struggled to mount a full-scale response, with major consequences for health and equity.

Before the pandemic, funds for public health represented less than 3% of health care expenditures in the United States. This imbalance in support persisted despite the worst public health catastrophe in a century. In early 2020, Congress provided $178 billion to support the health care system, even as many health departments could not scale their efforts or were forced to lay off workers. This disparity exposed the long-standing dynamic whereby powerful interests in health care can make their needs clear to policymakers, while public health agencies, which have much less visibility, rarely succeed in inspiring essential investments in disease control and prevention.

An audio interview with Dr. Sharfstein is available at NEJM.org

Political polarization has complicated matters further. Health leaders supporting evidence-based public health measures such as mask mandates have experienced unprecedented levels of harassment, intimidation, and threats. Hundreds of public health officials across the United States have been fired or have resigned, and 32 states have adopted new laws limiting public health authority during emergencies.[5]

Appreciation of the struggles of the U.S. public health system during the Covid-19 pandemic has created the best chance in many years for change. The American Rescue Plan, the most recent and largest infusion of funding for public health, includes, among other investments, $47 billion for Covid mitigation (including testing and contact tracing), $7.7 billion to expand the public health workforce, and $500 million for the CDC to update the public health information technology infrastructure throughout the country. A next step would be to establish a national plan for achieving a high-functioning public health system to guide new investments, establish realistic expectations, and deliver meaningful improvements in health, equity, and preparedness.

As the pandemic's impact wanes, the window of opportunity may start to close. The powerful desire to return to "normal" quickly, however, will not erase the fact that the United States relies on a patchwork public health system at its own peril. Only with a major and sustained upgrade to the national public health infrastructure will a salmonella outbreak at a food-safety summit be just an ironic news story, and not also a metaphor for the distance between the aspirations and the reality of health in the United States.

Disclosure forms provided by the authors are available at NEJM.org.

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This article was published on January 1, 2022, at NEJM.org.

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DOI: 10.1056/NEJMp2104881

HISTORY OF MEDICINE

Obstacles to Physicians' Emotional Health — Lessons from History

Agnes Arnold-Forster, Ph.D., Jacob D. Moses, Ph.D., and Samuel V. Schotland, M.A.

Beyond its obvious and devastating effects on patients, the Covid-19 pandemic has exacerbated deep-seated vulnerabilities in health care systems and revealed the challenges they face in protecting the mental health and well-being of physicians. Even before the pandemic, physician burnout was a concern for the medical community and, increasingly, for policymakers.[1] And although the conditions of the current crisis are unique, medical professionals have been known to struggle in the past, and remedies have been tried. Insights from the history of medicine may help us craft

Three Historical Obstacles to Physicians' Well-Being.

Obstacle and Definition	Reason for Persistence	Problems	Examples of Structural Solutions
Medical exceptionalism Regarding medicine as an extraordinarily self-sacrificing profession	Confers social privilege, financial capital, and prestige	Establishes institutional expectations for self-negation that can mask harmful practices and policies	Making changes to education and training, including reforms of the medical curriculum and hidden curricula, designed to empower students to better understand their rights and responsibilities in a clinical workplace Implementing workload reduction and duty-hour restrictions while ensuring that physicians are adequately supported by other members of health care and hospital administrative teams
Medicalization Considering physicians who have mental health or substance use problems to be sick	Legitimizes suffering and makes treatment available	Stigmatizes and sanctions "impaired physicians" as blameworthy	Eliminating stigmatizing language of physician licensing to ensure that practitioners with a history of mental illness are not discriminated against Providing tailored and dedicated mental health support as part of the occupational health services of hospitals and other health care institutions
Individual responsibility Considering physicians personally obliged to maintain their own wellness	Requires few alterations to existing work conditions or supports low-cost interventions	Tasks individuals rather than institutions with advancing workplace health	Implementing interventions suggested above to shift responsibility from individual physicians to institutions and systems Elevating workplace conditions to an institutional and system-level responsibility; prioritizing improved physician well-being as highly as the quality of care and the patient experience, because healthy and happy physicians make for better-quality care

solutions to these problems; history may not only explain why physicians are under such strain but also reveal why so many proposed solutions have fallen short.

We suggest that three key obstacles have historically prevented improvements to physicians' emotional health. Medical exceptionalism, medicalization, and an emphasis on individual responsibility are overlapping issues that have shaped our approaches to the well-being of health care professionals. At first glance, they may not seem like problems, but their effect has been to forestall key systemic reforms, to physicians' detriment (see table). An understanding of this history may benefit practitioners and health care policymakers who aim to alleviate work-related distress.

One of the central tenets of medical professional identity is the exceptional status of physicians and their work. Such exceptionalism has not always held sway. In the 18th century, though some physicians were associated with elite institutions and held in high regard as well-educated gentlemen, medicine overall was a busy marketplace populated as well by "mere retailers of physic," "quacks," and "nostrum sellers." Over the course of the 19th century, owing to a protracted and deliberate process of professionalization, physicians improved their reputation and became associated with humanitarianism, benevolence, and commitment to the public good.

As a result, physicians were believed to be driven by vocation and a sense of duty. Medicine was not just a job like any other, but a calling or commitment. In 1890, Governor J. Proctor Knott told the graduating class of the Kentucky School of Medicine, "No other calling . . . demands a more absolute self-negation than the one you have chosen. No other vocation — not even the sacred ministration of religion itself — requires a more constant exercise of the higher faculties of the human mind, or a more earnest devotion of the purer and nobler attributes of the human soul."

Today, in a section of its website devoted to "Considering Medical School," the American Academy of Family Physicians notes that, "medicine is not for everyone . . . as most physicians find that medicine is a vocation that

requires a commitment to service, lifelong learning, and the dedication to practice competently and compassionately."

Such devotion may seem like an admirable asset that has secured U.S. physicians their high social and economic status. But notions of medical exceptionalism have also had profoundly negative consequences: physicians are frequently denied basic workplace rights and protections, and their exploitation is rationalized on the basis of the belief that medicine requires self-sacrifice.[2] The mental and emotional health of physicians has therefore been insufficiently protected.

In the second half of the 20th century, physicians' mental health and well-being were increasingly scrutinized and deemed a problem worthy of attention. Waves of studies and books from the mid-1950s onward examined the unhappy physician. Works including *The Emotional Health of Physicians* (1967) and the conspicuously male-gendered "Doctor and Mrs. — Their Mental Health" (1969) discussed depression, substance use, and death by suicide.[3]

As physicians paid greater attention to these issues, medical societies concentrated on the problem of "impaired physicians" — doctors deemed to be compromised by psychological, emotional, or substance use disorders. Impaired physicians were depicted as a threat to themselves, public health, and the profession's reputation. By focusing on mental illness, organized medicine brought attention to the deleterious effects that physicians' emotional states could have on patients — but in the process, it stigmatized physicians' mental health issues.

By the late 1960s, there was a groundswell of interest, as Florida and later Texas passed "sick doctor" laws. These statutes empowered medical boards to investigate and suspend physicians on the sole basis of a mental health diagnosis or substance use. In 1973, the American Medical Association launched a series of conferences dedicated to physician impairment. At the local and state levels, impairment committees were created that would evolve into today's physician health programs. State medical societies pursued case finding, discipline, and rehabilitation of impaired physicians to stave off more comprehensive regulatory interference. Many of these licensure requirements remain in place today.

Although this medicalization brought much-needed attention to physicians' mental health and legitimized a serious problem endemic to the medical workforce, it also stigmatized unwell physicians as the source of the problem. This deflection allowed organizations to neglect structural problems, such as working hours and conditions, and to focus narrowly on individual blame.

Some of physicians' problems have been addressed not by medicalizing emotional health but by promoting wellness. In 1959, physician Halbert Dunn envisioned "high-level wellness" as an aspiration beyond curing or preventing illness. The modern wellness movement initially positioned itself as an alternative to biomedicine, but by the 1970s, mainstream medical centers began establishing wellness programs. Like contemporaneous offerings for businesses, these programs were charged with curbing costs and boosting productivity. A more peculiar similarity between corporate culture and New Ageism was their prizing of individual responsibility. In a 1977 edition of the widely read *Wellness Workbook*, written for health professionals, physician John Travis postulated that, "Wellness increases when an individual assumes more responsibility for his own health, including his physical, mental and emotional well-being." Wellness interventions accordingly sought to address a central question: "How does an individual learn to assume more responsibility?"[4]

Also in the 1970s, psychologists introduced the term "professional burnout." Herbert Freudenberger and Christina Maslach independently described the progressive disillusionment experienced by human service workers, especially those serving structurally vulnerable populations. Many of the psychological salves proposed early on emphasized self-care over institutional change.[5]

Wellness promotion and burnout prevention did not simply happen simultaneously: they were tied together by a belief in individual responsibility. Today, self-care programs have become fixtures in many health systems. Whether or not these programs have proved effective, the logic underlying these interventions implies that the sufferer bears responsibility for falling short of a wellness ideal.

Though they may be motivating and meaningful for some, these notions of medical exceptionalism, medicalization, and individual responsibility also cause harm. They promote a culture of excessive commitment and complete personal sacrifice, which not even physicians' elevated socio-

economic status can justify. But they also hamper efforts to improve the emotional health and wellness of clinicians. When physicians have been expected to be self-negating, have been stigmatized for being sick, and have been held personally responsible for their wellness, efforts to address emotional health have targeted individual clinicians.

Recent reports from the National Academy of Medicine emphasize the problems with relying on individual interventions alone and recommend a systemic approach to addressing clinician burnout and well-being. These calls are noteworthy, given the historical tendency to hold physicians personally responsible for tolerating occupational stress.

An alternative is to recognize physicians as workers who, like others in health care, deserve basic rights and adequate conditions. The historical obstacles have allowed health care to subsist on the goodwill of its employees rather than reckoning with structural problems. Recognition of these persistent barriers can spur structural policy innovations that numerous North American and European groups have identified, such as adopting work-limit protections, making occupational health a top-level priority on par with patient safety, and addressing social determinants of both patient illness and clinician burnout (see table). By attending to the lessons of the past, we can envision a better future for patients and their physicians.

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This article was published on January 1, 2022, at NEJM.org.

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DOI: 10.1056/NEJMp2112095

The Doctor's Oldest Tool

Elvin H. Geng, M.D., M.P.H.

I first came across Mr. B. while reviewing charts for new patients in my primary care HIV clinic. Even in a public hospital where many patients were down-and-out, his case struck me. He lived in a single-room–occupancy hotel and had a history of homelessness. He'd received an HIV diagnosis years before and had managed occasional contact with the health care system but had never started HIV treatment. He adamantly maintained that HIV was not the cause of AIDS and that the medications were useless at best and toxic at worst. He'd been hospitalized several times recently with life-threatening diagnoses, pneumocystis pneumonia and pneumococcal sepsis among them. He'd come to the clinic for urgent care and post-discharge visits, but never developed a lasting bond with any clinician.

Mr. B. looked thin and worn when we met. After discussing his recent hospitalization, I fell into a common trap. I brought up HIV treatment, and he confidently declared that HIV does not cause AIDS. I mentioned robust research, but he quoted early reports on HIV — citing journal, date, and author — and pointed out subtle inconsistencies. He asked me whether I knew a seminal paper from the 1980s, and I had to admit I'd never read it in detail. Asked why he thought he was sick, he sounded somewhat fearful but largely resigned: "I don't know." When the encounter ended, I put in a prescription for antiretrovirals and said, "If you change your mind, they are there for you to pick up." He chuckled.

Two weeks later, he didn't show for his follow-up visit, and the social worker said she would call him. Several months later, an inpatient team emailed me saying he'd been admitted with an advanced systemic malignant condition. The oncologists believed chemotherapy would be futile without HIV treatment, so he was being discharged to hos-