



One Size Fits Most

A recent holiday gift of a robe with a tag reading “one size fits most” (as opposed to *all*) made me wonder why it took so long for the clothing industry to get it right and also why the electronic medical record (EMR) systems marketed to hospitals shouldn’t be required to attach a similar label to their software.

There is no longer any question that EMRs will replace handwritten patient records for a variety of good reasons that include accuracy, legibility, availability afterwards, and financial savings. In the ED, the cost of illegible handwritten records, prescriptions, and orders is too high a price for patients to pay. In some hospitals, the only clinical department still using paper is the ED, and when an ED patient is admitted, the only part of the record still in the chart rack is from the ED. This means that the ED record may not be reviewed after the patient arrives on the inpatient floor—when the information is needed most and may be critical in understanding and managing the patient’s condition.

However, lagging behind the rest of the hospital is not necessarily the fault of the ED. In fact, emergency physicians were among the first to understand

and embrace the potential of the EMR. So what is the problem?

The problem is believing that for a hospital EMR, one size must somehow fit *all*. I spend a great deal of time trying to explain how and why the ED differs from all other departments and probably an equal amount of time trying to convince everyone that the ED is part of the hospital. Both concepts are relevant to developing a hospital-wide EMR system that includes the ED. The different style, length, and content of ED physician notes are not the main problem. The real issue is the time in which an ED patient must be evaluated and treated (length of stay) compared to that of most inpatients. One or two hours of scheduled or unscheduled EMR “down time” can be tolerated by most of the hospital with little or no disruption or impact on patient care. But in the ED, that same interval can literally be a lifetime. Backup systems such as paper that are acceptable for an inpatient service are too confusing or disruptive to the ED. The ED needs a full backup system, similar to emergency generators that click on after power failures.

But this is where the concept of the ED as part of the hospital offers the second EMR hurdle: It is not enough to have an automatic,

fully functional backup system exclusively for the ED because inevitably, emergency care involves most other departments in the hospital. Lab tests, radiographic studies, and medication orders must be acknowledged, analyzed, and reported back to the ED, so all of these departments and oth-

>> In the ED, the cost of illegible handwritten records, prescriptions, and orders is too high a price for patients to pay.<<

.....
ers must be included in the “ED” backup system. The importance of patient handoffs—in this case, “interfaces,” appreciated by survey and regulatory organizations such as JCAHO—must be incorporated into hospital EMR systems as well.

None of these problems is insurmountable, and none depends on technology not yet available. The only issue is cost. Emergency medicine pioneers who have successfully used EMRs for years have already paid much of the development price, and those who have waited until now can benefit. But the time has come for all of us to add *R* after *EM*. □