An EMR-driven talk

As a practising family physician in Scarborough, Ont, I read Dr Greiver's arguments in the October 2015 issue regarding electronic medical records (EMRs) not improving quality of care with interest.[1] I think that maybe Dr Griever just had a bad experience with her choice of EMR or vendor.

There have been great advances in the past 5 years in the adoption of EMRs and usability. I get all my laboratory, imaging, and even hospital reports electronically uploaded into my EMR system, Open Source Clinical Application Resource (OSCAR).

Electronic medical records are not used the same way as paper charts. It is a dynamic process.

I can proactively recall patients for Papanicolaou tests, fecal occult blood tests, hepatitis B follow-up, diabetes follow-up, etc, by searching for patients who need them. I even upload my Cancer Care Ontario screening assessment report in my OSCAR EMR for proactive recall. If there is a recall of a drug, I can search *all my patients* to see who is taking it and recall them. I can recall patients who do not control their hemoglobin A_{1c} levels. These features would be next to impossible or very tedious to do manually.

Also, I do not need any more filing clerks who used to misfile my paper reports! I also save thousands of dollars on rental storage space for charts and cabinets!

At the 2015 Family Medicine Forum in Toronto, Ont, I gave a presentation on the OSCAR EMR. Readers can find all the work I do on the OSCAR development online.[2]

—Ian Pun MD
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Competing interests
Dr Pun is an OSCAR McMaster EMR user and developer.

References

1. Greiver M. Do electronic medical records improve quality of care? No [Debates]. *Can Fam Physician* 2015;61:847-9 (Eng), 852-3 (Fr).
2. *OSCARMcMaster BC Users* [online forum]. Sunnyvale, CA: Nabble; 2015. Available from: **http://oscarmcmaster-bc-users.138173.n3.nabble.com/template/NamlServlet.jtp?macro=search_page&node=138173&query=ian+pun**. Accessed 2015 Nov 3.

Blind to patient's income

In a letter published in the October 2015 issue of *Canadian Family Physician*, Milburn wrote the following:

> [M]any authors talk of income equality as if there were a direct pathophysiologic pathway that leads from one's bank account to one's coronary arteries. How does one's heart sense that one is poorer than others in society? ...
>
> [P]eople's life circumstances ... are an outcome of their education, socialization, abilities, genes, and life choices.
>
> The thought that somehow giving poorer people more money will automatically result in health improvements is incredibly naïve and overly simplistic. Any physician ... is well aware that extra money can have a negative effect ....[1]

These observations are mean spirited and unprofessional. "Free will" is an illusion. Each person is influenced by his or her surroundings. Members of the College of Family Physicians of Canada are expected to follow "evidence-based guidelines," but some aspects of guidelines can later be proven wrong. People who watch television and read magazines can be convinced to eat cheeseburgers, drink colas, drive cars, and smoke cigarettes. People who consume cheeseburgers and sugary drinks and who get around by driving (rather than walking or cycling) will tend to be overweight and to have elevated glucose and low high-density lipoprotein cholesterol levels—risk factors for coronary arteriosclerosis.

Early life experiences have a big effect on a person's performance and outlook. A person whose parents were not attentive or who did not encourage education and polite behaviour will find it difficult to get a safe, well-paying daytime job. Economic deprivation and sleep deprivation from shift work induce the release of stress hormones, which have a deleterious effect on the cardiovascular system.

It is a privilege for a doctor to serve his or her patients. It is easy to look after well educated, polite people who speak like we do, and we tend to offer better care to people from an affluent background.[2] We must use our knowledge and skills to help every patient, regardless of the patient's income.

—Robert W. Shepherd MD CCFP
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Competing interests
None declared

References

1. Milburn CR. No pathophysiologic pathway between wallet and coronary artery [Letters]. *Can Fam Physician* 2015;61:855.
2. Alter DA, Naylor CD, Austin PC, Chan BT, Tu JV. Geography and service supply do not explain socioeconomic gradients in angiography use after acute myocardial infarction. *CMAJ* 2003;168(3):261-4.

Correction

L'article intitulé «Diagnostiquer l'hypertension artérielle. Données probantes à l'appui des recommandations 2015 du Programme éducatif canadien sur l'hypertension»[1] qui a été publié dans le numéro du mois de novembre du *Médecin de famille canadien* contenait une erreur dans une des recommandations, qui aurait dû se lire comme suit:

- Un brassard de la bonne taille doit être appliqué sur le bras non dominant à moins que la différence de la PAS [pression artérielle systolique] entre les deux bras ne soit de >10 mm Hg; dans ce cas, il faut utiliser le bras affichant la valeur la plus élevée

Le Médecin de famille canadien regrette sincèrement tout inconvénient que cette erreur a pu causer.

Référence

1. Gelfer M, Dawes M, Kaczorowski J, Padwal R, Cloutier L. Diagnostiquer l'hypertension artérielle. Données probantes à l'appui des recommandations 2015 du Programme éducatif canadien sur l'hypertension. *Can Fam Physician* 2015;61:949-55 (ang), e499-503 (fr).