AMA | STEPSforward®

The Value of Feeling Valued Playbook

How Organizations Can Support Individual Physicians

from the AMA STEPS Forward® Playbook Series

About the AMA STEPS Forward® Playbook series

This playbook is part of the AMA STEPS Forward practice innovation program. Each playbook curates the best content AMA STEPS Forward has to offer—toolkits, videos, podcasts, and ready-to-use tools, templates, and resources—into practical, actionable strategies and tactics to help you create positive change in your practice today.

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The AMA STEPS Forward Innovation Academy expands on the program to give participants the flexibility to customize their practice transformation journey. The Innovation Academy offers a wide range of opportunities to learn from peers and experts, including webinars, tele-mentoring, virtual panel discussions, bootcamps, and immersion programs.

Learn more at stepsforward.org.

The Value of Feeling Valued Playbook authors: Jill Jin, MD, MPH; Kevin Hopkins, MD; Jane Fogg, MD

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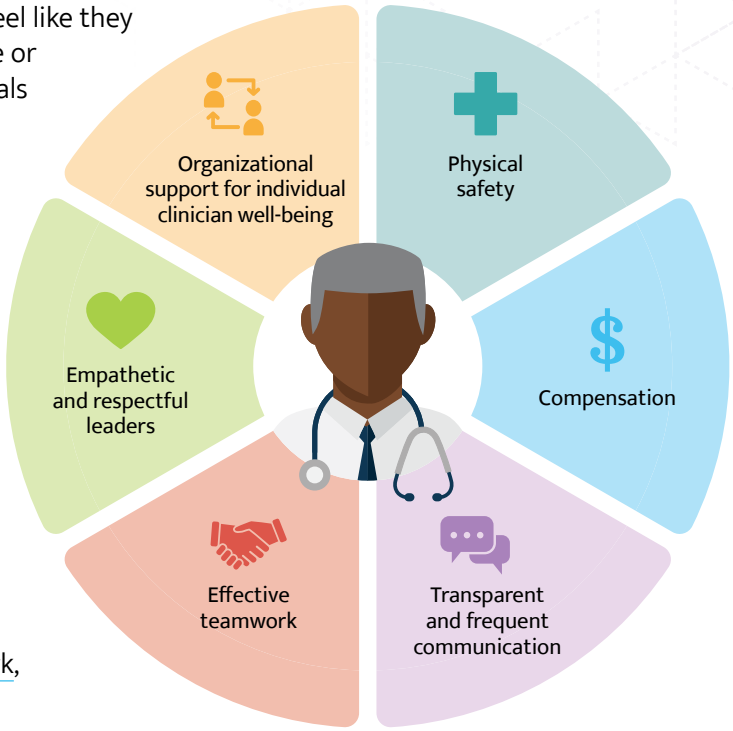
Introduction

> “I didn’t need a muffin. I needed years’ worth of good sleep. … I was so burned out and depressed I should have been seeing a psychiatrist. I was deep, deep inside a black hole, and instead of a rope and a flashlight, somebody had offered me a muffin.”

Jillian Horton, MD

What Does It Mean to Feel Valued?

The idea of feeling valued by an organization or practice refers to the notion that individual physicians feel like they *matter*—not purely as deliverers of patient care or generators of RVUs, but as real people, individuals with unique needs to support the best care for their patients and for themselves. The concept of feeling valued emerged as a mitigator of burnout during the COVID-19 pandemic, and recent studies have shown that feeling valued is associated with lower rates of both burnout and intent to leave the practice.[1,2] Thus, feeling valued matters.



A survey-based study from data collected during the COVID-19 pandemic of what makes physicians and other clinicians feel valued identified several key themes, including (1) physical safety, (2) compensation and pandemic-related finances, (3) transparent and frequent communication, (4) effective teamwork, (5) empathetic and respectful leaders, and (6) organizational support for individual clinicians.[3]

While the study did not look at the relative weights of these themes in terms of importance, and indeed there is some degree of overlap between them, this playbook will focus on the sixth bucket: **organizational support for individual clinician well-being**. This bucket is arguably the most important of them all when it comes to feeling valued as an individual, *and* one that many leaders may feel is the most nebulous and challenging to address. Similarly, it is one that many practicing clinicians may feel most frustrated about—there is just too large a chasm between their actual needs and what their organization provides them. In that chasm exists what physician and author Jillian Horton, MD, describes as "muffin rage," what physicians experiencing crippling burnout will feel when they're handed a muffin during an "appreciation day."[4]

This playbook offers 5 concrete strategies organizations can apply to support their individual physicians in a way that avoids muffin rage.

Invest in Your *People*: The Business Case for Feeling Valued

Why is feeling valued so important? Aside from the obvious humane reasons, organizations should recognize that investing in their clinicians also helps their financial bottom line.

A study looking at trends in burnout for over 20 000 clinicians (including physicians and advanced practice clinicians) during the COVID-19 pandemic found that feeling valued was 1 of the 2 strongest mitigating factors for burnout (the other being teamwork).[5] Among those clinicians who did *not* feel valued by their organization, there was a 69% burnout rate, whereas among those who *did* feel valued by their organization, the burnout rate was only 37%. [Figure 1]

Figure 1. Impact of Feeling Valued on Burnout

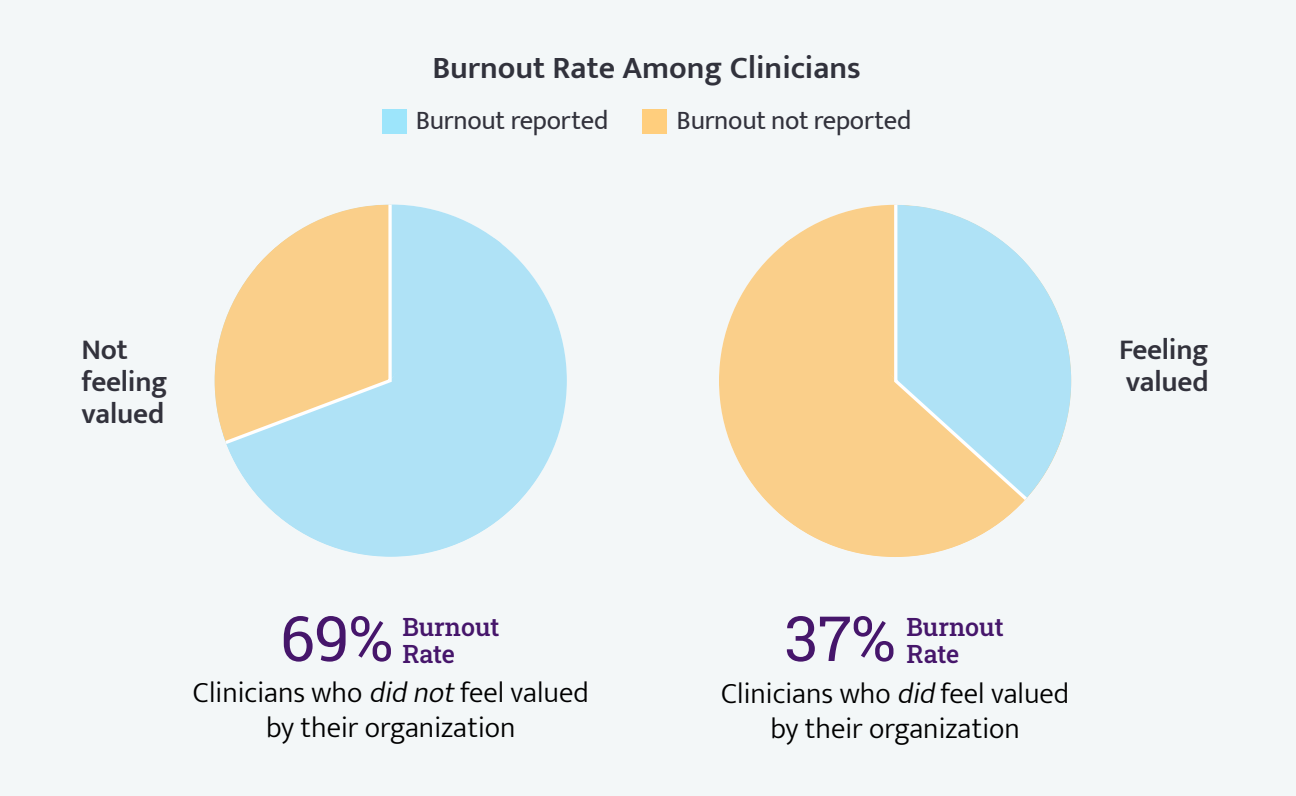
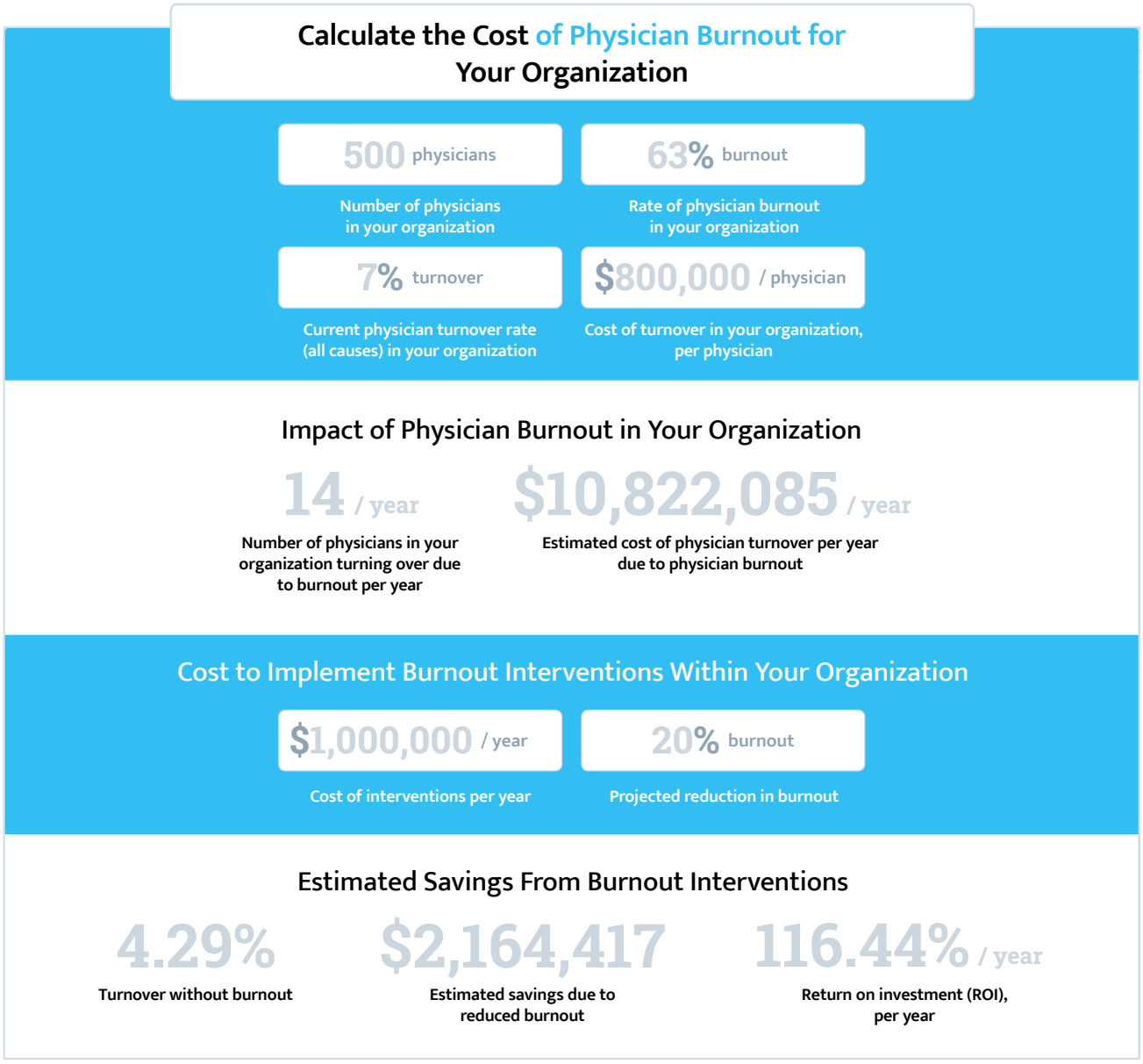


Figure adapted from data reported in Linzer, et al, 2022. Percentages represent rates of burnout reported in Q4 2021.

Given the known association between burnout and turnover rates,[6,7] and the costs of that turnover,[8] this difference suggests potentially significant cost savings for health care organizations.

Online Calculator: Organizational Cost of Physician Burnout



How important is compensation, really?

Physicians want to be compensated fairly. It is important that organizations and practices perform regular market comparisons and adjustments to maintain that fairness, but for most physicians, compensation is not the primary factor that determines whether they feel valued.

Outside of the numbers themselves, however, a physician compensation model can promote feeling valued by offering transparency and trust. The structure and formula by which physicians are paid should be clearly outlined and available to all. Additionally, compensation governance committees should include representative physicians who can give input on the design of their department's compensation. Organizations and private practices may differ in their financial models (fee-for-service vs value-based care) and the compensation model often reflects an alignment with the success of the organization's predominant payment model. Compensation evolves over time as health care systems adjust to changes in their financial model. Ongoing oversight by a physician-based governance committee can ensure alignment with the organization's success while promoting consistent transparency, engagement, and trust among physicians. An overly complex compensation model, or one that frequently changes, can discourage trust and feeling valued.

Notably, the relative importance of non-salary compensation package components for today's physician workforce is increasing. Some physicians may prefer to have more time off and more schedule flexibility rather than more money. Insurance and retirement benefits also remain important.

Who Is This Playbook For?

This playbook is for health systems and organizational leaders, medical directors and departmental leaders, operations leaders, practice managers, practicing physicians, and other clinicians. Anyone interested in improving the culture of wellness and work-life integration for clinicians can learn from the content outlined and linked to within this playbook.

Strategy 1: Support Schedule Flexibility and Autonomy

The amount of control an individual physician has over their daily, weekly, or monthly schedule is a major factor contributing to job satisfaction or dissatisfaction.[5] This can include the way in which their schedule template is designed, the flexibility in daily or weekly work hours, the ability to work from home doing telehealth, and other important factors such as panel size optimization. Additionally, it is crucial to include compensated non-patient-facing time into physician schedules for important panel management and administrative tasks.

The Challenge of Schedule Optimization

There are inevitably some competing priorities between the individual and the organization when it comes to schedule optimization. Individual physicians want to be able to customize their schedules to promote work-life integration when possible, as well as keep enough reserved slots to promote continuity (ie, see their own patients for urgent issues). Organizations want to maximize patient access, both for improved patient outcomes and increased revenue. Unused template slots also affect revenue to support team members such as nurses and medical assistants.

That being said, both organizations and individual physicians want to promote continuity of care when it comes to scheduling—the common goal is that physician schedules allow patients to see their own physicians when they need to. Thus, the best way to achieve schedule optimization is for physicians and administrators to work together to design their templates, rather than giving full power to one party alone. Any schedule optimization committee should have both a physician leader and an administrative leader on board. A collaborative spirit will set the stage for physicians to feel valued by their administrative team.

Table 1 shows some strategies to promote schedule flexibility and autonomy for physicians in an outpatient setting.

Table 1. Schedule Flexibility

	Allow physicians some ability to customize their schedules • Choose appointment length: 15/30, 20/40, vs 30/30 templates • Choose how to incorporate telehealth • Give physicians the ability to place holds on appointment slots without an "approval" process • Promote a collaborative approach to allow for flexibility in clinic start/end times while ensuring all necessary clinic hours are covered (eg, allow physician colleagues to get together periodically to discuss individual schedule needs)
	Set reserved slots based on objective metrics (eg, fill rates, no-show rates, number of urgent visits per week) to allow same-day access for urgent visits
	Set appropriate panel sizes (see panel size optimization below)
	Build in time for panel management that is not patient-facing
	Open the schedule template a minimum of 13 to 18 months in advance
	Proactively block off vacation time (ie, when opening schedule templates). Ensure physicians block off all their vacation time. It is easier to move a week of appointments to a different blocked-off week if vacation dates change, just as it's easier to unblock time off than to add it.

> “It’s essential to have the practice physicians work together to cover the necessary hours to ensure patient access, staff support, and fairness. When I worked in a smaller practice of 6 physicians, we adjusted our schedules and planned our time away to ensure even and equitable coverage of the practice.”
>
> **Jane Fogg, MD, MPH**
> Organizational Transformation Director,
> American Medical Association

What Is a Reasonable Amount of Non-Patient Scheduled Time?

The right amount of time will vary greatly based on such factors as practice setting, specialty, staffing, or patient population. The most important thing to recognize is that for ambulatory practices, if a physician is expected to work 40 hours per week, the number of patient-scheduled hours must be fewer than 40 to allow for panel management and administrative time, which can include documentation and other EHR work, patient portal message management, or team meetings.[9]

A 2016 study examining how a group of physicians spent their time showed that for every hour they spent directly seeing patients, they put in nearly 2 more hours on EHR and desk work during the clinic day. The 21 doctors in the study who tracked their after-hours work reported they spent another 1 to 2 hours each night on computer and clerical work.[10]

An example of one large medical center’s approach to primary-care panel management time is shown in Figure 2.

Figure 2. Sample Approach to Panel Management Time

Full-Time and Part-Time Primary Care Physician Employee					
	Schedulable Patient Hours	Panel Management	Admin	Total	Total FTE
Part-Time Clinical	6	3	3	12	0.30
	7	3	3	13	0.33
	8	3	3	14	0.35
	9	3	3	15	0.38
	10	3	3	16	0.40
	11	3	3	17	0.43
	12	3	3	18	0.45
	13	3	3	19	0.48
	14	3	3	20	0.50
	15	4	3	22	0.55
	16	4	3	23	0.58
	17	4	3	24	0.60
	18	4	3	25	0.63
	19	4	3	26	0.65
	20	4	3	27	0.68
	21	4	3	28	0.70
	22	4	3	29	0.73
	23	4	3	30	0.75
	24	4	4	32	0.80
	25	4	4	33	0.83
	26	4	4	34	0.85
	27	4	4	35	0.88
Full-Time Clinical	28	4	4	36	0.90
	29	4	4	37	0.93
	30	4	4	38	0.95
	31	4	4	39	0.98
	≥32	4	4	40	1.00

> “No scheduling system can fully compensate for an over paneled practice.”
>
> AMA STEPS Forward Wave Scheduling Toolkit
> Authors Christine A. Sinsky, MD, MACP, and Kevin D. Hopkins, MD

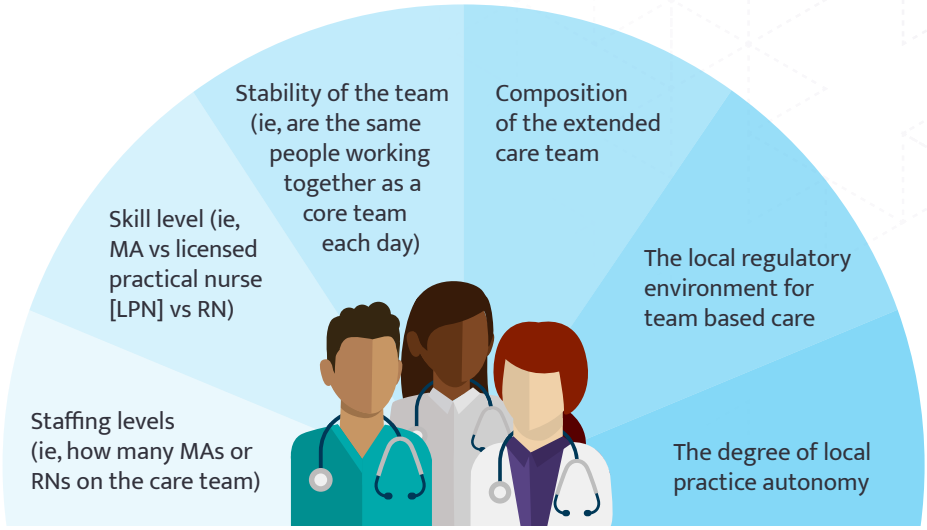
The Importance of Panel Size Optimization

A significant threat to scheduling success is having too many patients. This is true for primary care and subspecialties involving longitudinal care, such as endocrinology, rheumatology, gastroenterology, and others. Given available resources, a practice is likely over-paneled if its unstructured buffer time is consistently used for direct patient care or if patients routinely struggle to see their continuity physician. Panel size incongruent with physician and care team capacity contributes to a chaotic clinical environment, patient frustration, and physician burnout.

Over-paneling typically occurs for 1 of 3 reasons:

1. **Prioritizing new patients over existing patients.**
   For example, a health system may prioritize new patients in primary care to bring in downstream procedural and subspecialty care revenue without increasing capacity within primary care.
2. **Reducing clinical full-time equivalent (FTE) without a corresponding reduction in panel size.**
   For example, a physician may reduce their FTE to take on a leadership role or to cope with an overwhelming workload without reassigning a proportionate number of patients to a different physician. Typically, the over-paneled physician continues to try to manage the same patients in less time—an impossible task. This can result in an increased volume of care provided via patient portal messages and work-outside-of-work (pajama time), which are typically uncompensated.
3. **Having insufficient care-team size and skill level to support panel size.**
   For example, a practice that has not prorated the number of patients a physician can manage to that physician’s clinical FTE and the care team’s size, skill level, and stability (Figure 3). The number of patients alone doesn’t accurately represent the effort required to provide their care. The panel capacity for a physician with 2 nurses and 3 exam rooms fundamentally differs from that of a single physician with 1 medical assistant who may be different each day and only 2 exam rooms.

Figure 3. Factors That Influence Panel Size Capacity



Optimizing Schedules During the Onboarding Period

One of the most important ways to help new physicians feel supported and valued from the outset is to avoid overloading their schedules during their onboarding. Physicians who are thrown into a full patient schedule without adequate holds or limits to support acclimation for the first few months will inevitably feel overwhelmed and unsupported. The possible resulting resentment and distrust can be hard to undo and will affect the physician's perception of how the organization will value them throughout their employment.

Practices should have a specific protocol for outpatient schedule templates during the onboarding period that ramps up over 3 to 6 months. Physicians should receive ample time to shadow colleagues, get to know the rest of the team, and receive necessary EHR training. The ramp-up schedule may consider the physician's prior experience; that is, one who has just finished training may need more time than one who is transferring from another practice.

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- Treating Attention as an Asset

Webinars and Videos

- Team-Based Care
- Video: Implementing Team-Based Care

Strategy 2: Support Time Off

According to survey data, physicians are allotted an average of 25 to 35 days of paid time off (PTO) each year.[11,12] This generally includes vacation, sick days, personal days, and holidays. Some physicians receive an additional 5 to 10 days annually for continuing medical education (CME). And yet, in a 2024 study of over 3000 US physicians across multiple organizations and specialties, approximately 60% of physicians reported taking 15 or fewer days of vacation per year, and 20% reported taking 5 or fewer days per year.[9]

Why Don't Physicians Take PTO?

Three prominent barriers prevent the use of PTO.

1. First, there is inadequate clinical coverage for patient care tasks, including EHR inbox coverage, during physicians' time off. Thus, most physicians are still logging into the EHR during their PTO because they feel this is the only way that 1) they won't compromise patient care, 2) they won't burden their colleagues, and 3) they won't face an impossible load of EHR work upon their return. Survey data show that 70% of physicians reported working while on vacation on a typical vacation day.[13] As a result, their PTO is not truly time off—but rather "pretend time off"—so what's the point in taking it?

2. Second, physicians are not billing RVUs while on PTO. This becomes problematic if the benchmarks for RVU productivity and bonuses—as well as projected compensation calculators—do not take PTO time fully into account (ie, if the productivity targets are based on the potential RVUs generated over anything more than 44-45 weeks of productive time per year). This gives physicians the impression that they are losing money by taking their PTO and creates internal and external pressures to reach those unrealistic goals.

3. Third, the culture of self-sacrifice and 24/7 availability is infused into the sentiment that medicine is a calling—physicians chose the field because they wanted to help and heal, which inherently involves some degree of self-sacrifice and work outside of traditional work hours. However, when taken to the extreme, this culture becomes detrimental to both physician well-being and patient care.

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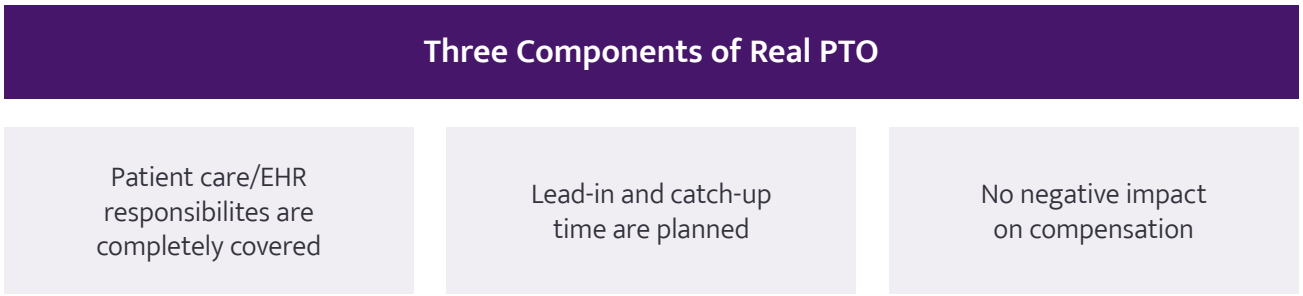
From "Pretend Time Off" to "Real PTO"

How can organizations support physicians and remove barriers to taking time off? The "Real PTO" for Physicians Toolkit describes 7 STEPS to get from "pretend time off" to "Real PTO," a framework for time off for physicians that:

1. Transitions all patient care and EHR responsibilities to other team members without feelings of guilt about burdening colleagues
2. Provides adequate lead-in and catch-up time before and after time away
3. Adequately accounts for PTO in compensation models

Figure 4. Three Components of Real PTO



Some of the 7 STEPS are described further here, but more details on each can be found in the toolkit.

1. Embrace 3 Components of Real PTO
2. Understand the Business Case for Real PTO
3. Normalize the Culture of Taking Time Off
4. Provide Adequate Coverage, Including EHR Inbox Coverage
5. Enact Reasonable On- and Off-Ramp Policies for Taking Time Off
6. Design a Compensation Model to Adequately Include Time Off
7. Track Time Off to Ensure Fairness

The Business Case for Real PTO

Real PTO is a strategy for health systems and practices to reduce burnout and increase physician loyalty and retention. Real PTO is a short-term expense offset by long-term benefits for individuals and health systems.

A 2024 study showed that taking more than 3 weeks of vacation per year and having full EHR inbox coverage while on vacation were associated with lower odds of burnout, whereas spending more than 30 minutes a day on patient-related tasks while on vacation was associated with higher odds of burnout.[9]

Thus, long-term benefits of successful Real PTO may include:

- Reduced physician burnout, which may reduce turnover, leading to increased patient access and improved continuity of care
- Improved engagement and vitality of the physician workforce
- Reduced costs for the organization related to physician burnout

Tables 2, 3, and 4 provide ways to tackle the cultural, EHR coverage, and compensation barriers to taking PTO.

Table 2: Normalizing the Culture of Taking Time Off

 Ensure that leaders model taking time off themselves	 Incorporate respect for time off into professional etiquette	 Don't praise physicians for working while taking time off	 Make PTO policies transparent and easily accessible	 Proactively block off PTO time into physician templates	 Engage individual physicians work-unit leaders for feedback and brainstorming	 Celebrate time away

Table 3: EHR Inbox Coverage Models

MODEL	DESCRIPTION	PHYSICIAN	BURDEN TO PHYSICIAN COLLEAGUES	PROS	CONS
Team coverage with APP	• The EHR inbox is fully triaged and addressed by the MA/RN care team • The care team brings messages that they cannot resolve on their own to an APP partner, who resolves these messages • A covering physician can be contacted for urgent issues that the APP cannot resolve	YES	LOW	• Patients receive care from team members familiar with them and to them. • Team owns EHR inbox, which supports camaraderie and sense of shared responsibility	• APP support for physicians takes extra resources
Team coverage without APP	• Same as above, but there is no APP level of support, so any issue unable to be resolved by the care team goes to a covering physician	YES	LOW to MEDIUM	• Patients are cared for by team members familiar with them and to them • Team owns the EHR inbox, which supports camaraderie and sense of shared responsibility	• Team member training to fully support EHR inbox coverage can be challenging
Physician-to-physician coverage or buddy system	• Physician finds colleague to cover on an ongoing basis	VARIABLE	HIGH	• Coverage is always "physician-level" and by a known colleague, which is reassuring to some physicians (and patients), and helps with expectations during coverage	• Some physicians may feel guilty burdening colleagues and will continue to log on during vacation • Coverage burden may be unequal depending on patient panel as well as disposition of covering physician (eg, the friendly and more "thorough" physicians are always asked to cover)
Physician float or "doc of the day" coverage	• Float, part-time, or semi-retired physician paid to cover EHR inbox from home	YES	NONE	• Someone who has dedicated time to address the inbox offers "physician-level" coverage	• Cost to cover salary of covering physician • Physician isn't familiar with patients
APP float coverage	• APP from a float coverage pool is assigned to cover	YES	MEDIUM	• Option costs less than physician float coverage	• APP isn't familiar with patients • APP will still have to bring complex issues to covering physician
Physician covering pool	• Physician signs out to pool of colleagues, each of whom will address and resolve messages as they are able to, depending on their schedules	YES	MEDIUM to HIGH	• Shared responsibility feels less daunting to any individual physician	• Inefficient; all colleagues receive all messages • Relies on honor system to address messages, which may result in uneven burden on colleagues
No designated coverage agreement	• Physician covers own EHR inbox while away	NO	NONE	• Physicians don't feel guilty about burdening colleagues	• Physicians cannot disconnect while away

Reprinted from the AMA STEPS Forward "Real PTO" for Physicians Toolkit.

Table 4: Designing Compensation to Support PTO

COMPENSATION MODEL	HOW THE MODEL CAN SUPPORT PTO
Salary-based (including shift-based)	• Salary includes at least 4 weeks of vacation time, with consideration for additional weeks based on the time at the organization (as a retention incentive). For example, for a full-time physician with 4 weeks of vacation, the organization budgets for 44-45 weeks per year of productive time, accounting for vacation, holidays, and CME time. • For shift-based roles, set the required number of shifts per month with PTO in mind. For example, if the emergency department needs 1000 hours per month of physician coverage and full-time status is defined as 100 hours per month, calculate the number of FTEs needed based on a lower number to account for a percentage of PTO days. Or, if 16 shifts are required per 4-week block and the physician takes a week of vacation time, only 12 shifts should be required in that block to receive full compensation (rather than squeezing 16 shifts into a 3-week block). • For extended leaves such as parental or medical leave, physicians should not have to "make up" call assignments that they missed while on leave. For parents with a newborn, returning to work with extra make-up call shifts is antithetical to retaining these physicians at full capacity. • Compensate for backup call for sick days. For example, physicians may be assigned 1 or 2 weeks per year to serve as sick-day backup coverage and are paid for the usual number of shifts that week *whether or not they are called in* (ie, they are paid even if they are not called in). Alternatively, physicians may be assigned a number of backup weeks per year at partial pay, with an increase to full pay if they are called in. • Develop a fair system for holidays (eg, based on set rotation, physician preferences, lottery system); carefully consider whether seniority should be a factor.
Productivity/Relative Value Units (RVU)-based (including base salary with productivity/RVU bonus structure)	All of those for salary-based, plus: • Calculate productivity targets that account for PTO (ie, using only the top 44-45 weeks of productivity per year). This signals that the organization only expects physicians to work 44-45 weeks per year and encourages the use of PTO. • For extended leaves such as parental leave or medical leave, impute RVUs so that productivity targets can still be met (and ensure that these weeks remain separate from vacation time). • If using a tiered compensation system, design one with a broad middle tier to avoid unnecessary pressure for physicians to strive to reach the next level. • When calculating base salary, use a 12-month look back rather than quarterly so physicians do not feel guilty taking several weeks off in the same quarter.
Alternative models (including panel-based, quality/outcome-based, and others based on non-RVU incentives)	• These models generally present fewer barriers to taking PTO. Organizations should focus on removing *perceived* barriers to compensation and setting achievable expectations while taking PTO.

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- Reducing Barriers to Physician PTO
- Team-Based Care

Success Stories

- Implementing Strategies to Optimize Efficiency and Workflow to Improve Physician Satisfaction

Strategy 3: Support Professional Development

Literature has shown that spending 20% of your professional time on what interests you can reduce and prevent burnout.[14] Figure 5 shows some of these areas of professional development.

Encouraging Physicians' Interests

Each physician will have unique areas of interest and passion, and it is important for organizations to encourage the pursuit of these interests.

Health care organizations can support their physicians in a variety of ways, including:

- Separate or optional add-on career tracks focusing on clinical medicine, education, research (eg, Master Clinician, Master Educator)
- Annual CME funds and protected time
- Internal leadership training programs for physicians, such as a Scholars of Wellness program
- Opportunities to participate in quality improvement (QI) or committee work that impacts care delivery
- Opportunities for organization-sponsored external leadership or business administration training (eg, MBA, MHA, MPH degree programs)
- Coaching and mentoring services, especially for early-career physicians
- Recognition for achievements (including academic promotion and tenure, but also other mechanisms for those outside academia)
- Collegiality dinners

Figure 5. Professional Development for Physicians

As a leader, how do I approach the conversation on professional development with physicians?

Embed conversations on professional development into your annual review process for every physician. While reviewing their achievements, strengths, and opportunities to improve, add open-ended questions about their professional goals. If you do not have an annual review process, you can still meet with each of your physicians to discuss how things are going, their suggestions for practice improvements, and whether they have interests in professional activities outside of clinical practice.

Health care organizations can support their physicians in a variety of ways, including:

- Where do you see yourself in 3 to 5 years?
- Outside of taking care of patients, what activities or pursuits excite you? (eg, teaching, mentoring, research, QI)
- We always need to improve how our practice works. Are there areas of improvement you would like to work on with others? (eg, local practice improvement initiatives such as teaming, improving workflows)
- Are there aspects of health care delivery that you want to learn more about? (eg, value-based care, population health)

These questions will help you both better know your colleague and build trust in your relationship.

Additionally, as a leader, advocate to senior leadership for the need to create professional development opportunities for practicing physicians, which includes a budget for these nonclinical activities. For example, a large practice can budget for 1.0 FTE of physician administrative effort to be used by the department chair at their discretion. This compensated time allows the chair to offer professional development activities for their physicians without asking physicians to do this on their own time. This can be divided into smaller FTE amounts to support multiple physicians.

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Toolkits

- What to Look for in Your First or Next Practice
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- Physician Burnout: It's Not a Resiliency Deficit
- What Makes a High-Performing Practice?
- Video: How Mayo Clinic Has Selected Change Initiatives

Strategy 4: Support Individual Resilience and Self-Care

Physicians on average have greater personal resilience than the general population, and it is known that high resilience is associated with decreased burnout.[15] Yet, physicians also have higher burnout rates than the general population. This dichotomy highlights the extent of the stress injury, fatigue, and exhaustion that physicians face in their profession.

Building individual resilience alone will not solve the issue of physician burnout, and programs that promote individual resilience cannot replace efforts to improve system-level drivers of burnout. However, it is important that organizations and individual physicians embrace self-care and understand its importance. The key message that organizations should give is that self-care is valued, supported, and needed.

Reducing mental health stigma for physicians

Many physicians struggling with high levels of burnout or mental health conditions may feel they need to "tough it out" and not seek care or help. Physicians too often make this decision out of fear their condition will be disclosed or they'll face punitive action in the workplace for seeking treatment. Health care employers can correct this mistaken belief by examining their own credentialing application process and removing any stigmatizing or inappropriate language about the disclosure of mental illness and substance use disorders. The Joint Commission and the Federation of State Medical Boards strongly encourage licensing and credentialing organizations to avoid using any probing questions about a clinicians' past mental health, addiction, or substance use history on licensure and credentialing applications.

The Continuum of Well-Being, Resilience, and Burnout

Figures 6 and 7 offer the American Medical Association's glossary of related terms, and illustrate how physicians typically experience burnout over time.

Figure 6: Well-Being and Burnout Terms

Stress Injury
Mental, emotional, or spiritual insult which may also cause physical symptoms

Margin
Space between our load and our limit

Fatigue
Tiredness, worn from physical or mental exertion

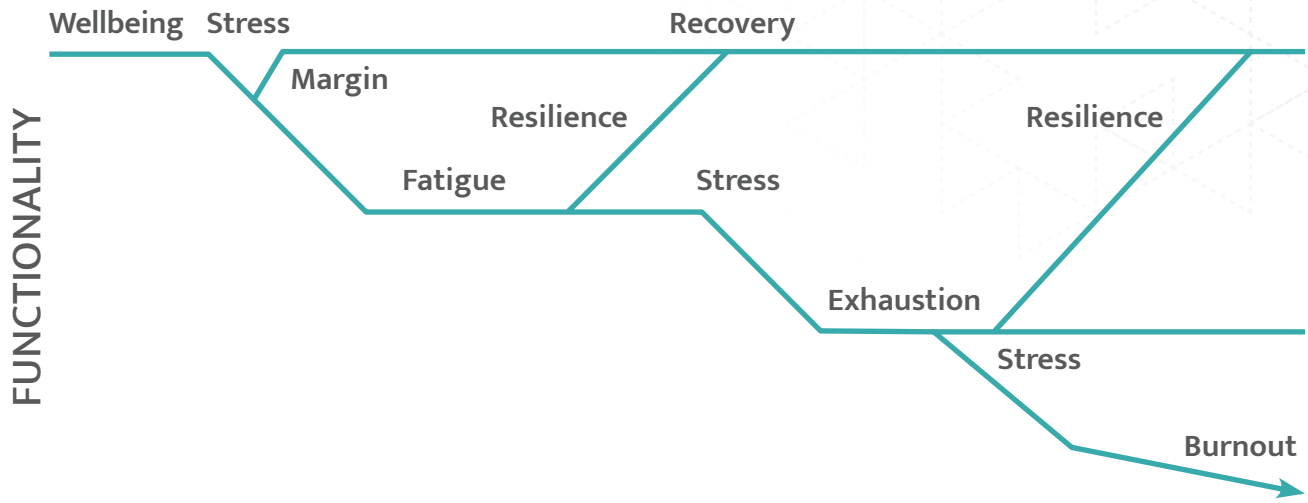
Resilience
Ability to withstand or recover quickly from difficult conditions; also, the ability to recoil or spring back into shape after bending, stretching, or being compressed

Recovery
Return to normal, baseline state and function after an injury or insult

Exhaustion
Extreme physical and/or mental fatigue, completely used up

Burnout
Stress reaction marked by depersonalization, emotional exhaustion, a feeling of decreased personal achievement, and a lack of empathy for patients

Figure 7: The Continuum of Well-Being, Resilience, and Burnout



When stress occurs, it results in a negative impact on well-being. Having margin available helps absorb this impact and allows a faster return to a normal state of well-being. Without adequate margin, stress can cause a more significant negative effect on function, leading to fatigue. Resilience supports a return to normal function, but recovery may take longer. Inadequate resilience or another significant stressor before recovery can cause further decline in function to the point of exhaustion. Again, resilience supports a return to normal function, but recovery from exhaustion may take longer and be more challenging. Inadequate resilience and/or further stress injury before recovery can lead to burnout.

The situation is similar to the physical injury-reinjury cycle commonly seen in clinical practice. Not having enough training, strength, or flexibility can increase susceptibility to a musculoskeletal injury. Incomplete healing and rehabilitation with too much demand can worsen the injury, prolonging lower-level functionality and delaying eventual recovery.

Table 5 provides some tactics to build individual resilience and create margin. The AMA STEPS Forward toolkit Individual Resilience and Well-Being provides additional concrete steps.

Table 5. Individual and Organizational Actions

Individual Goals	Organizational Actions to Support Individual Goals	Individual Actions to Support Goals
Prioritize your to-do list	• Communicate clear priority expectations (eg, required, optional, recommended) • Set realistic completion dates	Think about 3 categories of daily tasks: 1. Must Do 2. Should Do 3. Could Do
Set boundaries	• Do not contact physicians during their time off • Avoid meetings and other work obligations before and after normal business hours • Encourage taking time off	• Train your brain to leave work at work. One physician employed a ritual of saying, "With this breath, I'm coming all the way home."
Limit commitments (just say no!)	• Limit unnecessary meetings • Give permission to say no	• Develop a rule for yourself, eg. "if it's not an immediate yes, then it's a no."
Limit decisions (don't overthink it)	• Limit unnecessary surveys • Don't wait for 100% consensus, when the majority of physicians agree, go with it	• Have personal "policies" that cannot be broken (eg, no checking email on Saturdays) • Be decisive when decisions don't matter much (eg, where to go for dinner)
Limit distractions (multitasking is a myth)	• Create distraction-free work spaces • Be intentional when considering cognitive load in workplace design • Eliminate unnecessary alerts • Organize and batch communication	• Turn off device and app notifications • Use "Do Not Disturb" feature • Control your desktop-email and EHR notifications • Limit screentime
Take breaks (both during and between workdays)	• Build lunch breaks into schedules • Limit meetings to 45 minutes • Provide adequate PTO days • Clearly articulate PTO policies	• Schedule breaks into your work calendar • Use your PTO days
Connect socially	• Offer common spaces and opportunities for connecting with colleagues at work	• Prioritize time with family and friends

EXPLORE MORE!

Toolkits

- Individual Resilience and Well-Being
- Caring for the Health Care Workforce During Crisis
- Stress First Aid for Health Care Professionals
- Peer Support Programs for Physicians
- Listening Campaign
- Assessment of Clinician Burnout
- Creating the Organizational Foundation for Joy in Medicine™

Debunking Regulatory Myths Series

- Should Licensing/Credentialing Organizations Inquire About Clinicians' Past Mental Health?

Podcast Episodes

- Setting Boundaries
- Three Simple STEPS for Diagnosing Your Own Mental Patterns
- Creating a Culture That Supports Well-Being

Webinars and Videos

- Setting Boundaries to Prevent Fatigue and Build Resilience
- Well-Being Communications Strategies
- Physician Burnout: It's Not a Resiliency Deficit
- The Habit of Gratitude: Being Positively Contagious
- Building Well-Being Into Culture

Success Stories

- Authentic Connections Groups Contribute to Resilience and Less Burnout Among Physician Mothers

Strategy 5: Support Care During and After Trauma

Responding to Individual Trauma

As described in Strategy 4, part of individual resilience is the ability to recover from traumatic events. In addition to promoting resilience amid day-to-day stresses, organizational programs to promote resilience following adverse events (such as an adverse patient outcome or being named in a lawsuit) or other types of personal traumatic events are essential to valuing individual physicians.

These programs are described in detail in several AMA STEPS Forward resources, and include:

- A formal peer support program (using validated methods and tools, such as a Stress First Aid framework)
- Confidential mental health services for physicians as part of either an internal or external assistance program
- A suicide prevention plan as well as a suicide response plan

A credentialing process that does not ask about mental health history or treatment but rather focuses solely on current impairment

Table 6. Forms of Trauma[16,17]

 Individual	**Physical trauma** • A physical harm • Can progress to post-traumatic stress disorder (PTSD) or other mental health disorder **Psychological trauma** • An emotional response to experiencing or witnessing a shocking and threatening event or series of events • Can progress to post-traumatic stress disorder (PTSD) or other mental health disorder
 Group	**Collective trauma** • Traumatic events that affect an entire group or society and/or sever ties that bind community members to one another (eg, trust, connection, safety, and meaning) • Often, but not always, experienced as having a distinct beginning, middle, and end to the event • Collective recovery can be slow and may occur over many years • Examples include terrorist attacks, mass shootings, economic crises, political conflict and war, infectious disease epidemics, and natural disasters

Responding to Collective Trauma

Responding to collective trauma requires organizational efforts that target not just individual clinicians but also teams, departments, and the organization as a whole. Organizational resilience refers to the ability of organizations to anticipate, plan for, respond to, and learn or grow from adversity. Organizational resilience involves large-scale operations, strategic initiatives, and decision-making that can influence the response and health of the organization and the teams and individuals impacted through the provision of—and access to—resources, relationship building, and communication. The Collective Trauma toolkit and Caring for the Health Care Workforce During Crisis toolkit provide additional details and concrete STEPS for bolstering organizational resilience.

EXPLORE MORE!

Toolkits

- Caring for the Health Care Workforce During Crisis
- Collective Trauma
- Stress First Aid for Health Care Professionals
- Preventing Physician Suicide
- After a Physician Suicide

Podcast Episodes

- "I don't remember when I lost hope": One CMO's Burnout-to-Depression Story
- Rapid Supportive Debriefs: A Tool for Embodying Wellness-Centered Leadership After Stressful Events
- Expanded Peer Support and Second Victim Syndrome
- Frontline Connect: Eliminating Barriers to Mental Health Services for the Health Care Workforce

Webinars and Videos

- Dismantling Stigma for All
- Physicians Leading the Charge
- Stress First Aid for Health Care Professionals

Success Stories

- Success Story: Establishing Emotional Support for Clinicians in Times of Crisis

Conclusion

The COVID-19 pandemic showed us the significance of feeling valued by your organization. In the post-COVID era, health systems that have continued to prioritize supporting their individual clinicians' well-being at a level "beyond the muffin" have benefited from reduced burnout, decreased turnover, and a more solid culture of wellness.

Resources and Further Information

Related AMA STEPS Forward Content

Playbooks

- Wellness-Centered Leadership Playbook
- Saving Time Playbook

Toolkits

- Creating the Organizational Foundation for Joy in Medicine™
- "Real PTO" for Physicians
- Caring for the Health Care Workforce During Crisis
- Collective Trauma
- Preventing Physician Suicide
- After a Physician Suicide
- Cultivating Leadership
- Scholars of Wellness
- Change Initiatives
- Panel Management
- Team-Based Care
- Listening Campaign
- What to Look for in Your First or Next Practice
- Establishing a Chief Wellness Officer Position
- Change Management and Organizational Development
- Team Culture
- Individual Resilience and Well-Being
- Peer Support Programs for Physicians
- Assessment of Clinician Well-Being
- Stress First Aid for Health Care Professionals

Podcast Episodes

- Practical Strategies for the Wellness-Centered Leader
- Supporting Physician Wellness in an ER Environment
- Treating Attention as an Asset
- What to Look for in Your Next Practice
- Reducing Pajama Time or WOW
- Creating a Culture That Supports Well-Being
- Establishing a Chief Wellness Officer Position
- Chief Wellness Officer Road Map
- How a Chief Wellness Officer Manages His Own Burnout
- Building Bridges Between Practicing Physicians and Administrators
- Cultivating Leadership
- Setting Boundaries
- Three Simple STEPS for Diagnosing Your Own Mental Patterns
- "I don't remember when I lost hope": One CMO's Burnout-to-Depression Story
- Rapid Supportive Debriefs: A Tool for Embodying Wellness-Centered Leadership After Stressful Events
- No One Left Behind: Expanded Peer Support and Second Victim Syndrome
- Frontline Connect: Eliminating Barriers to Mental Health Services for the Health Care Workforce

Webinars

- Reducing Barriers to Physician PTO
- Team-Based Care
- Closing the Gap: How Physicians Are Driving the Future of Health Physician Burnout: It's Not a Resiliency Deficit
- What Makes a High-Performing Practice?
- Setting Boundaries to Prevent Fatigue and Build Resilience
- Well-Being Communications Strategies
- Physician Burnout: It's Not a Resiliency Deficit
- The Habit of Gratitude: Being Positively Contagious
- Building Well-Being Into Culture
- Dismantling Stigma for All
- Physicians Leading the Charge: Dismantling Stigma Around Behavioral Health Conditions and Treatment
- Stress First Aid for Health Care Professionals
- Implementing Team-Based Care
- How Mayo Clinic Has Selected Change Initiatives

Journal Articles

- Establishing a Chief Wellness Officer PositionStillman M, Sullivan EE, Prasad K, et al. Understanding what leaders can do to facilitate healthcare workers' feeling valued: improving our knowledge of the strongest burnout mitigator. *BMJ Lead*. Published online June 5, 2024. doi:10.1136/leader-2023-000921
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About the AMA Professional Satisfaction and Practice Sustainability Group

The AMA Professional Satisfaction and Practice Sustainability group is committed to making the patient-physician relationship more valued than paperwork, technology an asset and not a burden, and physician burnout a thing of the past. We are focused on improving—and setting a positive future path for—the operational, financial, and technological aspects of a physician's practice. Learn more.

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