exemplified by amicus briefs submitted in the *Skrmetti* case. At the heart of these efforts must be the lived experiences of transgender and nonbinary people, whose voices are critical to shaping equitable policies and driving impactful research.

The stakes are clear, and the urgency is undeniable. The policies being implemented in many states and proposed at the federal level lack scientific justification and fail to align with the ethical principles of medicine. Restricting access to care, dismantling nondiscrimination protections, reducing research funding, and eliminating collection of SOGI data will deepen disparities and further marginalize transgender and nonbinary people. Yet this moment presents an opportunity for positive action — a chance to reaffirm our commitment to equity, advocacy, and justice. Together, we can build a health care system that helps afford people of all gender identities the opportunity to thrive.

An audio interview with Alex Keuroghlian is available at NEJM.org

Disclosure forms provided by the authors are available at NEJM.org.

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Evidence-Based Work Design — Bridging the Divide

Marisha Burden, M.D., M.B.A.,[1] and Liselotte Dyrbye, M.D., M.H.P.E.[2]

U.S. health care is at a critical juncture. The shift of physician practices to employment models, coupled with the growing corporatization of health care, has contributed to organizational decision making that often prioritizes short-term financial gains at the expense of patient care. This environment runs counter to the values of health care workers (HCWs) and fuels widespread workforce problems, including high rates of HCW burnout and moral injury and erosion of safety culture, and has contributed to the impetus for recent HCW unionization efforts. Many of these challenges stem from modifiable work structures, processes, and environments that originate from organizational decisions and are therefore preventable.

"Administrative harm" — defined as adverse consequences of administrative decisions within health care that affect work structure, processes, and programs — is pervasive and often overlooked.[1,2] Though the term is relatively new, the concept is not: research and analyses suggest that administrative harm has long contributed to the substantial challenges faced by HCWs as well as to problems with patient safety and the quality of care.[1-3] Financial and productivity considerations frequently dominate decision making within health care, particularly when it comes to decisions about work design, including team structures, and resource allocation. This focus may be attributable both to a lack of evidence-based practices for optimizing work design and to organizations' short-term financial imperatives, though it may actually cost them more in the long run. Financially driven decisions in this area contribute to a growing divide between frontline HCWs and organizational leaders, perpetuating mistrust and misalignment within organizations.

Bridging this divide requires a new approach to achieve better outcomes. In clinical medicine, evidence-based practices inform decision making, as clinicians apply lessons from the best available research alongside their clinical expertise.[4] But despite the direct effect of organizations' administrative decisions on job demands and resources, as well as subsequent organizational outcomes — such as patient safety, health care quality, workforce retention and well-being, and operational and financial outcomes — there's no equivalent evidence-based approach on the administrative front. Although heavy workloads are associated with worse patient out-

comes as well as HCW burnout, there is no clear consensus on what constitutes an optimal workload. Similarly, there's no established optimal team structure to provide guidance in answering questions such as when to utilize a physician, an advanced practice clinician, or a team comprising both — questions that are becoming critical in the current health care environment. These knowledge gaps lead to challenging debates between financial and clinical leaders. Even more concerning is that decisions stemming from these discussions can inadvertently but directly contribute to harm, hence the urgent need for an evidence-based strategy.

Evidence-based work design integrates the best research findings, clinical and administrative expertise, data-driven practices, and rapid, iterative, outcome-based improvements to guide decision making, aligning job demands and job resources — key drivers of outcomes in workforce studies[5] — with actual outcomes. The outcomes, in turn, create a feedback loop, generating insights within the local context that enable refinement and adaptation of practices and shape future decisions. To guide effective broadscale change, work design should build on the rigorous, adaptive methods from fields such as implementation science, systems science, quality improvement, and design thinking and incorporate insights from occupational health. Developing and implementing evidence-based work design approaches will require a multipronged strategy that acknowledges the complexity of the health care environment and the dynamic interconnections among HCWs, patients, administrators, culture, resources, policy, reimbursement, and finances.

To build momentum toward evidence-based work design, an innovative research agenda is needed. Much of the current relevant work involves observational studies, but though these have value, changing organizational behavior requires even more robust studies. Some innovative approaches, such as rapid randomized controlled trial methods, could provide timely insights into work design. In some cases, trials may not be an optimal approach because of operational or safety challenges. Alternative approaches, such as simulation studies that play out hypothetical scenarios to predict how changes in workloads or staffing would affect critical outcomes, may also be informative.

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To advance research and expand the evidence base, targeted funding mechanisms will be needed and should prioritize collaboration among interdisciplinary researchers such as those in health services, organizational science, and economics, along with frontline HCWs, patients, and administrative and clinical leaders. These collaborations should create opportunities for co-designing solutions by leveraging the collective expertise and integrating the research findings into practice. The knowledge gained should also inform the training of future clinical, administrative, and financial leaders.

To effectively implement this approach, it will be critical to re-evaluate traditional measures for assessing work design, which have focused primarily on productivity (e.g., work relative value units [RVUs]) and financial considerations (e.g., budget optimization). Metadata on the use of electronic health records (EHRs) — which all major EHRs capture effortlessly as part of HCWs' regular work — can provide insights into hours worked, patient caseloads, message volumes, work patterns, and even the dynamics of teamwork. Though some limitations exist — for instance, patient-facing work and coordination efforts may not be fully captured, and time spent in various activities are approximations — these data offer a unique opportunity to develop approaches that will elucidate the relationships among work design, EHR-use patterns, and subsequent HCW, patient, and organizational outcomes.

Evidence-based work design will become even more critical as artificial intelligence (AI) tools become more pervasive in health care. These emerging technologies

may help boost clinical efficiency by means of virtual scribes, assisted clinical decision making, and AI-generated or AI-facilitated documentation, but the benefits will come with trade-offs. Safety concerns and high implementation costs are significant challenges. Given the high per-user, per-month fees for some AI tools and generally thin organizational margins, it's likely that clinicians will be asked to see more patients to cover costs and generate additional revenue. In light of the potential time savings, payers may also adjust reimbursement rates, exacerbating the mismatch between job demands and resources. Thus, understanding optimal implementation strategies and rigorously evaluating whether the technologies are driving the desired effect will be critical to ensuring sustainability as these tools are rapidly deployed across health systems.

Predictive analytics and machine-learning algorithms are poised to challenge the status quo of work design by enabling a shift from a simplistic, short-term focus on financial returns to a more proactive, data-driven approach to determining work structure and resource allocation. Safety-management platforms with early-detection systems could be the next wave of health care innovation. Like tools for detecting clinical deterioration, this type of electronic tool could provide organizational leaders with timely alerts when work design is leading to HCW harm, system inefficiencies, or patient and safety problems, permitting rapid, iterative adaptation. Health care leaders who are aware of the effects of increasing or decreasing an HCW's workload could then make data-informed decisions that take into account the trade-offs involved. For example, increasing the number of patients per hospitalist might seem to save a hospital money on immediate salary costs but could also lead to inefficiencies (e.g., longer lengths of stay), clinician burnout, or patient harm, potentially negating any financial savings.

Finally, evidence-based work design will continue to grow in importance as public scrutiny of health care costs and outcomes intensifies, cost burdens shift to patients, and workforce shortages create fierce competition for top talent. HCWs can be selective about their employers and want a voice in shaping their work environments. Evidence-based work design could be the solution that drives better organizational decision making, contributes to cultivating a thriving workforce and improving patient outcomes, and helps ensure long-term organizational success. Organizations that embrace this paradigm shift may truly achieve health care's quadruple aim: to improve population health, enhance patients' experience, reduce costs, and improve the work life of HCWs.

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What I Wish I Had Done for a Grieving Father

Ranjana Srivastava, F.R.A.C.P.[1]

"Doctor, I mean no disrespect, but why am I even here?"

No patient wants to "belong" to a geriatric oncology clinic, but over the years I've developed an acceptable explanation: "As people get older, they develop a variety of problems. The aim of this clinic is to help older people with cancer take advantage of cancer treatments while shielding them from dangerous side effects."

Noting the patient's name and slight accent, I offer to get an interpreter.