

**Hidden Data in Electronic Medical Records Could Surprise You in a Professional Liability Action:** Most physicians in the current environment use some form of electronic medical records (“EMR”) to maintain their patient charts. Indeed, the continuing trend, from Medicare, Medicaid, and private insurers, is to require the electronic submission of claims. MACRA encourages the electronic submission of claims as a method by which a physician may comply with aspects of MIPS, and the submission of claims in such a manner is facilitated by the use of a certified EMR system. However, just as any other computer or electronic record, electronic medical records contain hidden data, known as “metadata,” which are recoverable and viewable by anyone with access to the records and knowledge of computer systems. Of course, the first sign a potential professional liability action may be on the horizon is a request by a patient for a copy of his or her chart. Certainly, once a lawsuit is filed, the plaintiff’s attorney will immediately seek the chart in discovery. In the past, this involved making and providing photocopies of the paper chart, and possibly copies of x-ray films or other studies. However, where a patient’s chart is maintained in an electronic format, the Health Information Technology for Economic and Clinical Health Act (“HITECH”) requires the records to be supplied in electronic format if requested in that format. A physician or practice which makes use of EMR should be aware of the presence of metadata in these records, which show, for example, such things as how and when the data in the record was created, how many times it was accessed or viewed, and by whom, and whether or not the data had been changed after it was entered. Just as is the case with paper charts, once something is entered in EMR it should NOT be altered, unless the alteration is properly done, dated and noted as a revision, with the reason for the change noted. Any attempt to surreptitiously alter EMR will be revealed in the record’s metadata, and will result in far more problems for the physician than whatever issue the physician was attempting to hide by altering the record.

**Washington State Court Affirms Board Ruling Compelling “Bitterly Angry” Doctor to Undergo Psychological Evaluation:** In an April 11, 2017 decision, a three-judge panel of Washington’s Court of Appeals affirmed the state’s medical board’s directive that a “bitterly angry” physician must undergo a psychological evaluation before review of his application for a license to practice medicine in the state could move forward. The Court upheld the decision of the Washington Department of Health’s Medical Quality Assurance Commission that the doctor must receive a psychological evaluation before his application for a medical license would be considered. The doctor argued that he did not receive due process in connection with his application, as he contended he did not receive notice that his mental condition was at issue in the process. The charging document stated the doctor was “unable to practice with reasonable skill and safety,” and included a quotation from a state statute which clearly stated that this inability to practice was due to “a mental or physical condition,” and the Court held this sufficient to satisfy the doctor’s due process rights. The doctor had argued he had never been diagnosed with a mental illness, although a psychological evaluation had found him to be “bitterly angry, with little insight and little ability to reflect his own behavior in relationships with others.” The Court held “mental condition” does not necessarily require a diagnosable mental illness, and that the doctor had previously been found to suffer from “disruptive physician behavior” which, while not recognized as a diagnosable mental illness, nevertheless constituted an occupational problem posing a potential danger should he be granted a license to practice.

**New England Compounding Center Pharmacist Seeks New Trial:** In 2012, the New England Compounding Center produced and shipped contaminated steroid injections. These caused the largest outbreak of meningitis in United States history, in which more than 700 people became ill and more than 60 died. In the first criminal case arising from the incident to go to trial, the head of the Center was accused of second degree murder in the deaths of 25 people, as well as conspiracy, fraud, and racketeering in connection with the outbreak. On March 22, the defendant was convicted of 47 out of 77 racketeering acts, all mail fraud, and of 52 identical direct mail fraud counts, in addition to racketeering conspiracy; he was convicted on 57 of the 96 charges he faced, including conspiracy, fraud and racketeering. He was, however, acquitted of the murder charges. Following his conviction, on April 10th, the pharmacist’s attorneys petitioned the Federal Judge who heard the case for a new trial, on the grounds that the evidence introduced by the prosecution on the murder charges unfairly prejudiced the jury and tainted the case with respect to the remaining charges. The pharmacist’s attorneys argue that the presence of the murder charges in the case, and the prosecution’s focus on those charges, allowed the prosecution to introduce graphic evidence, such as stories about the pain and suffering of the individuals who died, as well as autopsy photographs, and testimony from sobbing physicians who had treated the deceased patients. The defendant’s attorneys argue that the presence of this disturbing evidence tainted the entire case against the defendant and prejudiced the jury, preventing it from dispassionately considering the other charges of conspiracy, fraud, and racketeering. The defense also argues that the racketeering count and a knowing conspiracy count were too “vague” to support criminal convictions. The Judge will rule upon the application in due course.

For more information on the above items, contact Kern Augustine, P.C. at 1-800-445-0954 or via email at [info@DrLaw.com](mailto:info@DrLaw.com).



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