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Productivity: the Industrialization of Medicine

Stephen Kamelgarn, M.D.

Just in case you've missed it, there seems to be a movement afoot to standardize, and ultimately industrialize, medical practice. As electronic medical records makes larger and larger inroads into our lives, this process becomes easier to institute and shove down our throats. EMR, with its pre-fab templates, constant reminders and biller friendly formats forces us into a mode of practice where we, as healthcare providers, are being downgraded to glorified cogs in an increasingly monolithic machine. The software engineers make the calls, not the physicians.

The latest buzzword that alludes to this change is "productivity." Everybody from Kaiser to Medicare wants us to improve our "productivity." The cover story in *Medical Economics* a couple of months ago was: "How to improve your productivity." It's everywhere. When I see all this stuff, I get the feeling that when my "productivity" is maximized I will have entered into a Golden Age, where all's right with the world, the sky's always blue and world peace will have been achieved. NOT.

I've looked up this nefarious word, and, according to *The American Heritage Dictionary* (3rd edition, 1996) productivity is defined: "*economics* The rate at which goods or services are produced especially output per unit of labor." Since when do we produce "goods" (i.e. make stuff for sale). And, although we do perform services for our patients, I don't see us as "service providers," an important sector of the economy to be sure, but it's not our role. Medicine is not a commercial enterprise. There are so many ways in which it differs from commercialism. It therefore, doesn't lend itself to the standardized protocols that our industrial and post-industrial society demand.

Increasing services per unit of labor *demands* standardization and standardized protocols. And medicine can only be standardized so far. Ultimately, the interaction between physician and patient is an individualized, one-on-one, interchange; impossible to pigeon hole and standardize. To give good medical care one must really see the patient, and, if possible, lay hands upon him or her. One must not stand behind the counter as though selling tickets at a shooting gallery.

If I remember my medical school education correctly, we take care of *patients* (not nameless things), and provide them with the means to improve their health. We don't stand next to a cash register and add up all the goodies they buy from us. We're not on an assembly line somewhere putting the fenders on cars as they roll down the line. Health care is a need, not a want. Continuing to promote the idea that healthcare is a "product" is ludicrous.

While productivity may have some usefulness in describing industrial output or comparing wages among workers in different industries, it should have no place whatsoever when describing the delivery of medical care. Whether we like it or not, whether the government bean counters and insurance executives like it or not, we are *not* engaged in making consumer goods or any other similar activity. We are actually more like a crafts guild that relies on a combination of science and artistry to deliver care to human beings. Individual human beings do not fit into an industrial model, and while people may be treated statistically when predicting election outcomes or the popularity of TV shows, individuals must be given time to explain themselves and develop relationships with their physician.

Medicine is probably the last profession where we can all remain "artisans." Over the years manufacturing has moved from customized, individualized crafts to assembly line standardized products and procedures. We no longer hand make cars or anything else. These items now roll off the assembly lines in their identical thousands. While this may be very good for providing inexpensive consumer products, it doesn't speak well for medical care. Office workers are now gauged by how many "productive keystrokes" they hit on their computers while at work. Is this how we wish to be gauged?

In medicine, each patient is an individual that requires individual, "customized" care. This holds true whether we're treating a strep throat, or trying to convince someone why it's important that they take their blood pressure pills regularly. While EMR is very good at reminding us of the health maintenance stuff we all must do (especially if we expect to get paid under P4P): colonoscopy at age 50, mammograms, flu shots, etc. there seems to be little evidence that performing most of this stuff actually improves health outcomes. And while we may be expected to practice evidence based medicine, it still takes time to convey those evidences to patients and work with them to improve their overall health. We also know that when patients try to follow sound medical advice and work on their own to maximize their health they do tend

to feel better–although this is an outcome that can't be quantified. And when we deliver this advice we cannot force it into a cookie-cutter mold, if we expect to make headway with our therapies.

As much as the bureaucrats may try, you can't pigeonhole a medical visit into a precut template. Although we may be jammed into a seven minute appointment there is both a qualitative and quantitative difference in using that seven minutes to treat a 16 year old with a cold and a 76 year old with end-stage heart disease. If we take the time that we actually need, our "productivity" goes down, although we may actually do a better job, and have higher job satisfaction. If we do what the bureaucrats and insurance people ask, and see four patients an hour, then our "productivity" can be measured, although the intangibles of both patient and physician satisfaction and the very nature of our vocations is consigned to the rubbish heap.

I know that health policy economists have devised a bunch of formulas that are supposed to state with amazing exactitude how many people we should be seeing based on our "patient mix." However, none of these "experts" actually sit in a room with a patient and try to tease out the elusive and unique aspects of the office visit. Even for two patients with identical conditions the visits cannot be standardized. One patient may be in total denial of the condition while the other wants to know everything he/she can do to make themselves better. The visit is dependent on our patients' level of education, level of motivation, complexity of health conditions and the patients' social milieu. I ask you, "How can this be standardized and measured as 'productivity'?"

Certainly, much of what we do is quantifiable: How long it takes to do a hip replacement; how many colonoscopies one does in a day, how quickly dictations are completed, etc. But when a physician is counseling, teaching or otherwise engaging intellectually and/or emotionally with a patient then all bets are off. That part of the medical visit cannot be measured, parsed or otherwise subjected to quantitative analysis. If we can't quantify the process, then how can we effectively standardize that process?

There always exists a dynamic, dialectic tension between having to see a large volume of patients and devoting the appropriate amount of time to each patient so that we may maximize their health care. A ten minute visit may be fine for some people, while others may require 45 minutes or longer. How each of us individually balances that dialectic is what ultimately defines

our practice. We should not be using the economic concept of “productivity” to resolve this dialectical dynamic. For this concept reduces people to widgets and physicians to nothing more than widget makers.

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