Spencer Miller, Plaintiff

v.

Beth Saubermanm, NP, John Delloso, M.D., West Side Medical Group, P.C., Edward Mendelsohn, M.D., Edward Mendelsohn M.D., PLLC, Village Care Rehabilitation & Nursing Center and Village Care of New York, Inc., Defendants

Supreme Court of the State of New York, County of New York

Index No. 805270/16

Filed on December 6, 2018

Madden, Joan A., Justice

In this action for damages for medical malpractice, defendants Village Center for Care s/h/a Village Care Rehabilitation & Nursing Center and Village Care of New York, Inc. (collectively "Village Care") move for a protective order pursuant to CPLR 3103 in connection with plaintiff's discovery demands for 1) the audit trail and metadata for plaintiff's patient care records created and maintained by Village Care, identifying each user entering, making, editing, viewing, printing and otherwise acting upon a plaintiff's medical record; and 2) a copy of the user manual for the Electronic Medical Record Program used from May through July 2014 at defendant Village Care. Plaintiff opposes the motion and cross-moves for an order compelling defendant Village Care to comply with the discovery demands.

From May 8, 2014 to July 29, 2014, plaintiff was a resident at Village Care's facility for rehabilitation following surgery to repair his femur. Plaintiff alleges that during that time, he developed severe bed sores, and as a result of the lack of proper medical treatement, he was admitted to the hospital and diagnosed with Fournier's gangrene, sepsis, and stage IV infected decubitus ulcers of the sacrum, scrotum and left heal with bone showing. Plaintiff alleges he required multiple surgeries and intensive care treatment, and has ultimately been left with a permanent colostomy as the untreated wounds and infection tunneled to the bowel and rectum.

In support of the cross-motion to compel discovery, plaintiff's counsel explains that she received conflicting versions of the plaintiff's medical record, which is electronically created and stored. The versions were provided at different times and contain conflicting entries for the same items on the same record for the same days, specifically with respect to the presence of pressure ulcers or bed sores. For example, on the "Physician Progress Note" for May 8, 2014, the day Mr. Miller was admitted to Village Care, the item delineated as "Pressure Ulcer" has three different entries. On one version of the record, "No" is checked off (Exhibits G and I to the cross-motion); on another version, both "No" and "Yes" are checked off (Exhibit H to the cross-motion; and on a third version, neither "No" or "Yes" is checked off.[1] Significantly, the records in Exhibit G were provided to plaintiff pre-suit. Plaintiff argues that given the materiality of the fact as to when plaintiff developed bed sores, he is entitled to the audit trail and metadata that would presumably show when plaintiff's electronic medical record was altered and by whom.

In opposition, Village Care submits the affidavit of Stuart H. Meyer, Village Care's Chief Information Officer since November 2015, and the affidavit of Bill Kilburn, Senior Software Engineer for Matrix Care, Inc., since July 2017, along with an "audit history and report" or audit trail created by Mr. Kilburn (Exhibit 1 to Village Care's opposition). Mr. Meyer explains that Matrix Care is Village Care's EMR ("electronic medical records") provider, and has remote access to all historical electronic medical records. Mr. Kilburn states that the annexed audit history and report "reflects the creation start and final modification dates of the data in plaintiff's clinical record from May 8, 2014 through July 29, 2014, as well as an electronic footprint and history of final changes, modifications or other editing of such records through the present." Mr. Kilburn further states that "[i]t is my understanding based upon personal knowledge that the "record history" is a "true record audit detailing any records with modifications that took place to the records after 7/29/14 for Mr. Spencer Miller in the EMR system owned by MatrixCare." Mr. Myer states that they have not been able to determine the "root cause of why certain fields in the EMR print differently from the electronic version as seen on the computer

screen."

In reply, plaintiff objects that Village Care has failed to provide an explanation for the "alteration" of the medical records, Village Care has failed to produce the metadata, and the audit trail exchanged is insufficient, since it does not cover the period after plaintiff's discharge.

On August 16, 2018, the parties appeared for oral argument and the Court issued an Interim Order granting the motion and cross-motion to the extent of directing Village Care to submit within 20 days an affidavit(s) from a person with personal knowledge providing the following information: 1) the software system used to produce the audit history; 2) the storage system from which the data was extracted; 3) the date the search was run; 4) the parameters of the search; 5) whether the data exists in other storage systems; 6) whether the data in each storage system can be accessed by software systems other than those used to produce Exhibit 1; and 7) the cost of producing the requested metadata. The Interim Order also directed plaintiff to submit within 30 days an affidavit based on personal knowledge regarding the basis for the request for metadata including the relevancy of such metadata for plaintiff's entire stay at defendant's facility.

In response to the Interim Order, Village Care submits an additional affidavit from William Kilburn and an affidavit from Joe Webber, both employees of MatrixCare, the vendor responsible for storing and maintaining Village Care's electronic medical records. As noted above, Mr. Kilburn is the Senior Software Engineer who generated the audit history report. Mr. Webber is Senior Vice President of Research and Development and Chief Technology Officer.

With respect to the audit report, Mr. Kilburn explains as follows. He generated the audit history report annexed as Exhibit 1 "using a software system called 'SQL Server Management Studio'" and the "storage system from where the audit report was generated is called 'SQL Server 2014.'" When he ran the search for the audit report on April 10, 2018, he used parameters for "all items classified as EMR [electronic medical record] Documents in the plaintiff's chart, with no restriction." He explains that medication and treatment administration records and other administrative records were not included since they are not stored as EMR documents, so other than excluding those records, the only restriction placed on the search was plaintiff's name, Spencer Miller. The back-up locations for the data are in Nashville and Chicago, where identical medication records are physically stored. Plaintiff's data can also be accessed through the "6N application" which is not in a single location, so a "user would have to enter the 6N application and locate the plaintiff's clinical documents individually then view the modification history." The audit report shows "all edits, changes or modifications to any single record from plaintiff's admission to discharge, thorugh the time the audit report was run" on April 10, 2018. According to Mr. Kilburn, "[i]t is my understanding based on personal knowledge that the record history annexed as Exhibit 1 to the Affidavit of Stuart H. Myer is a true record audit detailing any records with modification that took place to the records after 7/29/14 for Mr. Spencer Miller in the EMR system owned by MatrixCare, Inc."

Addressing the cost of providing metadata, Mr. Webber states that "[b]ased on my many years of experience in the software and information technology sector generally, and in the area of metadata extraction specifically, in my opinion the cost estimate of producting full metadata for plaintiff's entire medical record would be approximately $250,000 if MatrixCare were to outsource it to a vendor." He also states that while $250,000 is a "reasonable estimate, that could change extremely, either up or down, based on the specifics we would learn afer hiring the team and learning more about how the system gathers data." Mr. Webber explains that the "resources, software and man hours needed to extract the metadata is very costly since the 6N application is a legacy system that has long been discontinued and is no longer actively supported" and "no one on the MatrixCare team. . . actively works on it on a regular basis." He states that "[w]hether the metadata extraction effort for plaintiff's entire medical record is handled in-house or outsourced, the cost would be prohibitively expensive."

Plaintiff submits the affidavit of Michael Turner, a Systems Administrator employed by the law firm representing plaintiff. Mr. Turner states that metadata is "important and relevant to ascertain the identity, source and timing of the changes that were made to plaintiff's medical record," as there are three versions of the medical records produced by defendant Village Care. He states that the audit report is not complete, as "we know from the dates of the exchanges in this case that the changes to the medical record occurred sometime between September 18, 2017 and November 16, 2017." He also states that "we know for a fact that the record was accessed to print this law firm a copy of the medical record pre-suit and there is no such log of that accession, as it was viewed and printed. A complete Audit Trail would have every access into the chart, a date and time stamp and the username of the individual accessing the record." With respect to Mr. Webber's opinion that the cost of producing the metadata is approximately $250,000, Mr. Turner states that "to limit the extent of the search and reduce the costs associated, the metadata limited to the portion of the plaintiff's medical record entitled Physicians Progress Notes would be acceptable and satisfactory to identify

the origin of the changes to Mr. Miller's medical records."

Based on the foregoing, plaintiff has made a sufficient showing for the production of metadata. Defendant has yet to provide a credible explanation for the different and conflicting versions of plaintiff's medical record. At oral argument, counsel for Village Care improbably suggested that the "x" in the "yes" box "migrated" to the "no" box. Moreover, while the audit report is intended to show "all edits, changes, or modifications to any single record" from May 8, 2014 through April 10, 2018, the report produced by Village Care shows no changes or modifications. Under these circumstances, where there is no explanation for the different and conflicting versions of plaintiff's medical record, and where the issue as to when plaintiff developed bed sores is clearly material to plaintiff's malpractice claim, plaintiff is entitled to the metadata for his medical record to determine if the medical record was altered, and if so, when and by whom. The metadata, however, shall be limited to Village Care's Physician Progress Notes from May 8, 2014 through July 29, 2014. Failure to produce the metadata will result in limiting the medical record at trial to the version produced pre-suit without explanation (Exhibit G).

Accordingly, it is
ORDERED that Village Care's motion for a protective order is denied, and it is further

ORDERED that plaintiff's cross-motion to compel is granted to the extent that within 30 days of the date of this decision and order, Village Care shall produce the metadata for the Physician Progress Notes dated May 8, 2014 through July 29, 2014; and it is further

ORDERED that failure to comply with the preceding paragraph will result in limiting the medical record at trial to the version produced pre-suit without explanation (Exhibit G).

Footnotes
[1] The Court has compared the version of the medical record provided to plaintiff's counsel pre-suit (Exhibit G) with the version exchanged on November 16, 2017 (Exhibit H), and found different entries for the "pressure ulcer" item on the Physician Progress Note dated May 8, 10, 13, 14, 28, and 30; June 5, 11 and 23; and July 1 and 11. The two versions also have different entries for many other items.

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