North Coast Physician

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The Editorial and Publications Committee encourages our member's comments for publication. Please submit electronically prior to the 15th of the month preceding publication. hdncms@sbcglobal.net

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Cover Photo

"Ellen's rose bush, and digitalis plants, blooming on a rainy May evening.
LUTHER F. COBB, M.D.

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CMA PRESIDENT MESSAGE

Statement on George Floyd Death and Institutionalized Racism

Peter N. Bretan, Jr., M.D.

CMA President

"The physicians of the California Medical Association were among the millions of Americans horrified by the murder of George Floyd in Minnesota. The seeming indifference to his suffering before his death is a glaring reminder that institutionalized racism remains endemic to the United States. His senseless death also requires us to confront the epidemic of state-sanctioned violence against people of color. As physicians dedicated to healing, we cannot choose to ignore the consequences of hatred and discrimination because we know they contribute to disparities in health outcomes for communities of color. They also negatively impact every facet of our lives from public safety and criminal justice to economic opportunity and public health.

"We respect and commend the professional ideals of those serving in law enforcement. We also acknowledge the sacrifices of those committed to protecting and serving our communities with honor. But we cannot ignore the systemic problems embedded within our justice system that endanger the lives of Black and Brown communities. We cannot tolerate any culture that cultivates the infliction of racial violence and mistreatment of its people. This means we must also examine the systems and practices of our own medical profession.

"Our profession has its own history of abuses of Black and Brown bodies in the name of advancing medical science. We also understand the unconscious biases and prejudices that codify policies and programs disproportionately harming communities of color. We must do more to eliminate health inequities that undermine our state's public health and collective well-being.

"Through CMA, we support physicians using their influence to create solutions that disrupt the generations of institutionalized racism that fostered the tragic circumstances we are currently witnessing in our country. Many CMA physicians already work in partnership with health care and community leaders to formulate and execute programs aimed at addressing racial and ethnic inequities. Together, we can do even more to achieve our goal of health equity and truthfully represent the values of compassion and humanism that define our noble profession." §

Thank You to the Health Care Community

During this challenging time, we send our profound gratitude to all of you in the health care and public health community for your work on the front lines taking care of patients and protecting the public. We know that you are working under stressful conditions and even putting your own health at risk. We cannot thank you enough for your commitment and determination to the health of your patients and communities.

CONGRATULATIONS ***to our***

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for receiving

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EMR Strikes Out

Stephen Kamelgarn, M.D.

During the fifteen years that I've been using some form of electronic medical records (EMR), I've made no secret of my ambivalent feelings about the technology. I've lauded EMR's ability to track patients' medications and active problems; a task that was almost impossible in the "bad old days" of paper charts. In that sense, electronic medical records have been a boon. And while these two extremely important functions have made my professional life much easier in many respects, I haven't found much else about the technology to cheer about.

I've despaired watching practitioners (including myself occasionally) focus on the computer and not the patient in front of us. I've screamed loudly that EMR technology is designed for billers, auditors and insurance clerks, and NOT physicians or other health practitioners. I've complained ad nauseam about the instability of our electronic systems, and how we're completely stuck in the face of system crashes; an inevitability akin to the sun rising in the East.

Now, in this age of COVID, I've found another major defect in our electronic medical records systems. EMRs supposedly document every step doctors or other health care workers take in treating a COVID patient, from medicines prescribed to signs of progress or setbacks. Data collected from large numbers of patients could quickly yield answers about which treatments are succeeding.

Type in an ICD-10, press a button and voilá, instant data analysis on all patients with this particular ICD-10 in their chart. In fact, over the past decade we've spent more than $36 billion switching from paper to EMR, expecting, among other things, to harness volumes of medical data to reveal which treatments work best.[1]

But the COVID-19 pandemic is bringing into stark relief just how far the nation is from achieving EMR's promised benefits. Every EMR I've used has been sold as an ideal research tool, tracking trends in our patient populations. Well, EMR hasn't worked as advertised during this COVID crisis. Currently, it is almost impossible to get data on populations suffering from COVID-19.

An example: When President Donald Trump started touting hydroxychloroquine as "one of the biggest game changers" for treating COVID-19, researchers hoped electronic health records could quickly tell them if he was on the right track.

Yet pooling data from the digital records systems in thousands of hospitals has proved a technical nightmare thus far. That's largely because software built by rival technology firms often cannot retrieve and share information to help doctors judge which coronavirus treatments are helping patients recover. Even if two different hospitals are using software from the same vendor, the two systems often can't "talk" to one another, making data pooling almost impossible.[2] Wasn't "Meaningful Use" Stage 2 ("Improves interoperability by adopting new and updated vocabulary and content standards for documentation and exchange")[3] supposed to have taken care of this problem by 2015? Obviously, we're still having a lot of trouble achieving "interoperability."

Another example of system failure: A number of physicians have noted that thrombo-embolic phenomena (blood clots, strokes, pulmonary emboli etc) appear to be more common in patients with COVID. Yet, we cannot harness that anecdotal, yet vitally important, observation into any kind of data analysis to ascertain if thrombo-embolism is part of the "COVID syndrome" and if we should be putting our COVID patients on thrombo-embolism prophylaxis.[4]

"I'm stunned at EHR vendors' inability to consistently pull data from their systems," said Dale Sanders, chief technology officer of Health Catalyst, a medical data analytics company. "It's absolutely hampering our ability to understand and react to COVID."[5]

This failure is difficult to understand considering that EMR supposedly documents every step health practitioners take in treating a COVID patient, from medicines prescribed to signs of progress or setbacks. But the plethora of proprietary EMR systems that can't "talk" to one another make large scale studies almost impossible, at least until we get a national database.

In the meantime, we're stuck with systems that are clunky, time-consuming and present yet another hurdle to providing good care. Currently, clinicians typically spend an hour feeding documentation into a computer for every hour they spend with patients.[6] In an overcrowded ER or ICU that time spent away from patients and on the computer can be fatal.

"EMR", Continued on Page 17

LIKE TO WRITE?

Editorial and Publications Committee would like to encourage you to join the committee. Meetings are held quarterly 12:15 - 1:30 pm at the Medical Society office. Come help coordinate our member publications.

"EMR", Continued From Pg 5

Physicians in the frontlines are relying more on Twitter and other social media among themselves to rapidly find what works and what doesn't in dealing with COVID-19. [7] A cardiologist at Massachusetts General Hospital tweeted, "Why are nearly all notes in Epic . . .basically "useless" to understand what's happening to patients during their hospital course?" [8]

We know that EMR's were designed specifically for billers and auditors, but we never expected our records systems to fail so miserably at the task they were "ostensibly" supposed to perform – providing a summary of patient care and patient progress.

In fact EMR systems have failed so badly in New York that Governor Cuomo issued an executive order at the end of March, 2020, that states, *"Health care providers are relieved of record keeping requirements to the extent necessary for health care providers to perform tasks as may be necessary to respond to the COVID-19 outbreak. . . .Any person acting reasonably and in good faith under this provision shall be afforded absolute immunity from liability."* [9] A system designed to expedite and improve the delivery of health care was officially recognized as an obstacle in delivering good care.

So now, as our frontline health workers have to contend with shortages in personal protective equipment, a lack of reliable, rapid COVID testing and overwhelming numbers of sick patients, we now have to contend with electronic systems that make our jobs even more difficult and dangerous to patients.

**Epic is the EMR system used by most large hospitals, health systems and large medical practices across the country.*

Sources

1 Fred Schulte "As Coronavirus Strikes, Crucial Data in EHRs Hard to Harvest" *Medscape News* May 2, 2020 https://www.medscape.com/viewarticle/929841_print

2 Ibid

3 Bernie Monegain "Delay Stage 3 meaningful use, senator urges again" *Healthcare IT News*, September 17, 2015 http://www.healthcareitnews.com/news/delay-stage-3-urges-senator

4 Siddhartha Mukherjee "After the Storm: The pandemic has revealed dire flaws in American medicine. Can we fix them?" The New Yorker, May 4, 2020 pp 24-31

5 Schulte op cit
6 Mukerjee op cit
7 Mukerjee op cit
8 Mukerjee op cit
9 Mukerjee op cit

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