Opinion Medico-Legal

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Amending or erasing records – when you should exercise caution?

***Mr Liam Heffernan** on the issues involved in making amendments to medical records*

Increasingly, doctors are being requested to make amendments to their patients' records or even to erase them. In this article, we look at some the issues that should be considered when contemplating amending or deleting a patient's records.

Amending medical records

Doctors regularly find themselves having to look back over patient notes, whether to refresh their memory as part of ongoing care delivery to a patient, in the context of preparing a medical report or if responding to a complaint or claim. In the latter situation, we occasionally find the doctor wishing they had written a more detailed note or they may notice an error in the notes ranging from a simple misspelling to more fundamental error in recording.

For example, following a very detailed consultation with a patient about a particular procedure which included drawing diagrams for the patient, the consultation note recorded "no risks of infection discussed" instead of "all risks of infection discussed". The patient went on to develop an infection and claimed they were not appropriately consented. However tempting it may be to correct such an error, particularly when the doctor has a clear recollection of the consultation or where the error appears obvious, we strongly advise against taking such action.

The Medical Council's *Guide to Professional Conduct and Ethics for Registered Medical Practitioners* (the 'Guide') states doctors *"must keep accurate and up-to-date patient records either on paper or in electronic form. Records must be legible and clear and include the author, date and, where appropriate, the time of the entry, using the 24-hour clock."*

Issues do arise, in both medical negligence litigation and Medical Council complaints, concerning the accuracy of a doctor's medical records. Sometimes this occurs because a patient strongly disputes the content of the records. There have been instances where the concern became such an issue in the case or complaint that IT experts were instructed to examine the audit trail of computerised records to determine when the records were generated and whether they had been subsequently altered.

Records that are found to have been amended after the fact may understandably call into question their accuracy, impugn the credibility and honesty of the doctor in question, and also impact on the reliability of any evidence that the doctor may wish to provide in their defence. The courts and the Medical Council would almost certainly take a poor view if records were found to have been altered and the doctor could find themselves subjected to a Medical Council complaint as a result.

If any clarification/correction of a medical record is necessary, this should be very clearly marked as a retrospective additional entry with both the date of the amendment and the identity of the author. A reason for the clarification/correction should also ideally be included. These principles apply to both electronic and handwritten medical records. It should be absolutely clear to anyone viewing the entry that it was not written at the time of the event or consultation, but rather was added later. This will ensure transparency in the medical records and can show that it was a genuine subsequent clarification, with no intention to mislead any other individual.

Patient request to amend medical records

Under the General Data Protection Regulation (GDPR), patients have the right to request that information that is factually inaccurate be rectified. However, doctors should be mindful of the distinction between a simple factual inaccuracy (for example, the patient's date of birth in their records being incorrect), and, separately, a dispute about the medical opinion of a doctor contained in medical records (for example, that a patient was displaying psychotic symptoms or appeared anxious in a consultation). Dealing with a dispute by the patient in the latter circumstances should be dealt with on a case-by-case basis. One approach is to add a further note in the records, such as that the patient disagrees with the diagnosis. However, the original record made by the doctor should remain if the doctor is satisfied that it was a contemporaneous note of their clinical opinion at the time.

Request to erase medical records

Separately, patients may submit requests to their doctor for their medical records, or a part of their records, to be erased or deleted. This is due to their rights as data subjects under GDPR, which is the right to erasure, also known as the right to be forgotten. There may be a difference in opinion with the clinical decision reached and recorded by the treating doctor or a breakdown in the therapeutic doctor-patient relationship.

These requests can often give rise to confusion, due to the strong focus on the maintenance of good and accurate medical records from both a legal and ethical point of view.

Restrictions

Article 17 of GDPR provides for a right to erasure on a number of grounds, including where the data subject withdraws consent. A request for erasure can be made verbally or in writing. However, this right under GDPR is not absolute and is subject to restrictions.

Article 17 (3) of GDPR and Section 60 (7) of the Data Protection Act 2018 provide that these restrictions include reasons of public interest in the area of public health. This includes where the data is required for medical diagnosis or the provision of health treatment, or where the data may be required for the establishment or defense of a legal claim.

Ethical and contractual obligations

A doctor must also be aware of their ethical obligation to keep and maintain records. As above, paragraph 33 of the Medical Council's Guide, includes an obligation on maintaining accurate and up-to-date records, further:

33.4 You must comply with data protection and other legislation relating to storage, disposal, and access to records. You should understand the eight rules of data protection (see Appendix B).

33.6 You should keep medical records for as long as they are likely to be relevant to the patient's care, or for the time the law or practice standards require. You may also wish to take advice from your medical defence organisation or legal adviser about retaining records for medico-legal purposes.

It is also important to be aware that it is usually an express term of most doctors professional indemnity insurance policies to maintain good and accurate medical records.

Retention periods

There is also an obligation not to retain data for longer than necessary. The Data Protection Acts provide that *"personal data must be kept in a form which permits identification of data subjects for no longer than is necessary for the purposes for which the personal data are processed".*

The HSE retention of records policy provides guidance in respect of the recommended retention periods for medical records. There are a number of different categories which doctors should seek specific guidance on, including maternity records and records of children. In most cases, the healthcare records of an adult patient have a retention period of eight years after the last contact.

Dealing with an erasure request

Each request should be examined and considered on a case-by-case basis. The approach could include the following:

1. Review records/data

Review the information/data, which the patient has asked to be deleted in order to consider whether the records fall within the allowable restrictions/exceptions as mentioned above. More often than not, the request will concern entries in the patient's clinical records. The erasure request may relate to a specific consultation or it may request the deletion of the entirety of the clinical records held.

2. Consider restrictions

If, following review of the records/data, you are satisfied that the retention of the records is necessary for the purpose of medical diagnosis/treatment and/or in order to comply with your obligations under the Medical Council Guide and/or in order to defend a claim or complaint, then the data should not be erased.

3. Communicate decision

If the conclusion is that the data does fall within the restrictions and should therefore not be erased, the decision should be communicated to the patient as promptly as possible, along with an explanation of the reasons for the decision.

4. Consider alternatives

In communicating the decision to the patient, it can also be helpful to consider whether there are any alternative steps that could be taken to address their request or concern about their data being retained. For example, offering to include a note in their records documenting the patient's objection to the content of the record or noting their request to delete a specific entry for future reference and their reasons for the request. Consider providing reassurances about the measures in place to ensure that records are stored securely and reviewed in line with the recommended retention periods.

5. Right to complain

In line with obligations under GDPR, the patient should be advised that they have a right to complain about the decision to the Data Protection Commissioner (DPC) via the website (https://forms.dataprotection.ie/contact). It can also be helpful to direct the patient to your practice complaints policy in the hope of trying to resolve the matter at a local level.

6. Good record-keeping

It is important to maintain careful notes of the decision-making process and any communication with the patient as these may be helpful should a complaint be made to the DPC or the Medical Council at a later stage. If you do receive such a complaint, you should contact your indemnifier for specific advice.

As can be seen from above, there are many issues arising with amending or agreeing to delete medical records. If you need guidance specific to your circumstances, please contact your indemnifier for advice.