et al[2] reported that the crisis continues to worsen, and satisfaction with work-life balance showed similar deterioration. Olson concludes that burnout reduction and wellness promotion are of paramount importance and argues that improvement lies within minimizing the stigma associated with burnout and reducing workplace stressors. These measures, while a good start, only address the "effect" vantage point of this problem. Perhaps instead of trying to treat the results of the problem, we should focus on attempting to find and change the source or "cause" of the problem to begin with.

Interestingly, McBee et al[3] reported that burnout and work-life balance dissatisfaction rates are even higher among residents than board-certified physicians. As current trainees ourselves, this data is alarming. We, as a newer generation of physicians, should be invigorated and excited to transition from residencies and fellowships into careers as attending physicians. If more and more of us drag across the finish line of training feeling drained and overwhelmed, maybe it's already too late. Olson mentioned "workplace stressors."[1] As trainees, we learn from very early on in medical school that you put your head down, work, then work even harder. Complaining is unacceptable, and seeking help is a sign of weakness. The only justification for the perpetuation of this cycle from one generation of physicians to the next is "we all had to go through it, so you do too."

Maybe this archaic mantra is the reasoning behind Olson's desire to reduce the stigma of burnout and even the prevention of seeking help at a time when a physician may need it most. Recent literature demonstrates that physicians do not use currently implemented wellness resources. One study identified 9 institution-wide measures that improve physician wellness.[4] However, while these measures have demonstrated potential, they are only beneficial if used. In a separate study, only 5% to 7% of physicians, scientists, and administrators use "peer support resources" annually, despite measures to "minimize potential stigma and reduce barriers to seeking help."[5]

Given the higher burnout rates among resident physicians, this population should be targeted to establish behavioral patterns early, thereby altering the culture of the medical field as new physicians enter. Perhaps wellness as a process should be automated with resources offered during annual physicals or hospital-provided financial counseling. Such processes standardize wellness without the stigma of asking for help or association with performance indicators. Although Olson highlights a great start, the true obstacles are the culture and the "head-down" mentality on the pathway to becoming an attending physician. Cultural changes need to be made, and finding creative ways to do so earlier in the process, particularly in medical school or residency, will be for the better.

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In Reply—Physician Burnout: A Leading Indicator of Health Performance and "Head-Down" Mentality in Medical Education—I and II

I agree with Drs Peck and Viswanath, that residents should be transitioning into their careers "invigorated and excited." The fact that most physicians are experiencing burnout, and it is particularly high among residents, indicates a need for course correction. I concur with the logic that it is best to treat the root cause rather than its adverse effects. As I indicated in my editorial, the evidence suggests that the work and workplace stressors are the predominant drivers of physician burnout and the ensuing withdrawal from clinical practice, which frustrates our ability to provide the population with access to affordable high-quality patient-centered care.

Stressors have been identified as lack of value-alignment with leadership, lack of control over workloads, working at a hectic pace in a chaotic inefficient atmosphere, and ineffective teamwork[1] to manage time-consuming administrative and regulatory tasks,[2] expanding requirements to accomplish more during shorter visits with patients who have more complex comorbidities, and restrictions to and reimbursements for goods and services.[3] The electronic health record has become omnipresent at *patient* encounters, altering workflow, prompting and tracking metrics, and linking stakeholders.

Electronic health records compelled computerized physician order entry and increased clerical burdens,[4] made clerical work possible 24-7, and became a common and formidable stressor.[1] Physicians reported a lack of time for the more meaningful aspects of work—patient care, scholarship, administration.[5] They express discrepancies between what they expected of their careers and their actual work life.[6] They reported stress tied to threat of liability, educational debt, and lack of work-life balance.[7] The work itself entails managing illness and injury, preventing death and disability, easing suffering.

I agree with Dr Kaushik and Einstein that "we cannot solve our problems with the same level thinking that created them." The big questions are how to coordinate stakeholders to provide the population with reliable access to affordable high-quality patient-centered health care? What is and who defines quality and medical necessity (value) and how much autonomy can be afforded to patients and their physicians while dependent on payers and prices (2-3 times that of other industrialized countries)? How do we "bend the cost curve" down from 17.8% of the United States gross domestic product ($3.2 trillion per year)?[8] Physicians' decisions (made with patients) direct the flow of 80% of health care dollars,[9] thus considered a lever by stakeholders. Physicians perceive a "lack of control" and "chaos."[1] Eighty-six percent of physicians felt that their perspectives were not taken into account in crafting health care legislation,[10] which also accelerated the vertical integration of physicians into large hospital organizations as employees.[11] Now, the "quadruple aim" recognizes physicians' well-being as a reflection of their perspectives on system performance and quality care for patients.[12]

Pioneering health care organizations have recognized the value of engaging physicians' perspectives[13,14] and are discovering it can generate innovation and efficiency[15] and higher-quality care at lower costs with better satisfaction scores for patients and physicians.[16,17] Physicians' satisfaction is closely tied to their sense of agency to produce high-quality patient-centered care, in collaboration with the clinical team, colleagues, and leadership.[18,19] Physician partnership also facilitates the organizations' priorities.[19,20] Vanguard organizations are creating a culture of wellness (mission-aligned leadership, teamwork, collegiality, for meaning in work), managing the bureaucratic machine away from the clinical arena, partnering with clinicians to improve workplace efficiency to support clinical work, and facilitating work-life balance and personal resiliency.[13,14,21-23] Such organizations measure and monitor the well-being of the physician workforce via wellness metrics, the withdrawing behaviors or their adverse effects, or the presence of stressors via surveys such as Mark Linzer's Mini Z survey.[13]

Dr Kaushik's letter makes the important point that when burnout is pervasive in the workforce, organizational change can be difficult, and self-care and personal resiliency is required. While systematic reviews and meta-analysis find that organization-directed interventions are more effective than individual-directed interventions to remedy burnout,[24,25] it is understood that these interventions have reciprocal influences, and both are necessary to improve individual well-being and organizational performance.[23] Therefore, leaders and individuals both benefit from encouraging proactive self-care and personal resiliency while organizational stressors are addressed.

For example, my colleagues and I collaborated with Dr. Seligman's Positive Psychology Center at the University of Pennsylvania to provide physician-oriented resiliency tools and an optimistic mind-set to prevent languishing in psychological distress, and skills to bounce back and grow in adversity. Whole-hearted participation hinged on trust that the organization was also sincerely resolving stressors. Based on Seligman's PERMA model, a thriving workforce may feel inspiration and pride, deeply interested and involved, valued and supported, a sense of service and purpose larger than themselves, internally motivated toward mastery, and vitality. Beyond the absence of burnout and withdrawing behaviors, there is a physician workforce eager to engage in clinical work and creative problem solving.[26]

Resident physicians should feel excited and invigorated transitioning into their careers because I suspect we are witnessing a renaissance in physician work life. Now that the National Academy of Medicine and others have made physician well-being a top priority, there is an air of inevitability. Yet, there is much work to do. I agree with Drs Peck and Viswanath that physicians-in-training should receive support to develop a wellness practice and build personal resilience as soon as medical school. Dr Kaushik suggests a "tool bag of self-care." Normalizing wellness allows anyone to comfortably access peer support and necessary care and sets a good example for the patients we counsel. Change can be stressful, yet ripe with opportunity. Stay well. There is reason for hope.

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