How Your EHR Increases Your Malpractice Risk

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By Lori Abel Meyerhoff [3]

Can your EHR increase your risk? Yes, when used incorrectly. Here are potential technology pitfalls that can expose your practice to new malpractice risks.

With cash incentives now available to physicians who adopt electronic health records systems, it seems inevitable that most practices not already using EHRs will soon begin to do so. As an internist who has dictated "RRR without m/r/g" and "PERRLA" more times than I can remember, I'm for anything that makes a doctor's job easier.

But I'm also a lawyer who defends doctors from malpractice claims, and I can tell you that EHRs, while offering many real documentation and work flow advantages, can also introduce new problems for physician defendants. While EHR advocates will tell you that the systems reduce your malpractice risk by making documentation more systematic, and providing you important clinical alerts that reduce the likelihood of bad outcomes, it's also the case that when used improperly EHRs and other new information technologies can complicate your defense in the event of suit.

Much more information is discoverable in a digital world than in a paper world, and this information can be exploited by plaintiffs' lawyers. Indeed, the very notion of what constitutes the medical record is itself evolving, and can now include things that may not seem particularly relevant to a physician. If you're thinking of switching to an EHR system from paper records, or if you've already done so, you need to know how plaintiffs' attorneys are using electronic records to their advantage, and what you can do to protect yourself.

**Testing and diagnostic procedures**

In the paper chart era, it was clear that everything clinically relevant to a patient's case was placed into the paper chart and became part of the official medical record. In fact, a great deal of communication among physicians and other healthcare providers, and between doctors and patients, never made it into the paper record. In the electronic world, however, it is far more difficult to define the outer limits of information within the "official medical record." For example, some specialized equipment acquires abundant data points but only utilizes some portion of this information for the clinical output.

In ophthalmology, an orbscan obtained as part of a preoperative evaluation for laser vision correction surgery may also contain abundant additional data that the doctor wouldn't normally consider as part of the evaluation. This data could be considered a part of the medical record. Plaintiffs' attorneys can utilize the data to show the patient had an abnormality (for example, some form of a higher order aberration) that was a "contra-indication" to the procedure the ophthalmologist performed, even though it was not, at the time of the procedure, mainstream medical practice to consider such data outside of academic or experimental settings.

In the broadest sense, the medical record incorporates all data obtained electronically on a patient, including information the physician may have considered clinically irrelevant at the time they cared for the patient. This information is discoverable once litigation begins. Physicians should ensure that their EHR is regularly backed up, as is any data obtained on specialized equipment. Additionally, digital images obtained in color should be retained in color rather than printed in color and then scanned into an EHR in black and white.

**Electronic communications**

More patients are demanding e-mail communication with their physicians. Such communication should, at a minimum, be retained in its original format. The better practice is to save e-mails with patients directly into the patient's medical record.

Failure to retain this information within the EHR increases the likelihood that e-mails could become lost or deleted, and that could complicate a malpractice defense. The mere fact that such communication was not retained looks bad, and some of the lost e-mails might have provided defenses to the allegations within the plaintiff's complaint. The substance of all e-mail communication must be known from the onset of litigation as it may be critical to decisions regarding the merits of the claim and the defense thereof.
Digital, text-based pages represent another source of discoverable communications. Plaintiffs' attorneys are now requesting complete paging logs. When I trained, this information only contained a telephone number and the patient name. However, pages may now arrive as a detailed text message with abundant clinical information. This information can be used to attempt to demonstrate that one healthcare provider had concerns about a patient that were dismissed, or not properly considered, by the defendant physician.

Additionally, comments included within the digital pages that do not directly relate to patient care can damage a malpractice defense. For example, one physician texts information about a patient to share a clinical finding or test result, and includes within that text message a comment that he has a plane to catch.

Years later, when in litigation, the plaintiff will suggest to the jury that the physician was in a hurry and not paying attention to the patient. Communications through text pages should be limited to information directly relevant to patient care. Additionally, physicians should make reasonable efforts to document in the actual medical record whatever steps they took to address issues brought to their attention within a text page if it significantly alters patient care.

**Shadow charts**

Some physicians resort to keeping two separate charts: the official medical record (the EHR) and a "shadow" paper chart. Shadow charts tend to contain some of the information within the EHR, plus other information, including e-mail communications with patients that the physician might not consider part of the medical record; research information collected on patients; and nonelectronic information such as hand-drawn diagrams that were not scanned into the EHR.

You should not maintain a shadow chart unless it is for research purposes only and, in that circumstance, all direct patient care information should be within the EHR as well. There should be a single medical record only and it should include all information obtained or acquired on the patient.

**Auto-populated fields**

Many EHR fields are auto-populated — the EHR template may be prepopulated with the "usual" clinical finding. If the patient does not fit within this usual description, the physician must change it by choosing another selection from a drop-down menu or by typing the examination finding directly into the record.

For example, "Normal breath sounds in all lung fields. Clear to auscultation without wheezes, rhonchi, or crackles" may automatically populate the EHR field covering the pulmonary examination. If the patient's CXR shows a significant pneumothorax or pneumonia, any erroneous documentation of a normal examination will make defending a claim more difficult. Be careful not to over-rely on the EHR's prepopulated fields. A good plaintiffs' attorney will capitalize on poor documentation in the medical record even when a particular example is unrelated to the subject matter of the plaintiff's claim. The plaintiff's counsel will suggest to the jury that any documentation errors call into question the remainder of the documentation.

These situations are difficult to overcome and are entirely unnecessary. This type of error is more frequently seen in EHRs that have auto-populated fields than those requiring selection from drop-down menus or with free-texting fields. I understand that auto-populated fields save time in busy practices, but they should be utilized very carefully, if at all.

Even with drop-down menus, which are preferable to auto-populated fields, there is a tendency to select the "closest" match, which may not be appropriate in individual cases. As such, it is imperative that free texting is encouraged to ensure documentation is accurate.

**Copy and paste**

Another pitfall seen in litigation is the situation of an incorrect history or physical finding that is documented repeatedly in the medical record. This frequently occurs in the in-patient setting but can occur in the outpatient setting as well.

For example, a patient with a history of a deep venous thrombosis (DVT) is evaluated in the emergency department (ED) with acute onset of shortness of breath. The first ED physician fails to document a prior history of DVT. Each subsequent treating physician copies and pastes this incorrect history.

If the patient subsequently dies from a pulmonary thromboembolism (PTE), even if all physicians were aware of the prior DVT and treated the patient accordingly, the poor documentation will open the door for the plaintiff's attorney to argue the cause of death was the "missed" PTE and that the defendant physicians did not consider the diagnosis because they were all unaware of the patient's actual history. It is imperative to obtain and document your own history for each patient. If possible, the copy-and-paste feature of the EHR should be disabled.

**Standard dictations**
In most surgical specialties, similar procedures are performed repetitively. As a convenience, standard dictations for certain procedures are created since each is performed in the same general manner and most are uncomplicated. The problem arises when there is a complication during surgery that is not dictated or, even worse, a second procedure is performed but the "standard dictation" is still utilized. This second procedure may be performed flawlessly, but the dictation states that the patient underwent a repeat of the original procedure. Inevitably, this dictation is signed and made a part of the EHR. Only when litigation ensues does the surgeon recognize the error and then dictates a revised operative report detailing the actual surgery performed. This is generally years later. The plaintiff's counsel will quickly point out that the defendant physician not only dictated the wrong procedure on the day of the actual procedure, but also subsequently read and signed it, and only dictated the actual surgical procedure years later and then only from memory. The plaintiff's counsel will suggest to the jury that the defendant physician was not paying attention to the details of this patient's care. Even worse, plaintiff's counsel may allege an operative complication occurred that the surgeon does not recall due to the passage of time between the surgery and the dictation. Counsel may demonstrate that the physician violated the medical staff bylaw requiring the timely documentation of the actual surgical procedure performed. This type of documentation issue is frequent in malpractice claims and is difficult to overcome by the defense.

**Digital fingerprint**

One of the most difficult problems created in medical malpractice defense by the EHR is the so-called "digital fingerprint." Every time anyone accesses a patient's electronic record, evidence of the access is stored electronically. A digital forensic examiner can easily recover this evidence. Information recoverable generally includes date, time, specific information accessed, time spent in each section, and often whether any modifications were made to the medical record. This information becomes important in a number of ways. First, and most obvious, if the defendant makes any changes to the medical record, this is easily identified. This would be insurmountable in the defense of the claim.

Second, suppose a physician becomes aware of a bad outcome shortly after a procedure was performed. The physician then reviews the electronic record, and comes to believe, in hindsight, that he should have done something differently than what he did at the time. During the defendant physician's deposition, the plaintiff's counsel will question the defendant about his impression of the care provided after review of the medical record after the physician became aware of the bad outcome. The sworn deposition testimony of the physician's retrospective review of the medical record is generally adverse to the defense. The plaintiff must prove his case prospectively, but if the record is reviewed shortly after the bad outcome, the plaintiff's counsel will argue the clinical guidelines and/or physician's training and experience did not change significantly between the event and review and that the physician must have "just missed it." The physician needs to understand the risk of deposition questions pertaining to any review of the medical record subsequent to a bad outcome, since the plaintiff's counsel is reviewing the audit trail.

Third, this information can be utilized to demonstrate that some piece of information pertinent to the treatment of the patient was either reviewed and ignored or was not reviewed although ordered. All of these issues create abundant issues in the defense of a malpractice claim. Although many of the pitfalls associated with the digital fingerprint are impossible to overcome, the physician must be aware of the potential tracking information available to the plaintiff's counsel once a claim is in litigation.

Electronic medical records are not going away. Physicians need to educate themselves on the most appropriate system for their practice and how to efficiently and effectively utilize their EHR. Extensive training for the physician and staff as to the proper use of EHR is essential to successful defense of malpractice claims.

Lori Abel Meyerhoffer, OD, MD, JD, earned her medical degree at the University of South Florida, College of Medicine. She practiced internal medicine for 10 years before studying law at the University of North Carolina at Chapel Hill. She now works for the firm of Yates, McLamb & Weyher in Raleigh, N.C., where she defends physicians and hospitals in malpractice claims and in actions before the state medical board. She can be contacted at lmeyerhoffer@ymwlaw.com. This article originally appeared in the March 2011 issue of Physicians Practice.

* Want to know the other side of the coin? Editorial director Sara Michael writes about how your EHR can protect your practice against malpractice risk. Read "Using Technology to Manage Malpractice Risk."