

UNRAVELING THE MYSTERY OF MEDICAL RECORDS

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“All that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and never reveal.”

—The Oath Of Hippocrates, as quoted in *Rush Limbaugh v. State of Florida*, Case No. 4D03-4973, D. Ct of Appeal, 4th District, Brief of Amicus Curiae, available at www.aapsonline.org/judicial/aapsamicus.pdf.

EVERY TIME a person receives medical treatment, a record is made of that visit. The record should chronicle the patient’s complaints, the physician’s observations, and treatment outcomes. *Medical Records and Health Information Technicians*, U.S. Department of Labor, Bureau of Labor Statistics. It would, therefore, appear that counsel should have an easy time in retrieving

and analyzing a plaintiff’s medical records. Nothing could be further from the truth.

The American Medical Association’s Code of Ethics mandates that information disclosed to a physician during the doctor-patient relationship is “confidential to the utmost degree.” The purpose of this rule is to allow the patient to

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make a complete and frank disclosure of information, confident in the knowledge that the health care provider will protect the confidential nature of the information. This professional requirement has also been turned into law by federal and state statutes that prohibit the disclosure of confidential patient information unless very specific conditions have been satisfied. This is especially true since the enactment of the Health Insurance Portability and Accountability Act ("HIPAA") Pub. L. No. 104-191, 110 Stat. 1936 (1996), and its Privacy Rule (Standards for Privacy of Individually Identifiable Health Information), 45 C.F.R. Parts 160 and 164, which took effect on April 14, 2003. Patients have now gained unprecedented safeguards concerning the disclosure of their medical information.

Once the claimant's medical records have been obtained, counsel is confronted with a second obstacle: trying to make sense out of what has been recorded. The records may not be arranged in a uniform fashion, abbreviations abound, handwritten comments are often illegible, and procedures will be listed by diagnostic codes.

As one may remember from law school, understanding court opinions required a little time. Medical records present the same challenge. Armed with practice and a medical dictionary, however, attorneys will discover that making sense out of the medical records follows a learning curve that can be mastered. This article will offer suggestions on how to make the medical record retrieval process easier and will offer tips on how to understand those documents.

THE NEED TO OBTAIN THE MEDICAL RECORDS • It is important to obtain a claimant's medical records to ascertain the nature of the injury, to document or refute the alleged medical problem, and to establish a value for the claim.

From The Plaintiff's Perspective

Counsel for the plaintiff must obtain the medical records to investigate the merits of the claim and to properly document the injury. The records are also important so that counsel may learn about adverse health issues, such as prior claims or pre-existing medical problems that may play a role in the current complaints. In this regard, counsel for the claimant has a much easier task in retrieving the records since the client is not adverse and a properly worded and executed medical authorization should suffice.

The Authorization

The one or two paragraph medical authorization signed by the client is no longer the magic wand in obtaining the records. The authorization must now comply with the HIPAA requirements as set forth in 42 U.S.C. §1301 et seq. For more information on HIPAA, see www.hhs.gov/ocr/hipaa.

To expedite the receipt of medical records or to reduce the chances of encountering problems, counsel should check with the health care provider to ascertain if a specific form is required. For example, some hospitals are very demanding about the contents of the medical authorization and will not release the records unless specific language is used. Also, certain records enjoy an additional layer of protection. These include the disclosure of drug and psychiatric information, which require a specific authorization that satisfies the appropriate legislation on these issues. For instance, records dealing with substance abuse are protected by 42 C.F.R. pt. 2, Confidentiality of Alcohol and Drug Abuse Patient Records and section 543 of the Public Health Service Act.

Many states also have their own statutory schemes for obtaining medical records. These are subservient to the federal laws but may impose additional patient safeguards. For example, Pennsylvania has its own statute on the

production of medical records that is set forth in 42 Pa. Cons. Stat. Ann. §6155(b):

“(1) A patient or his designee, including his attorney, shall have the right of access to his medical charts and records and to obtain photocopies of the same, without the use of a subpoena duces tecum, for his own use. A health care provider or facility shall not charge a patient or his designee, including his attorney, a fee in excess of the amounts set forth in section 6152(a)(2)(i) (relating to subpoena of records).”

The Defense Perspective

Defense counsel has different reasons for wanting to obtain the medical records of a claimant. Although a client can provide defense counsel with a description of the accident or events on which the claim is based, the client can rarely supply accurate or detailed information about the plaintiff's health. At a minimum, however, counsel should ask the defendant to describe the claimant's medical condition at an accident scene, find out if the plaintiff was walking around, and ascertain if the claimant admitted that he or she was not injured.

Counsel for the defense should not rely on the medical specials submitted to the insurance carrier by the claimant or plaintiff's counsel. There is no mandate that these records be complete and plaintiff's counsel may disclose only favorable information.

Discovery Areas

Once the case is in suit, the defense should always issue formal discovery and obtain answers under oath. Unless court rules mandate the use specific interrogatories, the defense should always include a series of questions that focus on the claimant's general health, including:

- Visits to doctors within the 12 months before the date of loss;

- The name and address of the family doctor;
- Health insurance information such as the name of the carrier and policy number;
- The name of the claimant's pharmacy and its location;
- The name and policy number of the automobile insurance or workers' compensation carrier that has paid the medical expenses;
- Whether the claimant has received benefits from a disability policy.

Answers to these questions will provide the defense with a good start in learning more about the claimant's health and relationship of the claimed injuries to the accident, even if the plaintiff is not honest or is evasive in disclosing prior health issues.

Family Doctor's Records

By obtaining the records of the entities disclosed in response to these basic questions, the defense will obtain a blueprint of the claimant's health. The family doctor is the person most often seen when a health issue arises, especially in a non-litigation setting. These records may contain treatment about the claimed problem which pre-existed the incident. The documents may also shed light on another medical reason for the claimed injury. For instance, a diabetic neuropathy may cause numbness in an extremity instead of a herniated disk claimed to be the cause. Pain in the back may be related to Lyme Disease instead of a car accident. These records will also contain the reports of prior diagnostic tests and visits to medical specialists.

Pharmacy Records

The pharmacy will provide a computerized listing of medication and prescribing doctors. With a little detective work, one can easily ascertain the nature of the medication and the medical specialty of the prescribing doctor. For instance, a patient who has filled a prescription

for Darvocet, Vicodin, or Percoset within a few months before the accident is having significant pain somewhere in the body. Motrin, Vioxx, or Celebrex, will provide a clue that the individual is suffering from some type of inflammatory process such as a sprain or strain from a prior accident. If counsel is unsure of a specific drug, the *Physician's Desk Reference* ("PDR") is a quick and easy reference tool for learning the nature of a particular drug. The medication can also be searched online at: www.pdrhealth.com/drug_info/index.html. A medical directory such as Dorland's can provide a physician's medical specialty. Counsel may learn that the patient has had prior visits to an orthopedic surgeon or neurologist. This information can also be researched online at: www.dorlandhealth.com or by initiating a Google search by typing in the name of the medication.

Health Insurance Records

Most people do not like to pay for medical treatment especially when the premiums for health insurance are so high. By retrieving the claimant's health insurance records, defense counsel will obtain a computer listing of health care providers, dates of treatment, and diagnostic codes. Most carriers require bills to be submitted by use of diagnostic code numbers that have been established by the International Classification of Diseases. These codes were developed by the World Health Organization and may be found on the internet at www.eicd.com/EICDMain.htm. A variety of sources also publish the information in book form including the American Medical Association.

Obtaining the medical records from the automobile insurance or workers' compensation carrier in a third-party action is useful since these documents may contain reports of medical audits or independent medical examinations. These records may also contain state-

ments by the parties and potential witnesses, as well as photographs of the vehicles.

The Records To Obtain When Investigating A Claim

Counsel should always obtain the full medical records of the claimant and not just isolated pages such as a hospital discharge summary. One never knows what information may be gleaned from even the most seemingly innocent record.

Defense counsel should not limit a request to treatment records after the accident date. In fact, the medical authorization or subpoena should not contain an incident date. If the health care provider decides to issue only the medical records that follow the date of loss, or merely to provide the accident records, the defense should persist in efforts to obtain all of the records—even if it means issuing a new subpoena, taking the deposition of the records custodian, or filing a motion to compel production.

If a sufficient period of time has elapsed since the initial records were produced, consider serving a new subpoena to obtain updated information. Plaintiff's counsel may find a medical complication that the client has inadvertently failed to mention which may increase the value of the claim. The defense may find a new accident, an improvement in the claimant's medical condition, or a different medical cause for the problem.

PHYSICIAN OFFICE NOTES • Physician office notes do not follow a uniform format but typically contain certain standard types of information, including:

- An initial patient questionnaire;
- Progress notes;
- Correspondence from third parties;
- Notes of diagnostic procedures;
- Miscellaneous records.

Initial Patient Questionnaire

The first document in the chart should be the intake or initial patient questionnaire. This form will provide a narrative of the patient's past medical history, family medical problems, hospitalizations, medication, surgical history, and current problems.

Progress Notes

During each subsequent visit, the doctor will enter a progress report to document the examination. This note may be written or typed depending upon the custom of the physician. It is important to check for consistency of complaints over time and among health care providers. It is common to find variations of complaints among health care providers close in time. These variations make for interesting cross-examination and raise credibility questions.

It is also important to ascertain if the notes are mere images of each other. With the increased use of computers, some physicians in personal injury cases merely reproduce the same patient's notes over time. This raises questions about whether the doctor really treated the patient and how detailed the examination could have been when the notes are mere reproductions of each other.

Correspondence From Third Parties

Following the progress notes, the records should include correspondence from third parties including narrative reports from other health care providers. These letters will provide guidance about other medical problems or alternative causes for the current complaints. For instance, pre-accident visits to an orthopedic surgeon for a musculoskeletal problem will be contained in this portion of the file.

Notes Of Diagnostic Procedures

Reports of diagnostic procedures should be the next section in the record. These documents

will include the results of blood tests and diagnostic procedures such as x-rays and MRIs.

Miscellaneous Notes

The final section of the chart will contain miscellaneous items that cannot be classified neatly into a category. These records include notes about another lawsuit, letters from the attorney, or even a statement by the claimant.

"SOAP" Format

Health care providers have different ways of recording patient visits. Doctors may record office visits in loosely worded paragraphs or they may follow the "SOAP" format to provide a uniform recording system. This acronym stands for subjective, objective, assessment, and plan:

- "S" is a statement of the patient's subjective complaints on the date of the examination. For instance, the patient may state that "My neck is still very painful, and I am unable to sleep because of the discomfort";
- "O" represents the physician's objective observations and findings on examination. The doctor may feel a spasm when the patient's neck is palpated and there may be decreased sensation in the arm when pricked with a pin;
- "A" is the doctor's assessment of the situation. For example, the doctor may note that the patient has sustained a sprain and strain of the cervical neck with radiculopathy and diminished sensation in the left upper extremity;
- "P" explains how the physician plans on proceeding with treatment. The doctor may want the patient to undergo three weeks of physical therapy, have an MRI of the cervical spine, or return to the office in one month.

Even though the SOAP format may create a uniform record, the notes may not be in full sentences or they may contain abbreviations that are unique to that doctor's office. If counsel cannot understand a note, the handwriting, or an

abbreviation, the doctor's office can provide clarification. Many times, the doctor's staff can translate the puzzling words or abbreviations in an instant.

AMBULANCE RECORDS • When a rescue or ambulance squad is dispatched to the accident scene, a record will be made by the crew of their observations and physical examination of the claimant. This is a useful record since the comments will be from a neutral observer and will document the claimant's condition at the accident scene without the outside influence of a third person. Spontaneous utterances about the accident may be documented and a review of systems will be noted that can be compared with the claimant's allegations at a later date. This is especially true when a person maintains that he or she had a loss of consciousnesses at the accident scene but the ambulance record notes that the patient was ambulatory, alert, and oriented to person, place, and time.

HOSPITAL CHARTS • Hospital charts tend to be more formal than the records of health care practitioners, and will follow a more uniform format. Because of the many rules that regulate hospitals, including the requirement to maintain patient files, the records custodian or the medical records department will maintain and safeguard these records.

Archived Records

After the patient has been discharged, the hospital record will be transferred to this special unit to be maintained both chronologically and by section. The file is then placed in storage for future reference. Although the order of the materials may differ from hospital to hospital, the individual sections of the chart will remain the same. See Samuel D. Hodge, Jr. and Gerald Kaplan, *Analysis of a Hospital Chart*, *Thermography and Personal Injury Litigation*, at 52

(Samuel D. Hodge, ed., Wiley Law Publications, 1987). Also, most hospitals follow the standards established by the Joint Commission of Healthcare Organizations for accreditation purposes so the records are maintained in a more uniform fashion.

Contents Of Hospital Records

The individual units of the hospital record include the:

- Emergency room record;
- Patient registration;
- History and physical;
- Progress notes;
- Consultations;
- Laboratory studies and diagnostic tests;
- Nurse's notes;
- Medication sheets;
- Physician's orders;
- Operative notes and pathology reports;
- Discharge summary;
- Incident reports; and
- Consent and other miscellaneous forms.

EMERGENCY ROOM RECORDS • The emergency room record is a very important document in the investigation of a claim. It establishes a baseline for the patient's complaints and will usually contain a statement from the plaintiff concerning the event. In fact, the record may include the person's exact words about how an accident happened. This can prove helpful if the person subsequently changes the description of the incident to provide a more favorable fact pattern. *Id.* In an automobile accident, the patient may even be asked to explain the severity of the impact and to estimate the speed of the vehicles.

Biographical Information

Another important component of the emergency room record is the biographical information provided at the beginning of the form. Obviously, this record will contain the person's name, birthdate, and address, but it may also list the name of the family doctor, employer, and health insurance carrier. These are some of the key records to obtain when defending a claim.

Frank Observations

The job of the emergency room personnel is to treat the patient, so their comments will be recorded in an unbiased and frank manner. They will document the injuries sustained by the patient and will note whether the person lost consciousness or had open wounds. Likewise, the staff will record negative physical findings and will note their observations of the patient, if appropriate. For example, a person who claims to be in excruciating pain should be acting appropriately for a person in that condition. If the person, however, is observed walking around and constantly talking on the cell phone, a note may be entered of that observation because it is contrary to the expected behavior. Likewise, observations concerning the smell of alcohol on the patient will be placed in the record.

Accident Cases

Counsel for the claimant should ascertain if the defendant was brought to the emergency room following an accident. If yes, that emergency room record should be obtained. The emergency room chart may contain admissions on liability and will document any health issues that played a role in the accident. Perhaps the person forgot to take important medication or continued to drive the car after feeling dizzy. The record will also document if alcohol or drugs were detected.

Chief Complaints

Other noteworthy portions of the emergency room record include the patient's chief complaint section. Are the complaints consistent with the claimant's subsequent listing of medical problems in answers to interrogatories? The records will note the time the patient arrived at the hospital and the method of arrival. Did the patient go to the hospital by ambulance immediately from the accident scene or did the person walk in several hours later? The past medical history section of the record is worthy of review since it may list prior health problems relevant to the current claim such as a pre-existing back problem. Likewise, the failure to disclose a relevant prior health issue provides the appearance that the person is hiding that fact because of anticipated litigation.

Disposition

The emergency room physician has the obligation to order consultations or referrals if necessary to achieve a proper disposition of the case. Basically, there are three patient dispositions: release, refer, or admit. The most obvious order is to merely release the patient from emergency. A referral will be made when additional treatment will be needed, and the patient will be directed to a specific doctor or clinic. For example, a patient with a broken arm will be referred to an orthopedic surgeon for follow up care. The remaining treatment option is to transfer the patient to the hospital. Lawrence M. Deutsch, *The Hospital Chart*, Medical Records for Attorneys, at 26 (ALI-ABA, 2001). Also, the record should contain a notation anytime the patient leaves the Emergency Room "against medical advice." This is noted as "AMA" in the record and is important to ascertain in a claim. *Id.* at 39.

While the emergency room evaluation is not as detailed as an in-patient workup, the record should be fairly complete and well-document-

ed. Mistakes in the recording of information during the emergency room visit, however, are often repeated during the patient's hospitalization since physicians frequently rely on the observations and conclusions of the prior examiner. *Id.* at 39-40.

PATIENT ADMISSION • The Admission Record is usually the first document in the hospital chart. If the patient does not enter the hospital directly from emergency and the admission is planned, the process is much more structured. The admitting physician will initiate the process by contacting the hospital to check on room availability. The decision to admit will be based upon a number of factors:

- Medical problems;
- Past medical history;
- Concerns that the problem may be life-threatening;
- Abnormal test results;
- Abnormal physical examination;
- Unstable medical signs;
- Diagnosis and prognosis;
- Need for surgery; and
- Required care that can not be done on an out-patient basis.

Hospital Admissions—Decision to Admit, www.emedicinehealth.com/articles/11983-3.asp.

Once the date has been cleared by the hospital, a representative of the Admissions Department will contact the patient to arrange for Pre-Admission testing, and a report date and time will be provided. Some hospitals have expedited the process by allowing a patient to complete the necessary paperwork online. The individual merely types in the requested information about biographical data, employment, emergency contacts, insurance, and marriage and then emails the form back to the hospital. Other health care providers may call the patient and

obtain the information by phone. A sample Online Pre-Admissions form may be viewed at www.mission4health.com/admit/index.php?actn=step1.

Consent Form

Upon arrival at the hospital, the patient will proceed to patient registration to complete the final paper work usually called "Terms and Conditions." This document will contain a medical consent form and an authorization to bill the insurance company. *Hospital Admissions*, www.emedicinehealth.com/articles/11983-4.asp. Some hospitals may even ask about advanced directives such as "do not resuscitate" or "DNR." If the person is having same-day surgery, the patient will be escorted to that department. If the individual must be admitted, the patient will be directed to the appropriate hospital room depending upon the level of care to be rendered. For example, a person may be admitted to the intensive care unit ("ICU"), the neuro-intensive care unit ("NICU"), the surgical floor, telemetry, which is a step-down unit for coronary patients, pediatrics, maternity, or the general medical floor.

General Information

Entries in the hospital chart differ in format from those made in the emergency room record. Each event in the hospital will be recorded in a chronological fashion in different parts of the chart according to who made the observation, and the nature of the information. For instance, a hospital physician will conduct an examination of the patient and make an assessment of the patient's body systems. These observations will be detailed in the "history and physical" section of the record. An examination by a specialist will be chronicled in that portion of the chart devoted to consultations. It is also important to recognize that entries are being made concurrently in different sections of the chart, so

counsel must review the information on a date-by-date basis. See Hodge & Kaplan, *supra*, at 54-55.

HISTORY AND PHYSICAL • The history and physical portion of the chart is the starting point for why the person is in the hospital and the recorder of information is usually an intern or house physician.

Chief Complaint

The part of this section entitled chief complaint (“CC”) will detail the patient’s main problems and will be recorded in the person’s own words. For instance, a patient may report that “I have had severe back pain for six months and was told that I need surgery for a herniated disk.”

History Of Present Illness

This notation is followed by the history of present illness, or “HPI,” which sets forth in date order information about the patient’s chief complaints. The patient’s past medical history, (“PMH,”) is the next item and will detail illnesses, injuries, prior hospitalizations, drugs, and allergies. A discussion of the family history (“FH”) is also done because so many health problems have a hereditary foundation. See Hodge and Kaplan, *supra*, at 59.

Review Of Systems

A review of systems (“ROS”) will be undertaken by the examining physician. This review is detailed in a preprinted form that prompts the doctor to ask questions about each body system such as circulation, respiration, the gastrointestinal and urinary tracts, and the reproductive organs.

Physical Examination

A physical examination (“PE”) will be conducted by the doctor with a listing of vital signs

such as blood pressure, pulse, and respiration. One will also observe the abbreviation “HEENT.” This stands for a review of the head, eyes, ears, nose, and throat. *History and Physical Exam*, http://training.seer.cancer.gov/module_diagnostic/unit01_history.html.

Recording a patient’s history and conducting a physical examination is sound medical practice but it is also mandated by certain governmental programs. Medicare and Medicaid require that a physical examination and medical history be done no more than seven days before or 48 hours after admission. The hospital record must also contain information to justify the continued in-patient hospitalization supported by a diagnosis and description of the person’s progress. *Medicare and Medicaid Service Policy for Hospital Admissions*, Centers for Medicare and Medicaid Services, www.cms.hhs.gov/Medicaid/survey-cert/012802.asp.

PROGRESS NOTES • Once the patient’s hospital chart has been created, subsequent entries will be recorded in the progress notes. These remarks are made by the attending physicians, are usually the most detailed in the record, and represent their observations of the patient on a day-by-day basis.

These notes tend to be brief and will usually follow the SOAP format. Entries will also be accompanied by a date and time. *Progress Notes*, <http://mededucation.bjmu.edu.cn/reference/reference/chapter%20one/progressnotes.htm>.

The Need To Review Other Records

Most hospitals allow physicians to record entries only in the progress notes section of the chart. Therefore, other portions of the record must be reviewed simultaneously by date and time to gain an appreciation on how events unfolded. By reviewing the progress notes and then referring to the order sheets to ascertain

what directives had been issued for diagnosis or treatment, a blueprint is reconstructed through the maze of events. See Hodge and Kaplan, *supra*, at 60.

DISCHARGE SUMMARY • The discharge summary is one of the most frequently requested records by counsel but is the least accurate. Discharge summaries tend to be cursory, are often completed by a junior member of the staff, and may not be completed for weeks or even months after the patient has been discharged. At this time, the doctor's memory of events is no longer fresh, and the summary must be reconstructed from the chart. Also, if the patient suffers an adverse event before the discharge summary is completed, the document can be questioned as being self-serving to the extent that it contains exculpatory statements not otherwise contained in the chart. *Preventative Law in the Medical Environment—Discharge Records*, LSU Law Center's Medical and Public Health Law Site, <http://publichealthlaw.lsu.edu/Books/asp/Aspen-Discharg-2.html>.

Inaccuracies Common

A variety of research studies have been conducted to gauge the reliability, effectiveness, and accuracy of the discharge summary. Most have demonstrated glaring errors in these records. One such study found that the typical discharge summary was only 63.6 percent accurate, with errors occurring in all phases of production. Stephen Wilson, Warwick Ruscoe, Margaret Chapman and Rhona Miller, *General Practitioner—Hospital Communications: A Review of Discharge Summaries*, 21 J. Quality Clinical Prac., 104 (Dec. 2001). Another study reported considerable deficiencies in the completeness of the discharge summaries in 34 percent of the cases. Carl van Walraven, and Anthony Weinberg, *Quality Assessment of a Discharge Summary*

System, 152 Can. Med. Ass'n J. 1437 (1995). A sample discharge summary appears as Appendix 1 at the end of this article.

NURSES' NOTES • Nurses have the most patient contact and they will record their observations each time they visit a patient. This written information can include notations about the patient's vital signs, pain observations, and notifications to the attending physician of a patient's worsening condition or need for medication.

ORDER SHEETS • Each day during a hospital stay, a listing is made of tests ordered by the attending physicians or medications to be given to the patient. A request for a consultation by another physician will also be noted in the order sheets section.

OPERATIVE REPORT • Whenever surgery is performed, the physician is mandated to issue a preoperative statement of the purpose of the surgery, a preoperative diagnosis, and to list the procedure to be performed. For instance, the preoperative diagnosis may be a "herniated nucleus pulposus at L4-L5 with a laminectomy and discectomy." The physician may also note the history of present illness.

This information will be followed by a discussion of the actual surgery performed, the findings, and complications. For instance, the actual surgery may end up being a "two level fusion at L4-L5 and L5-S1." The name of the physicians in attendance will also be provided and a narrative description of the actual surgery may follow.

This part of the record may contain separate reports by the anesthesiologist or anesthetist and pathologist if a specimen was harvested for analysis. It is also useful to ascertain the amount of time the operation took, blood loss, and complications. This information is one way of minimizing or maximizing the seriousness of an op-

eration in the eyes of the jury. For example, a carpal tunnel release does not sound so serious if the jury learns that the procedure took 25 minutes with no accompanying blood loss and no complications. A sample operative report appears as Appendix 2 at the end of this article.

MISCELLANEOUS RECORDS • Miscellaneous records will include treatment and examination by members of the physical therapy department and incident reports such as a fall or possible malpractice claim.

Incident Reports

An incident report is an important way for the hospital staff and risk management department to communicate over patient care issues that may result in litigation. These reports are also mandated by certain regulatory reporting requirements and liability insurance carriers. The following are a few examples of clinical problems that mandate immediate reporting: blood administration errors, severe medication mistakes, missed diagnosis, infant discharge to the wrong family, and surgery on the wrong body part. *Incident Reports, A Guide to Legal Issues in Health Care*, University of Pennsylvania Health System, www.uphs.upenn.edu/legal/inre.html.

RESEARCH AND INVESTIGATIVE TIPS •

Any claim involving a doctor as a party or witness requires special handling. The physician is at an advantage because of the individual's superior medical knowledge. There are ways, however, of leveling the playing field.

Background Investigation

Many court systems maintain accessible dockets on the Internet. Conducting a docket search on the opposing party or medical expert may reveal interesting information about the

person's claims history as well as other litigation problems. Perhaps the treating doctor is having financial difficulties and has been sued by creditors. This may be an effective way of attacking a large bill for treatment.

Previous Litigation

If a previous lawsuit has been discovered involving the physician as an expert witness or treating doctor, contact the attorney who represented a party in the prior claim and ask about the doctor's credibility. If you are defending a personal injury claim, ask for copies of prior medical records authored by the doctor and depositions involving the plaintiff's medical expert. Perhaps the physician issues similar reports in different cases.

Credentials

Always check the credentials of the opponent's expert. Is the physician board certified? "The intent of the certification of physicians is to provide assurance to the public that those certified by an ABMS Member Board have successfully completed an approved training program and an evaluation process assessing their ability to provide quality patient care in the specialty." The American Board of Medical Specialties can be found at www.abms.org. In this regard, an expert may list a number of board certifications but they may not be recognized boards. There are only 24 approved board specialties. (Refer to the ABMS website for a list of the official board certifications.) To verify a physician's medical credentials visit the ABMS website and look for "Who's Certified." Verification may also be done by telephone at 1-866-ASK-ABMS (275-2267).

State Disciplinary Proceedings

Counsel should not overlook checking to see if the physician has been the subject of any disciplinary action. This may be done by checking

with the appropriate state medical board. www.fsmb.org.

National Practitioner Data Bank

In 1986, Congress found that there was a need to restrict the ability of incompetent health care practitioners to move from state to state without disclosing their professional histories. Thus, the National Practitioner Data Bank was created to maintain records on health care providers that track disciplinary actions and malpractice judgments. At the present time, this information is only accessible to hospitals and state medical boards. Some states, however, such as Massachusetts and New York, have opened their data banks to the public.

Special Interest Groups

Special interest groups maintain files on medical witnesses. The plaintiff's bar is extremely organized in this way and one merely has to contact the appropriate trial lawyer's association to obtain a dossier. The defense can contact an organization called IDEX to learn about the testimonial history of a medical witness, articles written by that expert, and disciplinary action involving that physician. IDEX may be contacted at 1-800-521-5596 or through the Internet at www.idex.com.

Internet Searches

The Internet is a wonderful source of medical information. Google.com is the best search engine and provides access to articles, pictures, and discussion groups on specific topics. Advanced searches can also be done to look for specific grouping of words. A similar site is www.AlltheWeb.com.

General Medical Information

Conducting medical research on the Internet is also easy. The numbers of websites that provide medical information are endless. Web MD

advertises itself as the most extensive library on the web. Its Internet address is <http://aolsvc.health.webmd.aol.com/home/default.htm>. An excellent source of medical article abstracts, or to conduct a search by author, topic, or journal is PubMed. This service is run by the National Library of Medicine and includes over 15 million citations for articles going back to the 1950s. PubMed also includes links to many sites that provide full texts to articles and other related resources. www.ncbi.nlm.nih.gov/entrez/query.fcgi?SUBMIT=y.

Specialty Information

Most medical specialty organizations maintain web sites that provide information on medical conditions within their respective disciplines. This information provides great cross-examination of a medical expert within that discipline whose treatment or opinion is contrary to the standards established by that Board. The following are examples of web sites maintained by various medical specialties:

- American College of Radiology—www.acr.org/html;
- American Academy of Neurology—www.aan.com/professionals;
- The American Academy of Orthopaedic Surgeons—www.aaos.org.

The Medical Multimedia Group offers one of the best sites for learning about different orthopedic problems. The Medical Multimedia Group provides easy to understand explanations along with a variety of multi-media tools to bring the subject to life. www.medicalmultimedialogroup.com/opectoc.html. American Spine.com focuses on back problems and its site offers animations on procedures involving the spine. www.americanspine.com.

Medications

Medication plays a large role in patient treatment and having a basic understanding of what

medicines are used for is important. This is not a difficult task when counsel has access to the Internet. The PDR is one of the best sources of learning about the purposes and risks of medication. This book may be purchased in most large bookstores and can be accessed at <http://www.pdrhealth.com>. MedLine Plus is another reference that provides information on thousands of prescriptions and over-the-counter medications. www.nlm.nih.gov/medlineplus/druginformation.html. Counsel can also type the name of the medication on the Internet to learn more about the medication.

Government Agencies

Government agencies provide useful information on specific medical issues, offer statistics on medical problems, and post research studies that are helpful in cross-examining a medical expert.

National Institute For Occupational Safety And Health

For example, the National Institute for Occupational Safety and Health (“NIOSH”) is the federal agency responsible for conducting research and making recommendations for the prevention of work-related injuries and illnesses. This agency’s site may be accessed at www.cdc.gov/niosh/homepage.html.

Centers For Disease Control

The Centers for Disease Control (“CDC”) maintains a site that explains a number of medical problems with links to additional research tools. The CDC is part of the Department of Health and Human Services which is the principal agency in the United States government for protecting the health and safety of Americans and for providing essential human services. www.cdc.gov/az.do.

National Institute of Arthritis, Musculoskeletal And Skin Diseases

The National Institute of Arthritis, Musculoskeletal and Skin Diseases supports research involving these topics and disseminates information on research progress in these disease processes. See www.niams.nih.gov/an/index.htm. The Food and Drug Administration is responsible for protecting the public’s health by assuring the safety, efficacy, and security of drugs, medical devices, and the public’s food supply, cosmetics, and products that emit radiation. This agency offers opinions on the efficacy and safety of different medications and medical devices. The FDA can be accessed at www.fda.gov/cdrh/ct.

Medical Illustrations

It is frequently desirable to obtain medical illustrations for trial. A number of organizations have materials that can be used for this purpose. For example, A.D.A.M., Inc. provides detailed illustrations and medical explanations for every part of the body. See www.adam.com/index.html. Frank Netter, M.D., remains one of the best medical illustrators and his collection of drawings can be located online at: www.netter-images.com. Medical Legal Art markets 3-D images as well as animations of various medical conditions and procedures. This organization is specifically geared to providing illustrations for attorneys. They may be contacted at: www.medicallegalart.com or www.doereport.com.

RETENTION OF MEDICAL RECORDS • The length of time a medical organization must retain patient records varies by state. For example, Pennsylvania requires medical records to be maintained for at least seven years from the last entry. In addition, the records of children must be retained for at least two years after the child reaches majority, or seven years after the last entry, whichever is later. 49 Pa. Code §25.213.

The American Medical Association offers the following guidelines on Retention of Medical Records:

“Medical considerations are the primary basis for deciding how long to retain medical records. For example, operative notes and chemotherapy records should always be part of the patient’s chart. In deciding whether to keep certain parts of the record, an appropriate criterion is whether a physician would want the information if he or she were seeing the patient for the first time.”

Even Medicare has issued directives on record retention and requires medical information to be maintained in its original or legally reproduced form for a period of at least five years. 42 C.F.R. §482.24 (b).

CONCLUSION • Medical records are critical to properly handling a personal injury claim. Obtaining and understanding these documents, however, is not always an easy task. A patient’s records are protected by federal and state laws. Even though a claimant waives the doctor-patient privilege when a personal injury claim is advanced, there are a number of procedural hurdles that must still be overcome before the documents will be released. A properly worded and executed release that complies with HIPAA is certainly the easiest way of requesting the records, but that route may not always be possible. The records may have to be subpoenaed and a technical mistake in the request may delay the receipt of the records for quite some

time. Some health care providers may also ignore the subpoena maintaining that the records will not be released without a properly executed medical release.

Regardless of the challenge, counsel must be diligent in the pursuit of these documents because of their importance. Cases can be won or lost based upon what is contained in a patient’s chart, so counsel needs to review this documentation. An attorney should also not overlook the importance of obtaining non-accident records, such as the family doctor’s records, and in obtaining updated records before trial.

Understanding the medical documentation once it is received takes a little practice. That task can be simplified when counsel understands how the records are arranged and the meaning of the various sections of the patient’s chart. Although the organization of those records may differ among health care providers, the sectional format should be the same and present a story of the patient’s care over time.

The Internet should not be overlooked as a reference tool in helping to understand the records and in conducting a background search on the medical witness. The expert’s testimonial history and medical qualifications are key points to investigate. Also, counsel has the ability to retrieve any number of documents from the Internet, especially medical abstracts on very specific medical issues and guidelines from medical organizations on how to treat medical problems. These documents are very useful in examining the physician at trial.

To purchase the online version of this article, go to www.ali-aba.org and click on “online”

APPENDIX 2
Sample Operative Report
Philadelphia Memorial Hospital
Operative Report

John Adams **Date:** 05/10/06
Number: 322798 **Dictated by:** Dr. Peter Smith
Pre-Operative Diagnosis: Grade II Spondylolithesis at L4-L5 with instability at L4-L5 and L5-S1.
Post-Operative Diagnosis: Same
Procedure: Bilateral L4-L5 and L5-S1 decompressive laminectomies/foraminotomies with fixation/ fusion.
Surgeon: Jonathan McCoy, M.D.
Assistant Surgeon: Peter Smith, M.D.
Anesthesia: General endotracheal with 12 cc of 1% Lidocaine.
Estimated Blood Loss: 1200 cc and 350 cc were transfused back.
Complications: None.
Objective Findings: A severely narrowed thecal sac between the L4 and S1 levels.

Summary:

Mr. Adams was involved in a motor vehicle accident two years ago and has developed intractable pain. During the past month, he has developed worsening neurological complications and his spine has become unstable. He is now brought to surgery for decompression and fusion.

Procedure Description:

The patient was turned on to the spinal table in the modified knee to chest position. An incision was carried down through the subcutaneous tissue, fat, and fascia. Using a large Leksell rongeur, the spinous processes at L4 and L5 were removed and decompressive laminectomies were completed. Foraminotomies were completed bilaterally for the L4-L5 and L5-S1 nerve roots. Once the nerve roots and thecal sac were appropriately decompressed, attention was made to the fixation/fusion part of

the procedure. Pilot holes were made and Steinman pins fitted. Harvested bone was then divided and placed over the appropriate transverse processes. The surgical cavity was copiously irrigated, the skin closed using a running stitch, and sterile dressings were applied. The patient was transported to the recovery room in stable condition. All sponge and needle counts were correct.

DD: 05/13/06

Jonathan McCoy, M.D.
Surgeon

PRACTICE CHECKLIST FOR Unraveling The Mystery Of Medical Records

Every time a person receives medical care, a record should be made of that visit and the record should which should detail the patient's complaints, the physician's observations, and treatment outcomes. These records, however, are usually confidential. In a personal injury setting, counsel can force the disclosure of the information in most situations but must comply with a variety of rules and regulations. Understanding the records once they are received can also be a challenge.

- There are a number of key points to keep in mind that should make an attorney's job easier when dealing with medical records. Armed with practice and a medical dictionary, attorneys will discover that understanding the medical chart follows a learning curve that can be mastered.
- Counsel for the plaintiff must obtain the medical records in order to investigate the merits of the claim and to properly document the injury.
- While the task of plaintiff's counsel in obtaining the records is easier than opposing counsel's, all authorizations must comply with the HIPAA requirements as set forth in 42 U.S.C. §1301 et seq.
- Counsel for the defense should not rely on the medical specials submitted to the insurance carrier by plaintiff's counsel. There is no mandate that these records be complete, and plaintiff's counsel may disclose only favorable information.
- Once the case is in suit, the defense should always issue formal discovery and obtain answers under oath. Unless court rules mandate the use of specific interrogatories, defense counsel should always include a series of questions that focus on the claimant's general health, including the names of the family doctor, pharmacy, and insurance carrier.
- Counsel should always obtain the full medical records of the claimant and not just isolated pages such as a hospital discharge summary.
- Medical records fall within two general categories: physician office notes and the hospital chart. If an ambulance or emergency vehicle was dispatched to assist the claimant, a record will also exist of that service.
- Physicians' office notes will not follow a uniform format but there will be certain standard types of information in these records, including an initial patient questionnaire, progress notes, correspondence from third parties, diagnostic procedures, and miscellaneous records.
- Doctors may record office visits in loosely worded paragraphs or they may follow the SOAP format to provide a uniform recording system. This acronym stands for subjective, objective, assessments, and plan. "S" is a statement of the patient's subjective complaints on the date of the exami-

nation. "O" represents the physician's objective observations and findings. "A" refers to the doctor's assessment of the situation. "P" explains how the physician plans on proceeding with treatment.

- When a rescue squad is at the scene, a record will be made of the crew's observations and examination of the claimant. This is a useful record to review since the comments will be from a neutral observer and will document the claimant's condition without the outside influences of a third person.
- Hospital charts are more formal than the records of health care practitioners and will follow a more uniform format. The individual units of the hospital record include:

- __ Emergency room record;
- __ Patient registration;
- __ History and physical;
- __ Progress notes;
- __ Consultations;
- __ Laboratory studies and diagnostic tests;
- __ Nurse's notes;
- __ Medication sheets;
- __ Physician's orders;
- __ Operative notes and pathology reports;
- __ Discharge summary;
- __ Incident reports;
- __ Consent and other miscellaneous forms.

- The emergency room record is a very important document in the investigation of a claim. It establishes a baseline for the patient's complaints and will usually contain a statement from the plaintiff concerning the event.
- The hospital admissions department will require the patient to complete the necessary paperwork including a medical consent form and an authorization to bill the insurance company.
- The history and physical section of the chart is the starting point for why the person is in the hospital and the recorder of information is usually an intern or house physician. This section will include the patient's chief complaints, a review of the important body systems, and physical examination.
- Once the patient's hospital chart has been created, all subsequent entries will be recorded in the progress notes. These remarks are recorded by the attending physicians and represent their observations of the patient on a chronological basis.
- The discharge summary is one of the most frequently requested records by counsel but it is the least accurate. Many times, the record is completed by a junior member of the staff subsequent to the patient's discharge and will be cursory in nature.
- Whenever surgery is performed, the physician will issue a preoperative statement regarding the purpose of the surgery, a preoperative diagnosis, and the procedure to be performed. The physician may also note the history of the present illness. This information will be followed by a discussion of the actual surgery performed, the findings, and complications.
- Miscellaneous records will include treatment and examination by members of the physical therapy department, and incident reports such as a fall or potential malpractice claim.