The electronic health record: Getting more bang for the click

The promise of the electronic health record (EHR) has not yet been realized. I find it extremely beneficial to have access to shared, accurate information during each patient encounter, but my expectations are still far ahead of reality. We should demand more-flexible software with more clinician-tailored utilities—more bang for the click. However, we users also need to improve.

Benefits and challenges of computers in the examination room

With the EHR, the monitor and keyboard have been interposed between the physician and patient. Physicians now must type or dictate their office notes, enter electronic orders and prescriptions, and remember to use specific phrases to fulfill compliance regulations. Many physicians have to see more patients in less time while incorporating the EHR into each visit. Under these new pressures, some have chosen to retire early or to drastically change the scope of their practice.

I too experience these challenges. I have more electronic tasks to do during each visit and wonder if this is really the best use of my time. I run even further behind than I used to, and I almost uniformly have to apologize to my patients for being late. I am not the world's best typist. Patients note my clerical challenges, and some of them offer to type in their information for me—a bonding experience I could do without.

Lest the computer become the primary object of my attention, I push back from the keyboard intermittently, with my hands in my lap, or make physical contact with my (human) patient. I try to make eye contact as we converse, and patients leave with a legible—albeit possibly misspelled—summary. During visits, I can share graphs of my patient's lab tests or vital signs over time, and I hope that more sophisticated EHRs will correlate this information with medication changes and other events. I have less work to do at the end of the day than I used to, since during my clinic time, multitasking as I go, I send prescriptions to pharmacies, review test results, and send letters to my patients and their referring physicians about their test results and my suggestions. I encourage patients to e-mail me directly with their questions or problems as they arise—an opportunity that many have used and none have abused. Technology is not all bad.

How the EHR needs to improve

The EHR is still evolving, and it needs to be better honed to the needs of the user. My EHR still does not give me reminders for routine screening and monitoring. It is not yet tailored to the specific problems shared by many of my patients. It does not yet provide snapshots or specifics about tailored measures of quality of my practice.

As nicely summarized by Dr. William Morris in this issue (page 410), we need to get the EHR to work for *us*, not mainly for those responsible for billing and regulatory compliance. But all groups can be served equally; "alerts" can be activated as screen pop-ups to drive physician behavior towards best practice—with the caveat that alerts must be meaningful, triggered intelligently, and individualized to avoid pop-up fatigue.

In addition, as Dr. James Stoller discusses in this issue (page 406), the solitary work

doi:10.3949/ccjm.80b.07013

involved in using the EHR has also affected the natural collegial interchange that took place around the chart rack in the past. He, Dr. Morris, and I agree that direct physician-physician communication has diminished in our medical centers. But I believe that this is the result of many pressures, not simply the renewed emphasis[1] on the physician's role as scribe and more-cloistered physician keyboarding. We all extol the value of the phone call and face-to-face conversation between consultants and primary care providers, and at times this is necessary to reach decisions of care. But physicians are more strapped for time than ever. In this era of the "flash mob" and instant texting and tweeting, we should be able to promote effective digital dialogue between physicians. We should embrace and facilitate digital communication.

How physicians need to improve

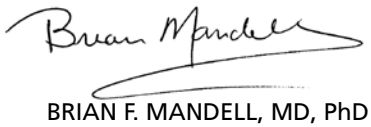
I see many copy-and-paste reiterations of semi-irrelevant (and I suspect, usually not independently confirmed) details of social history and physical examinations from visits gone by. I read completed templates with information that clearly was not collected at the time of the encounter. The potential for misuse and misrepresentation (even without any malevolent intent) with the use of templates and copy-and-paste functions is apparent. These bad practices must stop.

Another problem: some of my colleagues do not read their messages regarding forwarded charts or patient questions within our EHR—"It is just too many e-mails to check." This reluctance to fully connect in cyberspace is perhaps a case of failing to teach old dogs new tricks, and we do have too much e-mail. But I think it is also partly a result of paranoia over maintaining confidentiality of patient-related communication, at the expense of the efficiency of digital communication. The forwarding of EHR messages to our office e-mail system and phones is blocked by a firewall to ensure privacy—but this makes necessary medical communication more difficult. Is this the right trade-off? If the EHR is to become the hub for tracking patient-centered care, we need to use it to our advantage and to ease access to all aspects of the EHR from multiple venues.

Even when read, our notes leave much to be desired. Beyond the problem with copying and pasting of earlier notes, paragraphs of unfiltered, often irrelevant or untimely lab and imaging reports are repeatedly inserted into multiple notes, while a clearly expressed impression and plan are often nowhere to be found. Some of my colleagues dictate their notes with a delay before uploading, without any concise placeholder summary in the EHR, or they have an assistant or trainee enter a summary, without the nuanced explanation that I need to fully understand the consultant's reasoning. These behaviors negate the potential power of the EHR.

Bemoaning the new technology and developing work-arounds is not the answer. We need to refine the clinician-computer interface,[2] and we need to do much better with our documentation.

The basic principles of physician communication are as important now as they were 50 years ago, when notes were illegibly written with pen and paper and discussed by docs seated around the chart rack in the nursing station. We need to take ownership of the EHR and to insist with other stakeholders that all aspects work better for us and for our patients. This includes the software and, maybe more important, the user.



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1. **Siegler EL**. The evolving medical record. Ann Intern Med 2010; 153:671–677.
2. **Cimino JJ**. Improving the electronic health record—are clinicians getting what they wished for? JAMA 2013; 309:991–992.