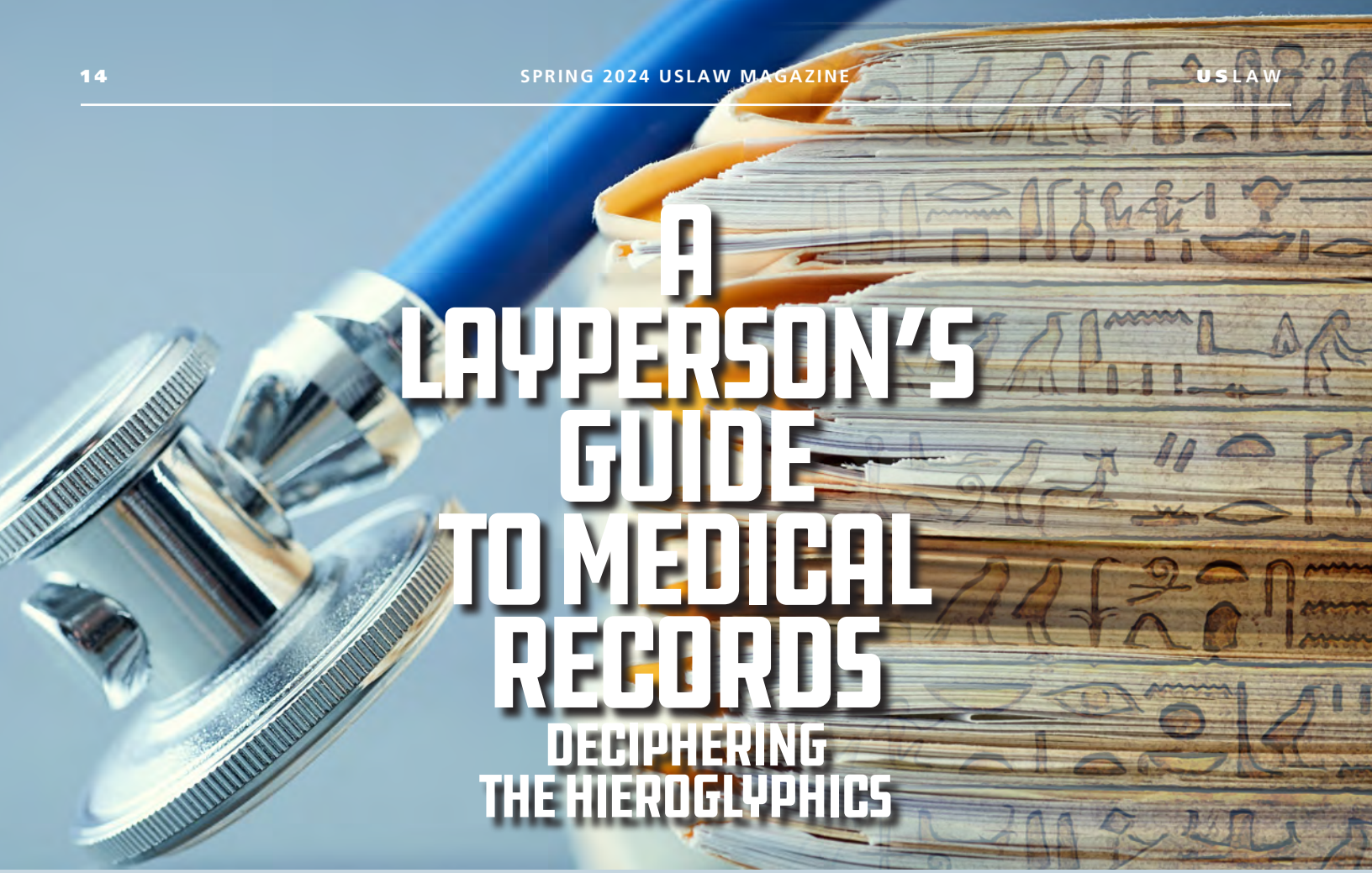

A LAYPERSON'S GUIDE TO MEDICAL RECORDS

DECIPHERING THE HIEROGLYPHICS

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I just finished a two-week trial defending a claim of traumatic brain injury following a significant crash involving an 18-wheeler. The property damage was enough to convince the jury that injury occurred. Only it didn't, at least in the immediate aftermath, as the plaintiff was able to walk away literally unscratched.

The plaintiff saw multiple professionals, claiming he suffered a litany of symptoms, including headaches, dizziness, forgetfulness, mood issues, and tinnitus. All of which are technically indicative of traumatic brain injury (TBI). It was the plaintiff's contention that this purported TBI was sustained as a result of the accident, and he asked for $10 million from the jury.

The plaintiff's attorneys showed excerpts of medical records to the jury and went through each symptom, using the word "documented," as in, "these symptoms were all documented in the medical records." This was to insinuate that the "documentation" of these symptoms in the medical records was conclusive evidence of the existence of these symptoms and, thus, proof of TBI.

The key to the defense in this case was to distinguish between the subjective symptoms the plaintiff complained of and the objective findings, which were practically non-existent.

It dawned on me that my background as a medical malpractice defense attorney may put me in a unique position defending catastrophic general liability claims, and I am hopeful that the information imparted here will help adjuster and defense attorney alike.

To that end, medical records are key, yet often avoided or given short shrift. Either they are given to a younger associate to summarize, or they are perused only to ascertain the treatment obtained and bills incurred. Often, they are outsourced to a service, as, unfortunately, insurance clients will not always pay for attorney time to more thoroughly analyze them. Moreover, records are often only sought from the date of the occurrence, and no prior records are obtained.

What if I told you this is a serious mistake? That the difference between a cursory review and an in-depth analysis could easily translate into thousands, or even hundreds of thousands, in savings in damage awards/settlement values?

Let's start with a primer on what the seemingly Greek terminology means.

SOAP NOTES

Almost all medical records utilize SOAP notes. SOAP stands for "Subjective, Objective, Assessment and Plan," which breaks down to the following:

Subjective: The information documented in this section is also called "symptoms." Symptoms by definition are the *subjective complaints* of the patient.

This is where the health care professional (HCP) will take a "history" from the patient and will note what the patient tells them. It is important to realize this section is solely the patient's narrative. As in, "what, brings you in, Mr. Smith?" "Well, I have a headache." This does not mean that it's true. This is what plaintiff's attorney claimed was "documented" in my TBI trial.

This section will include a "history of present illness (HPI). In the personal injury realm, this details the occurrence as the date of onset of the symptoms. Think "patient fell on leaking water at the store." While this is usually self-serving, occasionally you will find a helpful detail. Perhaps the records were obtained to defend a car accident, and the aforementioned HPI was provided. Now you know there was a possible superseding and intervening cause of the claimed injury.

The subjective section can also be helpful when the patient does NOT provide a history of the pain/injury as this can be great evidence they are not suffering as they claim. Always obtain records from the

primary care provider ("PCP"), where the plaintiff went for a physical in addition to the providers seen for the injury.

You may learn that the plaintiff had a prior cervical fusion or suffers from diabetes. A good HCP will take a thorough history noting the patient's personal history, family history and current medications. Sometimes the medications can be indicative of other relevant conditions or injuries. For example, if the patient is taking Sumatriptan prn, you have the clue that they suffer from migraines, and the current complaints of accident-related headaches can be discounted as pre-existing.

Objective: In contrast to the subjective complaints, objective findings are made by the HCP. These are also called "signs" and can range from an observation, such as "patient is sweating profusely," to vital signs to findings on physical exam, like range of motion ratings and strength evaluations. While these findings are more reliable than the plaintiff's subjective complaints, there is still a measure of subjectivity, i.e., a finding of weakness or loss of motion.

Assessment: The HCP provides their differential diagnosis, which is a list of all potential causes for the signs and symptoms. In the headache example (at least at the initial visit), a differential diagnosis would include migraine, stress, hypoglycemia, hypertension, and possibly even tumor, in addition to TBI. When a provider leaps to a conclusion designed to fit the narrative of the lawsuit, you can be assured you are dealing with ADM (Attorney Driven Medicals).

This is useful on cross examination, as you'll want to question that provider as to why they did not consider all other potential causes.

Plan: The HCP will suggest additional testing to rule out differential diagnosis and set out treatment recommendations.

The key to using this information is to note the date of these recommendations and compare that to the actual treatment sought and obtained by the plaintiff. If he was really suffering from debilitating headaches, why did he not fill the script for headache medication? Why did the claimant - with back pain causing limitations to her range of motion - not go to physical therapy?

APPLYING THE RECORDS TO YOUR DEFENSE OF A CLAIM

How badly was the plaintiff hurt? Even some of the worst injuries, like a fractured pelvis or ruptured organs, can heal remarkably well and quickly. Conversely, some simple herniated discs can result in multiple surgeries. It is important to actually read the medical records to determine the ratings of pain, the length of hospitalization, and the need for surgery. Obtain the employment records and cross check for dates the plaintiff missed from work.

What are the reasonable treatment modalities? If plaintiff is claiming a sprained ankle but then chiropractic records show back massage, well, you get where I'm going with this. Do not accept all bills submitted without giving them a hard eye. I have seen bills submitted for gynecological exams, glasses, hearing aids, routine blood work, and hypertension medication, none remotely related to the injury.

What is the prognosis for that injury - any permanency or loss of a normal life? Look for indications of 'treatment goals' and the records from when and if the patient was discharged from care. Do they say that they anticipate a return to pre-injury status? Think of this when countering plaintiffs who claim they can no longer do yard work when, before the accident, they never did yard work.

On the contrary, you may need to evaluate the claim for more money if the claimant is left with something permanent. Scarring, loss of range of movement, or a limp can all drive up the cost of a claim.

Taking a treater's deposition can yield interesting results as the treater will have a self-interest in establishing their treatment as effective and that they were able to bring the patient back to pre-accident level of function. Some well-crafted questions may have that treater giving you helpful testimony to counter the claims of future needs. This is important because the verdict form provides multiple opportunities to award future damages. It's easy to focus on past damages and forget that claims for future damages can result in big numbers from the jury.

CAN THAT INJURY BE ATTRIBUTED TO A PRE-EXISTING INJURY OR TO DEGENERATIVE CAUSES?

Records should be sought from a few years prior to the accident to look for pre-existing injury. Check the court docket for other lawsuits, do an ISO search, and get employment records for evidence of lost time from work, workers' compensation claims, and other on-the-job injuries or accommodations made, for say, a bad back. Be wary of states that have an unfavorable jury charge regarding exacerbation of pre-existing injury. This is the "eggshell skull plaintiff," or someone so fragile they were unreasonably injured by the simplest of incidents. It is important to find evidence of the problems that injury was causing before the accident, like claims of pain, treatments sought, medications prescribed, and imaging showing the already herniated disc, for example. Otherwise, you will get the counter that while the plaintiff may have had a herniated disc, it was not painful before this accident, and the defendant is then potentially on the hook for all post-occurrence pain and treatment.

Consider if the plaintiff is suffering from a degenerative condition which would have occurred irrespective of the occurrence. This may require expert testimony, but it should be considered when the records have evidence that a degenerative condition is causing the plaintiff's problems.

As far as degenerative conditions go, there are lots of synonyms. Look for words like arthritis, stenosis, osteoarthritis, degenerative disc disease and bone spurs. A quick Google search will often yield a definition that makes clear the condition is a chronic condition resulting from the normal aging process versus an acute injury.

HOW CONSISTENT ARE THE RECORDS?

Sometimes, a thorough review of the medical records will show that while the patient was treated often, the complaints were wildly different at each visit. At times, the patient complains of shoulder and neck pain, and then at the next visit, it's the knee that is bothersome. Not to say that the initial stages of an injury can't result in diffuse body aches, which may present differently on different days, but months of records that show inconsistent complaints can be used to discredit claims of injury. Again, this requires a more concentrated, thorough and comparative analysis of the medical records than we often give.

While medical records can first seem a bit daunting to read and decipher, they really are the key to defending personal injury claims, be it at the claims level for a simple slip and fall on commercial property or at trial in a traumatic brain injury case.

Melissa Casey is a shareholder at MehaffyWeber and a seasoned litigation attorney with an extensive background in personal injury and business litigation. She is a graduate of George Washington University, where she worked as an intern for Congressman John E. Porter, and DePaul University, College of Law.