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Me and My Electronic Health Record

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My recent physician visit was a reminder of the absurdity of my electronic health record (EHR).

Much has been written on the failed promise of the EHR for physicians[1,2]: the shift of gaze and focus from the patient to the computer[3]; required redundant and nonsensical tasks[4]; significant added time[5]; and associated frustration, burnout, and early retirement or career change.[6] In contrast, no published medical literature assesses how U.S. patients directly experience using the EHR. Designed in large part as a billing tool, the EHR disrupts, complicates, and may broadly shape clinical consultation.[7] Indeed, foreign EHRs from the same vendor are far simpler and less cumbersome than in the United States, likely due to fewer reporting and billing requirements.[8]

Online patient communication with physicians, record access, and appointment scheduling are real advantages. But in my experience, despite being insured through a Health Maintenance Organization with a large network encompassing an excellent hospital, numerous generalists and specialists, and affiliated out-of-network practices, the EHR has failed me miserably in many respects.

Going "Paperless"

Over the years, as my physicians' offices went online, I held out hope that the required completion of paper forms and receipt of printouts would become a thing of the past. Instead, at check-in I routinely receive a clipboard of multiple forms (each office has its own version) demanding data already in my EHR (e.g., contact information, insurance data, and history of medical diagnoses); Health Insurance Portability and Accountability Act (HIPAA) compliance forms; and payment information. I routinely received HIPAA form copies, a payment receipt, and pages of my after-visit summary (AVS) (listing medications, visit findings, and details on problem management). Happily, the HIPAA forms no longer appear at every visit, and some AVS are online-only, but the redundant forms required at check-in largely remain. Patients could directly update all of this information in the EHR. So much for a paperless utopia.

Physicians should bear in mind the inefficiency, redundancy, and annoyance of paper forms required of patients and, where possible, complete a transition to a fully electronic approach. Office, hospital, and legal requirements should be updated to the electronic era.

My EHR Medication List

Until recently, at each consultation, the medical assistant (MA) would inquire about individual medications that read like an archaeological dig. It included medications prescribed on a one-time basis, for a problem long since resolved, or for a drug I had discontinued. The medications simply accumulated and also appeared on my AVS. I would dutifully set the record straight, but the problem persisted. When I inquired why the drugs remained on my list, the MA replied that my doctor could differentiate which were historic versus current, yet the doctor would often run down the list with me again. Once, when I asked the MA if the list could be corrected, she replied that it was possible, but many MAs either did not know how or did not take the additional time to do so.

Frequently, medications on the AVS were confusing and I had to call my physician for clarification. Should I add the new medication to what I was already taking or only take the new medication? It seemed a potentially dangerous oversight to retain this endless pharmaceutical baggage and I wondered how it played out for other patients. Lately, the problem appears to be fixed, at least in my network. But what of the avoidable damage done without a reasonably accurate medication list, and how many other EHRs still have this serious problem?

It would behoove physicians to help ensure that medication lists are up-to-date and accurate and to make certain that instructions regarding new medications, stopping

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current medications, and side effects are clear as well as summarized in the AVS.

My Medical "History"

Like everyone, I endured the seismic disruption when my physician's practice shifted to an EHR. The EHR kidnapped my formerly focused, clever, and empathic doctor: she spent more and more time gazing at her computer, speaking to the screen, repeating questions, tapping keys, muttering to herself, and retaining less and less about me, her patient of many years. She told me my medical history would not fully migrate from my paper chart to my EHR, that she had spent hours entering what she believed was the most salient data on all her patients, but she had doubtless missed things. She encouraged me to let her know of any important omissions. My medical history became a bizarre patchwork that has only worsened over time with yawning gaps and an excess of information that is relatively unimportant, outdated, irrelevant, disconnected, or just plain incorrect.

My most recent consultation required a significant investment of online time in advance of my appointment: confirming my contact and insurance information, answering a variety of coronavirus disease exposure-related questions, and reviewing my medications and conditions. I was pleased the contact and insurance information would obviate completing paper forms, thanks to the pandemic.

However, I was taken aback by my problem list. I appeared to be a total wreck, with an abundance of diagnoses, symptoms, and findings that in no way reflected my reality. It contained archival footage, such as the osteoarthritis of my right hip, for which I received a total hip replacement five years ago, and carpal tunnel syndrome despite the successful corrective surgery performed on my right hand 12 years ago. Neither surgery is indicated. Fully eight symptoms and signs related to a relatively minor upper gastrointestinal (GI) problem that ultimately resolved on its own are individually itemized. The associated GI symptom dates are correct, but are not explicitly linked to one another or, more sensibly, collapsed into one past problem. Several of the entries, such as chest pain, would be cause for concern unless you understood that it was mild and transient discomfort rather than pain, related to my upper GI problem. Several of the entries are incidentalomas found when screening for my GI problem and are not serious. The dates for the majority of the remaining entries reflect when the information was posted, with no bearing on the date of diagnosis. It is a challenge even for me —a very organized person—to reconstruct an accurate history. I requested irrelevant issues be removed or noted as "past" or "resolved," yet they remain, irritating me and presumably confusing my doctors.

Perhaps equally stunning is the incomplete or absent medical information from several specialist consultations. My gynecologist of many years retained his own EHR, and information on annual tests is either missing from or incomplete in my network EHR. There are no records in my EHR of my consultations with orthopedists or with my podiatrist.

My medical group joined a teaching hospital where I have received outstanding care, but the EHRs for my medical group and the teaching hospital are separate and do not fully communicate. The hospital has none of my vaccination history and routinely alerts me to my overdue immunizations. My medical group EHR is missing information regarding visits to and diagnoses from hospital specialists. Thus, the picture of my health is even more fragmented.

While I understand that physicians see a different, and hopefully better organized, view of my health record, my EHR data should be accurate and consistent with that of my physicians. The patient narrative, core to a physician's work, is compromised by the EHR.[7]

Physicians have the unenviable but critical job of constructing an accurate patient history from an EHR system that is not designed for this purpose. Sufficient time must be dedicated to elicit, record, update, and clarify the patient's history to foster accurate diagnoses and optimal management. Although EHRs would surely benefit from a more provider-friendly design, physicians and other practitioners should seek and receive adequate training and assistance with EHR functioning, including updating medication and problem lists. In addition, fully sharing physician notes with patients (open notes) has been found beneficial to varied patients for managing and feeling in control of their health and understanding their care plan.[9] Ideally, patients can suggest additions and corrections to these notes. Investing in these efforts can prevent unnecessary or inappropriate tests, treatments, interventions, and referrals.

We have a highly dysfunctional health care system that often prioritizes profit over high-quality clinical care and patient understanding. Many aspects of EHR architecture reflect these priorities. Incorporating simple changes to the EHR to improve physician usability,[4] as well as engaging practitioners to provide a rigorous review of EHR processes and implement changes based on this feedback,[10] will go a long way toward resolving ongoing challenges. Patient surveys on EHR use, such as Norway conducted,[11] would further inform and improve the patient experience. As I age and my health history becomes more complex it pains me, figuratively and literally, that I cannot rely on the muddle portrayed in my EHR to depict my medical story. I look forward to the day that my EHR will enable me and my physician to manage my health together—accurately, efficiently, and meaningfully.

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Author Biography

Rani Marx, PhD, MPH, is an epidemiologist with expertise in health services research. She launched the Initiative for Slow Medicine to examine the care experience and outcomes associated with giving physicians as much time as needed with patients. For 24 years she worked at the San Francisco Department of Public Health where she led research on care needs, access, and quality among HIV-infected and at-risk individuals, and on primary care organization and quality. She previously studied sociomedical aspects of sexually transmitted infections, trachoma, and tuberculosis.