In the middle of the last century, the profession of medicine consolidated its identity firmly around an ideal: physicians were expected to be dedicated to the welfare of their patients above all other considerations, committed to the public good, and impervious to financial temptation or other self-interest. The insular training and long work hours that set the profession apart from most people’s experience further cemented this special identity. The past should not be unduly romanticized. Yet the professional ideal held a commanding presence, even when honored in the breach. Physicians enjoyed tremendous respect and trust from the public, and were granted near-complete autonomy and discretion in their work. By and large, they were delighted with their profession. Certainly, some physicians still feel the aura of a deep professional contentment that was more common in earlier, more idealistic times.

Today, medicine has more power to help people than it has ever had. We can be proud of transformative diagnostic and therapeutic advances, as well as large strides away from the elitism and prejudice that characterized some of our predecessors. Yet, although some argue that overall satisfaction with career choice has stayed roughly stable, more probing study suggests an accelerating discontent. The rate of burnout among American physicians increased from 45% to 54% just from 2011 to 2014, and half of residents leave their training already burned out. Some physicians believe that medicine is in decline, and would not choose medicine again, or recommend the profession to their children. The extent to which this attitude exists has not been well quantified through empirical studies, but may be substantial.

What happened to so change the medical profession? A lot. In most readers’ lifetimes, we have seen large changes in the practice environment, including the emergence of prospective and value-based payment systems, a rapid shift from independent small practice to employment by large medical groups and hospitals, increasing specialization, the growing role of nonphysician clinicians, the expanding presence of chronic disease and intensive care, a proliferation of quality measures, and burgeoning regulation and scrutiny by payers. Many of these changes have stemmed from efforts to advance the quality of patient care, but nonetheless have brought new frustrations for clinicians, such as increasing administrative complexity, large requirements for documentation, and the widespread deployment of electronic medical records that are not easy to use. Academic physicians face special challenges including increasing competition for research funding and the need to adapt to resident work hour limitations. Regardless of the value of some of these changes, in aggregate they represent an overhaul of the practice environment.

Have we paid enough attention to how these changes have affected physicians? In this issue of JAMA Internal Medicine is a review and meta-analysis by Panagioti and colleagues of interventions to reduce burnout in physicians. The findings are similar to those of another recently published meta-analysis by West and colleagues. Both studies demonstrate small but significant reductions in burnout, with widely varying interventions. Consistent with the hypothesis about the importance of changes in the practice environment, Panagioti et al found that organizational changes—including to physicians’ workload and schedule, evaluation and supervision, and job control—were more effective in reducing burnout than interventions targeted to improving physicians’ personal coping strategies. They note, however, that the organizational initiatives studied were rare and most often limited in scope, possibly because of the costs of delivering them. From a practical standpoint, it is likely that health care organizations can accomplish only so much in trying to reduce physician burnout, within the context of the broader and sweeping changes in clinical practice.

Given the sea changes in health care, what is perhaps most surprising is that so many traditions and characteristics of the medical profession have endured. But, closely related to changes in physicians’ well-being, the cohesive identity of the profession has frayed. Although physicians are expected to put advocacy for their patients above all other interests, they are now also increasingly asked to serve as stewards of costs. These goals often, but not always, align. Where many physicians once rejected commercialism, many now have relationships with industry, and by and large accept the idea that they can be “incentivized” to alter the care they provide by pay-for-performance programs. Where physicians once worked hours based primarily on the needs of their patients, they are increasingly in shift arrangements or, in the case of training, restricted in their work hours. Where physicians once cared for patients autonomously, they are now subject to oversight by employers and payers, and asked to follow standardized protocols. Although physicians were once unique, they now provide care side-by-side in teams, or in some cases in...
competition, with other types of clinicians. Physicians no longer enjoy unqualified trust: trust in the leaders of the medical profession has fallen to half the rate of 50 years ago.\(^1\) Some have even raised concern that medicine has been reduced to a trade, and is no longer a profession.\(^2\) Professional dedication, unity, and generosity of purpose was perhaps more easily rallied when being a physician felt decisively like a privilege and an honor for more physicians.

The membership of the American Medical Association—consisting of about three quarters of all physicians in the 1950s—has fragmented as specialty and local organizations have grown in importance, and today is closer to 1 in 5 physicians. Physicians have not surprisingly found it difficult to find a unified voice.

In 2014, Bodenheimer and Sinsky\(^3\) suggested expansion of the traditional “triple aim” for efforts to improve health care quality—population health, patient experience, and costs—to include a fourth aim: improving the work life of those who provide care. They pointed to evidence that this fourth aim is integral to the success of the other 3: poor work satisfaction and burnout are associated with lower patient satisfaction and adherence to care plans, inappropriate care, and overuse of resources. In addition, the well-being and work-life of those who provide care is important to the development and health of professional identity. Professional identity is perhaps the cornerstone of the quality of the care we give: it determines the expectations we hold of ourselves, and the people we attract into the medical profession.

*JAMA Internal Medicine* is launching a series, “Physician Work Environment and Well-being,” on the work life, well-being, and professional identity of physicians—and their relationship to quality of care. We invite submissions of original research (Original Investigations and Research Letters). We are also interested in scholarly Viewpoints, and will consider Reviews and Special Communications. If authors have questions about this series of articles or any other submission issues, please feel free to contact us. For guidelines on manuscript submission and preparation, please consult the *JAMA Internal Medicine* Instructions for Authors.\(^4\)

As we look in the mirror, should we again find strength in the traditional view of the physician, or is it time for a remodeling? Who are we, and how can we come together to advocate for a health care system that supports our identity and our best care of patients, now and for the generations to come? It is time to steer our own course, rather than ride the waves. We invite your contributions.

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