

Meaning and the Nature of Physicians' Work

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In a past era, the work of the hospital physician was done primarily at the bedside or in the adjacent wet laboratory. Residents had the opportunity to witness the unfolding of diseases (for which

we may now have cures) and to come to know their patients over the course of lengthy hospitalizations. The life was grueling and all-consuming — and those who took it up were almost invariably unmarried white men, with teaching hospitals actively discouraging marriage. Medicine was a fraternal order. Doctors' lounges were central locations where community internists, specialists, and surgeons ate together, socialized, and “curbsided” each other for patient consultations. Charts were kept on paper and were often indecipherable.

Every aspect of medicine and training has since evolved. Progress has been remarkably quick in some areas and painfully slow in others. The past 20 years have seen much debate over the amount of time worked by house staff. As residents' duty hours have changed, so has the nature of their work.

Typically in our field, internal medicine, residents arrive at the hospital at 7 a.m., get sign-outs from nighttime residents, and conduct “pre-rounds” to see patients they have inherited but don't know well, before heading to morning report or attending rounds. Attending rounds often consist of “card-flipping” sessions held in a workroom, frequently interrupted by discharge planning and pages, calls, and texts from nurses and specialists. Finalizing discharges before noon can feel more important than getting to know new patients. Increasingly, the attending physician doesn't see patients with the team, given the time constraints.

No longer are there paper charts at the bedside. The advent of the electronic era, while reducing the time required for tracking down laboratory or radiology results,

has not substantially changed the time spent with patients: recent estimates indicate that medical students and residents often spend more than 40 to 50% of their day in front of a computer screen filling out documentation, reviewing charts, and placing orders. They spend much of the rest of their time on the phone coordinating care with specialists, pharmacists, nutritionists, primary care offices, family members, social workers, nurses, and care coordinators; very few meetings with these people occur face-to-face. Somewhat surprisingly, the time spent with patients has remained stable over the past six decades.¹

The skills learned early by today's medical students and house staff — because they are critical to getting the work done — are not those needed to perform a good physical exam or take a history, but rather the arts of efficient “chart biopsy,” order entry, documentation, and sign-out in the electronic age. When a medical team gets notice of a new admission, it seems instinctive and nec-

essary to study the patient's record before meeting him or her. This "flipped patient" approach² has advantages, but it introduces a framing bias and dilutes independent assessment and confirmation of history or physical findings.

In short, the majority of what we define as "work" takes place away from the patient, in workrooms and on computers. Our attention is so frequently diverted from the lives, bodies, and souls of the people entrusted to our care that the doctor focused on the screen rather than the patient has become a cultural cliché. As technology has allowed us to care for patients at a distance from the bedside and the nursing staff, we've distanced ourselves from the personhood, the embodied identity, of patients, as well as from our colleagues, to do our work on the computer.

But what is the actual work of a physician? Medical students entering the wards for the first time recognize a dysjunction, seeing that physicians' work has less to do with patients than they had imagined. The skills they learned in courses on physical diagnosis or communication are unlikely to improve. Despite all the rhetoric about "patient-centered care," the patient is not at the center of things.

Meanwhile, drop-down menus, cut-and-paste text fields, and lists populated with a keystroke have created a medical record that (at least in documenting the physical exam) at best reads like fiction or meaningless repetition of facts and at worst amounts to misleading inaccuracies or fraud. Given the quantity of information and discrepancies within medical records, it's often impossible to discern any signal in the mountains of noise. Yet our entire health care system — including its financing,

accounting, research, and quality reporting — rests heavily on this digital representation of the patient, the iPatient, and provides incentives for its creation and maintenance.³ It would appear from our hospital quality reports that iPatients uniformly get wonderful care; the experiences of actual patients are a different question.

It's clear that physicians are increasingly dissatisfied with their work, resentful of the time required to transcribe and translate information for the computer and the fact that, in that sense, the work never stops. Burnout is widespread in the workforce, and more than a quarter of residents have depression or depressive symptoms.⁴ In response, health care leaders have advocated amending the "Triple Aim" of enhancing patients' experience, improving population health, and reducing costs to add a fourth goal: improving the work life of the people who deliver care.

A 2013 study commissioned by the American Medical Association highlights some of the factors associated with higher professional satisfaction. Perhaps not surprisingly, the investigators found that perceptions of higher quality of care, autonomy, leadership, collegiality, fairness, and respect were critical. The report highlighted persistent problems with the usability of electronic health records as a "unique and vexing challenge."⁵

These findings underscore the importance of reflecting on what our work once was, what it now is, and what it should be. Regardless of whatever nobility inhered in the work of physicians in a bygone era, that work was done under conditions and quality standards that would now be unacceptable. We practice in a safer and more efficient system with

measurable outcomes. Yet with the current rates of burnout, our expectations for finding meaning in our profession and careers seem largely unfulfilled.


We believe that if meaning is to be restored, the changes needed are complex and will have to be made nationally, beginning with a dialogue that includes the people on medicine's front lines. Perhaps the greatest opportunity for improving our professional satisfaction in the short term lies in restoring our connections with one another. We could work on rebuilding our practices and physical spaces to promote the sorts of human connections that can sustain us — between physicians and patients, physicians and physicians, and physicians and nurses. We could get back to the bedside with patients, families, and nurses. We could get to know our colleagues from other specialties in shared lunchrooms or meeting spaces.

In addition, we believe that in the coming years, the U.S. medical community will have to rethink the human-computer interface and more thoughtfully merge the real patient with the iPatient. We have an opportunity to radically redesign electronic health record systems, initially created for fee-for-service billing, as our organizations shift toward bundled payments, capitation, and risk sharing. Perhaps virtual scribes and artificial intelligence will eventually reduce our documentation burden.

But technology cannot restore our professional satisfaction. Our profession will have to rebuild a sense of teamwork, community, and the ties that bind us together as human beings. We believe that will require spending more time with each other and with our patients, restoring some rituals that

are meaningful to both us and the people we care for and eliminating those that are not.

Solutions will not be easy, since the problems are entangled in the high cost of health care, reimbursement for our work, and obstacles to health care reform. But we can start by recalling the original purpose of physicians' work: to witness others' suffering and provide comfort and care. That

 An audio interview with Dr. Rosenthal is available at NEJM.org

remains the privilege at the heart of the medical profession.

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Personal Health Budgets for Patients with Complex Needs

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Care for people with multiple medical conditions accounts for the majority of U.S. health care spending. Some of the highest-cost patients have functional impairments and social needs that necessitate long-term services and supports, and there is much debate about designing higher-value, more patient-centered services for them. One approach from England entails the creation of “personal health budgets,” a model for self-directed support that may be worth considering in the United States.

Current policy reforms in England mirror U.S. reforms, with a shift toward care integration and related payment changes. These reforms create financial incentives to better manage the care of patients with complex conditions. In 2015, a total of 50 sites in England were selected for the New Care Models program to deliver integrated care by groups of providers, using a single budget for a defined population.

Though these provider groups resemble U.S. accountable care organizations, one difference is their plan to use personal health

budgets¹: patients are given control over a budget to buy their own services, which can be defined more broadly than traditional care options, allowing patients to tailor their care to their situation. The approach is consistent with wider policy and English law, which in 2013 established a right to a personal health budget for people receiving long-term, complex care funded by the National Health Service (NHS). People with chronic conditions including diabetes, chronic obstructive pulmonary disease, Parkinson's disease, and serious mental illness have also been offered budgets. The average annual budget is approximately £10,000 (about \$15,000 at the time the program was evaluated), but budgets for patients with the most complex needs may exceed £300,000 (\$450,000).²

The approach relies on a goal-setting and care-planning process in which patients and their health teams consider medical and social needs. Patients determine their own service priorities but have incentives to pursue better-value care — a goal advanced by trans-

parency regarding spending. Patients and health teams negotiate a care plan within the agreed budget, which requires NHS approval.

Budgets are designed to meet all assessed needs and may be informed by the patient's historical and predicted costs for home-based, community-based, and other long-term care services. Access to NHS primary care and acute care services (hospital-based specialty and inpatient services) is not capped, and these services are excluded from the budget calculation.

Patients have considerable freedom in the services they can purchase with their budget. Most choose to spend the largest part on home-based support services, choosing whom to employ and for what functions. But the budgets also cover such services as transport, psychological and physical therapies, nursing, podiatry, and leisure and equipment that address a health goal.

For example, patients with mental health needs may reduce their psychologist visits and instead pay for help in securing stable housing. The parents of a