In this issue of *Mayo Clinic Proceedings*, Shanafelt et al. publish the fourth triennial survey of physician burnout in the United States. Taken during the first 6 to 9 months of the pandemic, the survey found that burnout continued to decline from its peak 54.4% (2014) to 38.2% (2020) using the 2-item Maslach Burnout Inventory. Yet, 2 years into the pandemic, the notion that burnout is declining may be met with skepticism.

Burnout has been established as an occupational hazard most amenable to organizational interventions. It was measured by symptoms of emotional exhaustion (“burnt out”) and depersonalization (“callous toward people”) and typically would also include a sense of lack of accomplishment. Facing burnout, physicians may physically or psychologically withdraw from clinical practice when obstacles frustrate their ability to provide quality care and to maintain work-life balance. Physicians engaged and empowered in value-aligned efficient practice management and medical decision-making may have a greater sense they belong and believe in the shared organizational mission, better able to contribute to health care’s quadruple aim to provide access to high-quality patient-centered care from professionally fulfilled physicians.

Reducing burnout is a minimum requirement for improving health system performance and professional fulfillment. According to Shanafelt et al., physicians are still 40% more likely to be burned out and 30% less likely to be satisfied with work-life integration compared with the general population. Wellness programs strive to optimize well-being in all respects—emotional, physical, social, intellectual, spiritual, social, occupational, financial—to support professional fulfillment and a high quality of life.

The overall reduction in burnout does not mean that all physicians are experiencing less burnout. Shanafelt et al. found that those thought to be most directly affected by COVID-19 (emergency medicine, hospital medicine, critical care) did not have a reduction in burnout, whereas other specialties may have felt less burned out and more satisfied with work-life integration as nonurgent care was often suspended, which may have created other stress not captured by the burnout metric. In multivariable analysis of COVID-19 experiences, Shanafelt et al. found that lack of personal protective equipment and economic consequences were independently associated with burnout, perhaps due to resources and control to manage job demands. Perhaps small, rural, and private practices may have been more susceptible if not affiliated with a large medical system.

Women represented a greater proportion of physicians than in previous years,
although they remained the minority in medicine, and they were more likely to experience burnout compared with male counterparts. COVID-19 and social distancing disrupted childcare, which was believed to explain a pandemic-related gender gap in achieving academic milestones and remaining engaged in work, exacerbating the existing gender gap in career success.\(^7,^8\) Shanafelt et al did not assess burnout by race or ethnicity, although the pandemic revealed that underrepresented communities were more vulnerable to the consequences of the COVID-19 pandemic. These examples highlight the need for diversity among medical professionals, reflective of the populations served. More might be done to retain a diverse workforce.\(^2,^8\)

Those at the front door of medicine remain the most burned out and least satisfied with work-life integration, including family medicine, general internal medicine, and emergency medicine.\(^1\) Each year, 85% of the 332 million Americans (comprised of 77.7% adults, 50.8% female) visit the doctor.\(^9,^{10}\) Approximately 80% of adults will see their primary care physician for a wellness check (94% of children); 28% of Americans will seek urgent care, 21% will visit the emergency department.\(^3\) Primary care physicians (general internal medicine, family medicine) account for approximately a quarter of the physician workforce, maintain health, manage chronic conditions, prevent hospitalizations and readmissions, and communicate and coordinate among specialists. Emergency department physicians care for citizens presenting with life-altering events (eg, trauma, heart attacks, strokes, compromised breathing). Citizens depend on these physicians being able to perform at their best.

Combating burnout is critical to a reliable US health care system. Health care’s quadruple aim is to provide all Americans access to high-quality patient-centered care from professionally fulfilled physicians. Academic physicians also conduct research, teach, and lead biomedical sciences. There are 897,107 physicians in the United States, with a projected shortfall of 37,800 to 124,000 physicians by 2034, primarily driven by the projected growth in the population older than 65 years (42% growth compared with 5.6% growth in those younger than 18 years).\(^3,^{11}\) Two in 5 physicians are approaching retirement age.\(^11\) Before the pandemic, 20% of physicians expressed an intent to leave clinical care within 2 years. Burned out physicians have a greater likelihood of withdrawing from clinical practice (physically or psychologically): physician burnout affects the patient’s experience, access, quality, and cost, with turnover estimated near $1 million per physician.\(^3\) US health care spending continues to rise and already accounts for 19.7% of the gross domestic product ($4 trillion per year, equivalent to $12,530 per person).\(^12\) This should afford a quality patient experience from a high-performing medical system. Retaining physicians is key.

Finally, it is conceivable that aspects of the pandemic reduced burnout. The call to service alongside colleagues may have appealed to physicians’ core values and intrinsic motivation. It called for abilities for which they are highly trained. Their expertise was needed and their perspectives taken into account. The survey was taken after physicians gained understanding of the virus and the disease it caused, and they had conquered the first wave.

The pandemic shook the US health care system out of a false sense of security and exposed faults and vulnerability. Through the struggle to adapt, health care organizations may recall examples of the posttraumatic growth that occurred in response to the need to withstand and to succeed in this crisis\(^13\):  

- **Meaning:** Facing an existential public health crisis, medical professionals rallied around a purpose bigger than any person, organization, or country.  
- **Deeper appreciation:** Health care executives recognized that they are unfamiliar with the novel virus and thus engaged perspectives from frontline physicians across disciplines with the aim of empowering them with the resources to be successful.
in caring for patients. Information was transparent, assumptions were questioned, differing opinions were welcomed, and decisions were contingent on buy-in from experts and representatives of complex decision-makers on the frontlines with lives on the line. Citizens banged pans from the windows each evening to encourage health care heroes.

- Open to new possibilities: Efficiencies and innovations to help manage hustles (volume and pace) and hassles (tasks that obstruct flow) were rapidly adopted to ease the delivery of care. Time-consuming clerical tasks were deprioritized or managed away from the clinical arena.

- Deeper relationships: Unified by a compelling mission and value alignment, old competitions were replaced with collegial collaboration and coordination. Teamwork was imbued with situational awareness for physical and psychological safety for self and others, compassion, gratitude, support, and a sense of belonging and belief in the mission. Virtual community gatherings, collegiality circles, and peer supports were created to decompress over the emotional aspects of work to create a sense of calm, control, and connectedness.

- Greater sense of strength: As stakeholders listened to one another and aligned efforts with purpose, the orchestrated whole was greater than the sum of its parts, and a willingness, strength, and cohesiveness emerged in addressing the attendant and often unexpected challenges of the pandemic.

Two years into the pandemic, the greatest surge of COVID-19 overwhelmed short-staffed hospitals and clinics and further strained health care professionals. Lessons learned in managing the first 6 to 9 months of this crisis may pull health care through the next crisis. The pandemic is health care’s crucible through which it may be reimagined and transformed.

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