Electronic Health Records: Patient Care and Ethical and Legal Implications for Nurse Practitioners

Melanie L. Balestra, JD, NP

ABSTRACT

Electronic health records (EHRs), with their adoption incentivized as part of the American Recovery and Reinvestment Act of 2009, are now a ubiquitous part of the health care landscape. Although these systems promised to improve the quality of patient care, increase efficiency, and reduce costs, health care providers are finding that current EHRs instead require time-consuming data entry, can interfere with patient interactions, and cause medical errors. Nurse practitioners should implement practical tips and best practices for navigating and successfully using EHRs, as well as risk management strategies to ensure better patient care and avoid malpractice litigation or licensing issues.

Keywords: best practices, electronic health record, liability, maintaining ethical standards, medical errors, malpractice/disciplinary action, risk management

Melanie L. Balestra, JD, NP works at the Law Offices of Melanie Balestra in Irvine, CA. She can be reached at balestralaw@cox.net. The author has no conflict of interest. This article was submitted on behalf of The American Association of Nurse Attorneys (TAANA).

INTRODUCTION

Health care innovations have had a significant impact on patient care, helping people live longer and with an increased quality of life. New treatments, therapies, drugs, and diagnostics are saving lives daily. Take, for example vaccines, which are among the most important medical advances of the 20th century. Since 1900, considerable declines in morbidity have been seen in 9 vaccine-preventable diseases, including smallpox, polio, and measles.[1] The discovery of antimicrobial drugs was another watershed moment, providing treatment options for bacterial infections.[2] Other important advances include surgical anesthetic and antisepsis, as well as improvements in heart surgery, cardiac care, and radiologic imaging.[3]

More recently, advances in health information technology have avowed to save lives and reduce

costs. Among these advances is the use of computers to track patient records and manage care, thereby improving health quality by reducing errors. Practice-specific electronic medical records (EMRs) were the first sources used to digitize patient information, followed by electronic health records (EHRs), to go beyond standard clinical data collected in a provider's office and include a broader view of a patient's care.[4]

An early study reviewing automation of information showed that patients treated in hospitals that ranked highest in use of health information technology to manage patient records and physician notes were 15% less likely to die compared with patients in lower ranking hospitals.[5] EHRs were found to offer the potential to provide medical practice efficiencies and cost savings. Thus, there also was evidence of early success. According to a national survey of doctors who had complied with all phases of the Centers of Medicare & Medicaid Services (CMS) Electronic Health Record Incentive Program, 79% of providers reported that, with an EHR, their practice functioned more efficiently, and 82% reported that sending prescriptions electronically (e-prescribing) saved time.[6,7]

But now, more than 7 years since the push to include EHRs as part of the American Recovery and Reinvestment Act of 2009, it seems unlikely that these goals will be reached. This was highlighted by the RAND Corporation, which in 2005 predicted that widespread use of EMRs could save $81 billion per year.[8] This report was promoted by the technology industry and used by the federal government to advance the stimulus plan to pay for the installation of electronic systems, only to be followed 7 years later by a new analysis from RAND showing that reduced costs with EMRs had not been achieved. According to the follow-up analysis, "the technology's impact on healthcare efficiency and safety are mixed."[9(p65)] The analysis cited that annual health care expenditures in the United States had actually *grown* by $800 billion.[9]

In addition to unmet cost savings, EHRs are negatively impacting patient care. RAND researchers interviewed physicians who reported that EHR technology "significantly worsened professional satisfaction in multiple ways."[9(p68)] According to the

report, aspects of current EHRs that were "particularly common sources of dissatisfaction included poor usability, time-consuming data entry, interference with face-to-face patient care, inefficient and less fulfilling work content, inability to exchange health information, and degradation of clinical documentation."[10(p98)]

Another study showed that physicians are now devoting more time to data entry than patient contact. A study of physicians using EMRs in emergency departments showed that doctors spent an average of 43% of their time on data entry and only 28% of their time on direct patient contact.[11]

Nurse practitioners (NPs) who routinely use EMRs and EHRs may agree. Rather than supporting patient care, computerized health information systems could create barriers, requiring NPs to act as data entry clerks, thus hindering patient interaction. These systems also could make it difficult to document a note in the patient record, write a prescription, or generate a referral.

With that in mind, this article provides a brief history of EMRs and EHRs, as well as a discussion about concerns NPs may have when using these systems, including patient care, privacy, ethics, and liability issues. In addition, it is clear that EMRs and EHRs are here to stay. So, until the promises of current systems are realized, this article will provide NPs with advice for navigating these systems and maintaining ethical standards, as well as risk management strategies and suggestions that NPs should implement to avoid and/or reduce litigation or disciplinary proceedings.

EHRs

The roots of current EHR systems go back to the 1960s and 1970s, when academic medical centers developed systems with the idea of compiling patient health information so that it could be centrally managed and shared. Development work also was underway by industry and the federal government, which instituted an EHR in the US Department of Veterans Affairs in the 1970s.[12]

This was followed by the Institute of Medicine's analysis of paper health records in 1991 (and with revisions in 1997) advocating for computer-based patient records.[13] Then, in 1999, the Institute of