

# Medical records



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Good medical records – whether electronic or handwritten – are essential for the continuity of care of your patients. Adequate medical records enable you or somebody else to reconstruct the essential parts of each patient contact without reference to memory. They should therefore be comprehensive enough to allow a colleague to carry on where you left off.

## Why good records are important

The main reason for maintaining medical records is to ensure continuity of care for the patient. They may also be required for legal purposes if, for example, the patient pursues a claim following a road traffic accident or an injury at work. For health professionals, good medical records are vital for defending a complaint or clinical negligence claim; they provide a window on the clinical judgment being exercised at the time.

In general, records that are adequate for continuity of care are also sufficiently comprehensive for legal use.

## Good medical records

Good medical records summarise the key details of every patient contact. On the first occasion a patient is seen, records should include:

- Relevant details of the history, including important negatives
- Examination findings, including important negatives
- Differential diagnosis
- Details of any investigations requested and any treatment provided
- Follow-up arrangements
- What you have told/discussed with the patient.

On subsequent occasions, you should also note the patient's progress, findings on examination, monitoring and follow-up arrangements, details of telephone consultations, details about chaperones present, and any instance in which the patient has refused to be examined or comply with treatment. It is also important to record your opinion at the time regarding, for example, diagnosis.

Medical records must be:

- Objective recordings of what you have been told or discovered through investigation or examination
- Clear and legible
- Made contemporaneously, signed and dated
- Kept securely.

**NB** Although abbreviations are undoubtedly a great time-saver, you should take care to use them only where their meaning is unambiguous and would be easily understood by your colleagues. Never use abbreviations for making derogatory comments about the patient.

Medical records should contain all the pertinent information about a patient's care and can cover a wide range of material including:

- Handwritten notes
- Computerised records
- Correspondence between health professionals
- Laboratory reports
- Imaging records, including x-rays
- Photographs
- Video and other recordings
- Printouts from monitoring equipment

## GMC expectations

In its publication, *Good Medical Practice* (November 2006, paragraphs 3f–g), the GMC states that “In providing care you must ... keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigation or treatment; make records at the same time as the events you are recording or as soon as possible afterwards.”

In addition, you should include referral or follow-up arrangements and, in particular, warnings you may have given patients about requirements for ongoing monitoring, or the consequences of not accepting particular treatments.

Patients have a right of access to their own medical records under the Data Protection Act 1998 (DPA). If a complaint or claim arises, the records are likely to be examined closely by experts, administrators, lawyers and the courts. Inadequate records that fail to address the key issues will create a poor impression, particularly if they include inappropriate subjective comments about the patient.

## Additions or alterations

If you need to add something to a medical record or make a correction, make sure you enter the date of the amendment and include your name, so no one can accuse you of trying to pass off the amended entry as contemporaneous. Do not obliterate an entry that you wish to correct – run a single line through it so it can still be read.

Patients have the right, under the Data Protection Act (DPA), to ask for factual inaccuracies in the record to be rectified or deleted. The Act does not, however, give them the right to ask for entries expressing professional opinions to be changed. You should only comply with a request if you are satisfied that it is valid – ie, the entry is indeed factually inaccurate, but if you decide that a correction is not warranted, you should still annotate the disputed entry with the patient's view.

If you decide that the request is valid, add a signed and dated supplementary note to correct the inaccuracy and make it clear that the correction is being made at the patient's request. Avoid deleting the original entry, though. If the patient demands nothing less than deletion, then this should be done in exceptional cases – and only then in paper records, never electronic. This must be discussed fully with the patient.

## Further information

- MPS factsheet, *Access to Health Records* – [www.medicalprotection.org/uk/factsheets](http://www.medicalprotection.org/uk/factsheets)
- MPS booklet, *Keeping Medical Records* – [www.medicalprotection.org/uk/booklets](http://www.medicalprotection.org/uk/booklets) (Free to MPS members on request)
- GMC, *Good Medical Practice 2006* – [www.gmc-uk.org](http://www.gmc-uk.org)
- NIGB, *Guidance on Requesting Amendments to Health and Social Care Records 2010* – [www.nigb.nhs.uk](http://www.nigb.nhs.uk)

This factsheet provides only a general overview of the topic and should not be relied upon as definitive guidance. If you are an MPS member, and you are facing an ethical or legal dilemma, call and ask to speak to a medicolegal adviser, who will give you specific advice.

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