I paid for an EMR \* and found I was treating the record rather than the patient. As a result, I returned to a MACRO transcription system that eliminates the need for a scribe in the exam room. It utilizes a check box/written encounter form that the transcriber uses to produce a concise type-written record of the visit in a short period of time.

Since the time that the EMR was conceived and put into effect, I can no longer trust the consultation information that I receive. In lieu of a 1-2-page letter that specifically addresses the relevant data regarding the patient, I now receive 5-8 pages of time-wasting and largely irrelevant information. I often rely primarily on the patient history (after reviewing lab and imaging reports that I request specifically at the time of the exam) rather than accepting the responsibility of a 5-8 page, largely irrelevant, record to incorporate in my system.

What is the answer? Each physician must be able to design a “meaningful synopsis” of his/her encounter and thought process that is devoid of the “unnecessary garbage” that is required in the examiner’s record according to regulatory agencies. The unnecessary garbage can remain in the computer and will certainly be reproduced by the second examiner, but need not be a part of the relevant transported record.

\*Please forgive the acronym EMR rather than EHR as spellcheck will not accept this without undo correcting; I think you should contact spellcheck to include this widely accepted acronym.