FLYING BLIND

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A costly medical error common in ERs all across the country was averted recently at the emergency room I work in, thanks to a rare experiment in health information technology. As a result, a good deal of time, money and possibly a patient's life was saved.

The patient came into Indianapolis' Wishard Memorial Hospital complaining of crushing chest pain, but was unable to give ER doctors his medical history. Based on his symptoms, my colleagues feared he was having heart trouble, possibly a heart attack. In these situations, ER physicians typically give patients blood thinners, as the medicine allows blood to restore the injured area of the heart. That didn't happen in this case. And it's a good thing.

Fortunately, the attending physicians were able to electronically access the man's medical records instantaneously, informing them that the man with chest pain sought treatment from a nearby hospital just three weeks prior for a head injury. Giving the patient a blood thinner might have increased bleeding to his brain, forcing an unnecessary head surgery and an injury that could have killed him.

With the right information, doctors were able to prescribe the proper treatment for their patient. The chest pain turned out to be angina, not a heart attack.

Had that patient gone to an ER without this technology, he would have been at risk to receive the blood thinner. Such medical mistakes are common because most other hospitals and doctors have to rely on a costly and inefficient paper-based system of medical records when caring for patients.

The inability for providers to get crucial medical information on patients seeking care leads to treatment that is redundant at best and can be ineffective, dangerous and even deadly. It's a big reason why more than 500,000 hospital patients are injured each year due to medication mistakes alone, and why thousands more die needlessly in U.S. hospitals each year.

My colleagues and I at Wishard are able to avert needless mistakes everyday because of an initiative allowing Indianapolis-area emergency medicine providers to immediately bring up a patient's medical record under a community-wide electronic medical record so that doctors can provide the right treatment at the right time to patients in need of emergency care. Almost every emergency room in America is unable to do this.

Instead, most emergency room departments are flying blind. It's like being an air traffic controller working at one of the nation's busiest airports during a blizzard and the radar goes out. You don't have much time or much information to make crucial decisions.

Everyday, emergency room physicians around the nation are making life-or-death decisions while flying blind. Whether they are saving the lives of victims of auto accidents, violence or other medical emergencies, the nation's frontline doctors too often don't know critical information needed to best care for their patients.

Contrary to most people's perception, emergency rooms don't have access to your medical record. Most ER doctors have never seen their patients before. Because the nation's health care system depends on paper records, an ER doctor can't access a record that is locked in a patient's personal physician's office, perhaps miles away.

I recently treated a patient who came to the ER only saying he didn't feel right. The patient couldn't volunteer any more information. Because of the community medical record, I discovered that the patient was treated at an across town ER for kidney failure only three weeks before. He didn't go to his follow-up appointments and wasn't taking his medicine. Knowing this, I admitted the patient to the hospital where the patient received treatment.

Knowing a patient's medical history or at least key parts of it helps 100% of the time. That knowledge helps me to zero in on a patient's problem, ensures needed care is provided more quickly, reduces unnecessary tests and treatment, and ultimately gives me a better change to save lives and avoid mistakes.

But most doctors rely on telephone, faxes and other 20th Century technology to track down their patients' test results, medication history and health care treatment records. And that can only be done during traditional business hours. Emergency situations aren't contained to 9-to-5 schedules.

If there's ever time that a patient wants a doctor to have his or her medical history in front of them, it's during an emergency. But unless you or a loved one constantly carries around your medical history, my colleagues and I are put into that position of the air traffic controller without working radar—at least as long as the system stays rooted in paper-based records.

I see how 21st Century information technology at work in other industries reduces mistakes, increases productivity and cuts costs. That's not the case in health care, or in the ER, where the inability to see a sick or injured person's medical record at the time when care is needed drive up health care costs with needless tests, force longer waits for treatment, and cut lives short.

The information revolution has made Americans' lives much easier and affords us more free time. Whether it's buying a home or a car, ordering gifts online or doing dozens of other daily transactions, electronic management of information has improved our lifestyle. However, when it comes to health care, McDonald's has more information management technology in their drive-thru lines than do most emergency rooms.

It's high time that we change this and luckily, the results of Wishard's high-tech experiment shows that we can.