

# Hypermetricosis: The Hidden Epidemic

Darren M. Donahue, JD, Adam V. Ratner, MD

There is no doubt that this is a difficult time to be a caring physician. Regulators and payers are attempting to force us to measure many of the aspects of patient care they think cost them money. We are asked to track outcomes, efficiency, efficacy, and patient satisfaction or, more often, some approximation or proxy of those. The presumption is that more measurement leads to better care for less money.

This collective zeal to measure has created an entirely new disease: hypermetricosis.<sup>1</sup> Hypermetricosis is the collection of large quantities of metrics and data, often in an inefficient manner, which distracts physicians, other health care providers, and staff members from delivering care to individual patients. This condition manifests in our interactions with electronic health and medical record systems and as part of third-party payer, benefit management, accreditation, compliance, and other regulatory processes. This disease is extremely common in the daily practice of medicine.

Hypermetricosis manifests from the innocuous extra box one must

check before one can advance in an electronic medical record (EMR) page to, at the other end of the spectrum, the forced transition from *International Classification of Diseases*, 9th rev, to *International Classification of Diseases*, 10th rev. In the latter case, providers have expended billions of dollars directly and indirectly to adapt infrastructure and computing systems, while physicians, other providers, and staff members have expended countless (and usually uncompensated) hours attempting to learn the new system. No one has calculated the enormous opportunity costs of this manifestation of hypermetricosis. Although the ultimate goal is the improvement of the quality, utility, and volume of data collected on each patient, in making this transition the attention and resources of health care providers are diverted away from treating individual patients.

Hypermetricosis is a spectrum of diseases, and each individual instance can vary in acuity, severity, and downstream consequences. One variant within the spectrum is dissociative hypermetricosis. In this form of the disease, not only does the data collection distract and burden physicians and staff members, but the acquired data are either misleading or completely wrong. One common quality measure asks whether a physician knocked on the door before entering an examination room. Although some may find this data point useful, a psychiatric

practice in which physicians meet their patients in the waiting room before personally escorting them back to the consultation room will fail this measure 100% of the time. Clearly not everything that is measurable is meaningful.

Although the costs and burden of useless and distracting data collection are certainly worthy of attention, the most deleterious form of dissociative hypermetricosis is the malignant variant. In malignant dissociative hypermetricosis, improper collection and use of poor-quality and inaccurate data directly harm individual patients. For example, some EMR systems warn against providing cephalosporins, a standard preoperative antibiotic therapy, to patients who report penicillin allergies. But there is very low cross-reactivity between penicillin and cephalosporins. Nevertheless, as a result of poorly constructed algorithms in the EMR, patients are given clindamycin instead, which can lead to an increase in the incidence of pseudomembranous enterocolitis.

Specifically naming these conditions is critical for the same reasons that we name diseases in medicine: precisely identifying and naming a condition is a prerequisite to communicating about it, which then enables studying its distribution and pathophysiology. Only then can we ultimately remediate, cure, and prevent it. And although physicians are used to enduring

<sup>1</sup>The term *hypermetricosis* is taken from the Patient Institute's Conditions and Diseases of Healthcare Systems (CDHS). CDHS was created to name and describe specific characteristics of the health care system and their stakeholders that lead to poor outcomes in medical treatment. The current copy of CDHS can be found on the Patient Institute's website at <http://www.patientinstitute.org/healthcarepolicy/>.

hypermetricosis, they are not used to identifying or effectively fighting it. Perhaps that's because it's not a disease of people but rather of the health care system. As the battles to reform and reshape this system are under way, we in the medical community ought to approach these challenges to the health care system as we would approach diseases affecting our patients.

---

Adam V. Ratner, MD, is from the University of the Incarnate Word School of Osteopathic Medicine, San Antonio, Texas. Darren Donahue, JD, is a medical student at the UT Health San Antonio Long School of Medicine, San Antonio, Texas.

Dr Ratner and Mr Donahue are editors of *Conditions and Diseases of Healthcare Systems*, published online and distributed to the public freely by the Patient Institute, a 501(c)(3) nonprofit organization. Neither author receives any compensation of any sort resulting from their involvement with *Conditions and Diseases of Healthcare Systems* or the Patient Institute.

**Adam V. Ratner, MD:** University of the Incarnate Word School of Osteopathic Medicine, 4301 Broadway, CPO #121, San Antonio, TX 78209; e-mail: [ratner@uiwtx.edu](mailto:ratner@uiwtx.edu).