

Position Statement by the Texas Medical Board on Electronic Medical Records

Medical record keeping by healthcare practitioners is an essential element of ensuring quality health care for the citizens of Texas. The primary function of the traditional Medical Record (MR) is:

- To memorialize the process of physician/patient care over time
- To manage data related to the care of individual patients
- To provide guidance for those providing future care

The widespread implementation and utilization of EMRs has compromised the Texas Medical Board's ability to provide efficient and adequate oversight to the practice of medicine. As a result, the TMB has adopted this position statement, with the intention to:

- Eliminate impediments to optimal patient care;
- Improve satisfaction among clinicians and patients; and
- Enable the Medical Board's ability to fulfill its duties regarding oversight of cases when evaluating complaints requiring the examination of EMRs.

While the Electronic Medical Record (EMR) was intended to improve patient care, to date EMRs have primarily functioned to administer, structure, and memorialize the individual encounters, which is only a portion of the care process. Since the adoption of EMRs nationwide, this deviation from the initial intended primary function of the EMR to the actual function of the EMR has impacted the patient care process and caused some fragmentation of that process. Specifically, EMRs generate a much larger mass of often-repetitive data which obscures key clinical medical information that is relevant to patient care and continuity of care, thus camouflaging the patient centric and longitudinal data that is crucial for improving the overall health of populations and for evaluating and treating patient-level medical problems.

To fulfil the overall objective of improving patient care while using EMRs, the necessary data elements must be properly identified, recorded, verified, and tagged in order to facilitate: 1) identification of relevant information; 2) accessibility to the information; and 3) transfer of information to patients and practitioners.

Therefore, it is incumbent on healthcare practitioners to be proactive and insure that their EMRs improve patient care by verifying that EMR data/information:

- Reflects accurate and complete information relevant to patient care.
- Memorialize each patient's care over time.
- Facilitate communication and coordination among all members of a patient's healthcare team.
- Guide those providing future care.
- Is transferred and exchanged with patients.
- Satisfies all regulatory duties.
- Assists in tracking for patient recall in the event of new health threats or new treatment options.

EMR technology, implementation and utilization are rapidly evolving and have presented numerous challenges along the way. In recent years, TMB has observed progressive difficulty obtaining medical decision making information from current records, which interferes with the accomplishment of our mission. It is not the role of the TMB to endorse EMR software or regulate technology. However, it is clearly within the TMB's scope and oversight duties to set forth standards and expectations for creating and maintaining a useful, meaningful and readable medical record. Accordingly, the Texas Medical Board is confident that current information technology can meet this challenge, if the right focus is applied by practitioners; thereby fulfilling the priorities for clinicians, patients, administrators and all others who use the medical record for their own purposes—while keeping patient care paramount.