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Well-being, burnout and value fulfilment: Let us situate individuals within systems

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> I don't know what's wrong with me. I'm not coping. I've been told I need to work more efficiently. My friend says I have all the signs of burnout. I think I need to leave.

Those of us who work clinically are likely to be familiar with versions of the above narrative, either because our own well-being has been compromised or because we have listened to friends or colleagues close to burnout. In recent years, there has been considerable attention paid to clinical well-being and burnout as professional groups and policymakers attempt to address the critical challenge of a declining workforce.[1] A recent shortage and 'exodus'[2] of GPs in the UK, for example, has attracted widespread media attention, public and political debate.[3,4] Initiatives to date have focused on individuals, examining 'career choice' factors that shape recruitment and influence decisions to leave practice or have focused on reducing hours and workload volume (i.e., factors that influence retention[5,6]). Such focus on individual factors, however, limits our understanding.

In recent years, there has been considerable attention paid to clinical well-being and burnout as professional groups and policymakers attempt to address the critical challenge of a declining workforce.

or constrain value fulfilment). More generally, we argue that for research to offer theories that can inform policies on well-being and burnout, we need to situate individuals within their work systems.

Clinicians can achieve 'value fulfilment' only when they are both cognisant of their values and critically reflexive of the systems in which they work.

Critical reflexivity enables us to examine the evolution of our own values and how they intersect and align (or not) with the nature of work in the system in which we function.[8] For many of us, the nature of clinical work increasingly involves the care of people with long-term conditions, multimorbidity and frailty. In contexts where there is no clear resolution to a person's condition, a narrow understanding of a doctor's role in terms of diagnostic management and expertise can lead to clinicians feeling disempowered and bereft of meaning. In contrast, an expanded person-centred understanding of role, which focuses on what matters to patients and values a facilitative and collaborative partnership with them, may enable these same circumstances to offer meaningful therapeutic activities.[9]

Critical reflexivity enables us to examine the evolution of our own values and how they intersect and align (or not) with the nature of work in the system in which we function.

In other words, we need to ensure we examine not only the individual and their ability to function or 'survive' in a particular situation but also how situational factors might be changed and adapted to enable meaningful participation. Might the ability to dis-engage with a setting be a good thing (rather than considering it a preventable 'individual failure') when clinicians feel patient care is not possible to provide in a way that aligns with their values? Might the ability to question and critique systems and standards be productive in developing and enhancing approaches to patient and population healthcare? To 'be well' might mean we can actively participate, but also have space to critique and to have autonomy and agency to initiate change and to 'be different' in the safety of a diverse, inclusive and equitable workspace.[10]

We need to ensure we examine not only the individual and their ability to function or 'survive' in a particular situation, but also how situational factors might be changed and adapted to enable meaningful participation.

If the system and community in which we seek to participate aligns with our own current values, then it is relatively easy to remain accountable to ourselves and the community.[11] However, if there is dissonance, then sustaining our participation and accountability becomes more complex and potentially (at least for a period of time) untenable. Our identity, belonging, alignment and participation as professionals are dynamic. We therefore need to be cognisant of our own and others' values to sustain dynamic and critical reflexivity about our position within the systems in which we work. A flourishing system needs to incorporate critical reflexivity at both system-level and individual-level learning to enable value fulfilment to be achieved, rather than failure persistently being laid at the door of the individual.

To broaden our thinking to account for system factors, it is important to broaden the lenses we apply to our investigations of well-being and burnout, moving from purely psychological methods (with their inherent focus on the individual) to inclusion of sociological methods. Psychological methods have their place, but in relation to well-being and burnout, they risk conceptualising an individual experiencing burnout as a 'failure'. A sociological approach enables us to consider multiple factors shaping how and why clinical work and learning are practised in particular ways. What, for example, is the basic change mechanism.'[7] In this commentary, we reflect on our views that clinicians can achieve 'value fulfilment' only when they are both cognisant of their values and critically reflexive of the systems in which they work (i.e., the degree to which those systems may enable

In this issue of *Medical Education*, Prentice et al. link the constructs of burnout and well-being with the concept of value fulfilment, leading them to recommend that 'interventions addressing burnout and/or well-being should therefore focus on value fulfilment as the

nature of work in which clinicians are expected to engage? Has this shifted over time? How have any shifts changed expectations about the values and belief systems that are positioned as 'acceptable' to use in practice? Drawing on a sociological lens, we can use new ways to examine factors that support clinical workforce well-being. Wenger, for example, has drawn our focus to examination of individuals as members of communities of practice.[11] Here, we begin to see the interrelation between individual and context as important. Likewise, the individual is positioned not as fixed, but part of on-going, rich and fluid interactions with others, shaped by the 'rules' that govern the community at that moment in time.

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If we broaden our theoretical lens to this more system-based examination, then the development of well-being and prevention of burnout will not just be attributable to the individual (and their resilience, success or failure), but will incorporate the complex and dynamic nature of the system that enables individuals to do their work. The 'problem' becomes not just individual people who leave the system, but the (in)ability of the system to be flexible, agile and responsive to the individuals working within it. This broader approach may offer systemic as well as individual solutions to the important and urgent issue of improving well-being and preventing burnout in our clinical workforce.

AUTHOR CONTRIBUTIONS

Sophie Park: writing of the original draft; conceptualization; visualisation; writing—review & editing. **Aarti Bansal:** conceptualization; writing—review & editing. **Emily C. Owen:** writing—review & editing; project administration; resources; validation.

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