Letters to the editor

Re "The academic medical center in a disrupted world"

Training physicians at academic medical centers to be politically adept technocrats, data miners, and team players in the "disrupted world" Steven Wartman describes in his recent editorial (Spring 2015, pp. 2–9) gives short shrift to what many of us heard when called to the guild of the Aesculapian helix. As he has written so eloquently about over the years, medical training involves imbuing doctors with wisdom concerning the nature of suffering and its amelioration. However, in this present editorial, taken up with the fiscal and sociopolitical crises we face at academic medical centers, and even in his otherwise excellent work as a medical ethicist, he barely hints at something critically important to reaffirm any time we speak of the basis of the social contract we honor as a healing guild: the teaching of the philosophical basis for, and the psychological aspects of, what physicians do, and helping create the good people to do it.

Our academic medical centers (AMCs) must not only produce efficient, articulate health care delivery specialists, fine scientists, researchers, and delegators of power: they are also providing role models with strength of character, maturity, and moral compass for their communities, but, even more critically, in the process of providing health care one patient at a time. In our rush to master the technical, economic, and political challenges of the day, the complexities of the caring role of the physician might have been underemphasized in our training at the AMC, and are even less likely to figure subsequently in CME opportunities through our practice careers. And even when referred to, in lecture or at bedside, it can fail to approach the emotional truth of what goes on when the act of healing hurts and/or exalts both patient and physician. Business and cost-centers notwithstanding, how are we preparing ourselves each day for the deeper soul work of health care? Do we doctors lack only for compensatory strategies that enhance our intellectual command of our specialties, our efforts as part of the health care team, our transparency in declaring conflicts of financial interest? Perhaps so, and as suggested by some, do we need only to improve our capacity at understanding patient informed consent and risk management, and develop skills for communicating pertinent facts?[1–3]

Most physicians, when pressed, would agree that we lack something else, and I believe it is one of the critical reasons for our loss of respect as a guild of healers. Without its being recognized and confronted, again and again, I fear we will continue to fall in society's estimation of our worth. By emphasizing our work as an industry, as producers of a product called health, we ignore the affective aspects of how both patients and we arrive at consensus about the world and their medical care. The question thus raised is not how do we make these messy aspects of thinking go away, but rather how do we physicians learn to shepherd and moderate the relational process of reaching common ground on the value of facts and feelings, as it plays out in clinical practice?

We must continually remind ourselves that, even in the midst of such crises as Dr. Wartman describes, AMCs must also produce psychologically and philosophically-aware physicians, able to identify and address ontological, epistemological, affective, and psychological aspects of the alliance of patient and physician. This is just as important as restructuring the institution financially and creating efficient ways of delivering team-based health care. There are critical experiences in the healing alliance that patients, and doctors, need and expect to be shepherded and nurtured, whether or not those needs and expectations can be articulated. Patient empowerment, the accessibility of data and opinions that we all share in the new internet age, the postmodern respectful approach to culturally bound values, do not take away from their inclusion—in some measure dependent on our characterologically-constrained openness to appreciate such things—and so understand what we can know, and how we know it; and as well, how to take a moral measure of everyone's approach to the issues at hand. But most of all, in the crucible of the health care encounter, fraught with fear, suffering, and the potential for healing, it is the physician's task to nurture the needs of all involved to love and be loved, to respect and be respected, to value and be valued, in the professional manner that our guild has evolved in its work for humanity.

Medical education may have emphasized behavioral science and a scholarly understanding of how health care functions in society, but for many of us it may have neglected the tools required to bring these to bear in one's work with patients, or importantly, on ourselves. It is critical to realize that book-learned comprehension, or even mentored clinical encounters, can still leave one without the psychological tools with which to practice, and live with, empathic clinical medicine, through our professional and personal lives. It's my observation that for most physicians there is a vacuum where there might otherwise be opportunities that allow us to "check in" and work on our capacity for psychological

insight into others or ourselves.

This is not solely about what is commonly called health management, nor is it simply a matter of dexterously inserting a bit of our personal magic into the rushed clinic visit. To make this work, we need to take the task of constructive empathy more deeply than simply interacting compassionately at the delivery end of the health care industry. Good doctors listen to patients, acknowledge the power of the patient's narrative, and realize the consequences of the biopsychosocial aspects of medical care. But even when this is done well, we can still be left with a gaping chasm dividing us from our patients on critical issues. Do our duties end at acknowledging such disagreements, and documenting them for defensive purposes?

Current medical knowledge and practice are indeed modeled on the biomedical sciences and the technology derived from them. In the main, physicians' anxieties about competency and expertise arise from our capacity to practice medicine measured by these yardsticks. And many ethicists' concerns with interactions with patients are aimed at getting everyone to an agreed recognition of what "rational," "scientifically valid" problem-solving brings to health care decision-making. However, in the tradition of David Hume, and supported by the work of social psychologists such as Jonathan Haidt, and Daniel Kahnemann, the bases for our capacity to understand ourselves and others are strongly influenced by how we use reason posthoc to justify our intuitions in establishing the value and ethical probity of actions and thoughts.[4,5] Much of what we intuit as being true about the world and ourselves is embedded in the stories we tell others and ourselves, rather than in reasons derived from the slower, more cognitively complex process of logical reasoning. And in spite of what we champions of the Age of Reason might think, this is not all bad.[4–6] There are fascinating implications here on how we think, feel, and decide, which can and should be applied to medical practice. The role of the doctor is more psychologically complex than we appreciate.[7–11] This is at least partly because the affective gestalt of the relationship is owned and expressed by both the patient and the doctor, in different and more intimate, personal ways than are facts. And, despite protestations of denial, both parties to the deed are letting feelings and affect permeate their process of arriving at decisions about risk with which they are comfortable.[9]

In this light, the proper approach to establishing meaning and value in all interactions with patients, whether it is about risk/benefit decisions, or sharing impending death, or in any ethically challenging health care interaction, is via an understanding of the conflicts and commitments, beliefs and expectations, fears and hopes operative in the psyches of all stakeholders. Importantly, relational work goes both ways. The test of our competence would be to bring such insights back to the relationship, and reframe the process for the patient and loved ones as it may be informed by such dynamics. In order to do so, the physician will likely also need to similarly try to understand what is driving her in the relationship with this particular patient, and how such issues of projection, transference, countertransference, trust, and emotional connectedness prioritize and value what is at stake. Does your academic medical center model this approach to medicine, and train its students, faculty, and community of physicians for this work? You get CMEs for working on this? And if these competencies are not in our skill set, can we still practice good medicine? What have we allowed our profession to become, if such goals are not among our key priorities?

Our confidence as physicians relies on the ability to master the mechanics and information flow of our specialty, what Wartman describes as "professional intelligence." And his six steps required of academic medical centers are needed. In the same breath, however, we need to reaffirm what health care ultimately is about, person by person. We physicians, curious amalgams of scientists, scholars, researchers, administrators and healers, should be aware of how we respond both intellectually and emotionally to the uniqueness of each of our physician-patient relationships, and be willing to explore ways in which the psychological and interpersonal dynamics influence the ethical, medically-correct choices we pursue in them. The mission of the AMC—to educate, research, and treat—must incorporate ways to emphasize and provide focus on these additional goals. The success of our institutions, the assembled multi/interdisciplinary teams, our patients, the community we serve, as well as the physicians leading our efforts, depend on it.

Acknowledgment

This letter draws upon material from Kachuck NJ. Medical decisions are not just about the facts: What a life-threatening virus can teach us about empathy, psychology, and the practice of neurology. Neurology Clin Pract 2012; 2 (2): 122–28.

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Re "The tragedy of the electronic health record"

Dr. Byyny's editorial (Summer 2015, pp. 2–5) should be read by every physician, hospital administrator, dean, medical student, government official, and patient. It is a perfect complement to Drs. Ober and Applegate's brilliant essay, and it is the best summary of the subject of the electronic medical record that I have read. I disagree only with his last sentence: he's too optimistic.

The issue arrived a day after I requested at our Family Medicine faculty meeting that our department discuss the negative impact the EHR has had on resident education, patient care, and staff morale. My note in advance of the faculty meeting is below.

> Subject: Engaging residents in periodic discussions on the role of the electronic medical record
>
> Returning this week from the Sixth International Conference on Graphic Medicine (which explores illustrated illness narratives, visual forms of patient education such as comic books, and reflective drawing and writing as an educational component of the medical school curriculum)—with the theme of "Spaces of Care" and at which I gave a talk entitled, "Drawing Patients Closer: Freeing the patient from the electronic medical record, the ultimate confined space"—I was confronted by a virtual stack of more than 60 clinic charts to sign in my Inbox.
>
> Several of the notes were exceptionally well-written and well-reasoned, but the majority reminded me of the observation in the attached article from *The Pharos* by the chair of the American Board of Internal Medicine: "One really doesn't 'write a note' any more; rather one charts on each of the patient's problems, one by one." This creates a string of verbiage that "outwardly appears to be the patient's progress note." But . . . "It's not really a note, it's a series of problems (each accompanied by a brief assessment and plan) held together with electronic Steri-Strips."
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> Following on the heels of nurses' retreat from the patient's bedside to the charting station, residents are now spending far more time in front of the computer screen than with the patient—as much as 90% of a resident's shift at the hospital.
>
> Accepting that the electronic record (and typing on the laptop in the exam room) as the new normals in medical care is one thing. But when the time spent on the computer winds up replacing time spent with the patient—creating an "iPatient" with which all too many emerging physicians seem to feel more comfortable, as Dr. Jeffrey Chi wrote last December in a commentary in *JAMA*—then there is all the more reason for us to require readability, understandability, and reflection of continuity of care as standard criteria for electronic progress notes.
>
> Let's take the lead on this (and take back our patients) by making the EHR adapt to family medicine rather than by being EHR lemmings. At the very least, I think that in the next week or two (once the responses to our EHR satisfaction survey have been submitted), the residents should receive the attached articles, and we should have periodic forums to discuss the EHR, not just from the standpoints of our practice's report card on Meaningful Use, potential data collection for research, or the quirks of the latest EHR "enhancements," but rather on the ways that the EHR affects our care of patients and our relationships with them.

Congratulations on a job well done.

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I read with interest Drs. Ober and Applegate's article (Winter 2015, pp. 8–14) concerning electronic medical records. I have a completely different take. I actually enjoy using these software products, and find them a marked improvement over paper charting. I considered writing a letter expressing my opinion but never got around to

it. However, after receiving my *Pharos* summer issue containing an editorial by Dr, Byyny, in addition to two letters to the editor disparaging EMRs, I felt I had to respond. I find clinical data much more organized, easily available, and easily read in electronic medical records. Data entry (charting) is much easier once one gets the hang of it.

I am not exactly sure why such negativity. Let me share my experience. When electronic medical records came to my office and hospital I heard several physicians say that they were going to learn just the minimum to get along. It was just too difficult to learn all the little nuances of the software programs. This seemed like a good idea initially, until I gave it some more thought. If I just learned the minimum then I might be unaware of a more efficient and accurate way to document clinical data. So I did the opposite. For thirty days I did not watch TV or read a newspaper or magazine. I spent every evening studying the EMR binder and practicing the software on the tutorials. It was fun, and I knew every nuance of the software when I was done. I still struggled for a few months when the EMR went live, but soon I loved the electronic medical record, and found I spent less time studying patients' charts and documenting. The piano is a beautiful musical instrument, but only if one knows how to play it. I hope I am not the only AΩA member who enjoys the EMR.

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I enjoyed reading your editorial, "The Tragedy of the Electronic Health Record," as well as the Letters to the Editor in this summer's *Pharos*.

Jim McGuinness's cover illustration, I believe, clearly suggests that a patient, who can only look at the back of the physician (and the computer monitor), is noting time pass without personal and meaningful interaction with that physician.

As I looked at the cropped illustration heading your editorial on page 2, I was struck by the image depicting "wondering where the time is going," as it relates to the overall inefficiency of our EHRs and specifically to your and Dr. Healy's point regarding the hidden costs involved. Each of the several administrative and clinical operations meetings that I have attended this week have referred to:

1. Additional resources necessary to develop "work-arounds" for either design flaws or illogically constructed algorithms, which then require additional resources to deal with the unintended consequences of those "work-arounds."
2. Additional time and personnel needed to extract and reassemble useful operational data out of currently collected EHR "data." Simple extraction to usable spreadsheets or statistical software seems to be restricted and designed to require additional vendor funding in order to perform what would appear to be standard analyses for any hospital in this day and age.
3. Lack of clinical logic to develop useful methods of linking important clinical information to order appropriateness for testing, medications, and bedside care. This in part relates to the array of quality metrics for which patient benefit has been overshadowed by "best practice advisories" or other time-consuming hard-stops, which could have been addressed during up-front EHR systems construction. Order sets designed to "not miss anything" now result in overuse of testing, and medication class duplication.
4. Physician and nurse time needed to perform tasks previously performed either by the physician personally or by other healthcare professionals in a much more time efficient manner. I agree with Dr. Block's observation regarding the value of a trained transcriptionist over a voice "recognition" computer program. I used to be able to round on postoperative cardiac surgical patients, including review of vital signs, laboratory data (two large sheets of paper record), and radiographic images, patient and nurse interview and patient examination, progress note entry, order entry and nurse clarification/debrief in five to seven minutes/patient. Now each step is prolonged by a series of mouse clicks, and screen searching, during which time we are turned toward the computer and away from the patient; progress note entry which could either utilize a series of drop downs necessitating additional mouse clicks, or meaningless cut-and-paste "information" (where inefficiency is compounded by my personal inability to type without errors), and correcting voice recognition transcription errors; and order entry, again slowed by my lack of typing skills, and which now requires ten to fifteen minutes/patient.

Referring to Jim McGuinness's illustration on page 43, I am clearly the square peg where the round hole of the EHR is involved.

Thank you for your comments and for Jim McGuinness's insightful illustrations.

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Thanks for writing such a clear review of the state of EHRs. Your piece is well-written and compelling. It is heartening that we seemed to have passed the tipping point and many commentators and leaders now see the shortcomings of existing EHRs.

In my own practice we've had an EHR (McKesson) since 2002. I wrote a commentary in 2008 about our experience,[1] and have testified twice to

ONC, been a co-author on the Institute of Medicine HIT and Patient Safety report and on the AMA advisory committee for the RAND study you quote. We need better tools and better regulation of those tools.

I also wanted to share with you that there are other solutions to all of the tasks now required in a patient visit besides scribes and voice recognition. Scribes help with only a limited number of tasks. And voice recognition likewise helps only with the SOAP note, but not the other clicks and taps, which now take up even more time.

In our own practice we have developed a "co-visit" model, with our nurses in charge of most of the prevention and the information management. They are with the patient from the beginning to the end of the appointment, making significant contributions and developing strong relationships with our patients. It is the best model of care we have ever given our patients. And we like each other and have fun together.

This week we converted to a new EHR. Early reports suggest it will not go well. This is not a learning curve issue. It is a design and regulation issue. Work previously capably done by receptionists has been transferred to nurses, and work done by nurses, billing clerks, pharmacists and transcriptionists has been transferred to physicians. We have been pushed down to the bottom of our license and our capacity has been constricted. In fact this implementation is completely dismantling the advanced team-based model of care which my husband and I have developed over the past two decades.

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It's hard to be a real doctor now

I and most other physicians went into the medical profession for similar reasons: we liked biology, we liked human beings, we wanted to reduce human suffering; and, we knew physicians held some degree of respect in society. Early in our lives we chose to commit to the required science courses in college, prepare ourselves for the rigors and also the intellectual and personal joys of medical school and residency, and then enter practice. Practice offered relationships that were exciting and fulfilling. We exchanged cases and ideas with our colleagues and developed collegialities within our community, our hospitals, and with our patients. We knew our patients, listened to their fears with them and their families. We treated our patients as human beings and made medical decisions based on the best available evidence, clinical experience, and how the patients perceived their disease(s) and prognosis. They trusted us. We were "real" doctors.

The joy in the practice of medicine has declined. The reasons for this are multifactorial, including the need to see more patients in less time in order to sustain enough revenue to pay costs; the diminution of humanism driven in part by the need to type electronic medical records rather than sit and listen to patients. The joy is also being influenced by the burdens of insurance preauthorizations and denials by payer employees with little or no medical training or licensure, or accountability to my patients. These insurance employees deny the "medical necessity" of my knowledge, based on forty years of clinical-academic education, of what I think is best for my patient. Denials are now the routine, not the exception. Denials create a greater degree of stress and hopeless fear for my patients; they don't deserve more uncertainty on top of what their basic disease has already given them. Additionally, the financial cost to my practice, by adding more medical assistants hired solely to "fight" the insurers is not reimbursable. These additional costs have driven many physicians out of business or into early retirement, or forced their employment by hospitals. Hospital administrators then become the deciders of what physicians can or cannot do. Even after I write appeals of the denials defending the necessity of the medical management plan and then have the phone calls—"the peer-to-peer" with some "medical doctor" employed by insurance companies who have little knowledge of the disease(s) I treat—can I obtain approval for the pharmacological treatment or radiological tests I have ordered. Insurers are now the "doctors" and doctors are now the commodity. Humanism in medicine across the board is vanishing.

What are the consequences of these firewalls? Time will define the costs, higher or lower, for these insurance denials and the distancing of real doctors mediated by the demand to type the EMR. Even if costs savings can be directly linked to denials, will the change in a profession transformed into a commodity be worth it? The costs in terms of decrease in my own passion for medicine or respect by my patients for the practice of medicine are already being felt. I am honored to do what I do, but cannot do it in the way I was trained.

Are there solutions? I hope so, but only when society in its broad terms allows doctors to be doctors. Patients have to have the confidence that their physicians are ***their*** advocates. While overall medical costs must be a concern for all of us, the burden of disallowing physician's good management of their patients is costly as well. That cost may not be obtainable. The training of insurance companies "phantom doctors" is not what medical school is about. Unaccountability of insurers is unacceptable. Every individual physician, professional society, academic center, industry executive, and government agency that respects what real practicing physicians deal with day in and day out must work to allow the return of sound and necessary medical

decisions made by well-trained doctors, done by well-trained, real doctors.

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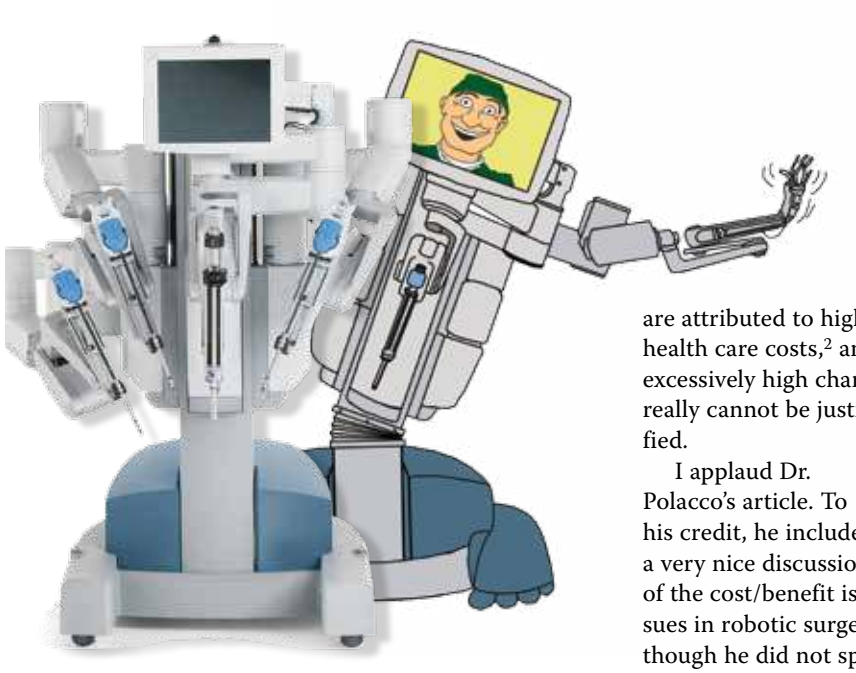
Re "The $6 million physician: A history of robotics making surgeons better, stronger, faster"

The title of Dr. Marc Polacco's recent article on robotic surgery (Spring 2015, pp. 11–15) is presumably a reference to the old television show "The Six Million Dollar Man," in which every week bionic man Steve Austin saved the day with his robotic skills—but the title held an uncanny irony for me.

I regularly lecture to medical students and residents about the high costs of medical care in the United States. Among the many causes of these high costs is a lack of cost containment leading to unnecessarily high charges and profits in some areas of medical care. One of several examples of these excess charges is from the bill a patient received for his robotic surgery. The physician billed $10,000 for his services, in addition to facility and hospital and operating room charges. This physician typically schedules twelve of these surgeries per week. Simple math shows this to produce bills of $120,000 per week, and if he works a typical physician year, occasionally adds extra surgeries, and also performs some outpatient procedures and clinic visits, this physician likely bills about six million dollars for his services per year. Even with high overhead costs and poor collection/reimbursement rates this physician might still be collecting an annual salary of 1.5 million dollars.



According to Medical Group Management Association (MGMA) data,[1] the mean salary for a primary care physician, likely working the same hours as this surgeon, currently is $181,000 to $196,000. per year. The average MGMA reported salary for specialist physicians ranges from $178,000 to $640,000,[1] depending on specialty, which averages to a reasonable 1.5 to 2 times that of a primary care physician. On the other hand, salaries that range up to eight times that of a primary care physician are among the contributing reasons to high medical care costs, along with the often excess charges for imaging, medications, and other health services. Granted, there are many other contributing factors to high medical costs, such as excess administrative burden, large numbers of unnecessary or ineffective tests and treatments, costs attributable to defensive medicine and malpractice, high costs near the end of life, and costly new technology that provides minimal improvement over older and less costly tests and treatments. However, since it has been reported that sixty-two percent of all personal bankruptcies in this country are attributed to high health care costs,[2] any excessively high charges really cannot be justified.

I applaud Dr. Polacco's article. To his credit, he included a very nice discussion of the cost/benefit issues in robotic surgery, though he did not specifically address surgeon charges. It is ironic, however, that his title might just as well refer to the very high annual charges some robotic surgeons might be billing, as to the Steve Austin-like robotic skills those surgeons now have with the robotic tools at their disposal. The type of six million dollar physician that I have presented here is definitely not a savior given the unsustainable high medical care costs that exist in this country.

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