Don't Drink the Kool-Aid

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I did and not just a little. I guzzled the entire Jim Jones carafe full of it. I was an early electronic health record (EHR) adopter and I loved it! In fact, I still do; however, as with any Kool-Aid (particularly when it's served in Guyana), you can't just guzzle it and hope for the best. You have to know what is in it or else it can bite you. Here's how you can be bit.

Improper Result Queuing

Say, for example, that you order a lab test on a patient that comes back abnormal—a serum potassium of 6.3. The EHR is set up such that abnormal results are first routed to the back office technician, who has to click on the result and then enter an action such as "referred to the provider." What happens if the software has a bug or glitch and the queuing to the technician fails or the result is not labeled as abnormal? Most providers would incorrectly opine that, "the EHR vendor is to blame."

The Health Insurance Portability and Accountability Act very specifically lays challenges related to maintenance of the integrity of the EHR on the health care provider, not the EHR vendor, consultant or integrator. A careful review of your vendor's contract likely states that the vendor has no liability for medical malpractice issues related to the EHR.

From the perspective of a plaintiff's attorney, if you purchased the EHR, you own the responsibility as well as any bad outcomes that result from its use. The take-home point is this: If you find errors, bugs, glitches, document them, report them, and keep a record of it. At the very least, you will be able to show a track record of identifying and trying to resolve the problem. Knowing about a problem and not trying to address it makes you complacent at best and complicit at worst.

Macros

Macros are the tool that was supposed to make our lives better. When you have a patient who presents with a headache and you have a "headache macro," with one click of the button, a complete history and physical can appear, as if by magic. "This well appearing gentlemen presents with a gradual onset of mild headache which is not the worst in his life. He has no other symptoms including visual changes, stiff neck, photophobia, thunderclap onset or weakness." The macro goes on to detail a normal physical including the lack of meningeal signs and a non-focal neuro exam. This is all great and will be applicable 99% percent of the time – until it isn't.

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The nurse notes the following: "48 year old female in acute distress secondary to pain. She reports an acute onset of 10/10 head pain after defecating. She states that her neck is sore and feels 'stiff.'" In addition, she complains about double vision and she feels like her R foot is dragging.

The patient goes on to have an acute subarachnoid "sentinel" bleed with a very large SAH 8 days later. A review of the medical record shows the discrepancies in the notes and, given the patient's outcome, the jury believes the nurse's documentation. What went wrong? In your haste to move patients in your busy center, you forgot to make the changes to your macro and instead simply clicked on the stored version of the macro and moved on.

You may have obtained the correct history and done the actual exam, however, your note reflects a completely different patient and scenario. Despite your testimony to the contrary, the medical record reflects the charting discrepancies. What happens next? Your med mal carrier writes a check.

Cutting and Pasting

In an effort to spend more time with patients and less time with our noses in our computers, many providers have turned to cutting and pasting from a previous encounter to a current encounter or from one patient to another. It's understandable;

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after all, how logical is it to simply type the same thing over and over? Cutting and pasting makes intuitive sense.

The challenge, of course, is if you cut and paste something incorrectly or that is not an accurate reflection of the current encounter. I have seen a number of charts that were clearly not reflective of the current patient encounter or even of the correct patient.

When this happens and a medical misadventure occurs, the provider and his or her attorney have an incredible uphill battle. The provider is always the responsible party for failing to completely review the medical record and make decisions about care based off the medical record. In *Short v. United States* the court held that the physician violated the standard of care by failing to review the patient's past visit notes, which, had the provider done, revealed the complete nature of his medical problem.

Less Face Time

Generally, inputting data into an EHR takes up more provider time, which means providers may be spending less "face time" with patients. Patients complain about the depersonalization of inserting a computer into the physician – patient encounter. Providers who spend less time with patients and more time during encounters with their heads down typing may be perceived as not caring, which could lead to patients filing suit when they are dissatisfied with their outcomes.

Meta Data

Generally speaking, EHRs track every key stroke, erased or pasted text and who was in the record and when. If you are notified about a bad patient outcome on a patient who was treated yesterday and you go into the chart to "make an addendum or add additional documentation" it is easily tracked and traced. If you do go into a record, date and time the addition or deletion in an actual note so that it does not appear that you are trying to manipulate the information to paint your care in the best light.

Plaintiff's attorneys always subpoena the metadata and typically retain an expert to evaluate that information in order try to impeach the provider who attempts to alter the record.

Meaningful Use

For an EHR to qualify as meeting Meaningful Use, it has to meet a number of criteria. One criterion is that drug–drug interactions and drug–allergy interactions are checked. If hundreds of thousands of providers are now, because of their EHR, automatically checking these, does a failure to do so mean that the provider who is not using an EHR certified as meeting Meaningful Use or who does not check for interactions has fallen below the standard of care?

For example, suppose you have a patient who presents after an ankle injury and you correctly diagnose an ankle strain. The patient has a history of depression and is on a selective serotonin reuptake inhibitor (SSRI). You place the patient on a nonsteroidal anti-inflammatory drug (NSAID). One week later the patient has a massive gastrointestinal (GI) bleed and dies. Did you know that the risk of GI bleeding is increased in patients on SSRIs and NSAIDs? Or, let's say that you see a patient who is complaining of vomiting and diarrhea. You check the individual's electrolytes and notice that the patient's potassium is 5.0. You correctly believe that the patient is not losing a significant amount of electrolytes and does not require aggressive intervention. You fail to find out that the patient was recently placed on an angiotensin-converting enzyme inhibitor along with their spironolactone. Are you aware that patients on this combination of drugs can develop severe or fatal hyperkalemia?

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Was it below the standard of care that you didn't know about these interactions and thus did not inform the patient? What if hundreds of thousands of providers would have made the connection because their EHR was Meaningful Use certified and warned of the interaction? All of a sudden your failure to inform the patient about a relatively rare interaction falls below the standard.

Conclusion

EHRs are here to stay – thankfully. With technology, however, comes additional challenges and responsibilities. For all the great things technology adds to patient care, it also adds some new wrinkles. Here are some take-home points to avoid simply guzzling the Kool-Aid:

1. Understand how your EHR works, its limitations and bugs.
2. If you identify a bug or glitch, notify the vendor and keep a record of the interaction.
3. If your EHR does have some pitfalls, identify them and develop work-around processes — even if they are manual.
4. Don't cut and paste from one record to the other or one patient to the other.
5. If you use macros for charting, make sure you review them prior to signing the record.
6. If your program does come with "best practice" suggestions and you ignore them, simply address the reason why in the medical record. ■