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# How To Read and Interpret Medical Records In Personal Injury Cases



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Congratulations, you now have a stack of medical records eight inches high that you either subpoenaed or your client provided! What now? The purpose of this article is to save the personal injury attorney some time and anxiety, and hopefully, help you to dig out the key information.

As when you are confronted with any task, it helps to first have a clear idea of what your objective is, and then work from the largest part of the task down to the finer parts. To begin, and even before you obtain the medical records, it will be most helpful to first have the client complete a medical questionnaire, so that you have a good idea of what records you will need to request.



## A. READ THE TYPEWRITTEN RECORDS FIRST

Once you obtain the records, your first task is to look at the ER “History and Physical” records, if there are any, and then to search your stack of records for any typewritten reports. Ignore all handwritten notes for now. For example, “Discharge Summaries” and “Consult Reports” are invaluable because they quickly summarize the case and point out for you where you will need to look next. Be aware that a “discharge summary” may simply refer to a patient being “discharged” from one unit in the hospital, such as the emergency room (ER) or intensive care unit (ICU), and transferred to floor care or some other unit within the same hospital. So there may be more than one “discharge summary” for the same patient.

You will now want to see if there are any “objective” findings in the ER records or consult reports. “Objective” can mean different things to different medical experts, but basically “objective” refers to findings which are not under the voluntary control of the patient. For example, an x-ray of a fracture is an ‘objective” finding since it will show an actual picture of the fracture.

Less obviously “objective” is an x-ray of the neck that shows a “loss of cervical lordosis” or a “straightening of the cervical curve.” The cervical spinal column in the neck has a natural curve, and a loss of this curve may show that the neck was going into muscle spasm and thereby caused the neck to involuntarily straighten.

“Spasm” is the involuntary tightening of muscles and is frequently associated with strain/sprain type injuries and pain. Healthcare practitioners, such as chiropractors and physical therapists, are trained to feel muscle spasm when they examine a patient. In particular, if you see a notation of asymmetric spasm, this might be a more reliably “objective” finding. For example, try tensing the muscles of just one side of the back of your neck, and you will realize just how hard it would be to fabricate such a finding.

You should now look through the records for whatever radiology reports are available. Fortunately, these are almost always typewritten and easy to read. Look for key words such as “acute” which indicate that the injury happened during the car crash. When looking at a spinal CT or MRI scan report, look for terms that indicate that the nerves are pinched, such as with an “impingement,” or that something is rubbing up against the nerves as when something is “effaced.” Disc bulges or protrusions are obvious, but also look for less obvious things, such as an “annular fissure” or a “torn annulus.” A simple annular tear may not seem like much, but this tear in the spinal disc can be quite painful and very difficult to treat. A finding of an annular tear is something to bring up with your neurology expert for a further opinion.

Much less reliable will be the intake notes as to how the incident happened. For a vehicle collision, the doctor will want to know the patient’s initial symptoms during the crash, but will not be concerned with who was at fault. It is still worthwhile to look for in the intake records, particularly if there is no police report, to at least get the plaintiff’s recollection of events close to the time of the incident. However, be forewarned that the caregivers who do follow-up care will frequently just quote the intake notes, along with any inaccuracies, when beginning their own chart notes.

Look for things that may require follow-up care. For example, “ORIF” is simply jargon for “open reduction internal fixation”



surgery to repair a broken bone using surgical screws. So in that instance, you would continue to search the typewritten records to see if there is anything about how long the cast (if any) was in place; if a course of physical therapy was started after the cast was removed; and if there were any adverse reactions to the surgical screws. It would not be too unusual to have to remove some of the surgical hardware if it was causing inflammation or some other sort of problem. There should be some indication of such inflammation in the follow-up reports if it existed.

While reading the typewritten or even handwritten notes, look for abbreviations which may easily indicate what is being referred to. For example, “C/O” in the “History and Physical” notes is shorthand for “complaining of.” What follows will immediately summarize the patient’s complaints as they existed at that time. Similarly, a number “2” with what looks like a degree symbol after it stands for “secondary to.” In other words, for example, neck pain “secondary to” a car accident simply means that the onset of neck pain happened after a car accident.

Other abbreviations refer to frequency, such as when an ordered medicine is to be given. QID means four times a day; TID means three times a day; BID means twice daily, and PRN means that the medication, such as pain medicine, is to be taken as often as needed for pain control. “PO” means that the medication is to be given orally. A small “c” with a line over it means “with” and a small “s” with a line over it means “without.” Remember that medical records use scientific terminology, so a small triangle means “change,” and not “defendant,” as it would in law.

Ordinarily, you can just ignore the reams of laboratory data that will inevitably accompany a patient’s records. However, if for some reason a particular lab value, such as blood sugar (glucose), is important to the case, there will usually be a guideline as to what “normal” values should be. Find these normal values at the top or bottom of the page, or sometimes on a separate page, and then just go back and look at what the actual measured values were.

Be aware, however, that the lab values found in an autopsy report are not exactly like the medical record of a living person. Alcohol, for example, ferments in the body after death. So a blood alcohol level taken on autopsy after death does not necessarily correspond with the blood alcohol as it existed at the time of death. You will almost certainly need to consult a pathologist for an expert opinion on the post mortem toxicology.

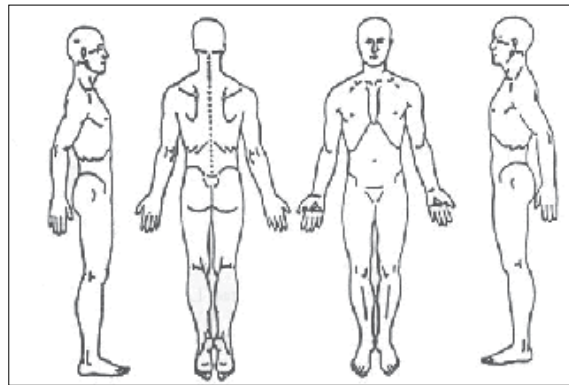
If you run into an unfamiliar medication or medical condition while reviewing the records, do not be afraid to “Google” it. We have available to us wonderful and instant access to a whole range of medical knowledge, if we simply take a few minutes to research it on the internet. Looking up a condition, such as “carpal tunnel” may not make you an instant expert, but you will at least know whether or not it can be caused by trauma.





## B. HANDWRITTEN NOTES

At some point you are probably going to need to deal with the handwritten notes. For example, there may be no typewritten discharge summaries or intake reports, and you are simply going to have to go through the records looking for documents entitled as such. Some practitioners, such as chiropractors, frequently have handwritten notes only, so you will have to try to wade through the usually unintelligible handwriting. Fortunately, even here there should be a couple of helpful areas in the file for you to focus on. The first is the “pain diagram,” which is a schematic outline of a body with coded areas of pain. This is usually filled out by the patient, and is an invaluable record, in the patient’s own “words,” of what the patient was complaining of at the time.



The other helpful handwritten records will be labeled “SOAP” notes. This is just a standardized “Subjective-Objective-Assessment-Plan” format. The doctor may not stick strictly to the format, but you should be able to at least make out what the patient’s subjective complaints were when first seen; what objective findings were found; and what the diagnosis (assessment) was. The other place to quickly find the typed diagnosis from a chiropractor is on the billing pages.

TIME	DATE	PHYSICIAN	PROCEDURE
	PLASTIC CLINIC	MAR 10, 1968	DR. JOHNSON, ERIC E.
			Nasal splint removed placed = rhinoplasty
			3 face left - feels it has fallen 2" edema
			<i>[Signature]</i>

Personal Information	Known Allergies	Notes
Name: Frank Smith Address: 343 SW Forest, Jackson, WI, 53474 Phone: 537-537-5435	a) Trees b) Grass	
Height: 5' 8" Weight: 215 Blood Pressure: 120/90 Cholesterol: 120 AB		
Medical Insurance: 02/31/1974 Dental Insurance: 02/31/1974		
In case of an emergency: Name: Ralph Baylor, Address: 122 Main, Carlsbad, CA 92009, Phone: 502-525-6484 J. White, Address: 323 SW Grant, Portland, OR, 97244, Phone: 502-525-6485 Dr. Doris Smith, Address: 122 Main, Carlsbad, CA 92009, Phone: 502-525-6487 J. White, Address: 323 SW Grant, Portland, OR, 97244, Phone: 502-525-6489		



## C. FOLLOW-UP

By now you should have a good idea of what is in the medical records, and there may not be any need to dig further into the handwritten notes. You can begin to decide if you want to hire a medical legal expert, such as a neurologist or orthopedic surgeon, or you may find that you need to subpoena more medical records first.

For example, go back now and pay particular attention to the “patient history” section of the ER and consultation reports. If there is any indication of pre-existing chronic pain or a previous accident, for example, there may be more records from other care providers that you will need to subpoena before you can contact your expert or complete the Judicial Counsel Form Interrogatory responses. Also, be sure to pay attention to the “current medications” section of the ER or “History and Physical” records. If the patient was already on narcotic pain medication, for example, there may be a pre-existing problem which you are not aware of.

In the example of carpal tunnel above, you would have found from your “Google” search that this is a syndrome that frequently comes on slowly over time from repetitive use of the wrist, such as when typing, rather than from a traumatic event. So you would now need to search the records for complaints of “parasthesias” (unusual sensation such as numbness) in the hands before the incident. You might need to subpoena previous records to find out if the carpal tunnel was caused by work and not by the incident.

Before you answer the Form Interrogatories or hire an expert, there is one last source of relatively cheap information that you should not ignore. Contact the treating doctor. For example, if you have a plaintiff who had a torn ACL in the knee repaired after a collision; contact the surgeon to confirm the surgeon agrees that the car accident was the cause of the injury and created the need for surgery. You can almost always set up a short free telephone conference or perhaps one costing only a couple of hundred dollars.

Although not strictly related to the records, you should make every attempt to attend the defense medical examination. At the defense medical examination you can personally observe what tests were actually performed by the doctor and, more importantly, see for yourself how the plaintiff reacts. Check the narrative report for the results of orthopedic tests that the defense doctor claims were performed.

## D. CONCLUSION

I hope this overview helps the next time you are reviewing a stack of apparently disorganized and illegible medical records. Always remember that whatever you find in the medical records yourself is only part of the picture. Ultimately you are going to need a medical expert who knows the records and can testify to an opinion on the cause of each injury, the nature and extent of each injury, and the reasonably necessary past and future medical charges associated with the injuries.





Albert G. Stoll, Jr.

Al dedicates his career to standing up for the rights of individuals in catastrophic personal injury, product liability, dangerous road and highway cases, insurance bad faith, nursing home neglect, medical malpractice and dangerous pharmaceutical drug cases.

In his more than 15 years of practice, Al has handled more than 40 jury trials. This experience, combined with a commitment to ethics and integrity, has earned Al an excellent reputation throughout the San Francisco Bay Area legal community. He is the recipient of Martindale-Hubbell's "AV" peer rating, which signifies preeminent legal ability and ethical standards, and has been named a Northern California Super Lawyer every year since 2006. In 2009, Al was awarded the prestigious 2009 Civil Justice Award by the San Francisco Trial Lawyers Association, given to attorneys who show integrity, grit, tenacity, ethics, and great advocacy skills, and who contribute to the betterment of consumers and/or injured victims and their families.

Al is often invited to speak to other attorneys on a variety of topics. He has been asked to share his ideas on personal injury cases by the National Institute for Trial Advocacy, Lorman Education, National Business Institute, the San Francisco Trial Lawyers Association, Consumer Attorneys of California, and the Bar Association of San Francisco. His book, *Plaintiffs' Lawyers Guide to Minor Impact Cervical and Lumbar Injury* (Thomson West 2008-2009), now in its fourth edition, is a strategic guide used by lawyers throughout America to fight back against the automobile insurance company tactics of deny, delay, and defend.

In addition to representing injury victims, Al is committed to informing people about accident prevention and safety. Outside his practice, he enjoys spending time with his family, golfing, exercise, travel, and the outdoors.







Stephen MacLean

Stephen is a trial attorney who has worked with Albert G. Stoll, Jr., A Professional Corporation as a contract attorney since 1997, focusing on representing plaintiffs in a range of personal injury matters. In addition to his trial experience, Stephen frequently appears before the California Court of Appeals.

Before attending law school, Stephen worked for two decades in the medical industry, including 14 years of experience at Stanford University Medical Center as a life support technician and respiratory therapy supervisor. This unique background gives Stephen an in-depth understanding of the medical issues involved in personal injury cases. Stephen is also committed to providing exceptional client service and keeps clients informed throughout each phase of their cases.





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