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Attacking the Electronic Medical Record

By Ben Rubinowitz and Evan Torgan

The electronic age has paved the way for speedy retrieval of medical records. It has allowed for instantaneous access to records that only a few decades ago would have taken hours if not days to retrieve or produce. Clearly, there are many benefits to such records including, theoretically, better patient care. But the problem is that the electronic record is only as good as the individuals who input the information into the record itself. While the record should accurately reflect the details of the ongoing medical treatment, a careful look at these records often reveals inaccuracies that not only adversely affect patient care -- the primary goal of all physicians-- but also serves to undermine the integrity of the entire record. To the extent that the medical record contains false or inaccurate information, it is not enough for the trial lawyer prosecuting a medical malpractice case to expose a limited error. The goal should be to attack in such a way as to show that the entire record is untrustworthy, less than credible and a document that is not worth the paper on which it is printed.

While the electronic age has allowed for speed in the creation of the medical record, it has also allowed for "professional laziness." Consider first the "copy and paste" option. Rather than taking the time to type an up to date patient history, now the medical professional can simply copy and paste that which was documented at an earlier point in time. While the history might have been correct at one time, the passage of time, in and of itself, has the potential to make that earlier entry incorrect. Take for example the first sentence of the beginning paragraph of a patient's history:

"44 year old female presents with the following symptoms..."

Assume the patient has been followed by a doctor for 5 years. Assume further that in year 2 the entry reads "44 year old female presents with the following symptoms..." In years 3, 4 and 5 the same line is repeated.

Assume further that the same medical record was created, in part, with auto populated text. That is, the computer generates a full text report with the push of a button for the type of exam performed, which in this case was a breast exam. Needless to say, the entry should be reviewed for accuracy before becoming part of the record. In this instance, however, a number of paragraphs are generated one of which reads "breast exam normal" and another in the same report reads "lump in upper outer quadrant right breast." These conflicting entries became part of the patient's record.

Next, assume that the medical record allows for word choice merely by typing in the first few letters much like a smart phone typing option. The doctor typed "am" fully expecting the word ampicillin, an antibiotic, to be written in the record but the computer generated the word amitriptyline, a medication used to treat depression, instead.

While these three errors might seem *de minimus* or unimportant in the grand scheme of things, if properly presented on cross they will not only serve to destroy the integrity of the record but will also serve to create a compelling and winning argument on summation.

While the trial lawyer could begin her cross by immediately focusing on the errors, this tack lacks the necessary punch for a successful outcome. Consider the following cross:

Q: You made three errors in the medical record, true?

A: Yes.

Q: You just copied the same history, correct?

A: Yes.

Q: You wrote “normal exam?”

A: Yes

Q: You also wrote “lump in upper outer quadrant,” true?

A: Yes, there was a lump and that's why I included the abnormality.

Q : You wrote amitriptyline ?

A: Although that is what is written, unfortunately the computer generated that word; however, I knew the patient had a bacterial infection and she was treated correctly.

The problem with this approach is that it lacks depth and control. It fails to emphasize the laziness on the part of the medical health professional. It fails to underscore the lack of care for the patient as reflected in the patient's own chart. And it fails to bring home the fact that the doctor simply failed to show the most basic concern for the patient by not even proof reading the document he just created.

The better approach is to set the witness up, emphasize the importance of the medical record, close off all avenues of escape and then, and only then, begin the attack. One of the best methods for starting the attack in this type of situation is to use what is known as the "voice of reason approach" to cross examination. This method allows the examiner to begin by asking questions that are so reasonable that if the witness dares to disagree with the basic premise of the question, he looks foolish:

Q: Doctor, can we agree that your most important concern is the health of your patient?

Q: Can we agree that you are concerned with the well-being of your patient?

Q: Would it be fair to say that, at all times the health, safety and well-being of your patients is the singular most important concern that you have as a treating physician?

Next, in continuing with the "voice of reason" approach, the examiner should work with the "negatives" as well, by modifying the initial questions ever so slightly to emphasize the point:

Q: To the extent that safety of the patient was not your most important concern, that would be inappropriate, true?

Q: To the extent that the health and well-being of your patient was not an important issue to you, that would be wrong, correct?

Q: That's why you understand the need to use your best efforts to ensure that the patient receives appropriate medical care at all times, true?

Since the medical record itself is the focus of this exam, its importance must be made clear to the jury before the attack starts. There is no need to inquire in angry tones or a loud voice. Calm, matter of fact, short, simple questions serve to drive the point home:

Q: Doctor, the medical record serves an important function in the treatment of the patient, true?

Q: It allows you to record important factual information concerning the patient's health, true?

Q: It allows you to record important information concerning the patient's progress?

Q: In fairness to you, you can't be at the hospital 24/7, right?

Q: But it is understood that every medical health professional treating the patient must input accurate information in the medical record, true?

Q: The medical record allows for continuity of care when you are not present, true?

Q: It serves as a reliable reference regarding, among other things, the patient's diagnosis, treatment, and prognosis correct?

In continuing this line of attack, the examiner must secure admissions that the failure to properly document the record has the potential to hurt the patient:

Q: To the extent that the record is inaccurate, it has the potential to mislead a physician, true?
Q: It has the potential to allow for misdiagnosis?
Q. It has the potential to allow for mistreatment?
Q: It has the potential to hurt the patient?
Q: That's why you yourself have taught residents the importance of the medical record?
Q.: And that's why you have taught them to make sure the record is accurate?

Often, the physician will try and wriggle out of an obvious answer. Proper control on cross by asking short, to-the-point questions often serves to make the point:

Q: Can we agree that an inaccurate medical record can be dangerous?
Q: Can we agree that an inaccurate medical record has the potential to defeat your goal of patient safety?
Q: And can we agree that a less than accurate medical record can serve as a source for medical error?
A: It depends on the context, counselor.
Q. Are you telling us that it's appropriate to put down inaccurate information in the medical record?
A: At times the entry might not be meaningful.

Here, change the tone with which the question is asked, and in a more forceful voice, demand an appropriate response:

Q: Are you telling this court and jury that it is appropriate to write down inaccurate information in a patient's medical record?
A: No.

Next, the inquiry must focus on the specific entries in the record. Clearly, the questions will be met with resistance; however, if the set-up is proper and the attack is appropriate, the failures will become clear to the jury:

Q: Doctor, you just told this jury that the care rendered to (this patient) was appropriate, true?
Q: That there were no departures from good care regarding the care of (the patient) right?
Q: You understand the importance of the medical history, correct?
Q: It allows you, and others, to have a basic medical understanding of the patient, true?
Q: Here, when the patient first came under your care she was 44 years old, true?
Q: As the years passed, you and others continued to render medical care to her?
Q: Although the years passed, according to your record, the patient didn't age, did she?
A: Counselor, that was an obvious, unimportant error that did not affect patient care at all.
Q: It was so obvious that you never bothered to change it, true?
Q: It was so obvious that you never took the time to proofread the record?
Q: It was so obvious that there was no need to correct an erroneous record?
Q: You maintain that excellent medical care was rendered at all times, true?

The issue of auto populated text must be brought out in a way that heightens its importance while at the same time suggesting that an error in this area is anything but obvious or

unimportant. Indeed, continuing this line of attack not only serves to undermine the integrity of the record but also serves to undermine the credibility of the witness:

Q: You realize that other medical professionals rely on the accuracy of the entries in the record, true?

Q: You're familiar with auto populated text, true?

Q: At the push of a button, text appears for a specific type of exam, right?

Q: The computer actually generates paragraphs of text, right?

Q: You simply have to pick and choose from a template and fill in the blanks for this patient?

Q: But in order for it to be accurate you have to take the time to read it, correct?

Q: Can we agree that asking a doctor to proofread an entry isn't too much to ask?

Q: Did (this patient) deserve the time for you to proofread her record?

Before continuing this line of attack, a large blowup of the record should be shown to the jury. Allowing the jury to see the exhibit while questioning the witness enhances the power of the examination:

Q: (pointing) This record reads that the breast exam was normal, doesn't it?

A: If you continue reading counselor you will see that it describes a medically significant finding.

Q: Did I read this correctly "breast exam normal?"

A: But if you keep reading it says "lump upper outer quadrant."

Q: So what you're saying is that anyone reading this would know that the breast exam was abnormal, true?

Q: To reflect the fact that the breast exam was abnormal, you wrote "normal"?

Q: The truth is doctor you didn't even take the time to proofread the record you created?

Q: You just expected other doctors to ignore your words when you wrote "normal" breast exam?

Q: The truth is doctor you never took the time to correct this error, true?

Q: And you still maintain that you rendered excellent medical care?

The auto text function on an electronic medical record is helpful if correct, but it can be dangerous if the resulting entry is incorrect. The main reason this function is used is for speed:

Q: Doctor, you chose to use the auto text function on your computer when you prescribed this medication, true?

Q: You typed in the first few letters and assumed that an antibiotic was written, correct?

Q: But in fact an antidepressant was written instead, right?

Q: At no point in time did you intend to prescribe an antidepressant?

Q: Would you agree that it would be a departure from accepted standards of medical care to prescribe an antidepressant when you intended to prescribe an antibiotic?

Conclusion

Careful study of the electronic medical record for automated errors can provide meaningful material for a fruitful cross. While simply pointing out the errors in the medical record may highlight the lack of care by a physician, the ultimate goal of the attack must be to undermine the entire record by focusing on those errors. Once the trial lawyer has undermined the record and established that it is not worthy of belief she can then argue that those errors in the record exemplify and define the lack of proper care and treatment rendered by the treating physicians.

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