Scribes—a mere soupçon to feed a flawed EHR?

By Christopher Langston

Hailed as a technology solution that would provide better healthcare management at lower cost, the Electronic Health Record (EHR) seems generally to have added work to the primary care encounter, slowing it down and, in its current rudimentary form, offering limited clinical benefits. This is particularly true in the care of older adults, where clinical complexity is high and many treatments require careful customization to patient function and goals of care.

Faced with a stark choice between working longer to see the same number of patients at a rate slowed by the addition of EHRs, or running a dual system of paper notes and electronic charting done late into the night, some primary care providers have turned to scribes—whose function is to feed the EHR while the doctor focuses on patient care.

The Scribe Specialty

A scribe is a specialist trained in the EHR system who understands enough of the flow of patient visits to capture findings from an exam and document the treatment plan. The scribe also ensures that the needs of billing and federal government requirements of “meaningful use” for EHRs are satisfied, while keeping the flow of business going at top speed.

Already, scribes are seen in many settings, such as emergency departments and outpatient clinics. There are estimated to be as many as 10,000 scribes working in the United States, making it a very fast-growing field.

Several studies have suggested that adding scribes (also known as physician partners) can be helpful even on purely economic grounds. At relatively low salaries, scribes can make several patient visits possible that otherwise could not be fit into a day, and thereby more than offset their cost. Other advocates for primary care have noted scribes’ potential for “returning joy” to the practice of medicine. If we add those non-monetized benefits of scribes in reducing stress, burnout and days that don’t end with hours of charting, using scribes seems to be a no-brainer.

A Band-Aid, Not a Fundamental Fix

The problem is that adding scribes does not address the fundamental issue: If we have any realistic hope of improving care quality and reducing cost, it will come from enhancing the ability of primary care to keep us well and to prevent exacerbations of chronic conditions that are so common among older adults—the conditions driving hospital use and other high-cost care.
We must have the right resources, technology and staff to do more and change the course of disease and care. We need radical change in primary care, not incremental changes at the margins—like scribes.

In quality improvement science, scribes would be described as a “workaround,” a home-grown improvisation enabling a process to go forward, despite defective design. Here, the defective design is in the EHR and the workflows of primary care. The scribe is a Band-Aid that enables the system to limp forward and, in so doing, removes the urgency for more systematic and fundamental change.

Inefficiencies and Empty Promises

It’s helpful to understand how we got here. The 2009 American Recovery and Reinvestment Act and its health technology provisions, known as the HITECH Act, offered a short-term bonus to hospitals and physician practices to adopt EHRs.

Unfortunately, the EHRs that most health systems and providers purchased have added hours of work to the day rather than increased the efficiency of work. And the promised clinical benefits have failed to materialize. For each time an EHR gives sensible treatment advice or prevention reminders, physicians report it offers 10 false alarms and endless busy-work distraction.

Since accepting initial federal payments, providers and facilities increasingly face incentives or penalties for meeting new standards of “meaningful use” for their EHRs, before they have caught up to earlier changes. Like many impulsive but well-meant gifts, this one has “kept on taking” long after the reimbursements for adopting qualified EHRs have been cashed and spent.

As with any major change, adopting EHRs could be expected to result in a temporary reduction in productivity that would be rewarded by future greater efficiency. However, in talking with primary care providers, specifically geriatricians (where care is more complex), many report that the hours of work added to their days with EHR introduction result in a permanent reduction in number of visits per day.

For many providers, especially those in primary care, their financial margin is precariously balanced on a knife edge, so a few minutes here or there that add up to an additional visit or two can make the difference between a day where revenue exceeds the fixed costs of space, equipment, insurance and salaries—or doesn’t.

Adding scribes to lessen the negative impact of the flawed, inefficient and inadequate electronic health records currently in use is not the answer.

Great primary care that provides continuous, comprehensive, coordinated and geriatrically expert care—all while keeping an expanded team of professionals (as well as the patient and informal caregivers) on the same page—needs a great electronic health record.

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