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Perspective

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RVU Medicine, Technology, and Physician Loneliness

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The increasingly sharp focus in the United States on the business contours of medicine and the related use of a productivity lens for basing salaries on Medicare relative value units (RVUs) have left many health care providers disheartened. Young doctors, especially, fill the unforgiving minute with clinical efforts, keenly sensitive to substantial school debts, mortgage and car payments, day-care costs, and the modest increases made in the professional fee schedule over time. Furthermore, the administrative burdens of enhanced documentation (important for institutional billing and risk management) and various compliance-training sessions can add drudgery to a physician's diurnal tasks. Clinicians speak of long days delivering care with less time to talk to patients and their relatives, to colleagues, and sometimes to their own family members. Many of us sense the erosion of time for reflection, for inhabiting that uplifting, quiet place where we know who we are, where we are going, and what we hold to be true.

Socrates underscored the perils of an unexamined life. Yet for some physicians, a closely examined professional life would force a painful recognition of what's missing. Robert Pirsig, whose philosophical writing focused on quality and values, crystallized the problem decades ago: "We're in such a hurry most of the time we never get much chance to talk. The result is a kind of endless day-to-day shallowness, a monotony that leaves a person wondering years later where all the time went and sorry that it's all gone."[1]

Yet the institutional goals of abbreviating hospital stays and accelerating clinic visits are not the only factors feeding professional loneliness. Meaningful advances in technology have also levied a significant toll in the form of separation from patients and colleagues. The advent of online patient portals has generated increasing quantities of email communications, often in lieu of face-to-face discussions. Thanks to expanding digitization, we no longer need to engage our colleagues in the laboratory or radiology suite while on rounds or to discuss recommendations with a consultant: we can see the information we need right on our own computer screen. In the clinic, we can choose to type while taking a patient's history, rather than making eye contact. We're saving time. Yet when a patient becomes an RVU statistic, when professional dissatisfaction is evident, empathy suffers and patients too are left dissatisfied.[2]

Between patient visits, we may be tempted to squeeze in an email, send a text, or post on social media, hoping to connect with friends and colleagues. But these acts of outreach too fall short of relating. Nobody gets our undivided attention. Arguing that we need to reclaim conversation, psychologist Sherry Turkle remarks on the sad irony that "We slip into thinking that always being connected is going to make us less lonely. But we are at risk because it is actually the reverse."[3]

In the mid-1980s, I spent a sabbatical at the London School of Hygiene and Tropical Medicine, where I initially failed to see value in the half-hour ritual of teatime. But I soon realized that it meant the entire faculty and graduate student body assembled every day at various tables in one room, where conversations flowed, ideas were exchanged, mentoring flourished, and perhaps most important, trust grew.

Back in the United States, when I became president of the Medical College of Virginia Physicians practice plan, my London experience inspired me to lobby for a faculty dining room and retreat center, open 24/7, with free coffee and tea, and banks of computers available for clinician documentation. Its first-floor location in the main hospital and low-cost meals encourage lunchtime exchanges among basic-science and clinical faculty who might otherwise not have occasion to meet. An important catalyst for early success was the initiation of prerounding sessions by consulting teams in an open area. The resulting informal cross-talk among team members was facilitated by greater familiarity.

Sustained engagement in such a retreat center between senior administrators and physicians might unexpectedly boost institutional creativity and simultaneously invigorate professional life. Especially under the competitive business model of medicine, it is critical for health care centers to avoid polarization of clinicians and administrators. At some institutions, frank conversations are needed now to address hard choices — for instance, between an expanding and authoritative administration that seeks financial security by deploying strict RVU targets and an organization with broader sharing of values, rewards, and risks.

Since physicians contribute unequally to the clinical, administrative, and cultural missions of their medical center, establishing fair compensation for effort and success is a complex task. Hospitals and practice plans may want to systematically invite and invest in new ideas for accomplishing that task among other improvements, giving physicians "professional effort credits" for preliminary testing of innovative approaches to current challenges, buying time to experiment by relieving them of some proportion of their clinical work. Part of such an initiative might focus on ideas for improving connectedness among physicians, perhaps awarding higher priority to projects proposed by multidisciplinary teams.

Independently, institutions could instruct their information technology (IT) teams to work toward freeing up clinicians' time, for example, by studying the benefits and shortcomings of centralizing clinical billing with the goal of implementing such a system. Or, since the accuracy of pharmacy technicians in medication reconciliation has been shown to be similar to that of pharmacists, pilot studies of IT-assisted oversight of medication reconciliation by pharmacy technicians might examine the effects on patient safety, professional satisfaction, and institutional costs.

The provision of high-quality care requires empathy and connections with patients, but also novel and creative approaches and the wise use of new technology. Yet no new idea will simply materialize without our reflection. It seems high time to challenge the assumption that increasing the rate of patient encounters and thereby increasing income is always beneficial for hospitals, practices, and individual practitioners. Studies have shown that professionals are less likely to be motivated by extrinsic factors such as money and more likely to be inspired by autonomy, mastery of skills, and a sense of purpose. Currently more than 50% of early- or mid-career physicians acknowledge having work–home conflicts and professional burnout, and almost half of such physicians would not recommend that their children pursue a career in medicine. National trends suggest that burnout and satisfaction with work–life balance worsened among U.S. physicians between 2011 and 2014.[4] Continuing to operate under the assumptions inherent in our current business model has brought us to a crisis in job satisfaction; RVU medicine and technology have conspired to cause a kind of professional loneliness.

Traditionally, medicine was one of the most personally rewarding professions. Many of us are still inspired by the mysterious art of

making an elusive diagnosis or the ability to help patients cope with illness or injury; others are motivated by the discovery of new epidemiologic links that can benefit whole populations of ill people. Microbiologist Hans Zinsser said, "Infectious disease is one of the few genuine adventures left in the world. The dragons are all dead and the lance grows rusty in the chimney corner."[5] He could have been describing any clinical subspecialty. We haven't lost medicine; its best features have merely been clouded by false assumptions that obscure alternative paths to our ideals. I think we need uninterrupted time to reflect, to converse, and to grapple with the downsides of the unrestrained embrace of technology. Such steps could be the beginning of a journey to reclaim our profession and recapture our most treasured relationships.

Disclosure forms provided by the author are available at NEJM.org.

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Navigating Loneliness in the Era of Virtual Care

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He was younger than I was when we diagnosed the disease that would kill him. Even as the words came out — "There is nothing more we can do" — I felt drained by the weight of his life cut short and the guilt of my own good health. I sought refuge in the residents' lounge. Amid the cacophony of clicking keyboards came the support of my colleagues, offering that blend of empathy and distraction that only the trenches of residency can produce. The lounge promised rehabilitation. The achievement of personal milestones was amplified by collective experience, and shared pain seemed to wound less. At times like this, sharing the pain seemed to be a necessary tactic to survive. Whether it was the first time we made a mistake or saw medicine's limits crystallized in a patient we could do nothing else for, there was always a resident in the lounge who could commiserate, provide on-the-spot therapy, or just listen.

Post-residency practice, on the other hand, can feel much lonelier. Midnights in the ED are solitary affairs. Painful moments are no longer eased by shared experience. The burden of losing a patient, once made lighter by the shoulders of co-residents, now lies heavier on a single set of shoulders. And virtual care, which has connected us to our patients in more natural ways than ever before, can also leave us lonely, spending hours one on one with our computer. The most commonly cited reasons for burnout — increased paperwork, more quality metrics, and less time with patients[1] — reflect physicians' need for meaningful interaction. Doctors, for the most part, are social creatures. So the transition away from routine interaction with patients and colleagues and toward more isolated and individual activities has contributed to loneliness and resulting burnout.[2]

But what can be done? The realities of modern health care are such that many current drivers of loneliness are not likely to disappear anytime soon. Virtual care is an important attribute of the medical village in the 21st century — unlike periodic appointments, it connects patients and their care teams in ways more in sync with the dynamic needs of managing a clinical condition. The model of a team of doctors on night float, a great support system in what might otherwise be the most isolating of moments, cannot feasibly exist outside the training setting. Moreover, the draws on physicians' time also change as we move out of training and into practice. My primary social circle surrounds