Meaningful and Meaningless Work among North Carolina's Family Physicians:

A Qualitative Investigation

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Introduction

"Meaningful work is why I get up and go to work. I mean, I love going to work knowing that there's gonna be meaning to what I do. Like, I could have a very hard shift, and I'll reflect on it on my drive home, and it's like, that was really hard and that was really difficult, but I know I made meaning in people's lives. So, like that is what powers me through burnout, empowers me through shifts, knowing that there's meaning to what I do." (P21)

This quote from one of our study participants captures an important truth: Meaningful work is deeply motivating. Scholars generally define meaningful work as the subjective experience that work has an existential significance (Lips-Wiersma & Wright, 2012). As such, experiencing meaningful work helps answer the question, "Why am I doing this job?" Research shows that having an answer to this question is critical for developing and maintaining desirable qualities such as self-efficacy, work engagement, and wellbeing (Allan et al., 2019; Both Nwabuwe et al., 2020; Mharapara et al., 2023; Steger et al., 2012). Finding meaning in work encourages individuals to reframe the negative aspects of their jobs as challenges, and it buffers them against exhaustion and cynicism (Allan et al., 2019). Yet, the meaningfulness of work is not always considered when designing jobs, professional roles, and broader work systems. Consequently, many aspects of the work environment can not only hinder meaningfulness but generate meaningless work.

In this study, we examine what makes work meaningful versus meaningless for family physicians working in North Carolina. The seed for the study was planted when Project Leader Tago Mharapara, who was in North Carolina on a Fullbright New Zealand Fellowship, met Rachel Keever (MD) at the 2022 North Carolina Institute of Medicine Annual Meeting. That initial conversation, in which Tago shared insights into the work he and his colleagues were doing on meaningful work in New Zealand's midwifery profession, led to further

discussions with Dr Keever and Mr Gregory Griggs (Executive Vice President—NCAFP) about the utility of researching meaningful (and meaningless) work among family physicians. Approximately one year later, Tago enlisted the support of Research Fellow James Greenslade-Yeats to launch a qualitative study exploring how North Carolina family physicians experience and respond to meaningful and meaningless work. In this report, we detail the methods, findings, implications, and limitations of that study.

Research Methods

Research Questions and Study Design

Our study was guided by three research questions:

1. What characterizes the subjective experience of meaningful and meaningless work for family physicians?
2. How do family physicians enhance the meaningful aspects of their work and reduce or cope with the meaningless aspects?
3. How does the organization and funding of US healthcare systems and organizations influence the experience of meaningful and meaningless work for family physicians?

We used a qualitative research design to address these questions. The primary strength of qualitative research is to reveal the rich and nuanced details of participants' experiences (Miles et al., 2014). Qualitative methods are recommended when the aim of research is to identify how the experience of a phenomenon is shaped by the specific context in which it unfolds (Gephart, 2004). Thus, qualitative methods were well suited to our aim of understanding how contextual factors (e.g., practice setting and funding models) influence the experience of meaningful and meaningless work for family physicians in North Carolina.

Participants

Upon receiving ethics (IRB) approval (AUTEC – 23/298) for our study, we recruited participants with the support of the NCAFP[1]. After learning about the study through advertising or professional contacts, participants made first contact with the research team by completing an online survey and consenting to be interviewed. Individuals were deemed eligible to participate if they were qualified family physicians with recent experience (within the last year) working in the profession in North Carolina. Most participants (n = 22) were

[1] The Academy's support was limited to advertising the study to potential participants. Members of the Academy did not have access to participant data at any point or influence data analysis in any way.

actively working as family physicians at the time of the study; one participant had recently retired from the profession, and another had recently moved into sports medicine from family medicine. Participants worked across a variety of organizational contexts, including independent private practice, corporate hospital systems, direct primary care, university-affiliated health systems, and government-subsidized health centers. A significant percentage of participants (33%) combined clinical work as family physicians (directly treating patients) with other paid roles and duties, including teaching, administration, and leadership. Table 1 provides basic demographic information about the participants in our sample.

Table 1: Demographic information of family physician participants (N=24)

Category	Statistic
Mean Years of Experience as a Physician	17.3 years (*SD* = 3.03)
Mean Hours Worked per Week	42.8 hours (*SD* = 3.54)
Education/ Training	
US Allopathic Medical School	59% (*n* = 14)
US Osteopathic Medical School	28.5% (*n* = 5)
International Medical School	12.5% (*n* = 3)
Mean Age	47.25 years (*SD* = 3.17)
Gender	
Female	46% (*n* = 11)
Male	54% (*n* = 13)
Ethnicity	
White	70.8% (*n* = 17)
Black or African American	8.3% (*n* = 2)
Asian	8.3% (*n* = 2)
Middle Eastern	8.3% (*n* = 2)
Mixed	4.2% (*n* = 1)
Relationship Status	
Married, Civil Union	70.8% (*n* = 17)
Single	12.5% (*n = 3*)
Separated or Divorced	8.3% (*n* = 2)
De Facto/Common Law Relationship	4.2% (*n* = 1)
Widowed	4.2 (*n* = 1)

Data Collection

We collected data from participants through semi-structured interviews, which we conducted over Zoom. Our interview guide covered the following topics: (1) the participant's background and work context; (2) the meaningful and meaningless aspects of work as a family physician; (3) the consequences and impacts of meaningful and meaningless work; (4) how the structure of US healthcare systems and funding models influences the experience of meaningful/less work; how family physicians enhance meaningful work and cope with meaningless work; and what family physicians would change about the US healthcare

system to enhance meaningful work and reduce meaningless work. On average, interviews lasted 56 minutes (range = 35 – 78 minutes). We recorded interviews digitally and transcribed them verbatim. Participants were given the opportunity to review their interview transcripts before analysis commenced.

Data Analysis

We analyzed interview transcripts thematically to identify overarching patterns that spoke to our research questions (Miles et al., 2014). We started by making notes about high-level themes during the data collection phase, which we continued until no new high-level themes emerged (Charmaz, 2006). Once we had our finalized dataset, we coded transcripts line by line to understand which high-level themes were best represented in participants' statements and stories. To support this process, we developed a coding framework which we constantly refined as we worked through all 24 interview transcripts (Charmaz, 2006). Concurrently, we refined our high-level themes to ensure they captured not only the common patterns in participants' responses, but also the nuances and complexities of the individual and contextual factors shaping participants' experiences of meaningful and meaningless work.

Findings

Our findings are presented under two major thematic categories: Meaningful Work and Meaningless Work. Within each of these categories, we explain and illustrate themes speaking to the common patterns, nuances, and complexities that make work meaningful versus meaningless for family physicians. To maintain anonymity, we use a numbering system when attributing verbatim quotes to specific participants: P1 = participant 1; P2 = participant 2; and so on.

Meaningful Work

"To me, that's like the luxury of being a family physician—you could take care of anyone and everyone that walks in the door. And that is something that (1) I'm really proud of, and (2) really, really, really gratifies me in the work that I do because I always wanted to be a doctor that could walk into a clinical room and feel comfortable with at least having an initial conversation with anyone, knowing that I am definitely not going to be the world's expert in, you know, kidney disease. I'm not going to be the world's expert in cardiothoracic surgery, and I'm totally fine with that. But I know that I could at least address basic needs medically for a newborn that's having difficulty in feeding, or, you know, one of my oldest patients, when she passed away, was 108 years old. And I could take care of anyone in between that spectrum. So clinically, that makes a lot of sense to me, and is really gratifying." (P16)

Meaningful work makes a difference

For family physicians in our study, work feels meaningful when it makes a positive difference to other people. Most commonly, those people are patients under physicians' direct care. As one participant stated: "I think what gets you out of bed in the mornings, what keeps you coming back to clinic when you go home thinking you had a good day in clinic versus a bad day in clinic, it usually revolves around the patients [and], you know, having good interactions with them. You're feeling like you make a difference" (P1).

Family physicians make a difference to their patients in myriad ways. They help manage disease processes, make critical diagnoses, support patients' mental health, assist patients to navigate the healthcare system, or simply improve patients' outlook on life. A key indication that family physicians are making a difference is that patients listen to, respect, and appreciate their expertise and views: "[it's meaningful] feeling like they value your opinion, and when you give your opinion, that it's heard at least, whether it's acted on or not, it's at least valued" (P1). An even clearer sign of making a difference is when patients achieve tangible outcomes in improving their health. For example, physicians commonly shared the stories of patients whose physical condition had improved significantly under their care, as in the following excerpt:

> She was severely underweight. She had a huge sacral ulcer when I saw her, in and out of the hospital, miserable all the time. Her daughter was taking care of her, you know, getting paid for it, having to take care of her all day, and I slowly got her off, like, most of her medications. We changed her medications around to help her gain weight, nutrition counseling, and she actually started doing so well that her ulcer healed, and her wound doctor even gave me props to her, which she passed on to me. (P2)

Physicians also stated that improving patients' health is even more meaningful when patients come from deprived or disadvantaged backgrounds. Our analysis suggests this is because underserved patients have the most to gain from primary healthcare—that there is plenty of room to make a difference in the lives of such patients. As one participant stated:

> What I find most meaningful is any part of my work where I feel like I'm making a difference in the health of people or communities that face health disparities. So, I would say of all those different things in my typical week, what I tend to find most meaningful is the half day that I get to work on those community based, participatory projects with community organizations that are working — like, one is

> with a community organization that provides doula care, both during pregnancy and in the postpartum period, for black families and other families of color in an effort to mitigate some of the effects of structural racism on pregnancy and maternal health and infant health. (P3)

In contrast, family physicians generally gain less meaning from their work when dealing with patients who do not value their expertise. These patients tend to have a transactional attitude toward their family physicians. They often make family physicians feel like “medical waiters” or “pharmacy assistants” by coming to consultations having “done their own research” and already knowing what they want in terms of prescriptions or referrals. This transactional attitude undermines physicians’ sense that they’re making a difference and, by extension, their experiences of meaningful work:

> So a lot of patients just see me, a family physician, primary care physician, really just as a gateway to them getting to the specialist they desire to see. And it creates a lot of expecting me to be just a medical secretary or medical waiter, and they come in and they, you know, they've already decided, they've done their research, and they want an MRI and a referral to an orthopedic specialist for their back pain, where I'm very competent at evaluating, diagnosing, and treating 80-90% of back pain. I can handle it. 80-90% of those patients do not need to see a specialist, don't need that MRI. But you know, I get a lot of those visits, you know, where they're just looking at me as the medical waiter. I'm the one who's going to make it happen for them. They're not interested in my judgment or my diagnosis or my diagnostic ideas or my treatment ideas. That's very unfulfilling and very meaningless. (P4)

Meaningful work is inherently relational

Interpersonal relationships are key to family physicians’ experiences of meaningfulness. Participants frequently discussed their relationships with patients as among the most meaningful aspects of their work: “The most meaningful part of my work is just the relationships with patients” (P6); “I think what's most meaningful are the relationships that I have with my patients and trying to build with them on things” (P7). Although patient relationships are important to physicians across specialties, family doctors are uniquely placed to develop longitudinal patient relationships: “I enjoy the relationships that I get to build with people over time. I particularly have an affinity for family medicine and those longitudinal relationships” (P9). For many family physicians, longitudinal relationships can involve multiple members and generations of the same family, making them even more meaningful:

> So that's an aspect and a beauty that I love, that I'm not sure every doctor gets to appreciate in their practice. I just really appreciate having that relationship with the patient, but also having had the relationship with maybe their parents and their grandparents. That's what makes medicine meaningful for me, to be able to sit down each visit and say, 'Hey, what college did you decide to go to?' Or …. It's that kind of [interaction]. So, it has nothing to do necessarily with disease, and it has all to do with the relationship with the patient. (P6)

> I've lived in the same community for 40 years, and the relationships I've developed with patients have been very rewarding, particularly since covid. You know, I didn't realize how much people valued their relationship with their physician until covid, because covid scared lots and lots of people, particularly those with healthcare problems, you know, and they'd come in and say, 'Well, if I get covid, are you going to take care of me, and what happens if I go into the hospital? Are you going to be there for me?' And then after covid, I've had a number of people that are my age — because I'm at the age now where I've taken care of 2, 3, 4 generations in the same family — and the older people in those families have come in since covid and said, 'You know, I just want to thank you for taking care of my family.' That's been quite rewarding. (P8)

Another unique feature of family physicians' relationships with patients is reciprocity. Participants in our study discussed how their patients reciprocated the care they provided by getting to know their physicians on a personal level, teaching them things, and even supporting them through difficult times:

> Over the last year, my husband passed away, and at the visitation of the funeral, his sons were there with me, and as we had the people coming in, the youngest one looked down at me and said, 'Gosh, I feel like half these people are your patients.' And I said, 'I think they are.' I mean, the outpouring of the patients in this community for me was amazing. And I think that goes to the relationship that I have with them, and that's what's meaningful for me. (P6)

A key reason patient relationships are important to family physicians is that they help physicians provide better care. Our participants cited both academic research and personal experience to support this claim:

> I think there're actually mounting studies that show that if you're a patient and you have more than a 10-year relationship with your physician, your health outcomes improve and the cost your medical care goes down significantly. And I think it's because so much of what you do in primary care is behavioral change, and so it's building trust, educating patients on how they can best care for their own condition. And so whether that is quitting smoking, eating a heart healthy diet, exercising on a regular basis, like, those things do not happen without some level of trust, rapport and relationship. (P9)

> I think most people have ideas about how they're being cared for. And, you know, those relationships help me gain a toehold, some credibility, so that when I'm making recommendations to them, they'll buy what it is that I'm trying to say. (P10)

Ongoing relationships enable physicians to understand their patients not only as "organ systems" but as "whole persons"—individuals whose health is shaped by unique social contexts and backgrounds. On this theme, several participants shared stories in which their strong personal connections and familiarity with patients helped make life-saving diagnoses. For example:

> I was taking care of this patient, and she came in and she said, 'You're going to think I'm crazy.' She had had cancer three times in her life, and it's because, as children, they were exposed to excessive radiation. And she said, 'I think I have cancer again.' And I said, 'Well, why do you think you have cancer again?' And she said, 'You're going to think that I'm crazy, but my dog keeps licking all of my saliva, and like, giving me kisses, and licking my mouth.' And so, like, that's a completely random thing. There's no medical — you know, in medical school, they didn't teach you that that's a symptom of cancer. And so I asked her a few other questions, but I trusted her, and I trusted her as much as she trusted me, and we investigated it further, and sure enough, she had thyroid cancer. (P9)

Control over time is essential for meaningful work

Family physicians view time as essential for developing trusting relationships with patients and, in turn, making a positive difference to their health outcomes. Thus, control over time is critical for family physicians who want to find meaning in their work. Yet, time is also among the scarcest of resources for family physicians, and many physicians work in highly time-pressured environments where they have little control over their schedules.

One participant—now a more senior physician—captured this notion when he stated: "Relationship is important in medicine, feeling that there's trust between myself and the patient, feeling like there's some mutual regard and respect between myself and the patient, and *it's difficult to do that on the fly in an assembly line fashion*" (P11; emphasis added). The same participant went on to talk about how the absence of time pressure in his current role enables him to find meaning in his work:

> The thing I like about the home health context is being able to take the time. I went out to see a new patient today for the first time, and it took me half an hour to review his chart in advance. It took me a little time to drive out there. I spent a little

> bit over an hour meeting him for this first visit and talking with his mother, and it probably took me, I would say, an hour and a half, actually, after the visit, writing up the report and updating his problem list and reviewing his hospital discharge summary and writing to various people who are involved in his care, to clarify certain points and to answer some questions that came up today. So, you know, if you roll it all together, it's probably close to three hours of extended time with the patient and with his chart. And I found that very satisfying, because I felt like I had a good grasp of his issues and was addressing the issues and was networking with other people who could contribute to his care in an effective way. And over my career, I've tended to gravitate towards positions where time pressure was not as great… I think that for people like me, trying to see people, complicated people, in the office setting under intense time pressure is just a non-starter. I don't think we do a good job. I don't think patient satisfaction is as high sometimes as it could be. I think provider satisfaction is definitely compromised. And I don't think the profession talks about this enough. (P11)

Another physician in independent private practice echoed these sentiments:

> I'm my own boss, and I know that is very different than many of my colleagues. I've just found that my job satisfaction increased greatly when I just had more control over my schedule. This is a stressful job. It's hard, but if I can have a sense of control over that, being able to maybe dial things back if things are getting too much, if I'm too stressed out, and finding myself not enjoying those relationships, I can take action and do something about that. (P4)

On the other hand, some participants feel they have very little control over their schedules: “So all the power lies with the operations team, so I have no say over who lands on my schedule. And yeah, I just have no power, so I see what I'm given” (P13). Such participants—who are generally at an earlier stage in their careers—often face pressure from their employing organization to see certain numbers of patients during paid work hours:

> So when I started out, they did like a ramp-up schedule of, like, starting with 12 [patients per day] and then with the goal in like six months to go to, like, 20 as my minimum, to meet the bare minimum salary pay that they guaranteed. I've actually asked not to be on the guaranteed salary, so I'm not beholden to those minimum requirements, because I'm okay with making less money. But they wouldn't let me. They were like, you have to make this much, and you have to see this many [patients per day]. (P2)

Participants with low levels of control over their time described how this undermines their ability to develop trust-based relationships with patients and, ultimately, to “get anywhere” in improving health outcomes:

> It almost feels like you're on this rat race, this wheel, or a treadmill, but somehow you're just going way too fast in a direction that you don't want to go… And the feeling was just horrible, like outpatient, just seeing so many patients, having to, like, review their record. You need double the time, but you only get, like, five minutes to review their record. The MA comes in, she tells you, you know, the report to which you're half listening because you're too busy doing something else. And then you see the patient, but you're typing the whole time, and you never really get to the core problem. I mean, you easily treat with a pharmaceutical. Anyone can do that, but you just never really get anywhere. And they just keep coming back, and then they go to the hospital because they're in acute or chronic heart failure. (P14)

Some physicians facing time pressures attempt to protect the meaning of their work by spending more than the allotted time with patients who need it. However, this typically forces physicians to run late and to sacrifice their own time by working beyond their paid hours:

> Starting at 1pm, I have all 20-minute slots. Because I'm in my first year, the organisation gives physicians a one-year ramp up phase. So, I started with seven in an afternoon, and now I'm up to nine in an afternoon. And eventually I'll be at either 10 or 11. So every three months, it goes up a little bit. And I'm generally — like today, for example, I was leaving at 5:45. So my last patient had booked for four o'clock, but I'm often running almost an hour behind because, you know, for example, today, someone came in and definitely had a stroke over the weekend, but decided not to go to the ER. So that kind of takes more than 20 minutes to argue and work up and decide about testing and what you do five days later. That type of thing comes in quite frequently. So the fallacy of 20 minute appointments is always present. (P15)

Meaning is enhanced by scaling impact

Work becomes more meaningful for family physicians when they can “scale” the impacts of their efforts to make a difference. Many participants in our study have gravitated toward roles in which they can make a difference not only to patients, but also to colleagues, employees, residents, and communities at large. Making a difference to these parties enhances meaning for physicians by enabling them to reach greater numbers of people through their work. A physician who divides his time between clinical and administrative duties explained this idea as follows:

> I think that there's a lot of power in the work that I do directly, where I can take care of the patients that are on my panel. But through the changes that I'm able to enact on a system, healthcare system level, now I can take care of millions of people across the state of North Carolina. I wouldn't be able to do that with just the direct clinical

> work that I do. So, to me, that's why I really, really enjoy fixing the problems that we have in healthcare, to make it so that it's more tangible and more accessible to people all across the state. (P16)

Physicians in our study scale the impact of their work in three main ways. First, they take on teaching duties, enabling them to reach patients indirectly by building residents' skills, confidence, and effectiveness. Teaching feels meaningful because it is not something that all doctors are capable of:

> So to me, the most meaningful [aspect of my work] is being able to make an impact on the learners and seeing evidence of some sort of success, just you know, seeing that development…It makes me feel like I'm making a difference, which is what I think maybe a lot of doctors would say about their care with patients. But I honestly feel like most average doctors could do the job that I do in clinic with their own patients, and they'd be fine. But not every average doctor can help a learner progress along in a certain way. So, I feel like that's what makes me feel more valuable to the residents… I feel like a lot of doctors can be a good doctor, but not every doctor can also teach. (P17)

Teaching also plays a critical role in ensuring that the family medicine profession is adequately staffed for future generations, and that newly qualified family physicians are trained in a way that promotes positive change at the system level:

> I think training people in a way that opens their eyes so that they're not just seeing patient after patient and adjusting high blood pressure medication, that they're actually engaging with patients, figuring out what matters to them and trying to figure out how they can have a positive impact on their life. I do believe that creating curricula and promoting those types of activities is really, really meaningful in changing the system. (P9)

Second, some physicians scale the impact of their work by moving into leadership and administrative roles. Here, they can advocate for systemic changes at the legislative level or directly influence organizational policies and procedures in ways that enhance meaningful work for themselves and other family physicians. For example, some participants used their expertise in information technology to support other physicians to become efficient and effective in dealing with the administrative burden of clinical work:

> I know that we have a lot of great doctors out there that are just burning out or not loving their jobs anymore. So, we've introduced AI tools. Our team has brought in AI tools, and has been kind of thinking outside the box on how to get the right support for our physicians to be able to do their job, and let our clinicians be clinicians. The kind of thing I find great joy in is when I hear of a physician saying, Man, I'm able to

> get home sooner because of whatever we've created for them. That makes me feel really good. That fuels the tank, or fills the tank, as you say. (P18)

> On the informatics side, being able to support physicians to achieve what we kind of jokingly call Pajama Time, Home Time, you know, time off the system, to adequately staff them through the population health side, and then to improve and teach them how to use their technology systems to buy them back the most important commodity to all physicians, which is time. You know everything you talk about at the end of the day, when you talk about burnout, when you talk about physician wellbeing, the common widget, the currency of the realm, is time, and being able to give that back to people to choose to spend it with their spouse, with their kids, in the gym, you know, having hobbies, going to church, whatever we can do to get them to have that freedom is rewarding. (P19)

Finally, some physicians scale the impact of their work by becoming involved in public health initiatives that go beyond their clinical roles. Participants often mentioned the limitations of treating patients directly in clinic, acknowledging that many patient health problems are strongly influenced by social determinants including access to healthy food, transportation, exercise facilities (and time to exercise), addiction support, and so on. A meaning-enhancing way to overcome the limitations of clinical practice is to initiate and support programs that improve health on a wider level. For example:

> I've gotten involved in a lot of projects over the years and made differences, and I've gotten to speak in various venues, present papers, you know, be creative. And you know, I'm involved in a large multi-county initiative right now dealing with the opioid crisis in our community. And I pushed a lot of different people in the county government and EMS - emergency medical personnel and technicians - and churches and primary care physicians to take the bull by the horns and, you know, help these people. And I have been in touch with somebody who is creating a database for us so we can follow these addicted patients and try to keep track of them. You know, I told the county manager recently, you can't fix the problem when you don't even have any data to know how many people you've got that are addicted, you know, you can't act on things you haven't measured. So again, it's all about being creative. You know, you're feeling you're creative, and you're helping people. (P8)

Meaningless Work

"So a lot of [meaningless work] has to do with the payment and the people at the top who are making money off of all this, and trying to make more money off all this. And, I mean, that's America, that's capitalism, that's what we run on, I guess. But I think that's the thing—a lot of Family Physicians aren't sort of capitalistic, you know, like we're in it to take care of patients, and we'd like to make a decent living and pay off our student loans in the process. Like we're not trying to become millionaires, you know, we just want to feel good, feel like we're doing good a job and taking care of people and helping people, and but also being able to be people outside of work." (P20)

Meaningless work is wasteful work

Family physicians associate meaningless work with wasteful work—tasks that take up time without contributing to the improvement of tangible health outcomes. Participants gave numerous examples of such tasks, most of which revolve around paperwork: note-taking for billing purposes, prior authorizations, box-ticking for compliance purposes, button-clicking to meet "meaningful use" criteria, and answering redundant MyChart Messages. One participant described how meaningless work shaped her decision to leave a corporate health system and start her own direct primary care practice: "I feel that I was just doing things for the system, for insurance, for billing. I wasn't effective. And as physicians, I would offer that we all just really want to be effective." (P14)

Participants acknowledged that not all paperwork is inherently meaningless. For example, some stated that notetaking can be important for transferring patient information between medical professionals, enabling more effective and appropriate care. However,

most participants agreed that the level of notetaking now required of family physicians has little to do with patient care and more to do with insurance companies' efforts to reduce their operating costs:

> So they outsource to people, like, somewhere in India, who do like all the chart reviews. So you have to be extremely detail oriented, so just tiny stuff like that's completely useless to any other provider. Like, I'm writing a note for insurance and not for other providers, which is really what you're supposed to do. (P2)

> The EMR [electronic medical record] is, in large measure, designed to support coding to support billing. And some of that is annoying. You know, being sure to enter all the problems that the system wants you to enter, and make sure you, you know, capture all the data that is needed for billing purposes. (P11)

In combination, meaningless tasks create an administrative burden on family physicians, eating up their most precious resource: time. As already discussed, time with patients is essential for physicians to do meaningful work. Consequently, the administrative burden of meaningless work creates a zero-sum tradeoff for family doctors: each minute they spend on meaningless work is a minute they can no longer spend on meaningful work. One participant described how button clicking to meet "meaningful use" criteria eats up valuable time:

> Meaningful use is things like, did you do a med rec, right? Like, check their meds, you confirm their allergies, maybe some other things that's considered meaningful. So, to show that meaningful use, you have to click those buttons under, like, review meds, but it's so many buttons, and you don't actually have time because you're trying to do other things that—I mean, you're constantly triaging just what's going to kill them next, right? So, you don't have time. So, you click a million buttons for meds, and you click a button for allergies that never actually works, and then you click other buttons. You have to do this for every patient without any presence of mind. You know, ideally, on paper, it sounds like it would be great, right, to do a med rec every time, but it's not. So it just takes so much time every single patient, just total bullshit, and it's just totally the most meaningless—"meaningful use" is the most meaningless use of time. There's a quote for you. (P15)

Meaningless work absorbs not only the time that physicians have for their patients, but the time they would otherwise have for themselves and their families:

> The meaningless work that we do in medicine just takes time, and the spillover effect is that the work still needs to get done. So, if I have to call an insurance company and waste a half hour to get a CT scan approved, well, that's a half hour I now no longer have, and I have to make up that half hour somewhere else, and that half hour is usually at nighttime or weekends. That's the spillover effect that the kids have seen. (P18)

The spillover effects of meaningless work have serious ramifications for individual family physicians and for the family medicine profession more broadly. Participants talked about administrative burden being a common cause of physician burnout and "churn." One physician believes that meaningless work is negatively affecting so many physicians that he has concerns for the future of the profession:

> I worry about the patients that I take care of and at some point, I've just got to let all that go, but I worry that there aren't going to be enough primary care physicians around to take care of people like me when I get older. And a lot of it has to do with the fact that, you know, they're burned out. You know, they're in practice for five or 10 years, and they're in a system that burns them out - system's failing them - and I have great concerns about that. (P8)

Meaningless work is driven by profit-seeking and dehumanizes healthcare

When asked about what drives meaningless work, most participants identified profit-seeking motives from insurance companies, pharmaceutical companies, and corporate health entities. Prior authorizations—which require physicians to seek pre-approval from insurance payers for certain treatment and diagnostic options—exemplify how profit-seeking engenders meaningless work. An early-career physician, who left an insurance funded military healthcare system to start a direct primary care clinic, shared a story about how prior authorizations have created absurd situations for physicians trying to treat patients:

> I've been on the drop zone with, like, one of my paratroopers that broke his ankle, and the thing's at a 90-degree angle, and I'm like, that needs an MRI and to go to surgery, like, tomorrow. And the MRI gets refused [by the insurance company] because they have to fail PT [physical therapy] for six weeks before they can get an MRI. It's like, what algorithm are you guys looking at that fails to say, like, an ankle at a 90-degree angle from the leg is worthy of surgery? You know? It's like, it's pointless. There's no brain. It's, like, lost its intelligence in the other system. It's all just entirely set up to serve the profits of the shareholders of health insurance companies and large health organizations. I mean, they have a fiduciary responsibility to those people—so it makes sense to them. But it's not made to benefit anybody else. So the huge struggle, like the lobbying you had to do in the fee for service system, the insurance system, to benefit your patients at all—it was just asinine and really discouraging. (P22)

Other participants echoed these views:

> The meaningless stuff—again, there's just the whole prior authorization thing, and it comes back to the payers. They're a profit motivated business. I mean, that's what they are. They're all —it's profit motivation. We get it. They're for profit. If they're not for profit, that's a lie. (P23)

Participants also stated that meaningless administrative work was harder to tolerate when it was clearly linked to profit-seeking motives: “I think that may be what bothers me the most is having to deal with or follow guidelines and rules and regulations that are thought up by people making money off of me.” One physician, who said he was thinking about exiting the profession due to meaningless frustrations such as prior authorizations, questioned at what point family physicians would refuse to tolerate the profit-driven system:

> Like, over 25 years I've seen the health insurance companies, just inch by inch by inch by inch, just like, no you gotta do one more thing. Just one more thing. Just do a little more thing. Just one more piece of paper. Just one more check, one more tick, one more click. Now, just, can you do it this way? No, now we need you to do it this way—to the point that these individuals who go to school for a ridiculous amount of years, who go into debt in order to become physicians, who are incredibly intelligent in the way that they understand the human body, are micromanaged to the point of, really, most of the time I'm spending with my patient is navigating the healthcare system. Some of it may be explaining, What is diabetes to you? Most of it is, How are we going to get your diabetes medicine to you? Why can you not see a nutritionist? And, What paperwork do we need to do in order to qualify for you to get your diabetic shoes that you need? And I have, out of the 11 employees I have, I have one full time employee that spends her entire day navigating the healthcare system, doing paperwork and navigating websites to approve medicines that would cost $4 to $5 per month. But it's this micromanagement, and that's absolutely meaningless work, and of course, it's also harmful to patients. It just delays—they do this to delay care, and it saves them money, and it creates more profit for them. But I wonder, at what point is there going to be a breaking point? At what point are physicians going to say, This is unacceptable? (P24)

A key reason family physicians struggle with meaningless work driven by profit-seeking is that it dehumanizes healthcare. Family physicians find meaning in the human-to-human connections they develop with patients, as discussed earlier. Yet, meaningless work creates barriers to human connection, encouraging physicians to view patients as part of a commercial system rather than a care system. One participant provocatively described this dehumanizing effect as follows:

> In the other system, I think it helps to understand who the patient is. The patient's not the customer. The patient is just the courier carrying the money. You know, the customer is whoever's paying the bill, and that's the insurance company, so the patient's almost the enemy, like the patient is the person making your life harder.

> Like, all I need to do is write these notes so that we can get paid. But now you're here sitting between me and my computer, where I could be writing the notes to get paid, right? So it makes you look at people—and you'll hear a lot of doctors say, like, 'I just realized I hate people.' But that's not true. Like, they hate things that obstruct their work, and they see their work as writing notes, because that's, in fact, what they're getting graded on and paid for. So, becoming resentful of humanity is part of burnout. (P22)

For physicians who resist the dehumanizing effects of corporate healthcare, meaningless work has serious on-flow consequences. Some experience spillover effects into their non-work lives, as mentioned earlier. More seriously, others succumb to a sense of moral injury, feeling like they are incapable of caring for patients in the way they should. For example, several participants felt that prior authorizations have been "weaponized" to block patients getting the treatments they need; they stated that this is because insurance companies want to create as many hurdles to expensive treatments as possible, to lower costs and increase profits. Yet, when treatments are denied, family physicians are the ones who must deliver the message to patients, which can make physicians feel culpable. The following interview excerpt illustrates this notion and emphasizes its damaging on-flow consequences:

> So, in the industry, there's this concept of burnout, and I don't agree with that term. The term that's much more appropriate is moral injury. These institutions, specifically healthcare insurance companies, create a scenario that, as a clinician, I can never be in an exam room, and have it be a win-win situation. There's always going to be a loser in almost any scenario with a patient. So, if I choose the best medicine for diabetes, the cost is going to be so astronomical that the patient's pocketbook loses. The insurance company might be angry because of the cost, but the pharmaceutical industry wins, so it's like a winner and sort of a - the patient's sort of neutral ground if they can afford it, maybe they hit the jackpot, and they have a lucky insurance company that covers an expensive medicine for this year, but next year, it's going to change its contract, and it's going to be expensive next year, but then I'm going to get dinged by the insurance company, and the insurance company is not going to encourage other patients to see me. Okay, I choose not to use the most expensive and best medicine. I choose an older medicine. Well, the patient's not getting the best care, but the insurance company is happy. It's scenarios like that that are always happening in exam rooms. And so when you're always picking winners and losers, it creates a moral injury, because you're this referee, unbeknownst to the patient. The patient has no idea, they're just like, 'I guess he's doing the right thing for me, the best thing for me.' But I'm constantly having to do that. Or if I pick a good medicine, but a medicine that I know is going to require paperwork, then my person that sits on the phone for hours on end, she's the loser, because I know I'm creating more pain and suffering for her, somebody who is in my office that I respect and don't want her to suffer. Um, and it's something that is not

> sustainable. At some point there needs to be an outlet. And so I think different clinicians cope differently, and one of the ways I cope is that I see less patients. Like I used to see patients five days a week, and then it was four days a week. Now it's three days a week, and then even, pretty soon it's going to be zero days a week, like I just don't want to keep putting myself in that situation - and I'm sure, well, I know other clinicians who cope in really unhealthy ways. And it's no good for the patient. It's no good for society to put really highly trained individuals in situations like this every day. (P24)

Coping with meaningless work is highly individual

Physicians in our study reported a range of strategies they use to cope with meaningless work. Certain participants have crafted their jobs and roles in ways that create time for meaningful work by minimizing the time they spend on meaningless tasks. For example, some use technology for assistance with administrative tasks, while others have outsourced such tasks by hiring scribes and administrative support staff. Many have simply reduced their face-to-face contact time with patients, which also reduces the accompanying administrative burden. Another group of participants has made even greater changes to their roles by starting their own direct primary care businesses. Under this model, physicians bill patients directly using a monthly or yearly subscription model. The participants said this model reduces the amount of meaningless work they do because they are no longer beholden to the billing requirements of insurance companies to get paid. In turn, this decreases their administrative burden, freeing up more time to interact with patients in meaningful ways:

> For example, a patient came in with chronic inflammatory prostatitis, young guy, and he's getting better. But that's not even what was most meaningful. What was most meaningful is that I got to spend time with him, and like, for example, during an appointment, I might have, like, a couple seconds where I just remember to breathe and remember to enjoy this time, and that it's so much better than my job as a resident physician and those type of interactions I had. (P14)

Other physicians cope with meaninglessness by dissociating themselves from their role in the system and focusing on self-care and their non-work lives as sources of meaning. These physicians believe that meaningless work is generated by the health system, and that it is beyond their control to alter that system. Accordingly, they accept meaningless tasks as inevitable, while trying to create boundaries and coping mechanisms that protect themselves and their families from spillover effects:

> I would say day-to-day, you just try and get through the day. But you do find yourself frequently dreaming outside your organization and looking at other stuff that might be out there. I mean, it just sort of it gets you to, I don't know, it forces you to look outside your organization at the way things are being done elsewhere. And because, you know, there's something out there that you might eventually be able to do, you just sort of bear with it and get through it. (P13)

> I accepted some days it's impossible to finish the notes, because it's depending on how many patients I see, depending on how complicated. Once I accepted that it's okay, some days I have to do it, then my anxiety level came down. Because previously it's like, 'I have to do it, I have to do it. I have to do it. That's all me.' But now it's like, I can do it. And now I learn to calm myself. And I said this, yoga helped me a lot too. Yoga, with the meditation, is what I have learned in the last three years. That's when the whole the way I look at things has changed completely. So now I enjoy yoga so much. That's why, when I come home, I don't worry about anything. Just go and do my yoga. So I'm more calm now. So when I'm calmer, then I'm more efficient. (P5)

Another strategy for coping with meaningless work is to reframe it as a way of creating meaningful connections with patients. For example, physicians might explain to patients how the system constrains their decisions and bring patients "on board" with them as they work through meaningless notetaking during consultations. This approach enables physicians to maintain positive relationships with patients by demonstrating that they are doing their best to help patients navigate the system:

> I'm attempting to be as intentional as I can about optimizing efficiency during the visit and kind of showing patients the work. So oftentimes, when sitting with patients, I used to think, 'Oh, gosh, I don't want them to see what I'm doing.' But then I realized, well, if I do let them see, then they'll see why I'm always running behind. Or, kind of truly what's involved in a 20-minute visit. So often when I'm with them in the room, I'm always on the computer, I kind of introduce myself, I badge into the computer, shake their hands and kind of get going. And I'm of that generation, right? Like I grew up with technology as part of how I became a human and also a physician. So I think I do a fairly good job with kind of eye contact and balancing the computer and this person, but I'm trying as much as I can in the visit to, you know, put in the refill, put in the mammogram order, like write to the specialist together, so they can kind of see that this too counts as caring, right? Like, this computer work is also how I'm taking care of them. (P15)

Finally, some physicians cope with meaningless work by actively pushing back against it. These physicians join advocacy groups that try to effect systemic change at the legislative level—for example, by talking to state legislators about the administrative burden and other issues facing family physicians and how these can be remedied:

> So I go to our government agencies and like, lobby to our, you know, Senators and Congressmen for the state saying, like, Hey, this is how this bill is going to affect us as physicians and like, educate them about the decisions they're making. So I feel like I get a lot of time with my colleagues talking about the issues that really affect us as a whole, as family physicians. I'm also on a board of directors, so I have been involved in these conversations for years now, and we talk about the same issues of administrative burden, payment, you know, payment for family physicians, reducing the burnout rates. (P12)

Some participants combine this active approach to coping with an acceptance that whatever change takes place at the system level will be slow and laborious. Thus, they cope with meaninglessness by finding meaning in their efforts at systemic change:

> I try to be more accepting of the system around me—of, this is the way it is, at least currently, and, you know, in the moment, it's not very helpful to get upset or mad or project it on other people. It is the system. Whereas I hope by doing other things—I do work with [a professional body] and work for kind of change overall… there's like an advocacy arm where we talk to legislators, we'll talk to insurance companies, to try to slowly bring about this change over time. And I think that is one of the more meaningful things I do, because I do feel like I am helping change the system, albeit very slowly over probably many years after my time. But there again, I think that's one way to kind of help with that. (P1)

Discussion

Our study of meaningful and meaningless work among family physicians in North Carolina has important implications for those involved in the profession. First, it highlights the importance of designing jobs and work systems in ways that give family physicians control over time. We found that time was the common denominator of meaningful and meaningless work: Meaningful work requires time, while meaningless work wastes it. Physicians with higher levels of time control are able to cope with meaningless work better, and to experience more meaning in their day-to-day activities, according to our findings. Yet, we also found that most physicians who have high control over time are those who have been in the profession longer and have achieved higher levels of seniority. A pressing concern for the family medicine profession is the generational shift in attitudes toward work-life boundaries. Many participants reported sensing a change in attitude among junior physicians, who are less likely to tolerate work impinging on their personal and family time. For junior physicians not overwhelmed by student debt, reducing FTE or workload appears to be a preferred option—although this response potentially exacerbates workforce shortages. We also found that junior physicians were more likely to experiment with alternative work models—especially direct primary care—that enable them to regain control over their time.

Second, our research shows that meaningless work has serious ramifications for family physicians and the profession. Participants frequently mentioned the spillover effects of meaningless work into family time, which contribute to work-life conflict (Dettmers, 2017; Greenhaus et al., 2006). Perhaps more concerningly, they commonly associated meaningless work with burnout (De Hert, 2020; Hiefner et al., 2022) and moral injury (Čartolovni et al., 2021). Whether these two conditions are related or interchangeable is a matter of debate (Dean et al., 2019). Either way, meaningless work that creates barriers to effective treatment of patients is a key driver of both conditions, according to our participants. A key conclusion of our work, therefore, is that “meaningless work” can be not only wasteful but actively *harmful*. This finding emphasizes the urgency of decreasing the administrative burden on family physicians and removing barriers to effective care, especially prior authorizations.

Third, our study suggests the drivers of meaningless work are predominantly systemic and are controlled by interests outside the family medicine profession. For clinicians, most meaningless tasks stem from insurance companies' efforts to reduce costs and increase profits, according to our participants. Moreover, participants stated that the time pressures preventing family physicians from finding meaning in patient interactions (e.g., daily patient quotas) are typically imposed by managers who approach healthcare from a business perspective. These findings suggest managerialism—the belief that management systems can be applied across industries without consideration for specific contexts (Klikauer, 2015)—is an overarching problem in family medicine. In turn, the findings imply that an effective means of addressing systemic drivers of meaningless work would be to advocate for more representation by family physicians in management and leadership positions in primary care organizations, especially corporate ones. Many participants also suggested that wholesale changes to the funding model underlying the US health system would be necessary to truly address systemic drivers of meaningless work. At the same time, these participants were generally skeptical that such changes will be realized without significant resistance from those who benefit from the current system.

Finally, on a more hopeful note, our research shows how intrinsically motivated most family physicians are to find meaning in their work. While some may dissociate themselves from their roles in what they perceive as a meaningless system, most participants in our study find ways to not only cope with meaninglessness tasks, but to actively enhance the meaning of their work. For example, physicians reframe meaningless computer work as a way of connecting with patients, and they find meaning in their efforts to address the systemic drivers of meaningless work through advocacy and lobbying. The strength of family physicians' intrinsic drive to find meaning suggests the profession is not lacking the political will to effect meaningful change. Family physicians continue to view their work as deeply important and meaningful and wish only that the system would not create so many barriers to providing quality care:

"I feel like, being a family physician, it's such meaningful work. And, you know, these meaningless frustrations get in the way and are distracting us from the meaningful work, you know. And that's really

hard. I think more than any other specialty, we're providing excellent care and medicine and guidance, but we're also helping patients connect to resources in the community. There's one of my friends who is a social worker, and one day, she's like, 'I get it. Family doctors are the social workers of doctors.' And I was like, 'Yes, I think you're correct.' You know, we're looking at the whole person. We're looking at the whole family. So, you know, we already have such a wide view of not just all the physical body systems, but the micro systems and macro systems around the individual—and that's kind of already an all-encompassing, really big job. And then when you just start throwing rocks in of like, 'Oh, it can't go that way. You can't do it that way' —you know, it's just a barrier to caring for patients and doing a good job."(P20)

Limitations

Readers should keep in mind the limitations of our study when considering our findings and conclusions. First, our findings are based on a qualitative study involving a relatively small sample of family physicians (N =24). Participants self-selected for the study by making first contact with the research team. As such, we cannot be sure the sample is representative of family physicians across the state of North Carolina, even if we ensured thematic saturation when collecting data (Charmaz, 2006).

Second, due to the interview-based design and small sample size, we cannot draw firm conclusions about how much time physicians spend on meaningful versus meaningless tasks on average. We suggest future research could provide valuable insights into the breakdown of meaningful versus meaningless work across different care settings by using a quantitative design, such as a diary study in which participants track the time they spend on meaningfulness versus meaninglessness work over the course of multiple days or weeks.

Third, because of our small and self-selected sample, we could not conduct rigorous cross-case analysis comparing the experiences of family physicians working in different organizational settings and models of care (e.g., corporate health systems, versus independent practices, versus academic health systems; or relative value unit systems, versus value-based care, versus direct primary care). We suggest that future studies could fruitfully explore such differences by purposively sampling physicians working in these distinct settings and models.

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