EHRs Prove a Difficult Witness in Court

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The EHR is a valuable clinical tool for streamlining and improving patient care. But it is complicating and confusing the courts.

As the first cases involving electronic health records make their way into legal proceedings, everyone involved is discovering the challenges of producing and interpreting the information they contain.

New EHRs will do a better job of presenting clinical records in court as vendors, providers, and attorneys gain more experience. In the meantime, facilities must work at understanding exactly how their systems track and record data and how they can best produce these data as evidence in court-concisely, unequivocally, and inexpensively.

Confusion Can Lead to Suspicion

Medical records are a vital part of any healthcare lawsuit because they document what happened during treatment. Paper medical records are relatively simple aspects of litigation. HIM staff pull the requested chart, track down additional information as necessary, and sometimes provide a deposition on the record's accuracy.

The process is far more complex with an EHR. The record of a patient's care that a clinician views on screen may not exist in that form anywhere else. When the information is taken out of the system and submitted into legal proceedings, the court has a very different view-one that often confuses the proceedings and, in the worst instances, raises suspicions about the record's validity.

The challenges stem from the design of the systems, which were built for care-not court. If the provider struggles in providing documentation, a trial involving malpractice can easily shift its focus from an examination of care to a fault-finding mission with the recordkeeping system. At other times, the provider's inability to put forward the information in a comprehensible format may raise suspicions that it is missing, withholding, or obscuring information.

Not Fit for Print

Terri Bunsen, chief privacy officer and senior director of health information record services at Northshore University Health System, learned this firsthand. For several years the Chicago-area health system has been litigating a malpractice lawsuit that has put the spotlight on its EHR system.

Three years ago a malpractice lawsuit was filed against NorthShore by a patient who claimed emergency department physicians failed to diagnose and treat sepsis/septic shock. This mistake, the plaintiff said, contributed to his eventual 63-day inpatient stay at a NorthShore hospital and serious medical problems.

The patient's attorneys requested all records relating to patient's 63-day stay. The request proved difficult, explained Bunsen, who shared the lessons learned at the AHIMA Legal EHR Summit held in August in Chicago.

Bunsen's only option was to print the EHR using the "print screen" function, which took HIM staff hours to complete. When the printing was done, NorthShore staff had produced four banker boxes of records. Little of the information appeared as it did on screen, and much of it was difficult to interpret.

The plaintiff was suspicious that NorthShore was not providing the best information possible, and eventually the court granted the plaintiff addition forms of access to the records.

This included an on-site review of the live EHR by the plaintiff's team, with Bunsen and other NorthShore staff overseeing the access. HIM was later ordered to create a computer-based, read-only version of the EHR that the plaintiff team could search offsite on their own.

The request was new ground for NorthShore. Bunsen and her staff had to work closely with their vendor and IT department to reproduce the disclosures.

But even direct access to the EHR system and an off-line copy have not solved all of the information issues in the case, said Mike Slovis, Northshore's council on the case, and a managing partner with Chicago firm Cunningham, Meyer, and Vedrine.

Once the information was produced, both sides of the case found the EHR had serve limitations in telling the patient's medical story, Slovis says. The case continues to be argued in court.

A Shifting View of the Data

The challenge of an EHR in court is complicated by its newness. Providers, lawyers, judges, and juries have very little experience with reproducing, introducing, and examining electronic health records.

"This is a new world for lawyers, and we are dealing with issues that we don't totally understand when it comes to EHRs," said Slovis, who spoke with Bunsen at the summit and with the Journal in an interview. Understanding how systems do what they do and explaining that to the court is a steep learning curve.

One challenge parties in the NorthShore case have discovered is the dynamic nature of electronic systems.

Unlike a folder of paper records, EHR systems change over time. Systems are updated, features are added or removed, and upgrades change the types of information that appears on printed documents.

For these reasons, it is nearly impossible for electronic records to reproduce exactly what the physician saw on his or her screen at the time of an incident-especially one that occurred years ago, Bunsen said in an interview.

Slovis noted the same challenge: "The EHR always provides complete data, but it doesn't provide it in the exact form that was ongoing at the time…."

Even during treatment screen views can differ between providers. A nurse may see a different set of information than what a physician sees depending on which systems they are using, what customized settings they have selected, and possible system configurations based on their user roles.

This presents problems for both plaintiffs and defendants when trying to determine if appropriate care was provided.

"The EHR looks and feels different depending on who the user is," according to Bunsen.

Conflicting Testimony

Interpreting the printed chart during her deposition proved somewhat difficult, Bunsen said. A major reason was that several terms recorded in system metadata had varying definitions.

"Accept" means different things in the metadata within NorthShore's EHR depending on what type of record it is attached to or the circumstances behind its recording. "Accept" could mean a record was pended, filed, shared, or officially accepted by a physician.

Determining "what the document says, and what it really means," may take multiple conversations with the vendor, the IT department, and other experts, Slovis said.

Questions arose in the NorthShore case when the plaintiff identified seeming discrepancies between the system's audit trail and the actual record. While some of the discrepancies may have looked suspicious on the surface, technical explanations could account for the differences, Bunsen said.

An example involved notes that were recorded in the audit trail but absent from the legal record.

The case's audit trail showed that an order was placed by a clinician and "accepted," but the actual order never appeared in the EHR. Opposing council could infer that this order had been erased from the record or had not been disclosed to them. But "accepted" in this instance meant that the order was merely pended; it was never executed and officially entered into the record by the clinician.

In the paper world, this pending of a record would be the equivalent of a doctor writing a note on a piece of paper and sticking it in her pocket. It was a helpful note at the time but not meant for the medical record. Only after learning how the system recorded information could Bunsen explain the circumstances of the entry.

Even time stamps, which would seem to be irrefutable, may need explaining.

For example, a nurse may take a temperature reading at 9 a.m. but not close the entry for another 30 minutes. The reading may post to the record with a time stamp of 9:30.

Or a nurse's credibility may crumble if she testifies that she was in the ER at 10:30 a.m. but the EHR indicates she accessed records on the other side of the building at the same moment. The time stamp may have been recorded when a coworker completed and filed the record-after the nurse raced to the ER. Both instances would require explanation in court.

Discrepancies like these that cannot be explained can lose cases for a healthcare facility, Slovis said, which is why he stresses that witnesses must know how the EHR records and subsequently displays information.

Given the complexity of the systems, explaining an EHR may require more people than the HIM director. In NorthShore's case, HIM, IS, medical informatics, and vendor representatives have all needed to testify on the system's audit trail.

Bunsen also stressed the risk of including data in the legal EHR that have been manipulated or reworked for internal use.

Prior to NorthShore's malpractice lawsuit, staff processed some record audit trails and put them into a spreadsheet for easier reading. But the case sensitized Bunsen and her department to the risk, because opposing counsel could perceive that the facility has changed or obscured information.

Since the lawsuit, no audit trail or metadata information is reworked for inclusion in the legal EHR or released for court. The information is harder to read, Bunsen, says, but it is in its pure form and its integrity cannot be challenged.

Know Your System, Define Your Record

NorthShore has had an EHR since 2003, which is why it is working through these challenges before most. But as more healthcare organizations transition from paper to electronic health records in the coming years, litigation involving EHRs will become common. HIM and healthcare attorneys should expect an increased workload until the wrinkles are ironed out.

Every healthcare facility should designate a legal health record set for release upon request to patients or attorneys, Slovis recommended. Once designated, staff must understand it and stick to it. This is essential practice for paper or electronic records.

Defining and managing the legal record is core work for HIM departments, which can get a jump on requests for electronic data by ensuring the facility's legal record takes its new and evolving health IT systems fully into account.

They then can work with their vendors and IT departments to ensure that record set can present to the court a clear picture of the care provided. This requires a deep knowledge of how the system works.

"Even if you weren't involved in determining what makes up that printed record, you need to understand where that documentation is coming from," Bunsen said.

That may require extraordinary measures. One of the most difficult aspects of this case for NorthShore's HIM department was getting trained on how their system works. In order to answer attorneys' questions about record creation, storage, and

metadata, NorthShore needed its vendor to send a hospital-based trainer to help answer questions and educate staff. The HIM department has since hired an employee who can serve as an expert on the inner workings of the EHR.

In time EHRs will become commonplace in legal proceedings, with electronic records showcased in trial. But for now HIM professionals producing records from EHRs will most often print the information-and then be called upon to explain it-sometimes with millions of dollars on the line.

Understandable, readable records can defend the medicine behind them, Slovis said. Records that cannot be satisfactorily presented to the court can "lose the case before you start."

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