CAN WE RETURN TO THE ABCS OF CRAFTING A MEDICAL RECORD NOTE?
ROBERT L. BARBIERI, MD (OCTOBER 2021)

Physicians can help provide EMR fixes

I appreciate Dr. Barbieri's editorials and insight on many issues facing our profession. I would like to offer my comments on a recent article.

If you want your brakes fixed, don't go to a shoe maker. Physicians seem to have lost our sense of who is most competent in determining the best way to practice and communicate medical care. Somehow we have turned this over to the bureaucrats, who seem to find ways to complicate the lives of both providers and patients. Maybe we are too busy caring for patients and trying to find ways to alleviate the burden placed on our time by the electronic medical record (EMR) system, which was touted as an improvement in medical care and increasing provider efficiency. Most of the time I hear my colleagues describing ways to "work around" an EMR system that has immense deficiencies in providing accurate information in a way that is easily digested by whomever is viewing the record. The universal ability to transfer information is simply not true. One colleague had the same office version of Cerner as was used in the hospital setting but was unable to send information back and forth due to the danger of the potential to corrupt the system.

Dr. Barbieri mentioned his work around to make the record easier for the patient to read. I ask, what about the coding descriptions, which most systems are now requiring physicians to put in at the time of the encounter? In the past this was done by certified coders, who undergo a 1- to 2-year training program, and is now being performed by physicians who have minimal to no training in coding. (And who, by the way, can be fined for both under- and over coding.) The example Dr. Barbieri put forth for obesity comes to mind and is part of the medical record in all cases. The terminology used by ICD-10 is not so kind and requires some imagination when trying to find the right code for many diagnoses.

When will we stop allowing others, who know little about medicine and caring for patients, to tell us how to provide the care that we have trained for 7-12 years on how best to deliver?

William Sutton, MD
Muncie, Indiana

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Dr. Barbieri responds

I thank Dr. Sutton for providing his experience with the electronic medical record. I agree with him that bureaucrats often create health care rules that do more to hinder than help patients. With regard to coding and billing, I use ICD-10 codes and usually bill based on time, which includes both face-to-face time with the patient and time spent reviewing the patient's medical records. Now that federal regulations require medical notes to be shared with patients, I craft my history, assessment, and plan with language that is easy for a patient to accept and understand, avoiding medical terms that patients might misinterpret.

Should microscopy be replaced?

I agree with many points Dr. Barbieri made in his editorial. However, I do not agree that the microscopic examination of the vaginal discharge should be replaced. NAAT offers some advantages, but it does not offer a complete assessment of the vaginal ecosystem and microbiome. I believe that NAAT should be used in conjunction with the pelvic examination and microscopic examination of the vaginal discharge.

Microscopic examination of the vaginal discharge can reveal:

- whether or not the squamous epithelial cells are estrogenized. The absence of estrogen will, along with physical findings, indicate the possibility that the patient is experiencing atrophic vaginitis.
- the presence of estrogenized squamous epithelial cells. Plus, a finding of erythema of the vaginal epithelium indicates that the patient has an inflammatory condition and vaginitis, suggesting a possible infection in addition to vaginitis.
- the presence of white blood cells >5/40X magnification, which indicates the possible presence of infection in addition to vaginitis (eg, BV).

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I agree that NAAT can confirm an initial diagnosis or refute it. In the latter case, the physician can change treatment accordingly. In the absence or in conjunction with the presence of a sexually transmitted infection, the composition of the vaginal microbiome is significant (ie, determining if vaginal dysbiosis is present). Performing a comprehensive evaluation, determining if the most common pathogens are present in aerobic vaginitis and/or BV, plus completing a *Lactobacillus* panel can be expensive. If insurance companies do not pay for such testing, patients will be reluctant to pay out of pocket for these tests.

My final comment addresses the administration of NAAT for aerobic vaginitis, and for BV, it is probably an ineffective treatment. Vaginal dysbiosis is based on whether the appropriate species of *Lactobacillus* is present, and the concentration. Treatment most likely will be based on replenishing or restoring the appropriate species of *Lactobacillus* to dominance.

Sebastian Faro, MD, PhD
Houston, Texas

Dr. Barbieri responds

I agree with Dr. Faro; when used by highly trained clinicians, microscopy is an excellent tool for evaluating vaginal specimens. Expert clinicians, such as Dr. Faro, with a focus on infectious diseases do not need to rely on NAAT testing except for identifying cases of T vaginalis infection. However, in standard clinical practice, microscopy performs poorly, resulting in misdiagnosis.[1] In the average clinical practice, NAAT testing may help improve patient outcomes.

1. Gaydos CA, Beqaj S, Schwebke JR, et al. Clinical validation of a test for the diagnosis of vaginitis. *Obstet Gynecol.* 2017;130:181-189.

A note of thanks

I am a 74-year-old ObGyn who finished training at the University of North Carolina in 1979. Currently, I am working at a rural health group 2 days a week as a source of in-house gyn referral for 17 primary care physicians and mid-level providers. Our patients are almost all underserved and self-pay. The bulk of my work is related to evaluating abnormal uterine bleeding and abnormal Pap tests. Your publication of OBG MANAGEMENT serves now as one of my main sources of information. I just wanted to thank you and let you know that the publication is important. Keep up the good work and best wishes.

Julian Brantley, MD
Rocky Mountain, North Carolina

Dr. Barbieri responds

I thank Dr. Brantley for taking time from a busy practice to write about how OBG MANAGEMENT provides practical information relevant to practice. Each issue of OBG MANAGEMENT is built on a foundation of insights from expert clinicians, which is crafted into a finished product by a superb editorial team. Our goal is to enhance the quality of women's health care and the professional development of obstetrician-gynecologists and all women's health care clinicians. ●

Instant Poll

Which state had the lowest primary cesarean delivery rate (15.5%) in 2021?

- Utah
- Washington
- Montana

Weigh in at mdedge.com/obgyn

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Please include the city and state in which you practice.