Competing interests
None declared

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Horses and buggies have some advantages over cars, but no one is turning back

Dr Hall argues that support for recording health care visits using electronic medical records (EMRs) should be stopped.[1] The evidence that helped convince him of this was apparently in a POEM (Patient-Oriented Evidence that Matters) that related to EMRs, as well as having a patient transfer to his practice from a clinician who made poor eye contact, presumably because that clinician used a computer to record encounters.

Electronic medical records are here to stay as part of an evolving, larger electronic societal ecosystem. Indeed, it is almost surprising that it has taken much of Canada so long to have EMR penetration in primary care. That EMRs are "excessively expensive, very time consuming, and complicated to set up and maintain"[1] are realities for many physicians. Yet, the benefits of using electronic charting far outweigh these challenges. Examples of modern-day conveniences we would not want to give up that once produced these kinds of challenges include cell phones and ATMs. We agree that the present generation of EMRs is a simple transposition of paper charts to an electronic format and that EMR-based clinical decision support remains immature.[2] Additionally, there are other aspects of health information technology (IT) that are similarly immature, such as appropriate connectivity with other data sources (hospitals, pharmacies, home care, patients). Perhaps with maturity, and when taken together, these systems can assist in improving health and health care outcomes. Putting clinical intelligence in EMRs has the potential to support family physicians' decisions in patient care. It also has the potential to enhance interprofessional collaborative work such as clinical task sharing and information continuity.

We do not yet have much capacity to add data in ways that are computable and usable for discovery. Electronic medical records have also not been programmed so that the data they contain can be easily searched and used to answer important questions posed by clinicians and other members of the health care system. We do not have Google searches to look for answers in our EMRs; however, until 1998, the Internet did not have Google either, and nobody thought the Internet was useless or that it should have been abandoned.

There are numerous conflicting articles on whether the EMR has a positive effect on the physician's office[3]; however, the benefits are beginning to emerge. The benefits of EMRs extend to many areas of practice including improvement of legibility in paper records, improved record completeness, enhanced organization, decreased documentation time, increased communication between patients and physicians, and improvement in quality of care.[4] But what about head-to-head comparisons with paper records for diseases common to family practice? A randomized controlled trial

comparing electronic health records with decision support to paper records showed that they improved the 2 most important outcomes—blood pressure and glucose—but the study was not adequately powered to discover a mortality benefit (as that would take many years).[5]

In terms of physician-patient communication, a systematic review found that the use of EMRs did not impede communication between patients and their physicians—instead, it was found that physicians using EMRs promoted questions from their patients.[4]

One patient's experience does not demonstrate that negative patient outcomes are due to the use of an EMR. There might be other explanations. A clinician could avoid meaningful patient-centred care by focusing on typing in an EMR or, in a positive case, share the EMR screen with the patient or use the resources available to provide the patient with helpful information. The literature demonstrates that most patients have positive perceptions of EMRs.[6] In an observation of consultations, one study found that issues did exist in terms of patient-centred care, but it did not propose a rejection of health IT as a solution; instead, it suggested that training in health IT use become more available.[7]

The assertion that money could be better spent elsewhere in the health care system could be refuted as well. In a recent focused review on the effects of primary care, Shi notes that high-quality primary care is "associated with enhanced access to healthcare services, better health outcomes, and a decrease in hospitalization and use of emergency department visits."[8] Without EMRs, policy makers and funders would have scant real-world knowledge about what types of primary care improve the health of Canadians. In the era of paper charts we were mostly limited to administrative data (ie, insurance-type fee claims) and studies that involved highly controlled populations that did not reflect the complexity of primary care. The research being carried out by practice-based research networks such as the Canadian Primary Care Sentinel Surveillance Network are answering these questions with EMR data from primary care.[9] In its short existence the Canadian Primary Care Sentinel Surveillance Network has already validated its diagnostic definitions and case-finding algorithms, while furthering our understanding of the context of chronic disease epidemiology and management.[8,10,11]

Rather than discontinuing the use of EMRs, what we need is a renewed investment to bring our IT up to the level of other sectors in Canada. The interoperability and analytic capacity of our EMRs are 10 to 20 years behind manufacturing, airlines, banks, and virtually any retail transaction. In terms of health care IT, many countries are much further ahead of us; nearly 100% of primary care physicians in Australia, the Netherlands, New Zealand, Norway, and the United Kingdom report using EMRs.[12] In Australia and New Zealand, more than 50% of physicians use EMRs with multifunctional health care IT capacity.[12] In Canada, only 10% of physicians do.[12] Most of us carry around far more sophisticated devices in our pockets than the clinical systems we use to care for patients. Thus, far more investment is needed to bring us to a point where truly transformative change can happen and so we might begin to know where to effectively spend our limited health care budget.

—Rick Birtwhistle MD CCFP
—David Barber MD CCFP
Kingston, Ont
—Neil Drummond PhD
Edmonton, Alta
—Marshall Godwin MD CCFP
St John's, Nfld
—Michelle Greiver MD CCFP
Toronto, Ont
—Alexander Singer MB BCh BAO CCFP
Winnipeg, Man
—Marie-Thérèse Lussier MD MSc FCMF
Montreal, Que
—Donna Manca MD CCFP
Edmonton, Alta
—Nandini Natarajan MD CCFP
Halifax, NS
—Amanda Terry PhD
London, Ont
—Sabrina Wong RN PhD
—Ruth Elwood Martin MD CCFP
Vancouver, BC
—Dee Mangin FRNZCGP DPH
Hamilton, Ont

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Dr Birtwhistle is Chair of the Canadian Primary Care Sentinel Surveillance Network (CPCSSN) Eastern Ontario Network. **Dr Barber** is Network Director of the Eastern Ontario Network. **Dr Drummond** is Network Director of the Southern Alberta Primary Care Research Network. **Dr Godwin** is Network Director of CPCSSN Newfoundland. **Dr Greiver** is Network Director of the University of Toronto Practice-Based Research Network. **Dr Singer** is Network Director of the Manitoba Primary Care Research Network. **Dr Lussier** is Network Director of the Quebec Network. **Dr Manca** is Network Director of the Northern Alberta Primary Care Research Network. **Dr Natarajan** is Network Director of the Maritime Family Practice Research Network. **Dr Terry** is Network Director of the Deliver Primary Healthcare Information project. **Drs Wong** and **Martin** are Project Co-Leads of the CPCSSN British Columbia Primary Care Research Network. **Dr Mangin** is McMaster Site Lead of CPCSSN@MAC.

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Prescribing income

In my practice, I am continually reminded of the saying I learned in residency: whenever a doctor picks up his pen, he's writing a cheque with someone else's money. It seems my special knowledge of this epigram must put me in a small or otherwise silent minority among family physicians.

No less than 2 articles in a single issue of your journal[1,2] promote the perennially bogus idea of "prescribing income" as if it were some sort of legitimate medical act, and as if it were not a wholly discredited and foolish economic notion. It can survive only within the most childlike visions of the world: one where money and all good things can be just wished into existence, and one where government money, when splashed about, by the haphazard pens of family physicians no less, can have only salutary effects. It is shocking that the starry-eyed proponents of such an extended dole cannot see the terrible side effects of their "income prescription": immediate price inflation, under-the-table labour markets, perverse incentives denigrating modestly paid work and encouraging idleness, and cruel pressure on the next highest tranche of working poor just not "poor enough" for prescription-pad incomes from their enlightened doctors.

But there is no need to argue only in the abstract. Here in Canada, we have a grim and tragically enduring example of decades of "guaranteed incomes," "social housing," progressive government welfare