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.