

## FROM THE EDITOR

## The Meaning Behind Meaningful Use

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The Centers for Medicare & Medicaid Services have instituted the carrot-and-stick approach to forcing physicians and health care systems to universally adopt an electronic medical record (EMR). In addition, presumably in an attempt to get physicians to manage population health, they have developed guidelines for practices to address inherent deficiencies in the EMR and ensure that we do not simply substitute paper for e-records but combine the power of technology with the practice of medicine. However, as I look around, physicians are erupting into panic. Stories of early retirement, open outbursts in practices, and threats of dropping complex non-complaint patients who don't follow instructions are heard everywhere—from national meetings to practice meetings. Graduating residents, talking to practicing physicians, are frightened by “what the government” is making us do. “*Is it worth it?*” seems to be a universal soul-searching question that everyone around me is asking—from the medical student entering a life path that no one can quite predict to the experienced physician.

As a relatively recent adoptee of the EMR, I have certain naïve assumptions about electronic health records:

- The technology that ensures that I can identify Cotard's Syndrome (aka walking corpse syndrome) at the point of care or during morning report became available when our medical record finally turned electronic. It took me 12 seconds to find what Cotard's syndrome was on Google, but it took me 45 minutes to figure out where Mr. Smith had his last

creatinine done two weeks ago and what the level was.

- The IT capability that ensures I receive annual updates from the veterinarian regarding shots that are due for my dog Chewbacca should similarly remind me when my patients need annual preventive exams or routine hemoglobin A1c monitoring. Unfortunately, the reminder process has been so confusing to laboratory folk that I had to disable the health management plan when an irate patient called because she had received the four hemoglobin A1c tests ordered for the year in the span of one month. No one bothered to check the dates! Luckily, Chewbacca is getting his health management plan just fine. Mrs. Gordon in our clinic—many “workarounds” later—just barely.
- With the focus on care coordination in health care, I was impatient to adopt the EMR. My dream: Sitting in my clinic—a mere stone's throw from the hospital—I would get an alert when my patients were admitted and discharged. Finally, after a decade-long wait, I would have the information that I needed. No more keeping the patient waiting for the results of the CT scan! The reality? Unfortunately, my patient Mr. Hun was admitted for “something wrong in my lung” and was treated with a medication that could have killed him if not monitored. Dashed were my hopes that the EMR could join the medication record to the transcription system, which could interface with radiology and prompt the intern

to dictate the discharge summary at just the right time. So Mr. Hun came back the next day because I could not see the Amiodarone, Coumadin, and Azithromycin that were prescribed until three days after his discharge.

- In the world where I practice medicine, my 24-year-old socialite patient with stretch marks appears in clinic with a print out from WebMD claiming that she has cutaneous larva migrans. (Stretch marks are not on WebMD!) Who could have anticipated that my sunny endocrinologist colleague would be reduced to tears because she could not order a cosyntropin stimulation test to save her life (or her patient with Addison's Disease) and that it would take four patient visits and four blood draws to get four useless cortisone levels?

I could go on and on, as I am sure many of you can, yet I am reminded of what my first computer cost me and my husband in our combined monthly salaries, forcing us to skip eating out for a very long time. It also required a sizeable swath of our dining room table due to its size and could perform only a fraction of what my iPhone can today. I am also reminded of the long time I waited (im)patiently for my dial up to finally connect, all the while praying that my restless two-year-old would not wake up to its uncontrollable humming and chirping. Finally, I empathize with the health system executives and practice owners who have had to make hasty decisions about buying an EMR. I am reminded of the \$10,000 car I wanted after finishing residency,

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which exploded into a \$20,000 proposition after all of the frills and excesses were taken into account. Needless to write, I ultimately chose a cheaper car that got me to and from work just fine. Now, as I prepare to buy a second car for my daughter, I see that most standard models have more features at less cost than they did many years ago.

So, my friends, we are hurtling towards full universal implementation of

the EMR—like it or not. We look forward to the cloud technology that links all our practices and health systems—just don't expect the iCloud. As we take on the challenge of ensuring that all our patients have their blood pressure checked and smoking cessation counseling provided, regardless of whether we as providers own a stethoscope or a scalpel or a monitor, just remember your first computer and glance down to your

iPhone: The transformation has taken decades. I am sure that getting it right will take several iterations; meanwhile, strive to offer Mrs. Jones, your diabetic patient, the same good care experience Chewbacca enjoys. Meaningful Use will frequently feel like meaningless use. It's like flying: Enjoy the ride, have a drink if you must—but not too many—and laugh about it because if you don't, the e-fear will paralyze you. Cheers!

*SGIM*