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Resident and Fellow Well-Being

Optimize Well-Being at Work for Physician Learners

Laura A. Hanyok, MD
Assistant Dean for Graduate Medical Education and Associate Professor of Medicine, Johns Hopkins University School of Medicine

Maureen Leffler, DO, MPH
Course Director, Chief Resident Leadership Training Program, Accreditation Council for Graduate Medical Education; Chief Wellbeing Officer, ChristianaCare

Jill Jin, MD, MPH
Clinical Associate Professor of Medicine, Northwestern University Feinberg School of Medicine; Senior Physician Advisor, American Medical Association

How Will This Toolkit Help Me?

This toolkit will help you capture a current "big-picture" view of the well-being approaches for residents and fellows at your organization. The toolkit guides organizations and offers resources to start a new well-being program or build up an existing program for physician learners.

Note: Physicians completing this toolkit to claim CME credit must read the text of the toolkit and all the downloadable resources.

Introduction

Resident and fellow physicians experience professional burnout at similar rates as practicing physicians, with 42% of residents reporting burnout in a survey conducted from 2022 to 2023.[1] The survey data showed that job stress, work atmosphere, workload, EHR stress, and staffing needs were the greatest contributors to burnout.

While their burnout rates are similar, physician learners have a different work environment than physicians in practice. These differences include:

	Less control and autonomy over their work hours, workload, and schedule
	Less time for healthy lifestyle habits such as exercise and adequate sleep
	Need to balance clinical autonomy and necessary supervision
	Need to balance education and service
	Personal life changes as part of a training program (eg, relocation, separation from family/friends, potential social isolation, uncertainty about future)
	Adjustment to new professional roles as physicians while developing competence
	Working within a hierarchical structure, which may result in feelings of powerlessness, potential mistreatment, judgment when advocating for own needs, or simply not knowing what to ask for
	Higher degree of financial stress

Historically, efforts to address burnout among physician learners have largely been directed toward individuals, with interventions to increase mindfulness or individual resilience.[2] While this approach is helpful in managing professional challenges, it does not address the structural drivers of burnout.

This toolkit provides a step-by-step guide to improve workplace well-being for physician learners by embracing a system-based approach to mitigating sources of burnout and occupational distress for this special group.

Five STEPS to Promote Well-Being for Residents and Fellows

1 Identify Key Players: Who Oversees Well-Being Interventions for Residents and Fellows?

Each Sponsoring Institution (SI) has a different landscape, so well-being interventions will be crafted according to individual institutions' structure. In smaller SIs, the residency or fellowship program may work directly with the hospital leadership to implement programs. In larger SIs, GME offices may coordinate larger-scale programs. Sometimes health systems have larger well-being initiatives for all employees, so a chief wellness officer or other institutional leader may be a key partner. Figure 1 illustrates the layers of oversight for well-being interventions for physician learners.

Figure 1: Spheres of Control for Well-Being Interventions for Physician Learners

Sponsoring Institution (eg, hospital, health system, university)

- Designated institutional official
- Executive leadership
- Chief wellness officer
- Human resources

GME Office/Academic Affairs

- GME-wide programming
- School of medicine
- Student health
- Resident/fellow councils

Individual Training Programs

- Department chair
- Residency leadership
- Faculty
- Resident wellness group

Q&A

What are the ACGME Common Program Requirements for well-being?

The Accreditation Council for Graduate Medical Education (ACGME) first established Common Program Requirements for well-being in 2017 and offers guides to the requirements for residency and fellowship programs. ACGME continues to regularly revise and update the requirements. Guidelines for well-being resources are part of these documents.

2 Assess the Current State of Your GME Program

To design and implement appropriate interventions and measure impact, it is important to understand the current state and unique needs of GME programs. While the ACGME requires administration of its own well-being survey, additional global assessments of burnout and well-being are likely to be helpful (Table 1). The information from these assessments should be used as a starting point but, importantly, it should be followed by thoughtful engagement of residents and fellows to better understand their specific needs, such as via listening sessions.

Aggregated data from assessments and trainee-specific feedback can be used to map out a strategy. Transparent, frequent, and closed-loop communication between program leadership and trainees is essential. These leadership behaviors alone may positively impact the well-being of the GME program.

Table 1. Well-Being Surveys With GME Focus

Survey	What does it measure?	Other information
ACGME Well-Being Survey*	Meaning in work, engagement, exhaustion, and autonomy	• 12 items • Free • Data collected annually by the ACGME • Every training program participates, and institutions receive aggregate trainee and faculty reports
AMA Organizational Biopsy®	Organizational culture, practice efficiency, self-care, retention	• 20-30 questions, including demographic questions • Free • AMA customizes assessment, conducts analysis, and provides an executive summary of findings • Recommendations for interventions aligned with AMA GME Competency Education Program content • Large national database for comparisons; updated annually
Well-Being Index from the Mayo Clinic	Composite well-being score measures, risk of burnout, severe fatigue, medical error, suicidal ideation, poor overall quality of life	• 7-9 items • Large national database for comparison of local data • Free for IRB-approved research
Stanford Professional Fulfillment Index™	Professional fulfillment, work exhaustion, interpersonal disengagement	• 16 items • Free for research and QI projects by non-profit organizations
Mini Z Resident: Mini ReZ[3] from the Institute for Professional Worklife	Satisfaction, stress, and burnout	• 15 items • Free

** Note: See Q&A in this section for additional details about this survey.*

Putting Theory Into Practice

Case Study

When comparing ACGME well-being data across programs, a designated institutional officer (DIO) notices lower scores in the "autonomy" domain in a specific program. Working with the program leadership, the organization anonymously surveys trainees to better understand specific challenges to autonomy. The survey results highlight that scheduling and input on clinical decision-making are areas of concern for trainees. This is further discussed in team meetings, with opportunities for open dialogue and problem-solving. Chief residents continue to gather ideas through individual conversations and emails, helping to ensure representation of all trainees. This data collection process yields 2 proposed changes: a new scheduling system for 2 core rotations, and a faculty development session specific to communication skills that build autonomy in decision-making for trainees. These changes are shared with residents and program leadership in both in-person and written formats and offer opportunities for feedback.

Q&A

What are the AMA National Resident Comparison Data?

This data provides a national summary of organizational well-being among residents, as captured from the AMA Organizational Biopsy® (see Table 1. Well-Being Surveys With GME Focus). The information is used to better understand how to support trainee well-being through coordinated strategic initiatives. Results from a trainee well-being assessment can be paired with a broader physician well-being assessment to give organizations additional insights into how the work environment impacts the well-being of both physician learners and physicians in practice. GME programs can learn more about obtaining the data through the AMA's web page about the Organizational Biopsy.

What does the ACGME Well-Being Survey measure, and does it impact accreditation?

The ACGME Well-Being Survey data are collected during the annual ACGME Resident and Fellow Survey to assess the well-being of the trainees and faculty. The ACGME Well-Being Survey data do not impact accreditation. The data collected from the 12 well-being items are separated from the accreditation process and are not shared with review committees or site reviewers.

Because well-being questions are included along with survey questions tied to program accreditation, there may be a perception that responses could jeopardize the accreditation of training programs. As a result, the survey may be less sensitive than other screening tools in detecting low well-being or high burnout rates. That said, GME program leadership should feel comfortable reassuring their trainees that well-being questions are separate from the accreditation process, will not impact accreditation, and should be answered honestly.

Program directors and DIOs receive trainee and faculty aggregate reports, allowing GME leadership to identify programs that may be thriving or struggling. Reports may provide insight into general areas for consideration—such as meaning in work, engagement, exhaustion, and autonomy. Using survey reports may help point you in the direction of an area for further exploration or could confirm something you already know.

3 Assemble a Working Group and Implement Realistic Interventions

Based on the data collected, you can decide on the focus and scope of your interventions. Are you focusing on 1 program? Multiple programs? A whole health system? Answering these questions helps determine who should be part of your team or working group. Team members should have the ability and influence to create and execute your intervention, as well as assess and share its impact. Members of the team may include residents and fellows, faculty members, program leadership, the GME office, student and employee health team members, a Wellness/Well-Being Office for the hospital or health system, and the chief medical officer.

With your working group assembled, build a plan to either start a new initiative or build upon what you already have started. Key considerations include:

- Choose something that is important and meaningful to your residents and fellows and is feasible. It's OK to start small.
- Perform an "environmental scan" and make use of existing local and outside resources.
- If additional resources are needed to fill a gap, use assessment data as well as individual physician stories to make the case for them. ACGME requirements, if applicable, can also help.
- While not the sole focus for interventions, do not forget about individual resilience (see STEP 4).

Putting Theory Into Practice

Case Study 1

A hospital with 4 residency programs noticed that many residents were becoming parents during training. The GME Office surveyed resident parents to learn about their needs. They found those trying to provide breastmilk to their infants had trouble finding sufficient time to pump while at work.

The GME Office assembled a working group of residents, the director of human resources, program directors, and the hospital's wellness director to brainstorm solutions. This led to 2 major actions: revising a hospital policy to help ensure sufficient break time for nursing parents to pump breastmilk, and adding 2 new "pods" for breastfeeding and pumping that were close to the clinical areas where most residents work.

Putting Theory Into Practice

Case Study 2

A teaching hospital with about 100 residents and fellows reviewed the results of their annual ACGME Resident/Fellow Survey and found that only 75% reported that they were "able to attend personal appointments" when needed. ACGME requires hospitals to allow trainees to attend health appointments during business hours, and it is a priority for the hospital to help ensure its team members can attend to their own health needs.

The DIO assembled a working group consisting of 2 residents from their resident council, 2 program directors, and a hospital administrator who manages schedules. The group set a goal of improving their ACGME survey response from 75% to 95% within 2 years. Based on guidance from The Second Trial Toolkit, they wrote a policy that designated protected wellness time—separate from other sick or leave time—to allow residents to attend health maintenance appointments and to attend to family or household needs, such as taking children to school or dropping a vehicle off for repair.

The working group shared the policy broadly with programs and residents. They also compiled a local resource guide with contacts for commonly needed clinicians (eg, primary care physicians, mental health clinicians, dentists) and posted it on their GME website. They then shared this information with residents and clinical fellows using several different channels. Their survey response improved to 87% in the first year and 98% in the second year.

Case Study 3

A large academic medical center collects annual responses from residents to assess burnout rates and shares the data with residency program leaders. One year's responses showed that the residents' burnout rates went up 5% from the previous year.

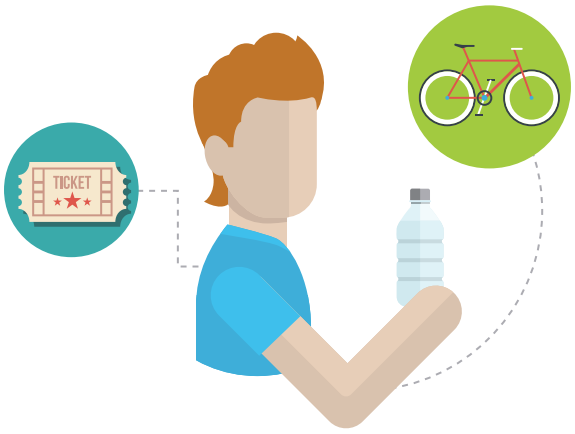
The chief residents met with the residents to get more information about why this might be the case. Many residents cited the burden of increased documentation requirements for all physicians who had been added to the electronic health record (EHR).

To try to reduce the documentation burden, the program director and a chief resident decided to establish a team with the clinical administrator and the department's vice chair for clinical affairs. They also worked regularly with their department's EHR IT lead.

Referring to the AMA's Getting Rid of Stupid Stuff toolkit as a roadmap, the group gathered information and suggestions and made 2 major changes in EHR workflows to reduce the amount physicians needed to type. Additionally, they lobbied to have 3 residents take part in a pilot program that uses AI to assist in note writing. The team meets every 2 months to check on progress and reassess after they receive the next burnout data.

4 Ensure Institutional Support for Individual Self-Care

As described earlier in this toolkit, the GME population may have some unique well-being needs, given their training status, geographical transitions, lack of support, and highly demanding work schedules. While organizational commitment to cultural and systemic infrastructure is likely to have the most significant impact on well-being, SIs should also commit to providing resources to support personal self-care and mental health for the GME population. The specific needs of a trainee population will be diverse and will require ongoing assessment to understand changing needs and gaps. Partnerships with human resources, benefits, wellness, and occupational health teams may be beneficial.



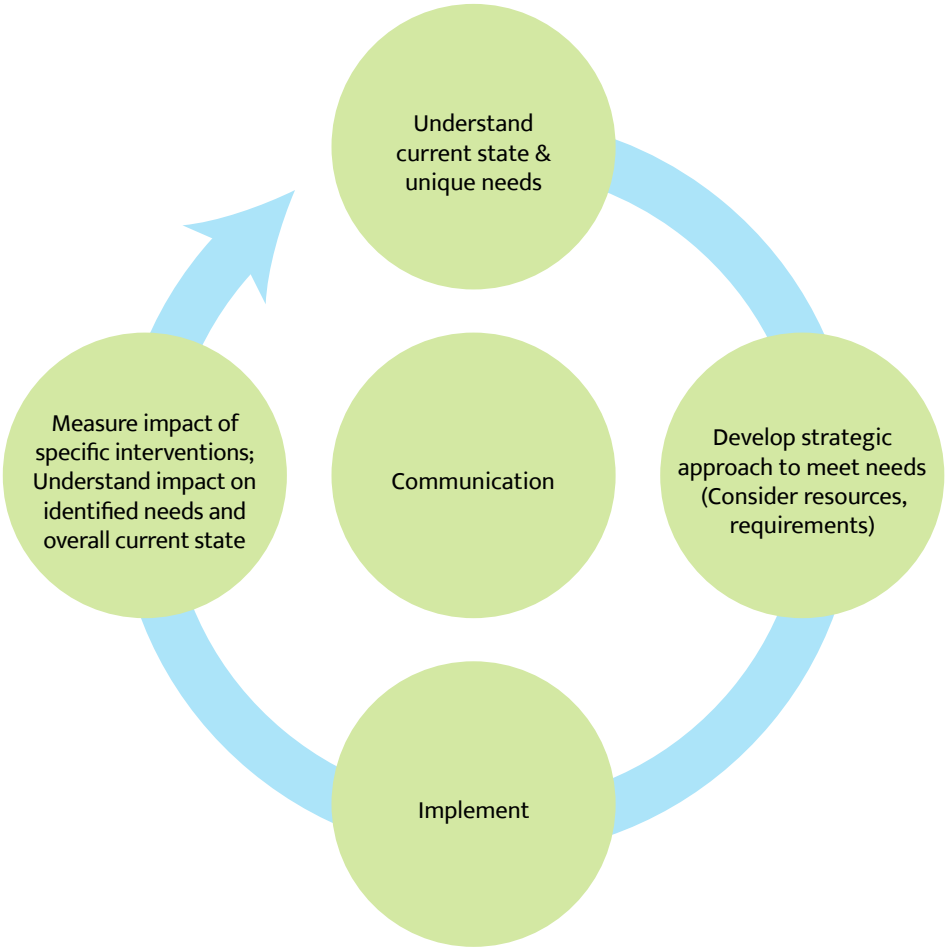
Examples include:

- Individual or group coaching sessions
- Opt-out-eligible mental health check-ins
- Pre-scheduled wellness days to allow space for their own medical appointments
- 24/7 access to mental health care
- In-house mental health services
- Peer support programs for trainees
- Free memberships to an on-campus or local health center
- Tracking of vacation days to encourage each person to take full vacation time
- Workshops on topics such as imposter syndrome, perfectionism, suicide prevention, mitigating conflict in a care team, difficult conversations, difficult emotions when caring for sick and dying patients, leadership development, or career transitions

5 Measure and Share Impact

It is important to measure and share the impact of interventions. This can be done in a variety of ways:

- Consider who the data are for and help ensure you are collecting data that is useful to your audience. Survey questions might assess burnout or flourishing and gather qualitative feedback. Other data include EHR use metrics such as work outside of work or "pajama time", or educational measures such as conference attendance.
- Make use of data already being collected. For instance, many health systems already survey their physicians about engagement, well-being, or other markers. Make sure your residents and fellows are included and that you have access to the data.
- Publicize your successes! Use hospital newsletters, resident newsletters, group meetings, social media, and any other method of dissemination to make your success visible.



Conclusion

Physician training is a demanding and challenging time for even the most resilient physicians. Training programs can support their trainees by embracing a holistic and balanced approach that focuses on institutional culture, the GME environment, faculty, and the trainees themselves. Initiatives are more likely to be effective when they are appropriately directed, conducted with broad partnership and collaboration, and use existing knowledge or resources. This approach not only mitigates the drivers of burnout during the training period but also sets the stage for future professional fulfillment.

AMA Pearls

- Understand and intervene to meet the specific needs of your program
- Conduct an environmental scan to make use of or build upon resources that may already exist within the health system
- Measure impact and share your successes broadly

Related AMA STEPS Forward® Content

Playbooks and Toolkits

The Value of Feeling Valued Playbook

Assessment of Burnout in Physicians and Other Clinicians toolkit

Medical Student Well-Being toolkit

Stress First Aid for Health Care Professionals toolkit

Caring for the Health Care Workforce During Crisis toolkit

Peer Support Programs for Physicians toolkit

"Real PTO" for Physicians toolkit

Hospitalist Well-Being toolkit

Individual Resilience and Well-Being toolkit

Preventing Physician Suicide toolkit

Getting Rid of Stupid Stuff toolkit

Podcasts

Well-Being Programming for Resident Physicians and Clinical Fellows

Reduce Burnout, Improve Self-Compassion With Group Coaching for Even the Busiest Physician

Physician Burnout: One Doctor's Story

Well-Being Strategies for Medical School, Residency, and Beyond

Mental Health Counseling for Physicians and APPs

No One Left Behind: Expanded Peer Support and Second Victim Syndrome

Stress First Aid for Health Care Professionals

Reducing Pajama Time and Work Outside of Work (WOW)

Webinars and Videos

Physician Burnout: It's Not a Resiliency Deficit

Beating Physician Burnout With Behavioral Health Integration

Stress First Aid for Health Care Professionals

Setting Boundaries to Prevent Fatigue and Build Resilience

Physician Peer Support

Physician Stress During Times of COVID

Further Reading

Journal Articles and Other Publications

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- Dyrbye LN, Meyers D, Ripp J, Dalal N, Bird SB, Sen S. A pragmatic approach for organizations to measure health care professional well-being. *NAM Perspectives*. 2018 Oct 1. https://nam.edu/wp-content/uploads/2018/09/A-Pragmatic-Approach-for-Organizations-to-Measure-Health-Care-Professional-Well-Being.pdf. Accessed May 2, 2025.
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Article Information

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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3. Linzer M, Shah P, Nankivil N, Cappelucci K, Poplau S, Sinsky C. The Mini Z Resident (Mini ReZ): Psychometric Assessment of a Brief Burnout Reduction Measure [published correction appears in *J Gen Intern Med.* 2022 Nov 16. doi: 10.1007/s11606-022-07934-2.]. J Gen Intern Med. 2023;38(2):545-548. doi:10.1007/s11606-022-07720-0