

## Mitigating the “Life-Sucking” Power of the Electronic Health Record

An article in PulmCCM discussed “life-sucking” electronic health care records (EHR) (1). It is in turn based on an article in the Annals of Internal Medicine on the work time spent by physicians (2). The latter, funded by the American Medical Association, observed 57 physicians in internal medicine, family medicine, cardiology, and orthopedics over hundreds of hours. The study revealed that physicians spend almost two hours working on their electronic health record for every one hour of face-to-face patient time. Interestingly, physicians who used a documentation assistant or dictation spent more time with patients (31 and 44%) compared to those with no documentation support (23%).

The PulmCCM goes on to list some of the reasons that the EHR requires so much time:

- The best and brightest minds in software design don't go to work for Epic, Cerner, Allscripts, and whoever the other ones are.
- There's a high barrier to entry for competition now that most major health systems have implemented the big-name systems.
- The vendors can't easily improve the front-end design's user-friendliness (like web pages and consumer software have) because it rests on clunky, proprietary frameworks built in the 1990s and which can't be substantially changed for stability reasons. Think Microsoft Office, but way worse.
- Software designers are congenitally incapable of accepting the reality that a user would be better off the less they use the product, and designing it that way. They think their EHR is super cool, and can't fathom that it actually sucks to use.

Let me add another possibility. Those who demand implementation of the EHR see documentation as being most important because of the bottom line. It if comes at the price of physician efficiency so be it-as long as it does not hurt payment. Physicians are not paid for the required increased documentation much of which is unnecessary, redundant and, in some cases, downright silly (3). Furthermore, the concept that this improves patient outcomes largely seems to be a myth (4). Those manuscripts that report improved “quality” of care usually have examined meaningless surrogate metrics that often have little or even inverse relationships with patient outcomes (3). For example, high patient satisfaction seems to come at the price of increased mortality (5).

What is the solution-charge for the time. As it now stands, there is no downside to demanding pointless documentation. Third party payers can deny payment when something like the rarely beneficial family history is omitted. There should be a charge for seeing and caring for the patient and another “documentation fee” that is based on time. That would mean that a 20 minute office call would not be billed at 20 minutes but at the 1 hour of physician time the visit really consumes. Those physicians who use a documentation assistant or dictation can

pay for these services by seeing more patients. Only in this way can the trend of wasting physicians' most precious resource, their time, be mitigated.

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### **References**

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