Missing the person

Are preventive medicine and clinical practice guidelines contributing to physician burnout?

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My 40 years of being a family physician were filled with joy. Despite the occasional sadness of patients' stories and the crushing blows of hardships in their lives, more common was the remarkable resilience of patients in overcoming adversity. *Burnout* was not part of the common lexicon or of my work life.

We now live in an age of burnout. What has unravelled? Is a "fix" available from within family medicine? The strains of increased demand for and undersupply of family physicians are beyond individual physician control; however, changes in the nature of care are within our domain.

We have lost what both patients and family physicians see as our strengths: relationships, adaptability, listening, and dynamism.[1] Many years ago Dr Ian McWhinney wrote that family medicine adapts to the particular.[2] Ours is a discipline based on knowing the person and their sense of being known. In bowing down to clinical practice guidelines (CPGs) and to the tyranny of practice guided by billing and prevention rather than by a patient-directed agenda, we have abandoned the particular and, in the process, lost the joy of knowing, really knowing, the people who are our patients. While the rhetoric of family medicine is patient-centred—eg, *the woman with diabetes* rather than *the diabetic*—the gulf between actual practice and patient- and person-centred approaches has widened. This gulf threatens to undermine the longevity advantage of primary care–led medical systems identified by Starfield et al[3] decades ago and, I suggest, is a key source of declining practitioner and, perhaps, patient satisfaction.

Clinical practice guidelines and the disappearing individual

At their best, CPGs save individual clinicians from having to sift through evidence. They distill research and provide a standard template for diagnosis and treatment. Embedded in CPGs, however, is the frequent assumption of homogeneity and a lack of consideration of the culture, race, gender, setting, and values of the person with the illness and of the characteristics of the participants or subjects whose data underpin research findings that inform CPGs. Medicine's increasing reliance on a top-down, standardized approach absolves and even discourages practitioners from knowing the person, and it implicitly renders time spent exploring individual context and variability wasteful. Sackett et al's vision of evidence-based medicine as the intersection of patient values, clinical expertise, and best research[4] becomes narrower as at least the first and possibly the second of these 3 components is discounted. Patients are reduced to an age, sometimes a sex, and a set of signs and symptoms while their knowledge of self is seen as irrelevant and ignored or even dismissed. The physician's autonomous thought is replaced by the application of the right algorithm. Neither patient nor physician walks away satisfied, and that intangible strength of family medicine to produce better outcomes also slips away.[5]

Overly focused on prevention

In the name of prevention, and prompted to some extent by industry's push to find new precursors of disease for profitable treatments, family physicians spend more and more patient encounter time on a search for risks of disease or risks of risks.[6,7] Despite a lack of current suffering in a patient, potential and frightening diagnoses such as cancer are hinted at as the outcomes of nonadherence. Nevertheless, the benefits of many screening maneuvers have been called into question.[6,7] "At risk" labelling is creating a population of the "worried well," people who fear that their future is inevitably one of multiple chronic diseases as they wait for the sword of Damocles to drop. As Dr Iona Heath wrote in 2010, "When the prevention of disease begins to assume greater priority than the relief of suffering, something very fundamental begins to go awry."[7]

The responsible family physician could spend 7 hours a day delivering preventive guidance and testing[8] and causing frustration for patients whose appointment time is taken over by their provider's goal of getting through a risk checklist. Current screening guidelines reduce patients to demographic characteristics. The person disappears, becoming a 52-year-old male with *prediabetes* (which sounds so much more ominous than *normal blood sugar*) instead of an individual with stories, hopes, and concerns. Recommendations linked to a few demographic indicators preclude the need or the time commitment to know the person, as do standardized approaches to checking blood pressure, lipid levels, or blood glucose levels, along with many other such tests. Family physicians sense patients' increasing frustration and are caught between doing what they are supposed to do and feeling, somehow, both inadequate and irritated. Although not the sole ingredient, this is part of a recipe for burnout and one that family medicine can change.

Is it about income?

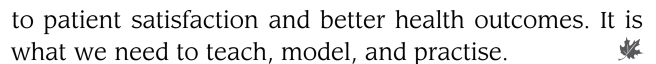
Clinical payments to Canadian family physicians have always and without reason been lower than those of other specialists.[9] This disparity has been blamed for the current shortage of family physicians.[10,11] I do not dispute that this inequity should be addressed, but I question whether money will fix the ever increasing levels of burnout I see among so many colleagues. I would suggest that some attempts to close the income gap may even have contributed to the family physician shortage. For example, in Ontario, the provision of various screening measures has been incentivized. Family physicians receive bonuses based on the proportion of female, transgender, and nonbinary patients between the ages of 50 and 74 in their practices who have had a mammogram in the past 30 months.[12] These payments drive practice focused on body parts and miss the essence of the strength and joy of—and the public's high regard for—primary care: that is, the interconnectedness of those parts in shaping the health of the whole person.[13]

In a health policy paper published in 2023, Stange et al state:

> [T]he combination of emphasizing access over continuity, expanding required checklists on electronic medical record templates, and compensating physicians on performance of a few selected disease measures, all work together to diminish the perceived value of the healing relationship and to create professional role conflict, moral distress, untenable data gathering and administrative burden, and burnout.[5]

Saving family practice and practitioners

Without evidence family medicine has no scientific foundation, but without patients' stories and values and our relationships with them we have only a single path to follow. This path optimizes neither health nor satisfaction for patients or physicians. Those of us who embrace a more person-centred approach often do so because, intuitively, it seems the right thing to do. Patients are people, a statement that would seem self-evident anywhere except in a scholarly medical journal. Individuals should be respected as such, rather than conceptualized as machines with potentially faulty parts to be identified and either fixed or replaced.[14] Scientific evidence is necessary but insufficient in guiding medical care if used in isolation. Rather than trapping patients by categorizing them according to diseases and risks devoid of human and social traits, we must open those categorical boxes and see who is inside. Knowing their stories, being known to them (and is this not why we chose for our specialty to be called *family medicine* rather than *general practice*?), bearing witness, staying "with" them over time—these are the aspects that make the specialty of family medicine special. It may also be part of the antidote to family physician burnout and the path back to patient satisfaction and better health outcomes. It is what we need to teach, model, and practise.



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