

## IT ROUNDUP: PART I

**EHR Through Not-So-Rose-Colored Glasses**

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**T**he benefits of operating clinically with an electronic health record (EHR) are touted everywhere. They are brought to us by the sales force of various products, they come through on subject lines of hundreds of emails, and they can be heard on the evening news or read in the paper. Even our federal government is so certain of its superiority to the traditional paper chart that it is mandating its use in the future.

Some of the most commonly cited advantages are accessibility of the records, improved management of paper, better efficiency in clinical care, enhanced patient safety, and higher-quality prevention and chronic disease tracking. If true, this should translate to improved patient care and enhanced patient and physician satisfaction.

My own clinic recently converted to an EHR, and some of the following issues have arisen.

**Accessibility**

There is no argument that the electronic chart is more accessible than a single tome that needs hands physically laid upon it to make use of its contents. The merging of the chart with various office locations and different specialties was once an impossible dream. Now, working late or off hours in clinic should no longer be necessary as the EHR allows for finishing notes, tasks, and responding to patient calls from home or anywhere with an Internet connection.

When we can access the chart easily, so can many more people. Consequences have been set for those intruding upon the chart of high-profile patients, including steep fines and loss of employment. Patients, already often mistrusting of the written chart, have good

reason to be wary of what gets put into a document so easily opened.

Constant accessibility also takes a toll on physicians themselves. Despite long hours and generally high-stress clinical work, physicians must intentionally declare a day off or be drawn into the sense of responsibility and concern for what lies in the electronic task list. The literature lags on the impact of this phenomenon on physician well-being. With the current sky-high prevalence of physician burnout, it is not much of a stretch to recognize we are playing with dangerous potential overload.

**Managing the Paper Monster**

The EHR should be paperless, but somehow many of the clinical systems with whom your office interacts may not have received that memo. Faxes nearly continuously stream into the office from consultants, insurance companies, pharmacies, and other participants in your patients' care. Managing this paper stack may be more cumbersome after the conversion to the digital world. Chances are you have dramatically downsized your medical records team. New processes are unlikely to have been specifically developed for these changes. Should you scan then task? Leave documents in the physician's mailbox already stuffed with journals and correspondence? If it needs a signature, does an electronic one count? It is not clear that physicians can answer these questions, which should make us feel more compassion toward the staff trying to manage the beast.

**Patient Safety**

There were many goals set out for the global adoption of the EHR. One

primary tenet was the improvement of patient safety. When all practitioners contributing to a patient's care are operating from the same chart, it is difficult to see how things could be overlooked or duplicated.

Unfortunately, the organization of the electronic chart may or may not be intuitive. The process through which one physician enters instructions following review of results will likely vary. With so many contributors, the chart rapidly becomes huge and much more cumbersome to flip through to find recent updates.

The issue of whether the EHR improves patient safety remains unsettled at best. The Institute of Medicine has gone so far as to issue a report urging governmental agencies to develop defined plans for implementing and assessing safety with electronic records.<sup>1</sup>

Message fatigue is another hindrance to the improvement in patient safety. Recently, I prescribed a short-term benzodiazepine to a patient with insomnia. In the same patient's social history, I had entered "denies" under alcohol use. The system was only able to notice that I had pulled "alcohol use" into her chart, not that it was in the negative. The flagged interaction between the sleep agent and her "alcohol use" was unnecessary and led to several clicks before the prescription could be activated. When we frequently see inaccurate warnings, we are likely to skim past them in an effort to maintain efficiency.

**Preventive Care and Chronic Disease**

EHR vendors have long touted the improved ability of the electronic record to remind physicians when screening studies are due. The days

continued on page 2

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## IT ROUNDUP: PART I

continued from page 1

of flipping to the radiology section and realizing a mammogram is more than one year overdue were said to be long gone.

But this, too, appears to be cumbersome in the EHR. While the system is designed to remind the clinician, the interval of reminders and past studies needs to be entered for each patient individually. EHRs, despite being “intelligent,” are unable to anticipate whether you are following the guidelines of the US Preventive Services Task Force, American Cancer Society, or some other professional organization. The

amount of data that needs loading has been a significant impediment in our own optimal utilization of this health screening reminder system.

The management of chronic disease is fraught with the same issues. Some markers are easily tracked, such as HgbA1c. Others, such as stress levels following a myocardial infarction, are harder to quantify to establish standards of care. The EHR does make an attempt to set reminders for all clinical conditions, which can quickly amplify the message overload concern described above.

In case you are unsure, I *am* a proponent of the electronic medical record. I believe its usefulness and potential are extraordinary. It does, however, come with some struggles that cannot be ignored if its clinical value is to be optimized.

### References

1. Health IT and patient safety: building safer systems for better care. <http://www.iom.edu/~media/Files/Report%20Files/2011/Health-IT/healthITbrief.pdf>. Accessed January 23, 2012.

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