

## Medical Liability Issues: Admissibility of Habit Evidence

AN EVIDENTIARY ISSUE that arises in many medical liability cases concerns the ability of defendant doctors to testify at trial to what they think, but cannot recall, happened based on so-called "usual medical practice."

Injured patients often place a high emotional value on interactions with doctors and can recall them in detail. In contrast, physicians often do not recall years later their clinical interactions with a specific patient. In the face of a physician's lack of specific memory of an event, especially if the medical chart is silent on the issue, should a doctor be allowed to testify about what happened based on claimed usual practice?

The answer depends on an analysis of the specific facts under evidentiary rules 602 and 406 with the result being that the testimony is least admissible if it lacks support in the medical record and recounts an exercise of clinical judgment, rather than implementation of an administrative routine. Rule 602 provides:

A witness may not testify to a matter unless evidence is introduced sufficient to support a finding that the witness has personal knowledge of the matter.

Perception and memory are the most common source of "personal knowledge" under the Rule. As one court has noted:

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In determining whether a witness is to be excluded because of a lack of testimonial qualification three processes are involved: First, it must be determined whether the witness has observed the incident about which he proposes to testify

and has received some impressions which he seeks to relate in court; second, whether the witness has a recollection of those impressions resulting from his observation which fairly corresponds with or reproduces the original knowledge or observation; and third, whether he is able to communicate this recollection to the tribunal.

Physicians, without memory of the specific events and no entry in the medical chart to refresh their recollection, without more, cannot be said to have "personal knowledge," permitting their testimony as to how the events occurred.

Nonetheless, physicians may be allowed to testify if their claimed "usual practice" satisfies the requirements of Rule 406. This rule allows the introduction of "habit" evidence to prove that conduct on a particular occasion was in conformity with the habit. To qualify as "habit," the conduct, according to the Reporter's Notes for the rule, must be "a regular response to a repeated specific situation." As attorney Douglas notes in his

*New Hampshire Evidence Manual*, habit is a "semi-automatic" response. Similarly, Professor Wigmore states that habit must involve "an invariable regularity of action." Indeed, as courts have noted, it is this "nonvolitional" character of habit evidence that makes it reliable.

Rule 406 thus permits the introduction of evidence of true habit, that is, actions which, due to their long repetition, have become reflexive, instinctive, and nonvolitional. A physician might establish that some administrative or ministerial acts in providing care have become so routine as to be true habit, such as putting on gloves before certain procedures, always checking the reflexes of the left or right side first, or always using the same implement for some procedure.

In contrast, certain tasks, due to their inherent need for the application of medical judgment to the specific clinical facts cannot be considered to be nonvolitional habit. For example, communicating the risks of surgery to a patient, assessing a patient's suitability for hospital discharge, or rendering a differential diagnosis by necessity require the exercise of judgment on the part of the physician. In these and similar cases, especially where there is no supporting reference in the medical chart, permitting the physician to testify to a claimed "usual practice" is out of keeping with the intent of the rule.

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