

Opinion

On the Trail to Better Patient Outcomes: Aren't Frontiers Scary Places?

We all grew up watching glamorized stories of the Wild West, as bold settlers pushed the frontier into uncharted territory. With arrows zinging and bandits robbing, it must have been hard for these early pioneers to keep focused on the promise the frontier held for them. It's not so different professionally, when a new frontier is made possible by breathtaking electronic advances. There is a lot of reluctance to venture out into a new frontier, a lot of concern about the possible negative repercussions, and, in all the hubbub, a loss of focus on the advances available to those brave enough to forge ahead.

I think we clinicians have an easier time dealing with technological frontiers in surgical care or in diagnostic testing. Where we seem to have more difficulty is at the frontier of the way we deliver medical care. Little wonder, because for the last 30 years that frontier has involved changes in the fee-for-service payment structure, with insurance, Medicare, Medicaid, documentation requirements, fraud and abuse regulations, and increasing intrusion into the physician-patient interaction. But there is a new frontier looming: how we improve the quality of care we deliver.

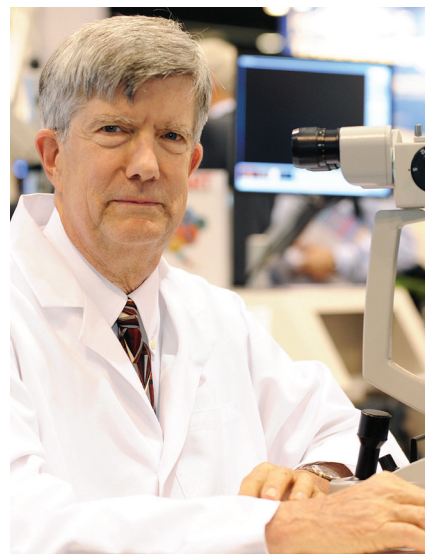
Consider for a moment your own practice situation. Like most of your colleagues, after training you settled into a practice, perhaps after a brief stint in academic medicine. You be-

came known locally as an ophthalmologist whose patients loved you, and you took pride in providing quality care to them. You even developed a few care innovations that you would dearly love to share with other doctors because it might improve the quality of their care, but there was no mechanism to do that. The on-ramp to the publication highway was permanently closed to you—or at least you felt it was—so you lost interest in sharing your quality improvements.

But the new quality frontier has different rules and different players. We are on the threshold of making quality improvements in real time, not six months or two years later, after the data from a study get crunched. The electronic health record is the vehicle for this frontier because it allows every practitioner to measure his or her outcomes in real time. If you have a better mousetrap, it will be immediately evident in the outcomes data, and you will be encouraged to share it with your colleagues. Will this innovation descend upon us overnight? No, at first the measurement tools will be crude, perhaps even unfair to those doctors saddled with tougher cases. There will be attempts to penalize those physicians who don't provide "above average" care. But the problems that will accompany the early generations of this quality frontier are merely arrows to be dodged. We cannot lose focus on the ultimate goal of a new era of

quality-of-care improvement in which we physicians, and the patients we care for, will be the beneficiaries.

As electronic health records become adopted, easily installed software will "piggyback" onto them and seamlessly extract data from every practice without any additional personpower. Where these data go is our choice to make. The Academy and the Foundation's H. Dunbar Hoskins Jr., M.D. Center for Quality Eye Care would like the data to go to an Academy-sponsored registry, where confidentiality safeguards can be enforced. The frontier for quality eye care is a scary place, but with the Academy on our side, it should be less threatening.



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