

Burnout isn't personal— It's structural

Change comes from eliminating inefficient work systems and introducing tools to better manage those systems.

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All through medical school, we were warned about burnout. There were lectures on resilience; mindfulness workshops; and the occasional wellness session reminding us to take breaks, breathe deeply, and remember our purpose.

During residency, those messages felt oddly detached from reality. On long call shifts, my colleagues and I survived on caffeine and whatever snacks we could fit into our pockets. We were told to take better care of ourselves, to be more mindful, to breathe through it. But something felt off. We were being given tools to manage ourselves, not the work.

I promised myself that things would be different once I was in independent practice. They weren't.

When I finished training, I assumed that overseeing my own practice would make things easier. I thought autonomy would translate into fewer headaches. Instead, I found myself just as tired, if not more so. Not from clinical work, but from a steady drip of small administrative tasks that filled every gap in every day.

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As physicians, endurance is built into us. It is how we get into medical school. It is how we survive long days and nights, physical discomfort, and the emotional weight of caring for other people. We learn early how to push through exhaustion and keep going. That ability serves us well in many parts of medicine.

But once I was in practice, I realized I was using that same endurance to tolerate something else entirely. Instead of questioning why the work felt so heavy, I pushed through. I told myself this was just the cost of the job. That this was what I had signed up for. The low-grade fatigue from scheduling problems, missing forms, repeated phone calls, and fragmented workflows became background noise. It felt normal. It felt inevitable.

That assumption is powerful. It allows poorly designed systems to persist without being questioned. We compensate. We adapt. We keep going. In the process, we absorb inefficiencies that do not need to exist.

Measuring the invisible workload

A few years into practice, I noticed how much administrative work had crept into my clinical time. Charting, scheduling, and follow-up coordination routinely spilled into evenings and weekends. Even on days when clinic ran smoothly, I felt behind. My MOA was equally stretched, juggling phones, documents, and interruptions that never quite stopped.

This did not feel like a personal failing. It felt like something was wrong with how the work was set up.

What made it harder to name was how invisible the problem was. The schedule could run on time. Patients could be seen. And still, the day would end in exhaustion. It was not one big thing. It was the accumulation of many small, preventable frictions that had quietly become part of the job.

I began paying attention to a very specific signal. Whenever I felt a particular kind of irritation, the buzzing frustration that comes from redundancy rather than complexity, I wrote down what I had just been doing. It was not the irritation of a complex diagnosis or a difficult conversation. It was a physical feeling that built up quietly over the day, and if it went on long enough, it would tip into a dry cough. My staff eventually started calling it my “paper-work allergy” cough.

That buzzing feeling showed up in the same situations again and again. Re-entering information that already existed. Manually creating files for referrals that had already arrived. Discovering eligibility issues only after a visit had happened. Over time, the pattern became obvious. This was not the irritation of medicine being hard. It was the irritation of work that did not need to exist.

Once I started writing these moments down, I could not unsee them.

Rather than treating these frustrations as personal weaknesses, I approached the clinic deliberately as a quality improvement exercise, loosely following a plan-do-study-act approach. Over several weeks, my MOA and I tracked how administrative time was spent during the clinic day. We recorded how long common tasks took, noted when work was interrupted or repeated, and

logged follow-up tasks that arose because information was missing or incomplete. In parallel, I kept a simple running list of moments that triggered that “paperwork allergy,” treating it as a signal of redundancy or unnecessary effort. Working together, this gave us a practical map of where administrative time accumulated and which steps generated the most rework.

Redesigning instead of coping

We did not set out to overhaul the clinic. The goal was simply to stop carrying work that did not need to be carried.

Wherever possible, we stopped manually overseeing tasks that could happen reliably without us. Information was entered once instead of being gathered and re-entered. Appointments were booked and confirmed without phone calls. Eligibility was checked automatically instead of being discovered late. Referrals and faxes triggered patient files in the background instead of sitting in an inbox waiting for someone to download, name, and upload each document by hand.

None of this changed the clinical work. It changed how much clerical supervision the day required.

Visits no longer began with a scramble for missing information. The day was interrupted less often by problems that could have been prevented. Each change was small. Together, they made the work feel different.

What changed was not just a handful of tasks. It was the constant background work of searching, reminding, resending, and compensating. The quiet mental effort of remembering what was missing, who needed what, and which loose ends were still floating around. The small acts of administrative heroism that made the day run but left no trace once they were done. When those things disappeared, the work felt lighter in a way that was hard to measure but impossible to miss.

Not all of this work needs to be done by clinicians or their staff. Some of it is simply work that should not be manual in the first place. There are systems designed to handle scheduling, intake, documentation,

and verification more reliably than humans can, especially at scale. Using them thoughtfully does not replace clinical judgment. It removes the need for constant supervision of clerical steps that add no clinical value.

Within weeks, clinic days stopped bleeding into evenings. Interruptions dropped. The work felt more contained. For the first time in years, I could close my laptop at the end of the day and actually feel done.

What this changed

The exhaustion I had been calling burnout felt different once the background noise quieted. It was not that medicine had become easy. It was that it no longer felt unnecessarily hard.

I do not think this is about resilience. Physicians already have plenty of that. I think it is about design.

In health care, it has become normal for a substantial portion of physicians’ working time, often estimated at about one-third, to be consumed by clerical and administrative work rather than patient care.¹ Much of that work exists to compensate for fragmented systems, not to deliver medicine.

In most fields, a system that routinely consumed this much professional time through duplication and rework would be questioned. In health care, it often is not.

Reclaiming that time is not just about physician well-being. It is about patient access. Every hour spent clicking boxes or chasing missing information is an hour that is not spent seeing patients.

How this can be replicated

This approach does not require specialized tools. It can begin with a defined observation period of 1 to 2 weeks, during which the goal is not to fix anything but simply to notice it. During that time, track how administrative work enters the day. Write down each recurring task, how often it appears, and whether it interrupts clinical work or generates follow-up.

Next, group these tasks into broad categories such as scheduling, intake, document handling, eligibility issues, and postvisit follow-up. Pay particular attention to tasks

that involve duplication, re-entry of information, or repeated back-and-forth, as these are often the highest-yield targets.

From there, choose one or two processes to redesign. Make small changes rather than sweeping ones. Test them, observe what improves or breaks, and adjust. The goal is not to eliminate work but to reduce rework, interruptions, and unnecessary supervision. Revisit the system regularly, as workflows tend to drift back toward complexity over time.

A shift in perspective

I did not set out to optimize workflows. I set out to survive. What started as self-defence became a different way of looking at my work.

Making the system quieter changed how I showed up. I listened better. I felt less rushed. My patients noticed.

The work did not become meaningful because it was more efficient. It became sustainable enough to keep doing.

I am not advocating for a single solution. Every clinic’s reality is different. But the mindset is transferable. Notice what creates that buzzing sense of pointless effort. Write it down. Look for patterns. Ask whether the work is necessary, or whether it is compensating for something that could be redesigned.

We cannot meditate our way out of structural problems. If we want healthier clinicians and better access for patients, we need systems that work with us, not ones that rely on our endurance to hold them together. ■

Competing interests

Dr Baldwin is a physician advisor for Cortico Health Technologies. The views expressed in this article are her own.

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