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CLINICAL VIGNETTE

Stop EMR Cloning – Reclaiming the Integrity of our Documentation

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Introduction

The benefits of electronic medical records (EMR) are numerous, including instantaneous access to health records, legibility of notes, and storage of large patient data.¹ However, the adoption of the EMR has its drawbacks, ranging from duplication of misinformation to medical errors.² It is up to us as clinicians to strive to maintain the integrity of our patients' medical documentation.

Case

A 98-year-old male with chronic systolic congestive heart failure, ischemic cardiomyopathy (left ventricular ejection fraction 35%), chronic atrial fibrillation, moderate aortic stenosis, recurrent c-diff, and numerous hospitalizations presents to clinic for a goals of care discussion. During this outpatient visit, his primary care doctor extensively explores his wishes, priorities and values. This conversation results in the patient's decision to reverse his do-not-resuscitate/do-not-intubate (DNR/DNI) status to full code. This is clearly documented under the diagnosis of goals of care discussion in the *assessment and plan* of the PCP's outpatient progress note. In the following eight months, there are at least 11 outpatient physician notes that erroneously document that the patient is still DNR. This error persists despite reconfirmation of his full code status during two hospitalizations during this period of time. While the patient prognosis is poor given his frailty and complicated medical history, patient repeatedly confirms that his wishes are to stay full code.

Discussion

In a time that clinical productivity and efficiency are a measure of a physician's success, documentation short-cuts are commonly utilized by clinicians, and often viewed as positive EMR features. The EMR provides a seemingly efficient way to *carry forward* information—referred to as *EMR cloning*, defined by Medicare as “copying and pasting previously recorded information from a prior note into a new note”.^{3,4} In other words, the clinician can use yesterday's note for today with minimal if any changes. Our EMR has the capacity to identify “copied text” from prior notes. In the above case, when reviewing the EMR closely, the notes that erroneously document the patient's status as DNR are clearly “copied forward.” While the above medical error did not result in any significant adverse outcome for this particular patient, it is clear that an erroneous DNR

status may result in mortality and/or significant morbidity for a patient.

Studies show that patients being resuscitated against their will when they are actually DNR is rare.⁵ In other words, *near misses* do not usually result in cases where the patient is wrongfully resuscitated. The more common case is when the patient's DNR order is not written given that their end-of-life wishes has not been discussed. Clearly in this case, there was a conversation about the patient's code status to ensure delivery of preference-concordant care. This patient wanted to be resuscitated with complete understanding of the likely poor outcomes post-CPR. In our case, hypothetically, in the case of cardiopulmonary arrest, contrary to his wishes, the patient may be allowed to pass away without any heroic interventions. As clinicians, who strive to provide patient-centered care, we need to regain the integrity of our medical records, especially when it comes to patient's DNR/DNI status. An acceptable approach may be to have more checks-and-balances in the EMR. For instance, the following interventions may be useful:

1. Utilize a bracelet identifying the patient's code status that must be scanned into the EMR at each medical encounter (i.e. visit)
2. Develop flags in the EMR that can/must be updated by all eligible practitioners
3. Automatic best practice alerts in the EMR encouraging clinicians or ancillary staff to reconfirm code status
4. Physician and patient/family education regarding the need to share code status with care team

Another common practice in the current era of the EMR is to auto-populate the patients' note with their past medical history, medications, drug allergies, family history, social history, (physical examination), diagnostic studies, and the assessment and plan. However, auto-populated templates, copying forward information, and incorporation of irrelevant data, has been shown to result in “patient safety errors and medical liability.”⁶ It is important to recognize that the tools marketed as time-saving strategies in the current EMR platforms may develop into bad habits in our documentation, that may carry incredibly high stakes for our patients and their families. It is our duty and responsibility to create strategies to ensure the safety and well-being of our patients.

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