Health Care in a Digital Age

On my way to a doctor’s appointment to check the efficacy of treatment for high blood pressure and lipids, I listened to the Diane Rehm Show on the car radio. The topic was “Improving Doctor–Patient Communication in a Digital World” (Rehm, 2016). One of the concerns expressed by the panelists, three physicians and a health researcher, was the amount of time devoted to filling in the appropriate boxes on the electronic record during today’s short outpatient appointments.

My own physician confirmed the electronic record problem. With eyes glued to the screen, she clicked along and tried to convince my health record that I actually had had a mammogram. She shared that in the large university practice each physician receives a “report card” that is red, yellow, or green based on the completeness of their electronic records and factors such as how many of their patients access their online chart using the e-mail messaging service.

There is a saying in the evaluation world, “What gets measured gets done.” So, if the outcome of the outpatient medical visit is a completed medical record and billing, the emphasis on red, yellow, and green electronic medical records completion is appropriate. As a client of the system, however, I would like to have improved health be the outcome. I also want to be a partner in my care. For that, two things have to happen. First, I need to feel comfortable. Comfort comes from the Latin cum forte, meaning with strength. I want an encounter that allays my anxiety and helps me claim the strength that I will use to pursue health, meaning my energy is not used in stress, but in healing. Second, I want to be empowered to be an active participant in my care. To do that, I need knowledge and ongoing encouragement to use that knowledge. My fear is that in a digital world we will lose sight of the human element of caring. I want more than a patient-centered care plan. I want person-centered caring.

There is little time in today’s outpatient practices, in some circles referred to as “cost centers,” for patient communication, hands-on care, and patient teaching. This care requires more than 12 to 15 minutes of provider time. The truth of the matter is that this may not be the best use of the physician’s time, as next to administration salaries, physicians are the next highest paid individuals in the system. But patient communication, hands-on care, and teaching are within the scope of nursing practice. In the practice that I visit, the only nurse is a nurse practitioner and most of the physicians think of her as a “physician extender.” On the Diane Rehm Show, a caller asked the panelists where the nurses were, for much of the care they described as absent falls within the purview of nurses. Nurses, according to one of the physicians, were not budgeted for in the practice model (Rehm, 2016).

Cost to society and the individual is precisely the reason that nurses should be included. As one example, heart disease, my malady, is the leading cause of death in adults 65 and older. I have a lot of company for 64.3% of noninstitutionalized women ages 65 to 74 have hypertension and/or are taking antihypertensive medications, as are 63.4% of men. By age 75 and older, this rate increases to 79.9% for women and 72.3% for men (Centers for Disease Control and Prevention [CDC] &
I believe nurses can change the picture of chronic disease progression to surgical intervention. There is much that can be done in addition to medications. Using my example of cardiovascular disease, a well-researched body of knowledge supports that smoking cessation, weight loss, diet, exercise, and stress reduction are all ways to stem or slow cardiovascular disease. However, one is more apt as a patient to gain access to this knowledge after a cardiovascular crisis than as a preventive measure.

I would like to propose a three-prong call to action for nurses to change the reasonable and acceptable level of care. First, expert nurse clinicians design and help patients navigate through cost-effective, research-based care pathways that provide knowledge, encouragement, and empowerment, leading to improved health for individuals diagnosed with or at high risk for a chronic illness. For example, for individuals with cardiovascular disease, the pathway might include a team comprising a nurse clinician navigator, dietitian, physical trainer with medical expertise, and yoga and tai chi teachers who would lead education and practice sessions as appropriate. Group settings would encourage peer support, socialization, and decrease cost. I am sure that such programs exist, but they are not the norm and have not been tested. Second, nurse researchers test, tweak, and retest the care pathways on both outcomes and cost. Irrefutable evidence is important when confronting an industry that generates profits for many. Third, nurses disseminate the research results and clinical applications to clinical nurses, nurse faculty, other medical providers, the public, and policy makers.

The idea of nursing leadership in health care change is not new. In 2010, the Robert Wood Johnson Foundation Initiative on the Future of Nursing at the Institute of Medicine (IOM; 2010) released the report, *The Future of Nursing: Leading Change, Advancing Health.* Among the recommendations the committee proposed (IOM, 2010) were “nurses should practice to the full extent of their education and training” (p. 2) and be “full partners with physicians and other health care professionals, in redesigning health care in the United States” (p. 3). The Committee concluded that the recommendations could “help to ensure that the health care system provides seamless, affordable, quality care that is accessible to all and leads to improved health” (IOM, 2010, p. 4).

Although the digital world of electronic records, telemedicine, e-mail, and such has given us tools to increase the effectiveness and efficiency of medicine, digital-centered care is not the ideal and may be even less so for the current generation of older adults. The Pew Research Center reports that 39% of individuals 65 and older do not use the internet compared to 3% of individuals ages 18 to 29 (Anderson & Perrin, 2015). Although 85% of individuals ages 18 to 29 own a smartphone, only 27% of adults 65 and older own one (Smith, 2015).

Moreover, an emoji does not convey the art of nursing, and e-mail portals with character restrictions do not capture the complexities of geriatric medicine. When care focuses on the digital, in lieu of the person, we may lose track of nurse–patient interactions that can result in decreasing client stress, teaching, and empowering patients to be major players in their health. Gerontological nurses have a unique role to play in society. Our care can decrease the financial (both Medicare and personal) and human costs of chronic illness by increasing health, function, and morbidity compression. Just as stethoscopes and sphygmomanometers are tools that improve our practice, digital tools will also enhance it. However, we must not permit our tools to become our treasure. Our treasure is and always has been the individuals we care for, the lives we touch, and the miracle of healing.

**REFERENCES**


Ann L. McCracken, PhD, RN
Cincinnati, Ohio

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