BCMJ BC Medical Journal

Letters for Personal View are welcomed. They should be double-spaced and fewer than 300 words. The *BCMJ* reserves the right to edit letters for clarity and length. Letters may be e-mailed (journal@bcma.bc.ca), faxed (604 638-2917), or sent through the post.

EMRs and specialists

As a surgical specialist, I wish to express my frustration with the EMR programs as made available through PITO. Months ago I had written a letter of concern to PITO regarding the fact that all of the EMR programs were designed for general practitioners. No further follow-up was provided regarding my concern. We are now working with one of the EMR programs. While the representatives of that company are very helpful and attentive, it is clear that this program was not designed for surgical specialists. Billing and scheduling are much more difficult than with our previous EMR, Accuro (Optimed), and we cannot access the electronic surgical booking form required by our health authority.

I would discourage any surgical specialist in the province from taking on a PITO-approved EMR until further refinements are made.

—N.P. Blair, MD
New Westminster

PITO is making an effort to make EMRs useful to BC specialists. Please see "Specialists and EMR adoption" published in the May issue of the BCMJ. *(2009;51[4]:154).—Ed.*

Ready or not

The topic on your April cover should really have read "Assessing EMR's readiness for BC physicians." I'm definitely not an expert, but I have keenly followed the EMR issue for several years because I firmly believe that technology can save general practitioners by rescuing us from the endless data drudgery in which we are increasingly mired. Unfortunately, it looks like we are only partway there.

It's 2009. I just don't understand why I can't have a patient in front of me talking about her depression while my computer, which contains the patient data showing she is diabetic, automatically determines that she is due for a HbA1c, lipid profile, and AC ratio; securely transmits an electronic requisition in my name to the appropriate lab facility; and prints a self-explanatory reminder explaining the nature of the lab work, the fasting required, and the location of the lab facility, which I can then hand to the patient as she leaves. Although systems have improved over the years, our best EMR systems fall well short of this level of functionality. They are roughly the computing equivalent to the wringer washing machine: definitely better than manual, but half the drudgery is still left to the operator. And I'm a tad worried that if we all settle for wringer washers, the fully automatic version could be a long time coming.

I practise in the Interior Health Authority, which means that in my community the Meditech lab system has a monopoly on our lab information. Until about 2 years ago, Meditech was unable to interface with *any* major EMR system in North America (except its own notoriously weak product). For our multidoctor clinic, which for several years has wanted to implement an EMR, this has been the showstopper. Recently, one system (Practice Solutions) has achieved an interface that I understand is now operating in a live environment but—guess what—it has been deemed PITO-ineligible! IHA has been working quite hard for around 2 years on an interface with a PITO-approved system, but this has apparently proved a daunting task and to my knowledge is

only just now getting to the point of real-life implementation. Isn't this all something like hiring a hospital administrator without realizing he only speaks, say, Polish, then implementing an employee Polish-language program, firing the administrator's Polish-speaking secretary, and then, when doctors fail to communicate, lamenting their lack of readiness?

How will maximal functionality be achieved? Improved vendor software for sure, but an integrated effort is also needed. The IT departments need to be convinced that their entire mission in life is to serve the needs of the patients and frontline health care providers, not, as it too often seems, the other way around; the bureaucrats need to listen to the frontline providers and be ready, willing, and able to remedy the progress-killing situations in the system; and doctors will need to come to the table with understanding, ideas, and useful feedback.

The saying "build a better mousetrap and the world will beat a path to your door" is as true as ever. BC doctors are not exactly beating a path to the EMR door, and I doubt it's from lack of readiness, whatever that really is. Instead of putting all our effort into frantically paving this untrod pathway with elaborate funding incentives and support programs, shouldn't we all be working harder on the mousetrap?

—Ivor McMahen, MD
Williams Lake

Bottled vs tap water revisited

Drs Copes, Evans, and Verhille[1] write compellingly on the evils of bottled water (not environmentally friendly) and the blessings of municipal water, but their discussion does seem a bit one-sided.

There is no doubt that water in urban British Columbia is bacterially and virally safe, but outbreaks of Cryptosporidia parvum[2] and others parasites[3,4] are well established. And one does not have to look far for examples of other municipal water outbreaks.[5]

As much as municipal water at the origins may be extremely safe and available with a high degree of confidence, this does not always speak to the quality of water at the tap, particularly in older buildings. Often tap water carries precipitate, grit, rust, and microbial contamination that come from old plumbing. While filter systems can address many of these problems, they are fine until they leak, putting many days of residual debris into a single glass of water. Drinking fountains in public places have largely disappeared, in part because of the expense of cleaning them to remove the evidence of their co-use as public spittoons. Bottled water in the workplace is a viable alternative to unpalatable and perhaps unsafe drinking water in many public places.

Outside the house or office, I agree that the recreational overuse of water in plastic bottles seems to be unnecessary and wasteful. But one doesn't have to get very far outside the city before carrying drinking water for hiking becomes essential, and glass bottles are hardly an acceptable alternative. Given the choice between the real and predictable risk of broken and damaged glass bottles and cuts from glass shards versus the theoretical risk of Bisphenol-A or other leachable molecules, it would seem that the balance of safety would strongly lean to the side of plastic containers.

Finally, we know and understand that every family needs to recognize and plan for natural and unnatural disasters that include earthquakes, being trapped in vehicles, and even the outcomes of terror. We are advised that municipal water may not always be present. Advice is to ensure an ample supply of bottled water.

Continued on page 192

Continued from page 191

While plastic water bottles may not be environmentally friendly, they are nonetheless safe, light, storable, and in some situations even lifesaving.

—Michael A. Noble, MD
Department of Pathology and Laboratory Medicine, UBC

References

1. Copes R, Evans GM, Verhille S. Bottled vs tap water. BCMJ 2009;51:112-113.
2. Ong CS, Eisler DL, Goh SH, et al. Molecular epidemiology of cryptosporidiosis outbreaks and transmission in British Columbia, Canada. Am J Trop Med Hyg 1999;61:63-69.
3. Aramini JJ, Stephen C, Dubey JP, et al. Potential contamination of drinking water with Toxoplasma gondii oocysts. Epidemiol Infect 1999;122:305-315.
4. Isaac-Renton J, Moorehead W, Ross A. Longitudinal studies of Giardia contamination in two community drinking water supplies: Cyst levels, parasite viability, and health impact. Appl Environ Microbiol 1996;62:47-54.
5. Hrudey SE, Payment P, Huck PM, et al. A fatal waterborne disease epidemic in Walkerton, Ontario: Comparison with other waterborne outbreaks in the developed world. Water Sci Technol 2003; 47:7-14.

Disappointed in BCMA

After 50 years as a member of the BCMA I feel comfortable in expressing some observations. I am disappointed.

The BCMA has remained a most divisive organization, as destructive and irreconcilable as the divisions of Islam at times, but more readily curable.

Instead of our factions fighting each other for the crumbs of government, each could employ a bargaining agent to promote vested interests and the struggle would be between them rather than between us. Some alternative to the traditional trenches needs to be developed so we do not eternally antagonize each other and waste our energies and our mission.

The feeble negotiating outcomes of the BCMA are responsible, second only to government, for the destruction of a once enviable quality of primary care in this province. Indirectly, we have been irresponsible in the care of the patient.

A few days ago I paid $160 for a routine dental check and minimal teeth cleaning. There was no disease to be managed or ongoing care, no tests to be ordered and evaluated, no consults to be dictated, no trips to the hospital, no interfering urgent phone calls, no consultation with the family, no hasty exits to emergency across town, no sleep deprivation, etc. For more than equivalent effort and expertise a family doctor or emergency physician is paid 20% of this ($29) and we are valuing this dental fee to equal that of a cardiology or neurology consultation.

Somehow we have not pegged our costs and reimbursements to the realities of other health professionals. Cost-of-living clauses do not mirror the costs of running an office. The BCMA has failed its members and the community in this matter. On issues of health such as seatbelts, bicycle helmets, and smoking, the BCMA has acted commendably and the officers of the BCMA have been enormously generous of their time and dedication.

But the bottom line is a disaster, as is the collegiality of the Association.

—Michael A. Ross, MD
Victoria