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How to Avoid EMR Legal Pitfalls

By: JOAN O. FORD AND NEIL SKOLNIK, M.D., Family Practice News Digital Network

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Although implementation of the electronic medical record is a work in progress, its capabilities clearly are endless. What's less certain is the EMR's impact on a crucial aspect of physician practice: medical liability.

For physicians' defense attorneys, the days of reviewing the original handwritten medical record are fading. The arduous task of deciphering illegible entries and uncovering tidbits of information that proved to be critical to the successful defense of a claim is sorely missed.

Joan O. Ford

Now, we sift through reams of printed data hoping to locate the coveted "free-text" note as we strive to breathe some life into a lifeless document. The satisfaction of finding that rare note quickly turns to frustration when it is later repeated throughout the record; a byproduct of the "cut and paste" feature favored by many. Any significance of the note is lost if there are errors or other data to establish obvious changes in the patient's condition. The intimacy of the physician-patient relationship is lost with the EMR.

Increasingly, we are dealing with the problem of the information hidden behind the EMR. It can be more significant to the claim or defense of a claim than the information that appears on the

record.

Allegations of record alterations, once debated by ink and handwriting experts who poked pin-sized holes in charts to obtain samples for ink dating or analyzed impressions and indentations to prove the timing of an entry, are now fodder for forensic computer experts. The "metadata" provide tangible electronic evidence of changes, additions, and deletions.

One of the biggest challenges has been the translation of the interactive live documentation systems into static documents to produce during the discovery phase of a case.

Dr. Neil Skolnik

Electronic storage of information adds a new dimension to reproduction of the EMR. A simple request for a copy of the medical record has become a document production nightmare. What formerly constituted the "official" medical record now may incorporate much more. And, there is no such thing as a "user-friendly" printed version of the EMR; it looks nothing like the "live" system and proves to be notoriously more burdensome to navigate. We are also finding that the periodic system upgrades can hinder access to prior documentation, in some cases making it virtually impossible. Addressing these problems requires resources.

Yet, we all need to embrace the technology and learn to use it to our advantage, in health care and in litigation. In order to maximize the benefits of the EMR and minimize the potential legal pitfalls, health care providers need to be aware of a few of the basics.

• **First and foremost, the EMR should never be deleted or altered.** The EMR needs to be preserved in accordance with the applicable laws in your state.

Keep in mind that the simple act of logging into a patient’s chart creates a permanent record, even if no entry was made. While you may have no recollection of doing so, an audit will identify when you were in a patient’s EMR. In fact, it will disclose every person who accessed the patient’s record, along with the date, time, computer from which the record was accessed, and whether the record was created, modified, or deleted. HIPAA permits an individual to receive an accounting of disclosures of his or her protected health information upon request for

up to 6 years.

• **Before you succumb to the urge to "cut and paste" a prior note, pause.** Read the note first; you might find that it no longer accurately reflects the patient's condition. The note needs to reflect the patient's current status. As the clinical condition of the patient changes, so should the note.

If the documentation system allows for "free text" notes, seize the opportunity. Consider capturing the visit in a more meaningful way to reflect your interaction with the patient. Although it can be faster to check off the boxes and move on to the next task, you are more likely to recall a patient or situation if you take the time to make a note.

• **The nuances of a patient encounter are frequently missed by a computer.** When you do "click" through documentation screens, click cautiously. Be careful with screens that offer drop-down options, and confirm that you are selecting the proper response. It only takes a slip of the mouse to make a mistake. We all know that typing can be onerous for those who lack keyboard skills, but try to catch the "typos."

• **Make certain that your documentation addresses the actual evaluation you performed.** There should be no documentation of an examination that was not done – that is called fraud.

• **Be mindful to time your entry, especially in those cases when it is well after the treatment.** The precise time can be determined, and disputes or discrepancies over timing of the entry can be resolved.

• **Take the time to familiarize yourself with the documentation system in place.** The next time you sign off on an entry, remember that the document created is only as good as the information entered.

An awareness of the potential pitfalls of the EMR is the first step to making the changes that will ultimately benefit everyone involved – your patient, you, and sometimes even your attorney.

Ms. Ford is a shareholder in the law firm of Marshall, Dennehey, Warner, Coleman, & Goggin, King of Prussia, Pa., and specializes in medical malpractice litigation. Dr. Skolnik is associate director of the family medicine residency program at Abington (Pa.) Memorial Hospital and professor of family and community medicine at Temple University, Philadelphia. He is also a partner in EHR Practice Consultants, helping practices move to EHR systems. Contact him at info@ehrpc.com

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