For Primary Care Doctors, Constant Pivots Take a Toll

Kelley Butler
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When Dr Ishani Ganguli leaves clinic, she tries to leave the day, too.

The primary care physician makes a point of finishing her patient notes before she gets in the car. On her drive home, sometimes she calls her mother or listens to a podcast. Sometimes, the act of driving away in the quiet gives her what she needs most: an emotional shift.

“The time on that drive creates this sort of transition, which I find is therapeutic,” said Ganguli, MD, MPH, an associate professor of medicine and health services researcher at Harvard Medical School and Brigham and Women’s Hospital in Boston.

That 20-minute buffer can be valuable after an afternoon spent caring for patients whose issues can move from grief to glucose levels within minutes.

One patient’s mother died and grief has given way to depression, “and then a moment later, I need to pivot to routine screening or discuss a cholesterol panel,” Ganguli said.

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She calls that breadth of experience “emotional whiplash.”

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But clinicians can blunt some strain by creating small moments of transition

between patients and finding ways to process difficult encounters rather than carrying them to the next patient. Health systems can help, too, by reducing unnecessary cognitive load and building in staffing, workflow, and team support that make those resets possible.

Reset What Doesn’t Register

For whiplash to register, clinicians first must notice the impact each encounter has on them emotionally — something medicine trains them remarkably well not to do, said Jessi Gold, MD, MS, a psychiatrist for healthcare workers and chief wellness officer at the University of Tennessee System in Memphis.

“We’re all really good at being there for someone else through their hard stuff but not being affected by it — at least in the moment,” Gold said. Primary care clinicians learn to be “both empathetic and removed,” — capable of sitting with a patient’s pain without being overcome by it in the exam room. A physician delivering a chronic diagnosis should be human, but the patient shouldn’t have to manage their doctor’s emotions, too, Gold said.

The trouble comes with what happens afterward.

“You just kind of think you’re not supposed to react,” she said. “We don’t deal with [emotions] in real time and kind of hope we never have to,” she said. “And things don’t work out that way.”

She compares buried emotion to holding a beach ball underwater. Eventually, the ball bobs back up — sometimes weeks later, in an emotional reaction completely disconnected from the event that caused it.

What often adds more strain to practicing medicine are factors that surround encounters, said Liselotte Dyrbye, MD, MHPE, a general internist and senior associate dean for faculty well-being at the University of Colorado School of Medicine in Aurora. She has spent more than two decades studying the work environment of physicians.

“When you have a lot of task switching, your cognitive load [illegible]” she said, noting that high cognitive load is strongly associated [illegible] occupational stress and burnout.

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Dyrbye said the acuity of the patients she cares for in primary care has risen during her career. Years ago, a relatively routine visit might sit between two complicated ones, providing a cognitive break. Now, nurses and advanced practice clinicians can handle many straightforward needs, leaving primary care physicians with a more consistently complex patient load.

As a result, “there’s not that cognitive reprieve in between,” she said.

Primary care clinicians also face increasing work outside the exam room: inbox messages, documentation, and prior authorization battles with insurers.

“The part that’s really, I think, hard for physicians [because it means] we can’t give patients the care that we think they should receive,” Dyrbye said.

Somewhere to Put the Day

Ganguli sees packed clinic schedules as contributing to overload. Even 10 minutes between visits could allow a physician to finish a note, answer a message, and present to the next patient without mentally carrying unfinished business from the last one, she said.

Gold suggests clinicians look for transitions small enough to fit inside the day. Her own therapist once invoked Mister Rogers, who famously came home, changed his shoes and put on a cardigan — creating a visible boundary between one part of his life and the next.

Clinicians need their own version of putting on the cardigan, Gold said. It could be a commute like Ganguli’s. A few breaths while washing hands between patients. Journaling after work. Or simply stopping long enough to ask, “How am I actually doing?”

“If you just go patient, patient, patient, patient and then the next day patient, patient, patient,” Gold said, “you never have a point where you go, ‘Well, that was a lot.’”

Organizations have responsibilities, too. Dyrbye suggests physician leaders push for fair workload distribution, peer support, effective [illegible] the measurement of burnout, rather than waiting for turnover, safety

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problems, or behavioral changes to reveal that something has gone wrong.

Research suggests those working conditions matter. Burnout reached 42.8% of family physicians in 2022. Physicians who reported having an appropriate amount of electronic health record work to do at home and had highly efficient teams showed substantially lower odds of burnout. The observational study cannot establish causation, but its authors identified teamwork and health record workload as potentially modifiable factors.

The goal, Gold said, is not for primary care clinicians to feel every patient’s pain in full nor is it for them to feel nothing. It’s to make room, eventually, for the person beneath the white coat to acknowledge that they were in the room, too.

“The best doctors forget sometimes. They just don’t show up for themselves,” Gold said.

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Workload Rises for Primary Care Docs as More Patients Take GLP-1s

Lambeth Hochwald
November 04, 2026

While we’ve reported extensively on how taxed primary care physicians are these days with the endless paperwork loop, charting, and electronic health record management, the widespread patient use of GLP-1s has changed the very nature of the primary care visit. Recent data reveals that 1 in 8 Americans (12%) are taking a weight-loss drug.

The reasons doctors may be overwhelmed vary, but the fact that some patients are self-referring, requesting specific drugs by brand name, or arriving at the office already on a regimen started elsewhere has added to the workload primary care physicians face.

In fact, whether patients order these medications via telehealth, at a medspa, or a compounded formulation from an online telehealth platform, such as Ro and Mochi Health, which offer weight-loss programs as well as prescriptions such as semaglutide and tirzepatide for a few hundred dollars per month in membership fees and the cost of the medications, more management is required.

Doctors often must untangle how patients got on the drug, where they got it from, whether it’s the right medication or the appropriate dose, among other issues. It has become an unexpected outcome and added burden to the patient visit.

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Medscape continually surveys physicians and other medical professionals about key practice challenges and current high-impact analyses. For example, in Medscape’s New Drugs in

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- 41% of doctors surveyed felt they will see a significant increase in prescribing GLP-1s.
- 33% reported they are currently very familiar with oral semaglutide.
- The share of employer insurance plans covering GLP-1s for weight loss and diabetes has hovered around 35% for the past 3 years, but changes are occurring.

“When a patient comes in on a GLP-1 that I didn’t start them on, it’s crucial to understand who prescribed it, whether they were offered any lifestyle support, and whether their other medical conditions and medications were reviewed to make sure the treatment was coordinated appropriately,” Jonathan Bonnet, MD, clinical associate professor at Stanford University School of Medicine in Palo Alto, California, said.

That’s just the beginning. “What I do next is to find out if whoever prescribed the medication talked about the risks and benefits, including whether they’re the right person for this medication to begin with,” Bonnet added.

Complicating matters is that what often happens during an appointment is that patients may reveal that they’re on these medications minutes before their annual exam is over, said Shannon Dowler, MD, family medicine physician in Asheville, North Carolina, and an American Academy of Family Physicians board member.

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“I’ve had many experiences where we’ve spent the entire appointment

dealing with three or four other things, and then the patient says, ‘By the way, I need you to fill the GLP-1 medication someone else prescribed,’” she said. “This is challenging because we want to talk to patients about these medications in the context of broader health and wellness. These are deep and thoughtful conversations, not ‘by the way’ conversations.”

The Cost of Compounding

Interestingly, while the learning curve of how to do the injections — the delivery mechanism for many of these medications — tends to be easy for patients to understand, what many patients may not know is that there are risks to filling these drugs via online sources or compounding pharmacies, especially if there are multiuse vials needed to administer the medication, Dowler said.

“There is the risk of contamination if patients use a vial multiple times,” she said. “There are also risks to using medications that aren’t FDA-approved, as there’s been reports of counterfeit medicine, and the product may have been shipped in a way that doesn’t preserve the drug.”

Understanding how patients are paying for these drugs adds another challenging layer because many insurance companies don’t cover the cost of these diabetes medications for weight loss.

“There are so many insurance companies and different plans, whether it’s a high deductible or a government-funded one,” Dowler said. “Trying to sift through what medicine can be covered and then doing all of the prior authorizations and appeals can be incredibly time-consuming for a clinical team.”

Adjusting the Meds Takes Time — and Communication

Unlike other legacy drugs, such as blood pressure and cholesterol medications, the GLP-1s require way more follow-up with primary care physicians, especially when patients have just begun taking them.

“When we start a patient on one of these drugs, it takes 5 minimum to adjust that dose and monitor side effects,” Bonnet said. “It can

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be even more resource intensive when you need to meet with a patient regularly to monitor them — for primary care doctors it’s a lot to see someone every month.”

If patients aren’t coming in regularly, they may also alternatively rely on email communication to share how they’re doing on the drug — another time-intensive dialogue.

“We want to track how patients are doing, offer modifications, and support them in their journey,” Dowler said. “Sometimes there’s a lot of portal activity, however, if patients want to titrate their dose up faster. You might have five to six conversations going on through the portal, and these can be difficult conversations if a patient is having side effects. That’s time you’re using on top of your already busy patient care schedule.”

Interfacing with the pharmacy as doses get titrated adds even more to a primary care physician’s daily responsibility.

“If you have a big clinical care team, these requests can be handled much more easily,” she said. “I call this hot potato medicine where the pharmacy doesn’t want to dig in because they’re busy, too, so they’re calling us, we’re calling insurance, they’re calling us back — in one big loop.”

Ultimately, Carlos Arias Morales, attending physician in internal medicine at SBH Health System in the Bronx, New York, who serves on the board of the American Board of Internal Medicine, says the time allotted for visits with GLP-1 patients should be expanded.

“We’re required to ask a lot of questions to make sure they understand what the medication is that they’re using, along with the side effects,” Morales said. “It’s important for us to create a plan not just for the medication but also for the other things that go along with weight-loss management, such as exercise, diet, and strength training.”

In the end, these medications have created new opportunities to manage obesity, but primary care physicians remain tasked with much more ongoing management than with other medications.

“Patients may come to the office for diabetes managemen deciding they want to start a GLP-1,” Morales said. “That conversation

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requires an appropriate evaluation, counseling, and follow-up. We’re also handling insurance authorization and making sure there aren’t interactions with the other medications they’re taking. In the end, the challenge is finding ways to add to our workflow without compromising how we manage these diseases.”

The experts cited in this article had no relevant disclosures.

Lambeth Hochwald is a New York City-based journalist who covers health, relationships, trends, and issues of importance to women. She’s also a longtime professor at New York University’s Arthur L. Carter Journalism Institute.

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