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Insights

Balancing Patient Privacy with Access to Electronic Medical Records Could Trigger Medical Malpractice Liability

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The Indiana Court of Appeals recently held that clinic policies relating to physician access to an electronic medical record system were not general negligence allegations but were subject to the Indiana Medical Malpractice Act. In ***Rossner v. Take Care Health Systems, LLC***, the Court affirmed the entry of summary judgment of a negligence claim against an on-site employee health clinic at the University of Notre Dame. The Court determined that the plaintiff failed to obtain a determination of a medical review panel before filing the case in state court. The opinion contains important takeaways about the potential risk associated with the configuration of electronic medical record systems.

Background

Shawn Rossner, a Notre Dame employee, visited the Notre Dame Wellness Center (the "Center") three times over a five-day period in early March 2014. The Center is an on-site employee health clinic operated by entities under contract with Notre Dame. Shawn saw the Center's medical director on his first two visits to the Center. He reported to the Center the third time on a Saturday and saw a *locum tenens* physician, Dr. Annette Millie. Dr. Millie did not have independent log-in access to Shawn's electronic medical records, per the Center's policy. A nurse assisting Dr. Millie, who did have access to the system, printed Shawn's medical records for Dr. Millie to review prior to her consultation with Shawn. The court found that Dr. Millie "did, in fact, review … progress notes from Shawn's prior visits."[1]

Unfortunately, Shawn's condition deteriorated rapidly over the weekend, and within two days of seeing the *locum tenens* doctor, he was admitted to a local hospital and diagnosed with bacterial endocarditis. While in the hospital, Shawn suffered a stroke that left him paralyzed and unable to speak.

Shawn's wife, Cynthia Rossner, filed a civil complaint on behalf of herself and as legal guardian for Shawn alleging general negligence by the entities staffing the Center. Rossner specifically alleged that her claims were not within the scope of Indiana's Medical Malpractice Act ("MMA"). Defendants denied this allegation, arguing that Rossner's negligence claim was actually one for medical malpractice under the MMA. Defendants filed a motion to dismiss, alleging that the trial court lacked subject matter jurisdiction because Rossner had failed to file a proposed complaint with the Indiana Department of Insurance ("DOI") as required by the MMA.

The trial court found that Rossner's claim for negligence centered on Dr. Millie's use of Shawn's medical records and the Center's "alleged failure to implement appropriate policies and procedures regarding physician access to medical records,"[2] both of which are related to the standard of care of a medical professional. Accordingly, the trial court determined that Rossner's claim was one for medical malpractice under the MMA, not general negligence, and dismissed it for failure to conform to the procedural requirements in the MMA.

Rossner appealed.

Rossner's Claim Was Subject to the Indiana Medical Malpractice Act

The Court of Appeals agreed with the trial court that Rossner's claim alleged medical malpractice under the MMA and not general negligence. The court found that the maintenance of patient records is a service intrinsically related to a health care provider's standard of care. Therefore, an allegation by an injured patient or patient representative that a provider failed to properly maintain patient records, or that a provider's records policy improperly prevented a physician from exercising professional judgment in treating a patient, is an allegation of medical malpractice by the provider that must be brought under the MMA.

The substance of an injured plaintiff's claim determines whether the claim falls under the purview of the MMA. If the claim is "based on the provider's behavior or practices while acting in his or her professional capacity as a provider of medical services,"[3] it is a claim for medical malpractice. Put differently, a claim for malpractice is distinguished from a claim for ordinary negligence by the presence of a "causal connection" between the conduct at issue and the nature of the relationship between the patient and the health care provider.[4]

In *Rossner*, the appellate court found that such a connection was present. Rossner alleged that Dr. Millie's failure to timely diagnose and treat Shawn was a direct result of the Center's policy preventing Dr. Millie, as a *locum tenens* physician, from "directly and independently" accessing Shawn's electronic medical records.[5] The Court observed that this alleged failure was "the very essence of Rossner's claim."[6] The Court further found that since Rossner filed her civil action without having first submitted her proposed complaint to DOI for review by an expert panel, as required under the Medical Malpractice Act, the trial court lacked jurisdiction to decide her claim on the merits and properly entered judgment for the defendants.[7]

What Can Providers Learn from this Case?

The decision in *Rossner* suggests that at least one panel of the Indiana Court of Appeals considers the maintenance of patient medical records to be directly related to patient care. As such, claims relating to a provider's failure to adequately maintain the records or provide sufficient access to the records, according to the *Rossner* Court, constitute claims for medical malpractice.

It remains to be seen how the courts will keep up with and view the innovation taking place with respect to electronic medical record systems and the federal government's emphasis on interoperability, privacy, and access. The development of new technology and applications will likely make policy decisions regarding integration and access more complex. The *Rossner* decision leaves open the possibility that IT developers could face liability to patients for poorly designed systems or programs containing bugs that interfere with appropriate provider access.

Third-party IT developers would likely not constitute "qualified providers" under the Indiana Medical Malpractice Act and, in many cases, may have negotiated indemnity agreements with the providers using the technology. Such a scenario could lead to the possibility that a provider may face unlimited liability arising from the terms of an indemnity agreement with an IT developer who is sued by, and ends up paying, an injured patient or patient representative on a claim for ordinary negligence, when the provider's exposure to damages for medical malpractice would have otherwise been limited by the damages cap in the MMA. Stay tuned as the law in this area evolves with (usually behind) the rapidly developing technology.

Please contact **Robert A. Anderson, Stephanie T. Eckerle** or any member of the **Krieg DeVault Health Care Team** with questions or for more information.

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[1]*Rossner v. Take Care Health Sys., LLC*, __ N.E.3d__, No. 20A-CT-1955, 2021 WL 2251627, at *5 (Ind. Ct. App. June 3, 2021). This would appear to make much of the opinion that follows regarding the policy of limiting electronic access *dicta* that was not essential to the Court's ultimate ruling.
[2]Id. at *3.
*3*Id. at *5 (citing Madison Ctr., Inc. v. R.R.K., 853 N.E.2d 1286, 1288 (Ind. Ct. App. 2006), trans. denied).
[4]Id.
[5]Id.
[6]Id.
[7]The court also found that the two-year statute of limitations in the Medical Malpractice Act barred Rossner from filing any future claims with DOI. *See id*. at *6 (citing Ind. Code § 34-18-7-1(b)). The trial court granted the motion for summary judgment on the basis that the allegations in the case sounded in medical malpractice, even though it found that undisputed evidence confirmed that the *locum tenens* physician actually had access to paper copies of the electronic medical record. The Court of Appeals noted that determination, but also affirmed the entry of summaryjudgment on the basis that the case sounded in medical malpractice. It appears that Rossner may have been asserting that *electronic* access to records was somehow substantively different from paper records. It is also possible that both courts viewed the access issue to be inextricably intertwined with a failure to diagnose allegation or implication, which was clearly an allegation of medical malpractice. Both courts may have viewed the question of whether a qualitative difference existed between indirect access to the electronic medical record and direct access as irrelevant since the issues were never presented to a medical review panel.