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A patient's health records are critical to all clinical encounters and almost all clinical negligence allegations. Accurate, up-to-date and clear health records are one of the most powerful tools when defending a medical negligence claim, complaint or investigation.

If your healthcare is ever called into question, your records will be scrutinised and will form the basis of expert opinion that may determine the outcome of a claim. An independent medical expert will review the records with the goal of determining whether the clinical treatment you provided was appropriate according to the standard of care demanded by law, or whether a reasonable body of peer experts would have provided the same level of care[1]. As such, medical records have significant evidentiary value.

In many medical negligence claims, records of treatment at other hospitals earlier or later than the impugned clinical intervention may also inform different aspects of a claim. On the other hand, they may relate to conditions not pertinent to a claim. A general practitioner's (GP) health records are almost always highly relevant[2].

What is the expected standard of practice?

The Medical and Dental Board Codes of Conduct outline the principles underpinning high-quality healthcare practice in Australia. It defines the standards of ethical and professional conduct expected of healthcare practitioners by their peers and the community. Section 10.5 of the Code of Conduct outlines the standard expected of record-keeping practice.

10.5 Medical records	
10.5.1	Keeping accurate, up to date and legible records that report relevant details of clinical history, clinical findings, investigations, diagnosis, information given to patients, medication, referral and other management in a form that can be understood by other health practitioners.

10.5.2	Ensuring that your medical records are held securely and are protected against unauthorised access.
10.5.3	Ensuring that your medical records show respect for your patients and do not include demeaning or derogatory remarks.
10.5.4	Ensuring that the records are sufficient to facilitate continuity of patient care.
10.5.5	Making records at the time of the events, or as soon as possible afterwards.
10.5.6	Dating any changes and additions to medical records, including when the record is electronic.
10.5.7	Recognising patients' right to access information contained in their medical records and facilitating that access.
10.5.8	Promptly facilitating the transfer of health information when requested by the patient or third party with requisite authority.
10.5.9	Retaining records for the period required by law and ensuring they are destroyed securely when they are no longer required.

Table 1: Good medical practice: a code of conduct for doctors in Australia (2020)[3]

The obligation to maintain accurate health records for the purposes of ongoing patient care is not only a professional duty, but also a legal one.

Consider the case of Hughes v. Staunton, Collins, Daly[4], involving three medical practitioners (a consultant neurologist and two GPs) alleged to incorrectly advising and prescribing an incorrect dose of a drug (Largactil) and failing to monitor its effects on a patient affected by Sub Acute Sclerosing Panencephalitis (SSPE).

There was also an allegation that the GPs had failed to keep appropriate health records. The court found Dr Collin's records to be substandard as they needed to contain more details for him to recall the patient's treatment. Shockingly, Dr Daly's records were non-existent.

Despite the fact that these issues had no bearing on liability and the prescription of the drug was found to be appropriate, the court stated that:

> "The primary duty of a doctor is to treat the patient. Included in that will be the keeping of such records as are necessary for the continued treatment of the patient on a properly informed basis."[5]

The case of *Rhodes v. Spokes & Farbridge*[6] also highlights the relevance of ensuring health records are kept up-to-date and written accurately. The GP, Dr Spokes, did not keep detailed health records, and the ones he kept often contained personal comments about the patient. At trial, the court found the evidence of all the parties to be substandard and unreliable. In addition, it was evident that the passage of time from the events to the time of trial did not assist, and this fact negatively impacted Dr Farbridge's accurate recall of the events that had taken place. Furthermore, the court made this significant observation:

> *"A doctor's contemporaneous record of a consultation should form a reliable evidential base…I regret to say that Dr. Farbridge's notes of the plaintiff's attendances do not provide any such firm foundation. They are scanty in the extreme. He rarely recorded her complaints or symptoms; he rarely recorded any observation; usually he noted only the drug he prescribed. These brief entries were sometimes accompanied by a cryptic or occasionally even derogatory comment as to the genuineness of the plaintiff's complaints.*

> *The failure to take a proper note is not evidence of a doctor's negligence or of the inadequacy of treatment. But a doctor who fails to keep an adequate note of a consultation lays himself open to a finding that his recollection is faulty and someone else's is correct. After all, a patient has only to remember his or her own case, whereas the doctor has to remember one case out of hundreds which occupied his mind at the material time."*[7]

This case highlights a common issue observed in medical negligence litigation - the time lag between when an alleged adverse incident occurs and when a complaint or claim is made can be very significant. As the court noted, **there is a critical difference between a healthcare practitioner's memory and that of a patient: the patient will only remember their case and the events that took place in one or a handful of encounters, whereas the doctor will have to recall one out of hundreds of patients at the time**. Also, consider that when an allegation is made, and a doctor's healthcare is called into question, a few years may have passed by, and they will have seen thousands more patients. Thus, their memory of the event in question would have deteriorated significantly. Commonly, a doctor in these circumstances will, in fact, not recall any of the events in question. Moreover, due to a long passage of time, "…

> *"either or both of the practitioner and patient may become polarised and perhaps mistaken in their recollection of what took place during their interaction."*[8]

In these circumstances, a well written recollection of events in the health records will be of upmost assistance in the defence of legal or regulatory proceedings.

Consider the case of O'Neill v Rawluk[9], where the clinical intervention had been performed 12 years prior to the trial, the relevance and assistance of written records was noted by the court. Moriarty J stated:

> "The unique experience of the plaintiff is likely to be more indelible than the recollection of one of many procedures undertaken by a busy neurological surgeon, with a clinical case load exceeding, on the defendant's own evidence, 350 patients per year. However, the defendant's practice of maintaining handwritten notes also gives a more reliable picture."[9]

What should be included in the health records?

Health records include a wide variety of documents generated on, or on behalf of, all the health practitioners involved in patient care. This includes:

- Clinical notes (electronic and handwritten).
- Correspondence between healthcare professionals regarding patient's care.
- Laboratory reports.
- Imaging and radiology records.
- Data produced by monitoring equipment.
- Models & molds.
- Photographs.
- Video and audio recordings.
- Information given to patients.
- Medications & other management information.
- Informed consent discussions (including financial consent).

Correspondence and conversations between a practitioner and their indemnity provider and lawyers may not need to be included in a patient's health records. For example, advice given over the medicolegal advisory service could be recorded if this provides a reasonable justification for the actions taken. In fact, this is required by law if the nature of the conversation is not legal advice. However, correspondence about managing an actual claim or complaint should not be included in the health records.

Who owns the records?

Generally, health records remain the property of the health service provider (practice or employer) who created the health record. However, the concept of legal ownership of records should not be conflated with the right of patients to access health information about them. The introduction of Commonwealth and state/territory privacy legislation, patients have a right to gain access (except in a limited number of situations) to all the information held about them.

How long should I store health records?

This varies between state and territory jurisdictions. However, in a number of states, health records should be kept for 7 years from when the patient was last seen or when any child patient turns 25 years of age, whichever occurs later. Records should only be retained beyond this period if it is suspected that a claim or complaint is likely to arise.

What are the consequences if a patient's health records are lost or destroyed?

Recent case decisions in medical negligence serve as a welcomed reminder of the importance of proper record storage.

Are audio and video recordings legal in Australia?

It may seem an easier way in this technologically savvy world we inhabit, to simply record information or other data about patients, either by audio or visual means. This is attractive as records are correct and comprehensive and may be utilised in the defence of any complaint. However, there are legalities surrounding such records and as a guide, as discussed below.

Audio records

The law surrounding audio recordings differ across each state and territory.

Things can be complicated if a person in one state or territory is speaking to someone in another state or territory – generally, it is the law of the state pertaining to the person who is doing the recording that applies.

Relevant legislation:

- NSW – Surveillance Devices Act 2007 (NSW)
- Victoria – Surveillance Devices Act 1999 (Vic)
- Queensland – Invasion of Privacy Act 1971 (Qld)
- South Australia – Listening & Surveillance Devices Act 1972 (SA)
- Western Australia – Surveillance Devices Act 1998 (WA)

The definition of a 'listening device' is wide. It generally includes anything used to overhear, record, monitor or listen to a private conversation, such as mobile phones or dictation devices. It does not include hearing aids or other similar devices.

A 'private conversation' is one where the parties may reasonably assume that they don't want to be overheard by others or the circumstances indicate that either of the parties wanted it to be confined to the parties.

If sensitive information is discussed, such as health information, this certainly constitutes a private conversation. It would be unusual for any conversation between a patient and a

health practitioner not to be private.

Alteration of health records

It is not uncommon to realise after a record has been created that an error had been made in that record. In those circumstances, it is appropriate (and indeed preferable) that the record be corrected. However, there is a proper process for doing this. The original record should not be deleted. Instead, an addendum should be created that refers to the previous erroneous record, outlining why the record is erroneous, how and when this error was identified, any explanation of the error and then a clear statement that corrects the record.

However, any inappropriate modification of health records e.g., for the purposes of misleading and changing the description of events that have taken place in a clinical intervention, will result in severe regulatory and legal action. Consider the case of Philp v. Ryan[10], where Dr Ryan claimed he had altered the health records, after the commencement of legal proceedings, in order to reflect the accurate facts of what had happened according to his own recollection of events. Despite the fact he agreed it was inappropriate to make such an alteration, this event was only recognised at trial. In addressing this action, the trial judge conveyed he had:

> "...absolutely no doubt that Mr Ryan acted quite improperly when he altered this clinical record."

€50,000 in aggravated damages were awarded for this "grossly improper behaviour" of altering the health records. Furthermore, the Irish Supreme Court manifested a stronger opinion:

> "This is an extremely serious finding against the first defendant. It is a finding that the first defendant deliberately and knowingly altered a document which he must have known would be used in court proceedings with the intention of, as the trial judge said, assisting his case, which in fact means with the intention of deceiving the court and of attempting to deprive the plaintiff of damages to which he has subsequently been found to be lawfully entitled. That matter is of itself extremely disturbing..."[11]

In summary, health records cannot be retrospectively altered for any improper purpose. If a genuine mistake occurs, or where a further entry is required in the record on a retrospective basis, any mistake should be clearly struck through with a line and this should be signed/initialed and dated[12].

Privacy and confidentiality of health records

It goes without saying that a person's medical records are confidential and normally not to be disclosed to anyone but his doctors. However, there are growing exceptions to the confidentiality of patient records. If you have any questions about disclosure of health information to third parties, you should contact the MIPS medicolegal advisory service. Relevantly to this module, in a personal injury action or a clinical negligence action he is taken to have waived his right to confidentiality so that the defendants are entitled to see all relevant records (and in most cases that will embrace all his records).

The Australian Privacy Principles (or APPs) are the cornerstone of the privacy protection framework in the Privacy Act 1988 (Privacy Act). They apply to any organisation or agency the Privacy Act covers.

There are 13 Australian Privacy Principles and they govern standards, rights and obligations around:

- the collection, use and disclosure of personal information.
- an organisation or agency's governance and accountability.
- integrity and correction of personal information.
- the rights of individuals to access their personal information.

The Australian Privacy Principles are principles-based law. This gives an organisation or agency flexibility to tailor their personal information handling practices to their business models and the diverse needs of individuals. They are also technology neutral, which allows them to adapt to changing technologies.

Conclusion

In summary, accurate and contemporaneous health records are critical in ensuring high quality patient outcomes and defending healthcare practitioners against medical negligence allegations. Health records are:

"...important evidence in medical negligence claims, as those records are intended to ensure that patients are treated effectively and appropriately by providing relevant

information to treating clinicians. The records, therefore, are likely to be the best evidence of crucial matters such as history, examination, investigations, referral, follow-up, diagnosis, treatment and advice/consent…."[13] .

Remember:

- Health records should contain sufficient information that would enable another practitioner to appropriately takeover care of the patient.
- If it's not documented, then it didn't happen
- Record any advice or warnings you routinely provide to patients.
- Never use derogatory and offensive comments, assume someone else (including the patient) may see the record.
- Use abbreviations with care, can be ambiguous or confusing.
- Don't tamper with notes, new additions should be separately dated, timed and signed.
- If a mistake is made, correct it with a single strikethrough. Then sign and date the correction.
- Avoid cutting and pasting from previous records.
- Explain to the patient what you are doing, and involve them in their record.

Complete assessment questions!

References

[1]Barry Nilsson Lawyers Medical Law Course (2021).

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[3]Medical Board of Australia. Good Medical Practice: A Code of Conduct for Doctors in Australia. 2020. Available at: Medical Board of Australia - Good medical practice: a code of conduct for doctors in Australia

[4]High Court, Unrep., Lynch J., 16/2/90.

[5]Fn 7 at p. 863.

[6]Rhodes v Spokes & Farbridge MLC 0640, [1996] 7 Med LR 135

[7]FN 20 at p. 139.

[8]Mills and Mulligan. Medical Law in Ireland (3rd Ed.) at p.55

[9][2013] IEHC 461 at para. 42

[10]Philp v Ryan [2004] IESC 105, [2004]

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[13]Jones,M (2021) Medical Negligence. Sweet & Maxwell, 6th Ed. (p. 1283).

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