Electronic Records Put New Focus on Accuracy

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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. 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 alterations 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.

Those 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 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.

He offered his verdict on the case example after a free-ranging discussion in which some physicians voiced concern that a move from "physician's record" to "patient's record" would hinder communication among providers.

"Part of the purpose [of the medical record] is it helps individuals plan care," said one physician. "So from this standpoint, you can't just delete things. … Or if there's going to be a patient medical record, maybe there needs to be another record [for providers]," she said.

It's true, Mr. Annas said, that "defense attorneys still say today that your best defense is a complete medical record."

Still, physicians, overall, "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 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're telling me? Is it right?' " ■