Addressing burnout and resilience in our profession

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I have recently been reflecting on my personal and professional experiences with respect to burnout and resilience.

As an internist, who for decades has cared for medical students, physicians, and faculty, and as director of medical student, resident, fellow, and faculty development programs, I was not aware of burnout in our profession until reading about it in the 1980s. When I reflect back, I realize that I intuitively knew that doing the same thing all day, day after day for 40 years would not be good for me. I was passionate about teaching as well as being a doctor. This made me prepare for work that would include both caring for patients and teaching of students, residents, fellows, and colleagues. This insight led me into a career in academic medicine which provided great diversity in caring, teaching, scholarship, and leadership, which is something I needed to keep from burning out.

Personal resiliency

As an academician, I was on a cycle that required reflection, thinking, and planning on a structured academic year. This allowed time for thought regarding my career path, both as a physician and as an academician. General internal medicine as an academic discipline was rapidly developing nationally. I was fortunate to be recruited from my Associate Professor position as head of the first section of general internal medicine at the University of Chicago to start a new Division of Internal Medicine as a Professor of Medicine and Vice Chairman of the Department of Medicine at the University of Colorado. This new role provided me the opportunity to care for patients; lead faculty, residents, fellows, and others; teach; conduct research; participate in scholarly activities; and work in the medical school and hospital administration.

I had excellent mentors, role models, and coaches, and learned how to teach, learn, work, and find the joy in caring and contributing.

Following the excellent advice of my mentors, I decided to evaluate what I was doing professionally and personally every five years. As a division head I developed a five-year experiential learning and practice plan. Much of the focus in this plan was on learning, developing education and learning experiences and programs, and descriptive scholarship-publishing articles on what I had learned and experienced. I reflected on and evaluated new opportunities to care, learn, develop, and contribute in my appointed position.

After the first five years, I realized that my greatest shortcoming in teaching internal medicine was clinical pharmacology. I volunteered to teach on the clinical pharmacology consultation service, went to their conferences, worked with clinical pharmacists on service and in the clinic, and read the literature. I became a knowledgeable clinical pharmacologist/ internist teacher.

Five years later I once again evaluated my goals. While I had trained in endocrinology and had a dual appointment, my primary focus was in general internal medicine. I realized that most of the consults for internal medicine on obstetrics and gynecology were for asthma, pre-eclampsia, diabetes, thyroid disease, and pharmacology. I knew that there was a weekly clinic for high-risk obstetrics with high-risk specialists, geneticists, and pharmacologists, etc. So, I proposed to the head of high-risk obstetrics that we have an internist, medical resident, and fellow participate weekly in the high-risk obstetrics clinic and conference to care for the patients and teach. While unheard of at the time, this new concept was accepted, supported, and very successful.

Five years later—still finding joy in my position and practice, I found that I was not doing as much research and scholarly work as I would like. My major interests were in cardiovascular disease, epidemiology, and cardiovascular risk factors. I decided to develop a clinical research team in cardiovascular pharmacology. I recruited a nurse research director, a few study nurses, and a biostatistician, and together we conducted phase I—IV clinical trials. We published early results for orlistat, and losartan. We also taught and wrote about informed consent. Our studies

Illustration by Jim M'Guinness

provided opportunities for other faculty to participate in the research. This was a very fulfilling five years.

My next area of focus was on clinical epidemiology as a research, teaching and clinical focal point of internal medicine. I completed my course work in epidemiology in one year, though I never submitted my thesis for a Master's degree in Public Health.

It had been 25 years, and I found myself caring for a university president. He asked me what I wanted to do next in my career. I told him I didn't know, but that I worked every day to be a better teacher, clinician, and at the time didn't want a new pursuit in research. He asked, "What did you want to do before you were professionalized as a physician?" I said that I was a history major and thought I would get a PhD and become a professor of history, write books, and teach, and maybe some day I would become the president of a small college." He asked, "Why don't you do that?" I explained that I had been "professionalized." His response was, "Physicians are much better prepared to be leaders and academic administrators than you give yourself credit for." He then nominated me for the American Council on Education fellows program. I was accepted and spent a year with my mentor President John Casteen at the University of Virginia.

I returned to the University of Colorado and provided academic leadership in several positions including serving for eight years as the chancellor of the University of Colorado Boulder.

Throughout this entire time, I made sure that I was able to care for patients at least one-half day each week since I knew that was what truly provided joy for me. It was critical to my health and well-being. I believe it kept me from burning out.

Family burnout

While I have never personally experienced burnout, my family has been affected by my work and commitment as an academic physician. There have been many occasions over the course of my career when I have, out of necessity, placed the well-being of my patients first. The middle of the night calls, the prolonged office hours, the weekend rounds, and the disrupted vacations, have all been reminders from my family of how they have been affected by my medical professionalism.

Many years ago, when my son was trying to determine his career path, he told me, "I definitely don't want to be a doctor. I don't want to be called away from my family like you have been from us." As it turns out, my son is a doctor in emergency medicine. There is a lesson here for all of us: being a doctor and taking the oath of medical professionalism is not something that we do in isolation, but rather something that includes our family members, our colleagues in and out of medicine, and our patients.

> *"Burnout at its deepest level is not the result of some train wreck of examinations, long call shifts, or poor clinical evaluations. It is the sum total of hundreds and thousands of tiny betrayals of purpose, each one so minute that it hardly attracts notice."*
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> —Richard Gunderman, MD, PhD
> (ΑΩΑ, University of Chicago, 1992)

A change in our profession

In the late 1980s, I read the occasional report on burnout in doctors, and heard about the episodic case of a medical student who had committed suicide.

We now know that something happened to our profession during this time that resulted in doctors who were being confronted with a previously tacit set of circumstances and issues that resulted in burnout. Burnout occurred prior to this time, but like mental illness, was not something that was spoken of, or discussed openly within our profession.

As it has been for centuries, those entering the profession of medicine are commonly drawn to a belief that physicians experience a high level of autonomy and job satisfaction; are highly educated and competent; work with responsive and receptive patients; and are compassionate and caring. All reasonable expectations for young physicians. However, also as it has been for centuries, many entering this profession are unprepared for the challenges and contemporary realities of their chosen occupation. This phenomena is common for anyone entering people-oriented, human services occupations where the relationship between the provider and the patient/client is central to the work and the provision of service, care, or teaching. This can, and does, create emotional stress.

As burnout came to the forefront, and began to be openly discussed, its severe professional and personal consequences emerged.

The most common definition of burnout comes from Maslach and Jackson who in 1986 wrote, "Burnout is a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do 'people work' of some kind."[1] This definition

was the result of the Maslach Burnout Inventory which was developed and widely distributed beginning in 1981.

The Maslach Test helped many to better understand burnout, and focused on occupational factors including job satisfaction, stress, workload, role conflict, role ambiguity, withdrawal, turnover, and absenteeism. It correlates to job expectations, relationships with co-workers and managers, social support systems, time in the position, and organizational policies. It also looks at personality variables including health, relations with family and friends, and personal values and commitment.

Over the past 35+ years, it has been found that occupational and professional factors are more strongly related to burnout than are biographical or personal conditions. Most of the studies correlate higher burnout with poor occupational factors, and that those experiencing burnout respond differently. The common thread throughout is that the vast majority of those experiencing burnout report occupational conditions as the cause. It is unclear if occupational dissatisfaction causes burnout, or if burnout causes occupational dissatisfaction, or if both are the result of poor work conditions.

A chronic condition

Burnout is a chronic condition that leads to physical symptoms. As with any chronic health condition, burnout depletes an individual's resources, and requires a long-term recovery process. Burnout is characterized by dysphoric symptoms that are similar to depression, anxiety, irritability, and fatigue.

The clinical symptoms are manifested by cynicism, impatience, irritability, sense of omnipotence, paranoia, disorientation, denial, and psychosomatic complaints. The exhaustion is both emotional and mental, demonstrated by problems with concentration, irritability, negativism, insomnia, increased use of alcohol and drugs, and marital and family problems.

Often times, physicians suffering from burnout try to defensively cope with the occupational stress by psychologically detaching from the job and becoming apathetic, skeptical, cynical, and rigid. They experience a loss of idealism, lack of energy, and absence of the purpose that brought them to the medical professional.

In 1997, Leiter and Maslach identified six major influences on burnout:[2]

- Workload and its intensity, time demands, and complexity;
- Lack of control of establishing and following day-to-day priorities;
- Insufficient reward and the accompanying feelings of continually having to do more with less;
- The feeling of community in which relationships become impersonal, and teamwork is undermined;
- The absence of fairness in which trust, openness, and respect are not present; and
- Conflicting values, in which choices that are made by management often conflict with their mission and core values.

Each of these influences are external to the individual, and typical of most medical environments today.

The causes of physician burnout are multifactorial and include unrealistic professional expectations, lack of endurance, time pressures, excessive work hours, professional threats, difficult patients, coping with death and disability, grief, sleep deprivation, isolation, and uncertainty.

Physician altruism and character traits also predispose those in the medical profession to burnout as physicians are expected to be compassionate yet competitive perfectionists who are responsible and available to care for others 24/7 in any situation and under any circumstances.

An epidemic

Burnout in the medical profession has now reached epidemic proportions with more than one-third of doctors dealing with some form of professional burnout, and more than 50 percent of physicians in the United States experiencing at least one symptom of burnout.

The fact that so many of our colleagues are experiencing burnout is a direct result of the abject debasement of our nation's health care system, and the businessification of health care organizations and academic health centers. Physician performance is often related to how many relative value units (RVUs) are billed, financial accomplishments to increase organizational revenue, and Press Ganey patient satisfaction survey scores. These performance factors are expected to be achieved via reduced patient contact time and diminished collegial interactions and consultation time in an environment of demanding regulatory and legal requirements.

Medical professionalism

Professionalism is a required core competency for physicians. We have developed clear and explicit professional expectations for all physicians, and a commitment for physicians to respect and uphold a code of professional values and behaviors, including a commitment to adhere to high ethical and moral standards—do right, avoid wrong, and

Professionalism in Medicine

Responsibilities to Patients
The care of your patient is your first concer
Care for patients in an ethical, responsible, reliable, and respectful manner
Do no harm
Respect patients' dignity, privacy, and confidentialit
No lying, stealing, or cheating, nor tolerance for those who do
Respect patients' rights to make decisions about their care
Commit to professional competence and lifelong learning
Communicate effectively and lis en to patients with understanding and respect for their views
Accept professional and personal responsibility for the care of patients
Be honest and trustworthy and keep your word with patients
Use your knowledge and skills in the best interest of the patient
Maintain appropriate relations with your patients
Treat every patient humanely, with benevolence, compassion, empathy, and consideration
Reflect f equently on your care of patients, including your values and behaviors
Social responsibilities and advocacy
Commit and advocate to improve quality of care and access to care
Respect and work with colleagues and other health professionals to best serve patients' needs
Commit and advocate for a just distribution of fini e resources
Commit to maintaining trust by managing conflicts of in erest

do no harm; subordinate personal interests to those of the patient; avoid business, financial, and organizational conflicts of interest; honor the social contract with patients and communities; understand the non-biologic determinants of poor health; be accountable, both ethically and financially; be thoughtful, compassionate, and collegial; continue to learn, increase your competence, and strive for excellence; work to advance the field of medicine and share knowledge for the benefit of others; and reflect dispassionately on your own actions, behaviors, and decisions to improve your knowledge, skills, judgment, decision- making, accountability and professionalism.

Medical professionalism as a construct has changed over the past 40 years. The centuries old model of professionalism is associated with virtues and ethics. A good physician is a person of character who is able to apply ethical principles, curb self-interest, demonstrate the virtues of compassion and respect, and be humanistic, trustworthy, and caring. This was based on the code of Hammurabi, Hippocrates, and Maimonides who developed oaths codifying the practice of medicine as the sacred trust of the physician to protect and care for the patient, and a set of values for physicians in the form of a social contract that codified what patients and society should expect from the physician.

More recently, professional organizations and leaders in medicine defined the fundamental principles of medical professionalism. Canmeds 2000 states, "Physicians should deliver the highest quality of care with integrity, honesty, and compassion, and should be committed to the health and well-being of individuals and society through ethical practice, professionally led regulation, and high personal standards of behavior."[3]

In addition, the American College of Physicians and The American Board of Internal Medicine developed a physician charter with three fundamental principles:[4]

- The primacy of patient welfare or dedication to serving the interest of the patient, and the importance of altruism and trust;
- Patient autonomy, including honesty and respect for the patients to make decisions about their care;
- And social justice, to eliminate discrimination in health care for any reason.

In the 1990s, a different model arose around behaviors and competencies. The behavioral model emerged in response to the perceived failure of the virtues model to translate ethical instruction into ethical action. The good physician, according to behaviorists at the time, was a person who manifested a defined set of behaviors and demonstrated professionalism competencies.

In the past decade, a third model of professional identity formation has been developed in reaction to concerns about the reductionist behavioral model, and described the progressive incorporation of the values and aspirations of the profession into the identity of the person as a physician. The good physician takes on the identity of a community of practice, and is socialized into the values, aspirations, and behaviors of the field. In 2004, Drs. Richard and Sylvia Cruess wrote that the profession of medicine is:[5]

> An occupation whose core element is work based upon the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning or the practice of an art founded upon it, is used in service of others. Its members are governed by codes of ethics and profess a commitment to compe-

> tence, integrity and morality, altruism, and the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which in return grants the profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice, and the privilege of self-regulation. Professions and their members are accountable to those served, and to society.

Professionalism can also be seen as adoption of appropriate behaviors and demonstration of an area of competence which tightly aligns instruction and assessment. It is the process of taking on the identity of a medical professional, a healer, and a physician, who is inspiring and embraces self-reflection. Professionalism can be viewed as a matter of character, humanism, and ethical reasoning which is inspiring to learners and practitioners.

Medical professionalism must be recognized as an active, ongoing, and iterative process that involves debate, advocacy, leadership, education, study, enforcement, and continuous transformation. However, there should be no capitulation to efforts or circumstances that undermine ethics, values, or medical professionalism.

A problem exists when there is a gap between the realities we experience and the ideals to which we aspire and commit. Many of the obstacles we encounter in medicine are technical problems which we can recognize and define. However, many problems are complex adaptive problems which are controversial and volatile. Medical professionalism issues are complex adaptive problems for which no clear solution is evident.

Medical professionalism issues and lapses by physicians may be caused by the system which fails to protect the physician, and consequently the patient. Professional challenges often require the physician to simultaneously manage the professional expectations, and with those of the patient, colleagues, nurses, students, and administrators. This causes conflicts that frequently result in professionalism challenges.

This is compounded by the inconsistent, ambiguous, and conflicting expectations from the organization to put the patients' needs above all else, while at the same time expecting physicians to do more with less time. That is expected to be accomplished while obtaining organizational rewards for high-volume throughput of patients, which is placed above high-quality patient care and teaching. Expecting a physician to behave in a way that is counter to human instinct creates challenges and is a contributing factor of burnout.

Social changes

Social changes have altered the relationship of the doctor and patient. In the corporate transformation of health care, many components of medicine have become businesses that do not put the patient first and diminish the special doctor-patient relationship. Medicine has also seen the introduction of entrepreneurs, investors, and corporate executives. The primacy of the care of the patient is not always the primary focus.

Serving as a physician and practicing medicine must be based on core professional beliefs and values, and those entering and practicing the profession must understand the values of medical professionalism and learn and demonstrate the aptitude and commitment to behave professionally. Physicians work in service to others, and success is measured by how well we benefit those in our care, not by financial returns.

We are evaluated and respected because of what we do and how we meet our responsibilities. Medicine is self-directed and therefore largely self-regulating. The privilege of self-regulation is granted to us by patients and society when we prove ourselves worthy of their trust by meeting our professional responsibilities to them.

Continuous learning

Adversity in the practice of medicine is inevitable. However, the capacity to quickly recover from difficulties, requires resilience. Resilience is about getting through the pain, disappointment, self-incrimination, and feelings of inadequacy. This is why we call it "the practice of medicine" since we are always practicing and learning from both our successes as well as our failures.

Failing is human, and requires the capacity to reflect, learn, and do better. It is an essential component of the practice of medicine. Failures should be perceived as just "stumbling blocks" on the path to success.

As physicians we must continue to improve and regain the joy of caring and helping others, only then can we overcome the setbacks and difficulties and become better and stronger.

One of the most important factors in resilience is optimism—the ability to regulate emotions and see adversity and perceived failure as a form of helpful feedback and insight. An optimist sees the opportunity in every difficulty. This helps dull the impact of stress on both mind and body.

Optimism gives us access to our cognitive resources enabling a thoughtful, mindful analysis of what happened, what might have been done differently, and consideration of learning approaches and behaviors that might be more

effective and productive going forward. Optimism can improve one's outlook and attitude and become an effective coping strategy.

Resilience is not necessarily intuitive and requires copious mental work to transcend adversity, hardship, and perceived inadequacy. Inevitable episodes of realism and adversity can help build resiliency so we can achieve our goals, aspirations, and find the joy in caring.

Factors that lead to resilience include finding meaning in work; control and flexibility; adoption of organizational culture and values; efficiency and resources; work-life integration; social supports; and development of a community of practice. When there is more engagement, vigor, dedication, and absorption it is most advantageous.

New opportunities

Professionalism as a pedagogical challenge provides new opportunities. We should expand our teaching about professionalism beyond descriptions of behaviors we expect and into skills that foster resiliency. None of these skills are routinely taught or assessed in our conventional courses on doctor-patient relationships, but should be added to all medical curricula. We need to focus on skills to manage self as well as to interact effectively in the health care environment.

Helping learners and physicians to recognize when the situation is complex and may include values or patient conflicts is imperative. They must recognize the need to slow down and make an explicit decision about what to do, rather than simply respond. It is important to learn how to switch from generally appropriate fast thinking to more methodical slow thinking.

The skills of self-awareness and self-control must be inculcated. Teaching residents and learners that they should pause and take stock of their own emotions before they deal with a predictably challenging situation can be life changing.

The ability to generate alternate strategies for action that go beyond the first instinctive response is compulsory. Formal training in diplomacy, conflict de-escalation, crisis communication, and negotiation are imperative for defusing tense situations.

These are different skills than the usual relationship building or transactional information gathering skills that are included in doctor-patient relationship courses. Education about, and skill in identifying and maintaining appropriate professional boundaries, is a focus in the training of psychiatry residents, but all physicians should be skilled in this competency.

A core responsibility and value of professionalism is professional self-regulation: the responsibility of the profession to police itself. Physicians must be taught how to intervene when a lapse seems imminent, and how to coach peers who have committed a lapse. Recognizing that lapses will occur even in the best of circumstances, we must teach our professionals how to express a genuine and effective apology if their behavior or words have injured another.

We must facilitate interprofessional teamwork incorporating shared values of professionalism and welcoming support and coaching from all in the health professions. We take steps to remove unnecessary stressors by ensuring that institutional policies and procedures reinforce rather than undermine desirable behavior. We must devise service recovery systems for all who have been harmed by a professionalism lapse. All organizations need to support reflection and renewal.

The development of a professional identity of a physician—how to think, act, perform, feel, and be a doctor—along with a well-defined set of expectations of the profession—the physician charter—are the first steps toward resiliency.

Community of practice

Physicians are part of a community of practice comprised of healers and medical professionals. Over the last several decades, the medical community of practice has changed resulting in an isolated role for the physician with silos and unintended consequences.

Traditionally, physicians cared for patients in a clinical community setting where they consulted with each other regarding difficult patient cases and diagnoses; shared the joys and tragedies of medical care; and enjoyed collegial relationships. Time required for the care of the patient was provided, and opportunities to learn and share experiences and knowledge were readily available. Physicians could teach and learn from each other, and from their patients. Social functions were organized for physicians, their families, and their medical community. They shared empathy, commiserated, and supported each other.

With the advent of RVUs, and the commercialization and businessification of medicine, these communities of practice have diminished, and in many instances become extinct. Now, dialogue among colleagues is through e-mail. Orders, lab requests and results must pass through an electronic portal, even if the person whose inbox you are about to overload is seated next to you.

The re-establishment of medical communities of

practice is one defense against burnout. Physicians need to have an opportunity to join a community of practice with other medical professionals who are educated and trained as healers.

In the community of practice I joined as an internist, we scheduled one-hour appointments for new patients and 30 minutes for follow up. If needed, I could schedule more time for a complex patient with special needs. We knew our patients quite well. Most of the visit was directly involved with the patient—no computer screen. We didn't have to negotiate with insurance or other non-physician intermediaries for approval of consultations, procedures, treatments, etc. We didn't have to solve problems using "work arounds". We simply did what was best for the patient.

Between patients, we could have a conversation with colleagues, team members, and staff. Sometimes we commiserated about problems, barriers, or system limitations, but often we would take joy in the care of the patient by presenting a great case and sharing what we had done and learned. We had opportunities to discuss difficult cases, share reasoning, and learn from a colleague.

These short intervals were collegial and provided an opportunity for education and reflection. Once a week, we would have organized clinical practice teaching conferences. Once a month, we would organize an evening together with colleagues, spouses, and significant others to socialize. We often went to the gym with colleagues to work-out, and had organized recreational sports teams. At least twice a year, we would have an entire group social event with families for an afternoon picnic or evening dinner. Many of these events were open to other specialties providing opportunities for cross-discipline collegiality.

This was our community of practice.

Today, patients are scheduled for 30-minute to 40-minute new patient visits, and 15-minute to 20-minute follow-up visits. Patient visits are booked from 8 a.m. to 5 p.m., Monday through Friday. There may be a scheduled lunch break though it is often used to catch up when extended patient visits muddle the schedule. Physicians have no flexibility in allocating time dependent on patient complexity, and other patient's needs. More than one-half of the patient visit is spent facing a computer screen. Much of the time is related to negotiation on behalf of the patient or documentation for billing and collecting revenue. There is no time allocated for reflecting on the joy of caring for the patient, or sharing that joy with colleagues for educational purposes. There is no time between patients to share or commiserate.

All of this contributes to physician burnout. This is a tragedy for our profession, and for the care of patients. The medical profession should strive to achieve a level of caring in which service transcends self-interests. Physicians can then provide for individual patients, and also for the greater good. The ability to focus outward and attain great joy from caring will help overcome the feelings of burnout.

Efficiency of practice

Bureaucratic and market forces will continue to battle for the hearts and minds of 21st century professionals unopposed by the ethos, ethics, and practice of professionalism. None of this is about saving the world for professionals; rather it is about saving health care for patients and the public in a world where mission is increasingly defined in terms of margins and profits.

Medical educators and leaders of health systems have the opportunity to shape the professional development of learners, thereby reducing the propensity for burnout. It is crucial to identify and build sustainable models to ensure that learners and new physicians are exposed to positive role models, and introduced to how professionals self-regulate, and why.

Physicians need to self-evaluate, and watch for signs of burnout in themselves and their colleagues. Self-reflection and honesty are useful in self-evaluation. Commitment to work, self-efficacy, learned resourcefulness, and hope may help with resiliency, and increased job control.

Cognitive-behavioral therapy improves coping and mental health through development of personal coping strategies that target solving problems and changing unhelpful patterns in thoughts, beliefs, attitudes, behaviors, and emotion. This uses mindfulness-based approaches and therapies that are problem focused.

Distortions and maladaptive behaviors can be reduced by learning processing skills and coping mechanisms. This helps by challenging patterns and beliefs to utilize new ways of mindfulness and conscious thinking. Replacing magnified negatives by thinking more positively and optimistically with realistic and effective thoughts can help re-establish the joy of caring, while at the same time coping with the systems and barriers. This is a way to become more open, mindful, and aware of cognitive distortions.

While physicians and their colleagues can learn to cope with dysfunctional health care systems, the only way to truly prevent and enable physicians to care for patients and avoid burnout and dysfunction in practice is with organizational change and reinstatement of the community of practice. Physicians and organizations must collaboratively create and support a culture of caring that emphasizes compassion, respect, values, and principles. This will allow

physicians and the care teams to be committed.

Organizational change includes realistic workloads and supportive systems; encouraging mentoring and mentors; recognizing role models; providing control for those providing the care; compassion; and appreciation. This is the heart of medicine's contract with society.

Organizations must recognize that the care of the patient is more than a commodity or a business. Caring for a patient and the well-being of the physician is more than RVUs. They must eliminate barriers, and decrease administrative burdens.

The care of the patient is more than understanding and treatment of disease. Health care systems and physicians must be prepared and supported to address the needs of the whole patient as a person. Professionalism combined with the ethics of doing the right thing for the right reason, along with a commitment to reflection and evaluation of what is being done and why it is being done are paramount to the success of our health care system. There must be a preparatory culture of caring in teaching and learning.

We must create and nourish a new community of practice in medicine with greater collegiality and support. These must be mindful organizations that create opportunities and responsibility to meet and have conversations about the virtues and challenges of being a physician and providing care for the whole person.

Culture of wellness

Caring and providing for patients also involves caring for each other and our profession, and contributing to the community in which we work and live. When the organization and system do not enable us to care for our patients and colleagues, we must be assertive to demand application of our ethics and values in the care of our patients.

Resiliency begins with changing our thinking and being open to constructive change and finding the joy in caring for patients. Don't allow burnout to take over your professional life. Find who you are as a physician and medical professional. Know you are the one who makes authentic commitments and helps others. Be the one who improves the human condition. Move your work, life, and community forward. Be worthy to serve the suffering.

As a community, we must also take responsibility for shaping the systems in which we practice so that they support our core values.

All of this will require that physicians demonstrate and exert leadership.

Leading the way

ΑΩΑ has made a major commitment to developing future physician leaders in medicine through the Fellow in Leadership and the councilor's Short Course in Leadership. According to the AMA, "The leadership skills of a physician's direct supervisor have a powerful impact on physician burnout."[6] One study of physicians reported that every one point increase in leadership score for a physician's immediate supervisor was associated with a 3.5 percent decrease in the likelihood of burnout, and a 9.1 percent increase in physician satisfaction. This emphasizes the importance of assessing the leadership performance of division chiefs, department heads, and other direct supervisors of physicians, and the development of leadership by physicians in organizations and clinical care, and including physicians in the oversight of the work environment and the nature of their work to improve care, satisfaction, and retention.

Research has also shown that providing physicians with 20 percent of their time dedicated to meaningful professional activities, including quality improvement work, community outreach, mentorship, teaching, meeting needs of underserved, and other professional activities reduces burnout.

The secret is finding and celebrating the joy in caring and participating, learning, and leading that community of practice.

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