



AMERICAN ACADEMY OF  
FAMILY PHYSICIANS

Recommended Curriculum Guidelines for Family Medicine Residents

# Physician Well-being

*This document is endorsed by the American Academy of Family Physicians (AAFP).*

## Introduction

This AAFP Curriculum Guideline defines a recommended training strategy for family medicine residents. Attitudes, behaviors, knowledge, and skills that are critical to family medicine should be attained through longitudinal experience that promotes educational competencies defined by the Accreditation Council for Graduate Medical Education (ACGME), [www.acgme.org](http://www.acgme.org). The family medicine curriculum must include structured experience in several specified areas. Much of the resident's knowledge will be gained by caring for ambulatory patients who visit the family medicine center, although additional experience gained in various other settings (e.g., an inpatient setting, a patient's home, a long-term care facility, the emergency department, the community) is critical for well-rounded residency training. The residents should be able to develop a skillset and apply their skills appropriately to all patient care settings.

Structured didactic lectures, conferences, journal clubs, and workshops must be included in the curriculum to supplement experiential learning, with an emphasis on outcomes-oriented, evidence-based studies that delineate common diseases affecting patients of all ages. Patient-centered care, and targeted techniques of health promotion and disease prevention are hallmarks of family medicine and should be integrated in all settings. Appropriate referral patterns, transitions of care, and the provision of cost-effective care should also be part of the curriculum.

Program requirements specific to family medicine residencies may be found on the ACGME website. Current AAFP Curriculum Guidelines may be found online at [www.aafp.org/cg](http://www.aafp.org/cg). These guidelines are periodically updated and endorsed by the AAFP and, in many instances, other specialty societies, as indicated on each guideline.

Please note that the term “manage” occurs frequently in AAFP Curriculum Guidelines. “Manage” is used in a broad sense indicating that the family physician takes responsibility that optimal and complete care is provided to the patient. To manage does not necessarily mean that all aspects of care need to be directly delivered personally by the family physician and may include appropriate referral to other health care providers, including other specialists, for evaluation and treatment.

Each residency program is responsible for its own curriculum. **This guideline provides a useful strategy to help residency programs form their curricula for educating family physicians.**

## **Preamble**

Physicians’ lack of well-being is a major challenge facing health care in the United States. Many physicians, across all specialties, suffer from burnout, which is defined as emotional exhaustion, depersonalization, and lack of personal efficacy. Family physicians suffer from significantly higher rates of burnout than physicians in most other specialties. Physician burnout is associated with increased medical errors, worse patient outcomes, high turnover, and other public health consequences. Physicians also have higher rates of depression and suicide than the general population. Physician death by suicide is a hidden epidemic.

Causes of physician burnout include the following: careers that do not meet expectations of service; loss of physician autonomy; excessive work hours; adverse patient outcomes; and administrative burden (e.g., electronic health records [EHRs]) that leads to less time with patients. These causal factors begin during medical training. In fact, rates of burnout among resident physicians are similar to rates among practicing physicians, with many reported rates greater than 50 percent.

Evidence regarding interventions to alleviate burnout and reduce physicians’ risk of depression and suicide is currently inadequate. Interventions must be multifactorial. Individual-focused strategies (e.g., small-group curricula, mindfulness-based approaches) and organizational strategies (e.g., shortened rotation length, modifications

to clinic work processes) have been shown to decrease burnout. Combining these approaches is ideal.

The 2018 Accreditation Council for Graduate Medical Education (ACGME) Common Program Requirements state:

“Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of residency training.

Residents and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. For example, a culture which encourages covering for colleagues after an illness without the expectation of reciprocity reflects the ideal of professionalism. A positive culture in a clinical learning environment models constructive behaviors and prepares residents with the skills and attitudes needed to thrive throughout their careers.” (Accreditation Council for Graduate Medical Education. ACGME Common Program Requirements (Residency). <https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf>. Accessed April 8, 2019.)

Family physicians should work toward creating cultures of well-being in their own lives, in their practice settings, and in their training programs.

## **Competencies**

At the completion of residency training, a family medicine resident should be able to:

- Sustain affirming, healing, collaborative working relationships with team members, colleagues, and patients (Interpersonal and Communication Skills, Professionalism)
- Recognize signs of burnout, depression, and suicide risk in self and others, and intervene or seek help, as appropriate (Professionalism)
- Design and implement quality improvement projects in the work environment to improve physician well-being (Practice-based Learning and Improvement )

- Apply principles of physician well-being and life harmony in the practice of medicine (Professionalism)
- Advocate in practice settings and health systems to improve physician well-being and work toward the Quadruple Aim (Systems-based Practice)

### **Attitudes and Behaviors**

The resident should develop attitudes and behaviors that encompass:

- Awareness that physician well-being is an essential component of public health
- Recognition that physicians are at increased risk of burnout, depression, and suicide
- Openness to self-reflection and conversations with team members and colleagues about issues related to physician well-being
- Dedication to destigmatizing burnout, depression, and suicide risk
- Comfort with regular assessment of physician well-being in one's current work environment
- Dedication of time and effort to individual activities explicitly intended to improve well-being for self and colleagues
- Appreciation of and dedication to quality improvement efforts to achieve the Quadruple Aim, including joy in practice
- Willingness to embrace a culture of change and continuous improvement
- Commitment to improving physician well-being by advocating at the local and national levels for work environment improvements

### **Knowledge**

In the appropriate setting, the resident should demonstrate the ability to apply knowledge of the following:

1. Physician well-being exists on a spectrum from burnout to surviving to "fine" to well to thriving (listed from most unwell to well). Well-being is not just the absence of burnout.
2. Burnout is defined as depersonalization, emotional exhaustion, and a sense of decreased personal accomplishment.
3. Burnout can be measured with the Maslach Burnout Inventory (MBI). Shorter assessments of burnout can include two statements:

- a. “I feel burned out from my work.” – Assesses emotional exhaustion
  - b. “I have become more callous toward people since I took this job.” – Assesses depersonalization
4. Burnout measures can be sensitive to specific rotations and may not be an overall reflection of well-being.
5. Several instruments, including the Physician Wellness Inventory and the Stanford Professional Fulfillment Index, can measure well-being. Reliable and valid measures can be accessed online through the National Academy of Medicine (NAM) at <https://nam.edu/valid-reliable-survey-instruments-measure-burnout-well-work-related-dimensions/>.
6. Burnout, depression, and suicidal ideation are common in physicians. Rates of burnout, depression, and suicidal ideation are higher in physicians than in the general population.
7. Burnout and poor physician well-being are important public health issues and affect patient safety concerns, decrease in physician work effort, physician turnover, recruiting challenges, and the viability of health systems.
8. In residents, greater mental well-being is associated with greater empathy.
9. Barriers to physicians seeking help when they are unwell, burned out, depressed, or at increased risk of suicide include stigma and issues related to credentialing and medical licensing.
10. Health systems and physicians should seek to improve care based on the Quadruple Aim of enhancing the patient experience, improving population health, decreasing costs, and improving the work life of physicians and health care staff.
11. Physicians should strive to improve life harmony with a focus on achieving concordance and balance between work, home, personal development, spiritual life, family, love, and community engagement.
12. Data on interventions to improve well-being are limited, but the following structural or organizational strategies have been shown in cohort or randomized controlled trials to modestly decrease emotional exhaustion and/or depersonalization:
  - a. Duty hour requirements and shortened resident shifts
  - b. Locally developed modifications to clinical work processes
  - c. Shortened attending physician rotations
  - d. Practice delivery changes

13. The following individual interventions have been shown in cohort or randomized controlled trials to modestly decrease emotional exhaustion and/or depersonalization:
  - a. Facilitated small group curricula
  - b. Stress management and self-care training
  - c. Communication skills training
  - d. Mindfulness-based approaches
14. A combination of individual interventions and structural or organizational changes may be required to substantially improve physician well-being.
15. Learning environments should be conducive to clinical mastery and progressive autonomy. The following factors are associated with resident well-being in observational studies:
  - a. Autonomy
  - b. Building of competence
  - c. Social relatedness
  - d. Sense of control
  - e. Pursuit and achievement of goals
  - f. Opportunities for learning
  - g. Increased confidence and sense of increasing mastery
  - h. Positive feedback
  - i. Positive relationships
  - j. Sleep
  - k. Physical activity
  - l. Time away from work
16. After-hours EHR work can contribute to poor physician well-being. Maximizing time spent with patients (i.e., getting “back to bedside”) and reducing clerical tasks and “e-work” may improve physician well-being. In other words, seeing the patient is the joy.
17. Accessible, confidential, affordable, destigmatized mental health services must be available to physicians.
18. Optimization of work schedules can promote well-being.

19. Well-being is associated with PERMA (positive emotion, engagement, relationships, meaning, accomplishment) and excellence.
20. Regular recognition and practice of gratitude is associated with well-being in physicians.

## **Skills**

In the appropriate setting, the resident should demonstrate the ability to:

1. Measure physician burnout and well-being to assess the impact of curriculum and culture, not to identify burned-out residents
2. Identify and employ personal strategies to maintain well-being, including ways to address life harmony
3. Effectively work on teams and build meaningful relationships with team members, colleagues, and patients
4. Design and implement quality improvement projects to address the Quadruple Aim
5. Collaborate with health systems and colleagues to lead change and address issues of well-being
6. Identify when self or colleagues need intervention due to burnout, substance abuse, depression, or suicide risk, and intervene appropriately
7. Develop plans to address weaknesses and achieve mastery in clinical skills and testing strategies

## **Implementation**

This curriculum should be taught during both focused and longitudinal experiences throughout the residency program.

Initiatives in family medicine residencies should prioritize efforts prevent burnout and enhance well-being. Some interventions are likely to yield a greater impact and some may be more feasible based on existing program resources.

The following initiatives are likely to have a high yield and have been identified by content experts as **essential** for family medicine training programs:

- Make well-being part of the residency vocabulary and culture by encouraging faculty to initiate wellness conversations during applicant selection interviews, throughout orientation, and regularly thereafter
- Create and maintain a culture of confidential, safe disclosure for burnout, depression, suicide risk, and impairment. Be explicit—early and often—about the mechanisms for residents to disclose this information in your program.
- Provide (directly or via referral) accessible, confidential, affordable mental health services
- Create and maintain mechanisms for residents to attend medical visits and a nonpunitive back-up system for work absences
- Include residents in planning their schedules, and publish schedules in a timely manner so that activities outside of work can be scheduled
- Identify one or more well-being champions
  - At least one faculty member and one resident should be identified.
  - The identified faculty member should have a leadership role in the program or be selected with explicit leadership support for this role.
- When planning and implementing well-being initiatives, include and engage all stakeholders
- Identify and implement solutions to improve the learning and work environment, flow, and efficiency. Solutions should:
  - Minimize time spent with the EHR, especially after hours
  - Maximize time spent with patients
- Measure resident well-being periodically throughout residency, being sensitive to survey fatigue. This is different than measuring burnout that might be more sensitive to rotations.
  - Annual assessment is recommended, but the program should determine its own frequency of assessment.
  - The program should determine which measure to use, maintaining consistency for comparison over time.
  - Resources for measurement are available online through the NAM at <https://nam.edu/valid-reliable-survey-instruments-measure-burnout-well-work-related-dimensions/>.



The following initiatives are likely to have a moderate yield and have been identified by content experts as **important** for family medicine training programs:

- Provide concrete resources, especially for new residents (e.g., information about housing, gym membership, and grocery stores that offer delivery; lists of community counselors; connections to primary care physicians and dentists).
- Invest in teaching effective team-based care (including integrated behavioral health) to residents, and empower residents with the autonomy to use staff fully and expand their roles
- Schedule protected time for residents to reflect and connect, including activities such as narrative writing, appreciative inquiry, Balint groups, Finding Meaning in Medicine groups, celebration of life events, celebration of accomplishments, and creation of individual well-being plans
- Develop and maintain a recurring or longitudinal well-being curriculum that includes all or some of the following:
  - Importance of sleep and fatigue mitigation
  - Importance of physical well-being, exercise, and eating well
  - Importance of recreation and hobbies
  - Mindfulness training
  - Meditation
  - Gratitude practice
  - Community engagement and volunteerism
  - Leadership, communication skills training, effective and mindful communication, and positive conversations
  - Empathy
  - Self-compassion
  - Self-reflection
  - Spirituality
  - Resilience
  - Avoidance of an attitude of delayed gratification
  - Boundaries and setting limits
  - Medical humanities
  - Time management

- Financial management and debt
- Create and maintain access to well-being spaces in the work environment that offer healthy food, exercise facilities, team rooms, and sleep rooms

The following initiatives are likely to contribute to an ongoing culture of well-being and perceived investment in the success of your learners:

- Offer academic and learning support, study strategies, and board exam preparation
- Measure and improve well-being strategies, and disseminate optimal well-being strategies
- Build, maintain, and nurture team relationships
- Schedule and support protected time to connect with colleagues and mentors
- Offer faculty leadership and training to ensure consistent messages and modeling of well-being from faculty and mentors

## Resources

Association of Family Medicine Residency Directors. Well-being action plan for family medicine residencies: creating a culture of wellness. April 2017. Available to members at [www.afmrd.org](http://www.afmrd.org).

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Wright AA, Katz IT. Beyond burnout—redesigning care to restore meaning and sanity for physicians. *N Engl J Med.* 2018;378(4):309-311.

## **Website Resources**

Accreditation Council for Graduate Medical Education. Improving physician well-being, restoring meaning in medicine. [www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being](http://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being)

American Academy of Family Physicians. Physician Health First. [www.aafp.org/membership/benefits/physician-health-first.html](http://www.aafp.org/membership/benefits/physician-health-first.html)

*American Family Physician (AFP)* Podcast: Bonus Episode 4 – January 9, 2017. Interview with Mark H. Greenawald, MD. [www.aafp.org/journals/afp/explore/podcast/bonus4.html](http://www.aafp.org/journals/afp/explore/podcast/bonus4.html)

American Medical Association (AMA) STEPS Forward. Professional well-being. <https://edhub.ama-assn.org/steps-forward/pages/professional-well-being>

National Academy of Medicine. Action Collaborative on Clinician Well-Being and Resilience. <https://nam.edu/initiatives/clinician-resilience-and-well-being/>

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