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ETHICS

The American Academy of Family Physicians wants to provide members with some form of electronic medical records. This is downright visionary. Too bad it can't work. One reason: More information means more work for doctors, not less.

Small Practices Unable To See Benefits of EMRs

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"That'll be the day."
— Buddy Holly

I recently responded to a survey from the American Academy of Family Physicians, soliciting reactions to the idea of the AAFP providing its members with some form of electronic medical record. This would be the most significant event since the invention of managed care. Too bad it won't happen.

The nice folks at the AAFP didn't call me personally, no doubt because they know me over there. I suspect my opinion would carry more weight if my name weren't directly attached to it. So, I'll use this forum to convey a secret message to the AAFP that nobody will ever connect with me.

Basically, the AAFP's idea is noble, exciting, and nuts. It's visionary in the sense that Joan of Arc was visionary. The strategy of "getting a big medical organization to leverage a mass purchase" is the software marketing equivalent of the Holy Grail. It's like landing the Michael Jackson account at Max Factor.

Don't get me wrong. I'm the world's greatest evangelist for EMRs. I am on record repeatedly (here it is again) saying, "In most settings today, a physician's failure to use an electronic medical record constitutes malpractice." To this I would add, "The most important challenge for primary care today is to solve the problem of capitalizing its informatics infrastructure."

Easier said than done

Unfortunately, I don't see how the AAFP can unilaterally do this. When I was a medical director with Aetna, some of us proposed a similar scheme, only with the health plan in the role of facilitator. We ultimately threw up our hands, but not from lack of desire. It was because of the Archimedes problem.

Archimedes said something like, "Give me a lever and a place to stand, and I'll move the Earth." The problem the health plan faced, and that the AAFP faces, is that, even if you have a fair amount of potential leverage, there's no vantage point from which you can use it.

You see, marketing medical record software to small groups is basically a futile exercise. The vendor has to recoup the costs of development, sales, configuration, installation, training, maintenance, and support. The products are generally so bad, and the competition so aggressive, that there is no market share for a low cost product even if it's terrific. The technology is fragile, vendors are evanescent, and the potential liabilities are dazzling.

What physicians want

Don't ask me why, but it seems that most doctors would rather spend $1,000 on golf clubs than on a drug-interaction system that would save lives. Plus, when doctors realize what a good EMR would actually do — slow the pace of practice, increase the amount of information dealt with at each visit, force them to respond in a timely way to critical data, and so forth — most react to the idea as they would to a malpractice suit. "Get thee behind me, Satan!"

But, these aren't the ultimate barriers. The simple fact is that most doctors don't keep, use, or rely upon medical records except as an administrative formality, and wouldn't know what to do with a real information system if they had it.

If you've spent any time reviewing charts, you realize they are mostly embarrassing junk. Why would doctors burden themselves to change this? (My fervent apologies to Kaiser Permanente, Mayo Clinic, and hundreds of other practices to whom this criticism does not really apply. You know who you are. You also know that your systems can't exchange data with anybody else's, so I'll speak to you after class.)

Same old questions

Several medical organizations I've been connected with over the last 20 years have sent surveys just like the AAFP's. They always ask the same questions. "Do you currently use an EMR?" "Would you use an EMR if it were essentially free and didn't require any training or new employees and didn't change the look and feel of your current records or exam room and didn't occupy space or demand that you do a single thing differently than you currently do today — plus it increased your income magically by 50 percent without any action on your part?" "Would you agree to even the most absurdly small up-front cost so that our organization can get some company to return our phone calls? No obligation, of course."

The problem is that they ask the wrong questions. I'm going to tell the AAFP what it should have asked, so it can fuggedaboudit and move on to another agenda (like figuring out what use the specialty of family practice is in a post-managed-care culture).

Question 1: "Did you buy the hype a few years ago, when HCFA inaugurated its 'correct coding initiative' and everybody was trying to sell EMRs on the premise that they were magic cash registers, able to print out fictions to support the laughable E&M categories you had to use to get paid?" (Some called these "fraud-o-matic" systems. They were designed like the consoles in fast food shops, where the clerk presses on a picture. "Let's see, one head exam, two lungs, and a biggie-sized abdomen. For here or to go?")

Question 2: "Did you join a large group during the venture capital delirium when thousands of private practices consolidated, under the economy-of-scale theory that a gang of doctors would invest in stuff that no single doctor would ever buy?" (Actually, this turned out to be right on the money for a lot of groups that are now bankrupt. The attitude was, "If lunch is free, sure I'll take it.")

Question 3: "Did you imagine that your partners, or the insurance company, or the IRS would front the cost of providing you with a shiny CRT on your desk, so you could do Internet day trading while your nurse answered annoying e-mails from the patients that you no longer needed to see because the computer made you so efficient? Are you one of those delusional souls who equates practicing better medicine with reducing the amount of patient contact time?" (Let me explain something: Having better information lengthens the patient encounter, it doesn't shorten it.)

Question 4: Do you believe the AAFP is going to find a product that is flexible, comprehensive, and usable enough to meet the diverse requirements of its 93,500 members, plus communicate effectively with the array of incompatible systems already in use, as well as others that the ASIM, ACOG, ACS, APA and A-everything-else might be tempted to sponsor someday, if this idea took hold?" (If so, you probably also believe the AAFP will provide the customization and support you'll need to make the system last more than a week in your practice.)

Question 5: "Don't you realize that the main obstacle to progress on a rational format for recording and transmitting medical information is the silly, outmoded reimbursement system based on the AMA's cash cow, the CPT? Do you think this dinosaur could survive under any valid system for describing the content of a medical encounter? Didn't the fiasco of E&M coding teach you anything? Do you even think using the CPT is ethical, given its faults? (Well, maybe this question is a tiny bit prejudicial. However, it represents a key point in my argument that dumping the CPT is a medically necessary procedure.)

Question 6: "If you did have an EMR, would you take the trouble to enter and maintain problem lists; provide patients with a medication list (interaction-checked) at every visit; implement a tickler system; use disease management flow sheets; provide secure e-mail access for your patients and colleagues?" (OK, I'm holding my breath.)

Despair, despair, despair

Please, don't take these gentle observations to indicate any negativity on my part about the ethical imperative for better information systems in health care. They just reflect two decades of despair at having been-there and tried-that. Despite the growing awareness of a few developers about what a decent EMR should be, and the availability of a handful of products that actually provide useful functions, the mainstream American doctor does not see the EMR as an essential tool for practice.

Ten years of distractions have clobbered the market for small-office EMRs. HCFA distracted fee-for-service practitioners by making them worry about getting nailed for fraud, and computer vendors responded with the fraud-o-matic systems. Managed care (mostly discounted PPOs, but also some stupidly designed capitation plans) distracted fee-for-service practitioners by making them worry about going bankrupt; computer vendors responded with revenue analysis and gaming systems.

The tort system keeps all practitioners distraught with worries about getting burned as a witch; computer vendors answer this with incantations about documentation. HIPAA has got everybody in a panic about privacy; and the vendors are ready with encryption and security systems. But, little commercial informatics activity over the last 10 years has had anything to do with improving care.

Two major Institute of Medicine reports (on errors and computerized records) have so far not gotten the attention of practitioners with the need to automate their prescribing systems (because the IOM doesn't touch anybody's income).

No trickle down

Still, a couple of vendors are ready if anyone is interested. And, several big systems have emerged in the last three or four years that could really be turning points for large groups interested in radical performance improvement (although not hospitals, in most cases). However, it's hard to see the economic model that will allow these to trickle down to small offices, as long as small practice docs keep their pupils fixed and dilated on the CPT.

E&M coding, trial lawyers, and hospitals buying practices and mismanaging them into rubble haven't yet been able to perform the work of Darwin on private practice. So, it's hard to see how being left in the dust by a few high-performing, computerized organizations will put paper practices out of business just by offering better service and outcomes. But, there's hope.

I just don't see how the AAFP could be the organizing principle behind such a long-needed revolution.

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