HappY Summer! We finally made it. It is time that we begin to enjoy all of those experiences that we have anticipated through the winter and spring months. This month’s journal presents an important focus for our specialty—the issue of physician wellness. Wellness and its threats have received increasing interest in the past year, given the recognition of the many adverse forces that lead to decreasing physician satisfaction and professional burnout. The journal invited authors to submit commentary and research in this area, and in this present issue, we explore the concept of physician wellness through the eyes of many of our colleagues—experienced, newly in practice, and in training. I hope you will find the discussion enlightening, and I would enjoy receiving feedback on your interaction with this month’s interesting content.

In our first article, which provides a sharp focus on the topic of physician wellness, Golub and Johns¹ provide a perspective on the importance of open dialogue around burnout and wellness for all otolaryngologists. The authors discuss the work of their research team on this critical topic dating back to 2005. Based on a series of studies in various centers in both the United States and the United Kingdom, Golub and Johns note that a moderate level of physician burnout is characteristic of all groups and is characterized in 3 areas: emotional exhaustion, depersonalization, and low personal accomplishment. They also note that physicians who have burnout are more likely to report medical errors, perform worse on measures of empathy, and plan to retire from practice early. Reasons common for experiencing burnout include such factors as relationship instability, poor work-life balance, and insufficient sleep. Golub and Johns discuss elements that will be important for improving physician wellness and make a case for the moral imperative in addressing burnout at all levels. Please enjoy reading this insightful and compelling article.

In our second paper, Huyett and colleagues² examine the clinical predictors and survival implications of perineural invasion (PNI) in parotid gland malignancies. The authors identified 186 cases of parotid gland malignancies from a single institution’s database with a mean follow-up of 5.2 years. They noted that at the time of presentation, both facial nerve paresis and facial pain were predictive of PNI at surgery, while facial paresthesia or anesthesia were not associated. In addition, the authors found that patients with PNI had worse T and N stages and poorer overall survival than patients without PNI on univariate analysis, but on multivariate examination, other factors appeared to mediate survival than PNI alone. Based on the results of their analysis, Huyett and associates discuss the implications of their findings for disease management and patient advising.

In our third article, Holcomb and associates³ review the practice patterns of physicians referring patients to a voice clinic, including adherence to evidence-based guidelines. In this study, the authors examined the records of 821 charts of patients with voice complaints seen at a tertiary voice center over a 5-year period. The authors noted that of those 821 individuals, 244 patients had been given a prior diagnosis, most commonly laryngopharyngeal reflux disease. For those patients, most of whom had no symptoms of reflux disease, proton pump inhibitors were often prescribed empirically. After referral to the voice clinic, more than 80% of individuals with prior diagnoses had these diagnoses changed after careful examination. Holcomb and colleagues conclude that empiric diagnosis and treatment are common among referring physicians and are often incorrect. In addition, this pattern delays referral and appropriate treatment in many cases. The authors stress the importance of timely referral in the appropriate treatment of patients with dysphonia.

In the fourth article, Baik and Brietzke⁴ perform a decision analysis to compare utility and cost outcomes for partial tonsillotomy (PT) and total tonsillectomy (TT). In this study, the authors developed a decision analysis model using a hypothetical cohort of patients undergoing either PT or TT and looked at outcome parameters including postoperative complications, including bleeding, dehydration, and tonsil regrowth requiring completion tonsillectomy. Using observed prevalence of complications, the authors concluded that TT had a slightly more beneficial utility than PT. With increasing incidence of tonsil regrowth, however, this utility declined, and costs significantly increased with the requirement for completion tonsillectomy. TT and PT were noted to have similar utility with regrowth rates of 17.8% or a post-PT recovery period of 7.4 days. Baik and

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Brietzke discuss the implications of their model and observe that small differences in assumptions of recovery time and likelihood of regrowth can shift the balance in utility between PT and TT.

In our final article, Kovatch and associates\textsuperscript{5} perform an ethical analysis of the necessity of residents to gain incremental autonomy through progressive entrustment. The authors compare the ethical position that academic institutions have an obligation to facilitate autonomy in residents through entrustment in decisions and procedures with the position that residents are not as skillful or experienced as attending surgeons and that progressive entrustment and autonomy in the resident setting do not facilitate the best patient care. They examine these principles using ethical arguments and present viewpoints that can assist otolaryngology faculty and program leadership in balancing the imperative of resident education with the requirement for safe and maximally effective patient care.

Once again, enjoy the discussions in this special feature on physician wellness, as well as all of the valuable articles in this June issue of \textit{Otolaryngology–Head and Neck Surgery}.

\textbf{References}