Electronic Medical Records: Are We Going Forwards or Backwards? — A Perspective from a Private Pain Practice

To the Editor:

I am writing to you to express my deep concern and frustration with regard to the utilization of electronic medical records (EMR). I am a fellowship-trained, multi-boarded interventional pain specialist, working with other fellowship-trained interventional physicians in a private practice in Mobile, Alabama.

In preparation for the EMR mandate, our practice implemented EMR in late 2008, as did many other practices in the nation, by purchasing PrimeSUITE (Greenway Medical Technologies, Inc., Carrollton, GA) at a hefty cost of $120K hoping to become truly "paperless." Over the past couple of years, we started to see more and more physicians in our community switching to EMR as well. However, we also started to see a steep increase in the volume of paper records when seeing patients referred to us from other offices that utilize EMR.

It is ironic that when we switched to EMR, we expected to be "paperless." Instead, we see piles of useless, redundant, and disorganized EMR printouts that patients bring with them. These poorly structured files are distracting, irrelevant, problematic, and to make it even worse, the useful data are buried in a sea of white noise — patient demographics, irrelevant historical data, normal physical findings, and diagnosis/billing codes, etc. The major problem in our practice has become what to do with these EMR notes? It is excessive and unnecessary labor for our staff to scan them into our computers since we know that we will never have time to read them and that we cannot obtain any useful information from reading these hundreds of EMR printouts to help make any clinical judgment, but we cannot throw them out either.

Gradually, we also started to feel that we more or less were becoming secretaries or billers, becoming more obsessed with getting the "notes" done "right" instead of spending more time interacting with patients to offer them the individualized care they need. It is scary to see how many physicians are being converted into medical secretaries/billers since the introduction of EMR. I personally find it truly insulting to my profession as a physician when patient care becomes secondary because of constant distraction/pressure caused by using EMR when my work as a physician is outweighed by the sheer number of words I have to write for the work done as a care provider.

EMR has certainly negatively affected my practice in many ways. First of all, the clinical evaluation process has changed from a rather intellectual and rewarding one into a robot-like, clerical type daily routine, i.e., gazing at the computer screen, playing with the mouse, checking boxes, and typing. I used to enjoy dictating my clinical note as well as reading notes from other specialists. Now, I do neither. It has gotten to the point that when I see EMR notes from other physicians, I reflexively become averse to them since I know the notes are simply regurgitations of the previous medical history, previous surgical history, social history, and family history, with over 20 items of irrelevant reviews of systems, reviews that have nothing to do with what I want to know or what I should focus on to take care of my patient.

Indirectly, EMR has negatively affected the professional relationship between me and my referring physicians, as I rarely read their notes any more, and that is true! On the rare occasion when I did read their notes, I would find something like "Patient is fine. Continue current plan" buried in 4-5 pages of single-spaced, small font monster notes, with all histories and systemic reviews reviewed. I rarely call my referring physicians like I used to when I needed clarifications upon finishing reading their notes, as I no longer read them.

With the focus of health care providers turned from direct patient care to EMR note composition to justify billing, the EMR notes created are very often inflated and contain things not done, but there, therefore the reliability and validity of these EMR records are often questionable, which may create serious problems from

a medical/legal standpoint, if found to be so later on. How many times have we seen errors in an EMR from one note get copied and pasted to other subsequent notes? When you have hundreds of pages of EMR printouts that no providers read, how could you expect errors to be reduced?

So far, I have found no proof that EMR improves the quality of health care. I actually find the opposite to be true in my practice. I used to spend more time interacting with patients, performing focused physical exams, etc., but now I am constantly distracted by the simultaneous clerical work during clinical encounters. I am not surprised when hearing my patients complaining about my rushing into the exam room with a laptop, paying no real attention to their complaints, and rushing out of the room when the computer note is done. I am very nostalgic for the old days when medicine was practiced. We looked like doctors, like medical professionals or medical detectives in front of patients, rather than looking like a medical bookkeeper as is common today. I am very disturbed to see our roles as care providers be converted into servants to documentations, and that special interest people have shoveled all these down our throat, yet, we are still taking it!

With the hefty cost of EMR and the ever-increasing regulatory burden on medical practices, along with severely reduced productivity associated with using EMR, and increased patient dissatisfactions, EMR has added little value to the practice of medical care. They are from others, powerful entities that clearly have their own agenda. They are not created to save money or reduce errors. They seem to be more like lies that enable others to justify their false mandate.

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