

Altered and 'lost' medical records

Evidence of spoliation of records in medical negligence actions can strengthen the client's case.

Robert Gray Palmer

Phyllis Clark, a slight, neatly dressed woman in her late 50s, leans toward you from the conference room chair. Her voice emphatic, she looks you in the eye and says, "The doctor never told me to have any kind of scope test." She seems earnest. She's just been diagnosed with metastatic cancer from a slow-growing tumor in her colon.

You look again at the photocopied progress note dated two years ago. The doctor's handwritten entry—"Test discussed with patient. Opts to recheck in three months."—suddenly seems more legible than the surrounding entries.

You suggest that the progress note may have been altered after she was diagnosed. "My doctor would never do that," she states. You look at her and picture the future, hearing defense counsel say, "Records don't hurt people"—imagine the jurors deliberating and the foreperson blaring in an accusatory tone, "Well, the doctor wrote it right there in the records." You envision the signatures inked on the verdict form finding for the defendant.

Jurors tend to believe what they see in black and white. Written or typed words

about a patient's medical history, chief complaints, examinations, proposed treatment, actual treatment, and discharge instructions often make or break a case. Physicians or other health care providers may retreat to written entries, even if they were changed, in order to "explain" or otherwise deflect liability for their medical negligence.

Attorneys must review all medical charts, even those from presumably reputable physicians, hospitals, or other providers, with the suspicion that something has been altered. Apply the mantra "Assume nothing." Record tampering is far too common to think that it could not have happened in your case.

"From where I sit, it seems that alteration of patient medical records is becoming a significant problem," stated Dr. Thomas Gretter, secretary of the State Medical Board of Ohio.¹

Health care providers should know medical records are legal documents and should be careful about creating and maintaining them. "Besides health care professionals, the record has become essential to insurers for financial reasons, attorneys for medical-legal reasons, and the government for payment and regulatory reasons," according to Gretter.²

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The State Medical Board of Ohio provides guidelines for the correct way to change a record.

After a record is made, it should be corrected or edited only by using the proper methodology. Once detected, errors should be corrected promptly. The proper method is for the author of the entry to draw a single line through the incorrect information without obliterating it. The correct information should then be recorded above, below, or beside the original incorrect data, and should be initialed and dated. Being able to read what has been edited or changed is important. This procedure applies to all records, including those generated in a practitioner's office and in the hospital setting. Remember, all records have the same scrutiny potential.

Deleting with correction fluid, erasing, blotting out, or adding information at a different time than the original note [was made] are not appropriate ways to correct a record. Any of these actions may be viewed as alteration.³

An attorney's question about a critical entry should always be "Is this valid?"

Some circumstances ought to alert the attorney to a potential altered record. As in Phyllis Clark's case, the medical record may look too good to be true in light of the client's medical condition and recollection of treatment. Or there may be a long period of time between the negligence and the development of the injury. For example, Phyllis Clark's slow-growing colon cancer lesion was missed for two years before a surgeon found and removed a softball-size tumor that had metastasized.

Progress notes or an office chart may appear "different." There may not be gaps between entries where the record-keeping routine suggests there should be, there may be entries in the margins, or entries may be compressed into an available space.

For example, in another cancer misdiagnosis case, the medical record had a slightly smaller note squeezed in among other progress notes dated a year before diagnosis. The note read, "Hx—claustrophobia: no CT scan or MRI of head. I must make [patient] reconsider CT scan of head."

The client emphatically denied being claustrophobic or refusing any tests. It turned out the doctor fabricated the claustrophobia to make it seem the patient had refused these tests, which would have shown the cancer a year earlier.

Other suspicious records include operative reports that appear to have been typed using language right out of a surgical textbook or those that do not include any personal details about the plaintiff. Obviously, the existence of two different operative reports should be a red flag. In other instances, patient card imprints on the records do not match the actual time of treatment. For example, an imprint on a chart might show the patient in the intensive care unit when the rest of the records show the patient in the emergency room. Another type of entry that should cast doubt is one that shifts the blame onto the patient for refusal of treatment—for example, "complained of no chest pain."

If there is time, you or the client should informally gather records from all providers who may have copies of the same documents. Be sure to check with all physicians and hospitals in the chain of treatment; the family doctor, who often receives copies; and any agencies involved in workers' compensation, Social Security disability, or private disability proceedings. Then, go look at the original records.

Once suit is filed, request documents including both the treatment file and the "financial" or "administrative" file from all providers. Then, attach these records to your request for admission to authenticate them as "complete and true copies."

Now you can use these as official records to depose their author about accuracy. If you haven't seen the original records, make sure they are brought to the deposition.⁴ Evidence of habit or routine practice⁵ is not only trustworthy and therefore admissible, it is compelling to a jury.

Discover the identity of every person who made entries in, organized, and main-

tained the records. Plan to depose them. At deposition, pin down when each entry was made and whether entries were made at the same time as the events. If you suspect there will be a discrepancy, take the entry maker's deposition before the plaintiff's. At the first or second deposition, get an explanation for the apparent discrepancy.⁶

For example, in another failure-to-diagnose-cancer case, the defense produced in discovery the defendant physician's "complete" note, which said:

June comes in today complaining of a rash that has appeared beneath her breasts. She has tried over-the-counter Lotrimin-4, and it has not helped significantly. She is also complaining of a cough productive of some yellowish phlegm, runny nose, and an increase in sinus drainage over the past two weeks as well. She states that it is her annual spring cold. She denies any fevers, chills, nausea, vomiting, or GI upset with this. She is also requesting a refill on her Premarin. She is due for a Pap smear.

The note went on to discuss treatment for the rash, congestion, and postmenopausal syndrome.

However, the handwritten note made at the same time as the exam said only

Candidal rash lanisil
sore throat—sinus drainage
Polyhistine-D
needs Premarin, needs CLE, No. 100 Premarin.

On reviewing the original records at the doctor's deposition, it was apparent that the typed version was pasted over the handwritten note. The typed version did not contain the critical symptom "sore throat," which was persistent on the patient's left side and should have been evaluated. If it had been, her throat cancer would probably have been diagnosed.⁷

In addition, the physician testified that the typed version was created over a year and a half after the plaintiff's visit, and then only after the physician was notified that the patient might sue.⁸

It is critical to preserve the physician's original chart before and during the litigation. Obtain a court order if need be. Oth-

erwise, you may be faced with testimony like this:

A. The last time I saw the chart . . . was when we finished the hearing when the case was dismissed at the time with prejudice, and it was in the trunk of my car . . . I believe that the chart may have been taken out of the car, not looking and knowing even what it was, and misplaced, and possibly even it's with the garbage.

Q. What kind of car is it?

A. It's an '86 Porsche 944.

Q. Were there other patient files in that trunk?

A. No.

Q. OK. What else was lost?

A. We haven't lost anything else.

Q. OK. What other records can't you find?

A. None.

Q. Dee's is the only chart that you can't find?

A. Uh-huh.⁹

Forensic science

Forensic chemists, document examiners, ink-dating specialists, fingerprint specialists, and even DNA specialists may be critical.¹⁰ Showing that records were tampered with will increase the case value, help prove your due diligence, and prevent witnesses from committing perjury.

For example, ink dating may prove the entry was made at a different time than its author claimed at deposition. The technique can detect an alteration made with a different pen, determine the age of the document, or determine the age of the particular ink. Ink can be dated to within six months of use with reasonable scientific probability, and current technology allows ink dating in about 70 percent of cases.

There are three primary methods of ink dating: (1) identifying a chemical date tag (these nonink chemical pieces are not found in inks made after 1994); (2) using chromatography to separate and identify the components of the ink (the process can date inks to within six months of use until they are approximately three to four years old); and (3) comparing a known dated standard with the questioned ink. For example, in the Phyllis Clark case, the critical entry was shown to have been made at least six months and up to two years after the physician testified he made the entry.

Ink of the same color used at different times can often be detected with infrared

Overcoming hurdles in a medical negligence case

Emmanuel E. Edem

As plaintiff attorneys handling medical negligence litigation, it is not enough to simply have a good set of facts. Facts are important, of course, but we must also take into account which experts we have chosen and the personal characteristics of the parties involved.

It is rarely easy to find local plaintiff experts, so most of us look to out-of-towners for help. If you are handling a medical negligence trial in Oklahoma City, for example, expect the defense counsel to refer to the plaintiff's experts as "this man from Chicago" or "this doctor from California." The implication to jurors is that the plaintiff's legal team—via its choice of experts—does not hold Oklahoma City hospitals and doctors in high esteem.

Deal with this problem at voir dire. Stress to jurors that returning a verdict for a doctor simply because he or she is local is wrongheaded. The same is true if they decide against your client just because the experts are from out of town.

Defendants may also attack your out-of-town expert's testimony regarding the local physician's departure from the proper standard of care. Certainly, geography has little to do with practicing sound medicine, but jurors may not view it that way. Consider using a nationally recognized treatise, such as the three-volume series of *Emergency Medicine* edited by Peter Rosen and others, to portray your expert's opinions as being consistent with the appropriate standard of care.

Besides, most states now operate on a national standard of medical care. Local plaintiffs, therefore, deserve medical care that is just as good as the care available in the country's best hospitals.

Important facets of trial preparation and presentation include modulating the plaintiff's image and recognizing the power a medical degree holds over jurors. Success may depend on suc-

cessfully addressing these intangibles through presentation of the plaintiff's story.

Imagine you have a clear-cut medical negligence case in which routine spinal surgery resulted in laceration of one of the vertebral arteries. You represent the young wife of a 32-year-old company executive who died in the operating room during this surgery. Also imagine the surgeon's reputation within the community has not been very good. It is not difficult under these circumstances to conclude that the facts alone would likely result in a verdict for the young widow and her family.

Now, let's examine a different scenario. The Gulf War has reached its most intense point, and Saddam Hussein slips and injures his back while inspecting one of his tanks. He is brought to the United States by a group of left-wing liberals for spinal surgery. Imagine that the surgeon involved in the case is well respected in a fairly conservative community and that he has spent most of this life doing free surgery on victims of childhood bone infection. Again, it is not difficult to predict the outcome of the trial.

These illustrations are extreme, but they make the point that the trial story must be woven around the parties in a way that makes the jurors feel comfortable returning the right verdict.

Presenting the client

Expect the defense counsel to present the doctor as brilliant, hardworking, and dedicated. You must, likewise, remember to present your client in the best light. Take this into consideration even before your client gives a deposition. He or she must be portrayed as a nice man or woman, not one who is bitter, defiant, or out of the mainstream.

Also pay attention to how jurors might view the plaintiff's motives. Pre-

resenting a vengeful, greedy plaintiff will result in a defense verdict even if you believe liability is clear. Jurors respect and empathize with a plaintiff who is stoic in the face of difficulties.

Plaintiffs who come to your office calling the doctor a "quack" and searching for a way to take away the doctor's license present special challenges. Firmly explain that a medical negligence case is not a licensing examination. If a client insists on taking this vindictive attitude to trial, it is time for you to try to remove yourself from the case.

The character of the defendant can have significant bearing on the outcome of the case. The local physician who has served a small community for the past 30 years as the only doctor in town remains a formidable opponent under any circumstance. Direct attack in opening statement or cross-examination may prove to be fatal.

This is a defendant you must kill with kindness and seek to discredit only with the facts. Present the doctor as one from whom you or your family would have accepted treatment—one who is a good person but not a perfect one.

Similarly, if the case involves a likable, hardworking young intern, consider dismissing this defendant before or during trial. Point out in closing argument that under the doctrine of respondeat superior, it is unnecessary for this person to be affected by the verdict. Under this doctrine, the hospital that overworked the intern would be responsible for his or her negligent conduct. It is easier to obtain a verdict against a faceless corporation than against someone who had a paper route as a young child and hoped to fulfill his or her dream of becoming a doctor.

Also recognize that plaintiffs' circumstances may have as much bearing on the outcome as their appearance and demeanor. Many lawyers have had diffi-

culties in death cases in which the spouse remarried. Even though such direct evidence may be inadmissible, some judges have allowed opposing counsel to address the widow by her new, married name. In this way, the elements of grief are neutralized and your overall trial story is affected.

Consider advising the woman to maintain her former married name until the trial is over. An in limine motion must be directed to this point. Evidence of a widowed spouse's subsequent remarriage should be inadmissible in most jurisdictions because the prejudice so outweighs any probative value.

Depending on who the plaintiff or plaintiff's decedent is, plan how to present the issue of damages. The easiest case to make for damages usually involves the death or permanent disability of someone between 20 and 50 who had young children at home.

If your client's case does not fit this model, explain why your client's losses—and his or her family's—are devastating and ought to be compensated. For example, it has been said that you can lock young children out of your workshop, but you can never lock them out of your heart. Likewise, the elderly are those who gave us the finest society we have ever had. Be sure to mention people such as Bob Hope, George Burns, or Benjamin Franklin, who reached creative heights when they were over 65.

The plaintiff begins every medical negligence case in the face of formidable obstacles. Ignoring prejudice in the courtroom is professionally foolish. On the other hand, it is also true that if the jury genuinely likes the plaintiff, success will be greatly enhanced.

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image converters or special lasers. Inks luminesce differently, and their emissions of light can be photographed to make effective court exhibits. In one case, it was alleged that a pharmacist dispensed the wrong medication, to which the patient had a serious reaction. The doctor's chart was partially marked over with a pen. That ink luminesced differently than the words revealed underneath, which said, "But she was prescribed Keflex not EES. I guess the pharmacy made a mistake."

Discovery revealed that the nurse altered the doctor's chart after the doctor died, and that she and the pharmacist had had more than a professional relationship.

Some records may include thermal markings, such as EKG strips or fetal monitor strips. These records, even if on microfilm, can be examined using scientific techniques that make legible otherwise disappearing provider notes. When notes were made on the record, they may have imprinted on paper underneath, which is easily detected.

Other tests, such as DNA analysis or fingerprint analysis, may be used to dispute whether someone has actually seen or mailed a document (for example, saliva on an envelope may link the defendant to the document). Furthermore, with computer-generated records, "deleted" entries can often be recovered from the hard drive.

Legal remedies

There are at least four legal remedies to help those abused by the alteration or spoliation of evidence. This appears to be a developing area of the law.

First, many states recognize that juries may infer that by altering or destroying evidence a defendant was trying to avoid liability. That a jury may infer either criminal guilt or civil liability from the destruction or suppression of evidence is well established.¹¹ *Omnia praesumuntur contra spoliatores*: "All things are presumed against the despoiler or wrongdoer."¹²

Second, parties can receive some protection through discovery. For example, Federal Rule of Civil Procedure 37 and its comparable state provisions authorize the court to enter sanctions for failure to produce appropriate documentation or inten-

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tional destruction of such information. In *Bratka v. Anheuser-Busch Co.*,¹³ the court granted default judgment on liability for the defendant's failure to produce relevant materials.

Third, when liability is determined and compensatory damages are awarded in a medical negligence case, punitive damages may be awarded on a showing of "actual malice" for the intentional alteration, falsification, or destruction of medical records by a physician to avoid liability for his or her negligence, regardless of whether or not the act directly caused compensable harm.¹⁴

Fourth, a separate tort claim for intentional spoliation of evidence is developing.¹⁵ Most of these torts are based on the seminal case *Smith v. Superior Court*, which, interestingly, was recently overruled.¹⁶ The *Smith* court held that the elements of a claim for spoliation or interference with or destruction of evidence are generally (1) pending or probable litigation involving the plaintiff, (2) knowledge on the part of the defendant that litigation exists or is probable, (3) willful destruction of evidence by the defendant designed to disrupt the plaintiff's case, (4) disruption of the plaintiff's case, and (5) damages proximately caused by the defendant's acts.

These claims may be recognized between the parties of the primary action or against third parties and may be brought at the same time as the primary action.

When things go wrong, people usually try to blame someone else. Altering records is one way to shift the blame. In this day of photocopies and electronic records, health care providers may expect that lawyers will not dig enough to catch them.

Often, it's the physician you would least expect who changes a record. Listen to your clients, and assume nothing. □

Notes

1. THE STATE MEDICAL BOARD OF OHIO, YOUR REPORT 2 (Winter 1997-98).

2. *Id.*

3. *Id.*

4. Usually something significant is in original records that have not been provided. Use a subpoena if the record author is not a party to the suit. Remind defense counsel, or the records may not be provided. Get a court order to preserve them if necessary.

5. See FED. R. EVID. 406 and comparable state rules.

6. Intentional alteration may affect the availability of coverage, depending on the terms of the defendant's insurance policy.

7. "It is more complete," the physician testified about the typed version at her second deposition.

8. In Ohio, patients can extend the one-year statute of limitation by six months if notice is timely made to the physician. OHIO REV. CODE ANN. §2305.11(B)(1) (Anderson 1998).

9. The destruction of records may actually improve your chances for success, as in this case.

10. The author gratefully acknowledges the assistance of Eric Speckin, Speckin Forensic Laboratories, Inc., Okemos, Michigan, concerning the forensic testing of documents.

11. CAL. EVID. CODE §413 (West 1999); CAL. PENAL CODE §135 (West 1999); 27 OHIO JUR. 3d, *Criminal Law* §1735 (1998) ("[T]he destruction or suppression of . . . evidence constitutes a circumstance of much weight against the accused."); 42 OHIO JUR. 3d, *Evidence & Witnesses* §137 (1998) ("If a party suppresses evidence . . . the presumption is that the evidence . . . would operate against him.")

12. *Welsh v. United States*, 844 F.2d 1239 (6th Cir. 1988); *Cedars-Sinai Med. Ctr. v. Superior Court*, 954 P.2d 511 (Cal. 1998); *Brown v. Hamid*, 856 S.W.2d 51, 56-57 (Mo. 1993); *Watson v. Brazos Elec. Power Corp.*, 918 S.W.2d 639, 643 (Tex. App. 1996); BLACK'S LAW DICTIONARY 1086 (6th ed. 1990).

13. 164 F.R.D. 448, 463 (S.D. Ohio 1995); see also *Turner v. Hudson Transit Lines, Inc.*, 142 F.R.D. 68 (S.D.N.Y. 1991); *Cedars-Sinai*, 954 P.2d 511, 518; *Chapman v. Auto Owners Ins. Co.*, 469 S.E.2d 783 (Ga. Ct. App. 1996).

14. *Moskovitz v. Mount Sinai Med. Ctr.*, 635 N.E.2d 331 (Ohio 1994) (holding that although the original chart had "mysteriously vanished," inconsistent copies proved the physician had inserted self-serving, false notes); *Dimora v. Cleveland Clinic Found.*, 683 N.E.2d 1175, 1181 (Ohio Ct. App. 1996) (finding that witness testimony was disparate from the doctor's notes); see also *Spadafore v. Blue Shield*, 486 N.E.2d 1201, 1205 (Ohio Ct. App. 1985) (finding evidence of altered medical records during a benefit denial process). In Ohio, a patient is presumed to be damaged when records have been altered or lost (*Moskovitz*, 635 N.E.2d 331, 342).

15. The following states have recognized some form of a separate cause of action for the tort of spoliation. Alaska: *Hazen v. Municipality of Anchorage*, 718 P.2d 456, 463-64 (Alaska 1986); California: *Johnson v. United Servs. Auto. Ass'n*, 79 Cal. Rptr. 2d 234 (Ct. App. 1998) (negligent); Florida: *Continental Ins. Co. v. Herman*, 576 So. 2d 313, 315 (Fla. Dist. Ct. App. 1991); *Bondu v. Gurvich*, 473 So. 2d 1307 (Fla. Dist. Ct. App. 1985); Illinois: *Rodgers v. St. Mary's Hosp.*, 597 N.E.2d 616, 619-20 (Ill. 1992); Kansas: *Koplin v. Rosel Well Perforators, Inc.*, 734 P.2d 1177 (Kan. 1987); Ohio: *Smith v. Howard Johnson Co.*, 615 N.E.2d 1037 (Ohio 1993); New Jersey: *Viviano v. CBS, Inc.*, 597 A.2d 543 (N.J. Super. Ct. App. Div. 1991) (recognizing the tort of "willful concealment of evidence"). But see *Callahan v. Stanley Works*, 703 A.2d 1014 (N.J. Super. Ct. Law Div. 1997).

16. 198 Cal. Rptr. 829 (Ct. App. 1984), overruled by *Johnson*, 79 Cal. Rptr. 2d 234.