



College of Physicians and Surgeons of British Columbia

Practice Standard

Medical Records

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Related topic(s):	Data Stewardship Framework , Medical Certificates and Other Third Party Reports

A **practice standard** reflects the minimum standard of professional behaviour and ethical conduct on a specific topic or issue expected by the College of all physicians 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.

PREAMBLE

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

COLLEGE'S POSITION

Physicians are reminded that the medical record documents the care provided to the patient. The role of the College is to regulate physicians, but the evolving technology of electronic records requires physicians to be familiar with provincial and federal privacy legislation, technology standards and data-sharing agreements.

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

IMPORTANT RESOURCES

Canadian Medical Protective Association (CMPA) – Electronic Records Handbook

https://oplfrpd5.cmpa-acpm.ca/documents/10179/24937/com_electronic_records_handbook-e.pdf

Canadian Medical Protective Association (CMPA) – Electronic Records 10 Tips to Improve Safety

https://oplfrpd5.cmpa-acpm.ca/documents/10179/301287261/com_electronic_records_poster_letter_size-e.pdf

Doctors of BC – Privacy Toolkit

<https://www.doctorsofbc.ca/resource-centre/physicians/managing-practice/privacy-toolkit>

CONTENT

What is a medical record?

Physicians are required by the Canadian Medical Association's *Code of Ethics*, as well as by the Bylaws made under the *Health Professions Act*, to create a complete and legible record of the medical care they provide to their patients.

Whether in paper or electronic format 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 or other communication with the patient, related to clinical care and follow-up, including documentation of telephone consultations or prescriptions
- copies of operative procedures, consultation reports, discharge summaries and other information created by other physicians or health-care practitioners which is relevant to the patient's medical care

What is legally required to be included in a medical record?

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

- a. be in English,
 - b. explain the reason for the visit,
 - c. provide the history and record of any examination, investigations, diagnoses, treatments, and medications, and
 - d. include a follow-up plan.
2. There is also a statutory requirement to promptly complete the medical records for which the physician is responsible in hospitals or other health-care facilities.
 3. The Medical Services Commission (MSC) of British Columbia defines what it considers an adequate medical record for the purpose of payment. This is detailed in section C.10 of the preamble to the MSC Payment Schedule.

May a medical record be altered?

Physicians 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 physician 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 electronic medical records (EMRs) must be made in a similar fashion using addendums, digital striking-out of text and/or using the “track changes” function found in most word processing programs.

Physicians 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 physician is in agreement, 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 physician is not in agreement, the requested correction must be documented along with the reason for declining to make the correction. (Section 24 of the *Personal Information Protection Act (PIPA)*)

CUSTODY/DATA STEWARDSHIP

Who owns the medical record?

Historically, the paper medical record in a private office was owned by the physician who created it. Medical records in hospitals or other public facilities were owned by the hospital or health authority.

Physicians are now increasingly working in settings where they have limited control over shared electronic medical records (EMRs) or electronic health records (EHRs) with user-based access.

In all situations where a physician 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 physicians and patients will be addressed, including following relocation, retirement or death of the physicians.

In all situations where a physician creating a medical record is not the owner of the clinic and/or of the EMR licence issues of custody, confidentiality and enduring access by individual physicians and patients must be documented in a formal contract with the owners and/or EMR service providers.

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

(Physicians are reminded that Canadian law does not currently address the ownership of medical records by a third party other than a hospital or health authority.)

The College cannot arbitrate ownership of medical records retrospectively.

CONFIDENTIALITY AND STORAGE

What are the legal requirements around confidentiality and storage?

The Canadian Medical Association's *Code of Ethics* (section 31) requires physicians to protect the personal health information of their patients.

Canadian statutes and court decisions have upheld the confidential nature of the patient-physician relationship.

Physicians must keep their medical records in accordance with relevant legislation:

- *Limitation Act* of British Columbia
http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_12013_01
- *Personal Information Protection Act (PIPA)* of British Columbia
http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_03063_01
- *Freedom of Information and Protection of Privacy Act (FOIPPA)* of British Columbia
http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/96165_00
- *Personal Information Protection and Electronic Documents Act* of Canada
<http://laws-lois.justice.gc.ca/eng/acts/P-8.6/index.html>
- *Privacy Act* of Canada
<http://laws-lois.justice.gc.ca/eng/acts/P-21/FullText.html>
- *Access to Information Act* of Canada
<http://laws-lois.justice.gc.ca/eng/acts/A-1/FullText.html>

Physicians 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. There must be protocols in place to address physical security, data sharing with other health-care professionals, backup of electronic data and user-based levels of access.

Although the principles of safe and secure maintenance and storage apply both to paper and electronic medical records, there is a requirement for physicians to choose technology that meets expected standards for this purpose.

Physicians may wish to consult with the Office of the Information and Privacy Commissioner for BC for more information about privacy requirements.

ENDURING ACCESS

Are physicians required to give patients access to or copies of their medical records?

- Patients own the information in their medical records, as affirmed by the Supreme Court of Canada in its decision in *McInerney v. MacDonald* in 1992.
- Subject to bullet point 3, patients are entitled to examine and receive a complete copy of their medical record, which includes any records created by other physicians, and this access must be provided to the patient upon request (usually within 30 business days).
- 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. Physicians must ensure that they know the applicable legislation and rules with respect to a patient's right of access. Physicians are encouraged to seek the guidance of the CMPA, or their legal counsel, if unsure about how to respond to a request for access.

Section 29 of the *Personal Information Protection Act (PIPA)* states that a physician must generally respond to a patient's request for that information within 30 business days.

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.

When must physicians provide medical records to other physicians or health-care practitioners?

Where two or more physicians or other health-care practitioners 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 practitioners. A referral of a patient to another physician implies such consent and must include transfer of appropriate medical records.

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

It is appropriate to bill patients privately for transferring copies of their medical records; however, transfer of medical records to another treating physician 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 16 of the CMA Code of Ethics.**

When must physicians provide medical records to lawyers, insurance providers or other third parties?

A physician 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. Physicians 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.

When must physicians provide medical records to coroners?

Coroners have the responsibility and authority under the *Coroners Act* to obtain copies of the complete medical record. Original medical records must never be provided, only copies. Physicians are advised to consider seeking legal advice when involved in a coroner's investigation.

How long must physicians retain medical records?

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. This retention period was extended by a section 3-6(2) Bylaw amendment reflecting the revision of BC's Limitation Act in June 2013: http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_12013_01

When transitioning to an EMR, how long must physicians keep the paper medical record?

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.

Physicians 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.

Can physicians transfer the original medical record to other physicians?

Physicians may transfer original medical records to another physician if the receiving physician has agreed to take custody of the medical record and provide enduring access to the transferring physician and the patients. Physicians must take reasonable steps to notify patients of the location of their medical record.

Transfer of a medical record to another health-care practitioner 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 physician notify the transferring physician if the location changes
- the transferring physician's right of access
- the patient's right of access
- duration of retention and appropriate destruction

Can physicians transfer the original medical record to a public hospital or health authority?

Physicians may transfer original medical records to a public hospital or health authority if the receiving public hospital or health authority has agreed to take custody of the medical record and provide enduring access to the transferring physician and the patients. Physicians must take reasonable steps to notify patients of the location of their medical record.

Can physicians destroy medical records after the legal retention period?

Medical records may be destroyed when the legal retention period has expired but this must be done appropriately. Physicians must destroy medical records by supervised cross-shredding, incineration or by electronic erasure of data, including any backup copies of the records.

What must physicians do with medical records that are still within the legal retention period when they retire or leave practice?

Medical records which are still within the legal retention period must be transferred to the custody of another physician, public hospital or health authority as outlined above, or placed in a safe storage facility if they remain in the custody of the original physician. Physicians 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. Physicians relocating or retiring must notify the College of the location of their medical records.