Metadata, malpractice claims, and making changes to the EHR

Kaustubh G. Joshi, MD

In 2009, the Health Information Technology for Economic and Clinical Health Act (HITECH Act), which is part of the American Recovery and Reinvestment Act, provided several billion dollars of grants and incentives to stimulate the implementation of electronic health records (EHRs) and supporting technology in the United States.[1] Since then, almost all health care organizations have employed EHRs and supporting technologies. Unfortunately, this has created new liability risks. One potential risk is that in malpractice claims, there is more discoverable evidence, including metadata, with which to prove the claims.[2] In this article, I explain what metadata is and how it can be used in medical malpractice cases. In addition, because we cannot change metadata, I provide guidance on making corrections in your EHR documentation to minimize liability in medical malpractice cases.

What is metadata?

Metadata—commonly described as data about data—lurk behind the words and images we can see on our computer screens. Metadata can be conceptualized as data that provides details about the information we enter into a computer system, creating a permanent electronic footprint that can be used to track our activity.[2,3] Examples of metadata include (but are not limited to) the user's name, date and time of a record entry, changes or deletions made to the record, the date an entry was created or modified, annotations that the user added over a period of time, and any other data that the software captures without the user manually entering the information.[3] Metadata is typically stored on a server or file that users cannot access, which ensures data integrity because a user cannot alter a patient's medical record without those changes being captured.[3]

How metadata is used in malpractice claims

When a psychiatrist is sued for medical negligence, the integrity of the EHR is an important aspect of defending against the lawsuit. A plaintiff's (patient's) attorney can more readily discover changes to the patient's medical record by requesting the metadata and having it analyzed by an information technology specialist. Because the computer system captures everything a user does, it is difficult to alter a patient's record without being detected. Consequently, plaintiff attorneys frequently request metadata during discovery in the hopes of learning whether the defendant psychiatrist altered or attempted to hide information that was contained or missing from the original version of the medical record.[3] If the medical record was revised at a time unrelated to the treatment, metadata can raise suspicion of deception, even in the absence of wrongdoing.[2] Alternatively, metadata can be used to validate that

Dr. Joshi is Associate Professor of Clinical Psychiatry, and Associate Director, Forensic Psychiatry Fellowship, Department of Neuropsychiatry and Behavioral Science, University of South Carolina School of Medicine, Columbia, South Carolina. He is one of Current Psychiatry's Department Editors for Pearls.

Disclosure

The author reports no financial relationships with any companies whose products are mentioned in this article, or with manufacturers of competing products.

doi: 10.12788/cp.0106

A plaintiff attorney may request metadata to learn if there was an attempt to alter or hide information in the medical record

Discuss this article at www.facebook.com/MDedgePsychiatry

the EHR was changed when treatment occurred, which can bolster a defendant psychiatrist's ability to rely on the EHR against a claim of medical negligence.[2]

Depending on the jurisdiction, metadata may or may not be discoverable. The Federal Rules of Civil Procedure emphasize producing documents in their original format.[4] For federal cases, these rules suggest that the parties discuss discovery of this material when they are initially conferring; however, the rules do not specify whether a party must produce metadata, which leaves the courts to refine these rules through case law.[4,5] In one case, a federal court ruled that a party had to produce documents with metadata intact.[5] Without an agreement between both parties to exclude metadata from produced documents, the parties must produce the metadata.[5] State laws differ in regards to the discoverability of metadata.

Corrections vs alterations

A patient's medical record is the best evidence of the care we provided, should that care ever be challenged in court. We can preserve the medical record's effectiveness through appropriate changes to it. Appropriately executed corrections are a normal part of documentation, whereas alterations to the medical record can cast doubt on our credibility and lead an otherwise defensible case to require a settlement.[6]

Corrections are changes to a patient's medical record during the normal course of treatment.[6] These are acceptable, provided the changes are made appropriately. Health care facilities and practices have their own policies for making appropriate corrections and addendums to the medical record. Once a correction and/or addendum is made, do not remove or delete the erroneous entry, because health care colleagues may have relied on it, and deleting an erroneous entry also would alter the integrity of the medical record.[6] When done appropriately, corrections will not be misconstrued as alterations.

Alterations are changes to a patient's medical record after a psychiatrist receives notice of a lawsuit and "clarifies" certain points in the medical record to aid the defense against the claim.[6] Alterations are considered deliberate misrepresentations of facts and, if discovered during litigation, can significantly impact the ability to defend against a claim.[6] In addition, many medical liability policies exclude coverage for claims in which the medical record was altered, which might result in a psychiatrist having to pay for the judgment and defense costs out of pocket.[6] Psychiatrists facing litigation who have a legitimate need to change an EHR entry after a claim is filed should consult with legal counsel or a risk management professional for guidance *before* making any changes.[3] If they concur with updating the patient's record to correct an error (including an addendum or a late entry; see below), the original entry, date, and time stamp must be accessible.[3] This should also include the current date/time of the amended entry, the name of the person making the change, and the reasons for the change.[3]

How to handle corrections and late entries

Sometimes situations occur that require us to make late entries, enter addendums, or add clarification notes to patient information in the EHRs. Regardless of your work environment (ie, hospital, your own practice), there should be clear procedures in place for correcting patients' EHRs that are in accordance with applicable federal and state laws. Correcting an error in the EHR should follow the same basic principles of correcting paper records: do not obscure the original entry, make timely corrections, sign all entries, ensure the person making the change is identified, and document the reason(s) for the correction.[7] The EHR must be able to track corrections or changes to an entry once they are entered or authenticated. Any physical copies of documentation must also have the same corrections or changes if they have been previously printed from the EHR.

You may need to make an entry that is late (out of sequence) or provides additional documentation to supplement previously written entries.[7] A late entry should

be used to record information when a pertinent entry was missed or not written in a timely manner.[7] Label the new entry as a "late entry," enter the current date and time (do not give the appearance that the entry was made on a previous date or at an earlier time), and identify or refer to the date and incident for which the late entry is written.[7] If the late entry is used to document an omission, validate the source of additional information as best you can (ie, details of where you obtained the information to write the late entry).[7] Make late entries as soon as possible after the original entry; although there is no time limit on writing a late entry, delays in corrections might diminish the credibility of the changes.

Addendums are used to provide additional information in conjunction with a previous entry.[7] They also provide additional information to address a specific situation or incident referenced in a previous note. Addendums should not be used to document information that was forgotten or written in error.[7] A clarification note is used to avoid incorrect interpretation of previously documented information.[7] When writing an addendum or a clarification note, you should label it as an "addendum" or a "clarification note"; document the current date and time; state the reason for the addendum (referring back to the original entry) or clarification note (referring back to the entry being clarified); and identify any sources of information used to support an addendum or a clarification note.[7]

Psychiatrists who need to change an EHR entry after a claim is filed should consult with legal counsel before doing so

References

1. American Recovery and Reinvestment Act of 2009. Pub L No. 111-5, 123 Stat 115 (2009).
2. Paterick ZR, Patel NJ, Ngo E, et al. Medical liability in the electronic medical records era. Proc (Bayl Univ Med Cent). 2018;31(4):558-561.
3. Funicelli A. 'Hidden' information in your EHRs could increase your liability risk. Psychiatric News. 2019;54(18):12-13.
4. Federal Rules of Civil Procedure, 26(f), 115th Cong, 1st Sess (2017).
5. Williams v Sprint/United Mgmt Co, 230 FRD 640 (D Kan 2005).
6. Ryan ML. Making changes to a medical record: corrections vs. alterations. NORCAL Mutual Insurance Company. Accessed February 3, 2021. http://www.sccma.org/Portals/19/Making%20Changes%20to%20a%20Medical%20Record.pdf
7. AHIMA's long-term care health information practice and documentation guidelines. The American Health Information Management Association. Published 2014. Accessed February 3, 2021. http://bok.ahima.org/Pages/Long%20Term%20Care%20Guidelines%20TOC/Legal%20Documentation%20Standards/Legal%20Guidelines