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Viewpoint

Burnout, Professionalism, and the Quality of US Health Care

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Physician burnout is a major threat to health care quality, patient outcomes, and the vitality of the medical workforce.[1] More than half of US physicians report at least 1 symptom of burnout—nearly twice the rate of the general working population—and many also experience depression, anxiety, or suicidal ideation.[2] Burnout is estimated to cost the health care system at least $4.6 billion annually, with the greatest burden attributable to turnover and work-hour reductions among primary care physicians.[2]

Many factors have been linked to burnout, including physician age, sex, and specialty; workplace leadership and culture; and practice type and compensation model.[1] Fundamentally, however, 3 forces drive burnout: pressure to care for too many patients in too little time and with too few resources; expectations to engage in activities felt to be rote, irrelevant, or counterproductive; and an inability to meet the medical or social needs of patients. Each assails physicians' professionalism and threatens the delivery of compassionate, high-quality care.

Critics sometimes portray professionalism as a self-serving myth, an ill-defined concept used to ward off needed quality control from external entities. But professionalism may be among the most effective tools we have to improve care.[3] Physicians are not perfect, but they are deeply motivated to do right by patients, to improve as clinicians, and to earn the respect of their colleagues. Moreover, the inevitable asymmetry of information between physicians and patients—and between physicians and regulators—requires the physicians' enthusiastic (as opposed to grudging) support of health system reforms.

But instead of taking professionalism seriously as a path to deliver better care, policy makers, insurers, and organizational leaders have often sought to replace it with extrinsic penalties and rewards, and in some cases, have abused it to fill gaps in a dysfunctional system. Many physicians experience a disheartening lack of control over their time and attention, over what must be discussed with patients, and over how clinical encounters are to be structured and documented. Payers have introduced pay-for-performance programs that, in addition to increasing administrative burdens, encourage physicians to focus on a limited set of process measures (many of which are not supported by evidence) at the expense of holistic and personalized care. Meanwhile, physicians often feel disconnected from or resentful of the organizations in which they work for failing to support professional autonomy, reasonable work hours, and healthy relationships.

Concrete steps can be taken toward a better system. These include reforming payment models to increase time with patients, reducing the burden of clerical tasks, and supporting physicians in meeting the medical and social needs of patients.

Reforming Payment to Increase Time With Patients

Despite widespread agreement on the need to transition to value-based care, relative value unit–based, fee-for-service compensation remains the dominant form of payment in the US. This reimbursement model promotes excessive workloads, both for physicians who perform lucrative procedures (and feel pressure from organizations to maximize revenue) and for physicians engaged in poorly reimbursed nonprocedural work (who must maintain high visit volume to remain solvent).

Value-based purchasing, especially programs that offer prospective, risk-adjusted global payments, may relieve the pressure to see as many patients as quickly as possible. Such models can

offer flexibility and remuneration to engage patients in creative and personalized ways, including through group visits, home visits, telehealth, phone calls, remote monitoring, and wraparound services. These activities may improve care and convenience for patients who do not require frequent in-person visits and allow physicians more time with those who do. Organizations remaining in fee-for-service models can consider softening productivity mandates, as research suggests that physicians with incentive-based compensation have higher rates of burnout than salaried physicians.[1]

The details of value-based payment are critical. Some programs, especially those using fee-for-service payments adjusted for performance on narrow process measures, may worsen burnout by introducing administrative burdens, exacerbating health disparities, and distracting from other important aspects of care.[3] Quality improvement initiatives using nonfinancial incentives, such as coaching, peer comparison, and real-time feedback, may be more effective at harnessing the intrinsic motivation of physicians.

Reducing the Burden of Clerical Tasks

Time spent on meaningful work is a key predictor of professional well-being.[4] But large-scale changes to the US health system, including the introduction of electronic health records, the pervasive use of measures that are not evidence-based, and a growing emphasis on billing and coding, have engendered a clinical environment in which many physicians spend more time engaged in clerical work than they do seeing patients. This arrangement is antithetical to their motivations for practicing medicine.

Achieving a major reduction in administrative burdens requires coordination across health care organizations, payers, vendors, and technologists.[5] Recent work suggests that organizations that regularly invite clinicians to audit internal processes can remove large amounts of redundant or unnecessary work by reducing superfluous data collection, extra keystrokes, and confusing protocols.[6] Organizations should also rigorously examine how clinical support staff can minimize the time physicians spend on clerical work and maximize the time they spend on the work they are uniquely trained to do.[7]

Payers can support these efforts by drastically reducing clinical documentation requirements and the use of prior authorization, since these are a source of frustration for physicians, a delay in care for patients, and an expense for medical practices. Going forward, technology may also play a role: as speech recognition and natural language processing software improve, virtual assistants could be used to document patient encounters, enter orders, engage with insurers, and retrieve and synthesize clinical data. The American Medical Informatics Association's 25 × 5 Initiative,[8] which recently convened stakeholders with the goal of decreasing documentation burden by 75% over 5 years, represents one promising interdisciplinary effort toward a system that prioritizes patient care and physician-patient relationships.

Supporting Physicians in Meeting the Needs of Patients

Physicians enter medicine to better the lives of patients, but a repeated inability to address the forces that impoverish health can lead to professional dissatisfaction and psychological distress. Although policy makers have recognized the centrality of addressing social drivers of health, they have offered inconsistent and insufficient support to help physicians in doing so. Consequently, physicians, who are already overburdened by clinical and administrative demands, have scant time and resources to tackle the root causes of illness and the social impediments to disease management.

Health care organizations should leverage social workers and care managers to screen all patients for social challenges and develop relationships with community partners that can help meet their needs. Payers are also part of the solution. The Centers for Medicare & Medicaid Services (CMS) recently introduced several models that, if successful, warrant expansion. For example, through the Maryland Primary Care Program, practices can receive additional funding and resources to support

integration with behavioral health counselors, community health workers, and social service providers.[9] In 2023, CMS implemented a new Accountable Care Organization Realizing Equity, Access, and Community Health program to support physicians and organizations caring for populations that have been historically marginalized.[10] Among other reforms, the CMS model increases spending benchmarks for clinicians who care for large numbers of socially vulnerable patients, allowing physicians to invest in programs to improve patient care.

Conclusions

The status quo has led to alarming rates of burnout among physicians. Paradoxically, this state is partly the product of well-intentioned but misguided efforts to improve the quality and efficiency of US health care. A better path is one that strenuously removes the obstacles to physician and patient well-being and that actively promotes the deep work of doctoring.

ARTICLE INFORMATION

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