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EDITORIAL COMMENT



I commend Drs. Marchalik et al on their manuscript and work to help define contributors and mitigators to burnout among urology trainees. Their findings are consistent with a similar study by Elmore et al (2014) that demonstrated a 69% rate of burnout among general surgery trainees.¹ It is both curious and worrisome that rates of burnout are consistently this high, despite ACGME efforts to reduce resident work hours, improve learning: service ratios, and build programmatic supports into our training programs. Why is this so alarming? Burnout has been consistently linked to medical errors, suicidal ideation and attempts, and substance abuse and thus poses a great risk to our patients and our trainees.^{2–5} In a review of the role of healthcare leadership on physician burnout, Shanafelt and Noseworthy⁶ point out that the burden of prevention or treatment for burnout is often placed on the individual, with interventions like stress-reduction activities and coaching. However, in reality an integrated approach that focuses on treatment and prevention at all levels (individual, work unit, organization, National) is more effective. Two organizational programs noted here—access to mental health and structured mentoring programs—were shown to be important to reducing burnout. All trainees should have access to mental health treatments and be provided confidential opportunities to seek care. We need to work hard to reduce the stigma and shame surrounding mental health treatment by normalizing mental health as a part of self-care. Structured mentoring programs mitigated burnout in both this study and in the Elmore study. In an era of ever-increasing pressures for clinical productivity on faculty, demonstrating the value of faculty participation in mentoring and finding ways to protect these programs will be critical. In addition to programmatic supports like mentoring and mental health, the most important thing faculty can do is role model the primacy of self-care, seek meaning in joy in work, and build collegiality and community at work so that our future doctors can learn and hone their own resiliency skills.

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AUTHOR REPLY



We agree with the comment and commend it for its nuanced overview of the tension that currently exists in burnout science: on one hand, awareness of burnout and interventions related to it are increasing around the country; on the other hand, the needle seems to be moving too slowly. This slow progress has serious implication. A recent financial model of the economic impact of burnout to the US Healthcare system estimated the cost to be between \$2.6 and \$6.3 billion per year.¹ The impact on patient and physician lives is even more troubling.

While the numbers remain concerning, we feel that there is cause for optimism. Evidence-based intervention can indeed make a difference. A meta-analysis of 52 studies revealed that burnout-related programs had the ability to decrease burnout rates by an average of 10%.² In this analysis, organizational and structural interventions played a particularly important role.

We also fundamentally agree with the need to move away from the historic tendency to blame individuals for their burnout and then look to them to remedy it through resiliency training. While individual changes like mindfulness-based cognitive training³ and reading⁴ have been shown to have a positive effects on surgery trainee well-being, these interventions simply cannot exist in a vacuum. Instead, what we need is a clear recognition of the need for change and a commitment to that change from departmental and organizational leaders.

This is particularly important because leadership has a tremendous impact on physician well-being. An evaluation of a 12-question organizational leadership composite revealed that, even when controlling for gender, age, and specialty, each 1-point change on a 60-point leadership scale resulted in a 9% increase in the likelihood of professional satisfaction and a 3.3% decrease in the likelihood of burnout.⁵ These findings are staggering both in their magnitude and in the seeming simplicity of

the required changes. The composite questions evaluated a variety of traits most of which we would consider staples of good leadership (eg, the supervisor “inspires me to do my best;” “holds career development conversations with me;” “treats me with respect and dignity;” “provides helpful feedback and coaching on my performance,” etc.). Would these qualities not fall under basic expectations of program directors and department chairs?

In this way, some of our most successful burnout interventions might not hinge on large investments and innovative new programming. Instead, a renewed focus on leadership training, medical education, culture change, and structured mentorship, and a commitment to tracking leadership performance and burnout rates in our departments, will be paramount to improving well-being for both faculty and residents alike.

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