

Thinking Out Loud... Pay Attention!

“With most men, unbelief in one thing springs from blind belief in another.”

—G.C. Lichtenberg, German physicist & writer (1742–1799)

I have often read that an electronic medical record (EMR) can be a barrier that wedges itself between the caregiver and the patient. There are several arguments given in support of this conclusion. The first argument is that an EMR misapplies the caregiver’s locus of attention—that is, the caregiver pays too much attention to the computer keyboard and screen, which are used to enter and view the patient’s visit data, and as a result pays too little attention to the patient. The second argument is that it is easier and faster to hand-write and find information within a paper record than it is to do the same using computerized tools.

I have written several articles that dispute the latter argument. Today’s discussion is with the former argument—misapplied locus of attention. I would argue that the paper medical record, while comfortable and traditional, is more of an impediment to effective communication between the caregiver and the patient than is an EMR. The EMR, in actuality, opens vistas of *communication* with the patient, as it organizes and distributes information *intact* across the entire care team. As a result, it magnifies appropriate attention on the patient.

Consider the following true-life story that occurred while I was my mother’s personal caretaker, from August to December of last year, as a case in point.

A Case for the Electronic Medical Record: An Integral Part of the Care Team

This was the second time that Mom was in the hospital, each stay lasting approximately four days. The reason for each admission was about the same... peripheral pain accompanied by irregular heart rhythms. For the most part, Mom was jovial and definitely brought smiles to her nurse’s face as she responded to the questions on the admission

checklist. The healthcare team seemed to like her, and vice versa.

I watched as her nurse began to review Mom’s orders, test results, current medications, and the progress notes that were sent from the skilled nursing facility (SNF). As she read each page of Mom’s medical record—a large document that was housed in a tight-lipped metal cover—she gripped the already-read sheets in her left hand and held them against the inside of the metal folder, so that they would not shift and fall down on the sheet that she would be reading next.

With head buried deep in the v-shape of the folder’s topmast, the nurse wrote selected notes here and there on another sheet of paper. This was the summary of information that she would need to take care of Mom. During this time of research, her attention was split between reading, writing, and keeping the sheets of paper in balance at the top of the folder... like a member of the Cirque du Soleil troupe concentrating on a trapeze handle as it moved to and fro between performers on the high rope.

I moved closer to the nurse and quietly asked her about the trend of Mom’s test results. She lifted her head, turned to look at me, and stated that Mom’s test results are private information, and that the doctor would discuss them with me later. At that point, she stood straight up, closed the metal folder, and left the room with it in tow.

Never had I felt more of an outsider. I felt unfairly put in my place. Mom had completed the appropriate legal document, a durable medical power of attorney that would authorize me, her personal caretaker, to view her medical record. I had given it and her Advance Directives to the appropriate caregivers at her physicians’ offices, at the hospital during admission, and at the SNF. Now—when it was

Elizabeth Evans is CEO of HII, Richmond, Virginia, the parent company of AMI Healthcare Systems Group, which has been providing clinical and financial software solutions for dialysis facilities and physician practices since 1981, and of HMG, which provides outsourced billing capabilities to dialysis facilities, physician practices, and emergency rooms.

especially important to view her records—an unnecessary, albeit temporary, barrier had been forged with *undistributed* information.

At first, I felt somewhat vulnerable, and then dependent. I thought about the medical scenarios that could potentially develop in which decisions would have to be made for Mom when I was not present. Without knowledge of her wishes that were spelled out in the legal documents I carried at all times in my attaché case, others would not be able to make those decisions as she would have them made.

These thoughts tempered my feelings and correctly focused my mind on what I should do. I grabbed my attaché case and headed to the nurses' station across from Mom's room and requested that the head nurse review her legal documents with me to ensure that their instructions were properly recorded and that Mom's wishes were followed. During our review of the documents, we concluded that a mistake had been made in the assembly of Mom's medical record at the hospital. Upon discovery of this, we reviewed the hospital's medical record for Mom and placed a copy of the two legal documents therein and under the correct tab.

Let's Be Practical, and Dream

Here's what should have happened: The registration information taken electronically at admission, as well as the electronic medical information accrued over time, should have been available across her continuum of care—on a hand-held tablet or on a computer screen. With information at bedside, the EMR would have been the care team's assistant, acting as an information practitioner who, in addition to keeping the patient's medical-legal information intact, also kept her test results up to date and reported outlier results and *evolving, before-their-time* trends that are easier to see—and far easier to research and study—right at the patient's bedside.

It would have removed barriers to the care team's productivity.

In Mom's real-life case, the Durable Power of Attorney and Advance Directives were excluded from her paper medical record because of a clerical oversight. The in-your-face question is, "How many other oversights occur in the medical context of which we are unaware, despite the sincere efforts of conscientious medical staff?" Oversights that could be avoided by entering the data only once in an integrated EMR, with the data then distributed *intact* many times to the care team wherever they reside—in a dialysis facility, at the hospital's nursing station, in an emergency room, at your own family physician's office, after a visit to the specialist.

The envisioned EMR would incorporate universal and standard data fields, such as standard test result codes, standard medication codes, and standard diagnosis codes, as well as non-standard codes specific to the knowledge bank of a specific EMR.

Let's seriously consider their mandate, because it is only when standard data sets rule that we will have the protection of having our own medical information at our side when we need it most—when we are vulnerable and when there may be no loved one to stand by us at the point of medical decision.

Look around yourself and see the human effects of not using technology to assist in this way. See the implications... clinicians caught in the upward spiral of wanting to do things the right way the first time. But then, in the face of resource limitations, seeing that this is not possible, and then feeling something other than success—a feeling that inbreeds itself and morphs to behavior not in alignment with their personal vision.

The Practice of Information

There is an expression... "No one goes to work to do a bad job." While technology is not a panacea for eliminating poor performance, it can contribute to

a model of thought that encourages excellence through *the practice of information*,¹ a notion that is gaining wider acceptance along an adoption curve similar to past improvements in medical technology and practices.

Take modern infection control, for example, compared to its control in the 1800s. Today, caregivers agree that germs can be passed from person to person. Consequently, it is standard medical practice to wash one's hands with antiseptic soap after seeing one patient and before going to the next. This has, however, not always been the case. In 1843... 159 years ago... Dr. Oliver Wendell Holmes, Sr., a well-known physician and writer, was derided by his fellow physicians for suggesting that it was physicians (not chance or a heavenly dictum), by virtue of not washing their hands after seeing a patient with puerperal fever, who were responsible for passing along that infection.

Now imagine 2161... 159 years into the future. How will history look back on 2002 and critique its medical technology and practices—a time when medical practices, for the most part, excluded an integrated EMR from the basic care toolset? As we move along the timeline from 2002 to 2161, caregivers will continue to integrate information technology into their work and redefine the continuum of care as a practice of information.

This *is* the vision that our company, AMI Healthcare Systems Group, has strategized within the TIME[®] System. The reality of this vision removes barriers of communication by keeping the patient's medical/legal information intact and available to the care team. Through the practice of information, the care team will be able to more strongly focus its attention squarely on the patient we will ultimately become.

References

1. Evans EA. The Influence of medical informatics on improved patient outcomes: The TIME System. *Dial Transplant* 1999; 28(2):84-86,99. **D&T**