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EMR and E-Discovery Part One: Questions and More Questions

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This may seem an odd way for an attorney to start a post, but while I know many of the questions, I do not have the answers. But the fact is that the intersection of Electronic Medical Records (EMR) and e-discovery is in the very early stages.

There are, however, lots and lots of questions—and those questions have the potential to impact far more than merely whether a physician or hospital wins or loses a particular medical malpractice lawsuit, important as that resolution may be to those involved. Perhaps risking hyperbole, one might say that recognition of the risks affiliated with e-discovery of EMR can impact important aspects of how medicine is practiced and the establishment of healthcare institution policies. And that recognition, combined with planning for how to respond to it, may *be* the first part of the answer. The need for such planning is the essential message of this series.

Over the past 15 years, federal courts have developed a large body of law and experience in e-discovery issues. That is a function of several factors, including: (1) the enactment of changes to the Federal Rules of Civil Procedure in 2006 that added an express reference to "electronically stored information;" (2) the wide publication of federal district court opinions, where most discovery rulings are made; state court trial court opinions are rarely published, and e-discovery issues are rarely the subject of appellate opinions; and (3) the tendency of federal court cases to involve litigation of large commercial matters where voluminous documents are at issue, creating more disputes about electronically stored information.

Medico-legal litigation, though, tends to occur in state courts. Most state court systems have only recently begun developing their own rules—often borrowed from the federal rules—pertaining to e-discovery. Most state court trial judges are only just beginning to have e-discovery disputes arriving at their desks. Moreover, the federal courts continue to tinker with the Rules regarding e-discovery, passing amendments in 2015. State courts will likely go through their own difficult learning curve, causing expense and angst for healthcare institutions.

Similarly, the ubiquitous nature of EMR is itself a relatively recent development. Even after large healthcare systems adopted EMR systems, smaller practices did not have the resources to do the same. As use of EMR became more essential to enable even smaller practice groups to perform, and as consolidation of individual

practices into larger systems increased, the availability of arrangements by which healthcare systems provided access to software and hosting of records for individual medical groups became more common. The days of patient charts being pulled from behind the reception desk before a patient visit are waning, if not entirely ended.

The medico-legal world is only slowly catching up. In medical malpractice litigation, even today, defense counsel typically receives a downloaded PDF of the patient's chart, and that is what is produced in discovery to the plaintiff. But that is changing. In contrast to their federal court-practicing counterparts who are long-familiar to the issues of e-discovery, the malpractice plaintiffs' bar is gradually becoming attuned to the potential treasure trove of information that may be available in the electronic record. As that knowledge grows, so will the scope of plaintiff's discovery requests, the scope of the issues raised, and the scope of potential liability. In my experience, few healthcare institutions have begun to consider the implications of this approaching paradigm shift. The time for preparation is now.

One of my partners described an example of the unanticipated effect of the use of EMR on the integrity of a patient's chart. A nurse divorced her husband, and returned to her pre-marriage name. Her sign-on to the EMR system at the healthcare system, though, did not change—only her name changed. She had, of course, cared for patients and made entries under her married name—and continued to do so under her new/old name. The EMR system, however, changed her name for *all* of her entries, both before and after her name change. In other words, the patient charts were not static, but dynamic, living documents. In the days of paper charts, an event like this would not have occurred.

This change was benign, but will all such changes be so? More important than the fact of the change was the healthcare institution's lack of awareness that such changes would occur. What other portions of the record might change when newer information is inputted into the system? Will an updated diagnosis or prognosis modify the record, or will earlier, historical entries on those subjects remain in the record and available to view? Are the answers to these questions different among different EMR software products and regimes? How many healthcare institutions have even asked these questions, much less determined the answers, and developed policies and strategies to understand and manage these effects?

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