Unmeaningful Work and the Practicing Physician

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With its goals of improving the experience of care, improving the health of populations, and reducing the per capita cost of health care, the Triple Aim attempts to achieve what Donald Berwick and associates have described as high-value health care.[1] However, since its publication, several factors continue to confound the Triple Aim, including three of primacy: the decline of primary care, physician burnout, and the accumulating amount of unmeaningful work for the practicing physician.[2] These three also may be interdependent and irreducible, and each must be mitigated to facilitate attaining the Triple Aim goals.

The decline of primary care has been persistent and progressive, despite several ongoing interventions by national vanguard organizations. It is predicted to exacerbate future health care gaps in an aging population with a burden of chronic diseases.[3,4] Physician burnout has been well known for over two decades; however, only relatively recently has its downstream sequelae on patients, populations of patients, and the cost of care been better understood.[5-7]

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While these two factors have been well-described, unmeaningful work has not. There is a paucity of extant work defining unmeaningful work, expanding its lexicon beyond simple administrative tasks, or elucidating if it is an independent risk factor to the decline of primary care and physician burnout. Defining unmeaningful work and its taxonomy can facilitate a better understanding of how it relates to the decline of primary care and physician burnout and may act as a synergistic antagonist to the Triple Aim.

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Any work associated with patient care can be meaningful. However, if that work is not license-level appropriate or does not contribute to direct patient care, it may be perceived as unmeaningful. Unmeaningful work can be further defined as cognitive work demanded upon a physician that is not license-level appropriate but is required to complete a clinical encounter, adds no clinical value for the patient or the physician, and acts as a barrier to care. Unmeaningful work for physicians may also be more than simple administrative tasks or routine workflow interruptions encountered by other professions and disproportionally affects the generalist specialist more so than others.[8,9] Although there are currently no formal categories of unmeaningful work, three can be identified: unmeaningful work units, electronic frustrations, and redundant layers of complexity.

Unmeaningful work units are the miscellaneous, unrelievable clerical tasks now omnipresent within clinical encounters. They may include the requirement of generalist specialists in some systems to perform written clerical referrals for patients to see other specialists due to the persistent and antiquated misinterpretation of the generalist specialist being a clerical gatekeeper versus a specialized coordinator of care.[10,11] Physicians also may be the only health care professionals in some systems allowed to enter computerized physician order entries due to the persistent misinterpretation of regulatory statutes,[12] or perform clinically unnecessary box-checking to document certain arbitrary patient attributes to finalize orders within clinical encounters (euphemistically titled “The Revenge of the Ancillaries”).[13] Unmeaningful work units

are ubiquitous, interwoven within the clinical encounter, and intrude into the cognitive space physicians need to complete that encounter.

Electronic frustrations are unique elements associated with the now widely perceived dysfunctional electronic health record (EHR) ecosystem and are disruptive to patient care. They include the generalized EHR attributes pervasively found within clinical encounters, subversively diverting the physician's attention from the patient to the computer, as repeatedly shown in time-motion studies.[14,15] They also may include the paradoxical EHR window-popups physicians need to navigate during clinical encounters ("popup fatigue"),[16,17] or the excessive mouse movements and mouse clicks needed to complete simple clinical tasks ("click fatigue").[18,19]

Electronic frustrations also include physicians' interactions when searching for clinical data uniquely imbedded within the EHR. Concerns were raised early in the EHR's advent about these interactions,[20,21] centering on the deficiencies of what can be considered the three essential Rs of clinical data: the need for it to be reliable, relevant, and readily available. These concerns persist. Data erroneously entered in the EHR can be difficult to remove, unreliable, may not accurately describe the diagnostic process, and can lead to medical misadventures.[22-25] Clinical notes, generated by an EHR ecosystem complacent with cut and paste techniques,[26] have become so excessively long and "note bloated" that they become irrelevant to subsequent treating physicians.[27,28] Physicians now spend extraneous amounts of time foraging across different electronic platforms within the EHR ecosystem for clinical data not readily available due to the promised EHR interoperability being unmet and incomplete.[29,30] The introduction of the EHR to clinical practice has been correlated to physician burnout;[31] electronic frustrations may also be the added independent risk factors to this relationship.

Redundant layers of complexity may include work required by health care entities for a physician to practice medicine within those entities in addition to state statutes. These statutes, including medical practice acts, ultimately define the requirements and boundaries within which a physician may practice medicine.[32] Redundant layers of complexity may include a requirement for physicians to complete discordant educational activities to work within an entity that are not required by a state's medical practice acts. They also include the disproportionate reliance health care entities place upon proprietary patient surveys, with the subsequent edicts attempting to change physicians' clinical behavior,[33,34] or the requirements for physicians to utilize overly complex or discordant diagnostic codes within the EHR.[35,36]

Unmeaningful work elements also include newly added administrative work burdens historically completed by others that are now presumed upon the physician during the "interstitial time between other work."[37] The unrestricted ability of unmeaningful work elements to enter into a clinical encounter and intrude into the cognitive space needed for the physician to complete that encounter is more worrisome than the elements themselves, and the widespread societal acquiescence of their presence infers that the medical profession has been little-prepared to protect the physician.

Medicine, as with other professions, draws its unity and authority with self-imposed and self-governed rules that over the millennia have evolved into ethics and codes of professionalism.[38,39] These ethics and codes define the profession by defining a high moral standard of conduct and professionalism expected of the physician toward his or her patients, fellow physicians, and society.[40] However, to date, there is no ethical construct that defines its corollary specifically; no ethic conceptualizes a high moral standard of conduct expected of the profession and its associated health care entities toward the physician. An ethic that protects and preserves the physician and the physician's cognitive space relevant to patient care – "The Physician Ethic" – should be considered. Its conceptualization and further development may also mitigate the three confounding elements of the Triple Aim and is long overdue.

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