A PCP's Call to Action: Addressing Professional Dissonance in Primary Care

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J Gen Intern Med 39(2):318–9
DOI: 10.1007/s11606-023-08368-0

It's a picturesque fall evening as I walk out of the inaugural narrative medicine session hosted for my practice: a cathartic night of dinner and dialogue about stories unique to "the PCP experience." Fifteen in attendance, ranging from newly minted faculty, such as myself, to those in their third decade. I was hopeful my colleagues would reinforce my excitement at the start of this new chapter. Yet, despite the beautiful amber glow of a New England sunset over the Charles River, I can't help but feel ambivalence. Grateful for the rich discussion and vulnerability that ensued, but keenly aware of the escalating challenges facing primary care.

We began by reading a *NEJM* perspective that details the painful reality of "the pressurized world of contemporary outpatient medicine… [where] there is simply no time to think [as we] race to cover the bare minimum".[1] With this piece as a nidus, the dialogue flows around the seemingly limitless barriers to care for our patients. Insurers and hospitals require shorter patient visits and higher volume, while increasing the administrative burden — as patients are becoming more complex due to an aging population, prevalence of chronic conditions, treatment advances, and worsening healthcare disparities. Time with patients feels inversely proportional to their complexity. I notice colleagues returning to clinical work outside of business hours, switching visit agendas to address time-sensitive issues, increasing referrals to subspecialists, and transitioning to part-time for work-life balance.

Like most internists with limited training in primary care, these issues resonate just a few months into practice. My new patient, "Sarah," is slotted for a twenty-minute visit to discuss "foot concerns." Hoping for something simple, I review her chart; "severe diabetes," "trauma," "homelessness." My heart sinks. I encounter a large non-healing foot ulcer that has been present for months. In thirty minutes, we scratch the surface of how to afford her copay and where to sleep. Defeated by the Band-Aid created — wound care and a podiatry referral — I mentally note to return to her chart at the end of clinic and shift to seeing my next six patients.

Received May 5, 2023
Accepted August 3, 2023
Published online August 24, 2023

Outside the clinic, these concerns are reinforced in my newsfeed: *The Boston Globe* details the rising instability of primary care leading to a "frightening" lack of access.[2] *The Washington Post* cites a study where an estimated 27-h workday is required to provide "appropriate, guideline-recommended" care in its aptly titled article, "*Why it seems like your doctor doesn't care about you*".[3] The message is clear: Outpatient doctors are undervalued, under-sourced, and overworked. Over 50 percent of US physicians experience burnout, with disproportionately higher rates among primary care doctors — a threat to the doctor, the patient, and a healthcare system with PCPs at the epicenter.[4] Consequently, more PCPs are transitioning to part-time or retiring early, and many struggle with a suitable work-life balance.[5] Thinking back to Sarah, I start to understand why. Facing situations where we cannot provide the high-quality care our patients deserve leaves a lasting psychological impact, otherwise known as moral injury.

To address moral injury, it helps to understand a root cause — *Professional Dissonance*: the discordance between professional values and the realities of practicing. Institutional priorities — such as compensation models and patient volume — conflict with providing high quality care. External factors include "unrealistic workloads," increasing "office work," impractical expectations of subspeciality colleagues, and unreasonable expectations from patients. Internal factors include feeling undervalued, a sense that work is never complete, and daily conflict between quality care and work-life balance.[4] These factors fuel the epidemic of burnout among PCPs, increasing moral harm and physician likelihood to leave their practice.[6] With this set-up, I don't know who should be more frustrated; myself, or Sarah.

Despite a failing system, there is still so much good. As a coworker said, "I do it for the relationships." Doctors are in a unique position to meaningfully impact the lives of others during their most vulnerable times — a privilege not lost on me. Tangled within the air of grievances live stories of patient connections and life-changing care through years of trust, communication, and deep connection. My joy comes from the glimmers I already see: The elderly patient inviting me to her family BBQ for salchichas; the severely depressed man smiling again after starting an antidepressant; Sarah making her two-week follow-up after connecting with social workers for compensated rides. This is where the reward is.

The grievances are not meant to denigrate the value of primary care, but to advocate for change. We need a systemic and systematic approach toward combatting professional dissonance including large-scale changes to address external factors of dissonance, and cultural buy-in to protect physicians from its consequence of moral injury.

For external factors, patient volumes and "office work" can be offloaded by incentivizing quality care over quantity. Short-term solutions include hiring support staff and providing time for non-clinical duties.[4] Long-term solutions are less direct, with one avenue centered around restructuring reimbursement models to redefine metrics that prioritize preventive health and inter-visit care while accounting for patient complexity. Granted, there is wide variety in US healthcare structures and conflicting priorities between for-profit insurers and providers. However, there is a lot to learn from existing models: Pay-for-performance (P4P) — attaching financial incentives to performance — has not been successful in improving patient metrics nor cutting healthcare spending. Further, it demonstrates worsening of healthcare disparities as clinics with socially complex patients are more likely to "fail" the metrics. P4P is a clear example of the need to redefine "high-quality" care, as it benefits insurer, provider, and patient.[7]

Addressing external causes of professional dissonance is time and resource intensive. In the meantime, PCPs continue to suffer from moral injury and burnout as we care for patients like Sarah. Targeting internal factors — feeling undervalued and overworked — at the clinic level may offer short-term solutions. Improving communication between clinicians and staff, implementing changes in workflow, and quality improvement projects in response to clinician concerns are shown to improve satisfaction and decrease burnout in primary care.[6] Additionally, artificial intelligence demonstrates huge potential ranging from assistance with documentation and patient outreach to data analysis. Lastly, we can foster collegiality and promote the PCP voice through safe spaces to debrief, such as my practice's narrative medicine session that ignited this personal reflection.

While I don't know the exact path toward a sustainable solution, I do know that *something* must change. And that change starts with dialogue. If healthcare companies and medical institutions increase the conversation around causes of professional dissonance and moral injury, we may find the infrastructure necessary to support meaningful, patient-centered practices — a model that universally benefits patients, providers, and institutions. A model that will support me and my colleagues in a long, fulfilling career.

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Declarations

Conflict of Interest *I have no conflicts of interest to disclose.*

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