

of those few individuals who, for whatever reason, buck a system which routinely fails to inform them of their right of access to their hospital records. In a setting where trusting patients are not routinely told of their right to access, it seems reasonable to assume that only the least trusting or most angry will ask to see their records. To locate the source of that mistrust in the patient's personality style or in the stress of illness and hospitalization is to forget, as Dr. Lipsett perceptively suggests, that "the doctor-patient relationship cannot be understood simply in terms of the patient's side of the equation."³ Altman *et al.* thus fall into what Professor Robert Burt of Yale Law School has referred to as "the conceptual trap of attempting to transform two-party relationships, in which mutual self-delineations are inherently confused and intertwined, by conceptually obliterating one party. . . ."⁴ Thus, it would seem that the ten women who asked to read their charts "to confirm the belief that the staff harbored negative personal attitudes toward them. . . ." were correct in that belief; the psychiatrists labelled them as "of the hysterical type with demanding, histrionic behavior and emotional over-involvement with the staff."

Altman *et al.* also seem unaware of the wide variety of settings in which patients have benefited from routine record access; and incorrectly assert that there were no strikingly beneficial effects in the two studies they do cite. In the first study, for example, two patients only expressed their completely unfounded fear that they had cancer after their record was reviewed with them, and one pregnant patient noted an incorrect Rh typing that permitted RhoGam to be administered at the time of delivery.⁵ In the other study they cite, 50 percent of the patients made some factual correction in the record.⁶

Experience under the new record access regulation enacted by the Massachusetts Board of Registration in Medicine indicates that patients want access to their records for a variety of reasons. In the period from October 13, 1978 (when the regulation went into effect), to January 31, 1980, the Medicine Board received more phone calls from consumers asking about the medical records regulation (approximately ten a month) than about any other single issue dealt with by the Board. There were also 33 formal complaints filed concerning record access during this period. Of this number, almost half (16)

needed help from the Board to get their physician to forward a copy of their record directly to another physician. Of the remaining 18, 6 needed information for insurance purposes, 6 wanted to review the record for various reasons, one alleged negligence, one wanted the record sent to a school nurse, one was moving to another state, one wanted a second opinion, and one wanted her contact lens prescription.⁷

Traditionally the medical rationale for withholding information in the chart has been patient psychopathology or medical paternalism. Both rationales fail to address the issue of rights. Patients have rights because they are people. If we believe in individual freedom and the concept of self-determination, we must give all citizens the right to make their own decisions and to have access to information that is widely available to those making decisions about them. It is as irrelevant in this connection that 2,489 patients at the Brigham did not ask to see their records as it is that more than 200 million Americans never have had to exercise their right to remain silent when arrested. Rights serve us all, whether we exercise them or not.

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Guest Editorials Welcomed

The editors of MEDICOLEGAL NEWS welcome letters or editorials from their readers. Please send double spaced typed pages to: Managing Editor, MEDICOLEGAL NEWS, 520 Commonwealth Avenue, Boston, MA 02215.

Earle Spring

A new and potentially important decision is expected from the Massachusetts Supreme Judicial Court on the issue of withdrawing life-sustaining medical treatment from those unavailable to decide for themselves. The case of Earle Spring is but an example of an increasingly familiar situation: individuals who are not totally "incompetent," and for whom there is a poor, dismal, and certain prognosis. The lives of hundreds of patients may depend upon being hooked up to life-sustaining or life-prolonging examples of medical technology, and some will indicate that they do not want such procedures to continue.

A right to refuse medical treatment is generally accepted and patients are, presumably, able to exercise this right and instruct their physicians to stop rendering medical care even if death is the clear result. But how and who decides for the legally incompetent person, or the elderly patient who lapses in and out of lucidity? The case of Earle Spring has heightened the debate concerning the role of the patient's family, physicians, and the courts in making the decision to terminate life-prolonging or saving medical treatment of allegedly incompetent persons.

Such questions are not easily answered. Although we tend to give credence to the statements of a competent terminally ill patient, what about the patient who desires "death" only because the life that suddenly presents itself is so unfamiliar or uninviting? Or the patient who only seeks the attention and concern that is evidenced by family and health care personnel when a patient with a controllable but incurable disease expresses a desire to have treatment stopped?

In assuring an informed and knowingly-made decision, the courts clearly have a role, but the extent of that role has been heavily debated. In the next issue of MEDICOLEGAL NEWS, two attorneys, both of whom authored separate *amicus curiae* briefs submitted to the Massachusetts Supreme Judicial Court in the Spring case, will outline their positions. Readers are invited to submit letters or editorials on the subject as well.

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