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EDITORIAL

What clinical records should we retain and for how long?

Good quality clinical record keeping is a foundation for good clinical and good occupational medicine practice [1]. Confidential and readily retrievable storage systems are integral to this concept. There are issues to be considered around clinical record storage: who should store the records, for how long and how data subjects are made aware of changes. These issues are further complicated by recent developments, including changes to Data Protection Legislation, greater use of electronic records and current business practice where employer changes of occupational health (OH) provider are common.

The Data Protection Act (DPA) [2] requires that individual identifiable data are recorded and stored only if there is good reason and the data subject agrees. The data subject must know how to access the data held and importantly, if it is transferred, they must be told that. Health and safety legislation for asbestos [3], lead [4] and ionizing radiation [5] and Section 6 of Control of Substances Hazardous to Health [6] requires a non-clinically confidential 'health record' to be retained by the employer for 40 years (or 50 years in the case of ionizing radiation). The legislation does not require clinical record storage for 40 years but Health & Safety Executive (HSE) codes of practice in effect expect this and HSE's principle medical inspector confirms this (Dil Sen, HSE Principle Medical Inspector, personal communication, 24 June 2011).

Health and safety legislation more generally [7] requires that health surveillance is undertaken where risk assessment indicates this but does not legislate on retention of associated clinical records.

The Faculty of Occupational Medicine (FOM) Guidance on Ethics [8] gives general advice about OH clinical records. It advises transfer of records on change of OH provider to facilitate continuity but does not consider practical issues flowing on from that. It does not directly speak about providers who arrange and collate independent assessments from different sources, each of whom commonly make a record of their assessment unconnected to other records. It refers to expert guidance to retain records for 8–10 years but does not reference this, and although this is sensible and consistent with advice from medical defence organizations, there is no accepted standard for retention periods.

National Health Service (NHS) guidelines [9] about OH record storage form part of a large document covering all types of NHS records. In relation to OH, they are confused and recommend storage of OH records for 3 years only, but general practitioner (GP) records for 10 years.

There are a number of other issues that are unsatisfactory. The health surveillance data set arising from OH records is fragmented when for example an employer changes OH provider and follows FOM guidance that records of current employees transfer to the new provider, but those of retired employees stay with the old provider. HSE appointed doctors are expected to keep clinical records for 40 years, but to do this, in compliance with all the provisions of the DPA, presents practical difficulties. The doctor will normally be retired before any of these records can be destroyed and have died before the last ones are 40 years old.

Obligatory retention periods for health surveillance data tend not to distinguish between the two types of data collected. For example, an asbestos medical does not generate data about adverse health effects from the hazard of concern, only information that respiratory and other health remained suitable for work as a classified worker. Other records which may be non statutory, for example audiograms provide a baseline which strengthens interpretation of subsequent audiograms later in employment and thus helps in the assessment of damage from noise. HSE requirements to retain data for 40 years do not necessarily correspond well with its usefulness.

Clinical records now include paper (A4 or other size, e.g. from test results); scanned paper records as pdf or other format; commercial OH record database records, e.g. Cohort, Orchid and data systems cross linking records between data bases. From a legal evidential point of view, electronic records generally rank on an equal footing with paper records provided that their creation and storage have followed appropriate standards [10]. There is a risk that even if created in accordance with relevant standards, e.g. for scanned paper records, the record of the quality process will be lost as it is transferred from one data controller to the next.

During the period in which the employee remains in the same employment, clinical records enable quality care and health monitoring. Once the employee ceases employment, clinicians normally want to ensure storage for 8–10 years in case of litigation against them. During that period, both the employee and the employer (with consent) may desire access to the data for litigation about adverse health effects. The employer may ask that employee's records are stored longer. Potential litigant employees can actively ask for their records before planned destruction—but often, they will not know that their records are being destroyed. Occasionally, records

may contain clinical data not kept elsewhere which could be useful in clinical care beyond 10 years, e.g. immunization record. Since a 'passive' approach tends to be taken to data harvest at destruction time (it is logistically difficult to offer data to employees who left a decade before), it may be wiser to routinely provide that data to employees at the time it is collected or to actively offer data at the time employment ceases and the record is archived.

In relation to data for putative future research, the DPA requires that individual subject consent is given for epidemiological research. Data gathered prospectively, e.g. HSE's asbestos worker study requires individual consent to participate in the study. Implicitly, therefore, any other clinical records that are retained in other situations could not be used for research purposes without further subject consent and this is difficult to achieve in dispersed cohorts of former employees. The legal basis upon which clinical records can be stored in anticipation of as yet unplanned future research is therefore uncertain.

The gap between making a record and the point 8–10 years later at which it can (normally) be destroyed means that record management and destruction will tend to fall to people other than those who made them. This may be an increasing issue as electronic storage makes boxes of data 'invisible' and therefore no longer an obvious cost. There are almost certainly large quantities of clinical records, which continue to be stored without clearly thought out reason and without data subject awareness.

If we think data may be required for epidemiology study, let us try and identify it and store it with explicit subject agreement, but it is unlikely that much of it will be very sensitive. Blood leads and audiograms are less sensitive than psychiatric history. Most retrospective epidemiological studies into putative workplace hazards rely on end points from cancer registers or death registers for their clinical information. It is the work exposure history, which is sought retrospectively from the employer, not the clinical record. Good quality employment records are likely to yield more useful data for these studies than old clinical records. Perhaps, it is time to rethink legislation and require that an employer-held 'health record' is electronic, contains employment, hazard and relevant health data stored securely and is compartmentalized. Elsewhere, electronic information is now a requirement and, for instance, businesses can only make Corporation and Value Added Tax returns electronically.

What should happen next? HSE guidance in relation to statutory medicals and associated records of employment, hazard and health surveillance data should be re-evaluated. Where HSE identify data that can be usefully collected prospectively and nationally, consideration should be given to a national database and in the interests of continuity, sponsored by government through the HSE. The current HSE expectation that a doctor can personally be responsible for storing patient data for 40 years and comply with the DPA is unrealistic.

Codes of practice about creation of a single OH record for an employee during a particular employment should be strengthened. Similarly, issues around transfer of electronic records and access by previous clinicians to their part of the records if litigation arises after they have transferred them should be harmonized. Best practice for a 'normal' record retention period should be more explicitly established—10 years?

In the meantime, occupational physicians and the businesses for which they work should ensure that they have explicit policies on data retention provided to employees when their records are created. This should ideally also cover record management if their employer changes OH provider. They should make sure that if they retain records beyond say 10 years, that they have identified a good reason to do so and informed the data subject. Occupational physicians should make arrangements which will ensure compliance with the DPA for records that they have made during the period after they retire or die or if their employer (unexpectedly) ceases to trade.

Occupational medical practice and its clinical record keeping have changed substantially within the span of an occupational physician's career. Influences today are very different from when some existing legislation was passed and GP records were upgraded from Lloyd George envelopes to A4. There is a strong case for a review of our approach to clinical record management, data retention and associated guidance.

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References

1. Faculty of Occupational Medicine. *Good Occupational Medicine Practice*. http://www.facoccmed.ac.uk/library/docs/p_gomp2010.pdf (8 December 2011, date last accessed).
2. *Data Protection Act 1998 (Commencement No. 3) Order 2011*. London: The Stationery Office. http://www.legislation.gov.uk/ukpga/1998/29/contents (8 December 2011, date last accessed).
3. *Control of Asbestos Regulations 2006 SI 2006/2739*. London: The Stationery Office, 2006.
4. *Control of Lead at Work Regulations 2002 SI 2002/2676*. London: The Stationery Office, 2002.
5. *The Ionising Radiations Regulations 1999 SI 1991/2289*. London: The Stationery Office, 1999.
6. *The Control of Substances Hazardous to Health Regulations 2002 (As Amended). Approved Code of Practice and Guidance L5 (fifth edition) Regulation 11 Health Surveillance*. HSE Books, 2005.

7. *Management of Health and Safety at Work Regulations 1999. Approved Code of Practice and Guidance L21*, 2nd edn. HSE Books, 2000.
8. Faculty of Occupational Medicine, Royal College of Physicians of London. *Guidance on Ethics for Occupational Physicians*, 6th edn. London: Faculty of Occupational Medicine, 2006.
9. Department of Health. *Records Management NHS Code of Practice Part 2*, 2nd edn. Gateway Reference 1068. London: The Stationery Office, 2009.
10. *British Standard BS 10008:2008*. Evidential weight and legal admissibility of electronic information. Specification London BSI.