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Commentary and Opinions

Revealing the blind spots: five key challenges for advancing physician wellness

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Abstract

Physician wellness is a critical yet unresolved challenge in medical education. Burnout, emotional distress, and systemic barriers undermine the sustainability of the healthcare workforce, with negative consequences for both physicians and patients. Despite widespread recognition, existing interventions often fall short, hindered by fragmented approaches and resistance to change. This article identifies five key challenges that will need to be overcome if we are to make meaningful progress in advancing physician wellness: (1) inconsistent definitions and flawed methodologies in assessing wellness, (2) overemphasis on individual-focused interventions, (3) the absence of unified, evidence-based frameworks, (4) ethical and methodological problems with wellness surveys, and (5) the commercialization of wellness. Each challenge represents deeply ingrained barriers within healthcare institutions that impede meaningful progress. I advocate for a paradigm shift toward evidence-based, systems-level strategies, focusing on Canadian and US medical education. By integrating theoretical frameworks like Self-Determination Theory (SDT) and the Job Demands-Resources (JDR) model into accreditation standards and institutional practices, healthcare organizations can address the root causes of physician distress.

Résumé

Résumé français à venir.

Introduction

Physician wellness—a multidimensional state of well-being encompassing both physical and mental health, and the psychological and emotional resources necessary to thrive—is foundational to patient care and the sustainability of the healthcare workforce. However, despite decades of research linking burnout to higher rates of medical errors, reduced patient satisfaction, and increased physician turnover, meaningful progress has remained elusive.[1] Burnout is not merely an individual issue; it is a symptom of deeper systemic problems, including excessive workloads, toxic organizational cultures, and inadequate institutional support.[2]

While efforts to address physician wellness have skyrocketed in North America, they often fall into one of two traps: superficial interventions that fail to address

systemic drivers or fragmented approaches that lack coordination and coherence. Accrediting bodies, like the Royal College of Physicians and Surgeons of Canada (RCPSC) and Accreditation Council for Graduate Medical Education (ACGME), have yet to establish comprehensive, evidence-based frameworks to guide wellness efforts, leaving institutions to their own devices. The increasing commercialization of wellness initiatives also diverts attention and resources away from systemic reforms.

This article explores five interconnected challenges currently hindering the improvement of physician wellness: inconsistent definitions and flawed methodologies, an overemphasis on individual-focused interventions, the absence of unified frameworks, ethical and methodological issues with wellness surveys, and the commercialization of wellness. Overcoming these barriers will require a shift toward systems-level approaches grounded in robust theoretical frameworks, such as Self-Determination Theory (SDT) and the Job Demands-Resources (JDR) model. SDT emphasizes supports for basic psychological needs—autonomy, competence, and relatedness—as essential for wellness.[3] The JDR model emphasizes the need for balance between job demands (e.g., workload, time pressure) and available resources (e.g., social support, autonomy).[2]

Challenge 1: Inconsistent definitions and flawed methodologies

Barrier: oversimplifications and fragmented approaches. The first barrier to advancing physician wellness is the lack of consistent, evidence-based definitions and practices. Wellness is often treated as a vague, catch-all concept that conflates physical, emotional, and mental health, overlooking the complex interplay between individual, organizational, and systemic factors. Additionally, wellness is frequently conceptualized in binary terms—*well* or *unwell*—which disregards its dialectical and dynamic nature. This oversimplification undermines the development of effective interventions and perpetuates reliance on superficial, non-evidence based strategies.[4]

Compounding this issue is the methodological weakness of much of the wellness literature. Studies often rely on cross-sectional designs, small sample sizes, and single-center data, limiting the reliability and generalizability of findings.[5] Moreover, there is an almost complete absence of replication studies, further undermining the robustness of the evidence base.[6] Meta-research highlights issues such as publication bias and inadequate control groups, which inflate the perceived success of interventions.[7]

Recommendation: establish clear, theory-driven definitions and measurement approaches. Addressing these challenges requires a shift from fragmented approaches to more cohesive, theory-informed frameworks that provide clarity around wellness definitions and metrics. Adopting theories like SDT and JDR not only offers a clear conceptualization of wellness but also offers a common language around wellness, ensuring that its multifaceted nature is addressed in consistent and evidence-based ways.[2,3] Integrating these theories also distinguishes between core concepts that can confuse medical educators, such as autonomy versus independence. Autonomy—an ethical imperative for educators—involves making informed decisions aligned with personal values, while independence—an end goal of training—refers to functioning without supervision.[8]

Challenge 2: Overemphasis on individual-focused interventions

Barrier: limited scope and ethical concerns. Individual-focused interventions, such as mindfulness training, resilience workshops, and stress management seminars, have become the cornerstone of many wellness programs in Canada and the US.[4] However, these initiatives fail to address the systemic drivers of burnout and can perpetuate the false narrative that burnout is a personal failing.[4] These interventions are not without merit, but their prioritization over structural reforms is problematic. Mandating participation in wellness programs can create undue pressure on individuals, leading to disengagement and distrust toward institution, and it can perpetuate a compliance-driven culture rather than a genuine commitment to wellness. The modest effect sizes of individual-focused wellness interventions also highlight their limitations in producing meaningful, sustainable change.[9]

Recommendation: prioritize organizational-level reforms. Institutions should prioritize systemic reforms, including reducing excessive workloads, improving leadership quality, and fostering supportive workplace cultures.[10] Faculty development programs should train educators to create autonomy-supportive learning environments while embedding equity, diversity, and inclusion into wellness strategies.[11] By integrating SDT and JDR into institutional practices (e.g., by restructuring workloads to balance demands with available resources and fostering open communication between leadership and staff), healthcare organizations can mitigate the systemic drivers of burnout.[2] Opt-out counseling should also be prioritized to provide accessible, stigma-free support for trainees.[12]

Challenge 3: Lack of a unified, evidence-based framework for wellness

Barrier: physician-led solutions and limited leadership from accrediting bodies. A key challenge in addressing physician wellness is the proliferation of isolated wellness models developed by individual institutions or physician groups, such as those at Mayo Clinic[13] and Stanford.[14] These models share similarities but fail to acknowledge and incorporate evidence-based theories like SDT and JDR, which already provide clear, actionable solutions. Another example is the WISH inventory,[15] which measures wellness *influencers* like leadership support and psychological safety. While it assesses the environment, it too lacks a theoretical underpinning, undermining its utility. For instance, the leader support scale asks about *support* and *trust* but provides no actionable guidance on how to foster these outcomes.

The root of this fragmentation seems to be an ingrained attitude among physicians that they must solve their own problems with wellness, even when existing frameworks such as SDT and JDR have defined the key contributing factors. This inclination often stems from a professional culture in which physicians—accustomed to high levels of control and self-sufficiency—are reluctant to embrace external, non-medical frameworks. As a result, time and resources are wasted in duplicating efforts and creating isolated models that address the same issues, without tapping into the theoretical rigor needed to make these initiatives more effective and scalable.

Exacerbating this problem is insufficient leadership from accrediting bodies, like the RCPSC in Canada and ACGME in the US. Both have yet to provide a comprehensive, unified wellness framework in medical education. For example, the ACGME's updated program requirements mention “autonomy” once, regarding patient care, but fail to acknowledge autonomy as a core need for trainees.[16] Meanwhile, the RCPSC highlights “self-determination” as a key factor in addressing health inequities and racism in medicine,[17] but offers no guidance on how to promote self-determination in practice. Hence, without frameworks like SDT embedded into accreditation standards, institutions are left to interpret wellness requirements independently, leading to uncoordinated approaches that lack a solid foundation for systemic change.

Recommendation: establish clear standards with leadership accountability. To overcome the current fragmentation, a shift toward collaboration with psychologists and organizational experts is essential. These professionals bring valuable expertise in understanding the root causes of burnout and can guide the development and assessment of wellness strategies based on established theoretical frameworks. For example, studies suggest that a deeper focus on reducing hindrance job demands and supporting basic psychological needs would reduce depression and burnout and foster sustainable engagement and wellness among trainees.[18] By acknowledging that the key elements of wellness have already been defined, institutions can avoid reinventing the wheel and instead focus on applying existing models to their specific contexts.

Accrediting bodies must also take a more active role in establishing comprehensive, evidence-based standards for physician wellness. These standards should incorporate principles from theories like SDT and JDR, providing clear guidance on addressing institutional culture, leadership, and resource allocation. Institutions should then be required to demonstrate how they are implementing these strategies, such as reducing hindrance demands and enhancing organizational autonomy support.[3,2] By building these processes into accreditation processes, accrediting bodies can drive systemic changes that integrate wellness into the core fabric of medical education.

Critics may argue that the role of accreditation bodies is purely regulatory, not transformational. However, this perspective underestimates the profound influence of their program requirements in shaping the educational environment. Accrediting bodies do not merely regulate; they define institutional priorities. Hence, their responsibility to lead institutions with wellness is not ancillary to their mission—it is central to fostering environments that promote learner and patient outcomes while ensuring the sustainability of the workforce. While resource constraints and institutional resistance may pose challenges to implementing these frameworks, this should not deter accrediting bodies from pursuing comprehensive wellness standards. Rather, these challenges should be viewed as an opportunity to strengthen collaboration between accrediting bodies, healthcare institutions, and wellness experts, and create actionable, sustainable reforms.

Challenge 4: Ethical and methodological issues with wellness surveys

Barrier: flawed methodologies and ethical concerns. Many wellness surveys suffer from significant methodological and ethical shortcomings, including a lack of validity, reliability, and contextual relevance. For example, the current ACGME wellness survey, which programs are required to implement, includes various

items with no clear rationale or theoretical underpinning. Results are then mirrored back to programs without guidance on how to address deficiencies. This lack of transparency and direction not only raises ethical concerns but also hinders the survey's potential to drive progress.[19] Additionally, surveys like these generally fail to capture the dynamic nature of wellness, relying heavily on superficial metrics, such as stress or burnout scores, that cannot fully assess systemic challenges or individual experiences.[20]

Further complicating matters is social desirability bias, where learners may feel compelled to respond in ways that conform to institutional expectations, fearing that negative feedback could jeopardize their program, such as affecting accreditation decisions.[20] Combined with the absence of a theoretical framework to guide interpretation, this bias skews the data, reinforcing existing assumptions rather than uncovering the true systemic challenges at play. The focus on survey results as benchmarks for wellness program success also risks falling into Goodhart's Law: when a measure becomes a target, it ceases to be a good measure. This pressure to achieve favourable outcomes often leads to superficial solutions that overlook the deeper, systemic issues that need to be addressed for sustainable wellness improvements.[21]

Recommendation: adopt rigorous, transparent methodologies. Institutions must adopt more rigorous, transparent methods for assessing wellness, using a combination of surveys and qualitative feedback mechanisms like focus groups and interviews. This approach provides a deeper understanding of wellness factors, with surveys and smaller focus groups offering insights from diverse learner populations. The qualitative data complements survey results, helping institutions identify systemic issues and local wellness challenges. To encourage honest participation, institutions should prioritize trust-building measures and clearly communicate how survey data will inform reforms.[22] Additionally, organizations can explore alternative metrics, such as physician retention, absenteeism, and patient outcomes, to better assess wellness program effectiveness and align efforts with the institution's broader mission.[1]

If accrediting bodies like the ACGME are unwilling or unable to adopt sound and ethically appropriate approaches to wellness surveys, they should reconsider their role in administering them altogether. While leaving institutions to create their own context-specific assessments may be less ideal, evidence-based frameworks like SDT and JDR can at least guide institutions in developing their own effective solutions.

Challenge 5: The commercialization of wellness

Barrier: profit-driven wellness solutions. The increasing commercialization of wellness has introduced a proliferation of for-profit solutions, including costly conferences, workshops, proprietary tools, and coaching programs. While these interventions can support individuals,[23] they often fail to address the core drivers of physician burnout, including workload, leadership, and workplace culture.[4] Moreover, they often bring significant costs, time constraints, and inherent conflicts of interest. Take the Maslach Burnout Inventory (MBI)—a widely used scale by institutions around the world that costs several thousand dollars to administer. It has not led to any significant improvement in physician burnout over the past five decades, mainly because it provides minimal guidance on how to address the underlying causes.

Many organizations also mistakenly equate wellness with mental health, focusing on Employee Assistance Programs (EAPs) while neglecting the broader, dynamic nature of wellness. This narrow focus overlooks systemic factors and reinforces the misconception that individual-focused interventions can solve complex organizational challenges.[3]

Recommendation: reallocate resources to evidence-based, systemic reforms. Institutions must prioritize systemic reforms over wellness events and *products*. This means reallocating funds from commercial wellness initiatives to interventions that address the system and culture, such as expert-led organizational redesigns and opt-out counseling programs.[12] Again, individual solutions like professional coaching may still have merit when it comes to physician wellness.[23] It is important, however, to ground these efforts in theoretical frameworks, and to not overstate their impact. This ensures that our approach is realistic and effective.

Conclusion

Addressing physician wellness requires a fundamental shift in how wellness is conceptualized and operationalized. The challenges outlined in this article underscore the urgent need for systemic reform. This transformation is not about working harder but smarter—embracing humility, collaboration, and evidence-based strategies to move beyond superficial solutions. By adopting well-established frameworks such as SDT and JDR, institutions and healthcare organizations can create unified, theory-informed approaches that target the key drivers of wellness. These frameworks offer a roadmap for

sustainable, long-term wellness initiatives that address both individual and systemic needs.

Success will look like institutions embedding these principles into their policies, aligning wellness initiatives with core psychological needs, and prioritizing resource allocation that reduces hindrance job demands. Accrediting bodies could develop standardized wellness frameworks, informed by SDT and JDR, incorporating measurable outcomes such as autonomy satisfaction, burnout reduction, and engagement. Clear metrics and definitions, grounded in these theories, enables consistent evaluation and replication of wellness interventions across institutions. Scalable efforts, backed by robust data and successful case studies, fosters a culture of continuous improvement, ensuring that physician wellness is not an isolated priority but a central element of healthcare sustainability. These reforms will not only catapult the field forward with physician wellness but also bolster patient care and ensure the longevity of the medical profession.

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References

1. Shanafelt TD, Boone S, Tan L, et al. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Arch Intern Med*. 2012;172(18):1377-1385. https://doi.org/10.1001/archinternmed.2012.3199
2. Demerouti E, Nachreiner F, Bakker AB, Schaufeli WB. The job demands-resources model of burnout. *J Appl Psychol*. 2001;86(3):499-512. https://doi.org/10.1037/0021-9010.86.3.499
3. Ryan R, Deci E. Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *Am Psychol*. 2000;55(1):68-78. https://doi.org/10.1037/0003-066X.55.1.68
4. West CP, Dyrbye LN, Erwin PJ, Shanafelt TD. Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. *Lancet*. 2016;388(10057). https://doi.org/10.1016/S0140-6736(16)31279-X
5. Todres M, Stephenson A, Jones R. Medical education research remains the poor relation. *Br Med J*. 2007;335(7615). https://doi.org/10.1136/bmj.39253.544688.94
6. Hope D, Dewar A, Hay C. Is there a replication crisis in medical education research? *Acad Med*. 2021;96(7). https://doi.org/10.1097/ACM.0000000000004063
7. Panagioti M, Panagopoulou E, Bower P, et al. Controlled interventions to reduce burnout in physicians a systematic review and meta-analysis. *JAMA Intern Med*. 2017;177(2). https://doi.org/10.1001/jamainternmed.2016.7674
8. Neufeld A, Kassam A. Why respect for learner autonomy is an ethical priority. *Clin Teach*. 2025;22(e70062):1-5. https://doi.org/https://doi.org/10.1111/tct.70062
9. Fendel JC, Bürkle JJ, Göritz AS. Mindfulness-based interventions to reduce burnout and stress in physicians: a systematic review and meta-analysis. *Acad Med*. 2021;96(5). https://doi.org/10.1097/ACM.0000000000003936
10. Schaufeli WB, Bakker AB. Job demands, job resources, and their relationship with burnout and engagement: a multi-sample study. *J Organ Behav*. 2004;25(3). https://doi.org/10.1002/job.248
11. Su YL, Reeve J. A meta-analysis of the effectiveness of intervention programs designed to support autonomy. *Educ Psychol Rev*. 2011;23(1). https://doi.org/10.1007/s10648-010-9142-7
12. Kevern T, Davies DR, Stiel K, Raaum S. Impact of opt-out therapy appointments on resident physicians' mental health, well-being, stigma, and willingness to engage. *J Grad Med Educ*. 2023;15(6). https://doi.org/10.4300/JGME-D-22-00898.1
13. Wieneke K, Birkland B, Kruse G, Priestley M, Teal D, West C. Charting a new path forward in addressing employee well-being in health care. In: Elsevier Inc on behalf of Mayo Foundation for Medical Education and Research; 2025. https://doi.org/10.1016/j.mayocp.2024.11.018
14. Shanafelt TD, Larson D, Bohman B, et al. Organization-Wide Approaches to Foster Effective Unit-Level Efforts to Improve Clinician Well-Being. *Mayo Clin Proc*. 2023;98(1). https://doi.org/10.1016/j.mayocp.2022.10.031
15. Higgins E, Wingert T, Duggan E, Mansolf M, Carcamo J, Park C. Measuring well-being influencers: development and validation of the WISH Inventory. *Anesthesia*. 2025. https://doi.org/10.1097/ALN.0000000000005401
16. Accreditation Council for Graduate Medical Education. *ACGME common program requirements (residency*). 2024. Available from . https://www.acgme.org/globalassets/pfassets/programrequirements/2025-prs/cprresidency_2025.pdf. [Accessed Mar 9, 2025].
17. Royal College of Physicians and Surgeons of Canada. *General standards of accreditation for residency programs.* 2020. Available from https://www.royalcollege.ca/content/dam/documents/accreditation/competence-by-design/non-resource-documents/canera/general-standards-accreditation-for-residency-programs-e.html. [Accessed Mar 9, 2025].
18. Brafford A, Ellis B, Guldner G, et al. A multi-wave study of factors associated with resident engagement, depression, burnout, and stay intent. *HCA Healthc J Med*. 2024;5(3). https://doi.org/10.36518/2689-0216.1837
19. Adams M, Willett LL, Wahi-Gururaj S, Halvorsen AJ, Angus S V. Usefulness of the ACGME resident survey: A view from internal medicine program directors. *Am J Med*. 2014;127(4). https://doi.org/10.1016/j.amjmed.2013.12.010
20. Appelbaum NP, Santen SA, Vota S, Wingfield L, Sabo R, Yaghmour N. Threats to reliability and validity with resident wellness surveying efforts. *J Grad Med Educ*. 2019;11(5). https://doi.org/10.4300/JGME-D-19-00216.1
21. Mattson C, Bushardt RL, Artino AR. "When a measure becomes a target, it ceases to be a good measure." *J Grad Med Educ*. 2021;13(1). https://doi.org/10.4300/JGME-D-20-01492.1
22. Linzer M, Poplau S, Prasad K, et al. Characteristics of health care organizations associated with clinician trust: results from the healthy work place study. *JAMA Netw Open*. 2019;2(6). https://doi.org/10.1001/jamanetworkopen.2019.6201
23. Dyrbye LN, Gill PR, Satele D V., West CP. Professional coaching and surgeon well-being: a randomized controlled trial. *Ann Surg*. 2023;277(4). https://doi.org/10.1097/SLA.0000000000005678