# THE IMPORTANCE OF PHYSIOTHERAPIST'S TREATMENT RECORDS: A LEGAL PERSPECTIVE

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

**The primary purpose of physical therapy treatment records and chart notes is to assist in providing quality care and treatment continuity for patients. It is critically important for physiotherapists and other frontline treating professionals to also understand these records are used (and often misused) in injury claims and bodily injury litigation.**

Practitioners and patients all benefit when there are careful, accurate and comprehensive clinical records. A common and good example of this is when a clinician is involved in treatment of a patient injured in a motor vehicle accident or workplace injury going through an ICBC, disability or WorkSafeBC claim. In these cases, patient records are usually required as part of the claims process or for any subsequent bodily injury litigation. These records may include post-accident and pre-accident clinical records from a full range of treating clinicians – with the breadth and depth highly variable and dependent on the factual circumstances of the case.

In British Columbia, two years of pre-accident clinical records is generally considered sufficient to obtain a sense of the patient's pre-accident clinical status, but absent extenuating circumstances may warrant a larger request.

Insurers, claims managers, insurance adjusters, claims representatives, and lawyers love reviewing and interpreting clinical records and this review process often yields strange results. The reviewer often "sees what they want to see". During bodily injury litigation especially, clinical records are reviewed, interpreted and scrutinized in considerable detail to determine the veracity and consistency of patient symptoms, complaints and reported disability. Records are also used to determine secondary injuries following a traumatic injury.

Reviews are used to deny, grant or extend treatment funding for patients. If injuries are due to the negligent conduct of another party (most commonly as a consequence of a motor vehicle collision), records are used to access treatment funding and Part 7 accident benefits for motor vehicle collisions.

What are they looking for? Three key issues that come up in this process are: a patient's subjective injury complaints (pain and limitation); documented treatment progress; and indications that current symptoms are related to a pre-existing injury or of non-traumatic origin (i.e. degenerative).

Without comprehensive and concise clinical notes, patient complaints and symptoms could be challenged; unflattering presumptions could be made in the mind of the record reviewer; and credibility could come into question. This is difficult to overcome.

It becomes even more of an issue when records are "silent" because of a discreet symptom or complaint (which may not even be the subject of primary treatment). "Leaving out" patient complaints, in the eyes of the law, means that the patient did not actually experience it.

This scenario could lead to potentially serious consequences within the injury claims process, but presumptions are only valid to the extent that careful and comprehensive clinical history was both obtained by and recorded by the treating clinician.

For example: A patient has been involved in a rear-end collision and experiences the onset of cervicogenic headaches as a consequence of, or secondary to, injury to the musculo-ligamentous structures of the neck. These patients may also experience vestibular-type complaints (dizziness, loss of balance, vertigo) and auditory changes (jaw/TMD injuries) associated with accident dynamics of a rear-end collision. In this example, a lack of reference or express documentation of these adjunct symptoms in patient treatment records will often raise the spectre of doubt, unwittingly leading to unfortunate outcomes through the legal process.

Best clinical practices dictate that a thorough patient history should be taken at the outset of treatment to obtain a clear clinical picture of injuries and corresponding clinical diagnoses; to develop rehabilitation treatment plans; to determine referrals to other allied health professionals; and to assist a patient's family physician with treatment recommendations.

The prospect of scrutiny and review from "outsiders" to the patient's care is always a possibility, and in this case the accuracy of patient information becomes even more critical. With this in mind, clinicians are encouraged to consider the use of their records outside of principal treatment — and take notes accordingly. It is in everyone's best interest to do everything possible to assist patients in overcoming the hurdles of a potential accident/injury claim by keeping thorough and indisputable clinical records.