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FROM THE EDITOR

Promises and Perils of Electronic Health Records

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Electronic health records (EHRs) and even their predecessor, the “chart,” would be unrecognizable to their originators.^{1,2} What started out in the 19th century as a place for handwritten, bedside observations now exists almost completely electronically and comprises terabytes of text, data, and images. Moreover, a chart’s original purposes included documenting case histories and facilitating communication among clinicians,¹ which are now often secondary to aims of code specialists, compliance officers, **legal reviewers**, and researchers. EHRs offer opportunities to aggregate enormous quantities of “big data,” streamline processes of care, and increase access to information. But EHRs have also fundamentally changed how health care is given and received—and not always for the better.

Although a patient’s EHR contains vast quantities of information, when it comes to determinations about which clinical information is relevant and why, **more is not necessarily better**. Much information in a patient’s record today is cut, copied, and pasted from other sources or derived from templates, and some of it is not accurate. Clinicians reading a patient’s EHR frequently find themselves drowning in data without a drop of information to meaningfully deepen their understanding of the patient’s illness or of how to help them get better. Many clinicians feel they are caring more for charts than for patients and can resent having less time being physically present with patients when they have to spend so much time entering data.^{3,4} Since EHRs are never more than a remote login away, the boundaries between work and home erode, which can diminish job satisfaction and exacerbate burnout.⁵

EHRs have also given patients unprecedented access to an abundance of clinical information, including raw data, notes from consultant specialists, unfamiliar language, and acronyms that require clinicians’ guidance to interpret and apply, even for patients with above average health literacy. Patients can not only review laboratory and radiology reports themselves but **access these data** at all hours. While access can help some patients, it can cause misunderstanding and unnecessary distress for others when clinicians are not around to help them interpret information and apply it to their health decisions.

Patients’ direct access to EHR data also makes some clinicians more careful about the language they use in their notes,⁶ as some patients demand not only access to, but control over the language used in, these notes. *Who should decide which words are used in patients’ records and why?* When patients should challenge clinicians’ impressions or analyses, omissions, or commissions in a record—and from whose points of view should narrative data in a health record be drafted, revised, interpreted, or used—are also pertinent sources of inquiry in this issue. Already, EHR capabilities have changed how some patients’ stories are constructed. Note templates can be easy to create but might over- or underemphasize unique aspects of patients’ experiences. Furthermore, how clinicians

create patient narratives in the EHR can, in some cases, undermine how complex human stories are communicated when nuance and detail are key.

Digitalization of patients' records has also increased the ease with which information can be shared. On the one hand, this capability has made care more efficient and been a boon for clinical research. On the other, with so much personal health information flying across the internet, all stakeholders might be pressed to adjust privacy expectations, since keeping health information private might no longer be practical.

Finally, artificial intelligence (AI) might free clinicians from spending hours in front of a screen and allow them to spend more time with patients—or it could diminish patient-clinician relationships. Judging whether AI is ultimately a boon or a bust for health care requires assessing its impact not only on efficiency but on clinical encounters and other features of current clinical practice. EHRs have already delivered significant benefits to clinicians and patients. Whether they will continue to increase access, reduce fragmentation of care, and improve efficiency without diminishing the quality of patients' and clinicians' experiences remains to be seen.

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