WELLBEING & WORKPLACE DIGNITY | MODULE 08

Recording facts and protecting confidentiality

Build a reliable chronology without collecting excessive, insecure or patient-identifiable material.

- ✓ 16 min reading
- ✓ Full teaching, practical next steps and reflection
- ✓ Six practice questions with answers and explanations
- ✓ Complete source list and jurisdiction notes

Prepared for SAS, locally employed and other UK doctors

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Using this module

Independent education

This is general professional information, not individual clinical, legal, employment, immigration, regulatory, tax or pensions advice. Current official instructions and the circumstances of the individual case remain controlling. Practice scores do not establish professional competence or accreditation.

The short answer

A useful record is contemporaneous, factual, relevant and securely kept. It distinguishes observation from interpretation, links documents without copying unnecessary confidential data and states the effect and action taken.

Three next actions

- Start a dated chronology with one event per entry.
- Separate direct observation, reported information and your interpretation.
- Remove patient identifiers and ask an adviser how evidence should be transferred securely.

Learning objectives

- Create a clear event chronology.
- Distinguish evidence from inference.
- Protect patient, colleague and organisational confidentiality.

Why a chronology helps

Stress disrupts memory and encourages accounts to become organised around emotion rather than sequence. A chronology restores sequence and lets an adviser identify patterns, missing information and deadlines. It can also prevent repeated retelling. The purpose is accuracy, not the construction of an adversarial dossier.

Start with date and time, location or system, people present, what you directly saw or heard, any words recalled accurately, what happened next, immediate effect, action taken and linked document. Mark estimates as estimates. Correct an error transparently rather than silently rewriting an earlier entry.

Fact, report and inference

A fact might be: 'The meeting invitation was sent at 16:42 for 09:00 the next day.' A report is: 'A colleague told me that the meeting had been discussed the previous week.' An inference is: 'I believed the short notice was intended to prevent representation.' All may be relevant, but they should not be presented as the same kind of evidence.

Use exact quotations only when you are confident of the words or have a reliable record. Otherwise say that the wording is approximate and record the substance. Avoid absolute language such as always, never or everyone unless it is literally supported.

Documents and witnesses

List relevant emails, policies, rotas, job plans, minutes, appraisals or messages and preserve them in accordance with policy. Note potential witnesses and what event they may have observed. Do not ask them to endorse your interpretation or circulate a draft statement for group agreement.

A missing document is not an invitation to access systems without authority. Ask the investigating officer or representative how disclosure and preservation will be handled. Keep work records within approved systems where possible and avoid insecure forwarding.

Patient confidentiality

Do not copy names, dates of birth, NHS numbers, clinical screenshots or identifiable narratives into a personal workplace chronology. Use the approved incident or clinical record for patient-specific facts and record only the incident reference in your private index where lawful. A representative can advise how relevant clinical material should be requested through the proper process.

Redaction is more than deleting a name: rare diagnoses, dates, locations and combinations of details can identify a patient or colleague. Share only what is necessary for the specific purpose and use secure channels.

Digital safety and shared devices

The website chronology builder operates in the browser and does not send entries to SAS Doctors Review. If you choose to save information on the device, anyone with access to the same browser profile may be able to see it. Use a trusted private device, remove identifiers and clear the tool after printing or transferring the information securely.

Do not assume cloud notes, personal email or consumer messaging apps are approved for sensitive employment or clinical information. Ask your organisation or representative about secure storage. The absence of a patient name does not automatically make a document harmless.

Prepare for an advice meeting

Send or bring a concise issue summary, chronology, key documents, relevant policy, current deadline, desired outcome and questions. Tell the adviser about related processes and previous advice. This helps limited appointment time focus on decisions rather than reconstruction.

Keep the full record, but identify the three to five events most important to the issue. A short accurate core account with an indexed chronology is usually more usable than an unstructured bundle of hundreds of pages.

Worked example: one chronology entry

A useful entry reads: '3 September, 14:00, departmental meeting. Present: A, B and C. After I asked who would provide senior cover, A said, approximately, that I was being difficult again. B then moved to the next agenda item. I emailed A at 16:10 asking for the cover arrangement. No reply received by 5 September.' It identifies an approximate quotation and subsequent action without asserting motive.

A weaker entry reads: 'Management always bullies me and planned the meeting to humiliate me.' That may express the doctor’s experience, but it does not show the event, source or sequence. Feelings and interpretation can be recorded in separate fields rather than presented as observed fact.

The minimum-necessary test

Before adding or sharing an item, ask whether it is relevant to the issue, whether you are entitled to possess it, whether the recipient needs it, whether identifiers can be removed, whether an approved channel is available and whether a reference would be safer than a copy.

If uncertain, keep the material in its authorised system and ask a representative or investigating officer how it should be obtained. A comprehensive case does not require uncontrolled duplication.

Common mistake

Avoid this	Collecting everything can create confidentiality breaches and obscure the strongest evidence; relevance and lawful possession matter.

Pause and reflect

Could a neutral reader distinguish what you observed, what you were told and what you concluded?

Takeaways

- Record sequence, source, effect and action.
- Label inference and approximate recollection honestly.
- Keep identifiable clinical information within authorised systems.

Knowledge check

Choose one best answer. These practice questions support reflection; they do not assess a real case or confer accreditation. Answer positions match the browser edition.

1. What is the purpose of a chronology?

A. To organise accurate sequence and evidence

B. To replace professional advice

C. To collect all patient data

D. To diagnose the other person's motive

2. Which is an inference?

A. The email was sent at 16:42

B. The meeting occurred on Monday

C. I believed the notice was designed to exclude my representative

D. A colleague said the issue was discussed

3. How should potential witnesses be handled?

A. Post their names publicly

B. Ask them to agree a shared account

C. Record who may have observed which event

D. Send them confidential documents

4. What belongs in a personal chronology?

A. Patient screenshots

B. An incident reference without unnecessary patient identifiers

C. Copied medical records

D. Full clinical histories

5. What is true of browser-local storage?

A. People using the same browser profile may see saved information

B. It is automatically encrypted for every user

C. It is approved clinical storage

D. It is sent to the website

6. What makes an advice appointment efficient?

A. A concise summary, chronology, key documents, deadline and questions

B. Only an emotional account

C. Withholding related processes

D. An unindexed data dump

Answers and explanations

1. A — To organise accurate sequence and evidence

A chronology supports accurate recall and advice.

Review the purpose and structure.

2. C — I believed the notice was designed to exclude my representative

Belief about intention is an inference and should be labelled as such.

Review the three categories.

3. C — Record who may have observed which event

Identify possible firsthand evidence without coaching.

Review witness and document handling.

4. B — An incident reference without unnecessary patient identifiers

Use approved clinical and incident systems for identifiable patient information.

Review confidentiality safeguards.

5. A — People using the same browser profile may see saved information

Local storage avoids server transfer but does not make a shared device private.

Review the shared-device warning.

6. A — A concise summary, chronology, key documents, deadline and questions

A structured pack helps the adviser focus on decisions.

Review preparation for advice.

Official and professional sources

Confirm the current source version and applicable nation, contract, scheme or specialty. A source list is not a statement that every rule applies to every reader.

Good medical practice 2024
UK · https://www.gmc-uk.org/cdn/documents/good-medical-practice-2024---english_pdf-102607294.pdf

Acas Code of Practice on disciplinary and grievance procedures
Great Britain · https://www.acas.org.uk/acas-code-of-practice-on-disciplinary-and-grievance-procedures/html

GMC confidentiality guidance
UK · https://www.gmc-uk.org/professional-standards/the-professional-standards/confidentiality

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