
— AI AND MEDICAL RECORD LITIGATION

When the Machine Helps Write the Chart

How to Judge an AI-Assisted Medical Record

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A clinical note can be well organized, grammatically clean, and easy to read, and still be wrong about what happened in the exam room. That's always been true. What's new is how fast polished notes can now be produced. Ambient listening tools draft a note from the conversation. Summarization tools shrink years of history into a paragraph. Predictive tools score risk and fire alerts. All of them can help patients. All of them can also change what a later reader, including a jury, believes the clinician knew.

So the useful question isn't whether a record "has AI in it." It's how a particular tool shaped a particular record, and whether the decisions made from that record were sound.

THIS ISN'T A FUTURE PROBLEM

AI documentation tools are already in routine use. In December 2025, HHS, through the Office of the National Coordinator for Health IT (now part of the Assistant Secretary for Technology Policy), published a request for information on speeding up the use of AI in clinical care, and in June 2026 ONC held a public session on the responses. The federal government wants adoption to go faster, not slower.

States are starting to set guardrails. California's AB 3030, in effect since January 1, 2025, requires certain providers that use generative AI to write patient messages about clinical information to include a disclaimer and tell the patient how to reach a human, unless a licensed clinician reviews the message first. Texas passed two laws in 2025. SB 1188, effective September 1, 2025, lets practitioners use AI for diagnosis and treatment only if, among other things, they review all AI-generated records under Texas Medical Board standards and tell the patient. HB 149, the

Texas Responsible Artificial Intelligence Governance Act, effective January 1, 2026, requires health care providers to disclose AI use in a patient's care. More states are considering similar bills. Whether any of these applies to your case, and what a violation means legally, is for counsel. The clinical message running through all of them is the same: a human is supposed to check what the machine wrote.

KNOW WHICH TOOL YOU'RE DEALING WITH

"AI" covers very different things, and the review depends on which one was in play. An ambient documentation tool turns a recorded conversation into a draft note, so the question is whether the draft kept the clinical meaning of what was said. A summarization tool condenses existing records, so the question is whether the summary got its sources right, including what it left out. A predictive or decision-support tool produces a score or an alert, so the questions are what data went in, what came out, and whether it changed what the clinician did.

Lumping them together hides the question that actually needs answering. I'd start with the ordinary clinical task, meaning what the clinician was trying to figure out, what they had to work with, what the patient said, and what they observed, and only then look at how the technology took part.

A FICTIONAL CASE

A woman sees her doctor after several episodes of dizziness. During the visit she mentions she sometimes feels pressure across her chest walking uphill. She also says she's anxious about all of it. The signed note focuses on anxiety and says she "denies chest pain." A few days later she's admitted with an acute cardiac problem.

That sequence deserves a hard look, but it doesn't prove the software caused a missed diagnosis. There's a real clinical difference between denying chest pain *right now* and denying chest pressure *with exertion*. Exertional chest pressure is a classic warning sign of heart disease; a present-tense denial isn't. If that distinction vanished when the note was drafted, every later reader would come away with the wrong picture. What matters is the meaning that got lost, not the fact that a computer wrote the sentence.

To sort it out, you need to know what was actually said, what the clinician typed, what the tool generated, and what the clinician reviewed before signing. And you need the full clinical context: the exam, her cardiac risk factors, whatever testing was ordered, and what she was told to do.

LOOK PAST THE SIGNED NOTE

The signed note is where the inquiry starts. Depending on the system and how it's configured, there may also be draft versions and the edit history between draft and signature, audit trail data showing who created, viewed, changed, and signed the note and when, metadata showing which text came from the ambient tool, which was templated or copied forward, and which the clinician typed, the vendor configuration and the organization's policies on AI notes, training materials and any attestation language shown at signature, and logs of corrections or feedback on AI drafts.

Two cautions. Don't assume there's an audio recording. Many ambient tools delete the audio once the draft is made, and retention differs by product and setup. Ask what was created and kept, instead of building a theory around a recording that may never have existed. And move quickly on preservation. The duty to preserve attaches when litigation is reasonably anticipated, and short-lived data disappears first. How to handle that is counsel's call; a clinical reviewer can help you identify which technical sources are most likely to matter.

HIPAA's Security Rule requires covered entities to have audit controls that record activity in systems holding electronic health information (45 C.F.R. § 164.312(b)). That doesn't mean every event you care about was captured at the level of detail you need, so ask precisely.

KEEP THREE CLOCKS SEPARATE

A note signed at 6 p.m. may describe a 9 a.m. visit. An addendum the next day may clarify what happened, or recast it. When you rebuild events, keep three times apart: when the care happened, when it was documented, and when it was changed. Hospital Conditions of Participation require record entries to be legible, complete, dated, timed, and authenticated (42 C.F.R. § 482.24(c)(1)), and state rules and professional standards expect much the same in other settings. The timestamps are evidence. Blur them together and information can look like it was available earlier than it was, or a late entry written after the outcome was known can slip by unnoticed.

Back to our patient. Say the doctor's handwritten reminder mentions exertional pressure, but the final electronic note records a denial of chest pain. That's a discrepancy worth chasing, and it still needs interpreting. Maybe the doctor asked more questions and reasonably decided the symptom meant something else. Maybe a key detail simply got dropped in the draft. Keep both possibilities open until the evidence tells them apart.

WATCH FOR ERRORS THAT COPY THEMSELVES

Clinicians downstream often read the summary instead of opening every source note. When an error slides from one summary into the next, repetition makes it look solid. Five entries saying the patient "denies chest pain" aren't five confirmations if they all trace back to one generated

sentence. They're one sentence, copied five times. Trace every important entry to where it started. This applies just as much to copy-forward text and templates, which caused the same problem long before AI.

WHAT "REVIEWED AND SIGNED" REALLY MEANS

"The note was reviewed and signed by the physician" sounds reassuring, but it can mean very different things. Did the doctor check the draft against the visit? Reconcile the medications and allergies? Confirm the negatives with the patient? Or accept it because it looked complete?

A signature proves authentication. It doesn't tell you how a disputed sentence got into the note or whether the doctor relied on it. Useful questions: What did the screen show at signature? Was AI-generated text visually marked? How long was the note open before it was signed, and was anything edited? What training did the organization give on reviewing drafts, and what did policy require? How were users supposed to report errors, and were similar corrections piling up?

The organization's setup helps explain the conditions a clinician worked under. It shouldn't be used to invent a universal legal duty that applies to every product everywhere.

And be fair in both directions. A doctor who spends less time typing may have more attention for the patient, and a good draft can make a complicated visit clearer. A tool being popular, or having an impressive demo, doesn't make its notes accurate either. What counts is how the actual workflow performed in the visit you're reviewing.

A BAD RECORD ISN'T AUTOMATICALLY A CAUSE

Say you prove the symptom was summarized wrong. Next question: did it change the care? If the doctor ordered a proper cardiac workup based on the conversation itself, the documentation problem and the clinical decision point in different directions. If a later clinician relied on the wrong denial and held off on further evaluation, the link may be significant. Even then, you have to look at what else that clinician knew, what options were reasonable, and whether a different response would probably have changed the outcome.

Serious outcomes make every earlier imperfection feel decisive. Good clinical analysis pushes back on that. Find the defect, explain what it meant clinically, and test the proposed causal link against the rest of the record.

HOW WE APPROACH IT AT LEXCURA

Record Integrity, the first pillar of the Lexcura Clinical Intelligence Model, asks how the information in an AI-assisted record was created, whether its sources can be traced, and whether the final version kept the clinically important meaning. Baseline Profiling establishes what was already known about the patient before the visit in question. Imaging Analysis, the third pillar,

makes sure a summary of an imaging report never quietly stands in for the report itself, or for a qualified read of the images when that's needed. Timeline Reconstruction puts everything in order, with care time kept separate from documentation time. The remaining pillars take up the standard of care, the regulatory picture, and causation. The structure keeps a good story from getting ahead of the evidence.

QUESTIONS TO BRING TO YOUR REVIEWER

Be specific in that first conversation. Point to the sentence or omission that worries you, ask what it would have meant clinically at the time, and ask what else could confirm or undercut that reading. Good questions sound like: Did the wording remove a symptom that would reasonably have changed the workup? Did an old medication or problem list slide into the current note without being reconciled? Did a later clinician rely on a summary that misstated its source? Could the doctor tell, at signature, which text the tool wrote?

Look just as hard for evidence that supports the care: a clear assessment written at the time, a documented discussion of uncertainty, sensible return precautions, or independent confirmation of the disputed history. A review that can't see those things isn't reliable when it says it found a failure.

As these tools become routine, the most useful questions will be the concrete ones. What was wrong? How did it travel? Who used it? What happened because of it?

SOURCES

- HHS/ASTP-ONC, *Request for Information: Accelerating the Adoption and Use of Artificial Intelligence as Part of Clinical Care*, Federal Register Doc. 2025-23641 (Dec. 23, 2025); ONC event, *Adoption of AI in Clinical Care: Updates from the HHS RFI* (June 25, 2026)
- California Health & Safety Code § 1339.75 (AB 3030, 2024)
- Texas SB 1188 (eff. Sept. 1, 2025); Texas HB 149, Texas Responsible Artificial Intelligence Governance Act (eff. Jan. 1, 2026)
- 42 C.F.R. § 482.24; 45 C.F.R. § 164.312(b)

This newsletter is for education only and isn't medical or legal advice. The case is fictional. Legal references reflect sources reviewed in September 2026; confirm current status in the relevant jurisdiction.

ABOUT LEXCURA CLINICAL INTELLIGENCE

Lexcura Clinical Intelligence provides integrated clinical and regulatory analysis for attorneys handling healthcare litigation. If the accuracy of an AI-assisted or templated record is at issue in your case and you want the documentation traced to its sources and tested against the decisions it influenced, we'd welcome the conversation.

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