Potential and pitfalls of email control as a burnout antidote

Saty Satya-Murti, MD; Allison L. Weathers, MD

Physicians endure a numbing increase in administrative tasks that value process-based measurements more than health outcomes. These requirements steal time away from physician–patient interactions and correlate poorly with health benefits that patients care about.¹ A lucid essay by Armstrong² in this issue of *Neurology® Clinical Practice* traces the background for physician burnout, and focuses on one of its underrecognized causes: an increasing email burden. Demands posed by mass email also contribute to the sense of low productivity among health care providers.

Armstrong lists mass emails, spam, sales pitches, dubious requests for journal contributions, and conference invitations as initiators of email fatigue. From this above mesh, physicians must be alert not to miss necessary and valuable messages about patient care. The author goes on to suggest measures to manage the inbox, adopting email etiquette and borrowing ideas from corporate practices that have succeeded in reducing email burden. A helpful table lists 5 potential approaches to handle emails. Certainly, within one's personal control are limiting access hours, curbing impulse peeking, and being aware of email addiction. At a departmental level, interested neurologists can take leadership roles for email management with cooperation from IT staff, when such is available.

This “how to” article is a worthy starting point for a trial either in departmental settings or in individual practices; however, there are obstacles and drawbacks. Without experimental proof of effectiveness, administrators might be reluctant to launch new email control initiatives. Small or solo practice neurologists do not have external agencies that could implement control processes. Empirically grounded proof for effectiveness of email control is difficult to come by. Armstrong has cited encouraging examples of such from corporate and non–health care settings. But their successes are not universal. For instance, a digital archivist appraised a control solution for email retention and archiving and found human intervention still necessary.³ Sometimes unsubscribe and spam tagging are counterproductive, with the former serving as a source identifier for alternative message barrage, and the latter occasionally derailing important messages to the spam box. Health systems rely on email for mass communications for important topics such as emergency announcements, site visits by regulatory agencies, electronic health record downtimes, and other patient care–related technologies. Contractual and medical staff policy obligations may require physicians to check their email at specified intervals. Any email control technique put into place should not prevent compliance with these obligations. Regardless of the chosen technique, whether in an individual practice or departmental level, it is vital to preserve awareness of and prevent misrouting of patient care–related and critical emails.

Corporate examples are impressive; however, physicians should not forget that our defining missions diverge from theirs. Brevity, subject line precision, message clarity, lean “ccs,” thread

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Health Policy Consultant (S.S.-M.), Santa Maria, CA; and Information Technology Division/Center for General Neurology (A.L.W.), Cleveland Clinic, OH.

Funding information and disclosures are provided at the end of the article. Full disclosure form information provided by the authors is available with the **full text of this article at Neurology.org/cp.**

Correspondence to: saty.murti@gmail.com

truncation, and “action item” labels are excellent ideas. These, however, are but an extension and successor of similar exemplar practices from the written word era. Eliminating “OK” and “thanks” may be viewed as impolite, depending on the sender. They are often used not only for politeness sake, but as confirmation of receipt, and acknowledgment. Therefore, they are not contentless and courtesy is never out of date. Many email services now allow for automation of these response choices.

Armstrong’s article identifies burnout-inducing administrative expectations and the smothering effects of mass emails. It makes several important suggestions to reduce this burden. Among them, those within personal control will work, but an equal number will stay refractory and beyond our domain of influence. However, this article is a critical first step to raise awareness and begin the conversation of potential solutions for this important contributing factor to physician burnout.

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AUTHOR CONTRIBUTIONS

S.S.-M.: contributed to the concept and drafting of the article and article revision. A.L.W.: contributed to the drafting of the article and article revision.

STUDY FUNDING

No targeted funding reported.

DISCLOSURES

S. Satya-Murti has participated in telephone consultations or in-person medical advisory board meetings for Evidera (formerly United BioSource Corporation [UBC]), Simon-Kucher consultants, Baxter, CB Partners, Avalere LLC, Medtronic, 1798 Consultants, Parexel, DeciBio, and AbbVie; has received funding for travel from United BioSource Corporation (UBC) (2010–2013), AstraZeneca, Avalere LLC, Evidera consulting group, Covidien, Michael J. Fox Foundation, Foley Hoag LLP, Baxter, and AbbVie; serves on the editorial board of *Neurology: Clinical Practice*; served on the American Academy of Neurology Payment Policy Subcommittee; and served as panelist and later (2010–2011) Vice-Chair CMS-MEDCAC (Medicare Evidence Development and Coverage Advisory Committee). For the duration of the MEDCAC meeting, usually 1–2 days, S. Satya Murti was considered an SGE (Special Government Employee). A.L. Weathers has received reimbursement for travel to attend AAN Practice Management and Technology subcommittee and Medical Economics and Management Committee meetings; serves on the editorial board of *Continuum: Lifelong Learning in Neurology*; and is Chair of the Adult Neuroscience Specialty Steering Board for Epic. Full disclosure form information provided by the author is available with the **full text of this article at Neurology.org/cp**.

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