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# Setting our sights on the right target: how addressing physician burnout may be a solution for improved patient experience

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**Abstract** Physician burnout is an important issue that can have serious implications for both physicians and patients. Many of the techniques used by larger medical groups attempt to compel improvements in patient satisfaction scores at the potential cost of increased physician burnout. Because burnout has been associated with poorer patient care and experience, medical groups large and small should work aggressively to reduce the causes of burnout as a way to also improve patient experience. In this contribution, the patient experience measure and the electronic medical record are reviewed in the context of the regulatory and bureaucratic pressures they place on physicians to examine how they may contribute to burnout and, therefore, worsen patient experience.

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## Introduction

The well-intentioned goals behind nationwide standardized measures of patient experience and the somewhat hurried roll-out of the electronic medical record tied to financial incentives and penalties may be contributing to the unfortunate side effect of physician burnout. The commonalities between these and other potential drivers of physician burnout are the regulations and bureaucracy that accompany them and the erosion of physician autonomy and the physician-patient relationship.

## Measuring patient experience

Measures of patient satisfaction or patient experience have long been present as a component of medical practice in one form or another. Arguably, concern over patient satisfaction

has existed as long as the practice of medicine inasmuch as patients who are either pleased or displeased with their physician are more likely to share their experience within their social group, thereby positively or negatively affecting the practice and livelihood of the physician in question. Most physicians are assumed to have chosen their career due to an interest in caring for others, so a natural extension of that desire would be an interest in ensuring patients feel that they have been cared for.

Attending to patient experience is not a new issue for physicians. What is new, however, are the methods used to judge and track patient experience and the increase in the overall regulatory and bureaucratic pressure currently applied to physicians.<sup>1</sup> The last decade has seen significant changes in medicine with the advent of electronic medical records, the consolidation of health care provision into ever larger organizations with their attendant management of how physicians practice, and an increased administrative burden including, but not limited to, governmental regulatory compliance, pre-certifications, and other methods used by payors to limit care,

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drug costs, and prior authorizations, among other issues. The erosion of both the patient-physician interaction and practice autonomy for physicians caused by these external forces is a departure from how many physicians envisioned their practice upon entering medicine and may partially contribute to physician burnout.

## Burnout

Burnout, which can involve depersonalization, meaninglessness, feelings of ineffectiveness, and thoughts of quitting, is on the rise, with one study showing a jump from 45.5% to 54.4% in the rate of physician burnout between 2011 and 2014 against a steady rate of workplace burnout in the general population of 28%.<sup>2</sup> A recent review in the dermatologic literature indicated that the three most important drivers of patient experience were communication, perceived time spent with the patient, and access to health care services.<sup>3</sup>

Common sense dictates, and increasing evidence appears to substantiate, that physicians experiencing burnout will also have lower scores on patient experience measures as individuals experiencing burnout traits have an impaired ability to provide a superior patient experience with excellent communication and a sense of an unrushed visit. To substantiate this, increasing burnout scores have been linked to medical errors, poorer performance on health care quality measures, and an increased risk for malpractice litigation.<sup>4</sup> In the context of an already existing physician shortage,<sup>5</sup> creating an environment where physicians see less patients, retire from practice early, and experience suicidal thoughts at increasing rates<sup>4</sup> is both tragic and profoundly counterproductive to improving patients' access to care.

## Regulatory forces around patient experience

Regulatory interest in patient experience began to increase in the early 2000s, when the Centers for Medicare and Medicaid Services (CMS) and the Agency for Health care Research and Quality (AHRQ) developed the Hospital Consumer Assessment of Health care Providers and Systems (HCAHPS) survey for hospital inpatients. This situation was driven, at least in part, by the concept that patient experience could be used as a proxy for health care quality.<sup>6</sup>

In 2007, a survey was developed by AHRQ for the outpatient arena called the Clinician and Group CAHPS (CG-CAHPS) survey, a variant of HCAHPS designed for outpatient interactions. In 2008, CMS began reporting HCAHPS data publicly on its Hospital Compare website. In 2012, CMS required that CG-CAHPS data be reported by physician groups with at least 100 providers to qualify for Physician Quality Reporting System (PQRS) incentives, and in 2015, these data were cleared to be made available publicly on the CMS Physician Compare website.

CAHPS data are also used by various private payer pay-for-performance programs as well as by CMS's Accountable Care

Organizations. The sum of these facts indicates that standardized patient surveys based on CG-CAHPS will increasingly affect both hospital and physician reimbursement as well as the online reputations of hospital systems and individual physicians, thus possibly affecting market share and revenue. This is the impetus for the mounting pressure placed on physicians by administrators in hospital systems and larger medical groups to improve performance on patient experience measures. The pressures placed on physicians vary by group but have included the public display of patient experience scores and comments, financial incentives or penalties, mandatory coaching, and other actions.

There is evidence to support that physicians feel pressure to treat patients inappropriately as a result of institutional or group pressure related to patient experience.<sup>7</sup> Focusing too much on a raw patient experience score at the individual provider level can produce undesired consequences. Acknowledging that physicians typically have an intrinsic desire to provide good care for their patients, if a physician is not meeting this goal, it may be better to work to improve the factors in the physician's practice environment that may be contributing to burnout rather than to pursue actions that socially or financially penalize the physician or drive clinically inferior behaviors.

## Advent of the electronic record

Changes in medical practice in general have also been significant, particularly in the last decade. Regulatory influences, such as the Health Information Technology for Economic and Clinical Health (HITECH) Act in 2009, forced the rapid adoption of electronic medical records (EMR), not by providing small incentives, as in the first 5 years of implementation, but by penalizing physicians and health systems that had not complied by 2015 with reduced reimbursement under Medicare and Medicaid. Due to this, EMR platforms were rapidly developed and deployed with a focus principally on compliance with government regulations, payer needs, and the needs of large health systems.

The goal was to capture all of the necessary data required to meet the needs of the stakeholders with attention to the physician and patient as an afterthought.<sup>8</sup> The result is that physicians have been insidiously made into clerical workers,<sup>9</sup> composing notes that are now double the length, on average, they were before the HITECH Act.<sup>10</sup> I often hear physicians lamenting the time they spend on the EMR, stating that they are the highest-paid data entry workers, but the opposite is actually true. They do the work for no added cost to payers or health systems.

The cost of physician time spent on EMR data entry is borne by patients who receive a less personal and possibly lower quality interaction with their physician. This is evidenced by patients who cannot access their physician due to either reduced schedules related to the time required by the EMR or a physician leaving practice due to burnout. It is also borne by physicians and their families who experience a financial

opportunity cost related to reduced schedules as well as the social cost of a family member feeling burned out at work or spending hours documenting in the evenings.<sup>11</sup> Studies of physician time have shown that in various specialties, physicians spend 2 hours on the EMR for every hour of patient contact time and approximately 1 to 2 hours on EMR work at home per day.<sup>12,13</sup>

## The EMR is subservient to regulation

The EMR has been linked to physician burnout, but the EMR itself is a symptom of the more basic problem of increased regulation and bureaucracy in medicine. EMRs are the product of federal regulation and have failed to meet one of their most important potential benefits: interoperability and the ability to exchange patient data freely between systems to improve care and potentially reduce cost.<sup>14</sup> EMRs also are designed to comply with medical documentation regulations related to billing and coding. This set of regulations grows more and more complex with each iteration of the *International Classification of Diseases* (ICD) and, at times, its nebulous coding guidelines may only become clear after an audit, inspection, or a visit from a costly consultant. Regulations also limit who can enter certain pieces of information and who may place orders, thereby limiting a physician's ability to delegate tasks to employees.

Although EMRs can and should be improved with a focus on the physician and the patient, until the underlying regulations that lie at the root of the processes they "facilitate" are improved, there will be a limit on the gains that can be made to improve conditions for physicians and, by extension, their patients. Data comparing physician satisfaction with the same EMR product in an international cohort versus a US cohort found much higher levels of satisfaction among the international cohort.<sup>10</sup> The length of notes in the international cohort was four times shorter than in the United States due to the absence of documentation related to compliance and the focus of notes internationally being only on critical points of the interaction. The authors of the study posit that as the US health care delivery system moves from a fee-for-service model to a value-based model, much of the regulatory documentation requirements could be lifted, thus giving US providers the same ability as their international colleagues to document only what they deem necessary. This theory has flaws, however, as it assumes that value-based care will provide such regulatory relief and inappropriately ties fee-for-service care to burdensome regulation.

## Shifting payment models may not provide regulatory relief

In the United States, the shift to EMR and the beginnings of value-based care via meaningful use, PQRS, and the Merit-

Based Incentive Payment System (MIPS) have been accompanied by additional documentation, not less. It is likely that any new system will be accompanied by a new complicated regulatory framework around documentation and data tracking. Further, in the aforementioned study, many of the physicians in the international EMR group work in a fee-for-service model, so fee-for-service itself may not be the issue, and value-based care may not be the solution in and of itself. It would be better to divorce conversations aimed at improving EMRs from conversations about payment models as this confounds the discussion. The more appropriate conversation should center on whether the regulations complicating the practice of medicine are worth the cost of physician burnout and the fallout for patients related to inattention to this issue.

## Conclusions

It is difficult to argue with the concept that physicians and health care systems should work to ensure that patients' experience with their care is as good as possible. Patient experience has been linked to improved health outcomes, and, in the most basic sense, all health care providers would prefer that their patients are satisfied rather than dissatisfied. Substantial financial resources have been invested, particularly by larger health systems, into patient experience infrastructure due to both the pressure placed on systems by payors as well as a desire to expand market share. It could be argued that these interventions are not addressing the root cause of poor patient experience. If similar attention and resources were directed to addressing the proven causes of physician burnout, patient experience scores may improve as a downstream effect, thus addressing two important and worthwhile issues with a single effort and quite possibly at a lower cost. The issue is not simply a local one, however; patient experience and physician burnout relief programs instituted by well-meaning groups and health systems will be limited in their ability to maximally achieve their goals in the current regulatory environment that created many of the extrinsic pressures that have been associated with physician burnout. The house of medicine may do well to target its lobbying efforts and appeals to elected officials toward regulatory relief with evidence that both physicians and, most importantly, patients will be better served as a result.

## Conflict of interest

The author declares no conflict of interest.

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