Wake Me Up!! I've Had Enough!!

Litigation Nightmares with the Electronic Medical Record

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There are few developments that have affected the practice of medicine like the adoption of the electronic medical record (EMR) approximately a dozen years ago, when President George W. Bush advocated for its complete adoption by 2014. As a commentator on this topic since then, I can state that if anyone declared at that time how the adoption of EMRs would affect medical liability claims with absolute certainty, they were less than truthful. Now, after 10 years worth of care involving the EMR, we are beginning to emerge from the fog of uncertainty in dealing with the novel clinical, preservation and production issues associated with the EMR. The following is an overview of what EMR issues we anticipated correctly a decade ago and where we were wrong.

WHAT WE PREDICTED CORRECTLY

Review of EMR Metadata Would Increase and Be Considered the New Normal

Ten years ago, few knew what "metadata" was. About that same time, the Federal Rules of Civil Procedure were amended following the seminal case of *Zubulake v. UBS Warburg*, where Judge Shira Scheindlin issued a series of legal decisions that provided the first guidance for preserving and producing the embedded data that tracks changes to computerized records.

Where metadata has impacted medical professional liability claims is in the "audit trail." In my practice, producing an audit trail along with a hard copy printout of the EMR has become the new normal. For those not familiar with the term, "audit trail" is essentially a chronological breakdown of when information was recorded in the EMR that is visually hidden onscreen but is fairly easy to recreate and produce in a printout. Due to its ease in production, the typical discovery objections that the information sought in an audit trail is "unduly burdensome" or "unlikely to lead to relevant information" is not the case. It is easy to produce, and it is likely to lead to relevant information.

One may ask why the audit trail is being sought. In medical malpractice cases, it can show large time gaps between when the treatment was rendered and when the documentation of that treatment was entered into the computer. It can also point out alterations or supplementation to the record. When documentation time gaps and supplemental entries are discovered, it leads to additional inquiries, such as, "Why the time delay—What were you doing between the care and the chart entry?"; "Was what you documented after treating the patient different from what you would have documented had it been done simultaneous to the treatment?"; and, "Why did you supplement and/or change the record?" The EMR's audit trail, which was not available with the hard copy record, has provided an opportunity for further inquiry into areas that were of little interest in the past. Now, healthcare providers should anticipate scrutiny regarding late or supplemental inquiries. They should be prepared to explain why it occurred because the audit trail will easily show the discrepancies. For health risk professionals, you may not like the answer.

Access to Entire Patient History Has Advantages and Disadvantages

One of the touted potential benefits of the EMR was that it would create a literal world wide web of health information on a patient, hypothetically providing a patient's complete record, from cradle to grave. In theory, this capability would improve care because physicians would have a patient's complete medical history at their fingertips. With more patient information, at least theoretically, most thought that healthcare would improve,

which would reduce hospital stays and lower healthcare costs.

However, in medical negligence claims, complete access to a patient's health record through the use of a comprehensive EMR system can be used against healthcare providers if they do not utilize it in the care of their patients. Healthcare providers need to be cautioned that, now that they have access to a patient's complete health record through the EMR, they are expected to utilize that information. For example, if a patient's chart from a separate institution years prior indicates they have a medication allergy, it can be anticipated that a criticism will be made against the healthcare provider for not reviewing that record if the patient was given that medication in error and suffered an injury.

Just as the complete healthcare record can be used by healthcare providers to assist in preparing a medical defense, the converse is true. Healthcare providers should be encouraged to access the complete medical history in the care of their patients, otherwise, the failure to use this new feature can be used against them.

There Would be Increased Scrutiny on Health Information System Professionals

The last area that was correctly predicted was that, in addition to the medicine, there would be an increased interest by patients' lawyers in how EMR systems are used and what features are available to healthcare providers when they are using these systems. It didn't take long for them to learn that the hard copy printout of the EMR does not demonstrate the breadth of the EMR system and what it can do. They've discovered that the hard copy of the EMR is a one-dimensional view of a three-dimensional system. Through research, education and learning from their experts, patients' lawyers realized that EMR systems offered different features that don't translate into paper production of their clients' health record. Screenshots of the EMR are not produced, nor is EMR data provided in native form to be viewed at a computer. In addition, they discovered that the options available to a healthcare provider in a drop-down box were not being provided, only what was selected. They learned that some EMR systems make clinical treatment recommendations based on the leveraging of treatment data for similarly situated patients.

Slowly, we are seeing an increase in requests by plaintiffs' lawyers, when conducting discovery, to view the EMR system "live" on a monitor to see how it works and what functions are offered. Why wouldn't they want to see how the EMR works? Given that the relevancy standard for discovery tends to be low (as opposed to the admissibility standard at trial) and that the use and complexity of the EMRs will increase, healthcare providers should anticipate that these types of requests will be permitted in the future and may become standard medical malpractice discovery practice.

WHAT WE GOT WRONG

In 2005, electronic medical record keeping was touted as a way to improve medical care by reducing errors due to documentation mistakes. It was projected that handwriting legibility issues would be eliminated and that the record would be very clear. While the handwriting issues associated with the chart have disappeared, we now know that new record keeping issues have developed that were not anticipated.

The EMR Would Offer More Patient Detail

One of the biggest differences in medical records documentation is that "charting by exception" is now the typical documentation practice due to the way the EMR works. By its own definition, "charting by exception" requires the documentation of pertinent negatives. Even with the paper chart, "charting by exception" did not reveal much about a patient. Now, with the addition of drop-down options using pre-determined descriptions, there is a tendency for healthcare providers to only "click-click-click" the drop-down options rather than use the narrative. Charts now look generic, lacking specific details about the patient and their treatment.

Along those same lines, drop-down boxes can be a challenge because, although EMR designers try to be exhaustive in their options, practical experience shows that not all options can be listed. As a result, in situations where the descriptive term is not available for the healthcare provider's selection, the next closest option is selected. While this practice may be appropriate in a multiple choice school examination, in healthcare this can result in inaccurate information being placed in the chart. Drop-down selections, although convenient, have not solved documentation errors and, in some instances, may encourage them if healthcare providers forgo the use of the narrative and choose dropdown options that are not completely accurate.

Medical Abbreviation Errors Would Be Eliminated

When free text narrative sections are being used, new and unanticipated abbreviation issues have developed. In the hard copy record, there may have been medical abbreviations being used that were misinterpreted because of sloppy penmanship or because the abbreviations could have had multiple meanings. Now we are seeing abbreviation errors based on society's reliance on personal text messaging from their smart devices. In essence, we have swapped the medical abbreviation problem with a texting abbreviation problem. To that, I say, "OMG!"

Log-Ins, the New Electronic Signature, Would Resolve Identity Issues

The signature associated with chart entries has also changed to "logon/ log-off." Theoretically, with the "log-on/log-off" practice, the identity of those who have documented in the chart should be 100 percent clear. However, in reality, when users log-in under someone else's identity, or under a group identity, it can be nearly impossible to retrospectively decipher who made a specific chart entry. So while the log-in process should clear up any ambiguity of who documented a specific entry, it is only as good as those who properly identify themselves using correct log-in protocol.

Embedded EMR Warnings Would Eliminate Medical Errors

One of the specific features the EMR would possess, that the hard copy did not, was the ability for the systems to warn healthcare providers ahead of time if they were going to recommend treatment that may be contraindicated or risky. However, we now know that EMR systems with too many warnings can cause "warning fatigue." Despite the ability to embed fail-safe patient safety warnings in the EMR, users may deliberately consider them "Henny Penny" and ignore them for no good reason, especially if they are considered cumbersome and another hurdle interfering with patient treatment.

Corrections or Amendments to the Chart Would Be Easy

The last documentation issue to be addressed centers on corrections and amendments. With a hard copy record, it is very easy to make changes to the record and can be done in a near universal format— line out/make the amendment in an area near the entry or in an area where one would anticipate a change, sign the change and date when the change was made. This was very simple because paper allowed for changes nearly anywhere—in the margins, additional spaces or altogether new pages. With the EMR, changes to the record are dependent on where the system allows you to make an amendment. In other words, if there is not a space or templated area where a change can be made, how will one know how and where to make a change? Furthermore, a change to the record directly (i.e., delete and change) is something that is tracked by metadata and revealed in the audit trail. If the change is made for self-serving reasons, the metadata/audit trail will make that clear. The EMR, while proficient in many ways, does not lend itself to the reality that after-the-fact corrections and amendments may need to be easily made in a universal manner.

The Production of Hard Copy of the EMR Would Not Be an Issue

As most know, when patients or lawyers request copies of the medical records, they are not getting screen shots, nor can they receive a copy of the EMR data in native form. Despite all the time, money and planning invested into the adoption of

the EMR, little thought was put into the production of the hard copy EMR printout for litigation purposes. To this day, EMR developers have never made the paper copy of the EMR easier to understand. This issue remains one of the biggest difficulties in medical malpractice cases for all involved.

Compounding this problem—that the hard copy of the EMR does not reflect how it looks on a computer monitor— is EMR system upgrades and changes. EMR systems are always being upgraded with new options and features, just like other computer programs. Remember how Windows used to look? Over the years, Windows has changed in appearance, made upgrades and eliminated some features. The same is true with EMR systems. The first version of an EMR may look nothing like the eighth version. For example, the drop-down options for various chart entries may have changed, including the number of options and descriptive terms. We know that when the EMR is printed, what is shown on the record with respect to the drop-down box is the option that was chosen, not all of other options offered. In this regard, unless the drop-down options are archived in some manner, it may be impossible in 2016 to recreate what was available as an option in a drop-down box in 2011, after several upgrades.

Another example deals with EMR system templates. A certain entry may exist in a 2016 EMR template that was not available in 2011. When the information from the 2011 EMR is printed in 2016, it shows the 2011 information in the 2016 template, not the one from 2011. Most persons, including healthcare providers, may not know or remember how the 2011 EMR template appeared. When the 2011 information is provided in a 2016 EMR template, there may be a 2016 template item that is blank, appearing to have been unanswered. The explanation for the blank template entry may be because that entry was not available in 2011. Verifying why an entry is left blank may mean questioning a health information professional if a templated entry existed in the past. Unless an older template is available in some manner, there may not be a way to answer that question. Further, if there is no older EMR template or version available, it may be impossible to recreate the record as it existed at the time at issue. This is a dramatic change in medical malpractice litigation because the hard copy record is a static document that cannot be easily changed. The hard copy record you had in 2011, when the care was rendered, is what is produced in 2016 for litigation purposes. Now, it may be impossible to recreate what medical information was available to a healthcare provider at a given time in the past.

The Future?

We dream of the return of the use of the hard copy medical chart, but make no mistake, it is never coming back. Change is the only constant, and EMR systems will continue to evolve and incorporate the latest technological advances, including the greater utilization of handheld smart devices in patient care. Issues will emerge five years from now that we simply cannot predict. For the health risk professional, it is imperative that you not only stay current on medical trends, but also on the technology being used at your facility, and that you anticipate where things may go wrong. There is no perfect ERM system, and its users are never infallible

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