Amending medical records - appropriate circumstances and how it should be done

Published: 24.02.2022

When might the records need to be amended?

There are reasons why a patient's medical record may need amending.

1. There are reasons why a patient's medical record may need amending.
2. The information is wrong.
3. The patient is requesting certain details in the record to be removed.
4. There is a difference between the 'facts' and 'opinions'.
5. Retrospectively adding further details to the notes.

Which legislation and professional guidance should I be aware of?

General practices need to be aware of the relevant legislation and guidance regarding the amending of medical records: when this is appropriate; how to do this correctly; how to respond to a patient, and; when the record should not be amended. The key legislation is the Data Protection Act (2018), which incorporated the General Data Protection Regulation (GDPR) into UK law.

General practices, as data controllers for the medical record, have responsibilities regarding data accuracy as defined by Article 5 of the GDPR.

1. Data should be accurate, relevant and limited to what is necessary for purpose.
2. Data should be kept up to date and inaccurate data should be rectified without delay.

The GMC in their guidance entitled Good Medical Practice states that a registered medical practitioner is required to;

- formally record your work, this must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.
- Keep records that contain personal information about patients, colleagues or others securely, and in line with any data protection law requirements.
- Be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.
- Include in clinical records:
    a) relevant clinical findings
    b) the decisions made and actions agreed, and who is making the decisions and agreeing the actions
    c) the information given to patients
    d) any drugs prescribed or other investigation or treatment
    e) who is making the record and when.

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Correcting factual inaccuracies

Under the GDPR legislation and GMC guidance, patients have a right to ask for factual inaccuracies in records to be rectified or deleted. This is termed a 'right to rectification'. Where the practice has discovered a factual error, they should inform the patient of this, explain any implications for their health/ treatment, apologise, and explain how the records will be amended. This discussion should be documented in the record.

The ICO has produced guidance on what a practice should do when it is asked by a patient to correct data which the patient believes is factually inaccurate. The practice should take reasonable steps to investigate whether the data is accurate and should be able to demonstrate it has done so. To do this it should consider the patients arguments and any evidence they provide. The practice should then contact the patient and either:

- Confirm it has corrected, deleted or added to the data, or;
- Inform the patient that they will not correct the data and explain why the practice believes the data is accurate.

If the practice refuses to correct the data, record in the medical record that the patient has challenged the data's accuracy and why. If the patient agrees, this can include details of what information the patient believes is inaccurate. If the patient is still unhappy, they may follow the normal complaints procedure or approach the ICO.

If the practice has disclosed the data to others, eg in a referral letter, it must contact them and tell them the data has been corrected or completed, unless this is impossible or involves a disproportionate effort. The practice should inform the patient which recipients have received the data.

Requests to delete/amend information

Patients do not have the right to ask for an opinion you have made as a professional to be changed. The ICO has provided some useful guidance for small health sector bodies. If a patient requests certain details of the consultation to be removed from the medical record, a detailed discussion is needed. This should explore the reason for removing the information and the consequences, to their ongoing care, of this information being removed.

Alternative solutions should be explored including redacting the information so that it is not shared with third parties or other methods of restricting access to the record.

If the patient still requests for the information to be removed, unless there are clinical grounds or medicolegal grounds as to why this would be inappropriate, the information should be removed but with a clear and transparent explanation that the information has been deleted (the date, time and person who deleted the information should also be recorded. Where it is inappropriate for the information to be removed, the practice may wish to invite the patient to prepare an addendum that could be held on their records to be read in conjunction with the relevant entry/ entries in the records.

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Retrospectively amending opinions

Where the record contains an opinion, judgement or a provisional diagnosis and that later proves incorrect, this should be noted in a subsequent record entry, but the original entry should not be amended.

Retrospectively adding further details

Retrospectively amending the records without an appropriate explanation in a non-transparent way (**please note it is not acceptable to simply rely on the computer audit trail**), especially when it has been done so in a self-serving way in the event of a complaint, claim, police or GMC investigation has serious implications that could result in criminal action, withdrawal of indemnity, a claim being upheld and/ or a GMC sanction (there have been cases in which doctors have been erased from the medical register for retrospectively amending the records inappropriately).

GPs work under immense pressure which can result not having sufficient time to write fully comprehensive contemporaneous notes. Whilst it can be frustrating is a complaint or claim arises if your record is not as comprehensive as you had hoped, you are still able to rely on any recollections that you had of the consultation and/ or your usual practice and whilst these are less then persuasive as a contemporaneous entry in the record, it may still be possible to defend allegations in the complaint or claim.

How to amend the medical record

When retrospectively adding more detailed notes to the patient's record, the record should include (in a way that is immediately apparent to an objective reader):

- The name of the person adding the information.
- The time and date of the addition.
- An explanation of which information has been added.
- An explanation of why these were not recorded at the time of the original entry and why they are being entered now.

If the amendment relates to a third-party letter correcting for factual accuracy, then the original letter can be deleted and replaced with the corrected letter if the original letter had only been recently received, and no subsequent actions/decisions had been taken in response to the letter. However, if there is a significant time delay in receiving the corrected letter and actions/decisions have taken place, the original letter should be kept in the record alongside the corrected letter.

When making a correction of factual accuracy, it should be documented at who’s request this correction is being made. Unless due to exceptional circumstances, the original entry should not be deleted but should be amended. If the request is to remove information from a paper record guidance should be sort from either the Caldicott Guardian or MDO.

The practice should respond to any request to amend the medical record within one month. If longer is needed (up to 2 months), the patient should be informed during the first month of this and the reason why.

Refusing to comply with a request for rectification

The practice can refuse to comply with a request for rectification if it believes that the request is 'manifestly unfounded or excessive'.

This decision should not be taken without due consideration and should take into account whether the request is repetitive.

In such circumstances the practice can:

- Request a reasonable fee to deal with the request. This is the only situation where a fee can be charged and it should be 'reasonable' to cover administrative costs associated with the request, **or;**
- Refuse to deal with the request.

In either case, you will need to inform the patient, provide them with an explanation and advise them that they can make a complaint to the ICO. Further information from the ICO about requests for rectification can be found on their website.

Summary

There are several legitimate reasons why the medical records may need to be amended. It is important to rectify inaccuracies in the record in a timely manner.

The patient should be fully informed of any amendments/corrections.

The key thing for practices to remember is that whenever retrospectively amending a medical record, it should be clear within the record who has made the change, the date/time when this was done and the reason the record was amended – it is not appropriate to rely on the computer audit trail alone for any of these purposes.