

The Electronic Health Record: Hopes and Cautions

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...we should determine what we wish to accomplish in order to improve health and then use the technology as needed to help accomplish the aim.



According to the US government's Office for the National Coordinator for Health Information Technology, "health information technology (health IT) makes it possible for health care providers to better manage patient care through secure use and sharing of health information."¹ As general internists, we may be uniquely positioned to recognize both the opportunities and the pitfalls of health IT.

When I think back over the past couple of decades, it is truly amazing how much clinical practice has been affected by health IT. The transition from paper to electronic medical records has greatly improved the availability of information to the numerous members of different health care teams (e.g. inpatient, emergency, and ambulatory teams). Having always practiced in large multispecialty settings, I can remember clinic days when only 50% to 60% of the patient's paper medical records arrived at the clinic prior to the appointment time. This led to many opportunities for exercising the provider's memory—but also many opportunities for mistakes. The situation was not much better on the inpatient side, with the chronic problem there being the inability to find the chart in reasonable temporal proximity to one's visit to the bedside—leading to numerous unnecessary return trips to the wards.

So when our institution decided to commit to an electronic medical record some time ago, my initial thoughts focused on how wonderful it would be to almost always be able to have access to the notes,

lab results, imaging reports, and myriad other pieces of data needed to care for my patients. I did not comprehend for some time the many other ways that health IT would provide opportunities for improved care. For example, I now have access to all my patients' immunizations if administered anywhere in the state of Wisconsin and can see glimmers of a future when I will be able to see the entire care record for episodes of care taking place anywhere in the country.

Similarly, health IT has opened patient records to the patient. My institution has a patient portal that permits patients to view their problem lists, medical/family/social history information, medications, allergies, selected test results, and immunizations—almost anything other than notes. Former SGIM President Tom Delbanco is actively studying the consequences of permitting patients routine access to their medical notes,² which I suspect will become standard practice.

Less anticipated benefits have been the changes in workflow attributable to the health IT system. While careful scrutiny of exactly who does what and in what order may be a painful process to undergo, I am convinced that this process can increase the efficiency of the care we provide. An unanticipated benefit for those of us residing in Wisconsin has been the fact that the large EMR firm Epic is located here, and its growth has led to a kind of full employment plan for many college graduates in this state.

I have to say that my initial expectations of health IT were so low

that those expectations have largely been met, even exceeded. The patient data I need (at least data from my own institution) is almost always available, I can use the chart while other team members also use it, and the ability to have access to data while covering for other colleagues has been wonderful. The challenges now have to do with pitfalls that were typically not anticipated in the past and the greater expectations that have developed now that we are gaining a clearer vision of what may be possible in the future.

For example, we now understand the incredible temptation to import material gathered or created during prior clinical encounters into a current encounter. The ability to do this is sometimes a benefit to the patient. However, this temptation is leading not only to poor communication (via rambling "cut and paste" notes) but also the inflation of billing levels and allegations of fraud.^{3,4} Another example of an unanticipated pitfall is the fact that alerts for possible errors have become so common that they are sometimes ignored, leading to suboptimal care.

Brad Crotty, SGIM Council associate member representative, is developing a plan for an SGIM Health Information Technology Task Force. As envisioned, this group would help the Society's members conduct research related to IT; improve their clinical use of IT; better engage patients in IT; and examine health disparities, professionalism, and education related to the role of health IT. Please contact Brad at

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crotty@post.harvard.edu if you have ideas or would like to be involved.

When thinking about the potential uses of health IT, we need to be careful not to be a slave to the technology. Rather, we should determine what we wish to accomplish in order to improve health and then use the technology only as needed to help accomplish the aim. For example, Tom Delbanco's goal of increasing transparency in health care may be accomplished in part by the availability of electronic records, but the electronic records are not what *drives* that goal. This point is also made in the excellent management book *Good to Great* by Jim Collins.⁵ In describing empirically based research on the characteristics of companies that outperformed their peers, Collins observed, "The idea

that technological change is the principal cause in the decline of once-great companies (or the perpetual mediocrity of others) is not supported by the evidence. Certainly, a company can't remain a laggard and hope to be great, but technology by itself is never a primary root cause of either greatness or decline." We must continue to be driven by our vision for better health and better health care outcomes rather than by the availability of alluring technology, including health IT.

References

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