Opinion

Why Family Physicians Should Not "Just" Be Family Physicians: Rethinking Physician Roles in Community Health Centers and Beyond

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Primary care in the United States and around the globe is in crisis,[1] and retention of inspired, engaged physicians and other clinicians is a crucial piece of the fight to preserve and expand it.[2-4] Yet primary care physicians are suffering from epidemic levels of burnout. Attending to the well-being of those who deliver care should be a cornerstone of current health care reform efforts in America.[5]

A major cause of this crisis is an unbalanced clinical role that focuses predominantly on individual outpatient clinical visits and separates physicians from most organizational innovation and strategy, as well as the colleagues, staff, and communities they serve. We propose broadening primary care clinician roles through innovative time-budgeting, meaningful participation in quality improvement, changing reimbursement models, expanding group visits, and softening the divisions between clinical and administrative work.

In some settings, the cause of burnout isn't having too much work — it's having the wrong type of work.

Clinicians must be paid to *think*, not just to *do*.

Unfortunately, health care organizations, particularly those with great resource constraints such as community health centers (CHCs) and federally qualified health centers (FQHCs), have developed work cultures defined by a chasm between clinical and "systems-level" work.[6-8] Clinicians see patients and perform associated patient-level administrative duties, and administration and staff take care of clinic operations and innovation initiatives, such as projects involving community outreach, patient navigation, public health, access, and population management. Research on job satisfaction suggests that this approach is ill-advised, as it leaves physicians with decreased autonomy and multiple risk factors for burnout.

Maslach, in a comprehensive model of job satisfaction, explains that workers require a reasonable workload, control, rewards, community, fairness, and alignment with their values to remain satisfied and productive.[9] Yet physicians today have less influence and control over the conditions that govern their day-to-day practice experience, and the intrinsic rewards of their practices are decreased as a result. Continuous outpatient clinical work, including the electronic health record (EHR) tasks associated with it, isolates clinicians from their clinical colleagues,

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other staff members, and their friends and families. It also challenges the values that brought most primary care clinicians to CHCs and FQHCs, including a focus on social determinants of health, community engagement, and "whole-person care."[10-11]

Just a generation ago, our predecessors held vastly different roles. Those physicians saw their patients, ran their practices, rounded in the hospital, and worked in the community. The variety and autonomy made for a robust and satisfying combination. Although this system obviously had its flaws, including longer work hours, these physicians were anecdotally *less* burnt out than we are today. It is notable that the first study of physician burnout was not conducted until 2002,[12] as a response to a startling nationwide trend.

It is essential for all health care organizations to envision the clinician role as something larger than the day-to-day practice of seeing individual patients.

Many physicians and other clinicians are also teachers, artists, researchers, community organizers, authors, and leaders, and they were drawn to the idea of using these skills in primary care to improve the well-being of individuals and communities.[13-15] Many are academics uniquely positioned to bridge the divide between university health centers and the communities they serve. They have vital input for the short- and long-term strategies of health care organizations. However, we have observed these skills are significantly underutilized, especially in community health settings; those who are using them are at risk of having their "passion projects" seen as distractions from the "real" work of patient care.

Clinicians must be paid to *think*, not just to *do*. Many other graduate-level professions build in time for reflection, strategy, and quality improvement. Lawyers are not expected to bill 100 percent of their hours. Professors are not expected to spend the entire day teaching. And yet primary care clinicians' only built-in time for "thinking" is a brief window during which they are also expected to plan their schedules with nursing staff, review labs, answer phone calls, interpret studies, call consultants, and complete paperwork.

It is essential for all health care organizations to envision the clinician role as something larger than the day-to-day practice of seeing individual patients.[16] This larger role is a vital ingredient in physician retention, whether a particular clinician chooses to focus on teaching, quality improvement, health education, advocacy, or other areas.[17] It is also a vital component of training and preparing qualified medical directors and physician leaders for future roles for which they are currently often unprepared.[18] Physician engagement in practice improvement is good for the clinic and good for physicians.[19]

WHAT CAN BE DONE

Expanding clinicians' roles as we've described is not included in traditional organizational strategies to address burnout and thus represents a novel approach to addressing the burnout crisis.[20] The hard work lies in operationalizing the idea.

In each of our practices, we have observed and piloted promising opportunities, though the literature on this subject is slim. As a first and clear step, we must prioritize making clinicians key ingredients in quality improvement.[21-22] Most primary care practices have practice transformation efforts in progress, but most have little room for physician and other clinician input.

Second, physicians need clear and available options to diversify their roles and the capacity to take advantage of them. For example, expanded roles include protected time for weekly case conference and journal review, monitoring evidence-based practice, working with patient registries, developing health education efforts, serving on hospital or community boards, or educating and training staff. We might consider budgeting a fraction of each clinician's hours to "systems" projects of the clinician's choosing, with general guidelines but no specific prescriptions regarding how this time should be used (akin to the CME model). Some of our organizations have developed new programs and initiatives after budgeting just

two hours a week to a single physician over a six- to 12-month period. This amounts to just 12 days annually.

Third, we might consider offering group visits as a part of every interested clinician's schedule. We know group visits are well accepted by patients and clinicians and they improve patient outcomes.[23-25] By offering them we could empower physicians to act as facilitators of real health changes.

Support for larger roles for physicians cannot be in name only or reserved only for senior clinicians. We must move beyond the idea that it "costs" something any time physicians are not seeing patients, and understand these activities are part of the short- and long-term balance of costs and benefits involved in a sustainable clinical role. We must also consider the costs of *not* providing these opportunities. When we lose a clinician, everyone loses — the clinician, the clinician's family, the clinic, and most importantly the patients. FPM

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