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Best Practices for Massage Therapy Care Documentation

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Whitelaw—Twining
Law Corporation

Best Practices for Massage Therapy; Care Documentation

We have been asked to provide our opinion regarding the keeping of professional journals by Registered Massage Therapists. This journal would include notations regarding situations in which an RMT felt uncomfortable during a treatment, or to document issues about a treatment that the RMT felt might arise in the future. Alternatively, we have been asked to recommend how sensitive information should be documented, if not in a personal journal or diary.

We understand that a "Best Practices" bulletin was provided to the RMTBC by CNA with respect to Massage Therapy Care Documentation. The bulletin stated "Do not keep personal/anecdotal notes (or diary) in situations that have not gone well. Given their probable subjectivity and potentially damaging consequences, personal notes are discouraged".

Recommendations

We agree with the recommendation made in the CNA "Best Practices" bulletin, for a number of reasons.

Any records created by an RMT which relate to a patient or their treatment would likely have to be produced in a number of circumstances, regardless of whether these records are created or stored separately from the official patient records. These circumstances may include during a CMTBC investigation; pursuant to a request by a patient for access under *Personal Information Protection Act* ("PIPA"); or through civil litigation disclosure. Notes created by an RMT following a potentially uncomfortable incident may not accurately reflect the situation, and may not reflect well on the Registrant from a legal perspective. If produced, the notes may serve detrimental to the interests of the Registrant in an investigation or civil proceeding. Furthermore, keeping such notes runs the risk of breaching the requirements for compliance with PIPA's strict regulations regarding the collection and use of personal information.

We recommend that if an incident occurs or the Registrant feels the need to document a specific situation with a patient, then the Registrant should first consider whether an appropriate note should be made on the patient's formal file. In general, documenting an incident in the patient's file should be the appropriate course of action, while recognizing that such notes would be subject to production to the patient, CMTBC, or during legal proceedings.

If an incident or situation arises which the Registrant does not feel comfortable documenting on the official patient file, then the situation should be reported to their broker/insurer and if necessary legal advice can be sought regarding how best to proceed at that time. In general, we recommend that Registrants notify their broker/insurer following any incident or situation which they are concerned may give rise to a claim or future complaint against them, so that appropriate action can be taken.

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Detailed Discussion

The keeping of a separate journal or diary regarding patient treatments by a RMT raises three potential areas of risk:

1. CMTBC Bylaws, Record-Keeping Requirements, and Investigations
2. Patient Privacy and the Personal Information Protection Act
3. Civil Litigation

Each of these risks will be discussed in turn.

1. *CMTBC Bylaws, Record-Keeping Requirements, and Investigations*

The CMTBC Bylaws, Schedule "E" set out the standard for Patient Records kept by RMTs. These include records regarding medical history, clinical impressions, and treatment provided. Section 8 of that Schedule governs College access to records. That section requires Registrants to ensure that all patient records, as well as "any written or electronic information relevant to those records" are made available for inspection by the College.

While there is no express prohibition on keeping extraneous notes such as a journal or diary set out in Schedule "E", Registrants should be aware of the likelihood that the wording of this provision is broad enough to capture journals or diary notes kept by RMTs regarding patient treatments, even if these notes are physically separate from the patient's formal treatment records. Registrants should therefore be aware that any such notes, journals, or diaries would therefore likely need to be made available to the CMTBC upon a request made under Section 8, Schedule "E" of the CMTBC Bylaws.

In addition to the obligation under the Bylaws to make records available, RMTs also have a duty, pursuant to Section 28 of the CMTBC Code of Ethics, to "respond to any inquiries, requests, and directions from the College in a professional, responsive and timely manner".

The current wording of the CMTBC's request for production of documents requires that RMTs produce "a copy of all […] records that relate in any way to your provision of massage therapy services to [the patient or patients]". It is our opinion that the wording of this request is likely broad enough to capture any external notes, journal, or diary kept by an RMT, even if physically separate from the patient's formal treatment record.

2. *Patient Privacy and the Personal Information Protection Act*

Schedule "E" of the CMTBC Bylaws requires RMTs to protect and maintain the confidentiality of patient information, and to take all reasonable measures to ensure that the collection, use, access, disclosure, care and disposal of patient information is done in accordance with the *Personal information Protection Act*, and any other legal requirements. A similar requirement is found in the Code of Ethics.

The *Personal information Protection Act* is a British Columbia statute which governs how the personal information of members of the public may be collected, used, and disclosed. PIPA also gives individuals the right to access the personal information that is being stored about them, and to request corrections to information if they believe it to be incorrect or incomplete.

For the purposes of PIPA, "personal information" includes any information that can identify an individual, directly, such as a person's name or contact information, or in combination with other information, such as physical description. It is possible that a description of an incident involving a patient would contain sufficient detail so as to fall within the category of "personal information" under PIPA.

PIPA contains numerous strict guidelines and requirements for the protection and use of personal information once it has been collected. By keeping a personal journal with notes relating to patient treatments or concerns with same, a Registrant runs a heightened risk of breaching the requirements set out in PIPA.

It is also important to be aware that PIPA requires an organization respond to requests for access to personal records. Specifically, it sets out that "individuals have the right to access their own personal information […] to know how you use their personal information […]". As a result, Registrants should be aware that journal or diary notes regarding patient treatment or concerns may fall within the scope of records that should be produced to an individual in response to a formal request for access under PIPA.

3. *Civil Litigation*

If a Registrant becomes involved in civil legal proceedings with a patient in which a claim is brought against them relating to the massage therapy treatment of the patient, they should be aware that they will be required to produce all documents and records relevant to the treatment, including any relevant journal or diary entries.

Pursuant to the Supreme Court Civil Rule 7-1, all parties to an action are required to produce all documents in their possession or control that could be used by any party of record to prove or disprove a material fact. It is highly likely that any notes made by an RMT relating to a patient would fall within the scope of production under that Rule.

Conclusion

Ultimately, the risks posed by a Registrant keeping a separate journal or diary regarding incidents or situations with patients appear to far outweigh any potential benefit. The content of such notes may not reflect well on a Registrant from a legal perspective, and would likely be required to be produced during an investigation or civil lawsuit. There is also the additional risk of breach under PIPA.

Therefore, in general we recommend that incidents should be documented in a patient's regular file when possible. If a Registrant is concerned about an incident or situation which occurs during the course of their practice, then they should provide a report to their broker/insurer, at which time legal advice can be sought if necessary regarding how to document or respond to the situation at that time.

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