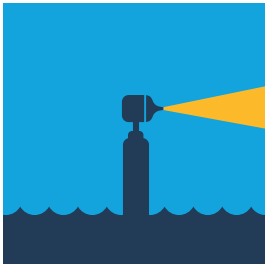


ELECTRONIC HEALTH RECORD CLOSED CLAIMS STUDY

An expert analysis of medical malpractice allegations



We shine a light on risks and trends others cannot see



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ELECTRONIC HEALTH RECORD CLOSED CLAIMS STUDY

INTRODUCTION

We shine a light on risks and trends others cannot see by constantly looking ahead and providing innovative tools to identify potential sources of patient injury and enhance safety.

We rigorously analyze the claims experience of our 80,000 members and translate the findings into patient safety initiatives that protect our members and their patients. Analyzing the collective experience of so many physicians provides broader, more reliable information. It also expands knowledge beyond the experiences of any single person—even if that knowledge is gained over a lifetime of practice. We hope that the information presented here will prompt physicians to collaborate with colleagues and hospital leaders to identify system weaknesses, thereby reducing the risk of harm to patients.

STUDY DESIGN

Our approach to studying electronic health record (EHR)–related malpractice claims* began by reviewing plaintiffs'/patients' allegations, giving us insights into the perspectives and motivations for filing claims and lawsuits.

We then looked at patients' injuries to understand the full scope of harm. Physician experts for both the plaintiffs/patients and the defendants/physicians reviewed claims and conducted medical record reviews. Our clinical analysts drew from these sources to gain an accurate and unbiased understanding of actual patient injuries.

We identified factors that led to patients' injuries, and physician reviewers evaluated each claim to determine whether the standard of care was met.

Our team studied all aspects of the claim and, using benchmarked data, identified risk mitigation strategies that physicians can use to decrease the risk of injury, thereby improving the quality of care.

*A written demand for payment

AUTHOR

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Special thanks to Lisa McCorkle, MSN, CPHRM, Patient Safety Risk Manager II, The Doctors Company, and Darrell Ranum, JD, CPHRM, Vice President, Patient Safety and Risk Management, The Doctors Company.

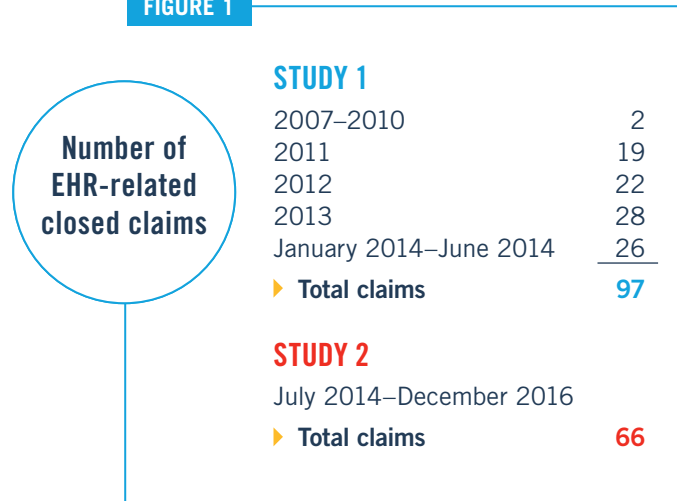
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EHR RISKS THAT CONTRIBUTE TO MEDICAL PROFESSIONAL LIABILITY CLAIMS

We became aware of potential liability risks related to the use of EHRs shortly after their introduction, and we anticipated that EHRs would become a contributing factor to medical professional liability claims. A search of The Doctors Company's closed claims database from 2007 to 2010 revealed only two EHR-related claims. As shown in **FIGURE 1**, the number of claims has increased continuously over the past 10 years.

FIGURE 1



The 97 EHR-related claims that closed from January 2007 through June 2014 were previously reported in “Analysis of EHR Contributing Factors in Medical Professional Liability Claims” (Study 1). An additional 66 EHR-related claims from July 2014 through December 2016 are now closed and are the subject of this report (Study 2).

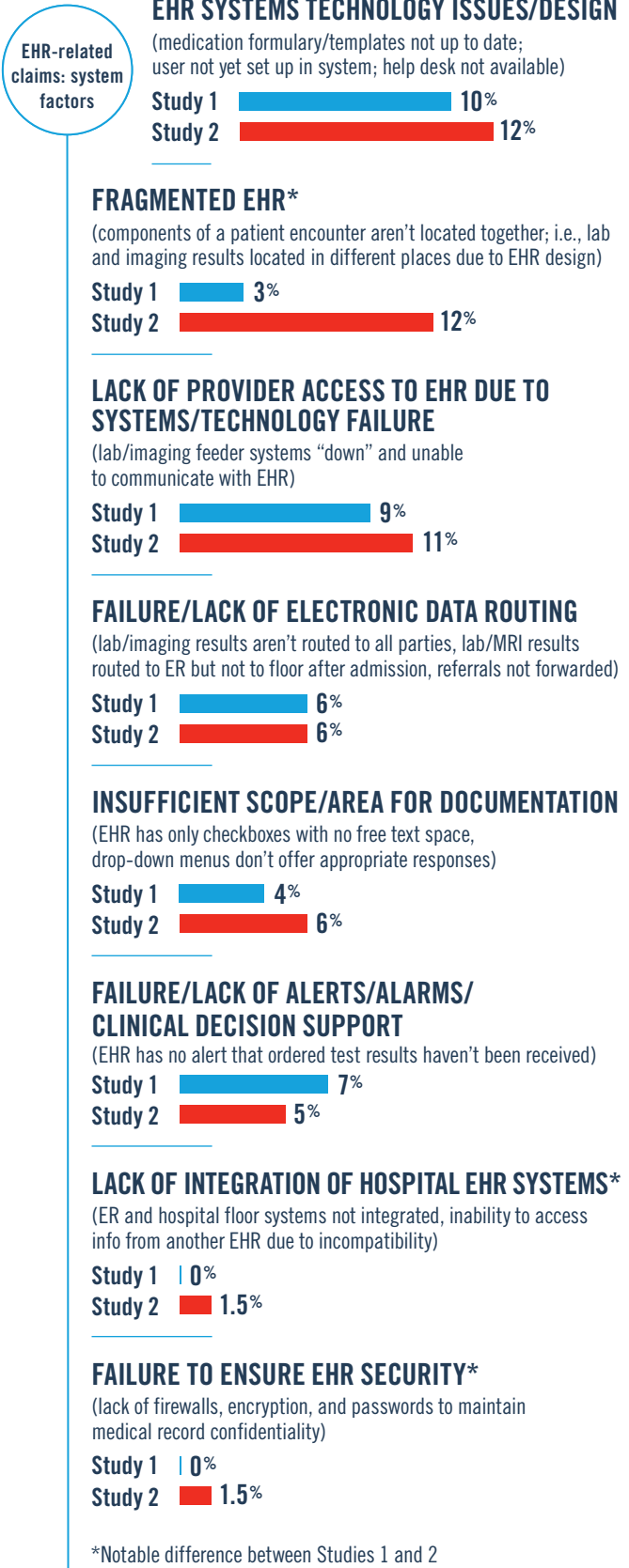
In Study 1, EHR-related factors contributed to 0.9 percent of all claims that The Doctors Company closed from January 2007 through June 2014. System factors contributed to 42 percent of these EHR-related claims, and user factors contributed to 64 percent.

In Study 2, EHR-related factors contributed to 1.6 percent of all claims that The Doctors Company closed from July 2014 through December 2016. System factors were present in 33 of the 66 claims (50 percent), and user factors were present in 38 of the claims (58 percent). Eight claims contained either more than one user or system factor or both.

FIGURE 2 compares how system factors involving technology, design, and security issues contributed to the EHR-related claims in Studies 1 and 2.

Note that because a claim may contain more than one system or user factor—or both—the percentages may not add up to 100 percent.

FIGURE 2



The following cases illustrate system and user factors that contribute to EHR-related claims.

CLAIM 1: LACK OF EHR DRUG ALERT

An elderly female saw an otolaryngologist for ear/nose complaints. The physician intended to order *Flonase* nasal spray. The patient filled the prescription and took it as directed. Ten days later, she went to the emergency room (ER) for dizziness. Two weeks later, the pharmacy sent a refill to the physician at his request. It was for *Flomax* (for enlarged prostate)—which has a side effect of hypotension. When ordering, the physician typed “FLO” in the medication order screen. The EHR automatched Flomax, and the physician selected it. Flomax is not approved by the U.S. Food and Drug Administration (FDA) for females. There was no EHR Drug Alert available for gender.

CLAIMS 2 AND 3: COPY AND PASTE

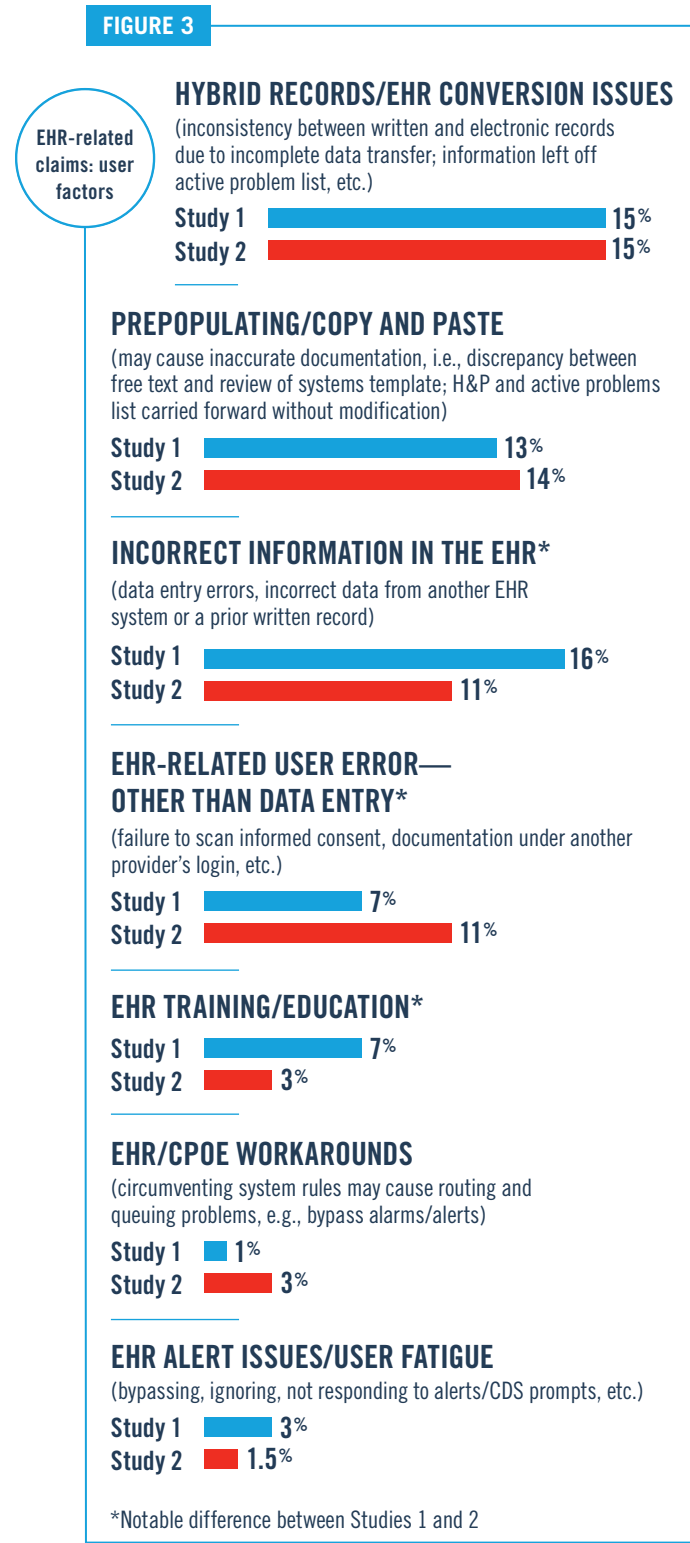
A physical medicine physician (PMP) followed a patient with extremity weakness due to a cervical vascular malformation. For four consecutive days, he entered identical progress notes into the hospital EHR, noting no change in symptoms, while nurses and physical therapy (PT) documented progressive neurologic changes. On the fifth day, PT spoke to the PMP regarding the patient’s deteriorating motor strength. The PMP ordered a neurosurgical consult but again entered the identical progress note into the EHR. The patient underwent decompressive surgery but now has incomplete quadriplegia. Defense experts concluded the identical progress notes resulted from copying and pasting.

A 35-year-old obese male presented to the insured for medical clearance. An ECG showed normal sinus rhythm, normal chest x-ray, heart rate 78, and BP 124/78. Three months later, he returned to the office complaining of chest pain, shortness of breath, and dizziness. His BP was 112/90 and pulse 106. Five days later, he died from pulmonary embolism due to deep venous thrombosis. Defense experts questioned whether the physician had done a complete assessment, because the progress note from the most recent visit appeared identical to the prior visit’s progress note—including the same spelling errors—suggesting that the note had been copied and pasted.

CLAIM 4: INSUFFICIENT AREA FOR DOCUMENTATION (DROP-DOWN MENU)

A female had a bladder sling inserted for urinary incontinence. Her surgeon was assisted by a proctor surgeon representing the product manufacturer and training the patient’s surgeon on the procedure. The patient was informed that another physician would be assisting. In the recovery room, there was blood in the Foley catheter, so the patient was returned to surgery. The bladder had been punctured by the sling. The proctor had approved the sling’s placement. The circulating nurse did not document the proctor’s presence in the OR due to lack of an option in the EHR drop-down menu. There was no space for a free-text narrative to document that the patient was informed of the proctor’s presence.

FIGURE 3 compares how user factors contributed to the EHR-related claims in Studies 1 and 2. Some claims contained more than one contributing user factor.



CLAIM 5: DROP-DOWN MENU

A patient was seen by her physician for pain management with trigger point injections of opioids. The physician ordered morphine sulfate (MS) 15 mg every eight hours. In the EHR, the drop-down menu offered MS 15 mg followed by MS 200 mg. The physician inadvertently selected MS 200 mg and did not recheck before completing the order. The patient filled the prescription, took one MS along with Xanax, and developed slurred speech—resulting in an ER visit with overnight observation.

CLAIM 6: IMPROPER TEMPLATE AND DOCUMENTATION ISSUES

A patient saw a hand surgeon due to pain in his left ring finger since a laceration two weeks prior. An x-ray showed no fracture. An MRI was not performed. The surgeon mistakenly documented the right ring finger throughout his EHR note, using an improper template for the patient's injury. It contained extraneous pieces of inaccurate default information (including mentioning a fracture and a medication the patient did not receive). It did not contain follow-up instructions, and the surgeon never finalized or signed the note electronically.

Six months later, the patient saw a different surgeon, who noted the left ring finger had no flexor tendon function. An MRI showed a complete tear. Subsequently, the first surgeon reviewed his EHR note from the initial visit and “corrected” the inaccuracies. He removed mention of a fracture, corrected the medication entry, and stated the patient had been told to follow up in 10 days. He then electronically signed and finalized the note. Defense experts were not supportive of the standard of care.

CLAIM 7: EHR CONVERSION (INCORRECT INFORMATION IN EHR)

A patient with Tourette's syndrome was treated with Haldol 0.5 mg documented in the written record. The patient called the office requesting a refill. The nurse entered

“Haldol 5.0 mg” in the new EHR for an electronic script. This refill request showed up as a task for the physician to complete. The EHR was new, and it was the first script for this patient. The intended dose (0.5 mg) was therapeutic. The patient took the new dose (5.0 mg) for six months before the office staff discovered the error. The patient had side effects: cough, weight loss, and not feeling well.

“We became aware of potential liability risks related to the use of EHRs shortly after their introduction.”

CLAIM 8: EHR TRAINING

A female presented to the ER with complaints of abdominal pain, nausea, and vomiting. An ovarian cyst had been removed two years prior. The emergency physician ordered an abdominal CT scan and called a gynecologist to evaluate the patient. The gynecologist reviewed a CT scan in the EHR that was later found to be the old scan showing the ovarian cyst. The patient was taken to surgery. No cyst was found, and the patient developed a methicillin-resistant Staphylococcus aureus infection. The gynecologist had not been trained on the new system so did not find the new CT scan that was available.

ANALYSIS OF LOCATION, SPECIALTY, AND TOP ALLEGATIONS

In Study 2, we analyzed the 66 EHR-related claims to determine where the EHR claim events occurred, which

specialties were involved, and the most common allegations. FIGURES 4, 5, and 6 compare the findings in Studies 1 and 2.

FIGURE 4

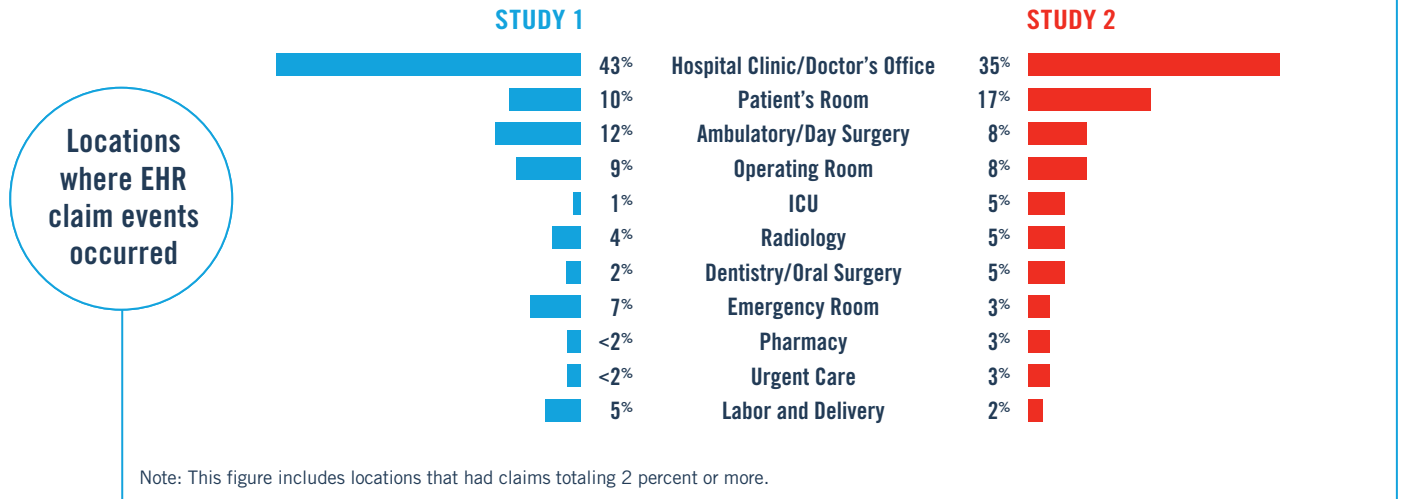
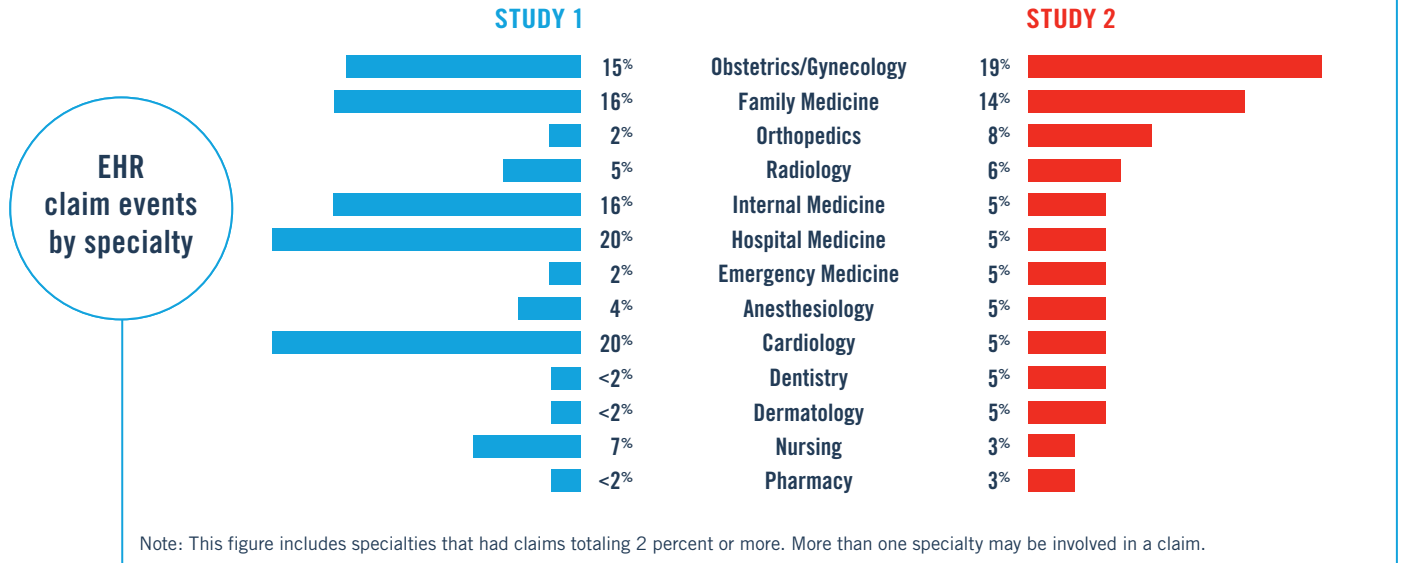


FIGURE 5



Study 1: January 2007 through June 2014

Study 2: July 2014 through December 2016

FIGURE 6

Top allegations in EHR claims

	STUDY 1	STUDY 2
Diagnosis-Related (failure, delay, wrong) (15% system and 21% user factors)	27%	32%
Medication-Related	19%	23%
▶ Improper medication management (3% system and 8% user factors)	7%	11%
▶ Wrong medication (2% system and 4% user factors)	7%	6%
▶ Wrong dose (3% system and 0% user factors)	5%	3%

DISCUSSION

The Doctors Company supports the integration of the EHR into physician office practices (currently at 80 percent) and hospitals (currently at 90 percent) and believes this has great potential to advance both the practice of good medicine and patient safety. However, there are always unanticipated consequences when new technologies are rapidly adopted—and the EHR is no exception.

Many EHR-related problems could have been avoided if the federal government had developed vendor standards for EHR use and interoperability and required beta testing in the healthcare environment to ensure usability and safety before the HITECH Act mandated its widespread adoption in 2009. However, the impetus for the rapid implementation of EHR use was to enable the transition from a volume-based (fee-for-service) payment system to an outcome-based (pay-for-performance) payment system—not to optimize productivity, workflow, and communication. Physicians and other healthcare workers played a minimal role in the initial design of the EHR, and their subsequent workplace experience and concerns have been largely ignored. Optimization of the EHR beyond the current model (digitization of the written medical record) will likely take many years and involve redesigning workflow, creating standardized protocols, using artificial intelligence, and applying big data techniques to healthcare, etc.¹

The 2011 Institute of Medicine report, *Health IT and Patient Safety: Building Safer Systems for Better Care*, concluded that the information needed to analyze and assess health IT (HIT) safety and use was not available and that our understanding of the benefits and risks of EHRs was anecdotal. The report recommended creating a government agency that would systematically and uniformly collect data to investigate harm and safety events related to HIT. In 2015, the Office of the National Coordinator for Health Information Technology (ONC) developed a plan to create a Health IT Safety Center to minimize EHR-related patient safety risks through the collection and analysis of event data reported by users. However, if implemented, the Health IT Safety Center is

unlikely to include an online mechanism for users to report EHR-related adverse events in “real time” when they occur.

“There are always unanticipated consequences when new technologies are rapidly adopted—and the EHR is no exception.”

Typically, the EHR is a contributing factor in a medical malpractice claim rather than its primary cause. In Study 2, user factors (conversion issues, discrepancy between free text and templates, copy-and-paste issues, data entry errors, alert issues, user fatigue, workarounds, etc.) contributed to 58 percent of EHR-related claims and system factors (systems technology and design issues, data routing problems, inappropriate drop-down menu responses, failure of alerts, alarms, and clinical decision support [CDS], etc.) contributed to 50 percent. Some claims contain both system and user factors.

Of all claims closed by The Doctors Company from January 2007 through June 2014 (7.5 years), 0.9 percent (97 claims) had EHR-related contributing factors. In this follow-up study of all claims closed from July 2014 through December 2016 (2.5 years), 1.6 percent (66 claims) had EHR-related contributing factors. This is a relatively small increase over Study 1 and may not be statistically significant, considering that the data have not been adjusted for the increased utilization of EHRs during the time frame covered in Study 2. It is reassuring that the incidence of EHR-related claims has remained low over a 10-year time frame (2007

through 2016). It suggests that EHR-related risks, while real, are relatively uncommon and infrequently result in adverse patient events of sufficient severity to develop into malpractice claims. While we have not analyzed our written health record (WHR)–related claims, it is likely that the WHR and EHR risk magnitudes are similar—and considering that WHR documentation issues are quite frequently a contributing factor to claims, the WHR risk may well be higher.

User factors accounted for 64 percent and system factors accounted for 42 percent of the 97 EHR-related claims that closed from January 2007 through June 2014. In contrast, in the 66 EHR-related claims that closed from July 2014 through December 2016, user factors accounted for 58 percent (a decrease of 6 percent) and system factors for 50 percent (an increase of 8 percent).

The 6 percent decrease in user factors may reflect greater user familiarity with the EHR, resulting from experience as well as greater awareness of the risks. However, it is difficult to explain the 8 percent increase in system factors; perhaps this increase reflects a growing sophistication in the analysis of the causes of EHR-related adverse events.

When compared with the findings of Study 1, more EHR-related claim events occurred in patient rooms and fewer occurred in hospital clinics/doctors’ offices, ambulatory/day surgery centers, labor and delivery, and ERs. Overall, with regard to the medical specialties involved in these events, internal medicine, hospital medicine, and cardiology showed marked decreases. Family medicine and nursing also showed decreases, while orthopedics, emergency medicine, and obstetrics/gynecology showed increases.

EHR-Related User Problems

- ▶ Issues associated with hybrid health records or with the conversion from paper records to an EHR were the most common user problem (15 percent of claims).
- ▶ Issues related to prepopulating fields or copying and pasting were the second most common user problem (14 percent of claims).
- ▶ Issues related to incorrect information in the EHR resulting from data entry and user error were the third most common user problems (11 percent each).

EHR-Related System Problems

- ▶ Issues related to “fragmented” EHRs (e.g., lab and imaging results from a patient encounter not located together) and systems/technology issues (e.g., medication formulary/templates out of date) were the most common system problems (12 percent each).

- ▶ Issues related to lack of provider EHR access resulting from system or technology failure were the third most common system problem (11 percent of claims).
- ▶ Documentation problems (e.g., no free text space or inappropriate drop-down menu responses) and electronic data routing problems each accounted for 6 percent of claims.
- ▶ Lack of or failure of alerts, alarms, and decision support accounted for 5 percent of claims.
- ▶ Lack of EHR systems integration/EHR incompatibility and failure to ensure security each accounted for 1.5 percent of claims.

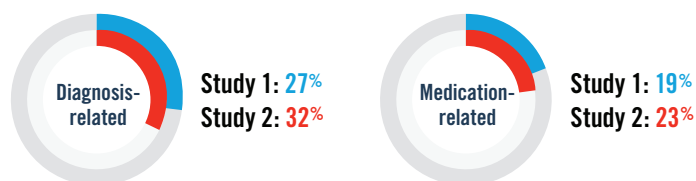
The top four factors responsible for over half of EHR-related claims are issues related to hybrid records/conversion from paper records, prepopulating and copying and pasting, EHR fragmentation (components of a patient encounter not located together), and EHR technology/design (formulary/templates out of date, etc.).

Diagnosis-related allegations were the most common allegation, and this was true whether the EHR-related issue involved user or system factors. Diagnosis-related allegations increased to 32 percent of all allegations in this study from 27 percent in the earlier study. User factors were involved in 21 percent of these diagnosis-related allegations, and system factors were involved in 15 percent.

Medication-related allegations were the second most common allegation, increasing to 23 percent of all allegations in this study from 19 percent in the earlier study.

- ▶ Eleven percent involved improper medication management (8 percent user and 3 percent system factors).
- ▶ Six percent involved the wrong medication (4 percent user and 2 percent system factors).
- ▶ Three percent involved the wrong dose (3 percent system and 0 percent user factors, suggesting that the EHR’s medication database contained erroneous entries).
- ▶ Three percent of claims involved other allegations.

TOP ALLEGATIONS



RISK MITIGATION STRATEGIES



Real and potential EHR-related liability risks are well documented in the medical literature, and it is important for physicians and other healthcare workers to become familiar with them.

1. Doctors are responsible for information to which they have reasonable access—and there is increased access to e-health data from outside the practice that can be accessed from the practice EHR or website or through Health Information Exchanges, e.g., hospital records, consultants' reports, lab results and radiology reports, and community medication histories. EHR metadata documents what was reviewed. If patient injury results from a failure to access or make use of available patient information, the physician may be held liable.



Review all available data and information prior to treating a patient. The healthcare setting, accessibility of data, and acuity of the patient's situation and condition will dictate what will be considered reasonable by a court.

2. E-prescribing, facilitated by the widespread adoption of the EHR, is currently used by more than 80 percent of office practices. Potential capabilities and benefits include the following:
 - ▶ EHRs have an e-prescribing module, which provides electronic routing to pharmacies, quick access to drug formulary and eligibility information, and the patient's prescription history.
 - ▶ Most e-prescribing programs check for drug interactions, dosage errors, medication allergies, and patient-specific medication factors.
 - ▶ While e-prescribing encourages patients to fill prescriptions, 28 percent of EHR prescriptions are not filled.
 - ▶ User transition to e-prescribing is risky. In one study, initial user error was 26 percent, falling to 10 to 15 percent after one year. (One-third of errors were potentially harmful.)

However, practices are exposed to community medication histories through e-prescribing. For example, Dr. A renews a medication, and his e-prescribing program sends an alert advising him that the medication could interact with another drug the patient is taking. He has not prescribed that drug, so his office staff will have to contact the patient to identify who has prescribed it, and then Dr. A will have to contact Dr. X to "negotiate" which drug will be discontinued or changed. If failure to take action results in patient injury from a drug interaction, Dr. A may be liable.



Make sure you adhere to any alerts within the e-prescribing module of the EHR and document any actions taken.

3. Drug-drug interaction lists generate frequent, annoying, and disruptive alerts, and doctors may develop "alert fatigue." It is estimated that two-thirds of alerts are overridden or disabled. If it can be shown that following an alert that was disabled would have prevented an adverse patient event (this will be documented in the metadata), the physician may be found liable for failing to follow it.



Do not disable or override any alerts in the EHR. Discuss alert fatigue issues with your organization's information technology (IT) department or your EHR vendor.

4. Doctors often copy information from a prior note or the history and physical (H&P) and paste it into a new note or H&P, making changes where appropriate, it is hoped. This may work for the past medical history, but it is risky for progress notes and the physical examination, both of which may change. Copying and pasting also contributes to irrelevant over-documentation, and important new clinical information may be obscured. Copying and pasting may also perpetuate incorrect or outdated information that may compromise patient care. By substituting a word processor for the physician's thoughtful review and analysis, the narrative documentation of daily events and the patient's progress may be lost, thereby compromising the record of the patient's course. The quality of notes and documentation may be further compromised by the use of templates.



Avoid copying and pasting except when describing the patient's past medical history. As with handwritten records, make sure your documentation is relevant, objective, and current.

5. The computer may become a barrier between the doctor and the patient. When the doctor fills in a computer template, it may divert attention from the patient, limit interactive conversation, and restrict creative thinking. This may depersonalize and weaken the doctor-patient relationship. The computer's location in the office is an important ergonomic consideration; i.e., the location of electrical outlets shouldn't force you to sit with your back to the patient.



Tell the patient that you are listening carefully, even though you will be typing during the appointment. Some treatment rooms are set up so the patient can watch the screen and see what is being typed. It is also helpful to summarize or read the note to the patient to demonstrate that you have listened.

6. The widespread adoption of the EHR has negatively affected doctor satisfaction, efficiency, and practice workflow. It is common to address these issues by using a medical scribe to untether physicians from the EHR. Patient satisfaction also increases, due to improved physician-patient interaction during office visits. A joint survey of our members by The Doctors Company and Oregon Health and Science University showed that a majority of physicians using scribes allow them to enter:
 - ▶ The medical history.
 - ▶ The review of systems and physical examination findings.
 - ▶ Vital signs, allergies, medications, and lab and imaging results.
 - ▶ Progress notes and the care plan.

The Joint Commission requires that scribe-generated orders be signed by a provider prior to implementation and that organizations must document the competency of scribes for the functions they deem appropriate.

The EHR risks discussed in this closed claims analysis apply to all users—including physicians and scribes. If an adverse event occurs because of a scribe's entry error, the physician will potentially be liable. With EHRs now used by most medical practices and nearly 20 percent of these practices using scribes, it is likely that scribes will emerge as a factor contributing to EHR-related adverse events.



The current lack of standardized training curricula, job descriptions, and certification needs to be discussed.

7. Many EHRs autopopulate fields in the H&P (from data derived from data fields in a prior H&P) and in procedure notes (from personalized or packaged templates). While over documentation may facilitate billing, it may also generate an inappropriate number of billing codes, and entering erroneous or outdated clinical information may increase liability.

Example: An internist was deposed and his EHR was the medical record. Some of the autopopulated fields contained obviously wrong information. At deposition, the plaintiff's attorney asked these questions:

- ▶ “So is the information in this record accurate or not?”
- ▶ “Do you bother looking at your records?”
- ▶ “If these ‘autopopulated’ fields are incorrect, can we trust anything in this record?”

- ▶ “Do you deliver the same level of care as you do in record keeping?”



Contact your organization's IT department or your vendor if you notice that the autopopulation feature causes erroneous data to be recorded. If the autopopulated information is incorrect, note it in the record and document the correct information.

8. EHRs are certified for compliance with Meaningful Use requirements, e.g., computerized provider order entry (CPOE), e-prescribing, CDS, and patient connectivity through Patient Portals. Physicians are encouraged to provide patients with clinically relevant, disease-specific educational and drug safety materials through these portals. However, providers are responsible for their content—which creates risk. Some EHRs have patient questionnaires that use an algorithm to interview the patient through these portals. The questionnaires may address—and memorialize in the record—issues that physicians are not prepared to pursue (depression, substance abuse, sexually transmitted disease, etc.). Lack of or incomplete follow-up can create potential liability—and provide a clear record for the plaintiff's attorney to follow.

Work with your organization to determine the best way to address information gleaned from patient questionnaires. If you are not part of an organization that governs its own EHR, decide how to address issues that the patient notes on a questionnaire. For example, if a patient notes a psychiatric history in the medical history questionnaire, document all follow-up questions asked about current treatment and/or referral to a psychiatrist.



9. Electronic discovery: Plaintiffs' attorneys generally request printed copies of the EHR as well as copies in native format, which shows how the data was used. (Were CDS prompts and drug alerts followed or overridden?) They will also request the metadata, which includes logon and logoff times, what was reviewed and for how long, what changes or additions were made, and when the changes were made. Smartphone and e-mail records are also discoverable.

It is important to remember that all physician interactions with the EHR are time-tracked and discoverable. As with paper medical records, notes written after a patient interaction should include the time of the interaction to avoid any suggestion of inaccurate or false information.



10. Templates with drop-down menus facilitate data entry. However, drop-down menus are usually integrated with other automated features. An entry error (accidentally selecting the medication above or below the one desired on the menu)

may be perpetuated elsewhere in the EHR—and it may be overlooked, resulting in a new potential for error.



Erroneous information, once entered into the EHR, is easily perpetuated and disseminated. Review your entry after you make a choice from a drop-down menu.

11. EHRs provide e-prescribing drug information and CDS databases. Clinicians should know the source of the medication and CDS information in their EHRs, because it may be in conflict with the clinical standards of care or practice guidelines for their specialty and with the information in FDA-approved drug labels or drug alerts.



Check any discharge or medication instructions produced by the EHR to make sure your patient receives the correct information.

12. Computer-assisted documentation uses point-and-click lists, drop-down menus, autofill, templates, and canned text to bypass natural language and produce structured progress notes. These contain redundant, formulaic information, making it easy to overlook significant clinical information that is lost in a sea of normal or irrelevant findings. Communication with on-call and consulting physicians may be compromised, and abnormal lab and imaging test results may be missed.



Utilize your EHR's tracking function to ensure that consults and tests are completed, returned to you, and communicated to the patient. When possible, enlist specific staff in your practice to monitor tracking.

13. CDS provides alerts, warnings, and reminders for medication and chronic disease management and preventive care, but physicians may have to justify departures from these guidelines (documented in the EHR's native format) if an adverse event occurs.



Always document why a prompt was overridden, i.e., the reason the patient's condition required a different treatment decision.

14. Don't allow staff to use office computers to visit websites for personal purposes, an activity that creates opportunities for hackers to compromise patient data and violate the Health Insurance Portability and Accountability Act of 1996 (HIPAA).



Staff should not be allowed to use the physician's password to review, update, or sign off on lab and imaging results. Allowing this type of activity could result in a report being filed without the physician seeing it.

15. EHR notes are dated and time-stamped when they are created—which will not reflect the time the patient was seen if the note is entered later.



It is important to document the EHR note with the date and time the patient was actually seen.

16. Most vendor contracts attempt to shift liability resulting from faulty software design or CDS data errors onto the physician. They often contain "hold harmless" clauses.



Keep in mind that some insurance policies may exclude coverage for product liability and indemnification of third parties. In addition, vendors and users typically settle disputes out of court with "nondisclosure" clauses that prevent open discussion of the patient safety issues involved.

Reference

1. Wachter, RM. *The Digital Doctor: Hope, Hype, and Harm at the Dawn of Medicine's Computer Age*. New York, NY: McGraw-Hill Education; 2015.

The guidelines suggested here are not rules, do not constitute legal advice, and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any treatment must be made by each healthcare provider in light of all circumstances prevailing in the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

LEARN MORE

Find Study 1, "Analysis of EHR Contributing Factors in Medical Professional Liability Claims," and a wide array of resources in our EHR and Telemedicine Resource Center at thedoctors.com/ehr.

A patient safety risk manager is always available to provide industry-leading expertise. For more information, call 800.421.2368, extension 1243, or contact patientsafety@thedoctors.com.



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