to clinical care and follow-up, including documentation of telephone consultations or prescriptions, and
- copies of operative procedures, consultation reports, discharge summaries and other information created by other registrants or health-care professionals which is relevant to the patient's medical care.

The Medical Services Commission (MSC) of British Columbia defines what it considers an adequate medical record for payment in section C.10 of the [MSC Payment Schedule](#), such as the location of service, and the identification of the patient and attending medical practitioner.

Registrants have an ethical, professional, and legal obligation to ensure that *before they create a medical record*, they comprehensively address the issues of custody, confidentiality, and enduring access for themselves and their patients.

Failure to address issues of custody, confidentiality and enduring access of medical records may be considered professional misconduct. Registrants are therefore advised to access appropriate legal counsel before providing medical services in situations where these issues have not been clearly addressed.

CUSTODY

Registrants who have custody of medical records are responsible for ensuring that they are maintained and stored in accordance with ethical, professional, and legal requirements, whether the records are paper or electronic.

In all situations where a registrant is creating medical records in a group or shared medical record environment, a data-sharing agreement must be in place which addresses how issues of ownership, custody and enduring access by individual registrants and patients will be addressed, including following relocation, retirement or death of the registrants. Where a registrant creating a medical record is not the owner of the clinic and/or of the electronic medical record (EMR) licence, issues of custody, confidentiality and enduring access by individual registrants and patients must be documented in a formal contract with the owners and/or EMR service providers.

Altering a Medical Record

Registrants may alter a medical record, but they must clearly identify what alterations were made and when. This is best accomplished by dating and signing or initialing the changes. If a registrant deletes part of the record, a simple line through that information with a date and signature is appropriate. The content of the entry being deleted must be visible. It may be helpful to indicate why the alteration is being made. Amendments to EMRs must be made in a similar fashion using addendums, digital strikethrough of text and/or using the “track changes” function found in most word processing programs.

Registrants must never alter a medical record after a complaint or legal action has been initiated, unless a clinical fact is missing, and a clear late entry is made to the record as discussed above.

If a patient requests a correction of their personal information in the medical record, and the registrant agrees, it must be made as soon as reasonably possible. The corrected information must also be provided to each organization to which the personal information was disclosed during the year before the date the correction was made.

If a patient requests a correction of their personal information, and the registrant is not in agreement, the requested correction must be documented along with the reason for declining to make the correction, in accordance with section 24 of the *Personal Information Protection Act (PIPA)*.

CONFIDENTIALITY

Although the principles of safe and secure maintenance and storage apply both to paper and electronic medical records, there is a requirement for registrants to choose technology that meets expected standards for this purpose. Registrants in private practice may wish to consult with the Office of the Information and Privacy Commissioner for BC for more information about privacy requirements.

Technology

Technology has provided registrants and patients alike with a more efficient way of maintaining and communicating personal health information. There are, however, several ways in which a registrant using modern technology may inadvertently breach patient confidentiality, for example: wireless network connections can pose security problems; emails can be inadvertently sent to the wrong recipient; inappropriate readers may access computer files and erased hard drives may contain private information. The College encourages registrants to capitalize on the advantages that electronic record-keeping and other technological advances have to offer, however, it is always the responsibility of the registrant to ensure that appropriate security provisions have been made.

The decision to disclose patient information collected by a registrant to an electronic health record (EHR) must be a thoughtful one. As the stewards of very sensitive information, registrants need to take care in the level of disclosure as well as the potential impacts of that disclosure. The decision should be evaluated for each instance of an EHR, for benefits and risks to the patient, for the ability to manage patients' wishes in the management of their information, and the rules and processes which govern the actions of information service provider. These conditions need to be re-evaluated when the parameters for the EHR are materially changed (e.g. when additional data elements are added, when the approved uses or access to information is extended).

The College strongly advises that registrants obtain patient consent to use electronic means for communicating personal health information. As part of obtaining consent, registrants must explain to patients the inherent risks of using this form of communication. As a way of recording the patient's express consent, the CMPA has provided a written consent form that can be used whenever possible. Completed consent forms should be included in the patient's medical record.

ENDURING ACCESS

Providing Medical Records to Patients

Patients own the information in their medical records and are entitled to examine and/or receive a copy of their medical record, which includes any records created by other registrants, upon request. Section 29 of the *PIPA* states that a registrant must generally respond to a patient's request for such information within 30 business days.

On the other hand, the *PIPA* also protects from disclosure certain categories of information. In particular, section 23(3) allows registrants 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.

The duty to provide a patient with access to the record may vary according to the applicable law, any relevant agreement with a third party and the consent of the individual. Registrants must ensure that

they know the applicable legislation and rules with respect to a patient's right of access. Registrants are encouraged to seek the guidance of the CMPA, or their legal counsel, if unsure about how to respond to a request for access.

Providing Medical Records to Other Registrants or Health-care Professionals

Where two or more registrants or other health-care professionals are caring for a patient, consent to share medical information is implicit in that sharing of care. That implicit consent to transfer relevant medical information includes documents arising from consultations with diagnostic specialists, mental health, rehabilitation, nursing, and other regulated health-care professionals. A referral of a patient to another registrant or other health-care professional implies such consent and must include transfer of appropriate medical records.

When patients request transfer of their medical records to another registrant or other health-care professional against the advice of the treating registrant, it may be appropriate to provide the copies of those records directly to the patient who can then dispose of them as they wish, subject to any legal restrictions.

It is appropriate to bill patients privately for transferring copies of their medical records; however, transfer of medical records to another treating registrant or hospital for the purpose of continuity of patient care must be done promptly and must never be delayed pending payment. Charges must be in accordance with section 26 of the *CMA Code of Ethics and Professionalism*.

Providing Medical Records to Lawyers, Insurance Providers or Other Third Parties

A registrant must provide a copy of records when provided with a written, dated authorization from the patient or the patient's legal representative specifying the records that are to be provided. Registrants are strongly advised to discuss these issues directly with patients whenever possible. If there is no valid authorization, advise that you have received the request but cannot provide the record until you have received the authorization. Original medical records must never be provided, only copies.

Providing Medical Records to Coroners

Coroners have the responsibility and authority under the *Coroners Act* to obtain copies of the complete medical record. Registrants are advised to consider seeking medical-legal advice from the CMPA when involved in a coroner's investigation.

Retaining a Medical Record

Medical records must be retained for a minimum period of sixteen years from either the date of the last entry or from the age of majority, whichever is later, except as otherwise required by law (section 3-6(2) of the *Bylaws and BC's Limitation Act*).

It is only necessary to retain one original medical record. Once the information has been fully transitioned to an EMR, it is not necessary to retain the original paper record. If only part of the paper record is transitioned to the EMR, then the remainder of the paper record must be retained as part of the original medical record. Scanned copies of paper records must be saved in "read-only" format.

Registrants who wish to use optical character recognition (OCR) technology to convert records into searchable and editable files may do so, but they must retain either the original record or a scanned copy.

Transferring the Original Medical Record

Registrants may transfer original medical records to another registrant, bonded record retention facility, public hospital or health authority within Canada if the receiving registrant, bonded record retention facility, public hospital or health authority has agreed to hold the medical records and provide enduring access to the transferring registrant and the patients.

Registrants who transfer medical records must take reasonable steps to notify patients of the location of their medical record. Registrants are expected to be familiar with other expectations outlined in the *Leaving Practice* practice standard.

Transfer of a medical record must also be documented in a written contract that includes

- the location, safe custody, and protection of confidentiality of the medical records,
- a requirement that the receiving individual or clinic notify the transferring registrant if the location changes,
- the transferring registrant's right of access,
- the patient's right of access, and
- duration of retention and appropriate destruction.

Transferring a Copy of the Medical Record

Registrants may transfer a copy of the patient's medical record in certain circumstances, such as when

- leaving a multi-registrant clinic to relocate in the same community to facilitate enduring registrant access to the medical records of patients who choose to follow, or
- copies of patient records are transferred from one registrant to another, in which case patient consent is implied.

Privacy laws oblige those receiving the records to only access the records of individual patients for the purposes of informing care, or, with explicit consent, to inform adjudicative processes such as insurance claims.

Destroying Medical Records after the Legal Retention Period

Medical records may be destroyed when the legal retention period has expired. Destroying a medical record must be done appropriately using secure methods, such as destruction of medical records by supervised cross-shredding, incineration or by permanent erasure of electronic data/information so that it cannot be reconstructed, including any backup copies of the records.

Retiring/Leaving Practice

Medical records which are still within the legal retention period must be transferred to the custody of another registrant, public hospital or health authority as outlined above, or placed in a safe storage facility if they remain in the custody of the original registrant. Registrants who contract with storage providers for maintenance and storage of their medical records are advised to ensure that there is a written contract for the service that gives patients appropriate access to their records. Registrants relocating or retiring must notify the College of the location of their medical records.