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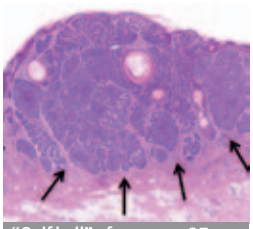

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BMJ

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The BMJ is published by BMJ Publishing Group Ltd, a wholly owned subsidiary of the British Medical Association.

Published weekly. US periodicals class postage paid at Rahway, NJ. Postmaster: send address changes to *BMJ*, c/o Mercury Airfreight International Ltd Inc, 365 Blair Road, Avenel, NJ 07001, USA. $796. Weekly

Printed by Polestar Limited

PAUL MOSELEY/FORT WORTH STAR-TELEGRAM/GETTY IMAGES

PICTURE OF THE WEEK

Aerial spraying to combat the West Nile virus in Fort Worth, Texas, which is spread to humans by mosquito bites. Residents are concerned about potential health risks posed by the insecticide because of heavy rain. The virus's greatest natural reservoir is in birds, which might explain its rapid dissemination.

bmj.com News: US hit by massive West Nile virus outbreak (*BMJ* 2012;345:e5633)

MOST COMMENTED ON BMJ.COM

Transcatheter aortic valve implantation (TAVI): risky and costly

Association between psychological distress and mortality

We should not let families stop organ donation from their dead relatives

Diagnosis and management of cellulitis

Management of osteoarthritis of the knee

MOST READ ON BMJ.COM

When financial incentives do more good than harm: a checklist

Integration of balance and strength training into daily life activity to reduce rate of falls in older people (the LiFE study)

The truth about sports drinks

Pharmaceutical research and development: what do we get for all that money?

Suicides associated with the 2008-10 economic recession in England: time trend analysis

RESPONSE OF THE WEEK

The NHS constitution enshrines the right to a comprehensive service. However local health authorities have been lopping bits off the coverage for financial gain. Removing NICE approved treatments from 'low priority' lists will just divert cost cutting activities to areas that have not (yet) been assessed.

"Common conditions like inguinal hernia repair, cataract surgery for the second eye, certain hearing aids and other prostheses among many other items have been banned from the 'comprehensive' NHS package in some areas.

Hendrik J Beerstecher, GP principal, Sittingbourne, UK, in response to "Nicholson acts to ensure that trusts and CCGs do not blacklist drugs approved by NICE" (*BMJ* 2012;345:e5465)

BMJ.COM POLL

Our last poll asked: "Has the current economic downturn adversely affected the health of your patients?"

80% voted yes (total 348 votes cast)

Observations (*BMJ* 2012;345:e5183)

This week's poll asks: "Should doctors allow families to veto organ donation requested by their dead relatives?"

Personal View (*BMJ* 2012;345:e5275)

Vote now on bmj.com

EDITOR'S CHOICE

Towards a unified theory of patient data

Electronic patient records should include clear audit trails that show who has accessed them, when, and why

Data on patients don't assemble themselves. Someone collects them. The question is: who then owns the data—the people who collected the data, or the people who the data were collected from? Some years ago, researchers' arguments that such data were theirs to release or withhold as they pleased didn't convince me. Eventually I decided that the data belonged to research participants, and it was they who should control the data's subsequent fate (*BMJ* 1996;312;1241).

Does this formulation work for medical records? Is the information record about a patient his or her property? Ownership and control of such records have recently achieved prominence because of the acceptance that soon all patients will have electronic records, just as they do electronic banking accounts.

In his feature, Peter Davies explains that, historically, medical records have been regarded as the property of clinicians or their institutions (p 24). So will opening up the record represent a profound cultural shift for the UK's doctors, as some claim? If so, you wonder where they've been. As Davies points out, patients have had the right to read their paper records since the 1990s. Antenatal patients have been carrying their notes around for years (as have private patients). Copying referral letters to patients has long gone from fringe activity to best practice.

Remaining doubters should read Davies's account of Intermountain Healthcare's experience of patient controlled records, which dates back to the 1990s. Its 22 hospitals and 185 clinics now offer patients virtually complete access to their data and must justify holding anything back. The system seems to works for patients and clinicians.

In his Personal View article, Mohammad Al-Ubaydli develops the arguments for a "personal health record": an electronic record that is controlled by the patient rather than the institution (p 34). Although he has strong competing interests (his company sells patient controlled record systems) he makes a convincing case that records should match the rhetoric of "patient centred care."

In her blog, Tessa Richards recommends the latest report from the Patients Information Forum for its description of current models of personal health records, ranging from "read only e-access," via "real time unfiltered, read, and annotate," to "full fusion of personal health information" (http://bit.ly/NDOjHJ).

But there's a worm in the bud. The return of Julian Assange to public prominence, and the steady drip feed of arrests of journalists from News International, reminds us of an uncomfortable truth: nothing in digital format can be kept truly safe from prying eyes (*BMJ* 2010;341:c5190).

So as we accept the inevitable shift to electronic patient records, with patients ever more in control, we need to insist that records include clear audit trails showing who has accessed them, when, and why. (And that shadowy government agencies aren't given a free pass.)

Tony Delamothe, deputy editor, *BMJ*
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Cite this as: *BMJ* 2012;345:e5678

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