Time to rethink EMRs?

I am a family physician, Assistant Clinical Professor in the Faculty of Medicine at Memorial University of Newfoundland, and a Town Councillor in my home town of Torbay, Nfld. I have been privately advocating against the increasing push for electronic medical records (EMRs) by provincial and national medical associations for the past couple of years. I have written to both the Newfoundland and Labrador Medical Association and the Canadian Medical Association on numerous occasions, but one voice is not likely to change the minds of policy makers in our profession, and so I write this letter to ask for input from my colleagues.

I read a recent meta-analysis[1]—one of my daily Canadian Medical Association POEMs (Patient-Oriented Evidence that Matters)—that highlighted recent research that showed the evidence for EMRs improving medical outcomes was very thin at best and likely nonexistent. We should be practising evidence-based medicine. Why are the organizations that represent us continuing to push EMRs?

My biggest issue with EMRs, other than that they do not help outcomes, is that they are likely deteriorating the physician-patient relationship. I say this because they are a distraction from the office visit, in that physicians are often spending more time looking at computer screens than at their patients. I recently had a patient move to my practice because his physician switched to an EMR and no longer looked at him during appointments, as the physician was so focused on the computer.

Electronic medical records are also excessively expensive, very time consuming, and complicated to set up and maintain. The country that has the most computerized medical system in the world is the United States. They also have an indebted, expensive medical system that, by all accounts and indicators, has far worse medical outcomes than most other industrialized nations do. One would hope that we could learn from our neighbour and not continue to waste our precious, scarce health care dollars on initiatives that have little benefit and potentially serious consequences.

I urge any physicians that share my worries about EMRs to relay these concerns to their local and national politicians and medical associations. Let's get back to focusing our limited health care resources where they can have the biggest effect and practise evidence-based medicine. I appreciate you taking your precious time to consider the above perspective.

—Thomas Hall MD CCFP
Torbay, Nfld

Competing interests
None declared

Reference

1. Canadian Medical Association. *Clinical decision support linked to EMRs doesn't decrease mortality. POEMs Research Summaries.* Ottawa, ON: Essential Evidence Plus; 2015.

Updated CMPA resource

I want to make a clarification about mentions of the Canadian Medical Protective Association (CMPA) in an article written by Dr Simon Moore entitled "Are you ready for an office code blue? Online video to prepare for office emergencies,"[1] published in the January 2015 issue of *Canadian Family Physician*.

The article mentions the CMPA in the following context: "Of all Canadian provinces and territories, only 3 regulatory authorities have policies on emergency equipment, and the Canadian Medical Protective Association is not mandated to provide such guidelines." This was referenced from a 2002 *Canadian Family Physician* article.[2] It also mentions that the CMPA website was among sources that were searched for articles published between 1991 and 2012 using the key words *office emergency* and *office emergencies*.

I searched the CMPA website and found an article published in 2013 entitled "Preparing for a medical emergency—anticipating the unexpected in an office or clinic."[3] This shows the CMPA does provide guidance on medical emergencies in office and clinic settings. However, as mentioned in the article, the scope of the literature review was to find articles published between 1991 and 2012, and the CMPA article was published in 2013. I want to provide clarification on these mentions in the article for future reference. *Canadian Family Physician* reaches an audience that consists of many CMPA members and it is beneficial for them to seek our guidance in preparation for emergencies in medical offices, and as a resource for educational videos and programs on this topic.

I appreciate that our website was used as a resource for the literature review and evaluation of the program. The CMPA continually adds new medicolegal resources

to its website. Please visit **www.cmpa-acpm.ca** to view the most current information available from the CMPA.

—Dima Hanhan
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Competing interests
None declared

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1. Moore S. Are you ready for an office code blue? Online video to prepare for office emergencies. *Can Fam Physician* 2015;61:e9-16 (Eng), e17-25 (Fr).
2. Sempowski IP, Brison RJ. Dealing with office emergencies. Stepwise approach for family physicians. *Can Fam Physician* 2002;48:1464-72.
3. Canadian Medical Protective Association [website]. *Preparing for a medical emergency—anticipating the unexpected in an office or clinic.* Ottawa, ON: Canadian Medical Protective Association; 2013. Available from: **www.cmpa-acpm.ca/en/safety/-/asset_publisher/N6oEDMrzRbCC/content/preparing-for-a-medical-emergency-anticipating-the-unexpected-in-an-office-or-clinic**. Accessed 2015 Feb 3.

Correction

In the article "Targeted temperature management after out-of-hospital cardiac arrest. Who, when, why, and how?"[1]—which appeared in the February 2015 issue of *Canadian Family Physician*—there was an incorrect statement published about the number of patients randomized in a study. The statement should have read as follows:

The Hypothermia after Cardiac Arrest Study Group randomized 275 patients aged 18 to 75 years after witnessed OHCA [out-of-hospital cardiac arrest] with an initial rhythm of VF [ventricular fibrillation] or nonperfusing ventricular tachycardia who had no "response to verbal commands" and an interval time of collapse to EMS [emergency medical services] arrival of 5 to 15 minutes.

The authors apologize for this error and for any inconvenience it might have caused.

Reference
1. Grunau BE, Christenson J, Brooks SC. Targeted temperature management after out-of-hospital cardiac arrest. Who, when, why, and how? *Can Fam Physician* 2015;61:129-34.

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