An Electronic Health Record for Scotland: Legal Problems Regarding Access and Maintenance

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Four models for an EHR

- **The Personal EHR**
  - patient as the chief manager and custodian of the record

- **The Shared EHR**
  - responsibility between patient and GP

- **The Trustee Model**
  - patients enter into contract with trustee, to keep and control the EHR

- **The Interoperable EHR**
  - Electronic equivalent to current system
Confidentiality issues

- **Personal EHR** – obviously less confidentiality problems, but: patients might approve access without appreciating wider privacy implications
- **Shared EHR** – depends where final responsibility lies – the more patient involvement, the less confidentiality problems
- **Trustee EHR** – patient decides what data will be transferred to trustee. But: trustee can break contract and process data → depend on the trustworthiness of the fiduciary
- **Interoperable EHR** – greatest risk of breaches of confidentiality as no patient involvement – stringent and enforceable access policy required
Liability issues

• Currently: error in the medical records leads to negative development in patient’s health, healthcare professionals responsible for error and subsequent treatment will be held liable

• larger patient involvement in creating and controlling the record may shift this liability

• First, liability will need to be explained, as UK system is fairly complex:
Liability in UK law

- Liability = non-contractual civil wrong.
- Main requirement: negligence
- Negligence has three requirements:
  - healthcare professional owes patient a duty of care
  - Breach of this duty has occurred (standard of treatment was below the ordinary skill of an ordinary man exercising this particular art)
  - Causation can be proven, (sub-standard treatment led to a legally-recognised harm)
- Duty of care has three requirements:
  - Risk of harm is foreseeable
  - Sufficient proximity between healthcare professional and patient
  - Fair, just and reasonable to impose the duty of care.
Liability continued

• If patients are responsible for maintaining the record and error leads to wrong treatment – shift of liability?

• Negligence? duty of care must exist – not in doubt.

• Breach of this duty – also unquestionable. (only the actual treatment to be considered – not record entry as doctors shouldn’t monitor this)
Liability continued

• Causation = problematic
  – wrong treatment must have led to patient suffering a legally recognised harm.
  – prima facie: wrong treatment led to patient being harmed.
  – But: When and where do we need to start looking for causation?
    • At the beginning of the treatment?
    • The hospital doctor consulting the records?
    • Won’t that lead further back to where the mistake in the entry occurred?
  – That line of reasoning → the rather astonishing conclusion that the patient herself must be held liable for the harm she suffered.
Liability continued

• Should hospital doctor check record? Would it be negligent to proceed on basis of record alone? System would lose its efficiency.

• If record monitored immediately after details are entered – health care professionals liable for not spotting mistake

• If record monitored only in intervals or just before use, maybe no check in emergency
Conclusion

• Several factors to recommend one model over another
  – Logistics – which model is most technically feasible
  – Time management issue – if patients have a larger role – will monitoring be possible
  – Is it in the patients interest to have greater influence over the record
• Application of IT to healthcare accompanied by legal and ethical problems
• Questions should ideally be answered before EHR converts from theory to practice in Scotland