

Electronic medical records - a great idea gone wrong

by Dr. Delia Chiamonte, [Baltimore Health Examiner](#)

I am worried about electronic medical records. Not because they are expensive for doctors to purchase or disruptive to implement in a busy practice. Not even because they insert a computer screen into the relationship between the doctor and the patient. No, I am worried about electronic medical records because they make it too easy for doctors to chart things that simply aren't true.

This may come as a surprise. Shouldn't a computer chart be MORE accurate than a hand-written one? We all know about doctors' handwriting, after all. The onscreen records are easier to read, but it is hard to know if what you are reading is actually the truth.

What started as a convenient time-saver in theory has become a serious liability in practice. Most electronic medical records have default settings that list many of the normal findings that a doctor might choose to include in the chart note: lungs clear, no rales, no dullness to percussion, for example. The doctor might just click on 'normal' for that organ system, the lungs in this case, and several specific negative findings will appear.

This is a terrific convenience if it accurately reflects the examination that the doctor performed. But in the above example, if the doctor listened to your lungs yet didn't tap (percuss) on your back, the chart note would be inaccurate. In order to be precise, the doctor would have to specifically delete "no dullness to percussion."

Would it be surprising if a stressed and harried doctor forgot that step? I have seen this in my own practice and it concerns me deeply. Patients will bring me printed copies from their electronic medical record and mention that their doctor never performed parts of the documented exam. I believe them.

It is the rare doctor who will chart an intentional mistruth in his or her own hand. If a doctor records in messy script "heart with regular rate and rhythm. No murmurs," then I believe that he listened carefully to that patient's chest. But if the electronic record says "strength normal in bilateral lower extremities, patellar and ankle reflexes normal and symmetrical," I don't know what to believe.

In the course of a standard, general exam the ankle reflexes may not be tested. So what should I think if I see them recorded as normal in the medical record? Was this doctor simply more complete than most other doctors? Maybe he did check the ankle reflexes. Or maybe, just maybe, he simply checked "normal neurological exam" and forgot to delete the sections that he didn't perform.

Medical records are taken as gospel. Doctors make medical decisions based on them and communicate with each other through them. Lawyers pore over them and patients search for answers in them. Medical records are important. They are powerful. They must be accurate.

Dr. Chiamonte is a private Health Advocate and the founder of Insight Medical Consultants. She has been quoted by CNN, The Wall Street Journal and USA Today as an expert on patient advocacy.

www.InsightMedicalConsultants.com