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COMMENTARY

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Physician Burnout: Fix the Doctor or Fix the System?

Burnout—emotional exhaustion and depersonalization (ie, treating patients like objects)—affects almost half of American physicians, even before the coronavirus disease 2019 (COVID-19) pandemic.[1] Burnout diminishes the quality of physician's lives[2] and undermines patient care by leading to more medical errors and physicians leaving practice.[3]

Physicians report that administrative burdens (eg, filling out forms, dealing with multiple formularies, prior authorization and network restrictions, and documenting quality metrics) are important contributors to burnout. Other factors include cumbersome electronic health records (EHRs), productivity pressures, long work hours, poor work-life balance, and loss of autonomy.[4]

Two types of remedies for burnout have been suggested: personal interventions to decrease stress and improving the work environment. The former category includes everything from resilience training, mindfulness, yoga, battle buddies and psychotherapy to doctors' dining rooms. However, these approaches, many of which put the onus of fixing burnout on already overburdened and time-pressured physicians, have mostly had little or no enduring effect.[4]

Suggestions for improving the work environment have included improving patient flow, using scribes, enlarging workspaces, having a social worker readily available, flexible scheduling, more vacations, and an executive wellness officer.[5] Although many such changes have merit, they generally require protected time for the physician, additional personnel or space, and expense. Moreover, they would not address the underlying cause of burnout.

As with most maladies, finding a cure requires understanding the cause. In the case of burnout, the main cause is not nonresilient physicians or suboptimal work environments. Rather it is our failed health care system, a system characterized by impaired access to care, high and uncontrolled costs, and suboptimal quality care for many. These shortcomings stem from a dysfunctional insurance system and the invasion of the profit motive into what should be a public service.

The insurance system's dysfunction is attributable to the multiplicity of health insurers, their pursuit of profit, and the tethering of private insurance to employment. A multi-payer system leads to billing nightmares. The profit motive means insurers seek to decrease costs by restricting care through prior authorizations and narrow networks. Because private insurance is tied to employment, patients lose their coverage, and often their doctors, when they lose their jobs, or their employer switches insurers. As a result, physicians are deprived of the gratification derived from long-term relationships with their patients.

For-profit enterprises have procured many hospitals, physician practices, dialysis units, nursing homes, home health agencies, and other health care entities.[6] They prioritize their bottom line, a priority that often conflicts with physicians' obligation to prioritize optimal care.[7] The drive for profit, which has infected even many nonprofit health care organizations, has reduced physicians' clinical autonomy and changed their role from leaders to expendable, albeit it, highly paid workers.[8]

To address burnout, we advocate moving to a single-payer, nonprofit insurance system, eliminating patients' out-of-pocket costs, and removing the profit motive from patient care. We are not alone: A single-payer system has been endorsed by the American College of Physicians and the Society of General Internal Medicine. How might such reform mitigate physician burnout?

Access: Because everyone would be equally and well insured, there would be no need to check whether a patient had insurance, a drug was on their insurer's formulary, or a specialist to whom one wants to refer a patient was in the patient's network. No time would be wasted searching for charity care or workarounds for uninsured or underinsured patients. Prior authorization requirements would be largely eliminated, as they have in many nations. Billing would be streamlined, and billing personnel redeployed to facilitate better care. Coding would be simplified and documentation for quality metrics decreased. EHRs could be redesigned for patient care rather than billing, and current commercially driven impediments to interoperability reduced. With

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administrative tasks decreased, and EHRs made more user friendly, physicians could spend more time facing patients and less time interacting with a computer—both during and after visits.

Cost: Physicians' offices would not have to collect copays or determine if a patient had met their annual deductible. Physicians could prescribe medications, imaging studies, and ancillary tests without worrying whether a patient could afford them.

Quality: Freeing clinicians from administrative and EHR burdens would allow them to devote more time to their patients and to thinking and learning. Eliminating insurance-mandated changes in providers would facilitate long-term doctor-patient relationships, a better understanding of patients' priorities and concerns, and the avoidance of redundant workups that often result from breaks in continuity. Patients would no longer have to skip medications because of cost. The pressure to meet productivity targets would be reduced, decreasing one source of errors. Care would be directed by clinicians and not by bureaucrats and businessmen.

Converting to a nonprofit single-payer system will not be easy. For-profit medical enterprises will need to convert to nonprofit status and our multipayer system of insurance replaced by a single insurer, the federal government. Although a majority of the public and of physicians already support such reform,[9] congresspeople, many of whom receive large donations from the corporate medical industrial complex, will need to vote for it.

It is unrealistic to expect that burnout would completely disappear with single payer reform. Care of sick patients will remain emotionally and physically taxing in any health care system. Stress from maintenance of certification would continue. Although a single-payer system would help alleviate health disparities, caring for disadvantaged patients who face challenges the physician cannot fix, like homelessness, would continue to cause provider distress.

We recognize that our view is somewhat speculative as little hard data is available on the effects of single payer on burnout. However, a recent Canadian Medical Association survey offers optimism. More than 80% of Canadian physicians said that their emotional and psychologic well-being was high, and only 30% met criteria for burnout.[10] To verify whether the level of burnout is lower in a nonprofit single-payer system such as Canada, a study using the same questionnaire in both countries at the same time would be informative.

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