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Editor's Note: This is a special issue about electronic medical record documentation.

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What if It's the EP's Word Against an EMR Timestamp?

'All the EP can do is settle. He or she has lost the case.'

Time-stamped electronic medical record (EMR) entries have been devastating for some EPs defending themselves against malpractice allegations, but these "smoking guns" often are very misleading.

"The time of the stamp is the time of the computer entry, not the time of the event. It has nothing to do with when the event occurred," explains **Michael Jay Bresler**, MD, a clinical professor of emergency medicine at Stanford (CA) University School of Medicine. He includes this statement in every ED chart: "The times documented are the time of computer entry, not necessarily the time the event occurred."

"I have seen this be a problem in litigation," Bresler says. "The EP and expert witnesses then have to explain it away on the witness stand."

Timestamps can make the EP's care appear negligent to experts hired by plaintiff attorneys to review the ED chart. "They may base a case on delayed administration of a drug in a critical situation, for example, and it comes out, only after years of depositions, that isn't what happened," Bresler says.

Kathleen Shostek, RN, ARM, CPHRM, vice president in the healthcare risk management and patient safety division of Sedgwick, a third-party administrator for professional liability claims, has seen ED cases in which timestamps were dated minutes or hours after the patient actually was examined. This opened the door for the plaintiff attorney to allege care was delayed.

"On retrospective review, this creates a misleading understanding as to when patients were actually seen or treated," Shostek explains.

If computer clocks are not synchronized hospitalwide, EMR timestamps will indicate gaps or delays incorrectly. Shostek gives this example: An ED patient with chest pain is seen at 23:55 on Dec. 31, 2016. An ECG is performed at 23:57. The ECG is uploaded, read, and interpreted. At 00:30 on Jan. 1, 2017, the ED physician documents the exam

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and orders admission for ST-elevation acute myocardial infarction (AMI).

However, upon review of the case, the timestamps tell a different story. They indicate the ECG was ordered at 23:57 but not completed until Jan. 1, at 00:45. This is 15 minutes after the EP's note stating that the ECG was completed showing ST-elevation AMI. This allows the plaintiff to cast doubt in the mind of the jury as to whether the ECG was delayed. In such cases, Shostek says "other evidence will be required to prove that the care and treatment were expediently provided."

Here are some other ways EMR timestamps can make ED care appear poor:

• Time-stamped entries show if documentation was altered or added after the ED visit.

Dean Sittig, PhD, professor in the School of Biomedical Informatics at the University of Texas Health Sciences Center in Houston, says "it is common for docs and nurses to chart after the fact, and the audit trail makes it clear exactly when the documentation took place."

If such charting occurs after an adverse event, EP defendants' credibility is marred. "Although charting at the end of the shift, or even from home, routinely occurs, plaintiffs will argue that this after-the-fact charting represents an attempt to cover up the problem," Sittig says.

Ken Zafren, MD, FAAEM, FACEP, EMS medical director for the state of Alaska and clinical professor of emergency medicine at Stanford (CA) University Medical Center, reviewed a case involving a patient at a skilled nursing facility on anticoagulants who fell and hit his head. Retrospective time-stamped entries became a key area of focus.

"There was only one entry, time-stamped long after the fact, but it was not believable," Zafren says. "I don't know if this possible attempt to buff up the record was a factor in settling the case, but it certainly might have been."

The medical director ordered neurological checks every 15 minutes. "The neuro checks documented a headache that did not lead to any action," Zafren notes. The patient was taken to the closest ED only after having a seizure. "By the time the patient was intubated and a CT scan was done, there was an inoperable fatal intracranial hemorrhage," Zafren adds.

The neurological checks were charted by a nurse to have occurred every 15 minutes on the hour and at 15, 30, and 45 minutes after the hour. The charting was completed several hours later, according to the timestamp. "I was prepared to testify at trial that the post-hoc charting cast doubt on whether neurologic checks occurred," Zafren says.

At the time the neurological checks were charted, the patient had already died at the hospital. As a plaintiff's expert, Zafren questioned whether the neurological checks were really performed as documented. "It is understandable that a busy nurse may document events after the fact," he explains. "But if the nurse was too busy to document the events contemporaneously, it was unlikely they occurred exactly at 15-minute intervals."

The EP was not named in the case, but attempted to help the defense of his colleague by developing a timeline based largely on the timestamps in the hospital record. "The EP alleged that even if the patient had been brought immediately to the hospital after the fall, by the time he could have had a CT scan and been taken to surgery, it would have been too late to save him from a fatal outcome," Zafren says.

• Timestamps can make it appear that test results weren't reviewed in a timely manner.

If timestamps show an ED patient underwent a test at 10:00 p.m., but the EMR shows that no one reviewed the results until 1:30 a.m., possibly because of a shift change or other issue in the ED, "the timeliness of response and patient care may be questioned," says **Ron Sterling**, who advises healthcare organizations on electronic health records and medical professional liability. Sterling is author of *Keys to EMR/EHR Success: Selecting and Implementing an Electronic Medical Record* (Greenbranch Publishing, 2010).

If the EP didn't review all the relevant laboratory results until the end of the shift, possibly after the patient was sent home, Sittig says "this will be abundantly clear."

ED patients with test results pending at discharge are fraught with legal risks, Sittig notes. The EMR makes it clear when the test results came back, and when, if ever, the EP contacted the patient. "These cases are often not recognized for a year or more; for example, in the case of an abdominal X-ray result that also shows a tumor in the lower part of the lung, possibly indicating early stage lung cancer," Sittig says.

In the days of paper records, an EP's testimony stating "I never saw that result until this case was filed" often went unchallenged. Before EMRs, there usually was no way for the plaintiff to prove otherwise. Now, if the EP did see the result, the audit log shows the exact time it occurred. "At that point, all the EP can do is settle. He or she has lost the case," Sittig says.

Sittig says ED cases with these fact patterns are particularly difficult to defend:

-The patient is discharged before the test is performed;

-The patient is discharged after the test is performed, but before the result is available.

"In the first case, the EP may assume that the test was completed, when it was not," Sittig says. In the second case, the EP doesn't always have an easy way of contacting the patient or their primary care physician about an abnormal result.

• Not all ED interactions are time-stamped.

If a patient is in the ED for hours, EPs might pop their head in to ask how he or she is doing, conduct a quick reassessment, or inform the patient that some labs are back but others are still pending. However, not all these interactions are documented. "Just because the documentation says you talked with the patient at 11:59 doesn't mean you didn't speak with them five other times," Bresler says.

EPs must make certain all relevant activities are recorded on a timely basis, Sterling explains. "Otherwise, the audit record may be taken as is, causing problems for the defense."

• Some EMRs actually create inaccurate timestamps.

Batching timestamps for orders or medication administration is one example. This is a very serious flaw, according to Bresler. "It is basically falsifying information on a legal document." For example, the EP may order a crucial drug at 12:01 for a critically ill patient, but the order isn't documented until 12:15. This makes it appear as though the EP's treatment was below the standard of care.

"The issue of batched orders has come up in litigation in which I've been an expert witness, making it appear that the doc was dilatory in ordering crucial meds," Bresler explains.

Surprisingly, some EMRs are capable of backdating previous records. If an ED patient's reported allergy is inserted into previous records, it makes it appear as though the allergy was documented at an earlier point in time. In the event of litigation, Bresler says "what it shows in discovery is that you gave a drug that the patient was allergic to."

Graham Billingham, MD, FACEP, chief medical officer of Fort Wayne, IN-based MedPro Group, says it's important for EPs to be aware of the type of information that the EMR collects, and how the time-stamped entries appear.

"Chart audits can be included in the ED's routine quality improvement initiatives," he suggests, adding that the audit process should focus on high-risk diagnoses, such as pediatric fever, abdominal pain in the elderly, and chest pain.

"It would be wise to review EMR functions associated with potential problems, such as drop-down menus, copy and paste, and auto populate," Billingham adds. He recommends EDs obtain an independent audit on a regular basis to provide feedback on the quality of EMR documentation.

"Review printed copies of patient records from recent visits, along with the associated metadata," Billingham advises. "Ensure they adequately represent the care provided and justify clinical decision-making."

Sittig adds that if the ED patient takes a turn for the worse between the time care is given and the time it was documented, "it always makes it harder to explain what really happened."

To help a jury understand how EMR charting works, a defendant could show in the audit log that the EP documented multiple patients one after the other at the same time. "This would illustrate that she was working on several patients, and then when she had a free minute, or the end of the shift came, that she then documented all her actions at once," Sittig says.

When reviewing the EMR audit

log during discovery, attorneys typically search for all the EP's interactions with the plaintiff. Instead, Sittig says "maybe we should look for all interactions by the defendant, regardless of patient. This would help recreate the defendant's actions during the time in question." ■

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Hard-to-Dispute Evidence Shows EPs Were Not Negligent

Malpractice case 'rapidly decided against the plaintiff'

A patient was brought by his family to an ED because of concerns about unusual behavior and depression. "The patient was annoyed with his wife and adult children for forcing him to see a physician," recalls **Corey M. Slovis**, MD, professor and chairman of the department of emergency medicine at Vanderbilt University Medical Center in Nashville, TN. The EP evaluated the man, who was transferred to the hospital's psychiatric evaluation area and later admitted for 24-hour observation.

"The patient retained legal counsel months later for the humiliation of being required to undergo psychiatric evaluation," Slovis says. The man alleged that a single cursory evaluation by the triage nurse and a resident physician resulted in an improper forced admission. He also alleged that no attending EP ever evaluated him.

The plaintiff noted that many of the triage nurse's comments also appeared in the ED attending's documentation. The lawsuit further alleged these were just copied without an in-person evaluation by the ED attending. "The patient was adamant that no attending ED physician ever laid eyes on him," Slovis says.

The electronic medical record (EMR) showed similar verbiage quoted by both the attending EP and the triage nurse, and the notes were documented just minutes apart.

"However, the EMR had three other separate timestamps of the physician reevaluating the patient, quoting other things he claimed, and documenting his responses to concerns raised by his family," Slovis says. The EP's documentation also commented on the patient's unusual outfit, a piece of information that was not included in the ED nursing notes.

Based on multiple reevaluations included in the EMR, quotes that could not have been made unless the EP had asked specific questions about family members, and the fact that the attending EP could describe the patient's attire, Slovis says "the case was rapidly decided against the plaintiff." Here are other ED malpractice cases in which EMR documentation helped the defense:

• EMR documentation countered allegations that a two-hour delay in evaluation contributed to the patient's bad outcome.

The defense used the EMR audit trail to show that the EP was seeing several other patients actively at the time the plaintiff was waiting to be seen. Each had been triaged as more emergent than the plaintiff, or had been waiting longer than the plaintiff.

"It completely nixed that allegation against the ED doctor," says **Jesse K. Broocker**, JD, an attorney at Weathington McGrew in Atlanta.

In general, Broocker sees plaintiff lawyers asking for the EMR and audit trail records more frequently in malpractice litigation. "If clever, they may seek an expedited deposition of the ED doctor, commit them to a version of events, then fact-check against the audit trail to see if the timing of everything checks out,"

Broocker says. Plaintiff's lawyers search for even minor discrepancies between the EP's testimony and the EMR documentation.

"Even innocuous things like 'I always review the transfer notes' — in a case where that has nothing to do with anything — where it turns out that did not happen, will be spun as evidence of overall sloppiness," Broocker says. The plaintiff attorney then can ask the jury, "If the EP failed to follow his own standard of practice here, where else did he fail?"

Broocker has begun asking for EMR audit trails from hospital attorneys, who usually are co-counsel, early in litigation. This way, the EP defendant is aware of what the EMR shows he or she was doing and when.

"Timing issues are almost always paramount in ED cases, and the records can make or break a case," Broocker explains. "I'd rather know bad news early so we can handle it moving forward."

• EMR documentation contradicted the plaintiff's allegation that the EP failed to inform him of X-ray results showing a mass and recommending follow-up.

"The metadata is what saved us. It proved we contacted the patient and told them the results," reports **Stephen J. Seitzman**, a senior claims specialist at ProAssurance Companies in Wilmington, DE.

The EMR contained the ED nurse's note, in her own handwriting, regarding the X-ray result. She noted that she told the patient of the results, and that the patient stated he would follow up with his primary care physician. The malpractice litigation was dropped. "The plaintiff expert saw it was rock solid, and clearly showed the patient was told the results," Seitzman says. ■

SOURCES

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How E-discovery Is Changing ED Malpractice Defense

In most cases, EMR proves standard of care was met

The key evidence in a professional liability action against an EP usually is the ED chart. This includes progress notes, expert consultations, imaging studies, and laboratory data — information that was available even with paper charts.

However, with the advent of electronic medical records (EMRs), "the concept of what a medical chart is, or should entail, has expanded," says **Richard F. Cahill**, Esq., vice president and associate general counsel at The Doctors Company in Napa, CA.

Unlike paper charts, EMRs give "a much more detailed perspective of the relevant course of events as they progressed in real time," Cahill explains.

Every Keystroke

With increasing frequency, counsel on both sides of professional liability litigation retain experts to review EMR data. "IT experts perform a deep dive into the available 'raw' information by conducting a highly technical metadata audit," Cahill says.

Prior to EMRs, identifying and then obtaining all the relevant documentation often was burdensome and time-consuming. Paper records relevant to an ED patient's care were maintained in several separate locations, and, in some cases, impossible to locate.

In contrast, metadata audits show who made every keystroke and at exactly what time. Every individual who reviewed the chart, made entries, and/or changed existing notes is identified. "In the new era of the electronic courtroom, key pieces of evidence can be readily displayed on monitors for simultaneous viewing by counsel, witnesses, the judge, and jurors," Cahill notes.

Cahill says that in most claims, EMR charting helps establish that ED care comported with community standards and was performed in a timely and legally defensible manner.

Conflicts still arise regarding interpretation of data, and whether the EP used good clinical judgment. Howev-

er, the basic facts, course of treatment, and reasons for the EP's decisions are less likely to be in dispute, according to Cahill.

"Surprises during the discovery phase of litigation, and incorrect evaluations by counsel as to the relative strengths and weaknesses of their cases are, in many cases, minimized," Cahill says.

Incomplete Picture

Matthew Grygorcewicz, JD, an attorney at Boston-based Hamrock, Puleo & Oh, says EMR metadata can be valuable information. It can help attorneys understand what occurred during a distant medical event that has become the subject of malpractice litigation.

"It is important to bear in mind, however, that metadata merely makes a record of when providers have interacted with the EMR," Grygorcewicz says. Metadata is not necessarily indicative of the overall time spent with an ED patient.

"The EMR never fully records a complete picture of real-time, on-the-ground human interactions between patients, practitioners, and the entire medical team, nor is it designed to do so," Grygorcewicz explains.

Linda M. Stimmel, JD, an attorney at Wilson Elser in Dallas, often sees plaintiff's counsel request the EMR audit trail. "This opens up an ED to more scrutiny and deposition requests," she says. During discovery in one malpractice case, an EMR printed incompletely. This made it look as though no ECGs were performed. "We didn't realize for almost a year that the chart was incomplete when it was printed. It caused undue stress and legal fees," Stimmel says.

When plaintiffs attempt to portray EMR metadata in a negative light, says Grygorcewicz, it's up to the defense team to give the judge or jury the entire clinical picture. Defense attorneys must explain any apparent discrepancies.

"Take the example of a timestamp that appears to show a provider interacting with a patient for only five minutes in the ED," Grygorcewicz offers.

During discovery, the EP defendant can fully explain this piece of data. "Even if the timestamp accurately reflects the duration of treatment, an explanation is still helpful," Grygorcewicz says. It's possible that ED care was provided that wasn't reflected in the metadata.

"The defendant will still have the opportunity to, hopefully, explain how that amount of time was sufficient to render care, and how the care rendered was appropriate and met the standard of care," Grygorcewicz says. ■

SOURCES

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EP Defendants Admit EMR Template Didn't Fit Patient

Limited choices offered by EMRs have triggered litigation

When a patient presented at an ED with severe leg pain and swelling, the EP clicked on a fever template in the electronic medical record (EMR), even though she knew the patient did not have a fever.

"This choice led to templates that were not relevant to the patient's clinical condition. Ultimately, it resulted in the patient being misdiagnosed," says **Donna Vanderpool**, MBA, JD, vice president of risk management at Arlington, VA-based Professional Risk Management Services.

The discharge diagnosis was viral gastroenteritis. The next day, the patient died at a different hospital of necrotizing fasciitis. "The case appears to have settled during trial," Vanderpool says.[1]

At her deposition, the EP explained that she had no option regarding the use of a template. She explained: "You have to choose a template. By that choice, a screen pops up and provides the doctors with other options or choices to make."

When the ED chart is reviewed during litigation, the chosen templates can give a misleading picture

of what really happened. "They may not fit the actual patient," Vanderpool says. "For example, the mental status exam of a child will be different from that of an adult."

Not So Neatly Categorized

Kimberly K. Bocell, JD, an attorney and shareholder at Chamblee Ryan in Dallas, is aware of multiple cases in which EMR charting with drop-down menus has wreaked havoc on the defense of ED malpractice claims.

"The problem is that people are not black-and-white boxes. Symptoms aren't always so neatly categorized," she says. A patient who initially reports chest pain might later complain of difficulty breathing, but the EP has already gone down the chest pain decision tree pathway. "It's so problematic that it can almost limit the EP's ability to accurately document," Bocell says.

EPs find themselves checking something that, while not exactly accurate, is the closest thing the drop-down menu offers. "In hindsight, you are now in a situation where you have to explain that you chose a box because it most closely fit the patient's situation," Bocell says.

This makes for an ED record that's somewhat inaccurate. "It takes away the EP's independent ability to pick and choose the words they want to use," Bocell explains. "That somewhat limits the ability to fully reflect the care provided." She urges EPs to take full advantage of free text options within EMRs to explain their decision-making more fully.

Here are two allegations that are included commonly in ED malpractice litigation:

• **The plaintiff attorney alleges that the EP missed an important piece of information that was available in the EMR.**

Michael B. Weinstock, MD, says, "It's a tremendous amount of data. There often are hours' worth of material — obviously beyond the time available during a busy ED shift."

Plaintiff attorneys comb through the voluminous record to find anything that conceivably could have prevented the ED patient's harm. For instance, the EMR might contain a years-old evaluation by a specialist documenting information that would have changed the EP's management of the patient in some way. If the EP missed the diagnosis of pulmonary fibrosis, the EMR might reveal that the patient had been given amiodarone, which may increase the chance for this uncommon but serious disease.

"You may have multiple records from multiple different specialists available with the EMR. You can bet if there's a bad outcome, the plaintiff attorney will say, 'If you had only seen that,'" says Weinstock. associate program director of Adena Health System's emergency medicine residency and adjunct professor of emergency medicine at The Ohio State University.

During the discovery phase of litigation, EPs sometimes find their own documentation is difficult to decipher. One reason is that the written format of the EMR looks very different from what the EP saw on the screen.

When the EMR documentation is produced for discovery, Bocell says "it is not visually friendly. Many clients say, 'That's not what it looks like when I view it.' That's problematic."

Weinstock says one problem is that EMRs often are used "out of the box" by ED groups. For instance, the ED nursing documentation might require too many clicks to get to, causing EPs to overlook important pieces of information continually. "There are ways to get the nursing notes to roll into the EP's note so they see it every time," Weinstock says.

• **The plaintiff attorney claims the EP checked something off that wasn't really done, or incorrectly checked a particular box.**

Weinstock says EPs faced with countless checkboxes can improve care, and protect themselves legally, by incorporating a "hard stop" into their medical decision-making. EPs can ask these two questions: "Would I feel comfortable explaining my evaluation in a courtroom, or to a parent, child, spouse, or friend?" and "Does my evaluation make sense in the context of the patient's presentation and the data gathering I've performed?"

"One nice thing about EMRs is you can see your chart in real time," Weinstock says. "Make an assessment about whether the evaluation performed was accurate, truthful, and logical."

During peer review of ED cases, Weinstock notes that someone in the room usually figures out what went wrong and what should have been done with the patient. "Instead of waiting for the conference when your peer is going to tell you how you screwed up, why don't we prospectively do that while the patient is still in the ED in front of us?" he asks.

If the decision-making in the EMR doesn't make sense, or if there are unaddressed abnormalities, the EP can obtain more testing or admit the patient. Weinstock asks: "Why wait until the next day when the patient bounces back to the ED?"

Vanderpool is seeing a "slow increase" in EMR documentation coming up in medical malpractice litigation. "In several reported cases,

the EHR is alleged to have caused, or at least contributed to, patient harm," she notes.

Bocell says plaintiff attorneys often raise issues with EMR documentation that are "just a red herring. The EP then has to get up and defuse that issue by explaining, 'We have problems with our EMR, and here's what I really did.'"

Such testimony switches the jury's focus from the good care the EP provided to problems with the EMR. "Poor documentation is something that tends to bother jurors," Bocell adds.

Otherwise defensible ED cases might end up settled or lost at trial because of this confusion. "In talking to your EP, you know that everything they did was appropriate, but the EMR just doesn't reflect that," Bocell says. "Now, their testimony is what makes or breaks their case." ■

REFERENCE

1. *Bowman v. St. Luke-Roosevelt Hospital Center*, 2013 WL 2369844 (N.Y.Supp.).

SOURCES

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EDs Expect 'Explosion' in EMR-related Malpractice Litigation

Experts warn cases soon will become routine

Can the defense successfully argue that an ED patient was harmed not because of the EP's negligence, but because of a problem with the electronic medical record (EMR)? "There are not a lot of cases like that right now, but they are starting to emerge," says **Sharona Hoffman**, JD, professor of law and bioethics at Case Western Reserve University School of Law in Cleveland, and author of *Electronic Health Records and Medical Big Data: Law and Policy* (Cambridge University Press, 2016).

"There are a tiny percentage of cases where lawyers bring up EMRs. Lawyers are still not educated about them," says Hoffman, who expects to see a surge in allegations that EMRs harmed patients. "These claims will become routine in the future. We are still in the very earliest stages of realizing how much these systems have the potential to contribute to patient care."

Raj Ratwani, PhD, acting center director and scientific director at the Washington, DC-based National Center for Human Factors in Healthcare, also says there will be a dramatic increase in adverse events linked to EMRs.

"We see numerous circumstances where the poor design of an [electronic health record] leads to a misdiagnosis or poor clinical outcome in ED patients," Ratwani says. "I think we're going to see an explosion in this area."

'Horrific' Data Presentation

Ross Koppel, PhD, FACMI, calls the way the EMR presents data on ED patients "horrific. Pieces of information that should be contiguous require 17 clicks and scrolling across the screens."

Data are organized differently within some EMRs, depending on the screen the EP is viewing. "On one screen, it's in chronological order; on another, it's in reverse chronological order; on the next, it's alphabetical," says Koppel, an adjunct professor of sociology at University of Pennsylvania, and chair of the American Medical Informatics Association's Clinical Information Systems Working Group.

Some drop-down menus continue for multiple screens but don't tell the EP to click down for more information. "Fonts and background colors differ, sometimes making the EMR look like a ransom note," Koppel adds.

Koppel is aware of one case in which an EP ordered a test that never appeared in the EMR audit trail. "The test was not ordered, and the patient died from the problem that would have been discoverable," he says.

If the EMR returns only part of the results of the lab work that was ordered, this, too, can be dangerous to an ED patient. "In many EMRs, the way the system is designed, it

doesn't show that a lab value is missing," Ratwani explains. A busy EP may see the returned lab values are all normal and discharge the patient, without realizing that not all the results are back. Ratwani says this was a contributing factor in the 2012 case of Rory Staunton, a 12-year-old boy who died after being discharged from an ED with undetected sepsis.[1] "In that case, one of the lab values that was an indicator of sepsis became available hours after the patient was discharged," Ratwani notes.

Another EMR-related risk involves patient identification. If the EP is about to click on a patient's name, and the data refresh at the moment he or she is about to click, the wrong patient could be selected. "You can end up with a medication being ordered on the wrong patient," Ratwani warns.

Are Vendors Liable?

If a poorly designed EMR contributed to harming an ED patient, it's possible that plaintiff attorneys could add additional defendants to the malpractice lawsuit. "That could enable the plaintiff to bring in the vendor, who might have a deep pocket," Hoffman says; however, she is unaware of any such cases. "Some contracts reportedly have 'hold harmless' clauses that protect the vendor from liability."

Koppel co-authored a 2009 paper arguing that "hold harmless" clauses shift liability to physicians, nurses, hospitals, and clinics, even when they are using the EMR as it was intended.[2]

"The vendors say they simply create a tool that is used by a learned intermediary, with unique knowledge, meaning a medical degree; therefore, the vendor is not responsible for any screw-up, even if the vendor has been informed about the problem 1,000 times," Koppel says.

A 2011 Institute of Medicine report stated that nondisclosure agreements in contracts between vendors and healthcare providers, and "hold harmless" clauses that shift the liability of unsafe health IT features to care providers, greatly discourage information sharing.[3] "Yet, the 'hold harmless' clauses are still there," Koppel notes. "I think people are more aware of them, and more frightened of leaving them in, but nobody wants to do anything about it."

However, the mere existence of a "hold harmless" clause doesn't tie the hands of a good defense lawyer. The lawyer still can explain to the jury that the EMR contributed to an ED patient's bad outcome. "A jury might decide to disregard the 'hold harmless' clause, even if the plaintiff lawyer mentions it repeatedly," Koppel says.

Since many cases are settled out of court, it's unclear how often EMRs are linked to ED adverse outcomes. "The doctor involved with a problem doesn't want to talk about it, the vendor sure doesn't want to talk about it, the family member who signed a nondisclosure clause doesn't want to talk about it," Koppel says. "So, the cases are unavailable to us to learn from."

'Easy Argument to Make'

At first glance, taking the stance that the EMR contributed to an ED patient's bad outcome may seem like a hard sell. Most defense attorneys shy away from making this kind of allegation, not wanting it to seem like a negligent EP is pointing the finger elsewhere. Ratwani adamantly disagrees with that stance. "If it's approached properly, I think it's an easy argument to make," he says. This is because the general public is used to seeing well-designed systems, such as Amazon, Google, and Twitter. "These are all good examples of interfaces that support the tasks and goals we want to accomplish," Ratwani says. A defense attorney could compare these systems with the shortcomings and poor design of EMRs. "This conveys the argument that EMRs should never have been designed that way in the first place," Ratwani says.

Ratwani expects to see additional experts become commonplace in ED malpractice litigation, on both the plaintiff and defense sides. These include IT experts to explain how the EMR was used in the ED setting, and to inform jurors about how the EMR was designed, developed, and tested before implementation.

To prevent EMRs from causing patient safety issues in the ED, Ratwani urges getting "deep insight and consensus" from frontline EPs early in the process. Take what they say seriously.

"EPs often have very clear descriptions of near-misses, and things that are likely to become actual harm events. They are often just not listened to," Ratwani says. "Only after it becomes a claim do people say, 'We need to go fix that.'" ■

REFERENCES

1. Dwyer J. An Infection, Unnoticed, Turns Unstoppable. *The New York Times*, July 11, 2012. Available at: http://nyti.ms/1P8l3uR. Accessed May 8, 2017.
2. Koppel R, Kreda D. Health care information technology vendors' "hold harmless" clause: Implications for patients and clinicians. *JAMA* 2009;301:1276-1278.
3. Institute of Medicine. *Health IT and Patient Safety: Building Safer*

Systems for Better Care. The National Academies Press; 2011.

SOURCES

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EP's Unlikely Defense: 'I Couldn't Find It in the EMR'

In a recent malpractice case, the plaintiff alleged that the EP failed to properly treat tetanus in a patient with a dirty puncture wound. "In part, this was because the important historical information was jumbled together confusingly in the hospital's EMR system," says **Kenneth T. Lumb**, JD, an attorney with Corboy & Demetrio in Chicago.

In reviewing EMR documentation, "it's easy for EPs to miss the forest for the trees," says **Dean Sittig**, PhD, professor in the School of Biomedical Informatics at the University of Texas Health Sciences Center in Houston.

Sittig, who authored a paper on the missed Ebola case in Dallas, says, "The ED doc and nurse missed the biggest, most important case of their lives while documenting the appropriate flu vaccination to meet quality measures."[1]

Part of the problem was that the EP either overlooked, or couldn't find, the nursing documentation of the patient's travel history. "This 'error of a lifetime' could have turned into a much more serious problem than it eventually did, with one patient dead and two nurses infected," Sittig says. "What if the virus would have spread wider?"

Sittig is aware of another ED case in which the EP missed the most recent MRI brain scan report that showed a small bleed. "This happened because the EHR's default sort order had been changed from most recent first — reverse chronological order — to earliest results first," Sittig explains.

Since the most recent result was now last on the list, the EP needed to scroll down to view it. "She decided that the report that was visible was the most recent, read it, and decided it was safe to discharge the patient when it obviously was not," Sittig says.

Although the EHR made the most recent test results difficult to find, it technically was "working as designed," Sittig notes. "The doctor simply made a mistake. There is really no defense for this error."

Similarly, EPs sometimes get caught up in clicking "all normal" for a long list of clinical exam findings that they didn't actually assess. "Many abnormal results are missed due to difficult-to-use EHR screens," Sittig adds. "But that is not much of an excuse in the eyes of the jury." ■

REFERENCE

1. Upadhyay DK, Sittig DF, Singh H. Ebola US patient zero: Lessons on misdiagnosis and effective use of electronic health records. *Diagnosis* (Berl) 2014;1:283.

SOURCE

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Is Everything in ED's EMR Admissible? Court Rulings Vary

Issues relating to admissibility of EMRs have occurred "with increasing frequency," both during the discovery phase of litigation and at trial, says **Pamela S. Gilman**, JD, a partner in the Boston office of Barton Gilman.

Kenneth N. Rashbaum, Esq., a partner with New York City-based Barton, notes that the EMR is, by definition, always hearsay, as it is an out-of-court rendition of events

offered as evidence to prove the truth of those events.

"It is admissible only, for the most part, under the business record exception to the hearsay rule, though it can also be admitted as an admission against interest if the patient testifies in a manner that contradicts a statement he or she made that was in the chart," Rashbaum says. However, since EDs rarely use printouts in the "regular course of business," namely, treating patients, "these printouts are vulnerable to a hearsay objection, that the printout doesn't qualify as a business record when it is offered into evidence," Rashbaum says.

There are two ways around this. First, the plaintiff also will want to use the printout in most cases, so the defense can stipulate with the plaintiff to the admission of the printout into evidence. Second, the EMR can be produced in "native format," the electronic form in which it is used daily by ED clinicians, and displayed on a monitor or screen for the jury.

"In some cases, particularly those which include MRIs, PET scans, or other images that don't display well two-dimensionally, this may be preferable to a printout," Rashbaum offers.

Internal Messaging at Issue

Gilman recently defended two cases in which information obtained by plaintiffs through court orders played a prominent role in the defense of the case.

"In the first case, a practice group was required to produce its internal staff messaging, which is something akin to private emails between colleagues," Gilman explains.

Informal banter about the plaintiff's condition led to the case being settled right before trial. "The messages gave the impression that the provider was cavalier, although she was very attentive to the patient and, according to the audit trail, reviewed the patient's chart for over seven minutes when the nurse called her to discuss the patient's complaints," Gilman recalls.

In the second case, two practice groups were required to produce their internal staff messaging and their audit trails. At trial, the court ruled that certain aspects of the internal staff messaging were protected by the peer review privilege.

"Internal staff messaging, standing alone, is discoverable. However, information within the staff messaging can be privileged," Gilman explains. For example, all staff messaging discussing other patients must be redacted.

"The court found that the purpose of the staff messaging was to notify the risk management department of the potential claim, which is protected by the peer review privilege," Gilman says. These issues played a prominent role in the trial of the case, which resulted in a defense verdict.

The court also ruled that the plaintiffs could not suggest the meaning of certain codes appearing on the audit trail, because they could have taken the deposition of the independent software vendor to obtain the meaning of the codes.

"Whether to allow the codes to be admitted is within the court's discretion," Gilman notes. "Thus, it may be important to have the court address the admissibility of the codes prior to trial." This allows defense counsel to decide whether to depose the software vendor.

Gilman expects to see more depositions of IT consultants and software vendors, given the complexity of EMRs. Her advice to EPs: "Be cautious about the substance of all communications, even those that you do not believe are discoverable." ■

SOURCES

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CME/CE OBJECTIVES

After completing this activity, participants will be able to:

1. Identify legal issues related to emergency medicine practice;
2. Explain how the legal issues related to emergency medicine practice affect nurses, physicians, legal counsel, management, and patients; and
3. Integrate practical solutions to reduce risk into daily practice.

COMING IN FUTURE MONTHS

- Little-known legal risks for ED patients waiting for transfer
- Common fact patterns in fraud and abuse cases against EPs
- Disprove allegations of failure to follow up on test results
- Unexpected legal exposure of "do not resuscitate" ED patients

ED LEGAL LETTER™

CME/CE QUESTIONS

1. **Which is true regarding time-stamped electronic medical record (EMR) entries?**

   a. Such documentation offers incontrovertible evidence of the actual time an event occurred.
   b. Timestamps indicate the actual timing of events, with the exception of review of test results.
   c. If computer clocks are not synchronized hospital-wide, timestamps indicate gaps or delays incorrectly.
   d. Timestamps dated hours after the patient was examined are an indication the standard of care was not met.

2. **Which is true regarding electronic discovery and ED malpractice defense?**

   a. Not all individuals who viewed the ED chart are necessarily identified, making it more difficult for the plaintiff to depose everyone who cared for the patient.
   b. The basic facts and course of treatment are less likely to be in dispute.
   c. Courts rarely allow evidence from EMRs to be displayed on monitors at trial.
   d. Metadata accurately reflect the overall amount of time spent with an ED patient.

3. **Which is true regarding templates within electronic health records?**

   a. If the EP defendant can show the available templates did not fit the plaintiff, the liability rests solely with the vendor.
   b. Use of the free text narrative to explain why a certain template was chosen, even though it was not quite accurate, works against the EP, since it appears overly defensive.
   c. The plaintiff can meet the burden of showing that treatment fell below the standard of care if the EP admits selecting an inappropriate template for the patient.
   d. EP defendants may need to explain that they chose a box because it most closely fit the patient's situation.

4. **Which is true regarding the admissibility of EMRs?**

   a. The EMR is admissible under the business record exception to the hearsay rule.
   b. A printout of an EMR cannot qualify as a business record, since EDs do not use printouts in the normal course of business.
   c. Plaintiffs in ED malpractice litigation rarely stipulate to the admission of the EMR.
   d. Internal staff messaging between ED clinicians is privileged.