Your EMR Is Watching You

Skeptical Scalpel

A recent article on *American Medical News* titled "Medical charting errors can drive patient liability suits [1]" led with a case involving a bad outcome after coronary artery bypass surgery. The plaintiff's attorney alleged that the doctors did not review the patient's lab results or x-rays because they did not specific say so in the medical record.

The article quoted a defense attorney who said, "By the time [the doctors] are deposed, it's three years later and they say, 'I'm sure I looked at that,' but there's no charting to back it up."

Unless there is something very unusual about the electronic medical record (EMR) used by the doctors in that case, there should be a very easy way to determine if they viewed the results in question.

A feature of every EMR that I am aware of is that each time a chart is accessed, the EMR records who accessed the record, where they accessed the record from, what they looked at and for how long they stayed on a page down to the second. It is like an electronic fingerprint with time included.

When I was a surgical department chairman, I had many opportunities to see how this worked.

For example, I was asked to review a situation in which a resident failed to call for help with a patient who was crashing in the ICU. An arterial blood gas showing severe metabolic acidosis was not acted upon on a timely way. The resident said that the nurse did not report the critical blood gas result to him after the lab phoned it to her. This could not be verified, but the EMR showed that he had seen the result some 30 minutes before calling his senior resident.

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