

Comparison of Arrangements Manually Operated Health Records California and the Republic of Slovenia

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Abstract

Theoretical background: health documentation has since its beginnings in ancient Egypt, that 3000 years BC, a very varied. Even the ancient Greeks were writing the symptoms and treatments. After the year 1750 were in European hospitals to develop a systematic and objective records of diseases. The expansion of science is meant better value accurate medical records that are already in the sixteenth century as a result of the book cases, called Casebook, following the example of the legal profession. Methods: based on the analysis of foreign and domestic law have devised a comparison of Slovenian legal system for health records and the California legal act and seek deficiencies in domestic legislation in the field of management of health records. Results: comparison of domestic laws and foreign legal act, says the legal void in domestic law and hence disorderly conduct medical documentation. Discussion: keeping health records throughout history, with the development of science and research is changing. For the exercise of patients' rights and their security, based on the health records, managers need accurate guidance. Conclusion: to realization the patient's rights and the rights of the operator documentation is very important. Important is also a record and storage of documents, which allows you to search documents.

Keywords

health records, documentation, preservation of documents

1. Introduction

Theoretical background: documentation is from the original description of the disease is changing in the description of the health status of an individual. Health records, with the development of science, nursing, physiotherapy and other branches of health activity record of disease signs and health treatment increasingly poured out on various documents. These documents together form the health records. In parallel with the development of patients' rights in healthcare documents also appear to represent an expression of his will. Methods: the analysis Californian legal act Legal medical record standard and the Medical Services Act'm looking shovel shortcomings in the legal system and highlighted areas of health records need to be regulated under domestic law. Results: domestic legislation does not provide for keeping health records on the way to the documents, consisting recorded. Discussion: health records

protects the rights of patients only if it is carefully managed, if the changes are documented, if the documents are protected from loss, theft and forgery.

2. The History of Medical Documentation

Known Casebooks authors formal and Napier (Note 1) are therefore considered the predecessor of modern nursing documentation (Note 2). Keeping health records in the late nineteenth century meant the possibility doctor analyzing data about the individual. The need for systematic collection of data is dictated by hospitals to keep medical records, even if the operators did not have standards of patient information should be collected. Individual doctors are data write in their own way, which were verifiable and compare the results almost impossible or at least difficult. The beginning of the twentieth century was brought to the hospital the expansion of education, which has increased the need for standardizing medical records (Note 3). In parallel with education, in health care began as research for which the medical record often basic matter. Operators of health records, but still do not have specific detailed legal frameworks, management of health records.

3. Documentation

Already in 1895, resulting Documentation, which has entered the processing of documents discipline of collecting and processing on the basis of classification and controlled distribution of documents of all kinds. In Slovenia, a request for classifying documents based on classification plan introduced only international standard ISO 15489 in 2001. On this basis, the 2005 Decree on Administrative Operations with the classification of documents. For health, it was necessary to adjust the classification scheme. Therefore, I am prepared in 2009 the Psychiatric Clinic Ljubljana, with the assistance of the Archives of the Republic of Slovenia and the Legal Service prepared the Classification Plan.

4. The Purpose of Health Documentation

The purpose of health documentation is therefore in the history of mankind and in the history of the file itself is changing. Clinical documentation is much wider concept than the old concept of medical documentation, because her information is recorded only doctor. Legal otherwise acting physician as the sole person responsible for medical records, but in practice in many institutions, only one of the creators of the records as documents managed health administrators or in the private sector nurses. Health records are important legal document giving rise to the state of health or disease, planned and carried out medical treatment, resulting in the judicial process is often the only source of evidence. At the same time it represents unregulated space in three ways:

- Sukcesiven emergence of medical documentation required in connection with the preservation of the rule set out a critical moment. Clinical documentation is created from birth until death of the person to whom it relates;
- History of the disease also contains records on other family members, which may affect both the

reputation and dignity of the individual and indirectly also to the dignity and reputation of his descendants and relatives;

- The content of medical records, the records held by the operator is not created (tertiary document).

It is therefore necessary to define eligibility for obtaining these documents;

- Health records represent records of various health professionals on paper or in electronic form, images in digital form, photography, digital images, computerized tests, as well as a letter or dictation medical content. Document security and the opportunity to explore allow only legally defined content management and defined health records.

Knowing the human body is the most intimate area of human privacy (Note 4), lead to the conclusion that the records contain medical records maximum details of the human body and the most sensitive data. With the creation of the legal significance of health records, there is a need for its targeted management. The first codification of the rule of an important collection of documents suggested Weed in 1968 (Note 5). Later, many authors have created criteria required volume of content, which was dependent on the meaning of information. The legal relevance of the information is so varied volumes and forms of health documentation (Note 6). Today's health records, according to Flis most important cornerstone in the process of health treatment. For this reason, is in countries with a well-protected human rights conduct medical documentation specifically defined by law. Flis health records separates the primary document that was created by direct contact between doctors and patients, as well as a secondary document, which is the product of several analyzes of primary documents. In addition to these two they appear in the collection of the tertiary documents, which represent all the Certificates, and other documents of other artists, which relate to the health of an individual. In conjunction with the records medical records are a legal and ethical standpoint all important accurate records of medical records, which increases the traceability and management controls. Well-managed health documentation is exemplary doctor and his diligence at work. In addition, the foundation of good treatment and legal certainty for patients and health care treatment. Detailed chronological records reflect important developments, which makes health records also important forensic document. Good practice of protecting health records arising from a legal act of the California Legal medical record standard. The legal provision is regarded health records as a hybrid record, since it is located in separate locations, as well as in paper and electronic form part. The regulation provides inter alia that the medical records to identify each page of a multipage document with full name and surname of the patient and the uniform number of the health card. Implementation of this provision prevents intentional or unintentional replacement parts medical files of different people. It is therefore not permitted from health records, to photocopy individual pages or send it by fax. It is important for the privacy of third parties, it is determined that the records of third parties in the medical documentation of the individual considered as an integral part of medical documentation and is subject to disclosure to the patient or the court. In the privacy of third parties in connection with the owners of health data is not protected. The regulation contains important operational provision which imposes a duty of the

contractor on completion of health treatment to complete health records in one day. Completion health records significant impact on the claims for compensation and the possibility to continue treatment for another. Access to health information is essential to define in operational terms—in everyday use. Also in this part of the Legal medical record standard foresees restrictions, through a review committee, quality management and documentation insights. Transparency processing of health data is a recording of requests for access or obtain photocopies of the information system. This rule must be followed by each issue's health files from the archive. Such records can therefore be transparent and immediate response to an individual request for the list of all those who were familiar with health data. That regulation also regulates the traceability insights, making each health professional access to the information system used only a single identification card. Preservation of health records is very important, but completely neglected in the Slovenian legal system. Under the California Legal medical record standard provision, therefore, the original health records from the facilities manager should not be removed, except by court order or as otherwise required by law. The doctor, therefore, at the service of the operator not to dispose in a public place original health documentation. This must be because of privacy at all times kept in a room and under conditions which prevent loss, destruction, alteration. Special attention is given to provision mental health documentation documentation are dependent on alcohol or people who abuse illicit drugs, child abuse, data on HIV-positive persons. Even more important for the security of documents, medical records, the obligation to keep the chronology of health documents, wherein Base is not allowed to delete anything, nor remove the documents. In order to avoid possible errors due to illegible writing and therefore misinterpretation of the text regulation imposes obligations on the legibility and clarity of the author records the record. In the case of electronically controlled health documentation is printed for the content provided clarity records. Also, the threat of possible errors due to illegibility is a big reason for keeping health records, including prescriptions electronically. Comparison with that regulation indicates that Slovenian legislation on health documentation provides only that the doctor on the basis of Article 50 *Medical Practitioners Act* (ZZdrS) (Note 7) obliged to keep records of the health status and other records provided by law. Neither said nor any other law does not give detailed instructions for managing health records and privacy protection in it. Therefore, the demonstration California law to conclude the necessity of a well-ordered an implementing regulation in Slovenian legislation. Tracking insights is the provision on the use of professional cards. In Slovenian law is not prohibited sharing of professional cards, to ensure reliable traceability insights. Even removing medical documentation from the premises of the operator in Slovenian law is not prohibited, nor defined as a felony, which represents one of the greatest threats to privacy. Necessary content formats and way of handling health records represent a legal vacuum in Slovenian law. Legally it is not determined a safe place where you can use this. For legal and technical security are also of great importance legibility of the recordings and the signature of the artist. In addition, the medical records of domestic law does not provide authentication, so the future legislation will replace the invalid record due to poor legibility of compulsory direct inputting data into electronic

form. Part of the health documentation required for the preparation of therapy, it is the temperature sheet must always be available to nursing staff. Inventory disease should always remain in the same room available as a reading room material. The scope of health documentation is not defined, therefore, it raises the question of what constitutes health documentation and legal importance, which partly responsible reasoning of court rulings shown below. In foreign jurisprudence Clark in conjunction with *Boyd v. US* notes that health records are also health card, which allows you to read health records and electronic health record without printing. The need for a holistic approach to health documentation also notes Information Commissioner RS, requiring records of documents within health records, which reduces the possibility of abuse. The traceability of the examination procedure only from the integrity of health records, which is legally very important collection. It contains all legally relevant facts as a basis for judicial review of the conduct of health, personnel and the development of diseases such as damage to health. Greater legal value of records provides a chronological and substantive accuracy of the records. The great importance of accurate records is also confirmed by the ECHR in the grounds of the decision in the case *McGlinchey and others v. The United Kingdom*. Changes in health status, causes and consequences are transparent in records in medical documentation. They serve primarily to clarify the adequacy of the treatment, which may be an indication of the cause of death, confirming the interpretation of the judicial decisions of the Supreme Court of Alabama, in the case of *Ex parte Northwest Alabama Mental Health Center v. Skip, Newman*. An expert in making decisions in addition to doctor's record of great help to the detailed records of nurses within the health records. From domestic case law is clear that health records are important legal document in court and redress procedures. For judicial review are in addition to accurate health records to remain relevant organization and management of precise chronological history of health and disease, as is clear from the reasoning of the decision of the Higher Court in Ljubljana in case *I Cp 2835/2009*.

5. Debate

Health documentation in the Republic of Slovenia does not have its legislation nor regulation, which would dictate keeping a consistently documenting the process of acquisition and recovery of health records from the archive and in the archive, maintaining a list of the contents, document processing health documents. Therefore, the health documentation does not serve the patient to exercise their rights in the event of loss or theft. Still healthcare professionals uncontrolled transfer paper medical records, both within the institution and outside and unattended photocopied.

Health documentation is an important document on the basis of which the implementation of the rights of individuals, and therefore requires a special law, which was already provided for in Article 54 of the Law on Health Care (ZZDej-UPB2) and Article 50 of the Law on doctors (ZZdrS-UPB3). Archiving and concern for the safe treatment, which starts in the reception office when the health documentation in place. Operators of health documentation (medical and non-medical institutions) but for the everyday work need practical guidance in the form of an implementing regulation. Such

regulation-regulation, governing the management of this dossier and the entire processing of health data archiving and administered by the disposal of the archives. Also, due to the absence of a legal document classification plan in healthcare is not alive. The Ministry of Health in 2015 prepared a single classification plan for health institutions, but does not reach the scope of work of all health care institutions. Above all, no legal basis to classification scheme introduced practice.

The big problem archives, both in the business, such as health documents is also poor educational structure of employees. In the the Republic of Slovenia employed workers who, for various reasons (disability or worse efficiency) seconded to work in the health archives. These workers do not meet the minimum legal requirements of the legislation on archives. Workers do not have a high school or have inadequate education (only primary school, as well as an electrician, a health worker, chef, gardening techniques) did not perform education for archivists, their work is therefore not conducted in a manner that would documentary material safely and properly, saved. The mentality of managers is still, in order to work in the archives suited everyone and education is unnecessary. Operators of health information must necessarily allocate more money to training workers, both in the main office where they begin documenting, classifying and archiving, as well as in the archives of health documentation. Only skilled workers will be able to deal with documents, preserving important data, processed documents in accordance with the law, duly cataloged and thus allow retrieval of documents when the beneficiaries will be needed.

The legislature must operator health records also impose a fundamental principle of keeping documentary material and archives. These fundamental principles require: comprehensive view of health problem, an analysis of the benefits associated with planned treatment, analysis of side and adverse events, record the explanatory duty with the presentation of the risks that have been presented to the patient and the patient's decision on this basis, which also take part responsibility.

6. Conclusion

I note that there is no uniform legal provision how long the need to protect a specific type of health records and when—if ever—to destroy it. Also, legal provisions, how to protect the data of third parties in the medical documentation of the individual, it is not. The lack of content and lack of health documentation contents list represents the unregulated area. It is therefore applies: “*quod non est and actis, and non est mundo*” (Note 8). Defined, documents that are an integral part of the health records constitutes a legal problem due to non-uniform designations at the national level. Treatment of the documents must be uniform in future legislation at the state level, along the lines of the Anglo-Saxon legal system. Despite the age of computerization is due to the growing importance of paper health records for the exercise of individual rights still absolutely legal protection manually kept records since health records are still largely kept manually. Selected manually-controlled health records represent archival documents. Within such archival documents will require legal protection of privacy in the future, making this area the legislature should not be ignored.

References

- Aamot et al. (2013). *BMC Medical Informatics and Decision Making 2013*. Retrieved June 10, 2015, from <http://www.biomedcentral.com/1472-6947/13/75>
- BRANDENBURGISCHES ARCHIVGESETZGesetz über die Sicherung und Nutzung von öffentlichem Archivgut im Land Brandenburg z dne. (1994). *Zakona o ohranjanju in uporabi javnega arhivskega gradiva v državi Brandenburg*. Retrieved June 30, 2014, from http://www.bravors.brandenburg.de/sixcms/detail.php?gsid=land_bb_bravors_01.c.15130.de
- Decision Administrative Court of Republica Slovenia in case III U 69/2011*. (2011). Retrieved March 1, 2016, from http://www.sodisce.si/znanje/sodna_praksa/upravno_sodisce_rs/2010040815259303/
- Decision Bundesgerichtshof (Federal Court of Germany) in case I ZR 277/03*. (2016). Retrieved March 10, 2016, from <http://www.dejure.org/dienste/vernetzung/rechtsprechung?Text=I%20ZR%20277/03>
- Decision of High court of Ljubljana in case I Cp 3514/2005*. (2005). Retrieved March 10, 2016, from <http://www.sodisce.si/vislj/odlocitve/36655/>
- Dujič, S. (1995). *Personal information—What does it and how widely to interpretation*.
- Etelke, H. (2011). *Korpič to the decision of the Constitutional Court*. Retrieved March 2, 2016, from <http://www.odlocitve.us-rs.si/sl/odlocitev/US29402>
- Gauthey, M. (2013). La protection de la Sante et du secret medical von de pair. *Bulletin des medicinas suisses*, 94(34). Retrieved June 18, 2015, from http://www.bullmed.ch/uploads/eps/fulltext_documents/ issues/BMS-Fulltext-2013-34-fr.pdf
- Health Services Act (ZZDej-UPB2) Official Gazette of RS*. (2005).
- Medical Practitioners Act (official consolidated text) (ZZdrS UPB 3) Official Gazette of RS*. (n.d.).
- Monreale, A., Rinzivillo, S., Pratesi, F., Giannotti, F., & Pedreschi, D. (2014). *Privacy-by-design in big data analytics and social mining*. EPJ Data Science 2014. Retrieved March 2, 2015, from <http://www.epjdatascience.com/content/3/1/10>
- Neubauer, T., & Heurix, J. (2011). A methodology for the pseudonymization of medical data. V: *Elselvier International Journal of Medical Informatics*, 3(3). Retrieved June 10, 2015, from <http://www.sciencedirect.com/science/article/pii/S1386505610002042>
- Pagliari, C. (2015). Understanding the Evolving Role of the Personal Health Record. *Computers in Biology and Medicine*, 2. Retrieved June 17, 2015, from http://www.researchgate.net/publication/272792644_Understanding_the_Evolving_Role_of_the_Personal_Health_Record
- Protection of Documents and Archives and Archival Institutions Act (ZVDAGA) Official Gazette of RS*. (n.d.).
- PUBLIC Opinion Surveys Survey of Canadians on Privacy-Related Issues Final Report*. (2013). Retrieved March 10, 2015, from http://www.priv.gc.ca/information/por-rop/2013/por_2013_01_e.pdf

Riordan, F. et al. (2015). Patient and public attitudes towards informed consent models and levels of awareness of Electronic Health Records in the UK. *V: Elsevier International journal of medical informatics*, 8(4), 237-247. <http://dx.doi.org/10.1016/j.ijmedinf.2015.01.008>

The reasons for the decision by the Supreme Court in the case. No. X Ips 474/2010. (n.d.).

The reasons for the decision by the Supreme Court in the case. No. U-I-70/12-7(e-vir). (n.d.).

Zoughailech, Y. (2014). *L'informatisation Des Donnees De Sante*. Universite Paris Descartes.

Notes

Note 1. A digital edition of Simon Forman's & Richard Napier's medical records 1596-1634.

Note 2. History of medical record-keeping, 2011.

Note 3. Look at O. Banner, 2012.

Note 4. Look at P. Leach, 2005, p. 315.

Note 5. Look at L. Weed, 1968.

Note 6. Look at I. R. MC Whinney, 1989, p. 378.

Note 7. Medical Practitioners Act (official consolidated text) Official Gazette of RS, no. 72/06.

Note 8. English: "Which is not in the files, this is not the world".