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RESEARCH REPORT

# Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy

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The RAND Corporation

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## Executive Summary

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### Purpose

This project, sponsored by the American Medical Association (AMA), aimed to characterize factors that influence physician professional satisfaction. In the context of recent health reform legislation and other delivery system changes, we sought to identify high-priority determinants of professional satisfaction that can be targeted within a variety of practice types, especially as smaller and independent practices are purchased by or become affiliated with hospitals and larger delivery systems. Based on project findings and input from other sources, including its membership and experts in physician practice design, the AMA plans to develop possible pathways for American physicians to practice in models that are more effective, efficient, sustainable, and conducive to professional satisfaction.

### Methods

Between January and August 2013, we gathered data from 30 physician practices in six states: Colorado, Massachusetts, North Carolina, Texas, Washington, and Wisconsin. We selected these practices to achieve diversity on practice size (<9 physicians, 10–49 physicians, >50 physicians), specialty (multispecialty, primary care, single subspecialty), and ownership model (physician owned or physician partnership, hospital or other corporate ownership). Although not designed to be nationally representative, this sampling strategy allowed inclusion of a broad swath of physician practice models and in-depth data collection from each. Each practice completed a structural questionnaire assessing its organizational structure, electronic health record use and capabilities, and participation in innovative payment models. We then visited each practice and conducted semistructured interviews with a total of 220 informants (108 with practicing physicians and 112 with practice leaders and other clinical staff), querying factors that influenced professional satisfaction within the practice, the local health care system, and the policy environment. Finally, we fielded a survey to 656 physicians in the 30 practices, receiving 447 responses (68-percent response rate). The survey used a combination of existing and new items to assess dimensions of professional satisfaction and factors that might influence professional satisfaction. We analyzed interview transcripts using qualitative software; identified common themes; and then, in the survey data, analyzed quantitative relationships corresponding to these qualitative themes.

## Main Findings

We found that factors in several broad categories were important determinants of physician professional satisfaction, as detailed below. In our judgment, the most novel and important findings concerned how physicians' perceptions of quality of care and use of electronic health records affected professional satisfaction. The findings for quality and electronic health records (EHRs) were

- **Quality of care.** We found that, when physicians perceived themselves as providing high-quality care or their practices as facilitating their delivery of such care, they reported better professional satisfaction. Conversely, physicians described obstacles to providing high-quality care as major sources of professional dissatisfaction. These obstacles could originate within the practice (e.g., a practice leadership unsupportive of quality improvement ideas) or could be imposed by payers (e.g., payers that refused to cover necessary medical services).

These findings suggest that, when physician dissatisfaction is attributable to perceptions of quality problems, such dissatisfaction could be viewed as a “canary in the coal mine” for the quality of care—assuming that physicians are correct in their perceptions. Interventions that address these quality concerns, simultaneously improving both the quality of care patients receive and physician professional satisfaction, should be attractive to multiple stakeholders.

- **Electronic health records.** EHRs had important effects on physician professional satisfaction, both positive and negative. In the practices we studied, physicians approved of EHRs in concept, describing better ability to remotely access patient information and improvements in quality of care. Physicians, practice leaders, and other staff also noted the potential of EHRs to further improve both patient care and professional satisfaction in the future, as EHR technology—especially user interfaces and health information exchange—improves.

However, for many physicians, the current state of EHR technology significantly worsened professional satisfaction in multiple ways. Poor EHR usability, time-consuming data entry, interference with face-to-face patient care, inefficient and less fulfilling work content, inability to exchange health information between EHR products, and degradation of clinical documentation were prominent sources of professional dissatisfaction. Some of these problems were more prominent among senior physicians and those lacking scribes, transcriptionists, and other staff to support data entry or manage information flow. Physicians across the full range of specialties and practice models described other problems, including but not limited to frustrations with receiving template-generated notes (i.e., degradation of clinical documentation). In addition, EHRs have been more expensive than anticipated for some practices, threatening practice financial sustainability.

Some practices reported taking steps to address the causes of physician dissatisfaction with EHRs. These steps were, most commonly, to allow multiple modes of data entry (including scribes and dictation with human transcriptionists) and to employ other staff members (e.g., flow managers) to help physicians focus their interactions with EHRs on activities truly requiring a physician's training.

In addition to quality and EHRs, we found factors influencing physician professional satisfaction in each area described below. In general, these findings agreed with earlier studies of physician professional satisfaction. These confirmatory findings, explored in detail in this study, demonstrate the persistent impact of these factors on physician professional satisfaction over time and through major changes in the U.S. health care system. The areas were

- **Autonomy and work control.** Greater physician autonomy and greater control over the pace and content of clinical work were both associated with better professional satisfaction. For some physicians, having a leadership or management role within the practice was a key way of achieving autonomy. However, practice ownership was not for everyone: Some physicians reported little taste for the “business side” of medicine, deriving satisfaction from employed positions that allowed them to focus more exclusively on clinical care.

Because interviewees reported that practice structure and ownership could facilitate or limit their autonomy and ability to control their work, we also investigated the relationships between practice model and overall satisfaction. In our sample, physicians in physician-owned practices or partnerships were more likely to be satisfied than those in other ownership models (hospital or corporate ownership). However, we also found that strategies to enhance physicians’ abilities to control the factors immediately affecting their day-to-day clinical work may be important to preserving or enhancing professional satisfaction within hospital- or corporate-owned practices.

- **Practice leadership.** Among the practices we studied, practice leadership affected physician professional satisfaction in two main ways. First, professional satisfaction was higher when physicians and their clinical colleagues reported that their values were well aligned with those of their leaders. Values alignment was especially important concerning approaches to clinical care. Some physicians reported that having leaders with clinical experience (either as physicians or other types of front-line clinical staff) enhanced the sense of values alignment between practice leaders and practicing physicians. Second, physicians reported better professional satisfaction when practice leadership took a balanced approach to new practice-wide initiatives, maintaining physician professional autonomy when possible.
- **Collegiality, fairness, and respect.** Physicians’ perceptions of collegiality, fairness, and respect were key determinants of professional satisfaction. Physicians reported four main areas in which these constructs operated: relationships with colleagues in the practice (including practice leadership), relationships with providers outside the practice, relationships with patients, and relationships with payers. Within the practice, frequent meetings with other physicians and allied health professionals (such as business meetings in physician partnerships) fostered greater collegiality. Some physicians who no longer co-owned their practices observed that, when business meetings ceased, interpersonal familiarity with their former partners decreased, leading to lower overall morale.

Physicians reported limited but important specialty-specific frustrations with unfairness and disrespect when interacting with other providers. For surgeons, these concerns surfaced most prominently in arranging hospital call duties. For primary care physicians, interactions with other physicians were problematic when primary care physicians (and their staffs) were treated as subservient.

- **Work quantity and pace.** Physicians, clinical staff, and practice leaders commonly reported challenges stemming from the quantity and pace of physician work. Especially in primary care specialties, physicians described how pressure to provide greater quantities of services effectively limited the time and attention they could spend with each individual patient, detracting from the quality of care in some cases. Some of the physicians we interviewed had joined practices in which payment did not rely on number of patients seen, but in doing so, they reported accepting lower incomes. Others reported that improvement strategies adapted from other industries (e.g., “lean” improvement techniques) had improved patient flow, making the pace of work more reasonable and reducing time pressures.

Importantly, a smaller number of physicians and practices reported that dissatisfaction (and worries about practice sustainability) could also stem from insufficient work quantity. These concerns were most commonly articulated by the surgeons in our study.

- **Work content, allied health professionals, and support staff.** In general, physicians described better satisfaction when their work content matched their training and dissatisfaction when they were required to perform work that other staff could perform—especially when they sensed that the content of their work was being dictated to them. Specific types of satisfying work varied by specialty and by individual, but some patterns emerged. For example, many primary care physicians appreciated providing care that was continuous, including inpatient care. Some of these physicians missed caring for hospitalized patients, expressing concern about lost skills when hospitalists cared for their inpatients. Among surgeons, some expressed a desire to develop expertise in a specific niche within their field.

Working with adequate numbers of well-trained, trusted, and capable allied health professionals and support staff was a key contributor to greater physician professional satisfaction. Support from such staff enabled physicians to achieve a more desirable mix of work content. Several study participants appreciated having long-term working relationships with allied health professionals and support staff, with some such relationships spanning decades. This theme was corroborated in quantitative analyses of physician survey responses, which revealed that greater staff stability (i.e., lower turnover) was a significant predictor of better overall professional satisfaction.

- **Payment, income, and practice finances.** Few physicians reported dissatisfaction with their current levels of income. However, physicians reported that income stability was an important contributor to overall professional satisfaction, and some described taking steps to preserve their incomes when pay rates decreased (or other changes threatened to reduce income). In addition, payment arrangements that were perceived as fair, transparent, and aligned with good patient care enhanced professional satisfaction. When practices changed their internal payment arrangements, clear and logical explanations for these changes were described as being important to preserving a sense of fairness. Physicians were less tolerant of income reductions that were perceived as resulting from the poor business decisions of practice leaders.

Interviewees from practices of all specialties expressed a sense that relative incomes would shift in the future, with primary care gaining and some subspecialties potentially losing income. This was a source of concern for some subspecialist physicians and for practices that had invested heavily in subspecialty care. Worries about practice financial sustainability, when present, were described as a source of dissatisfaction. For some physi-

cians, working in practices in which they did not have an ownership interest (e.g., working for a hospital-owned practice) alleviated the stress associated with ownership.

- **Regulatory and professional liability concerns.** Physicians and practice managers described the externally imposed rules and regulations under which they operated as having predominantly negative effects on professional satisfaction. Among these, “meaningful-use” rules stood out as having the greatest influence on professional satisfaction at the time of this study. While physicians agreed generally with the intent of meaningful-use rules, they expressed frustration with the time and documentation burdens these rules imposed—especially when they believed they were being asked to generate new documentation of activities that they had already performed.

Professional liability concerns were not prominent contributors to dissatisfaction among the practices we sampled. As our interviews revealed, recent state-specific reforms to professional liability laws may have contributed to this finding. Had the study been conducted in other states, this finding could have been different.

- **Health reform.** Aside from incentives to adopt EHRs, our study did not identify recent health reforms as prominent contributors to overall physician professional satisfaction, either positively or negatively. In general, physicians and administrators expressed uncertainty about how various aspects of health reform (including but not limited to those contained in the Affordable Care Act) would affect physician professional satisfaction and practice financial sustainability. Leaders in multiple practices reported that transitions from one payment model (e.g., fee-for-service) to another (e.g., shared savings or capitation) would be complicated, with physicians receiving mixed incentives from different payers. In response to these concerns, several practices sought economic security by increasing their size or becoming affiliated with hospitals and large delivery systems. Leaders of smaller, independent practices that did not initiate such growth or affiliation described feeling pressure to join larger systems, sensing that it would become more difficult in the future to remain independent from these systems as a consequence of health reform.

## Conclusions

Many of the factors influencing physician professional satisfaction identified in this study are shared by professionals and workers in a wide variety of settings. Therefore, the same considerations that apply outside medicine—for example, fair treatment; responsive leadership; attention to work quantity, content, and pace—can serve as targets for policymakers and health delivery systems that seek to improve physician professional satisfaction. This may seem an obvious conclusion, but considering the typical tools used to influence physician behavior (regulations, payment rules, financial incentives, public reporting, and the threat of legal action), refocusing attention on the targets identified in this study may actually represent a substantial change of orientation for many participants in the U.S. health care system.

EHR usability, however, represents a unique and vexing challenge to physician professional satisfaction. Few other service industries are exposed to universal and substantial incentives to adopt such a specific, highly regulated form of technology, one that our findings suggest has not yet matured. On one hand, only one in five physicians we surveyed would prefer to return to paper-based medical records. Nearly all physicians we interviewed saw the benefits

of EHRs (e.g., remote accessibility to patient data) and believed in the “promise of EHRs.” On the other hand, physicians cannot buy, install, and use a promise to help them deliver patient care. The current state of EHR technology appears to significantly worsen professional satisfaction for many physicians—sometimes in ways that raise concerns about effects on patient care.

Physicians look forward to future EHRs that will solve current problems of data entry, difficult user interfaces, and information overload. Specific steps to hasten these technological advances are beyond the scope of this report. However, as a general principle, our findings suggest including improved EHR usability among federal EHR certification criteria. In addition, the meaningful-use rules may not provide physicians with sufficient flexibility to match the needs of their practices—especially for those who do not provide primary care.

Finally, our finding that physicians are more satisfied when they perceive that they are meeting their patients’ needs by delivering high-quality care—and dissatisfied when they perceive barriers to delivering high-quality care—suggests an additional way of thinking about the relationship between physician professional satisfaction and the quality of care that patients receive. Aside from viewing better patient care as a potential consequence of better physician professional satisfaction, it may be useful to think of physician dissatisfaction, when it is caused by perceived quality problems, as an indicator of potential delivery system dysfunction.

In this view, the critical step is to understand *why* some physicians report dissatisfaction with certain aspects of their professional lives. Some obstacles to professional satisfaction may have limited direct relationships to the quality of care. However, when dissatisfaction stems from factors that physicians perceive as compromising quality, further investigation of these factors may help identify important opportunities to improve patient care.

Put another way, producing a greater number of “satisfied” physicians is not the only goal. Even physicians who report high overall professional satisfaction will have sources of stress, frustration, and burnout in their clinical practices. Some of these stressors interfere with patient care. Solving them should be a high priority for multiple stakeholders.

## Implications

This study raises important issues and questions to be addressed by researchers, policymakers, and health care leaders:

- **Physician practices need a knowledge base and resources for internal improvement.** In particular, many physician practices need help with managing change. Where will this come from? Larger physician practices have begun to apply such techniques as lean improvement with success, but for the majority of physician practices, such interventions are out of reach without help. Are hospitals and health systems the only sources of such practice improvement support?
- **As physician practices affiliate with large hospitals and health systems, paying attention to professional satisfaction may improve patient care and health system sustainability.** Consolidation of physician practices may improve or detract from physician satisfaction over the longer term. When dissatisfaction accompanies system consolidation, it will be important to understand the underlying causes: Does dissatisfaction stem from perceived barriers to delivering quality care, and if so, are these perceptions correct?

- **When implementing new and different payment methodologies, the predictability and perceived fairness of physician incomes will affect professional satisfaction.** Some but not all physicians and delivery systems seek alternatives to traditional fee-for-service payment, and transitions between payment models will be smoothest if incomes can be stabilized even as incentives change.
- **Better EHR usability should be an industrywide priority and a precondition for EHR certification.** Speeding the improvement of EHR usability may require direct incentives for EHR vendors. Until EHR usability improves dramatically, to the point that directly interacting with an EHR neither creates additional, excessive clerical work for physicians nor distracts from patient care, removing regulatory and legal barriers to using other practice staff (e.g., scribes) to interact directly with EHRs will allow physicians more time to perform work that requires physicians' training.
- **Reducing the cumulative burden of rules and regulations may improve professional satisfaction and enhance physicians' ability to focus on patient care.** Physicians reported feeling overwhelmed by the cumulative effect of rules and regulations on their ability to deliver patient care, especially when mandated activities (such as duplicative information entry) were perceived as a distraction from patient care. Reducing this burden in a responsible way will require cooperation between physician practices and both public and private sources of these rules and regulations.