The Journal of Emergency Medicine, Vol. 57, No. 2, pp. 263–265, 2019

0736-4679/$ - see front matter

https://doi.org/10.1016/j.jemermed.2019.03.046

Ethics in Emergency Medicine

PHYSICIAN INTEGRITY, TEMPLATES, AND THE 'F' WORD

Daniel M. Musher, MD, Christiana P. Hayward, MD, and Benjamin L. Musher, MD

Baylor College of Medicine, Houston, Texas

Corresponding Address: Daniel M. Musher, MD, Veterans Affairs Medical Center, 2002 Holcombe Blvd, Houston, TX 77030

☐ **Abstract—The medical profession is increasingly dependent upon electronic health records. Along with documented benefits, a number of potential ethical abuses have been outlined. Herein, we describe an ethical abuse that has received almost no attention, namely falsified medical records. We present three cases in which the medical record cited facts from history that were not elicited and findings from physical examination that was not performed. This is fraud. Prepopulated templates were almost certainly responsible. If a template is used, it must begin free of results–a skeleton onto which flesh is placed. If coders and third-party payers insist on having information than health care providers think relevant, then we, as a profession should "push back," but a template that has been prepopulated puts fraudulent data into electronic health record, seriously damaging physician integrity.** © **2019 Elsevier Inc. All rights reserved.**

☐ **Keywords—electronic medical record; ethics; fraud; physician integrity; templates**

INTRODUCTION

The electronic health record (EHR) provides a complete and legible record of patients' encounters within a health care system. The EHR may enhance care by increasing availability, completeness, and clarity of medical records, documenting preprocedure evaluations, focusing workups for specific diagnoses, and decreasing the risk of adverse drug effects (1–5).

Disadvantages of the EHR have also been documented. The EHR facilitates copying and pasting notes—one's own or notes by others, a feature that fosters intellectual dishonesty (6–8). When physicians become inured to intellectual dishonesty, fraud—openly dishonest or deceptive entries into the medical record—may be the logical outcome. The medical literature has used the term "fraud" to describe administrative practices, such as billing for services were not rendered, as well as to identity theft, falsified research data, or erroneous claims by purveyors of individual products and services. With rare exceptions, the word fraud has not been applied to physician behavior, specifically to physicians' notes in medical records (9–12).

We have been struck by the increasing presence of elegant and complete notes in medical records that appear to be so good that their credibility is questionable. The most plausible explanation is that these notes were generated by templates. We now present 3 cases from our own encounters with emergency departments (EDs) documenting fraud that could only have resulted from use of templates.

CASE REPORTS

Case 1

A 78-year-old physician presented to the ED at a public tertiary care academic hospital because of fever, chills, and a progressively severe, nonproductive cough for several

Received: 15 March 2019;
Accepted: 30 March 2019

days. The triage nurse recorded the chief complaint and ordered a chest radiograph that showed patchy bilateral infiltrates. The patient was instructed to sit in the waiting room. Without having spoken to or examining the patient, the emergency physician came to the waiting room and handed him a prescription for azithromycin. A review of the EHR revealed a note that contained a complete history, review of systems, and physical examination, including auscultation of the lungs, none of which had been elicited or performed but all of which were said to be negative except for the chief complaint as entered by the triage nurse.

Case 2

A 43-year-old physician with a history of migraine headaches presented to the ED of a private academic tertiary care hospital for the "worst headache of [his] life." The emergency physician took a brief history and ordered a computed tomography scan of the head, which was negative. The patient was treated symptomatically and discharged as improved. Although no physical or neurologic examination was conducted and the patient remained on a gurney during the entire time the emergency physician was in the room, the EHR detailed a normal comprehensive physical and a full neurologic examination, including gait.

Case 3

A 26-year-old medical resident visited a free-standing ED because of headache, fever, and malaise for 2 days. The impression was a "viral syndrome," and she was treated symptomatically. The record, however, stated that she was not pregnant and had no risk factors for HIV infection together with a long list of other negatives, none of which had been elicited by the examining physician.

DISCUSSION

A template is a prepared electronic document into which history and physical findings can be entered. Some practitioners use the skeleton, leaving blanks for the actual findings, whereas others populate the template as if all these findings were normal, allowing for changes to indicate abnormalities. In theory, practitioners may save valuable time and provide a higher quality of care by using these customized templates (13–16).

Disadvantages of the EHR have been amply documented, including the potential loss of patient confidentiality or problems resulting from copy and paste practices, such as unnecessary and distracting verbiage, perpetuation of out-of-date or frankly erroneous information, and the loss of nuanced narrative (2,5–8,17–19). Most importantly, however, although it was originally believed that the EHR would free physicians to spend more time with patients, studies have shown that this does not appear to be the case (20–22). In fact, and ironically, the EHR has increased stress and burnout in the medical profession (23).

More concerning, however, and less frequently mentioned, are ways in which the EHR erodes physician integrity. Copying and pasting allows a physician to sign his/her name to observations by others; there seems to be general agreement that this practice is bad but is widespread (9–11). Far worse, however, as we now document, is that customized templates may populate medical records with information from histories that were not taken and findings from physical examinations that were not performed—simply stated, fraudulent data ("fraud…an active instance of deception…a dishonest trick or stratagem," according to the Oxford English Dictionary (24)). The medical literature has largely avoided this issue. If templates that are already populated with normal findings are rigorously edited before being used, they may be time-saving and accurate. But if such editing fails to take place, the result is fraudulent data, and a subsequent reader of the EHR has no way to tell what is correct and what is not.

Our PubMed search revealed the following. Under "medical," "fraud," "electronic health record," and "template," 0 references; under "medical," "fraud," and "template," 0 references; under "medical," "fraud," and "electronic health record," 41 references; and under "fraud electronic health record," 72 references. In these references, fraud was used in relation to reimbursement, billing for services not provided, identity theft, and loss of patient confidentiality, but only rarely to the actual content of physicians' notes in the medical records (10,11,25,26).

These vignettes of patients seen in 3 different EDs all show evidence of fraudulent data in the EHR; we suspect that such fraud may be widespread. A prospective study might document the prevalence of fraud in current practice, but it is difficult to imagine how such a study might be conducted. Data for the vignettes presented herein were extracted from the medical records by the authors who were the 3 patients cited. Physicians and hospitals will be reluctant to participate, and, without their cooperation, patients cannot be identified and questioned about their medical experiences, and medical records cannot be reviewed. We conjecture that difficulty in obtaining data is only partly responsible for the resounding silence of the medical literature on this important subject. We are concerned that our profession may lack the political will to expose and then to control our own intellectual dishonesty, despite the fact that this dishonesty violates our code of ethics and adversely affects our core mission, which is to provide good medical care for our patients.

External forces also contribute importantly to the current situation. Billers and third-party payers require physicians to document a comprehensive review of systems and physical examination, which are not even indicated for the proper evaluation of a focused chief complaint, especially in an ED setting. Physicians are forced to choose between going unpaid or committing fraud by documenting a service that they have not actually rendered. Whereas reimbursement should be based on the complexity of the problem and the time spent with the patient, it is based on the length of, and detail contained in, the note in the medical record. Interestingly, investigative journalists have recently shown that the average level of acuity of care recorded as having been given to patients in EDs has greatly increased in the past decade, leading to greater costs nationwide for medical care (27). It is possible that lengthy medical templates may be contributing to this problem.

What can be done? This problem needs to be brought to light: to be written about, taught, and discussed. Templates can be constructed as a framework with blanks for answers, and the provider may choose to fill in "yes," "no," or just leave blank if information is not elicited. But false information in a medical record cannot be condoned, and each health care provider must be able to justify the integrity of his/her own work. If requirements for documentation to bill for services are excessive or unreasonable, it becomes our responsibility as a profession to work aggressively to change the system rather than to sacrifice our integrity by filling the medical record with untruthful statements. Silence on this issue does a great disservice to our profession and to our patients.

REFERENCES

1. Lobo SE, Rucker J, Kerr M, et al. A comparison of mental state examination documentation by junior clinicians in electronic health records before and after the introduction of a semi-structured assessment template (OPCRIT+). Int J Med Inform 2015;84:675–82.
2. Dean SM, Eickhoff JC, Bakel LA. The effectiveness of a bundled intervention to improve resident progress notes in an electronic health record. J Hosp Med 2015;10:104–7.
3. Ghani Y, Thakrar R, Kosuge D, Bates P. 'Smart' electronic operation notes in surgery: an innovative way to improve patient care. Int J Surg 2014;12:30–2.
4. Gupta A, Raja AS, Khorasani R. Examining clinical decision support integrity: is clinician self-reported data entry accurate? J Am Med Inform Assoc 2014;21:23–6.
5. Ozair FF, Jamshed N, Sharma A, Aggarwal P. Ethical issues in electronic health records: a general overview. Perspect Clin Res 2015;6:73–6.
6. O'Donnell HC, Kaushal R, Barron Y, Callahan MA, Adelman RD, Siegler EL. Physicians' attitudes towards copy and pasting in electronic note writing. J Gen Intern Med 2009;24:63–8.
7. Siegler EL, Adelman R. Copy and paste: a remediable hazard of electronic health records. Am J Med 2009;122:495–6.
8. Vogel L. Cut-and-paste clinical notes confuse care, say US internists. CMAJ 2013;185:E826.
9. Tamburello LM. The road to EMR noncompliance and fraud is paved with cut and paste. MD Advis 2013;6:24–30.
10. Sheehy AM, Weissburg DJ, Dean SM. The role of copy-and-paste in the hospital electronic health record. JAMA Intern Med 2014;174:1217–8.
11. Weis JM, Levy PC. Copy, paste, and cloned notes in electronic health records: prevalence, benefits, risks, and best practice recommendations. Chest 2014;145:632–8.
12. Hammond KW, Helbig ST, Benson CC, Brathwaite-Sketoe BM. Are electronic medical records trustworthy? Observations on copying, pasting and duplication. AMIA Annu Symp Proc 2003;269–73.
13. Green JD Jr, Postma DS, Giddings NA, Sapp KR, Skinner T. Computerized medical record in a private neurotology practice. Am J Otol 2000;21:589–94.
14. Jobanputra P, Arthur V, Pugh M, et al. Quality of care for NSAID users: development of an assessment tool. Rheumatology (Oxford) 2005;44:633–7.
15. Rosenthal BJ, Spiegel DM. Computer templates in chronic kidney disease care: a tool for improving patient management. Adv Chronic Kidney Dis 2008;15:37–41.
16. Trotman J, Trinh J, Kwan YL, et al. Formalising multidisciplinary peer review: developing a haematological malignancy specific electronic proforma and standard operating procedure to facilitate procedural efficiency and evidence based clinical practice. Intern Med J 2017;47:542–8.
17. Beck EJ, Gill W, De Lay PR. Protecting the confidentiality and security of personal health information in low- and middle-income countries in the era of SDGs and Big Data. Glob Health Action 2016;9:32089.
18. Cohen R, Elhadad M, Elhadad N. Redundancy in electronic health record corpora: analysis, impact on text mining performance and mitigation strategies. BMC Bioinformatics 2013;14:10.
19. Scruth EA, Soriano R. Quality documentation in the electronic medical record: ensuring safe practice of copy and paste. Clin Nurse Spec 2016;30:190–3.
20. Block L, Habicht R, Wu AW, et al. In the wake of the 2003 and 2011 duty hours regulations, how do internal medicine interns spend their time? J Gen Intern Med 2013;28:1042–7.
21. Sinsky C, Colligan L, Li L, et al. Allocation of physician time in ambulatory practice: a time and motion study in 4 specialties. Ann Intern Med 2016;165:753–60.
22. Mulvehill S, Schneider G, Cullen CM, Roaten S, Foster B, Porter A. Template-guided versus undirected written medical documentation: a prospective, randomized trial in a family medicine residency clinic. J Am Board Fam Pract 2005;18:464–9.
23. Downing NL, Bates DW, Longhurst CA. Physician burnout in the electronic health record era. Ann Intern Med 2019;170:216–7.
24. "Fraud, n. 3." Oxford English Dictionary. Salisbury, England: Oxford University Press; 2019:516.
25. Edelberg C. Medical record cloning: when documenting, avoid the temptation. ED Manag 2014;26:69–71.
26. Simborg DW. There is no neutral position on fraud!. J Am Med Inform Assoc 2011;18:675–7.
27. Deam J. Medical codes critical in costs. Houston, TX: Houston Chronicle. February 24, 2019.