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PATIENTS' RIGHTS OF ACCESS TO THEIR OWN MEDICAL RECORDS: THE NEED FOR NEW LAW

BARBARA L. KAISER*

Medical care delivery systems have come a long way since the time when most sick people relied upon the general practitioner who made rounds of the countryside or the neighborhood and came to the home of the invalid in response to a call. In that time, at least according to the prevailing mythology, the relationship between the patient and the doctor was a highly personal one, based upon the doctor's knowledge of the patient's intimate affairs. The doctor was in a special position to act as confidant and to become privy to the patient's secrets, including, of course, many matters unrelated to the illness he was called upon to treat. From time immemorial, as we know from the Hippocratic oath, this knowledge of the dark places of a patient's private life has been regarded as sacred.¹

The general practitioner has in large measure been replaced by the "primary physician," the "family practitioner" or the outpatient department of the local hospital. The house call is all but a thing of the past. It disappeared some time around the Second World War, with the result that doctors no longer have first-hand knowledge of their patients' personal and family affairs. Nevertheless, the ethical obligation of doctors not to disclose what they may learn of their patients' intimate affairs still persists. Care of the sick in any setting necessarily puts doctors in a position to learn what patients would not disclose to others, and, psychologically, patients still tend to rely upon the doctor and his auxiliary personnel. The ethical obligation naturally extends to the records that are made in connection with the patient's medical care, whether by the doctor in his office or by members of medical care teams functioning in hospitals.

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1. "Whatsoever things I see or hear concerning the life of men, in my attendance on the sick or even apart therefrom, which ought not to be noised abroad, I will keep silence thereon, counting such things to be sacred secrets." 15 ENCYCLOPEDIA BRITANNICA 95 (1968). The oath dates from approximately the fifth century B.C., and is contained in a collection of the works of Hippocrates known as the *Hippocratic Collection* brought together not long after 300 B.C. 11 *id.* at 519.

In legal terms, the ethical obligation of the doctor, or other providers of health care, can be considered an aspect of the patient's right to privacy. The protections the law gives to this right are, however, somewhat indefinite and can scarcely be termed ample. In New York, for example, there is a statutory tort action for violation of privacy generally, but because it applies only to the unauthorized commercial exploitation of someone's name or picture,² such an action cannot give satisfactory protection to the privacy of a patient's medical records. Also, there is a statutory privilege attaching to information obtained by a doctor about a patient in the course of administering medical care.³ The privilege belongs to the patient, and permits him⁴ to exclude from evidence in a litigation the records of his medical care, provided that the information falls within the statutory definition and provided that the privilege has not been waived.⁵ Like other such privileges created in deference to special confidential relationships, this one is much qualified with exceptions which represent efforts to accommodate the privacy rights of patients to other social needs of equal importance.⁶

2. N.Y. CIV. RIGHTS LAW §§ 50, 51 (McKinney 1948); see *Flores v. Mosler Safe Co.*, 7 N.Y.2d 276, 164 N.E.2d 853, 196 N.Y.S.2d 975 (1959). Constitutional rights of privacy are a different sort of question, and normally would not play a role in private relationships.

3. N.Y. CIV. PRAC. LAW § 4504(a) (McKinney 1963).

4. Unfortunately, the English language third person singular pronouns equate sex and gender. To avoid excessive awkwardness of style, the masculine pronoun has sometimes been used in its common-gender, or statutory sense, with full awareness that the subject of a medical record is as often a woman as a man, and that in fact the privacy problem may be even more acute for a woman.

5. See, e.g., *Mayer v. Albany Medical Center Hosp.*, 56 Misc. 2d 239, 288 N.Y.S.2d 771 (Sup. Ct. 1968).

6. In *Waters v. Moore*, 70 Misc. 2d 372, 377, 334 N.Y.S.2d 428, 434 (Sup. Ct. 1972), the court said of the privacy statute that it "strikes a delicate balance between the free dissemination of ideas and individual privacy," with the presumption generally in favor of the former. Some exceptions to the privilege occur: where the information was not required for the treatment of the patient, *Mayer v. Albany Medical Center Hosp.*, 56 Misc. 2d 239, 288 N.Y.S.2d 771 (Sup. Ct. 1968); in the interests of justice, when an intent to keep the information confidential has not been shown, *Jansons v. Jansons*, 45 Misc. 2d 795, 257 N.Y.S.2d 703 (Sup. Ct. 1965); *Milano v. State*, 44 Misc. 2d 290, 253 N.Y.S.2d 662 (Ct. Cl. 1964); and, significantly, when the physician has examined the patient for purposes other than treatment, *Milano v. State*, *supra*. Under a 1972 act, the privilege is abolished as to certain practitioners, and is replaced by a provision directing courts to protect medical records against publicity unless making the records public is necessary to protect the rights of a party. N.Y. PUB. HEALTH LAW § 3371 (McKinney Supp. 1974). Violation of a specific statutory direction limiting the power of an official to grant access to medical records, such as exists in N.Y. MENTAL HYGIENE LAW § 15.13 (McKinney Supp. 1974), may

Most people live out their lives without ever becoming involved in a law suit, much less one to which their medical records would be relevant in any way. Nevertheless, the mass of such records that accumulates around us is so great, and the social and economic relationships affected by them are so numerous, that we are all concerned with such important privacy questions as how such records are made, by and for whom they are made, how and where they are stored, and, most particularly, who may have access to them.

Much consideration has been given to problems of protecting patient records against unauthorized access by third parties. This is a subject, in fact, that has attracted a great deal of interest and generated a considerable body of literature.⁷ With all of this, however, one aspect of the problem has been relatively neglected; the patient's own interest in, and right to see and use, the records of his health history. It is the thesis of this paper that any person who is the subject of a medical record ought to have an enforceable right to see, examine, make copies of and otherwise use that record, regardless of who made it or who may be its custodian. Denial of that right is a significant abridgement of the ability of the subject of the record to assert and protect his own rights of privacy.

Before proceeding to the arguments, it will be useful to place the problem in its proper perspective, by examining briefly how the system of delivering medical care to patients has changed and how these changes have affected the keeping of medical records.

Not only has the house call become obsolete, but since the 1940's the omniscient general practitioner has come to be replaced by group and team practice, more and more frequently in an institutional setting. Many factors contributed to this metamorphosis. One, no doubt, was that an expanding patient load made single practice a

give rise to a right of action in a patient whose records have been improperly opened, provided the patient is fortunate enough to find out about it. See *Munzer v. Blaisdell*, 183 Misc. 773, 49 N.Y.S.2d 915 (Sup. Ct. 1944).

7. The institution of drug abuse programs has produced some interesting literature on the privacy of those under treatment. *E.g.*, McNamara & Starr, *Confidentiality of Narcotics Addict Treatment Records*, 73 COLUM. L. REV. 1579 (1973). Privacy problems of computer databanks are thoroughly discussed in A. WESTIN & M. BAKER, *DATABANKS IN A FREE SOCIETY* 360-73 (1972). The specific problems relating to computer storage and retrieval systems for medical records have produced a thick volume of papers, prepared by the Joint Task Group of the Medical Society of the County of Erie, New York and published by the *Journal of Clinical Computing of Buffalo, New York*. JOINT TASK GROUP, *MEDICAL PRIVACY AND COMPUTER TECHNOLOGY* (1974).

killing burden for the doctor. Perhaps even more significant has been the information explosion, which has made it impossible for the single individual to bring to bear on a serious medical problem all the relevant knowledge available. The answer to this challenge has, of course, been the breaking up of medical practice into specialties, and the specialties in turn into subspecialties, each with its own province, its own hardware and its own professional preoccupations. Finally, a third major development has been the fact that large segments of the population in the low and lower-middle income brackets can now receive good health care, where formerly such people had either inadequate care or none at all. This relatively new body of patients receives its care mostly at clinics and hospital outpatient departments from staff specialists.

Along with these changes in the style of health-care delivery, the keeping of records by the health-care providers has necessarily become enormously more complicated. Every member of the health-care team must contribute to the record notes of care given, observations and recommendations made, results of laboratory tests conducted, and anything else that has gone into the processes of diagnosis and treatment. The bigger the team, the more necessary it is that the records be kept, so that each member can have the benefit of what the others have done and learned. The sheer volume of paper thus generated has given rise to the kinds of storage and retrieval problems for which independent, computer-operated facilities are now being proposed and designed as an answer.⁸

Such facilities, of course, develop a technology and a life of their own apart from the skills and technologies involved either in the delivery of health care or in the maintenance of old-fashioned, file cabinet record libraries. A whole new body of technicians has thus been added to the corps of practitioners and their auxiliaries, responsible for keeping track of what happens to a patient. Because of the sheer number of people who make, read, use, encode, decode, store, and retrieve the records, the privacy of the records is placed in great jeopardy, and even more so when the storage facility is separate from and independent of the plant of the health-care provider. This is because of the extra steps in communication between the makers and

8. See materials cited note 7 *supra*.

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users of the records on the one hand and the storage and retrieval personnel on the other.

This proliferation of personnel and sophisticated equipment needed to care for patients has been an important factor—though certainly not the only one—in the skyrocketing of medical costs. It is commonplace in today's inflated economy that only the rich can personally afford a complicated or extended illness, especially if it requires hospitalization. In New York City, a stay of two nights in a teaching hospital for a simple diagnostic procedure can cost as much as \$900; a figure that does not include the fees of the private physicians who attend the patient.⁹

Partly because of the increased costs of health care and partly as a factor in solving the problems of medical and general indigence in distributing care to lower-income populations, there have also been changes in the ways in which health care is paid for. Most serious medical care is now financed either by insurance companies under private plans, often with employer participation, or by government agencies as a form of public assistance.

Application of "spread-the-risk" concepts to the financing of health care has certainly produced many social benefits, not the least of which—as has been indicated—is that it has made good care possible for many who would formerly have been unable to afford any care at all. This benefit, however, is not without its social costs, and one important item in this column is an accompanying loss of the protection of the privacy of the records. As banks supervise the affairs of their large borrowers, and foundations insist on an accounting for the use of their grants, so too third-party financers of health care should require accountability of the hospitals that receive the benefit of, and indeed depend heavily upon, their payments. In short, third-party financers, both governmental and private, want and get the privilege of inspecting the health-care records of individual patients.

Hospitals and other providers of health care, even though they may assert property rights in the records they maintain,¹⁰ do not have legal authority to release patient records to third parties. They do

9. This information was supplied to the author by a patient who personally incurred such a bill.

10. For example, the *Kaiser Foundation Hospitals Consent Manual* declares that the record is the property of the hospital, and states flatly that the patient has no right to it. KAISER FOUNDATION HOSPITALS CONSENT MANUAL 90 (1968).

have an obligation to the patient, sometimes reinforced by statute,¹¹ to maintain the confidentiality of the records unless the patient authorizes their release. This, however, has not proved a serious obstacle to compliance with the demands of the third-party financiers for access to the records. Along with the other releases and permissions a patient must sign upon entrance to a hospital there is normally included a waiver allowing the release of records to anyone under contract to pay the patient's charges. This is potentially a very significant incursion upon the privacy of the patient because it makes the records freely available to persons, agencies or groups that owe the patient no duty of confidentiality as to the information they obtain by this means. Moreover, the patient may not even know the identity of these third parties, or, if he does, he may find it impossible to uncover the ultimate fate of records in their possession, especially if the third-party financier is a sizable bureaucracy in its own right.

To a lesser degree, similar problems would arise in connection with storage of records in an independent databank. Presumably a patient would have to release the records for transfer to a free-standing storage facility, but once the transfer was made, the records would be substantially outside the patient's control. The contracts governing the conditions of storage and retrieval would normally be made between the health-care facility and the databank, with the patient standing in the relation of third-party beneficiary of any provisions that the direct parties to the contracts had seen fit to include for his benefit. It does not seem likely that there would be much patient input into the drafting of such contracts.¹²

The risks to patient privacy discussed so far have been only those relating to records made in the course of the administration of health care. But, medical records are not only made in a context of diagnosis and treatment of illness in a health-care facility. They are made for a great variety of other purposes, many of which are only tangentially related to the patient's welfare. People are often required, for example, to submit to a physical examination as a condition for receiving a benefit of some sort: a job, life insurance, the privilege of engaging

11. See, e.g., CONN. GEN. STAT. ANN. §§ 52-146(d)-(i) (Supp. 1974); MAINE REV. STAT. ANN. tit. 191, § 2256 (1965); MASS. GEN. LAWS ANN. ch. 123, § 36 (Supp. 1974); N.Y. MENTAL HYGIENE LAW § 15.13 (McKinney Supp. 1974).

12. See JOINT TASK GROUP, *supra* note 7, at 42-43. This is a part of a memorandum from Professor Barry Boyer of the State University of New York at Buffalo School of Law to the Joint Task Group.

in school athletics, or a marriage license, to name only a few. An accused person may have to be examined to determine whether he can stand trial. A convicted person may be examined in connection with sentencing, or in connection with an application for parole. The law may require the examination of children who are alleged to have been neglected or abused, or direct a psychiatric evaluation of parents in a legal battle over custody. The possibilities are virtually endless.

These health records made outside the context of health care often have very serious effects upon their subjects' lives. They all have in common the characteristic that they are usually made for, and kept by, someone who has no duty at all to maintain their confidentiality. This is certainly the case with medical records required to be submitted to an actual or prospective employer, or to an insurance company as a prerequisite to getting or keeping insurance. Insurance companies, in fact, have developed a Medical Information Bureau, a clearing house through which certain medical information furnished by any insured person or applicant to a member company can be made available to all. The very existence of such a bureau is antithetical not only to the idea of the confidentiality of the medical information received, but also to the recognition of any interest on the part of the subject in the privacy of his records.

It is clear that a wide variety of persons, agencies and organizations may at some time or other, without the subject's knowledge or consent, have access to or possession of an individual's health records. Under these circumstances it is almost grotesque that the subject himself, the person most intimately concerned and most directly affected, is routinely not permitted to see them. Most people, in fact, take this for granted although questions are now being raised as to the propriety of this state of affairs.

It is tempting to speculate upon how it came about that health records are customarily withheld from the subjects themselves. It may be because, from the earliest days, the practice of medicine has always had a powerful mystique. Medicine men were magicians, and the very essence of magic is that the onlooker does not know how it was done.¹³ Whether the effect produced is the cure of a disease or the materializa-

13. Compare the myth of Ceres healing the sick child in the course of her search for Proserpine. When the process was interrupted by the child's mortal parents, Ceres reproached them for foiling her efforts to make the child immortal. T. BULFINCH, *MYTHOLOGY* 53 (abr. E. Fullen 1959).

tion of a flock of pigeons out of an empty silk hat, the performer is expected to keep his audience bemused. And even in this day of scientific medicine, an important element of therapy is the faith of the patient in the healer. It is perhaps not surprising, in a culture that produced the Book of Job, that one who holds the power of life and death over others may demand from his worshippers (read patients) a certain amount of blind faith. Even apart from the element of superstition or faith, medicine is usually practiced upon people who, because of their illness, are in a genuinely dependent position or who need or want something that a doctor can help them to get or prevent them from getting. It may be that consciousness of this very real power in the medical profession, combined with its traditional fierce sense of autonomy, have been strong contributing factors perpetuating the practice of excluding patients from seeing their own records—a practice maintained not only by the doctors themselves but by all their surrogates in the administration of health care.

Apart from these speculations, however, when reasons are given for prohibiting patients or other subjects from seeing their own health records, those reasons purport to derive from the doctor-patient relationship. The assumption is that the doctor is the one who should control what information is given to the patient, for the patient's own good.

In justification of withholding the records from the patient it is frequently asserted, for example, that the records are in technical language which the patient will not understand. Since he does not understand the records, the argument proceeds, the patient will misinterpret them and possibly even indulge in self-medication and other hazardous pursuits. To protect them from themselves, patients must, therefore, be given information as they are given dangerous drugs: by doctor's prescription only, in measured doses.¹⁴

This argument is at odds with the proposition, accepted in law and at least nominally in practice, that no treatment should be given to a patient unless he has given informed consent to the procedure. Informed consent, if it means anything at all, means that the proposed procedure is explained to the patient beforehand in comprehensible terms. This places a clear duty upon whoever is responsible for treat-

14. See Entmacher, *Computerized Insurance Records*, in 3 HASTINGS CENTER REPORT 8 (1973).

ment to see that the patient does understand enough to give an intelligent consent. It seems reasonable that permitting a patient who wishes to do so to see his chart might help rather than hinder the process of obtaining informed consent.

Moreover, the fact that the record is difficult to understand hardly seems adequate ground to censor the patient's reading. Leaving aside the possibility that the makers of the records might take pains to write them more intelligibly, it is probable that the patient who cannot understand them will give it up anyway, or else will ask some knowledgeable person to explain them. The status of being a patient does not warrant being treated as an incompetent. In any event, there is no suggestion here that the records should be thrust upon a patient who prefers to rely upon the doctor for information.

The other principal ground for keeping patients from seeing their own records is that, for one reason or another, there may be material in the record that would harm the patient were he to see it. The kinds of information which the proponents of this argument commonly use as illustrations are fatal prognoses or diagnoses of malignant disease, which many think it preferable to withhold from the patient. But the question here dealt with is whether the records should be accessible to patients *who wish to see them*; again, it is not proposed that the records be thrust upon those who do not. It is assumed that the patient is competent, and not too young to exercise judgment; if such a patient asks to see the record, presumably he has considered the possibility that it may contain distressing information.

In any case, persons *sui juris* are supposed to have the privilege and the responsibility of making their own decisions and coping with their own errors. This is a basic assumption underlying the law of contract and tort, not to mention the rule requiring informed consent. To prevent a patient from obtaining important information concerning himself is to deprive him of the means of making important decisions in his life; choices that he might have made much more providently had the information not been denied to him. The impact of these choices falls not on the custodians of the information but on the subject himself and on the people to whom he relates in his ordinary life.

Furthermore, even if there is merit to the position that patients should be shielded from direct exposure to certain kinds of informa-

tion included in their records, it does not follow from this that all records should be withheld from all patients. What of the patient who has been treated for a self-limited disease, a broken leg, a tonsillectomy, an appendectomy, or has simply had an early delivery? And what of the patient who already knows the fatal prognosis? For these patients, and many others, the argument *in terrorem* is simply inapplicable.¹⁵

It would be well to note that psychiatrists sometimes advance an additional point in defense of keeping the record from their patients. For purposes of psychotherapy, these practitioners sometimes make use of statements made to them by third persons about the patient. Understandably, they do not wish to violate the confidences of the third persons by revealing them to the patient. But, in cases of this sort, other interests than those of the patient are present and require protection. The outside informers may have privacy interests of their own in the information that they have entrusted to the psychiatrist, and the psychiatrist may owe them a moral duty not to breach this trust by disclosing it against their wishes. The patient's right to see his own records may thus be limited by someone else's equivalent right not to have certain material disclosed. Admittedly, the problem is a delicate one, but is better solved by creating an exception to a general rule permitting access (if the exception could be very carefully drafted), than by creating a general rule denying access.¹⁶

There are, on the other hand, sound reasons for giving patients access to their own records upon request, whatever they contain. Assuming the worst, a patient with a short or a dubious life expectancy may have many arrangements to make for the disposition of his or her affairs. There may be a will to make or revise, there may be a need to designate guardians for young children and make provisions for other dependents, or there may be business affairs to conclude. In less drastic cases it may be useful, or perhaps necessary, for a patient to know what drugs he has been given. Drugs sometimes have undesirable or unexpected side effects. A patient should be in a position to refuse a drug that has produced an allergic response in him on a previous occasion; he cannot do so unless he knows both what he

15. See Gutman, *The Right to Know*, in 3 HASTINGS CENTER REPORT 9 (1973).

16. These problems are considered in an article by Robert M. Veatch, *Medical Records: Patient Rights and Responsibilities*, a publication of the Hastings Institute of Society, Ethics, and the Life Sciences, Hastings, New York.

was given on the previous occasion and what he is being offered now. He should also be prepared to understand that some of the symptoms he is feeling may be the result of the medication that has been prescribed for him, rather than the indicia of a new and frightening disease. A dramatic example of this is the recent discovery that diethyl stilbestrol, given to many pregnant women in the years between 1948 and 1965 to prevent spontaneous abortion, may be the cause of malignant disease in the daughters of these women. It is a grave disservice to the mother of a girl born during that period to deny her access to the records that would conclusively show whether that drug was given to her while she was pregnant with the child. Less dramatic, but nevertheless important, is the consideration that in a mobile society permitting a patient to have copies of his medical records will give him some assurance of continuity of care no matter where he may move.¹⁷

An obvious practical reason for permitting patients to see their own records is to give them an opportunity to make sure the records are correct. Even with the best intent in the world, errors still occur. Patients with like names are confused with one another, a house officer makes an improper entry, papers are shuffled or lost; the larger the bureaucracy where the records are maintained, the greater the risk. It is the patient and not the medical staff or the records custodian that will suffer the consequences of these mistakes; therefore, it is the patient who should have the opportunity to question the contents of the chart.

Finally, whatever right a subject may have to the privacy of his medical records is seriously prejudiced unless he can have access to them. If we acknowledge the basic premise of the law that the person with standing to assert a right is the possessor of the right—the premise implicit in the constitutional requirement of a “case or controversy” for federal jurisdiction—there is an inherent absurdity in placing the onus of protecting a right of privacy upon the one person most consistently deprived of access to, and information about, the materials as to which the right is asserted. Lawsuits are not brought to claim abstract interests in theoretical justice but to redress real wrongs that cause actual injury to real people. If a person’s privacy rights are to have any value where medical records are concerned, it is essential

17. *See id.*

that he have the legal right to know what is in the records, as well as where they are, where they have gone, and who has access to them.

It must not be forgotten that the persons who exercise the power to withhold access to the records cannot be assumed to be totally neutral, much less to be acting in the interest of the patient at all times. A doctor and a hospital with custody of the records may have substantial interests of their own, adverse to those of the patient, that would motivate them to conceal the contents of the records. For example, if the providers of health care are protecting themselves against a malpractice action, they cannot be expected to protect the interests of a patient who may be contemplating such an action. It is no answer to say that the patient can authorize the release of the records to an attorney. The patient may wish and should be able to make a preliminary decision for himself before engaging counsel.

The arguments are even more persuasive for allowing the subject to have access to the records when the custodian is not a provider of health care. Such custodians have no duty of confidentiality to the persons whose records they hold,¹⁸ although they may purport to derive their privilege of withholding the records from the asserted power and responsibility of the doctor.¹⁹ Moreover, they often have their own affirmative reasons to disregard the privacy interests of the subjects; such as the forming or joining of an information pool like the Medical Information Bureau, mentioned above. The very reasons that these custodians assert for obtaining the medical records are in derogation of the privacy rights of the subjects, who have sacrificed those rights in order to obtain benefits or comply with necessary conditions. Therefore, if the subject has no access to the records, he is placed wholly at the mercy of the custodian, who, in turn, is indifferent to the rights the subject is seeking to protect.

The idea of giving people access to their own health records is startling to some, but in fact it has been tried in a few places in connection with administration of health care, evidently without calamity. Richard E. Bouchard and his associates at the University of Vermont have reported favorably on the results of a program of giving patients an active role in the preparation of the records as well as full information as to their contents.²⁰ After a similar experiment at Yale, Budd

18. See *Milano v. State*, 44 Misc. 2d 290, 253 N.Y.S.2d 662 (Ct. Cl. 1964).

19. See Entmacher, *supra* note 14.

20. R. Bouchard, *The Patient and his Problem-Oriented Record* (undated).

N. Shenkin and David C. Warner have advocated full access and disclosure of the records to patients.²¹ The State of Massachusetts has a statute that gives patients, except mental patients, the right to see their own records.²² Lastly, efforts were made to include a patient right of access in a proposed New York City privacy ordinance, which, unfortunately, was defeated by powerful organized opposition.

At present, most of the law regulating control of medical records—apart from statutes conferring one or another form of confidential status and such exceptional enactments as that of Massachusetts—has been made piecemeal, based upon the exercise of the power derived from physical possession, the proverbial nine-tenths of the law. It is not likely that this power will be voluntarily surrendered. Organization, money, and other attributes of political strength are on the side of the custodians of the records, whoever they happen to be. Patients, on the other hand, are a mixed lot, normally acting as individuals, possessing very little in common and having no effective means of communicating with one another. Accordingly, if patients are to achieve access to their records and receive other help in asserting privacy rights with respect to them, it will have to be done by legislation.²³

In the interest of effectiveness and uniformity, this legislation ought to be generally applicable, in the manner of the Administrative Procedure Act²⁴ and its successor, the Freedom of Information Act.²⁵ At the least, it should include: (1) an enforceable right in a subject to see and copy his own records in the hands of any custodian; (2) a reasonable opportunity to point out errors and have them either explained or corrected; (3) reasonable notice of the identity of the person or organization to whom the information will be given, of the purpose for which it is to be given, and the circumstances under which the transfer will be made, if the information is to be placed in the possession of anyone other than the original custodian; (4) a duty of confidentiality toward the patient that will restrict the power of any holder of health records to publish or share them except as prescribed; and (5) a duty on the part of any custodian of health

21. Shenkin & Warner, *Giving the Patient His Medical Record*, *NEW ENGLAND J. MED.*, Sept. 27, 1973, at 688.

22. *MASS. GEN. LAWS ANN.* ch. 123, § 36 (Supp. 1974).

23. See materials cited note 2 *supra* & accompanying text.

24. 5 U.S.C. § 551-59 (1970).

25. *Id.* § 552 (1967); see Waples, *The Freedom of Information Act*, 74 *COLUM. L. REV.* 895 n.1, 896 n.2 (1974).

records to notify the subject of the records whenever it receives a subpoena to produce those records, so that the subject may have an opportunity, consistent with usual due process criteria, to contest the subpoena.

We are witnessing a steady shrinkage of the area within which we can be free of interference from outsiders, even as regards our most intimate affairs. And yet, as technology improves it is more and more important that we be vigilant in protecting whatever is left of our privacy. The enactment of a statute such as the one here advocated might prove to be a rear-guard action, but it would nevertheless have significant value as an assertion of a continuing, indestructible concern in society for the unique worth of the individual.