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Point-and-click medicine

Electronic records have opened a new realm of med-mal liability

By: Traci R. Gentilozzi in News Stories June 22, 2015

A woman is rushed to the emergency room with abdominal pain and, while being examined, her heart races out of control and she suffers a fatal stroke. Unbeknownst to the ER doctor, the woman had previously been diagnosed with tachycardia. This critical piece of medical information was not in the electronic medical file the doctor relied on while treating her.

An investigation reveals the woman's tachycardia history was not transferred from her paper chart to the facility's electronic medical record (EMR) system. A medical-malpractice lawsuit follows

The period of time when a health care provider converts from paper to electronic files poses the greatest threat for med-mal liability, according to Grand Rapids attorney Brian W. Whitelaw. During the transition, information can be erroneously transferred, inadvertently

missed or even accidentally lost due to a computer glitch.
"EMRs are good on many levels," said Whitelaw, who primarily defends doctors in negligence cases. "But EMRs were forced on the health care industry, so the entire process really moved faster than it would have normally. Transition is a tough time and is when most problems happen."

And while EMRs do have benefits, like getting rid of doctors' illegible handwritten notes, they have also created a new set of liability concerns for the health care industry.

"Doctors now need to be as precise with their keyboards as they should be with their scalpels," said Ann Arbor plaintiffs' lawyer Chad D. Engelhardt. "We have seen a number of issues emerge with improper use or abuse of EMRs, from inaccurate records caused by default settings, false information accidentally placed from sloppy copying and pasting, to altered medical records."

Electronic records are a "danger" and "the world was a safer place with handwritten charts," said Detroit lawyer Brian J. McKeen, who represents plaintiffs in med-mal suits.

"Computer records are given more credence than they deserve," he said. "We've lost the patient-doctor contact. There is no substitute for people using their own language to describe how they feel, instead of a checkbox or a drop-down menu."

Transition and training
"One real problem when it comes to med-mal liability is familiarity with the program," said Detroit defense attorney Paul J. Manion. "The bigger institutions run training programs for their staff, while individual providers do they best they can in-house."

Because liability potential increases significantly during the file transition process, "make sure the staff is trained," said Whitelaw, of Aardema Whitelaw PLLC. "And make sure staff knows how to get technical support on the phone when there is a problem."

Engelhardt, who is with Goethel Engelhardt PLLC, said some medical providers are "penny wise and pound foolish" and do not devote enough time to training, leading to a higher risk of being sued. Another problem, Whitelaw said, is that during the transition phase, the EMR system may not operate as expected. For example, a program may call up information for a doctor, but only give him what the system thinks he needs to know.

"This means the doctor may not see notes written by a medical assistant and, if he had known about those notes, he may have made another diagnosis," Whitelaw said. "So it probably looks like the doctor should have had the information, when the system actually determined what information he saw."

Yet another issue, Engelhardt said, is that many different types of EMR systems are being used. "Rather than having a standardized software program, there is a mix of record-keeping systems, some which can change by services within one hospital. For example, anesthesiology may use one EMR system while the hospital uses another. So this just reinforces the need for high-level training."

An 'electronic fingerprint'

Federal law requires that EMR software must have proper audit trail protections, Engelhardt explained. "This is software tracking that electronically stores the identity, time and terminal location of users accessing protected health information, and most importantly any changes or alterations to the records."

All med-mal discovery must include the complete audit trail, Engelhardt advised. "Attorneys need to become familiar with the interpretation of the sometimes complex and technical data. And sometimes this requires hiring EMR experts and deposing the hospital IT personnel or contractors."

Basically, the audit trail is an "electronic fingerprint" that tells when a person accessed the record, said Grand Rapids plaintiffs' attorney Robert J. Buchanan. "It's difficult for someone to go back and alter an electronic record because, anytime someone touches it, the

system picks up on that fact."

According to McKeen, of McKeen & Associates PC, electronic records must always be scrutinized in a med-mal case to determine whether they have been changed. "To really know for sure, you have to get the audit trail. I've seen several situations where someone went back after the fact and tried to alter a record."

Engelhardt said he, too, has used the audit trail to discover changes to medical records. "We have uncovered nurses and other providers entering false charting, such as the illegal and dangerous nursing practice of pre-charting, which means filling in assessments such as vital signs for the whole shift, without even seeing the patient."

However, Manion noted that legitimate corrections sometimes need to be made. And if a correction is made to a record, he said it must happen contemporaneously with the original entry.

"You certainly don't want to change anything once it's the subject of potential litigation and the notice of intent has been sent," said Manion, of Rutledge Manion Rabaut Terry & Thomas PC. "You'd then be in a position of having to explain it at deposition."

Also, many EMR systems stamp the record with a date and time, and lock a record after a certain number of days, Whitelaw pointed out. "So you can't wait six months and then go in and alter it. And even if you could, it's still on the audit trail."

Carry-over mistakes

When an error is made, it is often perpetuated through the EMR system, said Buchanan, of Buchanan & Buchanan PLC.

"Information that is carried over from an earlier time may not be accurate — maybe a box was not checked," he noted. "We often discover this through inconsistencies, like when the record says the patient complained about being nauseous but another entry says the patient can't speak."

According to Engelhardt, "sloppy mistakes" are often made in EMRs. "And it usually comes from cutting and pasting, and from the improper use of drop-down menus. Erroneous information is entered and then other clinicians rely on that information. The improper information is carried over."

Because of the carry-over risk, Manion cautioned that health care providers must be diligent when entering information. One small slip-up, he said, can create "a whole list" of problems. "Mistakes can happen and things can be included in the wrong category, for example. It's usually not intentional, but due to a lack of familiarity with the system."

And if a record is incomplete or inaccurate, Manion said this fact always goes against the credibility of the medical provider, even if it was unintentional. "Doctors and nurses now have to go to great lengths to make sure the record is filled-in correctly," he said.

'Alert fatigue' and other concerns

Some health care providers suffer EMR "alert fatigue," Whitelaw noted. "Systems will automatically alert the doctor of anything abnormal. The doctor then has to review it, no matter what it is. Alerts can be useful — but they can also be a pain in the rear." Because of the annoyance factor, Whitelaw said some doctors turn off their alerts. "Not a good idea," he advised. "Medical providers are expected to be aware of everything."

Whitelaw also cautioned that doctors should never give their system password to a resident or another colleague. If that person then enters the system using the doctor's credentials, "it will look like it was that doctor accessing the system, when it was not. And doctors should never, ever leave the program open on their monitor." Another concern with EMRs is that nothing "stands out," Whitelaw said. "Everything is given the same significance, where with paper charts you'd underline or circle something that should get attention. With EMRs, there is page after page of information, and then buried in the middle is the one item that makes the difference."

Buchanan agreed. “It’s easy to confuse the information,” he said. “It’s virtually impossible to find anything because of the way it’s structured and printed out. It’s like trying to find a needle in a haystack.”

EMR systems also force medical providers “to put square pegs in round holes” by offering limited options with checkboxes and drop-down menus, Buchanan said. “There is the ability to type notes in some systems, but that is often discouraged. So the question is, are we getting a complete picture of the patient? Or just an option in a multiple-choice box?”

But according to McKeen, the real problem with EMRs is the lack of face-to-face interaction between the doctor and the patient. “The prompts a computer gives are a poor substitute,” he said. “It has now become point-and-click medicine.”

Electronic records: The positives

Paper medical charts began their decline several years ago, as electronic medical record (EMR) software programs became more widely available. The Affordable Care Act also prodded the switch to EMRs by offering incentives to health care providers for converting to electronic files.

According to lawyers, while new liability risks have arisen with EMRs, they do have some positive attributes, including:

• Improved accuracy. It is more difficult to alter an electronic record because of the audit trail or “electronic fingerprint.”
• Checklists, drop-down menus and checkboxes. While they do have their downfalls, they also decrease the need for doctors and nurses to rely solely on their memory. Not only are diagnosis options are offered, but care plans are, too. And the choices presented can sometimes force an examination that a doctor may not have initially considered.
• Information is automatically and instantly captured.
• Records are legible and easier to read.

• A patient’s entire medical history is stored on a small USB drive. No more using, and having to store, bulky paper charts.
• It is easier to transfer patient data among health care facilities.
— Traci R. Gentilozzi