



Portfolio Media, Inc. | 111 West 19th Street, 5th floor | New York, NY 10011 | www.law360.com
Phone: +1 646 783 7100 | Fax: +1 646 783 7161 | customerservice@law360.com

Med Mal Attys Chasing Docs' Digital Tracks To Patient Wins

By **Y. Peter Kang**

Law360, Los Angeles (October 20, 2017, 3:19 PM EDT) -- With the widespread implementation of electronic health records by health care providers, attorneys representing injured patients are being increasingly drawn to the audit trails of those digitized files, which they say sometimes reveal behind-the-scenes information that can break a case wide open.

Audit trails are computer metadata that document every change or addition to patients' electronic health records, or EHRs, and can tell you which health care provider input or accessed which record and when, and, in most cases, if changes have been made. Plaintiffs attorneys told Law360 that mining this data is no easy task given the reams of printouts an audit trail can spew out, but if one knows how to work the system methodically, scouring audit trails can prove to be beneficial and help win a case.

"It's useful in all cases but it's turned the tide in five cases," said Jon Lomurro, a partner with Lomurro Munson Comer Brown & Schottland LLC.

The New Jersey-based plaintiffs attorney said in one of those five cases, he found tide-turning pathology slides for a patient that had never been disclosed and didn't exist anywhere in the patient's medical records or billings except for the audit trail.

"It was the greatest moment," Lomurro recalled. "I even amended the complaint to add spoliation of evidence for hiding the data. That was huge."

Tony Gentile of Godosky & Gentile PC in New York City said that audit trails are the "new hot item" among personal injury and medical malpractice plaintiffs attorneys. He once handled a case in which a patient suffered brain damage due to an allegedly botched jaw surgery that had been previously turned down by two major firms because there was scant evidence of what actually occurred.

But while deposing one of the treating physicians, he asked her to read aloud from the patient's medical record and as she did, it suddenly dawned on him that the record she was reading included a doctor's interpretation of a CT scan that was not included in his copy of the medical record.

He later went to the audit trail and discovered that the patient's record had possibly been altered. His copy was printed 11 months after treatment, whereas the doctor's copy was printed two months after treatment.

"I thought the two notes side by side were a real problem for the defendants," he said.

The case was later settled.

Gentile says the possible record manipulation was unlikely to have been performed by the hospital or insurance carrier.

"I find it hard to believe that it would be done institutionally," he said. "But would a practitioner change a note because they know something is wrong, or add an addendum that would impact diagnoses and treatment? Absolutely."

He added, "Doctors and nurses are people, they rise and fall on their own morals and ethics. I think there is a percentage that changes records, but I don't think it's a common thing. But if you ask me, 'Does it occur and is it something that should be remedied?' The answer is absolutely yes. If a patient doesn't have an honest record of their treatment, that's a horrible concept in many ways and violates the patient's bill of rights."

Currently, EHRs are used by 90 percent of hospitals and 80 percent of physician practice groups, while claims in which the use of EHRs allegedly contributed to patient injury have increased steadily over the past decade, according to malpractice insurer The Doctors Company. The insurance firm released on Oct. 16 the results of a study which showed that EHR-related claims it handled jumped from just two in the four-year period ending 2010 to 161 in the five-year period ending in December 2016.

It is likely these numbers will continue to rise in the future if plaintiffs attorneys embrace the audit trail like Lomurro, who says he sifts through them every day while having his morning coffee, looking at individual entries with trained eyes in the hopes of finding an aberration. He understands, however, that the older generation of attorneys may not be willing to pore over the audit trails, let alone take the time to learn the technical aspects of the metadata.

"Will you look through hundreds of pages to find that one mark useful to your case?" he said. "If you don't know technology, it's going to preclude you from doing a good job on either side, but I think anybody can learn anything, and if they sat down and got past that initial block, they could grasp it. The audit trail is written in plain English so it just becomes detective work."

While audit trails have not proved to be game-changers for some attorneys, they certainly provide interesting fodder for depositions, according to Mark D. Moreland of Moreland & Moreland LC in West Virginia.

"For years, I've heard clients say, 'That's not what happened, somebody changed the records.' Usually the client is wrong but sometimes they are right. If they say the treatment was a year and a half ago, and two days after the suit gets filed, the records show someone was in the reading station, it makes for a good question at a deposition," he said.

In a fatal patient overdose case Moreland handled, he used the audit trail to learn that a hospital utilized EHRs but did not have such systems in place for its morgue and laboratory, facts which he used while deposing the defendants.

"It made people nervous," he said. "The lack of good record-keeping in the lab and morgue and the testing that was done later at the state medical examiner's office made the evidence unreliable. That did help the case."

Even if it doesn't help a case, a health care provider who knows that an audit trail exists for EHRs

may be deterred from any temptation of altering the record, which could boost patient safety, according to Andrew Greenwald of Joseph Greenwald & Laake in Maryland.

"My sense is that when people know that there is a more detailed medical record which provides information that is not necessarily readily available, I think there is more of a tendency not to fudge around with it," he said.

--Editing by Katherine Rautenberg and Kelly Duncan.

All Content © 2003-2017, Portfolio Media, Inc.