

ACP Women in Leadership: Work-Life Balance

*Jacqueline W. Fincher, MD, MACP
President-elect 2019-2020
Board of Regents*

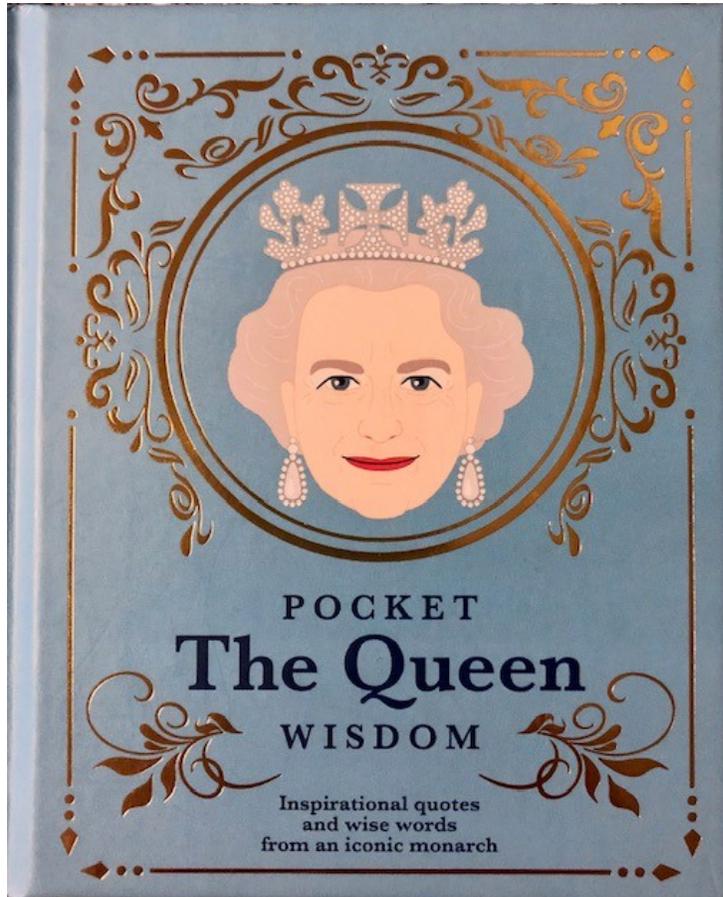
Considered being President ...



But decided it's better to be Queen!



Wisdom from the Queen



“I know of no single formula for success. But over the years I have observed that some attributes of leadership are universal and are often about finding ways of... **encouraging people to combine their efforts, their talents, their insights, their enthusiasm, and their inspiration to work together.** “

Darilyn Moyer, MD, FACP – First Woman CEO of ACP



Women in ACP Leadership: Physician Members on Senior Staff



Christine Laine, MD, MPH, FACP
Senior Vice President
Editor-in-Chief
Annals of Internal Medicine

Davoren Chick, MD, FACP
Senior Vice President
Medical Education

Cynthia (Daisy) Smith, MD, FACP
Vice President
Clinical Programs

Tabassum Salam, MD, FACP
Vice President
Medical Education

Current ACP College Officers, 2019-2020 – #HeForShes



Doug DeLong, MD, FACP
Chair, Board of Regents



Robert McLean, MD, FACP
President, ACP

Women in ACP Leadership: College Officers, 2020-2021

First time women in both positions at same time

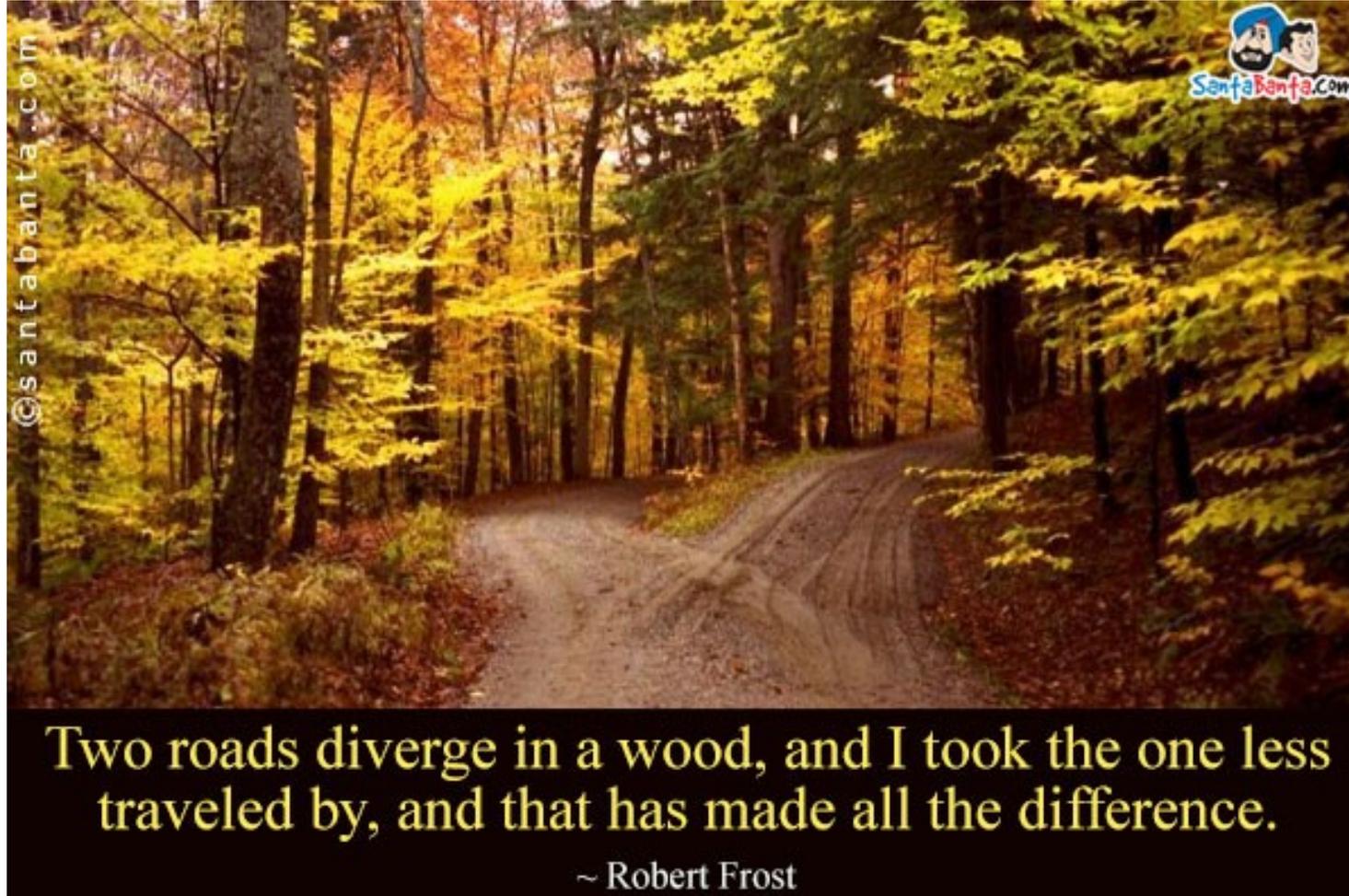


Heather Gantzer, MD, FACP
Chair, Board of Regents



Jacqueline W. Fincher, MD, MACP
President, ACP

There is no one leadership track



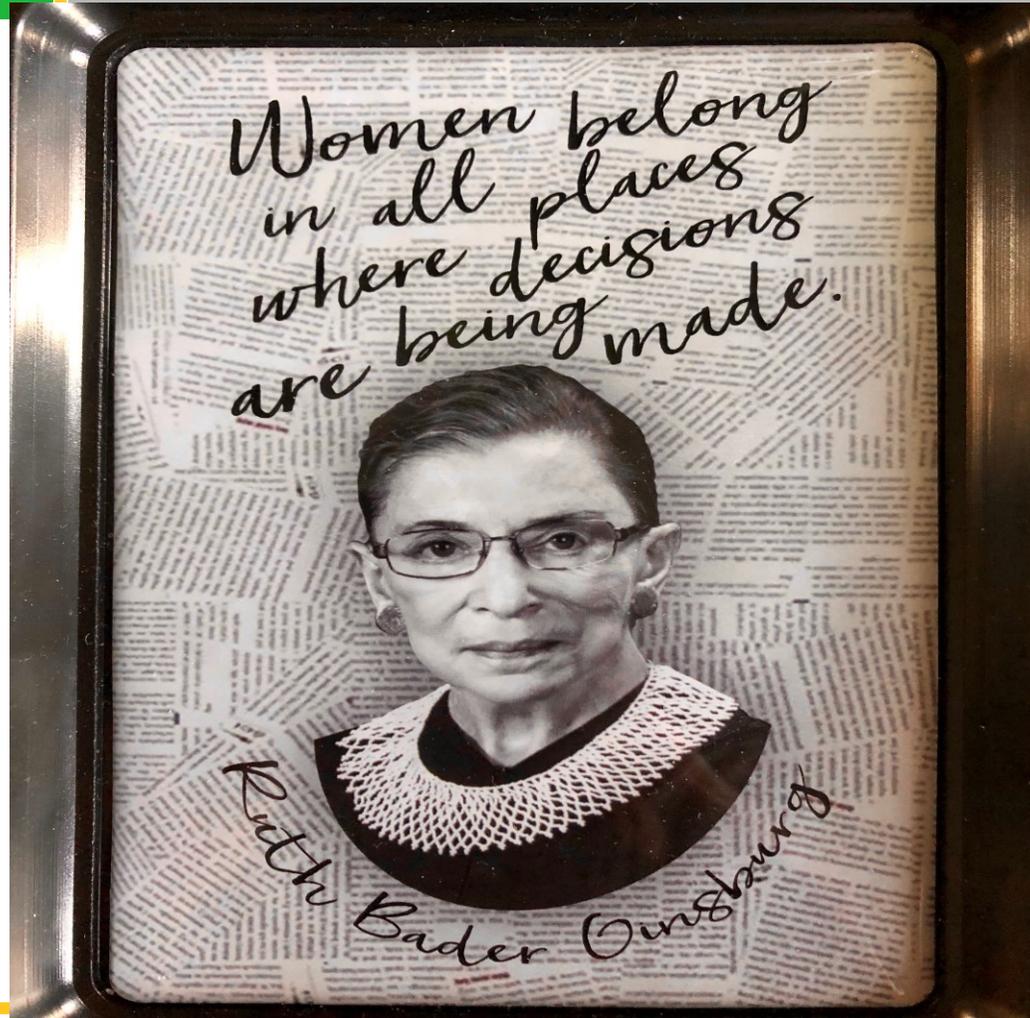
All Leadership Starts Local

- Start in your own community
 - YOU ARE the “local health expert”
 - Speaking & Writing opportunities abound t/o community
- Start within your own medical group, hospital or medical organization – what needs to change
 - Health care organizations are desperate for physician leadership
- Start in your own ACP Chapter & State Medical Society
 - Many leadership opportunities through committee structures
 - Scientific educational programs
 - Advocacy opportunities at state / national level

Developing Your Leadership Skills

- Show up
- Speak up
- Volunteer
- Find your niche and passion
- Learn & develop your skills
- Network
- Connect

Why is it important for women to be in leadership?



“Women belong in all places where decisions are being made.”

- The Notorious RBG

Achieving Gender Equity in Physician Compensation and Career Advancement: A Position Paper of the American College of Physicians

Renee Butkus, BA; Joshua Serchen, BA; Darilyn V. Moyer, MD; Sue S. Bornstein, MD; and Susan Thompson Hingle, MD; for the Health and Public Policy Committee of the American College of Physicians*

Women comprise more than one third of the active physician workforce, an estimated 46% of all physicians-in-training, and more than half of all medical students in the United States. Although progress has been made toward gender diversity in the physician workforce, disparities in compensation exist and inequities have contributed to a disproportionately low number of female physicians achieving academic advancement and serving in leadership positions. Women in medicine face other challenges, including a lack of mentors, discrimination, gender bias, cultural environment of the workplace, imposter syndrome, and

the need for better work-life integration. In this position paper, the American College of Physicians summarizes the unique challenges female physicians face over the course of their careers and provides recommendations to improve gender equity and ensure that the full potential of female physicians is realized.

Ann Intern Med. 2018;168:721-723. doi:10.7326/M17-3438

Annals.org

For author affiliations, see end of text.

This article was published at Annals.org on 17 April 2018.

In 2015, more than one third (34%) of the active physician workforce in the United States was female (1); an estimated 46% of all physicians-in-training and more than half of all medical students are women (2). Although women have made substantial progress in these areas, much remains to be done to improve equity and parity and increase opportunities for promotion and leadership.

Several recent studies have documented the compensation inequity between male and female physicians. A 2017 survey found that male primary care physicians made \$229 000 annually, compared with \$197 000 for women, a gap of 16% (3). This gap is even wider (37%) for specialists: Men earned \$345 000 annually and women \$251 000. In academic medicine, female physicians made an average of \$227 783 annually, compared with \$247 661 for male physicians (a gap of \$19 878), after adjustment for factors that included faculty rank, age, years since residency, specialty, funding from the National Institutes of Health, clinical trial participation, publication count, and total Medicare payments. For internists, this difference was \$16 159 (\$191 338 vs. \$207 497) (4). Another study comparing faculty income at 24 medical schools longitudinally over 17 years found that female physicians in academic medicine earned 90 cents for every dollar made by their male counterparts, an annual difference of \$20 000 (5). In addition, although the number of women entering the medical field has steadily increased, their proportion of leadership positions con-

fessors, 15% of department chairs, and 16% of deans (6). This lack of female physicians in leadership positions has traditionally been believed to be a pipeline problem; however, because women have made up roughly half of medical student graduates for years, the systematic origins of this problem are becoming more apparent (7). In addition, women in medicine face other challenges, including a lack of mentors, discrimination, gender bias, cultural environment of the workplace, imposter syndrome, and the need for better work-life integration (8, 9).

Many factors have been cited as causes of compensation inequity and the relative lack of career advancement for female physicians compared with male physicians, including specialty choice, years of experience, number of hours worked, choices made to balance work and family, and a dearth of mentors and senior role models (10, 11). Yet, researchers find these disparities even when controlling for age, specialty, number of hours worked, and practice characteristics (4, 12, 13). Although most data on workplace disparities come from public institutions of academic medicine, there is no reason to believe that similar inequities do not occur elsewhere in medicine. Additional research in all practice settings is necessary to determine the extent of the impact of these disparities.

Achieving Gender Equity in Physician Compensation + Career Advancement

It is important to recognize the progress that has been made to ensure gender diversity in the physician workforce. However, despite this progress, gender inequities have contributed to the disproportionately low number of women achieving academic advancement and serving in leadership positions.

Find full Position Paper published at Annals.org on 17 April 2018.

(F) = Female, (M) = Male

Pipeline Stats

- 34% of active physicians (F)
- 46% of physicians-in-training (F)
- 50%+ of medical school students (F) (and have been for many years)



Leadership in Medicine

- 38% of medical school faculty (F)
- 21% of full professors of medicine (F)
- 15% of Dept. Chairs (F)
- 16% of Deans of medical schools (F)



Compensation Inequity

- Females are paid 16% less than their male counterparts in primary care (\$197k vs. \$229k)
- Females are paid 37% less than males in subspecialties of medicine (\$251k vs. \$345k)
- 57.1% (F) versus 33.7% (M) academic physicians are paid less than \$200,000.



Me Too movement for Physicians (F)

- 51.3% of physicians (F) reported discrimination vs. 31.2% (M)
- 30.4% of physicians (F) have filed sexual harassment charge vs. 4.2% (M)
- 59% of females who filed harassment charges perceived negative effect on their professional self-confidence; 47% reported that it negatively affected their career advancement
- 69.6% of physicians (F) report gender bias vs. 21.8% (M)
- On 3:1 scale, females more likely to experience disrespectful or punitive actions than males
- Females more likely to be described as judgemental, rude or unfriendly by patients in online reviews



Parenthood

- Only 28.9% of physician contracts provide maternity coverage
- \$10k lost income while out for maternity leave



MOC Question #1

Which of the following best predicts a lifetime of wage earnings and could result in significant lost compensation over time?

- A. Time out for maternity/paternity leave
- B. Being a female physician
- C. Initial salary
- D. Leave of absence for medical or surgical illness

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MOC Question # 1 - Rationale

Initial salary negotiated at start of career is the best predictor of lifetime of wage earnings.

- There is significant evidence in the medical and surgical literature regarding physician compensation and career advancement, particularly in the academic sector, that **women accept lower starting salaries, which becomes their benchmark** for continued lower salaries throughout their career. Starting salaries for pediatrics for men and women are within 2%, but in orthopedics the difference is 40%.
- **Women are frequently offered less money to start and face greater challenges staying in the field while growing a family.** We need to empower women to seek equitable compensation early in their careers.
- **“Achieving equitable pay with male counterparts at the outset of their careers seems is an essential strategy for narrowing disparities later on.”**

Fischer-Wright,H, Evenson,T. STAT News. 12/4/2018. /// Le Sasso, AT et al. Health Affairs 2011; 30:193-201

What Do Women Need?

- *From birth to age 18, a girl needs ... good parents*
- *From 18-35, she needs ... good looks*
- *From 35-55, she needs ... a good personality*
- *From 55 on, she needs... \$\$\$ CASH*

- Sophie Tucker

Work Life Balance

the ever elusive unicorn



Burnout and Satisfaction With Work-Life Balance Among US Physicians Relative to the General US Population

Tait D. Shanafelt, MD; Sonja Boone, MD; Litjen Tan, PhD; Lotte N. Dyrbye, MD, MHPE; Wayne Sotile, PhD; Daniel Satele, BS; Colin P. West, MD, PhD; Jeff Sloan, PhD; Michael R. Oreskovich, MD

Background: Despite extensive data about physician burnout, to our knowledge, no national study has evaluated rates of burnout among US physicians, explored differences by specialty, or compared physicians with US workers in other fields.

Methods: We conducted a national study of burnout in a large sample of US physicians from all specialty disciplines using the American Medical Association Physician Masterfile and surveyed a probability-based sample of the general US population for comparison. Burnout was measured using validated instruments. Satisfaction with work-life balance was explored.

Results: Of 27 276 physicians who received an invitation to participate, 7288 (26.7%) completed surveys. When assessed using the Maslach Burnout Inventory, 45.8% of physicians reported at least 1 symptom of burnout. Substantial differences in burnout were observed by specialty, with the highest rates among physicians at the front line of care access (family medicine, general internal medicine, and emergency medicine). Compared with a probability-based sample of 3442 working US adults,

physicians were more likely to have symptoms of burnout (37.9% vs 27.8%) and to be dissatisfied with work-life balance (40.2% vs 23.2%) ($P < .001$ for both). Highest level of education completed also related to burnout in a pooled multivariate analysis adjusted for age, sex, relationship status, and hours worked per week. Compared with high school graduates, individuals with an MD or DO degree were at increased risk for burnout (odds ratio [OR], 1.36; $P < .001$), whereas individuals with a bachelor's degree (OR, 0.80; $P = .048$), master's degree (OR, 0.71; $P = .01$), or professional or doctoral degree other than an MD or DO degree (OR, 0.64; $P = .04$) were at lower risk for burnout.

Conclusions: Burnout is more common among physicians than among other US workers. Physicians in specialties at the front line of care access seem to be at greatest risk.

Arch Intern Med. 2012;172(18):1377-1385.
Published online August 20, 2012.
doi:10.1001/archinternmed.2012.3199

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ALTHOUGH THE PRACTICE OF medicine can be incredibly meaningful and personally fulfilling, it is also demanding and stressful. Results of studies¹⁻³ suggest that many physicians experience professional burnout, a syndrome characterized by a loss of enthusiasm for work (emotional exhaustion), feelings of cynicism (depersonalization), and a low sense of personal accomplishment. Although difficult to fully measure and quantify, findings of recent studies⁴⁻⁸ suggest that burnout may erode professionalism, influence quality of care, increase the risk for medical errors, and promote early retirement. Burnout also seems to have adverse personal consequences for physicians, including contributions to bro-

ken relationships, problematic alcohol use, and suicidal ideation.⁹⁻¹¹

Despite the extensive data on physician burnout, to our knowledge, no national study has evaluated rates of burnout among US physicians. Although there has been much conjecture about which medical or surgical specialty areas are high risk, this speculation has primarily been based on comparisons across studies of physicians from individual disciplines, for which differences in sample selection, study size and setting, participation rates, and year of survey administration confound interpretation. The literature on physician burnout is also hampered by a lack of data about how rates of burnout for US physicians compare with rates for US workers in other fields.

“Substantial differences in burnout were observed by specialty, with the highest rates among physicians at the front line of care access (*family medicine, general internal medicine, and emergency medicine*).”

Burnout by Specialty

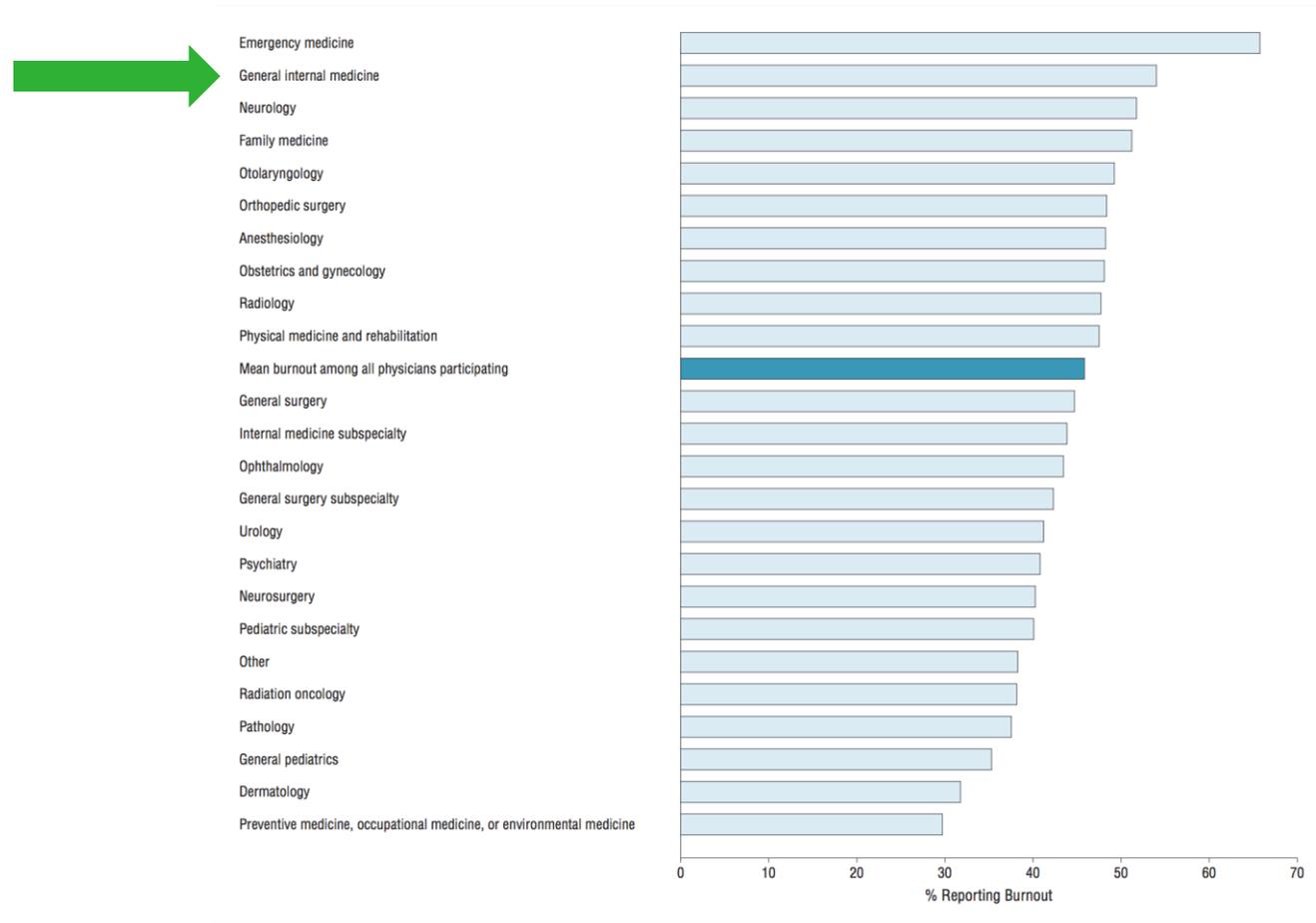


Figure 1. Burnout by specialty.

Physician Well-Being & Professional Satisfaction

- “The fact that almost 1 in 2 US physicians has symptoms of burnout implies that the *origins of this problem are rooted in the environment and care delivery system* rather than in the personal characteristics of a few susceptible individuals. Policy makers and health care organizations must address the problem of physician burnout for the sake of physicians and their patients.”
- **Conclusions:** Burnout is more common among physicians than among other US workers. Physicians in specialties at the front line of care access seem to be at greatest risk.

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Physician Burnout

- Highest rate of depression of any profession
- **18%** will experience alcohol and drug abuse
- **46%** will experience significant burnout
- **70%** higher suicide rate for male physicians compared to men in other professions
- **250-400%** higher suicide rate for women physicians compared to women in other professions

Physician Burnout

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Over **50%** of US physicians experience some sign of burnout. It is estimated that **80%** of burnout is related to **organizational factors**.

What drives burnout and what are the effects?

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Burnout is **driven by**:

- high workloads
 - workflow inefficiencies
 - increased time spent in documentation
- loss of meaning in work
 - social isolation at work
 - cultural shift from health values to corporate values

Burnout has repercussions at a **personal** and **professional** level

Association of Electronic Health Record Design and Use Factors With Clinician Stress and Burnout

1. information overload ($P < .001$)
2. slow system response times ($P < .001$)
3. excessive data entry ($P < .001$)
4. inability to navigate the system quickly ($P < .001$)
5. note bloat ($P = .01$)
6. fear of missing something ($P < .001$)
7. interference with the patient- clinician relationship ($P < .01$)
8. notes geared toward billing ($P < .001$)

Other Factors Associated With Stress and Burnout Factors Not Related to EHRs*

(associated with high levels of variance in stress)

1. office atmospheres
2. control of workload
3. time for personal and family life
4. time for documentation at work
5. value alignment with leaders
6. professional and personal life balance
7. physical symptoms attributed to EHR use
8. hours worked per week

* All P values of significance <0.001

Key Drivers of Burnout & Engagement in Physicians

Driver Dimensions



What are the effects of burnout on an organization?

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Health professional burnout is a threat to the **clinical, financial,** and **reputational** success of an institution for quality, humanitarian, and financial reasons.

Quality	Humanitarian	Financial
Each 1 point increase in burnout correlates with a 3-10% increase in likelihood of physicians reporting medical errors	Greater rates of dissatisfaction, divorce, drug and alcohol abuse, and depression	Replacement costs <u>per physician</u> costs between \$500,000 to \$1 million * Over \$5 million annually

Financial Cost of Physician Burnout

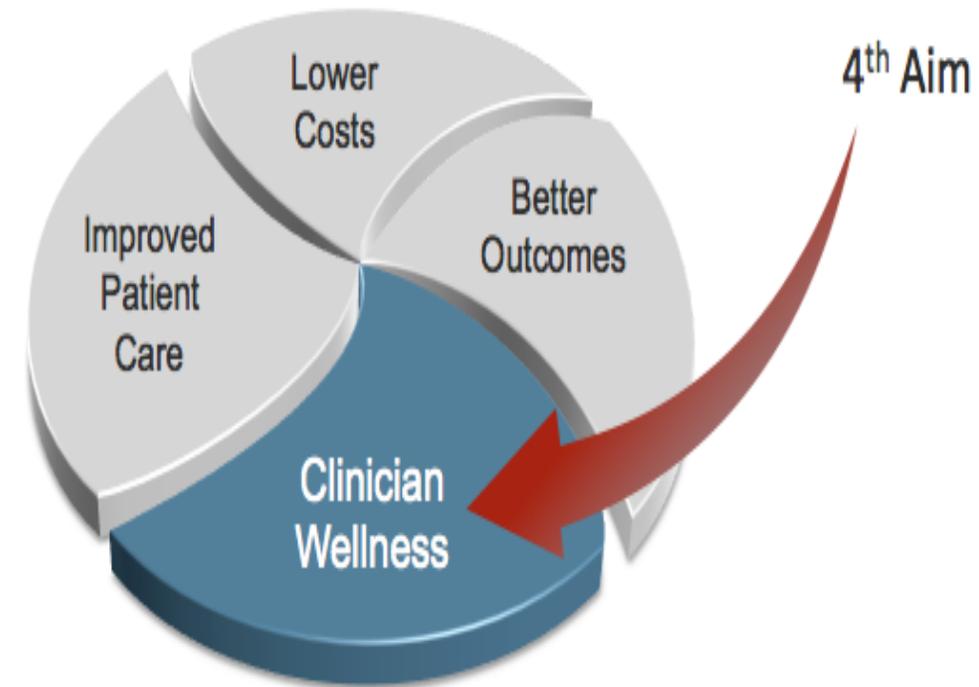
D. Frenz, MD Today's Hospitalist, August 2016

- **Recruitment** – direct cost - search, interview, relocate, sign on = **\$100K**
- **Onboarding** – train, credential (with all plans), market = **\$200-300K**
- **Lost revenue**
 - General Internal Medicine – MGMA **loss of \$435K in revenue**
MD leaving, others remaining pick some slack, average 18 months for new MD to get up to full panel
 - Hospital medicine - average direct **loss of \$40-70K**, but ramps up quickly if vacancy protracted, need to cover open shifts with premium pay, locum tenens, or reduce the census.
- **TOTAL COSTS – \$400-600K**

What is the goal?

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- Achieve the Quadruple Aim, with the fourth aim of clinician well-being.
- Create a joyful practice environment and create structural elements that support joy, purpose, and meaning in work.
- In return, a more engaged, satisfied workforce will provide **better, safer, more compassionate** care to patients.



MOC Question #2

2. According to the findings of a 2016 meta-analysis in the Lancet on interventions to prevent and reduce physician burnout, individual- and organizational-level interventions to address burnout showed what benefits?
- A. increased retention in primary care
 - B. improved adherence with ICD10 documentation requirements
 - C. decreased emotional exhaustion, depersonalization, and overall burnout
 - D. increased size of primary care panels

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MOC Question #2 - Rationale

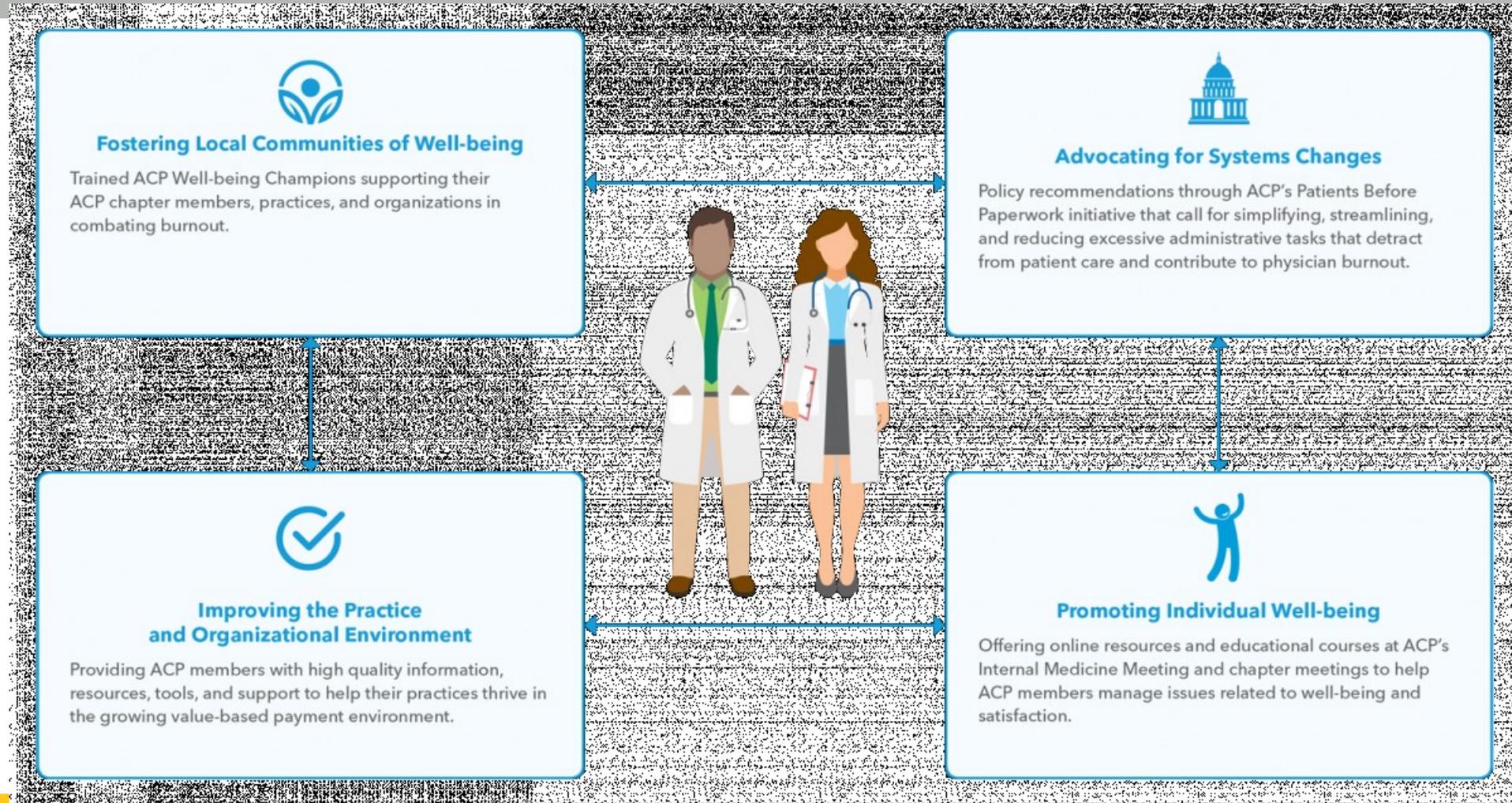
- A 2016 systematic review and meta-analysis by West et al of over 2600 articles found that **individual and organizational level interventions** to reduce burnout resulted in ***significantly decreased emotional exhaustion and depersonalization scores, and a decrease in overall burnout.***

West CP, Dyrbye LN, Shanafelt TD. Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. Lancet. 2016 Nov;388(10057):2272-2281. doi: [http://dx.doi.org/10.1016/S0140-6736\(16\)31279-X](http://dx.doi.org/10.1016/S0140-6736(16)31279-X)

ACP's Physician Well-being and Professional Satisfaction Initiative Goals

- 1. create a culture of wellness**
 - 2. improve practice efficiencies**
 - 3. enhance individual physician well-being**
 - 4. reduce administrative burdens**
- Physician Well-being and Professional Satisfaction Task Force
 - ACP Well-being Champions Program
 - ACP Practice Advisor Module: “Making the Case to Address Clinician Burnout”
 - Relevant Courses offered at Internal Medicine

ACP's Physician Well-being and Professional Satisfaction Initiative



Improving Physician Satisfaction and Patient Outcomes by Reducing Unnecessary Burdens

Unnecessary burdens lead to limited time with patients, too much paperwork and work/life imbalance.

ACP address these issues by:

- Seeking improvement to systems and documentation requirements
- Identifying and prioritizing burdensome administrative tasks
- Assessing tasks for impact on outcomes
- Developing policy recommendations to enact change
- Engaging in ongoing outreach and stakeholder engagement

Patients Before Paperwork Initiative



What is Patients before Paperwork?

ACP's Patients Before Paperwork initiative's goal is to reinvigorate the patient-physician relationship by reducing administrative complexities and eliminating unessential tasks that detract from patient care and contribute to physician burnout.



Policy Development

ACP policies provide a cohesive framework for identifying and evaluating administrative tasks, and offer detailed recommendations to analyze administrative tasks to determine whether they need to be challenged, revised, or eliminated entirely.



Tools You Can Use

Resources and tools help physicians put ACP's policies into practice. They include resources that assess practice efficiencies and resources on physician well-being and professional satisfaction.



Collaborating with Stakeholders

ACP engages with key regulatory agencies and stakeholders to help streamline regulations imposed by insurers, federal regulators and other external entities to reduce administrative burdens for physicians.



Advocating for Internists

ACP has long identified reducing administrative complexities or burdens as a priority. ACP works to advocate for changes in our health care system that simplify excessive administrative burdens that put a strain on physicians and patient care.

Creating the Organizational Foundation for Joy in Medicine™

Help physicians thrive through structured institutions



Nine steps to help clinicians thrive through organizational changes

40

Culture of Wellness

1. Engage senior leadership
2. Track the business case for well-being
3. Resource a Wellness infrastructure
4. Measure burnout and the predictors of burnout longitudinally
5. Strengthen local leadership
6. Develop interventions and evaluate their impact

Nine steps to help clinicians thrive through organizational changes

41

Efficiency of Practice



7. Improve workflow efficiency and maximize power of team-based care



8. Reduce clerical burden and tame the EHR

Personal Resilience

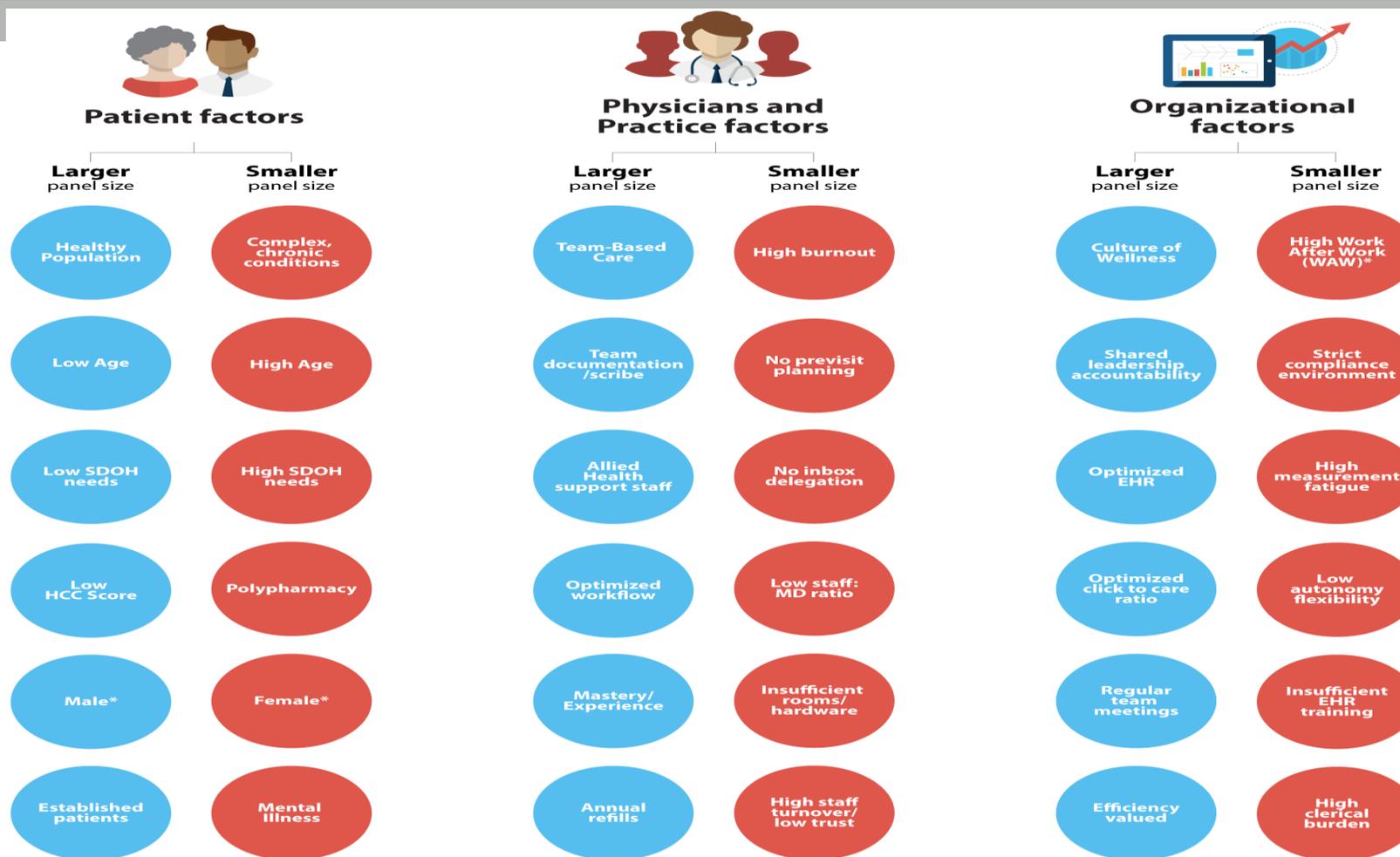


9. Support the physical and psychosocial health of the workforce

Workflow Redesign

1. Pair MAs with same MDs/Providers
2. Pre-visit planning
3. Pre-visit labs
4. Team documentation, consider use of scribes
5. Reassess time allotted for daily visits + Adjust panel size*
6. Optimize EHR use with expert training
7. Optimize click to care ratio
8. Optimize ancillary staff
9. Annual Refills

Adjust Panel Size



*Prepubertal males may be higher health care utilizers

*Work after work: time spent outside of physicians work environment completing work (such as completing charts)

Better Communication

1. Daily huddles
2. Co-locations of team members
3. Monthly physician/provider meetings
4. Connect with patients in empathic meaningful way in the “first golden minutes”

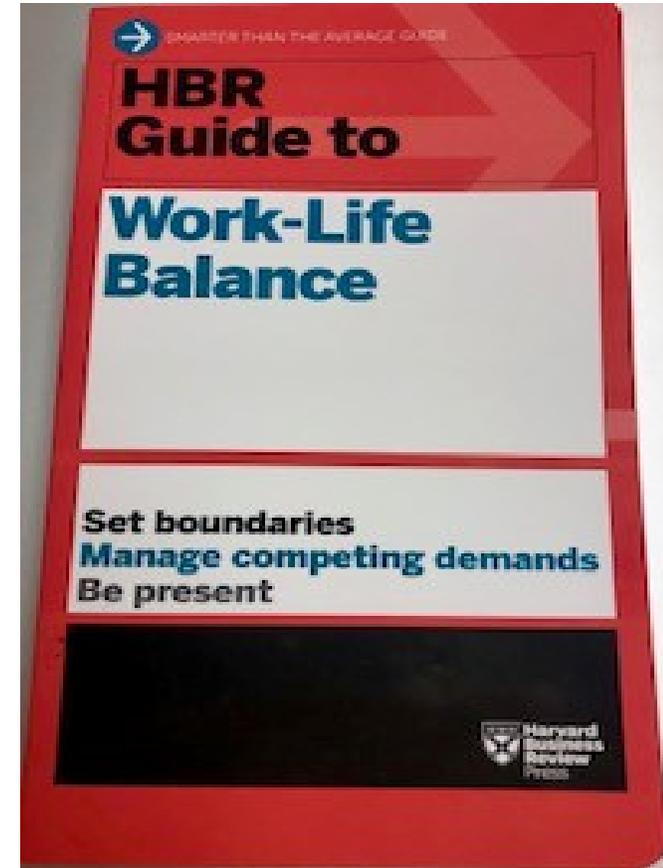
Self-Care - Forman, Tami. Forbes Dec 13, 2017

“Self-care is not an indulgence. **Self-care is a discipline.**”

“It requires tough-mindedness, a deep and personal understanding of your priorities, and a respect for both yourself and the people you spend your life with.”

TAKE STOCK - S. Friedman (HBR Guide to Work-Life Balance)

1. Make deliberate choices
2. Manage expectations
3. Set boundaries
4. Integrate aspects of your life (overlaps)
5. Work smarter not harder
6. Talk to key stakeholders in your life



Two Career Couples Need Long Term Plans

A. Wittenberg-Cox, (HBR Guide to Work Life Balance)

Co-Design: Plan a lifetime family career together to have:

- Meaningful work
 - Financial security
 - Great family
- ❖ Search for **complementarity** – each agree to contribute to building something that fits both people, over a life span.
- ❖ Family careers offer flexibility, security, and options

Two Career Couples Need Long Term Plans

A. Wittenberg-Cox, (HBR Guide to Work Life Balance)

From the Sum of the Two, to the Power of Two

- ❖ Your spouse may be your most significant career asset
- ❖ Don't compete for short-term trade-offs rather than cooperating for longer-term, mutually beneficial gains.
- ❖ Hand the baton back and forth.

“Two people end up up with a supportive partner who shares a life vision and is as invested in their spouse’s career choices as they are in their own. That is exponentially beneficial to both. “

Balancing Parenting and Work – D.W. Dowling (HBR Guide to Work Life Balance)

- Use your leading professional strengths
- Have a vision of what you want working-parent life to be and lead to
- Work differently – train your work team, be visible
- Manage the village
- Don't always be a doer – delegate and find shortcuts
- Bring workplace efficiency home
- Have a Plan B; don't wait for a crisis to use it (an effective contingency plan)
- Think long term to stay in the game (weathering rough/busy spots)
- To get flexibility, Don't Ask - Sell

Principles of Work-Life Balance: Prioritize Holistic Approach to Personal Wellness



Lessons from College

Lessons learned from cancer

Lessons learned from life

Focus on body, mind, spirit

*CANCER
AS
MESSENGER*



Principles of Work-Life Balance: Prioritize Holistic Approach to Personal Wellness

Lessons learned from cancer

- ❖ Priorities come to order at the snap of a finger
- ❖ Take your best shot the first time
- ❖ Work is important, but it is not everything
- ❖ Live one day at a time fully
- ❖ Value life celebrations
- ❖ Sharing your life brings love and support
- ❖ What will your legacy be? (what will your children say about you?)

Principles of Work-Life Balance: Prioritize Holistic Approach to Personal Wellness

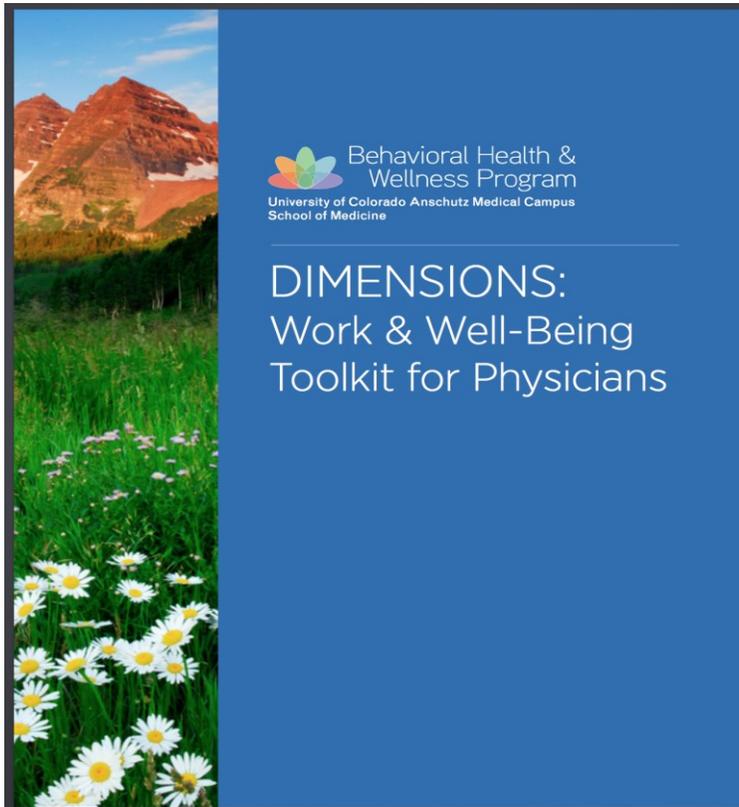
Lessons learned from life (as a 60 y.o. physician, wife, mother)

- ❖ “You can have it all!” *
- * ... just not all at the same time.
- ❖ Seasons of life - King Solomon, 900 BC, Ecclesiastes Chapter 3
 - 3:1 “There is a time for everything, and a season for every activity under the heavens.”
 - 3:22 “So I saw that there is nothing better for a person than to enjoy their work...”
- ❖ Be a part of something bigger than yourself : ACP, faith based group, community organization, charitable organization, etc.

FINAL THOUGHTS : LIFE BALANCE

- Healing others must start with healing ourselves.
- Life happens while we are making plans
- We need to **proactively** address the stress in our daily lives
- We need to utilize a holistic approach of body, mind, & spirit to our own health and help our patients do the same
- Set life priorities with your family. Update & communicate often
- Self care is not an indulgence. It is a discipline.
- IT IS YOUR RESPONSIBILITY TO TAKE CARE OF YOURSELF

Resources for Life Balance & Work Balance



www.acponline.org/practiceresources



The Happy MD, Dike Drummond,
MD

www.thehappy.md.com

FINAL THOUGHTS : WORK BALANCE

- Physician stress and burnout is common
- **We must advocate for changes within our own organizations**
Improved workflows for different aspects of job, attention to patient acuity and time requirements , efficient data entry by all team members, establish best practices for EHRs with least clicks, paid administrative time.
- **We must advocate for regulatory changes by government and payors** through the ACP especially – change in documentation requirements, value of cognitive services,

Resources for Work Life Balance

- **ACP – acponline.org**

Practice resources → Professional Well-Being & Professional Satisfaction

- AMA – ama-assn.org/steps-forward
- Stanford Model – wellmd.stanford.edu
- Harvard Business Review Guide to Work-Life Balance
- Christine Sinsky, MD, Mark Linzer, MD and TJ Shanafelt, MD write a lot of journal articles on this topic
- Your colleagues & mentors



