

'Patient's Record' Not Sacrosanct, Ethicist Says

BY CHRISTINE KILGORE
Contributing Writer

The long-held perception that medical records should never be altered at a patient's request is quickly becoming erroneous, according to health lawyer and ethicist George Annas.

"We can delete (items from the record), as long as we note that something has been deleted and who did it," said Mr. Annas, chairman of the department of health law, bioethics, and human rights at Boston University.

In a Webcast sponsored by the National Institutes of Health, he braced physicians for a future in which patients will increasingly ask them to correct, delete, or change items in the medical record that are either errors or items that they are concerned may pose harm to them.

"The real reason patients don't ask to make deletions [now] is because most people don't look at their records," he said. But with the advent of the Health Insurance Portability and Accountability Act (HIPAA), "now there's a federal right of access to medical records."

Moreover, President Bush's current emphasis on electronic medical records (EMRs) embraces "the idea that patients should be in control," and patients are generally much more concerned about the content of electronic records than paper records, said Mr. Annas, who is also professor of sociomedical sciences and community medicine at Boston University.

The Bush administration has not addressed, in the context of its EMR proposals, whether "a patient [should] be able to delete accurate, factual information [from medical records]," he said.

The bottom line, however, is that "we're in the process of radically changing the medical record ... into the patient's record," Mr. Annas said.

There are "lots of mistakes in medical records," making it likely that many changes made in the future will address actual errors. Debate about other types of al-

terations will ensue, but under this new climate "you could argue that patients should be able to change anything," he told the physicians.

HIPAA addresses the issue of corrections to medical records, saying that "patients have a right to request corrections in the record, and if there's no response, they can write their own letter and have it added," Mr. Annas explained.

The physicians who attended the NIH session reviewed a case in which a patient presented at the National Institute of Neurological Diseases and Stroke to enroll in a sleep study. He had a chief complaint of insomnia but, during a visit with an NIH clinical social worker, he also reported symptoms of severe depression and a history of drug use.

The day after the social worker evaluated the 37-year-old unemployed man, he requested that the information entered in the computerized record be deleted. "He was vague in his request, but he was concerned that someone would illegally obtain access ... and use [the information] against him," said Elaine Chase, of the social work department at the NIH Clinical Center, Bethesda, Md.

Mr. Annas said that if he were the provider faced with this request, he would agree to delete the information most disconcerting to the patient. "And if he wanted it out of a paper record, I'd still say yes," though, in the interest of research integrity, the patient should then be excluded from the NIH study, he said.

Overall, physicians "take the record too seriously" and, although questions remain, they are going to have to be more willing to consider patient requests to alter the medical records, Mr. Annas told this newspaper.

Theoretically, at least, the doctor and patient should review the content of the record before the visit ends, he said.

"It makes sense that when you take a history, you should go over it with the patient and ask, 'Is this what you tell me? Is it right?'" ■

Most Group Practices Still Use Paper Records, Survey Shows

BY MARY ELLEN SCHNEIDER
Senior Writer

Most group practices are still using paper medical records and charts, according to preliminary results from a survey by the Medical Group Management Association.

"Paper is still the dominant mode of data collection," William F. Jessee, M.D., president and CEO of the Medical Group Management Association (MGMA) said in a Webcast sponsored by the group.

But the scale is tipping, he said. About 20% of group practices report that they have an electronic health record of some kind.

In addition, 8% have a dictation and transcription system for physician notes, combined with a document imaging management system for information received on paper. "We're seeing a steady movement toward a paperless office," Dr. Jessee said.

The preliminary findings are based on responses from about 1,000 group practices that responded to an electronic

questionnaire. The second stage of the survey will include mailing more than 16,000 printed questionnaires to a sample of group practices across the country. Complete results from the survey are expected this spring.

The survey is part of a contract from the Agency for Healthcare Research and Quality to MGMA's Center for Research and the University of Minnesota.

The purpose of the contract is to provide a baseline that describes the use of new information technologies in medical groups.

Some of the challenges physicians face in making the transition to an electronic health record include knowing which product to buy, how to go about buying it, and how to implement the system, said David Brailer, M.D., national health information technology coordinator for the Department of Health and Human Services.

"Many groups stumble at every point along the way," Dr. Brailer said.

The private industry is working to create a voluntary certification process for electronic health record products. ■

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