

## THE IMPACT OF ELECTRONIC MEDICAL RECORDS ON THE DISCOVERY PROCESS

by: Anna M. Bryan, Esq., Debra A. Weinrich, Esq. and Edward F. Beitz, Esq.

As the electronic age has made computers and PDAs an integral part of daily life, both professionally and personally, it is easy to assume that this integration has taken place in every industry. It seems like a safe assumption. In fact, a study conducted at the University of California at Berkeley found that, as of 2003, only 0.01 percent of newly-created information is stored in paper format, while the remainder is stored in electronic formats. It is clear that computers have already changed how medicine is practiced. For example, many institutions utilize digital radiology programs and the x-ray films of old are no longer printed. However, as healthcare providers (and their attorneys) are well aware, the electronic age has not caught up to the practice of modern medicine in many respects, particularly with patient health records. Over the next five years, given recent federal initiatives, this will undoubtedly change.

We have developed expertise with the electronic health-record format to meet the challenges of medical-care documentation. A comprehensive search of cases in multiple jurisdictions has demonstrated the uncertainties of the “cyber” world as reflected in the context of day-to-day patient care and litigation. Because the process remains relatively new for most institutions, it is imperative to have a fundamental understanding of recent legislation.

In addition to implementing new HIPAA rules governing security and privacy, the Health Information Technology Act (HITECH Act) of 2009 was intended to hasten the nationwide development of electronic health record (EHR) technology. Through the HITECH Act, the government has allocated significant spending in the form of incentives and funding for medical providers who make “meaningful use” of EHRs. Using a phased approach, these incentives are designed to encourage providers to move from paper charts to electronic records between 2011 and 2016. While the early incentives will come in the form of additional funding, Medicare will actually impose adjustments (*i.e.*, penalties) on providers who have not begun to develop an EHR system by 2015.

The continuing increase in electronic record keeping will have a direct impact on medical malpractice litigation, particularly during discovery, as well as other areas of health law. Accordingly, healthcare providers and their attorneys must be familiar with changes in the law and the obligations they impose. In addition to new discovery rules, parties and their attorneys should familiarize themselves with the concepts of electronic data creation, “metadata,” nuances in software programs, data collection, data retention and storage systems, and all related institutional policies. Anticipating potential electronic discovery issues is a critical component of defending a medical malpractice case.

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## COURT WATCH

In a one-week time span, three White and Williams healthcare attorneys received defense verdicts for their clients.



**Anna Bryan** received a defense verdict in Montour County, Pa., in a three-week trial regarding the care and treatment of a 48-year-old woman who died in the hospital following uncomplicated surgery for breast cancer which had been diagnosed about four months earlier.



**Platte Moring**, Managing Partner of the Lehigh Valley office, received a defense verdict in Northampton County, Pa., in a case involving an orthopedic surgeon who performed an open reduction, internal fixation of a trimalleolar fracture of the left ankle, requiring a revision surgery due to non-compliance with doctor's orders.



**Kevin Cottone** obtained a defense verdict in Montgomery County, Pa., in a medical malpractice case after a two-week trial.

## FIRM ANNOUNCEMENTS

### CONGRATULATIONS NEW PARTNER AND COUNSEL

Please join us in congratulating **Ron Pingitore** for being elected to the partnership of White and Williams as well as **Steven Forry**, **Mary Dixon Levy** and **Amy Vulpio** who were promoted to counsel.

*For more information about Ron, Steve, Mary or Amy, please visit [www.whiteandwilliams.com](http://www.whiteandwilliams.com).*

### NEW YEAR; NEW EDITOR

**Dan Ferhat**, an associate in the Healthcare Group has been named Editor of the Healthcare Newsletter. This is his first issue in his new role. We invite you to contact Dan with suggestions for future topics.

*He can be reached at [ferhatd@whiteandwilliams.com](mailto:ferhatd@whiteandwilliams.com).*

### NEW APPOINTMENT

**Chuck Eppolito**, a partner in the Healthcare Group was elected to serve as Chair of the Medicine and Law Committee of the American Bar Association's Tort Trial and Insurance Practice Section.

*For more information about Chuck, please visit [www.whiteandwilliams.com](http://www.whiteandwilliams.com).*

## RECENT DEVELOPMENTS IN THE LAW

### THE PENNSYLVANIA SUPERIOR COURT REPUDIATES THE USE OF "ERROR OF JUDGMENT" JURY INSTRUCTIONS IN MEDICAL MALPRACTICE CASES

*by: Mary E. Dixon Levy, Esq.*

In *Pringle v. Rapaport*, 980 A.2d 159 (Pa. Super. 2009) (en banc), *appeal denied*, 2009 WL 5105009 (Pa. Dec. 29, 2009), the Superior Court held that an "error of judgment" jury instruction should not be given to the jury in medical malpractice cases.

In *Pringle*, the plaintiffs sued a defendant-physician for medical negligence after their child was born with a severe brachial plexus injury following complications during delivery (*i.e.*, shoulder dystocia). The case was tried before a jury that returned a verdict in favor of the physician. Plaintiffs appealed. The Superior Court reversed and remanded for a new trial, holding that an "error of judgment" instruction should not be given in medical malpractice actions because it does not inform jurors of the applicable standard of care. Instead, an "error of judgment" instruction informs the jury that physicians are not responsible for "mere errors in judgment" or the use of their best judgment unless the resulting error constitutes negligence. *Id.* at 165.

The Court initially observed that the Supreme Court of Pennsylvania has never addressed the appropriateness of this charge, and that existing decisions of panels of the Superior Court were irreconcilable. In reaching its decision that "error of judgment" jury instructions are improper in medical malpractice cases, the Court reasoned that the instruction tends to confuse, rather than clarify, the issues a jury must decide. In particular, the Court reasoned that the instruction "wrongly suggests to the jury that a physician is not culpable for one type of negligence, namely the negligent exercise of his or her judgment." *Id.* at 173. The Court further reasoned that the instruction also improperly interjects a "subjective element" into the jury's deliberations when their focus should, instead, be on objective considerations of the "knowledge, skill, and care normally possessed and exercised in the medical profession." *Id.* at 174.

The Court's holding in *Pringle* represents a significant blow to the defense of medical malpractice actions in the Commonwealth because it effectively deprives defendant-physicians of an important jury charge in those cases involving issues of a defendant-physician's professional judgment. Unfortunately, the Pennsylvania Supreme Court refused to accept further review in *Pringle* and, therefore, *Pringle* is binding on trial courts. In cases where the plaintiff's theory involves the exercise of judgment by a defendant-physician, healthcare defendants should work closely with their counsel and carefully consider whether to request an "error of judgment" instruction in your specific case – notwithstanding *Pringle*, and create a record on why *Pringle* was wrongly decided.

*For more information regarding the impact of the Pringle decision, please contact Mary Dixon Levy at 215.864.7068 or [dixonm@whiteandwilliams.com](mailto:dixonm@whiteandwilliams.com).*

## ELECTRONIC MEDICAL RECORDS CONTINUED...

Given the exponential increase in electronic data storage over the past two decades, it is not surprising that formal changes to the discovery rules have followed. For instance, the federal Rules of Civil Procedure were amended to specifically address e-discovery. While Pennsylvania has not formally adopted rules which govern e-discovery, a recent trial court decision suggests that the federal rules and case law may be instructive in resolving e-discovery conflicts in Pennsylvania.

In *Brooks v. Frattaroli*, PICS Case No. 09-1709 (C.P. Lebanon Oct. 5, 2009), the court granted the defendant's motion for a protective order, finding the plaintiff's discovery request to enter the defendant's property to inspect and copy computer files was overly broad. The court noted that granting unrestricted access to an opposing party's electronically-stored information poses a significant risk for discovery abuse and invasion of privacy. The court further noted that the courts must adopt a balancing test when reviewing requests for electronic

data, with the potential for truth on one side and a litigant's legitimate expectation of privacy on the other. According to the court, in order to obtain the kind of direct computer access requested in *Brooks*, "a party must travel the length of a football field" and cross the "ESI [electronically-stored information]-discovery goal line."

While the importance of state and federal e-discovery rules has been relatively limited in medical malpractice litigation thus far, the discovery process will be significantly impacted by the expected emergence of EHR systems. Proactive consideration, training, and development of related strategies will benefit providers and their attorneys, and prepare them for these looming issues.

*For more information about electronic health records and the impact on the discovery process, please contact Anna Bryan (215.864.6207; bryana@whiteandwilliams.com), Deb Weinrich (215.864.6260; weinrichd@whiteandwilliams.com), or Ed Beitz (215.864.6277; beitze@whiteandwilliams.com).*

## LEGISLATIVE ALERT

### LONG-TERM CARE LITIGATION UPDATE: HOW MUCH CAN PAIN HURT?

by: Deborah E. Ballantyne, NHA, Esq.

Pain management is coming under increased scrutiny by surveyors and families, and, more recently, litigators. More and more, evidence of pain and how it is treated is being used as "proof" at trial that a healthcare provider lacks compassion. Everyone has felt pain at some point in their lives, and if the jury believes a staff member overlooked a resident's pain, or a facility failed to put in place system-wide safeguards promoting identification and treatment of pain, then the jury very well might want to punish that facility.

The Joint Commission began to focus on pain management in Long-Term Care (LTC) facilities in the late 1990s. The Joint Commission expects that a "comprehensive pain assessment would be conducted consistent with the scope of care, treatment and services and the patient's condition."<sup>1</sup>

Federal and state regulators of LTC facilities continue to place increased importance on pain management. The federal Minimum Data Set (MDS) Assessment form completed on all LTC residents<sup>2</sup> includes an assessment for pain. Specifically, in Section J of the form, Health Conditions, the MDS tracks the frequency, intensity, and site of any pain. According to the State Operations Manual, state surveyors' off-site preparation completed in advance of licensure inspections review MDS responses to identify residents who suffered from moderate to severe pain. These residents will be reviewed by the surveyor during the on-site portion of investigating the facility. Such focused review of a facility's systems to assess, identify, treat, and monitor effectiveness of pain medication may become the subject of a deficiency against the LTC facility. Survey deficiencies can be fertile ground for punitive damages claims.

The following scenario is played out daily in nursing homes all over the country. If a resident is experiencing pain, and requires a Schedule II narcotic drug, his or her physician would be contacted, a verbal order would be given to the registered nurse, the nurse would contact the pharmacy, the pharmacy would provide the medication, and the resident would be given the medication as ordered. While these steps meet CMS<sup>3</sup> guidelines and nursing practice guidelines, they could be considered in conflict with DEA regulations that require the prescriber to communicate **directly** with the pharmacist. If you operate or work for an LTC facility, you should consider whether your facility's practice of dispensing Schedule II narcotics is also compliant with DEA regulations.

How does this come into play in litigation? Plaintiff's attorneys will try to use these perceived deficiencies as evidence of inadequate treatment and, additionally, as a weapon to maximize damages. Defendant facilities should move to preclude admission of survey results at trial. There are several types of damages that may be awarded in malpractice actions against LTC facilities. These include: (1) special damages, such as medical bills and lost wages (out-of-pocket expenses); (2) non-economic losses, such as **pain** and suffering; and (3) exemplary or punitive damages. It is important to note that damages awarded for medical bills, lost wages, and pain and suffering are **not** the same as a monetary award of punitive damages. Indeed, while monetary damages for medical bills, lost wages, and/or pain and suffering will be awarded if the jury determines that the LTC facility's negligence caused harm, punitive damages generally will not be awarded unless a plaintiff can establish willful or reckless conduct on the part of the facility. Punitive damages are not part of every malpractice case.

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### LONG-TERM CARE LITIGATION UPDATE CONTINUED...

Communication between the nursing staff and the physician, as well as documented interactions with the family, may prove helpful in defending a matter and minimizing your monetary exposure. If, however, communication is lacking between the care providers or with the family, plaintiff's attorneys will use this in an effort to prove that the care rendered was substandard.

Usually, damages for pain and suffering are alleged against LTC facilities when there is a chronic condition; this is commonplace in allegations involving the development and treatment of pressure ulcers. In defending a pressure-ulcer case, it is important to retain highly qualified medical and nursing wound-care specialists who are also familiar with treating geriatric patients. Expert neurology reviews may also be important to determine if the record meets the

standard of care regarding efforts taken to decide whether a patient is capable of experiencing conscious pain and suffering.

While all of these questions need to be asked once litigation has been initiated, do not forget to be proactive and review your organization's protocol that addresses pain management.

*For more information about this opinion, Long-Term Care and Assisted-Living related issues, please contact Deb Ballantyne, NHA, Esq. at 215.864.7171 or ballantyned@whiteandwilliams.com.*

*1 [http://www.jointcommission.org/AccreditationPrograms/LongTermCare/Standards/09\\_FAQs/PC/Nutritional\\_Functional\\_Pain\\_Assessments.htm](http://www.jointcommission.org/AccreditationPrograms/LongTermCare/Standards/09_FAQs/PC/Nutritional_Functional_Pain_Assessments.htm)*

*2 That is, residents who live at Medicare-certified facilities.*

*3 Center for Medicare and Medicaid Service (CMS).*

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