

ROUNDTABLE

The electronic medical record's role in ObGyn burnout and patient care

These experts share the solutions implemented at their institutions to help cope with the EMR–burnout problem

Megan L. Evans, MD, MPH; John J. Dougherty, MD, MBA; and Mark B. Woodland, MS, MD

IN THIS ARTICLE

EMR and burnout at author institutions

page 31

EMR and safety concerns

page 36

Needed EMR system changes

page 37



Physician burnout has been labeled a public health crisis by the Harvard School of Public Health and other institutions.¹ A 2018 Physician's Foundation survey found that 78% of physicians had symptoms of burnout,² which result from chronic workplace stress and include feeling depleted of energy or exhausted, mentally distanced from or cynical about one's job, and problems getting one's job done successfully.³ Among ObGyns, almost half (46%) report burnout.⁴ One-third of ObGyns responded on a recent Medscape Burnout

Report that the computerization of practice is contributing to their burnout, and 54% said too many bureaucratic tasks, including charting, were adding to their burnout.⁵

Inefficient electronic medical records (EMRs) have been implicated as one reason for burnout, with improvements in efficiency cited as one of several potential resolutions to the problem. About 96% of hospitals have adopted EMRs today, compared with only 9% in 2008,⁶ and many physicians report recognizing value in the technology. For instance, 60% of participants in Stanford Medicine's

ILLUSTRATION: PAUL ZIWOLAK FOR OBG MANAGEMENT

2018 National Physician Poll said EMRs had led to improved patient care. At the same time, however, about as many (59%) said EMRs needed a “complete overhaul” and that the systems had detracted from their professional satisfaction (54%) as well as from their clinical effectiveness (49%).⁷

With this roundtable, we explore the concerns with hours spent on the EMR with several experts, and whether it is a problem that has been contributing to burnout among staff at their institutions. In addition, are there solutions that their institutions have implemented that they can share to help to cope with the problem?

OBG MANAGEMENT: ObGyns report that the computerization of practice and too many bureaucratic tasks, including charting, are contributing to burnout. Do you see this problem at your institution?

John J. Dougherty, MD: Yes, absolutely. There is not a day that goes by that I don’t hear about or experience “Epic Fails.” (We use Epic’s EMR product at our institution.) Too many clicks are needed to navigate even the simplest tasks—finding notes or results, documenting visits, and billing for services are all unnecessarily complex. In addition, we are being held accountable for achieving a long and growing list of “metrics” measures, education projects (HealthStream), and productivity goals. When do we have time to treat patients? And it is not just practicing physicians and clinicians. Our resident physicians spend an inordinate amount of time in front of the computer documenting, placing orders, and transferring patients using a system with a very inefficient user interface, to say the least.

Megan L. Evans, MD, MPH: I absolutely agree. Over the years, my institution has created a conglomerate of EMRs, requiring physicians across the hospital to be fluent in a multitude of systems. For example, you finish your clinic notes in one system, sign off on discharge summaries in another, and complete your operative notes in an entirely different system. As busy attendings, it is hard to keep ahead of all of these tasks, especially

OBG MANAGEMENT Expert Panel



Megan L. Evans, MD, MPH

Dr. Evans is Assistant Professor, Tufts University School of Medicine, and Associate Resident Program Director, Department of Obstetrics and Gynecology, Tufts Medical Center, Boston, Massachusetts.



John J. Dougherty, MD, MBA

Dr. Dougherty is Medical Director, Women’s Health Center, and Associate Residency Program Director, Reading Hospital, Tower Health, Reading, Pennsylvania.



Mark B. Woodland, MS, MD

Dr. Woodland is Chair, Obstetrics and Gynecology, Reading Health System, and Clinical Professor, Obstetrics and Gynecology, Drexel University College of Medicine, Philadelphia, Pennsylvania.

The authors report no financial relationships relevant to this article.

when the systems do not talk to one another. Fortunately, my hospital is changing our EMR to a single system within the next year. Until then, however, we will work in this piecemeal system.

Mark Woodland, MS, MD: EMR and computerization of medicine is the number 1 issue relating to dissatisfaction by ObGyn providers in our institution. Providers are earnest in their attempt to be compliant with EMR requirements, but the reality is that they are dealing with an automated system that does not have realistic expectations for management of results, follow-up tasks, and patient communications for a human provider. The actual charting, ordering of tests and consults, and communication between providers has been enhanced. However, the “in-basket” of tasks to be accomplished are extraordinary and much of it relies on the provider, which requires an inordinate amount of time. Additionally, while other members of the medical staff are stationary at a desk, physicians and other providers are not. They are mobile between inpatient units, labor and delivery, operating rooms, and emergency rooms. Time management does not always allow for providers to access

FAST TRACK

“EMR and computerization of medicine is the number 1 issue relating to dissatisfaction by ObGyn providers in our institution.”

CONTINUED ON PAGE 36

computers from all of these areas to facilitate their managing the expectations of the EMR. This requires providers to access the EMR at off hours, extending their workload. Finally, the EMR is neither personal nor friendly. It is not designed with the clinician in mind, and it is not fun or engaging for a provider.

OBG MANAGEMENT: What solutions have been instituted in order to help physicians with data entry into the EMR?

Dr. Dougherty: When our institution compared EMR offerings, EMR companies put their best collective marketing feet forward. The general notion, at least with the Epic

Can EMRs be a safety hazard for patients?

EMRs are not just inefficient and contributing to physician burnout, according to a joint report from Kaiser Health News (KHN) and *Fortune* magazine, they are inadequate and contributing to patient safety concerns.¹ This was not the intended goal of the HITECH Act, signed into law in 2009 as part of the stimulus bill. HITECH was intended to promote the adoption of meaningful use of health information technology by providing financial incentives to clinicians to adopt electronic medical records (EMRs). It also intended to increase security for health care data—achieved through larger penalties for HIPAA violations.²

Ten years later, however, “America has little to show” for its \$36 billion investment, according to KHN and *Fortune*. Yes, 96% of hospitals have one of the currently available EMRs, among thousands, but they are disconnected. And they are “glitchy.” At least 2 EMR vendors have reached settlements with the federal government over egregious patient errors. At least 7 deaths have resulted from errors related to the EMR, according to the firm Quantros, reports KHN and *Fortune*, and the number of EMR-related safety events tops 18,000. The problem is that information, critical to a patient’s well-being, may get buried in the EMR. Clinicians may not have been aware of, because they did not see, a critical medication allergy or piece of patient history.¹

The problems with health information technology usability do have solutions, however, asserts Raj M. Ratwani, MD, and colleagues. In a recent article published in the *Journal of the American Medical Association*, the researchers propose 5 priorities for achieving progress³:

- Establishment of a national database of usability and safety issues. This database should allow sharing of safety information among EMR vendors, hospitals, and clinicians, and make the public aware of any technology risks.
- Establishment of basic design standards, which should promote innovation and be regulated by a board composed of all stakeholders: EMR vendors, researchers, clinicians, and health care organizations.
- Addressing unintended harms. Causes of harm could

include “vendor design and development, vendor and health care organization implementation, and customization by the health care organization.” Along with shared responsibility and collaboration comes shared liability for harms caused by inadequate usability.

- Simplification of mandated documentation requirements that affect usability. Reducing clinician’s “busy work” would go a long way toward simplifying documentation requirements.
- Development of standard usability and safety measures so that progress can be tracked and the market can react. EMR vendors cannot be directly compared currently, since no standards for usability are in place.

Ratwani and colleagues cite shared responsibility and commitment among all of the parties invested in EMR usability success as keys to solving the current challenges affecting health information technology, with policy makers at the helm.³ The federal government is attempting to respond: As part of the 2016 21st Century Cures Act and with an aim toward alleviating physician time spent on the EMR, the Department of Health and Human Services is required to recommend reductions to current EMR burdens required under the HITECH Act. It plans to revise E&M codes, lessening documentation. And the Centers for Medicare and Medicaid Services aims to make meaningful use requirements more flexible, require information exchange between providers and patients, and provide incentive to clinicians to allow patient access to EMRs.^{4,5}

References

1. Fry E, Schulte F. Death by a thousand clicks. *Fortune*. March 18, 2019. <http://fortune.com/longform/medical-records/>. Accessed September 9, 2019.
2. Burde H. The HITECH Act: an overview. *AMA J Ethics*. March 2011. <https://journalofethics.ama-assn.org/article/hitech-act-overview/2011-03>. Accessed September 9, 2019.
3. Ratwani R, Reider J, Singh H. A decade of health information technology usability challenges and the path forward. *JAMA*. 2019;321:743-744.
4. Hoffman S. Healing the healers: legal remedies for physician burnout. Case Western Reserve University School of Law. September 2018.
5. Morris G, Anthony ES. 21st Century Cures Act overview for states. Office of the National Coordinator for Health Information Technology. https://www.healthit.gov/sites/default/files/curesactlearningession_1_v6_10818.pdf. Accessed September 11, 2019.

EMR, was that “you can customize Epic to your liking.” It did not take long for a bunch of motivated Epic users to create “smart” stuff (lists, phrases, and texts) in an effort to customize workflows and create fancy-looking electronic notes. Shortly thereafter, it was obvious that, as an institution, our reporting efforts kept coming up short—our reports lacked accuracy and meaning. Everyone was documenting in different ways and in different areas. Considering that reports are currently generated using (mostly) discrete data entries (data placed in specific fields within the EMR), it became obvious that our data entry paradigm needed to change. Therefore, standardization became the leading buzzword. Our institution recently initiated a project aimed at standardizing our workflows and documentation habits. In addition, we have incorporated a third-party information exchange product into our health system data aggregation and analysis workflow. Much more needs to be done, but it is a start.

Dr. Evans: At my institution, as a group, we have created templates for routine procedures and visits that also auto populate billing codes. I know that some departments have used scribes. From the hospital side, there has been improved access to the EMR from home. Some of my colleagues like this feature; however, others, like myself, believe this contributes to some of our burnout. I like to leave work at work. Having the ability to continue working at home is not a solution in my mind.

Dr. Woodland: At our institution, we have engaged our chaperones and medical assistants to help facilitate completion of the medical records during the office visit. Providers work with their assistants to accommodate documentation of history and physical findings while also listening to the provider as they are speaking in order to document patient care plans and orders. This saves the clinicians time in reviewing and editing the record as well as making sure the appropriate care plan is instituted. Our EMR provider recently has begun experimenting with personalization of color themes as well as pictures as part of the

6 tips for improving use of the EMR

- 1. Engage the computer in your patient encounter**, says Rey Wuerth and colleagues. Share the screen, and any test results you are highlighting, with your patient by turning it toward her during your discussion. This can increase patient satisfaction.¹
- 2. Go mobile at the point of care**, suggests Tom Giannulli, MD, MS, Chief Medical Information Officer at Kareo. By using a tablet or mobile device, you can enter data while facing a patient or on the go.²
- 3. Use templates when documenting data**, advises Wuerth and colleagues, as pre-filled templates, that are provided through the EMR or that you create within the EMR, can reduce the time required to enter patient visits, findings, and referrals.¹
- 4. Delegate responsibility for routing documents**, says Brian Anderson, MD. Hand off to staff administrative duties, such as patient forms and routine negative test results.³
- 5. Involve medical assistants (MAs) in the process.** Make the MA feel part of the team, says R. Scott Eden, and assign them history-taking responsibilities, utilizing your EMR's templates. Assign them other tasks as well, including medication reconciliation, referrals, refills, routine screening, and patient education.⁴
- 6. Employ physical or virtual scribes who are specifically assigned to EMR duty.** Although drawbacks can include patient privacy concerns and reduced practice income due to salary requirements, employing a scribe (often a pre-medical or graduate student), who trails you on patient visits, or who is connected virtually, can leave the clinician free to interact with patients.^{5,6}

References

1. Wuerth R, Campbell C, Peng MD, et al. Top 10 tips for effective use of electronic health records. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3959973/>. *Paediatr Child Health*. 2014;19:138.
2. Giannulli T. 7 time-saving EHR use tips to boost physician productivity. April 28, 2016. <https://ehrintelligence.com/news/7-time-saving-emr-use-tips-to-boost-physician-productivity>. Accessed September 9, 2019.
3. Anderson B. 5 ways to increase your EMR efficiency. October 28, 2014. <https://www.kevinmmd.com/blog/2014/10/5-ways-increase-emr-efficiency.html>. Accessed September 9, 2019.
4. Eden RS. Maximizing your medical assistant's role. *Fam Pract Manag*. 2016;23:5-7. <https://www.aafp.org/fpm/2016/0500/p5.html>.
5. Hoffman S. Healing the healers: legal remedies for physician burnout. Case Western Reserve University School of Law. September 2018.
6. Caliri A. The case for virtual scribes. January 2, 2019. Becker's Hospital Review. <https://www.beckershospitalreview.com/hospital-physician-relationships/the-case-for-virtual-scribes.html>. Accessed September 20, 2019.

interface. Having said this, I still ask, “Why have medical professionals allowed non-clinical agencies and information technology groups to run this show?” It is also inconceivable to me that this unfunded mandate—that has increased cost, decreased clinical efficiency, and decreased clinician satisfaction—has not been addressed by national and international medical communities.

OBG MANAGEMENT: What changes do you feel your EMR system needs to undergo?

Dr. Woodland: I feel that we need to appropriately manage expectations of the EMR and the institution with relation to EMR and providers. By this I mean that we need to make the EMR more user-friendly and appropriate for different clinicians as well as patients. We also need to manage expectations of our patients. In a digital age where immediate contact is the norm, we need to address the issue that the EMR is not social media but rather a communication tool for routine contact and information transmission. Emergencies are not typically addressed well through the EMR platform; they are better handled with a more appropriate communication interface.

Dr. Dougherty: I feel that the biggest change needed is a competent, simple, and standard user-interface. Our old charting methods were great on a number of levels. For instance, if I wanted to add an order, I flipped to the "Orders" tab and entered an order. If I needed to document a note, I flipped to the "Notes" tab and started writing, etc. Obviously, manual charting had its downsides—like trying to decipher handwriting art! EMRs could easily adopt the stuff that worked from our old methods of documentation, while leveraging the advantages that computerized workflows can bring to practitioners, including efficient transfer of records, meaningful reporting, simple electronic ordering, and interprofessional communication portals.

Dr. Evans: Our systems need to better communicate with one another. I am in an academic practice, and I should be able to see labs, consultant notes, imaging, all in one spot to improve efficiency and ease with patient visits. Minimizing clicks would be helpful as well. I try to write as much as I can while in the room with a patient to avoid after-hours note writing, but it takes away from my interaction with each patient.

OBG MANAGEMENT: With an aim toward alleviating burnout, are there any tips you can offer your colleagues on interfacing with the EMR?

Dr. Evans: When I first started as a new attending, it would take me hours to finish

my notes, partly because of the level of detail I would write in my history of present illness (HPI) and assessment and plan. One great piece of advice I received was to be satisfied with good notes, not perfect notes. I worked to consolidate my thoughts and use pre-constructed phrases/paragraphs on common problems I saw. This saved time to focus on other aspects of my academic job.

Dr. Dougherty: We need to refocus on the patient first, and mold our systems to meet that priority. Much too often, we have our backs to the patients or spend too much time interfacing with our EMR systems, and our patients are not happy about it (as many surveys have demonstrated). More importantly, a renewed focus on patient care, not EMR care, would allow our practitioners to do what they signed up for—treating patients. In the meantime, I would suggest that practitioners stay away from EMR gimmicks and go back to old-style documentation practices (like those established by the Centers for Medicare and Medicaid Services in 1997 and 1998), and ask the IT folks to help with molding the EMR systems to meet your own standards, not the standards established by EMR companies. I am also very hopeful that the consumer will drive most of the health care-related data collection in the near future, thereby marginalizing the current generation of EMR systems.

Dr. Woodland: I would add that providers need to manage the EMR and not let the EMR manage them. Set up task reminders at point times to handle results and communications from the EMR and set up time in your schedule where you can facilitate meeting these tasks. When providers are out on vacation, make sure to have an out-of-office reminder built into their EMR so that patients and others know timing of potential responses. Try to make the EMR as enjoyable as possible and focus on the good points of the EMR, such as legibility, order verification, safety, and documentation.

OBG MANAGEMENT: Do you feel that the EMR has led to improved patient care?

Dr. Evans: Yes and no. Yes, in that it can be much easier to follow a patient's health care

FAST TRACK

"One great piece of advice I received was to be satisfied with good notes, not perfect notes."

history from other provider notes or prior surgeries. Information is searchable and legible. If an EMR is built correctly, it can save time for providers, through smart phrases and templates, and it can help providers with proper billing codes and documentation requirements. No, in that it can take away from important patient interaction. We are required to see more patients in less time all while using, at times, a cumbersome EMR system.

Dr. Woodland: This is a tricky question because the EMR has both positive and negative attributes. Certainly, the legibility and order verification has improved, but the ease of accessing information in the EMR has changed. Additionally, there has been a

drastic increase in provider dissatisfaction that has not been addressed. Provider dissatisfaction can lead to problems in patient care. If there was a clear-cut increased value for the cost, I do not think the EMR would be such a huge focus of negative attention. Providers need to take back control of their EMR and their profession so that they can utilize the EMR as the tool it was supposed to be and not the dissatisfier that it has become.

Dr. Dougherty: I do not believe patient care has been improved by EMR systems, for all of the reasons we have discussed, and then some. But there is an enormous amount of potential, *if* we get the interface between humans and EMR systems right! ●

References

1. A crisis in health care: a call to action on physician burnout. Massachusetts Health and Hospital Association. Massachusetts Medical Society. Harvard T.H. Chan School of Public Health. <https://cdn1.sph.harvard.edu/wp-content/uploads/sites/21/2019/01/PhysicianBurnoutReport2018FINAL.pdf>. Accessed September 9, 2019.
2. Physician's Foundation. 2018 survey of America's physicians practice patterns and perspectives. <https://physiciansfoundation.org/wp-content/uploads/2018/09/physicians-survey-results-final-2018.pdf>. Accessed September 9, 2019.
3. Burn-out. ICD-11 for Mortality and Morbidity Statistics. Version 04/2019. <https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/129180281>. Accessed September 11, 2019.
4. Peckham C. Medscape National Physician Burnout & Depression Report 2018. January 17, 2018. <https://www.medscape.com/slideshow/2018-lifestyle-burnout-depression-6009235#3>. Accessed September 9, 2019.
5. Kane L. Medscape National Physician Burnout, Depression & Suicide Report 2019. January 16, 2019. <https://www.medscape.com/slideshow/2019-lifestyle-burnout-depression-6011056#5>. Accessed September 9, 2019.
6. Fry E, Schulte F. Death by a thousand clicks: where electronic health records went wrong. *Fortune*. March 18, 2019. <http://fortune.com/longform/medical-records/>. Accessed September 9, 2019.
7. How doctors feel about electronic health records: National Physician Poll by The Harris Poll. <https://med.stanford.edu/content/dam/sm/ehr/documents/EHR-Poll-Presentation.pdf>. Accessed September 9, 2019.