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Electronic Health Records: Assessing Best Practices and Anticipating Liability Concerns

By Sean P. Byrne, Esq. and Neal H. Lewis, Esq.

Through "meaningful use" financial incentives with Medicare and Medicaid reimbursements, the federal government is fostering electronic health record (EHR) adoption. The goal behind EHR implementation is improved quality of patient care and patient safety. You have seen the results in your office and hospitals – the EHR now is a reality for many.

With widespread adoption of EHRs there are concerns regarding the use of the technology as a source of proof in medical malpractice litigation and as a potential area for unanticipated liability. In this article we discuss some practical aspects of EHRs to help you reduce risk in your practice.

From a litigation perspective, the EHR should create an accurate **RECORD**:

- **Reliable.** The EHR should accurately document and safeguard important clinical information. Data should be maintained with appropriate backups.
- **Efficient.** The EHR should make it easy for providers to record and access pertinent information. These efficiencies should translate into the printed record.
- **Consistent.** The EHR produced to the patient in response to a release, to an attorney in response to a subpoena, and to defense counsel when facing a lawsuit, should be the same regardless of when or by whom it is printed.
- **Organized.** The EHR should largely mirror the familiar structure of traditional paper records with, for example, orders, medications, progress notes and nursing flow sheets set forth in a logical manner.
- **Readable.** The EHR should go from the computer screen to the printed page in a way that is clear, logical, chronological and readily understandable by attorneys, witnesses and jurors. Truncated data fields lead to frustration and further scrutiny.
- **Detailed.** The EHR should contain important historical clinical information including history, allergies, medications, monitoring, assessments, interventions, communication and other treatment details.

Continued on page two

Coping with Malpractice Stress

By Wayne M. Sotile, PhD, and Mary O. Sotile, MA

Medical liability pressures are the third leading stressor in medical practice, behind long hours and insurance issues.[1] For 95% of physicians, being sued leads to periods of anger, depression, family tensions and career discernment.[2]

For more than 35 years, we have helped physicians and their families cope. In this column, we will highlight strategies and tactics for staying resilient during the medical malpractice process.

Recognize Your Risks

The style of coping you learned during medical training may complicate your coping during times of vulnerability. The pain of the malpractice process is fueled by perfectionism, fear of being humiliated and a general distrust that others will be nurturing when you are vulnerable. If you cloak such emotions with a shroud of withdrawal or anger, they will fester into shame and anxiety, which can fuel a full-fledged malpractice stress syndrome.

Continued on page three

Electronic Health Records: Assessing Best Practices and Anticipating Liability Concerns *(continued from page one)*

When these objectives are satisfied, the EHR can be a valuable source of proof in a medical malpractice case. But when the EHR lacks the characteristics of an accurate and persuasive medical record, problems are likely to ensue.

Liability Concerns Created by the Electronic Health Record

In addition to using the EHR as a source of proof, several specific concerns come to mind with the ongoing transition from paper charts to computerized medical records.

1. **Information Overload** With electronically available medical data, large volumes of data can be made available to healthcare providers. But just because you can access volumes of records and historical data, must you? The standard of care will evolve as access to information increases. The liability questions will include the familiar: What did you know and when did you know it? Now, the question becomes: What should you have known if you had accessed the available information?

2. **Decision-Making Support and Alert Fatigue** The EHR can store and analyze medical information, providing automated decision support. We've come a long way from the fictional computer assistant HAL in "2001: A Space Odyssey" to the reality of the "smart" computer or phone. The latest gadget, Siri, a voice-activated personal assistant on the iPhone4S, gives us a preview of what's to come as technology advances.

   Decision-support modules present risk along with benefit. Who will be responsible for the consequences of medical mistakes made based on the decision making of a machine?

   There are other technological consequences as well. The electronic record can alert the healthcare provider to an unending stream of potential problems, which can lead to "alert fatigue," a phenomenon in which the provider, after receiving too many automated alerts, begins to ignore and/or override them. Carefully designing alert settings and other decision-support matrices is a critical part of a well constructed EHR system.

3. **Privacy in the Era of Instantaneous Access** Digitized patient data create the opportunity for unintended privacy violations and unauthorized access. Weak data security, password sharing, technology malfunction or carelessness can result in unintentional privacy violations. Similarly, the ease and speed of e-mail, text messaging and social networks makes their use as a healthcare communication tool tempting. In this context, patient privacy must be carefully safeguarded and proper documentation maintained.

4. **The Trouble with Templates** Preformatted data entry fields are a benefit of electronic records, providing structure and reminder cues, and encouraging uniform and comprehensive data entry. But when customized fields do not match the clinical situation, inefficiencies or errors can occur. Systems that produce default "normal" assessments introduce potential mistakes, and efficient or cut-and-paste charting introduces potential for inapplicable entries to be memorialized. A common challenge in litigation is that the template charting does not match the patient and the actual exam performed, putting all of the recorded data into question.

5. **Jury Impact of the Computerized Record** In terms of persuasive impact, the sterile computer data field lacks some of the personal touch and resulting aura of credibility that came from the traditional hand-written, patient-specific, contemporaneous narrative nursing or physician progress note shared with the jury at trial as evidence of individualized special care and attention. The typewritten word cannot convey the sense of urgency seen in handwritten notes describing an emergent situation. Consider when the circumstances call for you to step outside of the technology box and write a narrative note free from the constraints of the checkboxes.

6. **Metadata: Tiny Information / Big Consequences** Finally, no discussion of electronic records is complete without mention of metadata, loosely defined as "data about data." In the EHR context, metadata may include information about when medical record entries were made, and whether entries were omitted, altered, or supplemented at a later date – and by whom. Healthcare providers are advised to remain mindful that computers hold data beyond those which appear on the printed page. These data are increasingly sought and produced in litigation as evidence of what was written and accessed, when and by whom.

   Conclusion As electronic health records become the standard in healthcare, we will see these concerns and others making their way to the courtroom. During system design and implementation, healthcare providers should remain thoughtful about the potential liability ramifications so that the goals of promoting quality care, patient safety, and maximizing the utility of the medical record at trial, are not sacrificed in the name of progress.

Portions of this article were originally published in the Virginia Medical Law Report, *Vol. 7, No. 6, November 2010. Sean P. Byrne is a malpractice defense attorney at HDJN in Richmond, VA, and an adjunct faculty member at the University of Richmond. Neal H. Lewis, Esq. is an associate at the firm, practicing medical malpractice defense. Lewis is a former editor of the* Richmond Journal of Law & Technology *and has significant experience with technology and e-discovery issues in medical malpractice litigation.*

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Thanks!

Coping with Malpractice Stress *(continued from page one)*

Use the Malpractice Stress Syndrome Checklist

From the list below, check any signs of malpractice stress syndrome that describe you.

- ☐ I am atypically cautious when treating patients.
- ☐ I am hesitant or refuse to treat difficult cases.
- ☐ I obsess on case details or on "cover my tracks" documentation.
- ☐ I am hyper-sensitive to perceived slights or criticism from colleagues.
- ☐ Due to my embarrassment over this suit, I have withdrawn from my colleagues.
- ☐ I find it difficult or impossible to talk with my family about this suit.
- ☐ I am questioning my commitment to my specialty.
- ☐ I am masking my vulnerability with a veneer of anger or indifference.
- ☐ I am considering changing jobs or taking early retirement.
- ☐ I am atypically struggling with some combination of depression, anger or other forms of emotional distress.
- ☐ I am self-medicating with alcohol or other drugs.

When facing an unrelenting stressor, the key resilience strategy is to boost perceived and actual control and support.

Accept the Process and Participate where Needed Stretch your time expectations. The typical malpractice suit unfolds over a period of two years – sometimes longer. No amount of urgency or obsessing on your part will alter this time frame. Salve your need for control by helping your attorneys and claims/risk management professionals understand fully your side of the story. If appropriate, participate in selecting expert witnesses. Initiate periodic contact with your attorneys throughout the long months that unfold between any clear events related to the suit.

Recognize This is a Family Affair Keeping your distress a secret from your loved ones will only serve to alienate you, confuse them and generally strain your family relationships. Let your loved ones know what you are going through. Reassure them that the details of the suit are being attended to. Ask for their support, and offer them support.

Seek Support from Trusted Colleagues You may be warned not to discuss details of your case with others, but supportive interactions with trusted colleagues about your own emotional needs and reactions are not discoverable. Let trusted colleagues know what you are going through, and ask for their support. Having self-confidence enough to admit when you are vulnerable will deepen others' respect of you.

Control What You Can This process can be a marathon. To protect your stamina and resilience, pay attention to the basics of self-care. Exercise regularly. Eat healthily. Avoid self-medicating with alcohol or other drugs. Get a medical check-up. Sleep when you can. Distract yourself from your worries by partaking of healthy pleasures. Appeal to a nurturing higher spiritual power. Learn a relaxation procedure, and practice it. Take care of yourself!

Be Mindful One antidote to preoccupying anxiety is mindfulness. Resist the tendency to let malpractice stress disconnect you from the many sacred moments of your work. Try to "harvest" moments of meaning, joy and fulfillment during your work day. Countering daily (and inevitable) hassles with uplifting messages is a key resilience strategy.

Reframe and Re-label Embrace philosophies that help you to make sense of this experience. Remind yourself that your profession is not your entire life, and that this malpractice suit is not your entire profession. As author Sara Charles reminds us, "This suit is not about competence. It's about compensation."

When In Doubt, Get Physician-Friendly Help In addition to specialized legal counsel, consider medical, mental health or coaching consultation from providers who appreciate the special challenges that come with a life in medicine.

Wayne M. Sotile, PhD, and Mary O. Sotile, MA, are founders of Real Talk, Inc. in Winston-Salem, NC, and co-authors of "The Resilient Physician" (2002) and "Letting Go of What's Holding You Back" (2007). They are speakers and consultants to medical organizations and group practices concerned about physician resilience and ways to make the workplace a positive interpersonal culture. Visit them at ***www.TheResilientPhysician.com****, or contact them directly at* ***Sotile@SotileMail.com****.*

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HR Question: Job Abandonment

Question: Is there a specific number of days that an employer can set that determines job abandonment? Typically we hear three days but are there federal and/or state laws that dictate?

Answer: Barring an employment contract or collective bargaining agreement, etc., an employer is generally within its rights to establish its own policy relative to employee no call/no show. Some employers determine that a single instance of no call/no show is grounds for immediate discharge. Others require an employee to be away from work without calling for a certain number of days before it will make a discharge decision. Each employer needs to decide for itself what kind of no call/no show policy is in its best interest. Any such policy, however, should be uniformly enforced and should have the flexibility for management to make exception when truly extenuating circumstances are present. We recommend having local counsel assist in drafting or reviewing any such policy before implementation.

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Adeptly and Professionally Documenting Disagreements with Consultants in the ED

By Pete D. Steckl, MD, FACEP

Clinical approaches among medical specialties may differ, and disagreements on appropriate care between emergency department (ED) physicians and consultants are bound to occur from time to time in the course of our work in the ED. Much emphasis is placed during emergency medicine training on the need for self-reliance in decision-making and tactics that can be used in getting one's agenda accomplished. I would like to take the discussion one step further by driving home the necessity for maintaining professional decorum when finalizing documentation of these, at times, fractious discussions.

We talk a lot about patient expectations and the importance of attempting to meet them. However, little dialogue has occurred regarding how to act when a patient's expectations are not met during encounters with admitting physicians and consultants. When a discussion with a disagreeable consultant goes south and you not only do not get the help that you seek, but in addition are treated in a disrespectful or condescending manner, the atmosphere is ripe for taking out your frustrations by documenting the conversation in an accusatory or unprofessional manner. Though it is tempting to believe that you have covered yourself by documenting a breach in conduct on the part of the consultant, in most cases, maligning your colleague can backfire and place yourself in legal jeopardy.

Though the above may seem at first glance to be counter-intuitive, past claims experience clearly indicates that pointing fingers serves only one party, and that is the plaintiff's lawyer – who, when he sees smoke, just redoubles his search for fire. Should legal action be initiated and the consultant's care (or lack thereof) is then brought into question, all care received by the patient comes under scrutiny. Should there appear a lapse in management, you could find yourself involved in the lawsuit you were attempting to avoid. Best tactics to utilize in these conflicts is to walk away, cool down and later document the details of your discussion in a dispassionate, "just the facts" sort of way. Do what you need to do to get the patient the care that he or she needs. Should your grievance with the medical staff member rise to a high enough level, discuss with your facility's medical director the possibility of filing a separate formal complaint through an "incident report" type of mechanism.

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Reference

ED Legal Letter, "Tempted to Cover Yourself? It May Backfire," May 2011, Vol. 22, No 5, page 59.

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