Aside from eroding the invaluable doctor-patient relationship by monopolizing the clinician’s time for data entry, fragmenting access between institutions when patient sharing is commonplace and functioning more as a billing platform than a therapeutic asset, electronic medical records (EMRs) have not lived up to their promise. Though the concept seems like a panacea, patients and doctors don’t live in a theoretical world. They live in a real one.

In this real world, each action has consequences. Some good, some bad. Hence, why the actual implementation of such a disruptive force as EMRs need also be held accountable for the adverse effects it generates. This so-called solution, created a host of new problems with more infrequent benefits.

But, here, the focus will be on the additional anxiety and panic they cause patients that is rarely if ever addressed.

Something intended to expedite care, wound up more routinely impeding it.

With this cultural shift of an ever increasing appetite for data collection and immediacy of information consumption, there is a faulty notion perpetuated that more and faster is better. This instant gratification epidemic doesn’t do much to help children become highly functional adults, so imagine what dilemmas and turmoil ensue when its emphasis is central to the medical realm.

In medicine, often less is more. When it comes to information, my standard refrain is “good information can save lives, while bad information can end them.” Occasion for watchful waiting can be an optimal plan. Allowing medications to be effective might not be an overnight event. In alternate scenarios, urgent and aggressive intervention is ideal. While in others, trends over time carry the greatest influence in decision-making. Once again, one-size-fits-all offers no superior
prescription.

Poorly obtained data can literally do harm. Poorly understood data can lead to unnecessary worry, inaction or erroneous decisive action that in some instances is irreversible. Take, for example, interpreting testing and laboratory values.

In pre-EMR living, a physician would order a test. They would pursue the result and discuss it with the patient extensively to ensure understanding, review its meaning and together would determine a treatment course. They would make copies for the patient if so desired and have further conversations as well as follow-up examinations that would generate more thorough intelligence. Together, the process and outcome would be entirely focused on the best interest of the patient.

This form of shared decision making is actually shown to yield improved outcomes.

In the existing EMR world and with the advent of direct-to-consumer “genetic” testing services advertised to fulfill curiosities that provide often unsubstantiated probabilities of disease without any accountability, counseling or appropriate interpretation, the train has left the station in terms of limiting access to good, useful data. The impact on the patient or consumer is a profound one—for better and worse.

Due to patient access to electronic health records which is overall a very desirable occurrence and positive influence of the technology, patients are receiving lab results and the like without adequate interpretation or in advance of talks with their doctor. The result is often panic typically from seeing lab tests outside of reference ranges, for instance, or language from radiologists that sounds scary and is entirely without context.

There are reasons it requires a medical license to order these procedures, labs or imaging modalities. Each has a risk and benefit that can put a person on a trajectory of further potential harm or help. Putting appropriate pieces of the puzzle together to formulate an accurate diagnosis requires doctoring. It is expressly here that interference in the doctor-patient relationship leads to suffering.

Though some institutions have systems in place where these findings must first be signed off by the physician, this is not universal. Additional worry should be avoided when possible in the patient experience.

Reference ranges can be variable between labs. Physicians might trust the methods of one entity more so for thyroid testing than another facility, but not have issue with other studies and so forth. Simply because a test says “high” on the lab sheet doesn’t mean that that applies to that patient. For example, newborns have higher levels of bilirubin than adults as their normal given their immature liver systems. Most lab results will indicate an out-of-range result due to adult reference ranges. This is where the doctor’s background and expertise come into play to interpret the findings and put them into context, sparing the patient and family preventable worry.

Medicine like law and other professions has its own language. Understanding a physician’s population depending on specialty and the individual patient’s comprehensive clinical picture are essential to interpreting radiology reports, findings and sufficiently appreciating nuance. If viewed in a vacuum with an untrained eye, then a skewed comprehension can arise and complicate the
healing process.

As a patient, seeing these results without the proper contemporaneous analysis can lead to delay in care from self-diagnosis and misguided self-referral, unnecessary anxiety and stress along with exposures to unwarranted interventions.

In the end, letting doctors be doctors and patients be patients—who together meaningfully address their concerns and determine an appropriate course of action—not only serves their physical well-being, but also their mental health. Recognizing the limitations of technology in this sphere along with appreciating its enhancements, can require a modestly delayed gratification. Though a big supporter of streamlining the fragmented nature of electronic medical records, improving patient access to their own medical information as well as uniform provider access, maybe waiting an hour or a day for a complete picture in a non-emergent situation could be in all of our best interest.

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