EDITORIAL

The Best of 2018 Is Also the Worst

I am a doctor, not an engineer.
Dr. McCoy, *Star Trek* "Mirror, Mirror" episode

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Last year in my annual wrap-up, I wrote back-to-back editorials (December 2017 and January 2018) on the worst and best of 2017 from a federal health care perspective, emphasizing ethics or the lack thereof. I featured the altruism of federal health care providers (HCPs) responding to natural disasters and the terrible outcome of seemingly banal moral lapses.

This year the best and worst are one and the same, and I am not sure how it could be otherwise: the Department of Veterans Affairs (VA) and Department of Defense (DoD) electronic health record (EHR) contract with Cerner (North Kansas City, MO). Former VA Secretary David Shulkin, MD, announced the deal in 2017 shortly before his departure, and it was signed under then Acting VA Secretary Robert Wilkie in May of 2018.[1] But the reason the Cerner contract is the most impactful and momentous ethical event of the year is perhaps not what readers expect. Search engines will efficiently unearth plentiful drama with ethical import about the contract. There were conspiracy charges that the shadow regime improperly engineered the selection.[2] The usual Congressional hearings on the VA leadership mismanagement of the EHR culminated in Sen Jon Tester's (D-MO) martial declaration in a letter to the newly sworn-in VA Chief Information Officer James Paul Gfrerer that "EHR modernization cannot fail."[3]

While all this is obviously important, it is not why the annual awards for ethical and unethical behaviors are bestowed on what is essentially an information technology acquisition. The Cerner contract is chosen because of its enormous potential to change the human practice of health care for good or ill; hence, the dual nomination. This column is not about Cerner qua Cerner but about how the EHR has transformed—or deformed—the humanistic aspects of medical practice.

I am old enough to remember the original transition from paper charts to VistA EHR. As an intern with illegible handwriting, I can remember breathing a sigh of relief when the blue screen appeared for the first time. The commands were cumbersome and the code laborious, but it was a technologic marvel to see the clean, organized progress notes and be able to print your medication list or discharge summary. However, it also was the first stuttering waves of a tsunami that would alter medical practice forever. The human cost of the revolution could be seen almost immediately as older clinicians or those who could not type struggled to complete work that with paper and pen would have been easily accomplished.

For many years there was a steady stream of updates to VistA, including the Computerized Patient Record System (CPRS). For a relatively long time in technology terms, VistA and CPRS were the envy of the medical world, which rushed to catch up. Gradually though, VA fell behind; the wizard IT guys could not patch and fix new versions fast enough, and eventually, like all things created, VistA and CPRS became obsolete.[4] Attitudes toward this microcosm of the modernization of an aging organization were intense and diverse. Some of us held onto CPRS as though it was a transitional object that we had personalized and became attached to with all its quirks and problems. Others could not wait to get rid of it, believing anything new and streamlined had to be better.

Yet the opposite also is true. EHRs have been, and could be again, incredible time-savers, enabling HCPs to deliver more evidence-based, patient-centered care in a more accurate, integrated, timely, and comprehensive manner. For example, Cerner finally could discover the Holy Grail of VA-DoD interoperability and even—dare we dream—integrate with the community. Yet as science fiction aficionados know, the machine designed to free humankind of drudgery may also end up controlling us.

The other commonplace year-end practice is for ersatz prophets to predict the future. I have no idea whether the Cerner EHR will be good or bad for VA and DoD. According to the insightful critic of medical culture, Atul

Gawande, MD, who has examined the practitioner-computer interface, what we must guard against is that it does not replace the practitioner-patient relationship.[5]

The most common complaint I hear from patients in VA mental health care is: "They never listen to me, they just sit there typing." Similarly, clinicians complain: "I spend all my time looking at a screen not at a patient." As an ethicist, I cannot tell you how many times the blight of copy and paste has thwarted or damaged a patient's care. And the direct correlation between medical computing and burnout has been well documented as all health care systems struggle with a doctor shortage particularly in primary care—arguably where computer fatigue hits hardest.[6]

What will decide whether EHR modernization will be a positive or negative development for VA and DoD patients? And is there anything we as federal HCPs can do to tip the scales in favor of the what is best for patients and clinicians? The most encouraging step has already been taken: VA and Cerner have set up EHR Councils composed of 60% practicing VA HCPs to provide the clinical perspective and 40% from VA Central Office to encourage synchronization of the top-down and bottom-up processes.[7]

Many experts have pointed out the inherent tension between how computers and human beings work, which I will simplify as the battle between the 3 S's and the 3 F's.[5] The optimal operation of EHRs requires systems, structure, stability; to function successfully human beings need flexibility, freedom, and fragmentation. VistA had more than 100 versions according to a report from the Federal News Network (FNN), which is a striking example of the challenge EHR modernization faces in bridging the 2 orientations. As former VA Chief Information Officer Roger Baker told FNN, replacing this approach of EHR tinkering with a locked-down commercial system will require "a culture change that is orders of magnitude bigger than expected."[8]

Think of the 2 domains as a Venn diagram. Where the circles overlap is all the things we and patients want and need in health care: empathic listening, strong enduring relationships, accurate diagnosis, accessibility, personalized treatment, continuity of care, mutual respect, patient safety, room to exercise professional judgment, and the data needed to promote shared decision making. Our contribution and duty are to make that inner circle where we all dwell together as wide and full as possible and the overlap between the 2 outer circles as seamless as human imperfection and artificial intelligence permit.

The Gawande article is titled "Why Doctors Hate Their Computers." Of course, his piece shows that we also love them. None of the proposed liberations from our EHR domination—be they medical scribes or dictation programs—has solved the problem, probably because they are all technologic and just move the slavery downstream. We have come too far, and medicine is too complex, to go back to the age of paper. If we can no longer do the good work of healing and caring without computers, then we have to learn to live with them as our allies not our enemies. After all, even Dr. McCoy had a tricorder.

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