

Paul M. Wangenheim, "Scribes, Electronic Health Records, and the Expectation of Confidentiality," *The Journal of Clinical Ethics* 29, no. 3 (Fall 2018): 240-3.

Scribes, Electronic Health Records, and the Expectation of Confidentiality

Paul M. Wangenheim

ABSTRACT

Electronic health record (EHRs) have largely replaced obsolete paper medical charts. This replacement has produced an increased demand on physicians' time and has compromised efficiency. In an attempt to overcome this perceived obstacle to productivity, physicians turned to medical scribes to perform the work required by EHRs. In doing so, they have introduced an uninvited participant in the physician-patient relationship and compromised patients' confidentiality. Scribes may be a successful work around for physicians frustrated by EHRs, but patients' confidentiality should not be sacrificed in the process.

INTRODUCTION

More than 30 years ago Mark Siegler, MD, asserted that confidentiality in medicine was a deceptively concept. He cited a case of a patient admitted for cholecystectomy and discovered that nearly 100 staff, students, and hospital personnel had access to the patient's medical chart. Despite reassurances that all parties had professional justifications to see his medical records, the patient felt his confidentiality was breached. In his essay Siegler proposed parti-

tioning the chart so that clinical information would be separated from financial information and access would be limited to legitimate inquirers on a "need to know basis."¹

Today EHRs have largely replaced obsolete paper charts. Access to EHRs is available to multiple simultaneous viewers. Confidential information shared between patients and physicians may be compromised by this open access to EHRs. Beauchamp and Childress explain that confidentiality is a "subset of informational privacy" and prevents "redisclosure of information originally disclosed in a confidential relationship."² Confidentiality is breached when private medical information is shared without consent and widespread access to EHRs potentially threatens patients' privacy.

THE ELECTRONIC HEALTH RECORD

In 1997 the Institute of Medicine called for the implementation of computer-based medical records. The Committee on Improving the Patient Record concluded that the "computerized patient record, in short, is an essential technology for health care" and promised to improve productivity, quality of care, job satisfaction, and customer satisfaction.³ Rapid proliferation of EHRs followed the Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009. This legislation provided incentives for both office-based physicians

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and hospitals to adopt EHR systems. The program was successful. In 2001, only 18 percent of office-based physician used some form of EHR, and by 2013 that figure grew to 78 percent.⁴

Similar exponential growth occurred in the hospital arena. Nonfederal acute care hospitals in the United States that provide care to Medicare and Medicaid patients and meet nine objectives and measures set forth by the Centers for Medicare and Medicaid Services (CMS) avoid penalties and reductions in payments by adopting EHRs. In 2008 only 9.4 percent of these hospitals had basic EHR systems compared to 75.5 percent in 2014.⁵

Despite the potential for improvements in patients' safety and the quality of care, the widespread implementation of EHRs have had a negative impact on physicians. The additional time required to navigate EHRs reduces productivity, income, and job satisfaction.⁶ In an effort to work around the demands of EHRs, physicians have created solutions that compromise patients' confidentiality.

PHYSICIANS, THE EHR, AND SCRIBES

A recurring complaint among physicians utilizing EHRs is the amount of time spent on the multiple tasks required for their meaningful use. Typing patients' histories, navigating myriad drop-down menus, entering orders electronically, and managing pharmacy prescriptions all add to the amount of time required per patient. Studies report a growing discontent with the quality of the physician-patient interaction as well as the length of physicians' work week.⁷

One solution for physicians who are burdened by the demands of EHRs is the use of medical scribes. These are unlicensed, unregulated employees who record clinical information on behalf of physicians, freeing them from the time requirements posed by EHRs. Scribes enter EHRs with ease and have full access to patients' medical charts including history, physical exams, labs, and consultations. These notes are then co-signed by the attending physician and entered into the permanent record.

There is a rapidly growing industry of private companies that offer the training and certification of medical scribes. The American College of Medical Scribe Specialists (ACMSS) is a nonprofit organization that provides aptitude testing, documentation of work experience, and pathways to certification for medical scribe specialists (CMSS). The organization has certified more than 5,000 individuals in its CMSS program since 2010.⁸ Regulatory agencies such as the Joint Commission and CMSS

have little to say about scribes, although both agencies emphasize that scribes should not be permitted to enter orders into EHRs.⁹

Critics suggest that scribes are not a solution to poorly designed EHR systems and "the rise of the medical scribe industry should not be a substitute for much-needed EHR innovation and transition to more highly effective and more functionally efficient EHR systems."¹⁰ Physicians have perceived scribes in a positive way, citing increased productivity, efficiency, and revenue.¹¹ Scribes are commonly found in emergency departments, clinics, ambulatory practices, and increasingly alongside inpatient hospitals. Notwithstanding the call for improvements in the inadequacies of EHRs, the scribe industry is likely to continue to grow.

PATIENTS AND SCRIBES

Surveys of patients' reactions to the presence of a scribe are generally neutral or favorable. Questionnaires emphasize the increase in attention, better explanations, and more attentive listening that occurs when scribes assist physicians.¹² There are little qualitative data that explore the comfort level of patients who discuss confidential or sensitive information when a scribe is present. A small survey of behavioral healthcare "consumers" indicated overall satisfaction with physicians' communication when scribes were introduced, but included only one question about patients' comfort.¹³ There are scant data about the potential chilling effect that scribes may have on patients when they discuss highly personal information. Scribes were viewed positively in a survey of primary care practices, but individual survey respondents expressed concerns about "invasive checkups" and sexual information when scribes were present.¹⁴

PATIENT'S EXPECTATIONS AND THE CONCENTRIC RINGS OF CONFIDENTIALITY

It is reasonable to expect physicians and nurses to share confidential information in order to deliver care. Patients' expectations for confidentiality can vary widely. Sankar and colleagues examined patients' views of confidentiality by searching more than 5,000 articles using Medline and Ethiconline. Four key areas were identified: patients' understanding of medical confidentiality, what limits should be placed on sharing information, how confidentiality affects patients, decisions to seek care, and finally how concerns regarding confidentiality influ-

ence patients' willingness to disclose information. This literature review reveals the wide variation in what patients think confidentiality means. Patients generally understand that information will be shared with staff, but express concern that such information will impact their social status in their community. Patients who were surveyed largely objected to the routine release of information to insurance providers, commonly expected that confidential information would be used only as a means to achieve good care, and were less concerned with regulations and compliance issues than they were with the fear that their private matters might become public.¹⁵

Siegler's 1982 *New England Journal of Medicine* article recommended that confidential information be shared on a need-to-know basis. The dissemination of patients' information can be imagined as a series of concentric circles emanating outward from the initial doctor-patient encounter. The innermost circle consists of physicians, nurses, nurse practitioners, and physician assistants, who are the most entitled to privileged information. In teaching hospitals this inner ring would also include house officers, residents, fellows, and medical students. The next circle of caregivers includes social workers, therapists, discharge planners, and case managers. These vital ancillary services require knowledge of personal information in order to provide good care and to fulfill patients' needs. Further from the inner circle are healthcare workers who can carry out their services without knowing intimate details about patients. Transporters, phlebotomists, technicians, nursing assistants, and aides require only minimal healthcare information to perform their duties.

Arguably, medical scribes do not have a justifiable place in the hierarchical rings of healthcare providers. Scribes may accompany physicians during the initial patient interview, taking notes and instructions that will later be entered into EHRs. In other situations the scribes operate remotely. Scribes may access EHRs from a separate location and take verbal instructions from the bedside physician to embellish the EHR template. In either case, scribes share confidential information in order to construct a physician's note in the EHR, and then return it to the physician for a signature before the note is entered into the medical record. Although these services are advantageous for physicians, they are of no benefit to patients.

CONCLUSION

Initially there was great enthusiasm for EHRs and the promise of providing "history-rich notes"

while maintaining "the humanistic elements of the record."¹⁶ Instead, EHRs have become a tool for billing and regulation and a distraction that interferes with the patient-physician relationship. To minimize the impact of EHRs on productivity, revenue, and work hours, physicians turned to scribes as a solution. In doing so they have introduced an uninvited guest into the relationship. Scribes improve physicians' difficulties with EHRs, but at the expense of patients' confidentiality.

When physicians utilize scribes at the bedside, they should be introduced to patients, their role should be clearly explained, and permission should be obtained from patients before proceeding. In the case of scribes who work on charts in remote locations, all identifying information and personal demographics should be redacted from the EHR template in order to maintain patients' privacy. As long as there are inadequacies with EHRs, scribes are likely to continue their growth in the clinical arena. However, the primary goal of every medical encounter is to put patients' interests first; maintaining patients' confidentiality is paramount. Scribes may be a successful work-around for physicians who are frustrated by EHRs, but patients' confidentiality should not be sacrificed in the process.

NOTES

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