COMMENTARY

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Work–Life Balance, Burnout, and the Electronic Health Record

United States physicians were studied by Shanafelt et al in 2011, and again in 2014, regarding burnout and satisfaction with work–life balance.[1] Physician burnout increased significantly, from 45.5% to 54.4%. Parallel studies of all US workers during the same period showed no changes.

There are several possible explanations for this. New physician members were added to the cohort between 2011 and 2014. It is conceivable new expectations could have changed the outcome. Since the internet-enabled smart-phone users born after 1982 had barely begun to graduate residency in 2014, however, it seems more than a stretch to blame yet another malady on ″Millennials″.

The rates of physician suicide and depression remained stable from 2011 to 2014, whereas the "healthy work–life balance" portion of the Shanafelt study dropped from 48.5% to 40.9%. The definition of work–life balance has been variously misused, but in the most general sense it focuses on satisfaction with work and the ability to have a happy life away from work. The Maslach Burnout Inventory was used to measures personal accomplishment, emotional exhaustion, and depersonalization.[2] Doctors are not depressed or less content at home, they are less happy at work.

Physician burnout is characterized by 1) a feeling of a lack of accomplishment; 2) feelings of cynicism; and 3) a loss of zeal, zest, and enthusiasm for work. Apart from the effects burnout has on individual physicians, there is evidence that relationships with patients and family also suffer. Although increased burnout has been found to be notably worse in primary care and emergency room physicians, it has also worsened in 18 of the 20 categories of specialist physicians sampled. When compared with the absence of worsening in the general US working population, and noting the spectrum of advancing earnings among the general US workforce compared with doctors in primary care, or higher earning Emergency Medicine doctors, or still higher earning subspecialists, we can conclude that higher physician earnings are neither a cure nor a cause of burnout. Something else is happening to our beloved profession.

LACK OF ACCOMPLISHMENT

The doctor–patient relationship has sustained the happiness of both doctors and patients for generations. This centuries-old relationship has only recently been threatened by a de facto insurer–employer–provider relationship. Medical boards and malpractice courts may cite the law of doctor–patient primacy, but urgent care centers, on-call hospitalists, on-call surgeons, and even on-call obstetric laborists have made continuity of care a romantic notion of a noble profession. More than 90% of graduating residents now choose to be employees rather than enter the old world of private practice. The new world penalizes patients who go outside of existing employer–insurer–provider contracts to see a noncontracted physician; and it makes no sense to blame new doctors for becoming group employees. They might otherwise wait up to 6 months to be accepted as new participating "providers" in Medicare or other insurance programs. Few recent residency graduates can afford food, rent, and the interest payments on a quarter million dollars of medical school loans while they wait for the contractual right to start a new practice. It is understandable that new physicians would feel an immediate "lack of accomplishment" were they to attempt to enter private practice as did their predecessors. It seems reasonable therefore that almost all new graduates would enter an existing practice or a hospital-owned healthcare system. Avoiding rural or independent practice is a rational means of dodging the first symptom of burnout: lack of accomplishment.

CYNICISM (DEPERSONALIZATION)

The second of the symptoms, cynicism (depersonalization), is more difficult to avoid. Although practicing doctors have and still find solace in the comfort of their doctor–patient relationships, the preservation of these person-to-person relationships can be beyond the control of the physician. Continuity of care historically provided the necessary bonds that

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regenerated the early career feelings of scientifically based benevolence that attracted most doctors into the healing arts. Physician burnout measures highest in Emergency Medicine, Family Medicine, Internal Medicine, and Pediatrics. We expect this in Emergency Medicine, which by definition lacks continuity of care. Primary care specialties, however, have only recently become arenas of episodic care. Patients now routinely change doctors, employers change insurers, and insurers change physician panels during yearly health insurance renegotiations with employers. Community health centers offer appointments of their *clients* (patients) to the "first available" provider. Continuity of care is no longer an expectation by the *health plan member* (patient). Perhaps physician happiness requires reframing of the future role of the physician along with expectation management. Mindfulness therapy also helps, but it is not magic.

LACK OF ENTHUSIASM

The last symptom of burnout is the lack of enthusiasm for work. Doctors love their profession, even as they lament what has happened to it. Every pre-med student jumps at the invitation to enroll in medical school. Every third-year clerkship student starts out each rotation with enviable enthusiasm. Even the long hours of residency do not keep interns and residents from donning their stethoscopes with pride. What events could extinguish the enthusiasm of helping others through scientific problem solving? Something has changed, and it has worsened over the past few years.

THE CHANGING FACE OF MEDICINE

There were at least 5 major transformational medical practice events that occurred between 2011 and 2014. These include pervasive hospital purchases of medical groups, rising drug prices, the Affordable Care Act, pay for performance, and mandated electronic health records (EHRs). We hypothesize that 1 or a number of the above 5 events deserve to be investigated as being contributing to the problem of physician burnout.

Because doctors voluntarily sell their practices to hospitals or large groups to escape chaos, we doubt the move from physician practice ownership to hospital or corporate ownership is a major factor in increasing physician burnout. Likewise, rising drug prices—although deleterious to those without insurance, businesses, individuals, and government agencies who must buy costly medications—do not keep doctors from using cheaper generic drugs. We believe we can forego escalating drug prices as a factor. The Affordable Care Act (Obamacare), although politically problematic, has in fact brought more people with a means of paying for their care to the doctor than ever. This is unlikely to be a factor. Pay for performance, the incentive/disincentive program currently being phased in by Medicare, has yet to deliver any significant payment boost or change any performance, and it cannot convince significant numbers of practicing physicians that it ever will. It is not a probable suspect. This leaves us to consider the EHR.

A recent study from the University of California, San Francisco on their use of EHRs showed that medical students, house staff, and faculty cloned approximately 80% of their patients' daily progress notes.[3] Concurrent studies show that doctors spend more face time on their EHRs than with their patients.[4] The hours spent cloning notes in a mandated doctor–computer relationship leaves the physician unable to experience the best part of being a doctor. No humanistic physician gets up with zeal in the morning, hopeful for a chance to have a meaningful relationship with Epic or MEDITECH. Rational people should feel cynical if the institutional accomplishment for the day is to produce 20 cloned medical records with enough federally mandated bullet-point entries to obtain fair reimbursement and survive a billing audit. Thus, in 1 paragraph about EHRs, we have defined lack of enthusiasm, lack of accomplishment, and cynicism: not one but all 3 of the attributes of physician burnout.

Burnout is not voluntary, and a fertile environment for its attributes has been placed before us. There are always nonmedical causes of interpersonal and professional strife, so it behooves us to guard our families, loved ones, pets, and hobbies against this menace. Meanwhile we must keep a sharp eye on novel medical entities, like EHRs, so we can avoid the potential effects that might distance us from our patients. Epic notes written by US doctors are vastly longer than Epic notes from Europe. Type less and spend less time staring at a screen. Prepare your notes in the presence of your patients. Leave the examination room without a monkey on your back. Use a scribe (if you have the money). Make your notes meaningful, and never make your EHR more important than your patient. Demand more productive voice recognition–linked diagnostic EHRs in the future. Lobby to rid medicine of bullet-point-based reimbursement. For the sake of our profession, get out of the current EHR rut, and enjoy the balance of the rest of your life as a doctor.

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