



**MEDICAL AND DENTAL PROFESSIONS BOARD  
OF THE  
HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA**

**GUIDELINES WITH REGARD TO THE RECORDS OF PATIENTS**

**BOOKLET 7**

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# MEDICAL AND DENTAL PROFESSIONS BOARD

## GUIDELINES WITH REGARD TO THE RECORDS OF PATIENTS

These guidelines are applicable to medical practitioners and dentists in private practice (including managed health care organisations), as well as to those in the employment of the public service.

### **1 COMPULSORY KEEPING OF RECORDS**

Medical practitioners and dentists shall enter and maintain at least the following information for each patient consulted:

- a. Personal particulars of the patient.
- b. Biopsychosocial history of the patient, including allergies and idiosyncrasies.
- c. The time, dates and place of every consultation.
- d. The assessment of the patient's condition.
- e. The proposed clinical management of the patient.
- f. The medication and dosage prescribed.
- g. Referral to specialists, if any.
- h. The patient's reaction to treatment or medication, including adverse effects.
- i. Test results.
- j. Imaging investigation results.
- k. Information on the times that the patient was booked off from work and the relevant reasons.
- l. Written proof of informed consent, where applicable.

Records shall be kept in indelible black ink and erasure fluid shall not be used.

### **2 ALTERATION OF RECORDS**

- a. No information or entry may be removed from a record.
- b. An error or incorrect entry discovered in the record may be corrected by deleting it with black ink and correcting it. The date of change must be entered and the correction must be signed in full. The original record must remain intact and fully legible.
- c. Additional entries added at a later date must be dated and signed in full.
- d. The reason for the amendment and or error shall also be indicated on the record.

### **3 RETENTION OF RECORDS**

- a. Records shall be stored in a safe place and if they are in electronic format, safeguarded by passwords. Practitioners should satisfy themselves that they are informed of the Board's guidelines with regard to the retention of patient records on computer compact discs.

- b. Records shall be stored for a period of not less than six (6) years as from the date they became dormant. In the case of minors and those patients who are *non compos mentis*, medical practitioners and dentists should use their own discretion whether the records concerned should be kept for a longer period.
- c. Notwithstanding the provisions in paragraph b. above, the records kept in a provincial hospital or clinic shall only be destroyed if such destruction is authorised by the Deputy Director-General concerned.

<b>4</b>	<b>OWNERSHIP OF RECORDS</b>
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- a. Where records are created as part of the functioning of a private practice, the records belong to the medical practitioner or dentist responsible for the care of the patient.
- b. The records, including specialist reports, X-ray films and pathology reports prepared in connection with the treatment of any patients at a provincial hospital, are the property of the Health Department and are to be filed at such hospital.
- c. As the ownership of records in a multi-disciplinary practice depends on the legal structure of the practice, the governing body of such multi-disciplinary practice should ensure that these guidelines relating to records are being adhered to.
- d. Should a medical practitioner or dentist in private practice (both in solo practice and in partnership) pass away, his or her estate, which includes the records, would be administered by the executor of the estate.
- e. Should the practice be taken over by another practitioner, the executor shall carry over the records to the new practitioner. The new practitioner is obliged to inform all the patients in writing regarding the change in ownership and that the patient could remain with the new practitioner or could request that his or her records be transferred to another practitioner of his or her choice.
- f. Should the practice not be taken over by another practitioner, the executor should inform all the patients in writing accordingly and transfer those records to other practitioners as requested by individual patients. The remaining files shall be kept in safe keeping by the executor for a period of at least twelve (12) months with full authority to further deal with the files as he or she may deem appropriate, provided the provisions of the rules on professional confidentiality are observed.
- g. It should be noted that certain partnership agreements may make specific provision for the management of a deceased partner's share in the partnership which would include the records.
- h. In the event of a medical practitioner or dentist in private practice who decides on closing his or her practice for whatever reason, the practitioner shall timeously inform in writing all his or her patients of the following, namely –
  - i. that the practice is being closed as from a certain date;
  - ii. that requests could be made that records be transferred to other practitioners of their choice;
  - iii. that after the date concerned, the records would be kept in safe keeping for a period of at least twelve (12) months by an identified person or institution (an

identified person or institution in this sense means a responsible person such as the practitioner's attorney, accountant or bank manager) with full authority to further deal with the files as he or she may deem appropriate, provided the provisions of the rules on professional confidentiality are observed.

- i. It should be noted that certain partnership agreements may make specific provision for the management of an ex-partner's share in the partnership which would include the records.

<b>5</b>	<b>ACCESSIBILITY TO RECORDS</b>
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- a. A medical practitioner or dentist shall provide any person of age 16 years or older with a copy or abstract or direct access to his or her own records on request in terms of the Promotion of Access to Information Act, 2000 (Act No. 2 of 2000).
- b. Where the patient is under the age of 16 years, the parent or legal guardian may make the application for access to the records.
- c. Information about the termination of pregnancy may not be divulged to any party, except the patient herself, regardless of the age of the patient.
- d. No medical practitioner or dentist shall make information available to a parent or legal guardian regarding a patient who is over the age of 14 years, but under the age of 16 years without written authorisation of that patient.
- e. No medical practitioner or dentist shall make information available to any third party without the written authorisation of the patient or his or her legal representative.
- f. A medical practitioner or dentist may make available the records to a third party without the written authorisation of the patient or his or her legal representative under the following circumstances:
  - i. Where a medical practitioner or dentist is a witness in a trial between a patient and another party or where a patient has instituted action in court against a medical practitioner or dentist and is ordered to testify on the patient's medical condition or to produce the records and he or she should request that such testimony be given *in camera* in accordance with section 153(1) of the Criminal Procedure Act, 1977 (Act No. 51 of 1977).
  - ii. Where a patient sues a medical practitioner or dentist and the latter testifies in his or her own defence.
  - iii. Where the Medical and Dental Professions Board has instituted disciplinary proceedings and the medical practitioner or dentist has to answer to a charge or defends himself or herself.
  - iv. Where the medical practitioner or dentist is under a statutory obligation to disclose certain medical facts, e.g. reporting a notifiable disease or in terms of the Child Care Act, 1983 (Act No. 74 of 1983), reporting any case of suspected child abuse.
  - v. In the event where the ailment of a patient becomes known to a medical practitioner or dentist and the nature thereof is such that the medical practitioner or dentist concerned is of the opinion that the information ought to

be divulged, in the interest of the public at large. Before the information is divulged the relevant information shall be given to the patient and voluntary authorisation shall be sought from the patient.

- g. In provincial hospitals the records shall be kept under the care and control of the superintendent. Access to such records shall be subject to compliance with such conditions as may be approved by the superintendent.

<b>6</b>	<b>RETENTION OF PATIENT RECORDS ON CD-ROM</b>
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- a. Storage of clinical records on computer compact disc (CD-ROM) would be permissible, provided that protective measures are in place.
- b. Protective measures referred to in paragraph a. would entail that –
- i. only CD-ROM technology is used, i.e. designed to record a CD once only so that old information cannot be overwritten but new information can be added;
  - ii. all clinical records stored on computer compact disc and copies thereof are to be encrypted and protected by a password in order to prevent unauthorised persons to have access to such information;
  - iii. a copy of the CD-ROM to be used in the practitioner's rooms will be in a read-only format;
  - iv. a back-up copy of the said compact disc must be kept and be stored in a physically different site in order that the two discs could be compared in the case of any suspicion of tampering;
  - v. effective safeguards against unauthorised use or retransmission of confidential patient information to be assured before such information was entered on the computer disc. The right of the patient to privacy, security and confidentiality should be protected at all times.