Letters to the editor

Re "The Electronic Health Record"

Last year circumstances required me to become an employee of a hospital that uses the EPIC electronic medical record system (EMR). After six months I have become fairly adept at entering the required data, but two problems, evident at the outset, now are glaring: first, in my thirty-nine years of private practice I never engaged in anything so cost-ineffective, to wit, it takes at least twice as long to see a patient because of the necessity for and time needed to enter data; second and more deeply rooted is my newly recognized and subsequently defined fallacy of logic implicit in EMR, i.e., *multa collatia, ergo multa informatio*, that is, "a lot of data must equal a lot of information" (I apologize to any Latin scholars).

I have only one disagreement with the superb essay by Dr. K. Patrick Ober in the Winter 2015 issue, having to do with the dictation of the office note. My first experience with a transcription device occurred in the Air Force in 1971, and I quickly learned that dictating my note in front of my patient was a practical and effective endeavor. First, the patient knew that I was paying attention; second, the patient could correct my note as I dictated it, and my transcriptionist and I could easily handle and insert the "Oh, by the way . . ." patient additions during the physical examinations or as the patient was about to leave; third, I never had to trust my memory or refer to my illegible handwritten notes in order to dictate my formal note after the patient left or later in the day.

There has been almost universal appreciation of this practice by my patients. Only once in all these years (which is why I remember it so clearly) did a patient complain, an elderly woman who confided sweetly, "I really don't like being reminded of all my ailments!"

With EPIC, I can use dictation software, but instead of looking at my patient as I dictate and observing whether the patient agrees with what I am saying, I have to warn my patient to speak up if I say something incorrect because I have to look at the computer to be sure the words are being spelled correctly (my transcriptionist knew how to spell).

There is, however, one advantage of EPIC: in the past, in order to provide my patient with my entire note once it was transcribed I would have to mail it; now, if I make sure my entire note is copied into the patient instruction section of the record, when the patient leaves the office he or she has the note in hand.

One final thing: it was my habit to go out to the waiting room, greet my patient, and walk with her or him back to my consultation room. There is a wealth of clinical information to be gained by this exercise that I will not expound upon in this letter, but it was a challenge to figure out how to do this with EPIC since medical assistants are supposed to see the patient first in order to enter a lot of data and prepare the computer for the visit. Now, when possible, I let the assistant first have his or her way with the patient and then return my patient to the waiting room.

Intellectually, I have been and remain very much in favor of the concept of EMR; practically, however, our current EMR systems have a long way to go to become first, patient centered, and second, an improvement of and not a detriment to practice efficiency and the effective delivery of medical care.

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Drs. Ober and Applegate are to be applauded for their detailed report on the critical issues associated with the introduction of the EHR into American medicine (Winter 2015, pp 9–14). Our current and future physicians and their patients must bear the burden of the negative aspects of this poorly conceived and tested idea, put in place in the name of improved patient care and safety. What they did not report was its cost. It is actually the one hidden cost in American health care which is never discussed or reported when dollars associated with care are debated. The real cost/benefit of these systems, sold by a few major vendors making enormous profits, is not being assessed. The only known costs are to the users and their patients. Our profession and professional organizations need to force an open discussion of these isssues before a permanent scar forever tarnishes our delivery system.

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