Records As Reliable Evidence: Medico-legal Litigation

Ian Freckelton

Dr Ian Freckelton is a barrister in full-time practice, admitted in Victoria, NSW, Queensland, South Australia, Tasmania, the Northern Territory and the ACT. He is also an Adjunct Professor of Law and Legal Studies, La Trobe University, an Honorary Associate Professor of Forensic Medicine, Monash University, a member of the Victorian Mental Health Review Board and a Board Member of the Australian Institute of Health, Law and Ethics. He participated in the team from the Australian Law Reform Commission which advanced the recommendations which led to the *Evidence Act 1995* (Cth) and the *Evidence Act 1995* (NSW). He is the editor of the *Journal of Law and Medicine,* the journal, *Psychiatry, Psychology and Law,* and of the five volume looseleaf service, *Expert Evidence.*[1]

Recordkeeping in all litigation is fundamental to decision-making by courts and tribunals. This is particularly so in cases where malpractice is alleged against healthcare practitioners. With records compiled by doctors, nurses, chiropractors and dentists becoming more readily accessible to patients, the onus falls upon healthcare practitioners to ensure that such records contain sufficient information to communicate the important aspects of patient-practitioner interaction. Failure to do so can result in significant forensic disadvantage. Compilation of healthcare records in a form which makes subsequent interference with them difficult but enables a clear perspective upon the key aspects of practitioner-patient communication has much to commend it both from the point of view of the quality of healthcare provision and also from the point of view of protecting practitioners and patients against erroneous allegations and misplaced recollections.

This is a refereed article.

Introduction

Documents form the backbone of a large part of litigation. Fact-finders, be they judges, magistrates or juries, need to be able to reconstruct reliably what happened on an earlier occasion or series of occasions. They do so on the basis of oral evidence, from the recollections of witnesses, sometimes from expert evidence, but primarily on the basis of evidence emerging from documentation. Much therefore depends upon the quality of the records that are adduced in evidence, as well as upon the integrity of the processes employed to create the records in the first place.

Criminal lawyers are well accustomed to the assertion that documents have been falsified, that evidence has been 'planted' and that people have been 'verballed' by false ascription of admissions by police recording in writing of their alleged statements.[2] Interference with traditional forms of recordkeeping has always been possible for forensically advantageous ends. With relatively few checks upon those unscrupulous enough to engage in such dishonesty, faking of records has been a bane of accurate fact-finding. While forensic science can now lend some assistance to litigants who wish to test the propriety of proffered documentary evidence, new forms of technology also afford the opportunity to dishonest defendants for 'rectification' of many kinds of otherwise inculpatory evidence, especially digitally recorded audio evidence, and most importantly, for the purposes of this article, documentary evidence. Incentives lie for many parties potentially involved in both criminal and civil litigation to bolster their cases, or even create their cases, by the fabrication, revision or enhancement of evidence in the form of business or other records.

This article focusses upon the use of records in medico-legal litigation, highlighting the forensic perils for defendant doctors of inadequate recordkeeping. It also draws attention to the difficulties posed by the potential for misuse and abuse of documentary evidence by medical practitioners. It argues that healthcare practitioners need to adopt modes of recordkeeping which establish not just a record of the quality of their notes, but the bona fides of the contemporaneity and integrity of their records. It also maintains that the law needs to become more sophisticated in its evaluation of tendered documentation in medical malpractice cases

to guard against the possibility for self-serving employment of questionably created records.

Documents in healthcare malpractice litigation

The starting point for medico-legal litigation is records, be they those of the doctor, the dentist, the chiropractor, the hospital, the nurse or the manufacturer of a product which is alleged to have caused injury. From the defendant's point of view, it is vital that healthcare records contain meaningful information, sufficient to allow a tribunal of fact to evaluate the material in them and to determine key issues such as:

- what procedures were undertaken;
- by whom the procedures were undertaken;
- why the procedures were undertaken;
- what information was given to the patient about the procedures;
- what information was provided to the patient about other practitioners who could conduct the procedure; and
- whether the patient gave informed consent to the procedures.

For plaintiffs, if the records of the defendant healthcare professional are inadequate, this can be a forensic boon.

From a legal point of view, healthcare records are quite readily accessible. In all Australian states and territories, they can already be obtained by an actual or potential plaintiff under preliminary discovery[3], pretrial discovery or under subpoena at the court hearing or shortly before. In most jurisdictions public healthcare records can also be obtained under freedom of information legislation. One way or another, unless healthcare records have been lost or destroyed, it is likely that the prospective plaintiff or the actual plaintiff in litigation will gain access to them.

Because of the nature of litigation which revolves around the allegation of

poor practice by a healthcare practitioner, much depends upon the information contained by the records that come before the court. On occasions there is alleged to be a discrepancy between the pristine state of such records and what actually makes its way before the tribunal of fact, be it a judge, magistrate or jury. This calls for evaluation by the tribunal of fact of whether there has been covert alteration of the records. In addition, there are often disagreements between the healthcare practitioner responsible for the authoring of the notes and the recollection of the patient about what transpired between, for instance, doctor and patient. In such circumstances, much depends upon the tribunal of fact's assessment of the credibility of the various witnesses and upon the quality and extensiveness of the records.

Prelitigation access to medical records

In 1996 the High Court in *Breen v Williams*[4] determined that patients do not have a general right to access to the records compiled about them by their medical practitioners. The Court held that implied terms of the doctor-patient contract, the nature of the relationship between doctor and patient, which has fiduciary elements to it, and the common law all failed to provide patients with rights of access to doctors' medical records. The decision was initially regarded by defendants as a dramatic setback in their ability to sue negligent healthcare practitioners.[5] This has proved not to be correct. The decision merely means that patients, other than those in the ACT, for the moment have entitlement to their medical records only under discovery, subpoena and under freedom of information legislation. This represents something of an impediment for patients to gain access to records held in respect of them by non-government healthcare practitioners, but in most circumstances the impediment is relatively easily overcome. In particular, the extent to which prelitigation discovery in many jurisdictions allows such access cures much of the problem posed by the loss by Mrs Breen in *Breen v Williams*. The only impediment in this regard is the costs of such applications.

For instance, under Rule 32.05 of the Victorian Supreme Court Rules

> Where
>
> (a) there is reasonable cause to believe that the applicant has or may have the right to obtain relief in the Court from a person whose description he has ascertained;
>
> (b) after making all reasonable inquiries, the applicant has not sufficient information to enable him to decide whether to commence a proceeding in the Court to obtain that relief; and
>
> (c) there is reasonable cause to believe that that person has or is likely to have or has had or is likely to have had in his possession any document relating to the question whether the applicant has the right to obtain the relief and that inspection of the document would assist him to make the decision -
>
> the Court may order that the person shall make discovery to the applicant of any document of the kind described in paragraph (c).

The purpose of such prelitigation discovery is to enable a potential litigant to determine whether or not he or she has a cause of action. Thus it enables a search for information before the filing of a statement of claim, ceasing to be available in the same form once a proceeding is actually commenced.[6] Most prelitigation discovery provisions are broad. Their major limitation is simply that

> The Court should be satisfied that a cause of action may be unearthed by the discovery. The court should be satisfied that there will be a real benefit from making the order, such as the possible avoidance of unnecessary or fruitless litigation, or the gaining by a potential plaintiff of information which only the party from whom the discovery is sought has, and which might assist the ends of justice and reduce the costs of litigation.[7]

An example of the utility of such a measure is to be found in the facts of the English case of *Dunning v Board of Governors of the United Liverpool Hospitals.*[8] The plaintiff had enjoyed good health all her life but developed a cough and was admitted to hospital for investigations. During the first few weeks after her admission she seemed to improve but one day when her

family came to visit her she was substantially worse and her family was told that she was very ill but would recover. Her speech was impaired, her face was drawn up on one side and she appeared gravely ill. The doctors were uncertain as to her diagnosis, at first identifying undulant fever and prescribing streptomycin and then later changing both diagnosis and treatment. After seventeen weeks she was released from hospital but her walking and memory were still impaired and there was suspicion that it was the streptomycin which had impaired her health. She obtained legal aid to procure a medical opinion but the physician whom she consulted and a neurologist were denied access to the hospital's clinical notes unless they were reassured that no action would be brought against them.

The plaintiff sought access to the documents under provisions which bear some similarity to the early discovery provisions existing in Victoria. The Court of Appeal ultimately failed to grant such access, but Lord Denning, the Master of the Rolls, commented

> It does seem to me that if a consultant of standing such as Dr JE asks to see the medical reports and casenotes - so as to enable him properly to advise the patient and her family - the hospital board ought to allow him to see them. They ought not to impose a condition such as 'You shall not see them unless you promise not to bring an action.' Such conduct heightens suspicion. The best way to remove it is, as Dr E says, to disclose them.[9]

As Lord Denning pointed out, failure to disclose medical, dental or chiropractic information fuels paranoias and anxieties and can lead to the institution of legal proceedings unnecessarily. By contrast, provision of information in a digestible form, perhaps assisted by the presence of the practitioner when the patient first reads the material for the purposes of interpreting passages that are difficult to read and to explain them, can allay concerns and suspicions, thereby reducing complaints and allegations of malpractice.

Legislated access to medical records

In spite of the High Court's decision in *Breen v Williams*, there have been a

number of signs that Australian governments will intervene to legislate for patients' rights of access as in 1991 they did in England and as in 1993 they did in New Zealand to make doctors' files available in most circumstances to patients. The change to the law in England occurred after the European Court of Human Rights[10] determined that the refusal to allow access to a patient's medical records was in breach of his right to respect for his private and family life under Article 8 of the *European Convention for the Protection of Human Rights and Fundamental Freedoms.* In New Zealand privacy legislation enables patients to have access to health information generally subject to certain exceptions, such as what in this country is termed 'therapeutic privilege'.[11]

In Australia the signs are that there will be some form of statutory reform of patients' entitlements to see what is written about them and their medical condition by doctors.[12] After Justice Kirby's dissent in the New South Wales Court of Appeal the then Labor governments at Federal level and in Queensland indicated that they proposed to introduce legislation to implement the terms of his dissent. The Australian Medical Association through its President, Dr Brendan Nelson, at that stage indicated its preparedness to co-operate with the proposed changes provided that the law was not to be retrospective and provided that a 'therapeutic privilege' was retained, allowing doctors to withhold records from patients where release of the records would be contrary to patients' medical interests.[13]

More recently, the Commonwealth Attorney-General's Department in its 1996 discussion paper *Privacy Protection in the Private Sector* proposed legislation along similar lines to that existing in New Zealand. This would extend the provisions of the *Privacy Act 1988* (Cth) into the private sector with the information privacy principles applying to the 'collection, storage and security, individual access and correction, use and disclosure of personal information.' The first legislation implementing this approach is the *Health Records (Privacy and Access) Act 1997*[14] in the Australian Capital Territory.

The consumer-driven trend toward professional accountability for services rendered, and the demand for professionals to make their decision-making and work practices more accessible to the general community, have fundamentally changed the relationship between doctors and patients. One

of the results is that, doctors' opposition notwithstanding, it is only a matter of time until patients are granted access by most legislatures to the work product that was created on their behalf, whether the patients' motive for inspecting such documents is to understand better what their doctor is thinking about their medical condition or whether it is to explore further the possibility of commencing legal action for malpractice. Continuing uncertainty attaches to whether such access will be retrospective to the date on which the legislation comes into force. However, the possibility that it may be retrospective and the fact that patient access legislation is probably not far away has important ramifications for healthcare practice from this day forward, given that all such practice has the potential to result in litigation.

The role of records in malpractice litigation

In a number of recent cases involving allegations of negligence against medical practitioners and against a dental surgeon, the existence and the quality of the notes that they have taken about the complaints made by their patients and the treatment and advice that they have provided to their patients have been highlighted as a key issue for the fact-finding process.

Some observations need to be made about the dynamics existing between patients and those providing healthcare services to them. By and large of course, patients do not take contemporaneous notes of their interactions with their doctors, their dentists, their chiropractors, those who provide them with family planning advice, or maternal and infant welfare nurses who give guidance for the rearing of children. If they do, this is probably indicative of an utter breakdown in the relationship or of pathological tendencies on the part of the patient.

Thus, generally, patient plaintiffs are dependent for their evidence about discussions between them and, for instance, their medical practitioners upon their recollections. Generally, memories are subject to the tyrannies of the effluxion of time, most particularly deterioration with the passage of months and years, and distortion in the processes of encoding, storage, retrieval and narration. However, this is subject to exceptions. Where an interaction

between persons is distinguished by its importance to one of the parties because, for instance, of self-interest and concern about an issue to which one of the parties attaches special significance, the memory of the interaction may remain much more clearly and accurately delineated than most other memories.

Recent cases have drawn attention to the fact that patients' recollections can be, and come across in evidence as being, specific and detailed. For a patient worried about their health, an encounter with a doctor can be memorable and an important life event. In many cases, such recollections have been delivered forensically so convincingly that they have been believed over the recollections of experienced medical practitioners. In the case of doctors of course, individual interactions with a particular patient are generally invested with limited significance, the patient simply being one amongst a great many of other patients seen, many of them suffering serious or potentially serious medical conditions. Unless detailed notes are taken at the time or shortly after a consultation, it is likely that a doctor's memories of a particular conversation with, or medical intervention in respect of, a patient will fade much more quickly than will the patient's.

This phenomenon means that doctors are dependent upon three things for establishing their account of what may have happened some several years before: their memories; their general practice (which, of course, is always subject to some degree of variation in the exigencies of practice); and the records that they compile. Evidence is often led by defendant doctors of their 'invariable procedures' but, if such evidence is not buttressed by adequate records, it is always liable to be 'trumped' by contradictory, convincing and detailed patient/plaintiff evidence. Thus the importance of good recordkeeping.

Recent cases in which patient records figured

The quality of the notes compiled by two general practitioners and an endocrinologist was the focus of the New South Wales Supreme Court of Appeal decision in *Holliday v Curtin*.[15] On behalf of the Court, Acting Justice of Appeal Clarke made the point that, 'the greater the detail of the notes,

the better the picture that is painted.' Although the plaintiff presented for some five years to her general practitioners complaining of pain in her breasts and a sensation of lumps and lumpiness, prior to being diagnosed with terminal cancer in her breast that had metastisised into her liver, the Court ruled against her claims of negligence on the basis of the reliance it was prepared to place on the detailed notes of her doctors. Where the notes were inconsistent with the claims of the dying plaintiff, it preferred the records kept by the doctors.[16]

Similarly in the New South Wales District Court case of *Vale v Ho*[17] a patient alleged that Dr Ho failed to warn of the risks involved before a second procedure to correct an apparent deviation of the patient's nose following reconstructive surgery, as he should have done under the criteria for doctors to warn of material risks of a medical procedure pursuant to the High Court decision in *Rogers v Whitaker.*[18] Dr Ho was able to base his evidence on extensive and detailed notes which he swore had been compiled contemporaneously. The notes contradicted much of the patient's evidence in relation to when, and if, warnings were given, including what was said by the doctor to the patient. Judge Sinclair found specifically that he preferred the evidence of the doctor on the basis of the contemporaneity of the doctor's notes and the fact that they had been compiled prior to any allegations of impropriety having been made by the patient.

By contrast the perils of inadequate recordkeeping were to the fore in *Locher v Turner*[19] where it was asserted by the plaintiff that the doctor had failed unreasonably to investigate adequately the condition of his colon for some twelve months after his initial report of symptoms. The doctor's records were in the short-form style and were somewhat cryptic. The doctor purported to give evidence in court that was additional to what was found in her notes. The Court of Appeal stated that it could not decide the appeal on the basis of the state of the doctor's oral evidence which purported to 'fill in' the gaps in her written notes as to do so would go beyond the proper role of an appellate court dealing with factual findings.

In *Burnett v Kaleokerinos*[20] the plaintiff had visited the defendant and complained of vaginal bleeding. The doctor made an appointment for her with a specialist some distance away. Ultimately, the Court accepted the

plaintiff's evidence that later the same day she returned to the surgery and told the doctor that due to transport, social and family reasons, she would be unable to keep the specialist appointment. She swore that the advice of the doctor was that in those circumstances 'we will see how it goes and see how it settles down'. Acting Justice Spender found that the doctor had failed in his duty to the patient by dint of his busy practice to make proper alternative arrangements. A key issue in the case was the quality of the doctor's notes. Of twentythree consultations, only six had been recorded in his handwritten notes. Yeldham has commented that 'the haphazard nature of recordkeeping resulted in the doctor only having a general recollection of the consultations, without any specific recollection of the plaintiff's complaints, and hence he was not in a position to deny much of what was alleged.'[21]

In the controversial case of *Backwell v AAA*[22] the plaintiff sued her doctor for pressuring her to have an abortion after an error in the insemination process. She was awarded exemplary damages because of the seriousness of the doctor's impropriety.[23] There were considerable differences of recollection between the plaintiff and the defendant doctor in respect of discussions between them concerning provision of a post-coital pill, as well as in relation to the consequences for the hospital if there were to be publicity about the erroneous insemination. The doctor was not helped by her inability to produce contemporaneously compiled notes in relation to her conduct and her discussions with the plaintiff.

In the important High Court decision of *Chappel v Hart*[24] an important issue was whether the plaintiff had sufficiently raised her concerns about the risk to her voice chords if the defendant surgeon undertook the proposed procedure by saying 'I don't want to end up like Neville Wran.' A finding which affected the whole course of the litigation was the acceptance by the trial judge of the plaintiff's recollection over the version advanced by the surgeon, which was unsupported by any significant documentation, saying:

> The plaintiff is in a situation where she not only has a memory of saying those words but she also has a memory of what was in her mind at the time and of what her concerns were. Dr Chapel, on the

> other hand, could only observe and have a recollection through what he heard, that is, by hearing the words used. He could not have the matter in his mind in any other way. In my view it is more likely that the words and the issue would remain in the plaintiff's memory, in the forefront of her memory, than they would in the defendant's memory.[25]

The High Court and the New South Wales Court of Appeal declined to interfere with the trial judge's findings of fact, although Mahoney P commented that there is 'something of unreality in a law which (if I may adopt a metaphor) hazards the whole of the damage suffered by a plaintiff upon the hazard that the plaintiff may be able to recollect, and to recollect accurately, a conversation or remark of this kind'.[26]

Another illustrative case is that of *Hribar v Wells*[27] where the plaintiff sued her dentist who was a specialist in oral and maxillo-facial surgery. The plaintiff alleged that the dentist had failed under *Rogers v Whitaker* to warn her properly about the potentially adverse consequences of the operation that he performed. The trial judge preferred the evidence of the plaintiff to that of the dentist who had few notes and relied upon what he maintained was his 'invariable practice' in relation to information which he provided prior to operations to his patients:

> For his part, the [dentist] relied, not upon his notes or any independent recollection, but upon his 'invariable practice'. I think that the defendant tended, with the benefit and wisdom of hindsight, to equate what he should have done five and more years ago with what he did do or would have done five and more years ago. In my view, there was a significant degree of reconstruction in his evidence.[28]

The Full Court upheld the legitimacy of this aspect of the trial judge's findings.

An example of how difficult it is for a practitioner to 'win' in the absence of full recordkeeping is to be seen in the case of *Talbot v Lusby*.[29] The plaintiff patient, at the time dying of breast cancer, sued her doctor on the basis that he treated her negligently in that he should have diagnosed

a lump as cancer, engaged in appropriate treatment and thereby have given her a relatively good chance of survival. Much depended upon the patient's and doctor's accounts of what transpired upon her presentation at his surgery. Justice Fryberg found that in giving his evidence 'Dr Lusby did not always inspire confidence in his accuracy.'[30] His Honour noted that Dr Lusby had 'clearly done considerable research as part of his preparation for trial to ensure that his position was supported in medical literature.' However, Justice Fryberg found that 'a number of his answers given from memory contained more detail than could reasonably be expected in a man whose answer to a suggestion that a particular note that he had written was not intended to remind him of something was: "At the age of 66 I certainly got to the stage of writing little notes for myself"'.[31] One example of Dr Lusby's problematical notes was 'ISQ - see 6/12.' He was examined-in-chief as follows:

> Q: And the abbreviation ISQ appears again?
>
> A: Yes, but again there's no doubt in my mind that it's mastitis.
>
> [...]
>
> His Honour: What's the ISQ?
>
> A: This means it's still mastitis as far as I'm concerned. It refers to the diagnosis.
>
> Q: Sorry. This is 28 August right now?
>
> A: Yes.
>
> Q: What does ISQ stand for?
>
> A: In statu quo.
>
> Q: You are using that referring to the fact of what?
>
> A: To the fact that I feel she's got mastitis.

Cross-examination, not surprisingly ran as follows:

> Q: Doctor, in August 1989 you've written 'ISQ'?
>
> A: Yes.

Q: What does that mean?

A: That means for me the diagnosis is still mastitis.

Q: Is it the case, doctor, that at that stage she must necessarily have had at the very least a continuing vague cystic feeling in a small lumpy area?

A: No. She was probably unaware of it. This wasn't superficial.

Q: Sorry, you haven't written down what the symptoms were, but you've indicated the same diagnosis and you've attempted to aspirate something. Now, doctor, we assume you are not sticking a needle blindly into her breast, there must have been something there?

A: Yes. I thought I was feeling something and I thought it might have been a cyst.

Q: All right?

A: I didn't get any fluid out of it. So, I could have been wrong, that I wasn't feeling a cyst, anyhow. I could have torn the cyst and lost the fluid. There could have been so little fluid I didn't find it.

Q: My question was directed toward the absence of any physical signs in your notes on that occasion. You haven't written down what was present, whether it was a single mass or a vague cystic feeling in a very small lumpy area or what. There was something there, though?

A: The only thing that was there at this stage obviously is something very, very small.

Q: Why do you say 'obviously', doctor? You haven't written it down?

A: I haven't written it down, but the first thing I wrote down apart from 'ISQ' is 'see in six months'

Q: And then attempted an aspiration?

A: Well, if she's getting another cyst I can get it emptied at that stage. I don't need to say, 'Come back in a month's time to check the cyst.'

The parlous state of the doctor's notes contributed substantially in the end to the doctor's loss in the negligence action. The damages were fixed at $389,902.31.

Use in litigation of medical histories

Within all competent doctors' records there is to be found a medical history of the patient, whether the practitioner is a treater or a medico-legal assessor. However, such matters can be problematic as the history that makes its way into the doctor's notes is frequently sourced wholly or predominantly from the patient's own narration. Where a medical history forms the foundation or part of the foundation for an expert medical opinion which a party proposes to lead in court, a series of judgments has established that the history, which forms a basis of the opinion, must be proved in evidence. This is a protection against the cynical supply by a prospective plaintiff of false, self-serving evidence to a professional who may later use it as the building blocks of his or her professional opinions.

Thus in *Ramsay v Watson*[32] Chief Justice Dixon CJ and Justices McTiernan, Kitto, Taylor and Windeyer observed that without proof of such a basis of an expert's opinion 'the physician's opinion may have little or no value, for part of the basis of it has gone.' Similarly in *Paric v John Holland (Constructions) Pty Ltd*[33] Acting Chief Justice Mason and Justices Wilson, Brennan, Deane and Dawson reiterated that for an expert medical opinion to be of any value the important (as against trifling) facts upon which it is based must be proved by admissible evidence. The matter was again traversed by the Supreme Court of the ACT in *Falasca v Morrissey*[34] where the plaintiff had seen a number of medical specialists about the impact of a motor vehicle accident upon the condition of cervical vertebrae. The plaintiff's case was reliant upon medical evidence that in each case was based at least in part upon the plaintiff's assertion that there had been no prior history of neck pain. The Master of the Court in hearing the matter at first instance found that the provision of this information had been untrue. Justices Gallop, Higgins and Crispin held that the decisive issue was the extent to which the medical opinions ultimately expressed by the assessors were dependent upon factual premises later shown to be untrue or inaccurate. The fact that there was a possibility that the examiners may have arrived at the same views by a different chain of reasoning had they not been deceived by the plaintiff was found not to assist him.

The *Evidence Act 1995* (Cth) and the *Evidence Act 1995* (NSW) do not

contain a preclusion upon evidentiary admissibility if the bases of an opinion are not proved. However, it is highly likely that the provisions which permit discretionary exclusion of evidence if its probative value is outweighed by the prejudice that it might bring, namely sections135 and 137, will result in a maintenance of the common law status quo in relation to the admissibility of medical evidence where the bases of the evidence, such as patient reports of illness or health, are not extrinsically proved to the satisfaction of a court.[35]

Problems with doctors' recordkeeping

Examples can easily enough be found of impoverished health recordkeeping by both treating and assessing health professionals - slips of paper jammed into files, likely to be lost, notes so cryptic that they are meaningless to anyone other than the practitioner, notes that indicate little more than that the patient attended at a certain time, notes distinguished more by doodling than by recording of symptoms or conversations between doctor and patient, notes redolent of judgmental and even hostile attitudes by the practitioner, and notes where there is every appearance that changes have been made after their initial compilation. The traditional temptation for the maintenance and creation of medical records by healthcare practitioners has been for them to contain only that which was to the practitioner significant for the further treatment of the patient. The result is that often enough the information recorded did not incorporate inquiries made by the patient, advice given by the doctor, or details of all drugs prescribed. Rather, what was found in the records was simply those developments which longitudinally seemed significant to the particular medical practitioner, well familiar with the patient or at least conditions comparable to those with which the particular patient was presenting. While the records were for some purposes adequate for the doctor, they did not present a substantial narrative of doctor-patient interaction such as is required in the forensic context where the doctor may bear the burden of explaining the history and detail of the contact between the medical practitioner and the patient. However recordkeeping is in the process of changing with the increasing rates of actions being brought against doctors, the high levels of insurance being paid by medical practitioners and the fact that even such insurance

in Australia is discretionary, allowing the 'insurers' to decline at their own discretion to indemnify medical practitioners. A key aspect of the new defensive medicine is the maintenance of fuller records of practitioners' interaction with their patients.

The contents of notes

Until recently legislatures have not attempted to prescribe the duty of healthcare practitioners to generate medical records or to stipulate what such records must contain. However, the Medical Practice Regulations 1998 (NSW) have now mandated the recording of a wide range of information about patients. The regulations are very prescriptive. They are likely to be emulated in other Australian jurisdictions and to consolidate the court-driven impetus for significantly fuller recording of information about interaction between patients and medical practitioners. Moreover, legislative changes being considered under the *Health Insurance Act 1973* (Cth) are likely to necessitate the keeping of 'accurate and contemporaneous records' by practitioners seeking to be paid Medicare benefits.

Under Regulation 13 of the Medical Practice Regulations 1998 (NSW), medical practitioners are obliged to make and keep a record, or ensure that such a record is made or kept, in respect of each of their patients. The record must be made contemporaneously with the provision of medical treatment or other medical service or as soon as possible afterwards.[36] It must be kept for at least seven years from the day of the last entry, unless the patient was at that time less than eighteen, in which case the record must be kept until the time the patient attains the age of twentyfive.[37]

Schedule Two to the Regulations prescribes that a record must contain sufficient information to identify the patient to whom it relates and 'any information known to the medical practitioner who provides the medical treatment or other medical services to the patient that are relevant to his or her diagnosis or treatment', as well as particulars of any clinical opinion reached by the medical practitioner, any plan of treatment for the patient and particulars of any medication prescribed for the patient.[38] The fact that details of clinical opinions and treatment plans are provided for is

significant as it has the potential to increase quite significantly the information included in many doctors' notes. The record must include notes as to information or advice given to the patient in relation to any medical treatment proposed by the treating practitioner.[39] This addresses the need to record the provision of information articulated by recent superior court decisions about risks, complications and options in relation to potential treatment.

The record is also prescribed to have to include significant details in respect of any medical or surgical procedure undertaken on a patient, including (a) the date of the treatment; (b) the nature of the treatment; (c) the name or names of the those who performed the treatment; (d) the type of anaesthetic, if any, given to the patient; (e) the tissues, if any, sent to pathology; and (f) the results or findings made in relation to the treatment.[40] The medical record must also contain any written consent to treatment made by the patient.[41] Somewhat cryptically, the regulations also specify that 'the level of detail contained in a record must be appropriate to the patient's case and to the medical practice concerned' and must 'include sufficient information concerning the patient's case to allow another registered medical practitioner to continue management of the patient's case'.[42] This latter consideration has traditionally been viewed as the primary determinant of the content of medical records.

All entries in the record must be 'accurate statements of fact or statements of clinical judgment'.[43] This constitutes a somewhat odd mandate for accuracy, but its more significant aspect is the clear articulation of an obligation on the part of medical practitioners to record their clinical judgments as formal entries within medical records. Even the use of abbreviations is now regulated in an apparent attempt to avoid the use of idiosyncratic contractions and terms not generally understood or susceptible of interpretation within the medical profession.[44] Entries must be dated and must identify clearly who made them.[45] Within a hospital, the responsibility of making and keeping medical records can be delegated but the record has to be kept in accordance with the rules and protocols of the hospital and the delegating practitioner must ensure that they are in accordance with the Schedule.[46]

Doctors are precluded from altering records, or causing or permitting anyone else to do so, but only when the changes made 'obliterate, obscure or render illegible information that is already contained in the record'.[47] The spirit of the provision appears to be to proscribe also the fabrication of entries.

Recording of notes

The traditional means for healthcare practitioners to record their notes was by the use of a card system upon which at the time of the consultation relevant details were jotted. The history of the patient's healthcare was therefore shortform and chronological. The form of such records had forensic ramifications. Such notes were readily enough reconstructed by dishonest practitioners faced with a legal suit. It was not at all difficult for doctors to rewrite the entries for the relevant period of time by insertion of an extra card or cards and to interpolate key details to exculpate themselves in face of the patient's allegations.[48] The more unscrupulous doctor defendants could even reconstruct years of notes to maintain consistency of depth and thoroughness in the revised recordkeeping.

The forensic protections to protect plaintiffs against this tactic were indifferent in their efficacy - comparison of the key (potentially concocted) entries with other entries for the same patient, comparison with the recordkeeping for similar patients, or patients with similar conditions and professional document examination of the alleged records.

If the period relevant to the litigation was characterised in the doctor's records by fuller notetaking than was to be seen elsewhere in the patient's files, this readily enough enabled the drawing of adverse inferences against the apparent state of the doctor's records. However, the exercise of a little subtlety in the doctor's reconstructive processes adequately addressed this porthole on the medical practitioner's dishonesty. It is also problematic for a patient to obtain access to the records of a medical practitioner defendant in respect of other patients. It has never been clear that plaintiffs were entitled to production of such records in order to explore whether the doctor had engaged in selective falsification of records. Therefore, the

capacity of plaintiffs to impose an effective check upon fabrications by medical practitioners has been limited.

The other means of identifying whether records have been falsified is via the science of document examination.[49] The application of infra-red and ultraviolet techniques will often provide definitive results in relation to erasures and enable reading of obliterated words or phrases. Electrostatic detection apparatus has assisted in the same objective over the past twenty years.[50] A number of techniques can also assist in the evaluation of whether documents have been recently created or date back a number of years. These matters are considerably more difficult of assessment, however, where files are kept in electronic form on computer without the installation of a system which identifies every occasion on which amendments are made to pre-existing documents.

In this electronic age the reality is that very soon most notes will be, and will be expected to be, electronically recorded via database applications and word-processing programs, both at individual surgeries and at hospitals. See, for example, Medical Practice Regulations 1998 (NSW) Schedule 2.1.3(3). This makes for increased efficiency and ease of access by healthcare practitioners, as well as patients. Ideally, such notes should be made within twentyfour hours at longest of consultation and should be in reasonably full form. One method adopted by some practitioners is to dictate quickly after each consultation or interaction relevant details, which in due course are typed up. Such details should include the purpose of the interaction, the symptoms observed, what was actually done or recommended by the doctor, the reasons for action or inaction, and a brief record of any important conversation between the practitioner and the patient - for instance, recording the giving of warnings of risk, or of documentary material to that effect, by the practitioner to the patient. If another person, such as a relative of the patient, a nurse, or other practitioner was present, that should also be recorded. There is no reason why such a dictation should take long, but it forms an invaluable, contemporaneous and highly probative piece of information should there be dispute about what occurred or what was done or said months or even years later.

It is even easier, of course, to change wordprocessing electronic records

than it is handwritten ones. Thus a system should be used which precludes alteration of such records within a set time of their being initially recorded, say sufficient time to allow the doctor to check the correctness of the typing, should he or she wish. This reduces the utility of the allegation that records have been changed to meet allegations made later or to assist the case of the person compiling the notes.

The evolving role of healthcare records

The maintenance of contemporaneously produced, electronically secure, thorough, discreetly compiled records of healthcare provider-patient interactions has many advantages. It will be the way of the future in the medico-legal context and many others. Such recordkeeping is a prudent exercise of defensive provision of services in these litigation-troubled times. It enables the provider to give a clear, convincing and highly probative account of what was done and said in respect of conversations and interventions that may have been unremarkable at the time and that occurred many years previously. It also reduces dramatically the potential for the claim by plaintiffs that practitioners have reconstructed and fabricated their records to exonerate themselves of culpability for malpractice. Without such recordkeeping, grim consequences in litigation can ensue, irregardless of the quality of the practitioner's actual work, the soundness of their communications and advice, their adherence to careful practices and the acuity of their long-term memory. Even more though, it is sound practice, especially in the healthcare context, enabling medical access to patient information that is considerably enhanced over the traditional cryptic and short-form card system.

Endnotes

[1] Parts of this article utilise material written in an editorial by the author, 'Medical Records in Litigation', *Journal of Law and Medicine*, Vol. 5, part 4, 1998, p. 305.

[2] Fewer such accusations can now be levelled plausibly in Australia since the passage of legislation in most jurisdictions mandating the audio or video recording of formal interviews by police.

[3] In Victoria, see Order 32.05 of the Supreme Court Rules.

[4] (1996) 138 ALR 259.

[5] N. Olbourne, 'Breen v Williams: A Doctor's Perspective', *Journal of Law and Medicine*, Vol. 6, part 3, 1998, p. 284.

[6] See *Ezzy v Commonwealth Bank of Australia*, unreported, Supreme Court of the Northern Territory, 27 February 1995 per Martin CJ.

[7] *Budget Corp Ltd v Ansett*, unreported, Supreme Court of Victoria, 23 April 1990 per Marks J.

[8] (1973) 2 All ER 454.

[9] Id at 458. However, under the then English provisions it was necessary for proceedings to be 'likely' to be brought by a person 'likely' to be a party, and for the defendant to be 'likely' to have pertinent documents in their possession for the prelitigation discovery to be available. The majority in *Dunning* were not convinced that there was enough evidence to establish the requisite factors under such criteria.

[10] See *Gaskin v United Kingdom* (1989) 12 EHRR 36.

[11] See the *Health Information Privacy Code* 1994 (NZ); *Privacy Act 1993* (NZ), *Health Act 1956* (NZ).

[12] See B McSherry, 'Access to Medical Records: What Legislation Must Take into Account', *Journal of Law and Medicine*, Vol. 4, part 3, 1997, p. 211.

[13] See Editorial, 'Patients' Access to Health Records', *Journal of Law and Medicine*, Vol. 2, part 4, 1995, p. 255.

[14] See C. Blomberg, 'Medical Records' in *Current Controversies in Health Law*, edited by I. Freckelton and K. Petersen, Federation Press, Sydney, 1999 (forthcoming).

[15] Unreported, New South Wales Court of Appeal, 15 August 1997.

[16] See further D. Noble, 'Case Note: *Holliday v Curtin*', *Australian Health Law Bulletin*, Vol. 7, No. 1, 1998, p. 7.

[17] Unreported, District Court of NSW, 11 May 1995 per Sinclair DCJ.

[18] (1992) 175 CLR 479.

[19] Unreported, Queensland Court of Appeal, 21 April 1995.

[20] Unreported, Supreme Court of New South Wales, 22 March 1995 per Spender J.

[21] B. Yeldham, 'Negligence by a GP: The Dangers of Overwork', *Journal of Law and Medicine*, Vol. 3, 1995, p. 102.

[22] Unreported, Victorian Court of Appeal, 20 March 1996.

[23] See D. Mendelson, 'The Case of *Backwell v AAA*', *Journal of Law and Medicine*, Vol. 4, part

2, 1996, p. 114; Editorial, 'Exemplary Damages in Medico-legal Litigation', *Journal of Law and Medicine*, Vol. 4, 1996, p. 103.

[24] (1998) 156 ALR 517.

[25] *Chappel v Hart*, unreported, New South Wales Supreme Court, 4 July 1994; see also *Chappel v Hart*, unreported, New South Wales Court of Appeal, 24 December 1996 at p.4, *Chappel v Hart* (1998) 156 ALR 517.

[26] *Chappel v Hart*, unreported, New South Wales Court of Appeal, 24 December 1996 at p.7

[27] Unreported, Full Court of South Australian Supreme Court, 8 June 1995.

[28] At p.13.

[29] Unreported, Supreme Court of Queensland, 14 July 1995.

[30] Id, at p.13.

[31] *Ibid.*

[32] (1960) 108 CLR 642 at 649.

[33] (1985) 59 ALJR 844.

[34] Unreported, 6 May 1998 per Gallop, Higgins and Crispin JJ.

[35] See further I. Freckelton, 'The Basis Rule' in *Expert Evidence*, edited by I. Freckelton and H. Selby, 5 volume looseleaf service, LBC Information Services, 1993- . Notably also the best evidence rule is abolished by S51, meaning that copies of documents may be tendered in evidence. Generally the documentary evidence provisions result in an easing of the technical rules that had previously circumscribed the admission of documents into evidence.

[36] Medical Practice Regulations 1998 (NSW), Reg 14(1).

[37] Medical Practice Regulations 1998 (NSW), Reg 15(1).

[38] Medical Practice Regulations 1998 (NSW), Schedule 2, cl 1(2)(a)-(d).

[39] Medical Practice Regulations 1998 (NSW), Schedule 2, cl 1(3).

[40] Medical Practice Regulations 1998 (NSW), Schedule 2, cl 1(4).

[41] Medical Practice Regulations 1998 (NSW), Schedule 2, cl 1(5).

[42] Medical Practice Regulations 1998 (NSW), Schedule 2, cl 2(1)-(2).

[43] Medical Practice Regulations 1998 (NSW), Schedule 2, cl 2(3).

[44] Medical Practice Regulations 1998 (NSW), Schedule 2, cl 3(1).

[45] Medical Practice Regulations 1998 (NSW), Schedule 2, cl 3(2).

[46] Medical Practice Regulations 1998 (NSW), Schedule 2, cl 5.

[47] Medical Practice Regulations 1998 (NSW), Schedule 2, cl 4.

[48] The extent to which some have been prepared to go in falsifying evidence may be seen in the context of what are alleged to be deliberate fakings of fingerprinting evidence. See I. Freckelton, 'Fingerprinting Evidence' in Freckelton and Selby (ed) *op cit.*

[49] Forensic linguistics can also play a role in gauging whether a person at a particular time was accustomed to expressing themselves in the way claimed. See also traditional handwriting analysis.

[50] See, for example, P.D. Westwood, 'Document Examination' in Freckelton and Selby (ed) *op cit.*, Chapter 95.