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BEFORE AND AFTER:

SPOLIATION OF MEDICAL EVIDENCE IN MEDICAL NEGLIGENCE LITIGATION ©

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by

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"These practices are not immutable. In an imperfect world they cannot be wiped out altogether; but surely they can be reduced and counteracted. I hope to have shown how often the justifications they invoke are insubstantial, and how they can disguise and fuel all other wrongs. Trust and integrity are precious resources, easily squandered, hard to regain. They can thrive only on a foundation of respect for veracity."

Sissela Bok, Lying 249 (1978)

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BEFORE AND AFTER*:*
Spoliation Of Evidence In Medical Negligence Litigation

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BEFORE AND AFTER:
Spoliation of Medical Evidence In Medical Negligence Litigation

by Elliott B. Oppenheim[1]

My interest in record falsification and clinical fraud in medicine began when I was a surgical intern in my first summer after medical school.[2] In the hospital where I trained I watched an anesthesiologist insert a 22 gauge hypodermic needle into the ante-cubital vein of a twenty-five year old man. The patient needed a thyroid resection since he had a "cold nodule." It needed to come out. The surgeon was one of the best, one of the most experienced in the city, one of most highly regarded surgeons in the state.

Since patients are fretful over surgery and of the hospital process, the anesthesiologist wanted to illustrate for me, a surgical intern of a few weeks, the anxiety free induction of anesthesia. As a surgical intern this man was my patient. I felt responsible for his well being. The anesthesiologist mixed up a barbiturate, succinyl choline, and morphine. This patient was in excellent health. I was the pupil; the anesthesiologist was the experienced teacher.

Blood entered the syringe barrel and I watched the clear mixture flow into the vein. After this inductive dose which would paralyze the man and permit placement of a life-assuring endotracheal tube, the anesthesiologist intended to place an intravenous line and commence a general anesthetic while ventilating the lungs with pure oxygen through the endotracheal tube. There was nothing at all unusual about the intended process with one exception. He did not place an intravenous line.

Soon the medicine took full effect, the patient went flaccid from the paralytic medication, an appropriate response, and the doctor began to bag the patient with oxygen prior to placing the IV line. An extraordinary thing then happened. The patient had bronchospasm, his blood pressure plummeted, and it

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[2] So far as this author knows, the anesthesiologist and surgeon died a number of years ago.

became impossible for the anesthesiologist to pump in life sustaining oxygen. The anesthesiologist was unable to insert either the endotracheal tube or an IV line; both were needed to save this man. Since there was no IV line in place, there was no way to effectively give the simple antidote, epinephrine. The patient turned blue. At the anesthesiologist's command, I called a "code" and personnel streamed into the cold OR.

I remember the event with complete clarity today, nearly a quarter-century later. The patient's surgeon entered the room while we performed CPR. A cardiac surgeon then responded to the code, entered the room, and opened the man's chest. He tried to massage the man's swollen heart with his big hand but the heart was tense, engorged, solid. The heart muscle quivered rather than pumped. Despite multiple injections of epinephrine into the heart, nothing happened and the man died.

The surgeon and the anesthesiologist told me not to write up anything, that they would handle the family and they would write the clinical notes. Later that afternoon I heard the surgeon tell the relatives that there had been an operative complication, that their loved one had died, that no one could have saved him: all nearly true statements. The anesthesiologist wrote a note nearly telling exactly what happened: bronchospasm during induction leading to death; a rare but well-known anesthetic complication. Both the surgeon and the anesthesiologist avoided the truth, and, as if by their fiat, as if they could wipe away the sight of that stone heart from my memory and make this deception fade, they explained to me that things like this happen in medicine, that this was unavoidable, and, after all, they were both highly skilled practitioners with many years of clinical practice. What amazed me at the time was that both seemed convinced that what they told me was accurate and that I accepted their fabrication.

The surgeon wrote up a benign discharge summary reflecting the facts as they appeared in the chart. So far as I know there was no investigation of any sort. I learned then the true meaning of the quip, "Doctors bury their mistakes." Even as naive as I was at the time, I knew that an IV line would have made the difference for this man between life and death; that without placing the IV, had a complication happened in the induction process, and it did, there would be no way to have critical IV access. Also, as a timid intern, I recognized if I spoke out that I could place my career in jeopardy.

I felt intellectually and morally filthy but I never mentioned a word about the true facts to anyone for a decade. But for the inconvenience of an IV line, and the anesthesiologist following well established hospital procedures, this man would be approaching fifty now, none the worse for his thyroid resection. I felt that the man's relatives should know what happened, the truth, the whole truth, but I remained silent. I was young and timid then.

I wrote a short article about this incident for a prestigious medical journal five years ago but they refused to publish it. Their editor, a physician, didn't believe what I wrote was true and he replied, annoyed, "Had this really happened something would have been done." I tried to get him to understand

that the problem was that there was no accountability.

During my nearly twenty years in medical practice I saw irregularities in medical record keeping not unlike what I detail in this paper and not unlike what I saw that summer. I know that what I saw that summer was in no way clouded by inexperience or some other defect within me. I have pondered what obligations physicians have to their patients with respect to disclosing untoward medical events for nearly twenty-five years and what the health care industry should do about creating contemporaneous correct records, and this paper reflects that thought.

This paper concerns acts of practitioner and institutional dishonesty in medical record keeping which in some way influence the course of events in medical negligence litigation. One of the main points in this thesis is that dishonesty in medical record keeping is rampant and unless it is detected, little can be done to rectify the problem. It is my hope that this paper will influence professionals from violating medicine's commandments; that it may facilitate both detection and punishment of those involved; that it may ultimately enhance patient safety for all of us who may at some time become patients.

In addition to the important others to whom I also dedicate this thesis, I dedicate this master's thesis to the memory of that trusting and unknowing man who died in the OR at the hands of a reckless practitioner; to physicians who may learn from these cases and from this analysis; to both plaintiff and defense trial attorneys who may better help their clients and further the search for truth and ethical conduct in medical negligence litigation. Perhaps this side view of medical practice I portray here will, in some small way, influence others away from incautious conduct in medical record keeping and prevent needless suffering not unlike what I witnessed when I was a surgical intern so long ago.

§ I.

INTRODUCTION

Personal war stories aside, it is important to frame this discussion by presenting a few qualitative examples of spoliation of evidence, its presentations, its scope in medical practice. The first report concerns Dr. Michael Elam, a cosmetic surgeon in Orange County, California. Dr. Elam was subjected to licensure proceedings in California after one of his patients claimed that "Elam drugged her in his office, then gave her a nose job and cheek implants that she never wanted. In addition, state investigators charge that Elam forged insurance documents to try to collect on the operation."[3]

"'He changed a Mrs. America runner-up into a recluse who hides in her house," charged Santa Ana plastic surgeon Robert Miner, who is president-elect of the Orange County Medical Association and also the state's chief medical witness against Elam. "It was irresponsible."

Dr. Elam responded with, "If I was as bad as the state of California says I am, why would I have all these patients, all this success? . . . Who have I hurt? Who have I killed? What have I done except have a couple of unhappy patients? . . . Ever since I did a face lift on Phyllis Diller ... I've been the target of people who are very jealous of my

success. I'm on television all the time. I get a lot of publicity. I'm in Vogue, People, all sorts of magazines. And usually when something happens in cosmetic surgery, I get a call. But (the publicity) is a double-edged sword-you get persecuted because of it," he said.

This doctor was named in more than two dozen malpractice claims in the Orange County Superior Court and has no malpractice insurance. Dr. Elam's *modus operandi* included altering insurance claim forms to reflect a medical condition which would qualify for insurance reimbursement. In one instance, Dr. Elam claimed that a patient had a nasal airway obstruction in order to favorably mask the indication for a rhinoplasty.

The San Jose newspaper[4] reported numerous licensure actions in California. Of the twenty or so reports, at least five contained serious disciplinary actions based upon medical record falsification or fraudulent or deceptive billing practices.[5] But this is not an isolated California problem as illustrated by another newspaper article from Minnesota which documented two physicians who lost their licenses for fraudulent billing practices. One physician lost his license for five years after he was convicted of a felony for falsely billing Medicare, Medicaid and Blue Cross and Blue Shield of Minnesota for services he

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[3] Eric Lichtblau, *Medical License on Line for O.C. Cosmetic Surgeon*, LOS ANGELES TIMES, Apr. 4, 1990, at A.1.

[4] Mitchell Benson, *Names, Accusations Revealed After Suit*, SAN JOSE MERCURY NEWS, Feb. 5, 1995, at Morning Final Section: Front Page, 19A.

[5] Including Robert M. Barr, of San Jose; Gilbert J. Elian, of Santa Clara; and Morgan Hill. Dr. Hill was convicted of two federal offenses, "conspiracy to defraud the United States, violating drug-prescribing laws, and eight state offenses, four counts of transporting controlled substances, four counts of unlawful prescribing, and unprofessional conduct, gross negligence, dishonesty or corruption, narcotics violation, excessive prescribing." *Id.*.

never performed. The other improperly managed his medical records and engaged in abusive or fraudulent billing practices.[6]

If one assumed that only flawed practitioners and shoddy institutions would participate in this calumny that assumption would be incorrect. In an unusual suspension of the state's statute of limitations on medical negligence cases, a Maryland court permitted a family to file suit twenty-one years after a couple lost their baby.[7] The death was covered up by lying staff at the prestigious and world famous Johns Hopkins Hospital. The deception was discovered when a family member attempted to discover whether there was a family genetic defect which caused the death of his three day old brother. The state medical examiner had recently issued a corrected death certificate at the mother's request indicating that "a transfusion of hemolyzed or bad blood into the baby's bloodstream caused an immediate respiratory arrest."[8]

According to the family, this was the first time they knew that death had occurred other than from "unpreventable liver failure,"[9] what they had been told years before by the Johns Hopkins Hospital's physicians. The couple, only seventeen years old at the time of delivery, were grief stricken and never felt they needed a death certificate. As would most unsuspecting "reasonable persons," this youthful couple fully accepted the doctor's explanation. In their $5 million suit,[10] the couple now alleges that they "were victims of 'willful and deliberate fraud and misrepresentation' by Hopkins health care workers, who

[6] Tom Majeski, *Medical Board Suspends Duluth Doctor's License: Panel Bars or Restricts Several other Physicians*, ST. PAUL PIONEER PRESS, Aug. 9, 1993, at 1C.
[7] Sue Miller, *Looking Back to Discover the Truth Family's Suit Alleges Fraud in Baby's Death*, BALTIMORE EVENING SUN, July 24, 1991, at A1.
[8] *Id.*.
[9] *Id.*.

'willfully and deliberately lied' to them about the circumstances surrounding their son's illness and death."[11]

"Two months ago" the decedent's grown-up brother "tried to obtain copies of his dead brother's records from the Hopkins' Medical Records Department. He said he was told the records 'were lost.' He then learned from the medical examiner's office that an autopsy had been performed" and obtained the autopsy from the medical examiner. The hospital has no explanation for the record disappearance and the family's suit asserts that the records were "'willfully and deliberately destroyed' to further deprive" the family of their "'right of action for the negligence' of the doctors and nurses at the hospital."

The truth about this child was that the mother delivered a healthy baby with normal Apgars but the baby developed jaundice, underwent an exchange transfusion, and died. Hospital workers had infused hemolyzed blood, "causing an immediate cardiorespiratory arrest" and death. While it took twenty-one years for the lie to ooze forth, as in a toxic chemical spill, it oozed forth twenty-one years later and poisoned the environment.

Litigants in medical negligence litigation depend upon the integrity of the medical record[12] in order to pursue or to defend its case and when either party alters the

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[10] The suit was eventually settled for an undisclosed amount. The author is indebted to Mr. Marvin Ellin of Baltimore, MD who graciously provided the author materials which greatly aided in this research endeavor.
[11] *Id.*.
[12] In this discussion, the term *medical record* means the actual patient records, laboratory test results, x-rays, pathology specimens or histologic slides, any material of whatever nature generated with respect to patient care. Other records include fetal monitor strips, EKG strips, EEG strips, the raw readout from nerve conduction studies, echocardiograms, the actual film from angiographic procedures. It is an inclusive term and also refers to records an hospital may generate in the forms of reports, surveys, and peer review materials.

medical record, falsifies it, or makes it unavailable, the opposing party may be greatly harmed. Spoliation of evidence or destruction of evidence can impair the ability of either party to appropriately present its case to the trier of fact and, therefore, this represents a significant systemic interference with the judicial process. It is a civil form of obstruction of justice.

While other authors have written about spoliation in the context of industrial accidents in the products liability setting,[13] in the areas of personal injury recovery or in conjunction with business and property transactions[14] and have considered whether this conduct should rise to the level of being considered a tort in itself,[15] only one other author has examined spoliation in medical negligence litigation.[16] This article differs from that one since it is written from an *hands on, in the trenches* viewpoint for practitioners who need to know what to include in pleadings, how to conduct discovery, and how to manage their case efficiently in terms of ultimate settlement postures or trial strategies.

Trial attorneys need this information in this specialized area and this author, with nearly twenty-five years experience in medical negligence litigation as a medical analyst both prior to and after legal training, and having appeared as a medical expert in the majority of states, is uniquely suited to write such a treatise. This paper will attempt to

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[13] *See, e.g.*, Mary A. Wells, *Pillage and Plunder in Aircraft Accidents: Potential for Spoliation Penalties for Spoliation of Evidence can be Serious, Including Exclusion of Evidence, Adverse Inferences and Liability for an Independent Tort*, 60 DEF. COUNS. J. 280 (1993).

[14] *See, generally*, Scott S. Katz & Anne M. Muscaro, *Spoliage of Evidence- Crimes Sanctions, Inferences and Torts*, 29 TORT & INS. L.J. 51 (1993).

[15] *See, e.g.*, Maurice L. Kerwin, *Spoliation of Evidence: Why Mississippi Should Adopt the Tort*, 63 MISS. L.J. 227 (1993).

[16] Anthony C. Casamassima, *Spoliation of Evidence and Medical Malpractice*, 14 PACE L. REV. 235 (1994). [hereinafter CASAMASSIMA]. This author has both MD and JD training.

create a thorough consideration of the problem of spoliation of evidence in the context of medical negligence litigation.[17]

First, this paper will discuss spoliation as it has arisen in products liability litigation and in general industrial and personal injury cases. Second, the paper will turn to a medical legal presentation of the duty for health care professionals to create and retain medical records at federal, state, and private levels. Then, third, there is a presentation of a number of illustrative medical negligence cases where spoliation of evidence has played an important part in discovery, trial, or settlement phases. This is a detailed section in which the author will try to present a real-world view of what may occur in medical negligence litigation. Finally, based upon the prior analyses and cases presentations, the paper makes recommendations about handling spoliation of evidence when it arises in medical negligence litigation. The conclusions and recommendations are directed to the health care industry, plaintiff and defense attorneys.

In general, the courts have considered civil destruction of evidence in the business or traditional tort setting where there is no particular duty to preserve evidence. This is not the case in medicine where professional ethics, federal and state statutes create a substantial independent duty for providers to create and preserve these important records. There is no area in American society where there are more rules and regulations than in medicine and perhaps no area in which litigation is more vehement than in medical negligence. The violation of the duty to preserve the integrity of medical records or to appropriately produce them could constitute, as the reader will see, substantial simultaneous violations of professional ethics, state, and federal statutes.

[17] Unless specified, this paper concerns non-oral evidence of whatever nature.

There is no question that medicine is an honorable profession and caring for the welfare of other people as a physician is an unparalleled responsibility which carries with it correspondingly unparalleled duties and obligations. In contrast to the medical practice setting, spoliators are frequent in medical negligence litigation. In actual medical practice, spoliators are the exception.[18] In order to fully understand this, one must understand how the medical record is created, how medical evidence is generated, and how and in what manner, in litigation, the medical record is treated. At each juncture, from medical record creation, to risk management review, through the hands of counsel, and ultimately before the court, the record is subject to alteration, falsification, redaction, or disappearance.

In many ways, this paper deals with the threads from which authors weave medical thrillers: fraud, deceit, lying, duplicity, shame, fear, and malice all wrapped up in a tense medical-legal ball.[19] But, as the reader will see, spoliation of evidence in medical negligence litigation is a gritty, real-world problem, not one of esoteric academic importance, or one viewed only from the vantage point of prolific pop authors. Spoliation is a problem which can greatly and irreparably damage litigants whose lives have already been damaged by medical accidents. Perhaps the worst injury would be that the spoliation never discovered. If this treatment is successful, by the time the reader arrives at the end

[18] The reason for this is that in medical practice, practitioners are motivated to produce a correct and accurate record. In medical negligence litigation, the practitioner's motivation has changed: to cast a favorable view upon his role in the medical care.

[19] Another prominent movie (starring Harrison Ford) and television series was The Fugitive. In the recent movie version, a crooked pathologist phonied liver biopsy lab results in order to obtain FDA approval for a proposed drug. Since Dr. Richard Kimball inadvertently uncovered the subterfuge, which involved a number of doctors and the hospital, he was killed by the one-armed man. If one is a skeptic about whether this medical conduct is so far fetched that "it could never happen," consider the cases presented *infra* , In re Jascalevich, p. 79 and at p. 101, *Cherovsky v. St. Lukes's Hospital*.

of this treatise, the reader should fully understand the answer to the question Dr. Elam intended as only rhetoric: Who have I hurt?

§ II.

Now You See It; Now You Don't

Presto, chango! Poof! With the wave of the hand the spoliator has made not only evidence vanish but the opposing party's entire ability to prove his case! He has tampered not only with evidence but with the judicial system and with the public's sense of integrity in the judicial process. Is spoliation as much an American past-time as baseball? It is everywhere. It was a major theme in the O. J. Simpson[20] and Snoop Doggy Dogg[21] trials and recently it was the subject of the popular movie, *Before and After*.[22] Although there are no precise statistics on how often evidence is destroyed or in some way modified in non-medical cases, it must occur frequently, human nature being what it is. As a moral choice, spoliation is a form of lying and deception. Spoliation is a form of fraud, and, as anyone who has lived in the post-war era knows, evidence destruction occupied prominent positions in major historic events.

What a different place America would be without evidence tampering in Watergate, the Viet Nam conflict, the Wall Street investment scandals, TV evangelists,

[20] In the celebrated People v. O. J. Simpson trial the defense raised many issues about police tampering with evidence and the People raised the issue of Mr. Simpson perhaps disposing of clothes and a murder weapon.

[21] Mr. Dogg was acquitted after a trial in which he had been charged with participation in a gang murder. Vincent J. Schodolski, *L.A. Prosecutors Lose Again: Rapper Cleared*, CHICAGO TRIBUNE, Feb. 21, 1996, at 4. "The prosecution ... was deprived of what could have been vital evidence when police inadvertently destroyed ... bloody clothing ... a bullet and a shell casing from the murder scene."

[22] With *big name stars*, Meryl Streep and Liam Neesen. Based on fact, when a father discovers that his son has been involved in the murder of a girlfriend, the father burned evidence and cleansed the vehicle the son

Iran-Contra affair, and even Whitewater. These serve to remind the skeptic that many people are subject to moral and ethical lapses they sometimes later regret. Mr. Nixon's eighteen-minute gap remains as one of the most glaring examples of the consequences of destruction of evidence. It is hard to imagine how history would have been altered had that gap eluded discovery and Mr. Nixon would have continued in office. Or, in the alternative, had the tapes been faithfully retained and undergone appropriate investigation, what might have resulted! Spoliators have changed the course of modern history through their ways and it is impossible to know how and in what ways history has been altered when the spoliation went undetected.

In one of her major philosophical contributions, in *Lying*,[23] Harvard Professor Sissela Bok pointed out nearly twenty years ago that "[t]he moral question of whether you are lying or not is not settled by establishing the truth or falsity of what you say. In order to settle this question, we must know whether you intend your statement to mislead." In contrast then, to the false speaker, one who alters a medical record, or who disposes of, or mutilates material evidence in medical negligence litigation settles the intent issue. Since, presumably, no one would tamper with physical evidence to shift guilt towards one's self, this leaves only one interpretation: a spoliator intended deception.[24] What distinguishes

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used in the crime. The loving father welded the murder weapon, a bumper jack, into a sculpture in order to further obscure its location and to detour the state's case.

[23] SISSELA BOK, LYING 6 (Vintage 1978).

[24] There are two additional benign explanations: after-the-fact corrections to the clinical record and unintentional error or omission. After-the-fact record corrections should be conspicuously made, titled as an "addition to the record," and contain signs that the additions are "intended to clarify." When a practitioner receives a lab update, for instance, she may write as the heading for the entry: Additional Lab Data. It is unacceptable, in contrast, to over-write numbers, change times by erasure, completely white- or black-out any information. Unintentional errors of omission or mistake tend to represent the ordinary mistakes every person makes and which would be understandable to the "reasonable person under the circumstances." In this author's experience in record review, it is not unusual for health care providers to innocently mis-state

culpable spoliation from innocent error, in an objective standard, would be whether the record as altered would more favorably portray the spoliator's role as opposed to that of the non-spoliator. Often this analysis remains murky and becomes a contested matter of fact.

As with products liability cases and other tort actions, there are no statistics as to how often spoliation of evidence occurs in medical negligence litigation. In this author's experience, though, spanning nearly twenty-five years in reviewing medical records and in consulting in medical malpractice litigation with attorneys throughout the nation, record alterations, deceptive record creations, and convenient disposal of records or of material evidence is a common occurrence.[25] One of the problems with medical negligence litigation is that record alterations can be difficult to spot unless one knows by way of background, training, and experience precisely what should be in the record. For experienced eyes, it is sometime impossible to detect when a typed record was added or when an handwritten record was substituted for an original version.[26]

Often medical record alteration will elude a graphologist's sophisticated scientific techniques because the writing itself is not disturbed; deception comes in the falsity of the thoughts expressed; the ideas are factually incorrect. That form of record alteration leaves no written trace other than that which is written may seem out of context, excessively

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right for left, mis-write 100 mg when they actually mean 10 mg, confuse AM or PM, inadvertently write the previous or coming year, confuse drug names (Demerol for Dopamine, Vicodin for Vistaril, Lasix for Lidex). Typically these would not be written with the intent to deceive but it is not to say that these mistakes may be fully excusable and not constitute professional negligence.

[25] No commentator states that spoliation of evidence is not a problem.

[26] *See*, Elliott B. Oppenheim, *The Medical Record Explained, 6 OHIO TRIAL 7 (1995)*. What this author has learned to spot is medical inconsistency. Typically this requires many years of medical practice in order to fully understand these contextual alterations.

self-serving, or simply factually incompatible with other medical events.[27] Idea alterations may be almost impossible to detect but, to give the client his best chance, a wise attorney will consult with one who is expert in this area.[28]

This author has postulated that if more medical care-givers knew of the consequences of spoliation of medical evidence, then they would do it less.[29] That educational message is one worthy goal of this treatise.

[27] *See*, Elliott B. Oppenheim, *Components of a Hospital Medical Record- A Checklist*, 10 PROF. NEG. L. REP. 196 (1995). It is critical to know what the record should contain.

[28] In this author's opinion, this expertise would require, at a minimum, M.D. training, or its equivalent, and experience in medical practice, in conjunction with considerable forensic experience in medical record analysis. In this author's experience, those with R.N. training and experience may be able to detect nursing note alterations or additions or deletions to the record *by nurses* but, since nurses never determine standard of care matters in medical practice outside of their own field, they have limited abilities when they evaluate physician entries. The author cautions attorneys to avoid "curb side" consultations with friends or relatives in these important matters unless these persons possess the requisite background, skills, and training. As one will see, as illustrated by the cases below, it would be very easy for one unskilled in this highly technical are to miss important details.

[29] *See, e.g.*, Elliott B. Oppenheim, *Keeping it on the Record*, 28(2) EMERGENCY MEDICINE 87 (1996).

§ III.

The Contours of Non-Medical Spoliation: Of Lying, Deception, and Fraud

To this point the word *spoliation* has appeared without express definition. What precisely is the legal meaning of *spoliation* or *destruction of evidence*?[30] The terms are usually interchangeable but spoliation is a general word of art which means, according to one judicial opinion, "failure to preserve property for another's use as evidence in pending or future litigation."[31] Another court, the Maryland Court of Special Appeals, in *Miller v. Montgomery County*[32] similarly defined spoliation as "the destruction, mutilation or alteration of evidence by a

[30] Scott S. Katz & Anne M. Muscaro, *Spoilage of Evidence-Crimes, Sanctions, Inferences, and Torts*, 29 TORT & INS. L.J. 51 (1993). This is a good review article from which the interested reader will be able to identify the important issues.

[31] County of Solano v. Delancy, 264 Cal. Rptr. 721, 724 n.4. (Ct. App. 1989) (on February 1, 1990, the California Supreme Court denied review and ordered that the opinion not be officially published). *See also*, Mary A. Wells, *Pillage and Plunder in Aircraft Accidents: Potential for Spoliation Penalties for Spoliation of Evidence can be Serious, Including Exclusion of Evidence, Adverse Inferences and Liability for an Independent Tort*, 60 DEF. COUNS. J. 280 (1993). (discussing in greater detail the etymology of the word *spoliation*).

[32] 494 A.2d 761 (Md. Ct. Spec. App. 1985).

party to an action."[33] *Black's Law Dictionary* defines spoliation as the "intentional destruction of evidence or the significant and meaningful alteration of a document or instrument."[34] Some courts view as spoliation of evidence merely not making evidence available for discovery.[35]

Spoliation is not a new phenomenon. Early courts took up the problem and considered what remedies might be appropriate as early as 1722[36] in *Armory v. Delamirie* where the true owner, in an action for trover, sought to recover a jewel which a chimney sweeper found. The jewel had been taken to a jeweler for appraisal and kept by the jeweler. The court ruled "[t]hat unless the defendant did produce the jewel, and shew it not to be the finest water, they should presume the strongest against him, and make the value of the best jewels the measure of their damages: which they accordingly did."[37]

The concept of recovery for destruction of evidence in a civil matter could be viewed to take its roots from the famous case of *Mogul Steamship Company, Limited v. McGregor, Gow, & Company*,[38] where the court reasoned, in its attempt to resolve the equities between traders in a competition war, that "[a] man is bound not to use his

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[33] *Id*. at 767.
[34] BLACK'S LAW DICTIONARY 1401 (6th ed. 1990) (citing State v. Langlet, 283 N.W.2d 330, 333 (Iowa 1990)).
[35] Rodgers v. St. Mary's Hospital of Decatur, 556 N.E.2d 913 (4th D. 1990), *affirmed*, 597 N.E.2d 616 (1992).
[36] *See, e.g.*, Mary A. Wells, *Pillage and Plunder in Aircraft Accidents: Potential for Spoliation Penalties for Spoliation of Evidence can be Serious, Including Exclusion of Evidence, Adverse Inferences and Liability for an Independent Tort*, 60 DEF. COUNS. J. 280, 286 n.3. (1993), (noting that cases going back to 1617 are cited in GORELICK, DESTRUCTION OF EVIDENCE § 1.3 (1989)).
[37] 93 Eng. Rep. 664 (K.B. 1722), contained in JESSE DUKEMINIER & JAMES E. KRIER, PROPERTY 65 (2nd ed. 1988).

property so as to infringe upon another's right." Further, in reasoning which is as viable in

the waning years of this century as in those of the last, the court concluded that "the act complained of should ... be legally wrongful as regards the party complaining ... it must prejudicially affect him in some legal right; merely that it will ... do a man harm in his interests is not enough."[39]

Spoliation of evidence is an interference with legal rights[40] based upon the social sense that destruction of evidence or tampering with evidence would constitute a "wrongful interference with a plaintiff's 'probable expectancy' of prevailing in a civil action."[41] In relying on the decision in *Smith v. Superior Court*, the *Delancy* court recognized that the *Smith* court inadvertently relied[42] on the tort of intentional interference with prospective business advantage in justifying the spoliation tort. The *Delancy* court compared the plaintiff's "opportunity to win" a lawsuit to the "reasonable probability" that a profit or contractual relationship would have resulted. Based on this comparison, the court concluded that a potential civil action is a "valuable probable expectancy" that the court must protect.[43] Whether states should or will recognize

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[38] 23 Q.B.D. 598 (1889), *aff'd*, A.C. 25 (H.L.) (1892), contained in PETER B. KUTNER & OSBORNE M. REYNOLDS, ADVANCED TORTS 179 (1989). [hereinafter, KUTNER].

[39] *See also*, Walker v. Cronin, 107 Mass. 555 (1871). (presenting the landmark case for interference with prospective business advantage with its elements: "(1) intentional and willful acts; (2) calculated to cause damage to the plaintiffs in their lawful business; (3) done with the unlawful purpose to cause damage and loss without right or justifiable cause on the part of the defendant, (which constitutes malice,) and (4) actual damage and loss resulting." In KUTNER at 175.

[40] Maurcie L. Kervin, *Spoliation of Evidence: Why Mississippi Should Adopt the Tort*, 63 MISS. L.J. 227 (1993).

[41] Smith v. Superior Court, 198 Cal. Rptr. 829, 837 (Cal. Ct. App. 1984). *See*, James F. Thompson, Comment, *Spoliation of Evidence: A Troubling New Tort*, 37 KAN. L. REV. 563, 563 (1989) (quoting Smith v. Superior Court, 198 Cal. Rptr. 829, 837 (Cal. Ct. App. 1984)).

[42] Delancy, 264 Cal. Rptr. 721, 728.

[43] Kervin, 63 MISS. L.J. 227, 248 n.9.

spoliation of evidence as a tort remains an issue for further academic analysis which has already prompted a number of law review articles.[44] Whether there should be a distinct and separate tort for spoliation, though, will not side-track this analysis.

When spoliation happens in medical negligence litigation, how should the courts react under present law? What legal obligations are affected when a party alters medical records? These concerns are the grist for the analytical grindstones here. There is another aspect to this paper, though. If the law could be different, what rules of law would best serve litigants? These, too, are some of the loose threads this thesis hopes to weave together.

The *law*, as a discipline, must evolve and recognize new causes of action. To that end, recognition of the spoliation tort was an important step. Of this evolution of law, Prosser stated:

> New and nameless torts are being recognized constantly, and the progress of the common law is marked by many cases of first impression, in which the court has struck out boldly to create a new cause of action, where none has been recognized before.... When it becomes clear that the plaintiff's interests are entitled to legal protection against the conduct of the defendant, the mere fact that the claim is novel will not itself operate as a bar to a remedy.[45]

California was the first jurisdiction to adopt spoliation of evidence as a separate tort. In *Smith v. Superior Court*,[46] the California Court of Appeals recognized explicitly a

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[44] *See*, Philip A. Lionberger, *Interference With Prospective Civil Litigation by Spoliation of Evidence: Should Texas Adopt a New Tort?*, 21 St. Mary's L.J. 209 (1989); John K. Stipancich, Comment, *The Negligent Spoliation Of Evidence: An Independent Tort Action may be the Only Acceptable Alternative*, 53 OHIO ST. L.J. 1135 (1992); Mary A. Wells, *Pillage and Plunder in Aircraft Accidents: Potential for Spoliation Penalties for Spoliation of Evidence can be Serious, Including Exclusion of Evidence, Adverse Inferences and Liability for an Independent Tort*, 60 DEF. COUNS. J. 280 (1993).
[45] PROSSER, TORTS § 30 at 143 (West, 4th ed. 1971).
[46] 198 Cal. Rptr. 829 (1984).

claim for the intentional spoliation of evidence and implicitly recognized the claim for negligent spoliation. The court held that "[t]he Supreme Court appears to have recognized a negligence cause of action for failure to preserve evidence for prospective civil litigation." The *Smith* court[47]cited its former analysis in *Williams v. State*[48] but it was in *County of Solano v. Delancy*,[49] where the California court provided the elements required to state a cause of action for intentional spoliation of evidence. The elements are:

> (1) pending or probable litigation involving plaintiff;
> (2) knowledge by the defendant of the existence or likelihood of the litigation;
> (3) intentional "acts of spoliation" on the part of the defendant designed to disrupt the plaintiff's case;
> (4) disruption of plaintiff's case; and
> (5) damages proximately caused by the acts of the defendant.[50]

The California court then recognized a cause of action for negligent spoliation of evidence needed for prospective civil litigation in *Velasco v. Commercial Building Maintenance Company.*[51]

Florida similarly iterated the elements for negligent spoliation of evidence in *Continental Insurance Co. v. Herman*,[52] but it was in *Bondu v. Gurvich*[53] that the Florida courts first recognized a negligence action in a medical case for failure to preserve medical records. According to the *Continental Insurance* holding, Florida required:

> (1) existence of a potential civil action,
> (2) a legal or contractual duty to preserve evidence which is relevant to the potential civil action,
> (3) destruction of that evidence,
> (4) significant impairment in the ability to prove the lawsuit,

[47] *Id.* at 832.
[48] Williams v. State, 664 P.2d 137 (1984).
[49] 264 Cal. Rptr. 721, 729 (1989).
[50] 264 Cal. Rptr. at 729.
[51] 215 Cal. Rptr. 504, 506 (1985).
[52] 576 So.2d 313 (Fla. App. 1991).
[53] 473 So.2d 1307 (Fla. App. 1985).

(5) a causal relationship between the evidence destruction and the inability to prove the lawsuit, and
(6) damages.[54]

In addition to California and Florida, above discussed, other states, including Ohio[55] and Alaska,[56] recognize intentional and negligent spoliation of evidence as separate torts.

Typically courts look to existing remedies for spoliation of evidence before recommending new ones.[57] Currently, courts which recognize negligent spoliation of evidence include Florida[58] and California[59] and those which recognize intentional spoliation of evidence are Alaska,[60] Ohio,[61] and California.[62] Illinois expressly rejected the tort in *Boyd v. Travelers Insurance Company*,[63] finding that there were sufficient traditional tort remedies which adequately addressed negligent spoliation of evidence and it declined to consider intentional spoliation of evidence as a new, separate tort.[64] Other courts align with the Illinois position; Arizona,[65] Indiana,[66] Kansas,[67] Michigan,[68] and Minnesota.[69]

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[54] Continental Ins. Co., 576 So.2d 313, 315.
[55] Smith v. Howard Johnson, 615 N.E.2d 1037 (1993).
[56] Hazen v. Municipality of Anchorage, 718 P.2d 456 (Alaska 1986).
[57] Boyd, 652 N.E.2d 267, 269.
[58] Continental Insurance Co. v. Herman, 576 So.2d 313, 315 (Fla.App.1990); Miller v. Allstate Insurance Co., 573 So.2d 24 (Fla.App.1990).
[59] Velasco v. Commercial Building Maintenance Co., 215 Cal. Rptr. 504 (1985).
[60] Hazen v. Municipality of Anchorage, 718 P.2d 456 (Alaska 1986).
[61] Smith v. Howard Johnson Co., 615 N.E.2d 1037 (1993).
[62] Smith v. Superior Court, 198 Cal. Rptr. 829 (1984).
[63] 652 N.E.2d 267 (1995).
[64] Lisa Fagan, *Court Refuses to Recognize Independent Tort of Spoliation of Evidence*, 83 IL. B.J. 319 (1995).
[65] La Raia v. Superior Court, 722 P.2d 286 (1986).
[66] Murphy v. Target Products, 580 N.E.2d 687 (Ind.App.1991).
[67] Koplin v. Rosel Well Perforators, Inc., 734 P.2d 1177 (1987).
[68] Panich v. Iron Wood Products Corp., 445 N.W.2d 795 (1989).
[69] Federated Mutual Insurance Co. v. Litchfield Precision Components, Inc., 456 N.W.2d 434 (Minn.1990).

New Jersey recognizes a tort of fraudulent destruction of evidence analogous to intentional spoliation of evidence[70] and North Carolina recognizes a cause of action for plaintiff's increased costs of investigation stemming from defendant's alteration of medical

records.[71] Georgia,[72] New York[73] and Missouri[74] have refused to recognize the spoliation tort for policy reasons. Maryland declined to adopt the tort since traditional remedies for the destruction of evidence were sufficient to protect spoliation victims and to deter future wrongdoers.[75]

The clearest and most simple line one would look for in the identification of spoliation is evidence destruction which interferes with a party's rights. If the spoliator knew litigation was underway and tampered with the evidence without regard for the effect upon the adverse party, most courts would view this as intentional spoliation of evidence. If the evidence were destroyed without this scienter, by inadvertence, then most courts would view this as negligent spoliation of evidence. After that brief background, attention turns to the landmark case law which the courts rely upon when examining spoliation of evidence: *Smith v. Superior Court* and its lineal and collateral descendents.

[70] Hirsch v. Motors Corp. 628 A.2d 1108, 1115 (1993); Viviano v. CBS, Inc., 597 A.2d 543, 548-549 (1991).
[71] Henry v. Deen 310 S.E.2d 326, 334-335 (1984).
[72] Gardner v. Blackston 365 S.E.2d 545, 546 (1988).
[73] Weigl v. Quincy Specialties Co., 601 N.Y.S.2d 774, 776 (1993).
[74] Baugher v. Gates Rubber Co., Inc. 863 S.W.2d 905, 909, 911-912 (Mo.App.1993).
[75] Miller v. Montgomery County, 494 A.2d 761, 768 (1985).

§ IV.

Evolution of the Tort
The Problem of The Empty-Handed Plaintiff

The broad question here is: Why would potentially adverse parties have a duty to preserve evidence for the other's use? All of these cases raise a more general concern, too. How should people conduct business and themselves either when involved in litigation or not, in terms of honesty and integrity? That is really the spoliation bottom-line, isn't it? If people routinely ignore the rules, of what purpose are the rules? How can courts remedy the situation where the plaintiff's entire right to recovery is intertwined with evidence which the defendant has in its possession but which it refuses to produce or where, in some way, it alters the evidence? The way the courts have chosen to handle this problem demonstrates the "common understanding of society" regarding the wrongfulness of evidence destruction.

(A) INTENTIONAL SPOLIATION OF EVIDENCE

As recognized above, the seminal case which established spoliation as a distinct cause of action is *Smith v. Superior Court*. In September of 1981 the left rear wheel from Mr. Ramsey Sneed's car flew off and struck the windshield of Mrs. Phyllis Smith's car.

She sustained grievous injuries "resulting in permanent blindness in both eyes and impairment of her sense of smell."[76] Immediately after the accident Sneed's vehicle was towed to Abbott Ford where the dealer agreed with Smith's attorney to retain certain parts for further investigation. Abbott Ford then lost or destroyed the physical evidence and this made it impossible for Mrs. Smith's experts to inspect the wheel in order to determine the cause of failure of the wheel assembly.[77] Without some judicial remedy, Smith was left without the critical bit of evidence she needed to meet her burden of proof.

In its complaint, Smith alleged that after the accident, Abbott Ford promised Smith's counsel that it "would maintain securely in their care, possession, custody and control for later examination and testing ... the left rear tire and wheel, lug bolts, lug nuts and brake drum which these defendants ... removed from defendant['s] van." Furthermore, Abbott Ford knew that the physical evidence would be essential proof in a civil action, and that Smith was induced to rely upon its promise "by forbearing from seeking a temporary restraining order to compel it to maintain the evidence securely."[78]

The damage Smith alleged over Abbott Ford's loss of the evidence was "significant prejudice" to her "opportunity to obtain compensation for ... grievous physical and emotional injuries."[79] In arriving at its willingness to create this new cause of action, the California Appellate Court relied upon Dean Prosser's commentary that the courts recognize expansion of causes of action

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[76] Smith, 198 Cal. Rptr. 829, 831.
[77] *Id.*
[78] *Id.*
[79] *Id.* Abbott Ford demurred to these causes of action on the grounds that plaintiff failed to state a cause of action. The trial court ruled that the tort did not exist but the Smiths then filed a petition for a writ of mandamus to direct the trial court to allow the cause of action. *Id.* at 832.

> ... where none had been recognized before. The intentional infliction of mental suffering ... the invasion of [the] right of privacy, the denial of [the] right to vote, the conveyance of land to defeat a title, the infliction of prenatal injuries, the alienation of the affections of a parent ... could not be fitted into any accepted classifications when they first arose, but nevertheless have been held to be torts. The law of torts is anything but static ....When it becomes clear that the plaintiff's interests are entitled to legal protection against the conduct of the defendant, the mere fact that the claim is novel will not of itself operate as a bar to a remedy.[80]

Compatible with the court's holding in the *Steamship Mogul* case, Prosser found that wherever there was an "unreasonable interference with the interests of others," the courts should provide protection.[81] According to California law "[f]or every wrong there is a remedy"[82]and the state has an history of allowing new torts through its legislative and judicial process.[83]

The California tribunal recognized that a new tort was needed in order to grant this plaintiff relief; the *Smith* facts neatly fulfilled Prosser's criteria and those precedents recognized in case law.[84] The court also drew the analogy between another tort involving similar principles; intentional interference with prospective business advantage. That tort permitted recovery for interference with business relationships or expectations even when no contract was in place or where the party's expectations are the subject of an unenforceable contract.[85]

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[80] *Id*. (citing PROSSER, TORTS § 1 at 3-4 (4th ed. 1971).
[81] *Id*. (PROSSER at 6).
[82] *Id.* (citing Civ.Code § 3523). This is *contra* to the way in which many states view remedies: that the law does not provide a remedy for every wrong.
[83] *Id*. at 832.
[84] *Id.* (citing its then recent opinion in Williams v. State of California, 192 Cal. Rptr. 233 (1983), a negligent cause of action exits if a duty existed on the part of the defendant to preserve evidence. In the Williams case, unless the state acknowledged the cause of action for the destruction of the evidence, the plaintiff would have had no opportunity to obtain compensation for her severe injuries. *Id.* (citing Williams, 34 Cal.3d 18, 21-22).
[85] *Id.* at 835. (citing Buckaloo v. Johnson, 122 Cal. Rptr. 745 (1975) and Lowell v. Mother's Cake & Cookie Co., 144 Cal. Rptr. 664 (1978).

Abbott Ford tried to argue that the intentional spoliation of evidence action was precluded under California statutory and case law since a penal statute had preempted the field under California Penal Code § 135:

> Every person who, knowing that any book, paper, record, instrument in writing, or other matter or thing, is about to be produced in evidence upon any trial, inquiry, or investigation whatever, authorized by law, willfully destroys or conceals the same, with intent thereby to prevent it from being produced, is guilty of a misdemeanor.[86]

Abbott Ford's theory, which the court rejected, was that only the state can prosecute an "obstruction of justice" crime and it wanted the court to conclude that there was no civil action available to the harmed party.[87] The *Smith* court distinguished *Agnew* on its facts from *Smith*, noting that a criminal prosecution "vindicate[s] the interests of the public as a whole" and is not concerned with "compensation of the injured individual against whom the crime was committed ... [H]e will leave the courtroom empty-handed."[88] The rationale behind a civil tort action is that it compensates the injured party for the damages he has suffered at the "expense of the wrongdoer."[89] California law, as pointed out above, will not permit this civil victim to leave the courtroom "empty-handed."

The court saw intentional spoliation of evidence as a form of obstruction of justice, which has a "devastating effect on a potential plaintiff and could prevent such a plaintiff even seeking justice in a court of law."[90] The court struggled with the "certainty of damages" as the most troubling aspect of the new tort since it was difficult to

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[86] *Id.*
[87] *Id.*. (citing Agnew v. Parks 172 Cal.App.2d 756, 766 (1959).
[88] *Id.*. at 834.
[89] *Id.*.

determine what damages proximately resulted from the defendant's conduct.[91] Here, the California court relied upon the United States Supreme Court's decision in *Story Parchment Co. v. Paterson P. Paper Co.*,[92] for direction on this matter and the Appellate Court surmounted the damage issue when it adopted the principle of making a "just and reasonable inference" to determine the damages.[93]

In recognizing the tort of intentional spoliation of evidence, the court found "prospective civil action ... is a valuable 'probable expectancy' that the court must protect from the kind of interference alleged."[94] Furthermore, the fact that the *Smith* case had not gone to trial did not preclude the cause of action.[95] The court found similarity between the facts in the *Smith* litigation and those of another case, *Gold v. Los Angeles Democratic League*,[96] and in the interests of judicial economy reasoned that all claims be simultaneously heard.[97]

After California recognized the spoliation of evidence tort, a number of other jurisdictions resolved the matter under their respective common law and statutory authorities and granted recovery for intentional spoliation of evidence. In *Welsh v. United States*,[98] brought under the Federal Tort Claims Act for wrongful death which arose from

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[90] *Id.*
[91] *Id.* at 835.
[92] 282 U.S. 555 (1931). (action for damages arising under Sherman Antitrust Act for alleged conspiracy).
[93] 198 Cal. Rptr. 829, 835. "Where the tort itself is of such a nature as to preclude the ascertainment of the amount of damages with certainty, it would be a perversion of fundamental principles of justice to deny all relief to the injured person, and thereby relieve the wrongdoer from making any amend for his acts. In such case, while the damages may not be determined by mere speculation or guess, it will be enough if the evidence show the extent of the damages as a matter of just and reasonable inference, although the result be only approximate." Story Parchment Co., 282 U.S. 555, 563.
[94] *Id.* at 836.
[95] *Id.*.
[96] Gold v. Los Angeles Democratic League, 49 Cal.App.3d 365, 375 (1975).
[97] *Id.* at 837.
[98] 844 F.2d 1239, 1246 (6th Cir.1988).

medical care provided in a Kentucky Veterans Administration hospital, the Sixth Circuit United States Court of Appeals found that spoliation occurs along a continuum of fault, ranging in degrees of culpability from the innocent through the varying shades of negligence to the most culpable, that of intentional conduct.

(B) NEGLIGENT SPOLIATION OF EVIDENCE

It was in the *Velasco*[99]case where the California court recognized the tort of negligent spoliation of evidence. In *Velasco*, the plaintiff was injured by an exploding bottle. The plaintiff then placed the bottle into a brown paper bag and took it to his attorney's office where the attorney left the bag on his desk. Then, an employee from the Commercial Building Maintenance Company discarded the bag as part of his cleaning routine, thereby depriving Velasco from civil recovery. When the plaintiff sued the maintenance company the trial court held that a cause of action may be stated for negligent destruction of evidence needed for prospective civil litigation.[100]

What the appellate court found as pivotal in *Velasco* was the forseeability issue. The court observed that the plaintiff's case rested "entirely on the fact that the bag ... had not been deposited in the trash can by plaintiff's attorney." The plaintiff argued that "it should have been reasonably foreseeable to the custodian ... seeing a bag on the attorney's desk that its contents would pertain to a client's case."[101] Further the court reasoned:

> ... [A] reasonably thoughtful janitor is entitled to assume that, if an item that seemed to be garbage were actually evidence, its container would be appropriately

[99] Velasco v. Commercial Bldg. Maintenance Co., 215 Cal. Rptr. 504 (1985).
[100] 215 Cal. Rptr. 504.
[101] *Id.* at 506.

> marked and, quite likely, not left lying about. ... [I]t is reasonable for a maintenance person who sees a bag containing a broken bottle ... to remove it in much the same way ... as he ... would throw away the remains of a mid-morning coffee break. No important policy would be furthered by a holding that maintenance workers have a duty not to throw away what appears to be trash simply because such objects are located in an attorney's office.[102]

If any party were negligent, it was the attorney, not the building maintenance company, the court observed.[103] The court affirmed the dismissal as it applied reasoning derived from *Williams* and *Smith* to the accidental destruction of evidence and found a cause of action for negligent spoliation of evidence in prospective civil litigation.[104] The California court cited *J'Aire Corp. v. Gregory*[105] where it recognized the tort of negligent interference with prospective economic advantage. The *J'Aire* court[106] relied on an assessment of the following criteria:

> (1) the extent to which the transaction was intended to affect the plaintiff,
> (2) the foreseeability of harm to the plaintiff,
> (3) the degree of certainty that the plaintiff suffered injury,
> (4) the closeness of the connection between the defendant's conduct and the injury suffered,
> (5) the moral blame attached to the defendant's conduct and
> (6) the policy of preventing future harm.[107]

It is wise to pause briefly at this juncture to compare and contrast *Smith* and *Velasco* on the salient differences between the respective torts, intentional *versus* negligent spoliation. One identifies the familiar "intent" language of intentional torts and

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[102] *Id.* at 506-07.
[103] *Id.* at 507.
[104] *Id.* at 505.
[105] 157 Cal. Rptr. 407, 598 (1979).
[106] 24 Cal.3d 799, 803-804, 157 Cal. Rptr. 407.
[107] Velasco, 215 Cal. Rptr. 504, 506. (citing *J'Aire Corp.,* 24 Cal.3d 799, 803-804). This line of analysis arose from Justice Cardozo's famous "forseeable plaintiff " or "zone of danger" view found in Palsgraf v. Long Island Railroad, 162 N.E. 99 (1928). The defendant owes a duty of care to those persons as to whom the reasonable person would have foreseen a risk of harm under the circumstances. The forseeable plaintiff would be located within the zone of danger.

the important difference permitted in certainty of damages. Once the litigant succeeds in showing "intent," damages are inferred in intentional torts whereas in the negligent tort, the successful plaintiff must satisfy each and every element of the negligence rubric and be capable to show the court that specific damages flowed from the noxious conduct.[108] These differences become significant when the courts analyze the medical cases.

(C) TIMING OF THE SPOLIATION OF EVIDENCE ACTION

Before moving to a consideration of the remedies courts use in spoliation of evidence problems in the next section, it is important to return to the products liability case recently decided by the Illinois Supreme Court, *Boyd v. Travelers*, to raise the issue of timing. In contrast to California law, Illinois does not recognize a separate tort for spoliation of evidence. In *Boyd*, the court considered the ripeness issue: Must the plaintiff plead and prove that he lost the underlying case or would it be sufficient that he merely plead a significant impairment to prove the underlying suit?

Justice Bilandic, writing for the majority, affirmed Illinois' position that it has never recognized 'spoliation of evidence as an independent cause of action'[109]since an action for evidence destruction may be stated under existing state law. What the plaintiff must allege in a negligence action are "sufficient facts to support a claim that the loss or destruction of the evidence caused the plaintiff to be unable to prove an underlying lawsuit." It is not necessary, however, that the plaintiff show "but for the loss or destruction of the evidence, the plaintiff would have prevailed in the underlying

[108] Palsgraf v. Long Island Railroad Co., 162 N.E. 99 (1928).
[109] Boyd, 652 N.E.2d 267, 270.

action."[110] This, the court concluded, was "too difficult a burden" since it "may be impossible to know what the missing evidence would have shown."[111]

As distinguished from other courts, which have not required an allegation of actual damages from the spoliation, in Illinois, without actual damages, the court will not permit the claim to go forward. Moreover, a threat of harm, "not yet realized, is not actionable."[112] The court explained that there are situations where a party may negligently lose or destroy evidence, but where it would make no difference to the plaintiff in his ability to prove the underlying action. Illinois will not permit recovery where a loss is theoretical or without real-world harm.[113] Other courts differ from the Illinois rule and those alternatives appear later in the medical section.

[110] *Id.* at 271.
[111] *Id.* at 271, n.2.
[112] *Id.*.
[113] *Id.* at 273.

§ V.

Traditional Spoliation Remedies

"The Responsibility of Fairness in Litigation"[114]

Whether a party should be punished for destruction of physical evidence and what remedy[115] the court selects, according to the previously presented case holdings, hangs on two factors: forseeability of harm to the plaintiff and whether the spoliator knew a lawsuit would be filed but went ahead and destroyed documents or evidence it knew or should have known would constitute evidence relevant to the case. Whether and how to punish parties for this conduct has long been a subject of controversy in the California court system. Since California was the first jurisdiction to recognize spoliation of evidence as a separate tort, in some ways the California courts lead the nation in fashioning remedies for this conduct.[116] Remedies have included gradations and mixes between (1) a discretionary jury inference against the spoliator[117] (2) a charge of obstruction of justice[118] and (3) various discovery sanctions.[119]

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[114] Barker v. Bledsoe, 85 F.R.D. 545, 547-48 (1979). This simple concept of the responsibility of fairness in litigation encapsulates the substance of this entire area of law. It is this subterfuge of the system which so endangers a fair trial in either criminal or civil matters.

[115] *See, e.g.*, Charles A. Cohn, *Tort and other Remedies for Spoliation of Evidence*, 81 ILL B.J. 128 (1993). (presenting a short discussion of this problem).

[116] Willard, 40 Cal.App.4th 892, 907, 48 Cal. Rptr.2d 607, 616

[117] *See, e.g.*, Cal. Evi*d.* Code, §§ 412, 413; Walsh v. Caidin, 232 Cal.App.3d 159, 164-165, 283 Cal. Rptr. 326 (1991); Bihun v. AT & T Information Systems, Inc., 13 Cal.App.4th 976, 994-995, 16 Cal. Rptr.2d 787 (1993)).

The California court system recently attempted to more sharply sculpt the form of the spoliation of evidence tort and the theory of culpability in *Willard v. Caterpillar, Inc.*.[120] This was a products liability case which involved a tractor defect in a vehicle manufactured in 1955. The *Willard* court began its spoliation analysis by examining the Restatement of Torts, § 870 which considered a well-trodden balancing test between the nature and seriousness of harm to the injured party, the nature and significance of interests promoted by actor's conduct, the character of means used by actor, and actor's motive.[121] After its analysis of applicable state and federal law in this area, the court created a remedy to fit the defendant's conduct ... no remedy. In this case the defendant was blameless. Mr. Willard was injured in 1990 while working on a 1955 Caterpillar D7-C crawler tractor and the jury in the trial court case found that Caterpillar destroyed documentation relevant to the case which substantially impaired Willard's ability to prove his case.[122]

Caterpillar "generated records" which related to development of the tractors and the component parts.[123] When, as part of discovery, plaintiff requested production of these documents, which contained incident reports of malfunctions and accidents of these tractors and of component failures, the defendant was unable to produce them. Caterpillar has a "Technical Information Center" in Peoria, Illinois and a policy of retaining only

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[118] *See, e.g.*, Cal. Pen. Code, § 135; Smith v. Superior Court, 151 Cal.App.3d 491, 497-500, 198 Cal. Rptr. 829 (1984).
[119] *See, e.g.*, Cal. Code Civ.Proc., § 2023; Puritan Ins. Co. v. Superior Court, 171 Cal.App.3d 877, 217 Cal. Rptr. 602 (1985).
[120] 40 Cal.App.4th 892, 48 Cal. Rptr.2d 607 (1995).
[121] Restatement (Second) of Torts § 870.
[122] 40 Cal.App.4th 892, 912, 48 Cal. Rptr.2d 607, 619. The court included a stirring academic overview of tort theory in which it began with Prosser, to the Restatement of Torts, and then into case law.
[123] 40 Cal.App.4th 892, 903.

those reports with long-term value to Caterpillar's engineers. According to company policy every five to ten years, due to storage problems, the company destroys these documents. Although Caterpillar destroyed no documents after 1985[124] Willard claimed the company destroyed design development reports relevant to his case prior to his injury.

In finding for the plaintiff on the negligent spoliation of evidence claim, the jury concluded that it was reasonably forseeable that there would some day be litigation involving the issues contained in the reports. Further, it concluded that Caterpillar intentionally destroyed the relevant documentation because it forsaw litigation as reasonable and it found that the plaintiff was impaired in bringing his action as a result of the company's conduct. The jury awarded economic damages of $707,098 and non-economic damages of $450,000. In a special verdict, however, the jury concluded that Caterpillar's conduct did not exhibit malice or fraud.[125] The Appellate Court reversed, stating:

> [The fact that] ... Willard was injured by a tractor that had been in use for 35 years diminished the harm resulting from the absent documents. When a product has been on the market for many years (in this case, more than half of its expected operational life), the manufacturer's theoretical risk/ benefit analysis and/or conscious disregard for the safety of users should be manifested in real life experience.[126]

A number of legal writers have pointed out that imposing liability for spoliation constitutes an interference with property rights and creates an undue burden to store records.[127] After all, it would be an unworkable rule that a company had to keep all

[124] As result of personnel cut-backs. 48 Cal. Rptr.2d 607, 614.
[125] *Id.* at 615.
[126] 40 Cal.App.4th 892, 918-19, 48 Cal. Rptr.2d 607, 622.
[127] *See, e.g.*, Steffen Nolte, *The Spoliation Tort: An Approach to Underlying Principles*, 26 ST.MARY'S L.J. 351, 399 (1995); Terry Spencer, *Do Not Fold, Spindle or Mutilate: The Trend Towards Recognition of*

records for all time! Caterpillar destroyed its own property not knowing that there was litigation underway and the court resolved the matter in its favor. In conclusion, the court recognized the "competing public policy issues entangled in the question of how far the spoliation tort should extend."

The court iterated that evidence tampering "undermines two important goals of the legal system- truth and fairness." It further commented that "alternative sanctions and remedies may not provide sufficient deterrence." But, it continued, to subject "individuals and businesses to potential tort liability for destroying their own property or documents necessarily imposes burdens which result in both economic cost and some loss of freedom."[128] This raises the important bottom-line question as to where courts should draw the line in the requirements for document retention.

Typically the remedy a court selects to remedy spoliation correlates to the nature of the conduct. To illustrate, consider *Carlucci v. Piper Aircraft Corp.*,[129] a wrongful death action alleging various design defects relating to the longitudinal stability of an aircraft. The defendant's flight test engineers purged department files and eliminated documents that might prove detrimental to Piper in a lawsuit and thereafter, the destruction of potentially harmful documents was an ongoing process. If the company had a legitimate document disposal program which was reasonable, that record retention policy could justify a failure to produce documents in discovery. On the other hand, however, where a party were to destroy documents when it knew litigation was

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Spoliation as a Separate Tort, 30 IDAHO L.REV. 37, 44 (1993-1994); Lawrence B. Solum & Stephen J. Marzen, *Truth and Uncertainty: Legal Control of the Destruction of Evidence*, 36 EMORY L.J. 1085, 1140-1142 (1987).

[128] *Id*. at 924, 48 Cal. Rptr.2d at 626.

anticipated or in an effort to frustrate ongoing litigation, even without a restraining order, then the spoliator would not be held blameless.[130]

In non-medical situations, what the courts accord great weight is the timing between destruction and the interference the destruction causes in litigation balanced against the foreseeability of harm to the nonspoliating litigant resulting from the destruction.[131] When spoliation clearly interferes with the plaintiff's recovery rights, then the courts will be more likely to impose responsibility.[132]

The case of *Lewy v. Remington Arms Co., Inc.*[133] considered whether the jury should be instructed with the spoliation inference when the spoliator asserts that documents were destroyed pursuant to a routine record retention policy. The court held that the propriety of giving the instruction depended on: (1) whether the policy was reasonable considering the facts and circumstances surrounding the relevant documents; (2) whether lawsuits concerning a complaint or related complaints have been filed, the frequency of such complaints and the magnitude of the complaints;[134] and (3) whether the policy was instituted in bad faith.[135] An inference of spoliation may also be proper where the corporation knew or should have known that the destroyed documents would become material at some point in the future.[136]

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[129] 102 F.R.D. 472 (S.D.Fla.1984).
[130] *Id.* at 481-482, 486; *See also* Wm. T. Thompson Co. v. General Nutrition Corp., 593 F.Supp. 1443, 1455 (C.D.Cal.1984); Synanon Church v. United States, 579 F.Supp. 967, 972-974 (D.D.C.1984). (viewing evidence destruction and culpability in accord with Carlucci).
[131] Willard, 40 Cal.App.4th 892, 923.
[132] *Id.* at 922, 48 Cal. Rptr.2d at 626.
[133] 836 F.2d 1104 (8th Cir.1988).
[134] For example, a three-year retention policy may be reasonable for appointment books and telephone messages, but not for customer complaints of product defects.
[135] *i.e.*, to limit damaging evidence available to plaintiffs.
[136] Id. at 1111-12.

The federal courts weigh a party's conduct prior to the commencement of the litigation to determine whether its failure to comply with a discovery order is willful or in bad faith. One federal appellate court concluded that a potential litigant is under "no obligation to preserve every document in its possession, whatever its degree of relevance, prior to the commencement of a lawsuit [but] ... some duty must be imposed ... lest the fact-finding process ... be reduced to a mockery."[137] Under the authority of *Wm. T. Thompson Co. v. General Nutrition Corp.*[138] the proper inquiry is whether the defendant, with knowledge that the lawsuit would be filed, willfully destroyed documents which it knew or should have known would constitute evidence relevant to the case.

Finally, at the other end of the spoliation liability continuum, courts do not impose liability where a party had no notice of the information's relevance to litigation. While one court reasoned that a potential for litigation arises at the moment of any injury, not every injured party seeks a legal remedy. Discovery sanctions were warranted only when evidence is destroyed after the action is genuinely contemplated, not when it is merely possible.[139] This was the reason the California court found no culpability in Caterpillar's conduct. Caterpillar destroyed evidence not in anticipation of litigation but according to its ordinary business practices. Destruction of the documents, at the time it was carried out, created no benefit to the defendant other than to save space.

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[137] General Atomic Co. v. Exxon Nuclear Co., Inc., 90 F.R.D. 290, 295-296 (S.D.Cal.1981). In anticipation of litigation in the United States, the defendant took advantage of Canadian law and housed its cartel documents in Canada.

[138] W. T. Thompson, 593 F.Supp. at 1445.

[139] Iowa Ham Canning, Inc. v. Handtmann, Inc., 870 F.Supp. 238, 244 (N.D.Ill.1994). *See*, Akiona v. United States 938 F.2d 158, 160-161 (9th Cir.1991), where sanctions were not warranted unless party had some notice the documents were potentially relevant.; PBA Local No. 38 v. Woodbridge Police Dept., 832 F.Supp. 808, 833-834 (D.N.J.1993) where the court did not find spoliation of evidence when defendants recorded over tape recordings at issue four or five years before plaintiff initiated suit.

Shimanovsky v. General Motors Corporation[140] preceded *Boyd v. Travelers* in the Illinois courts and took up a dilemma in a products liability litigation where the plaintiffs destroyed evidence in testing. This is an important case since the conduct bears a resemblance to medical situations where this issue of evidence destruction may arise in autopsies. The *Shimanovsky* trial court, in finding a sanction to fit the conduct, dismissed the plaintiff's action. In its reversal of the lower court, the Appellate Court concluded that in the first instance one must determine whether the manufacturer was unfairly prejudiced "such that it was unable to establish its case."[141]

Shimanovsky's engineering expert was a member of the nationally recognized American Society for Testing Materials,[142] but did not notify the defendants that the intended testing may destroy a questioned steering gear. ASTM standards require such notification so that the affected party may have an "opportunity to observe and record any examination likely to alter the state or condition of an item that may become involved in a product liability suit."[143]

After the destructive testing, and after receiving the favorable opinion from the engineer and a metallurgist retained through the engineer, the plaintiff filed suit. Initially, prior to GM discovering that the critical parts had already been destroyed, the parties stipulated to a protective order which would protect and preserve the car and its parts from "destructive inspection, testing or disassembly, except under conditions specified in

[140] 648 N.E.2d 91 (Ill. 1994).
[141] *Id.*.
[142] [hereinafter ASTM].
[143] Shimanovsky, 648 N.E.2d 91, 92. Notice the influence membership in a national accreditation organization had on the court and compare this to the medical counterparts.

the stipulation."[144] At some indefinite time, GM discovered that destructive testing had already occurred and filed a motion to dismiss, stating "the destruction of the steering gear ... violated engineering ethics, failed to produce evidence that could not be obtained by other means, and deprived [GM] ... the opportunity ... to show proper manufacture and operation of the gear."[145]

The Appellate Court here, in contrast to the more usual scenario, concluded that when the trial court dismissed the plaintiff's case, it was the plaintiff whose rights were prejudiced with complete dismissal of its action. There was no determination at the trial level that the destructive testing caused "substantial prejudice to GM such that GM is deprived of establishing its case."[146] This court then remanded to the trial court for an hearing on the degree of prejudice GM suffered and the nature of the sanction according to the degree of prejudice the party sustained.

Finally in this section is another case, in federal court, which resembles the destructive autopsy problems which appear later. In *Vodusek v. Bayliner Marine Corp.*[147] the Fourth Circuit's Court of Appeals decided that a jury could draw an adverse inference against the spoliator without a showing of bad faith. This is a fascinating recent case which presented two questions of first impression.[148] After Mr. Vodusek fueled his boat in Pasadena, Maryland by siphoning gas from cans, he turned on the bilge pump and the

[144] *Id.* at 93.
[145] *Id.*.
[146] *Id.* at 98.
[147] Vodusek v. Bayliner Marine Corp., 71 F.3d 148 (4th Cir. 1995). Decided 6 December 1995.
[148] *Id.* at 151. The first was whether a jury could resolve both a claim at law and an admiralty claim; the second was the spoliation issue presented here.

boat exploded. Vodusek died and his family sued the boat manufacturer and a marine repair concern which had performed a warranty repair several years before the accident.

The plaintiff contended that the explosion resulted from a faulty bilge pump repair. It was the plaintiff's expert who, along with the decedent's two sons, "virtually attacked the boat with a chain saw and sledge hammer" and the critical area "was literally ripped apart. The integrity of the structure was violated."[149] This made it impossible for the defense to verify the expert's theory or "to develop alternative theories based upon the evidence." The defendants sought to amend their answer before trial since they were unable to develop their own theory about what caused the fire. They sought an affirmative defense of spoliation of evidence: no liability, since they were not permitted the opportunity to develop their own theory. The district court permitted the amendment and then submitted the matter to the jury at trial.

The trial judge gave the following jury instruction:

> It is the duty of a party ... not to take action that will cause the destruction or loss of relevant evidence where that will hinder the other side from making its own examination and investigation of all potentially relevant evidence. If you find in this case the plaintiff[] ... failed to fulfill this duty, then you may take this into account when considering the [expert's] credibility ... and also you are permitted to, if you feel justified in doing so, assume that evidence made unavailable to the defendants ... would have been unfavorable to the plaintiff's theory in the case.[150]

The plaintiff then argued that she was prejudiced by the late pretrial amendment, that the court erred in the jury instruction on the spoliation of evidence claim since "bad faith is a necessary element" but there was no evidence of bad faith.[151] Further, the plaintiff pointed out that the expert "took photographs before, during, and after his

[149] *Id.* at 154.
[150] *Id.* at 155.

investigation and videotaped [the] alteration of the boat." The plaintiff contended that the expert "needed to cut up the boat with a chain saw to reach otherwise inaccessible parts of the fuel system."[152] For these reasons, the actions did not indicate bad faith and the jury should not have been given the adverse inference instruction.

The appellate court, in concluding that the district court acted within its discretion, ruled that the adverse inference is proper against a party "who destroys relevant evidence."[153] The court pointed out here that the spoliation of evidence adverse inference rule is merely a rule of evidence and not an affirmative defense and may be administered according to the "discretion of the court."[154] Under the authority of *Donohoe v. American Isuzu Motors, Inc.*,[155] the spoliation of evidence rule "'leads to the exclusion of evidence or the admission of negative evidence[]'" but need not be plead at any particular time.[156] Since the defendants are "required to plead only affirmative defenses, not evidence"[157] the plaintiff was not prejudiced when the court permitted the amendment.

The court noted that the plaintiff was "benefited from the defendants' advance notice of their intent to invoke the spoliation rule."[158] The plaintiff's principle argument was the necessity to show bad faith before the jury can be permitted to draw an adverse inference as to what the boat would have revealed had it not been damaged. Since there was no showing of bad faith, the plaintiff maintained that the adverse inference was

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[151] *Id.*.
[152] *Id.*.
[153] *Id.*.
[154] *Id.*.
[155] *Id.*. (citing, 155 F.R.D. 515, 520 (M.D.Pa.1994)).
[156] *Id.*.
[157] The court relied upon Fed.R.Civ.P. 8(c).

improper. In this analysis the court rejected the "bad faith" element and commented that "[a]s a general proposition, the trial court has broad discretion to permit a jury to draw adverse inferences from a party's failure to present evidence, the loss of evidence, or the destruction of evidence. While a finding of bad faith suffices to permit such an inference, it is not always necessary."[159]

In order for the jury to draw an adverse inference from the absence of the evidence, the court reasoned that the evidence itself would need to be

> relevant to an issue at trial and otherwise would naturally have been introduced into evidence. Even the mere failure, without more, to produce evidence that naturally would have elucidated a fact at issue permits an inference that 'the party fears [to produce the evidence]; and this fear is some evidence that the circumstance or document or witness, if brought, would have exposed facts unfavorable to the party.[160]

Although the court recognized that a party's inability to produce evidence may be "satisfactorily explained," if a proponent is unable to "produce original evidence ... because of loss or destruction of evidence, the court may permit proof by secondary evidence."[161] Only when a "proponent's intentional conduct contributes to the loss or destruction of evidence," then "the trial court has discretion to pursue a wide range of responses both for the purpose of leveling the evidentiary playing field and for the purpose of sanctioning the improper conduct."[162]

In addition, the court further explained:

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[158] *Id.*.
[159] *Id.* at 155-56. (Here the court cited to Glover v. BIC Corp., 6 F.3d 1318, 1329 (9th Cir.1993).
[160] *Id.*. (citing, 2 Wigmore on Evidence, § 285 at 192 (Chadbourn rev. 1979)).
[161] *Id.*. (See, e.g., Fed.R.Evid. 1004(1)).
[162] *Id.*. (citing, Welsh v. United States, 844 F.2d 1239, 1246 (6th Cir.1988); Nation-Wide Check Corp. v. Forest Hills Dist., Inc., 692 F.2d 214, 218 (1st Cir.1982)).

> Even if a court determines not to exclude secondary evidence, it may still permit the jury to draw unfavorable inferences against the party responsible for the loss or destruction of the original evidence. An adverse inference about a party's consciousness of the weakness of his case, however, cannot be drawn merely from ... negligent loss or destruction of evidence; the inference requires a showing that the party knew the evidence was relevant to some issue at trial and that his willful conduct resulted in its loss or destruction.[163]

While the plaintiff "may have been correct" that there was no showing of bad faith, the evidence was permanently destroyed by the plaintiff's intentional investigation. The plaintiff's expert may have made a determination that the evidence was "not relevant to his theory of the case, [but] that conclusion ignored the possibility that others might have entertained different theories to which the destroyed portions might have been relevant. In this case, both the defendants and the district court concluded that the destroyed portions were significant to the effort to explain where and why the boat explosion occurred."[164]

The court saw the necessity here for the defendants to have the opportunity to examine the original evidence at the same time as the plaintiff and it was a fair ruling for this appellate court to conclude that the jury should determine the effect of this lost or destroyed evidence had on the defendants' case through this adverse inference.[165] The appellate court concluded that it was preferable for the district court to provide the jury "with appropriate guidelines for evaluating the evidence" rather than "deciding the spoliation issue itself."[166]

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[163] *Id.*. (Nation-Wide Check Corp., 692 F.2d at 217-18).
[164] *Id.* at 156.
[165] *Id.*.
[166] *Id.*.

Both *Shimanovsky* and *Vodusek* present reasonable approaches for other courts to follow in fashioning remedies in the non-medical and medical situations. It is satisfying also to see that both the state court in *Shimanovsky* and the federal tribunal in *Vodusek* similarly approached the analysis. When a party precludes the opposing party from examining the raw evidence, there is no substitute for "the real thing" and the non-spoliating party is entitled to the adverse inference. The spoliation of evidence rule is a rule of evidence and not evidence itself; it is an abuse of discretion for the court to go further than giving the adverse inference instruction from which the jury may make its determination. In addition, it is unnecessary for the non-spoliating party to show bad faith in order to obtain the inference instruction. As the ensuing medical discussion will show, these principles enunciated in the non-medical cases are key when courts search for ways "to level the playing field" in the problems of missing medical evidence and in the destructive autopsy cases.

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§ VI.

Medicine's Second Commandment:

"*Thou Shalt Create and Maintain Records*"

In the beginning, long before Medicare and Medicaid, long before the Health Care Quality Improvement Act or peer review, in the ancient days of Hammurabi, Aesclepius, and Hippocrates, long before anyone worried about cost-containment, medical practitioners evaluated quality of health care[167] but did not create medical records. To the ancients, what was of utmost importance was medicine's first commandment: *Primum non nocere*.[168]A physician must, at all times, act in his patient's best interests and do no harm.

Now, it appears as if medicine's second commandment is, "In all instances, create true and accurate records." In modern times, though, some may think that it would be silly to seriously raise a question whether there is a duty to make and maintain medical records without alterations. It seems self-evident; axiomatic. To practice medicine without medical records would be like asking an airline pilot to take off in his plane, fly,

[167] The Oath of Hippocrates states, "I will follow that system ... for the benefit of my patients, and abstain from whatever is deleterious and mischievous. ... With purity and with holiness I will pass my life and practice my Art." Contained in BARRY R. FURROW, *et al., The Study of Bioethics*, BIOETHICS: HEALTH CARE LAW AND ETHICS 30 (1991).

and land without maps, navigational aids, or air traffic controls. While a skillful pilot may be able to safely fly in ideal conditions without navigational aids, in less than ideal situations, it just wouldn't be safe.[169]

It shocks the conscience to think about medical care without medical records but in order to fully conceptualize the impact that spoliation of medical records has on medical negligence litigation and to be fully prepared to manage this litigation complication, one must develop facility with the modern statutory and common law origin of this medical commandment: *Thou Shalt Create Medical Records.* Where did it come from?

Unlike the situation in profit driven industry and in other non-medical concerns where ethics and principle are a secondary concern, the nuclear concern in modern medicine is the physician-patient relationship, the fiduciary relationship between the provider and the patient, all subject to a complex system of medical ethics.[170] Fundamental to this is the requirement that the physician deals with the patient in a candid and truthful manner in all aspects of the relationship. In modern times, creation of accurate medical records is a requisite to meet medicine's first commandment.

Professor Sisela Bok examined the role of truth telling in science:

> Once revealed, the gap is especially shocking in someone whose profession ideally requires a concern for the truth. When judges and scientists are caught in fraud, the sense of betrayal is great. A fraudulent scientist goes against the most

[168] First, do no harm.
[169] See the discussion of Fox v. Cohen *infra* p. 59.
[170] AMA PRINCIPLES OF MEDICAL ETHICS 1980 state: "II. A physician shall deal honestly with patients and colleagues and strive to expose those physicians ... who engage in fraud and deception."

> fundamental standards of science. Yet he may, paradoxically, act fraudulently in part *on behalf* of what he takes to be science and truth.[171]

Professor Bok points that the philosopher Grotius advanced the concept that a falsehood becomes a lie when it conflicts with the right of the person to whom it is addressed and[172] truth is a requisite for an organized society.

> All our choices depend on our estimates of what is the case; these estimates must in turn often rely on information from others. Lies distort this information and therefore our situation as we perceive it, as well as our choices. A lie ... "injures the deceived person in his life; it leads him astray."[173]

In the forgoing case law discussion, notice how this concept of the interference with rights formed the foundation for the analysis. If there were an interference with a litigant's rights, then judges were willing to impose sanctions. If no interference; no discipline. There is a basic human sense that some things are dependable and true and, in order that society may optimally function, people must be truthful with one another in most dealings. It is this damage to dependability, the reliance on false information, which so changes the course of medical negligence litigation and, as will be demonstrated, potentially irreparably pollutes the process.

In the non-medical setting, as amply illustrated above, there are few requirements for businesses to keep records at all and, if record keeping is optional, then it is difficult to hold parties responsible when they destroy the records. The black letter rule of law in non-medical cases, as we have seen, appears to be that unless a party has knowledge that

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[171] BOK at 85. Medicine does not require truth telling at all times and under all circumstances. It is permissible, for instance, to withhold truth or to lie to a patient where that untruth is part of therapy. It would be cruel at some times to deflate a person's hope by providing a statistical portrait of the prognosis with cancer. Deception is often important in treating children in order to gain their cooperation where they would be emotionally unable to withstand truth's immediate shock. Such altruism, however, does not exist when a provider alters a medical record or makes a record unavailable for examination.

[172] BOK at 37, n.12. (citing GROTIUS, 3 ON THE LAW OF WAR AND PEACE, chaps.I, II).

an action is contemplated, then it is under no duty to retain documents or other materials for potential litigation. That is not the case in medicine and it is in this distinction, the duty to create and maintain records apart from the anticipation of litigation, which dramatically distinguishes the medical profession and institutions from other industrial forms and businesses.

There are three well accepted prongs to medical care: accessibility,[174] cost,[175] and quality.[176] It is this third prong, quality, with which spoliation of evidence interferes. Medical care is practiced in a web of interdigitating regulations, many of which are intended to assure quality.[177] There are at least three tiers of legal authority which govern medical practice: federal, state, and professional organizations. Keep in mind here that all of these regulations are interdependent.[178] For instance, provider or institutional Medicare de-certification would set in motion many other de-certifications. Through a violation of state law one might simultaneously violate federal statute or a professional regulation.

Even before embarking on the regulatory hunt, however, since the lawmakers responded to the early medical values in drafting these statutes, it makes sense to touch briefly on medical philosophy at the turn of the century. As early as 1917 Earnest Codman of the Massachusetts General Hospital observed a need to improve hospital standards and to be able to track patients to verify that their care had been beneficial and

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[173] *Id.* at 19, n. 3. (citing NICOLAI HARTMAN, ETHICS 2: 282).
[174] *See*, BARRY R. FURROW, HEALTH LAW 536-561(1995). [hereinafter FURROW]
[175] *See*, *Id.* at 162-234.
[176] See, *Id.* at 1-367.
[177] A complete discussion of this topic exceeds the scope of this treatise but a good starting point would be FURROW, at 2 *et seq.*.
[178] *Id.* at 3. *See, also,* Keith J. Mueller, *Politics of Health Care*, HEALTH CARE POLICY IN THE U.S. (1993).

effective.[179] In response to this the American College of Surgeons established a Hospital Standardization Program. This included five standards, one of which was to keep medical records which included the history, physical examination and laboratory results.[180]

By 1952 the American College of Physicians, the American Hospital Association, and the American Medical Association, joined the American College of Surgeons to form the Joint Commission on Accreditation of Hospitals.[181] At that time, observing this metamorphosis in health care, Avedis Donabedian, with great foresight, wrote the seminal work in the evaluation of the quality of care in 1966.[182] The duty to create medical records and to maintain them for review began along with a national movement to ensure quality in health care. These principles held that since physicians were scientists, health care quality should be subjected to scientific analysis; there should be accountability within the system to patients, the consumers, to the health care professions, and ultimately, after the War, this extended to the insurance industry, the payers.

(A) Federal Laws

The federal sources which one could cite for the proposition that there is a duty to create and maintain medical records, with little exaggeration, is perhaps the largest compendium of codes, rules, regulations, guidelines, and enactments ever conceived by mankind. It is virtually limitless. It could be fairly described to be as vast as the entirety

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[179] John M. Luce, *et al.*, *A Brief History of Health Care Quality Assessment and Improvement in the United States*, 160(3) WESTERN J. MED. 263 (1994).
[180] Id. at WESTLAW 2. The other four were: Organizing hospital medical staffs; Limiting staff membership to well-educated, competent, and licensed physicians and surgeons; framing rules and regulations to ensure regular staff meetings and clinical review; keeping medical records that included the history, physical examination, and laboratory results; and establishing supervised diagnostic and treatment facilities such as clinical laboratories and radiology departments. *Id.* at WESTLAW 2.
[181] Id..

of the United State Code, Code of Federal Regulations, the Federal Register, the policy statements and public pronouncements of all the applicable federal agencies, and the Congressional Record- combined!

The multilayer modern stratification includes today, at a minimum, the following federal regulatory agencies, acts, and commissions: (1) Medicare with all of the conditions of participation, including HCFA;[183] (2) JCAHO;[184] (3) Institute of Medicine of the National Academy of Sciences; (4) Physician Payment Review Commission; (5) Omnibus Budget Reconciliation Act; (6) Health Care Quality Improvement Initiative; (7) National Conference of State Medical and Licensing Boards and the National Board of Medical Examiners; (8) Health Care Quality Improvement Act of 1986; (9) ProPac;[185] and, finally (10) the Drug Enforcement Administration. One could easily include applicable IRS codes and general counsel memoranda.

The Joint Commission on Accreditation of Healthcare Organizations is the leading health care facility accreditation organization and it dominates hospital accreditation as well as the accreditation of nursing homes and laboratories.[186] Under federal law, despite the fact that JCAHO is a private organization, hospitals which meet the JCAHO standards for accreditation are deemed to meet most requirements for Medicare certification.[187] Unless an hospital is certified by Medicare it may not bill for

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[182] Avedis Donabedian, *Evaluating the Quality of Medical Care*, 44 MILBANK MEM. FUND. Q. 166 (1966).
[183] Health Care Finance Administration; includes the Office of Inspector General, the arm of the government which investigates Medicare violations.
[184] Joint Commission on Accreditation of Health Care Organizations.
[185] Prospective Payment Review Commission.
[186] BARRY R. FURROW, *et al.* HEALTH LAW 7 (West 1995). This includes 9,000 health care facilities of which 4,500 are hospitals.
[187] 42 U.S.C. §§ 1395x(e); 42 C.F.R. § 488.5; Thompson v. Sun City Community Hospital, Inc., 688 P.2d 605 (Ariz. 1984).

services it would provide to Medicare beneficiaries. Furthermore, an hospital that is found to be, as a result of a validation survey, out of compliance with Medicare standards[188] is subject to termination from the Medicare program.[189]

The JCAHO mandates record keeping in at least three areas: medical record services, quality assurance, and utilization review.[190] JCAHO Standard MR.1 states that "[t]he hospital maintain records that are documented accurately ... are readily accessible, and permit prompt retrieval of information." The standards delineate several purposes for the medical record, one of which, MR.1.2.2, states in relevant part that the purpose is "[t]o furnish documentary evidence of the course of the patient's medical evaluation, treatment, and change in condition during the hospital stay." Another purpose is "to document communication between the practitioner responsible to the patient and any other health care professional who contributes to the patient's care"[191]and a third is "to assist in protecting the legal interest of the patient, the hospital, and the practitioner responsible for the patient."[192]

In addition, the JCAHO requires that "all significant information pertaining to a patient is incorporated in the patient's medical record"[193] and this standard is a key factor in the accreditation process. As part of quality assurance, JCAHO requires a quality assurance program which reviews the written records[194]and written, accurate records are necessary for utilization review activities under standard UR.1. Here, JCAHO mandates

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[188] In many cases JCAHO standards = Medicare standards.
[189] 42 U.S.C.A. § 1395cc(b); 42 C.F.R. § 488.6.
[190] ACCREDITATION MANUAL FOR HOSPITALS, JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS (1996).
[191] MR.1.2.3.
[192] MR.1.2.4.
[193] MR.1.3. This is a very important standard for medical record analysis. Note the word "all."

that "[t]he hospital provides for and demonstrates appropriate allocation of its resources through an effective utilization review program.[195]

Peña commented that the sources of data for quality assurance may come from many sources but that the medical record remains an important source of data for JCAHO. According to the JCAHO standards a hospital must maintain a record system consistent with JCAHO guidelines.[196]

(i) Medicare[197]

Medicare law contains a number of conditions of participation which require record keeping and various acts create a duty for providers to document their activities.[198] The general provisions for the conditions of participation in the Medicare program and the requirements for peer review require that records are maintained to permit retrospective audit.[199] The Medicare statute[200] defines an hospital[201] as "a institution where physicians supervise the provision[202] of diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or

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[194] QA.1.
[195] This is a key standard, as with medical record services and quality assurance.
[196] JESUS J. PEñA, *et al.* HOSPITAL QUALITY ASSURANCE: RISK MANAGEMENT AND PROGRAM EVALUATION 216 (1984).
[197] *See,* Linda Oberman, *IG Asks Why More Hospitals Don't Report Adverse Actions*, AM. MED. NEWS, February 13, 1995, at 4(2). The OIG is worried that hospitals are circumventing the HCQIA in failing to report adverse hospital determination to the NPDB. The Bank's administrators, the Health Services Administration, fears that enough quality control auditing has yet to be implemented.
[198] An encyclopedic treatment of Medicare law with respect to record keeping requirements exceeds the purposes of this paper. This material is illustrative and sufficient to show that there is a duty to create and maintain medical records.
[199] 42 U.S.C.A. § 1320a-3.
[200] 42 U.S.C.A. § 1395x *et seq.*
[201] § 1395x (e).
[202] § 1395x (e)(1)(a)

rehabilitation[203] services for the rehabilitation of injured, disabled, or sick persons." The hospital "maintains clinical records on all patients."[204] In addition to the duty here to maintain medical records the hospital must have "in effect a hospital utilization review plan."[205] Not only must the hospital meet all federal regulations as a condition of participation in the Medicare program but it must meet all applicable state regulations.[206]

The above requirements apply to acute care facilities but essentially the same record keeping requirements apply to psychiatric and other long-term care facilities[207] The statutes provide for interdigitation between state and federal regulations[208]and this interdigitation in the acute facilities is also mirrored by statutes which apply to psychiatric hospitals.[209]

Finally here, under Medicare, the utilization review requirement[210]provides for review of medical necessity of duration of stay and of actual professional services.[211] This can be only achieved through a retrospective review of appropriate and applicable medical records.

Note that 42 U.S.C. § 1320a-7(a), the fraud and abuse statute, requires mandatory exclusion from the program for conviction of program-related crimes,[212] and for state or federal convictions with respect to patient abuse.[213] Exclusion is permissive, however, for

[203] § 1395x (e)(1)(a) (B).
[204] § 1395x (e) (2).
[205] § 1395x (e) (6) (A).
[206] § 1395x (e)(7), (A) & (B).
[207] § 1395f(f)(1).
[208] 42 U.S.C.A. § 1395x(e)(9)(iii)(1).
[209] § 1395(f)(f)(3).
[210] 42 U.S.C.A. § 1395x(k).
[211] § 1395x (k)(1)(A).
[212] 42 U.S.C.A. § 1320a-7(a)(1).
[213] 42 U.S.C.A. § 1320a-7(a)(1)(2).

fraud convictions "in connection with the delivery of a health care item or service or with respect to any act or omission" including a "criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility."[214] Other permissive exclusions include license revocation or suspension[215] "for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity,"[216] or excessive or unnecessary services and failure to supply requested payment information.[217] When subjected to financial audit a provider must permit record examination by Medicare in order to verify the services. This permission to audit extends not only to the federal Office of Inspector General but also to the state Medicaid fraud control unit.[218]

These standards and requirements require record keeping in order that the agency could have some evidence upon which to base its decisions. Without records and a requirement to keep records, it would be impossible to make any compliance determinations. Though the rules favor the government, the government may not always win. In *Summit Care-California, Inc. v. Newman,*[219] an injunction against the Secretary was not granted and exclusion was upheld where a nursing home failed to keep proper records. This government loss was atypical and the more usual prosecutorial triumph is typified in the renowned cases *United States v. Bay State Ambulance,*[220] and *Hanlester Network v. Donna E. Shalala*[221]and their progeny.

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[214] § 1320a-7(b) (1).
[215] § 1320a-7(b)(4)(A).
[216] § 1320a-7(b)(6).
[217] § 1320a-7(b) (11).
[218] As defined in 42 U.S.C.A. § 1396b(q).
[219] 705 F.Supp. 36 (D.D.C.1989).
[220] 874 F.2d 20 (1989).
[221] 51 F.3d 1390 (1995).

Some additional points about the federal structure[222]are germane here. Utilization review and quality assessment are accomplished through required audit procedures. All audits begin with the medical record as the primary source of data: "The primary source of data for the inpatient and ambulatory surgery indicators is abstraction from medical records, either by national clinical data abstraction centers or by PROs."[223]

It should be clear then that the medical record forms the starting point for all audits required under Medicare. The agency expects the records to be accurate when created and to remain accurate and unaltered.[224] Under the Health Care Finance Administration's Health Care Quality Improvement Program the agency utilizes the HCFA Quality Indicator System, comprised of measuring tools and supporting data systems.[225] The scope of the federal audit is broad, including "Medicare managed-care and fee-for-service acute, chronic, and preventive services, hospitals, nursing homes, ambulatory settings, home health agencies, and dialysis centers, and a variety of diseases and procedures; as well as Medicaid managed care and nursing home care."[226]

The agency audits for "access to care, desired care outcomes, or satisfaction or they [agency] measure processes of care that have been shown to strongly predict access, outcomes, or satisfaction." The data upon which such an audit is based must be both

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[222] *See,* R.L. Goldman, *The Reliability of Peer Assessments of Quality of Care*, 267 J.A.M.A. 958 (1992); HEALTH CARE FINANCING ADMINISTRATION, A HEALTH CARE QUALITY IMPROVEMENT SYSTEM FOR MEDICAID MANAGED CARE. (1993); HEALTH CARE FINANCING ADMINISTRATION: STATE OPERATIONS MANUAL: PROVIDER CERTIFICATION Appendix R, Resident Assessment Instrument for Long-Term Care Facilities (MDS 2.0), (1995).

[223] Stephen F. Jencks, *Measuring Quality of Care Under Medicare and Medicaid*, 16(4) HEALTH CARE FINANCING REV. 39, WESTLAW 8 (1995). [hereinafter, JENCKS]

[224] Recall here the Draconian fraud and abuse penalties of § 1320a *et seq.*.

[225] *See,* JENCKS AT 3.

[226] *Id.* at WESTLAW 3.

reliable and available since unreliable, erroneous, or unavailable data is "worthless."[227] Therefore, "measuring reliability and availability usually requires field testing, which can be complex if ... the validity of data in medical records is questionable."[228]

The Drug Enforcement Agency regulates the medical use of controlled substances under 21 U.S.C.A. § 800 *et seq* and it is under section 827 where one finds the mandatory language within these statutes which require record keeping.[229] The federal government closely regulates the manufacture, distribution, and dispensation of controlled substances and the code incorporates stringent record keeping requirements at all points along the stream of commerce. The states have similar regulations which will apply to health care professionals. The regulation of controlled substances forms yet another regulatory layer under which there is an affirmative duty for health care professionals who prescribe, dispense, or in any way handle controlled substances to create and maintain records in accordance with the federal rules and regulations.

Under federal law, every registrant is required to keep inventory records[230] "of each such substance manufactured, received, sold, delivered, or otherwise disposed of by him, except that this paragraph *shall not require the maintenance of a perpetual inventory.*"[231] These records must be made available for inspection.[232] If the pharmaceutical agent is a narcotic controlled substance the records must be kept separately from all other records of the registrant,[233] and the information must be retained

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[227] *Id.*.
[228] *Id.*.
[229] 21 U.S.C.A. § 827. Current through P.L. 104-45, approved 11-8-95.
[230] § 827(a)(1).
[231] § 827(a)(3). (emphasis supplied).
[232] § 827(b).
[233] § 827 (b)(2)(A).

for at least two years. If the substance is a non-narcotic controlled substance, the record must be "readily retrievable from the ordinary business records of the registrant."[234]

Note that these DEA regulations are mandatory requirements, not at all permissive, and in one case, *United States v. Clinical Leasing Service, Inc.*,[235] a clinic violated the statute when it failed to maintain its log in such a way that it could be cross-referenced to patient charts. Retrieval required a search of all patient records and this did not fulfill the letter of the regulation. While this does not seem to be a flagrant violation, it indicates the sort of close compliance the government requires in these record keeping matters.

Under federal law, however, there is room for mere sloppy record keeping.[236] The court ruled favorably for the registrant in *Norton*, where the court engaged in a balancing of the statutory requirements of record keeping and physician's efforts and expenses involved to change his system. But where a pharmacist filled prescriptions which were forged or exhibited mechanically reproduced signatures and failed to maintain complete and accurate records with respect to receipt and distribution of certain drugs, the court assessed criminal liability.[237] The court required a non-registrant drugstore owner who was not a pharmacist[238] to maintain DEA records and, in another matter, the agency was able to obtain records even where the subpoenaed evidence were corporate documents to which no privilege of self-incrimination applied.[239]

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[234] § 827 (b)(2)(B).
[235] 759 F.Supp. 310 (E.D.La.1990), *aff'd,* 925 F.2d 120 (1991), *reh'g denied* 930 F.2d 394 (1991), *cert. denied*, 502 U.S. 864 (1991).
[236] United States v. Norton, 640 F.Supp. 1257 (D.Colo.1986).
[237] United States v. Williams, 416 F.Supp. 611 (D.C.D.C.1976).
[238] United States v. Robinson, 707 F.2d 811 (C.A.4 (N.C.) 1983).
[239] United States v. Lartey, 716 F.2d 955 (C.A.2 (N.Y.) 1983).

Keep in mind at this point a conspicuous absence in the above statutes. There is no requirement that a patient is in any way harmed by any a licensee's activity. These statutes really are fiscal integrity statutes which permit auditing to verify aspects of patient care in order to support fiscal compliance. Quality control is a concern, of course, but the main thrust here is fiscal integrity.

(B) The Federal/State and State Mandates

The laws requiring medical record keeping are like a many-layered onion. After the federal duty reviewed above, the states each have similar regulations which apply to hospitals and to all licensees under their respective medical practice and state hospital licensure acts. The individual states license hospitals and practitioners. Many state acts incorporate precisely the language from similar federal statutes since acts such as the Health Care Quality Improvement Act[240] require exact statutory congruence for continued certification of institutions which bill Medicare and for those who participate in Medicaid. The HCQIA, among other acts, knits the federal programs to those at the state levels.

Each state has licensure laws and a medical disciplinary act through which a practitioner may be subject to discipline for acts of dishonesty or moral turpitude.[241] Obviously, the falsification of a medical record would qualify as violative conduct.

[240] The Health Care Quality Improvement Act of 1986; 42 U.S.C. § 1101 *et seq.*; 54 Fed. Reg. 42,722, codified at 45 C.F.R. Pt.60 *et seq.*. *See generally* BERNARD REAMS, THE HEALTH CARE QUALITY IMPROVEMENT ACT OF 1986: A LEGISLATIVE HISTORY OF PUB. L. 99-660 (1990). (including a requirement of compliance with Medicare statutes at state levels and granting immunity to persons or institutions which participate in peer review activities and created the National Practitioner Data Bank).

Federal authority, through the Medicare statutes and the HCQIA, mandate state reporting to the federal authorities and the federal authorities reciprocate to the states.

Professor Furrow noted[242] that "medical records are now the source of quality information and competence of physicians and other practitioners."[243] The HCQIA requires that providers collect information on physicians during the credentialling process and medical records can become central to the credentialling process whenever patient care is questioned. The record itself must reflect with accuracy all information which hospitals report to the National Practitioner Data Bank in order for credential committees to operate with confidence. The records must contain the basis of malpractice settlements and disciplinary actions against physicians and this information must be reported under the HCQIA.[244] Without objective support by testimony or through the medical record, according to the strict HCQIA statute, these reports would violate constitutional principles of substantive due process.[245]

In another article concerning the HCQIA, Darricades[246] explained how the internal hospital audit process relies upon the veracity of medical records:

> Medical peer review generally involves retrospective review of the medical records of patients treated in a hospital. These records are analyzed initially by hospital personnel who identify problems or issues relating to the quality of medical care. The records are then forwarded to a committee of physicians for

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[241] *See,* Fallon v. Wyoming State Board of Medical Examiners, 441 P.2d 322 (1968). Where a physician was disciplined for creating inaccurate, false, and misleading records. This is an interesting case since it is pre- Medicare and Medicaid.
[242] Barry R. Furrow, *Enterprise Liability and Health Care Reform: Managing Care and Managing Risk,* 39 ST. LOUIS U. L.J. 77 (1994).
[243] *Id.* at WESTLAW 134, n.210.
[244] 42 U.S.C. § 11131.
[245] Since there would be no reliable proof of violations without accurate medical records.
[246] Jeanne Darricades, *Medical Peer Review: How is it Protected by the Health Care Quality Improvement Act of 1986*, 18 J. CONTEMP. L. 263 (1992).

> further analysis. This committee may sanction a physician, or take other corrective action.[247]

With so much hanging in the balance under all of the Medicare section 1320 penalties and the reporting requirements to the National Practitioner Data Bank,[248] it is easy to understand that the preservation of the integrity of all medical records should be of utmost importance to practitioners and institutions.[249]

Fox v. Cohen[250] represents a landmark case where the court commented upon the duty to make and retain accurate medical records against the background of the timing of a spoliation claim. In its analysis the court found authority for the duty in a number of private, professional, non-governmental and governmental sources.

In this Illinois wrongful death action, the defendants negligently lost, destroyed, misplaced or disposed of EKG tracings and reports which they had a duty to retain. The plaintiffs alleged that this loss deprived the plaintiffs "of vital evidence" necessary to sustain her burden of proof in the medical negligence action. In granting the defendants' motion to dismiss, the trial court determined that the defendants owed the patient no such duty to maintain medical records.[251] The appellate court, however, in its reversal, relied on its former decisions in *Cannell v. Medical and Surgical Clinic*[252] and *Rabens v.*

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[247] *Id.* at 283, n.51.
[248] *See, also,* Robert M. Gellman, *Prescribing Privacy: The Uncertain Role of the Physician in the Protection of Patient Privacy*, 62 N.C. L. REV. 255 (1983).(discussing the traditionally sacrosanct nature of the physician-patient relationship and raising the question of whether there may be some good reasons, in modern times, that a physician may want to write circumspect records).
[249] *Id.* at 283, n.51.
[250] Fox v. Cohen, 406 N.E.2d 178 (1980).
[251] *Id.* at 179.
[252] 315 N.E.2d 278 (3rd Dist. 1974).

Jackson Park Hospital Foundation,[253] for support that there is a duty to retain medical records.[254] The appellate court stated that the "fiducial qualities"[255] of the physician-patient relationship required disclosure, upon request, of medical information to the patient. It is unnecessary for the patient "to engage in legal proceedings to attain a loftier status in his quest for such information."[256] The court agreed with the plaintiff's argument that "unless there is a duty to maintain medical records ... it would be meaningless to have a corresponding duty to disclose medical records."[257]

This Appellate Court then turned to the Illinois Department of Public Health under the Hospital Licensing Act[258]and Standards for Hospital Accreditation of the American Hospital Association, finding these relevant and authoritative "in evaluating the standard of conduct to which a hospital may be required to conform." The statute requires, in relevant part:[259]

> For each patient there shall be an adequate, accurate, timely, and complete medical record. Minimum requirements for medical record contents are as follows: physical examination report; ... diagnostic and therapeutic reports on laboratory test results, ... and any other diagnostic or therapeutic procedure performed.

[253] 351 N.E.2d 276 (1st Dist. 1976).
[254] Fox, 406 N.E.2d 178, 180.
[255] This is the critical point of differentiation between medicine and business or industry interests. The courts do not find that a businessman or industrial concern has a "fiducial quality" to its relationship with its purchaser. In medicine, the patient, at least until recently, correctly assumes that his physician or other providers place patient interests ahead of self-interest.
[256] *Id.* at 179. (citing Cannell, 21 Ill.App.3d at 385).
[257] *Id.* at 180. (citing Quinones v. U. S., 492 F.2d 1269 (3rd Cir. 1974)).
[258] Fox, 406 N.E.2d 178, 181. (citing Ill.Rev.Stat.1963, ch. 1111/2, pars. 142-157).
[259] *Id.*. (Illlinois Department of Public Health Requirements For Hospitals, Section 12-1.2(b) (amended May 12, 1976).

Then, section 12-1.4[260]requires that "[a]ll original medical records ... shall be preserved in accordance with a hospital policy based on American Hospital Association recommendations and legal opinion."[261] The American Hospital Association's Committee on Medical Records and the American Medical Record Association's Planning and Bylaws Committee issued a statement in 1975 which stated:

> The primary purpose of the medical record is to document the source of the patient's illness and the treatment he receives. Although the medical record is kept for the benefit of the patient, the physician, and the health care institution, it is the property of the health care institution with other interests recognized by law. [262]

Additionally the statement included that

> [t]he length of time medical records should be retained will vary depending upon the purposes for which the record is being kept. In formulating a record- retention policy, a health care institution must be guided by its own clinical, scientific and audit needs and the possibility of future patient litigation.[263]

The Illinois Appellate Court, in deciding *Fox*, acknowledged the American Hospital Association whose policy and regulations took into consideration that retention time would vary with respect to state statutes of limitations and the types of legal action contemplated. In addition, it is necessary for hospitals to comply with various state record retention acts. The court recommended that complete patient medical records should be retained for a minimum of ten years "after the most recent patient care usage."[264]

In its support for the duty to retain records the court went through a laborious analysis and found persuasive several authorities including the Record Retention Guide for Illinois Hospitals. This was published by the Illinois Hospital Association and

[260] *Id.*. (Section 12-1.4 (amended May 12, 1976).
[261] *Id.* at 182.
[262] *Id.*. (citing STATEMENT ON PRESERVATION OF MEDICAL RECORDS IN HEALTH INSTITUTIONS (1975)).
[263] *Id.*.

incorporated essentially the same language that the AHA adopted in its regulations. This Guide provided, "(a)n Illinois health care institution in formulating a record retention policy must be guided by its own needs ... the possibility of future patient litigation and state and federal laws." The Guide recommends that medical records and EKG tracings be retained for 10 to 22 years. The court also relied upon the Accreditation Manual for Hospitals published by the Joint Commission on Accreditation of Hospitals.[265] This Manual states that "(t)he hospital shall ... provide medical records that are accurately documented, readily accessible and can be easily used for retrieving and compiling information."

The manual lists various purposes for medical records: "to furnish documentary evidence of the course of the patient's illness and treatment during each hospital stay; to serve as a basis for review, study, and evaluation of the care rendered to the patient; and to assist in protecting the legal interests of the patient, hospital, and responsible practitioner." The regulations require that a hospital keep a complete and accurate medical record on each patient. The purposes relate to "the betterment and protection of the patient as well as the hospital."[266] The *Fox* court then concluded on this issue of medical records that

> [i]n view of the increasing number of medical malpractice actions being filed and in order to safeguard the patient's interest as well as the hospital's interest in such litigation, we think it necessary that reasonable care be used to maintain complete

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[264] *Id.*.

[265] *Id.*. (according to ACCREDITATION MANUAL FOR HOSPITALS, THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS (1970, updated 1973). This organization underwent a name change and is currently The Joint Commission on Accreditation of Health Care Organizations, "JCAHO". The author wishes to thank JCAHO General Counsel, Mr. Harold Bressler for his insight and direction he provided in this complex area.

[266] *Id.*.

> and accurate medical records. The authorities advocate that it is both desirable and feasible that a hospital assume the responsibility of keeping such records.[267]

Since the Illinois courts react to the same federal mandates as do all other states, presumably all other state courts would arrive at similar conclusions as the *Fox* court on this issue of the duty to make and retain medical records. A practitioner who tramples these rules would also trample patient rights since the rules reference rights patients posses for their medical care to be evaluated.

(i) Medicaid

Medicaid prosecutions for fraud, as with Medicare, involving medical record falsification are numerous and common.[268] States may prosecute on their own or may ask the federal authorities to prosecute violations. Some cases will illustrate the principles with respect to the pivotal role the medical record plays in these prosecutions.

The main Medicaid record keeping statute is located at 42 U.S.C.A. § 1396r-2.[269] Medicaid is a federal program formed under the Social Security Act which reimburses the states for covered expenses for qualified beneficiaries and as such, Medicaid fuses federal and state statutes in virtually all areas with respect to the delivery of health care. There is a requirement under the section 1396a(a)(49) that the states must report

> (A) Any adverse action taken by such licensing authority as a result of the proceeding, including any revocation or suspension of a license (and the length of any such suspension), reprimand, censure, or probation. (B) Any dismissal or closure of the proceedings by reason of the practitioner or entity surrendering the

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[267] *Id.* at 182.

[268] Pamela H. Bucy, *The Poor Fit of Traditional Evidentiary Doctrine and Sophisticated Crime: An Empirical Analysis of Health Care Fraud Prosecutions*, 63 FORDHAM L. REV. 383 (1994). This is a meticulous analysis of Medicare and Medicaid fraud prosecution. In all cases, the beginning of the investigation is the medical record. Under Medicare and Medicaid law, the provider bears the burden to support his course of diagnosis and treatment. Under these statutes, as in IRS audits, the absence of a record mandates an adverse determination.

[269] 42 U.S.C.A. § 1396r-2. Current through P.L. 104-98, approved 1-16-96.

> license or leaving the State or jurisdiction. (C) Any other loss of the license of the practitioner or entity, whether by operation of law, voluntary surrender, or otherwise. (D) Any negative action or finding by such authority, organization, or entity regarding the practitioner or entity.[270]

Furthermore, the state must provide the federal authorities access to all documents "as may be necessary for the Secretary to determine the facts and circumstances concerning the actions and determinations."[271] The information shall be made available to

> (1) to agencies administering Federal health care programs ... (2) to licensing authorities ... (3) to State agencies administering or supervising the administration of State health care programs ... (4) to utilization and quality control peer review organizations ... to eligible organizations reviewed under the contracts, (5) to State Medicaid fraud control units (6) to hospitals ... with respect to physicians ... [applying for staff privileges] (7) to the Attorney General ... (8) ... to the Comptroller General, in order ... to determine the fitness of individuals to provide health care services, to protect the health and safety of individuals receiving health care through such programs, and to protect the fiscal integrity of such programs.[272]

The Medicaid regulations require appropriate coordination between the states and the requirements of the HCQIA.[273] This statute links the HCQIA to Medicaid law.[274]

The states' powers are substantial as illustrated by some exemplary prosecutions including *Roggemann v. Bane.*[275] Dr. Roggemann participated in New York state's Medicaid program and the Department of Social Services performed an audit of 100 charts. Under New York law,[276] a physician must document and support his care and treatment plan. Dr. Roggemann ordered unnecessary and inappropriate prescriptions and

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[270] § 1396r-2(a)(1)(A-D).
[271] § 1396r-2 (a)(2).
[272] 42 U.S.C.A. § 1396r-2(b)(1-8).
[273] 42 U.S.C.A. § 1396r-2 (d).
[274] *See,* Mark A. Colantonio, *Health Care Quality Improvement Act of 1986 and its Impact on Hospital Law*, 91 W.VA.L.REV. 91 (1988-1989). *See also,* Austin v. McNamara, , 979 F.2d 728 (Cal. 1992) (affirming that the HCQIA's purpose is threefold: effective peer review, interstate monitoring of incompetent physicians, and granting qualified immunity from damages for those who participate in peer review activities).
[275] Roggemann v. Bane, 614 N.Y.S.2d 593 (1994).

tests and failed to fully document in the patients' charts the justifications for medications and services he prescribed. New York required the doctor to repay $68,190.84 and excluded him from the Medicaid program for two years.

In a dissenting opinion, Presiding Justice Mikoll took umbrage with the "shockingly severe penalty" the court imposed "considering the benign nature of the alleged "unacceptable record keeping."[277] This is mentioned here because of its unusual nature. Courts tend to react severely in record keeping matters and it is unusual for a justice to be so moved that he would comment in this way. His reaction may be a knee-jerk reaction by an judge who may not have fully grasped the importance of the physician's misrepresentations in terms of squandering public funds and trust.

Another New York prosecution for Medicaid fraud, more florid than *Roggeman*, is *People v. Bhatt*[278] where the state alleged 111 violations. Among other violations the government charged Dr. Bhatt with numerous counts of falsifying business records. Bhatt attempted to keep the authorities at bay by relying on grounds of the physician-patient privilege. He argued that the state had no ability to investigate private medical records of non-consenting patients. The defendant "correctly surmised" that the foundation for the prosecution's theory "lay within a comparison of the subject medical records and the Medicare claims purportedly submitted by defendant." In a novel question

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[276] 18 N.Y.C.R.R. 515.2(b)(1)(i)(c) and 515.2(b)(6) and (11).
[277] 614 N.Y.S.2d 593, 596.
[278] People v. Bhatt, 611 N.Y.S.2d 447 (1994).

to the New York court, after a full analysis in the interest of promoting public health, the court permitted the agency to proceed.[279]

The court considered whether state and federal Medicaid provisions created an exception to the physician-patient privilege.[280] In concluding that they did not, the court reasoned that in order for the "publicly funded Medicaid program to be carried out effectively, the public must be assured that the funds which have been set aside for this worthy purpose will not be fraudulently diverted into the hands of an untrustworthy provider of services."[281] The court further analyzed this problem and stated, "as a prerequisite to any judicial expansion of the Medicaid investigation exception ... it must be demonstrated that the Medicare program contains similar statutory record keeping and reporting requirements."[282]

The court distinguished Medicare and Medicaid, explaining that

> Medicaid ... enacted in 1965, is jointly financed by the federal and state governments and is administered by the states. Found under Title XIX of the Social Security Act ... Medicaid authorizes federal grants to states for medical assistance ... Medicare, like Medicaid, statutorily provides for record keeping and reporting of information concerning the beneficiaries, or patients, of the program.[283]

The *Bhatt* court further clarified its interpretation adding that it is the "express intent of Congress to establish a free-flowing information highway for the purpose of determining the legitimacy of Medicare claims, by the Health Care Financing

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[279] 611 N.Y.2d 447, 448. (citing People v. Roosevelt Hospital, 488 N.E.2d 94 (1985); Matter of Camperlengo v. Blum, 436 N.E.2d 1299 (1982); Edington v. Mutual Life Ins. Co., 67 N.Y. 185, 194 (1876)).
[280] 611 N.Y.S.2d 447, 449.
[281] *Id.*.
[282] *Id.*.
[283] 611 N.Y.S.2d 447, 450-51.

Administration."[284] In conclusion, the New York court acknowledged "the statutory record keeping and reporting requirements with respect to Medicaid investigations, are likewise present and applicable to the Medicare fraud investigation herein."[285]

The *Bhatt* court further considered the interdigitation of these record keeping requirements for both programs when it said,

> No rational distinction may be drawn, insofar as record keeping and reporting requirements are concerned, between these two publicly funded health insurance programs. It should be a matter of sound public policy that those officials, who are charged with maintaining vigilance over public funds dedicated to the Medicare program, have available to them a legitimate and unqualified means of access to medical reports required for specific investigations, in light of the potential for massive insurance fraud.[286]

People v. Ekong[287] reached similar audit and record issues as *Bhatt* where the court ruled that federal Medicaid legislation prevailed over state physician-patient privilege and, therefore, the agency could obtain medical records in the physician's possession for a grand jury examination. Furthermore, it held, "[a] review of the federal Medicaid laws and regulations discloses a clear congressional intention that the patient records kept by health-care providers be subject to disclosure during fraud investigations."[288]

In other case holdings it appears that when state or federal authorities seek to audit a Medicare or Medicaid participant, there is almost no way to prevent agencies from obtaining records for legitimate audit purposes. For instance, in *McMaster v. Iowa Board*

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[284] *Id.*.
[285] 611 N.Y.S.2d 447, 452.
[286] *Id.*.
[287] People v. Ekong, 582 N.E.2d 233 (1991).
[288] 582 N.E.2d 233, 234. *See,* In re Grand Jury Investigation, 441 A.2d 525 (1982). "The regulations set forth state plan requirements, standards, procedures, and conditions for obtaining federal funds. (42 C.F.R.

of Psychology Examiners,[289] Iowa authorities attempted to investigate a third party psychologist and the agency subpoenaed patient records. The psychologist resisted on the basis of psychologist-patient privilege but the Iowa Supreme Court held that the Board's subpoena power was valid, that privilege did not bar disclosure, but that the Board could only subpoena where its need for the records outweighed the patient's right to privacy. The state's need for records for audit purposes, in most cases, then, will exceed the patient's right to maintain confidentiality. The duty to keep and maintain medical records in this case extended to a third party and the patient's privacy interest was subverted to the state's interest in the program's fiscal integrity.

(ii) State Record Retention Acts; Physician and Hospital Licensure Acts

All states have record retention acts for medical records[290] which typically include all medical records or anything generated as a record of patient care. Usually the duration of retention is at least equivalent to the statute of limitations for medical negligence litigation.[291] Illinois has a specific x-ray retention statute.[292] One important federal statute

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§ 430.0(b)(1) (1980). One requirement is that the disclosure of patient records be for "conducting or assisting an investigation, prosecution, or civil or criminal proceeding ." 42 C.F.R. § 431.302. *Id.*.

[289] McMaster v. Iowa Board of Psychology Examiners, 509 N.W.2d 754 (1993).

[290]Anthony C. Casamassima, *Spoliation of Evidence and Medical Malpractice*, 14 PACE L. REV. 235, WESTLAW 38, n.126 (1994). Alaska Stat. § 18.20.085 (1993); Haw. Rev. Stat. § 622-58 (1985 & Supp. 1992); Idaho Code §§ 39-1394, 41-3909 (Michie 1993); La. Rev. Stat. Ann. § 40:2144 (West 1992 & Supp. 1993); Minn. Stat. Ann. § 145.32 (West 1989); Miss. Code Ann. §§ 41-9-69, -71, -73, -77, -79 (1993); Nev. Rev. Stat. Ann. § 629.051 (1991); N.M. Stat. Ann. § 30-44-5 (1989); Tenn. Code Ann. § 68-11- 302, -305, -308 (1992); Tex. Health & Safety Code Ann. §§ 262.030, 281.073 (West 1992); Va. Code Ann. § 42.1-79.1 (Michie 1990); Wash. Rev. Code Ann. § 70.41.190 (West 1992).

[291] *Id.* at WESTLAW 7.

[292] Ill. Ann. Stat. ch. 111 1/2. para. 157-11 (Smith-Hurd 1992).

requires retention for five years.[293] According to Oesterle[294] as of 1983 there were in excess of 1300 federal statutes and administrative rules which govern record retention and it seems safe to assume that thirteen years later, that number has only increased.

All states have hospital licensure acts which contain duties to make and retain medical records. A good example of this is *Bondu v. Gurvich*,[295] an important spoliation case in which the Florida court established negligent spoliation of evidence as a tort. Although *Bondu* will receive greater attention later, it is helpful at this time to review the court's analysis with respect to health care provider duty to make and retain records. The Florida court identified the "crux"[296] of the plaintiff's action against the hospital as the hospital's failure to keep and maintain records, "which failure rendered the plaintiff unable to prove the medical malpractice of the hospital and others."[297]

In a *per curiam* opinion, the court reasoned[298] that unless "it is 'clear that the plaintiff's interests are entitled to legal protection against the conduct of the defendant,'" no action could lie. Here, the court found that the Florida statute which imposes the duty was promulgated by the "Health and Rehabilitation Services."[299] The statute[300] provided that an hospital must have a medical record department, maintain records for all patients,

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[293] *Id.* at WESTLAW 38 n.125. (citing 42 C.F.R. § 482.24(b)(1) (1991). This section includes among the Medicare Conditions of Participation: "medical records must be retained in their original or legally reproduced form for a period of at least 5 years."
[294] Dale A. Oesterle, *A Private Litigants Remedies for an Opponent's Inappropriate Destruction of Relevant Documents*, 61 TEX. L. REV. 1185, 1245 n.99 (1983).
[295] 473 So.2d 1307 (1984).
[296] *Id.* at 1311.
[297] *Id.*.
[298] *Id.* at 1312 (citing Prosser's analysis, *see supra*, pp. 20-21, n. 79).
[299] *Id.*.
[300] *Id.*. (citing Florida Code 10D-28.59).

and that the records shall contain certain specific clinical data,[301] and, upon proper request, the hospital must furnish a copy of the records to the patient."[302]

In addition, the code expressly states that the records shall be kept in order to "assure that the records shall not be damaged, destroyed, or altered."[303] Then the court further supported its legal authority by the Illinois case, *Fox v. Cohen*,[304] in accord with the Florida court's ruling.[305] In reasoning which follows traditional tort analysis the Florida court found that Bondu stated a cause of action.

In the underlying action, Bondu's action against the hospital was dismissed since she could not produce an expert who had reviewed the medical records and could express an opinion in fulfillment of Florida law. Her reason for this inability was simple: the records were gone.[306] Here, the court concluded, the hospital breached its duty to provide her with records with which she needed to prove her case; that breach caused her damage since she lost her medical negligence action when she could not provide expert witnesses.[307] Further, the court stated that since there was no allegation that the hospital intentionally removed or destroyed the records, the hospital was not required to rebut an allegation of intentional destruction.[308] In fashioning its remedy the court determined that the hospital acted negligently, shifted the burden of proof to the hospital and ruled that it

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[301] *Id.* at 1313. Florida Code 10D-28.59(3): "Medical records shall contain the original of the following information: identification data; chief complaint; present illness; past history; family history; physical examination; provisional diagnosis; clinical laboratory reports; x-ray reports; consultation reports; medical and surgical treatment notes and reports; tissue reports; physician and nurse progress notes; final diagnosis; discharge summary; and autopsy findings when performed."
[302] *Id.*. (citing Florida Administrative Code, Ch. 10D-28, § 395.202 (1979).
[303] *Id.*. (citing § 395.202(1)).
[304] *See*, *supra* n. 250, and accompanying text at p. 59.
[305] *Id.* at 1313.
[306] *Id.* at 1307.
[307] *Id.* at 1313.

would have to prove "that the treatment which such missing records would reflect was performed non-negligently."[309]

The dissent position is interesting since Justice Schwartz's comment was exactly opposite to the court's opinion. "I am persuaded that the tort created by the majority opinion ... should not be recognized."[310] In Justice Schwartz's analysis, the rule elaborated "runs counter to the basic principle that there is no cognizable independent action for perjury, or for any improper conduct even by a witness, much less a party, in an existing lawsuit."[311] If the rule were otherwise, he continued, "every case would be subject to additional trials arising from other independent actions."[312] This jurist would have granted a rehearing but would have affirmed the hospital's judgment, having the effect of dismissing the suit.

The authorities the courts accepted in *Fox* and *Bondu* represent statutory requirements which hospitals follow throughout the country. This comes as no surprise since all states respond to similar accreditation guidelines elaborated by the federal mandates through Medicare, the JCAHO, Medicaid, the HCQIA and other federal statutes and private national rules implemented in order to regulate hospital practices.

Apart from federal mandates for accurate record keeping, in a way similar to hospital licensure acts, all states have similar medical practice acts which require that providers create and maintain medical records which would support any course of treatment. In addition, all states have language in their medical practice statutes which

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[308] *Id.* n.5. (citing Valcin v. Public Health Trust of Dade County, 473 So.2d 1297 (Fla. 3d DCA 1984).
[309] *Id.*.
[310] *Id.* at 1313-14.
[311] *Id.*. (citng Kessler v. Townsley, 132 Fla. 744, 182 So. 232 (1938).

prohibit fraud, deceit, dishonesty, moral turpitude in connection with the application for medical licensure or, after a license is granted, in medical practice.[313] Since discipline "is designed to improve the quality of health care services,"[314] protection of the public is the rationale for licensure and disciplinary action even when the state is unable to show actual harm to the public.[315]

The gateway to medical practice in an hospital for a practitioner is through hospital credentialling. JCAHO standards cross-link all federal, state, and private professional requirements. For instance,[316] to qualify for hospital staff privileges at any JCAHO accredited institution a physician must have a current valid state license, a current valid DEA number allowing the prescription of narcotics; the physician must have completed both medical school and a residency program, or must be board certified. In addition, most hospitals require medical malpractice insurance, and the hospital must verify the work history and professional liability profile. Additionally, the hospital must query the National Practitioner Data Bank[317] on the initial application. Every two years the hospital must update the NPDB, verify licensure, and various other quality associated

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[312] *Id.*.
[313] *See*, FURROW at 56 *et seq.*.
[314] *Id.* at 70.
[315] *See, e.g.*, Colorado v. Hoffner, 832 P.2d 1062 (Colo.App. 1992).
[316] JOINT COMM'N ON ACCREDITATION OF HEALTH CARE ORGS., 1995 ACCREDITATION MANUAL FOR HOSPITALS: VOL. I: STANDARDS 172 (1994). [hereinafter JCAHO STDS]; *See, also*, Peter R. Kongsvedt, *Primary Care in Open Panels*, in THE MANAGED HEALTH CARE HANDBOOK, 43, 49-50 (1993).
[317] [hereinafter NPDB]; JCAHO STDS at 172. Furthermore the applicant must disclose any licensure actions or felony convictions as well as all limitations of staff privileges or disciplinary actions.

factors.[318] At the center of these vital professional determinations sits the intact and unaltered medical record.

At this time, by examining a few cases selected for geographic and jurisdictional variety, it will be possible to illustrate the general liability theories supporting the duty to create and retain medical records and to learn of the breadth of the states' concerns over record keeping requirements in the licensure context.[319] The first case is *VanGaasbeek v. Chassin,*[320] where a New York obstetrician/gynecologist sought review of the suspension of his medical license pursuant to New York statute.[321] The New York State Bureau of Professional Medical Conduct of the State Health Department charged this physician with, *inter alia*, "failure to maintain accurate patient records and practice of the profession fraudulently, with moral unfitness and willfully making or filing a false report."[322]

When this practitioner mis-stated the precise condition of his hospital staff privileges in a subsequent written hospital privilege application, the authorities viewed this as fraud.[323] The appellate court concluded that, with respect to a patient's care and treatment by this physician, the medical record itself "was inadequate because it failed to sufficiently document a history of the nature of patient B's pain, its location, whether the taking of other medication was involved and whether she had previous treatment for pain. Petitioner's operative report also was found to be deficient in failing to describe the

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[318] See, Torin A. Dorros & T. Howard Stone, *Implications of Negligent Selection and Retention of Physicians in the Age* of ERISA, 21 AM. J.L. MED. 383 (1995). (presenting a careful consideration of negligent credentialling, ERISA pre-emption in the managed care setting).
[319] *See,* FURROW at 144.
[320] VanGaasbeek v. Chassin, 198 A.D.2d 572, 603 N.Y.S.2d 223 (1993).
[321] New York Public Health Law § 230-c[5].
[322] 603 N.Y.S.2d 223, 225.

ovaries."[324] In another instance, the court affirmed the administrative agency's findings and found as inadequate his medical records which did not contain the reason for inducing labor and where he failed to record pelvic findings.[325]

Breesmen v. Department of Professional Regulation[326] represents a curious instance where the physician followed his patient's record keeping instructions to his initial detriment but ultimate vindication. In its opinion the Florida court used standard of care language. Florida statute requires that a physician keep medical records[327] which justify the course of treatment of the patient. Here, however, Bressman's patient requested that he not make a record of her refusal of medical treatment. The patient was a nurse who did not want hospital personnel to know that she was refusing a course of treatment and, after she died of a transmural myocardial infarction, the Department of Professional Regulation filed an administrative complaint.[328]

The Department alleged that Dr. Breesman had violated the statute in "failing to practice medicine with that level of care, skill, and treatment recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances ... by failing to keep written medical records justifying the course of treatment of [the patient], including, but not limited to, patient histories, examination results, and test results."[329] A state witness testified that the "medical record is necessary for other

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[323] 603 N.Y.S.2d at 226.
[324] *Id.*.
[325] *Id.* at 227.
[326] Breesmen v. Department of Professional Regulation, 567 So.2d 469 (1990).
[327] *Id.* at 470. Fla. Stat. § 458.331(1)(m) (1987).
[328] *Id.*. Fla. Stat.. § 458.331(1)(t).
[329] *Id.* at 470-71.

physicians to determine the appropriateness of medical care."[330] The witness testified that while a patient clearly has the "right to request that treatment be non-aggressive, she does not have the right to deny the physician his duty or responsibility to document those wishes in the hospital record."

The Florida statute clearly subjects a physician to discipline when he does not create a full record but the court reasoned here that "the Board's evidence, at its best, showed only that Dr. Breesmen's actions were not in keeping with JCAH standards or those of a 'reasonably prudent physician.'" In finding Dr. Breesman not culpable the court found that the statute does not encompass the negligence standard "nor has any rule encompassing such standards been promulgated pursuant to [statute]."[331] Furthermore, and this was what was the most dispositive, the Board did not show that Dr. Breesman "did not record all medical treatment administered to his patient, or that the entries he made were false or inaccurate. The entire case against him rests on failing to note why he did not follow other courses of treatment."

The court noted another defect in the state's prosecution. The Board failed to reference "any statute or rule that fixes the standard of conduct to be followed by a physician whose patient refuses treatment and requests that his ... refusal not be documented in the hospital records." Additionally, the state failed to cite "any statute ... that requires a physician to document in the patient's medical chart the physician's reason for not performing particular tests or procedures."[332]

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[330] *Id.* at 471.
[331] *Id.*. (citing Fla. Stat.. § 458.331(1)(m)).
[332] *Id.*.

In *Weber v. Colorado State Board of Nursing*,[333] a nurse who did not provide medical records to a patient in a timely manner without justification was subjected to disciplinary action under the Colorado Nurse Practice Act.[334] There is a duty to provide medical records to patients in a timely manner.

Dr. Adler was required to pay a $200,000 fine and New York revoked his license[335] after he ordered tests which were not medically indicated, billed patients for laryngoscopies which were not performed and for office visits where he did not see or examine the patients. He perpetrated this fraud by filing false reports and he failed to maintain adequate medical records. The doctor routinely submitted claims to a private insurance company which contained false information, misrepresenting actual charges for medical services, with a $250,000 resultant overpayment. He repaid this amount to Metropolitan Life in settlement of a claim the insurance company brought under the Federal Racketeer Influenced and Corrupt Organizations statute.[336]

Additionally, Dr. Adler misrepresented his qualifications when he applied for a Connecticut license, falsely stating that he had received his undergraduate degree from Princeton University. The New York court relied upon two education cases in its *Adler* fraud analysis. In *Brestin v. Commissioner of Education*,[337] the court held that fraud contemplated under the Education Law required an *intentional* misrepresentation or

[333] Weber v. Colorado State Board of Nursing, 830 P.2d 1128 (1992).
[334] Colorado Nurse Practice Act § 2-38-101, *et seq.*, C.R.S. (1991 Repl.Vol. 5B).
[335] Adler v. Bureau of Professional Medical Conduct, 622 N.Y.S.2d 609 (1995).
[336] *Id.* at 609. Federal Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. § 1961 *et seq.*.
[337] 116 A.D.2d 357, 501 N.Y.S.2d 923 (1986).

concealment of fact. Then, in *Matter of Amarnick v. Sobol*,[338] it reversed a fraud conviction since there was no finding that the petitioner acted intentionally or knowingly.

In contradistinction to the above cases, here, however, in Dr. Adler's case, the court sustained a determination of fraud where this physician intentionally concealed prior employment and stated falsely that he was board eligible in pediatrics. The court viewed this conduct as permitting an inference of "guilty knowledge and intent."[339] Finally, where a licensee abuses the privilege of practicing medicine, using the license "chiefly as a means of personal aggrandizement rather than in the service of the people of this State," the court will sustain revocation of the license.[340]

In *Kearl v. Board of Medical Quality Assurance*,[341] the California appellate court upheld the suspension of an anesthesiologist's license on grounds of incompetence where he failed to record appropriate vital signs at five minute intervals after beginning anesthesia as required by practice guidelines and as supported by expert testimony from a board certified anesthesiologist.

In *Suslovich v. New York State Education Department*,[342] the New York Supreme Court, Appellate Division sustained the suspension of a psychologist's license for three months where the practitioner failed to maintain proper records and this constituted unprofessional conduct. The psychologist submitted a claim for ten therapy sessions when

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[338] 173 A.D.2d 914, 569 N.Y.S.2d 780 (1991).
[339] *Id.* at 611. (citing Matter of Sung Ho Kim v. Board of Regents of Univ. of State of N.Y., *supra*, 172 A.D.2d at 881-882, 567 N.Y.S.2d 949, 580 N.E.2d 410 (1991); Matter of Berger v. Board of Regents of State of N.Y., 178 A.D.2d 748, 751, 577 N.Y.S.2d 500 (1991), *lv. denied* 80 N.Y.2d 918, 589 N.Y.S.2d 302, 602 N.E.2d 1118 (1992), *cert. denied* 507 U.S. 1018 (1993). (standing for the proposition that intent and knowledge may be inferred from surrounding circumstances).
[340] 622 N.Y.S.2d 609, 612.
[341] 236 Cal. Rptr. 526 (1986).
[342] 571 N.Y.S.2d 123 (1991).

the patient only attended five. The practitioner explained to the licensing authorities that what records he did maintain he "kept in his head." Other than a diagnosis and a notation of "psychotherapy" treatment, and the dates of treatment, the licensee kept no other information about this patients. He averred, furthermore, that the insurance claim form constituted the patient's medical records.[343] In its finding against the psychologist, the New York court pointed out that the "purpose behind the requirement that a proper record be kept for each patient[344] is in part to ensure that meaningful information is recorded in case the patient should transfer to another professional or the treating practitioner should become unavailable."[345]

Ohio disciplined Dr. Stegall,[346] who practiced bariatrics and, along with other charges, the Court of Appeals upheld a finding that he could not escape "a disciplinary violation of [the] weight control rule by keeping poor records."[347] The case report is sketchy in describing in precisely what sort of conduct the doctor engaged, but it appears as if he failed to record various important clinical details with respect to patients kept on the weight loss regimen.[348] Under Ohio code,[349]a practitioner must keep "accurate medical records reflecting his examination, evaluation, and treatment of all his patients." When a physician prescribes controlled substances, the code mandates: "Patient medical records shall accurately reflect the utilization of any controlled substances in the treatment of a patient and shall indicate the diagnosis and purpose for which the

[343] *Id.* at 124.
[344] Citing 8 N.Y.C.R.R. 29.2[a] [3].
[345] 571 N.Y.S.2d at 124.
[346] Stegall v. Ohio State Medical Board, 635 N.E.2d 1291 (1994). *cert. den'd*, 631 N.E.2d 640 (1994).
[347] Stegall, 635 N.E.2d 1291, 1291.
[348] *Id.* at 1295.
[349] Ohio Adm.Code 4731-11-02(D).

controlled substance is utilized, and any additional information upon which the diagnosis is based."[350]

The State of New Jersey revoked Dr. Jascalevich's license[351] for "gross malpractice, negligence and incompetence" after he "included a post-operative note as to possible cancer when he knew the patient to be cancer-free" and "knowingly permitted a forged operative record to become part of [a] hospital record."[352] The Board concluded that Dr. Jascalevich lacked "the good moral character requisite for the practice of medicine."[353]

It is illustrative to specifically describe Dr. Jascalevich's conduct since this is the sort of conduct an attorney must be ready to detect in medical negligence litigation. In connection with a cholecystectomy, the doctor wrote an operative report which "knowingly misrepresented a mass in the pancreatic region," submitted a pathology specimen which he knew not to be that of the patient, falsified an hospital record, and made a knowingly false preoperative diagnosis and false post-operative record.[354] In the care of another patient, Dr. Jascalevich substituted a false operative record which "he knew not to be genuine."[355]

Since record falsification is so noxious to ethical standards in both medicine and law, courts reserve their strongest epithets to denounce this conduct. The New Jersey court in *Jascalevich* acknowledged that statutory definitions for some of these

[350] 635 N.E.2d 1291, 1295.
[351] *In re* Jascalevich, 442 A.2d 635 (1982).
[352] *Id.* at 644.
[353] *Id.* at 637.
[354] *Id.*.
[355] *Id.* at 641.

professional standards were lacking and relied upon a veterinarian's case, *In re Suspension or Revocation License of Kerlin*[356] to supply the needed semantics. In *Kerlin* the court held that terms such as *neglect* or *malpractice*, mean a "deviation from normal standards of conduct" but that *gross neglect* or *gross malpractice* "suggest conduct beyond such wrongful action-how far beyond has been left to the judgment of the Board, subject, of course, to judicial review."[357] The term *professional incompetence*, although not judicially defined, typically means "any inability to conform with proper standards of professional conduct, and to include the lack of moral as well as physical or intellectual fitness to practice medicine."[358]

With respect to *Jascalevich*, the Board used all of these terms in denouncing his reprehensible conduct and observed that "the knowing entry of a false entry in a patient's record and the purposes of self-protection also in the Board's opinion demonstrates a patent lack of good moral character required by" New Jersey statute.[359] The Board also concluded that the conduct involved in the forged operative report "demonstrated a lack of good moral character."[360]

In New Jersey, in the early 1980's, law in the area of disciplining physicians was in a nascent phase and the New Jersey courts had not considered the "question of lack of good moral character as a basis for the discipline of physicians" although "it has been assumed that it constitutes such a basis."[361] The New Jersey court had little trouble in

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[356] *Id.* at 641. (citing 376 A.2d 939 (App.Div.1977)).
[357] *Id.* at 642.
[358] *Id.*.
[359] *Id.*. (citing N.J.S.A. 45:9-6).
[360] *Id.* at 643.
[361] *Id.*. (citing *In re* Suspension of License of Wolfe, 388 A.2d 1316 (App.Div.1978), *certif. den.*, 396 A.2d 592 (1978).

reaching a decision in *Jascalevich* and held "that a deliberate falsification by a physician of his patient's medical record, particularly when the reason ... is to protect his own interests at the expense of his patient's, must be regarded both as gross malpractice and as endangering the health or life of his patient."[362]

As briefly touched upon above with respect to the federal regulations, in the case of licensure actions, there is no harm requirement in order for a licensee to be subjected to professional discipline.[363] There is no obstacle which would prevent a licensure board from seeking to discipline a physician who violated the record keeping statutes. This would be especially true where the doctor acted in a dishonest fashion.

[362] *Id.* at 645.

[363] *See, e.g.*, Palmer v. Board of Registration in Medicine, 612 N.E.2d 635 (1993). A Massachusetts physician was disciplined absent any showing of harm to the patient; In *In re* Eastway, 642 N.E.2d 1135 (1994), in the case of an alcohol dependent physician, Ohio statute did not require harm to a patient as a requisite. A physician violates the statute if he engages in conduct which is "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established." *Id.* at 1136; Colorado v. Hoffner, 832 P.2d 1062 (Colo.App. 1992). The Medical Practice Act did not require actual harm to the patient or in medical practice before the Board could take action against a licensee for habitual intemperance. *Id.* at 1068.

(C) Private Professional Organizations; The Hospital Staff

In order for a provider to practice in an hospital, she must join the medical staff. Hospital staff membership is a provider's voluntary association with a hospital under the hospital bylaws in which, as part of the *quid pro quo* of membership, both parties agree to abide by all relevant laws and private professional regulations. Any hospital with a Medicare contract or with accreditation by JCAHO is bound as above described to the federal provisions with respect to record keeping. The hospital is also forced to comply with all DEA, Medicaid, and all state hospital regulations. Suffice it to say, that when a physician joins an hospital staff, in compliance with all state and federal and professional regulations, he has duties to comply with all accepted rules and regulations and norms with respect to record certification.

One of the most important hospital documents a provider will complete in medical record keeping is the hospital discharge summary and final certification sheet. In compliance with state and federal rules and regulations, this contains an attestation: "I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge."[364] Medical professionals who alter these records or who in any way misrepresent the facts in these documents would be subject to criminal or civil prosecutions under the entire cascade of all applicable federal and state fraud provisions and would be liable for all possible professional sanctions.

[364] By way of example, this language was taken from the face sheet used by Emory University's main teaching hospital, Grady Memorial Hospital, Atlanta, GA. The author wishes to thank trial attorney Ms. Elizabeth Pelypenko, of Atlanta, GA for providing this document.

In addition to hospital membership comes membership in voluntary professional private organizations. It is important to point out at this time that professional organizations are private and have no official federal or state regulatory authority. Membership is voluntary and optional but, as a purely practical matter, a practitioner would be left with a meaningless slip of paper if he chose to avoid all non-governmental professional affiliations. While no state requires Board certification for licensure, medical practice quality assurance is "fine tuned" at the level of the hospital credentialling process, a non-governmental function.[365] Most hospitals in this era place Board certification by a Board organized under the aegis of the American Board of Medical Specialties as a threshold quality assurance requirement. In addition, many hospitals require local medical society membership. There is a current trend towards more certifications such that, in addition to state medical licensure, a practitioner in essence is required to belong to numerous professional organizations.[366]

While no private professional society has the power to bring a licensure action against a state licensee, under the HCQIA, adverse determinations by many of these societies or associations will be reported to the NPDB and that can trigger a licensure action. Some Boards require office or hospital medical record reviews as part of its certification or re-certification process. Fraud, deceit, omissions, or alteration of any of these records could trigger reporting to any of the various medical societies and result in

[365] To illustrate, a doctor may call herself a "cardiovascular surgeon" under state or federal law, but unless she is able to affirmatively document by clear and convincing evidence that she is competent and qualified to practice the specialty, no hospital will grant cardiovascular surgery privileges.

[366] To illustrate: a surgeon may become board certified by the American Board of Surgery but if he performs vascular surgery, he may also become a member of the American Society of Vascular Surgery. He could also be a member of his city, county, and state medical associations and be a member of the AMA. The possibilities are endless.

initiation of a professional licensure investigation from the state licensure authorities which could conclude with no action, reprimand, suspension, or revocation.

The American Board of Family Practice, requires that candidates hold a "valid, full, and unrestricted" medical license,[367] and a licensee is precluded from further consideration by the Board when a license is encumbered, "until reinstated in full."[368] An applicant who undergoes a disciplinary action has a duty to report the action to the Board. In addition to the licensure requirement, an applicant must satisfactorily complete an approved residency.[369] This requirement[370] alone incorporates all the record keeping requirements under applicable federal and state law.

In the case of Family Practice, which requires recertification every seven years, the candidate at that time must perform an "office record review," which is a detailed analysis of actual patient medical records.[371] Additionally, the Board requires that the physician submits four patient charts for scrutiny and, upon request, he must submit photocopies of charts from which "the data collection forms were completed."[372] Issuance of any certificate from the ABFP is subject to revocation in the event that he has made "a misstatement of fact in the application ... or in any other statement or representation."[373]

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[367] THE AMERICAN BOARD OF FAMILY PRACTICE, BOOKLET OF INFORMATION 2 (September 1995). To obtain this:, one may call or write the American Board of Family Practice, Inc. , 2228 Lexington Dr., Lexington, KY 40505-4294; Phone: 609-269-5626. This is an illustrative presentation and is not intended as a comprehensive review of all of the requirements for Board certification by the ABFP. Interested parties should obtain certification requirements directly from the Board.
[368] *Id.* at 3.
[369] *Id.* at 1.
[370] *See*, American Academy of Family Physicians, *Risk Management and Medical Liability*, 49(6) AM. FAM. PHYS. 1535 (1994). The ABFP recognizes that the medical record is at the core of quality health care and encourages medical record review in residency as well as in post-residency practice.
[371] The Board sets forth detailed requirements for adequate record keeping. *Id.* at 17.
[372] *Id.* at 18.
[373] *Id.* at 21.

How does this relate to spoliation of evidence and medical negligence litigation? Where this becomes important is that when a provider alters the medical record he may also violate multiple interdigitating professional regulations and be subject to professional discipline. When a licensee is subjected to loss of Board certification as a result of his conduct in a medical negligence litigation, this may trigger loss of hospital privileges and a licensure action by state authorities. In addition, if a local medical society member is subjected to discipline, the society is required under the HCQIA to make various reports. Consequently, if a Board revoked its certificate, then reports would be generated to state and federal agencies and to the hospitals where the provider had privileges. This creates a great incentive for licensed litigants to refrain from dishonest conduct.

In the field of obstetrics and gynecology, as another example of private professional regulations, applicants are certified by the American Board of Obstetrics and Gynecology and their process and certification is similar to that presented in Family Practice. Since obstetrics and gynecology is a surgical specialty, the applicant is required to document satisfactory performance in the residency program[374] and "each resident is required to keep a record of the number and type of obstetric and gynecologic procedures performed during residency to demonstrate the adequacy of their operative experience."[375] In contrast to the rigorous recertification record analysis required by the ABFP, no such requirement exists with ABOG.

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[374] AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY, BULLETIN FOR 1996 at 11 (1996). Rule # 9. Available from the American Board of Obstetrics & Gynecology, Inc. 2915 Vine St., Dallas, Texas 75204-1069, Phone: 214-871-1619.

[375] *Id.*. Rule #10.

The American Board of Surgery is composed of twenty-two nominating organizations[376] and certifies its candidates in much the same way as the two preceding organizations. This Board states that "furnishing of false information" may bar the applicant from examination or cause revocation of a certificate or other "appropriate sanction."[377] In addition, one of the requirements for certification by this Board is that the surgeon "must be actively engaged in the practice of Surgery as indicated by holding admitting privileges to a surgical service in an accredited hospital."[378] In terms of a records keeping requirement, this explicitly links this applicant into all state and federal systems even at this private, voluntary association level. Furthermore, the applicant must possess "a permanent, unconditional, unrestricted and unexpired license" and inform the board of "any conditions or restrictions" placed on his license.[379] These reciprocal licensee duties create a great incentive for the holder to refrain from medical record alteration.

As a result of this final layer of professional regulation, the provider[380] who sustains any adverse determination by Medicare, Medicaid, hospital staff, medical society, or state licensure authority with respect to medical record keeping, would be subject to additional proceedings at all levels. As illustrated by the forgoing cases, the consequences can be substantial.

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[376] THE AMERICAN BOARD OF SURGERY, BOOKLET OF INFORMATION 8 (July 1995-June 1996). Available from The American Board of Surgery, Inc., 1617 John F. Kennedy Boulevard #860, Philadelphia, PA 19103-1847.
[377] *Id.* at 25.
[378] *Id.* at 13.
[379] *Id.*.
[380] *See,* Mel Rutherford, *Small Patients, Big Legal Risks*, 57(9) RN 51 (1994) Nurses recognize that records must be retained "in its original form" and that the same policy applies to "x-rays, lab results, and other medical reports" since it "could one day be used as evidence." WESTLAW 2.

One final emphasis, too, about the professional organization memberships: Hospital credentialling hangs on these memberships in many ways, some of which elude precise articulation. There are unspoken admission requirements to these organizations. Note, too, that a practitioner who is not a member of an hospital staff, in most cases, will not be permitted to join the various managed care organizations which now deliver care to millions of Americans. Despite the "any willing provider" statutes, MCO's use the criteria of hospital staff membership as a technique to assure quality in its decision whether to accept a provider into various managed care entities.[381]

Courts may find authority in some surprising materials. For instance, in *Welsh v. United States*,[382] the federal appellate court relied upon a popular book written by a non-physician author, without the imprimatur of the medical establishment or any governmental authority. The court was much impressed with Jorgen Thorwald's *Century of the Surgeon*[383] as authoritative in support of the premise that pathology specimen examination is vital to medical practice. Without surgical pathology surgeons could only

[381] *See*, Richter v. Capp Care Inc., 868 F.Supp. 163 (D.C., Va., Nov. 1, 1994). This is the chilling tale of an orthopedic surgeon whose application was denied by a managed care health company since its threshold requirements screen out any physician who had been disciplined by a state medical board. The appellate court held that the credentialling policy did not discriminate unreasonably against the physician and it was permissible for the MCO to rely upon the conclusions of the state medical board in making its credentialling decision whether to grant the physician a preferred provider status. This scenario is chilling since, as managed care grows, there may be physicians who will become *de facto* unemployable as a consequence of disciplinary actions.

[382] 844 F.2d 1239 (1988).

[383] JORGEN THORWALD, THE CENTURY OF THE SURGEON 361-77 (1956) (detailing the crucial role pathological examination played in the late 1800's in development of modern appendectomy); See also, D. FLEMING, WILLIAM H. WELCH AND THE RISE OF MODERN MEDICINE (1954). Welsh, 844 F.2d 1239, 1247.

guess at the efficacy of their work, the court concluded, as they utilized a non-legal, non-medical, lay authority to support important legal analysis.[384]

The preceding discussion should have convinced those who require more than an empiric explanation that there is a duty for providers to create and maintain medical records and that such a duty exists at every level in medical care. This differs greatly from non-medical situations in the business or industrial world.

In a recapitulation now, the regulatory layers mandate cautious and complete record keeping. Federal authority creates obligations to make and retain records and there are similar obligations found at the state levels through Medicaid. The JCAHO is an important private factor since, due to its deeming status with Medicare, institutional accreditation by this organization is a condition precedent to Medicare certification. This requirement, consequently, serves to interdigitate all state and federal regulations with respect to record keeping obligations. The DEA imposes record keeping regulations at the federal and state levels which mandate precise record keeping for all registrants or for those who are involved even at the periphery with the manufacture, dispensing, distribution, or handling of controlled substances. State provider licensure laws, the HCQIA, and state hospital regulations knit state and federal regulations together such that there is complete mandatory reciprocity between all agencies. Finally, the professional organizations have created their own voluntary compliance with all federal, state and local rules, regulations, and national professional standards. Without membership in these

[384] This is extraordinary in the author's experience. One would not ordinarily present this sort of "authority" before the court. On a personal note, too, author found Thorwald's book impressive when he read it in sixth grade!

organizations, it would be nearly impossible for a practitioner to practice. At a minimum he would be excluded from hospital practice.

There is a duty for health care professionals to create and retain medical records for at least the statutorily mandated periods of time and there is a duty to retain these without deceptive alterations through additions or deletions. The same is true for evidence by way of x-rays, pathology specimens, laboratory test results, committee deliberation minutes, or other non-patient care records created in the ordinary course of business. Whether a private memorandum a provider makes contemporaneously with a medical event should be made part of the medical record is debatable but if the provider relies upon it to refresh a recollection, then its evidentiary importance is heightened.

One of the most important reasons for practitioners to faithfully retain records is that the records may become evidence in a medical negligence action. If it helps a practitioner's defense, then retention of the evidence is beneficial to the practitioner, but if the practitioner perceives that the evidence would inculpate rather than exculpate, the evidence could work an opposite effect and the practitioner might be tempted to spoliate. It is that consideration, where a practitioner would spoliate evidence, somehow would alter evidence by additions or deletions to the record or just makes it disappear, which will occupy the next section. To fulfill "first, do no harm" doctors must create dependable medical records. The discussion turns now to the problem of doctors who doctor the doctors' records.[385]

[385] *See also,* Burdge v. State Board of Medical Examiners, 403 S.E.2d 114 (S.C. 1991). (disciplining a physician for creating false and misleading records).

§ VII.

Spoliation of Evidence in Medical Negligence Litigation[386]

(A) GENERAL CONSIDERATIONS

If accountants may be said to "cook the books," medical professionals "doctor the records." In medical practice, it is often said that "if it's not in the record, it didn't happen" so that medical personnel, with judgment clouded by the fog of litigation, may make exculpating additions to records to show "that it did happen" or "that it did happen" in the way they might retrospectively wish. Or, when faced with the specter of an official question of medical care, the professional may attempt to make the matter disappear by destroying the record. For all of the following reasons and by way of examples, a decision to attempt to influence the outcome of litigation is a dangerous one ... at best. At worst? Read on.

Medical records become part of medical negligence litigation since they are the central evidence in support of either party's case. The Federal Rules of Evidence permit the admission of relevant medical records as a hearsay exception under "Records of

[386] A number of terms appear in the literature, all of which describe spoliation of evidence. In Medicare and Medicaid litigation one finds *falsification*. In criminal proceedings *destruction* is a common term and in other contexts as well as in medical negligence, one will find *spoliation*, *tampering*, *destruction*, *falsification*, and *altering* used interchangeably as terms with respect to changes made to evidence.

Regularly Conducted Activity."[387] Since medical records, in general, are "made at or near the time" of patient care, for the purpose of caring for the patient, pursuant to many regulations, and all providers rely upon them as authoritative, they are the best evidence of events which tend to fade in memory. All health care providers believe that medical records are accurate.

The true incidence of spoliation in medical negligence litigation is unknown but trial lawyers describe it as a common occurrence. Mr. Lewis Laska[388] of Nashville, Tennessee publishes *Medical Malpractice Verdicts, Settlements & Experts*,[389] which is a compendium of verdicts and settlements throughout the United States. Attorneys send their reports to the reporter and Mr. Laska publishes the information. Mr. Laska provided the author with twenty-six cases in which the records had been altered and where the case was either tried or settled. In the two year period, 1994-1995, which his summary covered, there were approximately 4440 medical negligence cases. Due to the obvious reporting biases involved here, no valid statistical data could be drawn with respect to a national incidence in medical negligence cases other than to state that in this reporting group the incidence was about 0.6% of the reported cases.[390]

The law firm of Pegalis & Wachsman, of Great Neck, New York, surveyed 1,000 medical negligence suits[391] and discovered that in 26% of cases, obstetrician negligence

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[387] FED. R. EVID. 803(6). For other applicable exceptions, consult any evidence treatise.

[388] The author gratefully acknowledges Mr. Lewis Laska, Attorney at Law of Memphis, Tennessee for his contribution to this project. According to Mr. Laska, his reporter is the "nation's only jury verdict reporter." Mr. Laska may be reached at: 901 Church St., Nashville, TN 37203-3411; Phone: 800-298-6288.

[389] [hereinafter, MMVSE].

[390] Mr. Laska reported 26 alteration cases ÷ (about 185 cases/ mo. X 24 months =) 4440 cases = 0.0058 or 0.6%.

[391] *Survey Shows That Negligence By Obstetricians Is Biggest Cause Of Medical Malpractice Lawsuits*, PR NEWSWIRE, Dec. 1, 1992.

was "unquestionable" and that in 8% of these case "it appears as if the medical records were forged in an attempt to cover-up the physician's or the hospital's negligence. Moreover, in an additional 12% of cases, malpractice victims were lied to when they asked their doctors about the cause of death or injury." According to Dr. Harvey Wachsman, a neurosurgeon and an attorney, his survey showed "that fewer than 1 % of the doctors being sued for malpractice had been subjected to disciplinary action by their state licensing boards and approximately 0.05% had actually had their licenses revoked as a result of their negligent behavior." Dr. Wachsman[392] further noted that his statistics were consistent with other malpractice studies by Harvard University and the State of California.

In a frustrating search through the MEDLINE databases, there was very little with respect to accuracy in the medical record, medical record alterations or falsifications, or discipline of health care professionals for medical record falsification but one study did address scientific misconduct in nursing. Hawley and Jeffers discussed the problem with nurses who falsify records.[393] The authors looked at deviations from ethical standards such as plagiarism and record falsification. In another study of a more directly clinical

[392] *Id.*. According to the article, "Pegalis & Wachsman is the largest law firm in the country representing victims of medical malpractice and their families. Dr. Wachsman is a member of the Congress of Neurological Surgeons, is licensed to practice medicine in eight states and is a member of numerous professional medical organizations. He has been an attorney since 1976, is admitted to the bar in seven states and is an adjunct professor of law at St. John's University School of Law and Brooklyn Law School. Dr. Wachsman is president of the American Board of Professional Liability Attorneys, has written extensively and is co-author of 'The American Law of Medical Malpractice', the definitive four-volume text on the subject."

[393] D. J. Hawley & J. M. Jeffers, *Scientific Misconduct as a Dilemma for Nursing*, 24(1) J. NURSING SCHOLARSHIP 162 (1992).

nature than the previous one, *Self-Report Versus Medical Record Functional Status*,[394] the authors discovered that there was a record deficit in 10% of the studied records where there was no record of the studied parameters, and when the authors looked at particular other clinical parameters, the deficiency varied between 20-50%. Under ideal circumstances the documentation would have been 100% for all records. What this says about the accuracy of clinical records is unclear but it raises the reasonable suspicion that clinical records are variable in their accuracy and perhaps dangerously unreliable. This further supports the general empiric clinical impression that medical records contain many mistakes and omissions. So far as this author knows no study has addressed the whole issue of medical record accuracy.

Medical records are vulnerable to alteration. Record tampering[395] may occur in the physician's office, in the hospital, or, as sometimes is the unfortunate case, at the defendant physician's attorney's office.[396] To paraphrase the poem, record alteration appears in many forms, just "let me count the ways." For instance, a practitioner may mis-state the site of an injection, confusing right for left;[397] or the record could reflect

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[394] R. B. Burns, *et al.*, *Self-Report Versus Medical Record Functional Status*, 30(5 Suppl.) MEDICAL CARE 585 (1992).

[395] The author is reminded of a scene from the 1996 movie, Jane Eyre, in which Jane remarked to Mr. Rochester that she achieved the full effect in her drawings as a result of manipulating both "shadows and light." This is also true in a medical record analysis. One finds remnants of the medical care, not an actual real-time record. Literary student, Ms. Heather Bossler pointed out that the *quote* in the movie was a distortion from the original manuscript. Apropos the topic of record falsification, there is no reference to "shadows and light" in the Brontë version. *See* CHARLOTTE BRONTË, JANE EYRE 130-132 (Oxford University).

[396] *See*, Oppenheim, 6 OHIO TRIAL 7, 7. *See, also*, Donald L. Gibson, *Putting The Medical Malpractice Puzzle Together*, 10(7) VERDICTS, SETTLEMENTS & TACTICS 226 (1990). (discussing the importance and significance of the medical record. This was written by an experienced trial attorney).

[397] Kiriak v. Dudukgian, Los Angeles County Superior Court, Case No. BC 020 004. Reported in 10(1) MED. MALPRACTICE SETTLEMENTS, VERDICTS & EXPERTS 32 (Jan. 1994). Defense verdict where plaintiff alleged alteration of office notes. The author thanks Mr. Lewis Laska, of Nashville, TN, publisher of MMSVE, for obtaining the following trial court information from his databank.

patient benefit when the opposite was true;[398]or the record may be created so that blame is shifted from the doctor to a child's mother;[399] or the record may reflect that different pieces of equipment were used when they were not;[400]or a hospital agent may add witnesses to a consent form when none were present.[401] Most alterations, though, consist of simple after the fact additions, deletions, or substitutions.

In this author's experience in numerous medical negligence cases where alteration arose, physicians alter records commonly when they dictate the discharge summary in the privacy of a cubicle in the physician's lounge or even in a phone-booth located in the medical records department. The physician has access at that time to the original record and all standard forms the hospital uses in medical record keeping. Typically, if inclined to do so, at that time the physician has custody of the full record and could add, delete, or substitute documents at will. If a hospital supplies pens for the physicians, he may even be able to match perfectly the actual ink used for various entries. He needn't sign out the record; they are neatly piled in his "to do" box. In a physician's own office setting, where he has complete control over every aspect of the record, the only limitations which exist to prevent record spoliation are the ones the physician imposes on himself.

In an editorial entitled *Doctors And Hospitals Must Take Responsibility For Their Mistakes*, trial lawyer of eighteen years, Mr. Richard Rogers of Portland, Oregon wrote,

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[398] Anderson-Baker v. LeMasters, Maricopa County Superior Court, Case No. CV 93-01910. Reported in 10(2) MED. MALPRACTICE SETTLEMENTS, VERDICTS & EXPERTS 16 (Feb. 1994). $1 million settlement.
[399] Kochan v. Nagel, *et al.*, Cook County (IL) Cir. Ct. No.: 88 L 12558. Reported in 10(3) MED. MALPRACTICE SETTLEMENTS, VERDICTS & EXPERTS 32 (March 1994); $2.75 million settlement.
[400] Knapp v. St. Mary's Hospital, *et al.*, Palm Beach County (FL) Cir. Court. Reported in 10(4) MED. MALPRACTICE SETTLEMENTS, VERDICTS & EXPERTS 27 (April 1994). $10.8 million settlement.
[401] LaCroix v. Denton Regional Med. Ctr., Denton Co. (TX) Dist Ct. Case No.: 92-40026-362. Reported in 10(11) MED. MALPRACTICE SETTLEMENTS, VERDICTS & EXPERTS 6 (Nov. 1994); $10.3 million jury verdict.

> What I have seen time and again are cases of clear-cut malpractice where doctors and hospitals have refused to admit their wrongdoing and have "doctored" the records to cover up their malpractice. This destruction and falsification of medical records have become so widespread that handwriting and ink specialists must now be consulted frequently in medical cases. The fact is, doctors and hospitals ... make mistakes ... result[ing] in a patient's death or a lifetime of disability and suffering. When patients seek compensation for these tragedies, they're only asking that health-care professionals be treated the same as the rest of us and that they accept responsibility for the consequences of their mistakes.[402]

In an even more heated and flagrant context than Mr. Roger's observation consider this report which appeared in *The Record, Northern New Jersey* on Christmas Day, 1992.[403] Here, on the day following doctor Dennis G. Kleinman's rape conviction, the victim sued both the doctor and the hospital where the rape occurred. In the criminal trial, the woman testified that "Kleinman sedated her, raped her, and sedated her a second time during what was supposed to be a treatment to alleviate chronic pain from a 1990 automobile accident." In his medical records, though, "Kleinman never indicated the dosage of pain killer and sedative given to the woman the day of the alleged assault and that he admitted falsifying medical records to indicate a nurse was present throughout the procedure."[404]

There are also instances of third-party spoliations like the one reported by the *Fresno Bee*. This was an instance where, as the decedent's children were preparing to file a medical negligence action in connection with their father's death, the funeral home cremated the body prior to autopsy.[405] This is not unlike the negligent spoliation of

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[402] Richard Rogers, *Editorial: Doctors And Hospitals Must Take Responsibility For Their Mistakes*, PORTLAND OREGONIAN, 1993 WL 6918483, June 7, 1993, at B6.
[403] Mary Jo Layton, *Malpractice Suit Filed Against Doctor Convicted of Rape Woman also Name Englewood Hospital*, REC. N. N.J., 1992 WL 9470851, Dec. 25, 1992, at B02.
[404] *Id.*.
[405] *Erroneous Cremation Alleged in Complaint Filed by Man's Family*, FRESNO BEE, October 14, 1994, Home Section at B4.

evidence cases of *Velasco* and *Shimanovsky*. Again, though, in negligent spoliation cases as with a case where the evidence modification would be easily detected and the facts would be certainly revealed, but where the deception lacked a specific intent to deceive component, obvious spoliation presents little litigation problem in terms of pure detective work. It is at the fringes of intentional and negligent spoliation where the problems crop up and it is in those instances where the attorney must have a full regiment of technical knowledge at her command.

There are few rules as to precisely when, at what time in the course of medical care, that medical records must be created. This is a professional custom and habit. There are no rules which state that a physician must write the history and physical at any particular time but there are hospital policies and rules which require that the history and physical is on the chart prior to surgery. On the other hand, in the case of an emergency surgery where life is more important than the completion of formalities, the history and physical may be written after surgery, after the surgeon knows the bottom-line. The potential for corruption is obvious.[406]

Hospital regulations may require progress notes on every patient, every day, but if the doctor forgets, and the nurses remind her to create the progress notes for three days, these notes may be simultaneously written, reflect three visits, but obviously do not reflect contemporaneous impressions. The same is true for in-hospital disasters:

[406] A recent case still in litigation presented a curious challenge. A surgeon dictated a very insightful consultation note which, on the surface, seemed to be flawless in its factual analysis of the patient's problem. He listed a differential diagnosis of an intraabdominal problem: either ruptured appendicitis, ruptured duodenal ulcer, or a ruptured diverticulum. Then, in surgery the next day, the surgeon found one of the clinical diagnoses he cited in his consultation; a ruptured appendix. The surgery began at 10:00 AM and concluded at 11:10 AM. Not only did he dictate the the operative report at the end of surgery, but he also

hemorrhage, dehiscence, acute chest pain, cardiac arrest, pulmonary emboli, post-operative strokes. It is not at all unusual that the notes would be written or dictated hours or even days after the fact. Unless the writer indicates when the entry is made, this practice is nearly impossible to detect.

In general, the history and physical should be written or dictated immediately following the admission to the hospital. The same is true for operative reports, consultations, and discharge summaries. Any deviation from contemporaneous record creation may imply greater inaccuracies than might exist if the document were created contemporaneously.[407] Little, insignificant variations, in all likelihood signify no irregularity and fall well within all accepted medical standards. However, an operative report or discharge summary dictated six months after surgery or discharge, after the surgeon or the doctor knows that a medical negligence case is threatened, is highly suspect for factual inaccuracies. In all respects in this challenging area, medical and forensic experience is critical to the analysis of these documents. Often, spoliation "is in the eyes of the beholder."

For illustrative purposes, discussion of the spoliation cases in medical negligence litigation begins with a case of medical care gone sour in *People v. Klvana.*[408] This represents the worst case scenario, involving a "medical monster" convicted of the murders of nine patients. He was also convicted of multiple counts of preparing false

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dictated the consultation note from the *day before* where it seemed as if he accurately predicted the intraoperative finding!

[407] For a full discussion of this, *see,* Elliott B. Oppenheim, *The Medical Record Explained, 6 OHIO TRIAL 7 (1995).*

[408] 15 Cal. Rptr.2d 512 (1992). This case *defies belief* and represents a worst case scenario of an errant physician who went from bad to deranged.

insurance claims and of other acts of dishonesty and perjury. In cases such as *Klvana*, though, once the attorney knows about egregious conduct, he would not be very surprised to discover even more in a medical negligence litigation involving this defendant. In an instance such as with *Klvana* the attorney would expect evidence tampering and be on guard for its detection.

It is in the subtle cases where the going gets tough; cases where the practitioner has never been sued, where the doctor is prominent in the community and for all external appearances, "he would never do such a thing" as alter evidence, that significant alterations take place. It makes an impression that in times of stress, many of the *best* doctors, when the specter of a medical malpractice suit raises its head, will doctor their records. None of these cases follow a clean line of either intentional or negligent spoliation of evidence, rather the courts seem to fret little over such theoretical distinctions, preferring to examine the degree of harm inflicted by the spoliating party. The court then creates an equitable remedy.

How courts deal with the spoliation depends upon a number of factors which will be highlighted later. Discovery sanctions could include monetary or non-monetary penalties which are intended to compensate the injured party for discovery costs, the cost of reconstructing evidence, and attorney's fees. Non-monetary sanctions might include total exclusion of evidence, deeming certain facts as established, dismissing the action completely, entering a default judgment, or holding the offending party in contempt.[409] Courts tend not to punish non-party spoliators unless they exhibit culpable conduct.

(B) FUNDAMENTAL CASES

There are many instances which include spoliation of evidence in medical negligence litigation but the basic model is simple and others represent variations on the theme. Evidence may be unavailable, for whatever reason, or tampered with by additions or deletions. To begin with, the ones presented next either typify or exemplify conduct. The cases at the margins come second.

(i) Inability to Produce Original Records

One of the earlier exemplary spoliation of evidence cases in medical negligence litigation was *Thor v. Boska*[410] where the plaintiff sued for failure to diagnose and treat breast cancer in a timely manner. The defendant was unable to produce his original records, and according to him, he recopied her original records for her subsequent treating physician. As to the originals? He could "only assume that they were thrown away."[411] What rights does this loss influence?

In its opinion in *Thor* the California Appellate court tried to rectify "a miscarriage of justice."[412] The court concluded that 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."[413] At the trial level the judge would not permit admission of the fact that the defendant lost his original record as too prejudicial to outweigh the probative value.

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[409] CASAMASSIMA at WESTLAW 4.
[410] 113 Cal. Rptr. 296 (1974).
[411] *Id.* at 297.
[412] *Id.* at 301.
[413] *Id.*.

In instructive dicta, in this instance, the court sought evidentiary principles from both Wigmore and McCormick for its analysis.

> 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, [t]hat 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, [a]gainst the whole mass of alleged facts constituting his cause.[414]

The court continued with Professor Wigmore's views. "But so far as a spoliation or suppression partakes of the nature of a Fraud it is open to the larger inference already examined namely, a consciousness of the Weakness of the whole case."[415]The opinion then cites Professor McCormick who "agrees that the proponent of such evidence ... should be entitled to an instruction that 'the adversary's conduct may be considered as tending to corroborate the proponent's case."[416]

Finally, here, the court invoked the principle of *Haft v. Lone Palm Hotel*[417] which stands for the proposition that an innocent plaintiff should not be denied recovery when the defendant caused the accident and the defendant's negligence has made it impossible for the plaintiff to prove proximate causation. Further, this requires the defendant to prove that it was his negligence which did not cause the accident.

Another case sheds light on this question of rights. In *Cherovsky v. St. Lukes's Hospital,*[418] decided for the defendant, plaintiff sued for unnecessary surgery after the

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[414] *Id.*. (citing 2 Wigmore § 278 at 120 (3d ed. 1940)).
[415] *Id. (*Wigmore § 291, 187)).
[416] *Id.*. (citing MCCORMICK ON EVIDENCE § 273, 661-62, n.70 (2d ed. 1972)).
[417] Haft v. Lone Palm Hotel, 478 P.2d 465 (1970).
[418] Cherovsky v. St. Lukes's Hospital, No. 245197, 1995 WL 739608 (Ohio App. 8 Dist. Dec. 14, 1995). (unpublished opinion).

defendant removed her right lung purportedly for cancer. In the course of a work-up for a lung lesion, Ms. Cherovsky sought care from a pulmonologist who performed a bronchoscopic lung biopsy. There were five slides made and the diagnosis was based upon review of those five slides. The pathologist read the slides as "well-differentiated adenocarcinoma." When the surgeon performed a thoracotomy, cancer was found only in a microscopic focus of 1.6 cm "with no evidence of metastasis." Plaintiff sued, alleging that she did not need pneumonectomy, that a lobar resection would have been sufficient. Soon after filing suit, the plaintiff discovered that four of the five slides upon which her original diagnosis was based were missing and she added a new claim for spoliation of evidence.[419]

At trial, the plaintiff lost. The jury did not find that the pathologists "or St. Luke's willfully destroyed biopsy slides with knowledge of pending or probable litigation and with the intent to disrupt the case."[420] The defense pathology expert testified that "that pathology slides frequently become lost or misplaced and it is a common occurrence for slides to be missing, especially at a teaching hospital like St. Luke's."[421] The plaintiff claimed that the absent slides would have confirmed the misdiagnosis and these missing slides remained a theme throughout the trial.

The undisputed evidence demonstrated that the biopsy slides disappeared about a week after surgery, well before the defendant knew that there may be litigation, and after "intensive search" they could not be found. Their disappearance was unusual and a departure from St. Luke's customary policies and procedures. Slides were customarily

[419] 1995 WL 739608 at WESTLAW 1.
[420] *Id.* at 2.

retained for 20 years and tissue blocks for 5 years. Defendants offered various explanations why slides are lost: "the pathology department at a major teaching hospital will handle thousands of slides; someone removes a slide and forgets to return it; it is misfiled; misplaced at a committee meeting; or sent out for consultation."[422] The judge then concluded that despite these possible explanations, "there was no evidence that these events caused the loss."[423]

The trial court refused to instruct the jury that the plaintiff was entitled to an unfavorable inference due to the loss of this critical evidence and the appellate opinion sustained the trial court. In reaching its opinion, the appellate court centered on the fact that the evidence introduced at trial did not support the instruction since the instruction assumes that at the time of trial the slides were under the defendant's control and in their custody. What was dispositive in this instance was that the slides disappeared a week after surgery, long before the plaintiff considered suit.

This was the proposed jury instruction:

> If a party fails to produce evidence which is under his control and reasonably available to him and not reasonably available to the adverse party, then you may infer that the evidence is unfavorable to the party who could have produced it and did not.[424]

While the plaintiff relied upon the 1882 axiom from *Pomeroy v. Benton*: *omnia praesumuntur contra spoliatorem*,[425] the Ohio court reasoned that the rule of *Pomeroy* was inapplicable under the facts in the instant case. It reasoned the following way:

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[421] *Id.*.
[422] *Id.*.
[423] *Id.* at 2-3.
[424] *Id.* at 4.
[425] "All things are presumed against a wrongdoer." Pomeroy v. Benton, 77 Mo. 64 (1882).

> The unexplained failure or refusal ... to produce relevant and competent documentary evidence ... authorizes ... an inference or a presumption unfavorable to such party. ... Further, it must appear that there has been an actual suppression or withholding of the evidence; no unfavorable inference arises where the circumstance[s] indicate that the document or article has been lost or accidentally destroyed, or where the failure to produce it is otherwise properly accounted for.[426]

The court further determined that the omission must prejudice the harmed party's interests and in the absence of "intentional destruction or suppression of the slides" the court was unwilling to find any liability for loss of this crucial evidence.[427]

Brown v. Hamid[428]represents an instance in a medical negligence litigation where The Missouri appellate court sustained a trial court's ruling that admission of evidence with respect to missing medical records was collateral to the main medical negligence case and hence would confuse the jurors. The judge commented, "We're here to try a medical malpractice case, not try to figure out what happened to some records."[429] In the instant case, in contrast to *Smith*, where the defendant promised to retain evidence for the plaintiff's use, and in comparison to *Pharr v. Cortese*,[430] where presence of the evidence made little or no difference to the plaintiff's ability to move forward, this court made no finding that the defendant physician spoliated. The judge decided that the reason for loss was "unknowable."[431]

The court concluded that the spoliation of evidence doctrine applies only where there has been intentional destruction which would indicate fraud and a desire to suppress

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[426] *Id* at *4.* (citing 31-A C.J.S. Evidence § 156(2) 401-02).
[427] *Id*..
[428] 856 S.W.2d 51 (1993).
[429] *Id.* at 56.
[430] Pharr v. Cortese, 559 N.Y.S.2d 780 (1990).
[431] Brown, 856 S.W.2d 51, 56.

the truth.[432] "Destruction of evidence without a satisfactory explanation gives rise to an inference unfavorable to the spoliator."[433] But in the *Brown* case, there was no such finding and the court affirmed the lower court's ruling on the spoliation of evidence claim.

The *Brown* court then turned to the duty to retain medical records, finding persuasive the Florida court's holding in *Bondu v. Gurvich*.[434] In contrast to *Bondu*, however, Brown was not prejudiced in her ability to bring her case. Missouri enacted a statute after *Brown* was filed which would have affected the statutory duty in Missouri to keep and retain records,[435] but the court held that patients have a common law right "to inspect and copy [their] ... medical records.[436] If a patient has a duty to inspect her own records and does not take advantage of that duty, then the courts are in no position to restore what the patient had the duty to obtain.

The next case is *Welsh v. United States*[437] where the decedent succumbed to *Escherichia coli* meningitis at a Veteran's Administration Hospital in Kentucky. The Sixth Circuit Court of Appeals upheld the bench trial award of $606, 000. Crucial to the case at both the trial and appellate levels, was the fact that the defendants destroyed evidence. The appeal centered on the effect this conduct should have on the plaintiff's burden of proof. The appellate tribunal concluded that the defendants were negligent when they destroyed a skull bone flap after a second operation and that they departed

[432] *Id.* at 56. Relying on Moore v. General Motors, 558 S.W.2d 720, 733 (Mo.App.1977).
[433] *Id.*. Under the authority of Garrett v. Terminal R. Ass'n of St. Louis, 259 S.W.2d 807, 812 (Mo.1953).
[434] *Id.*. 473 So.2d 1307, 1313.
[435] *Id.*. House Bill 925, § 1, Laws Mo.1988, at 637.
[436] 856 S.W.2d 51, 57. (citing Thurman v. Crawford, 652 S.W.2d 240, 242 (Mo.App.1983)).
[437] Welsh v. United States, 844 F.2d 1239 (1988).

from acceptable standards of care when they failed to submit the flap for pathological evaluation. Also at issue were missing records which would have documented some disputed clinic visits. The appellate court affirmed the trial judge's application of a "rebuttable presumption" of negligence in order to cure the defect of the missing evidence, creating a "middle ground."[438]

In applying Kentucky law,[439] the federal court noted that the surgeons "elected to discard the skull flap" which would have permitted further clinical testing.[440] All operative specimens must be sent to pathology unless any of six exceptions applies under JCAHO guidelines.[441] In arriving at its decision, the court reasoned that

> [o]ne can conceive of cases in which mere negligent destruction of bone or tissue might violate medical standards but have no significant legal effect ... In Mr. Welsh's case ... the medical purpose and ... evidentiary purpose[s] were identical. The outcome of the pathological examination would have proven or disproven the crucial fact at issue-the duration and cause of the infection.[442]

The court then drew an adverse inference about the loss of this evidence. Drawing inferences adverse to the defendants when the defendant is unable to produce evidence is well founded in Kentucky law.[443] Here, the Appellate Court affirmed the lower court's determination that the "VA surgeons' act of discarding the skull flap was, if not

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[438] *Id.* at 1249. The court concluded the effect of a "rebuttable presumption occupies a middle ground-it neither simply condones the defendant's negligent spoliation of evidence at the plaintiff's expense nor imposes an unduly harsh and absolute liability upon a merely negligent party." *Id.*.

[439] *See*, Erie R.R. v. Tompkins, 304 U.S. 64 (1938).

[440] *Id.* at 1243.

[441] *Id.*. (citing ACCREDITATION MANUAL FOR HOSPITALS 130-31 (1980 ed.)).

[442] *Id.* at 1244.

[443] *Id.* at 1245. (citing Electronic Sales Engineers, Inc. v. Urban Renewal & Community Development Agency, 477 S.W.2d 814, 816 (Ky.1972) (plaintiff's failure to produce its employee who had custody of lease justifies presumption her testimony would be adverse); Welch v. L.R. Cooke Chevrolet Co., 236 S.W.2d 690, 691-92 (1950) (adverse presumption against bailee when it failed to produce its ex-employee who was only witness to fire); Rice v. Rice, 50 S.W.2d 26, 30 (1932) (inference created by a letter confirmed by failure to call its author); C*f.* Whitcomb v.. Whitcomb, 267 S.W.2d 400, 402 (Ky.1954) (adverse presumption unwarranted when uncalled witness was expert equally available to both parties).

intentional, at least seriously negligent"[444]observing further that "an adverse presumption may arise from the fact of missing evidence."[445] The court concluded by observing that "at least two state appellate courts have endorsed the creation of a rebuttable presumption that would shift the burden of persuasion to a health care provider who negligently alters or loses records of medical care."[446]

Fetal monitor strips represent an important contemporaneous record of labor but, frequently, it seems, they are lost.[447]The following Texas cases illustrate how Texas courts have handled the problem. After her child died two days after birth, the mother sued, *Arredondo v. Hillard*,[448] and the trial court granted summary judgment to the defendants. The Texas Court of Appeals in considering the *Arredondo* matter held that no evidence supported her fraudulent concealment claim which she based upon the hospital's refusal to produce fetal monitor strips.

The Texas Supreme Court has not established whether the doctrine of fraudulent concealment operates to toll the running of limitations in wrongful death cases.[449] Here, the plaintiff averred that the hospital turned the fetal monitor away from the mother's view, refused to answer her questions about fetal distress, would not show her the monitor strips, and then failed to produce the strips after litigation commenced. This conduct, she asserted, constituted fraudulent concealment but the Texas court disagreed.

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[444] *Id.* at 1244.
[445] The court stated that "the 1722 principle of Armory v. Delamirie remains good law." *Id.* at 1245.
[446] *Id.* at 1246-47. *See,* Public Health Trust v. Valcin, 507 So.2d 596, 599-601 (Fla.1987). (negligent loss shifts burden to create jury question on negligence), modifying 473 So.2d 1297 (Fla.Dist.Ct.App.1984); Thor v. Boska, 38 Cal.App.3d 558, 569 n. 8, 113 Cal. Rptr. 296, 303 n. 8 (1974) (dicta); see also Barker v. Bledsoe, 85 F.R.D. 545 (W.D.Okla.1979) (negligent destruction of autopsy materials by expert hired in advance of litigation warrants more than rebuttable presumption).
[447] An example in law of "love's labor lost."
[448] Arredondo v. Hillard, 904 S.W.2d 754 (1995).

The court stated that the mother "was cognizant of the possibility of problems with the birth procedures" and would not excuse her untimley filing, thereby dismissing her action. The court further analyzed, "[t]he inability to obtain medical records does not, in and of itself, establish fraudulent concealment. Nor can loss of some of a person's medical records be evidence of a wrong."[450] In cautionary tones, the court concluded, "Arredondo had over 23 months from the date of the alleged negligence ... to sue even if the two-year limitations period had not been tolled. ... The record discloses that she was aware of a potential claim [on] the date of death."[451]

The plaintiff also lost in *Brewer v. Dowling*,[452] as the Texas Appellate Court affirmed the trial court's ruling that the plaintiff was not entitled to a jury instruction that the defendant's failure to produce fetal monitor strips created a rebuttable presumption that the information would have been unfavorable to the defendants. After a troubled delivery, the defendant physician attempted to review the monitor strips but they had disappeared. Both a physician and a nurse testified that the missing strips "showed nothing that would alert them to a problem" but that neither knew what happened to the strips.[453]

The plaintiffs contended that they were entitled to this instruction since every expert witness stated that those strips would have been the best evidence of what happened to the patient and the missing evidence was crucial to the plaintiff's objective

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[449] *Id.* at 758.
[450] *Id.*.
[451] *Id.* at 759.
[452] 862 S.W.2d 156 (1993).
[453] *Id.* at 157-58.

ability to prove the negligence.[454] The Appellate Court reasoned that the instruction was not necessary for the jury to reach its verdict. Under Texas law, when a party fails to produce evidence within his control, the presumption is that "if produced it would operate against him and every intendment will be in favor of the opposite party."[455]

Here, the plaintiff's expert testified "it was highly likely that the heart monitor strip would have shown fetal distress" followed by the defense expert who testified contrary to that position. The plaintiff was hampered without the strips even though there was some medical evidence which reflected conclusions drawn from the strips. Since the plaintiff had this conclusory information, substitute evidence for the strips, the plaintiff really was not prejudiced and, ruled the court, no presumption was warranted. Notice here an important inconsistency which the court did not consider. While at the time the defendants created their conclusions there was no impending litigation but it would be entirely probable that even at that time that the defendants would most favorably interpret what they saw on the strips.

Another Texas rule states that the "intentional spoliation of evidence relevant to a case raises a presumption that the evidence would have been unfavorable to the cause of the spoliator."[456] Here, again, the plaintiff offered no evidence that the defendants committed any intentional act. The strips were missing, nothing more.[457] In Texas, the plaintiff has a right to have the "jury make certain inferences in a situation where the hospital destroys evidence," but this does not apply where the evidence is lost. The

[454] *Id.*.
[455] *Id.* at 158-9.
[456] *Id.* at 159.
[457] *Id.*.

plaintiffs were permitted to place before the jury the facts that the strips were lost and the jury could weigh the evidence along with all other evidence in their deliberations, the court rationalized. The court stated, "[w] e will not infer spoliation or destruction of the strip-intentional or otherwise-from the mere fact that it is missing." The Texas court concluded its analysis by pointing out that Texas does not recognize the independent tort of spoliation of evidence.[458]

The dissent opinion was written by retired Justice Clyde Ashworth who sagely observed that "[t]he majority would impose ... the impossible burden of showing an intentional destruction or loss of the records-such a burden could rarely be met and to make it a requirement avoids the realities of life."[459] Justice Ashworth further addressed the problem with missing evidence and recommended the adoption of the opposite policy. Proper instructions on the loss of the evidence, he wrote, "may have the effect of more diligent and complete search for missing essential documents."[460]

Mr. Darrell Keith, an experienced trial attorney and the Brewer's attorney at both the trial and appellate levels, commented[461] that it would be an almost impossible feat to have a defendant testify that it intentionally destroyed or otherwise made evidence unavailable. He also emphasized that in states where there is no tort of spoliation of evidence, that judicial discretion with respect to jury instructions may be subject to particular judges' political affiliations and alignments. He emphasized, "as a consequence of this wrong and unfair decision, the people of the State of Texas are left with a badly

[458] *Id.* at 160.
[459] *Id.* at 161.
[460] *Id.*. at 162.

brain-damaged baby and an indigent mother and father while the hospital and doctors escape liability for their conduct."

Mr. Keith was frustrated in his attempt to influence the Texas court to adopt a similar position as Mississippi in this action[462] where he referred to the Appellate Court to the Mississippi case of *DeLaughter v. Lawrence County Hospital*.[463] *DeLaughter* was an obstetrics medical negligence action which bore similarities in regard to the presumption issue before the Texas court in *Brewer*. In arguing that Texas adopt the presumption in *Brewer*, the plaintiff cited "numerous out-of-state and federal cases that permit the presumption they claim exists" which required the instruction.[464] In addition to Texas, the plaintiff urged the court to follow decisions from Mississippi, Florida, Maryland, and Arkansas. Despite this weight of authority, the Texas court refused the instruction "because the presumption of unfavorable evidence was not raised."[465]

Justice Ashworth discussed *DeLaughter* at length in his dissent finding this case to be the preferred position.[466] In the Mississippi matter, the hospital impounded the decedent's hospital medical records with "instructions that they should not be examined by the family of the decedent." At a time when the records were to be provided to the decedent's family, the records had disappeared. The plaintiff sought three jury instructions with respect to a presumption arising from the disappearance of the records.

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[461] Telephone Interview with Mr. Darrell Keith, trial attorney of Fort Worth, Texas, (11 April 1996). The author acknowledges Mr. Keith's efforts in assisting with the preparation of this section.
[462] *Id.*.
[463] 601 So.2d 818 (Miss.1992). Brewer, 862 S.W.2d 156, 160.
[464] Brewer, 862 S.W.2d at 160, n.5. ("*See* Carr v. St. Paul Fire & Marine Ins. Co., 384 F.Supp. 821, 831 (W.D.Ark.1974); DeLaughter v. Lawrence County Hosp., 601 So.2d 818, 821-22 (Miss.1992); Public Health Trust of Dade County v. Valcin, 507 So.2d 596, 600 (Fla.1987); Grier v. Rosenberg, 213 Md. 248, 131 A.2d 737, 740 (1957); Miller v. Montgomery County, 64 Md.App. 202, 494 A.2d 761, 768 (1985)").
[465] *Id.*.

At the trial level, in *DeLaughter*, the trial court denied the instruction but on appeal "such refusals were held to be proper because they created an impermissible, irrebuttable presumption of negligence, permitted an inference that negligent treatment was contained in the missing records, and shifted the burden of proof."[467] Justice Ashworth noted that Texas is not bound by Mississippi law but found the principles sound and "subject to adoption" by Texas.[468]

Another lost fetal monitor strips case, *Hunter v. Skaggs Community Hospital*,[469] presents a different view with respect to hospital liability although the parties reached settlement for an undisclosed amount. In this Missouri case, the mother sustained premature rupture of the membranes at thirty-two weeks of gestation and the doctor admitted her to a community hospital which did not have a neonatal ICU or a neonatologist who could administer and monitor tocolytics. The doctor assured the patient that this facility could provide care equivalent to the larger center located thirty-three miles away.

The doctor then ordered continuous fetal monitoring "if possible"[470] and the nurses noted that the FHT's ranged in the 80's to 90's. The child was badly injured in this process and sustained cerebral palsy, spastic quadriplegia, functioning cognitively at an eighteen to twenty-four month old level. In discovery the hospital admitted that it destroyed the fetal monitor strips.

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[466] *Id.*.
[467] *Id.*.
[468] *Id.*.
[469] Christian County (MO) Cir. Ct., Case No. CV194-604CC (filed 24 July 1994). Reported in 12(3) MED.MALPRACTICE VERDICTS, SETTLEMENTS & EXPERTS 33 (1996).
[470] *Id.*.

Ms. Jan Y. Millington of Springfield, Missouri, who represented the plaintiff, commented:

> The loss of those strips made them look really bad and they scrambled. Their system was that the put monitor strips in a janitorial closet. When the box was full, the janitorial service disposed of the box. I asked them about what search was made. I deposed about five people trying to find the strips. The hospital admitted that the strips were a permanent part of the mother's chart. I felt the strips would have shown severe fetal distress. Inadequate record keeping, obviously, makes them look terrible. If they are unable to produce the fetal monitor strips, then the jury could conclude that the rest of the care was terrible.[471]

In this case, there was no culpable guilty hospital conduct, just "bad housekeeping" but the potential effect before the jury became an important factor for the defendants' settlement analysis. There is another point to be made with respect to the defense of a suit such as this. The strips could have been helpful to the defense but, since they were lost, that possibility was lost with them.

When records are merely lost, with no trace, no attached blame, which party should bear the burden? Is it fair for an injured plaintiff to suffer? Or, in the alternative, as the Texas interpretations would suggest, is it preferable for the defendants to escape liability?

(ii) Additions to the Record

The *New York Law Journal* [472]reported a medical negligence action, *Pharr v. Cortese*, [473] in which the plaintiff alleged a failure to diagnose breast cancer in a timely manner. In *Pharr*, the New York approach was similar to the Texas approach in *Brewer*.

[471] Telephone Interview with Ms. Jan Y. Millington, trial attorney, of Springfield, Missouri (3 April 1996).
[472] Alan Kohn, *Judge Refuses To Recognize Claim Altering Evidence*, N.Y.L.J., July 13, 1990, at 1 (col. 4). [hereinafter KOHN].
[473] Pharr v. Cortese, filed in Supreme Court, New York County, IA 29. Pharr v. Cortese, 559 N.Y.S.2d 780 (1990).

Here, Justice Stanley Sklar refused to permit a separate cause of action for spoliation of evidence when the plaintiff also alleged that the doctor falsified his records in order to avoid liability. "Dr. Cortese's note, written on his copy of a February 19 radiologist's report, also suggests that Dr. Cortese advised Pharr to get a biopsy but that she persisted in her refusal. Moreover, after Pharr underwent a biopsy in May, Dr. Cortese's May 20 note states "[f]inally permitted biopsy advised 2/87."[474]

According to the *New York Law Journal* article the judge reasoned in denying Pharr's separate spoliation of evidence claim that "she would have to spend 'roughly' the same amount of time and money to prove negligence, even assuming a falsification of records." The judge further stated[475] that the "spoliation claim could work 'significantly in her favor' because, if the jury believes the charge, it would likely assume the defendant was attempting to cover up his negligence."[476]

Finally, Judge Sklar noted that Pharr had misplaced her reliance on California and Florida cases where the spoliation made it difficult or impossible to prove the claims unless the cause of action was permitted to go forward. That was not present in her case. The judge also refused to follow a ruling in *Hazen* by the Alaska Supreme Court which supported the plaintiff's position. Judge Sklar felt that who was telling the truth was a jury question, but if the jury is satisfied that the physician intentionally altered his records, it "can infer that his purpose was fraudulent and that accurate medical records would have been unfavorable to his interests."[477]

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[474] KOHN.
[475] Pharr, 559 N.Y.S.2d 780, 781.
[476] KOHN.
[477] *Id.*.

In the actual case report,[478] the New York court considered the issue of whether "New York should recognize intentional spoliation of evidence as a tort when it is alleged that a physician falsified his records in order to avoid malpractice liability."[479] The court saw the role of falsification as a matter of credibility judging which the jury would be able to decide since either Pharr or Cortese was not telling the truth.[480] Pharr, however, suffered no actual damages from the spoliation of evidence.

Ms. Pharr based her argument in part on a New York statute[481] which requires physicians to create accurate records. In its refusal to create the new cause of action, the court commented that "a physician's failure to maintain accurate medical records would enable the New York State Board of Regents to bring disciplinary proceedings against the doctor, and does not give rise to a private cause of action under the facts of this case."[482]

In other litigation, according to North Carolina's Supreme Court, when a physician creates false and misleading records in the patient's chart, that was sufficient for the plaintiff to allege a civil conspiracy claim. These were the operant facts in *Henry v. Deen*,[483] where the estate's administrator spent $3,000 to investigate and collect evidence of the patient's wrongful death in a claim which arose from the physician falsifying records. An E.R. doctor evaluated the thirty-five year old patient who complained of chest pain and he reached the diagnosis of pneumonia. Mr. Henry then saw his private physician in follow-up. Part of the E.R. evaluation included a chest x-ray

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[478] Pharr v. Cortese, 559 N.Y.S.2d 780 (1990).
[479] *Id.*. Interestingly, Pharr's attorney was an adjunct professor at a law school and was unaware of intentional spoliation of evidence as a tort. Only after reading a student paper on the subject did he attempt to add the claim.
[480] *Id.*.
[481] *Id.*. (citing 8 NYCRR § 29.2(a)(3)).
[482] *Id.*.

which indicated "possible serious cardiac deterioration" and the radiologist urged a thorough evaluation of the chest condition.[484]

When the patient died from a massive myocardial infarction the estate brought a wrongful death action and it was then that the executor discovered that the defendants destroyed the private physician's medical records, obliterated portions of the record, and fabricated a record which reflected a consultation between defendants which never took place! Based upon this dishonest conduct, the plaintiff demanded punitive damages on the theory of civil conspiracy.[485]

The state Supreme Court reversed the Court of Appeals on the issue of whether the lower court erred in permitting amendment of the complaint, stating that, "[t]he gravamen of the action is the resultant injury, and not the conspiracy itself."[486] Further, the court analyzed, "to create civil liability for conspiracy there must have been a wrongful act resulting in injury to another committed by one or more of the conspirators pursuant to the common scheme and in furtherance of the objective."[487] The court viewed Deen's conduct as the civil equivalent of obstruction of justice.

In 1985 the North Carolina rule was

> This State has a policy against parties deliberately frustrating and causing undue expense ... [The statute][488] sets out the consequences for parties who refuse to allow discovery. [W]hen a party refuses to make an admission of fact or fails to make an admission concerning the genuineness of a document ... and that fact or genuineness is later proved, a trial court may award ... the costs of proving the

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[483] 310 S.E.2d 326 (1984).
[484] *Id.* at 329.
[485] *Id.* at 330.
[486] *Id.*. (citing Shope v. Boyer, 150 S.E.2d 771 (1966)).
[487] *Id.* at 334. (citing Muse v. Morrison, 66 S.E.2d 783 (1951)).
[488] G.S. 1A-1, Rule 37.

> fact.[489]... Where, as alleged here, a party deliberately destroys, alters or creates a false document to subvert an adverse party's investigation of his right to seek a legal remedy ... a claim for the resulting increased costs of the investigation will lie.[490]

The Supreme Court then remanded the matter back to the trial court where it was required to further consider the punitive damages issue.[491]

In contrast to the Texas and New York cases where there were no knowable "wrongful acts," the North Carolina court strongly reacted to a defendant who attempted to pervert the civil litigation. Additionally, in the following cases from various jurisdictions, look for "wrongful acts" but also consider this question: If the provider violates federal or state statute and professional rules which require the creation and faithful retention of records, should a defendant escape punishment when there is no harm to the litigant's case?

Paris v. Kreitz[492] was a medical negligence action concerning the diagnosis and treatment of a femoral artery thrombosis. At issue was the timing over when the treating physician became aware of certain determinative medical events and how he responded when he learned of the information. The plaintiff discovered that there was an original record which contained an handwritten note where the defendant had written, "Seen & agree- L.S. Averett, MD." This entry differed from another copy which stated, "Case discussed by phone. Seen & agree- L.S. Averett, MD."[493] The first notation, if believed, would have dramatically altered the case since, in general, physicians are not held

[489] G.S. 1A-1, Rule 37(c).
[490] *Id.* at 334-35.
[491] *Id.* at 337.
[492] Paris v. Kreitz, 331 S.E.2d 234 (N.C. 1985).

accountable in medical negligence actions when they exercise reasonable medical judgment after they fulfill their clinical obligations to physically come to the bedside. But in this case, it would have been a departure from the standard of care for the doctor to merely "phone treat" the patient.[494]

The trial court would not permit the plaintiff to amend the complaint and add a count of falsification of records[495] and the jury found for the defendants on all counts. Plaintiff appealed alleging that the physician's alteration of the records "constitutes gross negligence or wanton or willful conduct which, if proven, would entitle them to punitive damages."[496] In seeking punitive damages, under North Carolina law, plaintiffs must prove that the conduct was "wanton ... in conscious and intentional disregard of or indifference to the rights and safety of others."[497]

In sustaining the trial court, the appellate judges agreed that the defendant had altered the records, no other evidence supported the plaintiff's claim for punitive damages, and the falsification in no way frustrated their recovery.[498] Absent aggravation of the underlying conduct by the record falsification, the court would not permit punitive damages since "punitive damages can only be awarded where the underlying cause of action has been proved and a basis for compensatory damages has been established."[499] Whether *Paris* was wrongly decided will be considered later on but it does seem that,

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[493] "To see" a patient is a term of art when used in this context meaning to actually come to the bedside, take an history, physically examine the patient, and to perform laboratory testing if indicated.
[494] 331 S.E.2d 234, 238.
[495] Note that Paris' original records were kept in a locked room, accessible only for treating physicians and authorized hospital personnel. *Id.*.
[496] *Id.*.
[497] *Id.* at 241. (citing Hinson v. Dawson, 244 N.C. 23, 28, 92 S.E.2d 393, 397 (1956).
[498] *Id.* at 242-43. (i.e. "No harm, no foul").
[499] *Id.* at 243.

even in the absence of a demonstrable showing of actual prejudice against the non-spoliator, where a doctor makes a false entry which furthers his own pecuniary interests ahead of those of his patient, the courts should fashion some off-setting legal or equitable remedy. The reason is a basic one: to punish flagrant dishonesty in the practice of the profession. The opposite result is a *non sequitur*.

Juxtaposed to *Paris* nearly a decade later, and after the *Smith* case in California, is *Moskovitz* where the Ohio Supreme Court[500] in 1994 had the opportunity to consider a physician who altered medical records in order to avoid liability for his failure to diagnose and treat a malignant tumor on the plaintiff's left leg.[501]

Moskovitz vividly demonstrated the legal tail chasing involved when a record has undergone serious alterations. The spoliation greatly contributed to an award of $3 million plus pre-judgment interest and when compared to the result in *Paris*, *supra*, this court's result is more satisfying to a general sense of justice done. The court acknowledged the systemic injury to public trust and to professional ethics. After a $2 million jury award based upon the patient's pain and suffering in her last year of life, the *Moskovitz* court, in a majority opinion, reduced the trial court award by remittitur to the extent that it exceeded $1 million. The court did permit prejudgment interest and otherwise let stand the trial verdict.

The trial court, in considering the spoliation aspect, differed from the *Paris* analysis, and reasoned that intentional alteration, falsification, or destruction of medical records is sufficient to show actual malice and that punitive damages were appropriate

[500] Notice that the next several cases are drawn from Ohio courts in order to provide a variety in court interpretations.

even where the conduct caused no compensable harm. The record alterations were inextricably intertwined with the medical malpractice claim, and on that basis no requirement existed that the plaintiff show actual harm from the physician's conduct. Under *Moskovitz,* in effect, to falsify a record equals malpractice.

To pursue this in more detail, this case involved an elderly woman who sought care from Dr. Figgie. A year prior to that she had undergone an excision of a low grade dermatofibroma by another doctor. Dr. Figgie replaced Ms. Moskovitz's knee joints and in 1986 she visited him complaining about a lump on her left leg.[502] She was admitted to the hospital for a knee revision and a nurse noted the existence of a firm nodule on Ms. Moskovitz's left Achilles tendon. The mass was also observed by a resident physician and he duly recorded its presence in the medical records.

In November 1987 Dr. Figgie removed the mass which was an epitheliod sarcoma, "a rare ... malignant soft-tissue cancer."[503] Metastatic work-up revealed metastases to the shoulder and right femur. At this point Dr. Makley took over care since he was an oncologic surgeon; then the patient entered radiation therapy. Dr. Makley sent a copy of a page from Dr. Figgie's records to the Radiation Department and Dr. Figgie then sent a copy of the chart to Dr. Ashenberg. Later, Dr. Makely's secretary requested that Dr. Figgie's office return the original chart to their office but it had vanished.

In May 1988, due to the sarcoma, Dr. Makely amputated Moskovitz's leg. In October 1988 she filed a claim to investigate a potential medical malpractice claim but by December, Ms. Moskovitz died. At his deposition, Dr. Makely produced page seven of

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[501] Moskovitz v. Mt. Sinai Medical Center, 635 N.E.2d 331 (1994).
[502] *Id.* at 335.

the Figgie records, the page sent to the radiation oncology department, and plaintiff's counsel eventually obtained the whole chart from the Radiation Department, a copy they received directly from Dr. Figgie. Makely's copy contained an entry which stated: "Mrs. Moskovitz comes in today for her evaluation on the radiographs reviewed with Dr. York. He was not impressed that this [the mass on Moskovitz's left leg] was anything other than a benign problem, perhaps a fibroma. We [Figgie and York] will therefore elect to continue to observe."[504]

The other copy, from Figgie's office which was sent directly to radiology, contained a line drawn through "We will therefore elect to continue to observe.", and beneath the entry, Dr. Figgie wrote "As she does not want excisional Bx ... we will observe." Then, a September 21, 1987 entry was followed by a typewritten entry dated September 24, 1987, which stated, "I [Figgie] reviewed the x-rays with Dr. York. I discussed the clinical findings with him. We [Figgie and York] felt this to be benign most likely a fibroma. He [York] said that we could observe and I concur." Figgie then added "see above," referring to the September 21 handwritten notation indicating that Ms. Moskovitz did not want an excisional biopsy.[505]

When Dr. Figgie was deposed, a white-out had been made which left no indication that the sentence had been deleted from the original records. Dr. Figgie then claimed that he did not discover the mass until February 23, 1987 and that Ms. Moskovitz refused a work-up or biopsy. Dr. Figgie produced copies of his secretary's phone message books where one entry indicated that Ms. Moskovitz called Dr. Figgie and the entry

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[503] *Id.*.
[504] *Id.* at 336

stated, "Moskovitz, right foot, coming in today." Dr. Figgie then penciled, "Patient seen, refuses workup, left foot, workup left foot."

The log also contained another entry later that year which indicated that the patient again refused a biopsy but, controverting that refusal entry, there was another entry which stated that the patient agreed to have a biopsy. During discovery, there was another copy of Figgie's page seven, identical to the Markely record which Dr. Markely produced in his deposition. That document originated from Radiation Department at University Hospitals. What became apparent was that Figgie deleted with white-out the final sentence in his original office notes sometime between November 1987, when Radiation obtained the chart, and mid-December of that year, when Dr. Ashenberg received the chart. On a more probable than not basis, the alteration occurred when Dr. Figgie had the original chart in December 1987.

All versions of the September 27, 1987 entry which surfaced during discovery contained the entry with the exculpatory statement, "As she does not want excisional Bx [biopsy] we will observe." The contradictory original was typed and stated that it was at Dr. Figgie's option to watch what he considered to be the benign tumor. As discovery progressed the plaintiff's attorneys were able to fully reconstruct two charts: one original and one with alterations. The original clearly showed that it was Dr. Figgie who wanted to wait and to defer any work-up and the altered version thrust the decisional onus to the decedent, Ms. Moskovitz.[506]

In an entry of August 10, 1987 in the reconstructed chart, Dr. Figgie wrote:

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[505] *Id.*.
[506] Like *Paris*.

> Mrs. Moskovitz returns today. She has had some increase in that swelling and that mass behind her ankle. She is not particularly tender and it appears to be calcific. She did not want to proceed with radiographs or work-up today. We did discuss the possibility of needle or incisional biopsy but she deferred on this.[507]

Ms. Moskovitz denied refusal of any treatment in her videotaped preservation deposition and said that the lump on her left Achilles tendon, according to Dr. Figgie's assurances, was only "tendons."[508]

At the trial level, the court ordered that the arbitration panel could not consider punitive damages and the panel only found adversely against Dr. Figgie and University Orthopedic. Two panel members awarded compensatory damages of $1.3 million and a third dissented, suggesting that she should receive not less than $2 million. The panel then awarded $2.9 million in hedonic damages. The defendants did not accept this non-binding arbitration and the case went to trial where Dr. Figgie attempted to explain his record alterations. He denied that he made the alterations, admitted that there were contradictory entries, and denied that he fabricated the penciled-in additions. Further, he testified that "defacing and destroying medical records reflects a conscious disregard for the rights and safety of a patient."[509]

This time, the jury verdict was $2 million on the survival claim and $1.25 million on the wrongful death claim, plus $3 million in punitive damages. In its special verdict the jury commented, "Dr. Figgie did not maintain his records as according to medical

[507] *Id.* at 336, n.3.
[508] *Id.* at 337.
[509] *Id.* at 339.

standards."[510] The appellate court upheld[511] the punitive damage award noting that without the punitive damage award

> ... no punitive damages could be awarded to punish the unlawful conduct. [Without permitting punitive damages in the absence of a showing of actual harm caused] litigants and prospective litigants could alter and destroy documents with impunity so long as no actual damage was caused thereby. ... [I]f the damning evidence were destroyed without trace, no liability would attach ... since no evidence would remain to implicate the spoliator. ... Figgie's alteration of records was inextricably intertwined with the claims advanced by appellant for medical malpractice, and the award of compensatory damages on the survival claim formed the necessary predicate for the award of punitive damages based upon the alteration of medical records.[512]

The court then proceeded to explain that the purpose of punitive damage is, in addition to compensate the plaintiff, to "punish and deter certain conduct."[513]

> In strong language courts reserve for egregious conduct, the court editorialized:
>
> If the act of altering and destroying records to avoid liability is to be tolerated in our society, we can think of no better way to encourage it than to hold that punitive damages are not available in this case. We believe that such conduct is particularly deserving of punishment in the form of punitive damages and that a civilized society governed by rules of law can require no less. Figgie's conduct of altering records should not go unpunished. We should warn others to refrain from similar conduct and an award of punitive damages will do just that.[514]

The court stated that record alteration constitutes actual malice and

> ... Figgie's alteration of records exhibited a total disregard for the law and the rights of Mrs. Moskovitz and her family. Had the copy of page seven of Figgie's office chart not been recovered[515] from the radiation department records at

[510] *Id.* at 340.
[511] *Id.* at 341.
[512] *Id.* at 342-43.
[513] *Id.* at 343.
[514] *Id.*.
[515] This is a real possibility which should send shivers down the spine of any plaintiff's attorney. If one re-works these cases and makes the assumption that the spoliation is not discovered, it produces some shocking possibilities in terms of plaintiffs denied recovery. It is for this reason that all medical records should undergo careful physician-expert analysis in the earliest phases of case evaluation. Imagine the failure to detect the spoliation in this case and sending the Moskovitz family away wrongly concluding that

> University Hospitals, appellant would have been substantially less likely to succeed in this case. The copy of the chart and other records produced by Figgie would have tended to exculpate Figgie for his medical negligence while placing the blame for his failures on Moskovitz.[516]

While the court did uphold the punitive damage award it reduced the amount taking into consideration Dr. Figgie's net worth[517] and ordered a remittitur of $2 million, making the award $1 million. Moreover, since Figgie refused to settle even after the arbitration panel award, the appellate court awarded pre-judgment interest. There, it reasoned,

> If Figgie ever had a good faith, objectively reasonable belief that he had no liability, the fact that the "arbitration" panel unanimously found against Figgie should have apprise him that a finding of liability at trial was possible, if not probable. Given the substantial amount of conflicting evidence in this case, the fact that medical records disappeared and were altered and the unanimous determination of the panel of "arbitrators," the inescapable conclusion is that Figgie failed to rationally evaluate his potential liability.[518]

The dissenting opinion pointed out that the jury made no finding that Dr. Figgie committed spoliation and without this finding, to punish him was improper. The reasoning was that even with the spoliation, the original act of medical negligence was not malicious, and therefore there should not be punitive damages assessed for the spoliation.[519] The dissent concluded that there would be some measure of damages which flowed merely from the spoliation of evidence[520] but compensation should correlate to damages.[521]

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the doctor met the standard of care and that the patient refused treatment. That possibility is not untenable here, either, since some elderly patients might opt to forgo treatment in these circumstances.

[516] *Id.*.

[517] Between $2.1 million and $3 million.

[518] *Id.* at 351.

[519] *Id.* at 354. This is more like the Paris reasoning.

[520] i.e. additional discovery time.

[521] *Id.* at 354. (citing Ashby v. White, 2 Ld.Raym. 938, 955, (King's Bench 1703) which held that "[E]very injury imports a damage, though it does not cost the party one farthing, and it is impossible to prove the contrary; for a damage is not merely pecuniary, but an injury imports a damage, when a man is thereby

In a different case, the Ohio Court of Appeals affirmed the trial court's dismissal of a medical negligence claim in *Wolf v. Lakewood Hospital*,[522] which included a spoliation of evidence claim where defendants lost a metal fragment which had been removed from the plaintiff's leg. The plaintiff claimed that this metal was vital to her medical negligence action but this claim was dismissed for failure to state a claim. Here, the Ohio court relied not upon statute but upon its *prima facie* tort doctrine which it elaborated in *Costell v. Toledo Hospital*.[523]

Under Ohio law, the elements for a *prima face* tort are "the infliction of intentional harm, resulting in damage, without excuse or justification, by an act or series of acts which would otherwise be lawful."[524] This tort may be invoked when there is an intention to harm. According to the holding in *Costell* "[i]nquiry into the issue of whether a duty exists and to whom it is owed is inappropriate in a prima facie tort action"[525]and this tort arises where the specific acts relied upon "are not ... actionable."[526] Since Ohio had not adopted the spoliation of evidence tort, the *prima face* remained as a viable recovery theory in *Wolf*. Additionally the court noted that the motive behind an act is irrelevant when a party has a right to perform such an act. Since the hospital had no duty to retain the metal foreign body, they could not be held liable for their failure, under Ohio law, to retain it.[527] The plaintiff, however, alleged that the hospital had a contractual duty

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hindered of his right. As in an action for slanderous words, though a man does not lose a penny by reason of the speaking them, yet he shall have an action. So if a man gives another a cuff on the ear, though it cost him nothing, no not so much as a little diachylon, yet he shall have his action, for it is a personal injury."

[522] 598 N.E.2d 160 (1991).

[523] 527 N.E.2d 858, 859 (1988).

[524] Wolf, 598 N.E.2d 160, 163.

[525] *Id.*.

[526] *Id.*.

[527] *Id.*.

to retain the metal, and its failure to do so gave rise to an "act of negligent misrepresentation, with the 'breach of duty' and right to rely as the elements of the cause of action."[528]

(C) IS IT SPOLIATION?

In the next case the court tackled the question of how small a modification in the record would violate the law. Just as not every discard of records violates record retention statutes, not every addition to the record can constitute spoliation and, moreover, sometimes additions to the record after the fact, may be perfectly permissible or necessary for medical care. In *Martin v. Reed*[529] the patient was paralyzed after an auto accident and sued, alleging that the provider's failure to correctly read a cervical spine x-ray was the proximate cause of the paralysis. The plaintiff brought a claim for spoliation of evidence but the appellate court upheld the trial court's refusal of a jury instruction on this claim since there was no evidence of spoliation by defendants. The defendant placed a "mark"[530] on the plaintiff's x-ray, nothing more. The court did not accept this as spoliation.[531]

The Ohio Court of Appeals in Cuyahoga County affirmed a lower trial court decision in favor of the defendants in *Studier v. Tancinco*.[532] In this case, Virginia Moriana died six weeks after an hernia surgery and the family requested an autopsy. Dr.

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[528] *Id.*.
[529] Martin v. Reed, 409 S.E.2d 874 (1991).
[530] In *medicalese*, this is called "the positive arrow sign." Radiologists and other physicians frequently point out important findings with a grease pencil, a mark which is easily wiped away in the event that it is no longer needed.
[531] *Id.*.
[532] Studier v. Tancinco, 1994 WL 78050 (Ohio App. 8 Dist. 1994). (unpublished opinion).

Tancinco failed to include in his autopsy report a small bowel perforation and the plaintiffs claimed that this omission resulted in a lower damage award in the initial malpractice suit. The arbitrator refused to arbitrate the spoliation claim since it was not causally related to "a compensable medical claim," noting, however, that the pathologist "deviated from acceptable medical practice" when he failed to report autopsy findings which were "material to the mechanism which ultimately caused death."[533]

In *Washington v. City of Columbus*,[534] the plaintiff sought $14 million in damages in which they alleged that the defendants failed to carefully supervise housestaff and that the defendants altered medical records in an attempt to shift suspicion to the plaintiff for murdering her son. They further alleged that the defendants mutilated the child's body even if the defendants did not cause or contribute to the child's death. The court issued a directed verdict against the plaintiffs at the close of their case in chief since no real evidence supported their allegations.

The child was brought to the hospital in cardiac arrest but resuscitative efforts failed. Without consent to perform a four-quadrant abdominocentesis, but after the child was considered dead, the resident-doctor performed the tap.[535] The autopsy ascribed the death to the tap since the pathologist found intra-abdominal hemorrhage.[536] At this point the plaintiffs alleged the doctor altered the medical records,[537] but the plaintiff produced

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[533] *Id.*.

[534] 222 S.E.2d 583 (1975).

[535] In a teaching hospital, this is not at all unusual. The informed consent includes permission for performing procedures for teaching purposes so long as they are done for appropriate reasons and under the direct supervision of attending staff. Some of these might include: liver biopsy, cranial burr holes, pericardiocentesis, internal jugular vein cannulation, laparoscopy, arthrocopy.

[536] *Id.* at 535.

[537] The case does not state precisely what was the alteration but the consequence was to shift blame for the death away from the health care providers and towards the mother.

no evidence that the child was alive when it was brought to the E.R. Drawing an analogy to *Rushing v. Medical College of Georgia*, the court concluded that a "slight incision ... "does not constitute mutilation as a matter of law."[538] On this issue of whether the trial court erred in directing a verdict in favor of defendants the appellate court overruled the trial court.[539] The appellate court was hesitant to deny these plaintiffs their day in court and nothing the defendants did in any way changed the plaintiff's abilities to bring their case. The doctor's gravamen, if anything, was to perform a medically accepted procedure, nothing more.

The outer limit of what a court will consider as spoliation appears in the next case where the court took up the issue whether one must actually be able to point to a suspect addition to the record or may one merely allege an addition to the record.[540] After Kimberly Pyle fractured both the ulna and radius of her left arm, a Colles' fracture, the E.R. doctor placed a cast despite finding that there had been a small skin puncture. Since this became infected and the child sustained significant muscle loss as a result of a "myonecrotic process,"[541] and underwent left forearm amputation. The trial court admitted a nurse's testimony that a portion of the medical record was altered after surgery.[542]

The trial testimony in relevant part was:

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[538] *Id.* at 588. (citing Rushing v. Medical College of Georgia, 4 Ga.App. 823, 62 S.E. 563 (1907) where a physician made a slight incision into the cavity of the abdomen to discover the cause of death. Four-quadrant taps are a recognized medical procedure, frequently used for diagnostic purposes.

[539] *Id.* at 588.

[540] There is an analogy here to the criminal context in murder prosecutions where everyone knows the vistim was murdered but there is no body. Unless the prosecutor can produce a body, there has been no crime. Without the body it is impossible to satisfy the criminal requirement of a both a *mens rea* and *actus reus*. Is this necessary in the civil context? The Pyle court let the circumstantial evidence go to the jury.

[541] Pyle v. Morrison, 716 S.W.2d 930, 931 (1986).

[542] *Id.* at 932.

> Q. And when you looked at that record didn't you put your fingers there and tell me that you don't think that record--that paragraph in that record was on there when you typed Dr. Bourland's note?
> A. Yes, I did.
> Q. And didn't you tell me, Ms. Long, that your recollection was that that paragraph was added after this young lady had had her arm amputated?
> A. What I told you was that I was not certain that was there before. It was my impression that it was added after the amputation.[543]

Another witness controverted the testimony[544]as did the defendant physician. The appellate court sustained the trial judge's finding that the testimony was not so inflammatory as to be prejudicial and admitted the testimony about the supposed alterations.

(D) TIMING THE SPOLIATION CLAIM

Illinois law is confusing on the issue as to when a party must raise a spoliation claim. In *Fox v. Cohen*, for instance, the court concluded that it was premature to bring the claim prior until after the complete adjudication of the underlying medical negligence claim. The court reasoned, in *Fox*, that the plaintiff had "not yet sustained any injury" and that her spoliation claim at that time was mere speculation. Recovery, it further reasoned, "is contingent on the unheard proof and result in the malpractice action. That plaintiff will lose her malpractice action because of a missing EKG is, as of now, purely speculative and uncertain. Liability cannot be predicated upon surmise or conjecture as to the cause of the injury."[545]

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[543] *Id.* at 934.
[544] *Id.*
[545] Fox, 406 N.E.2d 178, 183.

In *Rodgers v. St. Mary's Hospital of Decatur*,[546] Ms. Rodgers died following a cesarean section and the husband sued but the defendant hospital obtained a summary judgment in its favor. Eventually, Rodgers obtained a jury verdict against the obstetricians for $1.2 million but the jury decided in favor of the radiologists who lost the decedent's x-rays, in violation of the Illinois State x-ray retention statute.[547]

Rogers further alleged that the radiologists failure to retain the x-rays or minified diagnostic quality versions breached the hospital's duty to retain this important evidence. The evidence was critical to the plaintiff's claim and would have established the radiologist's negligence. But for the defendant's negligence in retaining the x-rays, he would have won his claim against the radiologists. As a result, the plaintiff lost $400,000, the amount returned against the radiologists and obstetricians at trial. The court in its analysis first considered whether the tort of spoliation of evidence exists under Illinois law. Rodgers contended that the tort consisted of "violation of a duty owed a party entitled to the benefit of unavailable evidence."[548]

While in *Fox* the court dismissed the action as premature, the court sought direction from *Petrik v. Monarch Printing Corp.* where the plaintiff abandoned the spoliation of evidence theory of liability which the lost evidence would have supported.[549] Again, in *Rodgers*, though, the court dodged this issue since the plaintiff's amended

[546] 556 N.E.2d 913 (1990).
[547] *Id.*. (Ill.Rev.Stat.1987, ch. 111 1/2 , par. 157-11).
[548] *Id.* at 915.
[549] *Id.*. (citing Fox, 406 N.E.2d 178 and Petrik v. Monarch Printing Corp., 501 N.E.2d 1312 (1986)).

complaint stated another cause of action under the statutory x-ray retention act.[550] Within these narrow set of facts, the court held

> ... that when failure to preserve medical x-rays in violation of the relevant statute irreparably damages a plaintiff's litigation rights with respect to less than all of two or more alleged joint tortfeasors, a settlement with one of the tortfeasors with respect to which plaintiff's litigation rights were not damaged, does not bar an action for damages based on failure to preserve the x-rays.[551]

In declining to adopt a rule which would require parties to fully exhaust appeals before a spoliation of evidence action might proceed, the court analyzed that this could "require the filing of frivolous appeals for the sole purpose of preserving spoliation of evidence actions." This would waste judicial resources.[552] The court did not dismiss the claim on the basis of *res judicata* since "the evidence ... would not have sustained a verdict in [Rodger's] favor in his medical malpractice action against the hospital. Ergo, these two actions are not based on a common core of operative facts."[553]

In terms of timing the spoliation claim, the cases seem to support that the claim should be raised at the earliest possible time. Not only does this give the court and the litigant the best opportunity to cure any discovery defects, if possible, but the fact that the court will or will not permit the claim may greatly influence further tactical decisions. There will be more on this in the final section.

(E) Complex Facts and Legal Issues

[550] *Id.* at 915-16. (Ill.Rev.Stat.1987, ch. 111 1/2 , par. 157-11).
[551] *Id.* at 918.
[552] *Id.* at 918-19.
[553] *Id.*.

It is not at all unusual to experience record alterations, deletions, fraud and misrepresentations and perjury all in one case. In fact, when a party is willing to doctor records, he frequently will commit other related or unrelated deceptions. In *Rogers v. Ruiz*,[554] Dr. Ruiz misrepresented his cardiovascular surgery operative mortality statistics to the plaintiff[555] and, after he died, his wife discovered that misrepresentation and sued. Fortunately for the Rogers family, they uncovered the fraudulent concealment and the court permitted their case to proceed.[556] After Ms. Rogers discovered a "smoking gun" memorandum written by an offended scrub nurse, the Florida Appellate court held that the statute of limitations began to run at the time of death but that questions of fraudulent concealment of important portions of the medical record precluded the trial court from granting a summary judgment.

In a paradoxical turn for the spoliator, whether there had been fraudulent concealment which tolled the running of the statute of limitations constituted a question of fact which the jury must hear, the court concluded. Dr. Ruiz operated under a cloud of controversy and when Mr. Rogers died as a result of an attempted coronary artery bypass

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[554] 594 So.2d 756 (1991).

[555] According to the plaintiff's medical expert, Dr. Benson Roe, it was his opinion that "Dr. Ruiz was a FMG medical fraud and the hospital failed to appropriately credential him. Dr. Ruiz's results were so bad that it wasn't too hard to get him out of active surgery. The hospital was pretty reprehensible in the whole process ... but, to be the devil's advocate, this shows how hospitals have to operate in this climate where doctors can sue the hospital for their interference with the doctor's right to earn a living. That's the reason for the way these things happen." Telephone Interview with Dr. Benson Roe, cardiovascular surgeon and Professor Emeritus, University of California, San Francisco, School of Medicine, San Francisco, California (2 April 1996).

[556] The author would like to thank trial counsel, Mr. Thomas Masterson of St. Petersburg, FL and appellate counsel, Mr. Joel D. Eaton, Miami, FL for discussing the important aspects of this case with the author. Mr. Eaton commented, "Typically when something happens in a hospital everyone clams up. They [hospital and physicians] huddle around and lie. That's why it's so important to talk to everyone involved." Telephone Interview with Mr. Joel D. Eaton, trial attorney of Miami, Florida (1 April 1996). Mr. Masterson gave the opinion that, as a matter of public policy, there should be some procedure for communicating "incident reports" to the patient or to the family. Without that procedure, there is a separate secret record to which the

surgery at Dr. Ruiz's hands, a nurse wrote a "memorandum" following the death. Ruiz's operative mortality statistics had been the subject of hospital investigation and Nurse Lauren Burch no longer wanted to scrub with Dr. Ruiz. Following orders, however, she assisted him at Rogers' surgery.

Nurse Burch's memorandum criticized Dr. Ruiz and his techniques for the surgery:[557]

> As an open heart nurse with 10 years of experience, it is my observation that the internal mammary dissection done by Dr. Ruiz ... was done without due reguard [sic] to the delicacy of this vessel. There was no protective pedicle taken around the vessel, the vessel was pulled on and compressed numerous times with a large vascular forcep [sic], an excessively large number 8 hemoclips was used and I did not, at any time, see any blood flow through the IMA before it was sutured into the coronary artery. When I questioned Dr. Ruiz as to the blood flow through the IMA he told me that medication could be given to the patient later to improve the flow. We closed the incision although the patient did not appear to be doing well.[558]

The memo also reflected Ms. Burch's conclusion that Dr. Ruiz was responsible for the patient's death.[559] The O.R. personnel took exception to Dr. Ruiz's techniques and apparently were angered with the poor result. Nevertheless, Ruiz told the family, "God had simply taken Mr. Rogers" and the discharge summary documented the cause of death as left ventricular failure. Nurse Burch's memorandum was not placed into the permanent

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patient has no access yet it may greatly influence his legal rights. Telephone Interview with Mr. Thomas Masterson of St. Petersburg, Florida (1 April 1996).

[557] *Id.* at 759.

[558] *Id.* at 759-60. The full memorandum was excoriatingly critical of Dr. Ruiz.

[559] According to the author's interview with plaintiff's appellate counsel, Mr. Joel D. Eaton, Florida law states that the plaintiff has constructive notice of the contents of the medical record. Had the Burch memorandum become part of the medical record, their action would have been barred by the statute of limitations. In his appellate brief, Mr. Eaton expressly stated that this memorandum was not part of the medical record. In other jurisdictions, it is imperative for counsel to determine the status of extraneous memoranda since this could dramatically affect litigation. Further, Mr. Eaton has practiced appellate work for over twenty years and stated that spoliation of evidence is rampant and occurs "more frequently than not," in his experience.

patient chart. The hospital chart, according to the plaintiff's expert at trial, did not reflect any departure from the standard of care, merely that the death was "circumstantial and beyond the control of those taking care of him."[560]

Of interest is the magnitude of Dr. Ruiz's deception in the face of a bad clinical result, a suffering family, an hostile hospital staff, and turmoil with the nurses. It is ironic that the deception was discovered by pure serendipity. Dr. Ruiz offered a most patronizing and benign explanation of the death when he explained the death to the family. He gave them a "technical explanation," leading them to believe that

> ... the surgery had gone well; that he did not know what had happened; that it was just one of those things; that Mr. Rogers' death was merely one of those unexplainable deaths which results from this type of surgery; that Mr. Rogers' heart was old and tired and simply gave up; and that Mr. Rogers' time had come.[561]

Prompted by a rumor relayed through his nurse-wife who worked at another hospital, the decedent's son became curious and he confronted the hospital administrator. The hospital attempted to gloss over the fact that Dr. Ruiz's hospital privileges were suspended partially on the basis of the care and treatment rendered to Mr. Rogers and did not disclose this fact. Initially the hospital risk manager lied to the son but, after consulting an attorney appointed by the hospital,[562] the risk manager disclosed partial truths.

Simultaneously here, the hospital suspended Dr. Ruiz's privileges but in his phone conversation with the son, the risk manager again lied, telling him that while there was an

[560] *Id.* at 761. This illustrates the real danger in these cases: where spoliation of evidence goes undetected.
[561] *Id.* at 761.
[562] *Id.*. This attorney was not the hospital's usual counsel.

investigation but attempted to reassure Mr. Rogers that the investigation was a mere formality: everything was fine. The family relied upon the false explanation offered by Ruiz in collaboration with the hospital's agent, the risk manager.

Dr. Ruiz was vexed when various rumors circulated around the hospital community and he sued six physician claiming that they conspired to ruin his practice. Ordinarily peer review material is not discoverable in medical negligence litigation but this material formed the core for Dr. Ruiz's allegations in the defamation suit. The secrets were then released into the discovery process in the defamation litigation. As a result of this, it was in a newspaper article[563] where family first learned that Dr. Ruiz botched their father's surgery. This was the first time that this family discovered the hospital and physician subterfuge and cover-up and realized their false faith in Dr. Ruiz.[564]

Rogers stands as an example of how important it is to leave no stone unturned in determining the facts of a case. Presumably, had the plaintiff's deposed Nurse Burch they may have discovered the "smoking memorandum," but, had they, in the interests of economy,[565] not done the deposition, they may have fully accepted this "smoke and mirrors" conspiracy which Dr. Ruiz,[566] in concert with the hospital attempted to

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[563] Carol Gentry, *Records Show Hospital Hid Truth About Surgery Deaths*, ST. PETERSBURG TIMES, February 16, 1992, at 1A. This is a fine bit of journalistic sleuthing. The case stands as an ominous example of the sort of collusive conduct between the hospital and one of its doctors for which every attorney must remain vigilant. The hospital placed its licensure status in jeopardy. The plaintiff's expert, Dr. Benson Roe of San Francisco, testified that there was no way one could tell from the medical records that anything unusual had happened in any of the surgeries he reviewed. Had the family ignored the rumor or the attorney failed to pursue all of his leads in the discovery process, there may have never been any vindication of Mr. Roger's death. Parenthetically, Dr. Ruiz was exonerated of mis-conduct by the state licensure authorities.

[564] *Id.* at 763.

[565] Scrub nurses typically would not be deposed in a surgical medical negligence case.

[566] According to the Florida Agency for Health Care Administration, Dr. Ruiz was never charged with any professional wrongdoing in connection with the Rogers matter but at this time his Florida license is not active. He has moved out of state and did not pay his renewal fee. Telephone Interview with Ms. Mirabel Davis, Agency for Health Care Administration, Gainsville, FL (23 April 1996).

perpetrate. There is one further important matter in *Rogers* which the court left untouched. Should the Burch memorandum have become part of the medical record? The answer is not easy. Obviously had she written the memorandum into the chart, then it would have been part of the record. When an hospital employee issue a dissent opinion about medical care rendered, it could constitute a document made in anticipation of litigation. This "secret record" issue will be further considered in the final section.

Another case also touched upon what should be included in the medical record. In *Foster v. Lawrence Memorial Hospital*,[567]a college student died after a Coke machine fell on him while he was at University of Kansas. An E.R. physician made various notes about the case on paper which was not part of the patient's chart and he then used that information when he prepared a written narrative in response to plaintiff's counsel's request. He then discarded the notes.[568]

The doctor later replaced these notes with "alleged copies"[569] and attempted to resist the plaintiff's spoliation of evidence claim on the basis that Kansas did not recognize spoliation of evidence as a separate claim. But even if Kansas recognized the claim, Kansas statute "does not create a duty for a physician to keep his after-the-fact personal notes to be maintained,"[570] the *Foster* court concluded.

The plaintiff argued that the notes were made contemporaneously with the decedent's treatment and "constituted the file or records that Dr. Geist made regarding Foster's treatment." Further, as in the New York case of *Pharr v. Cortese* cited above,

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[567] 809 F.Supp. 831 (1992).
[568] *Id.*. at 834.
[569] *Id.*.
[570] *Id.*. (citing KAN. STAT. ANN. 100-24-1).

"the Board of Healing Arts may rely on patient's files and depositions when determining to revoke a physician's license." Although the plaintiff conceded that there were no damages flowing from the destruction of this evidence, they contended that the jury should be permitted to evaluate the doctor's motive for "condensing" his notes.

In an attempt to resolve the conflict, the federal court in *Foster* cited the six elements[571] which are necessary for the tort of intentional spoliation of evidence, and then distinguished this from negligent spoliation where "a legal or contractual duty to preserve evidence must exist before liability for the evidence's loss will be imposed."[572]According to that test, the case at bar failed.

The *Foster* court revisited *Koplin v. Rosel Well Perforators, Inc.*,[573] where the Supreme Court of Kansas concluded that "absent some independent tort, contract, agreement, voluntary assumption of duty, or special relationship of the parties, the new tort of "intentional interference with a prospective civil action by spoliation of evidence" should not be recognized in Kansas.[574]

Then, the federal court in *Foster* relied upon the Florida case, *Bondu v. Gurvich*,[575] in which a hospital failed to maintain medical records and the plaintiff lost its medical malpractice case. The Florida Court of Appeals, over a strong dissent by Chief Judge Schwartz, held that *because* of the hospital's statutory duty to maintain and make available medical records, plaintiff would be allowed to pursue a claim against the

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[571] *Id.* at 835. "(1) existence of a potential civil action, (2) defendant's knowledge of a potential civil action, (3) destruction of that evidence, (4) intent, (5) a causal relationship between the evidence destruction and the inability to prove the lawsuit, and (6) damages."
[572] *Id.*.
[573] 734 P.2d 1177 (1987).
[574] Foster, 809 F.Supp. 831, 836. (citing, Koplin, 734 P.2d 1177).
[575] 473 So.2d 1307 (Fla.Dist.App.1984).

hospital for alleged spoliation of evidence. Notice that the *Bondu* decision rested in a Florida statute which imposed a duty upon all hospitals to maintain and make available to patients their medical records. The *Bondu* court found that the hospital's breach of that duty gave rise to plaintiff's cause of action. The tort in *Bondu*, in contrast to *Foster*, was based upon a statutory duty, not upon any independent common-law duty to preserve evidence.[576]

In its struggle over the spoliation of evidence issue, the U.S. District in *Foster* concluded that at some point Kansas would recognize the tort but, in reaching its decision, it examined Kansas cases which the courts used as a basis for the state's refusal to adopt the tort. These reasons included:

> availability of alternative remedies such as discovery sanctions and negative inferences;[577] the uncertainty of the existence or extent of damages; the fact that the evidence was spoliated by a third party who was not a party to the action ... recognition of the tort interferes with a person's right to dispose of his property as he chooses; destruction of the property may be reasonable under the facts of a specific case ... destroying property for safety reasons; the tort may be inconsistent with the policy favoring final judgments; a plaintiff who loses his primary suit may bring a second suit by trying to establish that some relevant piece of evidence was not preserved.[578]

In addition to these general concerns, the court struggled with the same timing issue the court addressed in *Fox v. Cohen*.

It remains unsettled whether the underlying suit must be tried and lost before the plaintiff can bring a claim for spoliation. Some courts suggest that plaintiffs should present their spoliation claim at the same time as the underlying claim, while other courts

[576] Foster, 809 F.Supp. 831, 836-37.
[577] *Id.* at 837, n.3. (citing Headley v. Chrysler Motor Corp., 141 F.R.D. 362 (D.Mass.1991). (the plaintiff intentionally destroyed evidence and the judge precluded him from presenting "any expert evidence concerning alleged defects in the vehicle that was the subject of the plaintiff's action").

require the plaintiff to take the case through the trial phase and sustain a loss before bringing a spoliation claim.[579] Nevertheless, the United States District Court, in *Foster*, concluded that Kansas statute[580] imposed a duty on the physician to maintain his notes but, whether the provider breached that duty, would become a question for the jury to resolve.[581]

(F) Destructive Autopsy and Testing

So far we have considered medical record losses or destructions and improper additions to records by a note, a falsification, an amendment. Sometimes autopsies destroy evidence.[582] It would be impossible for a pathologist to competently examine a brain, for instance, without using the appropriate anatomic techniques. She must dissect off the meninges, remove vascular structures, slice the brain, and then she must make appropriate sections for microscopic evaluations. How shall potential litigants handle this situation? What happens when a third-party pathologist, one retained by either side of a controversy, performs a destructive evaluation? What about the situation where an

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[578] *Id.*.

[579] *Id.* at 838. Compare, Smith, 198 Cal.Rptr. 829, 837. (spoliation claim should be heard together with primary claim) with Kent v. Costruzione Aeronautiche Giovanni Agusta, S.P.A., No. 90-2233, 1990 WL 139414, 1990 U.S. Dist. LEXIS 12583 (E.D.Pa. September 20, 1990) ("Not until there is a disposition with respect to the underlying civil action can it be determined whether the destruction of evidence has prejudiced plaintiff."); Fox, 406 N.E.2d 178 (stating that the cause of action for negligent spoliation of evidence is premature until plaintiff actually loses her medical malpractice action due to lost EKG as damages are otherwise "purely speculative and uncertain"); Federated Mut. v. Litchfield Prec. Comp., 456 N.W.2d 434 (Minn.1990) (resolution of a plaintiff's underlying claim is necessary to demonstrate cognizable injury for purposes of a spoliation action, should such a tort be recognized).

[580] *Id.*. K.A.R. 100- 24-1.

[581] *Id.*.

[582] Refer to § V, Evolution of the Tort, *supra* at p.22 et seq., and consider at this point parallels between these new cases to those of Willard v. Caterpillar, Carlucci v. Piper Aircraft, Shimanovsky v. General Motors, and Vodusek v. Bayliner. *See*, p. 32 *et seq.*.

engineer sections and destroys an hip prosthesis? These were the conundrums placed before the courts in the next few cases.

In the typical autopsy, performed for clinical reasons, with no litigation underway or anticipated, the autopsy report merely represents "medical records." Neither party's rights are jeopardized in this situation and either party would have access to the reports, clinical materials, paraffin blocks, or other materials generated in the autopsy. Either party has equal access to the original evidence, however.

In a medical products liability case reminiscent of *Smith v. Superior Court*, however, *DePuy v. Eckes*,[583] the lower court entered a default against the defendant when it was unable to produce a hip prosthesis which had been entrusted to it pursuant to an agreed order which prohibited destruction of the fracture site. The defendant returned the prosthesis with the fracture site missing and as a result the plaintiff was unable to go forward with its case. In this important case, the Florida Court of Appeals upheld the lower court's ultimate sanction in favor of the plaintiffs.

The court utilized a Florida Rule of Civil Procedure[584] which "authorizes the imposition of sanctions for failure to comply with discovery orders." The judges wrote:

> Whether the prosthesis was destroyed in bad faith or accidentally is irrelevant in the present case. The evidence is unavailable for the plaintiffs' use and they have demonstrated an inability to proceed without it. ... When [DePuy] procured the evidence for their inspection, the[y] ... did so subject to the plaintiffs' right to the return of the evidence. Having lost the prosthesis, DePuy [is] ... accountable for the ramifications of [its] ... act.[585]

[583] 427 So.2d 306 (1983).
[584] *Id.* at 307. Florida Rule of Civil Procedure 1.380(b)(2)(C).
[585] *Id.*.

A companion to the *DePuy* case are the destructive autopsy cases of which *Barker v. Bledsoe*[586]serves as a somewhat offbeat example. Here, the plaintiff was the spoliator. The decedent sustained a subarachnoid hemorrhage and it was the plaintiff's expert who performed a destructive autopsy. A professional photographer[587] memorialized the event but after the autopsy "the body of decedent was destroyed, further examination of the body would be fruitless, and the photographs of the autopsy and his [the pathologist's] own findings were thus conclusive."[588] This case is not unlike the Texas case of *Brewer*,[589] where the defendants were unable to produce the fetal monitor strips although the court concluded that the defendant's contemporaneously recorded clinical conclusions were equivalent to the "real thing."

The defendants in *Barker* advanced the argument that the plaintiff's expert departed from generally accepted medical techniques thereby ruining the defendant's opportunity to evaluate the autopsy results, information critical to its defense. The court considered the destruction of evidence without notice to the adverse party[590] distinguishing its the facts from *Western States Construction Co. v. Stailey*,[591] a case where autopsy was performed "the day after death, before any suit was filed."[592] The court concluded here that "[h]owever abhorrent to principles of fair dealing, it appears that the tampering, destruction or suppression of evidence raises only a presumption that

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[586] 85 F.R.D. 545 (1979).
[587] Reminiscent of Vodusek, *supra*, at n. 147.
[588] *Id.* at 546-47.
[589] *Supra* at p. 149.
[590] *Id.* at 547.
[591] *Id.*. (citing Western States Construction Co. v. Stailey, 461 P.2d 940, 944 (Okl.1969).
[592] *Id.*.

such evidence would have been unfavorable to the party responsible for doing it.[593] The presumption is rebuttable and constitutes a question of fact."[594]

The court treated this case very differently from the Texas court's treatment of the defendant in *Brewer* as it then noted that American courts no longer "foster[] 'trial[s] by ambush", and articulated a viable rule of law.

> [T]his privilege [of fair discovery] carries a ... responsibility of fairness ... . The requirement of due process is not an ephemeral concept ... but extends to all litigants the standard of fundamental fairness in federal court. When an expert ... conducts an examination reasonably foreseeably destructive without notice to opposing counsel and such examination results in either negligent or intentional destruction of evidence, thereby rendering it impossible for an opposing party to obtain a fair trial, it appears that the Court would be not only empowered, but required to take appropriate action, either to dismiss the suit altogether, or to ameliorate the ill-gotten advantage. A presumption as to certain evidence is simply not sufficient to protect against such conduct.[595]

The court proceeded to prohibit the plaintiff[596] from introduction of any autopsy evidence including the testimony from the plaintiff's pathology expert who performed the autopsy. In addition, the court assessed costs and attorneys fees against the attorney who signed the pleadings.[597]

A false and misleading autopsy does not constitute, *per se*, spoliation of evidence. Dr. Gross, New York City's chief medical examiner, sued the New York Times[598] for defamation when it printed articles accusing him of creating false and misleading autopsies in his effort to cover up police misconduct. In dismissing the case, Justice

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[593] *Id.*. (citing Wong v. Swier, 267 F.2d 749 (9th Cir. 1959); S*ee generally*, 29 Am.Jur.2d, Evidence s 177).
[594] *Id.*.
[595] *Id.* at 547-48.
[596] In *Brewer* it was the defendant who lost the records but here it was the plaintiff who spoliated. Had the conduct been reversed in *Barker*, presumably the court would have similarly decided to burden the defendant in *Barker*.
[597] *Id.* at 549.
[598] Gross v. New York Times, 575 N.Y.S.2d 221 (1991).

Elliott Wilk noted that the allegations were that the pathologist reached wrong conclusions in eleven autopsies where detainees died in police custody.[599] A pathologist is not required to be "correct" in his diagnoses if what he has concluded is supportable to some reasonable degree by the medical evidence.[600] This case stands for the proposition that both medical practice and criticism of public officials permit widely divergent opinions rooted in constitutional interpretations and public policy.

On this topic of legitimate medical variability of medical record keeping, non-medical readers must appreciate that there is room for legitimate differences in clinical interpretations among skilled practitioners given an identical set of medical facts. Recently, the accuracy of death certificate completion has become a serious concern and this topic has received only scant attention in the medical literature. Although the following autopsy example is not one of after-the-fact medical record doctoring with the specific intent to deceive future users of the records, it does illustrate the sorts of systemic variables within medical practice which produce inexact results.

The death certificate occupies a pivotal role in many legal analyses. Its accuracy could determine the difference between execution, incarceration, or freedom for the accused. There are substantial differences between the implications of accidental death, negligent death, natural death, or death due to non-natural causes and the certificate of death constitutes a state document whose diagnoses are difficult to challenge. The death

[599] *Id.* at 223. "The Times defendants' criticisms of plaintiff fall into three categories, questioning (1) the soundness of his judgment regarding policy and procedures used in performing and reporting autopsies; (2) the correctness of his conclusions concerning causes of death in certain cases, and (3) the propriety of his motives underlying the actions referred to above. ... Those functions entail the exercise of medical judgment and the rendering of expert medical opinion."

certificate diagnoses demarcate those who will or will not receive payments of insurance premiums, in whether heirs may inherit, and whether a spouse may receive important benefits and the nature of those benefits. Correctness in this document creates a vital statistic, affects major governmental policies in the workplace or with respect to the environment. The accuracy of the death certificate may be the linchpin in major work-related litigation and is of substantial import in medical negligence litigation. A factual error has great potential effect.

Messite and Stellman, from the Office of Public Health of the New York Academy of Medicine and of the American Health Foundation, published the results of their study, *Accuracy of Death Certificate Completion: The Need for Formalized Physician Training* in the *Journal of the American Medical Association*.[601] The researchers presented six written cases of hospital deaths to twelve practicing general internists, twenty-one internal medicine residents, and thirty-five senior medical students. Of the group, only one internist and five residents had received formal training in death certificate completion. There was a 56.9% agreement among the internists over the cause of death, 56% for the resident physicians, 55.7% for the medical students, although agreement within each case varied between 15-99%. This indicates a 40% error rate!

"The variation in the extent of agreement between the subjects' death certificate entries and correct cause-of-death sequence appears to reflect a lack of training in death

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[600] *Id.* at 223. "The Times defendants, like the individual speakers and the plaintiff himself, are necessarily relegated to the realm of speculation and opinion when discussing causes of a death or autopsy policies and procedures. This is especially true when there is disagreement within the medical community."

[601] Jacqueline Messite & Steven D. Stellman, *Accuracy of Death Certificate Completion: The Need for Formalized Physician Training*, 275(10) J.A.M.A. 794 (1996). This study contains eighteen references and would be a good beginning point for further study in this area.

certificate completion at all levels of medical experience," concluded the authors.[602] The authors recommend developing physician manuals and training programs for physicians in the completion of these certificates. Additionally, they would improve the process by adding "software programs ... to guide physicians through the death certificate completion process and [these] should be disseminated to hospitals for every day use."[603]

Although a medical examiner may reasonably reach a wrong diagnosis and doctors may differ over the interpretations of medical evidence, a practitioner may not deceive. This was Dr. Sillery's problem when the Michigan Court of Appeals, in *Robert Sillery v. Michigan Department of Licensing and Regulation Board of Medicine*,[604] reinstated the Board's order in which it suspended the Oakland County Medical Examiner's license to practice medicine. In a consulting capacity, not in his official capacity, he performed an autopsy in a civil products liability suit against a pharmaceutical manufacturer. Dr. Sillery issued a report which substantially overstated the scope of his autopsy. Dr. Sillery falsely reported that "various body organs were removed and weighed although, in fact, that had not been [done]... that certain organs were examined although no such examinations were conducted, and (3) that petitioner had determined the thickness of the right ventricle although an incision necessary for such a determination had not been made."[605]

The true nature of the autopsy was discovered when the defense pathologist performed his own investigation and "determined that plaintiff could not have done as

[602] *Id.* at 795.
[603] *Id.* at 796.
[604] 378 N.W.2d 570 (1985).
[605] *Id.* at 571.

thorough an examination as the report suggested."[606] The opinion cited *Sullivan v. Russell* as authority for the proposition that "[w]here a professional's work product lacks such basic integrity as truthfulness, we believe that it is within the province of the layperson to determine that the conduct constitutes a failure to exercise due care."[607]

An interesting wrinkle surfaced in this litigation: that there is no real standard for what constitutes a competent autopsy report in Michigan. Also, there was no testimony "defining 'minimal standards of acceptable and prevailing practice."[608] Dr. Sillery did not detect a pulmonary embolus which the opposing expert did discover, "competently performed the task for which he was employed."[609] The hearing examiner concluded that Dr. Sillery issued a report which was "inaccurate [and] contained information that could not be supported from the examination ... [S]uch conduct would clearly constitute negligence or failure to exercise due care" in violation of the state statute.[610] But here, the Wayne County Circuit Court reversed, and held that "the standard pronounced ... 'negligence or failure to exercise due care', was not sufficiently precise to notify petitioner of the conduct proscribed." The court ordered additional proceedings to provide the doctor his due process rights.[611]

Finally, the D'Agostino's estate alleged that she died at the age of twenty-three as a consequence of medical negligence.[612] There was a four month delay between the gross autopsy and the analysis of the microscopic slides. This analysis changed the conclusions.

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[606] *Id.*.
[607] *Id.*. (citing Sullivan v. Russell, 338 N.W.2d 181 (1983)).
[608] *Id.* at 572.
[609] *Id.*.
[610] *Id.*. (citing MICH.. COMP. LAWS § 16221(a)).
[611] *Id.*.
[612] Brennan v. St. Luke's Hospital, 285 A.2d (1971).

Two of the plaintiff's contentions concerned a changed autopsy report and submission of a new report. Since the person who created the record was available for testimony and was subjected to vigorous cross-examination, there was no reversible error and the court denied plaintiff's motion for a new trial.[613] Medical practice permits changing the medical record to update new data, but it should be done conspicuously. Pathologists routinely issue "partial" autopsy reports and issue the final one only after all data has been considered.

[613] *Id.* at 473.

§ VIII.

Commentary, Recommendations and Conclusions

(A) Commentary

One vital conclusion requires that it appears first. The vast majority of practitioners and institutions are "first class"; they conduct their medical practices scrupulously, function ethically, professionally, and obey all the rules. But these obedient practitioners have not created the problems which form the topic for this discussion. This treatise has been concerned with the professionals who would knowingly and with the intent to deceive their patients, step over legal, ethical, professional, and moral lines.

Health care comes under the quality lens is when it is the subject of medical negligence litigation. Spoliation of evidence presents a complicating problem for the litigants and it is in this section that it will be possible to draw together the preceding discussions in order to arrive at some bright-line conclusions and practice suggestions for the health care profession and for legal professionals who work in the medical malpractice system. Keep in mind that the rationale behind spoliation remedies include the restoration of accuracy to the medical record, so far as is possible, compensation

of the victim of spoliation for his loss in attorney fees and time as well as compensation for his inability to bring his case, and, finally, punishment of the spoliator.[614] While the usual spoliator is the defendant health care provider, it is important to mention, as illustrated by at least one case, *Barker v. Bledsoe*, that whatever holds true for the defendant would be true for the plaintiff in the event that the plaintiff were the spoliator.

While many spoliation cases find their way into the state appellate systems, the majority are settled at the trial court level. One estimate concluded that in as many as 50% of medical negligence cases, the medical record has undergone alteration.[615] In order to seek the bright-line interpretations of trial problems, it is valuable to touch upon results in a few recent trial court cases. In *Gouge v. Dallas Pathology Associates*,[616] the plaintiffs discovered that the Texas laboratory falsified its output records with respect to technicians who read cytopathology slides. The laboratory violated the federal rules in the industry. The plaintiffs discovered altered and fraudulent records which created the false and misleading impression that the technologist spent greater time than she actually did spend in reading slides. These alterations, when combined with eighteen pages of violations of federal laws, contributed to an agreed settlement at $4.8 million. In this case, a forty-six year old woman died as a result of a misread Pap smear.

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[614] As pointed out above, when the table is turned and the plaintiff is the spoliator, courts have no trouble reacting accordingly and fairly.

[615] Robert C. Mathews, *Altering the Medical Record*, 10 AM. J. EMERG. MED. 162, 162 (1992).

[616] In 11 PROF. NEG. L.R. 6 (1996). Tex., Dallas County 44th Jud. Dist. Ct., No. 94-12238 (October 13, 1995). The author wishes to thank ATLA member Mr. Clay Miller, of Dallas, Texas for discussing the various important aspects of this case.

In Mississippi, a jury awarded $2.15 million in *Creason v. Paracelsus Woman's Hospital*.[617] In this case the hospital nurses amended their notes after the patient died and this spoliation influenced the defendant's willingness, after the verdict, to forgo appeal and settle for $1.5 million.[618] The nurses inadvertently dated their notes two days after the patient died and they were unable to explain how that happened.

Spoliation of evidence is a costly problem for patients and for defendants when it is discovered. Since the origin of the medical record is so complicated and there are so many ways in which additions or deletions may be made, it is virtually impossible to assure the integrity of a medical record. From review of the above cases, though, one caveat should emerge. There is great peril for the provider who would improperly alter or dispose of medical records.

From the various rules and regulations covering the creation of medical records, it is clear that what should be included in a patient's record should be broad in scope: all documents, laboratory reports, x-rays, pathology materials, fetal monitor strips, EKG's, EEG's; anything which any person used in the rendering of care to that patient should be in the medical record. What about "dissent opinions" as happened in *Rogers v. Ruiz*? If initially placed into the medical record, it must remain, especially if the provider who made the notation made decisions based upon whatever was expressed in the note. To remove such a note once entered into the record is a deception in this author's view.

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[617] In 11 PROF. NEG. L.R. 6 (Feb. 1996). Miss. Hinds County Cir.. Ct., No. 93-75-423 (Oct. 5, 1995). The author wishes to thank Mr. James B. Grenfell of Jackson, Mississippi for sharing details of this case. Telephone Interview with Mr. James B. Grenfell, trial attorney of Jackson, Mississippi (1 April 1996).

[618] Mr. Grenfell stated that the $1.45 million amount reported in the Professional Negligence Law Reporter, *supra*, was an error.

After all of the foregoing we can answer the question: What is spoliation? Any time where a person makes a false entry knowing that it is false, that is spoliation. This would cover all after-the-fact manipulations of the record and even contemporaneous entries if made with the intent to deceive.[619] In the event that records are "lost" without fault attached, who should bear the responsibility? As indicated elsewhere, it is this author's opinion that the statutes and regulations would place blame on the party with the responsibility to make and retain the records. Unless the record is unavailable after complete compliance with record retention statutes, this is a strict liability situation. The jury should be asked to then weigh the credibility of the testimony with respect to the conduct and assess blame. In general though, the failure to produce a medical record should never be treated as a "tie goes to the spoliator." May no record ever be thrown away?, one may ask. Every state has record retention statutes and compliance with those statutes should be the rule. More than one court concluded that spoliation should be viewed as actual malice and accordingly punished the wrongdoer. That seems to be a fair and just approach.

(B) Recommendations

(i) Health Care Industry

(a) Private Practitioners

It is the private office setting which contains the largest risk for the practitioner since in the office the provider can exert full control over all record keeping. Recall from

[619] Intent may be inferred from the attendant facts and circumstances and is a matter of fact the trier of fact should be permitted to decide.

the above that private practitioners are essentially free of mandatory audits from regulatory organizations. At various times, practitioners may be called upon to substantiate diagnoses for insurance reasons or to document care but few federal mandates reach the office practitioner and professional organization requirements count little. At the office level, other than DEA controlled substance records, regulation comes solely through state statutes. Spoliation is tempting when there has been an untoward patient outcome and the practitioner may contemplate additions or deletions to the record, to make retrospective, exculpating statements in the record, or, simply, to dispose of the record.

In terms of medical negligence and risk management, when there is an instance in which the practitioner fears that his care may be questioned, the practitioner should immediately contact his malpractice carrier and explicitly follow directions. It is never acceptable to alter the record in an attempt to "place spin" on the patient outcome. The other comforting assurance at this point is this fact. Those records and the truth they contain will be the practitioner's best defense. At least one judge recognized that the unaltered record is of considerable value in the defense of a medical malpractice case.[620]

Alterations only hurt; they never help. As illustrated above, California and other states routinely discipline doctors who alter their records. Another important litigation strategy should be noticed here. No matter what the allegations of medical negligence are, they will be best defended without altered records since one small alteration, if discovered, will be seized upon to cast doubt upon the practitioner's entire course of care and treatment.

(b) Institutions

The inability to produce hospital medical records never helps to defend a case so that it is imperative that records should be safeguarded. One of the ways that records innocently "disappear" is that persons entitled to access the record take the record without proper sign-out procedures. This may have accounted for the four "lost" slides in *Cherovsky v. St. Lukes's Hospital*. In this author's experience, records are rarely "lost" but they are frequently misplaced. When the plaintiff makes a request to produce the document, it may not reside physically in the Medical Records Department but in some other area. Over the years, this author has discovered that they were at the risk manager's office, the attending physician's private office, at a researcher's facility, being copied at the micro fiche company, at the defendant physician's home, or at the defense attorney's office.

The *Rogers v. Ruiz* case illustrates an important institutional problem with respect to internal risk management procedures. While the court never addressed whether the Burch memorandum should have been included in the chart, and one could make arguments on either side, the amount of trouble this discovered secret memorandum caused is evident. There should, however, be some way for persons with appropriate standing to become aware of important occurrences which influenced their medical care. In the case of an incident report which is unknown to the patient, some disclosure procedure or policy would ameliorate the harsh feelings which develop when the plaintiff discovers these facts under circumstances which happened in Rogers; in the newspaper.

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[620] Mirkin v. Medical Mut. Liab. Ins. Soc'y, 572 A.2d 1126, 1131 (Md. Ct. Sp. App. 1990).

When an incident report is filed, the patient should receive some notice of this fact and, perhaps, have an opportunity to meet with risk management personnel to candidly discuss the incident. The appearance of impropriety when a party discovers by surprise important events which they would have wanted to know introduces unfavorable factors which may actually impede resolutions in either the formal or informal setting. It is not unusual that plaintiffs come upon "smoking gun" memoranda and other written documents in the discovery process so that the candor of disclosure may help the defense. From the defense posture, collusive cover-ups would rarely improve a lawsuit's resolution, if the attorney knows of the conduct and does nothing to correct the situation, this violates professional ethics standards.

A problem which is apparent within institutions is the loss of important information which was integral to medical decision making, such as fetal monitor strips and x-rays. The hospital risk manager should develop a procedure to store fetal monitor strips with the mother's medical record. As *Brewer v. Dowling* and *Hunter v. Skaggs* illustrated, it is a dangerous practice to treat these valuable strips in any other way than the main medical record. The duty to retain this additional material is the same as with the other records and therefore should receive identical care.

Technology can provide substantial help in both the creation and maintenance of medical records. In this author's opinion, computer technology should fully replace antiquated manual record systems.[621] Handwriting is, in general, terrible, entries are often impossible to read, frequently the maker is unidentifiable, and, as a result, the actual

[621] *See*, Andrew A. Skolnick, *Experts Explore Emerging Information Technologies' Effects on Medicine*, 275(9) J.A.M.A. 669 (1996).

clinical utility of the information which the record hopes to convey is in question.[622] If no one can read the record and few can identify the writer, of what use and credibility is the entry? The time has come for all institutions to institute unalterable computerized records.

Additionally, medical records should be bar-coded for each patient. By this method, anyone who makes a chart entry would require a password, a unique identification number, and each entry would be dated and timed. This would eliminate phantom physician orders, progress notes, nursing entries, pharmaceutical administrations, and many other dangerous practices which occur as a result of record inaccuracies.

Since caregivers are the usual spoliators, the ones with interests to protect, hospitals should develop a system of bar-coding records such that no person may obtain a record unless that record is run through the bar-code system. This would hold true for physicians who must dictate records in order to appropriately complete medical records. Physicians should not have access to a pile of medical records which they retain for prolonged periods while they complete the records. Also, hospital forms should not be available to any person unless there is a patient identification stamp or bar-code imprint and authentic records should contain both a patient identification card stamp and a bar-code stamp.

[622] This author along with plaintiff attorneys has spent countless hours in discovery at various times and in many cases haggling over the purported content of handwritten entries. There is a reason, too, for all the jokes about doctor's handwriting! One trial technique this author has used effectively is to create a poster-sized exhibit of the doctor's unintelligible record. This demonstrative evidence tells "negligence" by showing and leaves a lasting impression to which jurors ascribe great weight. Often the jurors conclude, "if his records looked like that, just imagine what kind of a doctor he is!"

It should be impossible, for instance, for a practitioner to obtain both the bar-coder and the patient identification stamps. Further, even in the case of a dictated record, the medical record department should imprint the document with both stamps, without which the document would not be acceptable. Addition of some minimal security such as this would deter all but the most bold. It is unfortunately true that nothing, in all probabilities, will deter the determined spoliator.

Finally, here, is the role of educating young physicians and even experienced physicians in fundamental legal principles with respect to record keeping. As the death certificate example vividly portrayed, it is possible to change practice habits by education. Most medical schools shy away from legal training although recently many schools have instituted some programs. Typically, though, these programs tend to be "attendance optional" or given at times when few will realistically attend. Many programs are included as an afterthought.

Training in matters as important as fundamental principles of good medical record keeping should be introduced into the medical curriculum in an integrated fashion along with all other clinical skills. The best time to begin legal training would be coincident with third-year internal medicine or family medicine rotations. This information and consistent performance in these medical record areas is so important that it should be carefully evaluated along with the newly acquired skills in physical diagnosis.

(B) Plaintiff's Attorneys

The realist is a skeptic and will consider that all medical records contain some

spoliation unless proven otherwise. This is an unfortunate fact in medical negligence litigation. Detection is of the utmost importance. There is one important step trial lawyers should add to their process for obtaining and handling the medical record. As soon as litigation is anticipated, the family or patient should obtain a copy of the record from all providers. Without disturbing the record order, make two copies, number stamp each page, bind one and use the second as the copy from which all other record copies are made.

If litigation is commenced, request a medical record copy through discovery rules. When this arrives, do not disturb the order, number the pages, and again permanently bind this copy. Then, compare the two copies. By examining both the page order and the written entries, any irregularities should conspicuously pop up.[623] Always make requests for production of documents early in the litigation since any irregularity may lead to the necessity for wide ranging discovery techniques. Also, always review the records with your client since the client may make important factual contributions and point out modifications to the record.

In order to approach a spoliation matter consider that there appears to be a time-related spectrum over which courts increase penalties for the offending party. Obviously, if the lack of the evidence does not interfere with the party proceeding with its case, the situation may be viewed as, "No harm, no foul." When loss of evidence imperils a party's legal rights to make his case,[624] courts become very concerned and react according to

[623] When a document is seriously questioned, it is helpful to back-light the two versions. Discrepancies immediately become obvious.

[624] *See,* Headley v. Chrysler Motor Corporation, 141 F.R.D. 362 (1991). In this court's view, "apart possibly from cases where a party has destroyed relevant evidence with the sole purpose of precluding an

when the spoliation occurred and the precise circumstances involved. It is important for both strategic and remedy reasons, if possible, to determine as precisely as possible when alterations took place in reference to when the spoliator likely knew that litigation was suspected.

When courts determine remedies in spoliation of evidence instances, they should engage in the following analysis:

1. Whether any common law or statutory duty applied to the creation, failure to create, or destruction of the evidence.
2. Whether the questioned loss or destroyed evidence is part of the medical record.
3. Precisely when and under what circumstances did the spoliation occur? Is there culpable fault? Is there a concerted collusion between provider and institution?
4. Whether the spoliation imperils a party's right to bring his case.
5. Is a sanction appropriate?
6. What sanction?

According to the case law, under general industry and business standards, when a party destroys evidence in accordance with its routine procedures, prior to any suggestion of litigation, courts tend to assess little if any blame. When a party destroys evidence in violation of state statute but before they know of litigation, the offending party may escape sanction or the court may impose a "light" sanction, an unfavorable inference which is rebuttable. On the other hand, when a party spoliates, knowing that litigation is underway, the court is likely, at a minimum, to impose a presumption that the absence of the evidence would have been unfavorable. When such violations occur during discovery or in violation of a stipulated agreement or court order, courts react predictably, using "contempt of court" models to punish the wrongdoer. It would not be unusual in such a

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adversary from examining that relevant evidence ... all relevant federal cases-not to mention state cases -

case for the court to dismiss the violating party's case. When a party destroys evidence even innocently, when the adverse party is prejudiced in his ability to bring his case, the court is likely to impose a sanction.[625]

Both the fiduciary duty and the duty to create records distinguish medicine from industry and providers practice under the profound duty to make and retain records. Medical records are created for a number of reasons but one important one is to memorialize the details of medical care so that patients have a way for their care to be evaluated at some future time. Record loss under JCAHO regulations, federal or state record statutes, professional licensure statutes, or professional accreditation rules constitutes a *per se* violation of these regulations and of the fiduciary relationship between the provider and the patient.

As evidenced by the professional standards presented above with respect to ABFP, ABOG, and ABOS, among health care professionals, a failure to produce records or record alteration would be viewed as a serious defect in professional conduct. Since the medical profession regards this as a serious violation and the regulatory statutes view this violation so seriously, courts should take a more stern view. Never accept a "no harm, no foul" approach! *Shimanovsky* and *Vodusek* support this position.

Plaintiff's attorneys must bring these various professional rule violations, as well as federal and state violations to the court's attention when these spoliation issues arise in the medical negligence context and request the imposition of penalties commensurate with the professional violations. Unless judges understand that loss of fetal monitor

look to, among other things, prejudice vel non inuring to the adversary." *Id.* at 365.
[625] DePuy, 427 So. 2d 306.

strips, disposition of EKG's, disappearance of x-rays, or retrospective additions and deletions to the record represent great systemic threats to the integrity of the health care itself, beyond their mere loss even without actual harm to the patient, then this conduct will persist.

Unless the plaintiff's bar demands accountability through the judicial process, spoliation of evidence will continue as a major pernicious force in health care litigation. Spoliation needs to be determined early in litigation so that the matter may be brought before the court. It is only then that the plaintiff may seek appropriate remedy. Courts must be educated so that they do not view spoliation of evidence as, "No harm, no foul."

While states may discipline physicians who create false and misleading records, those who fail to create sufficient records, or those who in some way alter records, it would be an unusual prosecution for the state to move on a medical record violation alone.[626] Over the past decade or so the public has wanted greater physician prosecution and despite medical licensing boards taking 4,397 actions, Sidney Wolfe, MD, director of Public Citizen's health research Group criticizes the boards for their "cozy" relationship with the state medical societies and for being "too far removed from consumer influence."[627]

Total sanctions, according to data from the Federation of State Medical Boards as reported by *American Medical News*, including those for administrative reasons, rose 5.8% and 86.7% of those represented license revocations as well as restrictions. Wolfe's organization, Public Citizen, reported that in 1995, the boards took 4.29 "serious actions"

[626] This conduct is termed *unprofessional*, *moral turpitude*, or *dishonesty in the practice*.

per 1,000 non-federal physicians licensed in their states.[628] Interested parties should report instances of spoliation to the disciplinary boards and participate in the investigation.

When a plaintiff discovers spoliation, the attorney should point out various federal, state, and professional statutes and regulations to the court. Whether a licensee would violate a JCAHO rule, a licensure statute, a hospital bylaw, or state record requirement when she alters or disposes of medical evidence, that should be enough "foul" for the court to find damage and to appropriately penalize wrongdoers. None of these statutes require a showing of actual harm to the patient and the plaintiffs' bar can educate judges in this regard.

In addition, as above noted, *Armory v. Delamirie* is still good law. Of an innocent lay plaintiff and professional physician or hospital, upon which party should the courts lay blame for failure to produce the medical record? These records are part of the permanent medical record and should be retained with that record. This policy approaches strict liability and a failure to produce these records should receive stern treatment, absent a cogent explanation. The *Moskovitz* court imposed punitive damages when the defendant falsified records without an additional showing of harm and that is a reasonable holding for other courts to follow.

An aggrieved party should also enlist assistance from the various regulatory agencies in pursuing a claim. A plaintiff, upon discovery of a significant spoliation, may refer the matter to the appropriate licensure board, or various other federal and state

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[627] Linda O. Prager, *Board Issuing More Physician Sanction, but Critics Say 'Wrist-Slapping' Isn't Enough*, AM. MED. NEWS, April 22/29 1996, at 3, 45.

agencies. Typically these agencies will conduct their own investigation and may share their results. If a practitioner is charged with some form of unprofessional conduct, this may be an important factor in the tort litigation. One collateral aspect here might be that the licensure boards and various regulatory agencies are not constrained in their discovery as are plaintiffs in medical negligence litigation. Helpful information to the medical negligence case may turn up even where it is inadmissible under the medical malpractice statutes or discovery of the inadmissible evidence leads to the discovery of admissible evidence. For that reason alone, it is helpful to report this conduct to the licensure boards and to other appropriate state and federal agencies.

One of the most difficult challenges to a plaintiff is to determine whether there has been an alteration to the record. The most efficient way to approach this is through a physician who has the training, background, and experience to detect alterations. Then, the attorney may be able to discover additional alterations through careful and methodical deposition techniques. Here, it is important to depose all persons who have knowledge or who may be able shed some light on these questioned documents while the attorney remains vigilant for inconsistencies. Attorney Jan Millington used wide ranging discovery in *Hunter v. Skaggs* with success when she discovered, in the course of five depositions, that the fetal monitor strips had been placed into a janitor's closet for safe-keeping until the janitor threw the records away. Without arduous discovery, this important fact would have remained a secret.

What should be the appropriate penalty when a party is unable to produce fetal monitor strips, EKG's, or x-rays? The applicable medical duty to produce the medical

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[628] *Id.* at *3.*

chart does not differ from the medical duty to produce other records relied upon in the care and treatment of the patient. The fact that the party may prove his case by using other testimony is simply fortuitous and not a substitute for the duty to produce the whole record. The plaintiff's experts should have the same opportunity the treating physician had in the interpretation of this raw data. Conclusory statements found in the record never substitute for the "real thing." The hospital generally has a statutory duty to retain records, not only records it finds convenient to maintain.

Medical providers and institutions should bear the burden to produce these records and their failure to do so should not receive the innocuous brush off given this matter by the Texas Appellate Court in *Brewer*. When compared to the legal analysis and conclusions reached by the California court in *Smith*, in this author's opinion, decisions such as that reached in *Brewer* are unfair and unconscionable. In the face of such disaster, the plaintiff in *Brewer* should not have been forced from the courtroom "empty-handed."[629]

In *Brewer*, Justice Ashworth was correct in his dissent analysis where he saw the better public policy, that to impose the duty to produce evidence would foster better record keeping and better medical care. A workable rule would be congruent with the positions in Mississippi, Florida, Maryland, and Arkansas[630] which permit adverse presumptions with respect to the inability for a party to produce evidence. This was the

[629] Smith, 198 Cal.Rptr. 829, 834.
[630] *Supra* n. 464 *et seq.* and accompanying text pp.110 *et seq.*.

position in *Welsh*, furthermore, where the court concluded that a rebuttable presumption created a "middle ground."[631]

One might set forth the opposite argument at this point, that to be unwilling to withhold compensation from plaintiffs in the face of these sympathetic circumstances would in effect open up limitless compensation flood gates. A policy of excessive and sympathetic compensation would be as wrong as a policy in which worthy persons would go without. A workable policy must result in neither over- or under- compensation to parties. In fashioning rules courts should choose middle ground cures, when available, as the court sought in *Welsh*.

Middle-ground rules force both parties to play on a level playing field, nothing more. It is legally fair that the courts should use this rebuttable presumption which would have the effect of shifting the burden of persuasion to the health care provider who negligently lost or destroyed medical records.[632] The rule should also provide for sanctions commensurate with injury to the litigant but where there is no injury and a violation of statute, it is recommended that the court impose a substantial fine payable to the patient and refer the matter to disciplinary authorities. Defendants must not be able to wink at one another, assisted by favorable treatment by a conservative judiciary, and avoid liability in these serious matters.

Destructive autopsy cases should receive similar judicial treatments as with the fetal monitor strips cases. The lesson here with respect to autopsy or other forms of destructive analysis is that the examining party has a duty of fairness, must anticipate

[631] Welsh, 844 F.2d 1239, 1249; *see also supra*, text at p. 27 and p. 105 and accompanying notes.
[632] *Supra* n. 438 and accompanying text.

destruction, and advise the opposing party that there *is a likelihood* that testing may forever destroy the evidence. The parties could mutually agree to facilitate testing or, in the event of dispute, ask the court for guidance in advance of such destructive tests.

Apart from various professional consequences for dishonesty in connection with spoliation, when a provider has spoliated in the past and this becomes known, this conduct may be used as a "prior bad act." In a medical negligence action, *Delgaudio v. Romeguera*,[633] the New Jersey appellate court permitted the plaintiff to use for cross-examination of the defendant, twelve instances of failures to maintain accurate and truthful patient records concerning seven patients. In violation of professional requirements and state laws these instances included failures to record any history or physical examinations. The plaintiff's attorney wanted to use these instances in impeachment and to show habit. The Board accepted an ALJ's opinion that Romeguera was willing to distort the truth and that the record in the cases was "replete with examples where [the defendant's] records are not worthy of trust."[634] The State had revoked Dr. Romeguera's license based upon these findings and the court then permitted the plaintiff to use this "highly relevant impeachment opinion evidence"[635] at trial.

Collusive conduct between a provider and an institution may be difficult to uncover but, through careful depositions, one may achieve the success experienced in *Rogers v. Ruiz*. All hospitals have personnel who are responsible to sign records in and out of their repository and risk managers who frequently possess discoverable, non-privileged information. While it may be fruitless to depose the hospital CEO, chief-of-

[633] 654 A.2d 1007 (1995).
[634] *Id.*.

staff, or administrator on record matters since they may have had no contact with the records or the persons involved, it may be fruitful to take the depositions of medical record librarians, risk managers, and the director of nursing services. Minor inconsistencies in the testimony may unveil concerted conduct between various parties.

Many advocacy techniques become possible when the record has been altered. At a minimum, it is important, among other techniques, to gain admissions in depositions from all defense witnesses that tampering with the record would violate applicable federal, state, and professional standards. Only the most courageous defendant would consider trial before a jury when it is aware of significant record defects or alterations.

(C) Defense Attorneys

Can there be doubt that the best defense of a medical negligence case must begin with a clean original record? Typically defense attorneys do not become involved in a medical negligence action until after the chart has been reviewed by the insurance carrier and, in the case of an institution, the risk management executives. When records have disappeared, the best thing to do is to make a thorough search and attempt to locate them. As mentioned before, most records do turn up eventually. The key here, though, is candor with opposing counsel since the likelihood that tampering will be discovered is considerable.

There may be serious consequences to an attorney who participates in spoliation and violates the state's rules of professional conduct. This point is so obvious that it needs no further illustration than the recent case where the Florida Bar suspended an

[635] *Id.*.

attorney for one year after he, in prosecuting a medical negligence action, concealed an expert's memorandum and had his clients sign false answers under oath.[636] The literature and cases are replete with much worse results.

The *Moskovitz v. Figgie* matter stands as an harsh reminder of how a court may react when the defendant acts with callous indifference for his patient's rights and with disregard for the fundamental necessity of honesty in medical practice. The defendant's conduct was that of ordinary, garden variety mis-diagnosis and treatment if one were to subtract the spoliation and bad faith conduct. While it is impossible to know with any certainty how the jury may have treated the defendant absent the spoliation, typically a mis-diagnosis of sarcoma in an elderly woman is settled at a fraction of what the court eventually approved. Although, this too is speculative, without the aggravating conduct, had the case been tried, Dr. Figgie may have prevailed since these sarcomas are rare and juries, in general, hesitate to punish physicians. Dr. Figgie's dishonesty precluded him from a defense verdict!

When records have been knowingly altered, from the appellate cases and the rules of professional conduct, it is axiomatic that this must be disclosed. An attorney must not knowingly place before the court any false or misleading documents since his professional license may be jeopardized as well as his client's case.[637] Additionally, during the litigation process, sides may share original evidence and in that process each side has a duty to preserve the evidence from damage. It seems that candor with opposing counsel, even with spoliation, offers the best possibilities for the defendant.

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[636] Florida State Bar v. Rood, 569 So.2d 750 (1990).
[637] *See*, AMERICAN BAR ASSOCIATION MODEL RULES OF PROFESSIONAL CONDUCT 3.3(a).

Finally, here, in review of cases with large verdicts or settlements in which records were altered, it seems that the worst damage comes in discovery or trial where the defense discovers by surprise that records have been fabricated or altered. At the outset of a case, it may be beneficial to explain that the best defense would require that the attorney is aware of spoliations. Unlike criminal matters where the defendant receives Fifth Amendment protections, this is not the case in civil litigation. A wily plaintiff attorney may reserve record alterations as a trial surprise and its effect may side-track an otherwise defensible case.

There are a number of cases, however, where defendants have won at trial even with altered records.[638] This does not represent the rule, however, and evidence of spoliation introduces a dangerous variable into any defense case. When the defendant won these cases, it appears that the alterations were either easily explicable or subject to favorable interpretation. A cautious defense attorney will always remember what happened to Dr. Figgie.

(D) Legislative

Do we need more rules to protect parties or the system from spoliation of evidence in medical negligence litigation? Probably not. Although the problem of spoliation of evidence in medical negligence litigation has not been extensively studied, according to the *Wachsman* study and the experience with the Federation of Medical

[638] Colbert v. Primary Care Medical, *et al.* Wayne Co. Cir. Ct. Case No. : 91-123999-NH. Reported in 10(6) MED. MALPRACTICE VERDICTS, SETTLEMENTS & EXPERTS 11 (June 1994). Defense verdict where plaintiff made a spoliation allegation but the physician explained that he merely wrote in different inks. *See also, supra* n. 395**,** Kiriak v. Dudukgian; see also, Webb v. Dharmvir, McHenry Co. (IL) Cir. Ct., Case No.: 94L-176. Reported in 11(8) MED. MALPRACTICE VERDICTS, SETTLEMENTS & EXPERTS 24 (Aug. 1995). The defendant was alleged to have entered false power settings from an electro-cautery machine.

Boards, it appears that what is needed is enforcement of the current layer upon layer of existing rules.

One of the sanctions for a party who spoliates would be to initiate professional discipline as a part of the litigation process. This would enhance the social policy against record alteration and foster better record retention. If litigators turned over suspect conduct to HCFA, JCAHO, respective licensure boards, and professional organizations for investigation, it would advance gathering of statistical information as well as foster these organizations fulfilling their regulatory missions. This lack of statistical information hampers all parties and it does appear that there should be more agency and organizational disciplinary actions. It is a concern that the Federation of Medical Boards makes no particular tally of actions brought for medical record alteration. They should keep track of those sorts of prosecutions in the same way as they track impaired physicians.

Spoliation of evidence in medical negligence litigation dramatically differs from spoliation of evidence in non-medical settings: human lives are profoundly affected. Additionally, medicine differs from other industries in the intensity of its regulation. Perhaps, in order to send a message of stern condemnation and to eliminate the unfair "no harm, no foul" result, Congress should add a specific anti-spoliation statute to the Medicare code and the states should adopt a uniform anti-spoliation statue in their medical practice acts. In theory, this may be a beneficial idea but, since spoliation is an evidentiary problem, the adoption of such a statute may create more litigation rather than have the intended effect of enhancing medical quality and reducing evidence tampering.

(E) Conclusion

This discussion has been an humble introduction to the topic of spoliation of evidence in medical negligence litigation since the problem is one which remains in flux. This matter cannot escape legislative intervention and lack of compliance much longer. To a large degree it will be the plaintiff's bar which must lead this transformation and it is my hope that others will be stimulated by this work, write more and analyze deeper than I have done. Truth telling in the medical record in medical negligence litigation is intellectually, morally, legally, and economically correct and efficient. While either side is free to make appropriate good faith arguments in litigation, record alteration introduces an intolerable variable into the process which eventually harms all parties and the system. Professor Bok echos my final thought here where she commented on the "danger of expanding deceptive practices:"

> When should such a spread be thought most harmful? Surely when the opportunities to deceive flourish, and when the knowledge of these practices gives rise to a loss of trust, to imitation, to deceptive countermeasures. It is the fear of such spread which underlies the reluctance to condone professional deception, no matter how indicated it may seem in the individual case.[639]

The fundamental roots of medicine and law sprang from the well of scientific and moral truth. Spoliation of evidence does not justify the risk in medical negligence litigation and damages both professions since this conduct is incompatible with the continuation of either discipline. When a professional tampers with a record in violation of the professional cannons, not only does it raise the cost of litigation, but it potentially

[639] BOK at 119.

raises the costs required to resolve the matter. The cost to the professional could be professionally damaging, too, when this results in an avoidable federal Medicare, state Medicaid, or licensure prosecution. This study stands for the simple proposition that truth in all respects remains the best position for medical care, for justice, and for living.

§ IX.

Addendum and Update
1 March 1997

After completion of this monograph Mr. Kurt Bulmer[640] pointed out Mr. Phillip Carizosa's article in the *Los Angeles Daily Journal* in which he discussed two spoliation cases coming before the California State Supreme Court. In these cases[641] the Court will take up the question of whether plaintiffs who "accuse hospitals of negligently losing key evidence in a medical malpractice case" would be entitled to punitive damages.[642] Since both cases involve identical issues, it is instructive to analyze one as an example.

Cedars-Sinai Medical Center involved the loss of fetal monitor strips and *Temple Community Hospital* was a matter in which the hospital lost an oxygen tank after a patient was burned. Since the law of spoliation evolved from two earlier California Appellate Court[643] decisions, not from holdings from the state Supreme Court, there is a possibility

[640] Acknowledgement to Mr. Kurt Bulmer, Attorney at Law of Seattle, Washington for bringing these cases to the author's attention.
[641] Phillip Carizosa, *Court to Hear Spoliation of Evidence Case*, LOS ANGELES DAILY J., June 14, 1996, p.1.
[642] Cedars-Sinai Medical Center v. Superior Court, 43 Cal.App.4th 605, 50 Cal.Rptr.2d 831 (decided March 13, 1996), (review granted June 12, 1996). Associate Justice Fred Woods wrote this opinion in concurrence with Justices Lillie and Johnson.; Temple Community Hospital v. Superior Court, 43 Cal.App.4th 595, 51 Cal.Rptr.2d 57 (decided March 13, 1996), (review granted June 12 1996). Both cases involve virtually identical problems with interpretation of California Code of Civil Procedure § 425.13.
[643] Smith v. Superior Court, 198 Cal. Rptr. 829, 837 (Cal. Ct. App. 1984). This was an auto products liability case in which the California Appellate Court recognized the tort of intentional spoliation of evidence. Velasco v. Commercial Building Maintenance Company, 215 Cal. Rptr. 504, 506 (1985) established the negligent spoliation of evidence tort in the context of a maintenance worker who discarded a broken bottle while cleaning an attorney's office.

that the upcoming determinations could impact the way courts in California and other states view this tort. Although the California Supreme Court is not the first state supreme court to hear a spoliation of evidence matter, these California adjudications will be watched carefully because of historic and precedential importance. The influence and implications for medical practice are obvious no matter which way the California high court decides these issues.[644]

In the original case the Bowyer family was the plaintiff in *Cedars-Sinai* but did not participate in the instant appeal. The plaintiff alleged that there had been a pattern of missing records which had been purposefully removed after litigation commenced.[645] The plaintiff contended that the missing records related to the identification of the specific obstetric risk factors "and that the missing records interfered with his ability to prove his allegations of medical malpractice."[646] Bowyer argued intentional spoliation of evidence.[647]

The appellate point required the court to interpret the California Code of Civil Procedure section 425.13(a) which provides, in part, that

> In any action for damages *arising out of* the *professional negligence* of a health care provider, no claim for punitive damages shall be included in a complaint or other pleading unless the court enters an order allowing an amended pleading that includes a claim for punitive damages to be filed.[648]

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[644] In the following decisions, note how fine the court slices its distinctions.
[645] Cedars-Sinai Medical Center, 43 Cal.App.4th 605, 611, 50 Cal.Rptr.2d 831, 834.
[646] *Id.*.
[647] Here, the court used the definition of intentional spoliation of evidence from Willard, 40 Cal.App.4th 892, 907, 48 Cal.Rptr.2d 607. "Spoliation is the destruction or significant alternation of evidence, or the failure to preserve property for another's use as evidence, in pending or future litigation." Cedars-Sinai Medical Center, *Id.* at 612, 50 Cal.Rptr.2d 831, 834, and further noted that "The interest interfered with by the tort of spoliation of evidence is the possibility of winning a law suit. (citing, Smith v. Superior Court, 151 Cal.App.3d 491, 502-503, 198 Cal.Rptr. 829 and Willard, 40 Cal.App.4th 892,911, 48 Cal.Rptr.2d 607). *Id.*.
[648] 43 Cal.App.4th 605, 609, 50 Cal.Rptr.2d 831, 833. [emphasis added]

If Cedars-Sinai's conduct *arose from professional negligence* then Bowyer wins punitive damages; if not, Cedars-Sinai wins. The seminal case in which the court interpreted the term "professional negligence" and the critical requirement, "arising out of" was *Central Pathology Service Medical Clinic, Inc. v. Superior Court,*[649] where the court looked to legislative intent. The test is that the provider's act or omission must be the proximate cause of the "personal injury or wrongful death" with the limitation that "that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.'"[650]

> Here, the *Cedars-Sinai* court observed that
>
> > The measure of harm is the effect of the spoliation on the plaintiff's ability to establish his case. ... The harm flowing from spoliation is to a prospective pecuniary interest ... [h]owever, when the prospective economic harm impacts the plaintiff's ability to obtain compensation for physical harm to his person, the economic harm may be deserving of more weight in the determination of whether to impose tort liability.[651]
>
> The *Cedars-Sinai* court then distinguished the *Willard* rationale from *Jablonski v. Royal Globe Ins. Co.*,[652] where it concluded that
>
> > ... if fraud on the part of the carrier is sufficient to take the offending insurer outside of the protection of the Act, then the intentional destruction of evidence of that fraud would for the same reasons cause the forfeiture of its immunity. Any other rule would permit an insurer to profit by the destruction of evidence of its own fraud.[653]

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[649] 3 Cal.4th 181, 186-192, 10 Cal.Rptr.2d 208, 832 P.2d 924 (19XX).
[650] Cedars-Sinai Medical Center, 43 Cal.App.4th 605, 609, 50 Cal.Rptr.2d 831, 833 (citing Central Pathology, 3 Cal.4th 181, 187, 10 Cal.Rptr.2d 208, 832 P.2d 924).
[651] Cedars-Sinai Medical Center, 43 Cal.App.4th 605, 611, 50 Cal.Rptr.2d 831, 834.
[652] *Id.*. (Jablonski v. Royal Globe Ins. Co., 204 Cal.App.3d 379 (1988).
[653] 43 Cal.App.4th 605, 612, 50 Cal.Rptr.2d 831, 836. (citing Jablonski, 204 Cal.App.3d 379, 394, 251 Cal.Rptr. 160).

Was Bowyer's intentional spoliation of evidence claim "directly related to the professional services provided by Cedars"? The California Appellate Court decided that it was only indirectly related to the professional services and did not fall within the statute which would permit an award of punitive damages.[654] Under California statute, recovery is appropriate only where the negligence constitutes *professional* negligence.[655]

The court drew a pencil thin line here stating

> ... at the time of Bowyer's injury from spoliation (the disruption to a possible lawsuit), Cedars was not rendering services for which it was licensed. Even if Cedars did not commit professional negligence, it could still have committed spoliation of evidence. ... The nature and cause of the injury due to spoliation of evidence is different from that resulting from professional negligence. The damages from spoliation of evidence are not directly related to the manner in which the professional services were rendered and, therefore, did not arise out of professional negligence.[656]

While in one way it seems satisfying for a court to grant relief where the damage is directly related to professional services, it is a *non-sequitor* that in a medical negligence context, recovery for spoliation may be had only where the direct performance of medical care causes the injury. That could only happen where the provider stabbed the patient with a pen while writing in the patient's chart. How could that *ever* happen? No one is *ever* directly injured when the doctor creates false medical records or disposes of records. False medical records do not, in and of themselves break bones, cause contusions, result in hypotension, induce ischemia, or promulgate cancer metastases! Yet it appears as if this is the current state of the California law and the reason the state Supreme Court must resolve this instability.

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[654] *Id.*.
[655] *Id.*. (citing, Section 425.13 and Williams v. Superior Court, 30 Cal.App.4th 318, 324, 36 Cal.Rptr.2d 112).

If the law requires a direct injury between medical services and spoliation as a contingency for recovery, then there really is no recovery available in medical care since this directness will always elude the causation analysis. The court's interpretation of legislative intent is flawed. The better rule would recognize that destruction of evidence in medical negligence litigation which impairs a plaintiff's ability to recover constitutes a tort and that the only reason the medical record exists is as a direct result of the physician-patient relationship, the nucleus of professional medical services. The medical record arises only as a result of the relationship, only out of provision of professional services, and therefore is related directly to professional negligence. The medical record is another critical aspect of medical care and is as directly related to professional services as is an operative incision, the placement of a cast, or the diagnosis and treatment of myocardial ischemia. The medical record is as much a part of medical care as is the suturing of a laceration. This directness inquiry should not challenge the California justices too long in Sacramento.

As of this edition, these cases remain to be decided.

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[656] 43 Cal.App.4th 605, 614, 50 Cal.Rptr.2d 831, 836.

Afterword

My daughter Laura asked me after she read this thesis, "So, daddy, if what happened in the Prelude happened today, in 1996, what would you tell a young doctor to do? Should he go to the doctors and confront them? He's only a PGY-1 just beginning his career. Should he bring the alleged wrongdoing to the attention of the chief-of-staff? Should he tell the family? Should he call up the disciplinary officials and file an anonymous complaint? What should he do? What's the right answer?"

"Laura, I thought about this for a long time. It really is a difficult issue, isn't it? If he confronts the doctors, he's dust. If he goes to the chief-of-staff, there's a great possibility for retaliation. He needs a way to accomplish the goals of meeting his own personal standards of integrity while meeting his legal obligations, and at the same time fulfilling his duty to the patient. Certainly he could remain quiet. He has no legal obligation ...Wait a minute. He does have a legal obligation. Most state statutes require physicians to report serious wrongdoing to the state medical disciplinary board. Also, those statutes have a confidentiality protection and an absolute immunity for anonymous reports. If he believes that the doctors at the Board will not tell the doctors at the hospital, he should make an anonymous report to the Board ... but if the hospital docs find out ... You know what it really comes down to? I think he should trust the system and make the anonymous report."

"Dad, that's what I would do. I would take the chance ... it would be worth it. It will make him a better doctor and help the patient and help others in the system."

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