COMMENTARY

The Real Driver of Burnout: The 1.2-FTE Problem

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The work of a clinician rarely ends in the clinic. Consider a typical outpatient clinician: They are employed at 1.0 full-time equivalent (FTE) but effectively work 1.2 FTEs. This is the 1.2-FTE problem: a full-time schedule plus a routine, invisible second shift of administrative work. This problem is so pervasive that it has normalized the concept of "pajama time," referring to uncompensated after-hours work done at home, but seldom prioritized it with ownership and routine measurement. Traditional methods for addressing clinician burnout are myriad but often scratch the surface and are ineffective, failing to acknowledge the root cause of the problem. It is imperative to recognize that such a widespread problem is systemic in nature and not an individual failing. This viewpoint has been reiterated by the National Academy of Medicine (NAM) in its 2024 National Plan for Health Workforce Well-Being, which emphasizes a multidisciplinary and systems-based approach to address burnout (NAM, 2024). The focus must shift from simply coping with the problem of burnout to treating its root cause: the 1.2-FTE problem.

Quantifying the Second Shift

Individual experiences vary, yet clinicians are acutely aware of this "second shift" and almost all experience it to some degree, but find it difficult to articulate. This is not an abstract concept; the burnout rate in health care has been steadily increasing for several years. Depending on the specialty, 30 to 50 percent of physicians report symptoms of burnout, with primary care on the high end (Mohr et al., 2025). Health care has devolved into a rising tide of tension between clinical productivity and a relentless flood of administrative work. Administrative work insidiously accumulates by default, with insurance denials, appeals, and prior authorizations adding another layer to a long list of tasks that are invisible in the productivity metrics used by the system to determine clinician value. One study showed that on a per-visit basis, primary care clinicians spend a median of 6 minutes on pajama time and 8 minutes on their in-basket (Rotenstein et al., 2023). Extrapolating to an average of 18 patients per day, that translates to a median of 108 minutes of pajama time and 144 minutes of in-basket time per clinic day. The exact times are derived from median values and vary based on schedule mix, but the central point remains.

There is also distressing evidence that this problem has spread to graduate medical education: One survey showed that 33 percent of responding family medicine residents spent 3 or more hours per night working in the electronic health record (EHR; Barr et al., 2024). Unsurprisingly, such after-hours EHR usage by residents was found to correlate with career dissatisfaction, increased symptoms of burnout, and a decrease in in-training exam scores (Barr et al., 2024). Instead of solving the problem or easing the burden, burnout has been integrated into physician training. Pajama time is not routinely made transparent or tracked; instead, it is invisible work that clinicians are resigned to do daily and it can decimate morale very quickly. If time off is spent catching up and clearing an in-basket, then it is not really time off. A 2024 study showed that of the physicians who took vacation time during the calendar year, 70 percent reported working during their vacation days (Sinsky et al., 2024). That is not a sustainable model for workforce stability. The 1.2-FTE problem is one of the primary causes of burnout, and it is not getting better. Clinicians have

become so fatigued that many consider reducing their work to part time in order to solve the 1.2-FTE problem (Horstman, 2024). Administrative work is crowding out clinical work.

How Did It Get So Bad?

Why has administrative work spiraled out of control? Part of the problem is the lack of clinicians in leadership positions. Administrative bloat flourishes when no one who owns the work experiences the work. Physician leadership is associated with lower burnout; the remedy starts with leaders who shadow, measure, and fix the work they ask others to do (Spilg et al., 2025). Organizations can focus on addressing burnout by reducing administrative bloat and improving morale: Burnout is one of the highest contributors to clinician turnover, and turnover is costly. Reducing administrative strain and addressing burnout should be regarded as an investment in the organization and its workforce. Each physician departure costs an organization hundreds of thousands of dollars and even a modest reduction in such attrition generates outsized returns. Estimates show that it can cost an organization several hundred thousand to nearly $1 million to replace a single physician; a figure that should command much more attention from health care leaders (Banerjee et al., 2023; Dyrbye et al., 2017). And yet, the correlation between increased administrative work, burnout, and high turnover has not been prioritized; administrative work continues to accumulate via inertia. EHRs have only compounded this problem. For some clinicians, it seems like the in-basket has become the primary focus of their practice. Systematic reviews have directly linked burnout and increased EHR usage time, yet relatively little has been done to tackle the problem (Wu et al., 2024).

Reclaim Clinician Time

Solving the 1.2-FTE problem requires a deliberate, systemwide commitment from leadership. The NAM's *National Plan for Health Workforce Well-Being* succinctly describes a "well-coordinated plan that provides the government, health systems leadership and governance, payers, industry, education, health workers, and leaders in other sectors with the tools and approaches required to drive policy and structural changes" as the first step toward substantive change (NAM, 2024). The change process begins with a simple premise: Engage directly with clinicians to understand the work. From there, organizations must build a framework of accountability and investment. Introspection is key: There is a dire need for organizational self-reflection. When was the last time a health care organization audited how much administrative work has increased for clinicians over the last five years and the steps taken to reduce that work? At its core, the job of any health care organization is to deliver health care; yet it is not possible to do that effectively when clinical work gets pushed aside by administrative work. Reducing burnout is not a luxury, it is a financial and operational imperative.

Health care leaders must stop thinking with a quarterly mindset and look to the long term for stability and sustainability. Below are areas to focus on when starting the process of change.

Experience the Work

Leaders can shadow or work alongside clinicians for a minimum of five full days each year to embed with their workforce in a variety of settings and specialties. While formal time studies and productivity metrics are valuable, there is no substitute for direct observation. Understanding the real-time burden of clinical care, documentation, and in-basket management fosters empathy and informs better decision making. Executive "WalkRounds" have been described since 2003, primarily to improve patient and workplace safety rather than explicitly to measure administrative work (Frankel et al., 2003). Even so, when leaders log feedback and close the loop with follow-up action and communication, rounding and shadowing are associated with reductions in burnout (Sexton et al., 2018). Log opportunities for administrative work

reduction and follow up on previous initiatives with the people doing the work. Pajama time must be experienced firsthand to be fully understood.

Audit the Work

Organizations can perform a system-wide audit to quantify the administrative work burden of clinicians and staff, and track how this work has changed over the last 3–5 years. Establish a dashboard for metrics, such as physician turnover, pajama time, percent paid time off days with EHR activity, and in-basket minutes. These data can be readily collected via the EHR, making the work visible. Such audits track administrative work reduction and allow tracking of long-term trends to assess the efficacy of administrative work reduction initiatives. Atrius Health used this strategy to measure in-basket messages by folder to establish a baseline and implemented an "eliminate/automate/delegate/collaborate" system to cut overall primary care physician messages by 25 percent, with specific category reductions of 30 to 98 percent (Fogg and Sinsky, 2023). Establishing a baseline allowed for an accurate assessment of the impact of the project on reducing in-basket work.

Designate an Administrative Reduction Officer

Health systems can designate a senior executive whose explicit role is to reduce and streamline administrative tasks. Without leadership accountability, inefficiencies persist by default. This role would be empowered to coordinate across multiple departments, challenge unnecessary requirements, and elevate ideas from frontline staff. Many organizations have adopted the role of a Chief Wellness Officer to address clinician well-being; adding administrative workload reduction to this portfolio is a logical extension of the role (Ripp and Shanafelt, 2020). This executive could publish a report twice yearly detailing various administrative work reduction initiatives and results, letting the workforce know that reducing and streamlining administrative work is an on-going, high-level priority.

Establish a Feedback Mechanism

Create a simple and widely accessible process for employees to submit ideas for reducing wasteful administrative work. The people doing the work are often the ones with the best ideas on how to reduce waste. Health care systems can encourage innovation and ideas that reduce low-value work and increase efficiency. Submissions should be reviewed regularly and seriously. Feedback loops like these not only generate actionable ideas, they also signal that clinician and staff time and input are valued. Hawaii Pacific Health implemented a campaign inviting staff to nominate low-value EHR steps for removal. This campaign was designed to solicit staff feedback to identify and remove extraneous and redundant in-basket messages. The aptly named "Getting rid of stupid stuff" campaign saved the system about 1,700 nursing hours per month, illustrating how staff feedback alone can reduce wasted time (Ashton, 2018).

Leverage Technology

Health care as a field must leverage emerging technologies early on to its benefit so it reduces the burden on clinicians, rather than adding to it. Artificial intelligence (AI) is an exciting field that offers promising tools to offload in-basket messages, automate prior authorizations and appeals, and reduce low-value manual work. AI-based ambient documentation tools have developed to the point where they meaningfully reduce documentation burden (Ma et al., 2025). These AI tools capture the patient–clinician conversation, analyze it, and generate a structured draft note to be placed in the EHR for review and approval. A 2025 randomized clinical trial preprint found that use of an AI scribe led to reductions in burnout, work exhaustion, and task load (Lukac et al., 2025). At Kaiser Permanente Northern California, ambient AI scribes at scale reduced pajama time and documentation time, leading to approximately 15,700 saved physician hours in one year (Tierney et al., 2025). These tools should alleviate workload strain, not add to it, and tools that do not do so should be retired within a reasonable amount of

time. It is important to have strong governance in place in the initial implementation phases to make sure the focus on reducing workload is not lost.

Fund Administrative Reduction

Administrative work reduction should be a budgeted line item, not an afterthought. Allocating explicit funds toward automation, workflow redesign, staffing, and documentation tools embeds this priority into the organization's culture and shows that it is a serious priority. Acknowledge the short-term cost with a view to long-term gains. Given that replacing a physician can cost several hundred thousand to nearly $1 million, even reducing turnover by one or two physicians a year yields significant savings on replacement costs (Dyrbye et al., 2017).

Conclusion

The 1.2-FTE problem is not just pervasive; it is an active threat to workforce stability. This administrative inertia, though invisible on a balance sheet, is the defining struggle for many clinicians and a primary source of dissatisfaction. Health care leaders must stop treating burnout as a personal failing and start recognizing it for what it is: a systems-level failure. The 1.2-FTE problem is unsustainable, not just for clinicians, but for the future of health care. Measure it, assign it ownership, and fund its reduction; the 1.2-FTE workday must end.

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