Patient records, the WGBO and the GDPR: why the medical record is not a sellable possession

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In public debates on digitalisation in healthcare, the medical record is sometimes described as if it were "the patient's": something he possesses, can take with him or, at the extreme, can sell. Under the Dutch Medical Treatment Contracts Act (WGBO) and the GDPR that is a misconception. The physician keeps the record, on the basis of a statutory record-keeping duty, within a relationship of trust with the patient. What the patient has is a set of rights, not a title of ownership.

Who keeps the record? The record-keeping duty

Article 7:454(1) of the Dutch Civil Code imposes a record-keeping duty on the care provider. The physician must set up a record concerning the treatment of the patient and enter in it the data necessary for good care. That duty does not depend on the patient's consent; it rests on a statutory obligation within the treatment contract.

From the GDPR perspective this means that, in the ordinary treatment relationship, the recording and processing of the data usually rest on Article 6(1)(b) (performance of the treatment contract) and (c) (legal obligation, including the record-keeping duty) GDPR, in combination with Article 9(2)(h) GDPR (processing for medical diagnosis, the provision of care and the management of health systems and services) and the national elaboration in Article 30 of the Dutch GDPR Implementation Act (UAVG). In specific, mostly public-law healthcare contexts, Article 6(1)(e) (task carried out in the public interest) may additionally play a role.

Responsible for setting up and keeping the record is thus the care provider, in practice often within a healthcare institution. Not the patient. The WGBO concept of *care provider* and the GDPR concept of *controller* answer different questions: who determines purposes and means under the GDPR must be assessed for the organisation and processing concerned, and may for example be the institution. The record is a medical document kept by the care provider, bound by professional standards and retention periods, which also serves the continuity of care and the patient's exercise of his rights; an object of the patient's ownership it is not.

What the patient does have: access, copies, addition and destruction

The WGBO gives the patient a set of rights of his own. Article 7:456 of the Dutch Civil Code regulates the right of access and the right to a copy; Article 7:455 the right to destruction on request. In addition, under Article 7:454(2) the patient may have a statement of his own added to the record. These rights run parallel to the GDPR rights of access (Article 15), rectification (Article 16) and erasure (Article 17), which also apply in the healthcare context, albeit within the limits of, among others, Article 17(3) GDPR and the retention duties flowing from the WGBO.

Destruction is, for the ownership question, the most interesting right. An owner may in principle also destroy his property; Article 5:1 of the Dutch Civil Code describes ownership as the most comprehensive right a person can have in a thing, although even that power knows statutory limits. Under the WGBO the patient's right to destruction is expressly bounded. Article 7:455(2) makes explicit that the right does not apply in so far as the request concerns documents whose retention is plausibly of considerable importance to someone other than the patient, or in so far as

statutory provisions preclude destruction. This also covers situations in which other statutory regimes impose additional retention duties or restrictions, such as in occupational and insurance medicine (NVAB-OVAL, 2019).

The Central Disciplinary Tribunal for Healthcare (CTG) has refined this further: partial destruction may also be requested, even of a single word, phrase or paragraph in the record. The Tribunal accepts that such selective destruction may make a record less intelligible, but sees in that, given the text and purpose of Article 7:455, no ground to reject a request out of hand (CTG 19 March 2021, ECLI:NL:TGZCTG:2021:61, paras. 4.5-4.6; KNMG, 2024).

For the ownership question this arrangement yields a fundamental distinction. An owner destroys on his own authority; a patient destroys on request, within statutory conditions, and only in so far as another's interest does not preclude it. That is control, not a power of disposal.

GDPR and WGBO: two regimes side by side

The GDPR, as a directly applicable regulation, forms the overarching framework; the WGBO provides, within the room the GDPR leaves for it (notably via Article 9(2) GDPR and the national elaboration in the UAVG), a sector-specific elaboration of record-keeping, confidentiality and patient rights for the treatment relationship. In practice both regimes are applied side by side and complement each other (P&I, 2023).

This has practical consequences. Scientific research with patient data engages not only Article 9(2)(j) GDPR and Article 24 UAVG. Where disclosure from the medical record without consent is contemplated, Article 7:458 of the Dutch Civil Code also imposes its own conditions, including necessity, proportionality and safeguards against identification, depending on the applicable route. The appropriate Article 6 GDPR basis must additionally be identified. Both regimes must therefore be observed.

Two regimes together thus form the patient framework. The GDPR contains no provision that qualifies personal data as property; in the first contribution to this series I argued that a classical property regime does not fit here either (Bijvoets, 2026a). The WGBO adds to that a statutory duty of record-keeping resting on the care provider, and translates the patient's control into enforceable rights, not into a right of possession.

Medical professional secrecy as foundation

Medical professional secrecy is anchored in the Netherlands in Article 88 of the Individual Healthcare Professions Act (Wet BIG) and in Article 7:457 of the Dutch Civil Code. The physician may not disclose medical data to third parties without the patient's consent, save for statutory exceptions or a conflict of duties. In proceedings this is reflected in a functional testimonial privilege: Article 165(2)(b) of the Dutch Code of Civil Procedure and Article 218 of the Dutch Code of Criminal Procedure.

Professional secrecy is asymmetrical: the duty rests on the physician, not on the patient. A classical property regime knows no such duty of confidentiality resting on the holder. An owner possesses, others do not; the civil-law picture goes no further. But the medical record is kept by the practitioner under a duty of confidentiality owed to the patient, in a relationship of trust that is precisely not vested exclusively in the patient.

Why commercialisation is particularly problematic for health data

In an earlier blog in this knowledge base I argued that personal data lend themselves poorly to a commodity approach (Bijvoets, 2026c). For medical data that problem arises in intensified form. Three reasons, partly legal and partly a matter of policy:

Confidentiality is constitutive for care. The openness with which a patient discusses his complaints, fears or lifestyle with his physician rests on trust in professional secrecy. If patient data were regarded as tradeable, that openness would come under pressure, with consequences for the quality of care.

Stratified health rights. A consent-or-pay model in the healthcare context (think of hypothetical models in which a premium discount is coupled to the sharing of lifestyle data) risks a divide in which citizens with greater financial means can better protect their medical data. From the principle that fundamental rights belong equally to everyone

and that access to healthcare must remain safeguarded (cf. Articles 20 and 35 of the Charter), that is an undesirable outcome.

Asymmetrical power position. The patient does not negotiate from a position of equality; he needs care. Consent to commercial processing is under pressure in such a context. The EDPB counts situations of clear imbalance of power among the cases in which consent will often not qualify as freely given (EDPB, 2020, para. 16 ff.). Opinion 08/2024 develops that assessment for large online platforms and behavioural advertising, but cannot simply be generalised to healthcare. In the care relationship, caution follows primarily from the general consent guidelines and the concrete dependency involved.

What, then, is permitted?

Scientific research with medical data is possible within limits (Article 9(2)(j) GDPR, Article 24 UAVG and, for disclosure from a medical record, Article 7:458 of the Dutch Civil Code); the WGBO and KNMG guidelines impose additional duties of confidentiality and record-keeping but do not, without more, supply the required Article 6 GDPR basis. Only data that are truly anonymised fall outside the GDPR: under recital 26, identification must no longer be reasonably likely by the means reasonably to be used. Pseudonymised data remain personal data. In occupational and insurance medicine the WGBO does not apply in full: Article 7:464 may apply provisions mutatis mutandis, while specific public-law frameworks apply alongside, for instance in employment and social-security assessments (NVAB, 2024). In mandatory consultations or disability assessments there is consequently no unlimited right of destruction for the employee.

The boundary is therefore not "data from healthcare may never be re-used". The boundary is that re-use remains bound by professional standards, purpose limitation, professional secrecy and proportionality. That is an essentially different infrastructure from a market.

Conclusion

The medical record is not the property of the patient. It is kept by the care provider, on the basis of a statutory obligation, within a relationship of trust protected by professional secrecy. The patient holds enforceable rights of access, copy, addition and destruction, each within statutory limits. That is control, not possession. The line running through this series of blogs finds its sharpest expression in the medical context: personal data are not property (Bijvoets, 2026a), data portability is not a transfer of possession (Bijvoets, 2026b) and commodification runs into fundamental objections (Bijvoets, 2026c). For patient data a further layer is added, one older and broader than the GDPR regime: medical professional secrecy as the foundation of trust on which care rests.

It is precisely here that the distance from the ownership model is greatest. Even the most personal data, those about body, mind and history, cannot be governed from a regime of possession. They call for a different concept, older than ownership: trust.

References

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1 Dutch GDPR Implementation Act (UAVG), in particular Articles 24 and 30.

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