Right tool for the job

First, my sympathy goes out to Dr Greiver: the electronic medical record (EMR) she appears to have been forced to use can only be described as a "dog" if it has been so functionless as to temper her early adopter enthusiasm.[1] To have a query crashing a server is, frankly, pathetic and inexcusable.

Last week I had a patient get lost (another story) on the way to her medical examination so, suddenly, I had a spare 20 minutes. Just that morning, a patient encounter had reminded me that, for multiple reasons, our diabetes tracking had fallen to the bottom of the to-do list. The patient apologized for not following up. I had to apologize to him for not being flagged for recall. So, in my "spare" 20 minutes, I ran a diabetes recall report (no crash) for our clinic group, selected my own patients, sorted them by date of last hemoglobin A_{1c} measurement (although I could have chosen any of a number of metrics), then started messaging reminders to those missing in action who had fallen off a bit. I was also able to identify those few patients who had moved away and thus "remove" them. I was also able to use the EMR to check which patients had current standing orders at the laboratory and generate new ones for those who did not.

Can I prove that any of this will improve patient care? Like for all family practitioners, our patient populations and the intervention group are too small to show a benefit that will satisfy the statisticians and the meaningful use mavens. So all I can hope is that my EMR-driven, personalized care will maybe help a few of my patients. What I am certain of is that none of this could be achieved so easily with a paper chart system.

As described in Dr Ladouceur's editorial[2] that was in the same issue of *Canadian Family Physician* as this EMR debate,[1,3] the EMR is but a tool. I would not expect to hear anything with a toy plastic stethoscope, but my electronic variety has enabled me to manage the challenges of my hearing deficit. A poor tool foisted upon the end user because it serves administrative or government wants and needs rather than the necessities of the end user (or the receiver: the patient) will continue to engender unhappiness, resistance, and poor outcomes. As the Einstein Internet meme alludes, it is insane that we are still having this discussion and that governments and administrations continue to repeat the mistakes of the past yet expect different outcomes. Personally I would never "go back" from our EMR to the inefficiencies and deficiencies of the paper chart, but, then, the EMR is the system we chose (and switched to) to meet our needs and the needs of our patients, in defiance of government coercion. Our EMRs (and our ability to use them) are probably already a more critical tool than our stethoscopes (think about it: which do we use more in a working day?), so why would we let those who do not actually use them direct which we should use (and how we should use it).

So, I am hoping that Dr Greiver's enthusiasm can be restored by allowing her to have the right tool and control over how to use it for the benefit of her patients (and herself).

—*Paul V. Mackey MD CCFP FCFP*
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Competing interests
Dr Mackey is a volunteer board member of Applied Informatics for Health Society, a not-for-profit society that manages the electronic medical record Medical Office Information System.

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Response

I thank Dr Mackey for his response to my side of the debate in the October issue of *Canadian Family Physician*.[1] I also think that his patients are fortunate to have him as their family physician; it is very evident that the quality of care they receive is important to him and that he uses the tools available to monitor and improve this.

I do not feel discouraged at all and plan to continue working and doing research with and about electronic medical records (EMRs) and the data they contain. However, I think that we should have made much more progress after 10 years of EMR implementation. I do not think the limited progress is isolated to any particular area or EMR vendor, rather, it is the overall functioning of our health information technology (IT) system that is problematic.

This is not to say that there has been a lack of progress; there has been improvement in the past few years, for example, in electronic transmission of laboratory results, diagnostic imaging, and hospital reports. There

are also areas of excellent work; we need to hear more about those.

However, so much more still remains to be done. New medications are approved because they improve patients' health: the HOPE (Heart Outcomes Prevention Evaluation) study[2] was a large randomized controlled trial of patients at high cardiovascular risk that found that ramipril reduced the risk of strokes and myocardial infarction.

I cannot find evidence that use of EMR A leads to better health outcomes for my patients than EMR B does. We can do this type of study, and it does not take a randomized controlled trial; it takes data and analytics to enable us to generate the evidence. Even if EMR B is found to be inferior, we can look at the differences between the 2 and help our colleagues using EMR B by pushing for implementation of useful features through regulations and market forces.

You cannot improve what you do not measure. To improve outcomes for our patients and our health care system, we need data, we need analytics, and we need accurate and fair reporting using EMR data and other data sources.

I am not alone in asking for progress toward a more evidence-informed health IT system. I strongly believe that all of us share the same goal, that of using our EMRs to maximize benefits for the patients who have trusted us with their care. The actions to ensure that this comes to pass will need to be collective; EMR vendors and the health IT system need to support these goals by more consistently enabling all of us who use their products to monitor and improve the care we provide to our patients.

A wise clinician wrote, "Data orientation, the relentless pursuit of excellence, and a habit of inquiry are all second nature to clinicians."[3] Our profession is fortunate in having such clinician leaders; it is time for us and our leaders to collectively demand better from our EMRs.

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Competing interests
None declared

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