British Psychoanalytic Council
4.5b Guidelines on notes and records

Introduction

1. This document is intended to assist BPC registrants in maintaining proper, appropriate and confidential records of clinical work in line with the BPC Code of Ethics and Ethical Guidelines (2011). All BPC registrants will be expected to abide by the BPC Code of Ethics and Ethical Guidelines as well as the codes of good practice of their own professional bodies. Registrants who are training supervisors should ensure that these Guidelines are drawn to the attention of trainees.

2. These Guidelines have been drawn up to reflect the BPC's understanding of current legislation. In case of any query or dispute BPC registrants may find it useful to draw the attention of others concerned to these Guidelines and those of their own professional organisation. Registrants may also seek advice and guidance from the Ethics Committees of their individual member societies and from the BPC.

3. These Guidelines mainly pertain to independent private practice but will also be relevant to work in organisations and in the Public Sector. Those registrants working within the Public Sector should, while adhering to the spirit of these Guidelines, also be aware that their employing organisation will have its own case notes standards, requirements and conditions concerning the keeping of notes and records about patients.

4. As in the BPC document on Confidentiality, we recommend that a distinction be made between the factual Record a clinician keeps of their work with a patient and their working clinical Notes. **No such distinction is made in current legislation and registrants should be aware that all their Notes could be subpoenaed by a Court and should be securely kept in accordance with the Data Protection Acts** (see Guideline 3, below). The BPC recommendations are intended to help clinicians maintain a proper balance between keeping an appropriate, factual and confidential Record of their work, and being able to make use of the temporary written *aides memoire* of clinical material sometimes necessary in psychoanalytic and psychotherapeutic work.

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Guidelines

1. It is the responsibility of the individual registrant to keep strict standards of confidentiality[1] on all written Records and Notes about a patient and under all circumstances vigorously to resist identifiable disclosure of this material against his/her clinical judgement.

    i. It is a requirement of the Data Protection Acts that clinical Notes and Records should not be kept for longer than necessary and a clinician working in private practice must make arrangements for their secure disposal, including after his/her own death. Notes retained on a file in an Institution are kept according to the policy of the Institution and are independent of the individual clinician.

    ii. BPC registrants who are trainee therapists/analysts should establish clearly with training patients what the reporting requirements of their training are and what the implications are for the boundaries of confidentiality.

2. **Records** contain a minimal set of factual data necessary to provide a professional service. They are for use in very limited circumstances including communication with a third party when it is in the patient's urgent interest that it should take place.

    i. For some patients simply name, address and contact details will be enough. For others, the name of the GP and the referrer, and some basic diagnostic or other information, including periodic summaries, may be appropriate.

    ii. Patients[2] have access to information kept in their Record if necessary[3].

    iii. In anticipation of their own possible incapacity or death, clinicians will have made arrangements with a professional colleague for confidential access to their Record to provide for the notification and care of their patients.

Clinical Notes are material in the form of written notes and jottings sometimes made by clinicians, for example, after a session with a patient, solely in the services of their thinking about the treatment and the development of their understanding of the therapeutic task. These will be destroyed once they have served their purpose. **Please note that the distinction between Records and clinical Notes that we recommend here is made in the service of the therapeutic work and is not recognised in current legislation where it is held that everything written about a patient forms part of the Record.**

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[1] Registrants are advised that measures should be taken to ensure security of confidentiality in electronic communications e.g. patients names should not be used in emails; all recommendations in these guidelines apply to both paper and electronic communication and storage systems.

[2] In the case of work with children and adolescents, this extends to those with legal parental responsibility.

[3] This is a requirement of the Data Protection Act (1998).

3. These Clinical Notes, as distinct from Records, must at all times be anonymised, not kept as part of a filing system that is linked to a patient's name, and are never disclosed in a way that could identify the patient.

   i. Only strictly anonymised material should be used in supervision or in case discussion, as part of a registrant's continuing professional development (CPD).

   ii. Registrants should consult the Guidelines for Confidentiality in Publications of their own BPC member institution, and the confidentiality regulations of the publications concerned, before contemplating publishing anything based on clinical material. See also BPC Ethical Guidelines paragraph 17.

4. BPC registrants who are working in the Public Sector or other organisations will be required to adhere to that organisation's rules about case notes and records. It may be appropriate to discuss the content of this recorded material, including access to it, with the patient.

5. **Requests for disclosure**

   If the registrant decides to disclose information it should be strictly limited to what is considered necessary and pertinent. Wherever possible, disclosure must be with the patient's express permission. The response to a request for information can sometimes take the form of a written report. In this case, the registrant should keep the report and related correspondence as part of the patient's Record.

   The circumstance of a request for disclosure of information will often be difficult and painful (perhaps particularly in a Court case or for a Coroner's Court). The registrant will need to be sensitive to the situation and to exercise clinical judgement, perhaps in consultation with a colleague, in formulating the appropriate response.

   i. Court. Registrants should seek the support of their own Societies and the BPC in deciding on their response to any request for the disclosure of any material relating to a patient when ordered by a Court. Those working in the Public Sector should also seek advice from their employing Trust or Authority.

   ii. Solicitors or Insurance Companies. Requests for information by solicitors or insurance companies (even with the patient's own consent to disclosure) should always be resisted citing the Confidentiality Policy of the BPC and the registrant's own member organisation.

   iii. The Patient. A request from a patient would probably be treated as a communication in treatment and considered analytically in the first instance so that its meaning could be understood. However it should be noted that patients' right of access to information kept in their record is protected by law. (See B2. ii)