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ELECTRONIC HEALTH RECORDING SYSTEM AND MALPRACTICE

Interview of the Month

When medical treatment goes wrong and a patient is sickened or dies, it isn't just the doctor or hospital that could be to blame. It could be the fault of the electronic health recording system – a fact that plaintiffs' attorneys may want to keep in mind when they file malpractice suits.

So says an East Coast internist who claims the computerized systems are anything but the revolutionary fool-proof, cost-saving devices hailed by proponents. "I find them on balance to serve up impediments to safe and effective health care and they create problems that never would have occurred under the paper systems they're replacing," said the physician, who's been using computerized systems at his hospital for the past five years.

Case in point: a doctor ordered a twice-a-week dose of Digoxin, a heart medication, for a patient whose kidney failure made it toxic in larger doses. Instead, the patient received double the dosage and suffered heart arrhythmias as well as nausea and vomiting. The internist blames the computerized drug ordering system that limits the physician to a drop-down menu of standardized treatment protocols that can't be overridden for an atypical patient. "I suspect that the ordering physician found something that resembled the dose on the drop-down menu," and the doubled dose wasn't flagged because it's reasonable in a patient without kidney failure. These rigid prescribing limitations "take away the judgment and flexibility of a doctor to individualize care for complex patients with peculiar tendencies."

The systems not only dictate improper care in cases such as this, but the electronic records are so rigidly categorized and compartmentalized that an overview of the patient and the treatment history is cumbersome and time-consuming to access. "There's no search function," the internist said of the system he uses. "So if you had a patient around for five or six years and you want to find out if he ever had an MRI, you can't type in 'MRI' and get the information. So this whole notion of saving money on tests is flawed because doctors find it quicker to order new tests than to scroll through years and years of radiology reports."

Another complication is the automatic transmission of diagnostic test results without notification of medical staff, as opposed to a faxed or delivered document that demands attention. So, for instance, if a patient's potassium level is trending up – but isn't alarmingly high enough for the lab to alert the medical staff – a nurse could administer an ordered dose of potassium without knowing he or she is putting the patient at risk for potentially fatal complications. "Data gets deposited into electronic repositories and nobody knows it's there," the internist said. "It happens all the time. Basically to be safe, a hospital would have to have someone scanning the records all day."

There are other aspects of electronic health records that complicate, rather than enhance, medical treatment, the internist said, including a clinical monitoring function that issues pop-up warnings on the screen which are often "vapid and useless," but doesn't flag potentially lethal dosages or treatment caused by something as simple as a typo.

Government stimulus funds have enticed hospitals and physician groups to convert to electronic records, as part of healthcare reform. But the technology industry that designs the systems continues to resist government regulation and oversight,

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according to reports in national newspapers and websites. "People just assume that computers will make things safer," a safety engineering expert told Huffingpost.com. "While they can be designed to eliminate certain kinds of hazards, they increase others and sometimes they introduce new types of hazards."

The internist believes aspects of electronic health records are useful, but until the software kinks are ironed out, hospitals should use a "hybrid system" that maximizes the benefits of both paper and computers.

"Until the industry is held accountable for the defects and flaws and work-flow interruptions and impediments and toxicity to care that these devices cause, the likelihood is it's not going to get better," he said.

One path to accountability, he believes, is the legal system. "When lawyers examine cases of medical injury and death, they should be cognizant of the likelihood that the EHR and its electronic ordering systems contributed to or frankly caused the injury by any one of several mechanisms and carefully seek out the details of the product liability, especially in unexpected deaths of young and otherwise healthy people," he said.

"Accountability will come from lawsuits."

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