AAFP Backgrounder: Documentation Burden

At the core of family medicine is the deep interaction between physician and patient, contact that requires time and focus. Documentation burden disrupts that experience by distracting the physician. Left unchecked, documentation burden erodes family physicians' relationships with their patient panels and contributes to burnout.

Lost Time, Misplaced Focus

Landmark research published in 2017 revealed that primary care physicians reported spending more than half their workdays on electronic health records, averaging four and a half hours a day in clinic and another 90 minutes at home, after hours. Nearly a quarter of that time was devoted to EHR documentation tasks.

Burdened physicians have modified their workflows as a result, compromising their focus and ultimately diverting energy from patient care and personal wellbeing to often extensive clerical labor. Traditional EHRs have only made the problem worse. These systems, developed to support the fee-for-service, insurance-driven care model, have rendered cumbersome administrative tasks inseparable from the physician's clinical responsibilities.

The EHR user experience for visit documentation is outdated, using templates and forms that require excessive chart navigation, clicks, cursor placements, and typing. Completing EHR requires physicians to focus their eyes, hands, and minds on a system interface rather than on the patient; data entry supplants true documentation of medical decision making.

Stuck on the Hamster Wheel

Even as satisfying EHR portals diminishes the physician-patient relationship in the exam room, documentation burden robs clinicians of valuable time elsewhere: between visits, over lunch, nights, weekends. As one family physician said: "Something has to give, and it is time with my patients and my family." Another has described documentation burden as akin to being "on a hamster wheel."

At the root of this problem is the fee-for-service model of care delivery. Physicians have always kept careful records of their care, primarily to maintain accurate medical histories for their patients but also to enrich their relationships with patients with details that could otherwise be forgotten between visits. However, the fee-for-service insurance payment model, with its ever-decreasing reimbursement out of synch with mounting administrative requirements, has made documentation an unfair burden.

To survive financially, family physicians must take on large patient panels and fill their schedules with 24 to 32 short (15 minutes or less) visits each day. This makes both the clinician and the patient feel rushed. Meanwhile, research indicates that at least as much time ends up devoted to EHR upkeep. One study, using data from approximately 100 million patient encounters with about 155,000 physicians from 417 health systems, reported physicians spending an average of 16 minutes and 14 seconds per encounter using EHRs, with chart review (33%), documentation (24%), and ordering (17%) functions accounting for most of that time. The distribution of time spent by clinicians using EHRs varied greatly within specialty, according to that study, but the proportion of time spent on various clinically focused functions was similar across specialties.