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ObamaCare and Laptop Medicine

By Charles Battig

The era of laptop medicine is now upon us. Rather, make that laptop-computer medicine.

Visit your physician, and odds are that he will enter the examining room with his shiny new laptop in hand. The push for electronic records in the name of medical record portability and efficient record-keeping is documented in the press, and the potential advantages appear convincing.

As a physician, a medically necessary visit to another physician is always a bit of a worrisome event. Decades of practice have validated the notion that physicians can and do make errors. However, on this recent visit, my attention became focused on the central role that the laptop computer had assumed in the physician-patient interaction.

My answers to my own physician's questions were inputted to the laptop via a stylus touchpad. No typing skills necessary for the keyboard-challenged. One can only hope that the pre-programmed list of choices accurately reflected my potential responses. Chest discomfort? Would that be on exertion? How much exertion? Was that discomfort actually ribcage discomfort, as in a pesky costochondral rib joint, and not heart-related?

My physician hands-off -interview ended with his recommendation for a specific invasive, expensive medical-diagnostic procedure. Was this what the laptop computer decided upon? Was it his decision? As for me, my decision was to just say no, thank you.

It is easy to visualize how this new era of computerized record-taking might well fit into the more efficient model of care envisioned by Dr. Donald Berwick, President Obama's former recess appointment as head of the Center for Medicare and Medical

Services, and into the grand scheme of evidence-based medicine underpinning ObamaCare.

My education includes a graduate degree in engineering as well as a degree in medicine. The engineer in me responds to the appeal of the computer to present data in an organized and easily accessible form. The assembly line mindset of Frederick Taylor's time-and-motion efficiency business model was part of my training. Perhaps patients could be thought of as units of care, requiring a timed physician response. Perhaps the computer could aid the physician in improving his care of the patient and his unit output per hour. The stereotype of poor handwriting among physicians is based well enough on fact. Perhaps the privileged information of the doctor-patient trust can be maintained for the computerized record better than computerized bank and financial records appear to be.

As a physician in practice in California in the 1980s, I read with interest Paul Starr's 1982 *The Social Transformation of American Medicine*. It seemed that the practice of medicine was behind the times, as it was still mostly based on the trade-guild model of individual practice. Mr. Starr pointed the way to the corporate practice of medicine as the next logical step in the more efficient practice of medicine. He noted that the practice of law fell into a similar guild rubric.

California never seems shy in leading the way with new ideas, and soon corporate medical entities began to displace traditional solo medical practice and private hospitals. Entrepreneurs gave us "doc-in-a-box" drive-up medical practices. These have matured into various forms of stand-alone medical practices and walk-in emergency rooms. As yet, the legal profession has not given us a similar walk-in equivalent.

In designing an "economic transformation of American medicine," did Dr. Berwick and the ObamaCare bureaucrats conceive of the computer as the transitional tool of choice? It is possible that, by government edict, there will be a universal medical history computer program. Physicians would be required to enter all information via a touchpad, selecting from the menu of pre-programmed choices. The efficiency of typing in observational comments is dependent on the typing skills of the physician; a touchpad menu of choices would be less time-consuming. Would there be room for individualized side comments or observations, and how would they be fitted into the master paradigm and multiple-choice format? It becomes simpler to fit the patient to the computer rather than the converse.

When entered, the physician's choices would trigger a diagnosis based on pre-programmed, best-fit algorithms. Once the computer has made the diagnosis, the treatment plan would be offered from the corresponding "best-evidence-based"

program. Much like the software licensing agreements common on our computers, the computer might require the physician to click on "yes" that he agrees with the treatment plan. If he clicks "no," he will be informed that he will be personally and financially responsible if his alternate diagnosis/treatment fails or costs more than that of the government's computer.

A centralized computer system would monitor both patient and physician compliance. The number of minutes spent by the physician for each patient would be recorded by this same central computer, compared to the established standard, and be used to rank his performance and establish his payment. The California model of a "doc-in-a-box" will have been replaced by the "doc-on-a-clock" model. Both patient and physician would be able to contact an offshore-based complaint resolution center to dispute the computer decisions. Much like the Environmental Protection Agency's rating scale of automobile models, so would physicians receive an "A" through "F" grade based on their computer-graded performance.

The next logical ObamaCare cost-saving step would be to have the patient fill out his own yes-no computer-questionnaire. There are not enough primary care physicians to fulfill the law's mandate, and dispensing with the physician interview would conserve scarce resources. A consensus-derived, best-care, evidence-based treatment plan would be appear on the patient's "smartphone/pad"; prescription medications computer-dispensed from the central pharmacy would soon arrive in the mail. The computer program would generate a compassionate follow-up message, just to be sure that the recovery was going according to (computer) plan.

Welcome to the possible future.

Dr. Battig is a retired physician.