IADC COMMITTEE NEWSLETTER

MEDICAL DEFENSE AND HEALTH LAW

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IN THIS ISSUE

The production of electronically stored medical records and information in litigation has become an ever increasing issue. This article overviews some of the recent decisions addressing that issue.

Discovery of Electronic Medical Records, Audit Trails, and Metadata

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ABOUT THE COMMITTEE

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I. Background and Federal Requirements

As a part of the American Recovery and Reinvestment Act of 2009, all healthcare providers had to demonstrate "meaningful use" of electronic medical records ("EMR") by January 1, 2014, to maintain their existing Medicaid and Medicare reimbursement levels.

In conjunction with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") "Security Rule," which establishes national standards for safeguarding health information that is held in electronic form—healthcare providers must "implement procedures to regularly review records of information system activity, such as audit logs, access reports, and security incident tracking reports" (45 C.F.R. § 164.308) and "implement hardware, software, and/or procedural mechanisms that record and examine activity in information systems that contain or use electronic protected health information." (45 C.F.R. § 164.312).

According to the HHS, "a major goal of the Security Rule is to protect the privacy of individuals' health information while allowing covered entities to adopt new technologies to improve the quality and efficiency of patient care." However, implementing these new technologies, such as the EMR, has led to new challenges for the healthcare providers as well as the lawyers who defend them.

The technological advances associated with the EMR give users the ability to track activities that occur over the course of a patient's treatment. Metadata—or a set of data that describes and gives information about other data—reveals when certain data was collected, where it was collected, and by whom.[1] Because most metadata is generally not visible when a record is printed or converted to an image file, such as a PDF, Plaintiff's attorneys have begun specifically requesting metadata. A common request by Plaintiff's lawyers is for the EMR audit trail. Audit trails are a form of metadata that provide information in a sequential method to show when data was accessed, revised, or deleted.

Of course, these features of the EMR are not characteristic of the traditional medical chart. Because of these technological advances, Plaintiff's attorneys are increasingly using the EMR in medical malpractice cases as evidence to support their claims. Simply producing a paper copy of the patient's chart is often no longer satisfactory.

Attorneys defending healthcare providers are faced with issues such as if the EMR should be produced; how to produce it; and

[1] For a comprehensive discussion on the several distinct types of metadata, including substantive metadata, system metadata, and embedded metadata, *see Aguilar v. Immigration & Customs Enf't Div. of U.S. Dep't of Homeland Sec.*, 255 F.R.D. 350 (S.D.N.Y. 2008).

if it is produced, how to adequately protect and defend the healthcare provider after its production. The cases summarized below illustrate how different courts have ruled and may offer guidance on practical ways to protect and defend the healthcare provider when confronted with requests for the EMR, metadata, and/or the audit trail.

II. Relevant Case Law

Some courts have refused to order production of the EMR or audit trail absent a specific claim of spoliation, alteration, or privacy breaches of the patient's protected health information ("PHI").

For example, in *Bentley v. Highlands Hosp. Corp.*, 2016 WL 762686 (E.D. Ky. Feb. 23, 2016), Plaintiff requested: "copies of your policies describing the creation, storage, maintenance, destruction, and/or deletion of electronic health records. This Request includes, but is not limited to, guidance provided to users regarding the entry and/or deletion of data as well as enterprise-wide guidelines and/or instructions" and "copies of your policy for protecting the privacy of health information in the medical records collected and maintained by you."

To support its request, Plaintiff argued that because the healthcare provider "owe[d] a duty to enforce its own rules and regulations," she could review the report of user access to her EMR, given the healthcare provider's rules for who was permitted access to the records. The healthcare provider objected as the requests were "broad and oppressive," and that "there [was] no claim, allegation, indication or even suggestion that [it] engaged in improper access of Plaintiff's medical record, performed some alteration of those records, or violated the privacy of her health information."

The Court agreed and found Plaintiff's requests "broad and burdensome, as well as irrelevant to the pertinent issues at hand." *See also Vargas v. Lee*, 2015 WL 3857323 (N.Y. Sup. Ct. June 5, 2015) (holding that the audit trail was "system metadata," that is not typically disclosed, and that the plaintiff did not make an adequate showing challenging the sufficiency and authenticity of the medical records already produced, and could not receive the audit trail.).

By contrast, in *Gilbert v. Highland Hosp.*, 31 N.Y.S.3d 397 (N.Y. Sup. Ct. 2016), a wrongful death case, the patient died after being discharged from the hospital before being seen by a doctor. The Plaintiff sought production of the audit trail to determine whether a doctor reviewed the patient's records before she was discharged—which was the main premise of Plaintiff's case. The healthcare provider argued that the Plaintiff was not entitled to the records because she had not disputed the record's authenticity, and the request amounted to a fishing expedition.

The Court disagreed and held that the audit trail was material and necessary as it would reveal whether the attending physician accessed and viewed patient's electronic

records prior to her discharge from hospital. Further, the Court concluded the Plaintiff's request for the audit trail was not a "fishing expedition" because she requested "the decedent's audit trail… for the specific reason of quantifying the level of involvement of the emergency department attending physician with the decedent's care while she was in the emergency department."

In *Moan v. Massachusetts Gen. Hosp.*, 2016 WL 1294944 (Mass. Super. Mar. 31, 2016), the Court ordered the healthcare provider produce: "All audit trails or other documents sufficient to identify each person who accessed [Plaintiff's] medical records from October 2, 2014 to the present date; when they accessed it; during and for what periods of time they accessed it; what they accessed; and all changes or additions made to [Plaintiff's] medical records by each such person at each time each such person accessed it. In addition to paper form, the [healthcare provider] shall produce this information in electronic form, with adequate instructions as to how to access it." *Id*. at *1. Importantly, however, the Court did not order the healthcare provider to supply the names of the individuals who composed the Peer Review Committee or those individuals who investigated Plaintiff's medical incident on behalf of that Committee, as such was privileged and protected quality assurance. *Id*.

In *Peterson v. Matlock*, Plaintiff sought to compel the production of her medical records in "native readable format" or by "searchable headings." *Peterson v. Matlock*, 2014 WL 5475236 (D.N.J. Oct. 29, 2014). The healthcare provider produced the record in PDF format, but Plaintiff objected as the PDF "[was] not the view that the medical provider [viewed] rendering care" and the PDF lacked "the functionality, searchable data points, and metadata which are part of the electronic medical record and are available to a provider…" *Id*. Additionally, Plaintiff claimed that the PDF was missing the audit trail. *Id*.

The healthcare provider asserted that the "manner in which [the records] are stored in [the software] is dictated by the software developer… and cannot be modified by the end user." *Id*. Thus, the healthcare provider claimed that it could not change the format of the records or produce them in piecemeal fashion or chart format without undue burden. Specifically, it claimed that providing the medical records in chart format and organized into various categories as they are viewed through [the EMR] "would be an inordinate drain of time and manpower" because staff would be required to "sort through each page of the medical record and make the determination as to which category it fits into." *Id*.

The Court agreed with the healthcare provider and stated that although: "PDF format is difficult to interpret and navigate … and may be less convenient … requiring [the healthcare provider] to sort and identify each page of the medical record would create a substantial hardship and/or expense, which outweighs Plaintiff's

interests in receiving the records in their native format." *Id.* at *2.

III. Practice Pointers

1. Attorneys representing healthcare providers should become familiar with the healthcare provider's IT staff. Attorneys should also become knowledgeable regarding the software that is used to maintain the health records including how the entries are made, stored and accessed.

2. Attorneys should educate themselves on what the audit trail for the specific system can and cannot do.

3. There is an argument that metadata and audit trails are not part of the medical providers' decision making process and do not have a bearing on clinical judgement.

4. The EMR, metadata, and audit trails are complex and technical records that can easily be misinterpreted when viewed by a layperson or viewed out of context. Thus, expert testimony may be required when Plaintiffs allege that the EMR has been altered, improperly accessed, or destroyed. *See*, *e.g.*, *Desclos v. Southern New Hampshire Medical Center*, 2006 WL 4535962 (N.H. Super. July 11, 2006) ("Whether a medical record can be and has been altered on a computer, or on an electronic medical record system after having been transcribed, is an issue requiring expert testimony."); *see also Green v. Pennsylvania Hosp.*, 2013 WL 8596359 (Pa. Com. Pl. Apr. 15, 2013) (expert precluded when she had no experience with the electronic health record system and no evidence other than assumptions based on misplaced records that someone at the hospital was altering records).

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