# CLINICAL RECORD KEEPING IN PSYCHOLOGICAL PRACTICE – COMPLETE, ACCURATE, ETHICAL?

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# CLINICAL RECORD KEEPING IN PSYCHOLOGICAL PRACTICE – COMPLETE, ACCURATE, ETHICAL?

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**ABSTRACT**
The practice of psychology intersects with the processes of law in cases of disputed accusations of Unprofessional Conduct following an audit (for whatever initial reason) of a clinician's notes. So ubiquitously are repeated the five APA reasons for record keeping with minor rewording in different jurisdictions, that keeping "adequate" clinical records is regarded as beyond the need for discussion or proof. The present article reminds the clinician, the experimental academic, and the defending legal team of the missing empirical underpinning to the links between "good clinical practice" and "level of record keeping". Accepting that all of psychological endeavour is aimed at providing evidence-based pronouncements and practices, and further acknowledging the pivotal Natural Justice importance of accusation based upon evidence, it remains unclear what weight should be ascribed to strident "Expert" statements proffered in the absence of published studies providing relevant evidence. For the potentially accused psychologists and their counsel, taking shelter in the chasm between fact and assertion, there is the additional ethical concern that "too much" information may much later come back to disadvantage the client. For the academic psychologist, urgent attention to redress this empirical deficit is encouraged.

**KEY WORDS:** Adequate Records; Clinical Practice; Evidence-based; Psychology; Record Keeping; Expert Opinion; unprofessional conduct, ethics, ethical responsibility.

**INTRODUCTION**

With the potential of slipping from a matter of day-to-day psychological private clinical practice into a question of ethical transgression is the issue of psychological record keeping. The question of "*adequate* record keeping" may be raised in the wake of a practice audit which discovers instances of sparse documentation occurring in one or more clinical consultations. With the charge of "inadequacy of records" paired with the broader brush challenge of "unprofessional" or even "unethical" conduct disputed by the accused psychologist, the initially uneven contest is likely to advance beyond the level of "in house" (professional body or regulating authority) investigation, and a nominally more level playing field comprising an external tribunal with formal legal representation of accuser and plaintiff may be the arbitrating forum. Although there may be a perception of even-handed fairness about this next-level consideration of the charges, the present paper suggests that the principles of Natural Justice may be far from satisfied by the style and content of Expert Opinion that will be (and indeed has been) mounted against the accused psychologist.

While not condoning poor, shoddy, lazy or otherwise inadequate clinical practice in psychology or indeed in any other health profession, the present paper will discuss three defences which may diminish the negative implications of minimal records for clinical psychological sessions, with a particular emphasis upon the clinician in private practice. The present paper does not necessarily to apply to psychologists who may be part of a research team or working in a public funded clinical service in which there are likely multiple and frequent changes in provider.

Although conventional legal processes would first table the accusative case, and then listen to the defensive rebuttal, the current paper will start with the four (most common) defensive positions seeking to explain instances minimal sessional records:

1. Ethical responsibility to avoid future harm to the client;
2. Top-down analysis of the practice supporting the proposal of "adequate" conduct;
3. The reliability of clinician's memory in the case in question.
4. The absence of scientific/empirical evidence to link record keeping to clinical outcomes in psychological practice.

In discussing these four defences of minimal record-keeping with some specific case references from Australia, it is noted that although Australia is in population terms a minority in the English speaking psychological world (dominated as it is by North America and Britain), the particular cases referred in the present discussion to are drawn from this region with the full knowledge that the Australian regulations and approaches are consciously based upon primarily the utterances and attitudes of firstly the American, and secondly the British professional psychological bodies.

**The First Defence: *Ethical Responsibility to the Client***

Although it is occasionally mentioned in professional musings, the five standard reasons (listed and discussed under the "fourth defence") for "maximal" record keeping entirely side-step the ethical responsibility of the psychologist to the client: that the clinical notes would not ultimately harm the client. The true fate of private practitioner clinical notes is that they are either referred to by the clinician him/herself, or they are perused by an entirely external reviewer who does not have the client's best interests in mind. The logical third option of a client-supportive external review of the case is regularly covered by the clinician writing a relevant summary (to courts, to other psychological or social service providers, or to referring and collaborating medical services). It is the second (a non-benign reading) which raises the ethical dilemma of recording very little of the interactions (and being at risk of "unprofessional conduct" charges), or having the notes fall into the hands of the client's antagonists such as subpoenas for the "total file and all records" by work-related injury claims, family court matters, and the like. A recent case known to the writer of a work-related stress claim resulted in the client's opponents demanding "all clinical notes". As it turned out, this client had been seen a few years earlier and was helped to deal with the social/anxiety producing threat of having her family home taken by the bank because her husband was out of work. Calm discussion and appropriate connections led to a reduction in her anxiety at that time, however the fact that "anxiety" had been a clinical issue was now being used by the current employer's legal team to infer pre-existing neurosis. Putting aside the suggestion of "complete and accurate" records as the gold standard of clinical note taking, the practising clinician must bear in mind the ethical implications of the fact that each and every word written down may one day be viewed by an antagonistic legal team with a view to making negative assertions about this client in an entirely different forum. This threat, although only dimly perceived by the client, has the potential to entirely taint the phenomenology of the clinical interaction, and it surely behoves the psychologist to assure the client (and to ensure in reality) that not a single word which could ultimately harm the help-seeker will be recorded.

**The Second Defence: *Top Down definition of "Adequate Records".***

The overall quality of a clinician's practice could be determined by a top down analysis. Satisfactory clinical outcomes are indicated by confidence among the referring professionals (renewed referrals from medical doctors and the like), and/or further indicated by the absence of complaints by clients, and finally indicated by measured improvement in one or more target characteristic of a statistically convincing proportion of the clients.

In the absence of evidence to the contrary, in the absence of documentation-compliance complaints by various stakeholders which would include clients, referring health workers, or monitoring bodies (statutory injury-management organisations), the default interpretation of the top-down model would be that "record keeping", along with other aspects of the practice, were "adequate".

Contrasting with the "top down" defence is a Bottom Up analysis of clinical practice. Starting with individual components of practice is likely the chosen way forward in a teaching situation. Novice clinicians acquire this or that component one step at a time. The use of a psychological test illustrates bottom-up teaching: first how to administer different components of the test, next to score, to analyse, and to interpret the test, and then linking of test results to clinical goals. It is a compellingly defensible teaching approach (the step-by-step, Bottom Up model), and recognising that "experts" appealed to in an audit of clinical practice are likely to be university-ensconced "teachers" of clinical skills, it is not surprising to find dogmatic reliance upon the bottom up analytical approach in expert opinions gleaned from these sources.

In the teaching of clinical practice the evaluated outcome of the "record keeping" unit would likely expect the novice to make "complete and accurate" notes – that is notes which *never omit anything regardless of how trivial it may seem at the time*. The hope and expectation is that if all the sub-components are mastered, one by one, bottom up, and later combined, then the clinician emerging from the training program will be a clinician with an "adequate" practice gestalt. And (as if in an Orwellian Time Machine) chronologically reversing that bottom up teaching/learning process for the purposes of an investigation, the question posed becomes "is each and every separable step of the bottom up training program distinguishable", and if any step no longer distinct and manifest, then, by definition, the clinician's practice would be deemed "inadequate".

But the process of learning, of mastery, of blending separable steps into a unified meta-event does not go in reverse: you can't unscramble the eggs. Genuine "expert opinion" leads to the view that it is the *gestalt* of therapist, technique, and interaction with the client, the phenomenology of the consultation which leads to clinical benefit (eg. 1, 2). All steps involved in the process of the therapeutic process are not currently easy, or perhaps not even possible, to document. Consider, for example, the problem of documenting to a legally verifiable level in a "complete and accurate" manner the steps implicit in the following description of the counselling process:

> *Counseling* (sic) *is a process in which clients learn how to make decisions and formulate new ways of behaving, feeling, and thinking. Counselors focus on the goals their clients wish to achieve. Clients explore their present levels of functioning and the changes that must be made to achieve personal objectives. Thus, counseling involves both choice and change, evolving through distinct stages such as exploration, goal setting, and action* (3) (this 1996 work now in its 7th edition, 2012)

The top-down approach must accept the therapist's record keeping as "adequate" if there are "no overall grounds for complaint". The bottom up approach of practice investigation (conceptually seeking unscrambled eggs) could find "fault" (something not there) in any conceptual component of the therapeutic gestalt, even though there was no negative outcome.

Although this position has been (anecdotally) challenged, it is likely one of those "unchallengeable principles" that an "adequate" practice is one that generally leads to "good outcomes"[1], and that principle could justifiably be taken as the basis for future "expert opinion" upon practice adequacy.

**The Third defence: *Adequacy of Practitioner's Memory*.**

In a real-world example of accusative clinical scrutiny, having seen one particular client for ten years, the treating psychologist was confident that he could recall the pertinent details of the case and therapeutic approach he had been and was continuing to take. Relying thus upon his memory of the case, the clinician wrote nothing more than the date upon a sheet of paper. As their riposte in this instance the denouncing Experts rose in unison to decry any defence of adequacy of practice conduct which depended upon such a faulty device as the human memory. This attack was overtly and deliberately based upon the empirical (and certainly not disputed) fact that humans do not remember "everything" and so, it was posited by the Experts, the psychologist in question could not claim to rely on memory for the conduct of the session in question. The prosecution's argument here represents an appeal to the early (Piagetian) childhood thinking process of Transductive Logic.

Cognitive Processes at age 2-4 years is characterized by the child's inability to understand all the properties of classes. The child has acquired the ability to represent objects mentally and to identify them based on their membership in classes, however this child now reacts to all similar objects as if they were identical. This understanding is incomplete because they cannot yet distinguish between apparent identical members of the

[1] **The unchallengeable principle that "good outcomes" are anticipated**: a "psychoanalytic therapist" gave an address in which she said "at first, when I started out, I was worried that none of my clients were improving. Then I realised that the desire to have positive outcomes of therapy was just an example of counter-transference. After that I didn't worry any more about outcomes."

same class. Termed "Transductive Reasoning" this is a faulty type of logic that involves making inferences from one specific to another. It can lead to correct or accurate conclusions, but it is not guaranteed to do so (see for example, ref. 4). In the case of non-voluminous notes, the prosecution is seen to be working from the particular demonstrations that ***a human*** has not remembered ***something***, the Experts conclude that ***another human*** (the clinician under scrutiny) in another situation could not remember ***something else*** (the relevant details of this particular case).

Transductive logic and other faulty reasoning processes are common in the general population, with around half of adults never reaching the mature goal of (Piagetian) Formal Operational Reasoning – that is the ability to contemplate and apply abstract reasoning processes. However it would be expected, even demanded, that Experts (holding as they do Important University Positions) would have well transcended the early stages of non-logical reasoning, and it remains a mystery that an argument based upon primitive epistemological processes would be even advanced, much less accepted, in this forum.

**The fourth defence: *Absence of Evidence for Voluminous Record Keeping***

The foundation stone of evidence-based practice, whether in the laboratory, the psychological clinic or in legal decision-making, is that the evidence may change but decisions made "right now" are based on the best available evidence at the time. At any particular moment in time, the evidence-based components of practice could, and should, be the valid subject of scrutiny – first by the therapist, next by his/her peer-group discussion activities, and finally (as appropriate) by regulating bodies. The same is not true for those components of practice which are awaiting evidence but all the same are encouraged. The over-arching requirement that psychological practice (and the judicial evaluation of that practice) be evidence based would logically preclude the finding of "fault" in practices where some "asserted" but "not yet proven" component was absent.

The very nature of "as-yet-undiscovered" evidence is that if such future discoveries are to be other than trivial, then by definition we cannot know beyond a reasonable doubt the details of the awaited discovery. Clinical practice and its outcomes will likely improve in the future, in line with the improving state of evidence based knowledge. Anticipating that such advances will occur through the efforts of our investigative research-focussed colleagues, today's methods could, in some future forum, be deemed "not best practice". However the quite reasonable anticipation that one or another approach may one day be condemned – that does not empower the present-day adjudicators to impose on current psychologists practice requirements based upon their own anticipated version of what is yet to be discovered. They must work on the evidence of today, and take no thought of the morrow: *Sufficient unto the day is the evil thereof.* (5)

The conduct of clinical psychological practice may be held up against a conceptual template of the medical centre where a doctor makes a diagnosis (or orders a diagnostic test), then prescribes a pharmaceutical remedy. If either of those two steps were not fully documented with sufficient detail to clarify future uninformed viewers about what happened, then the clinical notes would be "inadequate". And in this specific setting, a "full and complete" record of the diagnostic and prescriptive process is the appropriate expectation. Clinical psychological practice may be regarded as somewhat analogous to physical-medicine, but "analogy" is not the same as being the same. On some occasions the psychologist's client attended but little was written down, and this leaves open to interpretation, indeed open to condemnatory Expert Opinion, the question as to what constitutes an "appropriate" quantity of descriptive writing for each session. For the prosecution, Experts (who are likely invited to come from their University postings) will eagerly give Expert Opinions which coincide with the proposition of insufficiency.

The "evidence" which supports the charge of shoddy work has not been based upon empirical or even epistemological deduction: rather the evidence relies upon Expert Opinion as to what standard of note taking would be "adequate", and this putative standard is, in a self-supporting cycle, derived by the Experts from the pronouncements of various psychological regulating bodies around the (at least English speaking) psychological world, these "pronouncements" in turn being based upon the opinions of Experts. Regarding clinical psychological practice, there is no wealth of "evidence" underlying the Expert opinions, simply layer upon layer of recycled opinion.

In the science of psychology, the requirement for *underlying evidence* has been addressed for over one hundred years. Around the end of the 19th century, and running parallel to the pseudo-science of inferring deeper meanings in nearly everything (dreams, slips of the tongue, toilet training in infancy, and the like) Charles Darwin's cousin was quantifying human qualities: inventing the correlation coefficient, formulating the notion of intelligence testing, and otherwise laying the foundations for the present-day gold standard that all "psychology" (our actions, decisions and opinions) should be based not upon thought experiments, nor upon "general impressions", but upon verifiable science:

> *General impressions are never to be trusted. Unfortunately when they are of long standing they become fixed rules of life, and assume a prescriptive right not to be questioned. Consequently those who are not accustomed to original inquiry entertain a hatred and a horror of statistics. They cannot endure the idea of submitting their sacred impressions to cold-blooded verification. But it is the triumph*

> *of scientific men to rise superior to such superstitions, to desire tests by which the value of beliefs may be ascertained, and to feel sufficiently masters of themselves to discard contemptuously whatever may be found untrue*. (6, emphasis added.)

The absence of empirical evidence linking volume of record keeping to practice outcome leaves open the conclusion that the Expert pronouncements on this topic are examples of Galtonian "sacred impressions" which have not been held up to ***cold-blooded verification***. This is not the same as saying that the Expert views on record keeping are "wrong", but in the absence of tangible empirical evidence, where does this leave the clinician and the legal team defending minimalist documentation?

The starting point of an answer might be found in analysis of The Case of Social Contract and Record Keeping**.** An Expert called by the prosecution whom we shall refer to as Professor Integer, tendered his Opinion to a tribunal investigating the adequacy of a psychologist's clinical record keeping. As if to cover the absence of an empirical basis for his Opinion, Prof Integer appealed to a "social contract" - a concept which, while well beloved of social theorists, has little traction in the science-based practice of psychology, and legally is likely assigned the weight of other unwritten agreements: *a verbal contract is not worth the paper it is written on.* (7).

Prof Integer opined:

> *Membership of a profession has many benefits . . . Professions have been described as social institutions established to ensure that members of society have access to specialist knowledge and expertise . . . the privileges can be seen as ways of ensuring that this* ***social contract*** *is strengthened and sustained . . . the* ***social contract*** *implies that by agreeing to avail oneself of these benefits . . . one also agrees to accept the responsibilities that ensue . . . the profession sets the bar in terms of conduct and competence, to ensure that its members practice effectively . . . in regard to record keeping, psychology, as a profession, has in its Code . . . standards required of psychologists . . .* (from Prof Integer's (8) "confidential opinion", **emphasis added**).

Notice that the professor, in emerging from one arbitrarily selected description of "professions", arrives a pseudo-legalistic "social contract", which once having been born, is then deferred to as though it had genuine and acknowledged substance: having credited (at least in his own mind) existence to **The** Social Contract, and having then linked psychological ethical guidelines to **This** contract, the condemnatory Expert Opinion offered by Professor Integer then fell back to dogma: repeating the "assertions" of the various geographically located codes (Australian, British, Canadian, American).

**Sources of wisdom**

The ethical and legal justification of deferring to an Expert Opinion is that such folk are deemed to have had access to a broader range of sources of wisdom than would be true of non-experts. While valuable court (or other legal forum) time should be saved by accepting the Expert's status, it behoves the present, less pressed-for-time review to consider the question *from whence derives the Expert Opinion?* There are three separable vectors of contribution combining to provide the sum of Expert Opinion:

- **Unchallengeable and ethical principles** which, in the present context, includes the principle that psychological opinion (and inferentially opinions about psychological practice) must be based upon tangible evidence. Notice that this fundamental essentially ethical principle itself is not seen as wanting for empirical evidence, and this distinguishes "ethical principles" from other classes of "opinions" and "assertions" and cherished beliefs. The primary unchallengeable principle of psychology is in line with the foremost thinkers of the last few hundred years: that psychological opinion and practice must be based upon evidence.

- **Assertions** which represent a recycling of the five points, themselves assertions, made by the American Psychological Association (APA)[2]. Assertions fall under the rubric of Galton's "general impressions" and thus constitute neither valid psychology nor compelling legal argument.

- **Empirical Data** which, within the limits of current efforts of discovery, does not speak specifically to record keeping in psychological practice, but evidence does exist in a broader setting which may be relevant

Providing some flesh of discussion to the second and third sources of information, an expansion "assertions" and of "empirical bases" follows.

[2]**APA and record keeping**: the five points are commonly referred back to the American organisation, but the present paper does not seek to formally ascribe authorship of the points to the Americans or anybody else.

**ASSERTIONS**

The American Psychological Association (APA) lists five distinct reasons for keeping records, and their ideas are repeated by, or reflected in, the utterances and prescriptions of other jurisdictions. The APA rationale for record keeping goes thus:

> *Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in order to*
> *(1) facilitate provision of services later by them or by other professionals,*
> *(2) allow for replication of research design and analyses,*
> *(3) meet institutional requirements,*
> *(4) ensure accuracy of billing and payments, and*
> *(5) ensure compliance with "law" (that is the requirements of regulating bodies).*

In summary of this point, the five APA-ascribed "reasons" for note taking may, or may not, be "good reasons", but they do not constitute a fundamental, irrefutable ethical platform: they are assertions which are passed without question from hand to hand among Experts. As such, these "reasons" for record keeping do not provide an ethically- nor legally-valid template against which to judge a particular instance of practitioner's notes.

**EMPIRICAL DATA**

By way of contrast to Professor Integer's (8) *unwritten social contract*, it is beyond dispute both in legal precedent and also in public opinion that the role of the psychologist is that of ***a scientist practitioner***, and upon the acceptance of this point, then it is tautological to assert that not just "some portion" but "the full Monty" of psychological practice should be data-based.

The practice of psychology has been well studied over the last century or so, and what is valid psychology has been steadily refined, moving forwards from an initial ***desire*** for tangible, evidence-based practice, to the current situation where evidence-based practice is not merely a "desire" but a ***requirement***. In Australia, for example, the medical rebate system does not provide financial support for practices other than those which are based upon the best (that is, the best to date) evidence based interpretations of what is effective therapy (usually labelled CBT or Cognitive-Behavioural Therapy).

The "scientist-practitioner" model of the conduct of psychology is coherently endorsed by various stake-holders and is defined by professional guidelines, by funding decisions, by professional opinion and also by legal precedent, to relate to experimentally demonstrated and empirically validated notions. This specific position of psychology in Australia is in no way significantly different from that of other English speaking domains (North America, Britain, for example) and is clear in the introduction of a recent review sponsored by the APS:

> ***Evidence-based*** *practice has become a central issue in the delivery of health care in Australia and internationally. . . . . Government sponsored health programs quite reasonably require the use of treatment interventions that are considered to be* ***evidence-based*** *. . . It is appropriate that these are interventions that have been shown to be effective according to the best available research evidence.*(9).

The present writer has not discovered any "evidence" which links record keeping with psychological-clinical outcomes, and essentially endorsing this absence is a manifestly defensive opinion from an Expert in the field under discussion (record keeping, that is):

> *there is an underlying assumption, that every action, decision and opinion of psychologists must be based on empirical evidence. I question this assumption and think that while this principle of evidence-based practice holds true in the main for our assessments, interventions and methods of evaluation, there are many other aspects of any professional practice which . . . are not, need not be, and cannot be expected to be evidence-based.* (10)

However there is a review of evidence to do with record keeping in an entirely different (non-health related) field which is at a minimum interesting. Illustrating that strongly held, even apparently self-evident, views may still fall under Galton's "sacred impressions" and be rejected when put to the test of being data based, Evans et al (11) report: "Although all of the key stakeholders . . . perceived (to varying degrees) direct relationships between poor . . . record keeping and . . . outcomes . . . those perceptions were not always confirmed by the evidence."

**AN ALTERNATIVE EMPIRICAL SOURCE: PUBLIC OPINION**

Given the scientific nature of the discipline, Expert Opinion in the world of psychology should a summary and interpretation of "facts". However in the absence of experimental evidence linking cause and effect, a guiding opinion could be based upon what the users of a service would prefer. A litmus test of what the public would prefer may be derived from either "Common Law Precedent" or from a "survey of public opinion". Both these sources represent a tangible version of the view of the public and thus can represent an important and valid and potentially a compelling underpinning to any otherwise ethereal "general or ethical guideline". Indeed it could be argued that public opinion (whether from survey or the wealth of accumulated thoughtful judgements which make up Common Law) is the final arbiter of the rightness of laws, of regulations, and of other controlling edicts such

as "professional guidelines". These two sources of wisdom (public opinion and Common Law) stand as more or less equal, the one filling in where the other is lacking.

In the case of professional registration and what this means, there exists a public opinion survey which not only uncovers those aspects of professional registration which are deemed important, the survey also ranks the responses of the public in order of the "credibility" of the respondent. Wechsler (12) asked a representative sample of the general public for their ideas on Professional Registration; the answers were then ranked such that the "most correct" were deemed to be those responses offered by the majority of the more intelligent proportion of the population. The advantage of the Wechsler procedure is that it provides "best" and "most thoughtful" and "the most favoured idea of the intellectually elite" version of public opinion. The Wechsler-derived consensus opinions do not include the idea that "professional registration" should be a process which ensures adequate note-taking. The circularity of the argument that a particular style of "record keeping" is an ethical/professional responsibility, or even that there is a Social Contract mandating . . . (whatever the Experts have proclaimed) remains a point which has yet to be underpinned by fact. The public simply does not see "record keeping" in itself as an important professional duty which must be oversighted by the regulating body.

The caution should be sounded that the descriptors of the Wechsler survey results did not include the category of "correct in absolute terms", and this distinction ("correct" as opposed to the "demonstrated consensus opinion") can be seen in another of Wechsler's items – *what is similar about space and time* (13) where the highest scoring responses includes "they are both dimensions" – a proposition which would be regarded as a "type 3 error" and receive a "fail" mark on any physics paper (a Type 3 Error is a blunder beyond probability levels or confidence intervals. When you make a Type 3 Error, then "you <u>are</u> wrong" (14)). The erroneous nature of this response does not prevent it being a view widely held by a majority of "highly intelligent" members of the sampled cohorts in the original (American) domain and further validated by local (for example Australian) confirmation.

In summary of the search for "evidence":

a. No studies linking *Psychologists'* record keeping to clinical outcome have been found.
b. Although the importance of copious records is widely held by Experts, the source of their wisdom remains unclear. The public does not rank "record keeping" as an important aspect of professional practice.
c. Whatever Common Law (at least UK and Australian) has to say on the practice of psychology is in line with the never-challenged (and thus tautologically "universally accepted") proposition that "admissible" (15) psychology should be evidence based.

Finally, it is important to bear in mind the potential legal arguments which would follow if the as-yet awaited research on clinical practice record keeping returns results in line with that of small business. Then – with the benefit of hindsight – it would be argued that any practitioner found "guilty" of "inadequate record keeping" would have been unjustly dealt with and that psychologist's practice harmed by a finding which is based upon a comparison of his/her practice with an ultimately discredited example of what Galton, over a century ago, referred to as "general impressions".

**DISCUSSION**

The self-evident "unfairness" and logical dangers of judging "adequacy" will now be discussed (a) in the light of Natural Justice and (b) from the perspective of top-down or bottom-up evaluation of clinical efficacy. Rounding up the discussion is a glimpse of the legally- and logically-untenable last ditch stand: that whatever Experts say must be right and must be revered and obeyed.

In any investigation of a practitioner's notes, the punitive finding of "inadequate record keeping" would be difficult to justify in the scientific sense given the absence of current empirical evidence, and thus such a finding could only be held by appeal to the legally untenable proposition that a particular empirical result will be found in the future. Alternatively a finding of "inadequate record keeping" could logically be returned if the judging body accorded to itself the right to compare the present case against standards which are not underpinned by empirical evidence. This approach of a judging body according to itself the right to make punitive findings in the absence of tangible evidence and also in the absence of defined criteria (see below) at first glance seems "unfair", and on second glance would equally run afoul of the long established and legally enshrined principles of natural justice.

**NATURAL JUSTICE AND THE ACCUSATION OF UNPROFESSIONAL CONDUCT**

> *"The principles of natural justice are . . . to legitimate, to ensure the acceptability, of the . . . (evaluation) mechanism by requiring rational and even-handed procedures that demonstrate a concern for the individual and for the individual's problems"*
>
> (16)

Eminent legal academic Professor Geoffrey Walker (LL.B., Master of Law, Doctor of Science), has sought a definition of Natural Justice - as it should apply in the Australian context. Walker (16) advanced, as a solid starting point, the six well tested and universally accepted criteria which determine how the notion of Natural Justice should apply in trial or other inquiry proceedings:

> *The (*Nuremberg*) War Crimes Tribunal identified (*six*) aspects of trial proceedings, <u>the absence of which could be taken as proof of the offence of **denial of a fair trial**</u> ... They are:*

*i.* *The right of the accused persons to know the charge against them, and this a reasonable time before the opening of trial*
*ii.* *The right of accused to the full aid of counsel, and preferably counsel of their own choice.*
*iii.* *The right to be tried by an unprejudiced judge.*
*iv.* *The right of the accused to give or introduce evidence.*
*v.* *The right of the accused to know the prosecution evidence.*
*vi.* *The general right to a hearing adequate for a full investigation of the case.*

Walker further developed the notion that Natural Justice applies in any setting where an individual is to be judged. From Walker's perspective it would be in violation of Nuremberg (v) not to provide a psychologist with the ***evidence*** underpinning the template of "adequate record keeping" against which the practitioner's clinical notes are to be compared. And fitting the bones of unfairness with more flesh, Nuremberg (iii) speaks to the proposition that that the judging body cannot be regarded as unprejudiced when that same body "creates" the law, rule or regulation underlying the charges, then interprets the charges as applying to this particular case, appoints its own cronies as Experts, and then decides upon the innocence or culpability of the accused.

The concern raised here is that the Board (investigating a case of supposedly faulty record keeping), is likely presented with at best tainted evidence from Experts who have no verifiable basis for their Opinions, and at worst nothing more than the Board's own opinion recirculated through the Expert. Such a scenario is exactly in line with Judge Latham's opinion (17):
*Accordingly, in my opinion ... the* (decision, action, etc . . . would be) *invalid on the ground that the Executive could not as reasonable men* (sic) *honestly reach the conclusion ...*

**A FINAL DESPERATE COUNTER-DEFENCE BY THE ACCUSERS.**
Assume that the now-challenged Experts would to try to maintain their position thus: ***This is beyond one of Galton's "general impressions". Belief in the need for extensive (if not quite "complete") records is so widespread among our "experts" that there must be some underlying validity in it: you can't fool all of the people all of the time.***

This counter-defence relies upon the principle that "cherished beliefs" which are maintained by "experts" are necessarily based upon "the truth" whether or not the factual evidence of this truth has yet been disclosed. *Cherished Beliefs* exist in other domains too: consider Flu vaccine, and prayer.

The present review has suggested that "right now, current, 21st century" professional-monitoring bodies may be taking a non-scientific and thus unjustifiable approach to the topic of record keeping. At first glance (perhaps revealing yet another cherished belief that in the 21st century we are entirely evidence-bound in our decisions), it is worth noting that at least two other widespread activities are not merely devoid of supportive evidence, but appear to be "unsupported" by available evidence. Each of the topics (flu vaccine, prayer and record keeping) has a strong following with few heretics daring to question the efficacy at the risk of excommunication, or even being burned at a conceptual professional stake. Yes, witch hunting is alive and well in the 21st century.

**<u>Prayer</u>** The true father of the correlation coefficient, Galton (18), examined the benefits of prayer on health and mortality, and concluded there was not only an absence of evidence supporting the efficacy of prayer, but a strong and clear "no benefit" result could be gleaned from the results of an extensive natural experiment:

> *<u>the longevity of clergy, lawyers, and medical men</u>. . . between persons of sufficient note to have had their lives recorded in a biographical dictionary. . . . We are justified in considering the clergy to be a far more prayerful class than either of the other two. It is their profession to pray, and they have the practice of offering morning and evening family prayers in addition to their private devotions, A reference to any of the numerous published collections of family prayers will show that they are full of petitions for temporal benefits. . . When we examine this category, the value of life among the clergy, lawyers, and medical men is as 66.42, 66.51, and 67.07 respectively, the clergy being the shortest lived of the three. Hence the prayers of the clergy for protection against the perils and dangers of the night, for protection during the day, and for recovery from sickness, appear to be futile in result*

Still today little is done to discourage what Galton concluded was a waste of effort.

**<u>The efficacy of flu vaccine</u>**, particularly in its present use of specifically targeting those at risk of death from influenza, has been assessed. Not merely a controlled experiment, not even a large representative sample, but the whole population of data have been analysed to conclude that there is zero benefit conferred to those at risk of death by influenza. Inferentially then, it might be reasonable to guess that there may be the same zero level of

benefit availed to those who are not at risk of death from flu: *Therefore, no obvious link existed between trends in vaccination and our results* (19), where "our results" refers to the analysis of total national "death by influenza" data in Australia, USA and France.

**CONCLUSION**

The "adequacy" of case notes in psychotherapy has been discussed in the present review. The arguments contained herein do not seek to eliminate record keeping from the duties of professionals (including therapists) but seeks to make the point that record keeping, along with any other definable components of psychological practice, needs to be formally linked to therapeutic outcome, or to the more general issue of "protection of the public" which (from data presented herein) is an established requirement of professionals which is endorsed by the non-silent majority.

So, although public opinion confirms that protection of the public is an important component of the registration machinery, the circularity of the argument that a particular style of "record keeping" is an ethical/professional responsibility solely because experts hold this as a "cherished belief" remains a point which needs to be proven, not merely asserted. The present review has glanced at record keeping in small business, but any "evidence" or findings from another domain are not necessarily compelling for the psychological therapeutic situation. Physical medical practice may make an appealing comparison with psychological practice, however much of the physical medical practice involves tangible (effectively "third party") components (drugs, prosthetics, or other invasive procedures. Psychological counselling is not necessarily analogous with small business nor with the practice of physical medicine.

In conclusion, the strength of the present discussion of prevailing assertions about psychological record keeping derives from the following features:

1. It does not rely upon some proclaimed special status of the writer as an "expert" in a field which is neither defined nor empirically investigated.
2. It makes no assumptions and relies upon no assertions outside the requirement that psychology practice (and therefore the auditing of psychology practice, and the standards up to which a practice is held in audit) be evidence based – and that requirement derives directly from Common Law (15), and is in not only line with present day professional opinion, but flows from over 150 years of steady development of empiricism in psychological practice.
3. It does not place weight upon the distraught responses of a clinician under duress.
4. It does not place weight upon "sacred impressions", however broadly held or stridently proclaimed.
5. It does not seek to define the level of detail that psychologists should (or should not) keep in records, but does aim to remind the reader that the judgement of the "adequacy" of records can only be achieved by either the top down question (*is there a valid and supported negative outcome which in turn hangs upon the record keeping practices?),* or the bottom up method which requires that each and every separable component of practice be compared against the as-yet unestablished empirical evidence base.
6. The writer's own professional view and/or practice of clinical record keeping, and the writer's personal view of prayer or influenza vaccination, is advanced neither implicitly nor explicitly.
7. The need for appropriate research is highlighted.

Taking into account the reliance upon *sacred impressions* of our Experts, in the near future any prudent practitioner will keep a tangible and permanent archive of each session – and it is recommended that this recorded memory should be at least "sufficient" for the purposes of deflecting criticism while not potentially violating the ethical duty to protect the client from future malign external perusal of such notes.

Looking to the longer-term future, it is the writer's prayer, and as well it is surely for others a *duty,* that some courageous clinical psychological academic will sponsor the search for any link between clinical outcome and record keeping.

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