

Guest Column: What's wrong with healthcare, Part 4

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There's a difference between meaningful innovation and just change: Each passing year seems to bring the latest or greatest new medication or surgical advancement. Some will withstand the test of time; some will fall by the wayside. Predictably all will be hugely expensive and inflate the cost of healthcare in the near term. Regardless of added value, the company selling the newer product will advertise, and make claims to promote it. For new surgical devices the usual claims tend to be that they will, "shorten the hospital stay, decreases pain, decreases bleeding or cause less complications". Often these claims are marginal at best, yet are used as justification of the hugely inflated prices for the new technology. In the past, medical devices with proper maintenance were designed to last for decades. Even then, prices for this equipment was relatively high, but you were getting lasting value and quality. Now most new devices are single use items. We live in a disposable society and medicine has become one of the worst examples, landfills be damned. Dispo medicine generously lines the pockets of medical products companies. There is zero incentive to produce a lasting product. It's true many of these technologies will improve patient care, and used

judiciously, add significant value. Others though just escalate costs and are essentially expensive options not really improving anything. The question should always be, was there a problem that actually needed solving, and if so, does the new device actually correct the issue? We see this all the time where a new device offers a slightly modified technique and backs up its use with the usual claims. Then through marketing, advertising and “scientific studies” it will evolve to become the new standard of care, justifying its inflated expense. Tonsillectomy is a great example here where it seems something new and expensive is constantly being offered for a “safer” removal of tonsils always claiming less pain. Over time, none have ever proven better or safer than just using a ten-cent blade and a 5-cent wire for removal of tonsils and have just been expensive experiments.

Could newer devices be designed differently? Could obsolescence of larger ticket items be slowed. I’m sure multiuse instruments could easily be engineered which would reduce costs greatly. The issue is, there is no profit incentive to do this. So many decisions are motivated entirely by profit. Because of this, as technology advances, costs will continue to spiral.

Our last topic is electronic medical records or EMR’s. I could write an entire series on these alone. I’ll start by saying these were not introduced for patient or doctor convenience, safety or to improve healthcare. Rather they are designed to allow for easier surveillance of the health care system, for controlling of your doctor’s management of you, and likely the eventual rationing of health care. An EMR is an overly comprehensive and excessively complex version of your medical record. It lists every single ailment you’ve been afflicted with and any drug you’ve ever been on. It lists everything from every time you are seen, and forever. First off, is this level of complexity at all helpful? Certainly, there are things in your past that are critical for your doctor to know. But, if you went in for a stomach ache in 2007, does this actually need to be added to your already 12-pages long, small print medical record, and show up for eternity? Do you now need to be saddled with the additional diagnosis of gastritis, and for the rest of your life when all you needed were Tums?

Next, how is it that a 15-minute doctor visit turned into a 12-page note? The answer is auto-population. Did your doctor or another practitioner actually do all that is seemingly recorded in your record for that visit? Of course not. No one can ask that many questions or complete such a comprehensive exam 4 times an hour much less document it. The computer automatically fills everything in. The problem is, these records are so complex, it becomes nearly impossible to find what is pertinent in this extensive document. So much time is wasted pawing through (or scrolling through) layers of unneeded information. A physician encounter used to be documented in an easily understandable single paragraph. It was called a SOAP note, Subjective, Objective, Assessment and Plan. Everything you needed to know was in there. Anything beyond this just adds to the landfills.

Another reason EMR’s were promoted was the promise that they could help to limit medical errors. Really? That hasn’t exactly panned out. Here’s an example just last week. My office sent a biopsy specimen to a lab where it was entered into their computer under the name of another physician. This means if it had come back showing cancer, I would not have been notified. How could this happen? Unfortunately, very easily. A

simple click error on the screen by the lab entered the wrong doctor. One thing I do know, I've never accidentally written down my wrong name on a lab slip. When that starts to happen, it means I have to retire. Perhaps the old system was safer? Eliminate medical errors? I don't think so, it just allows them to be made much faster.

EMR's were designed to make medical records universally accessible to your doctor, the hospital, as well as to you. Yet, the systems often don't work as intended. Not every entity is on the same system and systems frequently won't interact with other systems. It's kind of like your Apple iPhone charger not working with an Android phone (or even with your prior iPhone). The only solution would be to have everyone on the same system. But then I'm sure that monopoly, if ever established, would be fraught with even bigger problems and allow for a level of surveillance and control that wouldn't be to anyone's benefit. What would be an insurance company and governmental dream would likely be our worst nightmare.

Then there are the password issues which seem to require access limiting updates almost weekly. These electronic roadblocks are irritatingly restrictive, slowing access at almost every turn. I've seen emergencies where the physician or nurse, because of password update requirements, was not granted record access in a situation where vital information was immediately required. As the patient deteriorates they are struggling with a computer. The staff was terrified about just doing the right thing without the blessing of the EMR first. Repercussions from not documenting properly or getting approval in advance of an action can lead to severe reprimands which can affect one's career. Tell me that's not crazy. Since they were designed by non-medical people, EMR's are rarely convenient or medically intuitive. This is particularly frightening, since by design they more and more seem to be dictating patient care. Your doctor is no longer 100% in charge or your health care decisions anymore. The EMR is second guessing him every step of the way. Let's say your physician thinks you might benefit from one extra day in the hospital to recover from a medical condition or complex surgery. You may be out of luck if the data in the EMR says you don't meet some pre-set criteria. Home you go and don't let the door hit you in the ---.

We touched previously on the volume of specific documentation and physician involvement required to input data into your EMR. Your doctor must continuously adapt to a constantly changing system where there is always an endless stream of software updates. Your doctor is having to focus on the new system more than on you. Thus the complaints, "my doctor seemed more interested in his computer than he was with me". It's sad, but your poor medical professional has no choice. The new focus of medicine is not so much patient care, but rather proper EMR documentation. Documentation defines payment. This takes us back to the business side of medicine. Every medical interaction is defined by 2 sets of codes, visit/procedure codes called CPT's, and unnecessarily complex diagnostic codes called ICD-10's. What is documented in your EMR justifies the choice of medical coding and coding equals reimbursement. Should your doctor not be properly documented, or should he/she be just one digit off in the ridiculously complex 8-digit ICD-10 codes, they don't get paid. Additionally, the diagnostic codes must match the 5-digit service codes. If they don't, no one gets paid. Are you just slightly dizzy here? That response is normal. Lastly, if an office racks up a series of small mistakes, they run the risk a practice audit which never goes well for a medical office. These are often followed by demands for large repayments when the insurer or government felt

documentation was deficient (even if proper care was provided), stiff fines or worse. You get the idea. Your doctor is terrified, they lost control long ago.

And talk about waste? The EMR was supposed to be a “green” option, to save the environment by not requiring any paper use. But since the introduction of the EMR, copied medical records (and you will always have to make copies of medical records) have never been thicker, now literally stuffed with reams of unneeded information. It seems these days you can’t keep enough toner or paper loaded into the office fax machine.

So, if you feel that your latest interaction with your physician felt sort of impersonal, realize it’s not their fault. They are being pressured by insurers, medical companies, the government, the legal profession and maybe even their hospitals to do things which have very little to do with your care. I’d like to think that the pendulum may eventually swing the other way, putting the doctors back in charge once again, but I’m not going to hold my breath.

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