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Challenge Medical Indemnity

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by Asim A. Sheikh BL

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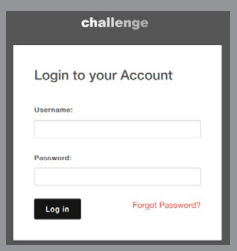

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Dear Consultant,

I hope all is well with you and your practice.

We are very pleased to bring you the Spring edition of our newsletter series.

Challenge completed another remarkable year with further growth across all of our indemnity products. The commitment and dedication of our team to continually encourage insurers to deliver comprehensive coverage at consistently competitive rates is helping bring stability to many of our private practitioners, hospitals and clinics.

In keeping with an ever evolving indemnity environment, the Challenge Healthcare Team are working on many projects which will continue to improve the cover and service delivery to you. We understand that your practice requires a stable indemnity platform with the flexibility to cater for your growing patient numbers.

We are excited to be launching Challenge indemnity for GPs in March 2020. This is very good news for many involved with primary care in Ireland who have been eagerly awaiting this product, which will run independent of other Challenge schemes. It has taken a considerable amount of work to get to this point and we are looking forward to its launch.

Good Clinical Risk Management reduces your exposure and ensures your practice is well positioned should you need to defend allegations of clinical negligence. Medical Records are a key element to achieving this and Mr Asim Sheikh BL has written a very relevant article for this edition, 'On the Record'. I think it is summarised well in his conclusion, *"it is well worth any healthcare provider considering an appropriate investment of time, resources and practice to ensure that the medical record remains the best evidence of crucial matters for not only medico-legal purposes, but also for the primary task of ensuring and being able to provide ongoing appropriate, relevant and safe patient care."*

Challenge are committed to delivering comprehensive medical indemnity at competitive rates. We are, also, committed to delivering service levels which integrate with the busy schedule of your private healthcare practice.

Thank you for your continued support,

David Walsh
Managing Director
Challenge.ie

ON THE RECORD: MEDICO-LEGAL ISSUES REGARDING MEDICAL RECORDS

– by Asim A. Sheikh BL

Introduction

This article examines some medico-legal aspects of clinical record-keeping. If issues arise with a clinical record, such an issue may have implications for both the care of the patient and for subsequent medico-legal purposes.

What are medical records and what is their purpose?

In looking for a definition of a "medical record", one is likely to find a variety of descriptions. In this respect, the Medical Council guidelines give the following description:

> "Medical records consist of relevant information learned from or about patients. They include visual and audio recordings and information provided by third parties, such as relatives."[1]

The HSE states that:

> "The healthcare record refers to all information collected, processed and held in both manual and electronic formats pertaining to the service user and their care. It includes demographics, unique identification, clinical data, images, investigations, samples, correspondence and communications relating to the service user and his/her care."[2]

Therefore, in this respect "all information collected… pertaining to the service user and their care", will mean that apart from what is understood to be the physical or electronic patient record in its standard format, any notes or entries written e.g. on a notepad, diary or logbook, for the purposes of a note regarding a healthcare provider's care in relation to the patient, will clearly be part of a healthcare record. In addition, recording formats such as audio and videotapes etc. and text messages either between the healthcare provider and the patient or between healthcare providers, and messages or letters as between the healthcare provider and secretarial staff, and messages or letters as between secretarial staff and patients, all form part of a healthcare record. Further in this respect, in accordance with the **GDPR** and the **Data Protection 2018**, if there exists *any* information in any record or note that is 'data concerning health' (s2(1)) about the patient – it is personal data that has been processed. Therefore, in a data protection request by a patient for all data concerning them, the Data Protection Act 2018 at section 91(1)(b)(iv) states clearly that:

> "…an individual who believes that personal data relating to him or her have been or are being processed by or on behalf of a controller, if he or she so requests the controller by notice in writing shall…
>
> where such data have been or are being so processed, be provided by the controller with the following information:
>
> (iv) a communication of the personal data concerned…"

Therefore s91 would apply and this data, be it contained in the formal clinical record, a logbook, a secretarial record or in a text/whatsapp message or in any other format or form, would be required to be released as a "communication of the personal data concerned."

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1 *Guide to Professional Conduct and Ethics for Registered Medical Practitioners* (Amended, Medical Council, 8th Edition, 2019) at para. 33.1.

2 *HSE Standards and Recommended Practices for Healthcare Records Management* (HSE, 2011) at s1.4.2 p.11

Patient Care, Safety and Quality

A medical record should consist of all relevant information regarding the treatment and diagnosis of a patient. This is because a patient's primary purpose in attending a medical practitioner/doctor/healthcare provider will be receipt of medical treatment. In order to receive such treatment, the patient discloses details about themselves including information such as their medical history and symptoms. This information will come from a number of sources, however, one of the main sources will be the patient her/himself. Communication with the patient is of course essential in the collection of basic medical data and "this information is essential for diagnosis and appropriate management and also to gain the patient's confidence, trust and involvement."[3] As this information is essential for diagnosis and appropriate management, it therefore requires to be recorded for the purposes of the patient's ongoing medical care and management. The keeping and maintenance of medical records allows a medical practitioner to check the history of a patient's care and also allows for a continuity of care[4]. It has been stated that:

> "The records form a permanent account of a patient's illness. Their clarity and accuracy is paramount for effective communication between healthcare professionals and patients. **The maintenance of good medical records ensures that a patient's assessed needs are met comprehensively.** Information in medical records should be documented on a daily basis and in chronological order demonstrating continuity of care and response to treatment. **The information should be comprehensive enough to allow a colleague to carry on where you left off.**"[5]

It has been observed that:

> "Although medical records serve many functions, their primary purpose is to record information about patients and their care… Medical records provide clinical staff caring for patients with information needed to deliver optimal care in present or future hospital episodes."[6]

The requirement to keep records for the purposes of on-going patient care has also been confirmed as a legal duty: in **Hughes v. Staunton, Collins, Daly**[7], an allegation was made against the three defendants (respectively, a consultant neurologist and two GPs) for incorrectly advising and prescribing an excessive dose of a drug (Largactil) and failing to monitor its effects on the plaintiff (who was suffering from Sub Acute Sclerosing Panencephalitis (SSPE). A further allegation was made against the GPs for failing to maintain appropriate records. The court found that the records were open to criticism as the first GP's records were not detailed enough to allow the GP to recall his treatment of the patient. In respect of the second GP's records, these were non-existent. However, this issue had no bearing on liability as the prescription of the drug was found to be appropriate. Nevertheless, 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."[8]

In **Armstrong v. Eastern Health Board**[9], the importance of medical records for the purposes of patient care was again stated. The plaintiff had a history of psychiatric admissions to other institutions. She wished to be admitted but was told by the defendant to get a GP's referral letter. This was done with the GP expressing the view that he agreed that the patient ought to be admitted since she had suicidal ideas. However, on the second attendance to the defendant's hospital, a duty doctor, who had never seen the patient before, nor had read the medical records, discharged her concluding that she was not clinically depressed or suicidal and was only suffering from simple schizophrenia. The plaintiff threw herself over a balcony sustaining serious injury. The High Court found the defendant negligent in failing to consider the referral letter and medical records, which if read would have led to an admission, thus preventing the injury. Egan J., stated that:

> "I do not hold that clinical notes or entries in log books must always be read in all circumstances. There must be many occasions when there is simply not sufficient time and an emergency decision is required. **Notes, however, are made for a purpose and should be read in the ordinary course.**"[10]

The quality of patient care is also linked to the quality of the medical record maintained.[11]

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3 Bowman and Cushing: "Ethics, Law and communication" in Kumar & Clark. *Clinical Medicine* (8th Ed., Elsevier Ltd. 2012) at page 8.

4 Zegers *et al*. "Quality of patient record keeping: an indicator of the quality of care?" *BMJ Qual Saf* 2011;20:314-318, where the authors state that, "The primary aim of recording information in patient's medical records is to support the delivery of good care, clinical decision-making, communication between healthcare workers and continuity of care."

5 Abdelrahman et al. "Medical record keeping: clarity, accuracy, and timeliness are essential". *BMJ* 2014;348:f7716.

6 Francois et al. "Medical record-keeping and patient perception of hospital care quality", *International Journal of Health Care Quality Assurance,* Vol. 27 No. 6, 2014, pp. 531-543 at p.531.

7 High Court, Unrep., Lynch J., 16/2/90.

8 Fn 7 at p. 863.

9 High Court, Unrep., Egan J., 5/10/90.

10 Fn 9 at pp. 2484-85.

11 Zegers *et al.* FN 4 at p. 316-317, the authors find that, "…poor quality (completeness, readability and adequacy) of the available patient information was associated with higher rates of AEs [adverse events]. The quality of the recorded information in patient records seems to be a predictor of the quality of care. Better registration of patient information could contribute to better patient outcomes and safer healthcare." See also: *HSE Standards and Recommended Practices for Healthcare Records Management* (HSE, 2011) which state that: "Structuring and organising service user information in the healthcare record … can result in improved service user safety and quality of care" (at p.9). s1.4.2 p.11.

On the Record: Medico-legal Issues regarding Medical records (Continued)

In this respect, there is a professional duty and obligation on the healthcare provider/medical practitioner in how they maintain the record:

In accordance with Medical Council guidelines:

> "You must keep accurate and up-to-date patient records either on paper or in electronic form. Records must be legible and clear and include the author, date and, where appropriate, the time of the entry, using the 24-hour clock."[12]

In accordance with HIQA Standards and Standard 8.3:

> "You can expect that people working in your healthcare service will record information about you accurately."[13]

Clinical Audit

A poorly maintained patient medical record will obviously compromise the ability to engage in clinical audit as the data required from the medical record to benchmark against a comparator practice may not be available[14]. As stated by the HSE, a healthcare record which is structured, "facilitates the monitoring of standards, audit, quality assurance and the investigation of complaints."[15] Therefore, if a medical record is poorly maintained, this impedes the ability of the healthcare provider to engage in clinical audit which in turn means that appropriate quality assurance measures cannot be engaged in. This will therefore hamper the delivery of high-quality patient care.[16] Further, whilst there may not be a definitive and proved link between a lack of well-maintained records and a patient's perception of the quality of care[17], it is hardly beyond the realm of imagination to suggest that a patient who discovers/examines their medical record which is not well maintained, might have reason to question the quality of care being received.

Medico-legal purposes

Medical records have a clear and obvious medico-legal purpose: they provide evidence of the care of the patient and therefore, can be looked upon by a court or tribunal in attempting to understand what occurred between the healthcare provider and the patient in terms of their medical care. Therefore, the medical record holds an important evidential value.

In relation to this, Kearns P, in **McManus v. Medical Council** stated that:

> "However inconvenient and burdensome it may be to write up medical records accurately, such records constitute a vital safeguard for both medical practitioners and patients alike in any situation where it later becomes necessary to conduct any form of investigation as to what transpired during the course of a patient's treatment. Every practitioner must be taken as knowing that records may later be used in court proceedings or other investigations or inquiries and hence their importance is self-evident."[18]

In the **Hughes** case, the court stated that:

> "It is … a council of wisdom in his own interests that the doctor should also keep sufficient notes of his dealings with his patient to enable him to refresh his memory therefrom and thus be in a position to state positively and precisely if required in the future what he did."[19]

The case of **Rhodes v. Spokes & Farbridge**[20] demonstrates the importance and relevance of keeping records accurately. The GP, the second named defendant, did not keep detailed records and those that were kept, were often parsed by personal comments in relation to the patient. At trial, it was

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12 FN 1, para. 33.2.

13 *National Standards for Safer Better Healthcare* (HIQA, 2012) at p.137.

14 A definition of 'clinical audit' is provided for in the Patient Safety (Notifiable Patient Safety Incidents) Bill 2019 where it is defined as: "a clinically-led quality improvement process in healthcare— (a) for the purpose of improving patient care and outcomes through systematic review of care against explicit specific clinical standards or clinical guidelines and taking action to improve care when clinical standards or clinical guidelines are not met, and (b) which selects aspects of the structure, processes and outcomes of care for systematic evaluation against explicit specific clinical standards or clinical guidelines…"

15 *HSE Standards and Recommended Practices for Healthcare Records Management* (HSE, 2011) at p.21.

16 See further: Sheikh A. A. "Medico-Legal Aspects of Clinical Audit" (2019) 25, 1 M.L.J.I. 2-4.

17 See FN 6 at p. 539.

18 [2012] IEHC 350 at p. 30.

19 See above FN 7.

20 [1996] 7 Med LR 135: Here, the plaintiff, when aged 11, suffered from hydrocephalus which was relieved by the insertion of an intracranial shunt. She reported beginning to suffer from headaches in 1984. She saw her GP, the second named defendant, Dr Farbridge in November 1985 and he thought the headache was due to stress and anxiety and prescribed tranquillisers. Between February and November 1986, the GP was consulted on 7 occasions where the patient complained of headache, but was prescribed various tranquilisers. She saw her GP again in February (when the GP wrote "as a hypochondriacal as ever") and March 1987 the patient complained of worsening headaches, double vision, slurred speech, deafness in one ear, unsteadiness on her feet, sleepiness and vomiting and some visual disturbance. The notes did not record the full extent of the symptoms (rather, on this occasion the note stated "migraine over 6 weeks: usual list of neurotic symptoms…"). The patient visited the GP again in April and May on 2 occasions after a blackout, and the GP then referred the plaintiff to a neurologist and the impression was of some sort of optical imbalance, which made no reference to the previous history of the shunt. After a further blackout, on examination by a neurologist, the past history was not discovered and it was concluded that the plaintiff was suffering from nerves and anxiety for which a prescription was given, without any referral for a CT scan. However, on attending again in July, the plaintiff was referred for a CT scan as a tumour was a remote possibility. The CT scan revealed grossly enlarged lateral ventricles and the doctor who examined the patient suspected a tumour but also identified what looked like a shunt. His investigation of the hospital records revealed the patient's past history. After a second CT scan the plaintiff was seen by the neurosurgeon involved in her initial treatment in 1959 and her raised intracranial pressure was relieved by the fitting of a ventricular abdominal shunt which relieved her symptoms. The GP stated that the plaintiff's shunt was always in his mind and that he considered blockage a differential diagnosis. However, this was rejected and he was found negligent for misdiagnosis and failure to refer the plaintiff onwards at an earlier stage.

apparent that the plaintiff was a poor narrator of the evidence and the court found the evidence of all of the parties to be unsatisfactory and not reliable. In addition, it was clear that the passage of time from the events to the time of trial, in a case which was not prosecuted with expedition, did not assist and this, as described by the court, militated "against accurate recall". In relation to the issue of medical records, the court made this important 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."[21]

This case demonstrates a common factor in relation to medical negligence litigation i.e. that the time lag between the happening of an alleged adverse incident and the commencement and thereafter participation in on-going litigation, can be very significant. As the court observed, there is a significant difference in relation to the circumstances of a doctor's memory and that of a patient: the patient will only remember his/her case, whereas the doctor will have to recall one out of hundreds of cases at the time, never mind the fact that by the time the defendant doctor is called to give evidence usually many years later, she/he will have seen thousands more patients, and therefore, his/her memory of the event in question would have deteriorated significantly. It is very common that a defendant in the circumstances will, in fact, not recall any of the events in question. Further, it has been stated that as a result of such 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."[22] In such a situation, a well maintained medical record will be of undoubted assistance to the court and to a defendant/healthcare provider in the defence of legal proceedings. Thus, in **O'Neill v Rawluk** where the procedure had been performed 12 years prior to the trial, the relevance and assistance of written records was noted by the court and 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."[23]

The effect of not recording a relevant "transaction" in the medical record was demonstrated in **O'Sullivan v Anor. and Bons Secours Health Systems Ltd**[24]. There, the failure/omission by the obstetrician to record a diagnosis of shoulder dystocia, in addition to not making a note to indicate that the plaintiff was placed into the McRoberts manoeuvre, led the court to prefer the evidence of the parents. First, the omission to note "shoulder dystocia" and instead mention merely "… difficulty delivering right shoulder?", led the court to believe that the obstetrician did not form the view that there was a shoulder dystocia. Secondly, the court found it remarkable that no mention was made of the relevant procedure used to overcome shoulder dystocia (the McRoberts manoeuvre with suprapubic pressure). O'Neill J noted as follows:

> "I consider to be remarkable and that is the fact that no mention at all is made in the note of the procedure used to overcome shoulder dystocia i.e. the McRoberts movement … together with supra pubic pressure. One would have thought it was of some importance to record what manoeuvre was used to overcome a problem such as this because that information might be of considerable relevance to the management of a subsequent delivery so that an obstetrician dealing with the later delivery would know what had either succeeded or failed.
>
> The first named defendants evidence was that it was not the practise to note the particular manoeuvre used and he went on to say that he had been trained to make short notes rather than long notes on the basis that shorter ones are more likely to be read and that in a hospital which wasn't a teaching historical [sic] shorter notes of the kind made here were the norm. He acknowledged that in a teaching hospital there was tendency to write essays.
>
> In my view the universal desirability of brevity simply fails to explain an omission such as this from this note. A single short additional sentence was all that was required, to say that shoulder dystocia had been

[21] FN 20 at p. 139.

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

[23] [2013] IEHC 461 at para. 42

[24] [2004] IEHC 78.

> encountered and was overcome by the McRoberts manoeuvre … with supra pubic pressure.
>
> The contents of this note tends to persuade me that the parents of the plaintiff are right in their recollection that Ms. O'Mahoney was not changed into the left lateral position nor was supra pubic pressure applied."[25]

It should, however, be noted that the medical records, in and of themselves, are not proof of the contents of those records. In other words, technically, they will become evidence in proceedings (i) if the parties agree to admit the medical records to trial without formal proof (in which case the author of the record will not be required to give evidence in relation to the content of the record) or (ii) the author of the record is called to give oral evidence and therefore prove the content of the record.

Therefore, where there is a dispute in relation to the alleged facts which are stated in the medical record, then, the author of that record must be called[26]. This is so the patient/plaintiff can give evidence and be cross-examined in relation to their version of events, and that the same can take place with the author of the record. Otherwise, the notes in question cannot be regarded as evidence which can be proved, as they cannot be appropriately tested in cross-examination.[27] The better the record, the easier it will be for the author of that record to stand over it and give evidence in relation to it, where its content is disputed.

In order, therefore, for medical records to be "better", the following should be kept in mind:

Contemporaneous nature of entries in the Records

The record should be contemporaneous. The medical record should be written/recorded at the time of the relevant event or immediately thereafter. Clearly, the longer the gap between the relevant medical event and the writing of the relevant medical record in relation to that event, the more open to scrutiny that record will be as it can be suggested that a record which is not written contemporaneously may not be accurate as the writer's memory of the event will become more problematic as this time gap becomes longer.

On occasion, a practitioner may be called away to deal with another patient immediately after his/her interaction with a previous patient. In the circumstances, if the only possibility is entering a note on the records at a later time, then: it should be written as soon as possible thereafter and, the fact that it is being written on a non-contemporaneous / retrospective basis should be recorded. Whilst there is no exact formula for what such a note might be, words such as "patient seen at [enter time], note entered at [enter time], as I was called away to see another patient…" might be suggested. Such a retrospective entry/note would assist in providing clarity in relation to when the patient was actually seen/dealt with and would note when the retrospective note was recorded and why such a note was retrospective. The more the clarity of any note recorded in the medical record, the easier it will be to provide an explanation of it should any dispute subsequently arise.

In understanding the importance of the medical record and its value as evidence, a medical record cannot be retrospectively altered for any improper purpose. If a genuine mistake occurs on a medical record, or where a further entry is required in the note on a retrospective basis, any mistake should be clearly struck through with a line and this should be signed/initialled and dated.

Alteration of Records

Any improper alteration of the medical records e.g. for the purposes misleading the parties and the court in subsequent legal proceedings, will result in a most serious admonishment by a court, and will undoubtedly be grounds for regulatory criticism in circumstances where there is a duty to maintain accurate medical records. Therefore, in **Philp v. Ryan**[28] the first-named defendant claimed that an alteration to the clinical notes, after the commencement of legal proceedings, was made to reflect the true facts of what occurred according to his own recollection. However, he agreed that it was improper to make such an alteration. The alteration was never brought to the attention of the plaintiff's legal advisers and it only emerged during the course of the trial. In describing this action, the trial judge stated that he had "…absolutely no doubt that Mr Ryan acted quite improperly when he altered this clinical

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[25] At pp. 9425-9426. There would seem to be a typographocal/transcription error in this passage: the word "historical" clearly is meant to state "hospital". See further an example where the records, inter alia, led the court to make a finding of a lack of care: Also e.g. in **Kelly v. Lenihan** [2004] IEHC 427, a relevant witness, a student nurse was not called to give evidence by the defendant. Therefore, the plaintiff gave evidence unchallenged. Further, other evidence persuaded the court there was a lack of care, including a lack of notes and comments in the records in relation to the state of the plaintiff's perineum and also, there were errors in the letter of discharge which the court stated "… would tend to allay suspicion of the credibility of the plaintiff's allegations being made against a respected professional…", per Abbot J., "Findings", para. 5.

[26] It should be noted that in a situation where a record/s is agreed and where the author of the record is therefore not called, the court will not be impressed if a defendant then attempts to impugn or criticise a relevant entry in such record. Again, the reason for this is that the record and its content cannot be tested by way of cross-examination of the author. In such a situation of effective silence by the author of the record (due to their now absence in the proceedings), the court will be entitled to reach an inference regarding the absence of a witness who was not called and to reach a conclusion on the evidence before the court: e.g. in **Hawkes v St. Vincent's Hospital** [2006] IEHC 443 and **Dunne v the Coombe Hospital** [2013] IEHC 58, where Irvine J at para. 195 observed that, "it is clear that in certain circumstances, a court is entitled to draw adverse inferences from the absence or silence of a witness who might be expected to have material evidence to give on a particular issue".

[27] See further: **Moloney v Jury's Hotel Plc** [1999] IESC 75.

[28] [2004] IEHC 77.

record." In awarding aggravated damages of €50,000 for the "grossly improper behaviour"[29] of altering the medical record, the Supreme Court expressed a somewhat stronger sentiment, stating:

> "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…"[30]

Consistency of recording in the Records

The more consistent the nature of medical record, the more this will be of assistance to a defendant in the defence of proceedings, as it allows the defendant to rely on such consistency. Therefore, e.g. in **Rossiter v. Donlon**[31], the plaintiff suffered from breast cancer with metastatic disease in other parts of her body with a survival prognosis of 6 months at the time of trial. An issue of conflict arose in relation to what was said about breast cancer in the course of consultation between the plaintiff and the defendant. The plaintiff claimed she had expressed a concern about breast cancer to the defendant. The defendant asserted that there had been no reference to breast cancer, except for a question which the defendant asked the plaintiff in respect of whether or not there was any family history of breast disease. The response to that question was recorded in the clinical notes. Further, the plaintiff had expressed a concern in relation to a lump in her left armpit which was also recorded in the notes.The defendant stated that if any concern had been expressed by the plaintiff about breast cancer, she would also have recorded any such concern. As a result, the court preferred the evidence of the defendant stating that:

> "I prefer the evidence of the defendant. In particular, I attach significance to the fact there is no reference to any such concern [of breast cancer] in the defendant's contemporaneous notes. She had recorded the concern on the part of the plaintiff in relation to a possible lump in her left armpit. There was absolutely no reason why the defendant would have recorded that concern which was expressed to her by the plaintiff, but would not have recorded any other concern was also expressed to her by the plaintiff. Accordingly, I am satisfied that the absence of any reference in her notes to the plaintiff been [sic] concerned about the possibility of having breast cancer, or been [sic] concerned about breast cancer generally, it is persuasive that no such concern was expressed by the plaintiff to the defendant on that occasion…"[32]

In this case, the defendant's consistency in recording the plaintiff's complaints in relation to one issue, meant that there would have been no reason for the defendant not to have recorded any other complaints which the plaintiff might have expressed. Therefore, the defendant's consistency in relation to her recording of a patient's complaints allowed her to rely on such consistency in defending an allegation over failure to record complaints made by the patient.

As was stated above, any information which is relevant to the care of a patient may be disclosable to the patient if requested through the data protection legislation. Further, in relation to legal proceedings, any medical records which are relevant and necessary for the purposes of the proceedings are likely to be discoverable.

Therefore, it should be obvious that the clearer the medical record, the better the understanding will be in relation to the entirety of the care of the patient. Thus, in turn:

- the more meaningful such a record will be to the medical team in the course of the care of the patient;
- the more meaningful such a record will be to the patient him/herself should they seek access to the record;
- the more meaningful such a record will be to any court or tribunal in attempting to understand the care received by a patient and;
- the more meaningful such a record will be for a defendant healthcare provider who is seeking to defend and/or stand over and/or explain their actions vis-à-vis their patient at any given material time.

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[29] [2004] 4 IR 241, Supreme Court, per McCracken J at para. 50, p. 258.

[30] FN 28, at para 41, p. 255.

[31] [2019] IEHC 105. No negligence was found and the case was dismissed against the plaintiff.

[32] FN 27 at para. 416 per Barr J.

Lessons from litigation: Reflections on your Medical Records

Therefore, it is advisable for healthcare providers to reflect on any potential anomalies in relation to the record keeping process:

- Are you keeping any record of the patient outside of what might be considered the formal clinical record 'bundle' e.g. a diary, a logbook, a notepad etc.?
- Is clinical information relevant to the treatment, diagnosis and care of the patient being recorded by secretarial staff?
- What is your record-keeping practice in relation to an outpatient appointment?
- Do you keep a written record of your transaction and consultation with the patient, or do you simply dictate a follow-up letter in relation to your consultation to the patient's GP?
- If so, is the dictation of such a GP follow-up letter appropriately recording the full extent of your consultation with the patient and is it properly contemporaneous?
- In relation to the consent process, if you have discussed the material risks of a procedure with the patient at their outpatient clinic, have you documented the discussion of these risks in the medical record?
- If a material risk discussed subsequently and unfortunately transpires, are you able to convincingly provide evidence that such risk was actually discussed, as opposed to having to rely on the narrative that "it is my practice to always discuss the risks, and I would invariably have discussed this risk…"
- Are you recording sufficient details of your consultation with your patient in the written/electronic record?
- This should include information in relation to your "safety netting" e.g. telling a patient that they should return/contact you or the accident and emergency department (depending on what is appropriate), should the symptoms worsen.
- Are you recording what is done when you receive any sort of laboratory report on foot of any test ordered by you?
- For example, what is your practice in relation to contacting the patient on the receipt of the test result – do you contact the patient in all circumstances or only if the result is negative?
- Do you tell the patient "I will only contact you if the result is negative", and then do you record the fact of this communication with the patient?
- Do you record all follow-up instructions and information, including any request that the patient should follow-up with you at a certain time?
- Do you record information received by individuals other than the patient e.g. information received from a relative on foot of a telephone call revealing potentially relevant clinical information/a symptom?
- Do you ensure the use of standard and appropriate abbreviations in your clinical records which could be expected to be understood by any other practitioner?
- Do you appropriately date, time and sign all entries?
- Do you ensure that your records are kept objective and factual and free from unnecessary subjective entries?
- Would you be happy for an independent expert to review/audit your records and which audit would conclude that the records provide a clear, accurate, chronological, consistent and complete picture of the care of your patients, such that you would be happy to stand over such a record before a court or tribunal and/or that such a record would assist you in your ongoing care of the patient and assist you in providing a proper and accurate history to deliver such care?

Conclusion

It is clear that:

> "Medical 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…."[33]

This being the case, it is well worth any healthcare provider considering an appropriate investment of time, resources and practice to ensure that the medical record remains the best evidence of crucial matters for not only medico-legal purposes, but also for the primary task of ensuring and being able to provide ongoing appropriate, relevant and safe patient care. Such an investment will obviously not be wasted if the patient therefore is able to receive such ongoing appropriate care whilst at the same time, any court or tribunal examining the record of such ongoing appropriate care will be confident that such care was in fact provided on foot of any examination of the medical record. Such a result is clearly and obviously to the benefit of all parties involved in the medico-legal equation: the patient, the healthcare provider and the court/tribunal.

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He is also Assistant Professor in Legal Medicine, at the UCD School of Medicine. He lectures and has published widely on aspects of medical law. He also lectures in the RCSI, the Honorable Society of King's Inns and the Law Society. He is a member of the National Advisory Council on Bioethics, and is Editor of the Medico-Legal Journal of Ireland.

[33] Jones, M. Medical Negligence (5th Ed) at p. 1283.

Guidance note for notifying **claims and circumstances**

These guidelines are intended to assist you in identifying what you need to report to Challenge under your Medical Professional Liability, Public & Professional Liability Insurance policy. They are not intended to replace the policy terms and conditions in any way.

Claims Process

Swift resolution of claims is reliant upon the quality of the initial information Challenge receives. The more complete the information is, the more quickly Challenge can move to resolve a claim.

A Claim/Circumstance Notification Form should be completed in respect of all new notifications and should be sent to: **insurance@challenge.ie**

What needs to be notified

You are responsible for notifying Challenge of Claims and Circumstances which may give rise to a Claim under the policy. Such notice should include:

a. details of what happened and the services and activities thatyou were performing at the relevant time; and

b. the nature of any, or any possible, bodily injury; and

c. details of how you first became aware of the Claim or Circumstance; and

d. all such further particulars as Challenge may require.

Claims

Under the terms of your policy, any Claim must be reported to Challenge in writing immediately. The definition of a "Claim" is any:

> *"1. written or verbal demand made of you; and/or*
>
> *2. assertion of any right against you, including but not limitedto any proceedings, including any counter-claim; and/or*
>
> *3. invitation to you to enter into alternative dispute resolution,alleging any occurrence, negligent act, error or omissionthat may give rise to an entitlement to damages."*

Examples of a Claim are:

- A letter of claim from solicitors.
- A letter or verbal demand from a patient or third party,alleging wrongdoing and requesting compensation.
- Legal proceedings (e.g. a Summons/Particulars of Claim, etc.).

Circumstances

Under the terms of your policy, any Circumstance must be reported to Challenge in writing immediately. A "Circumstance" is defined as:

> *"any circumstances of which you become aware, or should reasonably have become aware, that may reasonably be expected to give rise to a Claim."*

Examples of a Circumstance are:

- Any complaint, written or verbal, in which the patient orpatient's representative expresses dissatisfaction regarding the treatment received and alleges that, as a result, the patient suffered bodily injury.
- A request for access to medical records received from a solicitor or third party on the basis that a Claim against you/your service (to include any of your employees) is being contemplated.
- Any incident in which a Serious Untoward Incident Report is generated.
- Any unexpected or unusual death of which you become aware.
- Any adverse outcome or clinical "near miss" in which you believe there may have been a negligent act, error or omission, irrespective of whether or not the patient is aware of this or whether the patient or patient's representative hasmade a complaint.
- A loss of patient records (which after a relevant search cannot be found).

These examples are for general guidance only and this is not an exhaustive list. If you are in any doubt regarding whether an incident is reportable then you are encouraged to notify the matter to Challenge as a precaution.

Challenge Commendation Award for Healthcare Sustainability Project

We were delighted to receive a commendation at the recent Irish Healthcare Awards.

Our competitive and comprehensive cover offering has reduced consultant indemnity costs alone by over €25m in the past 5 years. More crucially Challenge indemnity and support services have facilitated:

1. The commencement of start-up consultant practices in the 23 private hospitals nationwide which would not have been sustainable due to high indemnity costs. In most instances this has meant doctors returning to practice in Ireland as opposed to practicing abroad.
2. The extension of practices where consultants were considering earlier retirement due to high indemnity costs
3. A return to specialist procedures being carried out in private hospitals which had ceased due to high indemnity costs e.g spinal and neuro

Thanks to everyone who has supported us to date, in particular our private healthcare clients whose trust and loyalty drive us on to continue to improve the medical indemnity environment in Ireland.