

Virtual Mentor

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OP-ED

Mindful Use of Health Information Technology

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EHR, EMR, HIT, HIE. The letters themselves evoke emotion. The young find their pulses quickening with excitement about the new world order. Members of the older generation of doctors are more likely to experience tachycardia when they read these letters, due to the dread they evoke. One thing is certain: the digital age is invading health care and not about to retreat.

Now that my hair is thinning and turning to a white-gray mix (probably prematurely as a result of my interface with the “digitization” of health care), I get to share some of my thoughts on the many new and interesting ethical issues for physicians as we “go digital.” I hope to stimulate us all to consider this change with excitement tempered by due introspection. It goes without saying that the privileges of being a physician impose a mandate to do the right thing, as we see it. This will always be true, even when there are strong motivations to accede to expectations that are contrary to what we judge to be the right thing for patients and their families. Our first responsibility should always be to our patients.

With that backdrop, I will turn to a discussion of competing motivations triggered by the digital interface with health care that can challenge our duty and desire to do the right thing.

Health care is a business as well as a service. Statements like “No money, no mission” have been around for years. So it is no surprise that if you ask any private practitioner who is thinking about installing an electronic medical record (EMR) system why he or she is considering doing so, you will invariably hear about potential increases in reimbursement and productivity as key reasons. Indeed, not considering money as a key driver would be irresponsible and even unethical. After all, to survive and fulfill our mission, we have to make money at some point or we close the door. Not counting the cost means someone else will foot the bill or we will be out of business.

Financial motivations to move into the electronic world in health care delivery center around billing and improving efficiencies. These were key considerations I brought to my group practice in 2002, when we made the decision to install our first EMR system. Much had been written about our tendency as pediatricians to undercode our billing and the EMR vendors said they could help alleviate this tendency by capturing coding opportunities we were missing. With the computerized physician order-entry (CPOE) system I helped implement at our children’s hospital in January

of 2010 came the hope that the system would better capture our charges. These are reasonable and expected advantages of an electronic health record.

The ethical dilemmas develop when we allow the electronic record to drive our care and decision making inappropriately. What we frequently see in electronic records is the use of templates for charting or ordering. This is certainly desirable in many instances; it helps us remember to order that medication or test we might have forgotten. It helps us remember to ask that particular review-of-systems question that points us in the right direction for our differential diagnosis, but conflicts arise when we move down the form and fill in the blanks without justification. For example, the patient who comes in to have sutures removed doesn't necessarily qualify for or need a review of systems or family history-taking that includes a discussion about porphyrias. I'm not saying the questions never need to be asked of a patient who is having sutures removed, but the instances in which that would be appropriate are few and far between. If it is in my template and I ask the question and then think this justifies "up-coding" the visit from a level-two to a level-four or -five visit, I've just committed fraud. If I do this knowingly, I commit a real ethical injustice, but even doing it mindlessly, so to speak, because it was on the electronic form I happened to be using and then billing for it is wrong. Ordering the rare chemistry test because it happened to be on my convenience order set and then billing my patient for the counseling it generated is also wrong. The digital age offers us many opportunities for help, but we must be ever vigilant about using that help and we must be certain that our reason is not simply increased remuneration.

Why do I want to use my iPad to care for patients? For one thing, it is a cool toy. Sure, there are other reasons; it allows me to interact with my patient without a computer between us. But the fun-toy factor can't be ignored, and adopting technology for the cool-toy factor can be cause for ethical concern. The cost of health care continues to grow in spite of all efforts to contain it, consuming resources that are needed in many other arenas. Every time we purchase a supply or good to help us deliver health care, we drive up the cost of that care. All of us would agree that urging a patient to undergo an elective surgical procedure so that I can earn enough to purchase a new Porsche is not ethical. I'm suggesting that, on a much smaller scale, we need to take care that our purchase of health care technology enhances patient care more than it drives up cost.

What about speed? When shopping for my first EMR system, one selling point I heard from other early adopters was that speedier documentation significantly increased the number of patients I could see, which resulted in more income. Those of us who have lived in the electronic documentation world for any time may be wondering about the validity of this argument. So often it seems that electronic recording slows us down instead of speeding us up. There are those, however, who design their electronic medical record for speed. They use templates or copy and paste all their notes. They then typically enhance their billing by having a more detailed note than was justified by the reason for the patient's visit. I will repeat that health care is still about the patient-physician interaction and not simply about seeing

as many patients as one can. Avoid the temptation to use an electronic record to decrease your need to provide true patient care. Don't document what you don't do and don't do what's unnecessary, given the reason for the patient's visit, without clear medical justification.

The digital age brings with it huge promises about decision support and knowledge management. No one still believes it is possible to read every new journal article and stay on top of ever-expanding medical science knowledge. We will by necessity become more and more dependent on computers to help us stay abreast of the latest treatment recommendations and options. The risk comes when we trust the computers to think for us and fail to continue a path of lifelong study. Medical education is full of questions about the right amount of help to give medical students and residents. Too much help and they will be more prone to "cookbook medicine" and failing to think. Not enough help and we take the risk of teaching outdated medicine and losing patient safety advantages an electronic health record can provide.

Now for a word about privacy. Physicians have traditionally been the custodians of very private information about our patients and their families. It is my contention that abdication of this responsibility by a few has led to the establishment of legislation such as the Health Insurance Portability and Accountability Act (HIPAA). Computers can greatly enhance our ability to do our work effectively. Teenagers all over the world have taught us, however, that any computer can be hacked. It is clearly incumbent on us to do what we can to protect the private information we receive about our patients and families. In the digital age of health care, we must stay informed on how best to protect our patients' privacy; anything less is irresponsible and will lead to further regulation from outside the profession.

The list of ethical issues raised by the digital interface with health care will grow year by year. I haven't even addressed how we should deal with the new types of medical errors created by electronic health records or the process changes that the digital age is bringing to health care. For example, every order set we create to help us remember also brings an increased risk of ordering inappropriate tests. I hope I have demonstrated that each time-saving, patient-safety-guarding attribute in digital health care technology brings with it opportunities to offer unnecessary care, reap unnecessary payment, and add to the country's overall cost of health care. This is why I advise that, each time we are about to perform an action prompted by an electronic system, we stop and ask ourselves whether that action is appropriate and effective for this patient and whether our motives go beyond "capturing billing opportunities."

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