
Patient Health Literacy, Electronic Health Records, and other Challenges of Modern Medicine: A Conversation with Dr. Danielle Ofri

| On typing while talking, the Internet data glut, the role of wellness coaches, and the efficacy of alternative medicines.



Owing to the advent of the Internet and social media, consumers and caregivers have more medical information—especially on diagnoses and treatment options—at their disposal than at any time in history. This increased access to information has shifted the traditional patient–clinician relationship. Some clinicians have embraced the changes wrought by this information tsunami and its easy availability, while others decry the way it has impacted and altered their roles.

Dr. Danielle Ofri, a physician at Bellevue Hospital in New York City, the oldest public hospital in the country, is co-founder and editor-in-chief of the Bellevue Literary Review, a regular contributor to The New York Times and other national newspapers, and most recently the author of What Doctors Feel: How Emotions Affect the Practice of Medicine (Boston, Mass.: Beacon Press, 2014).

As evidenced in the following interview, she has mixed feelings about access that consumers have to medical information and data, and electronic health records. Generations spoke with Dr. Ofri in January about doctoring in the modern age and the rise of “do-it-yourself” medicine.

Generations: How has the explosion of health and medical information on the Internet changed the traditional doctor–patient relationship?

Danielle Ofri: Patients now come in with a lot of information; before, the doctor was the sole source of information. This has changed some things for the good. Patients have a better work-

ing knowledge of illnesses and treatments. But much of the information is incorrect.

Yesterday was one of my busiest days in the clinic. One of my patients needed a flu shot and a tetanus shot, but he wouldn't accept them because of vaccination information he had from the Internet. I asked him what he was worried about, and he mentioned autism and chemicals in the vaccines, and various side effects. I told him the so-called autism link had been thoroughly debunked, and that there was no mercury in vaccines. But all the safety studies I showed him could not help refute what he had read on the Internet. Although the Internet has the potential to educate, once misinformation takes

root, it can be hard to talk patients out of it—and it sucks up inordinate amounts of time that could be used for other health issues. The mass of information (and misinformation) on the Internet can be very hard for nonprofessionals to navigate. It's hard for professionals, too!

G: How many patients do you see in a day?

DO: I'm usually booked for up to ten or eleven patients in a morning or afternoon session. I'm booked every twenty minutes—which includes bringing the patient into the exam room, taking a history, doing a physical, and documenting it all. Some patients have many chronic issues. Everyone has at least one or two acute concerns. Medications need to be renewed. Lab tests have to be reviewed. If every single patient on my schedule shows up—as happened yesterday—I can't do as good a job.

If everything goes smoothly, I'm still barely managing. But if anything goes awry, it's another story. In addition to the long discussion with the patient about vaccines yesterday, there was also a patient very sick with liver failure who I had to admit to the hospital. Another patient was Bangladeshi, and so I had to work through an interpreter. It was impossible to do a thorough job with every patient. I found myself cutting corners just to stay afloat, and that's terrible for patients and terrible for doctors.

G: Technology has enabled patients with chronic illnesses to monitor themselves at home or on the go and send continuous data to their clinician. Few clinicians have the systems in place to receive or monitor that data. Why is that and what can be done about it?

DO: This doesn't happen much in my practice . . . yet. But when it does, it can be problematic. How much data can you process? If a patient brings in ten pages of data, where would I find the time to examine it? Even now, when

patients bring in six pages of information downloaded from the Internet, it's a mixed blessing. I'm glad they are taking the time to research and learn, but it can take our entire visit to go through the information.

Although the Internet has the potential to educate, once misinformation takes root, it can be hard to talk patients out of it.

Let's say a patient e-mails me ten pages of data about his pulse and blood pressure recorded via a fitness monitor. The first question is whether or not the information is accurate. These machines are not being validated for accuracy by anyone, so nobody knows if the information is correct.

The second question is how much time is a doctor expected to invest in analyzing the data? Let's say it's fifteen or twenty minutes, including a phone call with the patient. That's the same as a full medical visit. Could a doctor bill for this like any other medical visit? Right now, the answer is no. Given the time crunch doctors are already facing, it doesn't seem feasible to expect them to carve out large chunks of time to evaluate all this extra data, especially when the accuracy is still in question.

It could be that we readjust how we pay for medical care, and how we utilize this external data, but right now it's a lot of extra work for the doctor, with dubious benefit for the patient.

G: How has the Affordable Care Act's electronic health records (EHR) mandate affected your practice?

DO: We were already electronic; we've been online for ten years, so it didn't change anything for us now. However, when we made the transition to electronic health records, the process was painful, arduous, and full of flaws. Now that

we've made the leap, there is a net gain overall. It has solved the problem of tracking down charts, X-rays, and lab results. There's no issue of things getting lost anymore. (And not having to read the surgeon's chicken scrawl is a huge benefit!)

But we're starting to see drawbacks. With so much technology and information, it's hard to find the most pertinent patient information in the chart. Before, with written notes in the chart, you could have four to five salient lines in a note and that information was very easy to see. With EHR, it's harder to find the meat. You click on this field for radiology, that field for medications, another field for lab results. It's fragmented and there's a lot of electronic clutter.

How much data can you actually process? If a patient sends me ten pages worth of data, when would I have time to look at it?

The EHR catalogues all sorts of data and everything is equal—it has no way to prioritize. So there's every possible bit of demographic information, and information as to whether there are any barriers to patient education, but what I really need to know is what the cardiologist said about the patient's heart condition. I have to dig through layers of less important information to get to the crucial nugget. The challenge is to make technologies that can discern the difference between being smart and being wise. Right now, the EHR is just tons of facts. There is no wisdom, judgment, or reasoning.

G: Because of the advent of EHR, new roles, such as medical scribes, have popped up to assist physicians with the heavy electronic inputting role by transcribing the visit into an electronic health record. Have you worked with someone in this capacity?

DO: No, I haven't had the opportunity to use them. It looks intriguing, and I could see how it

would be helpful, although [laughs] it could be creepy having someone record your every utterance. But there's so much documentation, and so much of it is busywork, so I'd love to try working with one.

G: In your book, *What Doctors Feel*, you write that the emotions of clinicians "can often be the dominant players in medical decision-making." Can you explain what you mean by that?

DO: We doctors tend to think of ourselves as extremely scientific, and rightfully so. But often when we practice medicine, we're responding to what may be our own experiences. One study I cited showed how oncologists deal with grief [Granek et al., 2012], and most [of them] talked about compartmentalizing it.

The study noted how ineffectual that approach was, and how instead the grief travels with them. Doctors would treat their next patient based upon their experience with the one before, subconsciously pulling back or over-treating depending upon what happened with the previous patient. We want to think we take each patient as an individual case, but the interaction is often ruled by our emotions.

G: In a recent *New York Times* piece [Ofri, 2014], you poignantly describe a patient expressing her anger at you for neglecting to give her a full physical on her first visit. Why did you choose to share that?

DO: I feel that I need to be as honest as I can; if I don't examine my own foibles, I'm not being fair. I also want to be a better doctor and part of that is facing up to my flaws. It's part of my responsibility.

I also want patients to be aware that doctors think about what they do. With that woman who was so angry at me, I wouldn't have had any idea why she was upset if she hadn't told me—I really didn't know. Now I remember that a physical

exam is very important to a patient even if, perhaps, it's not absolutely necessary.

G: Many Americans are turning to complementary and alternative treatments and placing their care in the hands of non-traditional clinicians. Does that concern you? Why, or why not?

DO: For some things, alternative or complementary treatments are fine—if you're not getting relief from chronic pain and are helped by acupuncture, that's great. But I once saw a 38-year-old woman who had early-stage breast cancer. She left the medical system to do high-dose vitamin therapy. She re-presented eight months later with advanced cancer and died shortly thereafter. It was such a tragic case. That naturopath should have been sued for malpractice.

But there are things Western medicine doesn't have a solution for—chronic pain, for example—in which case I'm open to some alternative treatments. But for those who don't take medicine because they don't want to put harmful substances in the temple of their bodies, they need to realize that many natural substances are quite damaging. Arsenic is natural! Some people will take anything 'natural,' but not their diabetes medications. People should know all the risks and benefits of everything—prescription medications, herbal medications, vitamins. Don't think that alternative medicine is necessarily risk-free. **[Editor's Note:** See article on complementary and alternative medicine by Dr. Josephine Briggs on page 56.]

G: What are your views on medical care teams?

DO: It's a very salutary advance. In the old days, doctors did everything, but it's not possible today. There are so many more chronic conditions, and so much less time. The more work we could do in a team, the better off everyone is, as long as it's coordinated. My schedule is so

booked that it can be hard for patients to get an appointment sometimes, so if they could see a nurse, or nutritionist, nurse practitioner, or physical therapist in the interim, all the better.

G: Increasingly, we are seeing enormous growth in the field of health coaching, usually performed by people with no formal medical training. What are your views on health coaching by non-physicians? Do you think the role of health coaches will escalate as we focus on prevention and wellness?

DO: I would have the same reaction as I did to naturopaths—with some conditions they can be helpful. When it comes to diet and exercise they're great, but if they were trying to treat diabetes or kidney disease, I would have some problems there.

With electronic data, there is no wisdom, judgment, or reasoning—just numbers.

With many of the medical challenges patients face today, there is the difficult issue of how to change parts of their lifestyle. Having some kind of coach (it doesn't need to be a doctor) could definitely help, especially if they're part of a medical team. Health coaches need to have training in nutrition and exercise, and need to understand how the needs of a 65-year-old are different from those of an 18-year-old.

G: What do you consider healthy aging, and how do you see your role as a physician in helping people to age healthily?


DO: When evaluating healthy aging, I consider one key question: Is a person happy and content in their life? For example, I have a patient, a lovely woman who is wheelchair-bound, and has some Alzheimer's. Her daughter wanted me to examine her because her sleep cycle was out of whack. Phy-

sically, she seemed fine. And then I asked her if she was happy. She said that she was. She was perfectly content with watching TV at night and sleeping during the day. I couldn't say this was wrong for her to do, if it wasn't harming her and she generally seemed happy.

Everyone doesn't have to age in the same way. I want to give them the tools for healthy choices. I talk about nutrition all the time: no soda, junk food, white rice. It's as important as medication. On the other hand, people shouldn't be miserable. If you take all the pleasure out of life, it's not good. If you're eating tofu and kale and are miserable, you're not achieving health. Eating should be pleasurable. Often people lose the aspect of pleasure because 'being healthy' becomes so regimented.

I encourage all of my aging patients to stay active—aging is *not* just settling down on a couch. I ask them what physical activities they enjoy—swimming, walking, dancing. Dancing gives such pleasure, and I recommend it to all

patients because it's great exercise and it forms community.

I ask all of them if they are happy. I want to know what they do for pleasure. Are they reading books? Are they meeting with friends? Are they listening to music? Are they playing music? For me, I play the cello, and it has become one of the most important things to me. After that hellacious day in the clinic yesterday, that's the one thing I wanted to do. I probably should have exercised, but I went for the cello. There are some circumstances in life for which the only 'cure' is Bach. 

References

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