Physicians’ Obligation to Review Electronic Health Records Prior to Treatment

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As shared electronic health records (EHRs) become more commonplace in the future, physicians may have much more information available than what they would have in a paper system or an unshared electronic medical record. If a physician has available large amounts of electronic health information on a patient that has been aggregated by a linked EHR, to what extent is the physician responsible for reviewing all of the available information?

In some instances, the standard of care may not require that a treating physician consult past medical records. In a Texas summary judgment case, plaintiffs alleged that Dr. Eyre, an anesthesiologist, breached the requisite standard of care prior to surgery in part by failing to obtain and review past medical records of the patient before the surgery.¹ Three expert anesthesiologists testified by affidavit in favor of Dr. Eyre, stating that the applicable standard of care did not require her to review all past medical records.² The court upheld the motion for summary judgment in favor of the defendant anesthesiologist, holding that there was “no evidence indicating that Dr. Eyre breached the standard of care in failing to obtain medical records.”³

In some cases, the standard of care does require that a treating physician consult past medical records. In one case, the plaintiff alleged that her physician failed to diagnose her breast cancer in part because of a failure to consult her past medical records.⁴ The parties’ experts disagreed as to whether the applicable standard of care required review of the past medical records.⁵ A jury verdict for the plaintiff was upheld on appeal.⁶

Although there is little or no decided law on the issue of whether shared EHRs will increase physicians’ liability, experts believe “that a duty to consult prior health records may arise where no duty exists today”⁷ and that the “standard of care to which providers are held will certainly change.”⁸ The legal standard of care “is that of an average physician in good standing who must exercise that degree of skill and learning ordinarily

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² Id. at *3.
³ Id.
⁵ Id.
⁶ Id.
⁷ Id.
⁸ Id.
possessed and exercised under the same or similar circumstances by other members of
the profession.”

Physicians who have shared EHRs available yet fail to consult them before beginning
treatment could face increasing liability in the future. First, as EHRs become more
commonplace and physicians find the information contained therein more useful in
diagnosing and treating patients, accessing the complete EHR may become more
customary. One approach to standard of care issues is to consider whether a particular
medical regimen (such as consulting an EHR) is “customary.” If so, the legal standard of
care would reflect that an “average physician” would ordinarily review such prior
medical records, and failure to do so could violate the standard of care.

However, changes in the standard of care for technological reasons can come more
quickly, and physicians can be held to a higher standard long before the conduct in
question becomes “customary.” Courts have “shown a willingness to impose their
determination that a practice was out-of-date and below the standard of care.”

For example, in Helling v. Carey, the court held that defendant ophthalmologists were
negligent in failing to administer a glaucoma test to a patient under age 40 even though
experts testified that the standards of the profession do not require such tests, since
persons under 40 years of age rarely suffer from glaucoma. The plaintiff in Helling
successfully argued that the standard of care for ophthalmology failed to protect her from
the potential devastating effects of glaucoma. The Helling court imposed a new
standard of care for ophthalmology since new technology made the pressure test easy and
inexpensive compared to the devastating effects of glaucoma. The court said “giving this
test ... is so imperative that irrespective of its disregard by the standards of the
ophthalmology profession, it is the duty of the courts to say what is required to protect
patients under 40 from the damaging results of glaucoma.”

Although Helling admittedly represents a minority view, using similar reasoning a future
court could hold that a physician’s failure to consult the patient’s EHR violates the
standard of care even if expert testimony fails to show that such review of prior medical
records is “customary.” A more likely result is that EHRs will be more widely adopted in
the future and physicians will become accustomed to consulting EHRs prior to
diagnosing and treating patients, making such consultation of EHRs “customary.” It
seems likely that in either event, easy availability of past medical records may lead to a
broader legal duty to consult prior medical records, changing the professional standard of
care to require such consultation.

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9 See 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, 471 (2002) (citing
RESTATEMENT (SECOND) OF TORTS § 299 A (1965)).
10 Id. at 481-482.
11 Helling v. Carey, 519 P.2d 981, 983 (Wash. 1974)).
12 Id. at 982.
13 Id. at 983.