CIVIL PRACTICE UPDATE: REVIEW ON E-DISCOVERY
ISBA – MAY 19, 2016 11:15 – 11:45 a.m.
MEDICAL RECORDS
GETTING THE HOSPITAL RECORDS & AUDIT TRAILS

GUY DELSON GELEERD JR.
ATTORNEY AT LAW
180 NORTH MICHIGAN AVENUE – SUITE 2100
CHICAGO, IL 60601
Telephone 312-236-9751
Email guy.geleerd@gmail.com
www.geleerdtriallaw.com

==========

10 ILCS 5/24C-2 defines an audit trail as a record documenting who accessed a computer system, when it was accessed and what operations were performed. Audit trails for medical records function as an access of a patient(s) medical record(s) management system. The audit trail provides information that is not otherwise accessible or discoverable in any other medical record. Audi trails are essential in medical negligence cases as the information contained in the audit trail reveals the patient(s) complete record where as before, records "became unavailable" or "missing" and often times complicated a plaintiff's burden of proof of the negligence that was committed. The audit trail can lead to relevant and discoverable evidence of a medical act or a failure to act and or intervene which lead to the tragic outcome.

Hospitals are required by law to maintain an audit trail for every electronic medical record. An audit trail shows the existence of an electronic medical record, when an electronic medical record was accessed, who accessed the electronic medical record, who made any additions or alterations to the record, and when these additions or alterations were made.

Maintaining an audit trail is a federal requirement to ensure that electronic medical records are not altered as a means of "covering-up" medical negligence.

The HIPPA Act of 1996 ("Health Insurance and Accountability Act") created a national standard for the maintenance of electronic medical records. HIPPA intended to ensure that electronic medical records could not be altered by a hospital without detection at a later date to further prevent the "cover-up" of incidents of medical negligence. In addition, HIPPA also stipulates that electronic medical records, including the audit trail, must be maintained by the health care provider for at least six (6) years.

An electronic audit trail in the context of electronic medical records is used for security purposes to confirm who logged into patient(s) records, medical billing and data for public health reporting and medical research. Electronic medical records should be protected and secure due to their online status. Most attorneys will not email medical records for the reason that not only could it be unsafe as the same could be accessible, but for fear of a HIPAA violation. Not only is it imperative to protect electronic medical records from unauthorized outside access but audit trails are necessary in order to make sure that the electronic medical records are accessed only by persons authorized to access them and on a "need-to-know" basis. HIPAA requires and limits that only authorized persons may have access to medical records.

The retention and storage of audit trails is also of most extreme value. Not only is retaining and storing the audit trail statutorily required, access to audit trail records must be strictly controlled to ensure the integrity of the electronic medical records. The hospital or other professional must ensure that all audit trails associated with the electronic medical

records are “turned on” and “fully functional.” The functionality of audit trials associated with the electronic medical record must be tested to ensure it is working and should it be found not functional, immediately addressed and repaired.

Audit trails for electronic medical records access points should be designed to ensure confidentiality, compliance and authentication. Not only are related HIPAA laws extremely important, but health care organizations are sometimes required by state and federal public health agencies to gather data diagnoses and disease outbreaks.

Another use for audit trails is to track medical billing records. When the medical record(s), such as progress notes, surgical notes or discharge treatment notes are entered into the electronic system, the code(s) for the diagnosis or procedure(s) is/are automatically sent to the billing department. When in medical negligence actions a party is looking to rule a procedure in or out, the audit trail to the medical bill to see if it has a matching medical record is very helpful.

Patient(s) medical records are essential not only to medical negligence matters, but in personal injury cases as well. The difference between causation of a new injury versus aggravation of a pre-existing symptomatic or asymptomatic condition can be won or loss in gathering a patient(s) prior medical records. With medical record audit trails, the patient(s) prior medical record(s) should always be available.

Audit trail records require a retention schedule. The retention schedule for audit trail records must adhere to legal and compliance needs, but it must also take into consideration records management needs.

With the increased visibility of audit trail records as discoverable information, courts are going to be presented with more audit trail issues to rule on in discovery and at trial. Although it is a Rule 23 Order, the following is an example of the appellate court encountering the use of the request for the audit trail. *Francisco v. Kozeny*, 2014 IL App (2d) 130677-U, (April 23, 2014) (Rule 23 Order)

The plaintiff argued that the trial court erred in granting a motion to quash a certain subpoena issued during trial. Prior to trial, the plaintiff issued a subpoena duces tecum to the hospital for its audit trail that showed, by both date and time, which individuals accessed the hospital's medical records for the decedent during her hospitalizations. The hospital sent the requested records to the plaintiff as well as to all counsel of record in this case. For example, the liver biopsy report of the decedent, dated October 26, 2005, and entered electronically into hospital's system concluded; the biopsy was reviewed by doctors at the Mayo Clinic and they agree with the diagnosis. They agree that the changes are consistent with drug injury and may be related to prior antibiotics, though a thorough drug history should be taken to identify other possible precipitating drugs.

The audit trail indicated that this report was reviewed by Dr. Pinsky on November 2, 2005 at 9:32 a.m. The plaintiff believed this evidence was critical because Dr. Pinsky had testified that that he signed off on the decedent's care as of October 31, 2005. However, because he viewed the liver biopsy report on November 2, the plaintiff believed Dr. Pinsky had a duty to conduct a thorough medication history.

After the trial commenced, on Saturday, February 2, 2013, the plaintiff issued a subpoena upon the hospital, requesting that the "person most knowledgeable" testify as the

audit trail concerning the decedent's records from her September and October hospitalizations. The subpoena requested that someone appear at trial on February 4, 2013. On that day, during trial, counsel representing the hospital appeared in court to orally request that the plaintiff's subpoena be quashed on the basis that it did not give at least seven days to produce a fact witness and because there was no name listed on the subpoena. That when she received the subpoena she contacted the plaintiff's counsel and asked what person he was looking for—the person who printed the audit trail, the person who scanned the records in, or the person who knew the record system? The plaintiff's counsel never responded.

The plaintiff's counsel explained that he had sent previous subpoenas in the same manner and never had a problem until this one. The plaintiff's counsel stated he did not put a name on the subpoena because he thought the hospital would just send the person who prints out the audit trail. The plaintiff's counsel explained that the audit trail was important because it would show that Dr. Pinsky looked at various documents even after he claimed that he no longer saw the decedent.

Dr. Pinsky's counsel argued that he originally believed the purpose of the audit trail was to show whether Dr. Kozeny was physically on the premises when the decedent went to the emergency room on October 18. He stated that this was the first time he was hearing that the audit trail's purpose was to somehow impeach Dr. Pinsky. Counsel argued that Dr. Pinsky had already testified and that there was no plan to bring him back into the case. Following argument, the trial court granted the oral motion to quash the subpoena.

The plaintiff argued that he was prejudiced by the trial court's ruling because the main issue in the case against Dr. Pinsky was whether he should have conducted a thorough drug

history and that the audit trail showed he viewed the results of the liver biopsy which stated that a thorough drug history should be undertaken. The plaintiff argued that if the jury had heard evidence of the audit trail it could have inferred that Dr. Pinsky was still on the decedent's case as of November 2 and should have conducted a drug history. The plaintiff argues that he is entitled to a new trial.

Upon review, the appellate court affirmed the trial court in granting the motion to quash. Supreme Court Rule 237(a) required that a subpoena be served at least seven days prior to the date on which an appearance is required. The plaintiff presented no valid reason for the non-compliance with the seven-day notice rule. The record indicates that the plaintiff was aware of the biopsy report and the audit trail as of August 24, 2010. Additionally, Dr. Pinsky testified in an August 21, 2009, deposition that he had “signed off” from the decedents' care on October 31, 2005. Dr. Pinsky also made the same statement in his Supreme Court Rule 213(f)(3) opinion served on the plaintiff on September 15, 2012. Accordingly, the plaintiff was aware of Dr. Pinsky's testimony and the audit trail at issue years in advance of trial. The plaintiff had ample opportunity prior to the start of trial to appropriately identify and subpoena a hospital witness to lay the foundation for the audit trail. Instead, the plaintiff waited until two weeks into the trial and after Dr. Pinsky had already testified. Under these circumstances, the trial court did not abuse its discretion in quashing the subpoena as untimely.

Moreover, a party is not entitled to a new trial unless a trial court's erroneous evidentiary ruling was substantially prejudicial and affected the outcome of the trial. *DiCosolo v. Janssen Pharmaceuticals, Inc*., 2011 IL App (1st) 093562 Even if the trial court had erred, the appellate court could not say that the error was so prejudicial as to warrant a new trial. Nothing

in the audit trail conflicted with Dr. Pinsky's testimony. Dr. Pinsky testified that after he conducted his initial evaluation of the decedent, he discussed with the attending physician, Dr. Olmstead, that the decedent was possibly suffering from a drug reaction and he recommended that Dr. Olmstead seek an allergy consult to help determine what medication could be causing the decedent's symptoms. He testified that he was not sure whether he reviewed the liver biopsy report before or after he had signed off on the decedent's case on October 31.

However, the plaintiff's counsel was able to cross-examine him on the significance of the liver biopsy report, which was admitted into evidence, and the comment that a thorough drug history should be taken. Dr. Pinsky testified that his purpose was not to investigate a drug reaction; his purpose was to determine whether the decedent's condition was caused by an infection. By ruling in Dr. Pinsky's favor, the jury apparently agreed. Accordingly, showing via the audit trail that Dr. Pinsky looked at the liver biopsy report on November 2 would not have affected the outcome of the trial.