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Deciphering medical hieroglyphics: The "how to's" of making the most of your medical discovery documents

Not much different than ancient hieroglyphics, deciphering medicals records can be a challenge for even the most seasoned attorney. Whether a medical malpractice, personal injury, elder or dependent abuse, Workers Compensation, product liability or criminal assault matter; cases with a medical component add an additional dimension of complexity.

Establishing a process for reviewing the medical records assures the best rate of success while decreasing the chance a critical piece of information will be missed. Creating a list of what documents one needs or expects the defendant to produce helps in assuring nothing falls through the cracks. You *know* records will inevitably have some missing parts. Having knowledge as to what you would expect in a medical record will make it much easier to quickly spot the missing piece. Following are exemplar tables from different health care settings which specify documents one should reasonable expect to be provided in a request for the same. That being said, critical key documents will vary depending upon the area of practice and injury.

Should counsel have someone other than themselves organize the medical records, (either a paralegal or legal nurse consultant professional), it is essential that person understand the plaintiff's complaints regarding the injury or malpractice, as well as the plaintiff's perception as to what went wrong. It is from these medical legal issues that the professional will need to understand what medical records are required to thoroughly evaluate and prove their case.

When considering a potential claim, we look at it with a critical eye – we look at both sides of the case, keeping an open mind. Is the clinical situation one in which either liability or causation can be defended? Can any of the four elements required be explained and therefore eliminated? These are elements one wants to consider not only when evaluating whether to take a case, but also when organizing the medical records and creating a chronology. This provides additional information as to what documents will be needed and how one will evaluate the medical records.

Use a logical sequence

It is not uncommon to receive medical records that seem to be in 52-card pick-up order! How is this possible, one asks? Surely, medical record departments do not maintain their records this way. Regardless of how it occurs, you have to deal with the result. To not take the time to properly organize the records as the first step of a case is penny-wise and pound foolish. As many times as the records will be referred to over the next two to three years, not having them organized, indexed and Bates-stamped will increase the time you (and each of your experts) will spend during every step of the litigation. For example, if the medical documents are not clearly labeled Medication Administration Record (MAR) or Intake and Output (I&O), identifying what the document is can be a challenge. How the MAR or I&O sheet looks will vary from institution to institution and often identifying what they are only comes with experience.

Prior to sending records for a medical expert to review, counsel will be best served by organizing the records in a logical sequence, much the way a medical record in a clinic, hospital or skilled nursing facility is organized. This is a format that is most comfortable and logical for medical experts and will therefore expedite their analysis. The faster the medical records can be reviewed, the more cost-effective it will be for counsel. When creating the chronology, records that are not really at issue can easily be skipped over or just given a cursory review, again, saving the attorney up-front expense.

In addition to saving money by having the records organized for experts, properly indexed and organized records are an invaluable help in responding to motions, discovery and preparing questions for depositions. This also becomes a great tool in learning and understanding the issues in your case.

A case in point

Organ transplantation in California has been in the news a lot of late. Taking that type of case as an example, the professional organizing the records will ascertain the plaintiffs' allegations to be that:

- The transplant coordinator negligently failed to communicate and schedule the requested pre-transplant workup required by the transplant team to the dialysis staff as well as the plaintiff.
- The transplant center negligently failed to timely complete a pre-transplant workup.
- The transplant center negligently failed to list the patient with United Network for Organ Sharing (UNOS), the national waiting list system in a timely manner as soon as the pre-transplant workup was completed.
- Due to the center's negligence, the plaintiff was denied organs which he would have been offered.

Once the medical legal issues are identified, the medical records needed to thoroughly evaluate of the case become clear.

In the example transplant case, at a minimum the attorney (and her experts) will need the following medical records:

- All medical records relating to prior care and treatment of organ failure.
- Pre-transplant workup including recommendations for testing. This is individual and based upon specific patient medical history.

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• All communication between the transplant center and the transplant coordinator.

• Any and all communication between UNOS and the transplant coordinator.

• Any and all records from the plaintiff's insurance and the transplant center.

• Copies of all contracts between an HMO and the transplant center which describes their relationship.

Dealing with questions

Once the initial records are obtained, organized and reviewed, additional questions may arise. A follow-up interview with the plaintiff might be required to answer those questions. From there, the experienced reviewer should suggest that counsel serve a request for production of additional documents. Almost without exception, this will include the facility's Policies and Procedures (P&P). Rather than request entire volumes of P&P, which is time-consuming and expensive to review, it is more cost-effective for counsel to have an expert suggest which specific P&P's are necessary. Again what is requested is illness/injury specific.

More often than not, a response to a request for medical records omits certain types of documents. The following types of documents are best requested with specificity to ensure their production:

• *Autopsy records*

If the circumstances surrounding an unexpected death are suspicious, it is wise to request re-cuts of the original slides or the original slides themselves for an independent pathologist to review.

• *Billing records*

Extremely helpful not only when there is a question as to what services were really required and/or provided but may disclose negligence by the healthcare provider as well. For example, while hospitalized, a patient sustains an unexplained fracture which is not addressed in the medical records. After obtaining the billing records, it is found that the facility charged ICD-9 code: *E8497 Accident in Resident Institution*. In order for that to have been on the billing, someone had to have known what happened.

• *Drugstore pharmacy records*

Pharmacy records can provide essential information in cases where a drug history is critical to the case – as in the matter of product liability cases and adverse drug reactions.

• *Emergency Medical Services transport records*

May have to be requested separately from the EMS service itself. One can also obtain copies of the actual tapes from paramedic runs. These records are automatically electronically time and date stamped to the second. This can prove invaluable.

• *Emergency room logs*

Time in and out of the ER is tracked. Specifically, one can extract information such as other types of injuries/illness seen at the same time which would be essential in cases involving delay in treatment or possible EMTALA violations.

• *Fetal monitor strips*

Frequently need to be requested with specificity – they are a part of the mother's medical record.

• *Laboratory logs*

Of importance when the medical records do not have tests which one would expect to have in the medical records based upon the condition of the plaintiff's illness or injury.

• *Operating room logs*

Often have critical information concerning the plaintiff as well as other types of surgeries that occurred on that date and time in question. It will also provide information regarding how many surgeries an anesthesiologist was supervising at the same time as well as OR staffing for that date and time.

• *Pharmacy records*

Controlled substance records for all hospital units are kept by the pharmacy as mandated by law. This would be of particular interest in drug overdose cases, for example.

• *Photographs and DVD's*

Many times tests and surgeries are recorded or documented photographically or electronically. Obtaining copies may provide evidence otherwise not documented.

• *Radiology*

Copies of X-rays, CT's and MRI's are best requested as early as possible in litigation. It is important to have the written reports of these studies as well as the films themselves.

Once organized, the medical records should then be indexed and Bates-stamped. It is advantageous to have the records scanned onto a CD with OCR (optical character recognition) software. When it is difficult to read the physicians' hieroglyphics, it is often helpful to blow up the image on the CD-scanned documents. This may better enable you to decipher what was actually written. (Hint: if you do not have the medical records on CD, covering it with a sheet of faintly tinted clear plastic will often clarify what was written.) The organized CD can be sent to experts saving on postage as well as record destruction costs after the case concludes.

Extracting the medical record information

Now that the records are organized, reading and extracting the important facts into a chronology will serve to assist you in telling your story. It will help in preparing for depositions, opposing motions for summary judgment, pretrial motions, in settlement conferences, and during trial. It is critical in putting together your case strategy. With a well-developed chronology, the key points and issues will become evident as will any defenses.

A fact chronology can be a tremendous asset as you prepare a case for trial. Yet, the majority of chronologies fail to live up to their full potential. There is no doubt that chronologies help win cases. From the first documents received, assembling case facts in an accessible format can put you on track to a courtroom victory.

Chronologies are thinking tools. The very act of logically organizing the facts clarifies thinking and makes the story of the case clear. Chronologies help ensure complete discovery. Which facts are disputed? Which still need sources that will be acceptable in court? A chronology is a communication aid. A good chronology makes it easy for everyone on the trial team to share case knowledge as well as to brainstorm strategy.

CaseMap©, for example, is one tool on the market that meets the needs and goals of creating an effective chronology.

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Using a word processor to develop a chronology is counter-productive to your case, as it does not allow for the level of manipulation of the data that one requires to ensure the best use of information abstracted from the medical records. With a database program, specific facts key to your case can be filtered into separate report forms. With a true database, facts can be kept in chronological order while at the same time they can be separated by type of document, by physician who saw the patient, by medication or whatever object you have set up to identify. In this way, you can truly *use* the information taken from the medical records, rather than just record what happened.

You can also, at the click of a mouse, export the information into an Excel file and make graphs of the information. This is very powerful when dealing with issues that concern variations in vital signs, medications given (or not) or lab results not recognized or diagnosed by health care providers. Disputed facts on which opposing counsel will rely also should be included. By recording these, a database makes it easy to identify those facts you have which disprove the defense position. Having the ability to manipulate the facts and information from your case without spending your time redoing your notes, helps tremendously in telling your story to a jury when the time comes.

Analyzing the medical record

You now have everything expertly organized, indexed, Bates-stamped and scanned. So where do you go from here? Enter – more hieroglyphics! Deciphering what is charted is a talent unto itself. Knowing what is reasonable and expected makes reading the records effectively possible.

If at this point you cannot read or decipher what is written, this may be a good time to ask your expert for assistance. Ignoring charting because it cannot be read is tempting, but not usually in your best interest – you could overlook a smoking gun, an oversight that could be costly. Often times, what is not said in a medical record is just as important or even more important than what is said. Invariably, there are records which will have conflicting information. A client can magically change from male to female, from a smoker to one who has never smoked, from being allergic to an antibiotic or having received chemotherapy to one who has no allergies nor cancer.

How does this happen? More likely than not, one person makes a mistake in a history and physical, and others down the line read that and carry the error forward, perhaps compounding it with their own misunderstanding of care previously rendered. These errors may have little bearing on your case; however, there are those times when the errors have everything to do with your case! There may be prior treatment received (or not received) that one needs to pay close attention to and then validate or invalidate what the chart reports.

Furthermore, these little mistakes, even if they do not go directly to the medical issues in the case can make the providers look bad, which can be invaluable in attacking credibility during cross-examination.

"If it wasn't charted, it wasn't done"

Nursing, medical and paramedical training begins with the mantra; "If it wasn't charted, it wasn't done." The deficiencies relating to inadequate or absent charting should be carefully noted as there are often state and federal regulations which mandate adequate charting in the health care setting. That being said, a nurse is responsible for knowledge of:

- Standards of Practice.
- All procedures, policies and protocols related to the job.
- Medications and treatments being administered to the patient.
- Equipment used on patients.
- Pathophysiology of common disorders seen with patients in general and specifically with the pathophysiology of the condition for which the patient was receiving care.
- California Nurse Practice Act

When identifying deficits, it is important to identify what was not charted and, presumably, not done. At the same time, it is crucial to look for behaviors (assessments, treatment, and medication) which may have been done, although absent in the charting. There are times when, although not charted specifically, one can ascertain that certain care or treatment was in fact provided. Case example: A patient enters the operating room with no skin burns. Upon arriving on the post-operative surgical floor, it is noticed that the patient has sustained a burn which is consistent with the grounding pad used in the operating room. As the circulating nurse failed to document placement of the grounding pad, one could take the position that, "If it wasn't charted, it wasn't done," and, therefore, try to establish that there was no grounding pad placed (also negligence and below the standard of care). In this situation there would be reason to believe, however, that a grounding pad was in fact used, albeit, improperly.

In this situation, further investigation would reveal that: 1) an electrosurgical unit will not work without a grounding pad, and 2) there is no other reasonable explanation for the burn. It is these actions that represent care that really was or was not done that can further prove negligence and substandard care.

Depending upon the circumstances of the case, expertise in the field of medicine or nursing may be provide an advantageous edge when reviewing the medical records. Often times, experts are needed to evaluate the signs, symptoms, treatment and outcomes to assure they meet the standard of care. One must be able to clearly understand them and their significance on all body systems. What constitutes below the standard of care, where does the reasonable person test apply and what would be considered "expected" possible complications? All of these questions are best addressed with the input of a medical or nursing professional.

Having organized and complete medical records for expert review will save time, money and result in a more expedient turn-around of the expert record review. Even more importantly, it will assist you in knowing your case and obtaining justice for your clients.

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Medical records checklists

The author has provided several checklists for reviewing medical records that will be useful to the practitioner. See below.

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Labor & delivery medical records

Form names
Face Sheet
Emergency Record
Prenatal Record
Labor Admission History & Physical
Labor Record
Obstetrical Anesthesia Record
Delivery Record
Obstetrical Operative Report
Consultations
Fetal Monitor Strips
M.D. Progress Notes
Anesthesia Records
Operative Reports
Laboratory
M.D. Orders
Graphics
Medications
IV Fluids/Medications
Nursing Assessment
Nursing Care Plans
Post Partum Nursing Notes
Nursing Discharge Planning
Nursing Discharge Summary

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Logs

Log form name	Should contain
Blood bank logs	Verification of type and cross match, signatures of blood signed out for administration, audit trail on blood reactions
Drug expiration check	Monthly check of all drugs in the facility for expiration dates
Environmental logs & record of repairs & preventive maintenance & service logs	Air conditioning room temperatures, Humidity (In OR daily record and Blood Bank), routine preventive maintenance & emergency repairs, repair orders Equipment electrical checks
Infection Control logs	Cultures and sensitivity
In-service Records	Attendees, dates, topics, summary of in-service
JCAHO & other Accreditation reports for surveys & facility responses & survey follow-ups	Surveys, complaint investigations, plan of corrective action
Medical Staff File	Privilege type & approved procedures , Medical Staff applications & renewals, verification of application and licensing, approval of privilege dates, Continuing education, DEA, Medical License, additional privileges, credentialing committee, suspensions, Malpractice Insurance.
Midnight Census	Valuable in nursing home cases. Patient census at midnight. Used as a baseline for staffing.
Narcotic Use Log	Sign out & medication use for all locations in facility
Operating Room Log	May be paper document log book or Computerized, Patient data, OR Room #, Staff, Surgeon, Assistant, Anesthesia provider, procedure, OR times, Time of pt. arrival, pre-op staff, PACU staff, Specimens, Implants, Complications
Operating Room Schedule	Room numbers, type, time and expected length of surgery
OSHA injury logs	
Pharmacy Formulary	
Point of Service reliability testing	Daily equipment testing of device
Preventive Maintenance reports for Equipment	
Quality Improvement Committee Meetings	Review of sentinel events
Refrigerator logs	Details temperature
Staff schedule	Daily assignments
Sterilization logs for Autoclave, ETO sterilization, GI scope disinfectant log including test strip results	Not a part of the MR, if surgical procedure, should be able to obtain sterilization records from facility to include the date of surgery & the Biological testing for the sterilizer
Request for repairs	for instruments, equipment, environmental services

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Adult inpatient medical records

Form Names	Should contain
Face Sheet (Record of Admission)	
EMS Ambulance Report	
Emergency Room Record	
History & Physical Examinations	
MD Orders	
Progress Records MD	
Consultations	
Nursing Assessment	
Nursing Notes	
Dietary	Initial Dietary Evaluation
Wound care	
ICU Notes	
Rhythm Strips	
Nursing Care Plan	
Graphics	Flow chart of vital signs
Medication Administration Records (MAR)	
Intake & Output	I&O
Consents	
Anesthesia Reports	
Operating Room Records	Preoperative Checklist, Preoperative record/checklist, Intraoperative Checklist, Intraoperative Nursing Record, Record of Implants, Anesthesia Record (preop assessment, Intraoperative & PACU notes & discharge from PACU), PACU record, Second Stage Recovery, Operative Report
Hemodialysis	Acute dialysis treatment record
Respiratory Therapy	
ABG's	Arterial Blood Gases
Physical Therapy	Initial Evaluation PT
Occupational Therapy	Initial Evaluation OT
Speech & Language Therapy	Initial Evaluation Speech

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Social Worker	
Laboratory	Blood, Urine, Cultures, Microbiology, Blood Bank,
Pathology Path	Reports
Cardiac Cath Lab	Coronary Angiogram, Cardiac Cath, Pacemaker insertion, Stent placement, Ventriculogram, Angioplasty, PTCA, Balloon Angioplasty,
Cardiac lab	EKG, Echocardiogram, Exercise Stress tests, Isotope Imaging, Thallium imaging,
EKG EKG	
EEG's	
Radiology	MRI / PET scans / CT scans / X-Rays / Fluoroscopy procedures /
CPR Records	
Discharge Record	Medications, Next office/clinic visit for follow-up
Discharge Summary	MD discharge summary with CPT codes
Autopsy report	Coroner
Death Certificate	
Insurance Information	
Signature page	Form that records initials, titles & signatures.

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Adult outpatient medical records

Form names	Should contain
Face Sheet (Record of Admission)	
History & Physical Examinations	
Physician Orders	
Progress Records MD	
Consultations	
Nursing Notes	
Medication Orders	
Medication Administration Records (MAR)	
Informed Consent for Anesthesia	
Informed Consent for Surgical Procedures	
Operating Room	Preoperative Checklist, Preoperative record/checklist, Intraoperative Checklist, Intraoperative Nursing Record, Record of Implants, Anesthesia Record (preop assessment, Intraoperative & PACU notes & discharge from PACU), PACU record, Second Stage Recovery, "TimeOut" checklist
Operating Room Log	May be paper document log book or Computerized, Patient data, OR Room #, Staff, Surgeon, Assistant, Anesthesia provider, procedure, OR times, Time of pt. arrival, preop staff, PACU staff, Specimens, Implants, Complications
Postoperative Patient Instructions	Receipt of patient instructions
Laboratory	Blood, Urine, Cultures
EKG	
Radiology	MRI / PET scans / CT scans / X-Rays / Fluoroscopy procedures /
Pathology	Path requests & reports
Patient Transfer Record	
Discharge Record	Medications, Next office/clinic visit for follow-up. Instructions
Discharge Summary	MD discharge summary with CPT codes
Insurance Information	