the Verdict

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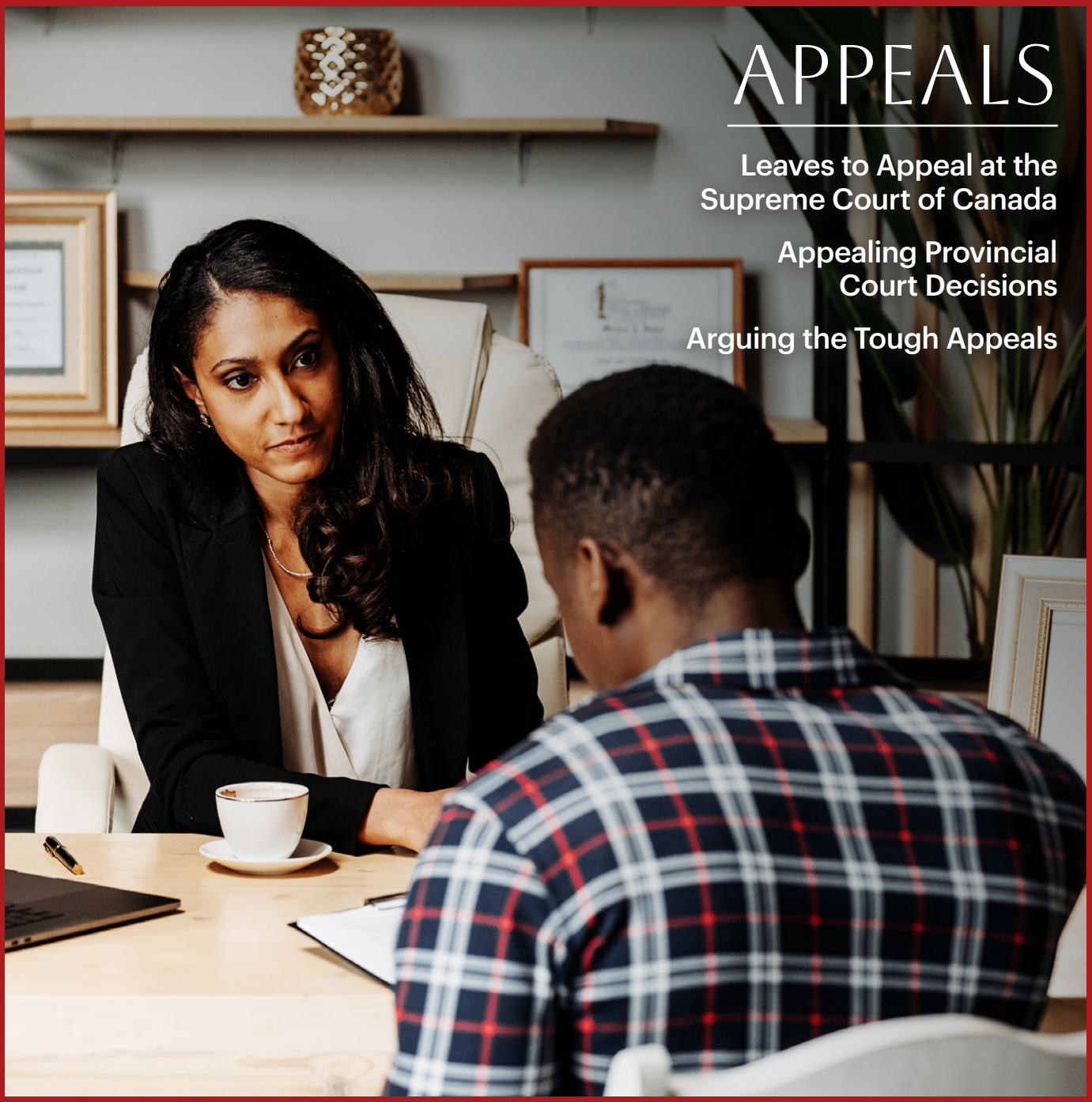

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MEDICAL MALPRACTICE ▸

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Medical Records in Birth Injury Cases

This is the seventh article in our series aimed at providing a detailed examination of the challenges and pitfalls in different types of medical negligence lawsuits and approaches to overcoming them. In this article Brenda Osmond reviews the importance of conducting a detailed review of the medical records in a medical malpractice lawsuit, with a focus on birth injury cases.

Introduction

Medical records provide the foundation for safe health care for patients. They are also the cornerstone of any medical malpractice lawsuit. They can be admissible in court as business records under an exception to the hearsay rule, without calling the maker of the notes to testify, provided they meet the requirements of the Evidence Act, RSBC 1996, c 124. s. 42. Whether the information in the records is an accurate representation of the care provided is a live issue in many medical malpractice lawsuits. The article will explore a number of recurring themes related to medical records, with a focus on how these themes play out in baby cases.

Nothing charted / nothing done

There is a saying in healthcare that if nothing was charted, then nothing was done. As trite as that sounds, it was the winning mantra in *Pinch (Guardian ad litem of) v. Morwood*[1] . Here, the plaintiff mother suffered an eclamptic seizure two days after being seen in the emergency room of the local hospital. In the ER her blood pressure had not been recorded in the chart, and despite hearing detailed evidence from the bedside nurse about her approach to taking and recording a patient's blood pressure, the court found that the blood pressure had not been taken, and if it had been taken it would not have been normal. This would have led to further testing, referrals and treatment which would have prevented the eclamptic seizure and the ultimate brain injury to the infant plaintiff. In this fact-driven case, the court noted that the absence of charting permits the inference that correct steps were not taken.[2,3] Citing *Skeels (Estate of) v. Iwashkiw*[4] *[Skeels]* the court noted:

> **112 The lack of charting does not necessarily mean that procedures were not conducted, nor is the mere lack of charting prima facie evidence of negligence in the treatment. However, the lack of charting makes it more difficult for a court to determine matters of credibility where individuals who are trained to chart, did not do so. This failing, despite the opportunity to do so, makes it harder for a court to accept that the correct steps were followed and appropriate procedures were done as it would have been logical for them to be recorded had they been done: ...**

There is a method of documentation known as "charting by exception" in which a nurse does not chart a parameter unless there has been a change from a previously documented result. *Skeels* involved a delay in delivery due to a failure to recognize and manage shoulder dystocia. The court was critical of the "charting by exception" practice

and specifically noted several examples where results of various assessments were charted even though there had been no change from a previously documented result, suggesting that charting by exception was, in fact, not the practice at that hospital.[5] By extension, this suggested that that the lack of documentation over a critical 1"½ hour period of time in which the plaintiff mother was fully dilated and the baby was eventually delivered, indicated that no care had been provided over that time period.

The lack of documentation in a medical record does not necessarily mean that nothing was done, although it is open to the courts to make that inference. These cases illustrate the importance of a detailed review of the records and the need for plaintiff's counsel to understand the expected workflow when routine procedures are being done, as well as the charting policies of an institution.

Inaccurate / incomplete charting

The importance of the completeness and accuracy of medical records was front and centre in *Brito et al v. Woolley et al*[6] *[Brito]*. This case illustrates the implications of a defendant's poor charting practice. In Brito the plaintiffs alleged negligence in the birth of the second twin who was deprived of oxygen due to the compression of the umbilical cord. The court dismissed the plaintiffs' claim due to a failure to prove causation, but in an unusual step awarded costs to the unsuccessful plaintiffs.

Here, the court noted the reckless conduct of all the defendants in the preparation of the medical records, noting that these records are often the only evidence as to the details of a particular event. The court described the records as being "variously incomplete, inaccurate, and inconsistent. ..."[7]. In addition, "the occurrence of material events was omitted completely from some of the medical records; the description of material events in some of the records was wrong; and the sequence and the timing of material events was inconsistent."[8] In describing the standard expected for medical charting the court noted:

> **[62] The law does not impose a standard of perfection on medical personnel in their preparation and maintenance of medical records. Rather, it is a reasonable standard of care, given the experience of the medical personnel and the context in which the medical records were prepared. Occasional inconsistencies, inaccuracies, and/or omissions are tolerated.**

The court rejected the defendants' contention that they should be awarded costs because the plaintiff unnecessarily pursued inconsistent theories as to the reason for the deprivation of oxygen. The only reason the plaintiff had to pursue various theories of causation was that the incompleteness of the medical records left them with no option other than to investigate various interpretations of those records. In addition, the sequence, timing and occurrence of events had to be proven at trial through lengthy *viva voce* evidence because of the incompleteness of the records.

Invariable / Usual Practice

Not everything done in an interaction with a patient is necessarily charted. Consent discussions are not documented verbatim. Every step taken in a physical assessment may not be charted. The courts recognize these realities, and also recognize that a busy physician will not remember the detail of every patient encounter.[9] Courts are often prepared to accept a nurse or physician's description of their usual practice.[10] But the medical records themselves can sometimes defeat that evidence. *Cojocaru v. BC Women's Hospital*[11] [*Cojocaru*] illustrates this point.

The plaintiff mother in *Cojocaru* had a rudimentary command of the English language having only immigrated to Canada four months earlier. The defendant physician conceded that she had no recollection of her discussion with the plaintiff and had to rely on her invariable routine and chart notes to determine what information she had given the plaintiff about the options and comparative risks of a repeat C-section or a trial of vaginal birth after a previous C-section. The court identified a number of examples where the defendant did not follow her other stated invariable routines, specifically with respect to charting crucial information about conversations with the plaintiff. In rejecting the defendant's "invariable routine" testimony, the court noted the pitfalls of giving too much weight to this kind of evidence:

> **[97] ...Most practitioners practice properly, most of the time. If evidence of "invariable routine" is given too much weight, no medical practitioner would ever be found to have been negligent. When a medical specialist makes no notes, or very scanty notes, and his\her evidence conflicts with other independent evidence of what occurred, the court must be very cautious indeed before accepting the "invariable routine" evidence. ...**

In addition to identifying examples in which the defendant had not followed her invariable practice, the court noted factors that weighed strongly in favour of the plaintiff's evidence that she had not been advised of the risks of a trial of vaginal birth after a previous C-section, including the plaintiff's beliefs, her experience from her first pregnancy as well as cultural influences.[12] Ultimately the court preferred the plaintiff's evidence and found that had she been advised of the risks she would not have considered a trial of labour, and ultimately the infant plaintiff's injuries would have been avoided.

In order to minimize the weight the court ascribes to "invariable routine" evidence it is necessary to comb through the medical records, often beyond the facts specific to the negligence, to identify potential deviations from an invariable routine. Carefully crafted questions at an examination for discovery can lead the defendant to identify a number of "invariable routines" for which exceptions may be found in the medical records. This could decrease the likelihood of the court finding that a critical "invariable routine" was followed.

Changes to medical records

If problems arise during labour and delivery and there are signs of fetal distress, the medical team may find themselves working furiously against the clock, administering resuscitative measures, reviewing and assessing the fetal heart monitoring strip and calling in additional personnel to help. The contemporaneous recording of the chart notes may fall by the wayside. What then?

From time to time it is necessary to make additions and changes to the medical records. The College of Physicians and Surgeons' "Practice Guideline – Medical Records Documentation" [*CPSBC Practice Guideline*] acknowledges that it can be appropriate for corrections to be made to medical records, provided that the physician clearly identifies what alterations were made and when.[13]

When proper procedures are not followed and changes are not marked clearly as "corrections" or "late entries" the possibility of self-serving motives can arise.

In *Paxton v. Ramji*[14] the infant plaintiff was exposed to the known teratogenic drug Accutane in utero. The defendant physician prescribed the medication to the plaintiff mother on the understanding that her husband had a vasectomy 4"½ years earlier. Nonetheless, she became pregnant while on Accutane, and the infant plaintiff was born with a number of birth defects.

The defendant physician kept typewritten clinical notes but made handwritten entries on these typewritten notes on days that were critical to the analysis of the Accutane issue. The plaintiff claimed punitive damages because of these handwritten changes. Although the court found that the chart alterations were made after the alleged breach of prescribing Accutane, and for the purpose of masking the breach, the court did not order punitive damages. Acknowledging that the alteration of notes heightens, complicates and prolongs the dispute, the court suggested this concern could be adequately addressed as a costs issue. The court labelled the act of altering a medical record as "reprehensible" but found that it did not reek of "enormity or gross impropriety" of the type recognized in awards of punitive damages.[15]

Steinebach v. Fraser Health Authority[16], [Steinebach] provides another example of changes made to a medical record after the bad outcome was recognized, and without being properly identified as late entries. Here the plaintiff called a handwriting expert

who testified that certain words in the chart notes that were dated *before* the birth of the infant were added in different ink *after* the birth of the infant, at which time it was known that the health of the newborn was compromised. In addition, some of the information that had been entered late was not even available at the time of the initial note.[17]

The plaintiff in *Steinebach* applied for an order for special costs against the defendant on the basis of those late additions to the hospital chart, among other things.[18] The court did not order special costs, finding that the trial judge did not conclude that these late entries even though not labelled as such, were not done to deliberately mislead the court or to bolster the defendant's evidence.

Although special costs were not awarded in this case, *Steinebach* does highlight the importance of reviewing the *original chart* in a case where the chronology of events, and the implications of what a physician knew at each moment of the case, is critical. Photocopies can be useful for an initial review of a case, but there is no substitute for viewing the original record.

Plaintiff's counsel needs to be alert to the possibility that after-the-fact additions or changes have been made to the medical record that are not properly annotated as late entries. Although this can helpfully call into question the veracity of the evidence of the defendants, it will not usually rise to the level of "gross impropriety" required to attract punitive or special costs awards.

Electronic Medical Records and Medical Data

As more and more clinics and hospitals move to electronic medical records, we lose the opportunity to identify notes handwritten in a different pen or written in the margin of a page. But electronic health records in British Columbia must include an audit trail that records when changes are made to the record, what changes are made, and by whom.[19] In addition to the medical chart, medical equipment often retains an electronic record of results. It can be important to ask for the electronic data from monitoring equipment, including fetal heart monitoring strips, to ensure that you have the complete picture of all of your client's assessments and monitoring. This information is not always available through the medical records department, nonetheless that might be the best place to start with your requests for information. The medical records department should be able to advise you where to direct your specific requests for information derived from the medical technology. Of course if the action is started and there is a hospital defendant, those requests will need to go through defence counsel.

Conclusion

Contemporaneous charting is one of the requirements for records to be admitted as business records under the *Evidence Act*. While late-entries into medical records are recognized as a necessity from time to time, they must be clearly marked as such. If they are not, and they are determined to be late entries either by handwriting analysis, comparison with facts that appear elsewhere in the records, or even by "time stamp" on a dictated operative or discharge note, the veracity of the witness/defendant can be called into question. Even chart entries not directly related to the alleged breaches can be important to impugn a defendant's claim of an "invariable practice." There is no substitute for a line-by-line review of the medical records, often assisted by an expert who knows what should be there, and what shouldn't be there, and can assist in spotting out-of-order entries and other problems.

1 *Pinch (Guardian ad litem of) v. Morwood*, 2016 BCSC 938 (CanLII).
2 *Ibid*, para 13.
3 Also see *Waap v. Alberta*, 2008 ABQB 544 (CanLII) at para 10 for a discussion of the court's prerogative to make an inference that if nothing was charted it is because nothing was done.
4 *Skeels (Estate of) v. Iwashkiw*, 2006 ABQB 335 (CanLII).
5 *Ibid*, para113.
6 *Brito et al v. Woolley* et al, 2005 BCSC 443 (CanLII).
7 *Ibid*, para 16.
8 *Ibid*, para 22.
9 See *Hewlett v. Henderson*, 2006 BCSC 309 (CanLII) at para 44 for an example of the court not accepting the defendant physician's evidence that events were ingrained in his mind even though they were not charted.
10 *Turkington v. Lai*, 2007 CanLII 48993 (ON SC) at para 93.
11 *Cojocaru v. BC Women's Hospital*, 2009 BCSC 494 (CanLII).
12 *Ibid*, para 100.
13 PSG-Medical-Records-Documentation.pdf (cpsbc.ca), September 1, 2014, last revised May 6, 2022.
14 *Paxton v. Ramji*, 2006 CanLII 9312 (ON SC).
15 *Ibid*, para 73.
16 *Steinebach v. Fraser Health Authority*, 2010 BCSC 832 (CanLII)
17 *Ibid*, para 56.
18 *Steinebach v. Fraser Health Authority*, 2011 BCSC 1369 (CanLII).
19 *Health Professions Act*, RSBC 1996, c.183, s. 3-5(2).