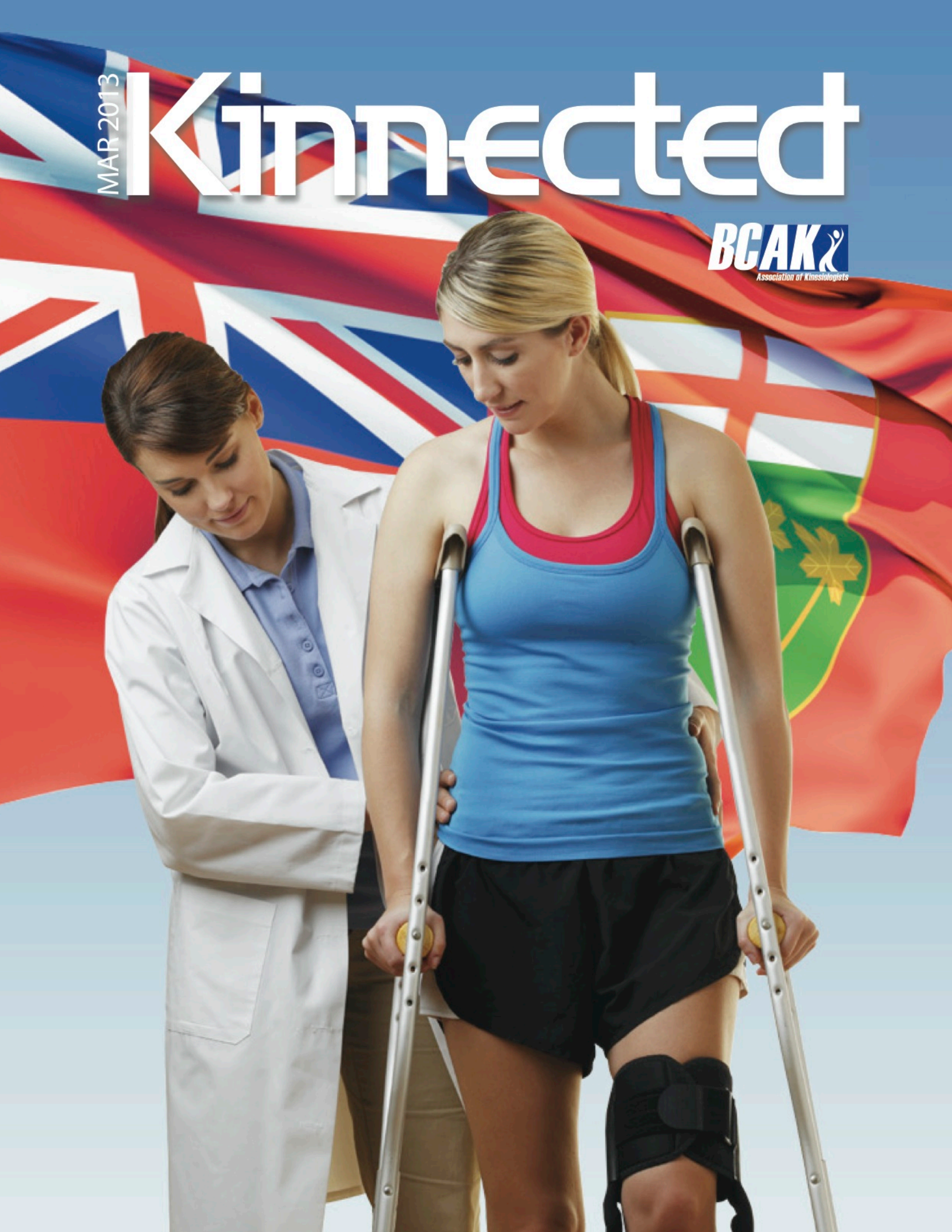
MAR 2013

Kinnected

BCAK
Association of Kinesiologists



PROFESSIONAL CORNER

THE IMPORTANCE OF TREATMENT RECORDS

David J. Wallin, Barrister & Solicitor, Director, *Whitelaw Twining Law Corporation*

There is no doubt that the principal purpose of any treatment record or chart note is to assist in providing the patient with quality care and treatment continuity of such care. However, treatment/clinical records are also useful for several other important purposes, which should not be overlooked by the busy healthcare practitioner.

There are numerous benefits to the practitioner and the patient alike when the treating professional maintains careful clinical records in the context of their care and treatment. A very common and good example of this often arises when the clinician is involved in the treatment of a patient who has received an injury following an event such as a motor vehicle accident, which may lead to potential litigation.

It is well known that when a patient's injuries arise within the context of a motor vehicle accident, there is an increased prospect that the patient's treating records will be required to be produced as a "relevant" treatment record within the context of the litigation. Such production will generally not only include the patient's post-accident treatment records, but in many cases will also involve the production of the patient's pre-accident records. The extent and length of the patient's pre-accident records is highly variable and is generally dependent upon the factual circumstances of the case. This subject is unfortunately beyond the scope of this discussion.

Insurers, case managers, insurance adjusters, claims representatives and lawyers love reviewing your clinical records. This typically arises in the context of your treatment of a patient that has been involved an incident that is the subject of bodily injury litigation. These records are reviewed, interpreted and scrutinized in considerable detail. While what is being looked for is also beyond the scope of this discussion, two of the matters that are often being considered are both the patient's complaints and the patient's treatment progress. Such a review will often serve as support for the consideration of denying, granting or extending the treatment funding for the patient.

In the event that your patient's injuries are due to the negligent conduct of another party (most commonly as a consequence of a motor vehicle collision), such records will frequently be considered and utilized in relation to accessing treatment funding and benefits that may be available to motorists involved in motor vehicle collisions.

Such treatment records are also carefully scrutinized by these same individuals in relation to determining the veracity and consistency of patient complaints, as well as in determining the existence of complaints and the emergence of secondary injuries or conditions that may develop following a traumatic insult.

To the extent that a thorough history is not obtained from the patient at the early stages following such a traumatic insult, the lack of clinical notation of such complaints in the healthcare professional's treating records is often used in the course of litigation to seek to refute a patient's complaints, or the existence of such complaints following such an injury.

Such unintentional and inadvertent lack of reference in the clinical records will frequently lead to certain presumptions in the minds of the readers that can often be difficult to overcome for the patient. Such matters will often make the patient become the subject of credibility challenges in the context of ongoing litigation. In this regard, patients (and even clinicians), can be and will often be challenged in the context of their bodily injury claims if the treating professional's records are "silent" with respect to a discreet complaint. As such, at least in the context of ongoing litigation, an absence of reference to the complaint in the clinician's treating records is often utilized for the purpose of seeking to establish a presumption that the patient did not actually experience such a complaint during the course of treatment.

Perhaps it goes without saying that in numerous circumstances such an interpretation can lead to erroneous assumptions and unfortunately potentially dire consequences to the Plaintiff. In this respect, this presumption is only as valid as the extent that a careful and comprehensive history was both obtained by and recorded by the practitioner.

Accordingly, best clinical practices dictate that a thorough medical history of the patient should be taken by the clinician upon patient intake, particularly where the prospect of scrutiny and review from "outsiders" of the patient's care is concerned.

For example, a client that has been involved in an acceleration / deceleration collision motor vehicle accident are well known to commonly experience cervicogenic headaches as a consequence of or secondary to injury to the musculo-ligamentous structures of the neck. Similarly, such patients may also experience vestibular-type complaints with respect to complaints of dizziness, loss of balance or vertigo complaints, as well as auditory changes, which may be secondary to possible jaw injuries and are also well associated with the accident dynamics of a rear-end collision.

Such thorough history taking at the outset of treatment will both assist the clinician and other healthcare professionals that may be involved in the patient's care. Such records can assist to obtain a clear clinical picture with respect to the nature and extent of the patient's injuries and corresponding clinical diagnoses, as well as assist in developing a rehabilitation treatment plan for the patient and possible referrals to other allied health professionals and assisting the patient's family physician with treatment recommendations.

The benefits of a thorough and complete clinical record are of great assistance to clinicians and patients alike. Clinicians should be encouraged to consider the use of their records by others outside the context of principal patient treatment.