Medical Malpractice: The Fraudulent Electronic Medical Record

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Proving that a defendant physician has falsified the medical record virtually assures a plaintiff victory in a medical malpractice lawsuit. The centerpiece of any malpractice case is the medical record which is relied on by lawyers, claims representatives, judges and juries in assessing the culpability of a physician or hospital charged with malpractice. Malpractice insurance companies and hospital risk managers drill physicians about the importance of careful documentation in the medical record. A physician note that is exculpatory, carefully explaining his medical decision making, promotes a successful defense to a medical malpractice claim. Oftentimes a patient's version of events differs dramatically with what is in the medical records. The frustrated plaintiff's attorney frequently rejects seemingly meritorious cases because the prospective client's version of events conflicts with the medical record. But if you can prove the records have been falsified (after sworn denials to the contrary), you can turn the tide in favor of the injured/ deceased patient.

All of the major hospitals now have some version of digital/electronic medical record (EMR) systems that have largely replaced handwritten physician and nursing progress notes. This is good news/bad news for malpractice trial lawyers. The bad news: These electronic medical records are very easy to falsify since physicians with user/login privileges can go into the EMR system with ease and make changes/ alterations in narrative notes. Now the good news: these falsifications are detectible by gaining access to the system through discovery into the bowels of the EMR system.

A typical falsification scenario: On day one, Defendant surgeon performs a gallbladder resection on a 42 year female with gallstones and the surgeon prepares a routine operative report. To write the report, he logs onto the hospital's EMR system and prepares the record by cutting and pasting from a "routine" operative report for gallbladder removal – one he has used many times before. The patient is discharged home with dull ache in her belly. On day 2, the patient returns by ambulance with severe jaundice. It is discovered that the surgeon had transected the common bile duct which allows bile to drain from the liver to stomach, a devastating complication. The panicked surgeon logs back into the patient's EMR and pulls up his operative report and begins rewriting, adding exculpatory entries explaining how he carefully inspected for leakage of bile (or describing scarring/adhesions that made the operation very difficult, or adding information that the patient had been specifically, warned of this complication). As far as the "clever" surgeon is concerned, the old operative report has been completely replaced by the new exculpatory version. However, through discovery every step the surgeon took to falsify the record can be documented. The EMR system has built in audit software – made to order for the patient's lawyer.

There are several features common to EMR systems that are discoverable through traditional written discovery and "PMK" depositions (CCP Section 2025.230). The EMR systems permit auditing of each individual medical record entry. For each entry that appears to exculpate the physician (suspicious entry) you should be able to discover:

1. The precise date/time of the original entry and the content of the original entry before exculpatory alterations;

2. The date/time of any changes and content of any changes to the original entry;

3. The date/time of each time the defendant logged into the plaintiff's medical record;

4. The content of the note/record both before and after the alterations.

I recommend that the discovery to detect medical record falsification should be conducted only after the defendant physician deposition is taken. The physician defendant will generally commit perjury by denying changes or alterations in the medical record. So once material alterations are demonstrated through discovery, the physician has got himself caught in a pickle of deepening the medical cover-up.

The written discovery should include asking defendant to produce all versions of the medical record entry in question (original, amendments, addendums, etc). Invariably, the defendant's insurance defense counsel will object and produce only the official printout from the EMR system, hoping that will satisfy the plaintiff's discovery request.

Following production of a printout of the EMR, a PMK deposition should be taken of a person with full access to the plaintiff's EMR medical record. The PMK deposition should be an IT person most knowledgeable about the operation of the EMR software -- one capable of performing audits of the designated record entries (date, time, authorship and content). The subject record entries should be included in the notice. The notice of deposition should request the deposition occur at the hospital in a room with computer terminal with full access to the plaintiff's EMR. The deposition could occur outside the hospital if the deponent has remote access to the system. Without cooperation of defense counsel, you will require a notice of an online digital inspection of the plaintiff's medical record. The PMK deposition should demonstrate each date/time the defendant logged into the system and every entry made, deleted or altered.

Although California courts have rejected the "spoliation" claim as a separate cause of action (*Cedars Sinai v. Superior Court* (1998)18 Cal.4th 1, proof of medical record falsification destroys the defendant physician's credibility and creates an evidentiary inference on causation. In *Thor v. Boska* (1974) 38 Cal. App. 3d 558, a case where the doctor destroyed his original and completely re-wrote the medical record, the court of appeal wrote:

The fact that defendant was unable to produce his original clinical record concerning his treatment of plaintiff after he had been charged with malpractice, created a strong inference of consciousness of guilt on his part…(at p. 565)

> The basic principle is explained by Wigmore: "It has always been understood -- the inference, indeed, is one of the simplest in human experience -- that a party's ... suppression of evidence by ... spoliation ..., is receivable against him as an indication of his consciousness that his case is a weak or unfounded one; and from that consciousness may be inferred the fact itself of the cause's lack of truth and merit. The inference thus does not apply itself necessarily to any specific fact in the cause, but operates, indefinitely though strongly, against the whole mass of alleged facts constituting his cause." (2 Wigmore, Evidence (3d ed. 1940) Section 278, p. 120. Italics added.) Again: "But so far as spoliation or suppression partakes of the nature of a fraud, it is open to the larger inference already examined (ante, section 278), namely, a consciousness of the weakness of the whole case."
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> "….the proponent of such evidence -- plaintiff, in this case -- should be entitled to an instruction that "the adversary's conduct may be considered as tending to corroborate the proponent's case generally, and as tending to discredit the adversary's case generally." (at 567).

Although rejecting the spoliation cause of action in Cedars, supra, the California Supreme Court recognized the imposition of discovery and evidentiary sanctions on the physician who concocts or falsifies the clinical record:

> "Chief among these is the evidentiary inference that evidence which one party has destroyed or rendered unavailable was unfavorable to that party. This evidentiary inference, currently set forth in Evidence Code section 413 and in the standard civil jury instructions, has a long common law history. (See The Pizarro (1817) 15 U.S. (2 Wheat.) 227, 240, 4 L.Ed. 226 (per Story, J.); 2 McCormick on Evidence (4th ed. 1992) § 265, pp. 191–192; 2 Wigmore on Evidence (Chadbourn rev. 1979) §§ 278, 291, pp. 133, 221; Maguire & Vincent, Admissions Implied From Spoliation Or Related Conduct (1935) 45 Yale L.J. 226.)
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> *12 As presently set forth in Evidence Code section 413, this inference is as follows: "In determining what inferences to draw from the evidence or facts in the case against a party, the trier of fact may consider, among other things, the party's ... willful suppression of evidence relating thereto...." The standard California jury instructions include an instruction on this inference as well: "If you find that a party willfully suppressed evidence in order to prevent its being presented in this trial, you may consider that fact in determining what inferences to draw from the evidence." (Citation omitted.) Trial courts, of course, are not bound by the suggested language of the standard BAJI instruction and are free to adapt it to fit the circumstances of the case, including the egregiousness of the spoliation and the strength and nature of the inference arising from the spoliation.

> In addition to the evidentiary inference, our discovery laws provide a broad range of sanctions for conduct that amounts to a "[misuse] of the discovery process." (Code Civ. Proc., § 2023.) Section 2023 of the Code of Civil Procedure gives examples of misuses of discovery, including "[f]ailing to respond or to submit to an authorized method of discovery" (id., subd. (a)(4)) or "[m]aking an evasive response to discovery." (Id., subd. (a)(6).) Destroying evidence in response to a discovery request after litigation has commenced would surely be a misuse of discovery within the meaning of section 2023, as would such destruction in anticipation of a discovery request.
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> The sanctions under Code of Civil Procedure section 2023 are potent. They include monetary sanctions, contempt sanctions, issue sanctions ordering that designated facts be taken as established or precluding the offending party from supporting or opposing designated claims or defenses, evidence sanctions prohibiting the offending party from introducing designated matters into evidence, and terminating sanctions that include striking part or all of the pleadings, dismissing part or all of the action, or granting a default ***255 **518 judgment against the offending party. Plaintiff remains free to seek these remedies in this case."
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> (Cedars, supra, pp 12-13)

Summary

Winning any medical malpractice claim is difficult for the simple reason that the juries tend to favor physicians. This is true no matter how egregious the malpractice. The judge (and standard jury instructions) tend to push the case in the direction of a professional debate between expert witnesses – a losing formula for the plaintiff. By proving a physician falsified the medical record (and then lied about it!), the plaintiff can change the nature of the trial from a medical "debate" to medical "cover-up" –- a winning strategy.