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Physician Well-being 2.0: Where Are We and Where Are We Going?

Tait D. Shanafelt, MD

Abstract

Although awareness of the importance of physician well-being has increased in recent years, the research that defined this issue, identified the contributing factors, and provided evidence on effective individual and system-level solutions has been maturing for several decades. During this interval, the field has evolved through several phases, each influenced not only by an expanding research base but also by changes in the demographic characteristics of the physician workforce and the evolution of the health care delivery system. This perspective summarizes the historical phase of this journey (the "era of distress"), the current state (Well-being 1.0), and the early contours of the next phase based on recent research and the experience of vanguard institutions (Well-being 2.0). The key characteristics and mindset of each phase are summarized to provide context for the current state, to illustrate how the field has evolved, and to help organizations and leaders advance from Well-being 1.0 to Well-being 2.0 thinking. Now that many of the lessons of the Well-being 1.0 phase have been internalized, the profession, organizations, leaders, and individual physicians should act to accelerate the transition to Well-being 2.0.

From the Department of Medicine, Division of Hematology, Stanford University, Palo Alto, CA.

Awareness of occupational distress among physicians and efforts to cultivate physician well-being have crescendoed in recent years. This awareness was amplified by the COVID-19 pandemic, which emphasized the foundational importance that well-being plays in physicians' ability to serve patients and for health care organizations to achieve their mission.

Although general awareness of the importance of physician well-being has increased during the past several years, the research that defined this challenge, identified the contributing factors, and provided evidence on effective individual and system-level responses has been maturing for several decades. The maturation of this field has evolved through several phases, each influenced not only by an expanding research base but also by changes in the demographic characteristics of the physician workforce and the evolution of the health care delivery system. This perspective summarizes the historical phase of this journey, current state, and insights regarding where

we need to go next. The summary of each phase is intended to be descriptive rather than a critique and to illustrate how the field of physician well-being has evolved and matured.

THE PAST: THE ERA OF DISTRESS

The historical era, or what I will coin the "era of distress," was characterized by a lack of awareness, or even deliberate neglect, of physician distress. This phase largely described the field before 2005. Although early data on physician burnout and evidence of its potential repercussions on quality of care had begun to be chronicled,[1-8] the issue of occupational distress was not a meaningful part of the conversation among the profession or society.

Evidence from other fields that occupational burnout was a system issue originating from problems in the work environment, rather than a weakness in the worker,[9-11] was not widely adopted by the field of medicine. Physicians were selected and winnowed through an arduous training

process and were, in many ways, expected to be superhuman. Medical school and residency training were characterized by a "rites of passage" mindset that subjected physicians to unlimited work hours, often involving many consecutive days on duty with little sleep, rest, or breaks.[12-14] The evolving science on sleep and human performance was not applied to physicians, who were expected to perform with equal excellence throughout the arc of extended-duty shifts independent of whether they had slept. Physicians worked regardless of whether they were ill, and there were few if any backup systems to provide coverage.[15-17] If physicians were unable to report for work, their colleagues "picked up the slack." For individual physicians, a desire not to shift the burden to colleagues created a powerful disincentive to attend to personal health needs or illness. Individuals who pointed out the inherent problems of this approach were often marginalized as being "uncommitted" or "weak."

From the demographic perspective, physicians in this era were predominantly men whose spouses or partners did not have a career of their own. This arrangement allowed the spouses and partners of physicians to devote greater time to "keeping things running on the home front" even though the physician was often absent or devoted little time to these activities.[18-20]

The practice environment was less consolidated, with fewer physicians a part of large group practices.[21] Electronic health record (EHR) use was not widespread, and measures of patient satisfaction and quality were not routinely assessed. In part because of the different structural characteristics of health care delivery at the time, physicians had greater autonomy, less oversight, and more control over the practice environment.[22-24] Nonetheless, payers and regulators in this era used a "gotcha" approach to auditing payment and documentation that communicated a lack of trust and questioned the integrity of all physicians on the basis of the unprofessional behavior of a few.

At the organizational level, there was limited if any attention to the impact of administrative decisions or regulations on physicians' work life. The concept that quality of care was a system characteristic had only begun to take hold.[25] If medical errors occurred, the default was to blame the individual. This typically took the form of accusatory "root cause analyses" and morbidity and mortality conferences that subjected junior physicians to humiliation and shaming by supervisors and peers.[26,27] The message conveyed was that the physician should be all-knowing and able to overcome every deficiency of the health care delivery system to ensure optimal care for patients under any circumstance (ie, physicians were supposed to have deity-like qualities).[28] There was inattention to the impact of physicians' personal well-being on the quality of care they provided patients. Institutional needs were prioritized above patient and clinician needs, and there was no appreciation of the economic implications of physician distress on the financial health of the organization.

During this time, the professional culture of medicine was characterized by a mindset of perfectionism that reinforced the concept of physician as deity.[29] This framework discouraged vulnerability with colleagues, encouraged physicians to project that they had everything together ("never let them see you sweat"), and contributed to a sense of isolation.[30] To the extent there was dialogue about physician distress, the focus was on individuals rather than the system or practice environment.[31]

Collectively, all these factors contributed to physicians' professional identity subsuming their human identity. There were no limits on work, and the concept of boundaries between personal and professional life was considered a lack of commitment. To the extent there was attention to "physician wellness," it centered on the concept of self-care: healthy diet, exercise, stress reduction, and getting enough sleep when not on duty.[32-34]

THE PRESENT: PHYSICIAN WELL-BEING 1.0
Over time, increasing evidence and research began to change many of these historical paradigms. The "Physician Well-being 1.0"

phase, to some extent, began between 2005 and 2010 and largely continues to present day. This phase has been characterized by knowledge and awareness. National studies began to chronicle the prevalence of distress among medical students,[35,36] residents,[5,37-39] and practicing physicians[40-43] as well as trends in distress over time. Publication of these studies in peer-reviewed journals also began to result in headlines in the widely disseminated physician press (ie, "throw-away" journals; Medscape) with occasional pickup by the lay press.[44,45]

Importantly, the repercussions of physician burnout and other forms of occupational distress (eg, moral injury, fatigue/exhaustion) began to be recognized and to have an impact on conversations within the health care delivery system. The personal repercussions of physician distress (eg, broken relationships, problematic alcohol and substance use,[46,47] depression and suicide[48-51]) began to establish a moral and ethical case for action. Research also demonstrated the links between physician well-being and quality of care,[52-54] including medical errors,[5,55-58] patient satisfaction,[59,60] and professional behavior.[6,61] This evidence began to bring together a broad coalition of stakeholders concerned with clinician well-being and resulted in expansion of the triple aim of health care (improving patient experience, reducing the cost of care, advancing population health) to a quadruple aim that included clinician well-being.[62] Other studies established links between physician burnout and clinical productivity[63] as well as turnover,[59,64] which drew attention to the economic costs of physician burnout for health care organizations and society.[65-67]

The demographic profile of physicians in this era evolved, with gender parity among medical school matriculates and an increasing proportion of women among the practicing physician workforce. More physicians were in 2-career relationships that assumed increased involvement of physicians in home responsibilities.[68-70] The historical pattern of professional identity subsuming human identity shifted to a dual role and the need to "balance" personal and professional identities (ie, work-life balance).[71,72]

In parallel with these demographic changes, tremendous change occurred in the training and practice environment. Residency and fellowship training transitioned to a competency-based framework, and substantial, new limits on work hours were instituted. Consolidation of medical practices occurred, resulting in a majority of physicians working in employed practice models.[21] Use of the EHR became widespread with the passage of the Health Information Technology for Economic and Clinical Health Act in 2009, which defined and tied reimbursement to "meaningful use" of EHRs. Although organizations also began to appreciate the administrative impact of the EHR on physicians,[73-76] the response was to provide opportunities for physicians to learn "tips and tricks" to become more efficient in their ability to use suboptimal technology.[77,78]

In an effort to quantify performance, organizations began to evaluate physicians using a host of new metrics, including measures of patient satisfaction, quality, cost, and productivity.[79-82] Physicians became familiar with terms such as relative value unit generation, visit/billing targets, payer mix, service lines, top-box score, and net operating income.[83] This contributed to a perception of misalignment between the professional values of physicians and the motives and priorities of their organizations.[84-90]

At the organizational level, awareness of the system nature of the problem began to develop.[7,91,92] The response, however, typically remained focused on individual-level solutions[93] and centered on providing treatment for physicians in distress (eg, mental health resources, peer support)[94] as well as cultivating personal resilience through interventions such as mindfulness-based stress reduction.[95,96] Despite these efforts, state licensure questions and stigma about mental health conditions remained a barrier to seeking help.[97-99]

Organizations began to view addressing physician distress as a necessary cost center,

but, to the extent they allocated resources to advance physician wellness, they viewed it primarily through a "return on investment" mindset. As they considered addressing defects in the practice environment, organizations viewed the issue as a zero-sum game problem. This mindset suggested that the only way to relieve physicians from excessive workload and administrative burden was to shift this work to others. This framework suggested that system approaches to improve physician well-being would invariably worsen the well-being of other members of the health care team, resulting in inaction.

At the professional level, discussions about a "culture of wellness" began to take hold but tended to focus on a message that encouraged physicians to "take care of themselves and become more resilient." Physicians began to express frustration that this approach failed to address the underlying problems in the practice environment that were the core issue.[90,100] Some physicians suggested that health care administrators were the root cause of the problem. That oversimplification was neither accurate nor constructive and led to divisiveness and reciprocal scapegoating (physicians blame administrators; administrators blame physicians)[101] that drove a wedge between physicians and the individuals they needed to work with to improve the practice environment.[84,102,103]

Although physicians argued about what label best described their occupational distress and how to measure it,[104-106] there was agreement that the problem was pervasive and that the practice environment was the issue.[107] Acceptance that distress was widespread created openness for more physicians to discuss occupational challenges. This helped move physicians who were struggling in isolation to realize they were not alone and created greater willingness to discuss distress with colleagues.[108,109]

THE FUTURE: PHYSICIAN WELL-BEING 2.0
Around 2017, vanguard institutions began to transition to the Well-being 2.0 phase. This transition has been accelerated by the COVID-19 pandemic, which illustrated the foundational importance of clinician well-being to health care delivery systems and the profound impact that work characteristics have on well-being. The Well-being 2.0 phase is characterized by action and system-based interventions to address the root causes of occupational distress.[110-115] The focus in this phase shifts away from individuals toward systems, processes, teams, and leaders.[112,116] The importance of transitioning to the Well-being 2.0 phase was validated by the National Academy of Medicine Action Collaborative on Clinician Well-being and the formal report from the Committee on Systems Approaches to Improve Patient Care by Supporting Clinician Well-being released in late 2019.[116]

The scapegoating and finger-pointing that divided physicians and administrators in the Well-being 1.0 phase are replaced with a mindset of physician-administrator partnership to create practical and sustainable solutions. There is acceptance that physicians are subject to the same human limitations that affect all human beings,[117] with attention to appropriate staffing, breaks, and rest as a part of performance. This phase builds from a foundation that burnout is codified as an occupational syndrome by the World Health Organization[118]; harmonized definitions for burnout have been established[106]; instruments to assess the syndrome have been developed, validated, and crosswalked[9,119-122]; the neurobiology of occupational distress has been recognized[123]; and the distinction between burnout and depression has been clarified.[124,125]

At the organizational level, the mindset in this phase centers on cultivating well-being and preventing occupational distress rather than simply reducing burnout.[110-112,115] Senior leaders, such as Chief Wellness Officers,[113,114] are appointed to address system-based drivers, and the infrastructure and resources to enable these leaders to drive organizational change are established.[111,126] The principles of human factors engineering and design are embraced.[127-129] The organizational focus shifts from patient needs to a people focus

that attends to the needs of all individuals in the practice environment as both necessary and mutually beneficial to achieve the desired outcomes. This includes caring for the team and creating an organizational environment that attends to leadership, professionalism, teamwork, just culture, voice and input, and flexibility.[102,112,127,130] The needs of individual clinicians, including sleep and work-life integration, are acknowledged and supported.[117,131] In the Well-being 2.0 phase, the organization transitions from viewing wellness as a necessary cost center to viewing it as a core organizational strategy.[65,110,111] The resource allocation mindset shifts from a return on investment framework to value on investment.

From a demographic perspective, it is recognized that there is an equal mixture of men and women physicians and that most physicians are in 2-career relationships with shared duty for personal and family responsibilities. To enable people to meet these responsibilities, organizations create flexibility in the practice environment that allows physicians to meet both personal and professional obligations. This provides organizations a competitive advantage in recruitment and retention and allows physicians to work full-time and still accommodate personal needs rather than having to work part-time to do so. At the individual level, physicians have transitioned from a mindset of balancing personal and professional identities to one of integrating professional identity and personal identity into a single identity that encompasses human, personal, and professional dimensions.[131]

The intersection between diversity, equity, and inclusion to wellness is recognized. Although these are distinct domains, promoting antiracism and addressing threats and system factors that undermine diversity, equity, and inclusion are appreciated as foundational to efforts to advance clinician well-being. Consistent with this premise, more authentic conversations about organizational deficits in these domains occur in concert with action.

At the professional level, the emphasis shifts from a culture of wellness to a culture of vulnerability[132,133] and self-compassion,[134] which acknowledges that physicians are not perfect, that they will make mistakes,[30] and that they need to be vulnerable and support one another.[135,136] Physicians recognize and acknowledge that they may have an Achilles' heel as it pertains to perfectionism and self-criticism and dedicate themselves to developing skills to address these mindsets.[134,137,138] Supporting colleagues involves creating not only connection but also community involving shared experience, mutual support, and caring for each other.[109] Training programs embrace these principles and work to actively develop these qualities as core dimensions of competence as well as holistically cultivating residents' and fellows' well-being.

CALL TO ACTION
We have now internalized the lessons of the Well-being 1.0 phase, and vanguard institutions have begun to move to the Well-being 2.0 phase (Table). The profession, organizations, leaders, and individual physicians should act to accelerate this transition.

At the broader professional level, physician leaders and professional societies must embrace the physician as human mindset rather than the physician as hero mindset (Figure 1). This mentality should permeate the values transmitted to the next generation of physicians at the earliest phase of training both cognitively and in the structure, design, and expectations of the clinical training process. This will require promulgating the core values of the profession (commitment to patient needs, service, altruism) along with the realities of human limitations and the concept that healthy boundaries, appropriate limits on work, work-life integration, and attention to personal needs are part of professionalism. These values should be embraced by the established members of the profession and care taken to responsibly impart them, along with other core values, to physicians in training. Deliberate efforts to change the professional culture of perfectionism to a culture of excellence in combination with self-compassion and growth mindset must be pursued.

TABLE. Characteristics of the Different Phases of the Physician Well-being Movement

	Era of distress	Well-being 1.0	Well-being 2.0
Awareness state	Lack of awareness	Awareness	Action
	Inattention to impact of physician distress on patients	Appreciation of implications of physician distress and well-being	System interventions to prevent distress from affecting patients
Professional culture	Culture of perfection	Culture of wellness	Culture of vulnerability and self-compassion
Professional icon	Physician with deity-like qualities	Physician with hero-like qualities	Physician with human qualities
Training mindset	Rites of passage	Competency-based framework	Organizational environment that attends to both developing competence and holistically caring for clinicians
Organizational mindset	Focus on institutional needs	Focus on patient needs	Focus on needs of people (both patients and clinicians)
	Individuals	Teams	Systems
	Self-care	Personal resilience	Infrastructure and leadership to advance well-being
	Blame individuals for distress (personal weakness)	Appreciation that system factors cause distress but promulgate personal solutions	Address system issues through human factors engineering; evolve characteristics of organizational culture that contribute to distress
Physician-administrator relationship	Mutual neglect	Adversarial: physicians blame administrators for the problems; administrators blame physicians	Physician-administrator partnership to create solutions
Physician mindset	No limits on work	Balance personal and professional life	Integration of personal and professional life including boundaries and healthy limits
Administrator mindset	Disregard of physician distress	Zero-sum game problem	Non–zero-sum game problem
Payers and regulators mindset	No attention to impact that regulations and administrative decisions have on clinicians	Awareness of impact that regulations and administrative decisions have on clinicians	Regulations and administrative decisions influenced by needs of clinicians
Orientation to colleagues	Isolation	Connection	Community (shared experience; care for each other, mutual support)
Approach to individual distress	Neglect/ignore	Treat	Prevent distress and promote professional fulfillment
Approach to technological contributions	Not applicable/lower relevance	Teach physicians tips and tricks to optimize their ability to use suboptimal EHR technology	Develop new models of team-based documentation and order entry Demand better EHR products from vendors Collaborate with EHR and regulatory bodies to limit low-value documentation requirements Track EHR measures to assess efficiency/work burden and proactively address

TABLE. Continued

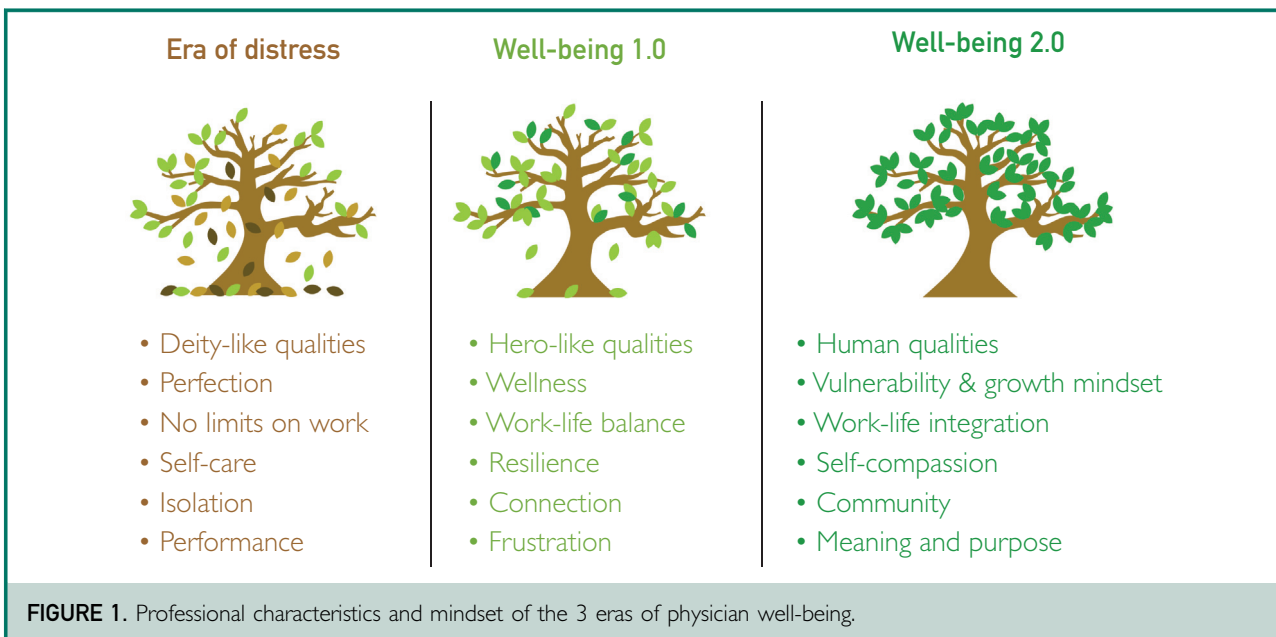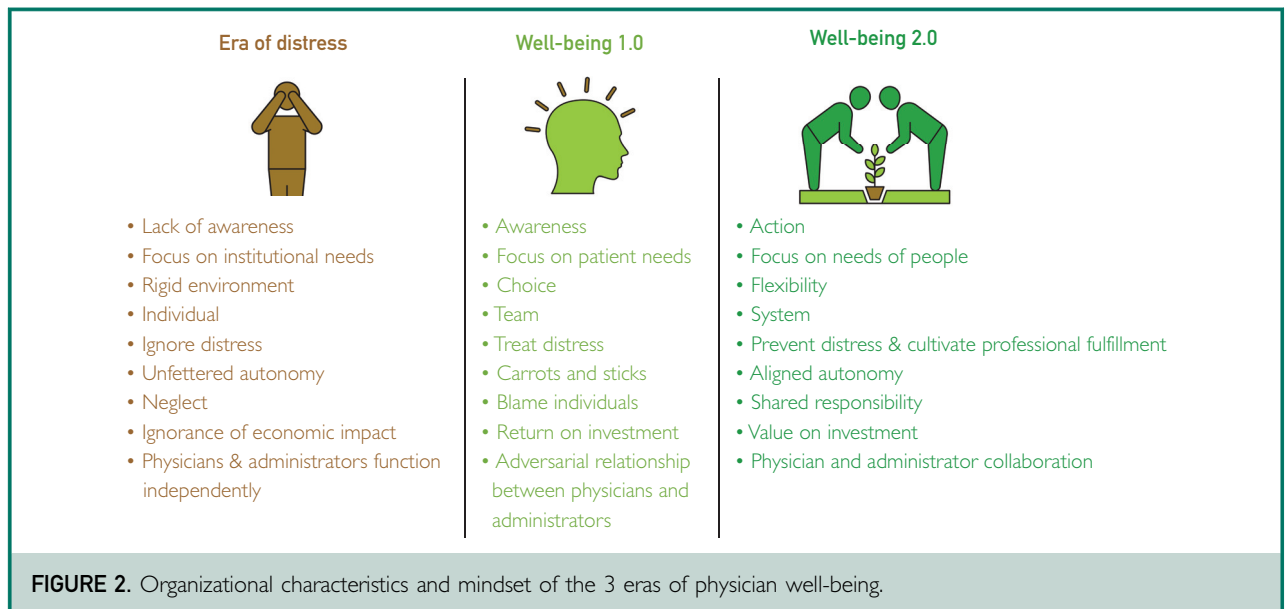|	Era of distress	Well-being 1.0	Well-being 2.0
Scholarship and research focus	Rare descriptive studies focused on individual mental health diagnoses (eg, depression), primarily in resident physicians	Describing the problem and its consequence in medical students, residents, and practicing physicians Limited testing of individual interventions to mitigate distress	Rigorous testing of system-level interventions to mitigate distress and to promote physician well-being
Resource allocation mindset regarding physician wellness	Ignorance	Return on investment Physician well-being is a necessary cost center	Value on investment Physician well-being is a foundational value and core organizational strategy

EHR, electronic health record.

At the organizational level, the transition to Well-being 2.0 requires a shift from awareness to action (Figure 2). It requires organizations to establish the leadership, structure, and process necessary to foster sustained progress toward desired outcomes.[111,113,126] This involves addressing system factors that drive occupational distress and reduce professional fulfillment. It includes attention to the efficiency of the practice environment and dimensions of organizational culture that can promote or inhibit well-being.[84] Organizations must embrace human factors engineering and pursue system redesign that creates sustainable workloads, provides coverage when physicians are ill, and incorporates appropriate breaks and rest.[127-129] Health care organizations must deepen their commitment to leadership development, increase receptivity to input from health care professionals, make a more authentic commitment to teamwork and optimization of team-based care, and foster an environment built on trust.[89]

For leaders, accelerating the transition to Well-being 2.0 requires attending to the leadership behaviors that cultivate professional fulfillment for individuals and teams.[102] This includes caring about people

FIGURE 1. Professional characteristics and mindset of the 3 eras of physician well-being.

FIGURE 2. Organizational characteristics and mindset of the 3 eras of physician well-being.

always, cultivating individual and team relationships, and inspiring change.[139] It requires both physicians and administrative leaders to foster a collaborative relationship and to engage in partnership to redesign and implement necessary changes. Working together to develop a shared sense of purpose and to create alignment of organizational and professional values is a foundational step.

At the individual level, the transition to Well-being 2.0 requires mindfully considering how to incorporate self-compassion, boundaries, and self-care alongside other professional values. Physicians must acknowledge that they are subject to normal human limitations and attend to rest, breaks, sleep, personal relationships, and individual needs. They must reject the role of victim, stop blaming administrators, and be part of the solution. This requires casting off the narrative that physicians are powerless to effect change in large health care organizations (learned helplessness), which is not true and is a barrier to creating the system change that is needed. Catalyzing such change requires physicians to work in partnership with operational leaders to improve the practice environment and health care delivery system. Physicians must hold fast to the belief that it is a privilege to be a physician and that honor requires dedication to others and responsibilities that involve sacrifice. That duty to patients and society, however, has limits. Times of intense work must be offset with appropriate time to recharge. Individual physicians are responsible to learn to simultaneously navigate the challenges of their career and attend to personal needs. This includes cultivating self-compassion and attention to self-care (sleep, exercise, rest) and work-life integration. Individual physicians must also preserve a strong commitment to supporting their colleagues. They should strive to create community with one another, including relationships that enable vulnerability and mutual support.

Roadmaps to facilitate these changes at the profession,[84] organization,[110-113,115,127,140-142] leader,[139] and individual[7,31,93,95,137] level have been developed, studied, and published. Organizations and individuals that have not started their journey should use these roadmaps as a place to begin. All physicians should work to accelerate progress in their sphere of influence. Continued research and organizational discovery will enhance current knowledge and provide new learnings to help the Well-

being 2.0 phase flourish. As this phase matures, the contours of a yet to be defined Well-being 3.0 phase will inevitably develop.

CONCLUSION

The last 3 decades have a been a time of tremendous progress for the field of physician well-being. We have moved from the era of distress, characterized by ignorance and neglect, to an era of awareness and insight. Leading institutions have now transitioned from knowledge to authentic action. Robust research and application by leading institutions has been the key to the maturation of the field. The profession, organizations, leaders, and individual physicians should commit themselves to accelerating this transition to the Well-being 2.0 era. Now is the time for action.

Correspondence: Address to Tait D. Shanafelt, MD, Professor of Medicine, Department of Internal Medicine, 500 Pasteur Dr, Stanford, CA (tshana@stanford.edu).

ORCID
Tait D. Shanafelt: https://orcid.org/0000-0002-7106-5202

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