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Family Medicine

LETTER TO THE EDITOR

Author Response: Perspectives on Quiet Quitting in Family Medicine Residency Programs

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TO THE EDITOR:

Our team appreciates the thoughtful response[1] to our article.[2] We agree that continued inquiry into quiet quitting and its associated factors is essential for informing future strategies—both systemic and individual—that may reduce the need for quiet quitting in medicine. We welcome the opportunity to provide additional context to clarify the intent and scope of our study.

First, when discussing quiet quitting, we intentionally used the definition provided by *Merriam-Webster*: "the practice of doing the minimum amount of work required for one's job."[3] This definition is descriptive of observable behavior and does not imply capacity, motivation, or moral judgment. Specifically, it does not presume that an individual is capable of doing more or that their behavior reflects disengagement, distress, or deficit.

The response to our article suggests that our work conflates quiet quitting with burnout and struggling learner challenges. This was not our intent. Quiet quitting describes a pattern of behavior, whereas burnout is a psychological state; and learner challenges reflect individual characteristics or circumstances. While burnout has been proposed in commentaries as a potential contributor to quiet quitting,[4,5] it was not identified as such by participants in our study. Distinguishing behavior from psychological state or individual characteristics is central to our analytic approach.

The motivations or contributors underlying quiet quitting behaviors do not alter the definition of quiet quitting itself. Some definitions in the literature describe quiet quitting as "opting out of tasks beyond one's assigned duties and/or becoming less psychologically invested in work."[6] This perspective, largely derived from commentary pieces, risks embedding a value judgment that positions quiet quitting as innately problematic. Our study did not seek to judge quiet quitting as good or bad; rather, we aimed to understand how quiet quitting is perceived by family medicine residency program leadership.

Our study explored leadership perceptions of quiet quitting in residency training, including perceived contributors, consequences, and potential strategies for prevention or mitigation. Participants identified concerns related to diminished competence development and potential risks to patient care, which underscores why quiet quitting should not be ignored. At the same time, our study did not identify potential positive consequences of quiet quitting, which may exist and warrant further exploration.

We recommend distinguishing the behavior of quiet quitting from its potential motivations or contributors and using person-first language rather than labeling individuals as "quiet quitters." This approach helps avoid conflating behavior with intent or character and reduces the assumption that quiet quitting is inherently negative.

Our work is an effort to move beyond predominantly editorial discourse by empirically examining perceptions of quiet quitting among residency leadership. We view this study as a first step toward operationalizing and quantifying quiet quitting, as well as understanding its multilevel contributors and perceived consequences. Future research focused on resident perspectives will be essential to developing a more comprehensive and balanced understanding of this workplace phenomenon.

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