

# EHR in Malpractice Litigation: How “Cloning” and The Audit Trail Can Lead to Unnecessary Claims

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As of 2016, 95% of hospitals and 60% of office-based physicians participating in the Centers for Medicare & Medicaid Services (CMS) Electronic Health Record Incentive Program had demonstrated *meaningful use*<sup>1</sup> of certified health information technology (*i.e.* use of the electronic health record).<sup>2</sup> These statistics demonstrate the fact that the EHR is no longer a novel idea, but rather is common practice and here to stay.

The benefits of the electronic health record (EHR) are well-known. The EHR facilitates ease of access to clinical information, including, but not limited to, patient demographics, past medical history, laboratory test results, and medications.<sup>3</sup> This enables a physician seeing a patient for the first time (*e.g.* a specialist in a multi-practice medical group) to access the patient’s pertinent medical data at the click of a button rather than having to obtain the patient’s paper chart and comb through pages of medical records, thus increasing efficiency and reducing time and labor. The EHR also permits physicians to order testing and prescriptions electronically thereby limiting mistakes due to illegible handwriting and preventing the ordering of duplicate medications from another different doctor.<sup>4</sup> The EHR further issues warnings about potential improper drug interactions as well as other reminders and alerts that may be of significance to the physician. Medical providers are not the sole beneficiaries of the EHR. Many EHR systems promote patient participation and engagement by permitting patients to access and review their medical records anytime through patient portals.<sup>5</sup>

For all that the EHR improves upon the paper record, like any technological advance, it is not without its drawbacks. Physicians have made various complaints about the EHR, including *inter alia* that the EHR is time-consuming<sup>6</sup>; impairs relationships with patients<sup>7</sup>; and, lacks interoperability platforms to share information with other outside medical practices<sup>8</sup>. Physicians also complain that drop-down menus do not always provide options that are appropriate for a particular patient and there is insufficient area to create a narrative. This last complaint was previously an issue in a medical malpractice claim<sup>9</sup> and we can expect more malpractice claims involving the EHR in the coming years due to the EHR’s various shortcomings.

Due to the relatively recent implementation of the EHR, there has not yet been substantial medical malpractice litigation directly involving issues with the EHR.<sup>10</sup> Most cases settle before trial and few cases, if any, have reached the appellate level (at least in New York). Yet, two issues with the EHR have come into focus as potentially leading to malpractice claims and litigation:

“cloning” of records and time-stamped entries. This article discusses these issues and how they have led, or could lead, to litigation.

## “Cloning” – Copy and Paste

One of the biggest issues that has arisen with the advent of the EHR is the ability for medical providers to copy and paste portions of prior notes into subsequent notes, also known as “cloning”.<sup>11</sup> A recent study published in the Journal of American Medical Association found that when reviewing thousands of progress notes from 460 clinicians at the University of California San Francisco, only 18% of the notes were entered manually. 46% of the notes were copied and 36% were imported.<sup>12</sup> Notably, residents were found to copy and paste more than both hospitalists and medical students, although hospitalists were found to copy more text.<sup>13</sup> However, these findings are nothing new. In a study of notes published in the Journal of American Medical Informatics Association in 2009, it was found that 54% of the information in progress notes and 78% in sign out notes contained information duplicated from previous notes.<sup>14</sup> Moreover, a study in 2008 found that 90% of physicians in the study reported that they had used the copy and paste function in progress notes.<sup>15</sup>

When seeing several patients in one day, it is expected that physicians will take advantage of measures that will save time and energy. Re-typing or filling out of categories in the EHR which may remain the same as a prior progress note (*e.g.* past medical/surgical history and medications) is time-consuming and can be avoided by simply cloning information from prior notes. This may be especially useful when seeing the same patient shortly after the last visit, or during a hospital admission when other medical professionals saw the patient earlier in the day.

There are also instances when an EHR system prepopulates certain portions of prior notes into the next note.<sup>16</sup> Indeed, this author previously encountered a physician in a medical malpractice action who testified in deposition that the past medical history and prior diagnoses sections from earlier notes were automatically included in subsequent notes. The physician made no attempt to modify the autopopulated portions of the note. This did not affect the overall issues in this specific malpractice case, but can shine an unfavorable light on the physician as it may present the physician as being lazy and uninterested.<sup>17</sup>

There are multiple other dangers that arise from copying and pasting portions from prior notes. For one, copy and pasted material can create lengthy notes (also

known as “note bloat”), with only a very small portion of the note containing new information. This can make it difficult for another physician subsequently reviewing the chart to determine whether there is new or updated pertinent information, potentially leading to unnecessary delays in care and treatment and possible missed information. Moreover, while copying and pasting a prior medical history may not be too risky, copying and pasting findings from a prior physical examination and/or laboratory and test results is dangerous as a patient’s condition can change from day to day.<sup>18</sup> For instance, in a patient receiving Warfarin therapy for treatment of atrial fibrillation, if a physician notes in the EHR that the patient’s PT/INR was normal on one visit and then copies that portion of the note on subsequent visits without checking updated laboratory results, the physician could be opening him/herself up to liability if the patient were to clot or stroke.

In early 2015, the Medical Director of The Doctors Company, David B. Troxel, M.D., disclosed the amount of EHR-related claims the company had closed from 2007 through the first two quarters of 2014.<sup>19</sup> 13% of the claims attributable to EHR-user factors were due to copy and paste and repopulating.<sup>20</sup> Dr. Troxel provided an illustrative example of a cloning claim where a previous note contained an error which was copied and pasted into the next note and into subsequent notes thereafter.

Following a trip abroad, a toddler experienced fever, rash, and fussiness. The physician considered a possible bug bite or flu and provided antibiotics and flu medication. The physician noted in the EHR that there was no TB exposure, but failed to note that the toddler had traveled to a country where tuberculosis was prevalent. The physician proceeded to clone this note into subsequent visit notes. Two weeks later, the toddler was diagnosed with tuberculosis meningitis and had suffered from permanent and severe cognitive defects due to the delay in diagnosis and lack of treatment.<sup>21</sup>

In another example presented by Mag Mutual Insurance Company, following an emergency department visit, a patient with atrial fibrillation and potential heart disease was to follow with his primary care physician for a stress test.<sup>22</sup> At the next PCP visit, the physician did not perform a stress test and did not diagnose the patient with cardiac disease. The patient had high blood pressure for which the physician prescribed medication. The plan was for the patient to call the PCP or go to the ER if symptoms worsened and to maintain a healthy diet. The physician thereafter copied and pasted this assessment and plan for office visits over the next two years. The physician never administered a stress test or performed a cardiopulmonary work-up, despite the patient intermittently complaining of shortness of breath. The physician apparently told the patient to see a cardiologist, but it was not noted in the plan. Rather, the plan was cloned from prior notes. The patient subsequently expired and the cause of death was noted as cardiac-respiratory arrest, chronic obstructive pulmonary disease, and cardiac

arrhythmia. The physician was sued and the case settled for “a high-dollar amount.”

In each of the examples discussed above, the physicians copied portions of notes from prior notes without providing new and updated information. The physicians relied on old information to continue the treatment in place while the medical conditions of each of their patients declined, leading to significant injury and/or death. The plaintiffs thereafter commenced lawsuits alleging that the physicians committed medical malpractice. While the cases did not solely turn on the copy and pasting of records, the cloning certainly played a role and likely affected the integrity of the notes in the EHR as well as that of the physicians.

When a lay jury cannot fully trust the medical chart, it can spell serious trouble for the defendant-medical professional driving potential verdict values into the multi-millions.<sup>23</sup> That is the case even if the issues with the EHR do not directly relate to the allegations of malpractice. In one case, a judge went so far as to dismiss the EHR as exculpatory evidence, stating that the record was not to be believed as it contained “plagiarism” characterized as cut and paste.<sup>24</sup>

Healthcare professionals and medical facilities should also be aware that cloning also has other negative effects outside of being sued for malpractice. Cloning records can lead to charges of fraud by the CMS, who will then deny payment for services.<sup>25</sup> Also, there are some who believe that cloning is considered “clinical plagiarism”<sup>26</sup> and have even led to the firing of medical professionals.<sup>27</sup> Thus, while there may be some benefit to copying portions of prior records to save time, the practice should be done with caution.

### Time-Stamped EHR and Audit Trails

The timing of an evaluation or visit by a physician or nurse may be imperative where the allegations in the case center on the failure to timely examine, provide treatment, medication, and/or testing to a patient. Prior to the EHR, physicians and nurses would typically date and time a progress note in a patient’s chart at the time of writing the note. However, if the medical provider did not author the note until sometime after he/she saw the patient, the time reflected on the note could be hours after the patient was actually seen. If the medical provider did not specify the time he/she actually saw the patient, then the timing of the visit may become a major disputed issue in the case.<sup>28</sup>

The EHR can assist in resolving this potential issue under the right set of circumstances. That is, if it is a physician’s custom and practice to log on to the EHR system when seeing a patient (possibly to look at the patient’s medical history and any previously entered notes, test results, etc.) then the audit trail (the EHR’s metadata) will typically provide a time stamp of when the physician saw this particular patient. Audit trails and metadata

record when the physician logged into the system and how long he/she remained in the system.<sup>29</sup> While the physician could technically create a note on the examination of the patient later in the day, the audit trail/metadata will provide evidence (pursuant to the physician's custom and practice) of the time the physician actually saw the patient. This can assist in reducing claims related to the timeliness of tasks, such as examinations and testing. Of course, this issue can only be rectified if it is in fact the physician's practice to log into the EHR when seeing patients. If not, then the physician will face an uphill battle to prove the time he/she saw or treated a patient if the physician did not log into the EHR until later in the day when entering the note.<sup>30</sup>

Yet, the ability of audit trails to track log ins/outs to the system generates a new set of problems for healthcare professionals and facilities. For instance, if the defense of a malpractice suit is predicated on the ambiguity of whether something did or did not occur (*e.g.* physician never became aware of the patient's symptoms) then metadata showing a log in by that physician into the EHR is clearly unfavorable to the defense. That is because if the physician logged into the system, he/she would be expected to have learned of the patient's symptoms, assuming they were in fact noted in the EHR.

Another problem occurs when a medical provider, such as a nurse, enters that he/she completed a certain task (*e.g.* administering medication; turning and positioning) without having yet done so. The nurse may make the entry in order to complete the note ahead of time with every intention of completing the task at some point later. Yet, the audit trail and EHR will track when the nurse actually made the entry. What may seem like a time-saving measure to the nurse at the time of the entry could damage an otherwise defensible case. Even if the forward-charted note was inconsequential to the malpractice issues in the case, it can impact a defendant's credibility.<sup>31</sup> The sense of impropriety has led to settlements prior to trial in order to avoid potential blowback from a lay jury.<sup>32</sup>

The above shows that the existence of metadata and audit trails can be a double-edged sword. Medical professionals must keep in mind that the EHR can track a user's every move, including editing, printing, and when an individual returns to a note well after the note was signed off.<sup>33</sup> Many EHR systems will make a notation when a prior note was "reviewed" which, while not improper by itself, can raise questions about the reason for returning to the note, especially if the note was "reviewed" after an adverse result, or after the commencement of a lawsuit.<sup>34</sup> Furthermore, contrary to paper records, if one wants to edit a mistake or add to a note, the audit trail will record the time of the amendment and/or addition. The EHR will likely also time stamp the edit. In paper records, unless the medical professional specifically noted the date and time of the amendment, it would be impossible to know by simply looking at the

note when the note was modified. Although improper pursuant to CMS guidelines, this ambiguity provided some mild protection in malpractice suits when a medical professional attempted to edit a note after an adverse result.<sup>35</sup> However, in the age of the EHR and audit trails, this protection is nonexistent. Any attempt at amending a note will be tracked and professionals can find themselves in significant trouble if an attempt to edit was made after an unfavorable outcome.

It is important to note that while metadata and audit trails can assist in authenticating the EHR, there is an indication that audit trails may also be able to be manipulated and altered. 45 C.F.R. § 170.304 (s)(2) and (3) prohibits the alteration of audit trails created by the EHR. Yet, in a December 2013 survey conducted of 900 hospitals, the Department of Health and Human Services' Inspector General's Office found that 44% of responding hospitals reported having the ability to delete their audit logs; 33% could disable the audit logs; and, 11% could edit the logs.<sup>36</sup> It is possible that since this survey was conducted approximately four years ago, electronic record systems have improved in preventing alterations to the audit trail, however, audit trails may still be able to be manipulated once copied onto a spreadsheet or other document.<sup>37</sup> The ability to alter the audit trail calls the integrity of the EHR into question.<sup>38</sup>

Of note, metadata and audit trails have been generally found to be discoverable in New York.<sup>39</sup> However, defense counsel should be prepared to object to such demands and even force plaintiffs to make motions, if the demands are unduly burdensome, expensive, and appear to be requested solely for the use of a fishing expedition.

## Takeaways

Cloning may be an efficient tool when re-stating facts that have not changed, such as past medical history or certain patient demographics, but it can be dangerous when copying test results, vital signs, essentially anything that can be different the next hour or day. If a medical professional should clone prior portions of notes, it is recommended to 1) ensure that the information to be copied has not changed; and, 2) specifically state the date and time of the note from which the copied portion was obtained. This will, at the very least, show that the medical professional acknowledges that the information is copied and will prevent from "clinical plagiarism". This can also assist physicians subsequently reading the note to quickly locate the new or updated information.

Prior to the implementation of the EHR, the timing of when an action occurred (*e.g.* treatment visit) was frequently an issue in malpractice suits. When the EHR is used appropriately, audit trails dispose of that problem. That is, if a medical professional logs into the EHR each time he/she treats a patient, then the audit trail will have an entry for when that professional logged in. The timing

of the treatment will not become an issue. However, that the audit trail tracks any use of the EHR is a both a blessing and a curse. Importantly, medical professionals must avoid the temptation to forward-chart the completion of tasks that have not yet been completed. Also, medical professionals must remember that any use of the EHR is tracked, and thus, any attempt to view or amend notes following an adverse result or commencement of a lawsuit, can shine a negative light on that professional.

With the vast majority of hospitals and medical facilities, as well as a growing number of private physicians, implementing the EHR, we can expect the number of medical malpractice lawsuits involving issues with the EHR to increase. In addition to cloning of records and issues caused by audit trails, other drawbacks of EHR may contribute to the rise of such suits, such as physicians ignoring incessant alerts and inadequate progress notes due to lack of options in drop-down menus. The EHR is now the common practice for documenting notes and recording interaction and will continue to evolve with further technological advances. Indeed, there is now word that Amazon and Apple are seeking to create their own EHR platforms.<sup>40</sup> As the EHR is here to stay, medical professionals must do their best to keep up with the ever-changing EHR landscape so as to avoid any potential legal liability.

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## #MeToo Goes Viral Healthcare Perspectives

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In recent months, the sexual harassment virus has assailed a multitude of industries with the same effect as an influenza epidemic. Healthcare organizations are by no means immune from such allegations and conduct. Society has reinforced a sexualized portrayal of those in the healthcare industry, especially nurses, and this may contribute to the conduct experienced in the workplace. From their portrayal in movies to Halloween costumes, at times nurses are seen in a sexualized manner rather than a professional one. Problems regarding sexual harassment are not limited to nurses, but extend to the rest of the healthcare profession as well.

Approximately 50% of female nurses, physicians, and medical students have reported experiencing sexual harassment. In 2016, one third of female physician-scientists reported having experienced sexual harassment during their career. In 2017, two-thirds of nurses, both men and women, stressed that harassment was an issue in the healthcare field. Furthermore, according to an analysis of charges filed with the EEOC, from 2005-2015 the Health Care and Social Assistance category had the fourth highest instance of complaints at 11.48%.

#### What is Sexual Harassment?

Actionable sexual harassment ranges from creating a hostile or offensive working environment to unwelcome sexual advances and requests for sexual favors. Victims and harassers are not limited to one gender and they can both be of the same sex. Harassment is illegal when it is so frequent or severe that it creates a hostile or offensive work environment or when it results in an adverse employment decision. The harasser can be the victim's supervisor, a supervisor in another area, a co-worker, or someone who is not an employee of the employer, such as a client, patient, or customer.

Harassment is not limited to physical actions. Verbal acts, such as offensive teasing, joking, or suggestive remarks or sounds, may also be considered sexual harassment, as well as whistling, catcalls, or inappropriate emails, letters, memos, or telephone calls. Non-verbal sexual harassment may include sexual gestures, winking, leering, looking inappropriately at a person's body, blocking a person's path, or giving personal and unwanted gifts.

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- <sup>9</sup> *Id.*; see also *Heskin v. Insite Advertising, Inc.*, No. 03–cv–2598, 2005 WL 407646, at \*20–21 (S.D.N.Y. Feb. 22, 2005) (holding that an employer can be held liable for the harassing acts of non-employees if a plaintiff “adduce[s] evidence tending to show that [the employer] either failed to provide a reasonable complaint procedure or that it knew of [the] harassment by [a non-employee] and failed to take any action”).
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- <sup>11</sup> This particular allegation involved plaintiff’s medical records being improperly accessed by another NYU employee raises HIPAA violations that are beyond the scope of this article, but are very important issues to address given the advent of electronic medical records.
- <sup>12</sup> Because it is common for healthcare professionals to receive treatment where they work, employers in this setting must impose a higher than normal standard of respect between employees.
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<sup>1</sup> *Harris v. Forklift Sys.*, 510 U.S. 17 (1993) holding that while Title VII of the Civil Rights Act of 1964 barred conduct that would seriously affect a reasonable person's psychological well-being, the statute was not limited to such conduct. The Court held further that as long as the environment would reasonably be perceived and was perceived as hostile or abusive, there was no need for it also to be psychologically injurious.

<sup>2</sup> *Clark County Sch. Dist. v. Breeden* 532 US 268 (2001); *Faragher v. City of Boca Raton*, 524 U.S. 775 (1998); *Smith v. City of New York*, 2016 U.S. Dist. LEXIS 118281 (S.D.N.Y. 2016); *Mack v. Paris Maint. Co.*, 2016 U.S. Dist. LEXIS 22071 (S.D.N.Y 2016); *Laudadio v. Johanns*, 677 F.Supp. 2d 590 (E.D.N.Y 2010).

### Additional References

1) Sexual Harassment in Healthcare. September 2017.

<http://www.rn.org/courses/coursematerial-236.pdf>

2) Title VII of the Civil Rights Act of 1964

3) *Bianco v. Flushing Hospital Medical Center*, NY 2009-32086 (September 11, 2009)

4) *MacCluskey v. University of Connecticut Health*, Case No. 17-0807-cv (2d Cir.Dec.19, 2017).

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