Physician Discontent

A Barometer of Change and Need for Intervention

Times have changed. Historically, physicians have been viewed as allies in improving health. Doctors have functioned with substantial autonomy, and have received significant societal prestige and reimbursement for providing a complex, socially useful job. Societal changes, including the growth of managed care,[1] increased accountability and requirements for documentation, burgeoning malpractice claims,[2] growing consumerism,[3,4] and an erosion of trust,[5] have changed the practice of medicine, and the relationships between patients and physicians.

At the beginning of the 21st century, many American physicians are discontented with their professional lives.[6–10] While professional dissatisfaction is clearly not new to physicians,[11] the causes and solutions have changed.[8] In this issue of *JGIM*, Murray et. al. demonstrate a significant decline in the professional satisfaction of primary care physicians in Massachusetts between 1986 and 1997.[12] To examine this trend, the authors compare two cross-sectional studies that incorporated identical questions about professional satisfaction. The most significant declines in satisfaction were related to the time spent with patients, autonomy in decision-making, and the availability of leisure time.

Studies have identified several facets of physician satisfaction: satisfaction with the quality of care; autonomy; compensation; relationships with patients; relationships with colleagues; and with the practice environment.[13–16] Work environment may differentially affect different domains of satisfaction. For example, physicians in closed-model HMOs may have lower satisfaction with resources than physicians in other settings, but they may be more satisfied with regard to autonomy in decision-making and administrative issues.[14]

Why is physician satisfaction important? Physicians may be more effective in their work if they are professionally satisfied.[17] There is an association between physician satisfaction, the quality of care that they provide, and patient satisfaction.[18–20] Dissatisfaction may contribute to poorer patient adherence.[18] Dissatisfaction also leads to job turnover and early retirement.[21] Both of these generate unnecessary costs associated with decreased continuity of care for patients, and the costs of training new physicians. Low professional satisfaction and high job stress are associated with more health complaints among physicians, and with the filing of disability claims by physicians.[22,23] Finally, the professional satisfaction of current physicians may influence the future supply of physicians.[24]

An understanding of the characteristics of physicians who are more likely to be dissatisfied may help to design interventions to improve physician satisfaction. Physicians who are younger,[13,16] female,[25] receive a lower income,[13] practice in an urban setting,[26] work a greater number of hours,[27] and perceive that the quality of care that they can provide is compromised[27] are less satisfied than their counterparts. Market and practice characteristics may also influence physician satisfaction. Physicians have had a strong negative reaction to capitation,[8,28] perhaps related to concerns of restricted autonomy and declining reimbursement.[27]

Interventions to improve physician satisfaction can be either local or more far-reaching. Since time constraints are one domain that is a current concern to physicians, one type of local intervention could be directed toward alleviating time pressures. In this issue of *JGIM*, Waterman et al. present an evaluation of a telephone-based anticoagulation service on the referring physicians' satisfaction with this service.[29] They report significant time savings associated with using this program, both for the physicians and their staff. This type of service offers many of the advantages and disadvantages of disease management programs.[30] While they may offer significant time saving, they can also cause a disruption of the patient-doctor relationship. Safeguards, like specific communication protocols, should be incorporated into these types of interventions. While utilization management techniques that curtail physician autonomy are negatively associated with physician satisfaction, the implementation of clinical guidelines is positively associated with satisfaction.[31] Other local activities could perhaps include programs to promote physician's self-awareness and expectations, since this may improve both professional satisfaction and the quality of clinical care.[32] While a variety of local programs are necessary to address the specific concerns of physicians in a particular system of care, broader attention to physician satisfaction is also necessary.

Times have changed and health care will continue to evolve. Physician discontent results from a mismatch of expectation and reality. While interventions are certainly necessary to improve the "realities" of practice in turbulent times, medical education should provide physicians with the skills needed to define and re-define their expectations.[33] Clearer expectations might enable better delineation of the causes of discontent, and allow for better definition of interventions to improve professional satisfaction and the quality of care.

Physician discontent is an important barometer in our evolving health care environment. While discontent may, in part, reflect discomfort with change and unmet

expectations, it also indicates areas for improvement and intervention. — **JENNIFER S. HAAS, MD, MSPH,** *Division of General Internal Medicine, San Francisco General Hospital, Department of Medicine and The Institute for Health Policy Studies, University of California, San Francisco, Calif.*

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