VERMONT MEDICAL SOCIETY RESOLUTION

Electronic Health Records and the Medical Record

Adopted October 19, 2013

Whereas, Based on Sir William Osler's guidance to "observe, record, tabulate and communicate," the basic structure of the medical record is to help the physician to filter, prioritize and provide clinical context out of the disorderly flood of information and observation presented by every patient; and

Whereas, The purposes of the medical record are to achieve four functions—recording, guiding thought, communicating, and teaching— and together they make the medical record a critically important tool in the achievement of the overall goal of medicine, namely, the care of the patient[1]; and

Whereas, Discussions of Electronic Health Records (EHRs) have tended to be dominated by descriptions of their potential benefits, while less attention has been paid to their potential hazards, among which are breaches of privacy, incompatibility of different systems, introduction of computer-based errors, and loss of productivity owing to cumbersome procedures that EHRs sometimes require; and

Whereas, One of the outcomes of EHRs use may be an overreliance on templates and checkboxes and incautious reliance on these tools leads to loss of nuance, a pressure to standardize what is often a highly discretionary encounter, and, perhaps most important, reliance on these tools can lead to a tendency to leave out of the medical record details that may be of great importance to the patient and their care: and

Whereas, Part of the pressure to standardize encounters comes from the nonclinical users of the medical records, and many of these changes reflect a fundamental misconception about the medical record that it is structured data; and

Whereas, The medical record is not data: it contains data – but, a finished medical record is information that has been transformed by the knowledge, skill, and experience of the physician, motivated by the goal to heal, into an understanding of human experience that makes the care of the patient possible[2]; and

Whereas, Most of this rich store of information found in the medical record is not available within the EHR unless it references a printed or faxed copy of the note or is keyboarded, sometimes by physicians; and

Whereas, In order to help address this problem, the Health Story Project has been formed as an industry collaborative working to accelerate the integration of the full "health story" into the EHR using the HL7 Clinical Document Architecture (CDA)[3]; and

Whereas, Since the Office of the National Coordinator (ONC) has focused on achieving a highly structured data set for health information exchange, Health Story has taken the same foundational standards and integrated them into the full range of clinical information, including: consult notes, history and physical, procedure note, and progress notes using a simple standard for unstructured documents using common identifiers and codes that allows for their portability; Now therefore be it

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[1] Foote, R, The Challenge to the Medical Record, JAMA Internal Medicine, July 8, 2013, Volume 173, Number 13
[2] Ibid
[3] http://himss.org/health-story-project

48   **Resolved, The Vermont Medical Society will encourage Vermont's Congressional delegation to**
49   **support the efforts of the Health Story Project to ensure that health information exchange**
50   **standards go beyond a narrow, common data set to encompass the common types of clinical**
51   **records; and be it further**
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53   **Resolved, The Vermont Medical Society will work to ensure that Electronic Health Records and**
54   **other communication applications respect the clinical voice and emphasize the medical record as**
55   **a critical element in providing high quality care to patients.**
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