Electronic health records: Is mindfulness the solution?

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Medicine is a demanding profession that requires a substantial commitment in education, work hours, and dedication to patient health and professional development. Beginning with their residency, physicians carry an enormous responsibility for the care and treatment of their patients. As William Osler summarized, “The physician’s challenge is the curing of disease, educating the people in the laws of health, and preventing the spread of plagues and pestilences.”¹ Although the work of physicians has always been challenging, levels of physician burnout have risen dramatically^{2–4} and erode patient care, professional conduct, and the physician-patient relationship.^{5–7} As Dr. Ronald Epstein explained,

Physicians and patients are disillusioned, frustrated by the fragmentation of the health care system. Patients cannot help but notice that I spend more and more time looking at computer screens and less time face-to-face. They experience the consequences of the commodification of medicine that has forced clinicians’ focus from the healing of patients to the mechanics of health care.⁸

Electronic health records (EHRs) are now recognized as a major contributor to physician burnout and dissatisfaction.^{9–12} Before the advent of the EHR, illegible records, missing records, lost laboratory results, prescribing errors, and faulty documentation plagued health care.¹¹ EHRs were implemented with the goal of digitizing patient demographics, history, medications, notes, and imaging, while making this information legible and easily accessible. As Curtis Kommer summarized,

The EHR helps me organize data in meaningful ways, not only to improve the care of individual patients but also to track the effectiveness of my practice as a whole, compare my results to national standards, and even assist in research efforts. I have also found the electronic prescribing functions to be most useful in preventing errors related to allergies, drug interactions, and dosing options. As a family physician, the electronic reminders regarding preventive care milestones have often prompted me to remember the “big picture” during a busy 15-minute visit.¹³

Long-term goals for the EHR movement included improved patient safety, improved adherence to evidence-based medicine through computerized decision support, increased population health initiatives, and knowledge discovery through the harvesting of “big data.”¹⁴

With rapid implementation of the EHR, many physicians believed that this technology would decrease the time spent documenting care and locating prior records while increasing patient interaction and satisfaction.^{11,15} Increasingly, studies are showing that EHRs have significantly reduced face-to-face physician-patient interactions and decreased overall efficiency within the clinical setting,^{16–18} despite attempts to address these deficiencies.¹⁸ As Kommer explained,

The EHR was never designed to facilitate a human narrative, which was what my great-grandfather’s documentation was all about. Like him, when I wrote my notes, I was forced to think about how best to describe my patient’s idiosyncrasies, heart sounds, or skin lesions. It forced me to think about how best to state my conclusions and concerns, and how best to justify my plan of action. In the writing of these things, I learned them, remembered them, and they became important to me. Now, with a single click, I can populate an entire physical examination, add reams of diagnostic tests, or even generate a complete comprehensive note. ... From a time-management standpoint, this is miraculous, and I use these tools to survive every day, but at what cost?¹³

Therefore, understanding the EHR factors that burden physicians could lead to strategies to improve physician wellness and the quality of their interactions with patients.

In our experience, we have found that it is best to document the patient visit on the computer while in front of the patient. This allows for additional patient-provider time together and signals that the physician has listened to the patient and that the physician is faithfully documenting what the patient has said. An additional successful approach by some physicians is to use “scribes” to reduce time spent with

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the EHR, improving productivity and increasing patient-clinician interactions.¹⁹ Alternatively, a nurse or medical assistant could collect the basic EHR information while the physician interacts with the patient, collects pertinent information, and finishes EHR documentation in the office. The American Medical Association is now championing “team documentation” to reduce physician documentation burden.²⁰ In this model, all team members, including pharmacists, nurses, and medical assistants, can contribute to the patient care document, lowering the burden on the physician. Furthermore, the Centers for Medicare and Medicaid Services is proposing new legislation to simplify documentation standards to improve physician burnout and improve documentation efficiency.²¹

We believe that the future will bring improvements in the EHR. Voice recognition and artificial intelligence will surely make the EHR easier and less burdensome to use. Together, these changes should ensure that the EHR can “offer insights into the thought processes, intuitions, and recommendations of the clinician. It should provide an assessment of the myriad psychosocial factors that may affect each patient’s care. It should be an honest and accurate reflection of both the clinician’s thoughts and the patient’s conditions.”¹³ In the meantime, we counsel a “mindfulness”-based approach to the EHR. As Jardim said, “It is important to get our work done quickly, finish our notes, and stay on schedule. But at the end of the day, what matters most is the quality of the interactions we have with our patients—not our electronic health records.”²²

Within the medical community, interest in *mindfulness practices* has grown to reduce physician burnout and improve work–life balance. Specifically, mindfulness practice includes an emphasis on clinician resilience, quality of care, and compassion, whereby the health care professional “assumes an open, receptive, nonjudgmental awareness of all physical sensations, thoughts, and feelings that may be transpiring ... without any attempt to alter them in any way.”⁸ In general, “mindfulness functions to decouple pleasant and unpleasant experience from habitual reactions of craving and aversion, by removing the affective bias that fuels such emotional reactivity. It is the absence of emotional distortions ... that allows mindfulness practitioners to ‘see things as they are.’”²³ Previous studies showed that patients who practiced mindfulness reduced the severity of their psychiatric conditions and increased brain activity in regions involved with regulating emotions.^{24–27} A large meta-analysis of clinical studies examining mindfulness and clinical practice showed improved stress, anxiety, mindfulness, resiliency, and burnout among clinicians.²⁸ Specifically, clinicians regularly practicing mindfulness practices had improved emotional tone with patients and communication and discussions about psychosocial issues.

Though undergoing a modern resurgence, mindfulness practices have their roots in the Buddha’s teachings, which emphasized awareness, detachment, and emotional balance

through meditation.²⁹ Buddha believed that mindfulness was practiced through dispassionately analyzing each experience while maintaining an openness to new possibilities and perspectives.³⁰ Within the Buddhist paradigm,

Mindfulness helps manage uncertainty and confusion. Buddhists speak of the “monkey mind,” those thoughts (and emotions and physical sensations) that divert us from this moment. ... The more readily we acknowledge monkey thoughts, feelings, and sensations without attending to them, the more easily they can pass through without disturbance.³¹

William Osler similarly remarked that physicians should practice “coolness and presence of mind under all circumstances, calmness amid storm, clearness of judgment in moments of grave peril, immobility, impassiveness, or, to use an old and expressive word, phlegm.”³²

With respect to the EHR, mindfulness practices may help recapture the joy of interacting with patients while alleviating the frustrations of technology diverting physicians from being fully present with their patients.²² One goal of mindfulness training is to “let go” of the frustrations that come from things that cannot be changed. We believe that physicians should not submerge themselves in the frustrations brought on by EHRs but rather let go of what they cannot control and focus mindfully on what they can control. Some physicians are succeeding in incorporating the EHR into their practices in a way that strengthens rather than weakens the physician-patient relationship. For example, Dr. Carla Jardim suggested that physicians “focus on the patient when you enter the exam room, get the chief complaint from the patient, know when to put away the keyboard, sit so the patient can see the computer screen, engage the patient in the use of the EHR, and look things up with the patient.”²²

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