

From: "Das, Subinoy"
To: "Dr. KJ Lee"
Date: Wed, 10 Mar 2010 12:35:21 -0500
Subject: Problems with large EMRs

Dear Dr. Lee,

Thank you for soliciting my opinions on EMRs at large institutions. I have experience with this by participating in a 3 person Physician Executive Team with the implementation of a large EMR at the Medical College of Georgia, and participating on the main hospital committee for EMR implementation at The Ohio State University.

Overall, I think EMRs have significant potential value to both the hospital and physician. However, just like pharmaceuticals, poorly designed EMR systems can be equally harmful to patients. Currently, at both institutions, the large EMR systems that have been implemented have been plagued with problems, lack of timely upgrades/maintenance, and an overstatement of their potential value.

Current large EMRs, such as the one at OSU, have been designed primarily for the benefit of primary care physicians that provide much of their medical care by coordinating care between multiple providers, and by prescribing outpatient medicines to benefit their patients. They have not been, in my opinion, adequately designed for specialists, whose primary role is to provide surgical or specialty care outside of the physician office, and use the office to perform significant administrative functions to ensure high levels of patient quality and safety. Specialists often have unique documentation needs and all physicians require their EMRs to reduce their administrative time spent in documentation. These large EMRs have been in many cases very frustrating because they significantly increase the administrative burden and waste much precious time, which delays access to other sick patients who potentially need to be seen quickly to prevent catastrophic outcomes from their diseases.

Specific problems:

1. The HIPAA requirements for password security have been tremendously onerous, inefficient, and have disrupted buy-in to large EMR systems. Here at OSU, the EMR system requires 2 minutes worth of effort to login, requires memorization of a difficult password that needs to be changed every 90 days. While with one password this would be manageable, most physicians are required to memorize 10-20 passwords that are constantly changing. Much time is wasted typing in these passwords, waiting to login, and calling the helpdesk for password resets. IT officials and the public in general do not realize how much of a true cost this is for a physician to waste several minutes a day during a busy clinic dealing with password issues.
2. After successful login has occurred into the system, it then becomes very problematic to quickly locate relevant information related to the patient encounter. This is because of "data overload" where telephone encounters, insurance forms, etc are listed as notes, and it is difficult to find which notes are actual patient-physician encounters. Furthermore, after the appropriate note is found, it often contains so much "copy and pasted" or "form generated" information, it is difficult to tell what was actually examined, what parts of the assessment and plan are new and related to that visit. As a result, many practitioners simply stop looking through the EMR and simply asking the patient what occurred. This is often less ideal than the previous methods of communications where physicians would call each other or dictate short, highly relevant notes to each other. Also, the EMR does not result in any paper savings as 3-5 page notes are often printed to find a few lines of relevant information
3. The EMR has helped in timely locating relevant lab values, and operative notes, and having these values easily compared to older values.

4. After a chart review has been performed, the EMR has led to a significant deterioration in the physician-patient relationship. Instead of maintaining eye contact and having a conversation with the patient, many providers are spending more time staring at a computer screen, often typing when a patient is not talking, clicking when patients are conveying what they believe is important information. As a result, in my opinion, many patients believe that their physician has become more concerned with computer level 4 documentation requirements than actually listening to their complaints.

5. The use of the EMR to document progress notes is much less efficient than paper notes. Often, providers have highly individualized and unique progress notes that are geared to the manner in which they practice medicine. Paper allows for jotting of anything that might be important quickly. Paper allows for diagrams that will assist in surgery. The act of having to type or put data into structured formats is so time consuming compared to traditional methods, that providers often limit their dictation, or use "shortcuts" to populate the EMR with unnecessary documentation to meet level 4 or level 5 billing criteria, but which add very little to improving patient care. This further compounds the limited usefulness of the EMR to others who are reading it. Many providers, including I (who thinks I am somewhat of a computer superuser), have simply refused to use the progress note function and simply use the EMR to scan in my notes. This would be helpful if my notes were probably labeled within our EMR system, because I could then readily access these notes anywhere over the internet without fear of losing a chart.

6. After the outpatient visit is completed, the physician typically orders several items, such as writing prescriptions for medicines, ordering imaging studies, scheduling surgery, etc. Our large EMR requires that the physician perform much of these functions, instead of our secretaries who traditionally performed these functions. This for me, in essence, is taking a surgeon who has trained for 14 years to surgically remove difficult tumors close to eye and brain while preserving vision and brain function, and instead, making me spend more time as a clerk. As a result, I see about 20% less patients a day. Im sure this looks on the surface as a good costsaving measure, since we need less ancillary staff, and by seeing less patients, total health care costs are probably less. However, what this has really done is ration care.

7. Futhermore, by using the EMR to transmit orders, people spend less time actually thinking about why these orders were done, and now mindlessly perform them. If there are errors, people dont think to question the order, they just follow instructions. There is less valuable communication. As a result of implementation of our EMR, i have had more errors in surgery from my intentions not translating to what equipment/staff I needed in the OR to perform my operations.

Overall, I think EMRs have a lot of potential. However, a one-size fits all approach, mandating that different classes of doctors use the same system in the same manner, has led to probably more harm than good. It definitely has decreased the amount of actual healthcare that I can provide to our community and has significantly increased my frustration with the practice of medicine.

respectfully submitted,
Subinoy Das