

risk associated with a higher amount of running, even compared with a lower amount of running (which provided the maximal mortality benefits), although it is still possible that more may be worse. Therefore, further exploration is clearly warranted to investigate whether there is an optimum upper limit of running beyond which additional running produces adverse health effects.

Conclusion. People run not only to improve health but also for competition, fitness, weight management, stress relief, socialization, or fun. As a popular and convenient leisure-time physical activity, running provides numerous additional health benefits, including lower risks of obesity, hypertension, dyslipidemia, type 2 diabetes, stroke, osteoarthritis, and certain cancers.¹ Many studies, including ours, support that a small amount of running, even below the current minimum guidelines (<75 min/wk), can substantially reduce mortality risk and extend life. Despite the study limitations, our results clearly suggest that regarding running and mortality, “more is not better,” and our highest runners (still only in the low to mid 30 miles per week range) had a trend of loss of benefit; nevertheless, these highest runners still had trends of lower mortality than did nonrunners and only a nonsignificant trend of higher mortality than did the lower-dose runners ($P \geq .05$). Therefore, until we have more compelling evidence on running doses and mortality, we should emphasize that “even a little is great” rather than debating whether “more is better or worse” from a public health perspective.

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Factors Affecting Burnout in Physicians



To the Editor: I appreciated the insightful data presented by Shanafelt et al¹ in their article in the December 2015 issue of *Mayo Clinic Proceedings*, and I share the concerns about burnout rates among physicians in the United States. Although burnout is undoubtedly a multifactorial issue, one wonders

about the role of recent federal mandates.

Speaking as an endocrinologist who is engaged in the care of patients daily, a major source of stress stems from the implementation of electronic medical records (EMRs), the pressure from the federally mandated Meaningful Use programs that provide incentives to physicians who meet the implementation criteria, and the financial penalties imposed on those who do not.² Although the goals may be beneficent—ie, to track and share clinical conditions and to use the information to engage patients and their families—the reality is that the currently employed EMR often results in needlessly complicated tasks for the physician with questionable clinical benefit to the patient. In addition, clinical notes have become much lengthier because of required information and verbiage, without containing more relevant data that have utility for the reader. Physician EMR training requires hours to complete, while familiarization with the system requires months of use. In addition, each upgrade of existing systems to meet the next stage of Meaningful Use is costly. Indeed, some senior physicians in our health care practice group have opted to retire early rather than be burdened by the “forced” complicated digitization of patient records.

Another issue relevant to physicians concerns obtaining supplies for Medicare patients. No longer is a prescription for glucometer strips for an insulin-dependent diabetic patient sufficient; health care professionals now need to justify why a patient needs to test more than 3 times a day and must periodically complete paperwork attesting to this need. Clinics are asked by some suppliers to keep a copy of patient glucose logs over a 6-month period. For patients requiring diabetic shoes, Medicare does not consider a podiatrist's

orders sufficient and requires the endocrinologist to certify that diabetic shoes are necessary and that a foot examination by the physician, not a nurse practitioner, has been done within 6 months of delivery of the shoes or inserts to the patient.^{3,4} This is illogical, as nowhere in an endocrinologist's 5 to 6 years of postgraduate medical education is one trained to diagnose foot problems or ascertain candidacy and prescribe specialized footwear for these patients. It is also beyond comprehension that a trained nurse practitioner who is licensed to practice medicine and prescribe even opioid drugs cannot prescribe diabetic shoes per Medicare.

Therefore, although there are numerous factors contributing to physician burnout in the United States, one wonders about the role of bureaucracy and additional nonclinical paperwork. Although some of these issues are specialty specific, in recent years there have been overall increasing clerical obligations set forth by the government or private insurers that affect every medical professional. Many of these changes were put in place within the past few years, with Stage 3 of Meaningful Use scheduled to take place in 2016.

Should Shanafelt et al repeat their survey in the upcoming years, one can expect further evidence that burnout rates are continuing to worsen.

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Editor's Note: When publishing a letter that comments on an article published previously in *Mayo Clinic Proceedings*, it is the journal's policy to invite the author(s) of the referenced article to publish a response. Dr Shanafelt was invited to respond, and although he was supportive of this letter, he felt the content of the letter did not require a reply.

1. Shanafelt TD, Hasan O, Dyrbye LN, et al. Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clin Proc.* 2015; 90(12):1600-1613.

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Burnout and the Ethos of Medical Practice



To the Editor: The article by Shanafelt et al¹ published in the December 2015 issue of *Mayo Clinic Proceedings* describes the very serious and worsening problem of burnout among American physicians, and the editorial by Ariely and Lanier² attempts to elucidate the causes, noting asymmetrical awards, loss of autonomy, and cognitive scarcity. I could not agree more on one point that Ariely and Lanier made, that the "micromanaging of physicians' time and decisions" in the name of productivity by their corporate overseers is a major factor in the burnout and that it needs to be addressed.

The social and cultural influences that have altered the ethos of medical practice are complex, and I have described them in detail elsewhere,³ along with possible remedies. In addition to that analysis, I strongly believe that medical societies need to be more proactive in developing and advocating positions to resist and modify the corporate control of medical practice. It is not a coincidence that physician burnout has grown exponentially and in parallel with the increase in the corporate control of medical

practice. This organizational change has occurred without the careful scrutiny of serious research on the long-term unintended consequences such change engenders in health care processes. Both research into and advocacy for maintaining and strengthening the role of medical professionals in the face of managerial technocracy are urgently needed.

The scrutiny of the quality of medical care is here to stay, but quality medical care also requires professionals with a satisfying work environment who find their work appreciated and respected. No one expects to eliminate the corporate entities that control medical practice today, but with effort, we can get them to be mindful that respectful interaction with clinicians is essential to quality medical care and physician well-being.

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Editor's Note: When publishing a letter that comments on an article published previously in *Mayo Clinic Proceedings*, it is the journal's policy to invite the author(s) of the referenced article to publish a response. Drs Shanafelt and Ariely were invited to respond, and although they were supportive of this letter, they felt the content of the letter did not require a reply.

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Spontaneous Bacterial Empyema: Its Association With Liver Disease



To the Editor: Spontaneous bacterial empyema (SBEM) is the spontaneous