Potential Liability Concerns in the Use of Electronic Medical Records

Introduction

The use of electronic medical records (EMRs) by hospitals and physician offices has greatly expanded in recent years. The financial incentives provided by the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 spurred adoption of EMRs. Advantages of EMRs include legible entries, automatic date/time stamp on entries, remote access to records, and clinical decision support tools and reminders. However, adoption of EMRs poses some unique medical professional liability concerns.

Potential Liability Concerns

Unintended Effects of Automation

Some of the functions intended to assist users with efficient documentation can have unintended consequences. The automatic date/time stamp precisely documents when every EMR entry is made. Audit trails also document what information was viewed, by whom, and for how long. Unlike a paper medical record, these aspects of EMRs provide specific information that could be used to support a plaintiff’s or defense claim. For example, if a claim of failure to diagnose a condition is based on the contention that a physician overlooked a test result, the EMR can indicate whether and when the physician reviewed the findings.

The use of autopopulation (or autofill) in a template may result in incorrect information in the note. If not corrected, the error may be perpetuated in the medical record. Drop-down menus, intended to assist the user in quickly entering information, may paradoxically allow selection of the wrong drug or dose, for example.

Templates provided in EMRs may add or omit information in the patient care note. For example, an annual examination template may include performance of a breast examination. If the breast examination is not conducted but the practitioner does not delete it from the list of services, liability issues may arise. If the documentation indicates that the results of examination were normal, but that examination did not occur, patients or providers may make treatment decisions on the basis of this misinformation.

Data Entry Errors and Inadequate Training

As with paper records, data entry mistakes can contribute to medical errors—and litigation. A misplaced decimal can result in a drug dosage ten times stronger than intended. Inadequate training in the use of an EMR can prevent a provider from seeing important patient information. For example, in one liability case, a gynecologist performed unnecessary surgery on the basis of an outdated ultrasound result; the gynecologist had not been trained in using the EMR system and so missed a more recent ultrasound result that would have affected the decision for surgery.
**Multiple Users**

Multiple caregivers document information in the EMR, and the record itself may appear different based on user settings and the type of user (e.g., physician, nurse). Because information may be located in separate areas of the record, information that impacts patient care may be overlooked. Discrepancies in documentation may occur, for example, between nursing and the provider that could contribute to liability. Providers should be aware that correction of discrepancies is recorded with a date/time stamp.

**Provider Practices**

Copying and pasting from previous notes may introduce outdated information into the current note or propagate incorrect information. For example, a clinician may use an outdated record of a patient’s weight to calculate a drug dosage, leading to potential under- or overmedication. In one liability claim, a physician neglected to include an important risk factor in progress notes, which, when copied and pasted, led to a missed diagnosis.

Copying and pasting may misrepresent the level of care documented, resulting in overbilling, which could be considered fraud by the insurance payer. Copying and pasting may result in unnecessarily lengthy progress notes that diminish timely, effective communication of key information. As a result, it may be difficult to determine the author of a note, the intent, or when it was created.

Ignoring clinical decision support tools, without documenting why recommendations were not followed, may put the practitioner at risk for claims of negligence. The EMR may have many alerts that are not clinically relevant, causing “alert fatigue” and leading the practitioner to ignore a significant warning that is lost among the other nonsignificant warnings. Workarounds are shortcuts created by practitioners that bypass the safety features in the EMR because these features make providing care disjointed or time-consuming. Taking such shortcuts may result in medical error.

Use of the EMR in the examination room can draw the practitioner’s focus away from the patient. Attention to documentation in the EMR can make patients feel they are being ignored. Patient perceptions of neglect may be cause for litigation when an unexpected poor outcome occurs. Some risk management experts recommend “introducing” the computer to the patient—that is, explaining the role of the computer in the encounter—to minimize perceived barriers to communication.

**EMR-Related Litigation**

The Doctors Company, a national medical liability insurer, analyzed 97 EMR-related closed claims from 2007 to 2014. Sixty-four percent of the claims involved user error, and forty-two percent were related to system factors (with some claims involving both). Table 1 describes common user errors identified in the analysis. Table 2 summarizes the system errors identified.
Table 1: Common User Errors Leading to EMR-Related Liability Claims*

<table>
<thead>
<tr>
<th>User-Related Error</th>
<th>Percentage of Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorrect information in the EMR</td>
<td>16%</td>
</tr>
<tr>
<td>Hybrid health records/EMR conversion</td>
<td>15%</td>
</tr>
<tr>
<td>Prepopulating/copying and pasting</td>
<td>13%</td>
</tr>
<tr>
<td>Training/education</td>
<td>7%</td>
</tr>
<tr>
<td>User error other than data entry</td>
<td>7%</td>
</tr>
<tr>
<td>EMR alert issues/alert fatigue</td>
<td>3%</td>
</tr>
<tr>
<td>Workarounds</td>
<td>1%</td>
</tr>
</tbody>
</table>

Table 2: Common System Errors Contributing to EMR-Related Liability Claims*

<table>
<thead>
<tr>
<th>System-Related Error</th>
<th>Percentage of Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure of system design</td>
<td>10%</td>
</tr>
<tr>
<td>Electronic systems/technology failure</td>
<td>9%</td>
</tr>
<tr>
<td>Lack of EMR alert/alarm/decision support</td>
<td>7%</td>
</tr>
<tr>
<td>System failure—electronic data routing</td>
<td>6%</td>
</tr>
<tr>
<td>Insufficient scope/area for documentation</td>
<td>4%</td>
</tr>
<tr>
<td>Fragmented EMR</td>
<td>3%</td>
</tr>
</tbody>
</table>


Notably, none of the claims reviewed involved failure to ensure the security of the EMR or problems resulting from incompatible systems or failure of integration.

Of the claims reviewed, the Doctors Company found that 15% were attributed to ob-gyn practice, making it the third most common source of EMR-related claims in the study. (Internal medicine specialties accounted for 20%, followed by primary care practice with 16%.) The study found that 7% of medication-related errors alleged in EMR-related claims occurred in ob-gyn cases; overall, 19% of the claims had medication-related allegations. The Doctors Company expects litigation related to EMR issues to increase because there is a 3–4-year lag time between an adverse event and filing of a claim.14

Conclusion

Good medical record keeping reduces exposure to medical liability claims. Well-documented, complete records can demonstrate that a practitioner met the standard of care.1 A well-designed EMR should make documenting the care provided easy. The legibility of records and access by multiple concurrent users offer a great advantage over paper medical records. The computer provides accurate and discoverable date/time stamping, which should support the diligent provider’s actions. Clinical support tools should assist the individual in making sound care decisions and provide reminders for the busy practitioner. Together, these functions should decrease the errors a fallible human provider is prone to make. Medical records that are incomplete, are missing information, contain inaccurate information copied from earlier documentation, or are altered may raise questions about the quality of care provided.1


5 Troxel DB. Analysis of EHR contributing factors in medical professional liability claims. The Doctor’s Advocate 2015;(1):2, 6-7, 9.


9 Helton JR. Avoiding fraud risks associated with EHRs. Healthc Financ Manage 2010;64:76–81.


The information in this article should not be construed as legal advice. As always, physicians should consult their personal attorney about legal requirements in their jurisdiction and for legal advice on a particular matter.