Patient requests to alter the medical record

Dear Dr Dermatoethicist: **During a recent visit, a patient with chronic cutaneous lupus mentioned that he occasionally gets blurry vision, which gave me pause about recommending antimalarials without a thorough evaluation by ophthalmology. However, he asked that I not document the symptom in his medical record out of fear of losing his job as a forklift operator. What is my ethical obligation?**
—Dr Worried

Dear Dr Worried: Patients might have many reasons for requesting inclusion or omission of information in their medical records. In 1 study, most patient requests for altering medical records were to correct false information, whereas the removal of valid information represented only 6.6% of requests.[1]

How should the provider best balance respect for patient autonomy and privacy with maintaining the integrity and accuracy of the health record?

A patient's right to review a complete medical record, except for psychotherapy notes, and request an amendment is protected by the Health Insurance Portability and Accountability Act (HIPAA) privacy rule.[2,3] Physicians maintain the right to deny amendment requests and are responsible for communicating the reason for denial to the patient.[2,3] According to HIPAA, it is not appropriate to ignore a patient's amendment request.

Expanded access of patients to their health records has a variety of potential benefits: greater accuracy of information, increased patient understanding of health, and improved transparency of the health care system. In this scenario, by honoring the patient's wish to omit information from the medical record, the dermatologist might show respect for and build trust with the patient, essential aspects of the provider—patient relationship.

However, there are many reasons to decline this patient's request. Maintaining accurate health information is essential to the integrity of the medical record and generally required by state law.[4,5] Aside from legal liability, the welfare of the patient, and perhaps others could be compromised by omitting this symptom from the medical record. Periodic blurry vision might represent a serious underlying disease that, without appropriate documentation, might go undiagnosed, putting the patient and others at risk. Further, if the patient does start antimalarials, it is important to establish that the symptom was preexisting and, therefore, not attributable to the drug.

The omission of relevant symptoms from the medical record at the request of a patient might ostensibly uphold the patient's right to self-determination in health care. However, state law governing medical documentation as well as beneficence to the patient, and potentially others, outweigh patient autonomy in this context. We recommend open discussion with the patient to clarify motives behind such requests as well as to explain the potential harm associated with omission of relevant medical information. If the patient remains persistent, HIPAA outlines the procedure by which an official request for altering the medical record can be made. The provider may decline this official request and must communicate the rationale to the patient.

— Dr Dermatoethicist

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Funding sources: None.

Conflicts of interest: None disclosed.

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https://doi.org/10.1016/j.jaad.2018.10.017