



Message from Doug Morris, MD, Director of The Emory Clinic

With the recent completion of both the academic and fiscal year (my first as Director of The Emory Clinic), I wanted to take this opportunity to share some personal perceptions (perhaps misperceptions) for the future direction of The Clinic. These observations are offered without conviction that they represent the total or absolute truth, but are presented to hopefully stimulate discussion and initiate action.

I. Changing Medical Landscape

We are all acutely aware that American medicine is moving rapidly and inexorably toward a phenomenal transformation. The complexities imposed by 21st century health care have overwhelmed our government, our economy and our profession. These complexities include the following:

- 1) the unsustainable cost of medical care
- 2) the moral obligation to expand our medical coverage
- 3) the disconcerting constellation of conditions manifest by an aging population
- 4) the increasing expectations and demands of an Internet savvy populace
- 5) the recognition of the enormity of medical errors

Given these complexities, it is imperative that Emory Healthcare, as one of the leaders in the advancement of medicine, step forward and identify those refinements in medical practice that will lessen the negative impact and enhance the positive impact of this transformation. Rest assured the transformation will occur whether or not we participate in the process.

For the past decade, physicians have often dispassionately lamented the unpleasant permutations that have confronted medicine. Equally concerning has been the stoicism displayed in their acceptance of the occasional misguided responses of organized medicine, the government and the health care industry to these permutations. Numbered among these responses are the:

- 1) propagandizing of quality data
- 2) creep into our profession of a shift worker mentality
- 3) increasing regulation of our training programs
- 4) intrusions of "peer to peer" reviews
- 5) increased likelihood of legal entanglements

While these intrusions have made the delivery of health care more burdensome, the complexity of medicine itself has progressed exponentially. The complexity of medicine now often exceeds the capability of the individual physician. In the face of the explosion of medical information during the past decade, it is impossible for any single physician to maintain mastery of all the facts pertinent to

his/her specialty. Furthermore, technological advances have rendered many procedures easier to perform and lessen the requirements for the skills and artistry of the “master craftsman.” (This assertion is made with the acknowledgement that there still exists a given body of work that requires very sophisticated skills and very specific knowledge to achieve and maintain expertise in that particular discipline.)

II. Response to Transformation

Often physicians have responded to impending change by choosing to ignore the warnings under the pretense of being too busy. Worse yet, some will disparage their colleagues who choose to become involved for being too focused on the business of medicine. I would submit that to successfully respond to the impending transformation, we must become engaged, hone our organizational skills and mimic the space industry and other modern industries that combine high risk and complexity. The space program radically transformed its functioning model by moving from the test pilot to the astronaut, from the individual to the collaborative team.

Bending to the inevitable by no means demands that we forsake those unique moral responsibilities we accepted as we received our medical degree. If ignorant of such at graduation, we quickly learned that accepting the commitment to another’s welfare demands moments of self-reflection when disease prevails, the audacity to occasionally proceed in spite of a degree of uncertainty, and sharing and shouldering the hurts and fears of our patients. Our profession and our patients will suffer if we replace the familiar face of “my doctor” with a “parade of strangers” more focused on achieving balance in their lives, forsaking a studious search for new knowledge with the irresponsible assumption that guidelines and protocols will cover for our ignorance, and avoiding self-reflection due to a misguided sense of corporate responsibility, rather than individual responsibility.

III. Collaborative Teamwork

A movement to collaborative teamwork has already swept through many non-medical organizations. The leaders of those modern industries have adopted collaborative teamwork as their most effective management tool. For medicine to shift in this direction, however, it will encounter resistance. For some, the resistance will be tied to the fact that our self-worth and our sense of accomplishment are linked to our ability to “heal the sick.” Others may fear their work will be devalued and less well compensated as revenue is funneled to the team. Finally, some will view as an imposition any request to meet together and settle (often after contentious discussion) on joint diagnostic and management protocols. Resisting this change, however, is like Don Quixote “tilting at windmills.”

There is probably no one formula for forming a team that executes with precision. The abundance of literature on the subject attests to this assertion. Nevertheless, such characteristics as collaboration, inter-dependence, transparency and discipline are often cited as key ingredients. In addition, William Osler’s admonition that a physician should “observe, record, tabulate, communicate” serves as sage advice for the modern medical team faced with demands for careful documentation, quality metrics and informative “hand-offs.” Most assuredly, the team functions best in a culture of openness, frankness, mutual respect and “service above self.”

Physicians must also align themselves (“team”) with their colleagues in the other disciplines of health care. Steering our health system through an era of shrinking reimbursement and rising expectations with regards to quality and safety necessitates such an alignment among physicians, nurses and other allied health professionals. The challenge for this team is balancing the decelerating price growth with continuing cost pressure. A \$110 billion reduction in Medicare fee for service rates and a \$36 billion cut to disproportionate share (DSH) hospital payments accounts for much of the shrinkage. The pace of these reductions in public payment will likely accelerate as proposals from both political parties stipulate further reduction in reimbursement. Additional factors in the decelerating price growth include the following:

- the shifting of payer mix away from commercial payers
- commercial cost shifting stretched to its limit
- increasing employer willingness to restrict potential health care choices

Running counter to these downward pressures on revenue are certain inflationary forces. These forces will make the task of cost cutting even more ominous. These drivers of cost growth include:

- an endless stream of medical innovations
- a looming nursing shortage
- a populace more health conscious and more insistent upon diagnostic certainty
- increasing prevalence of “lifestyle health hazards”
- The expanding cost of “defensive medicine”

Bending the cost curve of health care will also likely hinge on an ability to redefine the role of the physician and other health care providers (physicians playing a more supervisory role), embracing new health care delivery models (telemedicine, medical home, a more appropriate use of hospice) and consolidation of our health care systems.

The advice emanating from experts in health care economics is to learn to live on tomorrow’s Medicare margins. The health care team will only reach this goal if they benefit from the active engagement of the physicians. Such measures as increased volumes flowing through our existing infrastructure will only happen with full participation of the physicians. Competitive pricing will need the endorsement and thoughtful steering of the physicians. Physician engagement will also be essential as we move into the era of pay-for-performance. These programs offer upside potential to increase revenue, but also hold the threat of downside risk.

IV. Adoption of EeMR

The rising expectations regarding quality and safety necessitate that we physicians recognize the power of EeMR. While some physicians may bemoan the considerable expense, time commitment and loss of productivity required to install EeMR, it alone provides sufficient surveillance analytics to guide quality improvements. In a clinical sense, EeMR allows for more structured documentation which, in turn, offers a higher coding value. Cognizance of the initial reward and subsequent penalties tied to “meaningful use” and the pending peril of ICD-10 are convincing evidence that a failure to adopt EeMR is not a viable option for a health care system.

V. Stewardship of Finances

Finally, physicians must play a leading role in the stewardship of the health care dollar. As previously indicated, the dollars available have diminished as the needs for funding have risen. Emory is fortunate to have excellent leadership and governance, but this leadership faces a daunting task in directing the dollars flowing into Emory Healthcare to their most appropriate use. In a manner respectful of the budgetary demands and restraints Emory leadership faces, we must insist that they remain mindful of the dollars we must have to maintain an uncompromising fidelity to our patients, the dollars needed to allow Emory to be a leader in innovation and discovery and the dollars essential for Emory to remain market competitive with regards to technology, facilities and compensation.

VI. Conclusions

These observations have led me to the following conclusions:

- We must become agents of change
 - Some of you will need to propose and direct change
 - Some of you will need to serve as role models for adopting new approaches
 - Some of you will need to address the frustrations of staff and colleagues when change becomes disruptive
 - Many of you will need to learn a new language – if we don't understand the verbiage, we will not see the challenges ahead

- We must be team players
 - We must lead by reaching across disciplines as we develop checklists and standard protocols
 - We must collectively re-address compensation models and funds flow as new health care models appear
 - We must strive to link and intertwine our hypothesis-generating and postulate-proving efforts
 - We must breakdown fences and build bridges to better train our house staff

- We must be good stewards
 - We should demand accountability at all levels
 - We should promote transparency
 - We need to consider carefully what clinical and investigative efforts we should offer, which we should promote and which, if any, we should eliminate

Thanks for taking the time to read this and considering its contents. Thanks also to those of you who through your words and actions helped me to formulate my thoughts. I would appreciate your feedback.