HASLAM'S VIEW



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Patients should have access to their records

I HATE TO THINK HOW LONG AGO IT ALL HAPPENED, BUT I'M GUESSING IT WAS SOME 30 years. It's not that I remember everything I did that long ago, but the occasional situation remains unforgettable, and this was one.

I was doing a fairly routine surgery, in which 20 patients had expected me to make some sort of sense of what was going on in their lives. One of these patients was a young woman whose problem I don't recall, but as she was getting up to leave I clearly remember her asking, 'Oh, could I possibly have a look at my medical records?'

I passed them to her. She looked at the envelope, weighed them in her hand, and then – without opening them or reading a word, she passed them back.

'That's fine,' she said. 'I had a bet with some friends in the pub last night that you'd say yes!'

I think I felt flattered. No – I know I felt flattered. This seemed like a rather crude but reasonably effective assessment of patient-centredness – something that these days might take a 20-page questionnaire, 360 ° assessments, and supportive feedback.

Even that long ago I remember thinking that our attitudes to medical records were rather curious. After all, whose body is it anyway? The blood test results are carried out on the patient's blood, so surely the patient should be able to know what they say. The letters are about the patient, so surely the patient should be able to read them. The records are about the patient. The patient should be able to know.

At the same time I also do understand that some clinicians find this tricky, almost a step too far. Some doctors, particularly in general practice, use the records to record hypotheses rather than facts. They worry that these hypotheses, some of which may be highly unlikely, will upset and worry rather than inform.

'The letters are about the patient, so surely the patient should be able to read them'

Others, again particularly in general practice, may have recorded all manner of life information, perhaps about other family members that was always designed to be confidential. But the world has changed, and the evidence is clear, not just morally and ethically, that patients should expect to have access to their records. Whose records are they anyway?

And the digital revolution has made this even more logical. For the life of me, I wish I could understand why so few practices are able to email referral letters to their local hospitals. We all, and I suspect there are precious few exceptions, use email in every other aspect of our lives, so why not in healthcare? As the vast majority of our patients use email too, there is no reason why they can't be copied in to the correspondence. There are zero cost implications, and huge potential benefits – not least giving patients the chance to correct us when our records are incorrect.

Of course there are security and confidentiality issues, but they are far from insuperable. If we are prepared to use internet banking, then why not email referral on an inguinal hernia?

And at least computer records have rendered our notes legible. Looking back at some of the handwritten notes on Lloyd George envelope cards that still sit in so many medical records, it's a miracle that any of us ever had a clue what was going on.

But there is one serious disadvantage of computerised records. When asked for a summary it is wonderfully easy to generate a summary of the records that fails to be a summary of the patient. And when we are our patient's advocate, that matters.

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