



Voices of Medicine



By Del Meyer, MD

The Tenth World Congress on Health and Medical Information brought together an array of physicians, technocrats and bureaucrats.

I find the Medical Information Technology revolution fascinating. It is moving too fast for some, and not fast enough for others. This year, during our annual trip to London to visit our daughter, I attended the timely "Tenth World Congress on Health and Medical Informatics." Information Technology (or IT) is becoming so important that many firms have elevated their head of Information Technology to board status as Chief Information Officer (CIO) on a par with CEOs, COOs and CFOs.

I had no grasp of the resources both government and private organizations have devoted to converting all information into digital form for electronic processing. Nor did I fully understand that in many spheres there is resistance to making great amounts of information available to people who could use it to make our healthcare system more efficient.

My Late PDA

This past year, Parkstone installed a personal digital assistance (PDA) system that interfaced with my MediSoft billing software. It enabled me to write prescriptions digitally on a hand-held device. The PDA provided insurance data on each patient so that I knew, for instance, which bronchodilator or steroid inhaler or leukotriene inhibitor was covered by my patient's insurance. It seemed every insurance company had an arrangement that did not match the average wholesale price (AWP) listed in the Drug Topics Red Book. (The same applied to all drugs in any of the insurance carriers formularies.)

It saved my staff at least an hour a day of phone processing prescriptions written for equivalent drugs not on a particular formulary. (I'm sure there was a similar savings of pharmacist's time.) Saving 10 percent of a physician's overhead does reduce healthcare costs.

Unfortunately, Parkstone laid off its work force in the economic downturn. When a PDA window malfunctioned, there was no one to service it. The cost savings disappeared.

Large costs are also saved as hospital records are converted from handwritten to digital. If doctors write orders digitally on a computerized patient chart, and if the therapeutic indications and economic costs are instantly available, treatment improves and costs decrease. In one study, up to 13 percent of associated healthcare costs were saved.

But as our hospitals digitized pharmacies, laboratories and x-ray departments, the information was not instantly available to physicians. Hence, we work in a time warp. If, as we write an order, we instantly see a comparable drug that is equally or more effective

- or a test that gives equivalent information - we automatically save money, sometimes up to half or more of the cost. As annual healthcare costs in this country pass \$1 trillion and march towards \$2 trillion, reducing healthcare costs by 10, 13, 20 and sometimes 50 percent would provide substantial savings.

"Competition" in Britain

During the week of this Congress, The Economist reported there are now one million Brits in the waiting queue for obtaining healthcare, 47,000 waiting into their second year.

The UK is feeling the impact of the European Union. Its courts are giving Brits the authority to obtain healthcare on the continent, which would then be paid for by the NHS of the UK.

The article supported this as a market approach to medicine, but it isn't the true market - it simply pits the inefficiencies of one socialized system against the other.

It's not unlike a social scientist who refers to our HMO system as market-based, rather than as corporate socialized medicine. In a true market, the purchaser of healthcare (the patient, not his employer) chooses the highest quality (doctor) at the lowest cost (office calls competing with each other). An office call in the UK now averages seven minutes. It is inconceivable that information technology can allow the clinical decision-making process to occur faster and still remain a human or humane interaction.

The Economist article cites the number of doctors the UK needs to bring its standards in line with modern countries. There is a seven-year plan to correct these inefficiencies. The last plan apparently did not accomplish this goal. Remember, the Communist Russian 15-year plans failed in their goals also.

Doctors throughout the world are using IT with increasing frequency (from 10 percent to more than 90 percent in just over five years). Patients are also using it more. In the UK, up to 90 percent of patients come armed with computer printouts to discuss numerous options, diagnoses and treatment plans during their seven minutes. One speaker contended this may not improve care and may even have an adverse effect. Patients may be afraid to ask questions and, consequently, use information inappropriately. It certainly changes the equation.

One presentation at the Congress touted professions and citizens (notice the change to a political characterization of patients by government purveyors) who are networking for integrative care. The brochure introducing the "Miguel" story was illustrative. It showed how 18 government programs - listed as clinical messages, email, clinical bookings, shared records, care protocols, mobile services, home-care monitoring, telemedicine, surveillance information, [medical] yellow pages, professional guidelines, quality management, public health information, continuing professional development, reimbursement, electronic commerce, patient IDs, and resource management - all helped Miguel start his insulin administration, anticoagulant controls, antihypertensive management and a new diet. At the same time, his GP put him in touch with social security because his problems seemed incompatible with his work.

Then it showed Miguel at home inhaling a cigarette in his ideal, new, healthy environment, essentially negating the entire bureaucratic effort.

This World Congress was the 10th triennial conference of the International Medical Informatics Association, with 1200 participants from about 50 countries representing all continents. From the list of participants, it appears that about half were physicians and the rest were technical and administrative people who are trying to help us take care of patients.

Since nearly all countries have socialized medicine, healthcare - including IT - depends on current funding by political operatives. Many lectures were directed at how to influence the governments to fund medical information technology (MIT) systems as a way to

reduce healthcare costs. All lectures were Power Point presentations, and a CD was included in the handouts.

After one esoteric presentation on the global implications of MIT, a physician from Africa responded that all this information was probably quite useful to developed countries. However, in his homeland, where computers were rare and cell phones nonexistent, money for medications to treat people who are diagnosed clinically rather than electronically would be more useful.

In the final half day of presentations, a technocrat stated that the group needed to work more closely with the best diagnosticians to come up with the best possible protocols. A physician stated that unless MIT brought the information to the final point of the medical evaluation, asking a doctor to spend more time entering data deemed useless to the clinical process would never, in and of itself, be useful.

Relieve Pain, Go to Prison

I recalled entering the conference hall an hour before the first session, three days earlier. The Docking Railway car on which I arrived delivered about 200 people. We were herded into a queue by an officer with a badge. It took 30 minutes to work my way to the desk; I registered and was given a name tag and a receipt so that I could go to a queue for booth 28 and obtain my conference materials.

Another wait. When I asked why the satchels containing the conference materials weren't handed out at the first desk, the gentleman retorted, "You want me to lose my job?"

The next day when the certificates of attendance were ready, we went into an even longer queue. I recalled that the registration of 15,000 doctors at the American Thoracic Society never had a 30 minute wait; badges and all conference materials were given in one pass across a desk. I asked the conference secretary, "Wouldn't it be more efficient to give all these items out at one time at registration, rather than making the participants wait in queue three times for them?" She said she did not see any inefficiencies in their system.

When I asked about the toilets (British for restrooms), I was told to take the escalator to the third floor. There were no down escalators, and after three days, my left knee was in great pain. My orthopedist, however, was happy.

Can workers in a government hierarchy ever be efficient? How can they make information more efficient for our profession? It will only come when the real medical marketplace is re-established - each patient seeking care at the best possible price. The market is ruthless at decreasing costs. Medicine should be allowed that privilege, and physicians would be up to the challenge.

Once located, the toilets were quite unusual. I had never seen waterless urinals before. It was interesting to see the men all aim for the glistening porcelain hemisphere and watch the "golden glitter" turn crystal clear. Was it being recycled? Was the ladies room also waterless? I asked one woman attendee and thought for a moment I was going to get slapped.

Fortunately, my AT&T cell phone died three weeks before I left on the trip. My Nextel replacement with GSM technology, good in 75 countries, let me stay in touch with my office for 99 cents. It worked equally well in France, Monte Carlo and Italy. AT&T's telecommunication pre-eminence has become nearly irrelevant.

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