## EHR REPORT

# Examining Workflow

BY CHRISTOPHER NOTTE, M.D., AND NEIL SKOLNIK, M.D.

If you have been thinking of taking the plunge into using an electronic health record, you've undoubtedly wondered how the change will affect office productivity. After all, the process of converting from paper records to an electronic health record can take a long time and be quite tedious. Often, subtle roadblocks to success develop along the way that were not anticipated, leading to frustration for both patients and providers. That is why it helps to take a careful look at office workflow and plan ahead before making the leap.

Consider the following five-step plan to help maintain sanity and efficiency as you move forward with the conversion to an EHR:

► **Examine workflow from start to finish.** To some, this might seem obvious, but it is important to remember that patient care doesn't occur only in the exam room. It starts at the front desk, where appointments are made, phone calls are received, and patients are checked in to be seen. Next, the clinical staff takes over, triaging calls or getting patients into the exam rooms. At some point blood might be drawn, immunizations administered, and testing performed. Typically, the process ends at checkout, but often referrals are issued and follow-up appointments are made.

When properly analyzed, even a simple patient visit is made up of a complicated series of events. Ideally, these occur seamlessly, ensuring that the physician's and patient's time is respected. With the implementation of an electronic office, however, any of the aforementioned steps can derail the visit—by nature, any EHR magnifies the interdependence of each role in the process. Therefore, every employee has a part to play to ensure that the algorithm is followed and office efficiency is maintained.

► **Take nothing for granted.** Even the smallest of office tasks can seem cumbersome when translated into the digital age. For example, consider how sticky notes are used in your office. In many, they are a critical communication tool among the staff, and they may or may not become a permanent part of a patient's record. Unfortunately, while it is easy to attach any small scrap of paper to a traditional chart, this is not possible with an EHR. Information must be passed along electronically, and even trivial messages are saved permanently in cyberspace. Also, the process might take longer to perform, as it can be a lot quicker to jot down a note than enter it electronically.

Establishing a new workflow that is practical and efficient needs to take such things into account.

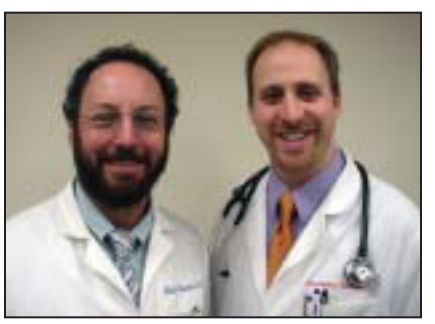
► **Involve others in the process.** Consider involving staff members from each area of your office when selecting an EHR. In addition to the care providers, this may include an office manager, clinical staff member, receptionist, and billing or referral specialist. They should be asked to individually examine and identify the critical steps in their daily routine. They should also be present to interview vendors and test the program, making sure to observe how their piece operates in any given software package.

► **Simulate the new daily routine.** Be sure to ask for a demonstration of all major office functions. Vendors often turn this into a sales pitch, highlighting their program's most attractive features while glossing over its limitations. Suggest several hypothetical complicated scenarios, from triaging phone calls to creating office notes. It is not typical for patients to present with only one concern, and the EHR should be able to accommodate that.

It also should be able to expedite common nursing and administrative tasks and allow all users to manage multiple patients simultaneously.

► **Consider hiring an EHR consultant.** Employing the services of an EHR consultant can be incredibly helpful. It not only provides peace of mind, but also can help you save a tremendous amount of time and money. A good consultant will "interview" your practice, speaking to staff and analyzing workflow, to help you match your office's needs to the right EHR product. He or she can also help to create a timeline for implementation and recommend hardware to maximize your budget and efficiency.

In the end, the cost of hiring a consultant will be insignificant compared with the long-term savings of making the right choice.



*DR. NOTTE (right) is in private practice in Chalfont, Pa. DR. SKOLNIK is associate director of the family medicine residency program at Abington (Pa.) Memorial Hospital. They contribute to EHR Practice Consultants (www.ehrpc.com). Contact them and send questions or desired topics for this column to info@ehrpc.com.*

## LAW & MEDICINE

# Duty to Third Parties

**Question:** Dr. E, an endocrinologist, diagnosed a patient with multiple endocrine neoplasia type I, a rare disorder that is inherited in an autosomal dominant fashion. Dr. E did not inform or counsel the patient's three siblings and two children. Which of the following best describes this situation?

BY S.Y. TAN, M.D., J.D.

**A.** Confidentiality prevents Dr. E from discussing the diagnosis with others.

**B.** Without an established doctor-patient relationship between Dr. E and family members, no legal duty of care exists.

**C.** Were Dr. E a general practitioner, his conduct would have met the standard ordinarily expected of a doctor.

**D.** Dr. E should have provided family counseling after securing his patient's permission.

**E.** Unless physical injury results, there can be no malpractice action.

**Answer: D.** In this case, an endocrinologist would be expected to offer counseling to family members after securing patient consent. This is an example of a physician's duty to "third parties." No doctor-patient relationship is required. Ideally, after obtaining the patient's permission, the doctor should contact family members and advise them to seek clinical and genetic screening.

The law requires that one act reasonably, and for a doctor this means adhering to the standards expected of fellow members of the profession. The requisite standard of care is different for the specialist than for the generalist, and it can be argued that a generalist may not be sufficiently familiar with this rare disorder to offer family counseling. However, the doctor still owes a duty to make a referral to a specialist.

For a malpractice suit to succeed, the plaintiff must prove, in addition to substandard conduct by the defendant, the elements of causation and damages. If no harm can be traced to the negligent act, no cause of action will ensue. However, for the purposes of tort damages, nonphysical injuries such as loss of consortium or emotional distress are every bit as relevant.

In a case such as the one involving Dr. E, a doctor can be found liable to someone other than his or her patient. Sometimes another person, referred to as a "third party," may sue the doctor despite the absence of a doctor-patient relationship. For example, an obstetrician may fail to treat a pregnant woman known to have been exposed to German measles, who then delivers a child with birth defects. A Rhode Island court has ruled that a cause of action could be instituted by the child (*Sylvia v. Gobeille,* 220 A.2d 222 [R.I. 1966]).

In another example, a missed diagnosis of meningitis in a mother led to her son contracting and dying from the disease. The son's estate sued. The appellate court found liability and held that the physician-mother relationship resulted in a special situation for imposing a duty of care for her son (*Shepard v. Redford Community Hospital,* 390 N.W.2d 239 [Mich. App. 1986]).

Similarly, the Supreme Court of Tennessee held that a physician has a duty to warn members of the patient's immediate family of the risk of a disease such as Rocky Mountain spotted fever, even though it is not contagious (*Bradshaw v. Daniel,* 854 S.W.2d 865 [Tenn. 1993]).

A doctor may even have a duty to a total stranger. The best-known case occurred in California, where a court imposed a duty on a college psychologist to warn an intended victim of harm, even though that meant breaching patient-doctor confidentiality (*Tarasoff v. Regents of University of California,* 551 P.2d 334 [Cal. 1976]).

An emerging area of malpractice litigation affects patients who drive. If a patient injures another driver or a pedestrian while taking a prescribed medication, the doctor could be faced with potential liability to the injured party, a total stranger.

The Hawaii Supreme Court recently held that: "A physician owes a duty to nonpatient third parties injured in an automobile accident caused by an adverse reaction to the medication … where the physician has negligently failed to warn the patient that the medication may impair driving ability" (*McKenzie v. Hawaii Permanente Medical Group,* 47 P.3d 1209 [Haw. 2002]). The medication in this case was an antihypertensive drug that caused syncope and loss of vehicular control. ■

*DR. TAN is professor of medicine and former adjunct professor of law at the University of Hawaii, Honolulu. This article is meant to be educational and does not constitute medical, ethical, or legal advice. It is adapted from the author's book, "Medical Malpractice: Understanding the Law, Managing the Risk" (2006). For additional information, readers may contact the author at siang@hawaii.edu.*