

SOURCES OF PHYSICIANS' WELL-BEING: AN EXPLORATIVE QUALITATIVE STUDY

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We explore the perceived sources of physicians' well-being at work. The study was conducted by applying a qualitative research design. Six hundred and eighty-seven physicians completed an online questionnaire. Data were examined according to the grounded theory, using N-Vivo 11. Results highlight four areas of the physicians' well-being experience: relationships at work, enhancement of competence and professionalism, physicians' institutional and social recognition, and autonomy and control over work processes. Well-being is the product of multiple factors depending on the way professionals perceive their work environment and their daily work experience, identifying them as sources of comfort and well-being. Interesting differences emerge by gender, age, and attachment style. Practical implications of findings are discussed.

Key words: Physicians' well-being; Qualitative research; Attachment styles; Grounded theory; Male and female physicians.

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Physicians are an important resource for society. They are entrusted with the responsibility of healing people, and advancing the health of populations. Physicians may be considered an "at risk" population. In addition to the direct impact of exposure to potentially harmful conditions and environmental risks, there are considerable risks of occupational stress which can lead to problems both personal and professional (Casalino & Crosson, 2015; Colin et al., 2014; Crosson & Casalino, 2015; Dewa, Loong, Bonato, Thanh, & Jacobs, 2014; Dyrbye & Shanafelt, 2016; Gong et al., 2014; Scheepers, Boerebach, Arah, Heineman, & Lombarts, 2015; Wallace, Lemaire, & Ghali, 2009). Patients' well-being and quality of life has been studied extensively (Leplege & Hunt, 1997). Although great strides have been made in the assessment of patient satisfaction (Hekkert, Cihangir, Kleefstra, van den Berg, & Kool, 2009), little attention has been paid to physicians' well-being and to the way it affects the quality of care (Angerer & Weigl, 2015; Firth-Cozens, 2001; Shanafelt, Bradley, Wipf, & Back, 2002). There is a large body of literature on causes and consequences of physicians' distress, but little is known about physicians' well-being (Colin et al., 2014; Weiner, Swain, Wolf, & Gottlieb, 2001). Shanafelt, Sloan, and Habermann (2003) argue that it would be important to explore the factors that contribute to, and promote physicians' well-being. In fact, understanding physicians' well-being may help prevent physicians' burnout, improve the quality of care they provide to their patients, reduce medical errors, and improve patient satisfaction.

PHYSICIANS' WELL-BEING: FROM THE ABSENCE OF IMPAIRMENT TO WELLNESS

In the middle of the last century physicians enjoyed high levels of autonomy, prestige, power, and public trust (Cockerham, 2004; Heijstra, Rafnsdóttir, & Jónsdóttir, 2011). Nowadays, physicians working in industrialized countries face a highly demanding combination of stressors in the workplace such as high workload, administrative duties, complex decision-making processes, emotional work, high cognitive demands and restricted autonomy, lack of resources, and heightened risks of physician-patient litigation (Cohen & Patten, 2005; Kynes et al., 2013). In addition, studies exploring physicians' work conditions (Koyuncu, Burke, & Fiksenbaum, 2008) are mainly focused on negative indices such as burnout (Colin et al., 2014; Dyrbye & Shanafelt, 2016; Dyrbye et al., 2013; Prins et al., 2007; Scheepers et al., 2015), depression and anxiety (Gong et al., 2014), divorce, suicide, drugs and alcohol abuse (Casalino & Crosson, 2015; Crosson & Casalino, 2015; Wallace et al., 2009). The epidemic features of burnout (Colin, Dyrbye, Erwin, & Shanafelt, 2016; Pedrazza, Minuzzo, Berlanda, & Trifiletti, 2015; Shanafelt, Boone, & Tan, 2012) are associated with high rates of dissatisfaction, lack of well-being (Dewa et al., 2014; Ruitenburg, Frings-Dresen, & Sluiter, 2012), and to the loss of enthusiasm for work (Goiten, 2014).

Moreover, burnout is typically associated with organizational direct and indirect costs such as: days lost per employee for short-and long-term leaves; employees' mental health problems; quick turn over; lateness and absenteeism; poor performance; interpersonal/coworkers/team conflicts; and abusive supervision (Tepper, Duffy, & Shaw, 2001). Physicians' poor commitment, low satisfaction, and poor well-being are associated with time pressure and poorly functioning technological tools (Heponiemi et al., 2012; Kuusio, Heponiemi, Sinervo, & Elovainio, 2010). For example, the complex and burdensome introduction of Electronic Health Records (HER) technology exerts negative consequences on physicians' satisfaction. Moreover, physicians reported that they spent more time on administrative tasks and computer-based activities than on face-to-face interactions with patients (Montague & Asan, 2012; Sinsky et al., 2013).

Tucker, Bejerot, Kecklund, Aronsson, and Akerstedt (2015) studied the impact of work time control on physicians' well-being. They did not directly measure well-being, but they referred to it as to the absence of distress, the absence of long-lasting stress (Hasson, Theorell, Wallen, Leineweber, & Canlon, 2011) and residual fatigue after work (Tucker et al., 2015). Results show that work time control can buffer the impact that night work has upon sleep and well-being. In addition, according to Weiner and colleagues (2001) physicians' health and, thereby, an important component of what physicians perceive as well-being, is referred to as the absence of impairment. This conceptualization, relying only on the absence or on the lack of certain features and characteristics, cannot be considered fully exhaustive, even though it is not unreasonable to assume that the absence of any type of impairment can indeed be associated with feelings of ease and comfort. Nevertheless, according to Shanefelt and colleagues (2003) physicians' well-being is much more than the mere absence of distress or disease.

Recently the traditional perspective of understanding well-being as focused almost exclusively on the disease pole has shifted toward the opposite pole, giving a different emphasis on what goes right, in line with a more person-centered (Meyer & Morin, 2016) approach to well-being. Well-being is comprehensive of physicians' physical, mental, and emotional health. In Diez-Pinol, Dolan, Sierra, and Cannings' (2008) multifactorial model, well-being lies on a continuum that goes from disease (burnout) up to health (vigor). Within this holistic approach, schol-

ars identify job satisfaction or dissatisfaction as the most important construct predicting both burnout and vigor. According to Wallace and Lemaire (2007), well-being may be indicated by an overall sense of satisfaction and balance in one's life, which reflects a genuine expression of the self, in life and work (Suchman, 2001). According to Scheepers and colleagues (2015) high levels of work-related well-being can be defined as occupational well-being. It can be defined as a positive experience related, for example, to job satisfaction, commitment, career satisfaction, and work engagement.

Simon and Durand-Bush (2014) studied Canadian physicians' well-being by using a positive approach that integrates psychological and affective well-being. They adopted the Scales of Psychological Well-Being (SPWB; Ryff & Keyes, 1995). This measure assesses six different dimensions of well-being: a) self-acceptance as the positive evaluation of oneself, b) positive relations with other people, c) autonomy expressed by the possibilities of self-determination, d) environmental mastery, that means the competence to have an influence on the events in one's life and on the surrounding world, e) purpose in life as the belief that life is meaningful, and f) personal growth as the capacity to improve and reach own full potential. To measure affective well-being authors adopted the Positive and Negative Affect Schedule (PANAS; Watson, Clark, & Tellegen, 1988).

EFFECTS OF PHYSICIANS' WELL-BEING IN HEALTH SERVICES

Since the mid '80s, stress among physicians has been assessed and associated with poor performance (Firth-Cozens, 2001). Health professionals' tribulation and suffering worsen clinical outcomes, increase costs of healthcare delivery services, and reduce the quality of those services (Bodenheimer & Sinsky, 2014; West, 2016). The exponential growth of liability insurance costs enhances physicians' dissatisfaction and the judicialization of care represents a rising risk factor for health organizations all over the world (Schaad et al., 2015). It is remarkable to note that the most important reasons that motivate patients to promote legal actions against physicians are associated with the perceived poor quality of the relationship and with the poor quality of the patient/physician communication.

Numerous literature reviews highlight that there is evidence of links between physicians' well-being, and the quality of care, better prevention, good disease management, patients' adherence to treatment, and patients' satisfaction (Prins et al., 2007; Rizvi, Raymer, Kunik, & Fisher, 2012; Scheurer, McKean, Miller, & Wetterneck, 2009; Williams & Skinner, 2003). Satisfied physicians are more likely to experience commitment with their work and are highly motivated to provide patients with support and full attention. Physicians' well-being is associated with less medical errors and less incautious prescribing (Scheepers et al., 2015; Williams, Manwell, Konrad, & Linzer, 2007). Satisfied family physicians are more likely to be sensitive to their patients' psychosocial issues and problems. In addition, they provide patients with more information about treatment and about the impact of disease on familial and work contexts (Perez-Carceles, Perenigues-Barranco, & Luna-Maldonado, 2006). The quality of the healthcare delivery experience can be improved under two conditions: (1) there has to be awareness on the part of the management board members and on the part of single professionals of the perceived sources of the health-staff's well-being in the context of interest; (2) a person-centered approach (Graves, Cullen,

Lester, Ruderman, & Gentry, 2015; Moran, Diefendorff, Kim, & Liu, 2012; Van den Broeck, Lens, De Witte, & Van Coillie, 2013) should enhance the possibility to assess differences in motivational profiles within-and-between different subgroups of the professional health staff, in order to act effectively and to enhance professionals' well-being in different work domains.

In 2008, Berwick, Nolan, and Whittington proposed the *triple aim* to optimize health-systems' performances which is centered on three goals: enhancing the individual experience of care, improving the health of the population, and reducing costs of healthcare. This triple aim was designed to guide the development of healthcare systems in the USA, but, over time, it has been adopted by health organizations all over the world. Bodenheimer and Sinsky (2014) suggest adding to the triple aim an additional goal, namely the improvement of the work life of healthcare providers. Sikka, Morath, and Leape (2015) state that "the core of workforce (physicians, nurses, in general healthcare providers) engagement is the experience of joy and meaning in the work of healthcare." By meaning they refer "to the sense of importance of daily work"; by joy, "to the feeling of success and fulfillment that results from meaningful work" (p. 608).

VARIABLES THAT AFFECT PHYSICIANS' WELL-BEING AT WORK

Studies and theoretical exploration of well-being in work psychology have generated a long-lasting debate engendering an apparent antinomy: on the one hand, well-being is a result of individual dispositions and attitudes (Fang et al., 2011; Simon & Durand-Bush, 2014), on the other hand, it is caused by job characteristics and context's variables (Bell, 2013; Shannon, 2013). In our study, we want to explore the effects of variables of individual difference (gender, age, and attachment style) on physicians' perception of well-being at work.

A recent study (Pedrazza, Berlanda, Trifiletti, & Bressan, 2016) revealed that female physicians report higher levels of dissatisfaction than men, with references to role uncertainty, decline in public image, responsibility toward patients, and relationships with staff. On average women seem to be generally less satisfied than men. McMurray and colleagues (2000) showed that women physicians indicate higher levels of burnout and are less satisfied with their pay. Typically, women earn less than men. Moreover, Gleichgerricht and Decety (2013) report that women feel that their job affects their lives negatively and that women are more empathic than men; according to Burke, Koyuncu, and Fiksenbaum (2009) female physicians are far more engaged in the communication with patients. In addition, they show more social, emotional, and care behavior than males. They also provide more cure, care, and consulting behavior during consultations. Women are more satisfied in activities that provide a sense of connection with others; by contrast males have difficulties with relationships (Neittaanmäki, Gross, Virijo, Hyppölä, & Kumpusalo, 1999). Men are more interested in remuneration and promotion; while women enjoy their work environment and friendly coworkers. In addition, female doctors' burnout and intentions to quit the job decrease consistently if women perceive the support from coworkers (Walsh, 2013). Heijstra and colleagues (2011) show that male physicians enjoy more autonomy than their female colleagues. Moreover, high autonomous male and female hospital physicians perceive lower levels of distress.

Soares and Chan (2016) show that vitality and social role functioning are worse in junior doctors compared to Australian age-matched general population. Moreover, Moutier, Bazzo, and

Norcross (2013) demonstrate that optimism, resilience, compassion, wisdom, and empathy remain stable or increase with age. In addition, Pedrazza and colleagues (2016) underline that the younger physician population suffers less from bureaucratization, perceives lower levels of job satisfaction and higher levels of dissatisfaction compared to the senior one.

The attachment theory is an established model of interpersonal relationships frequently applied to study several and differentiated interpersonal relationships in organizations (Deffayet Davrout & Pedrazza, 2015; Desivilya, Sabag, & Ashton, 2006; Hardy & Barkham, 1994; Hazan & Shaver, 1990; Krausz, Bizman, & Braslavsky, 2001; Mikulincer & Shaver, 2016; Pedrazza & Boccato, 2012; Pines, 2004; Ronen & Mikulincer, 2012; Schirmer & Lopez, 2001; Sumer & Knight, 2001). We underline the importance of this variable in this context because relationships (with patients, coworkers, and staff) constitute the *topos* within which medical proficiency and expertise are carried out on a daily basis. However, little or no attention has been paid to this variable within physicians' and medical professionals' populations in health services. In 1994, Dozier, Cue, and Barnett focused their attention on how clinicians' attachment style could exert its influence on the patient-physician relationship. Results showed that clinicians' attachment style could influence both physician's perception of patient's needs and the professional's subsequent response. A recent study (Pedrazza et al., 2016) demonstrates the correlation between physicians' insecure attachment style and job dissatisfaction: physicians' attachment insecurity is associated with subjective discomfort when medical professionals are charged with responsibility for severely ill patients and when in trouble because of relational problems with the staff.

Scholars' interest in looking at the relationship with patients through the attachment theory lens seems to be reduced to the influence patients' attachment style exerts on the relationship. Five studies examine the way patients' attachment style influences their own perception of disease-related items such as subjective acute stress (Maunder, Lancee, Nolan, Hunter, & Tannenbaum, 2006), feelings and reactions when stressed by illness and pain (Hunter & Maunder, 2001), and their attachment to health services (Blackburn, Berry, & Cohen, 2010; Randall, Crooks, & Goldsmith, 2012). Moreover, Maunder and colleagues (2006) show that insecure attached patients are experienced as more difficult than secure ones by the emergency medical staff.

Literature shows that anxiously attached individuals typically anticipate rejection and are extremely sensitive to negative or unfavorable evaluations from others. By contrast, avoidant individuals pursue autonomy and tend to remain emotionally distant from others. Moreover, organizational and work psychology research shows that attachment style affects individuals' overall perception of the social and material work environment. Insecure attachment style is related to high burnout rates and low job satisfaction (Ronen & Mikulincer, 2012). As already underlined (Arnetz, 2001; McMurray et al., 1997; Wallace & Lemaire, 2007), the relationship with patients represents one of the most rewarding sides of physicians' work, but at the end of an exhausting day, it may also turn into a really challenging problem. We therefore assume that physicians' attachment style deserves greater attention. The purpose of the present study is to explore the sources of physicians' well-being at work; we will also highlight the different maps of well-being sources for subgroups: males and females; junior and senior physicians, secure and insecure individuals.

METHOD

Participants and Procedure

The data for this study were collected from an online questionnaire. Ethical approval was obtained from the local medical board's ethics committee. The study was carried out between November 2013 and January 2015. Participation was entirely voluntary; participants were informed about their right to withdraw from the study at any time without incurring any penalties. The anonymity and confidentiality of answers were guaranteed. Questionnaires included an information sheet that explained the nature and purpose of the study, and a consent form. Informed consent was obtained from each participant.

The study was presented as a research on physicians' well-being at work. The questionnaire was administered to all physicians of Verona in Northern Italy. We contacted by e-mail 3,070 physicians. A total of 1,251 questionnaires were completed (response rate of 40.75%). We eliminated 564 questionnaires because they had missing responses in the open-ended questions about factors that promote well-being at work, and/or they had missing response in the Adult Attachment Types. The final sample consisted of 687 physicians.

The gender distribution was 410 males (59.68%) and 261 females (37.99%); 16 participants did not indicate gender (2.33%). The mean age was 51.88 years ($SD = 11.78$; range = 24-90; 91 missing data, 13.25%), and the mean length of service was 18.04 years ($SD = 12.23$; range = 0-55; 73 missing data, 10.63%).

Measures

The questionnaire included the following instruments.

1. Three open-ended questions about sources of well-being at work ("What is your first/second/third source of well-being at work?").
2. Some questions on demographic and occupational characteristics (gender, age, and length of service).
3. Adult Attachment Types (Hazan & Shaver, 1987, 1990). Physicians could choose among three alternatives: the avoidant type, the anxious type, and the secure type. They selected the one that best described how they typically felt in relationships. Avoidant type: "I am somewhat uncomfortable being close to others; I find it difficult to trust them completely, difficult to allow myself to depend on them. I am nervous when anyone gets too close, and often, love partners want me to be more intimate than I feel comfortable being." Anxious type: "I find that others are reluctant to get as close as I would like. I often worry that my partner doesn't really love me or won't stay with me. I want to merge completely with another person, and this desire sometimes scares people away." Secure type: "I find it relatively easy to get close to others and I am comfortable depending on them and having them depend on me. I don't often worry about being abandoned or about someone getting too close to me."

Data Analysis

We used grounded theory (Bryant & Charmaz, 2007; Charmaz, 2009; Glaser, 1992; Glaser & Strauss, 1967; Morse et al., 2009; Pidgeon & Henwood, 1997; Strauss & Corbin, 2008) as a methodology to analyze our data. This method is based on qualitative data. According to grounded theory, categories and interpretations already exist while data are being collected, given that data are already an interpretation of reality, a multifaceted, complex, social construct. The grounded theory research method is organized around three phases: 1) coding data to yield progressive abstractions, where the theoretical pathway in all its procedural rigor can always be reconstructed; 2) identifying concepts based on their intrinsic characteristics; and 3) establishing links between concepts to arrive at increasingly complex processes and models, and eventually one or more theories which can explain the phenomena. Analysis was structured around two conceptually progressive coding operations (Pedrazza & Berlanda, 2014; Strauss & Corbin, 2008). Codes are structured hierarchically. The first step of the interpretation process was open or substantive coding; in this first level of abstraction the data are explored analytically, fractured and assembled into superordinate categories (child nodes). In this way, we identified child nodes. Child node is a subnode of a parent node. Parent nodes are generated by the second step (axial coding), where data are organized and summarized and categories are drawn up and grouped into macrocategories. Parent node is the largest and broadest container. Research thereby investigated the interactions and the links between categories.

Three researchers have independently analyzed 1,951 sources of physicians' well-being at work. Qualitative analysis was performed with N-Vivo 11, which is a software that allows to classify and to examine relationships between concepts and categories. According to Dey (1993), qualitative analysis involves breaking up the data into smaller units then reassembling them in new ways. The three researchers detected independently regularities and generated categories ad hoc for each theme via an inductive process (key words or abbreviations). Thematic analysis (Rice & Ezzy, 2004) allowed them to identify salient themes, recurring ideas or language, and belief patterns. Conceptualizations are firmly rooted in the empirical data, with some original responses being used or generalizations made in the form of easily interpretable labels while remaining constantly faithful to the phenomenon. The categories gather together similar responses based on the principle of content equivalence/similarity. Each minimum unit of meaning is classified by attributing one or more categories to it. Categories need to be internally consistent but distinct from one another, we sought those with internal convergence and external divergence. We tried to attain theoretical saturation of all categories; in fact, no new or relevant data emerged regarding new or different categories. The development of category was sufficiently dense, and data were sufficiently rich (Strauss & Corbin, 2008). We performed a nonparametric analysis (Mann-Whitney tests) using SPSS 21.0 in order to explore possible differences regarding the category saturation between women and men subgroups, between senior and beginner subgroups, and between secure and insecure subgroups.

RESULTS

The qualitative analysis of the 1,951 sources of well-being at work allowed us to highlight four broad sources that nurture physicians' well-being: (1) relationships at work, (2) en-

hancement of competence and professionalism, (3) physicians' institutional and social recognition, (4) autonomy and control over work processes. These identified categories entail clusters around similar codes, which in turn correspond to diverse concepts as shown in Figure 1.

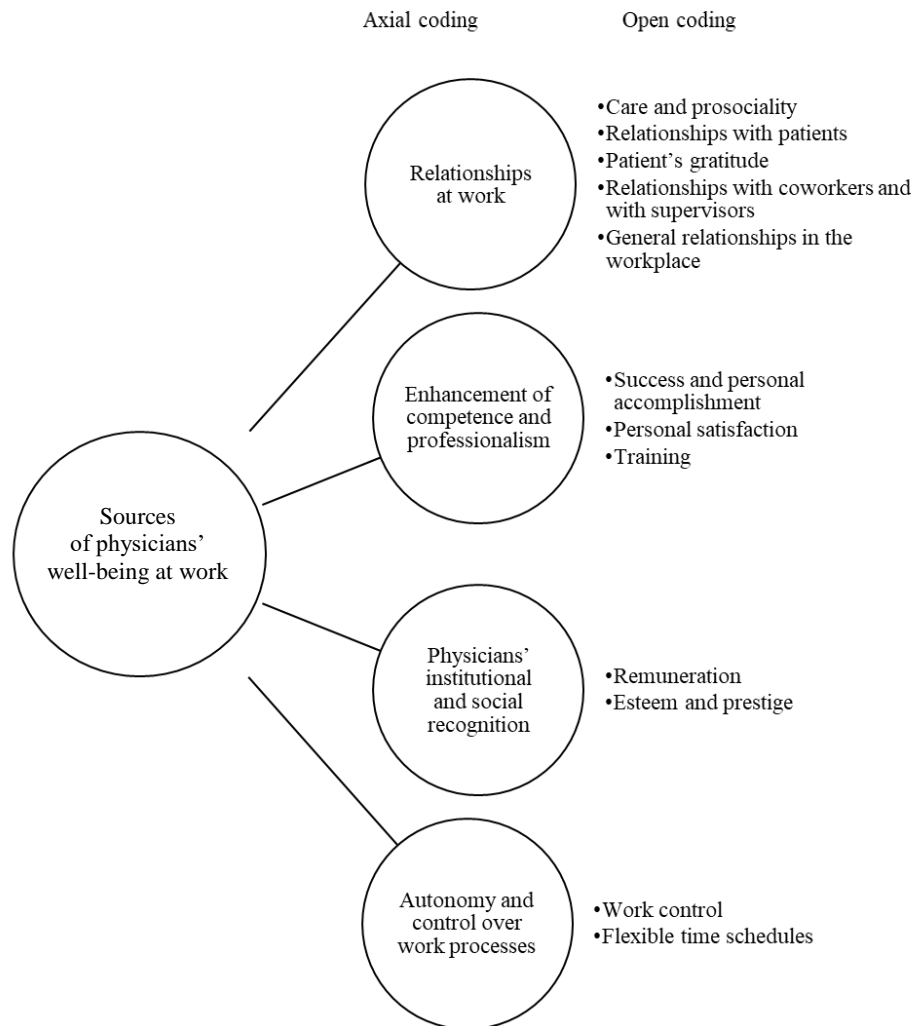


FIGURE 1
Sources of well-being at work.

The prevalent source of well-being is relationships at work (708; 36.29%). In this area (see Figure 1) our participants reported a wide range of issues concerning: care and prosociality (251; 35.45%; e.g., to be useful, to be helpful, to care, to cure, to treat, to do some good); relationships with patients (157; 22.18%, e.g., relationships with patients and their families, empathy and interpersonal trust); patient's gratitude (146; 20.62%; e.g., patient's pleasure and satisfaction, patient's recognition and appreciation); relationships with coworkers and/or with supervisors (100; 14.12%; e.g., interpersonal trust, relationships with coworkers and/or with supervisors, team relationships, perceived staff/equip support); general relationships in the workplace (54,

7.63%). The second source of well-being is enhancement of competence and professionalism (616, 31.57%). In this category there are: success and personal accomplishment (313; 50.81%); personal satisfaction (152; 24.68%); and continuous training (151; 24.51%). These activities and practices are related to experience of satisfaction from learning, from application of skills and development of their professionalism, from developing potentialities to improve the effective exercise of the medical practice, and from continuing medical education opportunities. The third source is physicians' institutional and social recognition (510; 26.14%). This dimension includes: satisfaction for remuneration (284; 55.69%); and esteem and prestige (226; 44.31%). Finally, the fourth source is autonomy and control over work processes (117; 6.00%). This dimension allows physicians to better regulate their actions in accord with their array of felt needs and perceived capacities: work control (80; 68.38%, e.g., control over work schedules, work control over protocols and procedures, user-friendly electronic health records, organization and work-flow); and flexible time schedules (37; 31.62%).

To explore differences with respect to the degrees of category saturation between women and men subgroups, between senior and beginner subgroups, and between secure and insecure subgroups we carried out Mann-Whitney tests. We identified the following differences (Figure 2): women assigned more importance than men to care and prosociality ($p < .005$), to relationships with patients ($p < .02$), to relationships with coworkers and/or with supervisors ($p < .005$); and to parent node relationships at work ($p < .001$; it is predecessor of the other child nodes). Whereas men reported as major sources of well-being at work: physicians' institutional and social recognition ($p < .001$), its child nodes remuneration ($p < .005$), esteem and prestige ($p < .001$); and autonomy and control over work processes ($p < .03$) and its child node work control ($p < .03$). Male physicians find pleasure and lasting satisfaction in activities that bring about positive feelings regarding the level of control they exert on their work environment and practices; in addition, they identify esteem, prestige, and income as important sources of well-being. By contrast female physicians find accomplishment and satisfaction in caring for patients and in diverse prosocial activities, they nurture their sense of satisfaction in caring about different social interactions and relationships in the workplace.

We divided participants into two groups on the basis of their length of service, using the median split method. We split the sample into two groups relating to the average of length of service (from 0 to 17 years and from 19 to 55 years). Significant differences emerged in esteem and prestige, in relationships with coworkers and/or supervisors, and in the parent node enhancement of competence and professionalism (Figure 3).

The results showed that esteem and prestige are significantly higher in the sample of older physicians than in the samples of beginners ($p < .04$). Instead beginners referred mostly to parent node enhancement of competence and professionalism ($p < .05$), and to child node relationships with coworkers and/or with supervisors ($p < .001$). Senior physicians are more concerned than beginners with esteem and prestige, which they enjoy among patients and colleagues. In addition, beginners find more satisfaction in activities related to the enhancement of competence and in their successful interventions.

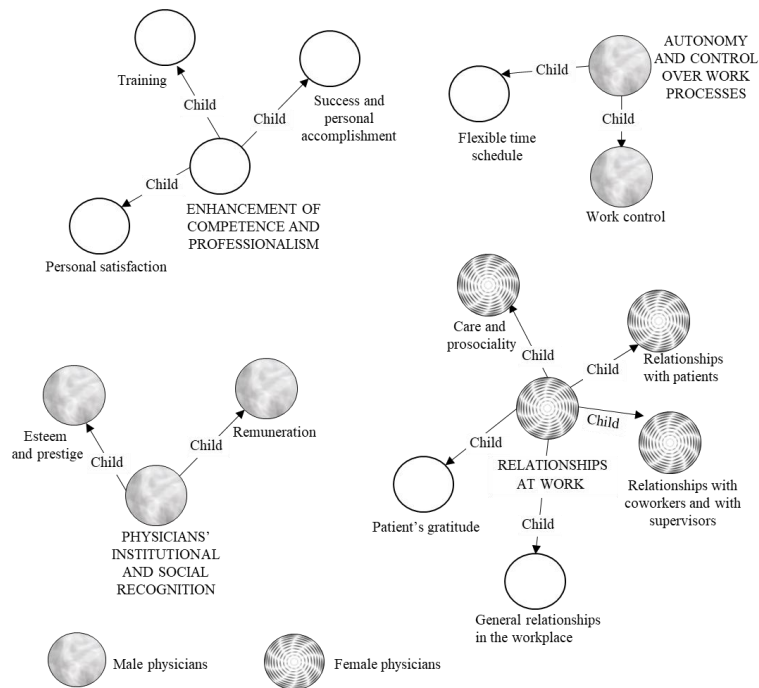


FIGURE 2

Well-being sources' map for male and female physicians' subgroups.
Child node is a subnode of a parent node. Parent node is the largest and broadest container.

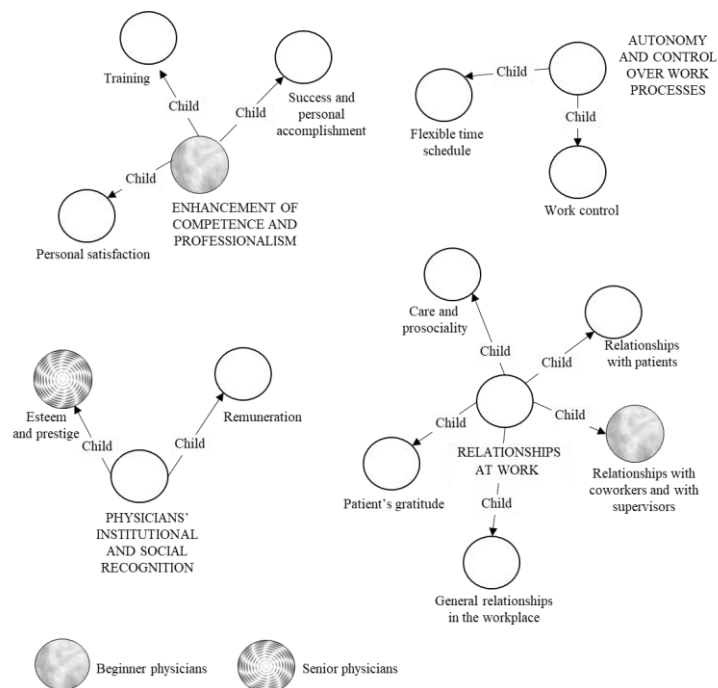


FIGURE 3

Well-being sources' map for beginner and senior physicians' subgroups.
Child node is a subnode of a parent node. Parent node is the largest and broadest container.

The attachment style distribution allowed us to identify 298 secure (43.38%) and 389 insecure (avoidant or anxious) physicians (56.62%). In our sample the attachment assessment allowed us to point out differences between secure and insecure physicians when confronted with relational issues (Figure 4): secure physicians reported the parent node relationships at work ($p < .01$), and its child nodes, relationships with coworkers and/or with supervisors ($p < .05$), relationships with patients ($p < .05$), and care and prosociality ($p < .045$) as main factors that promote well-being at work. According to recent literature (Mikulincer & Shaver, 2016), secure physicians feel more satisfaction than insecure ones in managing and caring about relationships with patients and colleagues and in general with interpersonal interactions within the workplace. In addition, activities they mostly welcome are prosocial interventions, providing patients with socio-psychological support and help.

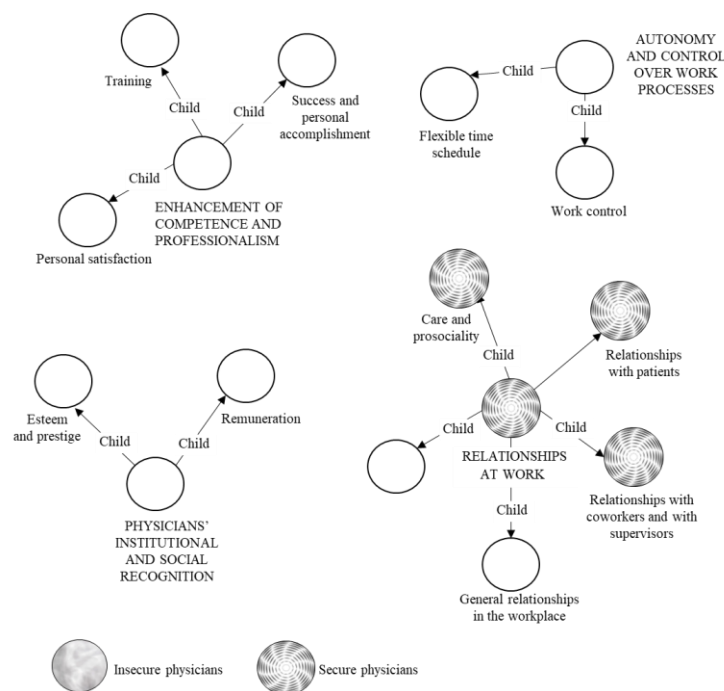


FIGURE 4

Well-being sources' map for secure and insecure physicians' subgroups.
Child node is a subnode of a parent node. Parent node is the largest and broadest container.

DISCUSSION

According to Shanafelt and colleagues (2012) physicians' well-being should be addressed to as a complex construct in order to go beyond a simplistic approach, which relates well-being at work mainly to subjective variables of individual difference. Thus, well-being should be addressed as a result of the combination and interaction of a variety of individual, contextual, and organizational elements and features, allowing us to identify at the individual professional's level potential sources of both well-being and stress. We identified four areas of potential physicians' fulfillment and well-being: relationships at work, enhancement of competence and professionalism, physicians' institutional and social recognition, and autonomy and control over work processes.

In the entire population, higher saturation scores are associated with categories, which entail references to features of the relationship with patients, with coworkers, with the health staff in general, with nurses and care assistants, with the organizational health management and even with society at large. This result is in line with literature. In fact, there is a large body of literature devoted to relational issues within health organizations and their detrimental effects on physicians' satisfaction and feelings of well-being. Quinn, Wilcox, Orav, Bates, and Simon (2009) and Sinsky (2015) identify psychosocial work conditions such as esteem, social support, and social conflicts with staff (Angerer & Weigl, 2015) as important sources of physicians' dissatisfaction. Autonomy and control over work processes are the least signaled source of well-being.

The present study fills a gap in literature concerning the exploration of physicians' sources of well-being at work. Interesting differences emerge when looking at subgroups identified by length of service, gender, and attachment style. In line with previous studies women assign more importance to relationships, care, and prosocial activities whereas men are satisfied with exerting control on their social and material environment. Moreover, secure attached medical professionals find fulfillment in caring for the relationship with patients, with coworkers and with the staff. Results can be used to develop specific training, support, or ergonomic changes to better meet insecure physicians' needs, above all where lack of well-being leaves room for further development and improvement. In fact, training may be useful not only regarding the implementation of competences but also relating to improvements in awareness and understanding of intra- and inter-personal self-regulation processes.

In our study, women seem to experience well-being in prosocial activities and relationships. This result is in line with previous studies (Burke et al., 2009; Gleichgerrcht & Decety, 2013; Neittaanmäki et al., 1999). Female physicians interiorize stereotypical features typically ascribed to women: caring is a female-dominated activity and one of the most commonly, inter-generationally transferred competences. In this case, gender differences could be ascribed to group membership: men (Whiteside & Butcher, 2015) are commonly considered less effective than women in engaging effectively in caring and nurturing practices. Older physicians seem to cling to an obsolete representation of their role associated with prestige, which no longer characterizes the profile (Pedrazza et al., 2016). Useful intervention and psychosocial training could allow older physicians to feel fulfilled by doing their work even in relational contexts where explicit manifestations of esteem are lacking. Beginners seem to feel mostly satisfied in activities which meet their needs for competence and professional self-development. However, they could also benefit from socio-psychological training in order to enhance the opportunities to experience well-being in relational context. The well-being younger physicians experience when engaged in work activities which allow them to improve their abilities and competences, is typically associated with beginners in every organization: they are more concerned about potential evaluations of their job than people who have more experience. Previous literature (Soares & Chan, 2016; West, Shanafelt, & Kolars, 2011) supports our results.

Our results show that insecure physicians (Mikulincer & Shaver, 2016) cite the lowest number of items in the relatedness area. Support with continuous socio-psychological supervision should be provided, addressing above all anxiety, preoccupation, and avoidance in order to enhance insecure professionals' satisfaction and well-being in relationships.

We recognize some limitations of the present study. We relied exclusively on self-reports, and participants may not necessarily be aware of their perceptions and thoughts, or may

respond in a socially desirable way. Moreover, this study was done with a qualitative methodology and this may affect the generalizability of our results. Further studies should aim to analyze our four sources of well-being at work with a quantitative methodology. Another limitation of the study is that it did not examine the role of medical specializations. Future studies should analyze the role of medical specializations and of other demographic and occupational characteristics not considered in the present study.

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