Invited Commentary | Health Informatics


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The article by Rotenstein et al titled “Assessment of Satisfaction With the Electronic Health Record Among Physicians in Physician-Owned vs Non–Physician-Owned Practices” is both provocative and tantalizing. It is provocative because it finds meaningful and important differences between electronic health record (EHR) satisfaction reported by physicians working in physician-owned practices compared with those working in non–physician-owned practices; it is tantalizing because, as robust and important as the finding is, the authors’ data don’t provide much insight into why this might be true. Using data from the 2019 National Electronic Health Records Survey of non–federally employed office-based physicians drawn from the master files of the American Medical Association and the American Osteopathic Association, the authors found rates of EHR satisfaction of 68.1% among those in physician-owned practices compared with 58.5% among those in non–physician-owned practices. Although they also found reported differences in various structural measures (such as staff support for documentation) and perceptions of burden (such as time spent on documentation), those factors did not fully explain the observed difference in EHR satisfaction. Some other factors that are associated with physician practice ownership must be at play.

There is a well-documented association between EHR satisfaction and burnout, which is not surprising given how much clinical practice today is EHR-mediated practice, and every clinician is constantly interacting with an electronic platform to do almost anything they are trying to do with patients, not to mention documenting what it was they did. The authors’ findings are especially ominous given the growing trend, accelerated by the COVID-19 pandemic, of physicians giving up control of their practices to entities not owned by physicians. A recent study documented that, as of January 2021, 69% of US physicians were working for entities not controlled by physicians, with 49.3% of those owners being hospitals or health care systems and 20% being either private equity or publicly traded insurance companies. Thus, the authors’ findings clearly suggest that a prevailing ownership trend may be a worrisome sign for the future of EHR satisfaction and rates of physician burnout, which makes it a matter of some urgency to understand what it is about physician practice ownership that could be associated with greater EHR satisfaction; however, this issue was not something the Rotenstein et al study was designed to address. Their findings about structural support suggest that simply providing more staff may be a good start, but it isn’t the whole story.

How might we explain the authors’ findings? What could it be about physician ownership that may be associated with the observed difference?

A remarkable thing has happened in the US with respect to EHR adoption. In 2002, 20.8% of practices reported using some EHR system; as the Health Information Technology for Economic and Clinical Health (HITECH) Act was coming into being in 2008, adoption of a basic EHR stood at 16.9%. Rotenstein et al found that in 2021, 90% of respondents to the 2019 National Electronic Health Records Survey were working in practices that used an EHR. Who taught all of those physicians how to use an EHR? For all the investment in training and education, it’s probably fair to say that it was compliance officers, those who could explain to physicians what they needed to do to qualify for meaningful use payments, who were the instructors. This situation is the equivalent of radiation safety officers teaching radiologists how to use computed tomographic or magnetic resonance imaging scanners. Early use of computed tomographic and magnetic resonance imaging technologies focused on questions such as, what can we point the scanner at that is clinically relevant...
and that might yield information that could help us take care of patients? It did not focus on how the technologies needed to be used to generate payment. But with EHRs, adoption happened in a way that extinguished clinical curiosity. Few clinicians were able to point their EHR at a problem and ask how it could help them solve it. The problems faced by practicing physicians in a paper-based world were overwhelming. What did your partner or colleague say to the patient in front of you 3 days ago (if you could even find the medical record)? How do you get prescriptions to the pharmacy or orders to the laboratory? How do you communicate results to patients? The EHR offered breathtakingly better solutions to these problems than anything available in the paper-based world. Physicians in control of their own environment were able to point the technology at those problems and solve them, giving them a stake in the success of the EHR and a reward for all the care and feeding the EHR required. Agency. Control. The ability to use a tool to solve real clinical problems experienced by the physicians themselves.

Clinicians value mastery, purpose, and control. Organizations that are employing physicians have every interest in ensuring that they are high functioning and not burning out. Perhaps this study provides some markers of a road map for health-preserving EHR use; if clinicians are able to exercise some measure of agency and control over how the EHR is used, to explicitly define some of the ways it can help them deliver better patient care, that could be an important principle of EHR use in large systems. Once an EHR is implemented, everybody’s job changes, entirely new roles come into being which, if not anticipated and designed for, all flow to the front-line clinician. Giving physicians some ability to redesign their workflows to assure that the right person is doing the right work is likely another important element. Surely the key is some version of collaborative design, something more likely to happen in physician-owned practices, but a technique that could surely be imported into a practice with any ownership structure. The result in many other industries has been both higher productivity and a happier, more engaged work force.9 Perhaps those organizations that currently employ physicians can be motivated by the compelling data produced by Rotenstein et al1 to optimize satisfaction and performance in their clinical enterprise.

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REFERENCES


