

# Ethics corner

## Patient's access to records

SADJ February 2013, Vol 68 no 1 p36 - p37

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A long-standing patient in an established practice requests her dental records and x-rays from the practice receptionist. She was last seen three years ago. Despite an intensive search, the receptionist is unable to locate the file. The patient says that she is entitled by law to have access to her records at any time. The receptionist then informs her that her record might have been destroyed the previous year, since she had not been to the practice for a long time.

### COMMENTARY

A patient's health record is an important medico-legal component of the consultation and the dental practice. The Health Professions Council of South Africa defines a health record "as any relevant record made by a health care practitioner at the time of, or subsequent to a consultation and/or examination or the application of health management. A health record contains the information about the health of an identifiable individual recorded by a health care professional".<sup>1</sup>

The keeping of a health record is compulsory. This is both a professional and a legal requirement.<sup>1-4</sup> A dental record may be used:

- (i) as a basis for planning and maintaining continued patient care;
- (ii) for documentary evidence of the evaluation and diagnosis of the patient's condition; the treatment plan and informed consent; the treatment actually rendered, referrals made; the follow-up care provided; and any and all communications with the patient whether written or verbal;
- (iii) as a record of communication regarding the patient and other health care providers, as well as interested third parties;
- (iv) to protect the legal interests of all parties involved;
- (v) to provide data for continuing dental education and research and
- (vi) for billing, quality assurance, and other administrative functions.<sup>5</sup>

The HPCSA<sup>1</sup> recommends that at a minimum the following information be kept on record:

- personal identifying information about the patient;
- the bio-psycho-social patient history, including allergies and idiosyncrasies;
- time, date and place of each consultation;
- assessment of patient's condition;
- proposed clinical management and treatment given;
- medication and dosage prescribed;
- details of referrals to specialists, if any;
- patient's reaction to treatment, including adverse events;
- test and imaging results;
- times the patient was booked off work and the reasons therefor;
- written proof of informed consent where applicable.

### Ownership of records

A patient's dental records are the physical property of the practitioner. The patient however, has a qualified right to the information contained in those records and to copies thereof. When making copies or duplicate records, the practitioner has the right to charge a "reasonable" fee. Under no circumstances should records be withheld (potentially compromising a patient's care) because of financial, personal or other differences. According to the HPCSA guideline,<sup>1</sup> where records are created as part of the functioning of a private practice, including the original x-rays or ultrasound or scanned images, such records remain the property of the dentist concerned. In cases where patients are required to pay for records and images such patients must be allowed to retain such records – "unless the health care practitioners deem it necessary to retain such records for purpose of monitoring treatment for a given period. Should the patient however require the records and / or images to further or to protect an interest (e.g. such as consulting with another practitioner) he or she must be allowed to obtain the originals for these purposes". Furthermore, as the ownership of records in a multi-disciplinary practice depends on the legal structure of the practice, the governing body of such a multi-disciplinary practice should ensure that the guidelines relating to records are being adhered to.

### Accessibility of records

A dentist shall provide any person of age 12 years and older with a copy or direct access to his or her records on request (Children's Act [Act No. 38 of 2005]).<sup>6</sup> Where the patient is

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under 16 years of age, the parent or legal guardian may make the application for access to the records, but such access should only be given on receipt of written authorisation by the patient (Access to Information Act [Act No. 2 of 2000]).<sup>4</sup>

No dentist shall make information available to any third party without the written authorisation of the patient or a court order, or where non-disclosure of the information would represent a serious threat to public health (National Health Act [Act 61 of 2003]).<sup>2</sup> Unauthorised disclosure of dental records to third parties may be sufficient to support a breach-of-contract claim. The patient's right to privacy and the practitioner's duty to confidentiality weigh heavily in balance with the acknowledged ownership rights of the provider. Patient consent is the primary protection against liability resulting from disclosure of information.<sup>7</sup>

### Retention of records

Practitioners should store records as long as possible, and for not less than six (6) years from the date they became dormant. Many indemnity organisations recommend retention of all records for at least 10 to 12 years or longer. However, a balance must be reached between the costs of (indefinite) retention of records (in terms of space, equipment, etc.) and the occasional case where the practitioners' defence of a case of negligence is handicapped by the absence of records. The value of the record for academic or research purposes, and the risks resulting from the handling or complications of the case, are additional considerations. Furthermore, where there are statutory obligations that prescribe the period for which patient records should be kept, a practitioner must comply with these obligations.<sup>1</sup>

In the case of minors and those patients who are mentally incompetent, health care practitioners should keep the records for a longer period - for minors under the age of 18 years health records should be kept until the minor's 21st birthday, because legally minors have up to three years after they reach the age of 18 years to bring a claim. For mentally incompetent patients the records should be kept for the duration of the patient's lifetime. In terms of the Occupational Health and Safety Act (Act No. 85 of 1993)<sup>8</sup> health records must be kept for a period of 20 years after treatment.

Should a dentist in private practice pass away, his or her estate, which includes the records, would be administered by the executor of the estate.

Scenarios may include

- (i) that the practice is taken over by another practitioner - the executor shall carry over the records to the new practitioner. The new practitioner is obliged to inform all patients in writing regarding the change in ownership and the patient could remain with the new practitioner or request his or her records be transferred to a practitioner of his/her choice;
- (ii) the practice closure - the executor should inform all the patients in writing and transfer those records to other practitioners requested by individual patients. The remaining files shall be kept in safe keeping by the executor for a period of at least 12 months with full authority to further deal with the files as he or she may deem

appropriate, provided the provisions of the rules on professional confidentiality are observed.

In the event of a dentist in private practice who decides on closing his or her practice for whatever reason, the practitioner shall timeously inform in writing all his/her patients as follows:

- that the practice is being closed from a specified date;
- that requests could be made for records to be transferred to other practitioners of their choice;
- that after the date concerned, the records would be in safe-keeping for a period of 12 months by an identified person or institution with full authority to further deal with the files as he or she deem appropriate, provided the provisions of the rules on professional confidentiality are observed.

### Concluding remarks

This case scenario highlights the importance of the ownership, access to and retention of health records. The Promotion of Access to Information Act (Act No. 2 of 2000)<sup>4</sup> grants individuals right of access to information that is necessary for the protection of their rights. This means that maintenance of proper and complete records is not only an ethical obligation but also a legal obligation.

**Declaration:** No conflict of interest declared.

### References

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