Reducing Medical Malpractice E-Discovery Issues and Costs

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The Legal Intelligencer

February 14, 2012

As most medical malpractice practitioners know, the patient's chart is the foundation on which a professional liability case is built or defense razed, and the procurement of the complete medical record is a priority for both the patient and the defendant health care provider. Until recently, not much had changed with respect to the creation, preservation and production of medical records. Medical records have been on paper for centuries, and if a patient's chart is requested, it would be physically maintained in storage for retrieval.

However, the rapid nationwide push for an integrated electronic medical record (EMR) system has changed all of this. Signatures have been replaced by sign-ins, charts are stored electronically and documentation is by keystroke instead of pen to paper. The law simply has not had enough time to keep up with these changes, and there is a dearth of legal precedent on how to handle EMR production and preservation issues in the context of medical malpractice litigation. Looking forward, there are ways to streamline medical malpractice discovery issues pertaining to EMRs to limit court involvement and keep costs in check.

No more catch-all requests

It was so much easier to produce a chart in the past. A handwritten chart was a finite medium and access to the information was limited to whoever was looking at it at a given time. If someone wanted a copy of the chart, it would be photocopied and turned over. What the legal community has to understand is that the traditional concept of producing the medical record is outmoded and that a request for "any and all health information" pertaining to a particular patient can be overly burdensome and expensive to produce for the defendant, while proving cumbersome to review for the plaintiff because it will include information that is not relevant to the litigation.

EMRs have transformed health information into electronic code that is deliberately fluid for data sharing. Health information is no longer maintained in a one-dimensional format but instead is shared at many levels. Electronic medical data can be integrated with other information systems for billing, treatment, patient census, scheduling, insurance, pharmaceutical/prescription and other administrative reasons. In this respect, the "any and all" request is overkill because it can be interpreted to mean records from information systems that have nothing to do with the care rendered. It may also legitimately draw discovery objections and motions practice that can lead to inconsistent results. To avoid this, requests should focus on health information contained within specific information systems rather than on a global scale.

Requesting information from specific information systems for purposes of medical

malpractice cases would set the boundaries for reasonable discovery for both parties. While a request for health information outside the clinical record from other integrated information systems will produce information not contained in the traditional chart, it will most likely be irrelevant and the associated costs in reviewing this information may outweigh the benefits.

Clarify when the duty to preserve data begins

E-discovery case law discusses that the duty to preserve relevant electronic data begins "whenever litigation is reasonably anticipated," meaning it can begin pre-suit. For some non-medical-malpractice corporate defendants, the event that triggers this obligation is obvious — the termination of an employee, the loss of a client or the meeting with the dissatisfied vendor. In some respects, the nebulous litigation-hold start date is appropriate because a rigid rule will not reflect the complexities of the real world. Yet hospital and health care systems are unlike most corporate defendants with respect to pre-suit notice of a potential claim.

In the absence of a true acute or sentinel event, when should a health care system reasonably anticipate a medical malpractice lawsuit? Is it when a patient or family member makes a complaint to the nursing staff? Complaints occur all the time, but it does not necessarily translate into a lawsuit. However, a complaint by a customer in a case involving a business transaction may be enough to trigger the duty.

What if a patient requests a copy of his or her medical records? Patients request their records all the time for purposes unrelated to evaluating the care rendered by their health care providers. In a legal malpractice claim however, a client's request for the copy of the attorney's file may be enough to trigger a litigation hold.

What about the reporting of an event to a medical regulatory or advisory entity? Should a health care provider institute its hold when a reportable incident occurs? An argument can be made that this should trigger the duty to preserve, but again, reporting does not always translate into a lawsuit. These scenarios demonstrate the challenge in determining when the duty to preserve begins. Notice of impending litigation does not neatly translate to medical malpractice suits arising from non-acute events.

Moving forward, consideration should be made in defining when a litigation hold should begin in a medical malpractice action. An unexpected acute negative patient event resulting in a significant injury could trigger a litigation hold. Additionally, attorney requests for client medical records for potential medical malpractice cases should trigger the duty to preserve, along with the pro se patient who submits a records authorization for the same purpose. Other than these three scenarios, health care providers should not be compelled to institute a litigation hold to preserve the EMR for purposes of the impending medical malpractice claim. Otherwise, they would be overwhelmed by their litigation holds.

Record should be limited to hard copy in most cases

Consistent with the premise that health care providers shall be judged by the standards of medical practice at the time of the care at issue, traditional paper medical records are static and look the same throughout the

litigation process. In this regard, hard copy records are superior to the EMR. If I, in 2012, requested a copy of a hard copy of a chart for care rendered in 2005, the chart I receive in 2012 would look as it did in 2005. With EMRs, that may not be the case for several reasons.

First, for reasons that I still don't quite understand, it is nearly impossible or cost prohibitive to print on paper what a record looks like on a computer screen. For all the money and time put into EMR systems, it is clear that they were not designed with litigation in mind. I have been told that the inability to print what is on the screen is a technical issue, and I have no reason to doubt this explanation. However, a colleague of mine once compared trying to print the EMR to trying to print the Internet — a one-dimensional piece of paper simply cannot capture the depth of a comprehensive EMR system. The hard copy EMR printouts are the best attempts to put the health information into a form that we are accustomed to.

As an alternative to receiving the printout, it may be suggested that health care providers give the electronic health information in native form on a flash drive to be loaded onto a lawyer's office computer for later review. Unfortunately, this may not be an option. On what program will lawyers be able to open and view the native health information data on their office computers? It's not like you can go to your local office superstore and buy an EMR records system like you would office software. Have the health care system provide you with a copy of its EMR system? Not likely. In most instances, the EMR system is owned by a vendor. The information on the EMR system belongs to the health institution, but the program that reads the data does not belong to it. So even if the health system wanted to provide counsel with the EMR system, it may not be permitted to do so.

Further, EMR systems are constantly upgraded to perform new functions, capture more information and improve prior versions. So even if there is an ability to print identically what the computer monitor looks like in a cost-effective manner, it may be impossible to print what the screen looked like in the past because of the upgrades. In 2007, a health care institution could be using the first version of an EMR system when the care at issue in a medical malpractice action takes place. In 2008, the year the patient/lawyer requests the records to evaluate a potential medical malpractice claim, the hospital has upgraded to the second version that records more information than in 2007. In 2009, when the suit is filed, it is at version three. When written discovery commences in 2010, version four is in place. When depositions occur in 2012, the EMR system is in its sixth version. At each upgrade, the screen could look different from how it previously did. Further, it's unlikely and probably unreasonable to think that institutions retain older versions of an EMR system so that they have the ability to print a past version as it looked on the screen. Given the number of upgrades an EMR system routinely undergoes, it may be impossible to provide an identical copy of a computer monitor unless it is done right after the care is rendered.

Unfortunately, progress has hampered rather than improved our practice when it comes to providing a snapshot of what a record looked like at a time at issue. While not the preferred solution, the only reasonable option in the absence of legal guidance is to continue what we have been doing, which is accepting a patient's hard copy of the EMR record.

EMRs are here to stay. Too much time and money has been invested in this technology to ever go back to the paper record. Medical malpractice lawyers must realize that they can no longer apply 20th century discovery principles to 21st century medicine. Until the law catches up with these developments, many gray areas will remain with respect to the preservation and production of the EMR in medical malpractice litigation.•

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