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Accessing medical records for research in South African public hospitals: a reflective narrative

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Abstract

Background Access to medical data is important for health system research in South Africa. Researchers must obtain authorization from gatekeepers to enter hospitals and access medical records. They engage with street-level bureaucrats to retrieve specific records and extract necessary data. This paper reflects on our experiences accessing patient records in a nationally representative sample of 60 public hospitals in South Africa.

Methods We chose narrative inquiry to deeply explore researchers' experiences accessing medical records in South African public hospitals. This qualitative method focuses on individuals' stories and personal experiences, providing rich, detailed insights into complex, context-dependent phenomena. Field reports documented our reflections and experiences during each hospital visit. Additionally, we conducted debriefing sessions to further explore these experiences. The themes that emerged from the field reports and debriefing sessions prompted us to delve deeper into the research process. To explore these themes, we conducted a focus group discussion (FGD) with all researchers. The FGD transcript and field reports were analyzed using MAXQDA. We adopted Gibbs's reflective model, incorporating structured debriefing steps, to present our findings.

Results Our reflections highlight the challenges encountered during the ethical review process, engagements with numerous gatekeepers, and street-level bureaucracy. The ethics review process experienced significant delays. Obtaining permission from various gatekeepers was arduous and complex, often presenting logistical challenges. We had both positive and negative experiences with the street-level bureaucrats, including hospital staff responsible for creating, curating, and safeguarding medical records. Some exhibited resistance that appeared to stem from their frustrations with superiors. Public hospital records were mostly poorly curated.

Conclusion Ethical review is essential for guiding complex research like access to abortion. However, an overcautious approach might impede needed research with vulnerable populations. Researchers need to be up to date with local processes and have sufficient resources to gain gatekeepers' permission to access public hospitals. Understanding street-level bureaucracy is imperative for researchers who need to interact with various hospital personnel to access medical records. The state of record-keeping in South African public hospitals may reflect the overall state of the health system, including examples of excellence and mediocrity.

Keywords Medical record review, Public hospitals, South Africa, Reflective narrative

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Background

This article presents researchers' experiences accessing medical records from public hospitals in South Africa. The primary study design was a multicenter, descriptive, retrospective medical record review [1]. The overall study aim was to analyze the incidence of abortion-related morbidity in South Africa. A representative, stratified, random sample of public hospitals responsible for treating gynecological problems in the nine provinces of South Africa (SA) was selected. The sample of 60 public hospitals included four hospital categories (tertiary, regional, rural, and urban districts). We aimed to identify records of all patients who were potentially treated for incomplete abortions during a fixed 21-day period (1–21 November 2018) in each of the sampled hospitals. Patients meeting our entry criteria could enter the hospital through the emergency department, gynecological or female wards, or the operating theatre. This varied by hospital and could involve different locations within each facility. Each of these locations has registers noting patient intake. A list of potential study participants was generated from these various registers. The list was then submitted to records office personnel with a request for medical records to be retrieved. The data extracted from medical records were entered into a REDCap database. As part of that study researchers who collected data compiled field notes after each hospital visit and debriefing sessions were conducted at various intervals to compare experiences and inform subsequent data collection efforts. Collecting data was not always straightforward and a review of the field notes and debriefing sessions indicated that there was something to be learned from the data collection process. At that point, we decided to review our experiences formally. A protocol was written for this study and ethical approval was requested and granted (Human Research Ethics Committee REF number R14/49). As researchers of the primary study, we had to navigate the ethical clearance process, obtain permission from numerous gatekeepers, and navigate street-level bureaucracy in 60 public hospitals. Our reflections reveal complexities associated with accessing medical records for research in the context of the public health system.

Context

Like most knowledge ecosystems, South Africa has rules governing research [2]. To access medical records, researchers need ethical clearance from a recognized ethical review committee, in our instance this is the Human Research Ethics Committee (Medical) at the University of the Witwatersrand. Researchers also need authorization to enter institutions (hospitals) and access medical records from those responsible for safeguarding them. Subsequently, they have to be able to retrieve the specific records of interest and extract the data. These are distinct but interrelated processes and involve engagement with various gatekeepers who control such access.

In South Africa, the National Department of Health is responsible for health policy and administration of the public health system. The nine Provincial Departments of Health administer the health budget and oversee health service delivery for the majority of the South African population. Health services are delivered in primary healthcare facilities as well as in public hospitals. Chief Executive Officers (CEOs) manage public hospitals, which are categorized into central, tertiary, regional, and district levels [3].

Specific laws, regulations, and professional guidelines govern medical record keeping. Public hospital management teams are legally responsible for medical records [3, 4]. Their responsibilities include overseeing the collection storage, and protection of medical records, as well as ensuring compliance with relevant laws and regulations [3]. The National Health Act 2003, Sect. 17 states that "The person in charge of a health establishment in possession of a user's health records must set up control measures to prevent unauthorized access to those records and to the storage facility in which, or system by which, records are kept" [3].

Protection of medical records is an international phenomenon. Like in other regions of Africa and globally, the South African government is responsible for effective data protection regulations for health research [5, 6]. This includes ensuring compliance with legal frameworks to protect individuals' sensitive and private information. South Africa has the Personal Information Act (POPIA) [7], which is similar to the Kenyan Data Protection Act No 24 of 2019 [8]. Such frameworks provide the foundation for personal data protection but do not sufficiently guide the use of health data for research [6]. The use of medical records for research is a valuable and ethical practice when performed with diligence and adherence to ethical and legal standards [9].

In this paper, we use the term gatekeepers. This includes the people, institutions, and processes that approve research and provide formal permission to access [10, 11]. The permission to enter the hospitals authorizes researchers to engage with various hospital functionaries who oversee record keeping.

Gatekeepers protect access to medical records and act as intermediaries between researchers and the institutions from which data are being sought [5]. Formal gatekeepers have the authority to grant permission needed to access research participants or data sources [10–12]. They hold positions of power that can expedite or impede the research process [13]. Researchers understand the crucial

role and influence of engaging gatekeepers, but they find this process difficult [14]. South African Research Ethics Committees recognize the role of gatekeepers and often insist on their written permission before releasing final ethical approval to principal investigators [5, 6]. Gatekeepers for medical records in South Africa include the national, provincial, and district departments of health as well as the hospital chief executive officers (CEOs).

The concept of street-level bureaucrats was coined by the political scientist, Michael Lipsky, in the late 1980s [15]. Public service workers, particularly those in direct contact with the public, are assumed to have significant discretion in their daily work [15–17]. In the ideal scenario, this discretion allows them to interpret and implement policies and make decisions that directly impact the lives of the individuals they serve. However, such a scenario may not be achieved in practice for many reasons, including inadequate resources and unfavorable working conditions [17]. Street-level bureaucrats in the context of accessing medical records in South African public hospitals, typically refer to the individuals responsible for creating and managing medical records in practice. This usually includes healthcare professionals, medical records clerks, and other personnel who work directly with medical records [9]. In the South African public health care context, street-level bureaucrats work in high-demand environments with high patient loads, and often inadequate organizational, personal, and other resources [16].

Methods

This research used narrative inquiry which is described as both a way of thinking about experience and a methodology for the study of experience [18]. Narrative inquiry was chosen because it allows for a deep exploration of the researchers' experiences accessing medical records in South African public hospitals. This qualitative method focuses on individuals' stories and personal experiences, providing rich, detailed insights into complex, personal and context-dependent phenomena. By using narrative inquiry, the researchers could capture the nuanced challenges and interactions they faced, offering a comprehensive understanding of the processes and dynamics involved in accessing medical records. Narrative inquiry is a qualitative research method that focuses on individuals' experiences as stories. It provides rich, detailed insights into how individuals interpret their experiences and can be used to inform practice and policy in various domains [18–20].

Field reports written after each hospital visit captured researchers' experiences. The debriefing sessions where researchers discussed their experiences and planned how to tackle the next research site were illustrative of what Clandinin (2022) describes as placing that experience in one's own personal, social, and material environment [20]. On re-reading the field notes themes emerged that inspired us to formally explore our fieldwork experiences. A research protocol was developed and submitted for ethical approval. Ethics clearance was obtained from the University of the Witwatersrand's Human Research Ethics Committee (Ref: M220676).

To supplement the existing field notes we decided that a focus group discussion which included all the researchers who collected data would give us a more in-depth understanding of the field work experience. Based on the reading of the field notes DC, who attended all debriefing sessions, and SF who was more distant from the data collection process, developed a focus group discussion (FGD) guide (attached as a supplementary file). One senior investigator, SF, did not take part in the fieldwork. Given her relative objectivity, she facilitated the FGD with the five researchers. The discussion covered the researchers' reflections on participating in the study and their views, experiences, and analysis of their experiences.

MS Teams was used to conduct the FGD, which lasted one hour and twenty minutes. One of the research assistants double-checked the MS Teams transcripts against the voice record and made necessary corrections to produce a verbatim transcript. The FGD transcript and field reports were uploaded to MAXQDA 2020 software for qualitative data analysis. The software was used to organize, code, and categorize the data. We derived deductive codes from the field reports, while inductive codes emerged from FGD. The analysis process entailed identifying patterns and themes from the data.

This paper presents our reflections in four parts inspired by the Gibbs reflective cycle [21]. The Gibbs model's six stages (description, feelings, evaluation, analysis, conclusion, and action plan) facilitate experiential learning through a structured debriefing process [21]. Consistent with Gibbs' stage one, the first part of this paper presents a detailed description of events during the research process. The second part (combining two of Gibbs' phases) presents our feelings and evaluation of the events, occurrences, and experiences during fieldwork. The third part, which encompassed Gibbs' evaluation and analysis, extracted meaning from our reflections and drew on relevant academic literature to explain the events. The last part of this paper presents our conclusions and recommendations which in this case is the last of the Gibbs' cycle, the action we took which is to write this paper. We conclude by offering a summary of our findings and recommendations for future similar studies.

Findings

The research team included three female clinicians who had worked in the public sector at some point in their careers. Two of these clinicians, with three research assistants, one female, and two males, were responsible for the primary study fieldwork.

A detailed description of the process of obtaining ethical clearance

Applying for ethical clearance is an anticipated and necessary requirement for any research involving human subjects. Nonetheless, the ethics review process can be cumbersome, especially for multicenter studies. An application to the Human Research Ethics Committee (HREC) at the University of the Witwatersrand, which understands the legitimate role of gatekeepers guarding access, required letters of permission from gatekeepers of the 60 sampled hospitals. However, those hospitals informed us that ethics clearance was a prior prerequisite for hospital permission. We had to negotiate with the HREC to accept our application without permission letters.

We had not anticipated major feedback from HREC because our proposal largely replicated a study design previously approved by the same committee, albeit some years prior. HREC queried, among other things, the prospective identification of patients and the use of hospital-based clinicians for medical data extraction. The prospective design, they argued put the confidentiality and privacy of already vulnerable patients at risk. They recommended a retrospective medical record review by researchers not based at the study hospitals.

We had several discussions with HREC, as we deliberated on the possible effects of the proposed methodological changes. The logic of why confidentiality would be compromised was not clear to us. We were most concerned with data comparability with previous research as the purpose of the study was to compare changes over time. Although three rounds of resubmission were necessary to secure ethical clearance, delays were not always related to the substance of the revisions but rather to the administration of the process. In the end, 15 months elapsed between the initial submission and obtaining the ethical clearance certificate. Due to this delay, we lost a preapproved research grant.

Experiences with gatekeepers tasked with safeguarding access to institutions and medical records

Once ethical clearance was received, we commenced the process of obtaining permission to collect data from the sampled hospitals. For this multi-center, national study permission was required from the National Department of Health, nine Provincial Health Departments, 34 District Health authorities, and Chief Executive Officers (CEOs) of the 60 sampled hospitals. Only after we sent numerous letters to the various health authorities did we learn about the National Health Research Database (NHRD). National and provincial research committees utilize the NHRD repository to monitor and manage health research conducted in South Africa [22]. We uploaded our application and monitored outcomes on the NHRD dashboard. Provincial responses included approvals, queries, and requests for additional information. Once a province approved our research we received a permission letter by email. Even though provinces supposedly communicated NHRD outcomes to sampled hospitals and relevant districts, we still had to obtain permission from hospital CEOs.

We sent emails to the 60 sampled hospitals requesting permission and attached the relevant provincial permission letter, HREC certificate, and research protocol. The various gatekeepers who influenced our access to hospitals included district health managers, hospital research committees, academic heads, clinical heads, hospital management teams, and CEOs. There was no uniformity in how hospitals handled our applications, making the process unpredictable and challenging. While some hospitals promptly grant permission, we experienced substantial delays in most hospitals. In many instances, our emails and telephone calls were not answered, or the email or telephone lines were not functional. Often, while we had ethical approval and formal provincial and district permission to access records, we failed to get any response from the relevant CEO. Our only remaining option was to visit each sampled hospital. Often hospital staff were understanding of this approach.

> *"We arrived at 08:30 and went to Ms. AAA's (CEO's PA) office. She was very surprised and shocked to see us. I then explained to her that I had problems reaching her, the phone rings, but no one picks up. She dialed her number, and indeed, her office phone was not working. She told us that the CEO was on leave and that their medical manager in charge was doing rounds. She called the doctor who arrived after 10 minutes. We went to his office and explained how everything works and what we require. He was very welcoming and understanding" (FGD, Researcher, Female).*

We observed differences according to the category of the hospital. For example, tertiary (academic) hospitals have complex systems and require approval from various gatekeepers before granting permission. One tertiary hospital responded with substantial comments on the already finalized and ethically approved research protocol. Some comments were not appropriate for a

multicenter study that sought to ensure consistency across different hospital levels. In addition, the gatekeeper insisted on a coinvestigator role as a precondition for granting permission. It took numerous back-and-forth emails, meetings, costly travel, and the intervention of the relevant Faculty Dean to resolve the matter.

> *"We also had our own gatekeeper, Prof. MMM, who gave us the hardest of times. Yeah, he made sure of that. He told us that we needed to get coinvestigators (from his university) to obtain access to the files. He said we needed to add him as a coinvestigator to make the process smoother and simpler. We had to meet with him multiple times. We had to appeal to his faculty. Even when we had a green flag, he still withheld a letter supporting us. In addition, yeah, no. He gave us a hard time in XXX hospital. We spent more than six months trying to reach that hospital yeah. (FGD, Researcher, Female)*

This experience contrasted with experience in a district hospital where staff were eager to allow us access to records, as it was rare for their facility to be included as a research site.

> *"GG is a 20-bed hospital in a small, rural area. It is also the most well-preserved facility in terms of appearance and function. Ms. M.M. and her senior colleagues were welcoming and engaged with us and the contents of the proposal. They designated junior staff members to assist us and even offered us lunch..." (Rural District Hospital, Field Report)*

The effect of street-level bureaucracy on access to medical records in public hospitals

Street-level bureaucracy is a phenomenon in which frontline workers make discretionary decisions according to their line of duty [15]. To access medical records, we interacted with various hospital frontline workers, including personal assistants, managers, clinicians, administrators, and recordkeeping clerks, among others. Our data collection process involved extracting records of potential cases from ward registers. In most cases, the nurse in charge of the ward and/or the ward clerk facilitated access to these registers. From the registers, we generated a list of patients and then requested the records office to retrieve those patient records. Our experiences with street-level bureaucracy varied in each hospital, as we navigated effective ways to access medical records.

> *"Ms. FFF (ward administrator) then took us to medical records, where we met Ms. RRR (record office administrator), who took us to her supervisor. We gave her (the supervisor) our list (of patient records). She told us that there are protocols and procedures to follow, so we will only obtain access to the records after 30 days. We then asked Dr. MMM (the clinical head who had granted us hospital access) to assist in the study. We politely asked him to ask the medical records team to prioritize these records and to have them accessible in at least the next week (while we were in the province) or so if possible." (FGD, Researcher 2)*

The medical records team cited rules that apply to all those that require access to records. However, the combination of not being able to obtain access except by arriving in person had to be balanced with a one-month wait for records. In a national study with vast distances to travel and with a limited budget going more than once to a facility was unaffordable. We had to deal with the consequences of appearing to have flaunted processes despite all efforts to the contrary. We negotiated divergence from usual processes in our attempt to utilize the flexibility that street-level bureaucrats have. This had mixed results.

In most cases, hospital CEOs delegated clinical staff to assist us and often clinical staff were helpful and showed interest in the study. Their enthusiasm facilitated smooth data collection.

> *"On arrival, we went to AAA the CEO's PA. She then informed Dr DDD (clinical manager) and the CEO of our arrival. We had a brief meeting with them where we were warmly welcomed. Dr DDD took over the responsibility of coordinating our research process." (Urban Regional Hospital Field Report)*
>
> *"Except for the issue of internal miscommunication that resulted in some delays, the staff at MMM Hospital were exceptionally helpful and did not pose a challenge in terms of granting access. Sister NNN did a lot of legwork in terms of allocating space for us to work and ensuring that we got the correct registers and patient files were given to us to peruse." (FGD, Researcher, male)*

In some hospitals, we had adverse experiences with street-level bureaucrats who obstructed the research process. Some of these adverse experiences looked like displaced anger. We felt like recipients of misplaced aggression. Staff described complex power dynamics in the workplace.

> *"There was a gentleman in the AAA province, and he just made himself a uniquely difficult obstacle. In addition, even with all the documentation and the approvals that we had, he then just decided that, actually, due to this internal breakdown in communication, he then made it our fault or our problem that the people within*

the hospital, his colleagues who were supposed to communicate with him, did not do it in time…and he just said actually this is not my problem. We will deal with this another day" (FGD, Researcher, male)

We found that hospital employees at different levels were frustrated, and we displayed empathy which was appreciated. These encounters not only affected our research process but also demonstrated a work environment that did not enable or promote professional behavior. Examples of unprofessional behavior were evident.

"In KKK hospital, we were helped by someone who had a hangover… at some point he was like, alright guys I will be back in in a few minutes. I just need to go get something, and he disappeared. He left us there … for all he knows after he left …we could have vanished with those records for whatever reason. (FGD, Researcher, Male)

In summary, negotiating access to records from multiple gatekeepers was complex, exacerbated by inadequate infrastructure that resulted in non-responses to emails and phone calls. Street-level bureaucrats played a crucial role (both positive and negative) in the data collection process. Interactions with different categories of hospital staff revealed varying attitudes, with some being enthusiastic and supportive and others demonstrating low morale, and displaced anger or appearing to be unprofessional. Both gatekeepers and street-level bureaucrats had a substantial impact on the overall research process.

Feelings and evaluation of the research cycle process

Even though we appreciate and respect the ethical review process, we found this process extremely challenging, and losing funding for the research due to the long delay in getting final approval was a significant setback and a lost opportunity.

During our fieldwork, we encountered both efficient and ineffective hospital record-keeping systems. The systems seemed to vary according to the hospital level, available resources, and use of modern technology. Unlike in most district hospitals, staff in teaching hospitals seemed familiar with the system of retrieving medical records and with research.

"Tertiary (academic) hospitals were better at finding (retrieving) the records, although accessing medical information was quite difficult. … In the district hospitals, the variance there was quite extreme. Therefore, like the QQQ hospital that was a former homeland hospital … so this is where you know yeah things just get very messy. That is where we did not get any records" (FGD, Researcher, Male)

Even though we observed dysfunctional record-keeping in most district hospitals, we also witnessed one of the best systems at this level of the health service. A passionate records officer created a color-coded filing system and could retrieve files with ease.

"In hospitals where people were dedicated…for example, at EEE hospital, the guy responsible for the records would just go straight toward the record in a very unique way of color coding. He was so very upset that he could not find one, only one, out of the total list of records that we requested." (FGD, Researcher, Female)

"Then, we went to a hospital where records were everywhere and nowhere. In addition, where we could not find even one file…It was a revelation on how bad our hospitals are managed and how that affected, you know, accessing the records." (FGD, Researcher, Female)

In instances where medical records were badly curated, we reflected that perhaps hospital staff were not aware of the legal and ethical implications of their conduct.

"People who are responsible for record-keeping do not seem to understand the importance of having… effective and efficient record keeping and record retrieving systems in place…What I saw in terms of records management. It is not something that is taken as seriously as it should be. …. You have got patients who can just disappear with their medical records. The fact that patient records can disappear during relocation...just the way records are handled in this country tells me that people do not take it very seriously (FGD, Researcher, Male).

We were surprised that some hospital CEOs did not look like they were aware of how and where records were stored. Some were as surprised as we were by the poor state of medical record keeping in their facilities. Even hospitals that appeared to be well-managed were found to lack adequate record systems. It appeared that some CEOs did not fully grasp or appreciate the legal obligations they had to protect medical records in their facilities.

"You'd find a very pleasant CEO who's always there with the management team. However, when you get to the records department, it is a totally different scenario. You are kind of shocked. How can a hospital this big and this well-organized from the top be so disorganized in regard to their records?" (FGD, Researcher, Male)

Interestingly, some gatekeepers, who had put great effort into ensuring that our research was ethically compliant, did not seem to have a similar appreciation for the legal requirements associated with keeping medical records in their own facilities. Most hospitals had poorly organized medical records, and our impression was that the responsible staff did not seem aware of the potential legal implications.

> *"We were then sent to the systems manager's office. We did not find him, so we went to the records room where we met DDD and the team. They helped us look for records until Mr. XXX (the systems manager) walked in; he also helped look …. they realized that they had sent a bunch of files for archiving at Ezinyokeni (isiZulu word for 'where there are snakes'). DDD went with us to look for the keys to the archives place. When we arrived there, the files were discarded all over the place. It was an old unkempt building with broken windows, dead mice, and mouse feaces everywhere. DDD seemed as shocked as we were. He called the systems manager to come to witness the havoc, but he never came. We changed our outfits for something more appropriate so that we could go through a mess of files; we went through two rooms full of records and had no luck finding our records. We then went back to the CEO to report the matter, but she was in a meeting. We reported to the nursing manager who was also shocked. She promised to take this up. (Urban district hospital field report)*

In several facilities, records were missing and there was no standardized system of record keeping. The researcher who used and liked public health services reflected:

> *I have always been a public hospital baby. I rarely go to the hospital. However, I'm generally a public hospital baby. I have grown up in a public hospital family, and my mom is a former public sector practitioner. ...and for the most of it, I have received the kind of treatment that I think I expect to receive in a public hospital… It could definitely be improved because nothing's perfect, but it is worth working toward getting it better. However, the treatment, I have less of a problem with that than I do with what I saw in terms of records management. It is not something that is taken as seriously as it should be. (FGD, Researcher, Male)*

Reflective analysis of the research process

In this section, we offer a critical analysis of the process of acquiring ethical approval and our experience with gatekeepers and street-level bureaucrats.

Ethical review process

The three major lessons related to the ethical review process were the unfeasible expectation to obtain prior permission from numerous gatekeepers, the major revisions to the research methods to address HREC concerns, and last, administrative hindrances. We were caught between the HREC which required the gatekeepers' prior permission of access and the gatekeepers who only considered requests for access once ethical approval was obtained. This "catch-22" must be well known to the HREC, as this is not the first time that multicenter public sector hospital protocols have been reviewed. Second, we were confused as to why the HREC thought the privacy of patients was at risk. Given that for good quality care, a detailed history leading to the diagnosis of incomplete abortion is standard practice. It is unclear how noting this on an anonymized data collection tool could disadvantage a patient.

It has been noted that excluding vulnerable populations from research could lead to the total exclusion of populations that stand to benefit from the research involving them. Murdoch & Caulfield (2016) suggest that harm caused by excluding those individuals perceived to be vulnerable is not well considered in research ethics policies [23]. They argue that research ethics bodies adopt a top-down approach, ingrained more in principles and hypotheticals than evidence, an approach that may permit overcautious discretionary action by research ethics members [23]. The long administrative delays, despite multiple appeals, and explaining that research funding was in jeopardy is hard to understand.

Gatekeepers and street-level bureaucrats

The research process involved working with hospital gatekeepers and street-level bureaucrats. In most cases, workplace conditions were not satisfactory, albeit with a wide range of variability. The literature validates our observations and reveals how poor conditions in public hospitals have a negative impact on employees [16, 24]. Reflecting on our experience, we were at times at the receiving end of frustrated street-level bureaucrats. We sensed that the noncooperation that we experienced was directed more to those in authority than to us. Nonetheless we also experience instances where some hospital staff remained passionate and dedicated to their work, notwithstanding their difficult work conditions, and supported our efforts to access medical records. Gaede (2016) recommended the use of a street-level bureaucracy lens when viewing the work of healthcare workers in the South African public health sector [25]. Such a lens uncovers how hospital frontline workers offset failing health systems, while others, at times, avoid work

or contribute to the inefficiencies of healthcare delivery [25]. A clinical manager refusing us access to records unless we name him a coinvestigator is an example of someone taking advantage of the system that allowed him such power. In contrast, being selected as a research site was affirmed by some staff, and it appeared to make them feel seen and heard. Either way, our experience seems to be consistent with the approach that Gaede puts forward. We found it useful to use the terminology and understanding of street-level bureaucracy when trying to describe and understand our experience.

Based on our combined reflective analysis, understanding street-level bureaucracy is imperative for researchers who need to interact with various hospital personnel to access hospitals and their medical records for research. Our observations are similar to the assertion that researchers need to be cautious and skillful when negotiating with gatekeepers to assist with access and navigating street-level bureaucracy [14].

While evidence reveals that electronic medical records, more than paper-based records, effectively contribute to improved quality, safety, and efficacy of health care [26, 27] they did not necessarily lead to improved access to records and that in low resource settings committed and skilled records clerks can run efficient record management systems. We also concluded that sharing this experience is worthwhile as an illustration of what researchers may need to think about and plan for in LIMC settings. This would likely also prove useful to researchers who are not familiar with LIMC health settings. Similarly, our retrospective analysis of numerous South African public healthcare facilities provides important insights for similar future studies.

We understood and acknowledged the importance of gatekeepers in safeguarding access to public hospitals and attempted to respect them to the best of our ability.

Reflexivity

Researchers are encouraged to use reflexivity to critically evaluate relations, specifically with gatekeepers and street-level bureaucrats, to enhance future research [13]. Some have warned against the indiscriminate use of reflexivity in qualitative research, while others have emphasized that it is a crucial tool for deepening the understanding of the phenomenon being studied and the researcher's role in it [28, 29]. In this paper, we decided to include a section on reflexivity to make clear our subjectivity to allow readers to assess the credibility of our findings and interpretations [30].

Concerning requests from the ethical review committee, while we disagreed about the need to change the methodological approach we nonetheless did so. That is the point of ethical review, to provide external disinterested guidance on how to conduct research. Our critique of the delay in finalizing the approval and that we lost funding, as a result, may suggest that we are being overly critical. However, the fact that these were administrative rather than substantive delays, makes us feel that our critique is valid.

Efficient data collection is of course desired by any researcher. We did in one instance disregard routine practice by requesting quicker turnaround time in receiving records. It was only done as a last resort when what we considered that adequate and correct correspondence and communication was unsuccessful. We do not think this biased our view about the difficulty in accessing records in general as it occurred in more than one place and there were many other examples, beyond having to wait, that illustrated how hard it was to access records. We also thought that sharing this would be helpful for others. On the other hand, our ignorance of the online process at the national and provincial level and the way in which it improved efficiency is openly noted, and we believe reinforces the legitimacy of situations where things were difficult, in particular, poor infrastructure such as phone numbers and emails that do not work appear to be fixable.

Our initial motivation for researching our research process was motivated by our surprise at how many things did not work – poor infrastructure, and low levels of commitment to work (which was only highlighted when compared to times when people were very committed and accommodating). It struck us that this was an indication of a public health system in decline. Our analysis did not lead us to make a definitive finding about this, but it has raised for us the question about whether the state of medical records can be used as a proxy for the state of a healthcare system.

Conclusion and recommendations

We believe that medical records present a unique and valuable resource for research. Medical records reviews aid researchers in identifying patterns and trends that can lead to better-informed decision-making for policies and practices [31]. Such research contributes to positive health outcomes, as professionals rely on evidence-based research findings to address evolving healthcare needs of the population.

Ethical review committee members may or may not be conversant with realities on the ground. Researchers should anticipate this and provide sufficient contextual information additional to that required on applications forms.

When researching "wicked problems" [32, 33] which can include access to abortion, the approach to ethical

review might limit research with vulnerable populations, where research is important and needed.

Researchers need to be up to date with local research management processes. In this case the National Health Research Database was efficient and useful. It was however also limited as decision loaded on the data base and communicated to researchers was not always communicated with the relevant people where the research was happening.

When we were able to communicate in advance of our data collection visits, we gained easy access to hospitals.

Unreliable infrastructure, such as non-functioning telephones and emails, or lack of response from hospital authorities frustrated access resulting in unannounced visits. There was no way to predict if gatekeepers would accommodate unexpected visits. Often, they did.

Either researchers need to have sufficient funds and time to make repeat visits, or they need to motivate gatekeepers to be flexible.

Even with gatekeeper permission in hand, one nonetheless must anticipate dealing with street-level bureaucrats and be able to develop methods of working with them. Future researchers planning to conduct medical record reviews should be savvy, prepared, and resilient.

The state of record keeping in South African public hospitals includes examples of pockets of excellence and examples of mediocrity or worse. If accessing medical records and how they are kept are valid indicators of the state of the health system, there is much that needs to be done in South Africa.

Researchers conducting similar studies should be prepared to address possible delays in the ethical process, the logistics of obtaining numerous permissions, dealing with gatekeepers, and navigating street-level bureaucracy. Consider strategies to mitigate such challenges to ensure the success and validity of their research. Given the tentative findings of this research, it might be worthwhile to conduct further research examining the motivations behind different levels of gatekeeping and whether the status of records indeed reflects the status of the health system.

Study limitations

The use of a virtual communication tool-imposed limitations on the data collection. One participant had limited participation because of network challenges. The participation of another participant was interrupted by load shedding. Participants, specifically those whose online participation was affected, were allowed to submit written responses to the FGD guide questions.

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12913-025-12285-9.

Supplementary Material 1.

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DNC & SF wrote the main manuscript text BK, EB, ZM & MB reviewed the manuscript.

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Data availability
The data that support the findings of this study are available on request from the corresponding author, [DNC].

Declarations

Ethics approval and consent to participate
Ethics clearance was obtained from the University of the Witwatersrand's Human Research Ethics Committee (Ref: M220676). All participants gave consent to participate in the study and to be recorded.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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