

Dissatisfaction Among Wisconsin Physicians Is Part of Serious National Trend

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The men and women on whom health care is dependent are running out of reserve. This cannot be good for patients. Care from discouraged or demoralized physicians is not optimal. Errors increase, empathy decreases. Costs may rise.

The 2014 Wisconsin Medical Society (Society) survey¹ adds to a growing body of literature pointing to physician dissatisfaction as a serious problem in the US health care system. Forty-seven percent of Wisconsin physicians report being moderately or significantly burned out. This is nearly identical to national norms reported in a 2012 Mayo-AMA study.²

How can a career as inherently meaningful and rewarding as medicine have rates of burnout that are significantly higher than those in the general public? The primary issues identified in the Society survey are similar to those identified in a Rand-AMA study³: the growing volume of indirect work (documentation, order entry, billing, inbox) and administrative work (prior authorizations, insurance forms, and paperwork), coupled with the impact of the electronic health record (EHR).

Almost a third of Wisconsin physicians report that their EHR has decreased the quality of care they can provide.

EHRs, and the federal and institutional policies around them, often have shifted responsibilities to physicians. Work previously done by receptionists, transcriptionists, medical record clerks, etc, has become the work domain of the physician. As a result, almost half of Wisconsin physicians take EHR work home—many giving up 1 to 2 hours of personal/family time each day to EHR tasks.

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What Is Going On?

In the past 7 years, I have had the opportunity to visit over 50 clinics across the country (including several in Wisconsin), large practices and small, rural and urban, private practices, academic centers, and federally qualified health centers, shadowing primary care physicians and staff as they do their work. The issues are similar in each setting.

I have observed that up to 70% to 80% of nurse and physician work output is waste—not waste from ordering unnecessary tests or treatments, but waste from doing work that doesn't add value for the patient. The degree of waste is often not recognized because it is so finely ingrained in our work that we do not see it.

I believe about half of this waste could be eliminated by re-engineering workflows at the practice level. About half of the waste is nonvalue-added work that arises from the mismatch of policy and technology on the one hand, to the clinical care on the other.

What Can Be Done?

Physicians can work smarter. Improving workflow efficiency is a powerful antidote to burnout. In a study of primary care clinics in the Upper Midwest and New York,⁴ Linzer found that burnout is 6 times more likely to improve with workflow interventions, such as empowering support staff to enter data into EHRs or doing pre-visit planning.

In a study I lead, *In Search of Joy in Practice*,⁵ we highlight practices that have re-engineered basic workflows to reduce chaos and waste. For example, several clinics have instituted proactive planned care appointments with pre-visit lab. This involves “flipping the clinic”—doing lab before the visit—rather than the traditional model where the patient is sent for lab after their appointment, and then notified by phone or e-mail about their results. One site found pre-visit lab saved \$25 of organizational costs per visit.⁶

Other innovations include empowering the nurse and/or medical assistant to filter the inbox, with the result that only a minority of the messages are passed on to the physician; and team documentation, allowing the physician to provide his or her undivided attention to the patient. One clinic found that team documentation saves 1.5 hours of physician time for every 4-hour clinic session, while also improving patient satisfaction with the amount of time they spent with their physician.⁷

Leaders can be bold. Leaders must recognize that the delivery models of the future cannot be managed with the staffing models of the past. The days of hero medicine, with the doctor doing it all, belong in the past. Higher staffing levels can result in better outcomes in both a fee-for-service payment model, as well as in a global payment model. In addition, Shanafelt⁸ found that organizational leadership is a strong predictor of physician satisfaction. Burnout is lower when leaders listen and communicate well, show concern for physicians' professional lives, and empower physicians with the tools and resources to do their best.

Technology vendors can be humble. Responsibility for health professional well-being extends beyond the clinic. Technology vendors have an ethical responsibility to create products that reduce the cognitive workload, increase the ease of clinical tasks, and that support advanced team-based models of care. This requires a deep level of respect for the work of clinicians and a responsiveness to their needs for tools that help rather than hinder in carrying out their mission.

Regulators can take a disciplined approach. More is not always better. Regulators need to create policy that is evidence-based, and that includes a clear accounting of the time-costs

associated with implementation. For every new time commitment, there should be consideration of what work will no longer be performed to make room for the new task. Likewise, metric developers need to create measures that are meaningful, minimal, and manageable.

There are reasons to be hopeful. The Wisconsin Medical Society has launched a task force comprised of physician leaders to address physician satisfaction. Others are also recognizing the importance of the “Quadruple Aim”⁹—adding the fourth aim of health professional well-being to the Triple Aim of better care for individuals, better health for the population, at lower costs. The Institute for Healthcare Improvement has established “improving joy in work” as one of its focus areas for fiscal year 2016; the American College of Physicians has identified “improving joy in medicine” as an initiative over the past year; and the American Academy of Family Physicians is focusing on improving physician well-being. In addition, the American Medical Association has identified “improving professional satisfaction and practice sustainability” as one of its 3 strategic focus areas

and has created a series of open-access practice transformation resources at www.stepsforward.org

A medical education is a terrible thing to waste. Patients need physicians who spend most of their time on work for which they are uniquely qualified. Improving career satisfaction in medicine is a shared responsibility.⁸ A single physician or individual clinic cannot solve these problems on their own, but collectively, multiple stakeholders can make a significant impact. Patients deserve to receive care from nurses and physicians who are not running out of reserve, but who instead come to work each day empowered and supported by technology, policy, and effective and efficient teams.

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