Physicians’ Reliance on Electronic Health Records

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In the world of paper medical records, a physician may simply order any needed tests rather than seek to obtain copies of a previous provider’s medical records that may or may not contain the necessary test results. With electronic health records (EHRs), it will be easier for a physician to check the EHR prior to ordering the lab work, so deciding whether to rely on such previous medical records will become a routine issue. If a physician relies on incorrect health information contained in an EHR that has been shared electronically from another provider, and the incorrect information leads to injury, is the treating physician liable for the resultant damages?

Medical records serve a variety of purposes including facilitation of communication between health care providers treating the patient.1 Medical records also help health care providers plan patient care and document care that has been provided.2 Medical records are used for purposes other than treatment, including complying with legal duties, facilitating payment, and to prosecute or defend medical malpractice cases.3 Accuracy of the medical record is critical. It must contain “complete, accurate and reliable information”4 since it is the physician’s “primary source of information about the patient’s prior complications and prescribed medications.”5

Although much has been written about the privacy and security of EHRs, less attention has been focused on the liability aspects of EHRs. One reason for this lack of attention may be that “[a]t the level of the individual health professional, the arrival of an electronic information era probably adds little new to the law of health information.”6 Although “[n]othing about the modern information age alters fundamental legal accountability for professional conduct”7 widespread adoption and sharing of EHRs could increase the legal exposure of providers as will be discussed below.

The question of whether a physician who relies on incorrect information contained in an EHR is liable for resulting damages may be initially addressed by familiar tenets of medical malpractice law. To successfully prove medical negligence, a plaintiff must establish: (1) a legal duty to the patient, usually proved by the existence of a physician-patient relationship; (2) breach of such duty established by departure from the required

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1 Roger E. Harris, The Need to Know Versus the Right to Know: Privacy of Patient Medical Data in an Information-Based Society, 30 SUFFOLK U.L. REV. 1183, 1190-91 (1997).
2 Id. at 1191.
3 Id.
4 Id.
5 Id.
7 Id.
professional standard of care; (3) causation, i.e., the departure from the standard of care caused injury to the patient; and (4) damages sustained by the patient.8

Assuming the existence of the requisite physician-patient relationship and attendant duty, and further assuming that the physician’s reliance on incorrect health information is a proximate cause of injury suffered by the patient, the question becomes whether the physician breached the professional standard of care by relying on the incorrect health information. Expert testimony is usually required to establish the standard of care. In a medical malpractice action, the plaintiff would present testimony that a reasonable physician would not have relied on the incorrect health information and the defendant physician’s experts would rebut such testimony arguing that reliance on the incorrect health information was within the standard of care. Experts suggest that providers’ “reliance on electronic data in an [EHR] may lead to exposure if the data are unreliable.”9

It is possible in a medical malpractice case to have multiple sequential breaches of the standard of care by different physicians. In such cases, issues of causation and calculation of damages become complex, but conceptually both the physician who incorrectly entered information into the EHR and the physician who relied on such erroneous information could both be liable to the patient. Arguably, the physician providing treatment could be liable if he unreasonably relied on incorrect health information in the EHR. This does not necessarily relieve the physician who incorrectly entered the information from liability. Clearly the standard of care requires physicians and other healthcare providers to maintain accurate medical records. Depending on the facts of the particular case, making a false entry on a medical record may constitute unprofessional conduct which could result in sanctions including forfeiture of a practitioner’s medical license.10 Also, physicians who enter incorrect or incomplete information in a patient’s medical record may have increased liability since the likelihood of that incorrect information being utilized is much greater where the information is incorporated in an EHR.

Physicians may indeed face greater liability exposure resulting from reliance on incorrect information in an EHR. Although the legal principles regarding reliance on EHRs and paper medical records are the same, shared EHRs could greatly increase the instances where a physician must decide whether to rely on information in a patient’s medical record or independently verify the information. Indeed, one of the major benefits of shared EHRs is precisely that they will help eliminate unnecessary duplication of laboratory and other tests.

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8 Amy Jurevic Sokol & Christopher J. Molzen, The Changing Standard Of Care In Medicine, E-Health, Medical Errors, and Technology Add New Obstacles, 23 J. LEGAL MED. 449, 470 (2002). Historically, a physician’s conduct was measured in reference to other physicians in the same or similar locality, but the trend today is to hold all physicians to a national standard of care. Id. at 473-75. Texas no longer requires the “locality” standard, and the standard of care is the duty to act as would a reasonable and prudent physician under the same or similar circumstances. See Hood v. Phillips, 554 S.W.2d 160, 165 (Tex. 1977).
10 Id. at 72 (citing Ky. Rev. Stat. Ann. § 311.595(10)).