

The Wicked Problem of Physician Well-Being



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KEYWORDS

• Physician well-being • Wellness • Burnout • Professionalism

KEY POINTS

- The collective threat to physician well-being is a complex issue that is difficult to solve.
- The COVID-19 pandemic has exposed existing problems within the health care system, resulting in widespread clinician burnout and moral injury.
- Clinician burnout has negative consequences for patient care, physician health, and the health care system.
- Clinician well-being efforts require both individual-focused and systems-level interventions.
- A sustainable culture of support in medicine is necessary to foster physician well-being.

INTRODUCTION

The collective threat to physician well-being is a complex issue with no clear solution emerging despite nearly a decade's worth of efforts dedicated to battling physician burnout. Even before the coronavirus disease 2019 (COVID-19) pandemic, physicians were struggling under a health care system where they felt micromanaged and demoralized due to a combination of increasing clerical burden and physician performance metrics that eroded the meaning, autonomy, and purpose in their work.¹ The COVID-19 pandemic has widened and exposed these cracks and worsened the situation by hurtling physicians into a collective crisis of moral injury. Health care professionals were already being pushed to the breaking point, with 59% of practicing anesthesiologists in the United States at high risk for burnout at the dawn of the pandemic.² It is hard to fathom that the situation has improved since.

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The issue of physician well-being is a “wicked problem” in medicine. The term “wicked problem” was coined in the 1970s and refers to social or cultural problems that are ill-defined and inherently unsolvable (Table 1).³ Unlike an arithmetical problem, a “wicked problem” does not have a clear-cut solution. Attempts at solutions tend to reveal new aspects of the problem, often changing the nature of the problem itself. For example, in the early months of the COVID-19 pandemic, masking and social distancing were the predominant solutions to flatten the curve, while a vaccine was being developed. Once the vaccine was created, it seemed as if the COVID-19 problem would be solved. However, issues of vaccine hesitancy, widespread misinformation, emerging variants, and inequitable global vaccine distribution then became the “new” problems.

The main characteristic of a “wicked problem” is that it is impossible to define. The word “well-being” itself is ambiguous because (1) it has no clear definition, (2) it is often used interchangeably with the word “wellness,” and (3) its meaning has markedly transformed over time. Initial efforts to promote “wellness” in the workplace focused on the individual with institutions encouraging clinicians to maintain a healthy lifestyle and improve resilience. Over time, the definition of “well-being” evolved to encompass the effects of organizational and systemic factors that support a culture and environment where clinicians can thrive.⁴ Yet, many physician well-being initiatives continue to fixate on the individual, reinforcing the idea that clinicians are solely responsible for their own burnout. When taking a step back to remember that “burnout” is by definition an occupational phenomenon,⁵ it becomes unacceptable to place the onus on the

Characteristics of “Wicked Problems”	Implications for Solving “Wicked Problems”
No clear definition of the problem	Requires a systems approach
No stopping rule	Unclear when the problem is solved because there is always the possibility of a better solution
Solutions are not right or wrong, they are better or worse	No clear consensus as to which solution will solve the problem
No immediate or ultimate test for a solution	Any solution creates waves of consequences over an extended period
“One shot” operation: each implemented solution has far-reaching consequences	No opportunity to learn by trial-and-error due to high stakes
Infinite number of potential solutions	It is a matter of judgment which solutions should be pursued and implemented
Every “wicked problem” is essentially unique	Effective solutions in one context cannot be directly transferred to another context
Every “wicked problem” is a symptom of an underlying, deeper issue	Solving a “wicked problem” often reveals a deeper problem that is more difficult to solve
No single explanation to the problem	The choice of explanation determines the way the problem is addressed
Problem solvers have no “right to be wrong”	Taking on “wicked problems” can be risky, and problem solvers must be fully responsible for their actions

Data from Rittel HWJ, Webber MM. Dilemmas in a general theory of planning. *Policy Sci* 1973;4(2):155–169.

individual. In this context, well-being efforts can ironically be turned into a weapon to blame and shame clinicians for a purported lack of personal optimization, potentially and paradoxically worsening clinician burnout.

Another characteristic of a “wicked problem” is that every attempt at a solution comes with high stakes because each implemented solution leaves “traces” that cannot be undone.³ Every time physicians are asked to attend a mandatory well-being lecture during their free time or fill out a well-being survey without clear follow-up or accountable change, they lose confidence that the time and energy spent participating in such efforts translate into tangible improvements to their workplace and well-being. Over time, this can rightfully lead to further dissatisfaction, demoralization, and disengagement in the health care workforce.

Clinician burnout is a pressing issue with negative consequences for patient care, physician health, and the health care system.⁶ The COVID-19 pandemic blew open the existing cracks in the health care system and continues to take an immeasurable toll on the physical, mental, and emotional health of health care professionals. A once highly motivated, engaged workforce of health care workers is now threadbare from moral injury, watching a nation divided and science repudiated. We are beginning to see an impending crisis of health care staffing shortages, and if for no other reason than the continued solvency of the overall health care system, we must reevaluate our approach to clinician well-being and course-correct before it is too late. If history is any teacher, we should expect reverberations in the health care workforce far exceeding those experienced following prior epidemics (eg, the 2003 SARS-CoV-1 outbreak in Canada), which were substantial.⁷ Here we discuss the evolution of well-being efforts in medicine and how we can move forward to build a sustainable culture of physician well-being.

A Brief History of “Wellness” in Medicine

“In no relationship is the physician more often derelict than in his duty to himself.”⁸ This statement, uttered by Sir William Osler, considered by many to be the father of modern medical education, underscores a truth about our profession that has not changed considerably over the past century. Physicians enter medicine with a laudable intention to help others—to bestow kindness to their fellow man via the highly trained and executed stewardship of their gifts. To this day, physicians in training dutifully recite the Hippocratic Oath at white coat ceremonies where they solemnly vow to place patients’ needs above their own. But who teaches them how to sustain this? Who lets them in on the secret that there are limits? Who prevents them from spiraling down the rabbit hole of competitive self-effacement and performative self-sacrifice? Certainly not the modern health care infrastructure that relies heavily on this mindset to ask a workforce already stretched thin to “do more with less.”

There has always been dysfunction and unwellness in medicine. Storied physicians, including Osler himself, were plagued by depression, suicidality, and substance use disorders.^{9,10} This burden of substance use disorder and suicide has declared itself and continues within our own ranks of anesthesiologists today.^{11–13} The work of helping the sick has always and ever will be difficult, but the fulfillment of a worthy practice held a promise that has continually brought bright, diligent people to the medical professions.

It was not until 2012 that a sharp focus on physician well-being emerged. Shanafelt and colleagues¹⁴ published the first large-scale study of burnout in the US physician population, revealing that nearly half of US physicians were at “high risk for burnout.” Burnout, an occupational phenomenon, had been studied widely in a range of human service industries, but never in medicine on a large scale. This, understandably,

caught the public's attention, and a flurry of lay press attention ensued with public now doubting the fitness of their physician workforce. At this point, with public scrutiny mounting, it was no longer a problem that could be ignored. For those already enmeshed in the work of physician support and well-being, this was a welcome change and justification for their ongoing work. But the focus was not as crisp as one would hope—the angle of attack was on physicians—something was wrong with doctors, so how do we fix them?

Over the coming years, hundreds of papers were published, focusing primarily on individual interventions to improve well-being, from meditation and mindfulness to nutrition, sleep, and physical fitness. Occasionally a pilot study would be published showing modest improvements in some metric of well-being, but this was rarely followed by larger randomized controlled trials. Throughout this time, a disdain for all things “wellness” was growing in the medical community—it was justified, as we will discuss in the next section.

Then in 2018, many forces began coming together, shifting focus from the individual to the systems and policies ultimately crafting the culture of medicine. Two national organizations in particular, the Accreditation Council for Graduate Medical Education (ACGME) and the National Academy of Medicine (NAM), have highlighted the importance of using a systems approach to address clinician well-being. In 2017, the ACGME revised its Common Program Requirements to emphasize the importance of positive learning and working environments for trainee well-being.¹⁵ In 2019, the NAM issued a report titled “Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being,” which introduced 6 goals to enhance clinician well-being (Table 2).⁴ National organizations, armed with datasets demonstrating the return on investment for well-being initiatives and the profound downstream effects of physician burnout on patient safety and quality of care, joined together to call for systemic change¹⁶ and began focusing on pragmatic solutions. This seismic shift in approach was punctuated by an editorial by Thomas Schwenk,¹⁷ where he stated that “Physicians in 2018 are the proverbial ‘canary in the coal mine.’ While the canary may be sick, it is the mine that is toxic. Caring for the sick canary is compassionate, but likely futile until there is more fresh air in the mine.”

Fast forward 3 years, and we are grappling not only with a global pandemic but also a reckoning of systemic racism and societal unrest. We are living in “unprecedented times” and with that comes new approaches and perspectives. Owing to the collective, slow-moving trauma experienced by the health care community during the COVID-19 pandemic, we are now more openly discussing the topics of mental health, well-being, and injustice that were previously stigmatized into silence.

Well-Being 1.0: Where We Failed

Given the history of well-being in medicine, it is not surprising that the first iteration of clinician well-being efforts leaned heavily on individual interventions such as mindfulness classes, yoga, and resilience training. One reason is that the primary objective of initial well-being efforts was to address burnout, and at the time there was a tendency to think of burnout as an individual problem. However, burnout stems from chronic workplace stress that has not been successfully managed.¹⁸ As workplace culture and environment affect burnout, individual-focused interventions alone cannot sufficiently address the issue, thus the inclusion of systems-level interventions is necessary.

Despite repeated calls for a systems approach to physician well-being, health care organizations have continued to predominantly allocate their attention and resources to individual-focused interventions. Physicians already exhibit high levels of resilience⁶

Table 2 National Academy of Medicine goals for eliminating clinician burnout and enhancing professional well-being	
Goal	Description
Create positive work environments	Transform health care work systems by creating positive work environments that prevent and reduce burnout, foster professional well-being, and support quality care
Create positive learning environments	Transform health professions education and training to optimize learning environments that prevent and reduce burnout and foster professional well-being
Reduce administrative burden	Prevent and reduce the negative consequences on clinicians' professional well-being that result from laws, regulations, policies, and standards promulgated by health care policy and regulatory and standards-setting entities, including government agencies (federal, state, and local), professional organizations, and accreditors
Enable technology solutions	Optimize the use of health information technologies to support clinicians in providing high-quality patient care
Provide support to clinicians and learners	Reduce the stigma and eliminate the barriers associated with obtaining the support and services needed to prevent and alleviate burnout symptoms, facilitate recovery from burnout, and foster professional well-being among learners and practicing clinicians
Invest in research	Provide dedicated funding for research on clinician professional well-being

Data from National Academy of Medicine, National Academies of Sciences E and Medicine. Taking action against clinician burnout: a systems approach to professional well-being. The National Academies Press; 2019. <https://doi.org/10.17226/25521>.

and they are being tested time and time again during the COVID-19 pandemic. Individual-focused interventions without organizational efforts to improve the work environment will inevitably breed resentment and resistance due to incongruence between the organizational leadership's words ("we value your well-being") and actions ("we are not fully invested in your well-being").

Another reason for the predominance of individual-focused interventions is that they are nimbler and take less time to implement than systems-level interventions. The urgency and widespread negative consequences of physician burnout prompted health care institutions to act swiftly. This focus on immediate action, although well-intentioned, can hurt physician well-being efforts by promoting quick fixes rather than long-term solutions. In medical school, many of us learned the adage *ubi pus, ibi evacua* or "where there is pus, evacuate it." Even though it is faster and easier to put a bandage on the abscess instead of draining the pus, this will not make the abscess go away and in fact, will make things much worse. Superficial well-being initiatives that do not address core issues related to well-being conversely worsen burnout and precipitate a loss of trust in leadership and the organization.

The "quick fix" mindset to reduce burnout also led to rushed efforts to define and measure clinician burnout. It is impossible to solve a problem without having a thorough understanding of the problem itself. The Maslach Burnout Inventory (MBI) evaluates 3 key dimensions of emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment.⁵ Although the original goal of the MBI was to study which factors are associated with each of the 3 dimensions of burnout, numerous organizations have modified or misused the MBI to measure burnout as a

single score to provide an individual diagnosis or organizational metric.¹⁹ As mentioned earlier, with “wicked problems,” the choice of explanation determines the way the problem is addressed. Thus, oversimplification of the concept of burnout inevitably leads to well-being interventions that are woefully inadequate or misdirected.

Well-being is much more than avoiding burnout. Well-being is the experience of positive perceptions and the presence of positive environments that enables individuals to thrive and achieve their full potential.⁴ In medicine, positive perceptions and environments are driven by pragmatic solutions that improve physicians’ daily clinical practice as opposed to initiatives that do little more than check off an arbitrary well-being box. Well-being permeates the entire work experience, and well-being efforts must begin with addressing physicians’ basic physical and mental health needs, followed by patient and physician safety needs, before focusing on higher-order needs such as respect, appreciation, and connection.²⁰ Burnout is a symptom, not the underlying problem. A well-being strategy that fixates solely on decreasing burnout lacks dimension and represents a lost opportunity to build engagement; it also embodies a reactive, instead of proactive, approach to well-being.

As is the case with many issues in medicine, preventing burnout is more effective than treating established burnout. A population health approach has been proposed to address physician well-being through the promotion of professional fulfillment, prevention of burnout, and selective mitigation strategies for physicians at elevated risk for burnout.²¹ Preemptive actions to promote physician engagement and protect against burnout help clinicians, patients, and health care organizations avoid many of the negative consequences of burnout, ultimately benefiting the entire health care system.

Eventually, we must drain the abscess. Every “wicked problem” is a symptom of an underlying, deeper problem. Physician burnout is a symptom of an unhealthy culture in medicine and health care industry that pushes physicians ever more toward moral injury.¹

Well-Being 2.0: Shifting Focus to a Sustainable Culture

Moving the needle on improving well-being in medicine necessitates a cultural overhaul of the medical system, understanding that the well-being of health care providers is essential for a safe, efficient, and effective healthcare system. “Checking the well-being box” without changing the system is as useful as rearranging deck chairs on the Titanic. Where is the hope? Where do we go from here? As thought leaders and well-being pragmatists, we believe there is a way to lower the temperature on the boiling pot in which we are swimming and shift toward a more sustainable culture. Physician well-being experts have known the secret for years: the answer is not group yoga or mandatory resilience training; the answer is the hard work of culture change.

Stop the glorification of excessive self-sacrifice

We are part of a culture that has traditionally upheld perfection and unrealistic self-sacrifice. We expect overworked physicians who are barely clinging to the lowest level of Maslow’s hierarchy of needs²⁰ to provide the highest level of complex, error-free care. Physicians perpetuate this mentality through the rituals of medical training. We give a pleased nod to a “tough” intern who arrives limping in pain or “help” a struggling colleague by placing an intravenous catheter for rehydration so they can finish a call shift. In medicine, we have created a culture where personal boundaries are discouraged and perceived as a lack of dedication to the profession. We create an artificial choice between a successful professional life and a fulfilling personal life, when in

fact they should coexist. The archaic model of medical practice, where the male physician worked long hours and was supported by a full-time, unpaid wife at home, is now a rare reality. Although today's diverse workforce has evolved to increasingly resemble the society it serves, the demands on physicians continue to be based on this antiquated model.

How do we enact limits on the Hippocratic Oath? The 2017 Revised Declaration of Geneva contains the words: "I WILL ATTEND TO my own health, well-being, and abilities in order to provide care of the highest standard."²² We must recognize, as a profession, that serving our own needs ultimately serves our patients, as demonstrated by the overused but accurate adage: "We must put on our own oxygen masks first." We must normalize physicians expressing the need to care for their own mental or physical health and those of their loved ones.

Litigation: stop blaming and shaming doctors

The litigious nature of the American health care system leaves little room for vulnerability. "First do no harm" often feels a distant second to patient satisfaction scores or online reviews. Physicians involved in a lawsuit are at increased risk for stress, personal consequences, and burnout.^{23,24} Increased litigation against doctors has not been shown to improve patient safety or quality of care; more likely, it is contributing to the exodus from medicine, ultimately decreasing patient safety through limited access to care.^{25,26} Clinicians may practice defensive medicine to avoid malpractice claims, which can lead to moral injury and damage the physician-patient relationship.²⁷ Well-designed and implemented liability reform is necessary to recapture the goal of upholding patient safety while minimizing the personal and professional trauma on doctors.

Normalize peer and mental health support

The lack of psychological safety in medicine is largely due to the lack of systems-level responses to events such as litigation, unanticipated bad outcomes, and critical events, leaving isolated clinicians to suffer in silence. Proactive, not reactive, robust support mechanisms must be established to respond to clinicians involved in these highly stressful events. These include peer support programs that can respond to clinicians in real time, provision of relief from clinical duties when appropriate, connection to professional mental health support, and longitudinal legal and risk management support. In other fields, such as law enforcement, there is mandatory time off after a critical event. However, in medicine, we are expected to proceed with the next case despite evidence that this is not in patients' or providers' best interests.²⁸ This mindset is built on the hubris and arrogance that physicians are somehow impenetrable. We do not have the capacity to care for those who are suffering without emotional repercussions nor should we desire this trait. We must normalize time off after critical events and provide a systems-level recognition of the emotional labor of medicine.

During the COVID-19 pandemic, state licensing requirements were temporarily suspended to mobilize physicians to states in dire need of providers. Yet predating the pandemic, many of these states enacted barriers to medical licensure if physicians had a history of seeking treatment for depression or anxiety or took an antidepressant medication, as 13.8% of Americans do.²⁹ To normalize physician self-care, state licensing organizations must give mental health parity with physical health. Nearly 40% of physicians report reluctance to seek care for mental health issues due to concerns about repercussions to their medical licensure.³⁰ We recognize the need for regulatory agencies to ensure the safety of future patients, but it should not come at the expense of a healthy physician workforce.

Stop the strip mining

Health care systems strive for efficiency. Although a desirable goal, it is not sustainable without a foundation of clinician well-being. The reimbursement structure of medicine in the United States is flawed and motivates health care institutions to prioritize short-term gains over sustainability. Clinicians are pressured to do more with fewer resources³¹; this production pressure can lead to moral injury when clinicians feel that patient care is compromised. This “carrot and stick” model devalues physicians’ compassion and expertise, reducing them to a cog in the wheel. Harnessing physicians’ intrinsic motivators, such as delivering high-level patient care and contributing to a shared purpose, is a more effective strategy to engage physicians.³² Clinicians are a valuable and finite resource and must be recognized as such. It is insufficient for health care institutions to focus solely on recruitment; they must adopt long-term strategies focused on retention by investing in and supporting employees.

Empower physicians to be the architects of their own environment

Physicians are well aware of clinical and environmental stressors that threaten well-being, yet often feel disempowered to voice concerns and suggest improvements.³³ This renders a disservice to patients, clinicians, and health care organizations because physicians provide unique insight and potential solutions to burnout. Health care institutions must invest in physician leadership to empower individuals with the skills and resources to enact necessary change in their clinical practice and work environment.

Furthermore, physician leaders’ time must be respected as a finite resource. Physicians are often asked to take on leadership roles without additional pay or protected nonclinical time.³⁴ This lack of adequate resources is a set up for failure. Leadership roles without protected time or compensation can lead to burnout due to exhaustion, feelings of incompetence, and a lack of achievement and productivity. In addition, physician leaders may experience resentment if the institution devalues their time and efforts.

Another way for health care institutions to invest in physician leaders is to offer physician leadership training. Medicine traditionally emphasizes intellectual rigor as the key to becoming a successful physician.³⁵ However, a physician cannot lead and effect change through academic excellence alone. An effective physician leader must, as David Chestnut posits, possess the attributes of “humility, servant leadership, self-awareness, kindness, altruism, attention to personal well-being, responsibility and concern for patient safety, lifelong learning, self-regulation, and honesty and integrity.”³⁶ Although most physicians are responsible for leading patient care teams in the clinical setting,³⁷ health care organizations rarely invest in developing physicians as leaders.³³ Early leadership training for physicians represents an opportunity to improve the clinical work environment for all care team members and achieve better patient outcomes. Although some graduate medical education programs provide leadership training, it is not currently a widespread practice in medicine and health care systems.³⁸

SUMMARY

“Do the best you can until you know better. Then when you know better, do better.”

– Maya Angelou

Efforts to study and address physician well-being are relatively new, and our understanding of physician well-being continues to evolve. Early well-being initiatives focused predominantly on the individual because burnout was initially framed as an

individual problem, but there is ample evidence that systems, policies, and organizations profoundly affect well-being. Therefore, both individual-focused and systems-level interventions are necessary. Rapid deployment of low-cost, one-off solutions are insufficient to adequately and holistically address physician well-being. We are in a crisis of burnout due to widespread moral injury and a longstanding culture of medicine that forces clinicians to “do more with less” and robs them of the meaning and purpose in their work.³¹ The COVID-19 pandemic has exacerbated preexisting moral injury for many physicians, and the stakes are higher now than ever. We cannot afford to let this vicious cycle continue. If we want to make real progress to address physician well-being, we can no longer focus solely on extinguishing the immediate fires of physician burnout. We must take the long and difficult path to heal our professional culture and develop a sustainable culture of support in medicine.

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J. L. Sinskey is the Vice Chair of the American Society of Anesthesiologists' Committee on Physician Well-being. R. D. Margolis is the cofounder of the Society for Pediatric Anesthesia's Special Interest Group for Physician Well-Being. A. E. Vinson is the Chair of the American Society of Anesthesiologists' Committee on Physician Well-being.

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