MEDICAL RECORDS - WHAT TO GET AND HOW TO GET THEM

By: Duncan Embury – Torkin Manes LLP and
John Morris – Borden Ladner Gervias LLP

Introduction

Medical negligence can occur in a number of settings and in a seemingly infinite variety of different scenarios. Regardless of the setting involved and the specific facts at issue, one thing is constant: the medical records will be the most critical documents in the process. The case cannot be properly evaluated, much less properly prosecuted or defended without a thorough understanding of the relevant records. Accordingly, it is imperative that counsel fully understand the various types of records which may be available, how and from where to obtain them and how to properly review and evaluate the information contained in the record. It is also important to know what is **not** in the medical records and what other documents have been created that may some bearing on the care of the patient.

The primary function of a medical record is to provide an outline of the patient care plan and allow continuity of care amongst the various caregivers. It is always worthwhile to keep this purpose in mind as one evaluates the records and considers what other contemporaneous records may exist.

Which Records Should be Ordered

From the Plaintiff perspective, during the initial consultation with your client, it is important to fully explore the sequence of events that lead up to the alleged negligence as well as all treatment which has been received as a result of the alleged negligence. The following may serve as a useful checklist in order to ensure that you have thought about and canvassed all relevant sources of information with the client.

1. Client name _____. Health Card number _____

2. Family doctor for the five years previous to the incident at issue

3. List of other physicians or other healthcare practitioners seen either independently or on a referral basis during the five years preceding the incident at issue

4. List of all hospital admissions in the five years preceding the incident at issue

5. Does the case involve laboratory tests and their interpretation. If so, what laboratory did the patient typically visit

6. A printout of the pharmacy records for the five years preceding the incident at issue

7. All relevant ambulance records;

8. A complete copy of all hospital records. Keep in mind that some portions of the hospital record may be kept separately ie, fetal monitoring strips, diagnostic imaging, maternal versus newborn records

9. A complete copy of the office charts of any involved specialists

9. Did the client undergo any diagnostic imaging? If so, what and when?

10. A list of all hospitals and rehabilitation facilities that the client has attended since the incident in question

11. In the case of death, a complete copy of the coroner's file including any post-mortem examination and any coroner's investigation statement. In the case of a child, was the Paediatric Death Review Committee involved and was a review undertaken?

12. An OHIP decoded list of services.

13. Did the client keep any contemporaneous notes of interactions or discussions with doctors or other health care professionals

The following points are offered for the reader's information in terms of what should be contained in the above list of records and to highlight the importance of some of these sources in understanding and evaluating the alleged negligence at issue.

Be specific when requesting hospital records to ensure you are provided with the patient's complete record. For example, the Ambulance Call Report and fetal monitor strips are not typically included in the "hospital record". The hospital records, from the Admission Record through to the Discharge Summary will provide a chronology of the events which have taken place during the relevant period of time. The records should be reviewed as a whole, with a view to cross-referencing the timelines to confirm whether there was any gap in the documentation or in the care that the patient received.

Hospital records will assist in identifying the names of treating physicians and nurses and radiologists involved in the patient's care during the relevant period. Many hospitals have a signature record which identifies the names and signatures of all of the nurses who were involved in the patient's care. If such a document is not included in the hospital record, it may be worthwhile to inquire separately of the hospital as to whether such a record exists. Similarly, a review of the family doctor's records will assist in identifying outside specialists and treating facilities.

Physicians' clinical notes and records of office visits can be either handwritten or electronically generated. The originals of any treating physician's clinical notes and records should be available for inspection at the discovery stage so that any apparent changes can be identified. Since electronic records can be modified, ensure that you specifically request any audit trails associated with those records.

Ensure that all relevant diagnostic imaging has been requested from the treating hospitals or independent facilities.

Also specifically request that the hospital, treating physicians or facilities ensure that all records, imaging and pathology are preserved until further notice.

Always request an up to date OHIP decoded list of services from the Ministry of Health and Long-Term Care. The decoded list of services is very helpful in identifying all physicians who have treated the patient. This information can then be cross-referenced to the physician's clinical notes and records. Please note that the Ministry of Health will provide a maximum of seven

years of records, and that records after April 1st of the seventh year are purged. Also note that the cost of obtaining these records are $20.00 for each year or part year.

Whenever potential medical negligence results in the death of the patient, autopsy reports should be obtained. When dealing directly with the Office of the Chief Coroner, ensure that you request both the Report of Postmortem Examination and the Coroner's Investigation Statement which will include a narrative of any interviews conducted by the coroner with family members, treating physicians, hospital representatives, etc. It will also include a summary of events and recommendations.

Additional Records

During the initial interview with your clients, explore whether concerns were ever brought to the attention of a hospital. If so, all related documentation should be requested through the Patient Relations Office of the Hospital[1]. Records requested should include (but not be limited to) any exchange of correspondence, written complaints, notes of telephone discussions, emails, communications or discussions with the patient, family members or treating physicians.

In some cases, the client may have already filed a complaint with the College of Physicians and Surgeons of Ontario. Where a CPSO investigation is undertaken, the College will independently obtain the patient records as well as responses from the doctors involved and potentially statements or information from other third parties. This information is not admissible in a subsequent civil proceeding pursuant to section 36(3) of the *Regulated Health Professions Act.* However, the documentation contained in the CPSO record may be a fruitful avenue of inquiry. It should be noted that once a decision is made by the College, if a review is requested before the Health Services Appeal and Review Board, the parties to the complaint will be provided with a full copy of the record generated by the College.

Incident Reports

When unusual incidents occur within a health facility that place patients or staff at risk, an incident report must be completed. Generally, the report describes the incident, the surrounding events, any resulting injuries and the corrective action taken. The incident report does not ordinarily become part of the patient record. It is an internal document, the primary purpose of which is to provide data to the health-care institution so that it may monitor, from a risk-management and quality-assurance perspective, actual or potential sources of harm to individuals.[2]

---

[1] There may be other names for this particular function. A hospital may have an ombudsperson or other person or office with a similar role. It may be difficult to obtain this information before litigation is commenced, but it should be considered as an appropriate production by the hospital once there is litigation.

[2] It should be noted that in at least one case, a court suggested that the incident report *should* form part of the "medical record." In *Fiege v. Cornwall General Hospital* (1980), 30 O.R. (2d) 691, 117 D.L.R. (3d) 152 (H.C.J.), the hospital, in a malpractice proceeding, took the position that the incident report should not form part of the medical record. Carruthers J. stated, however, that the "document should have formed part of the medical record because either it is a report of a 'physical examination', 'medical examination', or a 'progress note'. Reports of these examinations, by the provisions of s. 38, are required to be included in a patient's medical record." The decision focused on whether the hospital should have produced, prior to trial, a copy of the incident report and whether the hospital was entitled to claim privilege for it. It is not

Incident reports often involve patients and the incidents described may result in litigation. Such reports are made in the ordinary course of business, often for quality improvement purposes, and are very rarely made solely or predominately for the purposes of litigation.

Peer Review and Quality Assurance Documents

In *Steep (Litigation Guardian of) v. Scott*,[3] a medical malpractice action arising out of the birth of a child who sustained severe brain damage, the child's lawyer sought disclosure of two memoranda prepared by senior physicians at the hospital (who were not involved in the patient's care) about the events surrounding the birth, and the hospital refused on the grounds that they were "quality assurance reports" or "peer evaluations." In its decision not to order disclosure, the court emphasized the importance of quality assurance reports remaining confidential, given the expectation of those involved in such reviews that they will remain confidential. The process depends upon open and candid communication that only comes from the knowledge that such communications will be held in confidence. The judge commented that:

> the free exchange of information, promoted by confidentiality, goes to the very core of successful quality assurance reviews leading to the improvement of quality of care. It is in the public interest that hospital care and services are effectively assessed and improved to ensure a continuously improving quality of health care.[4]

However, the hospital was still obligated to provide the underlying facts contained in the documents to counsel, if requested. Therefore, it is important to determine whether such documents exist, and if so, to obtain any facts that add to or differ from the medical record.

Courts in Saskatchewan have broadened the potential admissibility of reports that do not form part of a patient's record to include minutes and notes that are prepared for Quality Assurance Committee meetings. In *Lancaster v. Minnaar*,[5] a patient sought access to unedited minutes of the Hospital's quality assurance committee meetings and unedited notes made by a nurse for the purposes of the same meetings. In her analysis of the patient's request, Madame Justice Gunn reasoned that privilege would attach to the documents if the court was satisfied that the facts recorded in the minutes and notes were also contained in medical and hospital records prepared for the care of the patient.[6] If, however, the documents contained any facts that were not fully recorded in the medical records prepared for the purpose of providing care to a patient, then these facts would need to be disclosed. In *Lancaster*, three facts were contained in the minutes but not in the records. The court held that the documents were admissible but only to the extent that there were edited to reveal the undisclosed facts. Justice Gunn reasoned that editing the

---

clear that the judge intended to suggest that the incident report should be kept with the patient chart or that it had any treatment purpose, only that unless there is a justifiable claim of privilege, the record must be produce if relevant to the particular proceeding.

[3] (2002), 62 O.R. (3d) 173 (S.C.).

[4] *Ibid.* at para 26.

[5] 2006 SKQB 380, 288 Sask.R. 31 (WL) [*Lancaster*].

[6] *Ibid.* at para. 21.

document would satisfy the need to get at the truth and avoid injustice while still permitting the quality assurance committees to achieve their mandates.[7]

Electronic Records

In considering retention and production obligations it is important to distinguish between records that are originally created and maintained electronically (e.g. e-mails, draft documents, power point presentations, etc.) and communications that are originally created and maintained in paper format which are subsequently transformed into electronic data (e.g. through scanning or transcription). Many hospitals and health facilities are moving to "real time" electronic record-keeping that is in digital from. A "print-out" of the record may give a different picture than viewing the digital record in dynamic form. In some cases, it will be important to obtain access to the actual software used to create the digital documentation (Meditech is a supplier used by most hospitals in Ontario) in order to understand how the record relates to the events under scrutiny.

Policies and Procedures

All hospitals maintain policy and procedure manuals. In most instances, such policies and procedures are now maintained and organized electronically. The manner of organization may differ between different institutions, but generally, the hospital will have a main policy and procedure manual which contains policies which apply on a hospital wide basis and will then have separate manuals which cover individual departments or services within the hospital. As part of the documentary discovery process, you should consider requesting copies of any policies which relate to issues raised in the litigation. As well, request a copy of the indexes to all policy and procedure manuals which existed at the time of the events. This will allow for a full review of the indexes to determine if there were other policies in effect which might be relevant to the inquiry.

The importance of hospital policies should not be underestimated. They provide a framework and a standard by which the care provided can be measured. For instance, consider a case where the central issue is whether the physician or nursing staff responded in a timely or appropriate way to changes in the patient's blood count. The hospital will have a policy which governs the turnaround time for laboratory testing. It should also have a laboratory policy which governs the reporting of abnormal laboratory tests and the processes which need to be followed in the event of critical results.

Cost of Records

In October 2010, the Information and Privacy Commissioner of Ontario issued Health Order HO-009 after an investigation into a patient complaint regarding the fee charged for access to her records. This Order sets a precedent regarding the issue of "reasonable cost recovery". Both the Ontario Medical Association and the Ontario Hospital Association submitted representations.

---

[7] *Ibid.* at para. 38

Order HO-009 states that the fee to be charged for access to records is now **$30.00 plus $0.25 per page for each page over 20 pages** for the reasonable cost of copying, printing, reproducing or transmitting medical records. Despite the acknowledgment of both the OMA and OHA which have recommended that this Order be followed, there continue to be hospitals in Ontario who continue to charge prepayments of as high as $200.00 for the first 20 pages, and $1.00 per page. This could mean a difference between a disbursement cost to your client of $1,200.00 for 1,020 pages and $280.00.

Prior to requesting hospital records, make enquiries to determine whether the fees being charged are in line with the IPCO Order. In some cases, a physician may attempt to charge an exhorbitant fee for the cost of reviewing and photocopying his records. Bringing the above-noted Order to their attention may

Retention of Records

Some cases of medical negligence require review of records which are a number of years old. It is extremely important to note the differences in the length of time hospitals and independent health facilities are required to retain records. Hospitals are required to retain health records at least ten years after the date of discharge and imaging (excluding mammography) for at least five years after the day on which the image was created. Independent health facilities are only required to retain health records for six years and diagnostic imaging (excluding mammography) for three years following the patient's last visit. Mammography must be retained by hospitals for ten years after the day on which the image is created, and by independent health facilities for ten years after the patient's last visit.

How to Review Medical Records

It goes without saying that in order to properly review the medical records, it is imperative that one has the necessary background knowledge of the underlying medical condition, its typical presentation and symptomology and the appropriate tests, differential diagnosis and considerations that should be brought to bear. In the event one is any doubt as to whether they have a sufficient knowledge base to conduct a review, it makes good sense to obtain outside assistance. This can be done through the retainer of medical consultants, review of relevant text books and literature and/or consultation with other counsel who may be more familiar with the medicine at issue.

Always conduct a detailed and careful review of the nursing progress notes. Nurses typically see and assess the patient more often than physicians and their notes can provide useful information in many different relevant areas including when various symptoms actually started, when physicians were paged and responded, what the patient's vital signs were and how they changed over time, to name just a few.

It is also important to ensure that you have fully cross-referenced all of the records. In the event that the physician orders indicate that an MRI was ordered, was the MRI done and what were the results of it. In the event that the relevant laboratory results indicate an increase in the white blood count, was this noted in the progress notes, were any relevant physician orders made. In the event that a radiologist or other consultant recommended a further test, procedure or consultation, was this recommendation carried through and what were the results. These types of inquiries and cross referencing appear self-evident, but again require that the reviewer have both

the necessary medical knowledge and a thorough grasp of all of the various types of records that get generated and conduct a full review of these records.