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Voices of Medicine

By Del Meyer, MD

Electronic Medical Records have some advantages; and anesthetizing an orangutan.

Before and After EMR

Lee Leer, MD, discusses "EMR From the Trenches" in the Humboldt-Del Norte County Medical Society *Bulletin*:

Much has been written lately about Electronic Medical Records (EMR's). Some of the authors have even spent a bit of time working with an EMR.

Many authors are not particularly positive though at least recently even those who don't like EMR's bow to their inevitability. Most seem to feel that something is lost in the patient interaction when computers come into play.

I propose to paint another picture. I believe, and have experienced, that EMR's not only contain the tools to improve "objective" quality (such as health screening benchmarks), but also "subjective" quality (what goes on in the exam room and its impact on patient satisfaction).

Before moving on, however, I must remind myself what pre-EMR life was like. I would get a chart (or charts, in the case of complex, long-term patients) with various bits of loose and bound paper in and on the chart. I would hopefully review all these bits of paper (x-ray reports, labs, consult reports, and the like) before going in the room with the patient. Every few days, a chart simply could not be found in time for a patient's visit. It would often have been buried in the stack of charts on a provider's desk.

You know the gig (pre-EMR): I get in the room, hopefully with a chart balanced on my knee, and begin to review current results with the patient. Often, they ask, "What were the results last year?" Leisurely flipping through the chart is followed by frenzied tearing through misfiled pages, different volumes, and sections devoted to Workers' Comp. Concurrently, I'm attempting to jot a few notes from our encounter, or else keep it all in my head to dictate at the end of the visit. If the patient asks me about a drug or disease or procedure I've never heard of (an increasingly frequent occurrence, I fear), I take notes and promise to get back to them. If we are beginning a new medication, I "fire up" my memory banks and "run" a drug interaction check. If the potential drug interactions are significant, or if my memory banks are empty, I excuse myself and try to find printed material on interactions. This can consume several minutes. Finally, I fill out a visit charge and a diagnosis on a paper form. I give that paper to the patient

and hope they won't discard it before they reach the front desk. When the person working outbound acquires the paper and successfully interprets my scribbles about follow up, we're done!

Currently (post-paper records), I turn my computer on each morning, look through my list of patients, and review potential problems with my medical assistant. We make sure that all studies to be reviewed are available and in the chart (i.e., on the computer). When the patient is ready, I walk into the exam room carrying my small laptop. I sit, make eye contact, and have a several minute conversation with the patient, during which time my computer does nothing but warm my knee. Eventually during the discussion, I will look down to the computer and type in a few words. Typically, by the time the visit is complete I'll have finished at least the rough outline of the "subjective" portion of my note. All labs, current and old, are retrieved, reviewed, and compared with a couple of clicks. Medications are renewed by a few more clicks. Drug/drug interactions, drug/ allergy and drug/diagnosis contraindications are automatically checked. Usually, the prescription is electronically transmitted to their local pharmacy as we speak.

To read all of Dr. Leer's article, go to www.humboldt1.com/~medsoc/images/bulletins/NOVEMBER%202008%20BULLETIN_for%20web.pdf

Otis, One Ornery Orangutan

Dr. Stanley Perkins details his encounter with an orangutan named Otis, in "Animal Rites: Some Patients are Wilder than Others," in the Summer 2008 *Bulletin* of the California Society of Anesthesiologists. Dr. Perkins is an anesthesiologist at Sharp Memorial Hospital in San Diego, where he cares for a variety of humans. When not putting people - or animals - to sleep, he flies his Turbo Commander with his dog, Amy, in the co-pilot's seat:

It had all the elements of a horror flick: a gurney, two unsuspecting doctors, and a violent yet sedated patient. In dim light the gurney glides onto a freight elevator, a dull clang reverberating as the wheels bump across the threshold. Slack-faced, with gazes riveted upward, the men watch the lighted arrow make its slow arc. Suddenly, a huge hairy hand springs up, seizing one of the men by the wrist. His eyes wide with panic, the doctor struggles to free himself while the elevator lumbers on, slowly carrying the men and their charge out of sight.

As every fan of horror knows, such a scene never bodes well for the doctor. This time, though, the scene was real; I was the doctor and my patient was one ornery orangutan. In the two decades I've volunteered at the San Diego Zoo and Wild Animal Park as a veterinary anesthesiologist, that tussle with Otis was the closest I've come to being the guy who, when the elevator door opens, is sprawled lifeless on the floor.

Otis was one of two male orangutans at the zoo. The other, Ken Allen, had earned acclaim as an escape artist. Whenever he grew bored, he would set about loosening the bolts of his cage. A quick slip through the door, a scamper up an incline, and a swing over a wall, and Ken Allen would be out, strolling amid a crowd of people, as if he were just another zoo patron. Each time his keepers discovered one of his escape routes, they closed it off, but he would devise a new one. He never seemed to mind being led back into his enclosure, though; he simply relished the challenge of finding new flight paths.

Otis had none of Ken Allen's geniality. He was a bundle of hirsute hostility, and he detested veterinarians - and anyone associated with them - most of all. With the highest strength-to-weight ratio of any primate, orangutans are not to be trifled with, especially when they have Otis's disposition. Whenever I received a call from the zoo about an animal in distress, I would jump into my car and head right over. If that call was about Otis, though, I had to fight the urge to jump into my car and head home instead. On the day he grabbed me, Otis was scheduled for cosmetic surgery: He needed a wart removed from his nose. But at the zoo even the simplest examinations require sedation. Jeff Zuba, the veterinary intern, tranquilized

Otis with a dart so we could transport him to the veterinary hospital. I administered the anesthetic while the veterinarians removed the wart, conducted a physical exam, and untangled his long locks.

During the return trip, I administered the last of the anesthetic. Since we were only minutes from Otis's enclosure, I figured we'd be fine. Unfortunately, I had forgotten the sluggishness of the freight elevator that led down to his cage. Jeff and I were cramped into the tiny elevator with our bodies pressed against the gurney. I was holding the oxygen mask over Otis's face when suddenly I felt his prehensile grip. Now gasping for breath myself, I peeled his leathery digits one by one from my wrist and struggled to reinstate his oxygen mask. When the elevator door finally banged open, Jeff and I sprinted, with the gurney in tow, back to Otis's cage. By the time we had settled the orangutan in his bedroom, he was fully awake and spitting mad. Jeff later confessed the escape plan he had formulated as soon as Otis grabbed my wrist: He would dive under the gurney - and leave me to my own devices.

For more on anesthesiology and animals, go to www.csahq.org/pdf/bulletin/animal_57_3.pdf

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