

PATIENT REQUESTS FOR ERASURE OR AMENDMENT OF RECORDS

A high level of caution should be exercised in relation to requests to amend or erase a patient's records, writes Sile O'Dowd of Medisec

GPs are obliged to keep accurate medical records documenting treatment provided to patients. It is a condition of many professional indemnity insurance policies to maintain accurate medical records, in accordance with relevant retention periods.

The Medical Council's *Guide to Professional Conduct and Ethics for Registered Medical Practitioners*¹ (the 'Guide') says:

38.1 "You must keep accurate and up-to-date medical records either on paper or in electronic format. These must be legible, clear and include the author, registration number, date and, where appropriate, the time of the entry and should be made contemporaneously in so far as possible."

The keeping, maintenance and retention of medical records serves many functions, their primary purpose being to support and facilitate quality patient care. However, contemporaneous records are also usually crucial to the defence of legal claims and complaints. A failure to record vital clinical information can significantly hamper the ability to respond to and/or defend a claim and/or complaint. So while records are essential to support quality patient care, they are also an important form of protection for you.

Amending medical records

GPs regularly review patient notes in the course of their daily work. They may need to refresh their memory as part of ongoing care delivery to a patient, to prepare a medical report or to respond to a query, complaint or claim.

It is not uncommon, with the benefit of hindsight, to wish you had written a more detailed note or to be tempted to correct an error or omission in previous notes. However, tempting as it may be, particularly when the GP has a clear independent recollection of the consultation or where the error appears obvious, we strongly advise against taking such action.

Unfortunately, serious issues arise

in the medico-legal context when there is a question mark over the accuracy or contemporaneity of medical records. We are aware of situations where 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. A finding that records were covertly amended after the fact will irreparably damage the credibility of a doctor and will compromise the strength of any evidence that the doctor may wish to put forward in their defence. It is also likely to give rise to a Fitness to Practise complaint.

The Guide deals with the issue of retrospective notes and should always be consulted carefully if faced with a situation where a retrospective note is considered appropriate.

The Guide says:

38.1 "Retrospective notes are acceptable in circumstances where it was not possible for the GP to record the notes at the time of the event. In these circumstances you must document:

- That it is a retrospective entry
- The date and/or event that it relates to
- The date/time the retrospective note was made.

38.2 "Clinical notes contained in the medical record must not be altered. If it is necessary to amend a clinical note a new entry should be made."

These principles apply to both electronic and handwritten medical records. It should be clear to anyone viewing the entry that it was not written at the time of the event or consultation but rather was added retrospectively.

Patient request to amend medical records

Under GDPR, patients have the right to request that information relating to them that is factually inaccurate be rectified. However, GPs 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 GP contained in medical records (for example, that a patient appeared anxious in a consultation).

The original record made by the GP should remain if the GP is satisfied that it was a contemporaneous note of their clinical opinion at the time.

One potential means of resolving a request is to add a further note in the records noting that the patient disagrees with the diagnosis. This approach would be in keeping with paragraph 38.2 of the Guide.

If you find yourself navigating such a request, you should contact your indemnifier for case-specific advice.

Right to erasure/right to be forgotten

Separately, patients may submit requests to their GP for their medical records, or a part of their records, to be erased or deleted. This flows from the right to erasure, also known as the right to be forgotten under GDPR, and such requests can be made on a number of grounds. In healthcare, such requests can arise where there is a difference in opinion with the clinical decision, a breakdown in the therapeutic relationship, or where a patient considers aspects of their records may be unhelpful in the context of applying for life assurance or similar products.

We strongly advise seeking specific advice from your indemnifier should you receive such a request and the following information is intended as general guidance only.

The right to erasure under Article 17 GDPR (Section 60 of the Data Protection Act 2018) is not absolute and is subject to restrictions. 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 defence of a legal claim.

In addition, the Guide also specifically advises on steps to take if requested to

delete or destroy records under data protection principles, stating that a GP should first consider whether there is a professional and/or medico-legal requirement to retain them.

Each erasure request should be examined and considered on a case-by-case basis. The erasure request may relate to a specific consultation entry or a particular section, or it may request the deletion of the entirety of the patient's clinical records.

It may be helpful to implement a protocol on the steps to take to deal with such requests which could include the following:

- It is advisable to consider if retention of the records is still appropriate, in line with the HSE Code of Practice for Healthcare Records Management²
- There should be a review of the information which the patient has asked to be deleted, to consider whether the records fall within the allowable exceptions to the right to erasure as mentioned above
- If, following review of the 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 professional



obligations and/or in order to defend a claim or complaint, then the data should not be erased

- Following review, if the conclusion is that the data does fall within the restrictions to the right to erasure and should not therefore be erased, the decision should be communicated to the patient or data subject as promptly as possible, along with a clear explanation and the reasons for the decision
- In communicating the decision to the patient or data subject, it can also be helpful to consider whether there are any alternative steps that could be taken to address a patient or data subject's

request or concern about their data being retained. Such measures might include inserting a note into the record documenting a patient's objection to the specific information or their request to delete a specific entry and the reasons for this, or alternatively, restricting access to the data

- 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 Commission (DPC) via the website (dataprotection.ie)
- It is important to maintain careful notes of the decision-making process and any communication with the patient or data subject, as these may be helpful should a complaint be made to the DPC at a later stage.

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References

1. Medical Council 2024. Guide to Professional Conduct & Ethics for Registered Medical Practitioners, 9th Edition 2024
2. Health Service Executive Standards and Recommended Practices for Healthcare Records Management 2025-2028



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