# Designing and Regulating Wisely: Removing Barriers to Joy in Practice

Policy, regulation, and information technology are 3 external levers that have been applied to clinical practice in an effort to create better value in health care. Yet, like clinical interventions, these initiatives may have adverse unintended consequences for patients and their care teams.

In response to these outside forces, the daily work of physicians and their teams has increasingly been oriented around administrative tasks, such as prior authorizations, computerized order entry, billing-related documentation, compliance, and performance measurement. This orientation is associated with costs that only recently have been quantified. For example, administrative tasks associated with reporting performance measures alone are estimated to cost $15.4 billion annually in the United States (1).

Such tasks as documenting pain levels, learning styles, advance directives, or fall risk may each require only a minute or two, so the time costs to an entity imposing such requirements may seem trivial. Multiplied over the hundreds of daily tasks performed by physicians and their staff, however, these costs become substantial. Taking 10 minutes per visit to ask patients mandatory, one-size-fits-all questions directs focus away from activities of greater importance to individual patients. Likewise, 30 minutes spent obtaining a prior authorization for a magnetic resonance imaging scan, ordered by a physician with a track record of appropriate imaging requests, is 30 minutes that physician or staff is unavailable to other patients who need care.

Physicians may now spend more time documenting care and complying with administrative and regulatory requirements than caring for patients. For example, physicians in ambulatory practice currently spend nearly 2 hours on computer and deskwork activities for every 1 hour of direct clinical face time. Despite spending half of their clinic day on such administrative activities, physicians routinely spend another 1 to 2 hours of their personal time on documentation and other administrative tasks (2).

The high volumes of clerical work, along with poorly designed technology, and the resultant time pressures are among the major drivers of alarming levels of physician burnout (3). More than half of U.S. physicians now exhibit signs of burnout, a condition that has increased dramatically in only 3 years (4). Most physicians would not recommend a career in medicine to their children (5). High levels of physician burnout threaten quality (6) and safety (7), potentially contribute to rising health care costs (8), and may exacerbate the upcoming physician workforce shortage that is predicted (9).

To address the growing number of administrative tasks, as well as the direct and indirect costs of these tasks to patients, professionals, and the U.S. health care system, the American College of Physicians (ACP) has put forth a bold set of recommendations aimed at technology vendors, payers, measure developers, regulators, and other accountability organizations (10).

The ACP challenges each stakeholder to take a holistic view—to consider how actions in their domain affect physicians, their practices, and the patients and families they serve. For example, the ACP recommends that stakeholders develop impact statements that quantify the financial, time, quality, and burnout costs of administrative tasks.

The ACP also suggests that U.S. stakeholders clear the deck of outmoded or ineffectual policies; streamline those that remain by harmonizing measures and focusing on measures that matter to patients; include greater flexibility within the measures to adapt to individual physicians' performances (that is, decreased regulatory oversight for physicians who consistently perform at a high level) and to evolving payment models (that is, eliminate prior authorizations for physicians in risk-sharing payment models); increase research to determine optimal practice models; and develop a stronger evidence base for policies.

The ACP position paper also advises that electronic health records be designed primarily for clinical care and that secondary administrative uses not detract from this purpose. This recommendation will require many stakeholders to collaborate toward this goal; suboptimizing around a particular stakeholder's narrow objective is no longer adequate.

In addition to the 7 recommendations included in this report, an additional one may be considered. At the most basic level, for example, one might ask, what is the value of a signature? Does every hearing aid battery, cane, pair of diabetic shoes, mastectomy bra, ear wash, influenza vaccination, or lipid profile order need to pass through the physician's inbox for a signature? To my knowledge, no evidence exists that such paperwork advances patient safety or quality. In fact, the opposite may be true. The average family physician manages more than 75 inbox messages per day. By virtue of clogging up the works and contributing to professional burnout, the case may be made that these requests for signature contribute to a hazardous practice environment.

Physicians currently spend much of their day (and some of their nights) on administrative tasks that do not require their expertise or benefit their patients. Most other industries would not waste the work of their highest-level professionals in this manner. Patients deserve the full and undivided attention of their physicians, populations deserve access to care, and

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society deserves more from its investment in medical education.

The medical community has come to expect evidence-based medical practice. A similar expectation for evidence-based policy, regulation, and information technology has not yet been established. The ACP recommendations are a timely call for greater evidence-based regulation and for a shared responsibility to create better value in health care.

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