The Future of Medicine—Are You Prepared?

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Medicine is changing. I have heard those words many times over the past several months. In fact, I have even uttered them myself. And, I believe them to be true. But I remember being on rounds as a third-year medical student and getting a sidebar lecture by a pediatric attending who was frustrated by "the changes in medicine". That was 15 years ago that now begs the question, "Isn't medicine always changing?"

The practice of medicine is influenced by so many different factors: technology, economy, politics, sociology, and even theology. Since all of these things change with time, it is no wonder that the practice of medicine is always in a state of flux.

Physicians tend to have risk-adverse personalities. We do not like change. The uncertainty that accompanies change makes us very uncomfortable. Yet, when a new technology is introduced, we often have to change the way we practice. If not, our services will become obsolete. Worse, we would not be providing our patients the best care available. For example, less than 100 years ago, antibiotics were not readily available; now, no clinician would contemplate treating an infection without one. Today, there are very few surgeons (if any) who routinely perform open meniscectomies. Clearly, orthopedic surgeons as a group have demonstrated the ability to change—when there is motivation to do so.

Anticipate and Prepare for the Future

How different is adopting an electronic health record (EHR)? The purpose of an EHR is to provide better documentation and transportability of both the current patient encounter and the patient's medical history. These are noble goals that we, as physicians, would like to accomplish. Unfortunately, there is often a steep learning curve associated with adopting this new technology. My practice switched to an EHR 18 months ago. Documentation of the patient's medical history did improve. Unfortunately, my ability to see patients efficiently was significantly compromised, and the actual care my patients received did not improve. But, I suspect 30 years ago, surgeons who switched from an open technique to arthroscopic surgery also faced a steep learning curve. As they began to adopt the new technology, they too, complained of decreased efficiency and no significant improvement in patient outcomes. Thus, I predict that 30 years from now, the paper chart will be as obsolete as the open meniscectomy.

So if medicine is changing, how should physicians, approach the future? I believe the key is to look ahead and try to anticipate and prepare our practices for the inevitable. Practices that adopted EHRs 10 years ago had time to work with software designers to develop systems that both complemented their practices and satisfied meaningful use criteria. If you waited until 2012 to adopt an EHR, you might have had to make a rash—and possibly costly—decision when choosing a platform, and the implementation of the system may have been unnecessarily challenging.

As reimbursements inevitably decrease, we must look for ways to increase our efficiency. This may mean hiring more ancillary staff. One way my practice combated the decreased efficiency created by imputing data into the EHR was to hire a medical assistant whose responsibility was to obtain the medical history from each patient and document the data in the EHR. Another way to increase practice efficiency is to employ physician extenders such as physician assistants and nurse practitioners. Using these employees to see simple follow-up and postoperative patients frees the surgeons' time to see new consults and grow his or her practice.

Does Pay-for-Performance Provide Appropriate Incentives?

The fee-for-service reimbursement model physicians have grown accustomed to may soon be replaced with a performance-based schedule. In theory, a pay-for-performance (P4P) model makes economic sense—incentivize physicians to obtain good outcomes rather than the fee-for-service model that incentivizes them to increase the number of services and procedures they provide. However, I believe that most orthopedic surgeons are ethical and do not perform unnecessary surgeries. Furthermore, I believe they want

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Author's Disclosure Statement: The author reports no actual or potential conflict of interest in relation to this article.

Am J Orthop. 2013;42(8):350-351.

their patients to have the best results possible and already do everything in their capacity to ensure good results. Therefore, we, as a group, must question if P4P models truly provide appropriate incentives. Or, does it simply shift a physician's priority from patient care to documentation?

Regardless of the answer, P4P models have already started to affect our reimbursements. Physicians must not stand by helplessly; rather, we need to take an active role in developing P4P models that make medical and practical sense. The parameters that are employed to define performance need to be verified using evidence-based medicine. Additionally, any P4P system that is implemented must not penalize physicians for treating patients with comorbidities that ultimately affect patient outcomes. Otherwise, patients with obesity, diabetes, cardiac disease, and/or drug addiction—to name just a few comorbidities that are often found in the orthopedic patient—may find it very difficult to obtain care.

Practicing surgeons understand these delicate issues much better than administrators or government agents. We must serve as advocates to make sure that both the patient and the physician are protected from well-intentioned policy that has negative consequences. We need to be actively involved in our national and local professional societies, since it is through these organizations that we have the loudest voice and can invoke the most influence on those who make the policies that directly impact our future.

Yes, medicine is changing. But change is not necessarily a bad thing, especially if we are adaptable and change with the times. Instead of lamenting change, physicians must engage, embrace, and be leaders of change. It is the only way we will control how medicine is best practiced now and in the future. We must stay current, both with new medical techniques as well as with policy and political shifts that may affect our practices. If physicians are not at the forefront of thought-leadership and implementation on these issues, the solutions may be shaped by less-informed actors, and the resulting systems may not provide the best outcomes for patients or society. ■