A Critical Look at PI Cases; How We Analyze The Story and What Can Influence the Value of Your Case

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Accident Details are Key

- **Police Report**
  - MVA, assault
- **Incident Report**
  - Work-related injuries
- **Accident Report**
  - Private property injuries, slip/fall at a business
- **Witness Statements**

Defense Case Documents

Complaint

Answers to Interrogatories

Requests for Production

Medical Records

EMS Records – if applicable

ED or Urgent Care Records

Follow Up Treating Providers:

- PCP
- Chiropractor
- Orthopedic Surgeon
- Neurosurgeon/Neurologist
- Physical Therapist

Past Medical History

- Looking for pre-existing medical conditions that might explain any of the alleged injuries.
- Process is the same for plaintiff or defense case.
- Don't want any surprises to come up at deposition/ settlement/ trial.
  - Prior head injuries
  - Orthopedic injuries
  - Migraines
  - Diabetes/HTN
  - Chronic pain
  - Ht/Wt/BMI

Example:

Past Medical History:

- Breast cancer status post bilateral mastectomy [40 years ago]
- Cervical/neck pain with radiation to both arms [x 25 years]
- Low back pain radiating into both legs [x 25 years]
- Severe anxiety [dx 15 years ago]
- Has fallen on head 5 times; LOC with at least one episode
- "Was hit by a truck, was hit in the throat, pronounced dead, and was severely traumatized" [15 years ago]
- Severe bilateral carpal tunnel syndrome [2005]
- Rheumatoid arthritis
- Recurrent headaches [since 2010]
- 5' 3" tall, 158 lbs.; BMI 28.0 [average size]

Past Surgical History

- Any major surgeries?
- Any back surgeries?
- Repeated abdominal surgeries?
- A hip or knee replacement can increase the risk for falls.

Example:

Past Surgical History:

- Hysterectomy [1977]
- Partial colectomy, 18" removed [1989]
- Open debridement right knee [age 22]; ACL reconstruction right knee [age 29]; right total knee replacement [1999]; "5 right total knee replacements"
- Right hip fracture and surgery [no date]
- Right rotator cuff repair [no date]
- Arthroscopic medial meniscectomy, left knee [2007]
- Right hand carpal tunnel surgery [2008]
- Laser eye surgery for wet macular degeneration

Past Social History

- Marital Status
- Employed? What type of work?
- Smoker?
- Illicit drug use?
- Alcohol intake?
- On Disability?
- Any prior legal issues?

Example:

Past Social History:

- MVA 1984, MVA 2001, MVA 2003
- Cervical spine injury/sprain after being accosted during robbery at a mall [2010]
- Former smoker
- Fell at a casino [2015]
- Reported she has 3 Master's degrees, has been a researcher and discovered the laser beam; works part-time at the Army Guard [2005]
- "Retired but works as a security guard part-time (taking time off right now)"
- Married
- Funded by Medicare

Brief Case History

Narrative format to briefly explain medical history and events of injury

Example Brief Case History:

Following her visit at AB Clinic, Ms. Smith was involved in an MVC that same afternoon. According to EMS records, she was the restrained front seat passenger of a pickup truck that was at or near stopped and rear ended by a Sprinter step van on 06/26/15. Impact was flat across the back of the pickup and the bumper was in about 1 foot with back 1/3 of the truck bed buckled. There was broken glass in the back of the cab behind the seats. The windshield of the pickup was intact with no compartment intrusion. Ms. Smith reported there were two impacts. The first impact was when she went forward, then back "striking back of head on back of seat of window. Second impact pt went forward. She had braced herself with hands on the dashboard. She did strike her chest on hands and dashboard" [AMR, PDF, p. 2].

EMS personnel found her sitting in the front seat of the pickup awake and alert. She did report neck and chest pain. Ms. Smith was able to get out of the pickup by herself [Orthopedic and Fracture, PDF, p. 4]. There were no obvious marks on her chest, but there was point tenderness on either side of the anterior chest, none on the sternum. She did not exhibit any respiratory distress and was able to speak easily. During transport, she complained of tingling in hands, but had no loss of dexterity. Records reflected her blood pressure was significantly elevated at 183/97 and 151/87 during transport. Pain was reported as 2/10.

Body of Report

- Significant case events can be broken down in chronological format to "tell the story"
- Bates stamps can be used to reference key entries
  - [SMITH-AB-0001]
  - [AB Clinic, PDF, p. 12, no bates]
- Footnotes to explain unfamiliar terms
- Diagrams can be embedded into report to help explain complex anatomy

Example:

She was transported to Southwest Medical Center in a rigid C-collar for neck mobilization where she reported pain in her head, chest and thoracic region of her back. Ms. Smith denied loss of consciousness [Orthopedic and Fracture, PDF, p. 6]. She also reported right hand paresthesia. Examination by the ER physician revealed neck tenderness to palpation of the spinous processes, chest wall tenderness, tenderness on palpation to bilateral lumbar spine, and tender right knee [Orthopedic and Fracture, PDF, p. 7]. Ms. Smith also reported the middle finger on her right hand felt "less sensitive" than left middle finger, but no neurological deficits were identified by the provider.

Ms. Smith was diagnosed with neck pain, back/lumbar pain and discharged home ambulatory with her family [Orthopedic and Fracture, PDF, pgs. 3-5]. She was instructed to follow up with her PCP in 3 days. No specific limitations or recommendations were provided in the instructions. The ED provider further noted that Ms. Smith was sent home with a Deroyal [neck] collar "for comfort" and "pt neurologically intact" [Orthopedic and Fracture, PDF, p. 10].

Tables to Enhance Information

- Significant Diagnoses
- Imaging/Tests
- Procedures/Surgeries
- Pertinent Providers
- Pain/LOC Documentation
- Easily Customized

Example: Imaging/ Tests

Date	Diagnosis/ Procedure/ Imaging Study	Provider/ Facility	Comments	Reference
[There were no pre-injury medical records available for review]				
Date of Injury 06/17/18				
06/17/18	CT scan head without contrast: "1. No acute intracranial abnormality. 2. Chronic appearing volume loss/ encephalomalacia of the right frontal lobe with prominent chronic appearing ex-vacuo dilation of the body of the right lateral ventricle"	MMC ED	Trauma scan while in ED	MMC, p. 702
06/17/18	CT scan spine complete without contrast: "**Mildly comminuted sacral fracture involving the right sacral ala** which extends into the S1 vertebral body and into the posterior elements on the right side with involvement of the right S1 neural foramen. There is 3 mm of retropulsion of the S1 fracture fragments into the central canal"	MMC ED	Trauma scan while in ED	MMC, pgs. 703-704
06/17/18	CT chest, abdomen, pelvis with IV contrast: "1. **Comminuted, mildly displaced sacral fracture with extension into the right S1** neural foramen and posterior elements and probably right S2 neural foramen. 2. **Mildly displaced right superior and inferior pubic rami fractures and left inferior pubic ramus fracture.** 3. **Nondisplaced fracture of the right 11th rib**. 4. No visceral traumatic injury"	MMC ED	Trauma scan while in ED	MMC, pgs. 706-708

Example: Significant Providers

Name/Specialty	Date Range	Comment	Source
Southwest Orthopedics including Jeffrey Young, PA-C,	2014-2016	Initially evaluated for left radiculopathy	63889-4 ABC Providers Part 3, PDF, pgs. 215-219, 00808-00812
Ralph Noble, MD [Neurologist]/ ABC Providers	2014-10/16/15	Treated for radiculopathy and back pain – referred to neurosurgery; 1st provider seen after 04/07/15 and 07/04/15 MVAs	63889-4 ABC Providers Part 3, PDF, pgs. 191-200, 00784-00793
Baptist Neuroscience Associates/ Zachary Dayton, MD [Neurosurgeon]	10/21/15	Recommended decompressive lumbar laminectomy	63889-4 ABC Providers Part 2, PDF, pgs. 196-197, 00489-00490
Juliet Fuller, MD [Pain Management]/ Neurosurgery Spine Clinic	02/03/16-present	Provided ESIs and RFAs	Neurosurgery records, PDF, pgs. 1-5

Date	Pain Rating/ Reference	Pain Medication	Comment	Source
10/20/14	9-10/10, reported "severe pain" to lower back	Given Fentanyl 75 mcg IV for pain	EMS records	Regional #1, part 2, 004.PDF, pgs. 63-64
	No data	Given Dilaudid 0.25 mg IV x 9 doses for pain (total 2.25 mg)	While in ER at Southwest Medical Center	Regional #1, part 2, 004.PDF, p. 46
	7/10 back pain		Initial ER pain rating at Legacy Emanuel Medical Center	Regional #1, part 2, 001.PDF, p. 17
		Given 0.5 mg Dilaudid IV in ER for pain		Regional #1, part 2, 003.PDF, p. 66
		Given 50 mcg Fentanyl IV for pain at 2:13 pm after transfer to floor		Regional #1, part 2, 003.PDF, p. 73
		Hydromorphone/ Dilaudid PCA pain pump initiated		Regional #1, part 2, 003.PDF, p. 41
		Acetaminophen/ Tylenol 650 mg orally scheduled dose every 6 hours ordered until discharge	New physician's order	Regional #1, part 2, 003.PDF, p. 79
	4-8/10		Nursing flow sheets	Regional #6, part 2, 001.PDF, pgs. 80-81 Regional #6, part 2, 002.PDF, pgs. 8, 10, 19, 20, 23, 30

Strengths/ Weaknesses

- Detailed listing of case strengths and weaknesses
- Highly dependent upon plaintiff or defense case
- Maximize potential injuries if plaintiff
- Mitigation of damages if defense

Additional Recommended Records/ Experts

IDENTIFICATION OF ANY MISSING OR ADDITIONAL RECORDS

RECOMMEND POTENTIAL EXPERTS TO REVIEW/OPINE ON CASE ISSUES

Education

- Educate attorney-client on complex medical issues involved in case
- Provide diagrams to help explain anatomy and procedures
- Explain issues in easy to understand terminology
- Literature search for pertinent articles specific to standard of care issues
- Assist attorney-client to understand why particular issues complicate/ compound the case

Case Study:

80-year-old married woman; front seat passenger in stopped pickup rear ended by Sprinter step van at a stop light. Back window of pickup broken; back bumper intrusion of 1 foot
Able to self-extricate and ambulate at scene; taken by EMS to ED for evaluation; C-collar; no LOC
At ED - Reported neck pain, chest wall tenderness, lower back pain, right knee pain
X-rays of cervical spine, lumbar spine, right knee – no fractures, extensive degenerative changes.
Diagnosed with neck pain, back/lumbar pain – DC home with neck collar – no meds
Significant pre-existing orthopedic conditions/issues; social issues

Called PCP office 3 days later "demanding" Tramadol; seen few days later – conservative tx
Seen by numerous other providers with varying complaints – requesting water PT

IME approx. 3 years post-MVA; numerous orthopedic complaints including concussion symptoms; noted "extremely poor historian"; diagnosed with several strains & HA
Because she had a complicated situation prior to the MVA – her expected course of recovery was reasonable to be 6 months post-MVA rather than the usual 6-12 weeks for strains

Questions