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The Medical Record as Evidence: How will your chart look to a jury?

by Patricia Daehnke

It is a fundamental tenet that clinically relevant information should be documented in the patient's chart to fulfill state board, medical-legal, billing and standard of care requirements.

When a physician provides good patient care and documents the steps taken to provide such care, this results in the best documentation which also conveys vital information to other health care providers. Accurate, legible and thoughtful charting can also make the difference between a defense victory and a plaintiff's verdict in a medical malpractice action.

It is the physician's duty to maintain adequate and accurate patient medical records wherever the care is provided, be it a hospital, nursing home or in the office. Despite wide recognition of this duty, the Medical Board of California reports an upward trend in administrative actions against physicians that involve failure to keep adequate and accurate medical records. See Medical Board of California Newsletter, Volume 103, July 2007. Violations prosecuted include improper altering of medical records and creating false or fraudulent medical records. This type of violation can form the basis for a spoliation or destruction of evidence claim in a civil lawsuit subjecting the defendant to punitive damages. Spoliation of evidence is defined as the failure to preserve property for another's use as evidence in pending or future litigation. Spoliation may also include the alteration or fabrication of evidence to support a defense or claim. Altered records are invariably discovered and plaintiffs' lawyers engage forensic document examiners to determine when records were created to prove alteration. If there is evidence of altered medical records admitted at trial, a jury instruction will be given against the party who altered the records. The credibility of the defendant physician is greatly undermined by alteration of medical records.

Even seemingly innocuous documentation inadequacies can result in board penalties. For instance, California Business and Professions Code Section 2266 provides: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct" which could result in a citation and a fine. Simply inadequate record-keeping is no longer just a Medical Board matter as it too presents significant challenges in medical malpractice litigation in the defense of individual physicians and other health care providers. On the whole, jurors want to find in favor of the physician if they believe him or her to be trustworthy and credible. If the medical records support the facts as the physician presents them, it provides a credible base of supporting evidence for the defense case.

This point was driven home earlier this year when a jury awarded over $20 million in damages in a medical malpractice case to the family of a man who succumbed to advanced lung cancer. The plaintiffs claimed wrongful death based on a failure to diagnose by an ER physician and an urgent care facility where the patient had presented several times prior to death. This was the jury's evaluation despite the less than 15% survival rate of the decedent at presentation. Liability for this extraordinarily high verdict is thought to be due in good part to the lack of sufficient documentation that the results of the patient's chest X-rays had been conveyed to his primary care physician by the urgent care facility with a recommendation that further testing be done.

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Another recent $6 million jury verdict against a hospital involved evidence at trial of inconsistent and inaccurate record keeping by hospital nursing staff during a prolonged labor and delivery wherein the OB/Gyn obtained a defense verdict. This suggests documentation errors, even those that do not affect the outcome of the patient, may very well affect the outcome of the trial.

It is also very important to clearly document instructions given to patients on follow-up care. A patient, later a plaintiff, invariably recalls little or nothing of what has been told to them by their physician. Similarly, it is also crucial to document non-compliance together with any warnings given to the patient as a result of non-compliance. The documentation should be thoughtful, objective and factual. Avoid remarks that would be inflammatory to a jury if blown up as a trial exhibit.

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It is critical to document contemporaneously to the event. Late charting needs to be so designated. One recent case involved a physician who extensively documented multiple aspects of a patient's presentation and the risks explained to the patient regarding the surgery to be undergone. It became apparent this documentation was not contemporaneous, as the form used to document this pertinent information was discovered to have been manufactured the year after the date of the documentation. Fortunately, this discrepancy was recognized by defense counsel prior to discovery and trial and mitigated.

Adequate and accurate medical documentation is particularly crucial in cases involving the issue of informed consent where the plaintiff will likely testify the risks and complications of a procedure or treatment were not adequately explained. Because jurors often identify with the plaintiff, good record keeping can make a difference in a he said/she said type of case.

Multiple discrete factors influence every jury trial and verdict. However, the key to achieving a medical malpractice defense verdict is to provide the jury with an explanation of what happened that makes more sense and is more persuasive than the interpretation provided by the plaintiff. The facts of the case will be presented to the jury by both lay and expert medical witnesses, and through the medical records. However, the most important facts will come from the defendant physician who will tell the jury what happened. The defendant physician's credibility can be bolstered or undermined by documentation or the lack thereof. Although the physician will likely be the best witness at trial on his or her own behalf, good backup always helps. ■

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