

Versatility of the Medical Chronology

Author: Patricia Henry RN, MS, MBA

Date: September 6, 2008

Introduction

The definition of *chronology* is; the science that deals with the determination of dates and the sequence of events; the arrangement of events in time; a chronological list or table. A *medical chronology* is much more than a simple timeline of events. It is a mechanism of organizing facts based on medical records and a complex sequence of events. A medical chronology is presented in a table and/or narrative format. It paints a picture of events and tells a story. It enables health care professionals or legal professionals to organize multiple volumes of complex medical records in a clear and precise format. It allows an attorney to quickly and masterfully navigate through the complexity of medical history and key events and facts. It also aids in the preparation of interrogatories and depositions.

Format

A medical chronology normally begins with a narrative summary of a case;

- Jane Doe is a 90 year old female who presented to the emergency department of County Medical Center on April 7, 2004 complaining of weakness, dehydration, difficulty walking, disorientation and fever. Jane was admitted to County Medical with a diagnosis of urosepsis¹ and was treated with a hydrating intravenous fluid and antibiotics. On April 10, 2004 at 4:00 a.m. Jane fell and hit the back of her head. The blow to her head required ten stitches. Jane was examined by a physician at 5:00 a.m. and he found no

¹ Urosepsis is a systemic infection of the blood stream originating from bacteria in the urinary tract.

neurological deficits. At 8:00 am, Jane’s nurse notes; “patient highly agitated and with blood pressure 200/115 and heart rate 140”². The nurse attributes these symptoms to agitation and gives Jane 2 mg of morphine sulfate intravenously. When the nurse checks Jane at 11:30 am, she is unresponsive to tactile stimulus and her pupils are unequal. An urgent CT scan ordered by the physician reveals a large intracranial bleed. A neurosurgeon determines the bleed to be inoperable. Jane Doe dies the next morning at 10:00 am.

The remainder of the medical chronology is presented in a table format;

Date	Source/Provider	Event	Comments
04/07/2004	000001 – 000002 CMC	Admitted to County Medical Center Emergency Department complaining of fever, weakness and confusion	
04/07/2004	000003 – 000004 CMC	Dr. Fredericks, ED physician diagnoses urosepsis and orders hydration and antibiotics	Urosepsis is a systemic blood infection originating from bacteria in the bladder
04/07/2004	000008 – 000010 CMC	Mary Jacobs, RN documents patient is high risk for fall, but does not place patient on ‘fall precautions’	‘Fall precautions’ is a protocol designed to prevent falls in patients at high risk of falling
04/10/2004	000100 – 000103 CMC	Nurses’ Notes document patient fall at 0400. “Patient found on floor bleeding from head. MD notified, patient received ten stitches to close gash on back of head.”	
04/10/2004	000260 – 000261 CMC	CT scan reveals “large occipital bleed with brain shift.”	A bleed large enough to cause a brain shift can lead to brain death.
04/10/2004	000300 – 0003001 CMC	Dr. Tennison notes at 2:00 pm: “Clinical exam consistent with brain herniation. Family informed, they wish to make patient a DNR/DNI” ³	

² Normal blood pressure ranges from 100/60 to 140/80; normal heart rate is 60 to 100 beats per minute.

³ DNR stands for ‘do not resuscitate’ and DNI stands for ‘do not intubate’, meaning *do not place an artificial airway for mechanical ventilation*. This is commonly known as a ‘no code’ patient.

Maintaining Confidentiality

Maintaining patient confidentiality is extremely important from the medical-legal standpoint, as confidentiality is mandated by the health insurance portability and accountability act (HIPAA⁴). Information obtained from medical records must be managed in the strictest confidence whether it is production of a medical chronology by a Legal Nurse Consultant (LNC), or ongoing communication within the legal team managing a case. The HIPAA privacy act is applicable to all health care providers, health plans, health care clearinghouses⁵ and business associates who perform functions on behalf of these entities (i.e. contractor). The privacy rule refers to this information as protected health information (PHI). A covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request. They must also develop and implement policies and procedures defining how to limit uses and disclosures to the minimum necessary.

Customizing the Chronology

The medical chronology can be customized to meet the needs of an attorney by creating subsets of a comprehensive chronology. A comprehensive chronology may be 50 to 100 pages in length. As the attorney prepares for interrogatory, deposition or trial, the LNC may extract a ‘mini-chronology’ of lab work, diagnoses, providers

⁴ A major goal of the HIPAA Privacy Rule is to assure that individuals’ health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being. The Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing. (www.hhs.gov/ocr/privacysummarypdf)

⁵ *Health care clearinghouses* are entities that process non-standard information they receive from another entity into a standard (i.e., standard format or data content), or vice versa.

or diagnostic tests. It is also beneficial to provide definitions of medical terminology in the ‘reviewer’s comments’ or footnotes, because chronologies can be technically complex.

Finally, every chronology should be accompanied by a narrative of the case. The narrative must be clear, factual and include dates. Placing the narrative at the beginning of the chronology ‘sets the stage’ for the legal team to understand the overall breath of the case.

Conclusion

The medical chronology is an invaluable source of information for the entire legal team. The LNC must work closely with attorneys to customize the chronology, to develop a clear profile of the plaintiff, or build a powerful case for the defense. When producing a medical chronology, the LNC must remain unbiased, objective and pull from their clinical experience, creativity and research findings to produce a comprehensive product with customized subsets to optimize contributions to the case.

References

1. Jones, M.P., 2008. Strategies for an Effective medical Chronology. The Journal of Legal Nurse Consulting. Vol. 19(3): 7 – 11.
2. Summary of the HIPAA Privacy Rule, 2003. Retrieved from www.hhs.gov/ocr/privacysummarypdf