**25 quotes that show just how fed up physicians are with EHRs**

Written by Max Green | October 02, 2015

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More than half of the physicians who bill Medicare in the U.S. are currently being penalized 1 percent of their 2015 payments as a result of the meaningful use program, according to Steven J. Stack, MD, president of the American Medical Association.

"Imagine, in a world where a 2-year-old can operate an iPhone, you have graduate-educated physicians brought to their knees by electronic health records," Dr. Stack told [WBUR](http://commonhealth.wbur.org/2015/09/doctors-vent-frustrations-emr) in Boston. "When you have more than a quarter million physicians being penalized by the government, by a single program, I think that most people will understand the math. It's not the 250,000-plus physicians that are the problem, it's most likely the single program they're being punished by."

Though Dr. Stack may be the most vocal physician airing his grievances about EHR functionality and performance in the clinical care setting, he is far from the only one with gripes. One component of the AMA's Break the Red Tape town hall events, which aim to foster an open discussion of physician critiques on EHR technology, is the equivalent of an open-mic slam for clinicians, featuring a revolving door of medical professionals stepping up to share their frustrations and horror stories with this technology.

Here are 25 quotes illustrating just how much physicians can hate their EHR.

*Unless otherwise noted, all statements were either given at the AMA's Break the Red Tape Town Hall event or subsequently submitted to the Break the Red Tape website. Some statements have been lightly edited for style and clarity.*

1. **John Rogers, MD. Fairview Park Hospital (Dublin, Ga.).** "Initially you drop about 30 percent [of productivity following an EHR implementation], sometimes more. You recover a little bit, but you never regain your total productivity. What we've had to do is [use] some workarounds by employing other providers, scribes, mid-levels, and that comes at a cost. But what we really want from our investment is free flow of information, because that will allow us to improve the care that we can provide."

2. **John Rogers, MD.** "Too often I pull up a record, either in peer review or another setting, and it's almost impossible to really get an understanding of the story line. On a daily basis I can't find the information, particularly nurses' notes and things like that that are really valuable to me. In a sense it's turned us into data entry clerks. Communication with patients is not only suffering, but communication with nursing and others, as well. It breaks down, we all communicate now just by what goes into that electronic record."

3. **John Rogers, MD.** "Emergency physicians as a whole share the vision and promise that electronic records provide. We do not select the electronic record or pay for it, the hospital does. But we pay for it in other ways: lost productivity, workflow interruptions, usability frustrations. That is our investment, and we deserve a return on that investment. The number one thing we ask is sharing of information."

4. **Kay Kirkpatrick, MD.** Resurgens Orthopedics (Atlanta). "We can communicate easily within our 21 locations, that's not the problem. The problem is we operate at 20 different hospitals in the city, all of which have their own systems. I even go to two hospitals that have the same systems set up completely differently, and it's a totally different experience at the two places. Most of our consultants or people we communicate with have their own EMR systems, and unfortunately the way we get their reports is they fax them. We then print them and scan them, so they're not searchable. They're not electronic in any way, any stretch of the imagination. It's hard to retrieve information."

5. **Albert Johary, MD.** **Emory Healthcare (Atlanta).**"The patients definitely sense that we're a lot more stressed now. We're spending three hours more per day — and that's no exaggeration — just trying to get caught up. I do mine real-time, I do my charting when I'm in the room with the patient, but still that leaves no time to answer the phone calls, to answer the people that have called in, or sign off on the labs, etc. So I'm leaving at 7:30, 8 o'clock every single day. That's not sustainable."

6. **Gary Botstein, MD. Dekalb Medical (Decatur, Ga.).** "It's very easy to record large amounts of data and click-off boxes. So the emphasis is really on data collection, but what physicians ought to be doing is data synthesis. They ought to be taking that data, putting it together and coming up with a differential diagnosis and then figuring out what the best diagnosis is and then the best treatment. That has been lost in just five short years of using these products. When electronic medical record notes are generated, in the last five years I haven't seen a single differential diagnosis. I haven't seen hardly any rationale for why somebody thinks somebody has something. The only thing that goes in the impression slot is an ICD-9 code and a diagnosis name. Totally anathema to how medicine ought to be practiced."

7. **Gary Botstein, MD.** "In my program I have to collect large amounts of data. For example, I would see a very complex lupus patient and I counted up in my charts that it took me 48 data points to see this patient. That was vital signs, medications, potential side effects, symptoms, assessments of disease activity to come up with an impression and a plan. When the certified EMR was in front of me, I had 280 data points...to complete. To do this voluminous review of systems that was irrelevant to my patients' visits, it was like looking for a needle in a haystack. Once all this data was collected you couldn't even find it. As opposed to looking at the patient, thinking about what's important with this patient, asking the relevant questions, then proceeding to take care of this patient, there's this huge fountain of collection of data, then you've got to go wading through it hoping you can find the relevant piece of information. It's a totally backwards approach."

8. **Gary Botstein, MD.** "I participated in stage 1 and at six months I discarded my certified EMR in favor of going back to my old EMR, which helped me take care of patients. It didn't distract me from talking to them — it provided me what I needed to provide high-quality care."

9. **V.K. Puppula, MD.** Alliance Spine and Pain Centers (Atlanta). "As an attending physician, I really think that we need to drive home the message to the public that this is an impediment of access to safe, quality patient care...Most systems today are not [designed around clinical care]. They are set to comply with the federal regulations and with policymakers as opposed to actual physician-patient care, and the concern is we're basically being turned into data miners in order to spend all of our time and effort on documentation as opposed to the key issue of medical decision-making."

10. **Hayes Wilson, MD.** Piedmont Rheumatology Consultants (Atlanta). "Our PA quit because she typed with two fingers and it was too lugubrious for her. For me to review one note of hers, it was 38 clicks. If she saw 20 patients, it was 760 clicks a day just to review her notes."

11. **Steven Wertheim, MD.** **Emory Healthcare (Atlanta).** "When we first undertook this, we were excited. We started working with the EMR company to say, 'Look, if we're an orthopedic practice, we need to tailor this to us.' After about a year and half of that we were making some progress, but as soon as the meaningful use issue came out, that was it. Since that day the only thing that our EMR vendor is focusing on is qualifying their systems for the next meaningful use. There has been no ability for us to customize our system for orthopedics since that day."

12. **Steven Wertheim, MD.** "It's been a nightmare for us. Because of the way these meaningful use requirements are set out there isn't really a patient portal that is efficient. Our patients hate the patient portal we use and we've used two different patient portals. They just think it's very inefficient."

13. **Manoj Shah, MD. Advocate Health Care (Park Ridge, Ill.).** "We are not able to meet the stage 2 requirements. We did meet with stage 1, and for three years we did well. This year we just could not do it because they want a portal, they want a connection with an HIE, they want secure messaging and we are not able to do it."

14. **James Smith, MD. Emory Specialty Associates (Lawrenceville, Ga.).** "A current system doesn't exist for all of the hospitals to communicate in our area. We service a two-hospital system...that communicates with one another but obviously patients go to other hospitals in the area. It's impossible for me to know unless the patient has shared with me if they've been in other emergency departments in the surrounding area. If I want to get that information it's a very laborious process to get it. I'd like to know what were they seen for a couple of days ago. Was a CT scan performed? What other studies were done? I want to know mainly because you don't want to reproduce those things, the increased costs, radiation to the patient, etc. That would be a huge step in the right direction if we had the communication between those systems."

15. **James Smith, MD.** "I noticed that my patients noticed that as I was trying to talk to them and enter their history and put orders in as I was going — I could tell that they felt I was very detached and more focused on this. So beyond annoying them and my almighty Press Ganey scores going down, I just knew that it wasn't the right thing. I personally had to hire a scribe to do that. That has alleviated a portion of that and allows me to sit at the bedside and be more engaged with a patient, but that's now at a cost of between $25,000 and $30,000 a year out of my pocket."

16. **Melissa Rhodes, MD. Respiratory Consultants of (Cartersville) Georgia.** "When I'm in the ICU trying to titrate something where I could write a bunch of orders saying 'If this, do this, if this, do this' — you can't do that. You can't take care of an ICU patient, a critically ill patient. The nurses don't have the time to call you every ten minutes...The nurses can't put the orders in, so I'm supposed to enter them at night. Oh really? At two in the morning when I'm on call all weekend I'm supposed to get up and enter an order on a critically ill patient? You can't. There are so many orders that you can't. It only leads to harm for patient care, more medical errors, not less."

17. **Melissa Rhodes, MD.** "I picked a large EHR program, thinking they're most likely going to be around for a long time. It was very costly and I'm still paying a huge amount...I now see probably two-thirds the number of patients I saw when I was handwriting my notes. Not only that but when the Internet goes down you're stuck. And the Internet goes down. We have a redundant system that we pay two different Internet providers for, so once again the cost goes up. Does that fix it? No. Not only that but if you get a slight blip in the Internet connection you have to sign back in three different times because of all the privacy rules. It slows you down and the patients just laugh...Not only are you slow, but every day I go home without finishing my notes, every weekend I'm trying to catch up to make sure my notes are accurate. For several hours every night and at least four on the weekend, I'm trying to play catch up."

18. **Andrea Juliao, MD. Dekalb Medical (Decatur, Ga.).** "When we first started using EHRs, there was probably six months lag time trying to adopt the system. Patient schedules were cut in half, so that obviously had a burden for patients and us. Now I probably spend a good extra eight to 10 hours per week that I used to not spend just navigating the chart, navigating the documentation, electronic prescriptions, patients communication — that used to be a lot quicker before EHR. I just think that giving up 10 hours of my time a week that used to be family time is significant."

19. **Marie-Elizabeth Ramas, MD. Mercy Medical Center Mount Shasta (Calif.).** "I can tell you that over the last three months, since EHR implementation, my clinical productivity — my ability to take care of patients — has dropped by about a third. People's health is endangered." As reported by American Association of Family Physicians News.

20. **Gary Gaddis, MD. St. Luke's Hospital (Kansas City, Mo.).** "The EHR our hospital uses does some things well. My prescriptions are all legible and it is more rapid to use the EHR than to handwrite them. However, the designers of the software did not design the system to communicate in the manner that doctors use to communicate efficiently and effectively. The designers of the EHR software seem to labor under the delusion that to have more data is equivalent to having more useful and actionable information. For instance, the first data field I see should be the patient's chief complaint, not how they arrived or whether or not they have a primary care doctor. There are just so many things that seem poorly designed or incomplete in current EHRs. As for 'incomplete,' here is an example: I can prepare a prescription with the software, but if I select a number of days for the prescription to be filled, and how many doses for day, I still have to hand-enter how many pills will be dispensed. Finally, systems don't search strings of text efficiently. It would be great, for example, if I wanted to learn what a patient's normal vital signs were, I could type the search term "vital signs" and then the system would offer me choices, the way Google does."

21. **Jerome Seid, MD. St. John Providence (Warren, Mich.).** "The idea of EHR is a great concept. Idealistic, but not practical. My eight-member single specialty practice has had EHR for 10 years or so. While it allows for some innovative ways to store and look at data, the process of data entry has made a workday so long that the job cannot end at a reasonable time if a full-time partner is to see the volume of patients needed in a usual clinic day. This has resulted in decreased and lower quality face time due to the need to look at a screen. It has resulted in the inability to fully see, examine, analyze and talk to a patient in the previous 15 minute slot that was given to a routine follow-up visit. That has resulted in a choice I must make between direct care for sick, needy, dying and suffering patients, and the need to satisfy the many EHR requirements to complete the visit.

"The end result is either a rushed visit, with attendant patient and doctor dissatisfaction, risk for errors, omissions and/or inevitable delays in the office patient flow as I try to catch up. I often take the patient care path and leave dictation and charting for home in the evenings. For example, I counted seven mouse clicks just to enter a prescription. This, in turn, makes for less satisfying home and family time and results in its own damage to relationships, rest and physical activity. It is causing burnout, and will (as already documented in many media sources) cause many seasoned physicians to leave practice. The health of patients is taking a back seat to the need to chart ostensibly to satisfy administrative, regulatory and financial needs, in my opinion. I am considering accepting a financial penalty by not participating in stage 3, rather than the burden of meaningless abuse (not meaningful use, in my opinion).

"The need for additional staff (mid-level and clerical) to accomplish the myriad tasks has created understaffing, poorer staff retention ability and a decaying work environment, also felt by the patients. This EHR mandate needs urgent review and overhaul if we are to avoid a system of healthcare delivered by a harried, uncaring workforce. I worry about my own care as I age, knowing my care will be delivered with focus on data entry and billing accuracy. This has become a 24/7/365 career just to keep up — not what I anticipated or previously experienced. I cannot let my patients suffer this — they do not deserve it."

22. **Thomas Young, MD. Greenville (S.C.) Health System.** "After watching my take-home pay drop by 30 percent over the past few years (largely due to the incessant demands of 'meaningful use'), I decided to start a low overhead solo practice. I no longer give a thought to 'meaningful use' and am prepared financially to take the penalty. My patients and I are much happier."

23. **Robert Herwick, MD. Dermatology Medical Group of San Francisco.** "Prior to government-mandated EHR we employed a full time scribe and dictated all our office notes. They were customized for the individual patient and were easy to read. These took almost no time to create because they could be dictated with pocket units while walking down the hall, checking email or going across the hall to the bathroom. Rather than checking boxes or trying to select the closest option on an EHR screen, our six-person group would create a customized note. This has not only added about five minutes per patient encounter but has caused the compilation of an inferior record. Then came 'meaningful use'. Stage 1 was easy. Everything beyond that is a caricature of absurd federal bureaucracy, literally impossible to complete without hiring a full staff. The Physician Quality Reporting System is no better and we have given up on both. The equally ridiculous ICD-10 is simply piling on. It is my opinion that this is all calculated to make the private practice of medicine so intolerable that physicians will jump at the offer of a single payer system somewhere down the line and the social engineers will have achieved their goal. Shame on all of us for tolerating this!"

24. **Charles Leonard, MD. Family Practice Physicians (Talbott, Tenn.).** "As a solo, rural family physician practicing for 34 years, I tried EMR two years ago and spent an additional 2-3 hours per day entering data. I never did meet meaningful use stage 1. I gave up on the EMR and went back to paper charts. My patient flow is now great again. My patients love the fact that I communicate with them face to face and they love the fact that it is impossible to 'hack' their data. They know their information is safe in my office and their chart will never leave my office. I am not alone. There are other physicians in my area who use paper charts. I will gladly take the penalty rather than spend additional hours entering meaningless data to satisfy insurance companies or government entities who only want to mine data for their own interests rather than improve patient care."

25. **William Strinden, MD. Memorial Hospital (Lufkin, Texas).** "Both hospitals in our town implemented EHRs which were not ready for prime time. One was obviously a beta model which was first being utilized in about six hospitals, one of which was ours. Each week input was gathered from doctors, nurses and pharmacists about the problems that needed fixing. Patches were put into the software sporadically and now, over a year later, a major update is being made. Nurses quit, doctors complained bitterly, anger boiled over and the hospitals stuck their thumb in the eye of the doctors. One Friday I went in at 6 a.m. to discharge a patient at one hospital before starting a long day of surgery at the other. Logging in, I faced a screen of numbers. The nurse said that they updated early and 'it takes a while for the computers to come back online.' A second computer also was a screen of numbers. She offered to let me use one of her computers. They are slow and bulky, so she sits between two computers, allowing one to digest input on one patient while she works on a second patient's input. After 45 minutes I finished what should have taken 10 minutes total: To see and discharge one patient. That is not unusual.

"The haughty, overbearing audacity of our federal government and hospitals which forces us to absorb millions of dollars in lost time is maddening. Each hospital visit requires at a minimum ten minutes longer than it did before. I see thirty patients each office day. If I wasted only three minutes per patient, that would add up to an extra hour and a half of work. I have an RN and three employees who have been with me at least 12 years and do a good job and are well-compensated. It would cost me at least $100 per day extra just in lost time. The verbose morass of information also causes a waste of time, embraced by some doctors so that the pre-populated paragraphs enable high-level billing, but one must wade through a lot more 'noise' to discover the real information needed. I use technology daily and whenever possible to enhance my efficiency. However electronic records are not ready for prime time and are costly. If a CEO in private industry implemented a program so costly and so inefficient he would be fired posthaste. The same should happen to the government bureaucratic leaders and hospital CEOs who agreed to such a boondoggle."

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