

Electronic Health Records

A Discovery Landmine for Physicians and Counsel

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While most physicians today have yet to make the leap into using electronic health records (EHR), more and more physicians are implementing EHR technology in their practices. As a result, physicians and their counsel are now confronting the various hurdles relating to e-discovery in their defense of medical malpractice claims.

Proponents of EHR claim that such systems provide a more complete and legible medical record, improve organization, decrease medication-related errors and increase office efficiency and billing accuracy. However, putting aside the two most significant criticisms physicians have expressed toward EHR — its difficulties of use and potentially significant costs — there are also risks associated with the use of EHR that can adversely impact the physicians' defense in litigation.

POTENTIAL PROBLEMS

By way of example, if the EHR does not provide a mechanism to show how and when a correction was made, the physician could find himself the subject of an allegation that he intentionally altered the record in a self-serving manner. On occasion, the

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performance of a "spell-check" is treated by the computer as a "modification," as are other, innocent ministerial functions. Similarly, if a disgruntled employee, or a disaster, or possibly even a hacker should destroy some of the information and the physician does not have adequate back-up, the physician risks being in violation of the medical record retention laws and a determination by the court that there was spoliation of evidence.

Admittedly, some of these risks are also inherent with traditional paper records, yet there are some risks that are truly unique to EHR. For example, the physician needs to be aware of "formatting issues," with respect to software. One format would bring up the patient's initial presenting symptoms each time the patient came for an office visit. To the uninitiated, the records read as if the initial presenting symptoms continued for years, when, in fact, they resolved relatively quickly.

An additional quandary is presented when a physician is asked to produce the EHR of a particular patient; how should the data be produced? Depending on how the physician requests the information, the EHR of the very same patient can be produced in different formats and with different information. Thus, unlike the paper record, there *can* be different versions of a particular patient's EHR.

These issues should give rise to concern, because if the court decides that spoliation of evidence and/or abuse of discovery has occurred, both physician and counsel may face a variety of ominous results, including the imposition of criminal charges, preclusion of evidence, the making of an adverse inference, a contempt holding or even dismissal of the physician's pleadings.

Moreover, if counsel is held to be responsible for such adverse results (or even if the court does not make such a finding but the physician client does), counsel could find himself in a legal malpractice lawsuit.

Attorneys representing physicians need only examine some of the few e-discovery cases on record to better understand the liability exposure they face if they do not advise their clients appropriately. In *Coleman Holdings, Inc. v. Morgan Stanley & Co., Inc.*, 2005 WL 679071 (Fla. Cir. Ct. 2005), Morgan Stanley was found to have failed to comply with the court's order governing the discovery of its e-mails, and awarded the plaintiffs \$1.45 billion. Morgan Stanley then turned and blamed its attorneys, claiming they were at fault in terms of the advice they rendered.

In *Zubulake v. UBS Warburg LLC*, 229 F.R.D. 422, 439 (S.D.N.Y. 2004), an employment discrimination and retaliation case, the court sanctioned UBS for having deleted and failing to produce relevant e-mails. The court in its decision explained the role of counsel: "[C]ounsel has a duty to effectively communicate to her client its discovery obligations so that all relevant information is discovered, retained and produced. In particular, once the duty to preserve attaches, counsel must identify sources of discoverable information. This will usually entail speaking directly with the key players in the litigation, as well as the client's information technology personnel. In addition, when the duty to preserve attaches, counsel must put in place a litigation hold and make that known to all relevant employees by communicating with them directly. The litigation hold instructions must be reiterated regularly and compliance must be monitored. Counsel must also call

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for employees to produce copies of relevant electronic evidence, and must arrange for the segregation and safeguarding of any archival media (eg, backup tapes) that the party has a duty to preserve. Once counsel takes these steps (or once a court order is in place), a party is fully on notice of its discovery obligations. If a party acts contrary to counsel's instructions or to a court's order, it acts at its own peril."

WHAT ATTORNEYS CAN DO FOR PHYSICIAN CLIENTS

With traditional records, the physician has simply to walk to the file room and make sure he or she has all the medical and billing records. With EHR, the documents could be in the form of e-mails and their attachments (which in and of itself should be a sufficient enough reason to convince the physician not to use e-mails with patients); word-processing files; spreadsheet files; database files; internet and intranet files; browser cookies; software files; and even deleted files. Furthermore, the information may be located in multiple locations, including the physicians' desktop and laptop computers (both in the office and at home); network servers; back-up tapes; CD-ROMs; DVDs; offsite storage systems; PDAs; and even cell phones and voice mails. To further complicate matters, while stored information should be readily accessible, there is always the possibility that information produced and stored using older and outdated software may not be easy to find and would take considerable time, effort and cost to locate.

Though the physician should already have a mechanism in place governing the manner by which EHR is maintained, stored, retained, destroyed and modified, once litigation is commenced, counsel must inform the client to preserve all forms of EHR (as well as any paper records) that may be relevant to the litigation. Counsel should carefully review the client's policies and protocols — at a minimum to ensure that the retention policies preserve all records which can reasonably be foreseen to be the subject of discovery and that the practice is in compliance with the

Health Insurance and Portability Act of 1996 (HIPAA) and all other relevant state and federal laws governing protected health information. The data should be examined to determine which relevant and non-privileged information should be produced, and production should be conducted in a timely manner and in a format to ensure that the EHR cannot be electronically altered (such as a PDF). Metadata should not be provided without approval from counsel, as it may contain sensitive or privileged information about how the data was collected, created and modified. It should only be produced with a court order, and even then should be strenuously objected to. In fact, the New York State Bar Association Committee on Professional Ethics noted the dangers of producing metadata in its Opinion No. 782 (Dec. 8, 2004): "[M]etadata," ... may be loosely defined as data hidden in documents that is generated during the course of creating and editing such documents. It may include fragments of data from files that were previously deleted, overwritten or worked on simultaneously. Metadata may reveal the persons who worked on a document, the name of the organization in which it was created or worked on, information concerning prior versions of the document, recent revisions of the document, and comments inserted in the document in the drafting or editing process. The hidden text may reflect editorial comments, strategy considerations, legal issues raised by the client or the lawyer, legal advice provided by the lawyer, and other information. Not all of this information is a confidence or secret, but it may, in many circumstances, reveal information that is either privileged or the disclosure of which would be detrimental or embarrassing to the client."

As the court in *Zubulake* recommended, counsel should meet with the client's "key players" to better understand how the client's EHR system functions, to confirm that the information is being preserved and to better prepare them for their depositions, during which time they will have to explain what EHR guidelines are in place and how they were implemented.

Physicians and counsel should expect that the EHR they produce will

be carefully scrutinized by forensic electronic data experts who will carefully dissect the records to determine whether there are any alterations, and also to "manipulate" the records and information therein in a manner that may best support their position. Thus, defense counsel should retain their own forensic experts to evaluate the client's EHR policies; to address any e-discovery issues; and to ensure that only relevant discoverable information is produced, or counsel may face the possibility of losing their client's case on a "technicality."

WHO SHOULD PAY?

As far as costs of production are concerned, traditionally it is the party that is responsible for producing the documents that has to bear the costs. Hopefully, for most physicians, the cost will not be greater than it was for paper production. Nevertheless, there is a possibility that the physician may be asked to produce relevant and non-privileged EHR that will require the practice to undertake additional efforts to search for and access documents, particularly if they have been deleted. In addition to strenuously objecting to such discovery requests as being overly broad, counsel should ask the court to shift the costs of such production from the physician to the plaintiff by having the court consider various factors including: 1) that the data requested are not accessible and would result in too great a burden and expense for the physician; 2) that the data were not requested in a specific enough manner, would not produce critical information, and is available from other sources; and 3) that the physician has already acted in a reasonable manner to produce the information with the limited resources available.

CONCLUSION

Electronic health records may help physicians practice better medicine and improve the quality of care their patients receive, but physicians and their counsel must be aware of some of the e-discovery issues they will face if they are to successfully defend their case and continue to remain in practice. However, in the end, if the physician acts in a reasonable manner and demonstrates good faith — and counsel

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provides the appropriate guidance and advice — the quality of the defense should not be adversely impacted.

