



-DR. BILL HAVER, MEDICAL EDITOR -

## Physicians and the EHR ... What is the issue?

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I went to the TEPR Conference in Seattle (May 13 - 15) to see if I could find out what our American colleagues were up to. The apparent availability of cash in that country has always created different solutions within healthcare and I was curious about how they have progressed along the road to electronic health records when compared to our own country's journey. In the past, I have found that the comparison was good for my soul.

I find working with, and talking to, my American colleagues both educational and enjoyable; however, having said that, I must also say that I find it a challenge at times. The political and economic differences are not the only hurdles to clear; the presentation of information is not always what it appears to be.

This particular conference has noble intentions and the title itself gives ample direction (Toward an Electronic Patient Record) but the presentation makes separating the wheat from the chaff a very real challenge. The glitz is everywhere and the presentations are filled with biased information presented by individuals with a vested interest in the concept they are speaking about. This is fine with me as long as there is a clear disclaimer and a believable explanation of the relationship. No pretensions, no deception, no omissions.

There is nothing wrong with marketing (give your head a shake if you think you don't do it yourself) but don't ever confuse it with education. Education requires that there is at least some form of objectivity, scientific analysis, and accumulated evidence that can be cited to support your conclusions. Marketing may include valid educational material but, by its very nature, it is slanted to present one specific product in the best light possible.

My challenge was to glean whatever knowledge I could from the material offered. No small task, indeed.

The discussions were excellent; questions were pointed and insightful (this is one of the criteria I use to assess both the quality of the speaker and the quality of the audience). The doctors that were in attendance reminded me of why I was there. They reminded many of the speakers about the realities of seeing patients all day, about the demands on physician's time, about the effect of rapidly advancing knowledge, and about the real costs in the practice of medicine (most are not monetary).

They also reminded me about the real economics of medicine; the concept of "value added" versus "profit" versus "return on investment". Their questions included requests for clarifications of such terms as "cost containment", "cost effective", "physician work flow", and "transparent to the user". They quickly identified that the politician, the hospital, the payer and the vendor all have different ideas of what is best for the system and for the doctors. It

was readily apparent that the conclusions reached by those other agencies were almost always inaccurate and misleading.

The truth, as it turns out, is that there is no solution that is best for everyone. The solutions proposed, discussed, and demonstrated almost all had some significant virtue but none were above criticism. As a matter of fact, the systems that tried to address everyone's needs turned out to be the most obviously inappropriate. They were either too complex or too costly (usually both).

The economic realities of medicine are no less apparent in Canada. Any EHR that hopes to stand a chance of adoption has to show a benefit. The value proposition is based on a number of factors (efficiency, convenience, adjunct knowledge, analysis, etc) but the single most important one for the doctor is cost and cost benefit. Doctors on both sides of the border earn a living by practicing medicine. The method of payment varies but the truth is that time is money and, even on a salary, if you can save time you have saved money.

Ah yes, money. By the way, Canada, that is not a dirty word. It is necessity and reality. It is motivation and gratification. It is reward, it is reimbursement, and it is bread on the table. It may not be the reason that you chose to do what you do, but it is why you continue to do it. That is the truth. Deal with it.

And, by the way, it is not just an American concept. It may be a dirty word in Canadian healthcare but that attitude is at least part of the reason we have the problems that we have. We seem to have this misled self-righteousness that dictates that if you make money at something, it somehow undermines the actual value of what you do. Bull. You wouldn't judge the character of a person that way so don't judge a system that way. Canada has a lot of advantages but this is not one of them. Getting a return for what you do is a proven, fair, just, and honest principle. Period. As I said before: deal with it.

As I was saying: it was the physicians in the group that were doing this questioning. Why? Well, because the collective brain trust present had the revelation that the concept of the EHR requires physician involvement at the point of care. In the examining room. At the primary care level. Why? Well, it appears that they realize that virtually all pertinent clinical information is maintained at that level. It may not all originate there but even that portion that does not is copied to that person responsible for primary care - everything from home care to consultants reports, from hemoglobin to antinuclear antibodies, from colds to astrocytomas are the purview of the primary care physician. If you want to have a comprehensive record you have to involve the people who actually maintain the record.

So why has it taken so long? What is holding the doctors back?

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Here are the themes that I heard over and over again:

1. There is no clear-cut value proposition. This includes all the parameters mentioned above but mostly it is money. Cost vs. benefit in actual dollars.
2. There are no physician drivers. The “killer app” argument is one variation of this but actually this is a motivation issue that involves everything from political regulation (compliance requirements) to legal and professional issues (standard of care, insurance) and even the concept of economic and professional incentives. And all of this requires physician involvement (champions) in order to be effective.
3. There is a poor understanding of the concept of EHR within the medical community. This is purely an educational issue.
4. Physicians are already inundated with new information on a daily basis and the prospect of having to learn something else seems to be prohibitive. This is also an educational issue but it is much more dependant on age, computer experience, personality, and attitude.

Sounds familiar doesn't it? The story is the same in Canada.

The EHR is a great concept. Everyone that is associated with the industry has their own motivation but the fundamental issues outlined above have not been addressed adequately by any of them and, thereby, the person most critical to the success of the EHR has been ignored. You could argue that they chose to be ignored but that obviously ignores item #2 above.

Our progress toward the electronic health record will continue at glacial speed until the issues outlined above, both in Canada and in the U.S., are addressed by politicians, payers, institutions, and vendors. As is most often the case, you have to get involved if you want something to succeed, and in this case, if you work within healthcare IT and you are not part of the solution then you are part of the problem.



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