Electronic Medical Records: Litigation Experience and Risk Management Tips

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The electronic medical record (EMR) has only recently started to appear in litigated medical malpractice cases. This article will discuss the positive effects of an EMR in defending claims, point out the ways we have seen EMR used by opposing counsel, and offer some risk management tips for using EMR.

The Benefits of EMR

One of the positive effects of EMR has been more detailed and complete documentation. The templates used for various chief complaints provide a handy and thorough checklist to facilitate history taking and documentation. For example, the template for chest pain sets forth a series of important descriptors such as associated symptoms, location, quality, radiation, duration, timing, context, and modifying factors. The typed-in history taken by the clinician can then address these issues. The templates also offer a helpful section for the review of systems in which the clinician can ask about related symptoms and simply type in a “no” if the patient’s history is negative. This provides accurate documentation of what previously may not have been written down due to a presumed negative response by the patient. Such EMR-facilitated documentation of a negative history has recently been helpful in a case where the patient later died and the clinician could point to actual documentation of what turned out to be a very pertinent negative in the review of systems. Had this not been affirmatively documented through the EMR, the evidentiary rules excluding verbal statements by a decedent would likely have prevented the clinician from defending herself with this key point.

Another positive aspect of EMR has been its ability to prompt the clinician to follow up on abnormal lab values, results of other diagnostic tests, and overdue preventive-medicine screening tests. The EMR can flag abnormal test results in the clinician’s e-mail and can even signal scheduling personnel to follow up by calling the patient for an appointment. The EMR can also keep track of preventive-medicine screenings and generate a reminder letter to the patient and a trigger to the clinician when he or she next sees the patient. Because of the good use of EMR capabilities, we are now seeing a near elimination of specific allegations of failure to follow up appropriately on abnormal tests or needed screening.

How EMR Can Hurt a Clinician’s Case

However, we are also starting to see the EMR used against the defendant clinician in several important ways. First, we are beginning to see requests for the EMR’s underlying metadata—that is, the information about the data that describes, for example, how, when, and by whom the data was received, created, accessed, and modified. Many, many data fields are not printed or regularly viewed in the EMR as it is used daily by clinicians. For example, the EMR’s audit trail feature tracks individual
access to the EMR, and we have had to produce EMR audit trails in the litigation context. The audit trail tracks certain portals in the EMR, causing a tripwire-type notation in the audit log when those portals are accessed. The audit trail thus provides a permanent record of each time the patient’s EMR is accessed, and by whom, even if no entry is made. It is important to keep in mind that each time you access a patient’s EMR, an electronic “footprint” of that access may be permanently created.

Second, plaintiff attorneys are suggesting that the defendant clinician is so preoccupied with typing in the EMR that he or she isn’t paying adequate attention to the real live patient in the exam room. We have heard plaintiff patients testify at deposition that their clinicians were typing throughout the interviews, making their patients uncomfortable and unsure if the clinicians were really listening. You can reduce such a perception in your practice by explaining why the EMR is used instead of handwriting—and then listening intently and typing separately.

Third, plaintiff attorneys have been placing an overemphasis on the EMR’s “date and time stamp” feature. The EMR creates a date and time stamp for nearly all entries—from the documentation of vital signs by the medical assistant to the clinician’s review of diagnostic test results. Plaintiff attorneys are using the date and time stamps to try to show the actual length of the visit at issue and the amount of time spent between clinician and patient.

The Risk of Date and Time Stamps

Be aware of the “date and time stamp” feature in the EMR. Plaintiff attorneys try to use this as proof of when the clinician first reviewed an abnormal lab result. In reality, the date and time stamp is triggered when the clinician formally opens and reviews the lab result, test, or other report. Depending on the EMR, date stamping a lab result or report might be accomplished by clicking on a button, check box, or other feature. The clinician may well have seen and acted upon the result earlier when accessing the EMR for another reason that did not trigger the date and time stamp. That is, the clinician may have seen a lab result through an auto-preview feature on his or her e-mail but did not activate the date-stamping feature in the record indicating his or her review because there were still outstanding lab results to receive. It is important for clinicians to “mark” the record with the date and time stamp when they first review results, tests, or reports. This practice documents the clinician’s prompt review of patient tests and supports an accurate chronicle of clinical care.

The Risk of Automatic Text

Pay attention to the automatic text that is placed into the EMR when certain actions are taken. The automatic text may be different from what is intended and may not fit the clinical situation. For example, when the medications list is reviewed and updated, the EMR may insert an automatic text stating “Medications discontinued at this visit.” In a recent case involving an alleged failure to diagnose an aortic dissection, the patient had been seen 18 months earlier and had reported during the visit that he had not been taking the anti-hypertensive medication prescribed a year earlier but had been taking an herbal supplement instead. When the clinician cleaned up the medication record, he took the prior prescriptions for anti-hypertensives off the patient’s list. Therefore, in the EMR, the notation “Medications discontinued at this visit” automatically appeared, giving the impression that the clinician, rather than the patient, had decided to stop this treatment for high blood pressure.
Conclusion

For risk management purposes, the “e” in electronic medical records stands for “eternal.” Any and all access, changes, edits, or modifications to the patient’s record are preserved and may even be date and time stamped. Despite the eternal and omnipresent nature of the electronic eye of the patient’s electronic chart, careful and attentive use of the EMR with these risk management tips in mind will generally help the defense if the patient’s care is subsequently litigated.