

## **The Electronic Health Record, does it make our records better?**

The patient's medical record has changed dramatically over the last many years. There was a time that the medical record had a fairly simple function. It served as the guide to what the patient was experiencing, the diagnosis, and to document the treatment and plan for further care. In its ideal form, it clearly represented what was done and served as a communication tool to others involved in the patients care. This no longer seems to be its primary function.

I recall one of the most useful areas of the patient chart in the hospital was the hand written nurses notes of what happened since the last time I saw the patient. There was real clinical information there. However when our hospital switched to computerized nursing documentation, the value for me as a clinician was taken away. I am now seeing that happen with physician notes and consults as more and more are moving to electronic health records.

The medical record has morphed into much more than a clinical document. It is very clearly a medical legal document. Every word, lack of work, punctuation mark, smudge or smear can be analyzed to use in liability claims. It is a document used for disability claims, accident claims, workman compensation claims, and many other aspects of our legal system. It is used to justify FMLA, whether a patient can have a motorized scooter, whether they can have diabetic shoes, how often they are allowed to test their blood sugars. (I need to rant here... why should I have to write a prescription or fill out a form for diabetic shoes? Do I need to inform my patients of side effects of the diabetic shoe? Will they interact with other meds? Will my patient abuse use of the diabetic shoe or accidentally overdose on diabetic shoes?... sorry, back to the point...) The medical record is a repository for all the documents we have to sign as physicians to take medical legal responsibility (whether we said it was ok to go on a diet plan or join a fitness club). We have to keep our HIPAA, Privacy and other government imposed documentation in the medical record. It is also a repository for living wills, MPOA, and other advanced directives.

The medical record is used for a payment document. Our reimbursement is dependent on there being enough bullet points, complexity scores, procedure details, time documentation, systems analysis and number of diagnosis. None of this of course has anything to do with whether we did the right thing for our patient (this indeed is another topic entirely). By the way, I wonder what other business outside of health care has to spend 6-12 percent of its income to get paid?

With the implementation of electronic medical records I am now seeing 3-5 page notes that I have to sift through to find out what the clinical impression is and what was done.

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I swear sometimes that information is not even in there. I am sure all the reimbursement bullet points are there and the medical legal documentation is there but the clinical information is missing.

There have been many outside forces that have influenced the form, function and details of the medical record. In attempts to deal with this, the Electronic Health Record can be a useful tool. I am a proponent of the EHR and all it can do to facilitate caring for patients. I suspect there are many that feel this is being forced upon them and are not finding the EHR easy to implement. I encourage each of us, as physicians, to look at our records and make sure the clinical relevancy is there, and not allow the external forces that we have to deal with corrupt how we communicate to each other on the care of our patients.

As always welcome your comments at [briveland@mcmsonline.com](mailto:briveland@mcmsonline.com)

See you next month.

**Brian R. Riveland, M.D.**

**President**

*"Don't part with your illusions. When they are gone you may still exist, but you have ceased to live". Mark Twain*