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Evidence from medical records in civil cases with the participation of the patient.

Abstract

The subject of this dissertation is evidence from medical records, which play a very important role in civil proceedings. Therefore, the specific nature of the evidence from medical records was presented, which under the civil procedural law is evidence of a complex nature, having the features of evidence from an official document, private document, or other means of evidence.

Due to the specific features of the evidence from medical records and the lack of detailed characteristics of this issue in the doctrine of civil procedural law, a thorough analysis of legal definitions of medical records, their types and forms, also in the subjective aspect – depending on the entity which is obliged to create and complete them, was performed in this study.

First, the concept of evidence, means of evidence and source of evidence are explained. For the purposes of this study, it has been assumed that the evidence is facts that are crucial to the outcome of the case. The means of evidence is the information medium that allows the determination of existence or non-existence of the fact. And the source of evidence is any means of evidence that allows the determination of the specific facts in a pending court case.

In the following part, an attempt was made to define medical records on the basis of the analysed key features in terms of their functionality (also in the aspect of evidentiary proceedings in civil cases) and the content of medical records. As a consequence of distinguishing a group of constitutive features of the records and mandatory or optional elements of their content, medical records were extracted *sensu stricto* and *sensu largo*. The records *sensu stricto* are records that strictly concerns medical procedures performed by medical professionals and their purpose is to reflect the diagnosis, treatment, or therapeutic process. In contrast, records *sensu largo* are the aforementioned records *sensu stricto* extended to all documents related to the diagnostic and therapeutic process, not directly related to the patient's state of health, but to other issues relevant to this process, such as patient's consents, documents regarding the determination of a person representing the patient etc.

The study showed the civil-procedural nature of medical records as *sui generis* means of evidence. An analysis of medical records was presented in relation to the concept of a document within the meaning of Art. 77^3 of the Civil Code[1], according to which a document is an information medium, allowing familiarization with its content. The introduction of such a way of understanding a document by the legislator has opened up new possibilities also in the area of shaping norms of civil procedural law and their application in practice. Such a broad approach to the concept of the document, also on the basis of evidentiary proceedings, was reflected in the classification of the components of medical records as carriers of information relevant for determining the facts relevant to the resolution of the case, such as: electronic record of the magnetic resonance, X-ray image or ECG record.

The doctoral dissertation includes an analysis of the hypothesis of the specific nature of medical records as a means of evidence under the provisions of the procedural law, since the Code of Civil Procedure does not introduce a classic exhaustive definition of a document, indicating only examples of this type of means of evidence (official documents, private documents, document form), which opens the catalogue of components of medical records that can be qualified as a document containing a text or a document that does not contain it, with the consequences arising from the procedural law.

In connection with the above, the truth of the thesis was verified, according to which a medical record is a set of means of evidence of various nature, which separately give only partial information. For this reason, they must be perceived not only individually (e.g. in terms of their truthfulness and authenticity), but also analysed in the functional aspect in a specific context – as elements of the whole that has a value for the determination of the facts relevant to the resolution of the case.

Next, the types of medical records which are present both in medical entities which are hospitals, as well as in outpatient clinics and entities dealing with patients of various status were discussed. Records highlighted due to the special status of the entity creating them (e.g. in prisons, psychiatric hospitals, health resorts), as well as records of a special nature due to the specificity of the patient (e.g. in the event of an infectious disease necessitating the use of specific procedures) are a good example.

Further, the method of obtaining medical records by the patient, relatives and other entities for the purposes of presenting them in the course of court proceedings was explained, as well as mechanisms related to counteracting obstruction by medicinal entities in the scope

[1] Act of 23 April 1964 – the Civil Code, Journal of Laws of 2019, item 1145, 1495, hereinafter referred to as: CC.

of providing access to medical records. In these considerations, the topic of the negative side of the obligation to provide access to medical records related to the limits of the protection of doctor-patient privilege and privileges of other medical professionals in the event of the obligation to provide access to medical records was taken up.

Finally, the concept of medical error, medical incident, and causal relationship, e.g. between medical error and patient injury, are defined as key concepts for civil disputes in which evidence from medical records is used. In this context, a verification of the significance of evidence from medical records, also in view of the principle of free assessment of evidence by a civil court was performed. In this section the evidential value of medical records as a means of evidence in civil proceedings was analysed. The growing importance of medical records in civil cases was also emphasized, due to the increase in public awareness of the civil and legal consequences of medical errors and other non-medical legal events resulting in loss of life or damage to health, which causes an increase in the volume of civil cases with the use of medical records as an instrument to determine the facts being the basis for obtaining compensation or redress, due to e.g. a mistake made by a medical professional, as well as e.g. in relation to an accident at work or inability to work for other reasons.

In researching this issue, various research methods were used, primarily dogmatic, analytical, and historical. The dogmatic and analytical methods were used to analyse the generally applicable substantive and procedural law relevant to shaping the title issue, as well as literature in the field of civil law and medical law relating to the status, content, and form of medical records, as well as the civil-procedural aspects of their use in evidentiary proceedings. The historical method was aimed at presenting the evolution of the concept of medical records in legal provisions, occurring with the development of medicine and the introduction by the legislator of subsequent legal solutions aimed at the harmonization of Polish legislation relating to medical records with EU standards. The purpose of these legislative measures is to ensure that the patient and the healthcare provider make full use of medical records not only in the entire diagnostic and therapeutic process, but also to document and demonstrate its course for the purposes of other proceedings relevant to the proper protection of the interests of the patient, other authorized persons and the healthcare provider.