



Jeffrey R. Unger, MD, FACE
Director, Unger Primary Care
Concierge Medical Group
Rancho Cucamonga, Calif

Dr. Unger is on the Editorial Board of The Journal of Family Practice. He reported no potential conflict of interest relevant to this article.

Med students: Look up from your EMRs

I was feeling anorexic and chilled as I sat with my wife at a local diner. The right lower quadrant pain that had been worsening over the past 3 days could no longer be ignored.

"I have acute appendicitis," I told my wife. "I need to go to the radiologist."

A computed tomography (CT) scan of my abdomen confirmed my suspicion. After learning that I also had leukocytosis, we headed to the emergency department. The ED doctor was pleasantly surprised that someone had come to his facility completely evaluated. All he had to do was call the surgeon. But first he introduced me to a 4th-year medical student who was participating in a surgical rotation.

Prioritizing the EMR over the patient

The student wheeled his large computer to the side of my gurney and began to question me about my abdominal pain. Within 5 minutes, this unsupervised student had somehow acquired all the information he needed for my admission. He thanked me for my time and told me that he would see me in the operating room.

It frightens me to think what might have happened during my hospital stay if I hadn't provided information that wasn't required by the EMR.

Unfortunately for him, I was not about to let him leave my cubicle without a redirect. I told him I have type 1 diabetes and several comorbidities. I wear an insulin pump and continuous glucose sensor that alerts me to impending hypoglycemia. I take 11 medications to successfully manage my metabolic disorders.

The student wheeled his machine back to the side of my gurney.

With his eyes fixed squarely on his computer and his finger on a mouse, he asked me to list all of my medications. He had never heard of a rapid-acting insulin analogue, nor was he familiar with my GLP-1 receptor agonist or SGLT2 inhibitor. And the pump and sensor?

There were no check boxes for these devices in his electronic medical record (EMR).

He—like several of the doctors I met during my subsequent stay—suggested that I remove the pump and meter so that they could manage my diabetes.

Still in considerable pain, I suggested to the student and anyone else who would listen that my pump and sensor were off limits. As long as I was conscious, I would self-manage my diabetes.

I also told him that his history and physical exam were deficient. Although he did listen to my bowel sounds (or lack thereof) through a blanket and hospital gown, he overlooked examining my heart, lungs, eyes, mouth, and feet.

"You failed to ask me about my medical history or my diabetes," I said. The student searched his EMR for the appropriate questions to ask, but to no avail. Stunned, he appeared to be at a loss of words. I suggested that he ask about the type of diabetes I had, the duration of the disease, how well my glucose levels were controlled, my

EDITOR-IN-CHIEF

JOHN HICKNER, MD, MSc
University of Illinois at Chicago

ASSOCIATE EDITORS

BERNARD EWIGMAN, MD, MSPH
University of Chicago Pritzker School of Medicine

RICHARD P. USATINE, MD
University of Texas Health Science Center
at San Antonio (Photo Rounds)

ASSISTANT EDITORS

DOUG CAMPOS-OUTCALT, MD, MPA
Mercy Care Plan, Phoenix

GARY N. FOX, MD
St. Vincent Mercy Medical Center, Toledo,
Ohio

RICK GUTHMANN, MD, MPH
University of Illinois, Chicago

KEITH B. HOLTEN, MD
Berger Health System, Circleville, Ohio

ROBERT B. KELLY, MD, MS
Fairview Hospital, a Cleveland Clinic hospital

GARY KELSBERG, MD, FAAFP
University of Washington, Renton

E. CHRIS VINCENT, MD
University of Washington, Seattle

EDITORIAL BOARD

FREDERICK CHEN, MD, MPH
University of Washington, Seattle

JEFFREY T. KIRCHNER, DO, FAAFP, AAHIVS
Lancaster General Hospital, Lancaster, Pa

TRACY MAHVAN, PHARM D
University of Wyoming, Laramie

MICHAEL MENDOZA, MD, MPH, MS, FAAFP
University of Rochester, New York

FRED MISER, MD, MA
The Ohio State University, Columbus

KEVIN PETERSON, MD, MPH
University of Minnesota, St. Paul

MICHAEL RADDOCK, MD
The MetroHealth System, Cleveland, Ohio

GOUTHAM RAO, MD, MPA
University of Chicago

LINDA SPEER, MD
University of Toledo, Ohio

JEFFREY R. UNGER, MD, ABFP, FACE
Unger Primary Care Concierge Medical Group,
Rancho Cucamonga, Calif

DIRECT INQUIRIES TO:

Frontline Medical Communications
7 Century Drive, Suite 302
Parsippany, NJ 07054
Telephone: (973) 206-3434
Fax: (973) 206-9378

➤ I suggested that the medical students needed to unplug their smart phones, computers, and iPads and spend a day or 2 with one of us “old-time docs.”

most recent HbA1c, and if I had developed any long-term microvascular or macrovascular complications. He politely thanked me, moved the mouse around on his computer stand, and began to wheel his computer away.

“Wait!” I thought. “Don’t you think you should examine my eyes, mouth, and feet?” I reminded myself that this student hadn’t evaluated me for peritoneal signs. So why should I insist that he look at non-critical parts of my body?

My physical pain was increasing and I was becoming increasingly distressed. The student was more interested in inputting data into the EMR than learning about acute abdomens and type 1 diabetes.

Postop: From bad to worse

My postoperative course was dreadful. I nearly died from complications that included acute renal failure, dehydration, hypokalemia, and a postoperative ileus that persisted for 8 days. My blood glucose levels, however, were perfect. Still, the Attendings and the students blamed my complications on diabetes.

“Yeah, I see this all the time,” said the hospitalist who was caring for me. “Diabetes causes gastroparesis. What we should do is have you take off that pump and sensor device. We’ll have the pharmacist help you manage your diabetes.” The hospitalist who suggested this course of action was immediately relieved of his duties by my wife as I drifted in and out of consciousness in the intensive care unit (ICU).

Despite the state of my health, I began to provide professional guidance for my own care. I demanded that the nurse give me a 250 cc rider of normal saline and increase my IV flow rate from 50 cc to 150 cc. The nasogastric tube was removed and I began using IV erythromycin, which increases gastric motility. I received oral and IV potassium.

While in the ICU, I was questioned by physicians and medical students, but never examined. I am convinced that had I not been an experienced family physician, I would have suffered a fatal postoperative event. The medical students assigned to my care would not have known that I died, unless they received a notification via Twitter.

Providing care in a digital age

My experience as a patient was in stark contrast to the way I practice medicine.

I use an EMR only to e-prescribe, and have chosen not to participate in submitting meaningful use data to the government. Rather than spending 2 hours a day making eye contact with an EMR, I prefer to use that time to listen to my patients’ concerns about their health. I know how to conduct a review of systems and I touch my patients at each visit. I look at their feet, skin, and eyes, listen to their heart and lungs, and palpate their abdomen. I perform a rectal exam on every patient who presents with abdominal pain.

I have learned to communicate my suspicions and thoughts (both positive and negative) to all of my patients. I take notes on scratch paper, not on a computer, just as my grandfather and father used to do when they were practicing medicine. I only order tests to confirm a suspected diagnosis, not as a primary means of evaluating patients.

Could my hospital experience lead to change?

Upon my discharge from the hospital, I reached out to the director of clinical studies at the local medical school and explained the deficiencies I’d encountered. I explained that the 4th-year medical students were ill-equipped to perform an adequate history or physical exam. They lacked knowledge of basic pharmacology. And they failed to appropriately follow a patient during the perioperative period.

The director appreciated my concern and provided me with the details of a corrective action plan that she had been working on.

“We need to implement our patient simulation computer program designed to teach our students how to appropriately interact with their distressed patients,” she said.

Really?

I suggested that the medical students needed to unplug their smartphones, computers, and iPads. Let them spend a day or 2 with one of us “old-time docs” who still work with our hands—hands that are skilled at evaluating patients, rather than texting and data entry. We’ll show these students how to become caring, intelligent, and dedicated clinicians. **JFP**