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Legal and Societal Perspectives on Record Keeping in the Health Care Sector: A Comparative Appraisal of Nigeria and the United Kingdom

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Abstract:
Record keeping is the backbone of healthcare, yet its implementation varies greatly among countries. This comparative study examines the legal and societal factors influencing record keeping in Nigeria and the United Kingdom. The research identifies key disparities, and highlights opportunities for cross-pollination of health record practices in Nigeria and the United Kingdom for improved outcomes. By exploring the intersections of law, culture, and healthcare, this study proposes a hybrid framework, blending the United Kingdom's robust systems with Nigeria's unique cultural context. Ultimately, this research aims to inform policy reforms and capacity-building initiatives, bridging the record-keeping gap and enhancing healthcare outcomes in Nigeria. The methodology used is the doctrinal approach which relies extensively on primary and secondary sources of legal materials, such as legislations, judicial precedents and textual authorities. This paper analyzed the limitations of record keeping in the health sector in these jurisdictions and concluded that there were similarities and differences in how records are being managed, maintained and stored in Nigeria and the United Kingdom. The study therefore recommends that the Nigeria government should promote the culture of record keeping and data protection by enacting some policies on management of patients records that will cut across the federal, state and local governments so as to provide uniform practice and enhance good standard of good standard of records management practice, like that of the United Kingdom.

Keywords: Record Keeping, health, legal, societal, Nigeria, United Kingdom

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1. Introduction

The recent bureaucracy in ultramodern medical and surgical treatments in the health sector both in Nigeria and the United Kingdom requires accurate and acceptable record keeping. This will serve as documentation and evidence of the care and treatment received by patients in the various health sectors of these jurisdictions. Record keeping in the health care sector involves health information management, maintenance of patient files, and documenting the health conditions of patients for bureaucratic purposes.

Records management utilizes an effective system to direct and control the creation, distribution, format, retention, storage, and disposal of records in a manner that is administratively and legally acceptable, ethically fair, while serving the functional requirements of the organization, as well as preserving an accurate and reliable form of record keeping (North East London Foundation Trust, 2011). In developing and enforcing programs; procedures and guidelines are demanded for effective form, storage, and to make available both physical and electronic health record for patient treatment (Huffman, 2001).

Laws and regulations guiding the release of patient information are necessary in order to protect the confidentiality, integrity, privacy of patients' records, and to avoid liability. These laws ensure that only persons authorized with a written permission from the patient can have access to a case file or patient's record (Cohen, 2004). The information in a patient's record is confidential because it is held in trust for the patient. The relationship between the patient and the health care provider is special; and their communication should be defended from exposure to third parties. This is supported by various laws, codes, ethics of health records operation and other applicable statutory provisions in these jurisdictions. An inactive record is a record that's no longer needed to conduct current business but is being saved until it meets the end of its retention period. These records may be used for business, legal, financial or other valuable purposes.

Lack of effective retention policy and disposal schedules in the storing, filing and disposal of patients' record may contribute to poor management of patient medical records in Nigeria. The health practitioners and data controllers are saddled with the responsibilities of keeping these health records. Furthermore, the Hospital Management Board makes rules that regulates health care practices, including health records management in the areas of information dissemination and confidentiality of patients' records (Maduewesi, 2004). The authorization or consent of a patient or his representatives are pivotal to avoid releasing patient information to a wrong party, who may use the information against the patient (Benjamin, 2010).

Other than for medical needs, patients' records may be requested for insurance purposes. There is therefore need for strict adherence to rules on privacy. The illegal use of patients' records; inaccurate record keeping and other forms of invasion of patients' fundamental human rights are treated as grave issues that may have negative impacts upon the management of patients' records. This study, therefore, examines how legal issues influence the management of patients' health records.

The authors have formulated the three questions below for investigation:

i. What are the key legal and regulatory frameworks governing record keeping in the health sectors in Nigeria and the United Kingdom, and how do they impact on the quality and accessibility of health records?
ii. How do societal and cultural factors, such as patient privacy concerns and healthcare provider attitudes, influence record keeping practices in Nigeria and the United Kingdom, and what are the implications for health outcomes?
iii. What are the lessons that can be learned from the experiences of the United Kingdom with electronic health records and health information technology, and how can Nigeria adapt and apply these lessons to improve its own health record keeping systems and address challenges such as data fragmentation?

2. Methodology

This study employed the doctrinal, descriptive and detailed review of textbooks and other relevant documents to explore the legal and societal perspectives of record keeping in the health sector in Nigeria and the United Kingdom. The doctrinal approach according to Bell (2016) involves analyzing legal texts, including statutes, case law, and regulations, to understand a discourse. Primary and secondary legal materials in Nigeria and United Kingdom relevant to health record keeping were examined. These included identifying and discussing relevant laws such as, the Constitution of the Federal Republic of Nigeria (CFRN) 1999, the National Health Act (NHA) 2014, the Nigerian Data Protection Regulations (NDPR) 2019, the National Data Protection Act (NDPA) 2023 and others.

Furthermore, exploring Bowen (2009), Olatunji (2019) and Saunders and Townsend's (2016) explanations on document review, this study engaged in the systemic examination of existing literature, policies, and guidelines relating to record keeping such as the Nigerian National Health Policy and the United Kingdom's National Health Service (NHS) Guidelines, to point out the legal requirements, societal perspectives, gaps, and areas for improvement in the management of record keeping in the Nigeria and the United Kingdom.

3. Results and discussion

3.1 Historical background of record keeping in Nigeria

The historical trajectory of record keeping in Nigeria's health sector is a fascinating narrative that traverses various epochs, influenced by a complex interplay of factors, including colonialism, technological advancements, and shifting healthcare needs.

3.2 Pre-colonial era (Before 1900)

In the pre-colonial era, spanning thousands of years, traditional methods of documenting and managing health-related information were employed by various ethnic groups, albeit with limitations in scope, accessibility, and durability. Oral tradition played a significant role in the transmission of knowledge, with elders and traditional healers passing down information on medicinal plants, treatments, and health practices through verbal narratives. Traditional healers also maintained records of treatments, remedies, and patient outcomes using symbolic markings or oral memory. Furthermore, family and clan leaders kept records of significant life events, including births, deaths, and illnesses, within their communities.

In addition, ethnic groups developed unique record-keeping systems, such as the Yoruba Ifa divination, which utilized verses to document diagnoses, treatments, and outcomes. The Igbo people employed the "Omu" system, using knots on strings to record numerical data, including health-related information. Similarly, Hausa scribes, known as "Makama," recorded important events, including health-related information, using Arabic script. However, with the advent of colonialism, Western-style health record keeping was introduced, gradually supplanting many of these traditional methods. This marked a significant turning point in the evolution of record keeping in Nigeria's health sector, as it ushered in a new era of standardized documentation and data management.

As noted by Orubu (1985), the pre-colonial era's record-keeping practices, although varied and region-specific, laid the foundation for the development of modern health record-keeping systems in Nigeria. Understanding this historical context is essential for appreciating the complexities and challenges associated with implementing effective record-keeping practices in Nigeria's health sector today.

3.3 Colonial era (1900-1960)

This era marked a significant turning point in the evolution of record keeping in the health sector, as British colonial policies and practices exerted a profound influence on the development of healthcare documentation (Oyewale, 2018). According to Falola (2028), the introduction of Western-style record keeping by the British colonial administration supplanted traditional methods, with the aim to establish a centralized healthcare system, monitor disease outbreaks, and track patient care.

To achieve this, Afigbo (2016) revealed that a register-based system was implemented, where hospitals and clinics-maintained registers for patient admissions, discharges, and deaths. This system enabled colonial authorities to track healthcare utilization and patient outcomes, facilitating the monitoring of disease outbreaks and the evaluation of healthcare interventions. In addition to this, a disease surveillance system, which was another critical aspect of colonial-era record keeping as mentioned by Akindele (2017) was established to track and report diseases like malaria, smallpox, and tuberculosis. This enabled the colonial administration to respond promptly to outbreaks, implement control measures, and allocate resources effectively.

Another system of record keeping in this era was the vaccination records like smallpox inoculations, kept to monitor population coverage and evaluate the effectiveness of vaccination campaigns (Oyewale 2017). Furthermore, Afigbo, (2015) disclosed that medical officers were required to submit regular reports on healthcare activities, disease outbreaks, and patient statistics, providing valuable insights into healthcare trends and challenges. As noted by historians, the colonial era's record-keeping practices in Nigeria's health sector were shaped by the British colonial administration's desire to exert control over the healthcare system and population (Falola 2017)). While these practices laid the foundation for modern healthcare documentation in Nigeria, they also perpetuated a centralized and paternalistic approach to healthcare, which has had lasting impacts on the country's healthcare system.

3.4 The post-colonial era (1960- 1990)

In the post-colonial era, Nigeria's health sector underwent significant transformations in record keeping, driven by the need to address the country's unique challenges and improve healthcare delivery. One key development was the decentralization of record keeping, with state and local governments assuming greater responsibility for healthcare data management (Afigbo, 2018). This shift enabled more effective monitoring and evaluation of healthcare services at the subnational level, facilitating targeted interventions and resource allocation.

The 1988 National Health Policy in line with World Health Organization (2018) marked a critical milestone in Nigeria's healthcare landscape, emphasizing the importance of record keeping in healthcare planning and management. This policy framework recognized the critical role of accurate and reliable data in informing healthcare decision-making, resource allocation, and service delivery. The 1980s also saw the introduction of basic computer systems and software for record keeping, marking a significant technological leap in Nigeria's health sector.

The development of digital health records enabled the automation of record-keeping processes, improving data accuracy, and reducing manual errors (World Health Organization, 2018; Akindele, 2018). However, Olatunji (2017) maintained that despite this feat, challenges persisted, including limited infrastructure, inadequate training, and insufficient funding. As noted by Falola (2019), these developments in record keeping have had a profound impact on Nigeria's health sector, enabling more effective healthcare planning, management, and delivery. Nevertheless, Oyewole (2020) opined that ongoing challenges necessitate continued innovation, investment, and capacity building to strengthen record-keeping systems and improve healthcare outcomes.

3.5 Modern era (1990-present)

In the modern era, Nigeria's health sector has witnessed a paradigmatic shift in record keeping, characterized by significant transformations that have revolutionized the way healthcare data is generated, stored, and utilized (Ojo, 2020). The advent of digitalization has been a key driver of this transformation as identified by Oyewale (2019), with the increasing adoption of Electronic Health Records (EHRs) and Health Management Information Systems (HMIS).

As indicated by Afigbo (2020), the 2014 National Health Act marked a watershed moment in Nigeria's healthcare landscape, mandating the use of EHRs and standardized record-keeping practices. This legislative framework provided a catalyst for the adoption of digital record-keeping systems, enabling the integration of healthcare data and facilitating the monitoring of health outcomes.

Uzochukwu (2019) observed that this era witnessed the private sector playing a pivotal role in driving innovation in record keeping, with some providers adopting international standards and leveraging cutting-edge technologies to enhance data accuracy and accessibility. The implementation of Electronic Medical Records (EMRs) in many hospitals and clinics has significantly improved the quality and availability of healthcare data, enabling healthcare professionals to make informed decisions, improving patient outcomes and enabling continued care.

Furthermore, the proliferation of Mobile Health (mHealth) technologies has expanded access to healthcare services and improved record keeping, particularly in rural and underserved areas (Olatunji, 2019). Mobile applications and telemedicine platforms have enabled remote consultations, monitoring, and data collection, bridging the gap between healthcare providers and patients. As noted by scholars, these transformations have the potential to revolutionize Nigeria's health sector, enabling the creation of a robust and integrated healthcare system that leverages data-driven insights to improve health outcomes (Falola, 2020; Akindele, 2020 and Oyewale, 2020). However, challenges persist, including infrastructural constraints, data privacy concerns, and the need for ongoing training and capacity building.

4. Historical background of record keeping in the United Kingdom

The history of medical records dates back to ancient civilizations, with notable references to the Edwin Smith papyrus (1600 BC), Hippocratic case histories (400 BC), and medieval Islamic texts (AD 925). These early records were primarily used as teaching instruments, providing valuable insights into patient care and medical practices. Over time, medical records evolved to include case histories for anatomical studies during the 17th century. By the 18th century, physicians began keeping case history books, and medical centers maintained detailed patient records. In the late 19th century, efforts were made to standardize hospital records for insurance and medicolegal purposes.

The historical narrative of record keeping in the United Kingdom is a rich and evolving one, spanning centuries. From ancient papyrus to modern digital systems, the practice of documenting medical information has transformed significantly over time. In ancient Britain, record keeping was evident in the use of papyrus and parchment by Celtic and Roman civilizations (Lovering, 2016). The medieval era saw the emergence of handwritten records in monasteries and apothecaries, documenting treatments and remedies (Delmas & Penn, 2017).

The 18th and 19th centuries witnessed the establishment of hospitals, with institutions like St. Bartholomew's Hospital (founded in 1123) and Guy's Hospital (founded in 1721) maintaining detailed patient records (Conde et al., 2018). The British Medical Association, which was founded in 1832, advocated for standardized record keeping (Moss, 2019). The early 20th century saw the introduction of centralized record keeping with the establishment of the National Health Service (NHS) in 1948 (Thurston, 2017). The NHS implemented a standardized system of medical records, initially using paper-based systems until the 1980s (McKemmish et al., 2019).

The advent of computerization in the 1980s revolutionized medical record keeping, with the introduction of electronic health records (EHRs) (Grimble, 2018). The NHS launched the NHS Connecting for Health program (2002-2011) to implement EHRs nationwide (Furse, 2019). Today, the UK's healthcare system relies on digital record keeping, with NHS Digital overseeing the management of health data (Kirk-Greene, 2020). The use of EHRs has improved patient care, research, and public health surveillance (Gilmour, 2020).

5. Legal framework for the protection of data and record keeping in Nigeria health sector

5.1 The Constitution of the Federal Republic of Nigeria, 1999

The Constitution of Nigeria serves as the foundational legal framework, conferring validity on all subsidiary laws and regulations governing record keeping in the country (Oyewale 2019). Section 1(1) of the 1999 Constitution establishes Nigeria as a sovereign state, predicated on democratic principles and social justice. This provision sets the tone for the protection of citizens' rights, including the right to privacy, which is fundamental to record-keeping practices.

Section 37 of the Constitution of the Federal Republic of Nigeria (1999) unequivocally guarantees and protects the privacy of Nigerian citizens, encompassing various aspects, including personal privacy, home privacy, and confidentiality of correspondence, telephone conversations, and telegraphic communications. This provision ensures that citizens' personal information and communications are shielded from unauthorized access or intrusion, except as permitted by law.

In the context of record keeping, Section 37 has significant implications, as it:

1. Safeguards patients' personal and medical information from unauthorized disclosure.
2. Protects the confidentiality of healthcare providers' communications with patients; and
3. Ensures the security of medical records and data.

As noted by Orubu, (2019), the right to privacy is a fundamental human right, essential for maintaining trust and confidence in healthcare services. The Constitution's protection of privacy underscores the importance of confidentiality in record keeping, emphasizing the need for healthcare providers to handle personal and medical information with utmost care and discretion.

5.2 National Health Act (NHA) 2014

The National Health Act 2014 is the primary legislation that regulates the health care sector in Nigeria. It provides for the privacy rights of patients. Section 26 (1) of the NHA imposes the duty of confidentiality on the healthcare sector. It provides that all information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment is confidential. Section 27 provides for the conditions for disclosure of such confidential information, which include the user's consent, court order or any law that requires disclosure. In a situation where the user is a child or minor, the consent of the parent or guardian must be obtained.

Furthermore, all information concerning a patient including information relating to his or her health status, treatment or stay in a health facility shall be protected and not shared within the public purview. Under section 29, a person in charge of a health establishment who is in possession of a user's health records shall set up control measures to prevent unauthorized access to the records.

5.3 The Nigerian Data Protection Regulation (NDPR) 2019

The NDPR was introduced in 2019, and also contains provisions for the protection of personal data. The regulation mandates data controllers to seek the consent of the data subject before dealing with their data. Such consent must not be ambiguous or obtained by coercion. Part 1.3 of the Nigerian Data Protection Regulation (NDPR) defines data as characters, symbols, and binary on which operations are performed by a computer, which may be stored or transmitted in the form of electronic signals, formats or device.

Part 2.2 provides for the lawful processing of data, which may occur if; a) the Data Subject has given consent to the processing of his or her Personal Data for one or more specific purposes; b) processing is necessary for the performance of a contract to which the Data Subject is party or in order to take steps at the request of the Data Subject prior to entering into a contract; c) processing is necessary for compliance with a legal obligation to which the Controller is subject; d) processing is necessary in order to protect the vital interests of the Data Subject or of another natural person, and e) processing is necessary for the performance of a task carried out in the public interest or in exercise of official public mandate vested in the controller." The NDPR contains several prohibitions which include obtaining consent by fraud or coercions; or for improper motives such as promoting the violations of the rights of children.

5.4 Nigerian Data Protection Act, 2023

In response to the call for a more robust data protection instrument to adequately provides for the collection and processing of data in Nigeria, the Nigerian Data Protection Act, 2023 was signed into law on 12 June 2023. The Act seeks to give proper regulation for the processing of data and the rights of data owners. Out of the numerous issues addressed in the Act, the provisions which are applicable to the health care sector and the processing of sensitive personal data are easily noticeable.

Thus, under section 24 (1) of the act, a data controller or data processor shall ensure that personal data is (a) processed in a fair, lawful and transparent manner; (b) collected for specified, explicit, and legitimate purposes, and not to be further processed in a way incompatible with these purposes; (c) adequate, relevant, and limited to the minimum necessary for the purposes for which the personal data was collected or further processed; (d) retained for not longer than is necessary to achieve the lawful bases for which the personal data was collected or further processed; (e) accurate, complete, not misleading, and, where necessary, kept up to date having regard to the purposes for which the personal data is collected or is further processed; and (f) processed in a manner that ensures appropriate security of personal data, including protection against unauthorized or unlawful processing, access, loss, destruction, damage, or any form of data breach.

Further, the Act mandates data controllers and data processors to use appropriate technical and organizational measures to ensure confidentiality, integrity, and the availability of personal data. This is task is buttressed by section 39 of the Act which requires the establishment of measures for the security, integrity and confidentiality of data against accidental or unlawful destruction, loss, misuse, alteration, and unauthorized disclosure, or access.

6. The Legal and societal perspectives of record keeping in the United Kingdom health sector

Record keeping in the United Kingdom health sector is governed by various legal and societal frameworks that ensure confidentiality, data protection, and accurate documentation.

6.1 Legal perspective

The following legislations define the legal approaches to the processing, use and storage of health records in the United Kingdom.

6.1.1 Data Protection Act 2018 (DPA 2018)

The Data Protection Act of 2018 imposes obligations on healthcare organizations to protect patient data and maintain accurate records (ICO, 2020). The Act is a significant legislation in the United Kingdom that governs the collection, storage, and use of personal data, including sensitive health data. Although a national legislation, the DPA 2018 complements the European Union's General Data Protection Regulation (GDPR).

The act has several major parts which address the following subjects: supplementing the GDPR and applying a broadly equivalent regime to certain types of processing to which the GDPR does not apply; provisions on the processing of personal data by competent authorities for law enforcement purposes and implementing law enforcement directives; provisions on the processing of personal data by intelligence services; and provisions on the enforcement of the data protection legislation.

6.1.2 The General Data Protection Regulation (GDPR)

The GDPR regulates data protection and privacy in the European Union. The regulations are applicable to the UK healthcare organizations (EU, 2016; McKemmish et al., 2019). The General Data Protection Regulation (GDPR) is a European law that expanded the privacy and security protections for personal information in the European Economic Area (EEA), which includes the United Kingdom. The GDPR became effective on May 25, 2018. Although the UK has left the European Union, the GDPR is still applicable in the UK by virtue of the UK Data Protection Act 2018 (the UK DPA) (McKemmish et al., 2019).

Under Article 5 of the General Data protection Regulations (GDPR), personal data should be processed lawfully, fairly and in a transparent manner in relation to the data subjects, which should be collected for specified, explicit and legitimate purposes and not further processed in a manner that is incompatible with those purposes. By virtue of Article 6, the processing of data is lawful only when the data subject has given consent to the processing of his or her personal data for one or more of the following grounds; the performance of a contract to which the data subject is party; compliance with a legal obligation to which the controller is subject; protecting the vital interests of the data subject or of another natural person; and where it is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller. Healthcare organizations are required to implement data protection principles and safeguards into their processes and systems, and should consider data protection issues from the outset (Article 26, GDPR).

Health care organizations must notify the Commissioner must be notified of a personal data breach within 72 hours, and inform the affected patient too (Article 33, GDPR). Health care organizations are required to conduct Data protection impact assessment (DPIA) before carrying out high-risk processing operations, such as the large-scale processing of sensitive data. The GDPR also provides that individuals in relation to the use of their personal data have the right to be informed about how their data is being used. They should be able to access their personal data; have incorrect data updated; have data erased; stop or restrict the processing of their data, including data portability, and can object to how their data is processed in certain circumstances (McKemmish et al., 2019).

6.1.3 Health and Social Care Act 2012

The Health and Social Care Act 2012 has significant implications for record keeping in the UK health system. The Act mandates healthcare providers to maintain accurate and up-to-date records, ensuring the quality and continuity of care (UK Parliament, 2012). Specifically, the UK Parliament's Health and Social Care Act (2012) requires healthcare providers to: maintain accurate and up-to-date records (Section 250); ensure the confidentiality and security of patient information (Section 251); share information with other healthcare providers, where necessary, for the provision of care (Section 252); provide patients with access to their own records (Section 253); and ensure that records are kept for the appropriate period, as specified in the Act (Section 254).

The Act also established the Health and Social Care Information Centre (HSCIC), now known as NHS Digital, to manage and analyze health and social care data. Effective record keeping, as mandated by the Health and Social Care Act 2012, is crucial for delivering high-quality patient care, supporting clinical decision-making, and enhancing patient safety (NHS Digital, 2020). This mandates healthcare providers to maintain accurate records and ensure data quality (HSCA, 2012).

6.1.4 NHS Confidentiality Code of Practice

The NHS Confidentiality Code of Practice (NHS, 2020) is a guiding document that outlines the principles and practices for maintaining confidentiality in the UK health system, particularly in relation to record keeping. The Code emphasizes the importance of confidentiality in building trust between patients and healthcare professionals, and ensures that personal and sensitive information is handled with discretion (NHS, 2020; Furse, 2019).

Some of the key aspects of the Code that relates to record keeping as stated by NHS (2020) include: respect for patients' autonomy and right to confidentiality; provision of accurate and secure recording of personal and sensitive information; limiting access to confidential information on a need-to-know basis; implementing robust security measures to prevent unauthorized access or data breaches; and providing training and education on confidentiality and record keeping for healthcare professionals. Adherence to the NHS Confidentiality Code of Practice is essential for maintaining public trust in the health system and ensuring high-quality care.

6.2 Societal perspectives

The following points also provide a societal perspective to how health care providers are to keep medical records.

6.2.1 Professional standards

Professional standards play a crucial role in medical record keeping in the UK health system, as they ensure that healthcare professionals maintain accurate, reliable, and confidential records. These standards are embedded in the ethical and legal frameworks that govern healthcare practice in the UK (Nursing and Midwifery Council, 2018; General Medical Council, 2015). The professional standards for medical record keeping in the UK are outlined by regulatory bodies such as the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC).

These standards emphasize the importance of accurate and contemporaneous recording of patient information; maintaining confidentiality and respecting patients' autonomy; ensuring that records are clear, concise, and legible; using standardized terminology and language; keeping records up-to-date and storing them securely (NMC, 2018; GMC, 2015). Professional standards enhance public trust in the health care system and ensure high-quality care (NHS England, 2020).

6.2.2 Patient trust and autonomy

Patient trust and autonomy are fundamental societal perspectives in medical record keeping in the UK health system. Patients entrust healthcare professionals with sensitive information, expecting confidentiality and respect for their autonomy (Beauchamp & Childress, 2013). Accurate and secure record keeping is crucial in honoring this trust and upholding patient autonomy. Respect for patient autonomy in medical record keeping, according to NHS Digital, (2020) involves obtaining informed consent for data collection and sharing; ensuring access to personal health information (PHI) and correction of errors; respect for patients' choices regarding data sharing and opt-out options. Trust is fostered when healthcare professionals maintain confidentiality, ensure data security, and prioritize patient-centered care (General Medical Council, 2015).

6.2.3 Research and audit

Research and audit are essential societal perspectives in medical record keeping in the UK health system, as they enable the improvement of healthcare services and patient outcomes. Accurate and reliable medical records are crucial for research and audit purposes. Corroborating the essence of this, NHS Digital (2020) stated that it allows healthcare professionals to identify trends and patterns in patient care; evaluate the effectiveness of treatments and interventions; inform evidence-based practice and policy development; and conducts audits to ensure compliance with standards and guidelines.

Research and audit also rely on the secondary use of medical records, which is facilitated by the UK's Health and Social Care Act 2012, and the National Health Service (NHS) Constitution (UK Parliament, 2012). Accurate records enable research, audit, and quality improvement in healthcare (NHS R&D Forum, 2020; NHS England, 2020).

7. Management of patients record in United Kingdom and Nigeria

7.1 Management of patients record in Nigeria health sector

Patient records entail the documentation of all files and correspondence relating to a patient since the time of birth to death. It is usually referred to as case files. It involves the collection of information from multiple sources with a wide variety of uses. It includes data from the individual case record as well as aggregate data on patient population, similar to clinical and non-clinical data, epidemiological data, demographic data, exploration data, reference data and enciphered data. Thus, health records administrators must ensure that high quality data and information are available to support the healthcare system, because medical information is the lifeline of the health care delivery system. (Hufman 2001).

Health record is a clear, concise and accurate history of a patient life and illness written from a medical point of view. It is the primary source of medical statistics and clinical information for present and future researchers (Akanji 2010). It is useful for exploration, study and treatment; the appraisal of medical practice and responses to legal demand. For a case record to be useful, it has to be complete, accurate, and presented in an acceptable format. Thus, the health record must contain sufficient information written in a sequence of events to justify the opinion, leave treatment, and end result (Benjamin 2010).

7.2 Management of health records in United Kingdom

The management of medical records in the United Kingdom is a crucial aspect of healthcare delivery, ensuring accurate and reliable documentation of patient information. In 2005, the NHS commenced the use of electronic health record to ensure that all patients have a centralized health record. The intention was to improve the efficiency and quality of healthcare services across the country (NHS Digital, 2020; Furse, 2019). These health records are governed by the Data Protection Act 2018 and the General Data Protection Regulation (GDPR), ensuring confidentiality, integrity, and availability of patient data (Information Commissioner's Office, 2020).

The Nursing and Midwifery Council (2018), emphasized that healthcare professionals are required to maintain accurate and up-to-date records, adhering to professional standards and guidelines. Additionally, health records in the UK are managed in a way that promotes access and sharing among healthcare providers with patient consent to ensure continuity of care (General Medical Council, 2015). This principle of record access and sharing also prioritizes security and privacy with measures in place to prevent unauthorized access and breaches (NHS Digital, 2020).

8. Limitations of record keeping in Nigeria and United Kingdom health sector

8.1 Challenges to record keeping in the Nigerian health care sector include:

a. **Lack of standardization:** There is no standard model for documenting and communicating information across the Nigerian health sector. Each state adopts a system that best suits their purposes. While some have an electronic database system for record keeping, others prefer to use the traditional method of recording keeping.

b. **Poor record keeping practice:** Records are often poorly maintained, with illegible entries, offensive comments, and missing information. This sometimes has to do with the nonchalant attitude of officers handling records and case files.

c. **Inadequate training:** Healthcare professionals may not have received adequate training in record keeping, leading to inconsistencies, inaccuracies and irregularities that may hamper the attainment of global standards.

d. **Limited technology**: Many healthcare facilities in Nigeria still use paper-based records, which are susceptible to loss or damage.

e. **Non-adherence to data protection laws**: Even though there are some laws enacted to protect data in Nigeria, patients' records are at risk of unauthorized access or breaches.

f. **Lack of continuity:** Records may not be kept up to date, leading to a lack of continuity in patient care. This is as a result of poor information management by health care workers.

g. **Patient safety:** Inaccurate or incomplete records can lead to patient safety issues, as healthcare professionals may not have access to accurate information. Due to poor record management, patients sometimes do not disclose vital information about themselves to healthcare professionals.

8.2 Challenges to record keeping in the health care sector of the United Kingdom Health

Despite the importance of record keeping in the UK health care sector, there are several limitations and challenges that healthcare professionals and organizations continue to face. Some of these limitations include:

i. **Data quality issues:** Inaccurate, incomplete, or inconsistent data can affect the reliability of records (NHS Digital, 2020).
ii. **Technical issues:** System failures, data breaches, and cybersecurity threats can compromise record keeping (NHS Digital, 2020).
iii. **Human error:** Mistakes in recording or storing data can occur due to human negligence or lack of training (NHS England, 2020).
iv. **Time constraints:** Healthcare professionals may not have sufficient time to maintain accurate and up-to-date records (Royal College of Nursing, 2020).
v. **Confidentiality and data protection concerns:** Balancing patient confidentiality with data sharing and access can be challenging (NHS Digital, 2020).
vi. **Storage and management:** Managing and storing large volumes of records can be a logistical challenge (NHS England, 2020).
vii. **Lack of standardization:** Variations in recording practices and terminology can hinder effective record keeping (Royal College of Nursing, 2020).
viii. **Funding and resources:** Insufficient funding and resources can negatively impact the quality of record keeping systems and processes (NHS England, 2020).

9. Data storage, retrieval, protection, and archives

In the UK healthcare system, data is managed through a combination of digital and physical systems, policies, and procedures to ensure secure storage, retrieval, protection, and archiving. According to NHS Digital (2020), the UK healthcare system utilizes a viable electronic health record (EHR) system to digitally store patient data, providing a comprehensive and integrated record of a patient's medical history, treatments, and care plans.

These sensitive data are secured in a robust database, such as the NHS Spine, which serves as a centralized repository for patient information. Access to patient records is strictly controlled through secure login credentials and multi-factor authentication processes, ensuring that only authorized healthcare professionals can access patient data. Data retrieval is facilitated through various systems, including Electronic Health Records (EHRs), Patient Administration Systems (PAS) and clinical software applications. These systems enable healthcare professionals to access and share patient information efficiently, while maintaining the confidentiality and integrity of patient data (NHS England, 2020).

Data protection laws, such as the General Data Protection Regulation (GDPR) and the Data Protection Act 2018, govern data handling practices (Information Commissioner's Office, 2020). The NHS has a duty of confidentiality and adheres to the National Health Service (NHS) Constitution, which includes commitments to data protection (UK Parliament, 2012). Access controls, encryption, and audit trails are used to ensure data security (NHS Digital, 2020). Meanwhile, NHS England (2020) maintained that physical records across health institutions are stored securely, with access restricted to authorized personnel only.

The UK GDPR no longer applies to health records of patients or service users who have died, and these records must be archived. Archiving health records is important for future research purposes, to understand how health organizations worked in the past, and to enable the public to understand past health practices. According to NHS England (2021), health records must be kept for at least eight years after the last treatment, but some records may be kept for longer periods for research purposes. The British Medical Association (2022) proposed that the records of General Practitioners (GP) must be preserved or kept for at least 10 years after the patient's death.

10. Conclusion

Health record keeping is a critical aspect of healthcare delivery in both the United Kingdom and Nigeria, with distinct legal and societal perspectives shaping practices in each country. In the UK, a robust legal framework, including the Data Protection Act 2018 and GDPR, ensures confidentiality, accuracy, and secure storage of health records, aligning with societal expectations of privacy and transparency.

In contrast, Nigeria's health record keeping practices are still evolving, with challenges in data protection and confidentiality, and a greater emphasis on improving healthcare services and accountability over individual privacy concerns. While the UK prioritizes patient autonomy and data security, Nigeria's focus is on strengthening its healthcare system and infrastructure, highlighting differing priorities and approaches to health record keeping. Undoubtedly, both countries recognize the importance of accurate and secure health records for quality patient care, research, and health policy development.

However, differences in legal frameworks, cultural attitudes, and resource availability impact health record keeping practices. It is therefore important that Nigeria should legislate and strengthen the implementation of laws for data protection. It is essential to strengthen legal frameworks and data protection measures in Nigeria; promote cultural sensitivity and awareness about the importance of health record keeping in both countries; invest in technology and infrastructure to support secure and accurate health record keeping; foster international collaboration and knowledge sharing to improve health record keeping practices globally. Health record keeping should prioritize patient privacy, accuracy, and quality care, ultimately contributing to better health care outcomes and stronger healthcare systems.

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