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Electronic Medical Records and Litigation

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"Electronic Medical Records and Litigation" is both a reference and practice manual that will be valuable for both attorneys and forensic experts involved in medical malpractice litigation. If they can gain access to the information discussed in this guide, the effectiveness of their case will be substantially enhanced.

Keris's book provides valuable specific contributions to understanding, identifying, preserving, analyzing and introducing Electronic Medical Records (EMRs) as evidence.

For the forensic systems investigator:

Application developers and forensic examiners tend to think in terms of the data: How it is collected, processed, stored, and presented. In the field of EMRs, unique factors are present that the expert doesn't usually encounter:

- Time lags between patient care steps or vital signs collection and entry of the data, and possible effects on the accuracy of the medical record
- The implications of interim paper notes, and their retention or destruction after data entry
- Subtleties of data-entry methods (drop-down list, freeform entry, or default values pre-loaded) and how they can affect the integrity and accuracy of health care data
- The possibility of after-the-fact data changes by the caregiver or others in the institution in order to mask events or to record steps that were not actually executed
- The critical importance of the system's audit trail in tracing the relationships between events and their representation in the EMR
- The intricacies of providing EMR information for use during depositions: printed records vs. live access to the EMR system

Mr. Keris has brought these unique attributes out, along with many others, as helpful training (with examples) for the systems engineer dealing with medical systems.

For the attorney prosecuting or defending the case:

- For each aspect of this practice area, the book discusses various approaches and supports many of those points with relevant case citations
- Issues are covered from both points of view, to the benefit of both plaintiff's and defense counsel; in addition, both sides get some information as to the likely responses in each area
- For the future benefit of patients and health care providers, there is a section on best practices, to help the institutions (and software developers) to take the safer route on EMR-related issues and decisions
- The largest section contains extensive labor-saving samples for counsel: client questionnaire, document requests, objections to requests, and interrogatories
- A table of citations lists 37 cases which have contributed to the development of this area, with links to the related discussion in the text

Two case studies from the book illustrate its practical value for attorneys and forensic experts alike:

Gilbert v. Highland Hosp., 31 N.Y.S.2d 297 (N.Y. Sup. Ct. 2016)

In Gilbert v. Highland Hospital, the court granted a motion to compel in favor of a plaintiff seeking production of the audit trail of a decedent's medical records. Gilbert, the decedent, presented at Highland Hospital with severe abdominal pain, nausea, and vomiting, and described a history of bowel obstructions. The decedent was discharged a short time later without being seen or evaluated by a medical doctor. The next day, the decedent collapsed and died as a result of twisted and perforated intestines which were undiagnosed by the medical professionals at Highland Hospital. The decedent's estate sought discovery of the EMR's audit trail because the produced medical records did not indicate whether the attending physician of the emergency room ever reviewed the decedent's medical records or plan of care prior to discharge, and the audit trail might provide this information. The defendant argued that the audit trail was not relevant because the plaintiff was not arguing that the medical records that were produced were

not authentic, and thus the plaintiff would not otherwise be entitled to the audit trail pursuant to precedent case law. However, the court determined in this case that the audit trail was relevant to the allegations made in the complaint, namely that the decedent was not seen or evaluated by the attending physician prior to discharge. The court further determined that, while the audit trail itself may not account for the attending physician's actions with respect to review of the record, the plaintiff may wish to explore that topic further during deposition or cross-examination, and thus the audit trail was material and necessary evidence supporting the plaintiff's allegations. The court in this case found that the metadata that would be captured if and when the attending physician accessed the decedent's medical records was directly at issue, and granted the motion to compel production of the EMR audit trail. This case illustrates that the audit trail can be critically important in not only tracing the relationship between events documented in an EMR, such as who accessed the records and when, but also an important piece of evidence that can be used in deposition or cross-examination to further explore the topic of the attending physician's review of the EMR.

Pranter v. United States, No. 10-4157 (D. Minn. June 7, 2012)

In Prantner v. United States, the court ruled that evidence in the audit trail of an EMR, combined with deposition testimony, was sufficient for a reasonable jury to conclude that a physician knew of a medical abnormality requiring immediate care when the EMR was created, yet did not render appropriate care. The plaintiff suffered post-surgical complications resulting in amputation of his lower left leg and sued for medical malpractice. The EMR contained three important entries relevant to this case. First, the plaintiff's lab results, indicating an increased c-reactive protein (CRP) level, were entered at 11:09 am on October 3, 2007. Three hours later, the first progress note was entered at 2:09pm, documenting a discussion between Dr. Gardner, an orthopedic resident, and his supervisory physician, Dr. Schmidt, concerning the plaintiff's medical assessment and treatment plan, in addition to a reference to a dictated second note. The dictated second note was entered at 2:15pm and documented the plaintiff's increased CRP. Dr. Schmidt later testified that the CRP level in the EMR indicated infection that required immediate medical attention. The court used this evidence to infer that Dr. Gardner knew of the increased

CRP before the 2:09pm note documenting his consultation with Dr. Schmidt was entered into the EMR. Both Dr. Gardner and Dr. Schmidt testified that, as a resident, Dr. Gardner would be expected to relay as much information as possible concerning lab results of which he was aware to the supervising physician, Dr. Schmidt, and would in fact do so. The court further inferred that if Dr. Gardner knew of the increased CRP prior to discussing the assessment and plan with Dr. Schmidt, then Dr. Schmidt also knew of the increased CRP prior to the 2:09pm note. Thus, the court concluded that Dr. Schmidt knew of an emergency medical condition that required immediate care, and failed to render that care. Further, the court held that a reasonable jury could find that Dr. Schmidt's failure to render medical treatment deviated from the requisite standard of care, thereby causing the plaintiff's amputation, and denied Dr. Schmidt's summary judgment motion. This case illustrates the critical importance of a system's audit trail in tracing the relationships between factual events and their representations in an EMR, and how reasonable conclusions can be drawn from factual inferences that may be dispositive.

This book, although not inexpensive, is immensely helpful to both counsel and forensic examiners charged with investigating malpractice claims where understanding and navigating the fine points of EMRs is key to the investigation and the inferences that can be gained from it.

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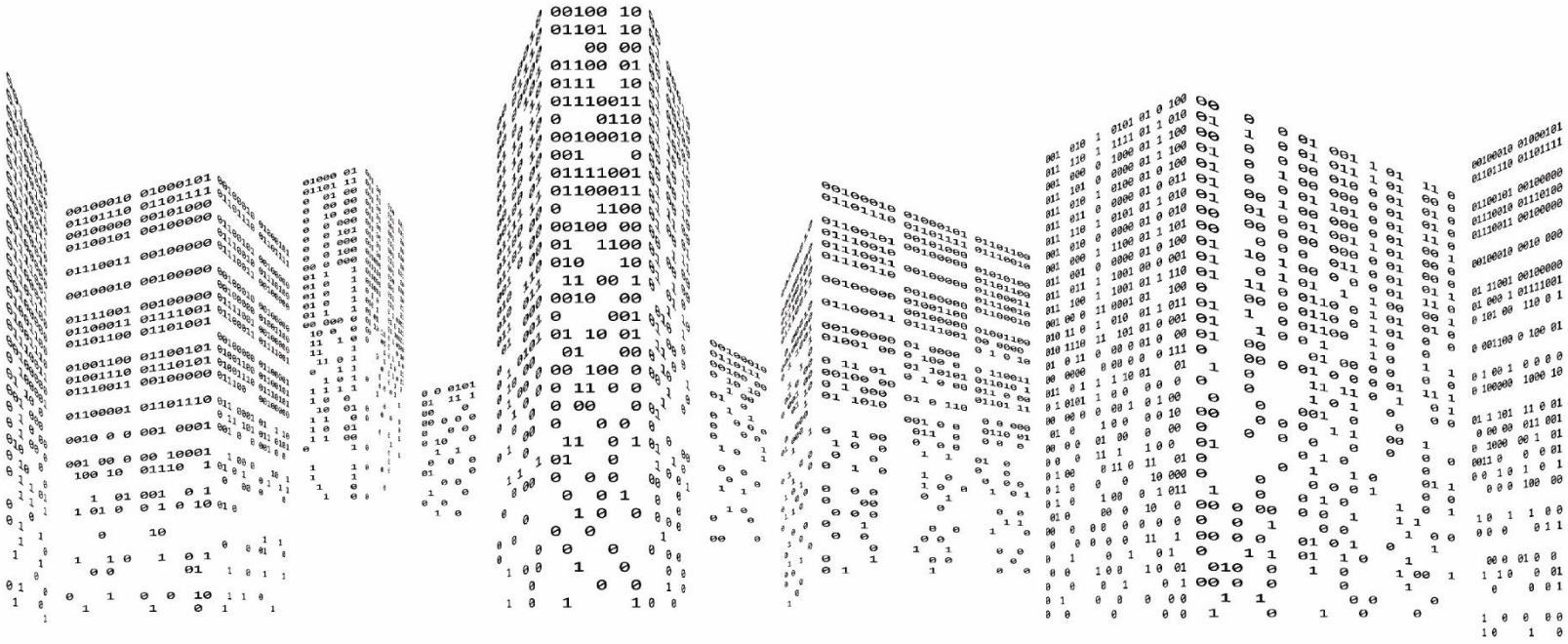
Hunter Jones has over 40 years of experience as a systems engineer, working in IT consulting and computer system development. As a systems developer, he is intimately familiar with the internals of computer systems, both operating systems and application programs. As a certified computer forensics specialist (EnCase Certified Examiner and GIAC Certified Forensic Examiner), Hunter has established credentials in the fields of computer forensics and electronic discovery. Hunter also has deep knowledge of computer forensics as it relates disputes concerning medical malpractice, video files, patent infringement, and internet misconduct.



If you are an attorney in need of a computer forensics expert, we invite you to consider DisputeSoft.

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