The Access to Medical Records: a systematic review

Cardoso AB, med05113@med.up.pt
Lima AF, med05120@med.up.pt
Pereira AF, med05121@med.up.pt
Silva AF, med5122@med.up.pt
Corte AF, med05123@med.up.pt
Correia AI, med05124@med.up.pt
Machado AI, med05126@med.up.pt
Pinto AI, med05127@med.up.pt
Pereira AL, med05128@med.up.pt
Saavedra, AM, med05131@med.up.pt
Adviser: Ana Ferreira, amlaf@med.up.pt, Class: 2

Abstract

Background: Nowadays, the access to the patient medical records is becoming easier. The developments in information technologies makes fairly common for patients to review and amend their medical records routinely.

Aim: Analyze the potential benefits and drawbacks of providing adult patients access to the information within their medical records, in terms of patient attitudes, doctor-patient relationship and on medical practice, by reviewing previously published research.

Methods: The articles were identified through PubMed using MEDLINE and Scopus. The articles that resulted from the research with the query were analyzed considering inclusion and exclusion criteria. The included articles were then evaluated according to methodological quality criteria, previously defined. The articles with methodological quality were the ones used in our study. In order to extract data from the articles we fragmented our theme in 14 sub themes.

Results: From the 165 articles obtained in the PubMed search a total of 13 articles was achieved. From the Scopus research 2 articles were obtained and so a total of 15 articles has been analysed to write this paper. Ten of the articles referred the theme Patients Interest and Acceptance while 12 of them referred the theme Improving Doctor-Patient Communication. The theme Causing Confusion and Misunderstandings was only referred on 3 of the 15 articles and the theme Creating Anxiety was referred in 5 of the articles.

Discussion: In general, the studies suggest potential benefits, for example in improving doctor-patient communication, empowering patients and promoting their adherence. The drawbacks (for instance causing confusion and anxiety to patients) seem to be minimal. Although, patients continue to show concerns about security, confidentiality and understanding what is written in their records. The studies showed that the use of electronic medical records is becoming more common and brings several advantages.

Conclusion: The majority of patients and doctors seem to be unanimous in their belief that the impact of the access to electronic health record is positive for both. Therefore the importance and need for this kind of studies to be further pursued and done in a regular basis.

Key-words: Medical Record Systems, Computerized (MeSH); Medical Records (MeSH); Patient Access To Records (MeSH).
Introduction

The advent of the electronic era with its legal and technologic trends is making the access to the patient medical records much easier. In the past, things were not so easy, because it only existed a single copy of each medical record and patients had to obtain an authorization to look at it [1]. Nowadays, patient access to paper records is fairly common. Some countries like United Kingdom, New Zealand, Canada and USA have enacted legislation to ensure subject access to health records [3]. In 1996, was stipulated by the HIPAA (Health Insurance Portability and Accountability Act) that “patient must be able to see and get copies of their records and request amendments” [6].

The patient access to medical records can facilitate doctor-patient relationships by enhancing doctor-patient communication, which allows the flow of information among them and help reduce errors and improve quality. However, at the same time, it can undermine trust and so harm doctor-patient relationship [1]. This access can potentially provoke some effects on the patients like improving satisfaction, causing confusion and anxiety, improving autonomy or self-efficacy [1, 5].

Outside the health care sector, personal health records can influence many aspects of life, such as obtaining employment, life insurance or consumer credit [3].

The wider dissemination of data is made possible by developments in information technology, for example the creation of electronic medical records systems. Although some of these systems fragment medical records by adopting incompatible means of acquiring, processing, storing and communicating data. Medical records can also be fragmented across multiple treatment sites, posing an obstacle to clinical care, research and public health efforts [2].

The objective of this review is to analyze studies and conclude about the potential benefits and drawbacks of providing adult patients access to the information in their medical records, in terms of patient attitudes, doctor-patient relationship and on medical practice.
Participants and Methods

We intended to perform a systematic review, based on articles written between 1990 and 2005 which made a retrospective study and evaluate the relation between patients having access to records and medical practice. The dependent variable is the effects on medical practice and the independent variable is patients having access to records. The target population was adult patients and studies that gave parents access to paediatric records were excluded.

The articles were identified through PubMed using MEDLINE and Scopus. The search was limited to publications from 1990 to 2005. The query, used on pubmed, was made with mesh terms. The resulting for pubmed was ("Medical Records Systems, Computerized"[MeSH] OR "Medical Records"[MeSH]) AND "Patient Access to Records"[MeSH] NOT (pediatric[All Fields] AND ("records"[MeSH Terms] OR records[Text Word])) AND ("1990"[PDAT] : "2005"[PDAT]). The main mesh terms used were “medical records” and “patients access to records”. As many medical records are being computerized the mesh term Medical records systems, computerized was added to analyse the access to records thought computers. The publishing type Review was excluded as well as the parents’ access to paediatric records, in order to focus the study in the impact of a patient reading their own records. In Scopus research three queries were used: ALL("Medical Records Systems") AND ALL(Computerized) AND ALL("Patient Access to Records") AND PUBYEAR AFT 1990 and ALL("Medical Records Systems") AND ALL(computerized) AND ALL("Patient Access") AND PUBYEAR AFT 1990 and ALL("Medical Records Systems") AND ALL(electronic medical record) AND ALL("Patient Access") AND PUBYEAR AFT 1990.

To increase the sensibility of the selection, new rules were established. So as inclusion norms was defined that all articles that analysed the effect of patients accessing their medical records and medical information, that studied the consequences on patients, health care providers, medical practice and doctor patient relationship of the patients access to their records should be selected. Also the articles referring to the access of medical records through electronic files were included. The languages selected were English, Portuguese, French and Spanish. As exclusion criteria was established that,
articles referring to specific cases, that analysed the property of medical records, the patients’ rights, judging cases, the confidentiality between patient and doctor, identification of gametes donators, legal documentation and health systems were excluded from this review.

After the articles were distributed by two groups of three people each who read the abstracts and titles, considering the established criterions. Then the full articles were researched through internet, magazines available and mails send to the authors. In a second step, the methodological quality of the articles was evaluated. Unfortunately there wasn’t a check list available for evaluating the quality of the recollected articles and we had to make one. For each article was given grade between 0 and 22 based on 6 criterions. The criterions taken into consideration were: (1) Objective of the study - if it fully coincides with ours should be given 14 points if it has nothing to do with it should receive 0 points and for each sub theme it had 1 point was given; (2) The kind of study – if it was a letter or an editorial it should be given 3 points and if it was a letter or editorial it receive 2 points; (3) Type of sampling – It was given 2 point for an randomized sample and 1 points for a non-randomized; (4) Size of the sample – If the article studied a sample of [0-50] people should receive 0 points and if it studied a sample with more than 50 people it would receive 1 point; (5) Method used to collect data – If it was considered appropriated for the conclusions we wanted to achieve it was given 1 point otherwise it should receive 0 points; (6) Concordance between the results and the initial objective of the study (objectivity of the study) – if there was concordance it should be given 1 point and if there wasn’t any concordance it would be given 0 points;

After analysing all the articles considering these criterions, the ones who received a grade inferior to 11 were excluded.

As there aren’t many scientific studies available we decided to include letter and editorial in the review. For these it couldn’t be considered the last four criterions, so it was given a grade between 0 and 17. If it had a grade superior or equal to 6 it was included. This means that a letter or editorial to be included had to refer at least 4 sub themes (Table 1 – Annex).
In order to extract data from the articles we fragmented ours theme in 14 sub themes: Patient Interest and Acceptance, Confusion and Misunderstandings, Patient Education, Creating Anxiety, Providing Reassurance, Empowering Patients, Promoting Adherence, Concerns about Sensitive Items, Concerns about Confidentiality, Improving Doctor-Patient Relationship, Correcting Errors, Improving Patient Satisfaction, The Use of Electronic Medical records.

This paper is a systematic review, its results can’t be statistical analysed. In order to present some statistical analyses we made some graphics in SPSS that show the relation between the number of articles selected, found and used, and for each topic, the number of articles that write about it.

Results

Research and selection of the articles

From the 165 articles obtained in the PubMed search, 52 were selected as potentially important after reading titles and abstracts.

Then 22 full articles were found which were analysed considering the quality criterions and from those 22, 9 were excluded. A total of 13 articles was achieved from PubMed research. On Scopus a total of 21 articles were achieved. From these only 9 were included and we managed to acquire 3 full articles. The quality criteria selected 2.

A total of 15 articles has been analysed to write this paper (Figure 1).

![Figure 1. Percentage of included and excluded articles](image)
**Data extraction**

As described before, in order to extract data our theme was subdivided in 14 sub themes. Figure 2 shows the chart with the number of articles referring each theme.

![Chart showing the number of articles referring each theme](image)

**Patient experience with access to medical records**

**Patient Interest and Acceptance**

In a study [12] with patients with cancer, 91% of patients declined the offer to see their medical records and the reasons given were: they trust totally on what the doctor had told them, they think that they knew enough or they wouldn’t understand it anyway. The ones that inspect their medical records affirmed didn’t gain new information and believe that any questions could be answered by the clinical nurse or doctor.

Although the situation referred above presents us a very strong percentage of people who refused the access to their medical records, the interest’s level of patients in seeing their records is generally high [5, 8]. This is revealed by the answers of patients, in a study [19] that asked them about shared records, in general, and about shared records online, in particular. 95% of patients agreed with the statement, “Overall, I think it is a
It is also confirmed by this study that the interest was age dependent reducing steadily from 95% for those aged 21-30 down to 68% for those aged 71 and over. Most patients knew that they had the right to access their records although only 5% had done so; and that the majority of patients would like to control access to their records.

Studies [8, 19] have demonstrated the interest was related with many factors, such as: general concern about health, independent of health status, interest in health information, concerns about patient safety and having a less trusting relationship with their primary physician and also the desire to be more involved in their own care. This study [9] also showed that interest wasn’t, however, health status or health care use related, nor was it education or income related. This study [9] concludes that the vast majority of patients endorse the concept of patient-accessible medical records, and about half support online access. This survey further demonstrates that these attitudes are shared even by patients in ethnically diverse and socioeconomically disadvantaged populations. Focusing specially the access through the internet to the medical records, this study revealed, through a multivariate analysis that demographic features such as age, gender, race, and education did not predict an interest in online patient-accessible records. The primary predictor was previous experience with the Internet, followed by expectations of the benefits and drawbacks of reading the medical record.

Other studies [8, 9] have concluded that patients who have looked at their medical record in the past remain interested in reading it. Patients who didn’t know that they had the legal right to inspect their records were more than twice as likely to be very interested in reading their record [8]. Another aspect revealed was that women are more interested in their medical records than men [8].

Other finding of many studies [8, 10] was that the specific portions of the medical records the patients were more interested in seeing was the laboratory results, followed by the physician’s notes. Patients were least interested in seeing past medication [8]. Most of patients were interested in reading their medical record at regular intervals, but not frequently.
Confusion and Misunderstandings

Some studies [13, 14] have revealed that incomprehensible jargon or pejorative comments will understandably confuse or distress the patients. This was an argument used many times in order to keeping secret the medical records. However, this is a most powerful argument for changing the way records are written and presented to the patients, in order to give them the chance to understand it clearly.

Other study [19] refers patients of community health centers were more likely to anticipate being confused by various parts of the medical record and being embarrassed or offended by the doctors' notes, in comparison with academic primary care clinic patients.

Patient Education

The articles collected refer that in the majority of cases, an advantage of the access to the medical records was the patient’s education. The access to the records helps patient to understand their health condition and what the doctor thinks [6, 15].

Patients, who had access to their electronic medical records, improved their own knowledge about their disease – heart failure. It also increased ownership of their health care as consequence of being able to access their own medical data. This fact helped them to be more involved in their treatment and increased patient’s ability to coordinate their care: allowing them to confirm the doses of medications and to provide laboratory results or medical information to their other doctors. This has promoted patients’ sense of personalized support and capacity to look up their results [8, 10].

A disadvantage referred by selected patients is the difficulty to understand medical records because of the use of technical language.

Creating Anxiety

Many doctors and studies had referred that the access to medical records causes damages to patients, nominated anxiety and upset. However recent studies and letters demonstrated that this is, in majority of cases, invalid.
Recent experiences with patients, who had access to their own records, showed that doctors and patients considered the experience positive and that it didn’t cause any kind of anxiety or upset[13,14]. Psychiatric patients may response less favourably than other patients. In spite of causing distress in a short term, in longer term the access to records may be therapeutic. In a transversal study using adult psychiatric patients, who had access to a written clinical summary about themselves, only 28% of patients were upset with what they had read, and 51% rated the written assessment as having provided helpful information.

**Providing Reassurance**

All patients who accepted reading their records felt more reassured about their disease or their health condition, after reading and understanding what their doctor wrote about their health care [8]. Patients felt reassured because reading their records gave them clear ideas about their health care and because their anxiety and worries decreased so they felt better and more relaxed [15].

**Promoting Adherence**

In agreement with an American study based in the analysis of American legislation about this theme, the simple fact of open access to medical records improves patients’ adherence to treatment, the efficiency of the service, and strengthens the role of the profession [2]. A descriptive article about the adherence shows that patients’ interest in viewing records, after one interview which explains the objectives or the consequences of that access, increases [2]. In these cases, patients change their style of life starting to be more careful to follow medical recommendations. However, a randomized controlled trial study [9] revealed that the access to an informatic program that provides patients access to their clinical notes did not result in any significant differences in their health status, clinic visits or hospitalizations, but increased in 31% the messages sent to the system. The patients can have more interest
in access to their medical records, but that doesn’t mean that they will change their way of life.

Concerns about Confidentiality
When patients were questioned about electronic access to their medical records they were worried about the security of some sensitive items. Although they find the inclusion of these items appropriate, they also think that they could be identified by a code [5].

In a randomized controlled trial [15] several individuals voiced theoretical concerns about the security of their records online and were particularly concerned that their records could become available to employers or governments agencies without their permission, although many didn’t mind sharing the record with close family members.

In other study [6] 24% of the patients expressed concerns about the confidentiality of their medical records which included the ability of others to get into the system where the health records were available. They didn’t trust the staff people and didn’t know how the system worked, which caused insecurity. On the other hand, some of the patients didn’t show any concerns about this subject.

Effects on Doctor-Patient Relationship
Improving Doctor-Patient Relationship
In a transversal study [6] over 75 % of respondents stated that having access to their notes would break down barriers between them and the doctor and give information which one was not sure about. Over 70% felt it would give them more confidence in the doctor and over 65% felt it would help them to understand their condition and feel that their doctor understood them. There were 67% of the patients that disagreed that it would give them less confidence in their doctor.

In another study [15] the majority of patients and doctors were unanimous in their belief that the impact of the access to electronic health records was positive for both, improving the level of communication between them.
Effects on Medical Practice

Correcting Errors

Although patient accessible medical records offer them the opportunity to correct errors in the record, patients may also introduce errors if they make unauthorized additions to or deletions from the medical record.

The utility of patients auditing and being able to correct their computer held records has been shown in several studies, including studies of administrative records in hospital and problem and drug lists in diabetes outpatients clinics and general practice.

In one study[17] in general practice 24% of patients said that were mistakes and 30% omissions in their records, including allergies, dates of birth, addresses, current drug treatments and items on the problem list, smoking details, height, weight, alcohol history, and family history.

The Use of Electronic Medical records

There are several kinds of medical records and, as the technology evolves, the electronic medical records are becoming more common. In seven [5, 6, 7, 9 10, 15, 19] of the fifteen selected articles the patients were given access to their electronic records.

There are also many ways of accessing electronic health records. In some randomized clinical trials [9, 10, 15] patients and doctors were given access to health records through the internet and electronic systems. In the end, the majority of patients and doctors found this kind of systems easy to use, useful and considered that it can improve their communication with health care providers and their health care quality.

In another randomized clinical trial [6] the patients were given access to their electronic records, in the waiting room, through a secure access system that used a fingerprint recognition technology. When these patients were asked how interested they were in seeing their electronic records, a mean of 8.05 was obtained (in a scale of 0 to 10).

Some of the patients said why they were interested on accessing electronic records: “not taking up anyone’s time”, “no bother for anyone” and “can just come in and sit down (at computer)”. Forty one patients were asked if they were interested in looking at their electronic records over the internet: 18 said that were very interested and 14 not
interested at all. Some of them even added the comment: “don’t think it should happen at all”.

In one study [19], 56% of all patients agreed with the statement “Overall, I think it’s a good idea for patients to be able to review their outpatient medical records using the Internet”, meaning that about half of the patients support online access. This study also concluded that previous experience with Internet, expectations of the benefits and drawbacks of accessing their medical records were the primary predictors of an interest in online patient-accessible records.

Other study [8], patients were divided in terms of the preferred mode of access to medical records: through a paper copy of their medical record (49.3%) or through an electronic version at a secure, private web site (43.8%).

In an editorial [18] was said that by allowing patients interaction with the EMR physicians have much more accurate and up-to-date information for managing therapy. Although there are still certain problems with access that must be overcome, such as ensuring privacy of personal medical data and determining the ways in which patients should be able to influence their charts.

Discussion

Our review presents some limitations such as: not all the studies used were randomized trials, in general it was used a small sample size and small study duration time, the studies used unstandardized measuring instruments and the number of articles found wasn’t very high. As the number of scientific articles found was reduced, it was decided to include letters and editorials, which don’t present the quality of a scientific study.

On the other hand the scientific papers referred to questionnaires where patients were asked their opinions about accessing their medical files, or simulations in which patients were given access to their medical and then asked their opinions. Due to these limitations it is not possible reaching definitive conclusion.

Nevertheless, and overall, the studies reveal that patients’ access to medical records is beneficial both for patients and doctors, since it enhances communication between them and makes patients understand better their health condition.
Accessing medical records has shown improvements on patient’s education, better knowledge of the disease and participation in their health treatment. Improvements on adherence made patients more careful in following medical recommendations, and self-empowerment providing them more autonomy and self-efficacy, increasing therefore the sense of ownership of their medical records.

However, patients find some parts of the medical records difficult to understand because some notes are intelligible or illegible to them. The access to medical records helps correcting errors and omissions, but patients can also make unauthorized additions or deletions, which become much easier with the use of Electronic Medical Record (EMR). So the patients’ actions on their medical record must be ruled.

The EMR raises several concerns about the security of sensitive items and confidentiality of the records. Some suggest the use of codes to identify sensitive items. As for confidentiality the possibility that technology gives of using security or any other security device reinsures patients. This is a possibility that paper records don’t have, so the security issues are harder to solve in this case.

EMR makes it possible to solve some of the problems concerning the access to medical records, such as understanding doctor calligraphy, and it can allow reducing errors by increasing the opportunities of patients accessing medical records.

The use of EMR implies previous technological knowledge, which can be a problem, especially for older people.

A 2004 review [1] analysed the access to medical records but it didn’t focus on EMR. The conclusions reached concerning the themes analysed in the results are similar to ours, but we analysed the EMR possibilities in our review and agree that it brings solutions for some paper records problems and enhances the opportunities of patients accessing their medical records.

**Conclusion**

The majority of patients and doctors seem to be unanimous in their belief that the impact of the access to electronic medical record is positive for both.
Not only are there some real benefits in the patient accessing his/her medical record but also new technologies can help improving and support even more this access. We agree that the EMR can bring some security solutions as well as the possibility of improving both the quality and completeness of the record. Allowing therefore for better treatment and trust in healthcare by the patients.

Due to some limitations we can’t take definitive conclusions nevertheless, we can stress the importance and need for this kind of studies to be further pursued and done in a regular basis. This review can be used as a future platform for research.

References


Annexes: Table 1. Relevance/Quality criteria

<table>
<thead>
<tr>
<th>Articles</th>
<th>Objective (14)</th>
<th>Kind of study (3)</th>
<th>Type of sample (2)</th>
<th>Size of sample (1)</th>
<th>Methods of data extraction (1)</th>
<th>Objectivity (1)</th>
<th>Total</th>
<th>Exclusion/inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHIMA e-HIM Personal Health Record Work Group. Practice brief. The role of the personal health record in the EHR. J AHIMA.</td>
<td>0</td>
<td>_</td>
<td>_</td>
<td>_</td>
<td>_</td>
<td>_</td>
<td>0</td>
<td>E</td>
</tr>
<tr>
<td>Honeyman A, Cox B, Fisher B. Potential impacts of patient access to their electronic care records. Inform Prim Care.</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>12</td>
<td>I</td>
</tr>
<tr>
<td>Waegemann CP. Closer to reality. Personal health records represent a step in the right direction for interoperability of healthcare IT systems and accessibility of patient data. Health Manag Technol.</td>
<td>0</td>
<td>_</td>
<td>_</td>
<td>_</td>
<td>_</td>
<td>_</td>
<td>0</td>
<td>E</td>
</tr>
<tr>
<td>Winkelman WJ, Leonard KJ, Rossos PG. Patient-perceived usefulness of online electronic medical records: employing grounded theory in the development of information and communication technologies for use by patients living with chronic illness. J Am Med Inform Assoc.</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>11</td>
<td>I</td>
</tr>
<tr>
<td>Pyper C, Amery J, Watson M, Crook C. Access to electronic health records in primary care—a survey of patients’ views. Med Sci Monit.</td>
<td>9</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>17</td>
<td>I</td>
</tr>
<tr>
<td>Hassol A, Walker JM, Kidder D, Rokita K, Young D, Pierdon S, Deitz D, Kuck S, Ortiz E. Patient experiences and attitudes about access to a patient electronic health care record and linked web messaging. J Am Med Inform Assoc.</td>
<td>0</td>
<td>_</td>
<td>_</td>
<td>_</td>
<td>_</td>
<td>_</td>
<td>0</td>
<td>E</td>
</tr>
<tr>
<td>Fowles JB, Kind AC, Craft C, Kind EA, Mandel JL, Adlis S. Patients’ interest in reading their medical record: relation with clinical and sociodemographic characteristics and patients’ approach to health care.</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>13</td>
<td>I</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Title</td>
<td>Journal</td>
<td>Year</td>
<td>Volume</td>
<td>Issue</td>
<td>Pages</td>
<td>Type</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>-----------------------------------------------------------------------</td>
<td>--------------------------------------</td>
<td>------</td>
<td>--------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>Ross S, Lin CT.</td>
<td>A randomized controlled trial of a patient-accessible electronic medical record</td>
<td>AMIA Annu Symp Proc.</td>
<td>2005</td>
<td>0</td>
<td>0</td>
<td>16</td>
<td>I</td>
<td></td>
</tr>
<tr>
<td>Jones TM.</td>
<td>Patient participation in EHR benefits</td>
<td>Health Manag Technol.</td>
<td>2005</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>Cimino JJ, Patel VL, Kushniruk AW.</td>
<td>The patient clinical information system (PatCIS): technical solutions for and experience with giving patients access to their electronic medical records</td>
<td>Int J Med Inform.</td>
<td>2005</td>
<td>0</td>
<td>0</td>
<td>11</td>
<td>I</td>
<td></td>
</tr>
<tr>
<td>Hughes G; American Health Information Management Association</td>
<td>Practice brief. Patient access and amendment to health records</td>
<td>J AHIMA</td>
<td>2005</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>Dyer C.</td>
<td>Patient denied right to see medical records</td>
<td>BMJ</td>
<td>2005</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>Warden J.</td>
<td>Patients to see medical records</td>
<td>BMJ</td>
<td>2005</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>I</td>
<td></td>
</tr>
<tr>
<td>British Medical Association.</td>
<td>Patients’ rights to see records</td>
<td>BMJ</td>
<td>2005</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>Jones R.</td>
<td>Patient access to records must be acceptable to both parties</td>
<td>BMJ</td>
<td>2005</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>Rostom AY, Gershuny AR.</td>
<td>Access to patient records</td>
<td>Lancet</td>
<td>2005</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>Bernadt M, Gunning L, Quenstedt M.</td>
<td>Patients’ access to their own psychiatric records</td>
<td>BMJ</td>
<td>2005</td>
<td>5</td>
<td>3</td>
<td>11</td>
<td>I</td>
<td></td>
</tr>
<tr>
<td>McLaren P.</td>
<td>The right to know</td>
<td>BMJ</td>
<td>2005</td>
<td>7</td>
<td>2</td>
<td>9</td>
<td>I</td>
<td></td>
</tr>
<tr>
<td>Reuler JB, Balazs JR.</td>
<td>Portable medical record for the homeless mentally ill</td>
<td>BMJ</td>
<td>2005</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>Author(s)</td>
<td>Title</td>
<td>Year</td>
<td>Journal</td>
<td>Volume</td>
<td>Issue</td>
<td>Pages</td>
<td>EPEC</td>
<td>Type</td>
</tr>
<tr>
<td>-----------</td>
<td>-------</td>
<td>------</td>
<td>---------</td>
<td>--------</td>
<td>-------</td>
<td>-------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>Jones R, Cawsey A, Bental D, Pearson J.</td>
<td>How should we evaluate patient access to their own records? An example with cancer patients in Scotland.</td>
<td>2001</td>
<td>Stud Health Technol Inform.</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Tsai, C.C., Starren, J.</td>
<td>Patient participation in electronic medical records (2001)</td>
<td>2001</td>
<td>Journal of the American Medical Association</td>
<td>285</td>
<td>13</td>
<td>7</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Kim, M.I., Johnson, K.B.</td>
<td>Personal health records: Evaluation of functionality and utility (2002)</td>
<td>2002</td>
<td>Journal of the American Medical Informatics Association</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>