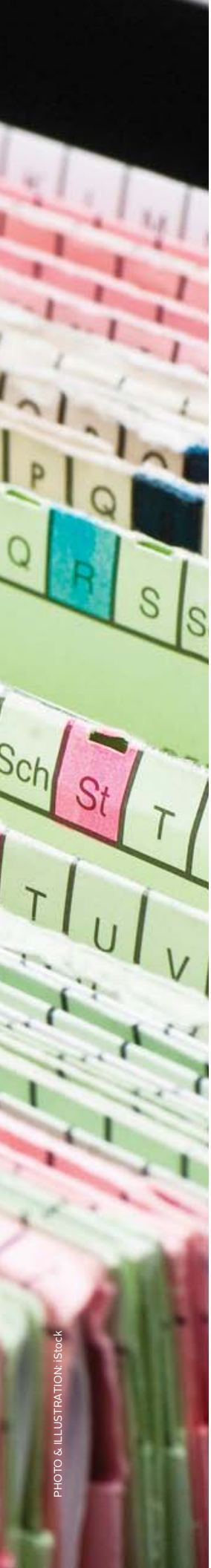

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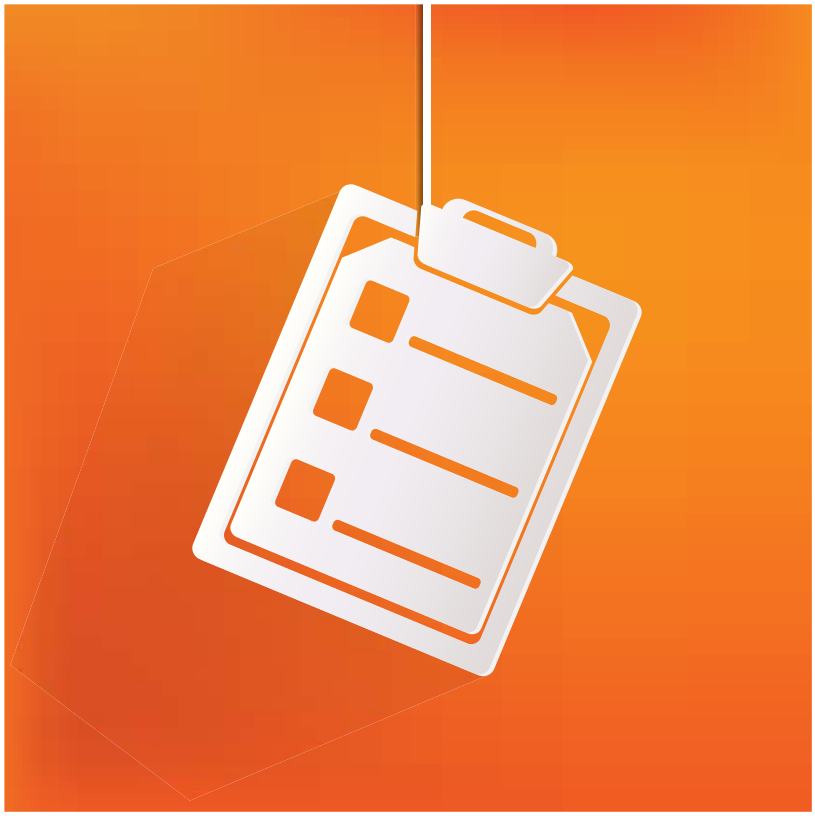

Clinical records can play a large role in a legal proceeding and many practitioners wonder how their records are used, and how they can improve their record keeping to facilitate the interpretation and use of their notes in a legal matter.

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Why are your clinical records being requested by legal counsel?

MANY MEMBERS ARE NOW RECEIVING REQUEST TO PRODUCE THEIR PATIENTS' CLINICAL RECORDS TO THIRD PARTIES, SUCH AS LAWYERS. Because of the variety of different avenues by which records can be requested, it is important that your records remain detailed and complete. Not only can patient records be compelled in the context of a legal proceeding or a complaint to a regulator initiated by a patient, but they can also be requested by third parties. For instance, a patient may have sought physiotherapy treatment following his or her involvement in a motor vehicle accident or a slip-and-fall on icy city sidewalks and has decided to sue the other individual or the municipality involved in the accident. If a plaintiff is seeking compensation for the injury, also known as "damages", their state of health will be an important issue and copies of their clinical records will be requested from all treating healthcare practitioners.

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Why are patient charts requisitioned?

Not only do clinical records help establish an objective factual chronology, but they can be used to determine and either bolster or detract from a patient's claim for financial compensation during a legal proceeding.

Think of your patient records as a non-fiction book chronicling your patient's story with you as the author. It is your job as the author to commit an accurate and chronological account of your patient's story to paper. If something is not recorded in the book, it will not be conveyed to the reader, and the overall picture

may be skewed. Records are not just for the use of the author who can rely on his or her memory to fill in missing gaps in the story. The purpose of clinical records is to accurately represent a patient's health status, health history as well as current issues and treatment plans so that other practitioners can pick up and continue to implement the author's treatment plan in his/her absence.

In a legal proceeding, the individual bringing the claim (the "plaintiff") must establish the injuries that they have sustained and demonstrate the impact that they have had on their lives. These injuries can be emotional, physical, psychological or financial in nature. The general rule when awarding damages to a plaintiff in a case is that the compensation should put them back in the position that they would have been, had the wrong, or injury, not occurred. In a contract situation where a quantifiable amount has been lost, this process can be rather straightforward. It becomes more difficult to determine appropriate damages when a plaintiff has suffered physical, emotional or psychological injuries which are difficult to quantify. Courts will look to other cases where similar injuries have occurred to assist them in the determination of a range of appropriate damages awards. Central to this analysis will be the current state of the plaintiff, and their state post-accident or injury. For the purposes of our discussion, this would be an analysis as to the pain and suffering sustained by the plaintiff, and their state of health at the time of trial.

What are lawyers looking for?

When reviewing clinical records, lawyers are looking for information which will either support their client's position, and refute the position put forward by the other parties in the litigation.

In a case where a patient puts their health in issue, lawyers for the Defence will review the records for pre-existing conditions which contributed to the patient's alleged injuries and therefore, treatment records prior to the accident may also be compelled. Lawyers will review a patient's pre-accident treatment to determine what limitations existed and how their life was affected (i.e. absences from work) prior to the date of the incident. If the patient only saw the physiotherapist after the accident, they will review the records to determine if the complaints made in the litigation are supported by the notes made by the physiotherapist. A review will also be conducted of the patient's progress over time. The degree to which they have recovered from their injury may curtail the amount of damages that they may recover at the end of the matter.

In a legal dispute, a patient has a legal obligation to minimize, or "mitigate", their damages. Accordingly, lawyers will review the records for signs that the patient is not following the prescribed exercise or treatment plan, or has been frequently missing or cancelling appointments. It is therefore important that such information be recorded clearly in clinical records.

Interactions from patients which did not occur in person must also be recorded and are helpful to lawyers when reviewing clinical records. For example, if a patient has called or e-mailed the office to advise that their symptoms have been exacerbated following the introduction of a new treatment or exercise, this information should be clearly noted in their file.

Here are some further examples of what lawyer's look for in clinical records:

- The objective observations of the physiotherapist as well as the subjective complaints of the patient. A patient's subjective understanding of their limitations and progress is important. It is especially important to have both the subjective patient opinions as well as your objective views noted in the event that they do not concord with one another.
- How the plaintiff has described limitations on their life due to their injuries or chronic conditions.
- Whether the injuries with which a patient is presenting are chronic in nature, or acute following a recent trauma. If a recent trauma has exacerbated pre-existing issues, this should be noted as well.
- The treatments and modalities used on the patients must be clearly noted in the file. Their corresponding informed consent should also be clearly recorded.
- Information as to whether the at-home exercises are being completed and to what success should be recorded.
- An analysis of how a patient's health status has progressed or changed since treatment began for that issue should also be frequently noted.
- The support personnel's identity and an accurate description of the treatment provided by them, should support personnel be involved in the treatment of the patient. Whether you were present during the administration of this treatment by support personnel should also be noted.
- Whether patient has been required to miss work or school as a result of their injuries.

Additional information which may not immediately seem relevant to your treatment may ultimately help explain information noted later in the chart

Always remember that your records allow someone to obtain a snapshot of a patient's health. If information is missing, it may colour the reader's view of the story as it unfolds. Additional information which may not immediately seem relevant to your treatment may ultimately help explain information noted later in the chart. For example, a court will view a patient who is missing their appointments due to disinterest in their treatment and recovery differently than they will view an elderly widow who lives far from the clinic and misses her appointment as she is reliant on others to drive her into town to receive treatment. Therefore take the time to note additional information such as medications being taken, diagnoses given by other medical professionals, results of diagnostic tests, as well as the patient's support system and living situation. This information is helpful in documenting the patient's story. The source of this information should also be clearly noted: i.e. the name of the physician who has provided a diagnosis or prescription.

How can you improve the quality of your records?

Simply following the standards of practice and guidelines related to record keeping[1] will assist lawyers tremendously in their review and analysis process.

- Be as detailed as possible.
- Keep shorthand and abbreviations to a minimum. Should you use shorthands, ensure that all abbreviations have been previously defined in the record for reference.
- Sign and date your notes so as to be properly identified and to allow treatment to be appropriately attributed to the correct person.
- Note objective observations as well as subjective presentation as stated by patient.
- Note any questions asked by the patient.
- If you need to make a change or addition, mark them clearly.

Finally, the most crucial item to keep in mind is: **Legibility! Legibility! Legibility!** Your story is of no value if no one can read it.

1 Standards of Practice and Guidelines for record keeping of the Colleges of Alberta, Manitoba, Ontario and Nova Scotia were consulted.