Medical law reporter

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CARNEY v NEWTON: EXPERT EVIDENCE ABOUT THE STANDARD OF CLINICAL NOTES

In Carney v Newton [2006] TASSC 4 the Tasmanian Supreme Court heard a claim that the defendant breached his duty of care by failing to properly diagnose and treat a node positive carcinoma in the plaintiff's breast tissue. At trial, argument turned on the actual dialogue that took place during the initial consultation, with significant reliance on the clinical notes of the defendant. The court gave considerable weight to "expert" witnesses in ascertaining the acceptability of the defendant's conduct concerning the maintenance and interpretation of his clinical notes. This raises important questions in relation to proof of quality of medical records as part of the current professional standard of care, as modified by recent legislation in most jurisdictions.

INTRODUCTION

Access to and interpretation of clinical records about the discourse between medical practitioners and patients have always been critical to both the protection of the doctor from medical negligence actions and, in evidentiary form, to the patient's standing to sue should he or she be wronged. This was demonstrated recently in *Carney v Newton* [2006] TASSC 4. The basis of this Tasmanian Supreme Court action was a claim that the defendant breached his duty of care by failing to properly diagnose and treat a node positive carcinoma in the plaintiff's breast tissue. At trial, a focus of argument concerned evidence about the examination and actual dialogue that took place during the initial consultation. Of particular concern was the extent to which this should have been, and was, accurately recorded in the clinical notes of the defendant. Much weight was given by the court to the testimony of expert witnesses in ascertaining the acceptability of the defendant's conduct and the interpretation of the clinical notes. This raises important questions as to the viability in Australia of this form of evidence about this aspect of the current professional practice standard of care.[1] It also highlights one particular implication of the recent alterations to this standard by legislation in most Australian jurisdictions. It is suggested that the ongoing lack of uniform guidelines and standards-based regulation of the nature and quality of clinical records remains a cause for concern within the Australian medical profession and for those patients who come into contact with it.

THE FACTS: CARNEY v NEWTON

The plaintiff attended a consultation with her general practitioner, the defendant, in January 2002. At trial, the plaintiff alleged that during this consultation the defendant conducted a breast examination and detected an abnormality. The defendant allegedly said, "We'll keep an eye on that", and suggested that she continue with regular self-examination and return if there were any significant changes.

Nine months passed before the plaintiff, a doctor herself, returned due to swelling and tenderness in the breast. She was now pregnant. At this second consultation, the plaintiff suggested that her condition might be that of mastitis. The general practitioner defendant agreed and referred her for a diagnostic ultrasound for confirmation.

Following the ultrasound, which confirmed mastitis, the plaintiff made an appointment with Mr Wilkinson, a general surgeon. A biopsy was conducted by Mr Wilkinson, which returned positive results for high-grade adenocarcinoma.

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[1] *Civil Liability Act 2002* (Tas), s 22. See also *Civil Law (Wrongs) Act 2002* (ACT), s 42 and similar legislation in other States.

The plaintiff then consulted Dr Kimber, an oncologist, whose notes reported that the plaintiff had said that she had only noticed some irregularity in her right breast since May 2002, that is, after she became pregnant. This was a point of contention at trial due to the claim by the plaintiff that her initial consultation with the general practitioner defendant, in January 2002, was the first time she was told an irregularity had been detected. In evidence the defendant expressed that it was his practice to report in his notes any abnormalities in a patient's breasts. Examination of his notes here showed no evidence of such a finding. His records for this consultation included the note, "breasts ✔✔", which the general practitioner defendant interpreted to the court as indicating that an examination had occurred and both breasts were normal.

One expert witness suggested that the defendant's notes were highly inadequate. However, the court accepted the opinions of other practitioners who attested that the conduct of the defendant, based on his notes, was of an acceptable standard. Crawford J held that, on the basis of expert evidence about the clinical notes, it was more probable that no abnormality was detected during the initial consultation, that this was communicated to the patient and the defendant consequently did not fail to meet an acceptable standard of care.

The case thus illustrates the old problem of concerns likely to be experienced by medical practitioners in ensuring their conduct and communications with a patient are accurately demonstrable in court should a medical negligence action be pursued by the patient. It also, however, highlights an often underestimated feature of expert evidence in ascertaining an acceptable professional standard of care: the standard of the clinical notes and the conflicts they may reveal. This column explores these features in the context of a prospective system of improved regulation of Australian clinical records.

ETHICAL PRINCIPLES AND CLINICAL NOTES

Read as a whole and in its contemporary formulations, the Hippocratic Oath still retains a profound symbolic relevance to encouraging an ethical approach to the practice of medicine and shaping the professional standard of care in areas such as maintenance of medical records.[2] It is often forgotten that such an "ethical approach" starts and ends with virtues such as respect for patient dignity (recently including autonomy) and loyalty to the relief of individual patient suffering, which may be regarded as a central, coordinating professional virtue.[3] Keeping this in mind, an "ethical approach" to medical practice should be taught professionally and regarded judicially as involving the consistent application of the principles found in such documents in the face of obstacles. The formulation and limits of these principles are not rigidly determined, as has been demonstrated time and again when they have been tested in judicial proceedings about the standard of care in a variety of jurisdictions around the world. The passage of the Oath concerning confidentiality is merely one example of this:

> All that may come to my knowledge in the exercise of my profession … which ought not to be spread abroad, I will keep secret and will never reveal.

Nowadays, exceptions to this ethical principle routinely are justified under a variety of public health statutes and when required of the medical practitioner in a court. Indeed, as King CJ noted in *F v R* (1983) 33 SASR 189 at 194, the inclination of practitioners in some circumstances to act in a manner that primarily protects their professional self-interest routinely cuts across the consistent application of traditional ethical principles that support patient interests.

Routinely keeping good clinical records should be regarded as a means by which a doctor can effectively signal to other practitioners (including those in relevant medical boards), patients and the legal profession, the extent to which he or she is consistently applying ethical principles in the face of obstacles. Certainly, such textual self-promotion, if engaged upon cynically, could be regarded more as a core medical vice than a virtue. Yet each day we move closer to closed-circuit recording of every consultation and many patients now have the technological capacity to readily record their interaction

[2] North M, *Hippocratic Oath* (2002), US National Library of Medicine, http://www.nlm.nih.gov/hmd/greek/greek_oath.html viewed 2 May 2007.

[3] Faunce TA, "Will International Human Rights Subsume Medical Ethics? Intersections in the UNESCO Universal Bioethics Declaration" (2005) 31 *Journal of Medical Ethics* 173 at 173.

with doctors. Shared electronic access to a single national database of medical records detailing all health system encounters over a patient's lifetime is likely also to soon be a reality.[4] This creates grave problems for civil liberties and patient protection, given the steady erosion over the last decade of an independent public service, freedom of information laws and the continued absence of constitutional protections of fundamental rights such as privacy. A considerable and crucial discrepancy between the clinical notes and such audio-visual recordings will undoubtedly soon become a core point of contention in a medico-legal action. Regardless of what it may indicate about the sincerity of a doctor's commitment to applying ethical principles in the face of obstacles, it creates a huge liability risk. Such a risk by an individual practitioner may soon become unacceptable to those managed-care, private medical insurance and medical defence organisation executives who increasingly dominate the regulatory architecture of doctor-patient relations.

CLINICAL NOTES: PREFERENTIAL EVIDENCE?

The basis for an action in medical negligence fundamentally proceeds from a claim that a practitioner failed to exercise a reasonable standard of care and skill in providing medical advice and treatment.[5] In the course of judgment, the court will invariably rely on evidence presented by the doctor, and this will frequently be based substantially on medical records.

In *Carney v Newton*, notes by the defendant, including two ticks next to the word "breasts", were criticised by one of the plaintiff's expert witnesses for being too vague (at [37]). Crawford J rejected this and accepted the interpretation offered by the defendant as to the meaning: that this identified both breasts as normal, that is, objectively free of diseased tissue.

The defendant's notes in *Carney v Newton* were given weight by the judge over the allegations by the plaintiff that the doctor failed at the initial consultation to palpate her breasts in response to the swelling that she claimed that doctor said they were to "keep an eye on".

Crawford J was faced with a lack of relevant detail in the clinical notes, an inability on the part of the defendant to recall the event and differing expert opinions as to whether the quality of clinical notes met the professional standard of care. He noted in his concluding remarks (at [52]) that the point turned on the inconsistent nature of the plaintiff's evidence. How illustrative this is of some of the warnings routinely given to medical students:

> Often medico-legal proceedings will take place so many years after the actual events you will have no independent record apart from your notes. If you mostly keep accurate notes you are more likely to be able to mount a case about your routine practice. Record key aspects of conversations as direct quotes. Supplement discussions with individualised clinical information sheets. Similarly, where the professional practice standard relates to protecting public safety,[6] evidence from many clinical notes can be used to show your routine practice does not infringe that standard.

In Australia, post Ipp Committee legislative tort reforms have led to variations in approaches to determining the standard of care. In general, the analysis of a doctor's notes and subsequent conduct may be judged by expert witnesses in order to decide whether the doctor acted in accordance with practice considered proper by a body of medical practitioners (peer professional opinion), that opinion not being deemed irrational or unreasonable by the court.[7] Fundamentally, it remains for the court to decide what is an appropriate standard.[8] Legislative provisions such as those relevant to *Carney v Newton* state that a breach of the standard of care may be established by looking to whether the conduct of the defendant accords with a modified form of what is known as the "*Bolam* test", emphasising the importance of opinion of even a minority of reasonable competent practitioners as to

[4] Iacovino L, Mendelson D and Paterson M, "Privacy Issues, HealthConnect and Beyond" in Freckelton I and Petersen K (eds), *Disputes and Dilemmas in Health Law* (Federation Press, Sydney, 2006) p 604.

[5] *Rogers v Whitaker* (1992) 175 CLR 479 at 483.

[6] For example, *Health Professionals Act 2004* (ACT), s 18.

[7] Bennett B and Freckelton I, "Life After the Ipp Reforms: Medical Negligence Law" in Freckelton and Petersen, n 4, p 381; *Civil Liability Act 2002* (NSW), s 50; *Wrongs Act 1958* (Vic), s 59.

[8] *F v R* (1983) 33 SASR 189.

what constitutes competent professional practice.[9] Here, clinical notes were critical to finding that the diagnosis made by the defendant and the treatment prescribed was acceptable and appropriate (at [50]). Similarly, in the Australian Capital Territory, the relevant provision requires expert witnesses, in deciding whether a particular case amounts to negligence, to have regard to the opinion of respected practitioners in Australia in the relevant field.[10]

A 1998 New South Wales Regulatory Impact Statement recognised that poor record-keeping is evidence of sub-standard medical practice, though not negligence.[11] If a decision as to whether a doctor has acted negligently rests largely with the opinion of fellow practitioners, there is a strong case for greater uniformity across the board in record-keeping to ensure all relevant facts are recorded and are of legible quality.

CONCLUSION: TOWARDS GREATER CLARITY AND CONSISTENCY IN RECORD-KEEPING

Such controversies concerning the facts of a given case, and the judicial tendency to preferentially interpret the notes of the practitioner, provide support for greater regulation concerning the nature and quality of clinical records. Currently, under New South Wales legislation, there exists a provision for the creation of regulations concerning medical records.[12] Subsequent regulations were implemented in 1998.[13] Of particular interest is Regulation 2, which states that the detail of a record must correlate to the patient's circumstances, without explanation of what this means in a practical sense.[14] Another regulation states that shorthand may only be used if it is a generally acceptable abbreviation understood as such by the medical profession or the wider medical community.[15] The question raised is whether this approach should be broadened and standardised throughout Australia.

Regardless of such regulatory efforts, when medico-legal claims reach court the notes made by the practitioner seem a perpetual source of uncertainty. Cripps AJ, for instance, has spoken of the clinical notes made by a defendant as being "almost indecipherable" and that there were "significant omissions" given the circumstances.[16] On the other hand, in cases such as *McClelland v Zacharias* (2004) BCSC 1077 the importance of thorough clinical notes in the protection of the doctor is clearly demonstrated. Despite the plaintiff's claims that the defendant failed to act on the presenting symptoms, it was held that, based on the clinical records of the defendant, relevant symptoms were, in fact, not disclosed by the plaintiff (at [50]). The trial was later described by the defendant's solicitor as a credibility contest where the defendant was successful primarily due to his thorough records.[17]

It should now be more widely recognised that a national system of electronic medical records will fail unless a national standard for the quality of medical records is devised and implemented. Maintaining comprehensive medical records is crucial to any medico-legal defence and that any costs associated with maintaining such good standards in practice are readily offset by the benefits that ensue should a doctor be sued.

Indeed, Australia may benefit from replicating schemes initiated in Britain where incentives for reaching certain standards in areas of hospital care have been implemented. Reducing insurance

[9] *Civil Liability Act 2002* (Tas), s 22; *Civil Liability Act 2003* (Qld), s 22; *Civil Liability Act 1936* (SA), s 41; *Wrongs Act 1958* (Vic), s 59; *Civil Liability Act 2002* (NSW), s 50.

[10] *Civil Liability (Wrongs) Act 2002* (ACT), s 87(4).

[11] New South Wales Health, *Medical Records Regulation NSW 2003 Regulatory Impact Statement* (2003) at [7.1].

[12] *Medical Practices Act 1992* (NSW), s 126(1)(: "The regulations may make provision for or with respect to requiring registered medical practitioners and corporations engaged in the provision of medical services to make and keep specified records."

[13] *Medical Practice Regulations 2003* (NSW), reg 2

[14] *Medical Practice Regulations 2003* (NSW) .

[15] *Medical Practice Regulations 2003* (NSW), reg 3.

[16] *PD v Harvey* [2003] NSWSC 487 at [7], [8].

[17] Rogers B, "Detailed Notes Save BC Doctor in Credibility Contest" (2004) 40(39) *Medical Post* 32 at 33.

premiums upon reaching a specified standard in areas such as patient records has proven to be a successful mechanism for improving the quality of clinical notes.[18] In addition, one study conducted into the quality of medical records before and after a pro forma was introduced, showed that the pro forma improved patient management as well as comprehensive documentation in the event of litigation.[19] Voice-to-text transcription of notes is a further option that provides for expeditious and clear documentation. This system involves a doctor dictating the notes into a recording device that is then uploaded and sent to a central agency which redirects them to a transcriptionist for processing.[20] Regardless of the preferred method, *Carney v Newton* highlights the need for greater action in improving professional standards in this area.

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RECENT DEVELOPMENTS

HEALTH AND OTHER LEGISLATION AMENDMENT ACT 2007 (QLD)

On 24 May 2007, the *Health and Other Legislation Amendment Act 2007* (Qld) (the Act) was passed in the Queensland Parliament. The Act amends the *Ambulance Service Act 1991* (Qld) and the *Health Services Act 1991* (Qld) to create a regulatory framework for the conduct of "root cause analysis" (RCA). Section 38H of the Act defines RCA as an analysis of a reportable (adverse) event which:

> (1) means a systematic process of analysis under which –
> (a) factors that contributed to the happening of the event may be identified; and
> (b) remedial measures that could be implemented to prevent a recurrence of a similar event may be identified.
> (2) However, a ***root cause analysis*** or ***RCA*** of a reportable event does not include –
> (a) investigating the professional competence of a person in relation to the event; or
> (b) finding out who is to blame for the happening of the event.

RCA is a quality improvement technique that explores the chain of events responsible for adverse incidents in order to identify the factors which caused or contributed to the incident. RCA also considers what measures may be implemented in order to stop such adverse incidents from happening again. It is widely acknowledged within health and other industry sectors that adverse events rarely have a single cause, and that they most commonly result from a combination of individual, team, organisational and environmental factors. As a result, the primary focus of the RCA should be on identifying and improving the policies, procedures or practices relating to the provision of the health service that contributed to the happening of the event, rather than on the conduct of individuals (s 38J of the Act). The goal of the RCA technique is to encourage reporting and acknowledgment of adverse incidents. To facilitate this goal and to encourage participation in RCA by health professionals, involvement in the process is voluntary and the Act provides statutory privilege to information and documents produced for RCA purposes (thus removing fear of blame and reprisal). RCA is to be used by health service facilities parallel to, and not as a substitute for, consumer complaints systems, professional standards regulation and/or legal processes (civil and criminal).

[18] Office of Safety and Quality in Health Care, *Introduction to Clinical Governance – A Background Paper Information Series No 1.1*, www.health.wa.gov.au/safteyandquality/ viewed 11 April 2007.

[19] Schmidt M et al, "An Audit of Completeness of Clinical Histories: Before and After Introduction of a Pro Forma" (2005) 16(12) *International Journal of STD and AIDS* 822 at 824.

[20] Taft DK, "Tech Duo Prescribes Solution for Doctors; DTS, Ajilon Team Up on Net-based System that Automates Voice-to-Text Transcription" (2005) 22(3) *eWeek* 4 at 5.

MENTAL HEALTH ACT 2007 (NSW)

The *Mental Health Act 2007* (NSW) (NSW) was passed by the New South Wales State Parliament and assented to on 15 July 2007. The objects of this Act are to make provision with respect to the care, treatment and control of mentally ill persons and mentally disordered persons and other matters relating to mental health.

Chapter 2 (proposed ss 5-11) sets out the circumstances in which a person may be admitted to a mental health facility as a voluntary patient under the proposed Act. It also sets out the additional requirements relating to the voluntary admission of children and persons under guardianship. An "authorised medical officer" (that is, a medical superintendent of a mental health facility or a medical officer nominated by the medical superintendent) may refuse to admit a person as a voluntary patient and may discharge a person as a voluntary patient. A right of appeal is provided to the medical superintendent against any such decision by a medical officer nominated by the medical superintendent. The case of a voluntary patient must be reviewed at least once a year, if the patient remains in a mental health facility.

Chapter 3, Pt 1 (proposed ss 12-16) provides that a person must not be involuntarily admitted to, or detained in or continue to be detained in, a mental health facility unless an authorised medical officer is of the opinion that the person is a mentally ill person or a mentally disordered person and that no other care of a less restrictive kind is appropriate and reasonably available to the person. An authorised medical officer has a duty to discharge a person if not of that opinion. This Part sets out the criteria which a person who is suffering from mental illness or who is mentally disordered must satisfy before being considered to be a mentally ill person or mentally disordered person for the purpose of involuntary detention under the proposed Act or being made subject to a community treatment order under the proposed Act.

Chapter 4, Div 1 (proposed ss 68-72) sets out general principles for the care and treatment of people with a mental illness or mental disorder, including the principle that people with a mental illness or a mental disorder should receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given. The Division makes it an offence for an authorised medical officer or an employee at a mental health facility wilfully to strike, wound, ill-treat or neglect a patient or detained person. It also requires interpreters to be provided for medical examinations if a person cannot communicate adequately in English. The Division also provides for primary carers under the Act, including the process for nominating primary carers.

SJ and TAF

