Review and Organization of Medical Records

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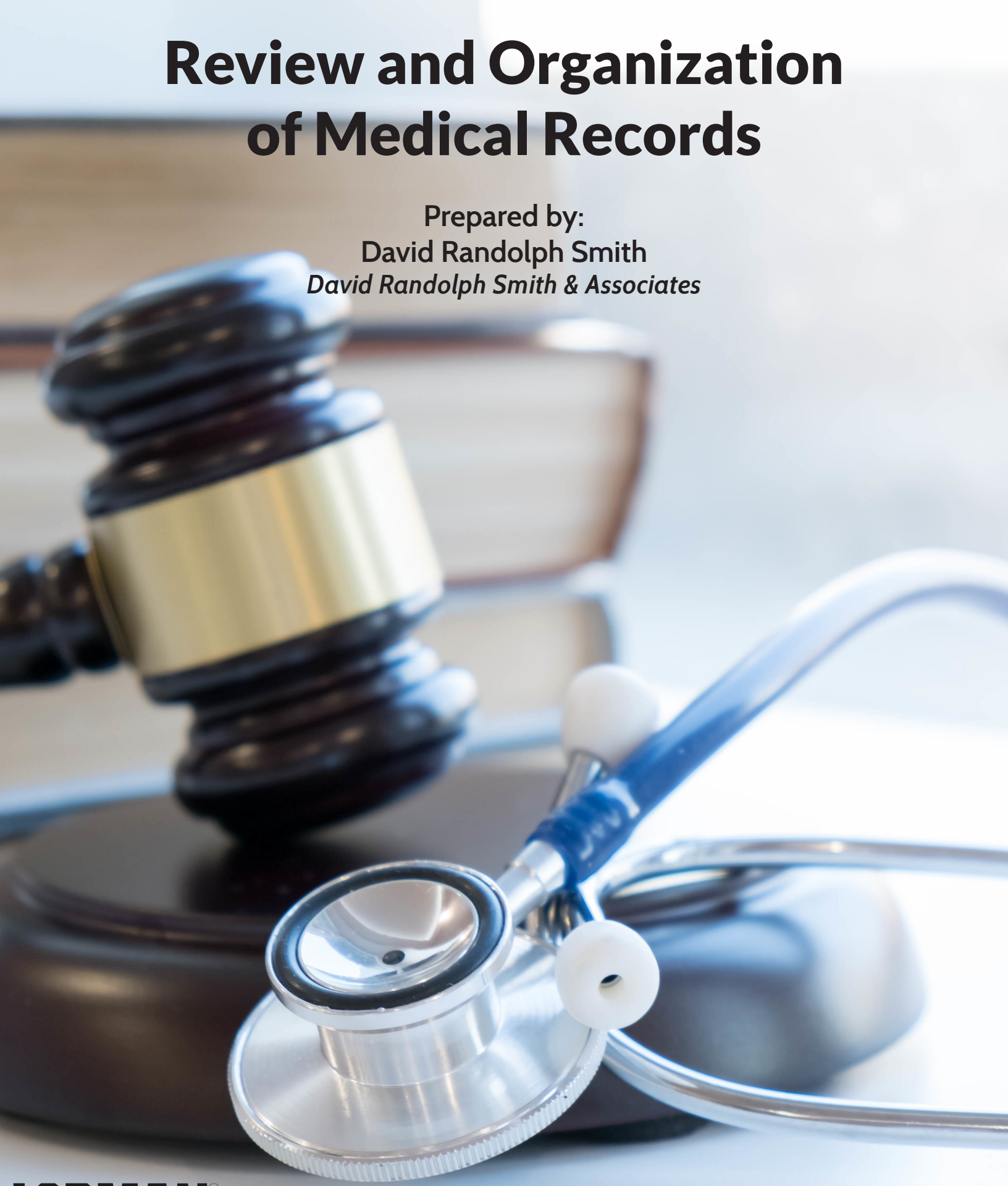

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Review & Organization of Medical Records

A. Organizing Hospital & Doctor Records

With the advent of the EMR, pdf files, and OCR scanning the goal should be to organize all records in electronic form (pdf) by obtaining searchable pdf files or if not available scan and OCR the records with annotations for handwritten entries. Medical records rarely are provided in an organized or usable fashion. Physician records should be organized into office notes, operative records, lab reports, and any other special categories that may appear in the patient record. When you receive the physician records they should be organized by category of record and each category should be arranged *chronologically*. The next agenda task to is create a timeline from the organized medical records. It is, we think, preferable to organize hospital physician and clinic records chronologically, no matter the number of hospitalizations. There should be separate electronic files for each physician/clinic. Once organized, the record can be printed and placed into a looseleaf notebook with dividers for each notebook divider and an index using the notebook dividers as a point of reference.

B. Bates Stamping; Software Programs

Bates stamping applies a unique number to each page of each case document to quickly review and retrieve specific pages. No matter how the pages are numbered by the hospital

or physician/clinic once you have organized the records in an electronic file that file should be Bates stamped. Instead of searching through a chart to locate a certain notation, you go to a unique page number. We used to mechanically add "Bates stamps" but now this is almost always done and electronically. With electronic Bates stamping the documents are in an electronic format and then using software such as Adobe Acrobat (full versions, not Reader) you create a sequence of electronic numbers on documents. With this method, you can type additional information, such as the case name, to the stamp. Next, you should an index to identify which numbers correspond to each set of documents

C. Staff, Expert and Vendor Review

Now that the records have been obtained and organized it's time to read and carefully review the records. Before diving in, however, you should *"map out" the allegations and theory of the case*. On the plaintiff's side, what are allegations of medical malpractice? What will need to be proven? You are looking for records to prove your case. In a medical malpractice case: standard of care; deviation from the standard of care; causation and damages. On the defense side, what are the facts and issues to show compliance with the standard of care or lack of causation? Next, *understand the medicine*. If the case hinges, for example, on a failure to treat or diagnose sepsis you need to thoroughly know the signs and symptoms of sepsis, pertinent

lab, and tests and understand the treatment and causation issues.

With the issues and medicine understood it's time to review the records. I believe that the attorney responsible for the discovery and trial of the case should personally review the organized records. *In addition*, other people should also review the records: another attorney in the firm paralegal, nurse, legal nurse consultant, or record review firm/vendor. Then the records can be sent to an expert for review with a view to prepare a report and ultimately testify at deposition or trial.

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