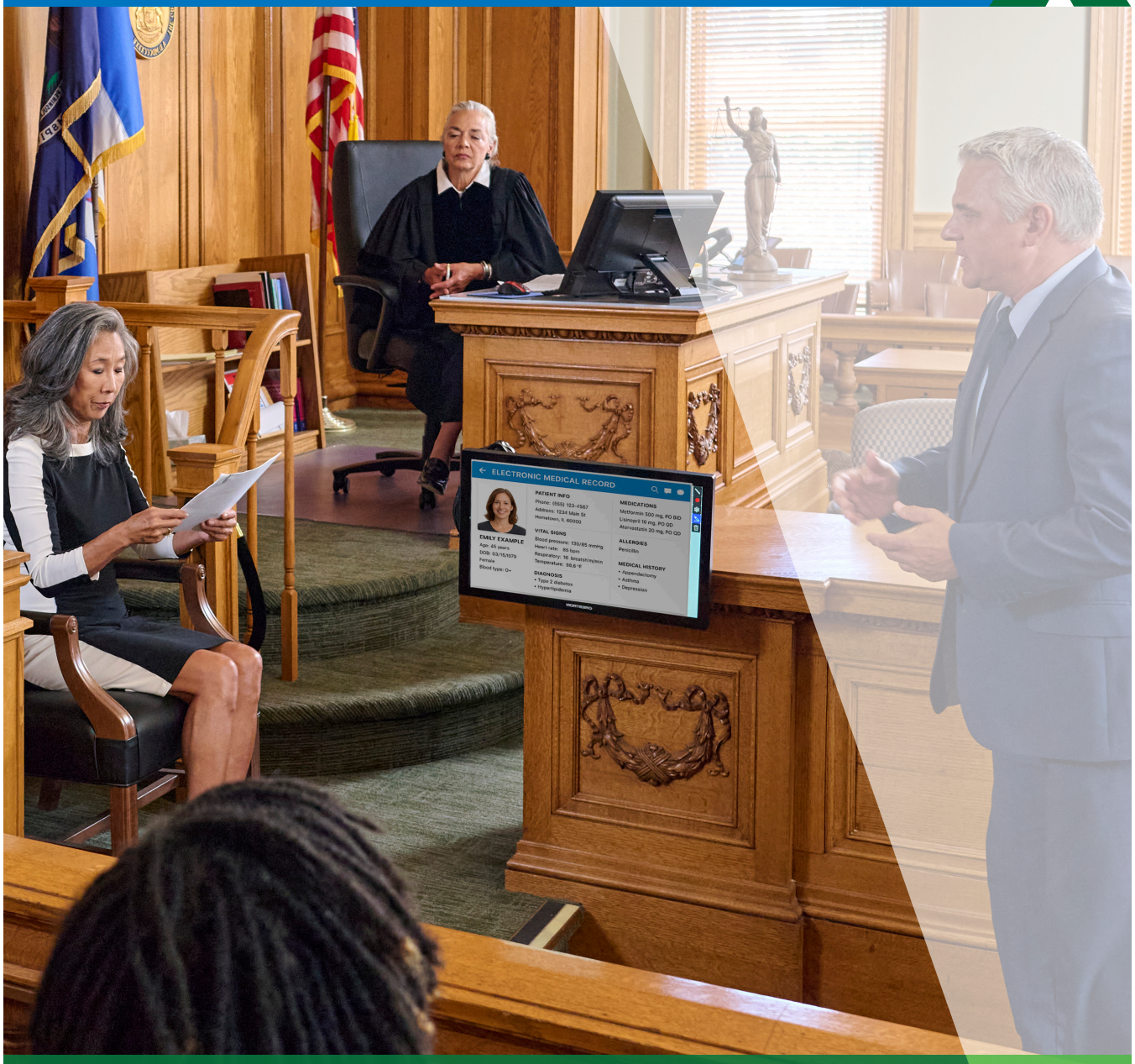
SEPTEMBER

CLAIMS Rx '25

RISK MANAGEMENT PERSPECTIVES



Spoliation of Evidence:
Don't "Spoil" A Good Defense

ProAssurance
MEDICAL MALPRACTICE INSURANCE

CLAIMS Rx
RISK MANAGEMENT PERSPECTIVES

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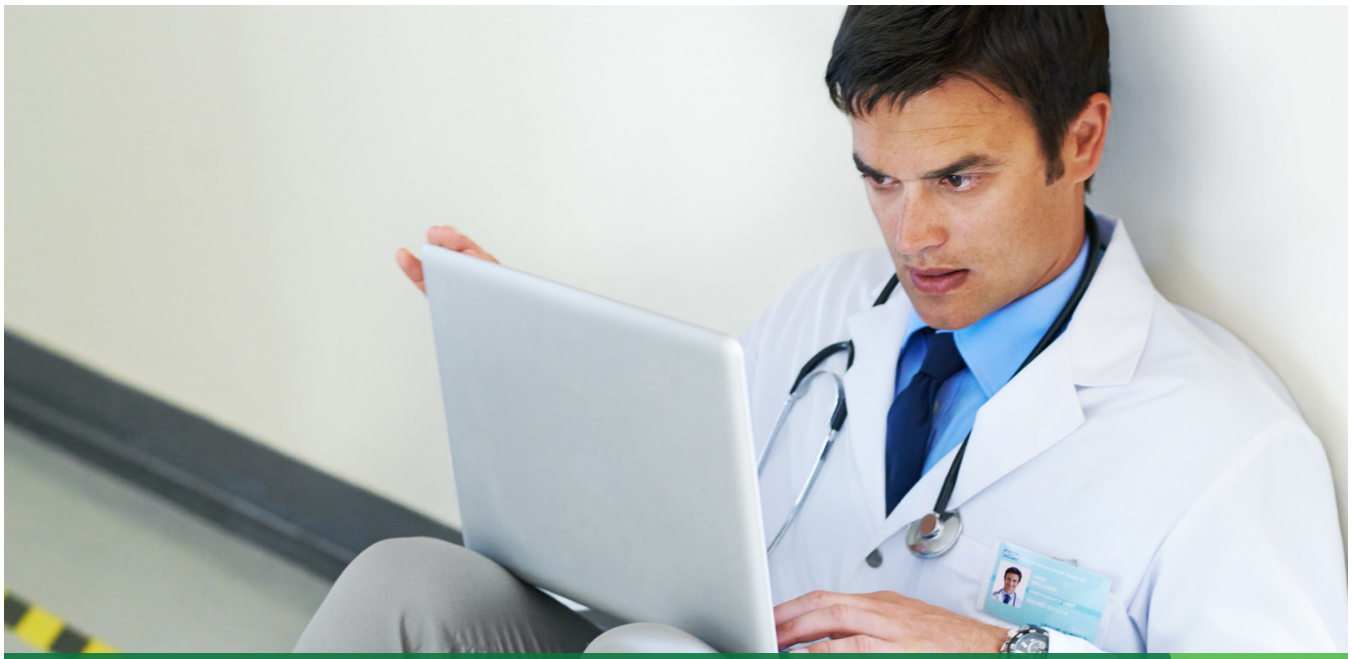

Spoliation of Evidence:
Don't "Spoil" A Good Defense

INTRODUCTION

Medical malpractice occurs in a myriad of ways when providers fall below the applicable standard of care for a given medical situation. Wrong site surgeries or missed diagnoses perhaps seem obvious when contemplating how things can go awry, and providers then be held accountable. However, most physicians likely are unfamiliar with the legal concept of spoliation as an avenue for liability or sanction. Overall, spoliation is defined as "the destruction, loss, or disposal of evidence that is relevant to litigation."[1] In medical liability claims, common examples of spoliation are the failure to preserve, or alteration of, medical records. Spoliation can happen when records or other evidence are intentionally destroyed but can also be the result of negligence, mistake, or failure to preserve. Physicians and medical entities need to consider the concept of spoliation in everyday practice, not just after finding themselves the subject of a claim.

In general, physicians are likely aware that they are required to retain medical records for a certain period, often designated by a state statute. However, they may not realize that they also have a legal duty to preserve evidence when they are subject to a claim or lawsuit and that failure to do so, whether intentional or not, can lead to dire consequences. Litigation holds require the preservation of all evidence germane to litigation. When served with a claim or lawsuit, physicians and institutions need to immediately consider all the items and records that may be evidence in the matter and take action to protect and preserve them.

Having considered the concept of spoliation, physicians should also contemplate the wide variety of evidence that could be the subject of, or proof of, spoliation. Today's medical world utilizes everything from texting to artificial intelligence, to the cloud, for both communication with patients and other providers, and for storage of records and images. You may understand that the medical records themselves are evidence of your care, but you may not realize that things like metadata are also tracking your every foray into an EMR, for example. Functions in texting platforms may lead to auto deletion of text messages after a certain timeframe. Loss of physical items like tissue or lab samples and slides, or medical equipment, can also provide the basis for a spoliation instruction to a jury in a medical liability trial.

This article will focus on the ways spoliation hinders or even prevents the successful defense of good medical care and provide risk management strategies to avoid such scenarios.

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CASE ONE:
Sample Preservation Mishap

It may come as a surprise that institutional policies and procedures unrelated to medical care may be the basis of success or failure in medical malpractice liability. Issues such as improper storage of lab samples, diagnostic results, or even staff training materials may complicate or doom the defense of otherwise reasonable medical care.

As you review this case, consider how the medical care and the defense of the claim are compromised by failures in hospital procedure.

A 38-year-old female presented to her ob-gyn physician (OB1) after a positive at-home pregnancy test in December. An in-office ultrasound confirmed pregnancy with an estimated delivery date of July 20. Her pregnancy progressed without any issues, and she elected for prenatal genetic testing which revealed no abnormalities. There was some concern for macrosomia during the pregnancy, so additional ultrasounds were performed for closer monitoring.

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On July 17 at 4:30 a.m., the patient presented to a regional medical center with uterine contractions. Upon exam the patient appeared 1 cm dilated with the baby at -3 station. Staff initiated electronic fetal monitoring (EFM). At 08:27 a.m. OB1 saw the patient, ruptured her membranes, and placed an intrauterine pressure catheter (IUPC). Contractions arrived steadily every three to five minutes. At 8:44 a.m. OB1 ordered oxytocin for inadequate uterine contractions.

At 9:09 a.m. an anesthesiologist started an epidural, increasing the infusion rate several times based on the patient's continued reports of pain.

At 1:05 p.m. OB1 documented inadequate contractions and increased the oxytocin.

At 6:00 p.m. the patient's care transferred to the on-call obstetrician (OB2).

At 8:00 p.m. a nurse noted the fetal heart rate (FHR) showed a baseline of 160, moderate variability, positive accelerations, and no decelerations. The IUPC showed contractions every 2½ to 3½ minutes. Nurses called OB2 at 8:16 p.m. and received direction to allow the patient to labor down another 30-45 minutes.

At 9:00 p.m. a nurse documented fetal tachycardia—baseline 165, moderate variability, positive accelerations, and no decelerations. The patient began pushing at 9:18 p.m., and within five minutes OB2 arrived at the bedside. The patient exhibited a temperature of 100.4° at 9:30 p.m., and a nurse noted the FHR showed fetal tachycardia of 170, moderate variability, positive accelerations and early decelerations. Antibiotics were administered, and by 10:30 p.m. a nurse noted early and late decelerations with FHR at 140. At 10:41 p.m. oxytocin was increased to 18 mU/minute. At 11:00 p.m. the FHR was 170 with early decelerations.

At 12:00 a.m. the nurse documented fetal tachycardia at 180, moderate variability, 10 x 10 accelerations, and both early and late decelerations. OB2 returned to the bedside at 12:02 a.m., and the patient delivered an eight-pound, two-ounce male infant at 12:09 a.m. Nurses notified the NICU of meconium and fetal tachycardia. The baby exhibited no respiratory effort and appeared pale and limp. Documentation listed FHR in the 80s with Apgar scores of 1, 2, and 3 at one, five, and 10 minutes. Staff dried and stimulated the baby with no response and then administered positive pressure ventilation. At two minutes, the HR increased to greater than 100. The FHR increased to 160 when intubated, but the baby still demonstrated no respiratory effort. At nine minutes, the baby was transferred to the NICU where he underwent neuroprotective cooling.

Two days after delivery an MRI of the infant's head revealed findings indicative of hypoxic-ischemic encephalopathy (HIE). Placental pathology showed chorioamnionitis. After discharge home the infant ultimately received diagnoses of a seizure disorder and cerebral palsy. Over time he demonstrated significant developmental delays including cognition, speech, fine motor skills, and gross motor skills. He also required G-tube feedings resulting from dysphagia.

The parents of the infant filed a medical malpractice lawsuit against OB2 and the hospital alleging that negligent delivery delay and inadequate resuscitative efforts caused the infant's brain injuries.

DISCUSSION

Experts were mixed but generally supportive of OB2's care in this case. A pediatric neuroradiologist expert opined that the MRI was suggestive of an injury that developed from hypoperfusion over hours to days and is typically seen with placental insufficiency. Defense experts opined that intrauterine conditions present for several days prior to the delivery likely contributed to the outcome for the infant. They referenced the pathology report which showed chorioamnionitis and cord funisitis. Specifically, that the enlarged placenta was consuming a higher-than-normal amount of the oxygen and nutrients from the mother depriving, the fetus in the days leading up to delivery and making the baby more susceptible to the effects of stress. The defense intended to show that the MRI and placental findings collectively supported a conclusion that injuries resulted from an intrauterine condition rather than a delayed delivery.

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Plaintiff's experts disagreed with the MRI findings and believed a more acute process occurred. To dispute the defense theory, the plaintiff subpoenaed the pathology slides for an independent analysis of the diagnosis and delivery course. Despite rigorous efforts to locate the pathology slides, the hospital failed to find and produce them.

The plaintiff requested a spoliation jury instruction based on the lost tissue samples. Had the hospital produced the samples, it may have been able to show that the unfortunate outcome was simply a terrible twist of fate and not the result of any medical malpractice. However, a spoliation instruction would allow the jury to assume that the missing samples showed or proved something negative about the hospital's case. Therefore, the case settled prior to trial.

RISK REDUCTION STRATEGIES

Consider the following strategies:

- Put in place procedures that ensure clear and accurate labeling and storage per state requirements of all diagnostic tests, including biological samples.
- Consider using barcode tracking systems.
- Train staff to accurately collect and properly seal sample media/containers to avoid contamination or decay.
- Regularly review disaster mitigation procedures for your practice or institution, with a focus on records and sample preservation.
- Educate staff about litigation holds—what they are, how to comply, when to expect that one is imminent, and when preservation or sequestration should begin.
- Designate and educate staff to accurately and timely respond to record subpoenas.
- Ensure proper transfer of ownership/location/storage of medical and business records upon changes to practice (e.g., sale, merger, retirement).

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DELETING TEXT MESSAGES: THE SPOLIATION RISK

As the use of electronic communication escalates in medical care, physicians need to be aware of the potential pitfalls of using text messages, including those within an EMR system. The following exchange occurred during ProAssurance's Rapid Risk Review podcast entitled "Health in Your Hands: Navigating Text Messaging Risks." ProAssurance Risk Management department's Bradley Byrne, Southeast Regional Manager, interviewed Brian Whitelaw, a partner in the law firm Foley, Baron, Metzger & Juip, PLLC.

Bradley Byrne: I think it would help our audience to kind of talk to them a little bit about the fact that if you're communicating both with patients and other providers via text message, that that might be something you're going to have to preserve for litigation purposes. Just kind of talk to them a little bit about what that looks like and what can happen if those records are deleted or destroyed.

Brian Whitelaw: Sure. Every state has what's called a spoliation of evidence rule. And this is how the rule reads in Michigan, but every state's about the same: If a party with evidence in their control fails to produce it without a reasonable explanation, the jury can be told in a jury instruction that they may infer that the evidence would have been unfavorable to that party. Spoliation can happen when a party fails to preserve relevant evidence after a suit arises, regardless of whether it was intentional or negligent. "I changed phones." "I lost all my text messages." Not good enough. The jury will still, in all likelihood, get an instruction from the judge that says, the evidence has shown that there were text messages sent from the patient to the doctor, and the doctor to the patient, or from provider to provider. The defendant cannot produce that evidence. You may assume that that evidence would have been contrary or unfavorable to their position at trial. That can be devastating. Another circumstance in which you'll want to preserve that kind of evidence—text message history—is if you receive what's called a litigation hold letter or any indication that a suit might be filed. A litigation hold letter is usually a letter from a lawyer saying, we intend to file suit. Please preserve all of your records, your text messages, and everything else. It's pretty obvious what it is. And you should know what it is when you receive it and certainly talk to your lawyer about it. But if you get a notice of intent to file a claim or an actual lawsuit, the same rules apply.

Don't start deleting any text messages. That would be no more sensible than altering a medical record. Once a suit is filed, you have to consider all of the evidence sacrosanct and do everything you can to preserve it. Good, bad, or indifferent, whether it hurts you or helps you, lawyers will be able to assist in explaining anything that you've got within a text message. If the text message is so devastating to your own situation that resolution is mandated because of it, then that's what's going to have to happen. It's far better to be open and honest, preserve everything you've got, and then work with your lawyer to make sure it can be presented in the best way possible.

Bradley Byrne: That's excellent information and advice, Brian. And as we kind of wrap things up, I know this is just kind of like the tip of the iceberg on this particular topic, but if there's one piece of advice you could give our audience with regard to communicating via text message, what would it be?

Brian Whitelaw: Well, it's hard to divide it into like a single unit of advice, so I'll give you two. One, don't use your personal phone to convey information regarding any patient, either to a patient or to another provider. A corollary to that would be, don't give your phone number to patients. And number two, never say anything in a text message that you don't want shown to a jury.

Additional Resource
ProAssurance *Claims Rx*: Is It Safe to Send That Text? The Patient Safety and Liability Risks Associated with Text Messaging

LISTEN TO THE ENTIRE PODCAST

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CASE TWO:
Records Management Distorts Credibility

When seeing patients, most physicians are unlikely to be considering whether the purchase records for any equipment they are using are properly maintained. Similarly, the full range of functions or settings of said equipment is probably not top of mind. However, from a litigation standpoint, even things as remote as tax records can come into play despite the seemingly nonexistent connection to medical care. The following case illustrates how failure to maintain even nonmedical records within a practice can affect litigation.

As you read through this case, consider how the equipment management practices could undermine the defense of the physician's medical care in a future lawsuit.

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In January, a then 58-year-old female patient presented to an anesthesiology and pain management specialist with complaints of low back pain that radiated to her lower extremities. The patient provided a long history of back pain that began with a workplace injury nearly 20 years prior. The patient described trying so many medications to remedy the pain that she could not remember the full list of what had been prescribed to her. She had endured numerous rounds of physical therapy but had not undergone any back surgeries.

The pain management specialist referred the patient to several other specialists, including a neurologist, and obtained numerous imaging studies over the next few years attempting to address the pain. Various surgeries and therapies, including medication, were recommended. The patient again declined surgery but did attempt some of the suggested therapies.

In March of the next year, the patient reported severe neck pain. Imaging showed that the patient suffered herniated discs, stenosis, and foraminal narrowing from C3/4-C4/5. The pain management specialist's partner referred the patient for a trial of gabapentin and medical branch blocks in May, and the patient underwent injections for several months. The patient experienced significant but incomplete pain relief. In June the partner recommended bilateral radiofrequency ablation (RFA).

The pain management specialist performed the RFA procedure in August without complication and with the patient in a supine position. (Notably, a few years after this procedure, the practice sold the radiofrequency (RF) generator used by the pain management specialist to a medical supplier when the practice upgraded equipment.) After the procedure the pain management specialist recorded that the patient was stable, able to ambulate, and that motor stimulation at 2.0 volts produced no extremity motor response.

The day after the operation, the patient contacted the pain management specialist and reported numbness on the right side of her face and an inability to use her right hand the prior evening. The pain management specialist prescribed prednisone and told the patient to go to the ED if the symptoms worsened. Two days later the patient arrived at the local hospital ED complaining of numbness and pain on the right side. On the way to the hospital the patient experienced bradycardia, dizziness, and briefly lost consciousness. The ED performed imaging studies. They showed no hematoma or mass and did not otherwise identify a source for the patient's numbness. While at the hospital, the patient suffered additional incidents of bradycardia, and she was sent to a tertiary care hospital for a cardiac work-up. However, by the next day her symptoms had resolved. Despite reporting numbness, the patient's arm strength and sensory response remained intact.

Over the 14 months following the RFA procedure, the patient saw the pain management specialist and numerous other doctors and specialists. She reported varying levels of pain, numbness, and spasms in her neck, right arm, and hand. A neurosurgeon documented that the patient suffered from complex pain syndrome with complicating issues of radiculopathy, myelopathy, peripheral vascular disease, and other problems.

DISCUSSION

The patient insisted that all her symptoms were worse following the RFA procedure. She alleged that the pain management specialist caused a thermal injury to her nerve roots on the right side of her cervical spine when performing the RFA, resulting in sensory and nerve damage.

Several experts, including a neurologist and a cardiologist, supported the pain management specialist's care of the patient in this matter. They pointed out that the patient suffered from numerous conditions that could explain her reaction after the procedure, and that all her subsequent neurological examinations were normal. Further, they accused the patient of embellishing her post-procedure symptoms to the point that later reports did not reconcile with contemporaneous notes.

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Despite expert support for the pain management specialist's care in this matter, the judge in the case believed that the sale of the RF generator that was used in the patient's procedure was not inadvertent. The defense team's efforts to recover the RF generator proved futile, and the judge ordered production of all documentation related to its purchase and sale, including tax records. Further, the RF generator possessed the capability to save procedure data from each use, but the pain management specialist did not download any of the data. The judge indicated that she was prepared to issue a spoliation jury instruction because she inferred data on the device might be damaging to the defense. The judge believed the machine could have shown that the pain management specialist used improper settings during the procedure that related directly to the patient's outcome. For this reason, and potential damage to the pain management specialist's credibility due to the spoliation instruction, the case settled.

RISK REDUCTION STRATEGIES

Consider the following strategies:

- Document patient care completely, concisely, and contemporaneously.
- Maintain complete business records for your practice or organization.
- Understand and utilize the full functionality of equipment to record procedure data.
- Ensure you understand the full capabilities and settings of any technology-based system utilized, including storage, automatic deletion, and security.

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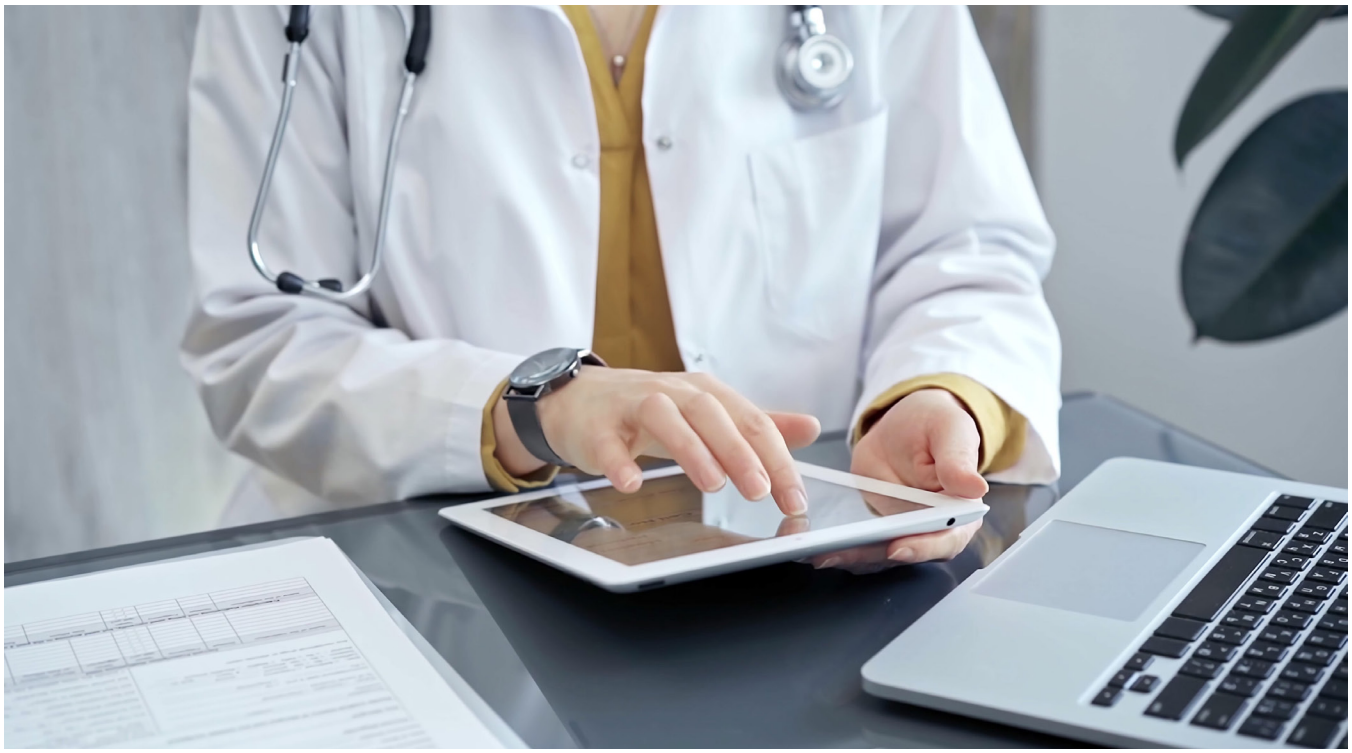

CASE THREE:
Medical Record Manipulation

No physician wants to find themself the target of a claim or lawsuit. Nonetheless, one of the first considerations upon receiving a claim or summons is preservation of evidence that might be used during litigation. Alteration or manipulation of medical records places the credibility of a physician in doubt and can be illegal. Even in the absence of a spoliation jury instruction, sloppy record-keeping and practice management can simply leave a poor impression with a jury about how a physician practices actual medical care. Credibility issues potentially arising as a result of such actions can make otherwise excellent care extremely complicated to defend. Further, in comparison to the previous case examples, maintenance of the medical record is one aspect of the patient care landscape that physicians may have more control over. The following case demonstrates how suspected alteration of medical records can damage the defense of a liability claim.

As you read through this case, consider how the ob-gyn's documentation could complicate the defense of a future malpractice claim.

On July 11, a 68-year-old woman presented to her ob-gyn to receive her annual Pap smear. During this visit she also expressed complaints of pelvic pain. The patient's medical history included caesarean section, bilateral tubal ligation, and diabetes. Despite a normal Pap smear, the patient reported continued pelvic pain, and the ob-gyn ordered a follow-up ultrasound.

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The ob-gyn discussed with the patient the findings of the ultrasound, which showed suspected fibroids. The ob-gyn informed the patient that additional diagnostic testing could confirm the status of the fibroids and possibly treat them.

The ob-gyn performed a diagnostic hysteroscopy with dilation and curettage on the patient on September 19 at 8:00 a.m. at an ambulatory surgery center (ASC). Preoperative informed consent was obtained. It notably included, but was not limited to, the risk of perforation and/or injury to nearby organs, and death. The gynecologist treated the cervix using silver nitrate to achieve hemostasis, sent the specimens to pathology, and noted no complications. The patient's vitals remained stable throughout the procedure, and she went to recovery in stable condition. The ASC discharged the patient to home at 11:05 a.m. with a follow-up appointment scheduled in two weeks.

The pathologist called the results in to the ob-gyn on September 20. Notably, the specimen contained fragments of both adipose tissue and colonic mucosa. While the report described otherwise normal uterine tissue, this clinically relevant finding indicated both a uterine perforation and a bowel perforation. The final report referenced mixed fragments of adipose tissue and colonic mucosa and further stated that the pathologist discussed the results with the ob-gyn on September 20.

Metadata showed the ob-gyn accessing the patient's chart to enter a note on September 19, around 4:00 p.m., and two more times on September 21 at 5:34 p.m. and 6:18 p.m., summarizing a call she made to the patient.

> *I called to ask how she was feeling postoperatively. She stated that she was feeling okay. Denied pelvic pain and stated she felt gassy. I asked if she had any pain and she said, "just stomach pain." She stated she had eaten a little breakfast and just part of a sandwich for lunch. She stated she wasn't very hungry. She denied fever or chills.*
>
> *She denied vomiting, denied vaginal bleeding, and denied fever or chills. She said she felt weak.*
>
> *I then informed her that the pathologist called me and said there was "some fat" in her endometrial biopsy sample in addition to the uterine polyp. I explained that this meant the instrument used to remove tissue from the uterus had gone through the wall of the uterus. I advised her to go immediately to the Emergency Room for evaluation. The patient stated that she would go to the ED if her symptoms worsened.*

On September 20, EMS responded to a 911 call from the patient's husband at her residence. The husband explained that the patient had polyps removed surgically by her ob-gyn on the morning of September 19. She later experienced abdominal pain and had contacted her doctor who scheduled her for a follow-up appointment. The husband denied that the ob-gyn told either him or the patient that she needed to go to the ED. Instead, the ob-gyn recommended ginger ale and antacids. Just prior to her death, the husband followed the physician's advice in response to his wife's complaints of abdominal pain. She vomited after taking one sip, became unconscious, and stopped breathing, so he called 911. The ob-gyn learned of the patient's death when the coroner's office called on September 21 seeking additional records from the patient's surgery. The final autopsy report listed the cause of death as septic peritonitis due to perforation of the uterus and colon from complications of a uterine polypectomy procedure. The patient's husband filed a wrongful death lawsuit.

DISCUSSION

Experts supported the ob-gyn's medical care in this matter. However, a dispute arose over whether the ob-gyn explained to the patient that she urgently needed to go to the ED. The patient's husband testified at deposition that both he and the patient had spoken with the ob-gyn, but neither of them were told that information. As noted during discovery, the metadata contained in the EMR system indicated that the ob-gyn had accessed the notes in the patient's chart at least twice after her death, although she insisted no changes were made. Plaintiff's counsel for the husband alleged that the ob-gyn altered the medical record to fit her ultimate deposition testimony that she had told the patient she needed to go to the ED. Despite expert support for the medical care, the ob-gyn's credibility in front of a jury was compromised by the potential alteration issues exposed with the metadata. For this reason, the case settled before trial.

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RISK REDUCTION STRATEGIES[2]

Consider the following strategies:

- Never alter (or allow anyone else to alter) any part of a completed medical record at any time, including upon notice of a claim or lawsuit.
- Upon notice of a claim or lawsuit, have a means to secure and preserve the original medical record and utilize a copy for any ongoing or future patient care needs. For example, sequester original paper records and/or copy the complete electronic health record onto a portable storage device. Securely store the device and/or records, as well as any other related health records of that patient (e.g., x-ray films or DICOM images), until the event is resolved.
- Develop a medical records correction policy and procedure based on the following recommendations:
  - Define commonly used terminology for record amendments, and implement guidelines for accomplishing the task (e.g., corrections, addendums, retractions, resequencing, deletions, late entries, etc.).
  - Maintain transparency with any record change, regardless of the type of medical record utilized.
  - Do not allow changes to be made to a record indiscriminately or anonymously. For example, changes to a record should be made as addenda, and dated and signed appropriately, so that the change cannot subsequently be construed as an alteration.
  - Guidelines should include direction, proper tracking, and audit trails (e.g., EMR systems) to ensure clarity of changes and indicate what changes were made, why they were made, and by whom.
  - Never backdate an entry. Always direct the reader's attention from the original, erroneous entry to the corrected entry if it is not readily apparent that the subsequent entry is a correction.
  - Never physically remove or permanently eliminate information from a medical record; instead, use methods to retract information with an annotation to consult the retracted information as necessary. Be aware that a retracted erroneous entry may have been relied upon by other members of the healthcare team. To completely remove an original entry without proper transparency and follow-up would jeopardize the integrity of the record.
  - Have systems in place that will flag and track any amended record to indicate what changes have been made.
  - Ensure that processes are in place to forward amended record information to any other place or person that should receive updated information.
  - Address how patient requests for amendments to their record will be processed, following HIPAA regulations.
- Choose an electronic medical record system that automatically does the following:
  - Dates, timestamps, and authenticates all entries (usually based upon the individual user's password).
  - "Locks" all entries upon the author's sign-off and after a designated timeframe (e.g., seven days after an encounter).
    - Does not permit data changes or removals once entered and signed off—software vendor claims about information security should be verified.
  - Tracks all additions, edits, and changes that are made in a medical record.
  - Prints the entire record in a readable format.
- Designate an individual(s) with authority to "unlock" an entry, following defined guidelines. The guidelines should outline specific circumstances in which changes can be made and tracked with an audit trail and explanation.

ADDITIONAL RESOURCES

ProAssurance Risk Management Guidelines: Medical Records

ProAssurance Article Library: Optimize Your EHR to Manage Risks – Case Studies and Best Practices

Spoliation of Evidence:
Don’t “Spoil” A Good Defense

CONCLUSION

Spoliation problems can damage your ability to defend good medicine in a medical liability lawsuit. You may provide excellent care that is defensible in a claim, yet undermined if critical records or other information go missing. Physicians and institutions need to keep the concept of spoliation in mind as they conduct themselves, even as it may seem to have nothing to do with the practice of medicine. Even unintentional loss or destruction of evidence may interfere with your ability to defend yourself in a medical liability claim. The best way to protect yourself is to enact policies and procedures that prevent spoliation from occurring in the first place.

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ENDNOTES

The documents referenced in this article, along with many other risk management resource documents and past editions of *Claims Rx*, are available on the ProAssurance website, by calling Risk Management at 844-223-9648, or by email at RiskAdvisor@ProAssurance.com.

1. Brianne Goodwin, "How Spoliation of Evidence Can Cost You in Court," *Urology Times*, November 1, 2016, https://www.urologytimes.com/view/how-spoliation-evidence-can-cost-you-court.
2. Portions of the Risk Reduction Strategies originally appeared in "Medical Record Documentation Risks and Strategies," *Claims Rx*, May 2021.

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