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GUEST EDITORIAL

The madness of mandated wellness

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Medicine has become plagued with 2 problems: an increasing report of physician burnout, and an unclear vision of how to deal with it.

Although we have accepted the fact that many physicians are burned out, we do not fully understand how to define burnout,[1] given marked differences in the criteria by which it is measured[2] and its unclear relationship to exhaustion, depression, frustration, and other issues. Regardless of a precise definition, many physicians in the United States experience some form of burnout, and burnout is more common among physicians than it is among other types of workers in the United States (37.9% vs 27.8%).[3] This problem will likely continue for some time, as the upcoming generation of physicians appears to experience burnout from the onset of their medical careers.[4]

We are a bit less clear about the reasons for or causes of physician burnout. There are many causes discussed in the literature, including problems that occur at both the health care system and physician levels.[5] The list of potential causative factors is long. It includes but is not limited to long working hours, excessive workloads, inefficiencies in work processes, prolonged stress, low work satisfaction, tedious documentation in various electronic health records (EHRs), depression, loss of control over how to provide health care because decisions are made by large corporations, a damaged sense of meaningfulness, lack of respect, focus on monetary aspects of medicine, falling income, and disregard for the concept of service. In the past, burnout was frequently considered a physician-only problem. However, "Recently, there has been a shift from viewing burnout as an individual problem to a problem of the health care organization as a whole, rooted in issues related to working environment and organizational culture."[6] For many, this view seems like a step in the right direction.

However, we are not clear about how to best approach and manage burnout. Health care organizations and hospital systems have developed various interventions. In a systematic review and meta-analysis of controlled interventions to reduce burnout in physicians, Panagioti et al[6] stated these interventions "can be classified into 2 main categories,

physician-directed interventions targeting individuals and organization-directed interventions targeting the working environment." The organization-directed interventions seem to make more sense because, in a way, they present *preventive measures*. Interventions that aim to reduce workload and time spent documenting in an over-inclusive and often counterintuitive EHR, or those that increase the level of physician participation in the health care organization's decision-making, would likely reduce work-related burnout. Simply canceling annual computer courses required for privileging (eg, we had to complete an instructive course on how to wash our hands multiple times) would also provide relief, reducing stress and possibly burnout.

Nevertheless, it seems that organizations prefer physician-directed interventions. Some institutions offer mindfulness and yoga classes, teach cognitive-behavioral techniques and communication skills, give advice on healthy eating, and provide other so-called "wellness activities." In order to demonstrate concern and provide evidence of intervention, some residency programs require all trainees be evaluated by psychology and psychiatry services or participate in education sessions related to burnout and coping strategies. The same can be said of medical schools that are instituting mandatory burnout-related curricula for students. From the organization's point of view, these interventions likely have 2 advantages: they are less expensive in the short term and easier to implement. Yet, they may actually add more stress to an already strained individual because such interventions take away more of their time. It seems unthinkable to add mandatory time for these programs to physicians who are working 60 hours a week, or in the case of residents and students, 80 hours a week (assuming compliance with duty hour restrictions). Yet, it happens. Should we continue to mandate these types of "wellness" programs? Isn't prevention of a problem better than the treatment of its consequences?

As we live in times of evidence-based medicine, we should look for strategies that have been proven to help. Panagioti et al[6] showed that "interventions for physicians were associated with small significant reductions in burnout. Organization-directed interventions were associated with higher treatment effects compared with physician-directed interventions. Interventions targeting experienced physicians and delivered in primary care showed evidence of greater effectiveness compared with interventions targeting less experienced physicians and delivered in secondary care, but these group differences were nonsignificant." The authors state that their findings provide support for the view that burnout is a problem of the whole health care organization, rather than that of individuals.

The question may be where to start changing systems. A recent Perspective aptly titled "Getting rid of stupid stuff" offers one useful recommendation.[7] The author describes an effort to reduce some of the unintended burnout imposed by an EHR by simply asking employees to nominate anything that "they thought was poorly designed, unnecessary, or just plain stupid." Embraced by both nurses and physicians, the Stupid Stuff program has led to small but meaningful changes in the EHR, and perhaps more importantly, it provides a message that daily frustrations are important enough to attend and reduce daily frustration. It is one small way to start changing the burnout-related problems of health care organizations. We could all benefit from initiatives such as this.[8]

Constructive, inventive changes to the health care system seem to be a better solution than having mandated individual-wellness programs to address physician burnout! ■

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CORRECTION: The article "A prenatal supplement with methylfolate for the treatment and prevention of depression in women trying to conceive and during pregnancy" (Freeman MP, Savella GM, Church TR, et al. Ann Clin Psychiatry. 2019;31[1]:4-16) contained an error in the key for Figure 1; the symbols denoting Group 1 and Group 2 were transposed. The article has been corrected online.