

# From the President: Will Electronic Medical Records Doom Your Practice?

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**Kenneth D. Christman, M.D.**

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The electronic medical record (EMR), a.k.a. health information technology (HIT), is being widely promoted by governments, HMOs, large employers, hospitals, and even organized medicine.

Doctors are now being urged to restrict EMR purchases to systems that will ultimately be certified by CCHIT (Certification Commission for Healthcare Information Technology). Why is it so important to have CCHIT? The key word is “interoperability.” CCHIT is supposedly a nonprofit entity with a contract with HHS to accelerate the development of “interoperable” systems.<sup>1</sup>

CMS Secretary Michael Leavitt has formed a committee to spur the development of the interoperable EMR: the American Health Information Community (AHIC). Buried deep in these deliberations is the true purpose of interoperability: “We want the data.”

Why do “they” want the data? Most importantly, it will enable “them” to implement standards that will easily translate into pay for performance (P4P).<sup>2</sup> P4P will lead to cost savings to payers who will refuse payment for what is considered “poor performance.” Could “poor performance” be the new label for superior or costlier care?

Interestingly, one of the arguments served up for enticing physicians to buy into the EMR is that better documentation will translate into higher reimbursements! This actually happened when some Ohio doctors started coding more Level 4 visits when using EMRs. Anthem’s response, however, was to “blend” the rates for levels 3 and 4 in order to circumvent the higher payout: “Anthem regional executives refuse to discontinue their blended rate policy until the company can devise a solution that allows them to maintain their profit margins.”<sup>2</sup>

Make no mistake about this: once enough physicians are fully interoperable, P4P will become a nightmare—all in the name of “quality,” of course.

As physicians, we are sworn to fiercely protect our patient’s confidentiality. Yet, we hear numerous reports of patient records being stolen, such as 72,000 medical records with personal information stolen from a private managed-care agency.<sup>3</sup>

A burglary of a home of a mid-level data analyst resulted in the Social Security numbers and birth dates of 26.5 million veterans being stolen.<sup>4</sup> It seems that medical records are not very safe in the EMR format!

What about governments that gather data without patients’ permission? A New York City diabetes-monitoring program has clinical laboratories sending results of all HbA1c tests to the health department.<sup>5</sup> How is this proper without patient consent?

Although AHIC was to appoint an individual to ensure patient confidentiality, AHIC was not able to supply the name of that person when asked—until after AAPS filed a lawsuit alleging noncompliance with the Federal Advisory Committee Act (FACA).

Once the EMR becomes interoperable, patients will be legitimately concerned about what information they divulge to their physicians, knowing that any sensitive material will become part of a permanent record that may be mined by any number of prying eyes. How accurate will medical histories then become?

We’ve been told, as in a free practice assessment offer from the Medical Society of the State of New York (MSSNY), how useful the EMR will be in the event of a national disaster such as Hurricane Katrina. Yet, such records will be totally useless without a computer to read them. What if the emergency is a power outage? Or worse, in these days of nuclear and missile proliferation, an electromagnetic pulse (EMP) from a high-altitude explosion of a nuclear weapon, which destroys computers and shuts down the electric grid nationwide? Recall that at Ochsner Hospital in New Orleans, doctors went back to paper and pen. Dependent on emergency generators, doctors deemed the EMR system to be the least important consumer of electricity. Additionally, the temperature inside critical computer equipment topped 150 °F.<sup>6</sup>

In view of these significant concerns, in addition to the high cost of implementing EMR, why do state medical societies sponsor conferences to “optimize practice operations by using EMR, select a successful EMR, and use EMR to enhance quality”?

The “free” assessment promoted by MSSNY will provide trained professionals to help doctors incorporate the EMR, e-prescribing, and e-clinical decision-making. This is all funded by our tax dollars.

Just how much creativity can organized medicine employ to sell doctors on the need to receive “free” advice on how to practice medicine?

In a recent issue of our state medical society publication, *Ohio Medicine*, Brian Bachelder, M.D., predicted that P4P “eventually will become a significant part of a physician’s revenue stream.” He continued, “I believe that reimbursement will change from the fee-for-service model to include a fee-for-quality component.”<sup>7</sup>

Traditionally, the consumer has been the ultimate arbiter of quality. In my opinion, the patient should be the judge of “quality.”

According to Bachelder, however, “Purchasers of health care are beginning to demand proof about the quality of care that physicians are providing.”

Is nobody concerned about the potentially enormous gap between patients' assessments of quality and the determinations of "purchasers"?

Bachelder maintains that history has shown weaknesses of the HMO model, and says that "some legitimate questions about the P4P process already exist. However, these are addressed by the principles developed by the MGMA and AMA."<sup>7</sup>

I recently listened to Duane Cady, M.D., chairman of the AMA Board of Trustees, expound upon P4P at the Loma Linda University Alumni Postgraduate Convention on Mar 3, 2006. I recoiled at hearing him promote the notion that the AMA needs to be involved in this process so that it can be controlled by the AMA, and that the AMA was actively developing 140 guidelines. That's astonishing! What happens to doctors and patients who might wish to deviate from AMA guidelines? What if they deviate from HMO guidelines? Or government guidelines? Are they fined? Incarcerated? What happens to innovation when such guidelines must be rigidly adhered to? Are doctors now being reduced to mere robots, being forced to follow mandates from the rich and powerful?

I spoke with Dr. Cady privately, and expressed my deep concerns that it is immaterial whether or not the AMA initiates the guidelines process, because ultimately others will control these guidelines. He was aware of the AAPS lawsuit against AHIC, but declined the invitation for the AMA to join in this battle against the EMR and P4P.

Why would the AMA stand against patient and physician freedoms, and the sanctity of medical records—and approve the intrusion of government mandates? Is it not profitable to publish CPT codebooks, HIPAA compliance manuals, etc.? Will it become even more profitable to publish manuals on how to succeed in the P4P environment?

AAPS derives virtually all its income from member dues, and fiercely advocates for maintaining the independence and

integrity of the medical profession. When projected Medicare reimbursement cuts are replaced by miniscule reimbursement increases, AAPS sees no reason to boast. Savvy physicians recognize that a 0.5 percent increase in reimbursement is actually a substantial loss if the practice cost increases by 5-10 percent.

Yet, organized medicine has the audacity to boast about how many thousands of dollars your practice has been "saved" by averting Medicare cuts.

Even if you still think that the EMR will save money or offer other advantages for your practice, please don't buy an interoperable system. Furthermore, if you don't bill electronically, you need not be HIPAA compliant.

Why should doctors participate in the charade of HIPAA compliance? Do you really think HIPAA is concerned about protecting patient privacy when HMOs and governments are allowing sensitive medical records to be stolen, and even intentionally furthering the violation of patient confidentiality?

**Kenneth D. Christman, M.D.**, President of AAPS, practices plastic surgery in Dayton, OH. Contact: KSCDChristman@aol.com.

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