Health Law Daily Wrap Up, STRATEGIC PERSPECTIVES: Electronic health records: The future of standard of care?, (Aug. 18, 2016)

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Electronic health records (EHRs) are a recent innovation in the medical world and are meant to simplify patient care, save medical practitioners time on charting, and make a patient's medical history more easily navigable. But no new technology is implemented without its own accompaniment of bugs, errors, and a learning curve. A sampling of lawsuits closed between 2007 and 2013 showed that EHRs were cited as a factor in only 1 percent of the cases. The number of EHR related lawsuits doubled between 2013 and 2014, consistent with widespread adoption of the electronic technology.

One potential reason this may have occurred is because EHRs hold more data than paper records. While increasing data in a patient's medical chart may sound entirely positive, doing so creates more complexity and may increase liabilities to health care providers because small details buried in mounds of data may more easily be missed.

The most commonly cited errors in EHR-related malpractice claims are incorrect data input and other user errors. These type of errors commonly include drop down menus that address the most common scenarios, auto-correct, auto-population of data fields, cut and paste, having hybrid records (paper and electronic simultaneously), or simple user mistake when inputting information. These types of errors are ones that may begin to show up in litigation of medical malpractice suits as EHRs become more commonly utilized in the healthcare arena.

Other data tracked by EHRs such as the length of time a physician spends on various tasks also may be at issue in a medical malpractice suit. This data regarding time spent on a specific task, or the various medical providers who made entries and edits to the records could possibly be compared to metadata. Such data could prove to be especially significant in a situation in which a primary care physician and a specialist are both recorded in the EHR as having reviewed test results where abnormal findings were undetected or not acted upon.

Another issue that has recently presented itself is the way courts have dealt with EHRs. Rene Quashie, senior counsel with Epstein Becker Green, was quoted saying "[U]nlike paper records, where incomplete or illegible records are expected, with EHRs they're expected to be complete and immediately accessible and portable." Such expectations could impact the discovery process. An issue known to those who practice in the defense of health care professionals and facilities is the difficulty in getting a complete, uniform, and consistent print copy of a patient's EHR for litigation purposes when requested by a party. The complexities involved in obtaining print copies of something intended to be viewed on a computer screen are well recognized by practitioners.

Other issues the courts may see in the future include whether a physician who overrides an alert created by the EHR could be accused of deviating from the standard of care, and whether failure to use an EHR may itself constitute a deviation from the standard of care.

In *Laskowski v. United States Department of Veteran Affairs* (918 F.Supp.2d 301, M.D. Pa. 2013), a District Court for the Middle District of Pennsylvania case, a veteran brought claims of medical malpractice and negligence against the Veterans Administration Hospital for failure to treat his Post Traumatic Stress Disorder. This case issues included an instance where electronic medical records were not used, resulting in a breakdown of communication regarding which medical providers had done what. The Court found in favor of the veteran and awarded him $3.5 million dollars in damages. While the nonuse of the EHRs was not the only factor that the veteran argued, it was one that will likely only become more prevalent as EHRs become the standard in medical practice.

An article recently published about the role of EHR in patient harm, errors, and malpractice claims, titled *Electronic Health Record – Related Events In Medical Malpractice Claims* from Journal of Patient Safety, uses an interdisciplinary author team to examine these interactions. The article provides an appendix with a lengthy

list of cases in which the use, or misuse, of an EHR contributed to a patient's injury or death. Some of the cases included a medical provider electronically signing a discharge order omitting a patient's medication, resulting in the patient being readmitted with a stroke; a patient receiving a medication in the emergency room despite a known allergy that was documented in the paper record but not uploaded into the EHR; a doctor intending to order one medication but accidentally selecting the one below it on the drop down menu; a prescription being ordered for a patient allergic to a medicine family but the doctor over-rode the alert provided by the EHR, causing the patient to have a serious allergic reaction.

Once use of EHRs is mastered and the common missteps are avoided, EHRs actually can help physicians defend their care by better documenting medical decision making and the rationale behind them."

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