

Study finds discrepancy between what symptoms patients report, what appears in electronic medical record

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Researchers found significant inconsistencies between what symptoms patients at ophthalmology clinics reported on a questionnaire and documentation in the electronic medical record, according to a study published online by *JAMA Ophthalmology*.

The percentage of office-based physicians using any [electronic medical record](#) (EMR) increased from 18 percent in 2001 to 83 percent in 2014. Accurate documentation of patient symptoms in the EMR is important for high-quality patient care. Maria A. Woodward, M.D., M.S., of the University of Michigan Medical School, Ann Arbor, and colleagues examined inconsistencies between patient self-report on an Eye Symptom Questionnaire (ESQ) and documentation in the EMR. The study included 162 [patients](#) seen at ophthalmology and cornea clinics at an academic institution.

The researchers found that at the participant level, 34 percent had different reporting of blurry vision between the ESQ and EMR. Likewise, documentation was not in agreement for reporting glare (48 percent), pain or discomfort (27 percent), and redness (25 percent). Discordance of symptom reporting was more frequently characterized by positive reporting on the ESQ and lack of documentation in the EMR. Return visits at which the patient reported blurry vision on the ESQ had increased odds of not reporting the symptom in the EMR compared with new visits.

"We found significant inconsistencies between symptom self-report on an ESQ and documentation in the EMR, with a bias toward reporting more symptoms via self-report. If the EMR lacks relevant symptom information, it has implications for patient care, including communication errors and poor representation of the patient's reported problems. The inconsistencies imply caution for the use of EMR data in research studies. Future work should further examine why information is inconsistently reported. Perhaps the implementation of self-[report](#) questionnaires for [symptoms](#) in the clinical setting will mitigate the limitations of the EMR and improve the quality of documentation," the authors write.

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