

## Physician Office Records: Are They Complete?

### Who we are...

Since 1989, Med League Support Services, Inc. has aided attorneys in 37 states. We perform these services:

- Analyze medical records
- Develop case chronologies
- Screen malpractice cases for merit
- Prepare PowerPoint presentations for settlement negotiations or trial
- Provide literature searches
- Prepare pain and suffering reports
- Transcribe handwriting
- Prepare life care plans
- Prepare Life Activity Calendars
- Assist with demonstrative evidence
- Prepare medical illustrations
- Assist with preparation of demand letters and settlement brochures

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Attorneys often ask Med League to organize medical records for the purposes of doing a medical summary or to send to an expert. The question may arise: Are these records complete? There are wide differences in how records are kept and supplied to an attorney. Some physicians' offices will yield everything in the file, whereas others will decide what the attorney (or patient) should receive. Knowing what should be in the file enables Med League's nurses to recognize what is missing.

Office records may span the lifetime of an individual, although this is not common with today's mobile society. Office medical records are typically not as voluminous as hospital or nursing home records. The method of organization for the following sections is variable from office to office. In addition, some physicians will keep laboratory, radiology, and correspondence next to the corresponding office visit note. The following list details components that may be found within office records.

**Initial intake form:** This is a document that is typically filled out by the patient and details complaints and other illnesses. The intake form summarizes current medications, allergies, past



surgeries, previous hospitalizations, prior illnesses, vaccination record, social history, which includes employment, marital status, lifestyle habits such as smoking, alcohol intake, seat belt usage, exercise, the presence of advanced directives in place and power of attorney. Also noted is family history including the health status of parents and siblings or current illnesses of these family members, and a check-off list of symptoms previously or currently experienced.

### **Initial history and physical:**

The physician performs a detailed history and physical the first time the patient is being seen.

**Problem list:** Once the initial history is obtained, the physician office will frequently make a separate and continually updated list of medications, allergies, and vaccinations, as well as a list of all chronic illnesses or conditions. These are sometimes

consolidated into one summary sheet and kept highly visible on the left hand side of the patient file as it is opened.

**Physician office notes of visits:** Notes may be dictated and transcribed, handwritten, documented in the form of reports to a referring physician, or entered into an electronic medical record. Data should include weight, blood pressure, pulse, complaints, examination findings, diagnoses, treatment and plan for care, including prescriptions and advice on when to return to the office. Physician assistants and nurse practitioners may alternate with the physician in seeing the patient and recording in the chart. Appointments missed by the patient may be noted as “NS” (no show), or “DNKA” (Did Not Keep Appointment.)

**Laboratory, radiology, EKG and other medical procedure results:** Test results should have some notation either on the test report itself or within the physician office notes that the results were reviewed by the physician, communicated to the patient, and that follow-up was given to the patient, if necessary, to further evaluate the results or monitor the findings at a specific time interval. This can be accomplished through a phone call, letter, or follow-up office visit. Some physicians simply initial the test results. Routine and normal results may be communicated to the patient by the office staff following a specified office procedure.

**Correspondence:** This section includes letters sent to and from the physician, consultation notes with other physicians, outpatient services such as physical therapy, and letters sent to or received from the patient. It should also include email messages to and from the patient.

**Copies of hospital records:** Included are discharge summaries, histories and physicals, operative reports, and consultations from other physicians. Copies of hospital records are not always included and may be incomplete if present.

**Home health care records:** The office records may include reports from the agency providing care under the direction of the office. Records typically

include the plan of care and discharge summaries. **Phone call records:** These are frequently noted before or after office visits to maintain an easily readable time sequence of events. Phone message slips may be taped or stapled to office records.

**Billing records:** These documents may or may not be kept within the body of the medical record and should be compared with the dates of the office visits to see if all visits are documented in the form of notes.

**Prescriptions:** On occasion, copies of prescriptions for medications or therapeutic treatments will be found within records.

**Return to work or excuse from work/school notes, and disability records:** Copies of these forms are kept in the records.<sup>1</sup>

Med League’s legal nurse consultants have been asked to transcribe difficult to read physician handwriting and to provide an analysis of records that look altered. Contact us for further information about these services. Refer to [www.medleague.com](http://www.medleague.com) for information on our new product, Detection of Tampering with Medical Records Toolkit.

1. Modified from Starke, K. and Starke, G. *Office-based Records*, in Iyer, P., Levin, B., and Shea, M.A., (Editors) *Medical Legal Aspects of Medical Records*, Tucson, Lawyers and Judges Publishing Company, 2006. See the webstore at [www.medleague.com](http://www.medleague.com) for ordering information.

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### ***“I did not know that you did that too!” Most frequently requested services from Med League:***

-Screening a medical malpractice case for merit, with services provided by our board certified physician reviewers to enable the plaintiff attorney to select the most viable cases

-Locating nurses, physicians, pharmacists, physical

therapists, physician assistants, and others to serve as expert witnesses to save you time in finding well-qualified people

-Transcribing healthcare provider handwriting to improve understanding of the content of medical records

-Preparing medical summaries and chronologies to encapsulate the essential details of a case

-Developing comprehensive summaries of medical records to effectively communicate to a mediator or jury the details of symptoms and treatment

-Identifying key pieces of information such as blood alcohol levels or mental competency at the time a will was signed to help determine legal issues

-Assisting in the preparation of medical illustrations and timelines to use to communicate with the mediator or jury

See the services section of [www.medleague.com](http://www.medleague.com) for more information.

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## Resistance to Expert Fact Witness Role Decreasing

The decision by Judge Sabatino in Trenton, NJ in May 2002 in the Heinzerling case has, in my experience, reduced the objections to the use of a nurse to explain medical records. In Heinzerling, which was ultimately settled, a nurse prepared a report to explain the months of treatment a patient received following a delayed diagnosis of lung cancer. After the defense filed a brief to exclude the report of the nurse, Judge Sabatino determined that it was acceptable to use a nurse to conveniently and effectively explain medical records. Gerald Stockman was the attorney in this case.

I have been providing this service since the early 1990s, and have testified in New Jersey and Pennsylvania in this capacity. Most recently, in *Richmond v. Electrolux Home Products, Inc*, an Essex County jury awarded \$5 million to two toddlers who were burned when a pot of boiling water

landed on them. My role involved explaining the medical records and the details of burn treatment to the jury. One of the children was horribly disfigured by the incident with burns on her scalp, shoulders, and back. Other portions of her body were used for skin grafting donor sites. This was the 10<sup>th</sup> in the top 20 personal injury awards of the year, according to NJ Law Journal, September 19, 2005. The attorney was Kenneth Cohen of Jacoby and Meyers.

In a trial held in the electronic courtroom in New Brunswick, NJ in September, 2005, the judge was fully supportive of my role in explaining the medical treatment and responses of William Levine, a man who was hit by a car. Mr. Levine lived for about 21 days after the injury. My testimony was augmented by Powerpoint slides created from the exhibits in my report. The majority of the testimony focused on the first portion of his admission when he was alert, talking, and aware of his injuries before he was sedated to reduce his awareness. Although the jury found that the defendant was negligent, they did not find that the negligence was the proximate cause of the patient's injuries. This case was tried by Morris Brown and Michael Barrett of Wilentz, Goldman & Spitzer.

In a workplace accident case, Hector Valentin was a new employee who was pulled face first into a lathe. The impact crushed portions of his forehead and face and removed his eye. Hector suffered brain trauma, emotional scars, and disfigurement. His tendency to form keloid scars meant that reconstructive plastic surgery was not effective in erasing the effects of the trauma. My report included scanned photos of the patient, and a summary of the voluminous medical records generated during the course of his acute care admission and subsequent rehabilitation stay. The case was settled by Marc Saperstein of Davis, Saperstein, and Salomon for \$4 million.

Use of a nurse to explain medical records is effective when records are voluminous and the injuries are significant. The report may incorporate timelines, medical illustrations of injuries, lists of major problems, graphics showing medication that was required, scanned portions of medical records, and other exhibits. This presentation uncovers the information in the medical record in a way that helps the layperson understand what happened to the patient. *Pat Iyer*



*From the  
President's  
Desk*

## From the President's Desk: What did I say?

The Joint Commission for the Accreditation of Healthcare Organizations has found that a deficit in communication is the number one reason medical errors are made. Treatments are missed, steps are omitted, wrong operations are performed, orders are heard incorrectly, and patients are misidentified or misunderstood. Distractions, lapses, accents, noise, fatigue, stress- all play a role in communication barriers. I often say that one of the hardest aspects of life is delivering and receiving accurate communication. Communication barriers affect trial attorneys in their roles from the moment a client is first seen to the time the jury delivers its verdict, and beyond.

What can you do to improve communication at the office? Consider these top ten suggestions.

1. Recognize that we talk at 125 words per minute, but can listen at 900 words per minute. Active listening requires us to concentrate and not use the excess time to think of other things.
2. Hold discussions in an environment that is as quiet and non-distracting as possible. Close the door to your office, hold calls, and focus on the person or people in front of you.
3. Speak the same language as your listener. Use examples and words that will be easily understood by your listener. While this is readily understood as a skill needed when communicating with the jury, it is equally valuable in the office.
4. Acknowledge the role of intimidation in communication. Your ability to receive another's message is affected by how you feel about that person and his or her authority. Similarly, your employees must feel comfortable and respected by you in order to hear your messages. A hierarchical, autocratic management style shuts down communication.
5. Time constraints affect our ability to receive information. Being rushed and feeling out of control and pressured leads to errors in communication and performance. Checklists that are followed in these situations help to ensure that errors are not made. For example, have a checklist that directs what needs to be taken to a mediation or deposition so critical documents are available.
6. Assign a team leader to a project. One person should coordinate all of the steps needed to complete the assignment. For example, if you are redesigning your marketing campaign, make one person in charge.
7. Design structures to deal with handoffs or the turning over of responsibility for a file to another person. What information needs to be conveyed to the person who is accepting the responsibility? For example, when the associate is sent to attend a deposition, what needs to be understood?
8. Be aware that lack of communication, or a withdrawal from another person may be interpreted as a lack of interest, concern, knowledge, leadership, or respect.
9. Periodically ask the listener to rephrase or repeat what you've said to ensure that the message has been understood. Some people will outwardly indicate they understand, while inwardly feeling confused about the message.
10. Hold regular staff meetings to discuss plans, performance, and problems. At Med League, we start each day in a brief session. We prioritize the activities for the day, discuss any systems issues, and keep focused on long-term projects, such as getting ready for an exhibit or seminar. This daily planning session has reduced interruptions over the course of the day and last minute rushes and has improved our communication.