Electronic Medical Records: The Good, The Bad, and The Ugly

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James W. Saxton, Esquire
Chairman, Health Care Litigation Group
Co-Chair, Health Care Department
jws@stevenslee.com
James W. Saxton, Esquire

- Co-Chair of Stevens & Lee’s Health Care Department and Chair of the firm’s Health Care Litigation Group
- Past Chairman of the American Health Lawyer’s Association Healthcare Liability and Litigation Group (2002-2005)
- Works nationally with physicians and health care organizations including hospitals, and medical practices in areas of risk management, liability reduction, and health law and all litigation related issues
- He is an active trial lawyer – a practice he has sustained for over 25 years – representing physicians in state and federal courts in professional liability cases
- Has used his extensive experience as a litigator to develop new litigation strategies as well as new loss control tools in collaboration with leading experts in high risk clinical areas
- Has authored in excess of 200 articles and textbooks, created films, and is involved in national teleconferences
- Lectures frequently and is an invited speaker across the country on health care issues, including liability reduction and risk management, and presents to nationally prominent health care organizations such as the American College of Surgeons, the American Society for Metabolic and Bariatric Surgery, American Health Lawyers Association and the American Society for Healthcare Risk Management
- He is a fellow of the College of Physicians of Philadelphia, the oldest professional medical organization in the country
“By computerizing health records, we can avoid dangerous medical mistakes, reduce costs, and improve care.”

-- President George W. Bush
State of the Union Address, January 20, 2004

It’s About Safety!
Broad use of health IT will:

**Improve** health care quality

**Prevent** medical errors

The systems are designed to:

- Reduce error
- Improve quality

Why didn’t it work?
Mr. Smith went to ED with complaints of
  - Fatigue
  - Headache
  - Fever
  - It is the middle of the summer in a potential “tick” area

All of the signs and symptoms are entered into EMR

EMR pop-up recommends Rocky Mountain Spotted Fever titre

But...Dr. Jones closed it after 2 seconds
  - Did not read the recommendation
President and HHS had it right!
  - EMR leads to safer environment

Dr. Jones had the life-saving information there

He was on the committee that recommended EMR
  - E-mail – “The benefits are incredible – it will make our jobs easier”

Didn’t read it...in fact, ignored it!
Why Does it Matter?

- Rocky Mountain Spotted Fever
  - Is a killer
  - But...easily tested and curable when caught early
  - If caught early, when EMR told him to test for it, he would be alive today

- Instead
  - 36 year old husband is gone
  - Sole breadwinner - $124,000/year
    - Benefits (20%)
    - Household help
  - Leaves behind a wife and 3 young children
  - But most importantly...had the information and ignored it!
  - That is why the Judge is instructing you on what we call punitive damages
So...Can This Really Happen?

- **Yes**
  - But it does not have to happen
  - These scenarios are worth preventing…

...and preventable
June 18, 2008¹

Electronic Health Records in Ambulatory Care — A National Survey of Physicians

Most of those with fully functional systems reported averting a known drug allergic reaction (80%) or a potentially dangerous drug interaction (71%), being alerted to a critical laboratory value (90%), ordering a critical laboratory test (68%), and providing preventive care (69%)

Some continued barriers to adoption

- Cost
- Whether it meets the need
- Whether it will become obsolete
- Return on Investment
- Resistance from others in group

And...Technical Concerns

- What happens when the power goes out?
  - Paper worked without power

- Implementation issues
  - Kaiser Permanente\(^3\)
    - Wrong patient lists and bed assignments
    - Malfunctioning point of service scanners
    - Power outages delayed ER care
    - Lost orders in the system

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3. Source – Costello, KAISER HAS ACHES, PAINS GOING DIGITAL; Patients' welfare is at stake in the electronic effort, experts say.; HOPE-FOR COST SAVINGS, LA Times, 2/15/07
And...Fear of Glitches Slowing Adoption

- Dallas Morning News – May 28, 2008
  - 41% of surveyed physicians were reluctant to adopt due to fear of system shutdowns and technical glitches

Physicians debate computerizing medical records

11:33 AM CDT on Wednesday, May 28, 2008

By JASON ROBERSON / The Dallas Morning News
jroberson@dallasnews.com
Consider...

- If there is an error tied to the EMR, Plaintiffs will use the “benefits” against us
  - Earlier example – Smith v. Jones
  - Corporate negligence?
    - Responsible for assuring systems work…and back-up!
So...

- We know
  - Absolute benefits
  - Necessary in the future
  - Will be tied to reimbursement
- Now...Understand the risk...incorporate strategies
- **Cannot** ignore these risks
What are the Top 3 Risks?

- Missed Information
- Ignored Prompts
- Electronic Discovery
Missed Information

- The data is only valuable if you can
  - Find it
  - See it
  - Understand it
  - Use it

Off the Record — Avoiding the Pitfalls of Going Electronic
Pamela Hartzband, M.D., and Jerome Groopman, M.D.

Many of us remember searching frantically for a lost chart or misfiled laboratory results in the wee hours of the morning as we cared for a sick patient in the emergency ward, or requesting in vain the most recent note from a specialist about a patient who returned to our office after a consultation. The ultimate goal of the electronic medical record—a technological solution being championed by the Bush administration, the presidential candidates, and New York Mayor Michael Bloomberg, as well as Google, Microsoft, and many insurance companies—is to make all patient information immediately accessible and easily transferable and to allow its essential elements to be held by both physician and patient. The history, physical exam findings, medications, laboratory results, and all physicians’ opinions will be collected in one place and available at a single keystroke. And there is no doubt that these records offer many benefits. We worry, however, that they are being touted as a panacea for nearly all the ills of modern medicine. Before blindly embracing electronic records, we should consider their current limitations and potential downsides.

As we have increasingly used electronic medical records in our hospital and received them from...
What happens if your system inadvertently “hides” the information?

- Example – facts
  - Patient presents to ER with febrile illness
  - Reports abdominal pain
  - Triage BP – 60/32
  - Next reading – 90/47
  - System “flags” the low BP in red, but “locates” it at the bottom of the list
  - Physician does not see flagged vital sign and only sees most recent, which was normal
Most recent BPs are listed, but have to hunt for prior readings
Missed Information (cont’d)

◆ How is this different from paper record?

  ● The trended vital signs are all visible on the same page in the paper chart
    - In ER, the face sheet and triage assessment are visible without scrolling

  ● If a paper chart, missed vital would not have occurred
Missed Information (cont’d)

- Paper record
  - Trended data in one place and easy to see
  
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- But not always easy to read...but right there!
Additional Issue

- Corporate liability
  - Failure to construct appropriate e-record system
  - Was there a failure to train and/or supervise

- Vendor liability?
How do we mitigate this risk?

- Question the vendors on the construction
- Take active role in system customization
- Involve providers in system testing
- **Train** the providers
- Get an EMR risk management **audit**
Many systems use built-in guidelines and automatic prompts to enhance safety

- OB – ACOG guidelines
- Cardiology – ACC/AHA guidelines
- Bariatric – ASMBS and SRC guidelines
Ignored Prompts (cont’d)

Example

- Recall – Rocky Mountain Spotted Fever
- Physician *closes* the window and continues the encounter
  - Condition is too rare, doesn’t want to be distracted...
- Family sues and discovers that the doctor was “told” to order the potentially life-saving test
- Sues for negligence and punitive damages for reckless disregard for ignoring the system’s recommendation
Ignored Prompts (cont’d)

◆ In the Courtroom

- Different from paper record since paper records do not offer suggested tests
- Evidence will be presented that shows the prompt and the timing of clicking it closed
- Cross-examination of the doctor will focus on the test that could have saved a life
  - Creates the “plus”
Other issues

- Who decides what guidelines go into the system
- How are they kept current?
- Will the built-in guidelines create a new or different standard of care?
- Does the vendor installing the guideline modules have liability
  - Is this part of your contracting process?
Electronic Discovery

- Big issue in litigation
  - The electronic file is discoverable
  - More than just printing out the screens
    - Now - produce the native files
  - Lawyers will ask for the e-chart and look for
    - Late entries
    - Edits
    - Access to the chart
Key issue – metadata

- Literally, data about the data
- Shows what was changed and when
- Exists behind what you see
  - Who wrote what and when
  - Who looked at what and when
  - Did someone access the data who was not part of care team?
  - Will try to make it look like the electronic data has been changed
  - Create a plus
Courtroom issues

- All changes will be seen
- Everything is now captured
  - What you reviewed
  - When reviewed
  - For how long you looked
  - For every time you access the chart – even after suit initiated
  - The system will show if you clicked the prompts off right away
Includes if you are at home on call

- Did you access the entire record?
- Do you need to?
- Did you document that night or did you wait?
Electronic Discovery (cont’d)

- Policies and Procedures

  - Plaintiffs lawyers are trying to move toward suing the entity in addition to the doctor
    - Corporate liability
  - Paper record – policy text and some context
  - eRecord – text, edits, persons editing, comments, insertions, deletions, etc.
  - Opens the door to more issues
Example

- New policy being proposed regarding nursing checks on past-CABG patients
- Before E-Discovery
  - Conversations that were subject to passage of time and meeting minutes that were benign
- Now
  - More conversations done via e-mail
  - Tracks it word for word
The Smoking Gun in the E-Mail Box

Effective examination of witnesses using electronic documents.

By David K. Bissinger
Texas Lawyer
August 23, 2007

Many articles talk about the new e-discovery rules, but few address how to use electronic information in examining witnesses.

Just 10 years ago, a lawyer examining a witness might have had only one or two memos in a typical business case. Now, e-mails and other electronic documents give lawyers day-by-day -- and often minute-by-minute -- records of the ideas and actions of key witnesses.
From:  
Sent:  
To:  
Subject:  

Frank:

I have reviewed the proposed policy regarding nursing care post-CABG. I do not think we can cover hourly vitals for the first 12 hours. We don't have the staff and there is no room in the budget to hire more staff. Can't we just do it for the first 3 hours, and then every 4 after that? We can then stay in budget. Perhaps we can then revisit in a few years when revenue improves.

John
EMR Risk Reduction

- System construction
- Contractual obligations and updates
- Implementation and training
- EMR Risk Audit
- eDiscovery/legal issues review
  - Retention policies
  - E-mail etiquette
  - “Training”
■ Remember...e-mail is never truly deleted...

  ● “What do you mean you want a copy of my e-mails?”

  ● “My e-mails are all deleted...sorry...”
    - “Oh...they’re not...”
Electronic Personal Health Records

- Relatively recent product
- Loosely defined as electronic repository created by and maintained by the patient
- Will likely interface with EMR systems
- Creates risks and opportunities
- Large push from
  - Employers
    - New employee benefit
  - Health Insurers
    - Mass. BC/BS offering Google Health as of June 12, 2008
What are the Issues?

- Will the standard of care require that physicians and hospitals ask for and link to PHRs?
- Whose responsibility is it for accuracy and completeness?
- HIPAA issues with release of data to patient’s PHR?
- Who owns it?
What are the Issues? (cont’d)

◆ Does the doctor need to ask for access?
  ● Ask new patients as part of the intake process if they have a PHR
  ● Established patients should be asked to update their information
  ● Important data in the PHR but the record is not sought by the doctor, and there is an event, this will be used against the doctor
  ● What is the doctor’s responsibility at home on-call?
Accuracy and Completeness

- Can patients change the information in the PHR
  - What if patient “corrects” his history regarding narcotic painkillers so he can doctor-shop and get more?
  - What if patient “corrects” her history so that her new OB/GYN is not aware of prior HPV infections
And New Opportunities?

- Can we use PHRs to increase patient compliance and thereby reduce risk?
  - Chronic disease monitoring
  - Enhanced (and documented) communication
  - P4P benefits
  - Potential responsibility improves
  - Preventative medicine improves
More New Opportunities

- Use EMR and PHR to
  - Improve education
    - Remember technology in the courtroom
  - Bolster five-star customer service
    - The public is expecting this
  - Improve efficiency and satisfaction
  - Document great care which is provided
  - Document responsibility
Take Advantage of Both Opportunities

Clinical Clusters
- Asphyxia in Labor
- Brachial Plexus
- Neonatal Death
- Post-Partum Hemorrhage

Professional Liability
- Documentation of Specific Issues
- Informal Consent
- Medication Contraindication

- Mindful of risks
  - Contracting issues
  - Educational issues
  - Construction issues
  - Risk audit
Realize...

- Absolute benefits (it’s coming…)

- Work in progress

- Must
  - Understand
  - Educate
  - Audit
Stevens & Lee’s 225 lawyer and non-lawyer professionals assist health care providers and organizations meet the challenges they face in a changing and consolidating industry. Our Health Care Department is comprised of approximately 31 professionals – including 25 attorneys whose exclusive practice is in health care – who serve as general counsel to acute care and specialty health care organizations, health systems, long-term care providers and physician practices and regularly litigate cases in state and federal court.

Stevens & Lee’s health care litigation and risk management team has designed customized risk reduction programs focused on both risk reduction and economics. Some of those programs include “Five-Star Service Excellence”, Disclosure Training, Risk Assessments, as well as the new EMR risk reduction program. Specialty specific programs are available as well. All programs combine education, training, communication, as well as documentation services.

For more information, please contact James W. Saxton:
STEVENS & LEE
51 South Duke Street
P.O. Box 1594
Lancaster, PA 17608-1594
717-399-6639
jws@stevenslee.com