International Perspective on Electronic Medical Records

From March 17 to 19, 2017, I attended a conference sponsored by Brown University's Warren Alpert Medical School entitled "The Patient, The Practitioner, and The Computer." My intense response to the presentations at this conference reflects my experience of nearly forty years of practicing family medicine.

After I started a solo family practice near Providence in 1978 and grew it to a group of seven physicians and 35 staff, I burned out prior to the introduction of an Electronic Medical Record (EMR). When I decided to leave my private practice, I learned about opportunities to travel and assist for limited periods in practices with primary physician shortages via locum tenens contracts. I thought I might extend my career for two or three years through locum tenens work, but the travel and medical experiences have been so fascinating that I have continued to work all over the U.S. for eleven years.

In deference to my academic colleagues, I must disclose my conflicts of interest and biases. I have worked in 26 practices and have worked in only one where the EMR was more of an asset than an obstruction to patient care. (I am sticking with the designation EMR, because I have found nothing healthy in the more trendy "electronic health record.")

My second locum tenens contract in 2006-7 was in Reefton, New Zealand. This is a village of 1500 persons on the South Island, one hour from the nearest hospital. On my arrival in Reefton, I was told that the receptionist of the practice would teach me the use of the Medtech EMR. The training session took two hours, and I was off and running with my first EMR. Office notes were a few pertinent lines requiring one or two minutes per visit. I had, what felt astonishing to me for the first time, remarkable connectivity with hospitals, emergency departments, labs, radiology, specialists, pharmacies, behavioral health and social services, that I had never experienced in the United States.

Upon my return to the U.S. , my next 25 assignments in health centers, hospital clinics, private practices, urgent cares, and big corporate (read: Kaiser) clinics in

MA, RI, SC, NC, FL, NM, CA, AK, and HI revealed all the worst of EMR implementation in this country. In all of these settings, my documentation requires 3-4 times more time than in New Zealand, and my access to information from outside facilities is much more limited than I had in my tiny New Zealand village.

During my last locum with the Marin Community Clinics in California, I received the invitation to this conference from the Brown CME office. Since I had planned to be home in March, I thought I might learn how younger folks might be improving use of and coping with EMR's.

The morning mindfulness program on Friday was useful. I believe I can use some of the techniques to assist my functioning in survival mode as I interact with my EMR's. But I was deeply saddened by subsequent sessions and the keynote speech Friday evening. There I heard a well-spoken practitioner and researcher recommend doubling office support staff to repair the damage done by our EMR's.

On the same days we heard doctors from Israel, Britain, and Australia all say, "We love our EMR's!" As far as I know, they have not had to double their staffs or reengineer their facilities to fall in love with their EMR's. And I have had the experience of loving my EMR in New Zealand, a country that spends a much smaller fraction of their GDP on health care and has significantly better health outcomes than the United States.

All providers and researchers from the United States addressed the problems and obstacles that computer technology has introduced to the doctor-patient relationship and to physicians' work satisfaction. My own experience with U.S EMR's indicates that the problems stem from the producers/vendors of these programs; they are developed with the primary goals of facilitating billing and data collection. Patients care and physician documentation convenience are secondary considerations. Communication with other health care data sources is usually ignored completely.

The system I used in New Zealand and those described by foreign attendees at the March conference were apparently designed with patient care as the highest priority. The satisfaction of the international users could not be more different from that of our domestic colleagues.

How can we in the U.S. be so self-involved that we cannot take note of and adopt successful technology applications from other countries? If a surgeon in South Africa performs a successful heart transplant, our U.S. thoracic surgeons rush to copy and improve the procedure. But we have not the political or societal will to adopt successful EMR systems or health systems models from our global neighbors.

The EMR problem here is a microcosm of our health system's dysfunction. We have special interests (also termed stakeholders) in our medical-industrial complex which obstruct the adoption of proven technologies from other countries and keep our system hurtling toward ever more expensive and inefficient medical care.

Our colleagues from abroad have shown us the answers. How long can we avoid implementing proven technology?

Joshua Gutman, MD

Joshua_gutman@yahoo.com