# President's Page

# A new epidemic

How did I get here? What is happening? The joy of medicine appears to be evaporating. The art of medicine is now in laptops, tablets and multiple mobile devices.

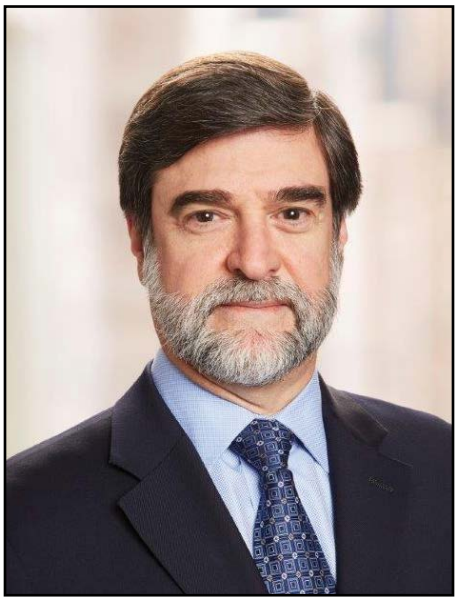
In addition to this sad situation, physicians are dealing with a new epidemic on the horizon — burnout. Physician burnout has been a major topic of discussion in hospitals, at the American Medical Association, and in other medical organizations, including the Dallas County Medical Society and the Texas Medical Association. One primary cause can be heard in the cry of many physicians: Please let me be a physician again; let me enjoy medicine again.

When we became physicians, we mostly were thinking of patient care and direct face-to-face patient contact. We never thought about the significant time we now spend doing the wrong work. It seems that due to regulatory pressures, the winds have blown our sails in the wrong direction.

Physician burnout is not a new concept, but in the last 10 years, its prevalence has increased and it has taken hold in many of our lives. Burnout has been described as an emotional exhaustion and a syndrome of depersonalization, decreased effectiveness, loss of engagement and commitment, and poor self-image. A study by the AMA and the Mayo Clinic showed that the rates of burnout among physicians were up to 54 percent in 2014, an increase of 10 percent since 2011.

Factors that contribute to physician burnout include increased workloads, electronic health records, inefficient environment, loss of flexibility, lack of control, sleep deprivation, and other problems with work-life integration. This affects health care in many ways. Physicians who show signs of burnout are unable to optimally care for their patients, as demonstrated by higher rates of medical errors, decreased patient satisfaction and lower physician productivity. The worst outcome is the increase in physician depression and suicides.

EHRs have been in the middle of this dilemma. The increased clerical burden caused by our current health records and other regulations has driven good clinicians to consider retiring early or selling their practices. EHRs have increased the after-hours workload, most of which is done at home. This "pajama time" has increased the disruption of quality family time and resulted in unhappiness at different levels. The home had been a place where physicians could recharge their batteries to be ready for the next day, but in this new environment, we are taking home some of the pressures and responsibilities we live with on a daily basis. This "recovery time" is shortened; without noticing, we have added more hours to our workdays.



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It is ironic that EHRs originally were touted as having potential to bring new life into the practice of medicine when, in fact, their use has taken life away. With some of these EHRs, we have lost communications critical to the practice of medicine. In a way, they have fractionated health care. In addition to receiving many pages of nonessential medical information, EHRs have moved physicians away from face-to-face patient contact. A physician's use of EHRs during a patient encounter has been compared to texting while driving. It has increased the clerical

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burden on physicians, resulting in their spending more time in front of computers, laptops and other devices, and less time with their patients. A recent breakdown of physicians' time showed 40 percent spent directly with patient care and close to another 40 percent with EHRs, computers and the other administrative duties. In addition, physicians take an average of one to two extra hours of EHR work home every day. So, for every hour that physicians spend with direct patient care, they may spend two hours on electronic health records and other desk-job duties, according to an Annals of Internal Medicine study. Interns and residents are following the same path, spending a significant percentage of their time with EHRs and computers, and less on direct patient contact.

EHRs have created other problems. Copy and Paste Abuse has become a national problem and one which regulatory agencies closely monitor. EHRs have created Click Fatigue and have developed Notification Fatigue, Task Fatigue and Alert Fatigue. In a broader sense, irrelevant government metrics seem to have replaced clinical judgment.

How are we to deal with this mess? We cannot close shop and forget our patients. Electronic health records were here to make our life better and help us become more efficient and deliver better patient care. I have not seen this yet, so what is missing?

Although EHRs can be a significant tool to improve our efficiency and the care we give our patients, for many reasons, the available systems have not achieved their full potential. We spend too much time measuring the wrong things, while watching regulatory burdens constantly expand.

The initial step in solving physician burnout is to recognize that it is a problem. DCMS, the TMA and the AMA are concerned about physician burnout and physician wellness. Numerous large organizations have become involved in identifying physician burnout, and are creating tools and support systems to deal with this issue. In addition, the AMA is engaging in a regulatory relief agenda to try to limit and decrease unnecessary mandates. Many of our leaders in Congress now understand that burnout is a real problem that must be dealt with if we are to improve health care for our patients.

Physicians have to be drivers in this situation; we cannot be passive passengers on this bus. We must engage more to remove barriers to efficiency and patient care. Hospitals are key players in supporting and improving the efficiency and effectiveness of physicians' work for patient care. When hospitals and physicians work together and support each other, it leads to improved patient care, outcomes and efficiency. Physicians engaged with hospital systems can promote optimal health care. It also improves physician wellness, making them of value to any organization. DCMS sees this as one of many ways for physicians and hospitals to align for common goals and more efficient healthcare delivery. But let's be clear that for efficient healthcare delivery, physician wellness is a priority.

The National Academy of Medicine, previously known as the Institute of Medicine, in collaboration with more than 130 organizations, has created a national Action Collaborative on Clinician Well-Being and Resilience. They are coordinating with others to share knowledge, tools and ideas, and identify solutions. Visit their site at https://nam.edu/initiatives/clinician-resilience-and-well-being.

There may be a light at the end of the tunnel, but it is very hard to see. **DMJ**