



CMA 2021

National Physician Health Survey

Prepared for the Canadian Medical Association

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Executive summary

With physicians and medical learners experiencing unprecedented levels of personal and professional distress, supporting health and wellness in medicine has never been more important. The Canadian Medical Association (CMA) is committed to bringing the profession together to work to achieve our shared vision of better health, health care and a thriving health workforce.

With this in mind, the CMA conducts a national survey every three to four years to monitor health and wellness trends among physicians in Canada. Even before the global COVID-19 pandemic was declared in March 2020, research showed physicians are at a high risk of developing symptoms of burnout, depression and other psychological distress (2017 NPHS).

The pandemic has only exacerbated these issues. While everyone has been affected by personal stressors, physicians have had to face additional workplace and systemic challenges. With physician wellness as one of the CMA's key priorities, the 2021 NPHS comes at a pivotal juncture as the need to reform Canadian health care system intensifies.

The overarching goal of the 2021 NPHS is to generate an in-depth, up-to-date and relevant data set for a range of audiences, including organizations, researchers, educators and stakeholders, to inform and advance physician wellness initiatives. The survey uses an equity lens to track specific demographic subgroups; the results will help inform recommendations for system-level changes to improve physician health and wellness — from medical school through retirement. The survey is also crucial in supporting the work of the CMA as outlined in *Impact 2040*, a bold strategy to improve health, health care and the health workforce.

In comparing the results of the 2021 NPHS with those of the 2017 survey, it's clear that physicians' well-being has decreased significantly; indeed, many rate their mental health as being worse now than before the pandemic. Notably, there has been a sharp increase in the proportion of respondents reporting burnout and suicidal ideation in the past 12 months (1.7 and 1.5 times higher, respectively) compared with in 2017. It's likely that the pandemic has contributed to these increases, and this is particularly true among practising physicians, for whom larger shifts were seen since 2017 on several psychological indicators compared with medical residents.

Overall, the majority of respondents score low on professional fulfillment, which consists of sentiments around contentment, satisfaction and meaningfulness in one's work. Those who score low on professional fulfillment also show greater signs of fatigue and a lack of work-life integration; they are significantly more likely to be burned out and less likely to be thriving in terms of mental health.

The key findings from the study reveal that numerous subgroups are experiencing more negative wellness outcomes, including medical residents; those under 35 years of age; those identifying as women; those practising six to 10 years; caregivers of a child and/or parent or family member in the home; those living with disabilities; and those working in small town/rural or isolated/remote areas.

Still, not all the results are discouraging: there are signs of a culture shift toward prioritizing wellness. That is, medical residents and younger physicians report accessing support for their mental health challenges more frequently than practising physicians who are at a later career stage. While some of those who need wellness supports are accessing them, there are still significant barriers to overcome, such as stigma, availability and concerns around confidentiality.

A total of 4,121 physicians, medical residents and medical students completed the 2021 NPHS ($n = 3,489$ practising physicians, $n = 375$ medical residents, $n = 257$ medical students) using an open link survey offered in both English and French from Oct. 13 to Dec. 13, 2021. The survey was promoted by the CMA via email to its members, social media and creative advertising and through the CMA's communications channels, including partner organizations.

Respondents participated in the survey voluntarily for no monetary compensation and were asked numerous questions capturing behavioural, occupational and psychological factors. This report includes responses from practising physicians and medical residents only ($n = 3,863$ henceforth referred to as "respondents") and compares the results for key measures with data from the baseline 2017 NPHS.

Background/Introduction

Being a physician can be deeply gratifying, but it also comes with stresses and challenges that can take a toll on one's health and wellness. Heavy workloads, demanding standards of training and practice, and complex practice environments are just some of the factors that can put any physician at higher risk of personal and professional dissatisfaction, burnout and depression. The impacts of this — on physicians, on patient care and on the performance of the overall health system — make supporting physician health and wellness an imperative for the CMA and the system at large.

Previously, there was a lack of national data on health and wellness indicators for physicians in Canada. In response to this critical gap in knowledge, the CMA conducted the 2017 National Physician Health Survey (NPHS) to gain a deeper understanding of how physicians and medical residents are affected by a multitude of factors impacting their health and wellness. The goal of the 2017 NPHS was to generate an up-to-date and relevant baseline dataset for use by other organizations, researchers, educators and stakeholders and to use this dataset to inform and advance physician health initiatives. The survey included psychological measures (e.g., burnout, depression screening, suicidal ideation, mental health), behavioural measures (e.g., physical activity levels, sleep, diet) and occupational measures (e.g., work hours, collegiality, career satisfaction), as well as measures related to awareness of available physician health services, use of such services and barriers to accessing services.

The overarching goal for the 2021 NPHS was to generate an up-to-date and relevant dataset for a range of audiences, including organizations, researchers, educators and stakeholders, to inform and advance physician wellness initiatives, as well as support other strategic priorities for the CMA Enterprise. The COVID-19 pandemic drew attention to a deeply concerning mental health crisis. This is the very socio-cultural context that can provide essential data on major mental health and wellness indicators pertinent to the functioning of physicians. In general, how well are Canadian physicians coping with the pandemic? How different are mental health outcomes from the 2017 baseline data? As with socio-cultural vulnerabilities identified in managing a pandemic (e.g., age, gender/sexual orientation, racial/ethnic identity, education, socioeconomic status, occupation, physical/clinical comorbidities), are there key risk groups in the physician population? The purpose of this second iteration of the NPHS is to track changes in wellness indicators and to understand the key drivers of those changes. A secondary aim of this study is to identify demographic subgroups that are more vulnerable to poorer outcomes.

Moving forward, the CMA aims to administer the NPHS on a continuous, three-to-four-year cycle to ensure that data remain up to date and relevant. This allows for making comparisons between datasets over the years, to track any improvements and/or declines in wellness, as well as to identify emerging challenges facing physicians.

Methodology

Survey design

The development of the NPHS was guided by an Expert Working Group (EWG) including representatives with physician health expertise from the Forum of Canadian Physician Health Programs, the College of Family Physicians of Canada (CFPC), the Association of Faculties of Medicine of Canada (AFMC), the Canadian Medical Protective Association (CMPA) and Well Doc Alberta. The group was led and supported by internal expertise from the CMA. A third-party research firm was commissioned to collect and analyze the data with oversight from the CMA Physician Wellness and Medical Culture Team.

To begin the questionnaire drafting process, the 2017 study was reviewed to identify priority areas to obtain tracking data for comparison purposes. The EWG, including the CMA team, then generated a list of new concepts to be included in the current survey. From this, a draft of the 2021 questionnaire was developed, which was later edited (e.g., removing, rewording and rearranging questions) with an eye to maintaining sufficient consistency to enable comparison with 2017 results. The average length of the survey was 30 minutes.

The 2021 NPHS expands upon the 2017 NPHS to include a wider variety of concepts within the broad categories of psychological factors, behavioural factors, social support, environmental/cultural factors, accessing wellness supports and the impact of the COVID-19 pandemic. Please refer to Appendix C for the full questionnaire.

Before proceeding with the survey, ethics approval was obtained from the University of Ottawa Health Sciences and Science Research Ethics Board.

Participants and procedure

An open link survey, offered in both English and French, was promoted by the CMA via email to CMA members, social media, creative advertising and CMA communications channels including partner organizations. An open link survey methodology was used to ensure that physicians beyond the CMA membership were invited. The survey was open from Oct. 13 to Dec. 13, 2021. Participation in this study was voluntary.

A total of 4,121 physicians and medical learners completed the 2021 NPHS ($n = 3,489$ practising physicians, $n = 375$ medical residents, $n = 257$ medical students). This report includes responses from practising physicians and medical residents only (total $n = 3,864$) to facilitate comparison of results to the 2017 NPHS. When referring to responses from practising physicians and medical residents **combined** in this report, the term “respondents” is used. Note that a separate report on the medical student results is forthcoming.

Moreover, a separate survey was conducted during the fall/winter of 2021 among a sample of non-physician, employed Canadians ($n = 1,973$). This Employed Canadian Population Comparator Survey serves as a benchmark. The results for this comparator study will also be provided in a forthcoming report.

Throughout the NPHS 2021 report, special attention has been paid to various socio-demographic groups, including career stage (i.e., practising physicians vs. medical residents), gender, age, area of practice, years in practice, community size, disability and caregiver status.

Table 1 below provides a breakdown of the respondent sample.

Respondent sample counts and proportions

	Base size n	Proportion		Base size n	Proportion
TOTAL sample	3,864	100%	COMMUNITY SIZE		
PHYSICIAN STAGE			Urban/suburban	2,750	71.2%
Practising physician	3,489	90.3%	Small town/rural	740	19.2%
Resident	375	9.7%	Isolated/remote	108	2.8%
GENDER			Cannot identify/ prefer not to answer		
Men	1,486	38.5%	DISABILITY		
Women	2334	60.4%	Self-identify as having disability	794	20.5%
Neither applies ¹	12	0.3%	Does not self-identify as having a disability	2,945	76.2%
No response	32	0.8%	CAREGIVER STATUS		
AGE			Caregiver of parent(s) and/or child(ren)	1,829	47.3%
<35	662	17.1%	Not a caregiver	2,035	52.7%
35-54	1,822	47.2%	Caregiver of child(ren)	1,551	40.1%
55+	1,361	35.2%	Caregiver of parent(s)	393	10.2%
AREA OF PRACTICE			Caregiver of both parent(s) and child(ren)	115	3.0%
General Practitioner	1,564	40.5%	ETHNIC AND RACIAL IDENTITY³		
Medical Specialist	1,410	36.5%	Self-identify as 'White' only	2,857	73.9%
Surgical Specialist	369	9.5%	Do not self-identify as 'White' only	644	16.7%
Other/Admin ²	500	12.9%	Other mentions	176	4.6%
YEARS IN PRACTICE			Indigenous only	66	1.7%
5 or less	469	12.1%	Prefer not to answer	121	3.1%
6 to 10	481	12.4%			
11 to 20	826	21.4%			
21 to 30	803	20.8%			
Over 30	905	23.4%			

Table 1. Sample counts and proportions by subgroups of analysis

¹ Note that the proportion of those who selected "Neither applies to me" was too small to run in the subgroup analysis. Several respondents who selected "neither applies to me" identified as "non-binary;" there were also single mentions of "gender neutral," "gender fluid," "Trans FTM - Male."

² "Admin" is defined as "administrative position"; "other" includes a range of responses including addictions, critical care, infectious diseases, palliative care, long-term care, among others.

³ Results by ethnic/racial group were analyzed but there were very few differences at the aggregate level, i.e., identifying as white vs. others. Where differences did exist by ethnic/racial group, it was often due to intersectional characteristics, e.g., Black physicians in the sample were more likely to be medical specialists and with greater number of years in practice.

The sizes of the overall sample and the subgroups with larger sample sizes were sufficient to achieve statistical power; however, this was not the case for subgroups with small sample sizes (e.g., practising in isolated/remote areas).

In reporting, sample sizes may be further reduced because of survey skip logic, exclusion of “prefer not to answer” responses, respondents not giving consent to collect data on sensitive question topics, and respondents not completing the optional section of questions asked near the end of the survey.

In terms of overall representativeness of the respondent sample to the demographic distribution of practising physicians and medical residents in Canada, women in the study are over-represented, as are those in the Atlantic region (New Brunswick, Nova Scotia, Prince Edward Island and Newfoundland and Labrador), the Prairies (Alberta, Manitoba and Saskatchewan) and British Columbia and the Territories (Northwest Territories, Yukon and Nunavut). Respondents in Ontario and Quebec are under-represented in the respondent sample. As a part of the initial analysis, the data were weighted to determine how outcomes might be affected by the weighting. It was found that there were no major differences in outcomes when comparing the weighted and unweighted datasets. The decision was, therefore, made to leave the data unweighted to minimize the interaction of the weighting of a variable with the weighting of another variable.

Please refer to Appendix A for more details on the methodology for this research.

Measures

The NPHS is made up of a variety of scales and questions that were used to assess psychological factors (mental health and well-being, burnout, anxiety, etc.), as well as behavioural and occupational factors related to physician wellness. These were carefully selected on the basis of several criteria, including psychometric properties.

Psychological indicators included overall mental health and well-being (Mental Health Continuum Short Form [MHC-SF]), burnout (two-item Maslach Burnout Inventory),⁴ anxiety symptoms (General Anxiety Disorder 7-Item Scale), depression screening (Patient Health Questionnaire–2), professional fulfillment (Professional Fulfillment Index) and suicidal ideation.

Behavioural and social support indicators included having a personal primary care physician, level of fatigue/optimal sleep, participation in self-care activities, healthy lifestyle barriers and perceived social support.

Occupational indicators included task-specific work hours, psychological safety, collegiality, workplace wellness supports, workplace harassment and bullying, work–life integration, satisfaction with efficiency/resources, and professional misconduct inquiries (i.e., college complaint or lawsuit).

Please refer to Appendix C for the full survey instrument.

Statistical analyses

The general procedure for statistical analysis in this report is as follows:

- **Descriptive statistics** were generated, which were then cross tabulated with demographic groups of interest (e.g., physician stage, gender, age, years of practice, type of physician, community size, self-identification of disability, and caregiver status).

⁴ Note that the survey asked the full set of items for the Maslach Burnout Inventory for Human Health Services (MBI-HSS) for professionals. The results of further investigations will be presented in additional publications.

- A **chi-square test** was carried out on many measures:
 - In the instance of a 2x2 relationship being tested, statistical significance was taken to mean a *p*-value equal to or less than 0.05.
 - In the instance of a relationship other than 2x2 being tested, adjusted residuals were calculated for each category of the cross-tabulation. An adjusted *p*-value calculation was done, which was compared with a more conservative threshold for significance that considered total number of categories tested. Note that in some cases, base sizes were too small for statistical differences to show.
 - Chi-square tests were **not** run for questions with multiple response options (i.e., “select all that apply,” such as barriers to maintaining a healthy lifestyle).
 - Chi-square values, degrees of freedom and *p*-values for statistically significant differences are noted in Appendix B.
- A **t-test** (95% confidence interval) was used to determine a significant difference between the means of numerical variables (e.g., total hours worked) for subgroups. It was also used in questions that were multi-select to help guide interpretation of the data.

Notes on terminology and reporting conventions

TERMINOLOGY

This report includes responses from both practising physicians and medical residents. When reporting on the two groups is combined, the umbrella term “respondents” is used. Findings for each group are also reported on separately, with the groups referred to as “practising physicians” and “medical residents.”

REPORTING CONVENTIONS

Unless otherwise indicated, all questions reported exclude “don’t know” and/or “not applicable” responses.

Statistical differences determined by chi-square testing are indicated by green or red lettering/ asterisks, where green means significantly higher and red means significantly lower. Statistical differences determined by *t*-tests are indicated by green and red arrows.

The term “statistically significant” is clearly stated in reporting on statistical differences (using chi-square tests or *t*-tests). For cases where there are notable differences that are **not** statistically significant, the terms “more likely” or “less likely” are used, and the results are not colour coded.

Where applicable, tracking to 2017 NPHS is provided. Note that respondents were not asked their age in 2017, so there are no tracking comparisons available for this subgroup.

In addition, reporting in the NPHS 2017 on key psychological factors included *no responses*. These *no responses* were excluded from the data in the NPHS 2021 report, resulting in minor discrepancies in the proportions reported for 2017 data in the 2017 and 2021 NPHS reports.⁵

⁵ Example: In 2017, the incidence of flourishing mental health was 58%. In removing the 2017 *no responses*, the incidence increased to 63%. For reference, see: [CMA NATIONAL PHYSICIAN HEALTH SURVEY](#)

Survey results

Section 1. Psychological factors

OVERALL MENTAL HEALTH

While almost half of respondents are classified as “flourishing” in their mental health, an equal proportion are “moderately” mentally healthy, and almost one in 10 are “languishing.”

Mental health and well-being are measured using the Mental Health Continuum – Short Form (MHC-SF).⁶ The scale measures mental health on a continuum from positive feelings and high psychosocial functioning (i.e., flourishing mental health) to lower levels of positive feelings and impaired psychosocial functioning (i.e., “languishing mental health”).⁷ Results show that over half of respondents are classified as either “moderate” (46%) or “languishing” (7%) in their mental health, while 47% are classified as “flourishing.” Practising physicians are more likely than medical residents to be classified as “flourishing” (48% vs. 40% of medical residents).⁸

Mental Health Continuum – Short Form (MHC-SF)

MHC-SF is a scale measuring subjective well-being. Individuals are classified into categories of flourishing, moderate or languishing mental health on the basis of responses to emotional, psychological, and social well-being items.

The presence of positive feelings and positive functioning in life is characterized as flourishing mental health and the absence of is characterized as languishing. Those who are neither flourishing nor languishing are moderate in mental health.

MENTAL HEALTH CONTINUUM SHORT-FORM - MENTAL HEALTH

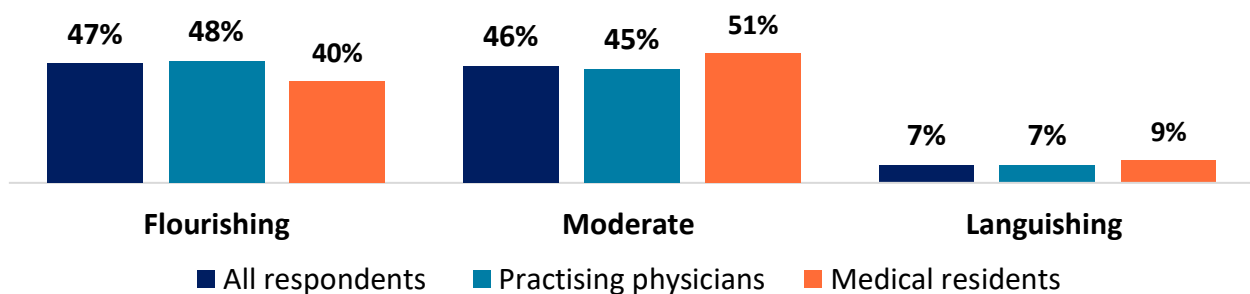


Figure 1. Mental Health Continuum Short-form (MHC-SF) Index created from responses to question 64. How often in the past month did you feel...Base: All respondents who opted into additional survey question (n = 3234), practising physicians (n = 2933), medical residents (n = 301).

⁶ MENTAL HEALTH CONTINUUM SHORT-FORM (MHC-SF) INDEX. Responses to 14 questions assessing emotional well-being and aspects of psychological and social functioning are scored and scaled to categorize respondents into one of three categories (languishing, moderate or flourishing).

⁷ Corey L. M. Keyes. (2002). The Mental Health Continuum: From Languishing to Flourishing in Life. *Journal of Health and Social Behavior*, 43(2), 207–222. <https://doi.org/10.2307/3090197>

⁸ P-value 0.045, not statistically significant but on the threshold.

Compared with before the pandemic, the proportion of respondents who are “flourishing” in mental health has declined significantly.

Overall, mental health among respondents has declined significantly since 2017: 47% are now classified as “flourishing” compared to 63% in 2017 (–16 percentage points). A larger proportion are classified as having “moderate” mental health, 46% compared with 33% in 2017 (+13 percentage points), and 7% are classified as “languishing” (+3 percentage points since 2017).

ALL RESPONDENTS	2021	2017	Percentage point difference between 2021 and 2017
Flourishing	47%	63%	–16
Moderately mentally healthy	46%	33%	+13
Languishing	7%	4%	+3

Table 2. Mental Health Continuum Short-form (MHC-SF) Index Categories, 2021 vs. 2017.

Base: Those answering all items to question 64.

Both practising physicians and medical residents have seen a similar percentage point decline in “flourishing” mental health; among practising physicians, it is now 48% (–16 percentage points since 2017); among medical residents, it is now 40% (–15 percentage points since 2017).

BY PHYSICIAN CAREER STAGE	2021	2017	Percentage point difference between 2021 and 2017
FLOURISHING			
Physicians	48%	64%	–16
Medical residents	40%	55%	–15
MODERATELY MENTALLY HEALTHY			
Physicians	45%	32%	+13
Medical residents	51%	40%	+11
LANGUISHING			
Physicians	7%	4%	+3
Medical residents	9%	6%	+3

Table 3. Classified as “flourishing,” “moderate” or “languishing” by career stage, 2021 vs. 2017.

Base: Those who did not answer at least one question item in question 64 were excluded from the calculations.

By gender, age, area of practice, years in practice and community size

Men are *significantly* more likely to be classified as “flourishing” in their mental health (**51%*** vs. 45% of women). Both groups have seen similar decreases in “flourishing” mental health since 2017 (–14 and –16 percentage points, respectively).

Older respondents (55+ years of age) are *significantly* more likely to be “flourishing” than those who are younger (**57%*** vs. **41%*** of those aged 35 to 54 years and 42% of those <35 years old).

There are no significant differences by area of practice. However, note that the proportion of surgical specialists who are languishing has doubled since 2017 (5% in 2017 to 11% in 2021), and the proportion of respondents working in other/administration who are languishing has tripled from (2% in 2017 to 7% in 2021).

With respect to years of practice, physicians with the greatest number of years in practice (over 30 years) are *significantly* more likely to be classified as “flourishing” than those with six to 10 years (**63%*** vs. **35%***, respectively). Those practising from six to 10 years and 11 to 20 years have seen the sharpest declines in “flourishing” mental health (–24 and –22 percentage points, respectively).

There are no significant differences by community size, although those practising in isolated/remote areas are less likely to be “flourishing” and have seen the largest percentage point decrease (–29 percentage points).

	Mental health “flourishing” in 2021	Mental health “flourishing” in 2017	Percentage point difference between 2021 and 2017	Mental health “languishing” in 2021	Mental health “languishing” in 2017	Percentage point difference between 2021 and 2017
GENDER						
Men	51%*	65%	–14	7%	5%	+2
Women	45%	61%	–16	7%	4%	+3
AGE						
<35	42%	–	–	7%	–	–
35–54	41%*	–	–	9%*	–	–
55+	57%*	–	–	5%*	–	–
AREA OF PRACTICE						
General practitioner	48%	63%	–15	7%	4%	+3
Medical specialist	45%	62%	–17	7%	5%	+2
Surgical specialist	47%	60%	–13	11%	5%	+6
Other/Admin	51%	84%	–33	7%	2%	+5
YEARS IN PRACTICE						
5 or less	40%	59%	–19	9%	4%	+5
6 to 10	35%*	59%	–24	10%	4%	+6
11 to 20	40%	62%	–22	9%	5%	+4
21 to 30	49%	65%	–16	6%	4%	+2

	Mental health flourishing" in 2021	Mental health flourishing" in 2017	Percentage point difference between 2021 and 2017	Mental health languishing" in 2021	Mental health languishing" in 2017	Percentage point difference between 2021 and 2017
Over 30	63%*	74%	-11	4%	3%	+1
COMMUNITY SIZE						
Urban/suburban	47%	63%	-16	7%	4%	+3
Small town/rural	46%	64%	-18	9%	5%	+4
Isolated/remote	36%	65%	-29	3%	2%	+1

Table 4. Classified as “flourishing” or “languishing” by gender, age, area of practice, years in practice and community size, 2021 vs. 2017.

*** Statistically significant using chi-square test of independence. See Appendix B for more details.

WELL-BEING

A majority of respondents score higher on emotional and psychological well-being compared with social well-being.

Using the Mental Health Continuum Short Form sub-indices,⁹ respondents are more likely to score higher on emotional (79%) and psychological well-being (77%) than they are on social well-being (53%).

Practising physicians are *significantly* more likely to score high on psychological well-being (78%* vs. 72% of medical residents).

MENTAL HEALTH CONTINUUM SHORT FORM - WELL-BEING

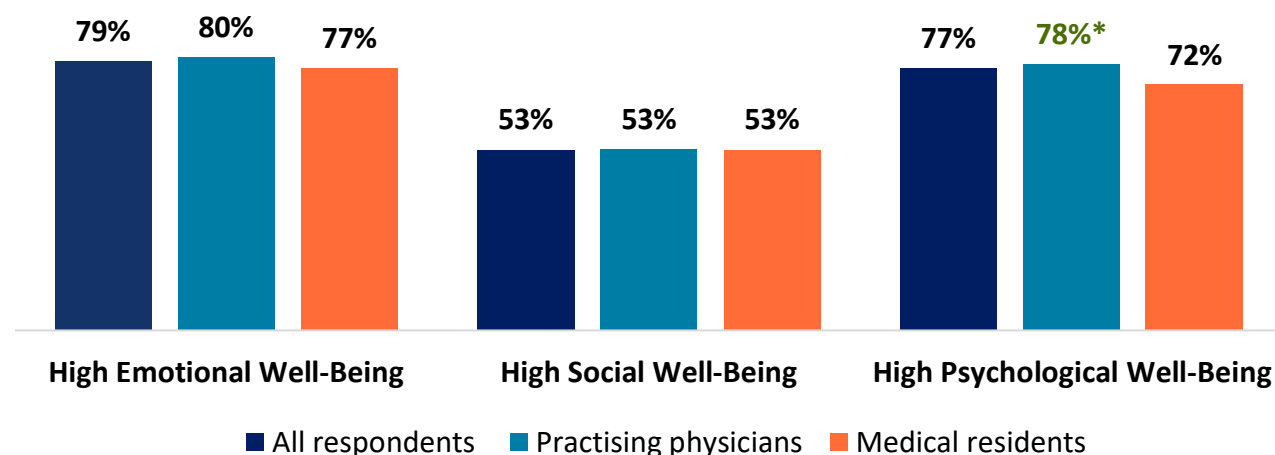


Figure 2. MENTAL HEALTH CONTINUUM SHORT FORM (MHC-SF) INDEX. Responses to question 64. Base: All respondents who opted into additional survey question; those who did not answer at least one question item were excluded from the calculations. (n = 3234), practising physicians (n = 2933), medical residents (n = 301).

⁹ MHC-SF indices: Each response is scored 0.00 = “Never,” 1.00 = “Once or twice,” 2.00 = “About once a week,” 3.00 = “About 2 or 3 times a week,” 4.00 = “Almost every day,” 5.00 = “Every day.” Sum scores for each respondent are classified above or below midpoint. Emotional well-being: 0–7 is low; 8–15 is high. Social well-being: 0–12 is low; 13–25 is high. Psychological well-being: 0–15 is low; 16–30 is high. Those who did not answer at least one question item were excluded from the calculations.

Across all three scales related to well-being (emotional, social and psychological well-being), there have been significant declines since 2017, with the largest decline in social Well-being (–16 percentage points).

BY PHYSICIAN CAREER STAGE	2021	2017	Percentage point difference between 2021 and 2017
HIGH ON EMOTIONAL WELL-BEING			
All respondents	79%	91%	–12
Physicians	80%	91%	–11
Medical residents	77%	88%	–11
HIGH ON SOCIAL WELL-BEING			
All respondents	53%	69%	–16
Physicians	53%	69%	–16
Medical residents	53%	67%	–14
HIGH ON PSYCHOLOGICAL WELL-BEING			
All respondents	77%	86%	–9
Physicians	78%*	87%	–9
Medical residents	72%	83%	–11

Table 5. Score high on emotional, social and psychological well-being indices by career stage, 2021 vs. 2017. Base: All respondents who opted into additional survey question (n = 3234), physicians (n = 2933), medical residents (n = 301).

** Statistically significant using chi-square test of independence. See Appendix B for more details.

By gender, age, area of practice, years in practice and community size

While there are few differences between men and women in terms of emotional and social well-being, men are *significantly* more likely to score high on psychological well-being compared with women (80%* vs. 76%). Women have seen a steeper decline in social and psychological well-being compared with men (–17 and –10 percentage points, respectively).

Older respondents (55+ years of age) are *significantly* more likely than those 35 to 54 years old to score high across all of the subscales:

1. Emotional well-being (83%* vs. 76%*)
2. Social well-being (62%* vs. 47%*)
3. Psychological well-being (85%* vs. 73%*)

With respect to years of practice, physicians practising 30 or more years are *significantly* more likely than those practising 11 to 20 years to score high on emotional well-being (87%* vs. 73%*, respectively). This group is also *significantly* more likely than those practising six to 10 years to score high on both social well-being (65%* vs. 41%*, respectively) and psychological well-being (87%* vs. 69%*, respectively).

There are no significant differences by area of practice and community size.

	High emotional well being 2021	High emotional well being 2017	Percentage point difference between 2021 and 2017	High social well being 2021	High social well being 2017	Percentage point difference between 2021 and 2017	High psychological well being 2021	High psychological well being 2017	Percentage point difference between 2021 and 2017
GENDER									
Men	81%	91%	-10	55%	69%	-14	80%*	86%	-6
Women	79%	91%	-12	52%	69%	-17	76%	86%	-10
AGE									
<35	82%	–	–	51%	–	–	75%	–	–
35–54	76%*	–	–	47%*	–	–	73%*	–	–
55+	83%*	–	–	62%*	–	–	85%*	–	–
AREA OF PRACTICE									
General practitioner	81%	92%	-11	54%	70%	-16	79%	87%	-8
Medical specialist	78%	91%	-13	51%	68%	-17	77%	86%	-9
Surgical specialist	75%	86%	-11	51%	64%	-13	76%	83%	-7
Other/ Admin	81%	96%	-15	56%	81%	-25	75%	94%	-19
YEARS IN PRACTICE									
5 or less	79%	91%	-12	45%	67%	-22	72%	85%	-13
6 to 10	79%	94%	-15	41%*	67%	-26	69%*	86%	-17
11 to 20	73%*	90%	-17	48%	67%	-19	73%	83%	-10
21 to 30	79%	89%	-10	57%	67%	-10	81%	88%	-7
Over 30	87%*	95%	-8	65%*	75%	-10	87%*	91%	-4
COMMUNITY SIZE									
Urban/ suburban	80%	91%	-11	54%	69%	-15	78%	87%	-9
Small town/ rural	78%	90%	-12	50%	69%	-19	76%	86%	-10
Isolated/ remote	79%	89%	-10	52%	66%	-14	75%	86%	-11

Table 6. Score high on emotional, social and psychological well-being indices by gender, age, area of practice, years in practice and community size, 2021 vs. 2017.

*** Statistically significant using chi-square test of independence. See Appendix B for more details.

BURNOUT

Over half of respondents surveyed are experiencing symptoms of burnout, 1.7 times higher compared with pre-pandemic.

Burnout was measured using the Maslach Burnout Inventory (MBI) two-item scale.¹⁰ Over half of respondents (53%) report symptoms of burnout, that is, they report a high level on at least one burnout indicator of depersonalization (28%) or emotional exhaustion (50%).

The prevalence of overall burnout is higher among medical residents (58%* vs. 52% of practising physicians), specifically on depersonalization (35% vs. 28% of practising physicians).

BURNOUT AMONG PHYSICIANS

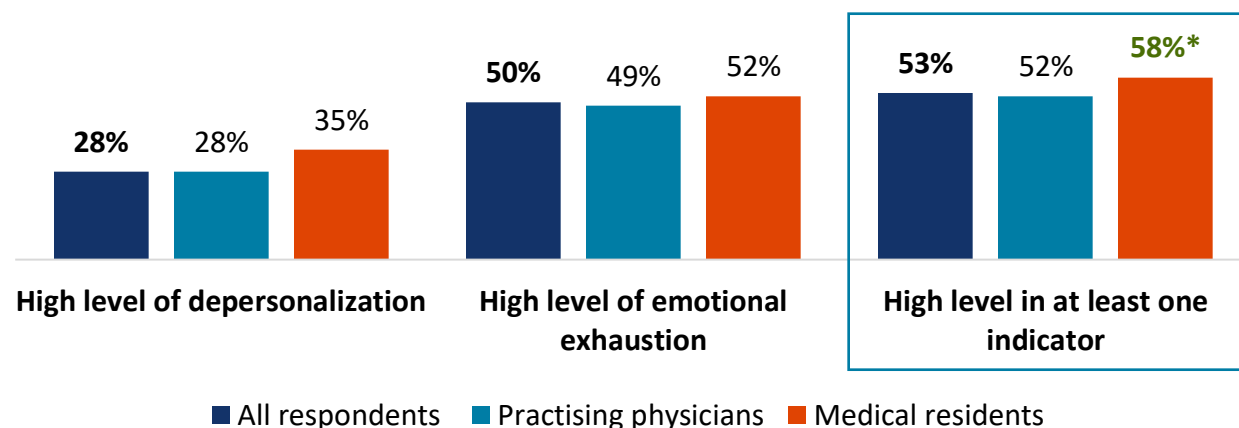


Figure 3. Maslach Burnout Inventory two-item scale. Base: All respondents (n = 3864), practising physicians (n = 3489), medical residents (n = 375).

Burnout is significantly higher among respondents in 2021 compared with those in the 2017 NPHS (53% in 2021 vs. 31% in 2017, 1.7 times higher or +22 percentage points). Both depersonalization (28% in 2021 vs. 16% in 2017) and emotional exhaustion (50% in 2021 vs. 26% in 2017) have roughly doubled.

ALL RESPONDENTS	2021	2017	Percentage point difference between 2021 and 2017
High depersonalization	28%	16%	+12
High emotional exhaustion	50%	26%	+24
High overall burnout	53%	31%	+22

Table 7. Maslach Burnout Inventory individual items and overall burnout, 2021 vs. 2017.

Base: All respondents, practising physicians + medical residents (n = 3864).

¹⁰ MASLACH BURNOUT INVENTORY TWO-ITEM SCALE. Scoring on MBI two-item scale: To be classified as burned out, an individual must experience high levels of emotional exhaustion (item 1 – “I feel burned out from my work or training environment”) and/or depersonalization (item 2 – “I have become more callous towards people since I took this job or started this training”). Rating high on these two items in question 41 is defined as occurring at least weekly (i.e., a respondent must select “everyday,” “a few times a week” or “once a week” on at least one of the two items to be classified as burned out).

Compared with 2017, overall burnout has increased at a higher rate among practising physicians (1.7 times higher or +22 percentage points) compared with medical residents (1.5 times higher or +19 percentage points).

BY PHYSICIAN CAREER STAGE	Overall burnout in 2021	Overall burnout in 2017	Percentage point difference between 2021 and 2017
Physicians	52%	30%	+22
Medical residents	58%	39%	+19

Table 8. Maslach Burnout Inventory overall burnout, by career stage, 2021 vs. 2017.

By gender, age, area of practice, years in practice and community size

Burnout is *significantly* higher among women (**59%*** vs. 43% of men). The increase in burnout since 2017 is much higher among women (+26 percentage points from 2017 vs. +14 percentage points among men).

Respondents under the age of 54 (**61%***) are *significantly* more likely to be experiencing burnout than those 55 and older (38%).

The prevalence of burnout is *significantly* higher among respondents in general practice/family medicine (**57%***) compared with physicians practising in other/administration positions (**40%***).

Regarding years of practice, respondents with 20 years or less in practice are *significantly* more likely to be experiencing burnout compared to those late in their career (over 30 years): those who have been practising five or less years (**62%***), six to 10 years (**68%***), and 11 to 20 years (**60%***) vs. over 30 years (**32%***). While symptoms of burnout increased across all groups from 2017 to 2021, the largest increase in burnout is among those earlier in their career at 6 to 10 years of practice (+35 percentage points from 2017).

Respondents practising in small towns (**58%***) or isolated/remote areas (**60%***) are *significantly* more likely to be experiencing burnout than those in urban/suburban areas (51%*). The rate of increase in burnout is also higher in these two areas: it increased by 27 percentage points among respondents in small town/rural areas and increased by 16 percentage points, among respondents in isolated/remote areas.

	Burnout in 2021	Burnout in 2017	Percentage point difference between 2021 and 2017
GENDER			
Men	43%	29%	+14
Women	59%*	33%	+26
Age			
<35	61%*	—	—
35 to 54	61%*	—	—
55+	38%	—	—

	Burnout in 2021	Burnout in 2017	Percentage point difference between 2021 and 2017
AREA OF PRACTICE			
General practitioner	57%*	33%	+24
Medical specialist	52%	30%	+22
Surgical specialist	53%	30%	+23
Other/Admin	40%*	19%	+21
YEARS IN PRACTICE			
5 or less	62%*	36%	+26
6 to 10	68%*	33%	+35
11 to 20	60%*	34%	+26
21 to 30	51%	31%	+20
Over 30	32%*	19%	+13
COMMUNITY SIZE			
Urban/suburban	51%*	31%	+20
Small town/rural	58%*	31%	+27
Isolated/remote	60%*	44%	+16

Table 9. Experiencing burnout by gender, age, area of practice, years in practice and community size.

** Statistically significant using chi-square test of independence. See Appendix B for more details.

ANXIETY

One-quarter of respondents report moderate to severe levels of anxiety.

Using the General Anxiety Disorder 7-Item Scale screening tool,¹¹ the study finds that one-quarter (25%) of respondents indicate experiencing “severe” (10%) or “moderate” (15%) anxiety. Nearly one-quarter (24%) of practising physicians experience severe/moderate anxiety, while one-third (34%) report “mild” anxiety and 43% “minimal” anxiety.

Overall, medical residents are *significantly* more likely to score moderate/severe on the anxiety scale than practising physicians (33%* vs. 24%, respectively), while practising physicians are more likely to classify as having a minimal level of anxiety (43%* vs. 33% of medical residents).

¹¹ Anxiety (General Anxiety Disorder) 7-Item Scale. This is calculated by assigning scores of 0, 1, 2 and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days” and “nearly every day.” Scoring is 0–4: minimal anxiety; 5–9: mild anxiety; 10–14: moderate anxiety; 15–21: severe anxiety.

GENERAL ANXIETY DISORDER SCALE

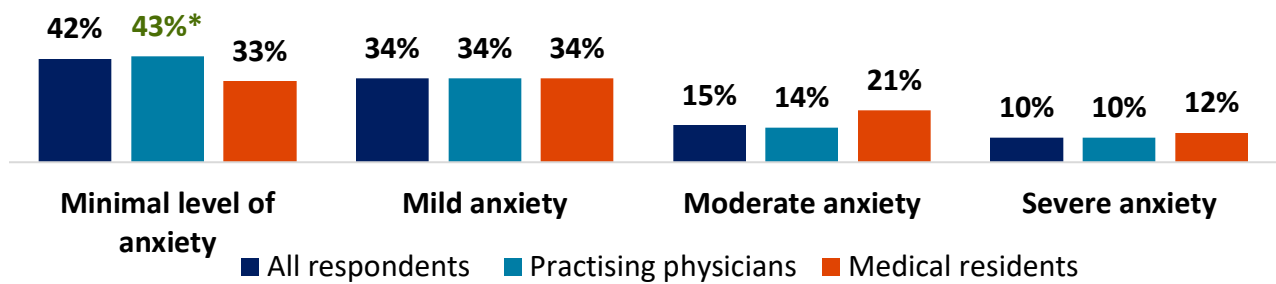


Figure 4. Anxiety (General Anxiety Disorder 7-Item Scale: GAD-7). Base: All respondents (n = 3864), physicians (n = 3489), medical residents (n = 375).

By gender, age, area of practice, years in practice and community size

Women are *significantly* more likely to report severe/moderate anxiety (**27%*** vs. 19% of men).

Respondents 35 to 54 years old are *significantly* more likely to be experiencing a severe/moderate level of anxiety (**30%***) compared with those 55+ years old (**15%***).

Physicians practising for six to 10 years are *significantly* more likely to report severe/moderate anxiety (**33%***) compared with those who have been practising over 30 years (**11%***).

There are no significant differences by area of practice or community size.

	% "Severe" + "moderate" anxiety
GENDER	
Men	19%
Women	27%*
AGE	
<35	29%
35 to 54	30%*
55+	15%*
AREA OF PRACTICE	
General practitioner	24%
Medical specialist	26%
Surgical specialist	28%
Other/Admin	21%

	% "Severe" + "moderate" anxiety
YEARS IN PRACTICE	
5 or less	29%
6 to 10	33%*
11 to 20	27%
21 to 30	24%
Over 30	11%*
COMMUNITY SIZE	
Urban/suburban	24%
Small town/rural	26%
Isolated/remote	25%

Table 10. Anxiety (General Anxiety Disorder) 7-Item Scale, scoring moderate + severe anxiety by gender, age, area of practice, years in practice and community size.

** Statistically significant using chi-square test of independence. See Appendix B for more details.

DEPRESSION (SCREENING)

Not surprisingly, depression is also higher compared with before the COVID-19 pandemic, with almost half of respondents screening positive for depression.

The Patient Health Questionnaire-2 (PHQ-2) depression screening tool was used to measure depression in the survey.¹² Nearly half of respondents surveyed (48%) screened positive for depression, up significantly since 2017 (34%, +14 percentage points). There are no significant differences by career stage: 48% of practising physicians and 50% of medical residents screen positive for depression.

DEPRESSION SCREENING

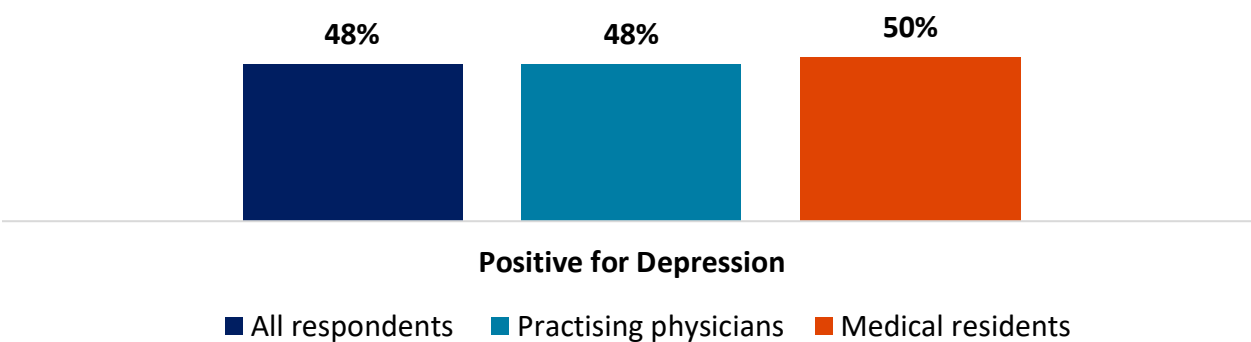


Figure 5. PHQ-2 Depression Scale. Base: All respondents (n = 3864), physicians (n = 3489), medical residents (n = 375).

Interestingly, practising physicians have seen a steep increase in positive screening for depression (48% in 2021 vs. 33% in 2017, 1.5 times higher or +15 percentage points), bringing the scores for practising physicians closer to those consistently reported by medical residents (50% in 2021 vs. 48% in 2017).

BY PHYSICIAN CAREER STAGE	Screen positive for depression in 2021	Screen positive for depression in 2017	Percentage point difference between 2021 and 2017
All respondents	48%	34%	+14
Practising physicians	48%	33%	+15
Medical residents	50%	48%	+2

Table 11. Mental Health Continuum Short-form (MHC-SF) Index Categories, 2021 vs. 2017.

¹² PHQ-2 DEPRESSION SCALE. If respondents answered “yes” to either item 1 (“Felt down, depressed or hopeless for two or more weeks in a row”) or 2 (“Lost interest or pleasure in most things like hobbies, and/or work activities that usually give you pleasure”), they are classified as “positive” for depression. If both items are “no,” then they are classified as “negative” for depression.

By gender, age, area of practice, years in practice and community size

Women are *significantly* more likely to screen positive for depression (**50%*** vs. 43% of men). Both men and women have seen an increase in positive screening since 2017 (+12 and +13 percentage points, respectively).

Respondents 35–54 years (**53%***) are *significantly* more likely to screen positive for depression compared with those 55+ years old (**41%***).

Positive screening for depression is more prevalent among those in the earlier stages of their career. Those practising 6 to 10 years are *significantly* more likely to screen positive for depression (**56%***, +23 percentage points since 2017) compared with those practising over 30 years (**38%***, +10 percentage points since 2017).

Respondents practising in small town/rural areas (**55%***) are *significantly* more likely to screen positive for depression compared with those in urban/suburban areas (**46%***).

There are no significant differences by area of practice.

	% Screen positive for depression 2021	% Positive for depression 2017	Percentage point difference between 2021 and 2017
GENDER			
Men	43%	31%	+12
Women	50%*	37%	+13
Age			
<35	48%	–	–
35 to 54	53%*	–	–
55+	41%*	–	–
AREA OF PRACTICE			
General practitioner	50%	36%	+14
Medical specialist	54%	33%	+21
Surgical specialist	52%	39%	+13
Other/Admin	55%	19%	+36
YEARS IN PRACTICE			
5 or less	49%	35%	+14
6 to 10	56%*	33%	+23
11 to 20	52%	36%	+16
21 to 30	48%	31%	+17
Over 30	38%*	28%	+10

	% Screen positive for depression 2021	% Positive for depression 2017	Percentage point difference between 2021 and 2017
COMMUNITY SIZE			
Urban/suburban	46%*	34%	+12
Small town/rural	55%*	37%	+18
Isolated/remote	49%	35%	+14

Table 12. PHQ-2 depression scale. Classify as “positive” for depression by gender, age, area of practice, years in practice and community size.

*** Statistically significant using chi-square test of independence. See Appendix B for more details.*

SUICIDAL IDEATION

Over one-third of respondents report having had thoughts of suicide at some point in their life, almost doubled since before the pandemic.

Over one-third (36%) of respondents have had thoughts of suicide at some point in their life, an increase of +17 percentage points from 2017. There are no significant differences between practising physicians (36%) and medical residents (39%) although the increase is higher among practising physicians (almost doubled, or +18 percentage points from 2017) compared with medical residents (1.4 times higher or +12 percentage points from 2017).

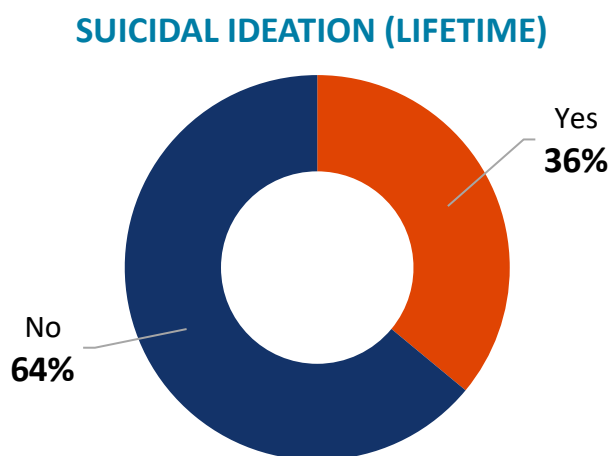


Figure 6. Responses to question 47. Have you had thoughts of suicide? Base: Those respondents consenting to the collection of sensitive data (n = 3750).

BY PHYSICIAN CAREER STAGE	Suicidal ideation (lifetime) in 2021	Suicidal ideation (lifetime) in 2017	Percentage point difference between 2021 and 2017
Total	36%	19%	+17
Physicians	36%	18%	+18
Medical residents	39%	27%	+12

Table 13. Suicidal ideation (lifetime) by physician vs. medical resident, 2021 vs. 2017.

Risk for suicidal ideation increases once physicians start their formal practice. Indeed, practising physicians are at higher risk for suicidal ideation during medical practice (24%), twice the rate compared with earlier stages leading to their medical career (12% in residency, 10% during medical school and 10% before medical school).

	Practising physicians
Yes (lifetime) NET	36%
Yes, before medical school	10%
Yes, during medical school	10%
Yes, during residency	12%
Yes, during medical practice	24%

Table 14. Suicidal ideation (lifetime) at different points among practising physicians. Base: Those respondents consenting to the collection of sensitive data AND who have had thoughts of suicide: practising physicians (n = 3386).

By gender, age, area of practice, years in practice and community size

Prevalence of suicidal ideation (lifetime) is *significantly* higher among women (**38%*** vs. 32% of men). Both genders saw an increase from 2017 to 2021, with men reaching +15 percentage points and women +17 percentage points.

Respondents in younger age groups are *significantly* more likely to have ever experienced suicidal ideation (**39%*** of those <35 years old and **38%*** of those 35 to 54 years old vs. 31% of those 55 years and older).

The number of years of practice does not associate significantly with lifetime suicidal ideation; however, those practising six to 10 years have seen the largest increase since 2017 (increased 2.6 times or 26 percentage points), followed by those practising 11 to 20 years (increased 2.3 times or 20 percentage points).

Respondents in urban/suburban areas (**34%***) are *significantly* less likely to have experienced suicidal ideation compared with those in small town/rural areas (**42%***) and are less likely compared with those in isolated/remote areas (48%).

There are no significant differences by area of practice.

	Suicidal ideation (lifetime) in 2021	Suicidal ideation (lifetime) in 2017	Percentage point difference between 2021 and 2017
GENDER			
Men	32%	17%	+15
Women	38%*	21%	+17
AGE			
<35	39%*	–	–
35 to 54	38%*	–	–
55+	31%*	–	–
AREA OF PRACTICE			
General practitioner	37%	20%	+17
Medical specialist	37%	18%	+19
Surgical specialist	30%	16%	+14
Other/Admin	35%	19%	+16
YEARS IN PRACTICE			
5 or less	41%	22%	+19
6 to 10	42%	16%	+26
11 to 20	36%	16%	+20
21 to 30	34%	18%	+16
Over 30	31%	16%	+15
COMMUNITY SIZE			
Urban/suburban	34%*	18%	+16
Small town/rural	42%*	19%	+23
Isolated/remote	48%	32%	+16

Table 15. Suicidal ideation (lifetime) by gender, age, area of practice, years in practice and community size.

* * Statistically significant using chi-square test of independence. See Appendix B for more details.

Fourteen percent of respondents have had thoughts of suicide in the past 12 months.

Those who indicated having had thoughts of suicide at some point in their life were asked a follow-up question about whether they had thoughts of suicide in the last 12 months (“recent suicidal ideation”). Fourteen percent of respondents (rebased to total) have had thoughts of suicide over the past 12 months, an increase of 6 percentage points from 8% in 2017.

Medical residents are significantly more likely to report suicidal thoughts in the past 12 months (**20%*** vs. 13% of practising physicians).

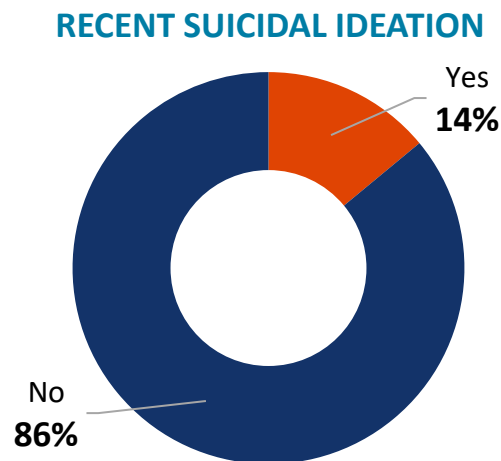


Figure 7. Responses to question 48. Have you had thoughts of suicide in the last 12 months? Base: Those respondents consenting to the collection of sensitive data AND who have had thoughts of suicide, rebased to total (n = 3750).

Even though medical residents are significantly more likely to report recent suicidal ideation (past 12 months), the prevalence among practising physicians increased at a slightly higher rate when comparing data from 2017 to 2021.

The number of practising physicians reporting recent suicidal ideation increased at a higher rate of 1.6 times from 2017 (13% vs. 8%, +5 percentage points); the number of medical residents reporting suicidal thoughts increased at a lower rate of 1.3 times over this same period (20% vs. 15%, +5 percentage points).

	Recent suicidal ideation in 2021	Recent suicidal ideation in 2017	Percentage point difference between 2021 and 2017
Total	14%	8%	+6
Practising physicians	13%	8%	+5
Medical residents	20%*	15%	+5

Table 16. Suicidal ideation in past 12 months among practising physician vs. medical residents in 2021 vs. 2017. Rebased to total (n = 3750).

By gender, age, area of practice, years in practice and community size

There are no significant differences in the proportions of men and women who experienced suicidal ideation in the past 12 months, although both have seen an increase in prevalence from 2017 to 2021 (+5 percentage points each).

Younger generations tend to have experienced suicidal ideation more in the past 12 months, particularly those aged 35 to 54 years (**16%***) and under the age of 35 (**19%***), compared with 9% of those 55+ years old.

Physicians with 6 to 10 years of practice are significantly more likely to have experienced suicidal ideation in the past 12 months (**21%***, +15 percentage points from 2017) compared with those with over 30 years of practice (**8%***, +4 percentage points from 2017).

There are no significant differences by area of practice or community size, although those practising in isolated/remote areas are more likely than those in urban/rural areas to have had recent suicidal ideation (21% vs. 13%, respectively).

Rebased to total sample	Suicidal ideation past 12 months 2021	Suicidal ideation past 12 months 2017	Percentage point difference between 2021 and 2017
GENDER			
Men	13%	7%	+6
Women	14%	9%	+5
Age			
<35	19%*	–	
35 to 54	16%*	–	
55+	9%	–	
AREA OF PRACTICE			
General practitioner	15%	9%	+6
Medical specialist	13%	8%	+5
Surgical specialist	15%	7%	+8
Other/Admin	12%	3%	+9
YEARS IN PRACTICE			
5 or less	18%	12%	+6
6 to 10	21%*	6%	+15
11 to 20	14%	8%	+6
21 to 30	11%	8%	+3
Over 30	8%*	4%	+4

Rebased to total sample	Suicidal ideation past 12 months 2021	Suicidal ideation past 12 months 2017	Percentage point difference between 2021 and 2017
COMMUNITY SIZE			
Urban/suburban	13%	8%	+5
Small town/rural	16%	10%	+6
Isolated/remote	21%	13%	+8

Table 17. Suicidal ideation (past 12 months) by gender, age, area of practice, years in practice and community size.

*** Statistically significant using chi-square test of independence. See Appendix B for more details.*

BOX 1. SUICIDAL IDEATION BY PSYCHOLOGICAL FACTORS

Physicians who are classified as "**languishing**" in mental health are 10 times more likely than those "**flourishing**" to have had thoughts of suicide in the past 12 months (50% vs. 5%, respectively).

Those who score **high on burnout** are more than three times more likely to have had thoughts of suicide in the past 12 months (21% vs. 6% of those who score low on the burnout scale).

Physicians experiencing **moderate or severe anxiety** are also at higher risk: they are eight times more likely than those who have minimal anxiety to have had thoughts of suicide in the past 12 months (33% vs. 4%, respectively). Among those with a mild level of anxiety, 13% report suicidal thoughts.

Physicians who score positive for **depression** are five times more likely than those scoring negative to have had suicidal thoughts in the past year (25% vs. 4%, respectively).

Section 2. Impact of COVID-19

IMPACT OF COVID-19 ON MENTAL HEALTH

Mental health is self-reported to be worse than before COVID-19.

When asked “Compared with before the COVID-19 pandemic, how would you rate your mental health now?”, six in 10 respondents indicated that their mental health is worse now than before the pandemic: 39% rate their mental health as “slightly worse” now than before the pandemic and 21% rate it as “much worse.” One-third rate their mental health to be “about the same,” while less than one in 10 (8%) rate it as “much better” or “somewhat better” than before the pandemic.

Practising physicians are *significantly* more likely than medical residents to indicate their mental health is “slightly” or “much” worse during the COVID-19 pandemic (60%* vs. 53%, respectively).

RATING OF MENTAL HEALTH COMPARED WITH BEFORE THE PANDEMIC

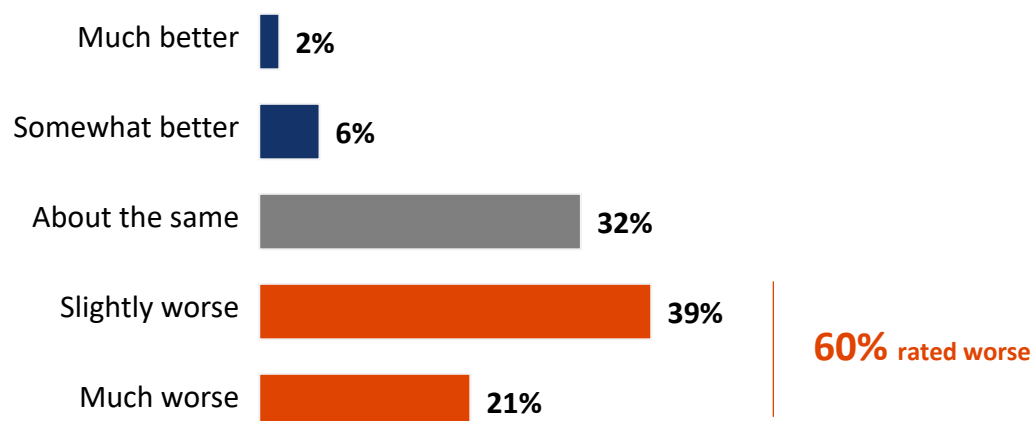


Figure 8. Responses to question 54. Compared with before the COVID-19 pandemic, how would you rate your mental health now? Base: All respondents (n = 3864).

By gender, age, area of practice, years in practice and community size

Women are *significantly* more likely than men to say their mental health is worse now than before the pandemic (64%* vs. 52% of men).

Respondents aged 35 to 54, compared with those who are older, are *significantly* more likely to rate their mental health as worse than before COVID-19 (68%* vs. 50%* of those aged 55+ years).

Physicians practising six to 10 years (69%*) and 11 to 20 years (70%*) are *significantly* more likely to rate their mental health as being worse than before COVID-19, compared with those practising over 30 years (46%*).

There are no significant differences by area of practice or community size.

	Mental health rated slightly + much worse compared with before COVID 19		Mental health rated slightly + much worse compared with before COVID 19
GENDER		YEARS IN PRACTICE	
Men	52%	5 or less	65%
Women	64%*	6 to 10	69%*
AGE		11 to 20	70%*
<35	58%	21 to 30	61%
35 to 54	68%*	Over 30	46%*
55+	50%*	COMMUNITY SIZE	
AREA OF PRACTICE		Urban/suburban	60%
General practitioner	61%	Small town/rural	63%
Medical specialist	61%	Isolated/remote	56%
Surgical specialist	59%		
Other/Admin	53%		

Table 18. Responses to question 54 by gender, age, area of practice, years in practice and community size.

*** Statistically significant using chi-square test of independence. See Appendix B for more details.*

The largest self-reported contributors to poor mental health during the pandemic are increased workload, rapidly changing work policies/processes and the social impact of COVID-19 public health measures.

Several factors have negatively contributed to the worsening mental health of respondents since the onset of the pandemic. The top four factors are as follows:

- increased workload and/or lack of work–life integration (57%)
- longer time with social restrictions/social isolation (55%)
- rapidly changing policies/processes (55%)
- continued uncertainty about the future (51%)

As seen in the table below, practising physicians are more likely than medical residents to feel the impact of increased workload and/or lack of work–life integration (58% vs. 49%, respectively) and rapidly changing policies/processes (55% vs. 47%). Practising physicians are also more likely than medical residents to select personal factors such as family issues and obligations (35% vs. 27% of medical residents) and financial insecurity (18% vs. 10% of medical residents), as well as health system factors such as long waitlists (35% vs. 14% of medical residents) and adjustment to virtual care (29% vs. 19% of medical residents).

Medical residents are more likely than practising physicians to feel the effects of social restrictions and isolation (72% vs. 53% of practising physicians) and continued uncertainty about the future (61% vs. 51% of practising physicians). Adjustment to virtual learning is also a key issue among this group (37%), as is a lack of peer support (21%).

BY PHYSICIAN STAGE	All respondents	Practising physicians	Medical residents
Increased workload/lack of work–life integration	57%	58%	49%
Longer time with social restrictions/ isolation	55%	53%	72%
Rapidly changing policies/processes	55%	55%	47%
Continued uncertainty about the future	51%	51%	61%
Lack of human resources	35%	36%	29%
Family issues and obligations	34%	35%	27%
Long waitlists	33%	35%	14%
Adjustment to virtual care	28%	29%	19%
Concerns about vaccine rollout	23%	23%	20%
Adjustment to virtual learning	18%	15%	37%
Financial insecurity	17%	18%	10%
Challenges acquiring PPE	16%	16%	11%
Lack of peer support	14%	14%	21%
Physical health struggles	14%	14%	14%
Interpersonal conflict	12%	12%	11%
Concerns about long-term care	10%	10%	6%
College complaint or lawsuit	7%	7%	2%
Decreased workload	4%	4%	3%
Other	18%	19%	12%
None of the above	4%	4%	3%

Table 19. Responses to question 55. What do you believe has contributed negatively to your mental health during the pandemic? Select all that apply. Base: All respondents (n = 3864), practising physicians (n = 3489), medical residents (n = 375).

By gender, age, area of practice, years in practice and community size

Women are more likely than men to select the majority of the listed factors contributing to worse mental health. Compared with men, they are more likely to select increased workload (62% vs. 49% men), family issues and obligations (38% vs. 28% men), lack of human resources (38% vs. 30% men) and continued uncertainty about the future (54% vs. 47% men) (data not shown in table).

While the top three to four factors are relatively consistent across age groups, the ranking differs slightly (see Table 20). For those <35 years old, longer time with social restrictions/social isolation (69%) and continued uncertainty about the future (61%) rank as the top two. For those aged 35 to 54 years, it is increased workload (66%) and rapidly changing policies/processes (58%); family issues and obligations is also a key contributing issue for this age group (44%). For those aged 55+ years, longer time with social restrictions/social isolation (51%) and rapidly changing policies/processes (50%) rank highest.

The top three to four factors are also relatively consistent across areas of practice, although respondents in general practice/family medicine are the most likely to select increased workload/lack of work–life integration (62%) as the largest factor negatively affecting their mental health. This group is also more likely to select long wait lists (41%, along with surgical specialists 43%) and adjustment to virtual care (35%) as key issues, more than other areas of practice.

Respondents practising in small town/rural and isolated/remote areas are more likely to cite lack of resources (43% and 48%, respectively, vs. 33% of those practising in urban/suburban areas) (data not shown in table).

	<35	35 to 54	55+	General practitioner	Medical specialist	Surgical specialist	Other/admin
Increased workload/lack of work–life integration	3rd (58%)	1st (66%)	3rd (44%)	1st (62%)	1st (56%)	3rd (44%)	2nd (54%)
Longer time with social restrictions/isolation	1st (69%)	3rd (54%)	1st (51%)	2nd (54%)	1st (56%)	1st (55%)	1st (56%)
Rapidly changing policies/processes	4th (54%)	2nd (58%)	1st (50%)	3rd (59%)	2nd (53%)	2nd (53%)	4th (47%)
Continued uncertainty about the future	2nd (61%)	4th (54%)	2nd (46%)	4th (52%)	3rd (51%)	2nd (52%)	3rd (51%)
Lack of human resources	5th (35%)	6th (41%)	6th (27%)	6th (36%)	4th (36%)	4th (32%)	6th (33%)
Family issues and obligations	6th (27%)	5th (44%)	7th (25%)	7th (35%)	5th (35%)	5th (29%)	5th (35%)
Long waitlists	7th (23%)	7th (37%)	4th (33%)	5th (41%)	6th (26%)	3rd (43%)	7th (25%)
Adjustment to virtual care	10th (20%)	8th (28%)	5th (32%)	8th (35%)	7th (24%)	8th (19%)	7th (24%)

Table 20. Rank ordering top responses to question 55. What do you believe has contributed negatively to your mental health during the pandemic? Select all that apply. Base: < 35 (n = 662), 35–54 (n = 1822), 55+ (n = 1361), General practitioner (n = 1564), medical specialist (n = 1410), surgical specialist (n = 369), other/admin (n = 500).

FEELING MORAL DISTRESS

Moral distress is pronounced among respondents, with one in five saying they feel it “very often” or “always,” and a further 33% saying “sometimes,” since the start of the pandemic.

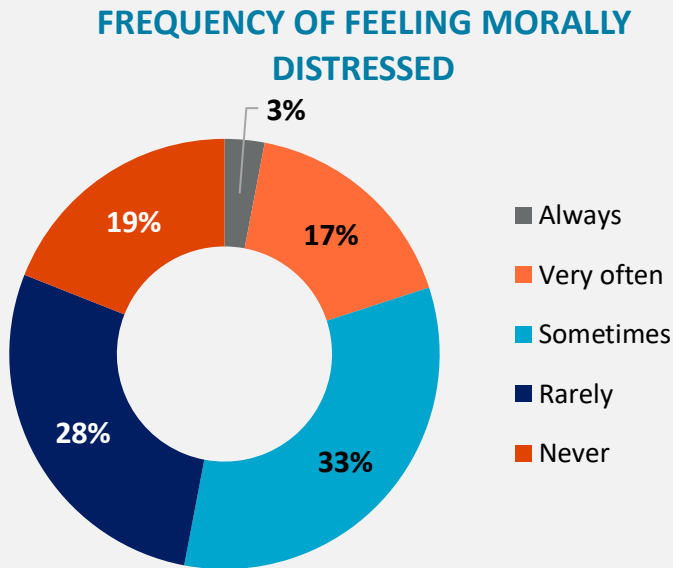
Overall, 20% of respondents say they frequently feel morally distressed in their work: 3% say they “always” feel morally distressed and 17% say they feel it “very often.” Another 33% say they feel morally distressed “sometimes,” and 47% feel it either “rarely” or “never.”

The prevalence is *significantly* higher among practising physicians (21%* vs. 14% of medical residents).

Box 2. Moral distress by psychological factors

Frequent feelings (always/very often) of moral distress are higher among respondents who:

- are “languishing” in mental health (44% vs. 14% of those who are “flourishing”),
- score high on overall burnout (30% vs.10% of those who do not),
- screen positive for depression (30% vs. 12% of those who do not), and
- have had recent suicidal thoughts in the past 12 months (35% vs. 28% of those who have ever had such thoughts and 17% of those who have never had such thoughts).



Moral distress is defined as psychological distress that results from events that go against one’s values and moral beliefs. It occurs when one feels unable to take what they believe to be an ethically appropriate or right course of action because of institutionalized obstacles.

Figure 9. Responses to question 56. Since the onset of the COVID-19 pandemic, how often have you felt morally distressed? Base: All respondents (n=3864).

By gender, age, area of practice, years in practice and community size

Women are *significantly* more likely to report feeling moral distress always/very often (**22%*** vs. 17% of men).

Respondents 35 to 54 years old are *significantly* more likely to say the same compared with those older (**26%*** vs. **15%*** of those 55+ years old).

Physicians practising six to 10 years (**28%***) and 11 to 20 years (**26%***) are also *significantly* more likely to report feeling morally distressed frequently compared with **14%*** of those practising over 30 years.

There are no significant differences by area of practice or community size.

	Feel morally distressed % always + very often		Feel morally distressed % always + very often
GENDER		YEARS IN PRACTICE	
Men	17%	5 or less	21%
Women	22%*	6 to 10	28%*
AGE		11 to 20	26%*
<35	16%	21 to 30	20%
35 to 54	26%*	Over 30	14%*
55+	15%*	COMMUNITY SIZE	
AREA OF PRACTICE		Urban/suburban	21%
General practitioner	21%	Small town/rural	21%
Medical specialist	21%	Isolated/remote	24%
Surgical specialist	18%		
Other/Admin	19%		

Table 21. Feel morally distressed always + very often, by gender, age, area of practice, years in practice and community size.

****** Statistically significant using chi-square test of independence. See Appendix B for more details.

REDUCTION OF CLINICAL HOURS AMONG PHYSICIANS

About half of physicians say they are likely to reduce or modify their clinical hours in the next two years.

Nearly half (49%) of respondents say they are likely or very likely to reduce or modify their clinical work hours in the next 24 months (higher among practising physicians: 51%* vs. 22% of medical residents).

LIKELIHOOD OF REDUCING/MODIFYING CLINICAL WORK HOURS

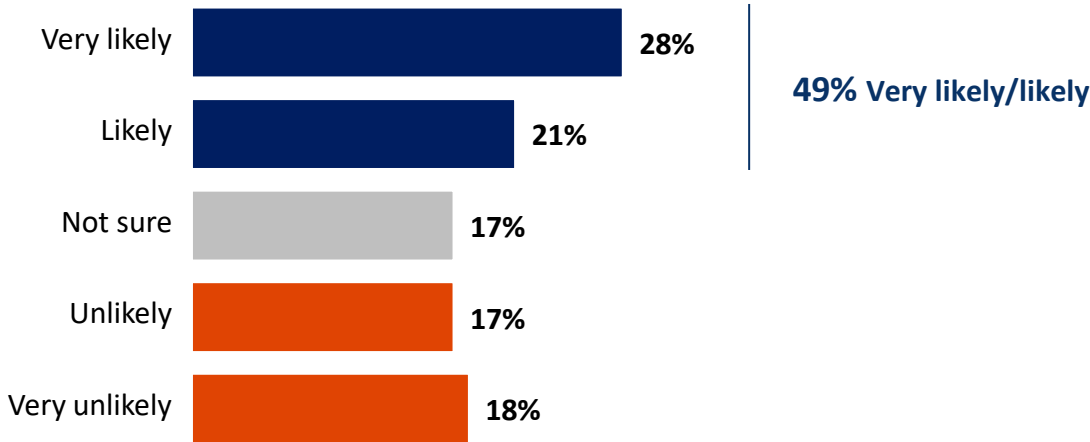


Figure 10. Responses to question 57. How likely is it that you will reduce or modify your clinical work hours in the next 24 months? Base: All respondents (n = 3864).

Box 3. Intention to reduce clinical hours by psychological factors

The following respondents are 1.3 times more likely to reduce their hours in the next 24 months:

- those whose mental health is languishing vs. those who are flourishing in mental health (59% vs. 45%, respectively)
- those experiencing overall burnout vs. those who do not score high on burnout (54% vs. 42%, respectively)
- those who have a moderate or severe level of anxiety vs. those who have a minimal level of anxiety (56% vs. 43% respectively)
- those who screen positive on depression vs. those who score low on depression (54% vs. 43%, respectively)

Those who score low on professional fulfillment are 1.4 times more likely than those who score high (52% vs. 37%, respectively) to say they will reduce their work hours in the next 24 months.

By gender, age, area of practice, years in practice and community size

Respondents who are ages <35 (**34%***) and 35–54 (**44%***) are *significantly* less likely to reduce or modify their clinical work hours in the next 24 months compared with 61% of those 55 and older.

Physicians practising 30 or less years are *significantly* less likely to reduce or modify their clinical work hours in the next 24 months (**48%*** with five or less years, **43%*** with six to 10 years, **45%*** with 11 to 20 years and **50%*** with 21 to 30 years vs. 64% of those practising 30 years or more). Notable is the large proportion of each of these subgroups of physicians practising 20 years or less (ranging from 43% to 45%) who say they are likely to reduce their clinical hours in the coming two years.

There are no significant differences by gender, area of practice and community size

	% Selected very likely + likely to reduce or modify clinical hours		% Selected very likely + likely to reduce or modify clinical hours
GENDER		YEARS IN PRACTICE	
Men	49%	5 or less	48%*
Women	48%	6 to 10	43%*
AGE		11 to 20	45%*
<35	34%*	21 to 30	50%*
35 to 54	44%*	Over 30	64%
55+	61%	COMMUNITY SIZE	
AREA OF PRACTICE		Urban/suburban	48%
General practitioner	52%	Small town/rural	51%
Medical specialist	44%	Isolated/remote	56%
Surgical specialist	49%		
Other/Admin	47%		

Table 22. Intention to reduce clinic hours, by gender, age, area of practice, years in practice and community size.

**** Statistically significant using chi-square test of independence. See Appendix B for more details.**

Section 3. Behavioural factors and social support

LEVEL OF FATIGUE AND OPTIMAL SLEEP

Over half of all respondents surveyed say they “always” or “often” feel fatigued at work/school, and only a third of respondents feel they “always” or “often” get optimal sleep.

A substantial number of respondents (57%) report they frequently (“always” or “often”) feel fatigued at work/school. Whereas over half of practising physicians (55%*) report frequently feeling fatigued, this figure is *significantly* higher for medical residents (73%*).

Similarly, a little over a third of practising physicians (36%*) report “always” or “often” feeling they get optimal sleep, in contrast to significantly fewer medical residents (22%*).

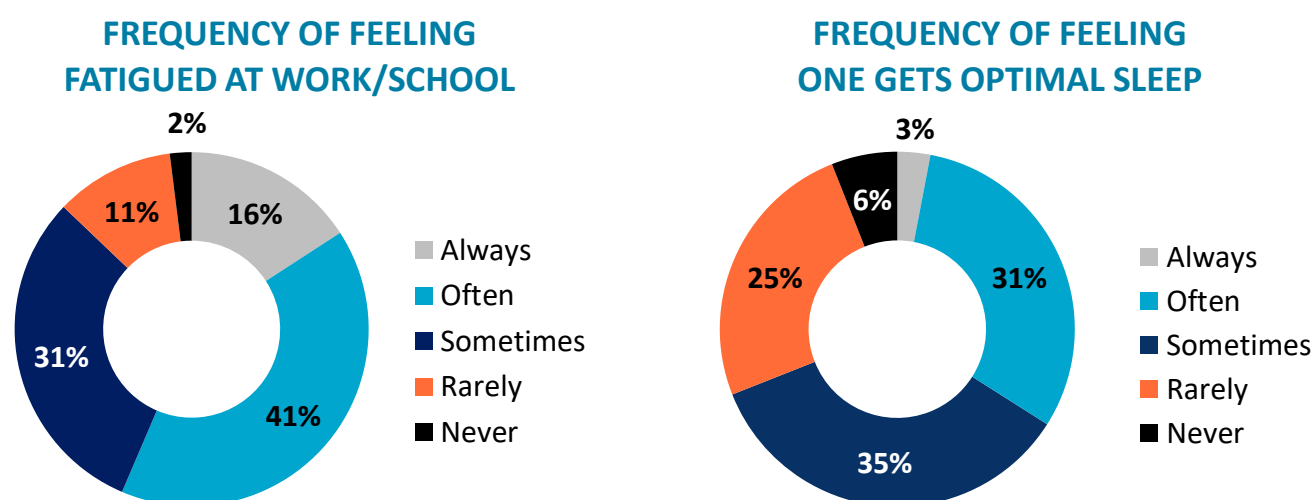


Figure 11. Responses to question 35. How often do you feel fatigued at work/school? Base: All respondents (n = 3864). Responses to question 37. How often do you feel you are getting optimal sleep? Base: All respondents (n = 3864).

By gender, age, area of practice, years in practice and community size

Women are *significantly* more likely to report frequent fatigue (i.e., “always” or “often”) (**64%*** vs. 46% of men), and *significantly* less likely to report optimal sleep (i.e., “always” or “often”) (**31%*** vs. 39% of men).

Respondents <35 (**70%***) and 35 to 54 (**64%***) years old are *significantly* more likely to report feeling fatigued than those older (41% of those 55 and older) and *significantly* less likely to get optimal sleep (**28%*** and **27%***, respectively, vs. 46% of those 55 and older).

General practitioners are *significantly* more likely than respondents practising in other/administration to feel fatigued frequently at work/school (**61%*** vs. **46%***, respectively)

Physicians with over 30 years in practice feel they get optimal sleep *significantly* more frequently (**50%***) than physicians with fewer years in practice (**28%*** 11 to 20 years; **25%*** six to 10 years; **29%*** five or less years in practice).

Respondents living in isolated/remote and small town/rural communities (**66%*** and **62%***, respectively) indicate that they feel fatigued at work/school *significantly* more frequently than physicians in urban/suburban communities (55%).

	Fatigued at work/school (“always” or “often”)	Optimal sleep (“always” or “often”)
GENDER		
Men	46%	39%
Women	64%*	31%*
AGE		
<35	70%*	28%*
35 to 54	64%*	27%*
55+	41%	46%
AREA OF PRACTICE		
General practitioner	61%*	36%
Medical specialist	57%	32%
Surgical specialist	55%	33%
Other/Admin	46%*	37%

	Fatigued at work/school (“always” or “often”)	Optimal sleep (“always” or “often”)
YEARS IN PRACTICE		
5 or less	69%*	29%*
6 to 10	70%*	25%*
11 to 20	61%*	28%*
21 to 30	55%	37%
Over 30	35%*	50%*
COMMUNITY SIZE		
Urban/suburban	55%	34%
Small town/rural	62%*	34%
Isolated/remote	66%*	26%

Table 23. Frequently (“always” or “often”) fatigued at work/school and frequently (“always” or “often”) getting optimal sleep by gender, age, area of practice, years in practice and community size.

**** Statistically significant using chi-square test of independence. See Appendix B for more details.**

SELF-CARE ACTIVITIES

A large majority of respondents do some kind of activity for self-care, with socializing and physical activity topping the list.

Eighty-eight percent of respondents report supporting their well-being through healthy lifestyle behaviours, mostly in the form of physical activity at 79% (higher among men and those 55+), as well as healthy eating at 55%. They also turn to hobbies (87%) as a form of self-care, with reading topping the list (61%), followed by cooking and baking (42%) and music (39%).

A majority prioritize social time with family and friends as a form of self-care (82%). About half say they turn to spiritual and mindful practices to support their mental health (48%), including a quarter who use mindfulness or meditation (a proportion that is higher among women).

SELF-CARE ACTIVITIES TO SUPPORT WELL-BEING

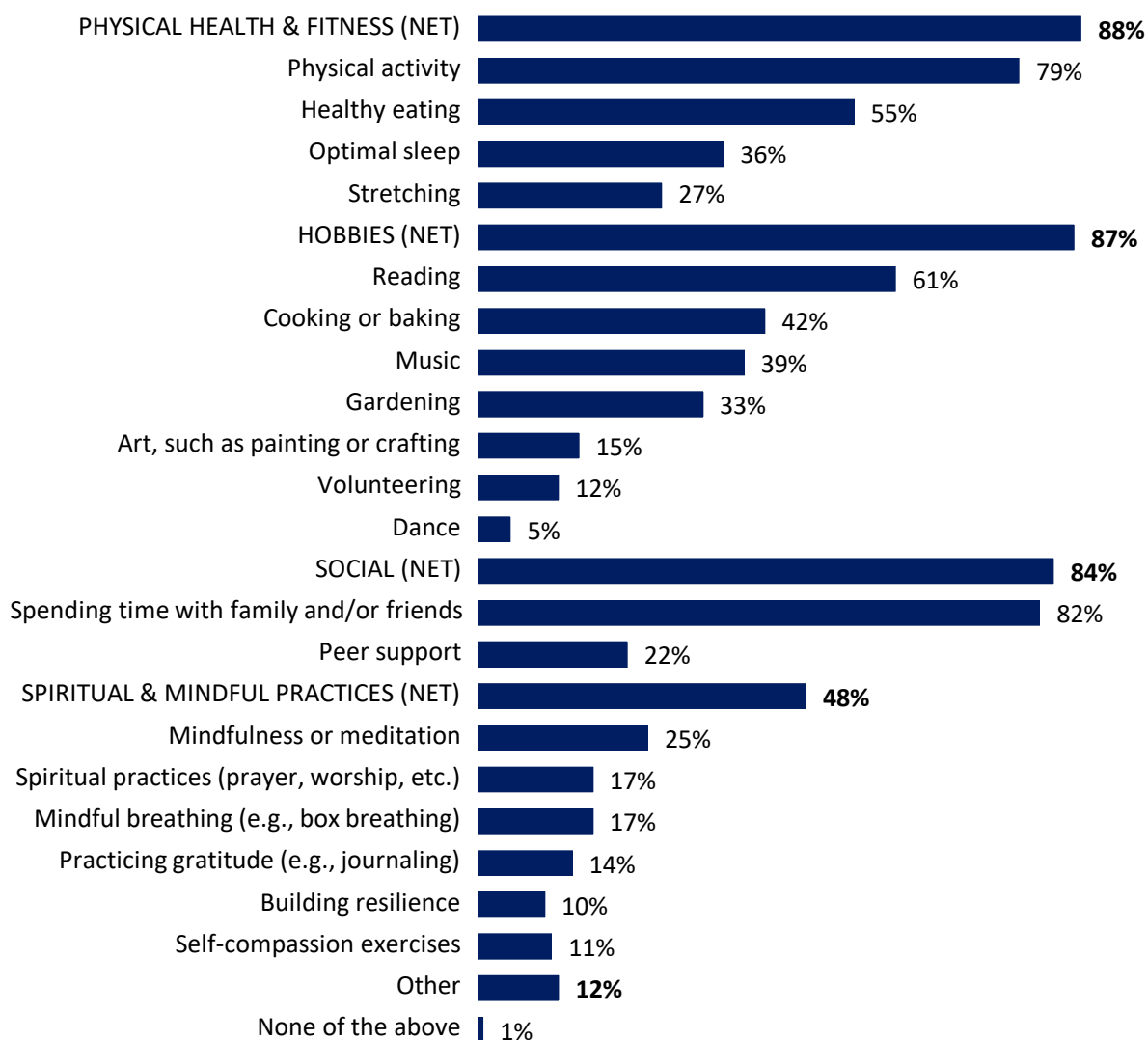


Figure 12. Responses to question 38. What self-care activities do you do to support your well-being in your personal life, outside of work (excluding household duties/chores/responsibilities)? Base: All respondents (n = 3864).

By gender, age, area of practice, years in practice and community size

While both men and women engage in self-care to a relatively high degree, women respondents are more likely to say they take part in self-care activities such as spiritual and mindful practices (52% vs. 43% of men), social activities (86% vs. 80%) and hobbies (88% vs. 85%).

As for men, they are more likely to say they engage in physical activities (81% vs. 77% of women), spiritual practices such as prayer or worship (20% vs. 16%) and music (45% vs. 36%) (data not shown in table).

Younger respondents (under 35 years of age) are more likely to say they do social activities, particularly peer support (30% vs. 22% among 35–54 and 19% among 55+). Older physicians (aged 55+ years) are more likely to say they engage in a variety of physical health and fitness activities (e.g., physical activity, healthy eating and stretching) and hobbies (e.g., music, gardening, volunteering and reading).

Middle-aged doctors (35–54 years) are less likely to say they are getting optimal sleep (30% vs. 45% of those under 35 years, 39% among 55+ years) (data not shown in table).

There are no strong differences by area of practice, years in practice or community size, although those in isolated/remote communities are less likely to participate in social activities (76%) compared with those practising in small town/rural and urban/suburban areas (83% and 84%, respectively).

	Physical health and fitness	Spiritual and mindful practices	Social	Hobbies
GENDER				
Men	88%	43%	80%	85%
Women	88%	52%	86%	88%
AGE				
<35	89%	46%	89%	82%
35 to 54	85%	49%	82%	85%
55+	92%	49%	83%	92%
AREA OF PRACTICE				
General practitioner	88%	52%	85%	87%
Medical specialist	89%	47%	83%	86%
Surgical specialist	88%	42%	84%	87%
Other/Admin	87%	47%	83%	86%
YEARS IN PRACTICE				
5 or less	84%	46%	86%	83%
6 to 10	83%	45%	82%	82%
11 to 20	85%	48%	86%	86%
21 to 30	91%	52%	90%	90%
Over 30	92%	49%	92%	92%

	Physical health and fitness	Spiritual and mindful practices	Social	Hobbies
COMMUNITY SIZE				
Urban/suburban	88%	48%	84%	87%
Small town/rural	86%	51%	83%	89%
Isolated/remote	87%	51%	76%	87%

Table 24. Self-care activities taken part in by gender, age, area of practice, years in practice and community size.

BARRIERS TO MAINTAINING A HEALTHY LIFESTYLE

Only one in 10 respondents say they do *not* face any barriers to maintaining a healthy lifestyle.

While a majority of respondents take part in some form of self-care activity for wellness, many also note a number of barriers that can hinder maintenance of a consistent healthy lifestyle. A lack of time (64%), a heavy workload and/or stressful work environment (60%), as well as challenges arising from scheduling (56%) are cited as the most common barriers preventing respondents from maintaining a healthy lifestyle.

BARRIERS PREVENTING A HEALTHY LIFESTYLE

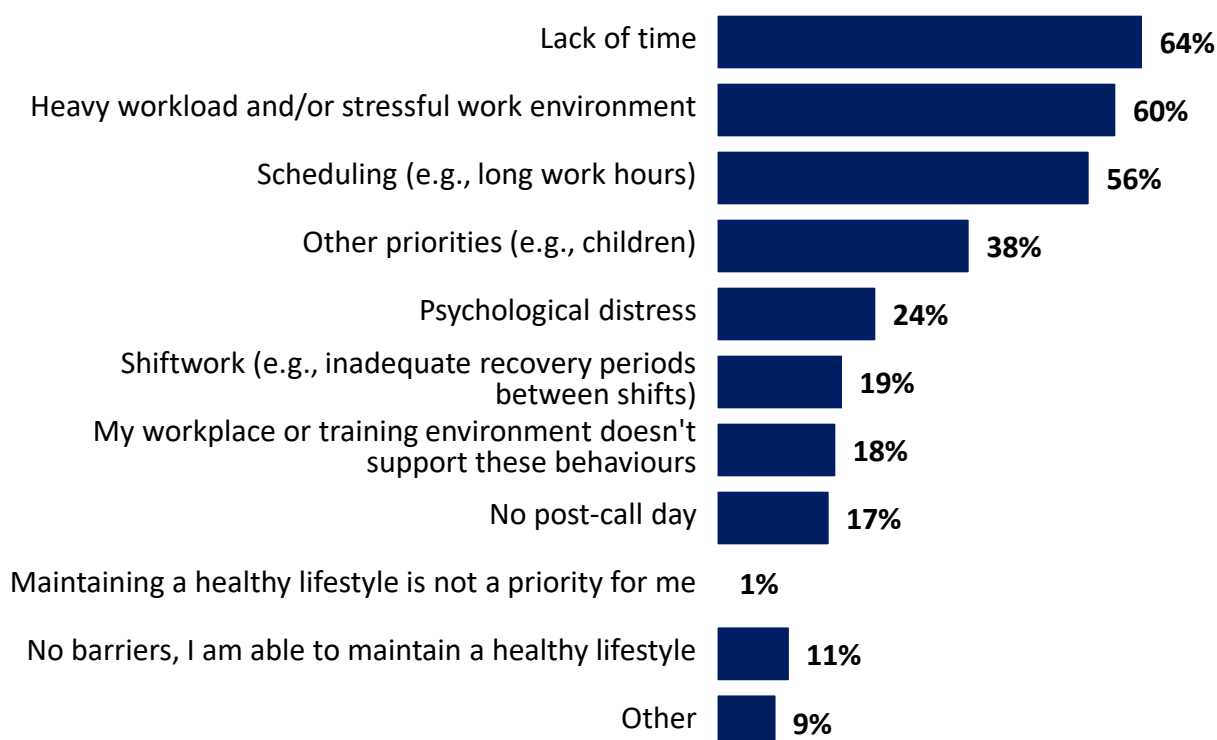


Figure 13. Responses to question 39. Which, if any, of the following barriers prevent you from maintaining a healthy lifestyle (e.g., being physically active, eating healthily, getting adequate sleep)? Check all that apply. Base: All respondents (n = 3864).

By gender, age, area of practice, years in practice and community size

Men are more likely to say that they don't experience any barriers to maintaining a healthy lifestyle (17% vs. 7% women). Women are more likely than men to cite lack of time (69% vs. 57% men), heavy workload and/or stressful work environment (64% vs. 53% men) and scheduling (59% vs. 51% men) as barriers to maintaining a healthy lifestyle, as well as having other priorities such as children (43% vs. 29% among men) (not shown in table).

Older respondents are also more likely to say they don't have any barriers to maintaining a healthy lifestyle (23% among those aged 55+ years vs. 5% among those aged 35–54 years, 2% of those under 35 years), as are those with more years in practice (28% among those with over 30 years in practice vs. 13% among those with 21 to 30 years, 5% with 11 to 20 years and 3% with less than 10 years). Respondents under 35 years of age are significantly more likely to cite lack of time (79% vs. 48% among those aged 55+), heavy workload and/or stressful work environment (71% vs. 46% among those aged 55+), scheduling (73% vs. 43% among those aged 55+) and shiftwork (32% vs. 10% of those aged 55+) as barriers to a healthy lifestyle.

Surgical specialists are more likely than other physicians to say scheduling is a barrier (63%).

Those working in small town/rural and isolated/remote areas are more likely to cite scheduling issues (e.g., long work hours) (60% and 66%, respectively, vs. 54% of those practising in urban/suburban areas) and shiftwork (e.g., inadequate recovery periods between shifts) (27% and 25%, respectively, vs. 17% of those practising in urban/suburban areas). They are also more likely to say that no post-call days are a barrier (24% small town/rural and 30% isolated/remote vs. 15% urban/suburban areas) (not shown in table).

	Lack of time	Heavy workload and/or stressful work environment	Scheduling	Shiftwork	No barriers
GENDER					
Men	57%	53%	51%	17%	17%
Women	69%	64%	59%	20%	7%
AGE					
<35	79%	71%	73%	32%	2%
35 to 54	71%	66%	60%	21%	5%
55+	48%	46%	43%	10%	23%
AREA OF PRACTICE					
General practitioner	65%	60%	54%	15%	12%
Medical specialist	65%	61%	57%	26%	8%
Surgical specialist	64%	62%	63%	20%	14%
Other/Admin	59%	51%	53%	11%	16%

	Lack of time	Heavy workload and/or stressful work environment	Scheduling	Shiftwork	No barriers
YEARS IN PRACTICE					
5 or less	75%	70%	58%	23%	3%
6 to 10	77%	68%	63%	24%	3%
11 to 20	69%	66%	62%	23%	5%
21 to 30	60%	59%	52%	14%	13%
Over 30	44%	39%	37%	8%	28%
COMMUNITY SIZE					
Urban/suburban	64%	59%	54%	17%	11%
Small town/rural	66%	62%	60%	27%	10%
Isolated/remote	63%	63%	66%	25%	6%

Table 25. Main barriers to a healthy lifestyle (greater than 50%) by gender, age, area of practice, years in practice and community size.

SOCIAL SUPPORT

Seven in 10 respondents score “high” on perceived level of support.

For measuring social support, the Multidimensional Scale of Perceived Social Support (MSPSS) was used.¹³ A majority of respondents score “high” on the MSPSS; one-quarter score “medium” and only 3% score “low” on social support. There is no significant difference between practising physicians and medical residents.

MULTIDIMENSIONAL SCALE OF PERCEIVED SOCIAL SUPPORT (MSPSS)

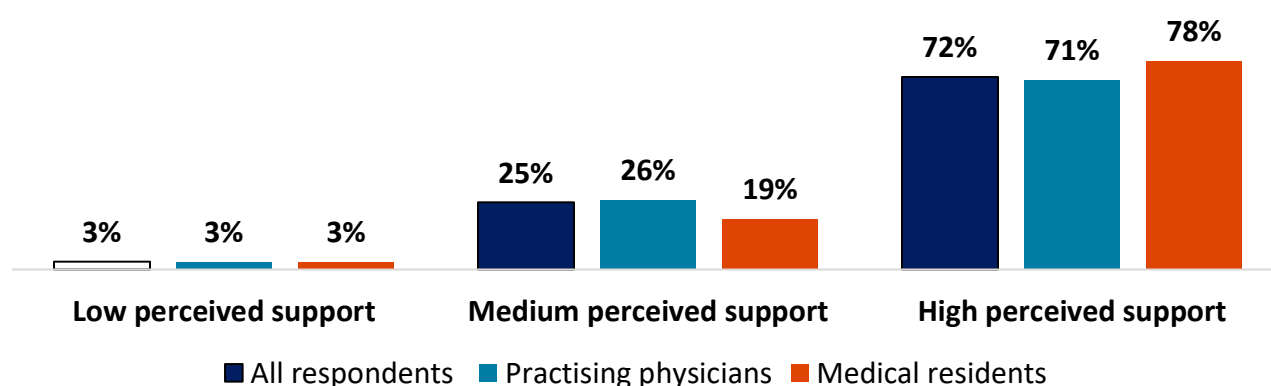


Figure 14. Scoring for Multidimensional Scale of Perceived Social Support (MSPSS) by practising physician and resident groups. Base: All respondents (n = 3864), practising physicians (n = 3489), medical residents (n = 375).

¹³ The MSPSS measure accounts for social support received from family, a significant other and friends. To calculate total MSPSS score, scores across all 12 items in question 65 were summed together (those indicating “don’t know” or refusing to answer for any of the 12 items were excluded). Those with an MSPSS score of 12–35 were classified as “low,” 36–60 as “medium” and 61–84 as “high” perceived social support.

By gender, age, area of practice, years in practice and community size

Younger physicians (<35 years old) (**80%***) are *significantly* more likely to have a “high” degree of social support compared with those 35 to 54 years old (**69%***).

There are no statistically significant differences when it comes to gender, area of practice, years in practice and community size.

	Low social support	Medium social support	High social support
GENDER			
Men	3%	25%	72%
Women	3%	25%	72%
AGE			
<35	2%	18%	80%*
35 to 54	3%	28%	69%*
55+	4%	24%	72%
AREA OF PRACTICE			
General practitioner	3%	24%	74%
Medical specialist	4%	25%	71%
Surgical specialist	3%	24%	73%
Other/Admin	3%	28%	69%
YEARS IN PRACTICE			
5 or less	3%	22%	75%
6 to 10	3%	27%	69%
11 to 20	3%	30%	66%
21 to 30	4%	25%	71%
Over 30	3%	22%	75%
COMMUNITY SIZE			
Urban/suburban	3%	26%	71%
Small town/rural	4%	23%	73%
Isolated/remote	5%	28%	67%

Table 26. Multidimensional Scale of Perceived Social Support (MSPSS) by gender, age, area of practice, years in practice and community size.

****** Statistically significant using chi-square test of independence. See Appendix B for more details.

Social support was also measured using a single self-reported item in the survey using a five-point scale: “How often do you feel supported by your social network?” Seventeen percent indicate they “always” feel supported, 45% “very often,” 30% “sometimes” and 8% “rarely/never.” High social support (62%; 17% always + 45% very often) is slightly lower for this self-reported question compared with the MSPSS (72% high perceived support).

PRIMARY CARE PHYSICIAN

Eight in 10 respondents have a regular primary care provider.

Seventy-nine percent of respondents indicate they have a regular primary care physician (PCP). Medical residents are *significantly* less likely to have a PCP (66%*) compared with practising physicians (81%).

HAVE A REGULAR PRIMARY CARE PHYSICIAN

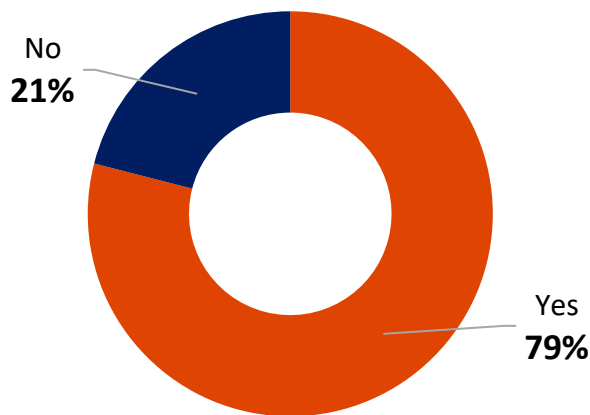


Figure 15. Responses to question 30. Do you have a regular primary care physician (i.e., registered)?
Base: All respondents (n = 3864).

By gender, age, area of practice, years in practice and community size

- Men are *significantly* less likely to say they have a family physician (77%* vs. 80% women).
- Younger respondents (<35 years old) (67%*) are *significantly* less likely to have a regular family physician compared with 85%* of those 55 and older.
- Physicians with over 30 years in practice (86%*) are *significantly* more likely to have a family physician than those with five or less years in practice years (74%*).
- Respondents practising in isolated/remote communities are *significantly* less likely to have a family physician (64%* vs. 81%* in urban/suburban areas).

	% Have a primary care physician		% Have a primary care physician
GENDER		YEARS IN PRACTICE	
Men	77%*	5 or less	74%*
Women	80%	6 to 10	78%
AGE		11 to 20	77%
<35	67%*	21 to 30	82%
35 to 54	79%	Over 30	86%*
55+	85%*	COMMUNITY SIZE	
AREA OF PRACTICE		Urban/suburban	81%*
General practitioner	77%	Small town/rural	78%
Medical specialist	81%	Isolated/remote	64%*
Surgical specialist	78%		
Other/Admin	80%		

Table 27. Have a regular primary care physician by gender, age, area of practice, years in practice and community size.

*** Statistically significant using chi-square test of independence. See Appendix B for more details.

WORKPLACE WELLNESS SUPPORTS

Less than six in 10 respondents say their current workplace offers wellness support offerings.

Psychological supports and/or peer support programs (33%) and back-up call for urgent life matters (21%) are the most commonly reported wellness supports offered by workplaces.

Overall, 75%* of medical residents say their current workplace offers at least one wellness support, *significantly* higher than practising physicians (54%). Medical residents have more access to psychological supports (58% vs. 30% of practising physicians), exercise facilities (15% vs. 11%) and other wellness-related activities and/or incentives (11% vs. 6%), and interestingly, also access to primary care physicians, although the proportion is relatively low (17% vs. 8%).

WELLNESS SUPPORT OFFERINGS AT CURRENT WORKPLACE

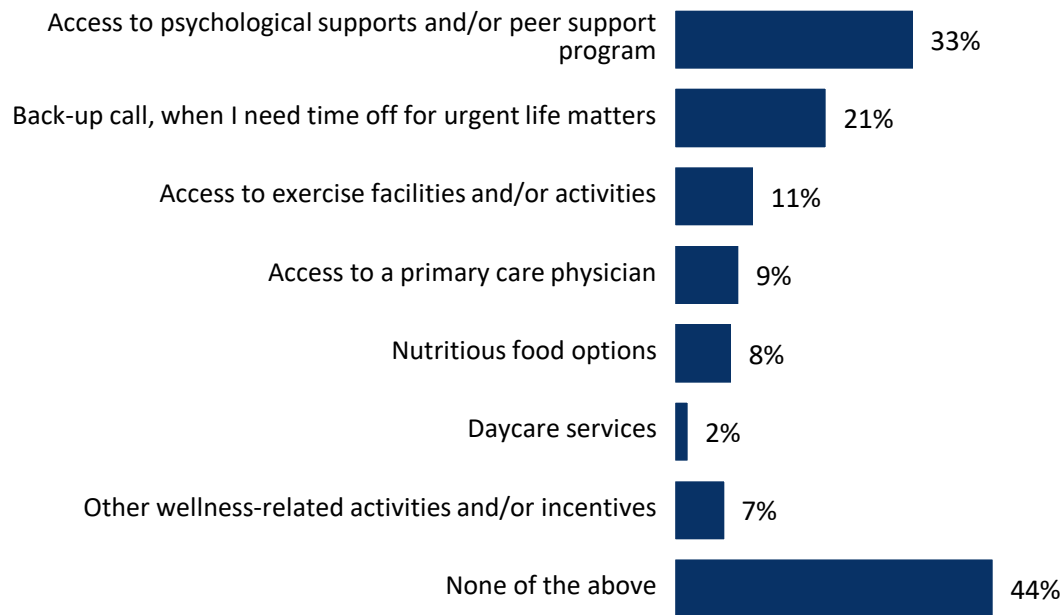


Figure 16. Responses to question 40. Which of the following does your current workplace offer to support your wellness (if any)? Base: All respondents (n = 3864).

By gender, age, area of practice, years in practice and community size

Respondents who are over 35 years are *significantly* less likely than their younger counterparts to say they have access to wellness supports offered by their current workplace (**55%*** among those 35–54 years and **54%*** among those 55+ years vs. 62% of those under 35 years).

General practitioners are *significantly* less likely than medical specialists to say their current workplace offers any wellness supports (**49%*** vs. **61%***, respectively).

Those practising in small town/rural (**51%***) or isolated/remote areas (**45%***) are *significantly* less likely than those in urban/suburban communities (57%) to report that their current workplace offers wellness supports.

There are no statistically significant differences in workplace wellness supports when it comes to gender or years in practice.

	% Indicating current workplace has wellness supports		% Indicating current workplace has wellness supports
GENDER		YEARS IN PRACTICE	
Men	54%	5 or less	53%
Women	57%	6 to 10	56%
AGE		11 to 20	52%
<35	62%	21 to 30	56%
35 to 54	55%*	Over 30	52%
55+	54%*	COMMUNITY SIZE	
AREA OF PRACTICE		Urban/suburban	57%
General practitioner	49%*	Small town/rural	51%*
Medical specialist	61%*	Isolated/remote	45%*
Surgical specialist	55%		
Other/Admin	63%		

Table 28. Availability of wellness supports by gender, age, area of practice, years in practice and community size.

* * Statistically significant using chi-square test of independence. See Appendix B for more details.

WELLNESS SUPPORTS ACCESSED IN PAST FIVE YEARS

When asked about the type of wellness supports (including mental health and crisis supports) accessed in the past five years, almost half of respondents say they have not accessed any.

One-third (32%) of respondents say they have accessed their primary care physician, one-quarter have accessed a mental health professional (psychiatrist, psychologist, licensed counsellor, etc.), 15% have accessed their Provincial Physician Health Program (PHP) and 12% have accessed mentorship or coaching.

Forty-six percent have **not** accessed any wellness supports. This is *significantly* higher among practising physicians **47%*** vs. 37% of medical residents.

WELLNESS SUPPORTS ACCESSED IN PAST FIVE YEARS

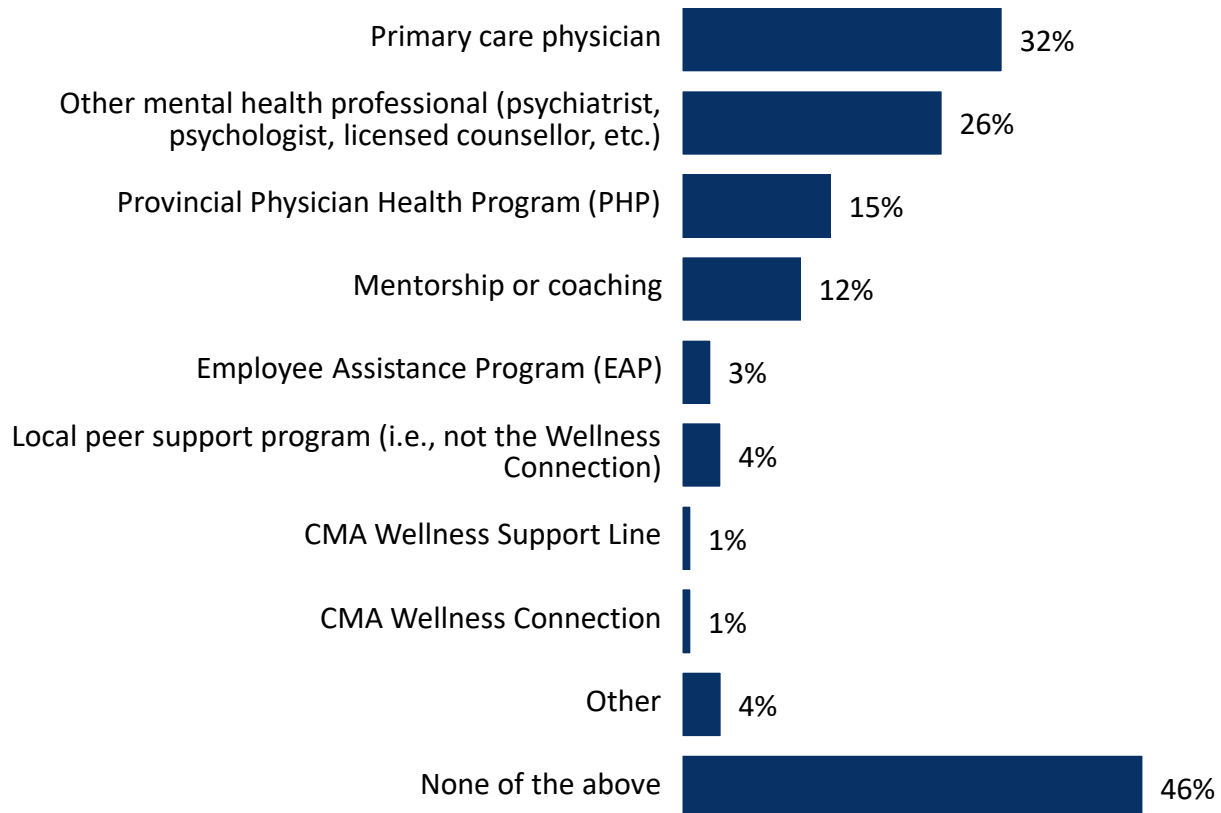


Figure 17. Responses to question 58. In the last five years, have you accessed any of the following wellness supports (including mental health and crisis supports)? Select all that apply. Base: All respondents (n = 3864).

By gender, age, area of practice, years in practice and community size

Men are *significantly* more likely than women to say they have **not** accessed any wellness supports in the past five years (**58%*** vs. 38% among women).

Younger respondents are *significantly* less likely than older ones to say they have **not** accessed any of these resources (**40%*** of those under 54 years old vs. 57% of those 55+ years).

Generally, physicians practising 10 or less years (a factor also related to their age) are *significantly* more likely to access wellness supports (**63%*** of those practising five or less years and **62%*** of those practising six to 10 years).

Respondents working in urban/suburban areas are less likely to have accessed wellness supports in the past five years (53% vs. 58% in small town/rural and 63% in isolated/remote areas), although not significantly.

There are no statistically significant differences in accessing wellness supports by area of practice.

	Have accessed wellness supports in past five years	Have not accessed wellness supports in past five years		Have accessed wellness supports in past five years	Have not accessed wellness supports in past five years
GENDER			YEARS IN PRACTICE		
Men	42%*	58%*	5 or less	63%*	37%*
Women	62%	38%	6 to 10	62%*	38%*
AGE			11 to 20	59%	41%
<35	60%*	40%*	21 to 30	51%	49%
35 to 54	60%*	40%*	Over 30	41%*	59%*
55+	43%	57%	COMMUNITY SIZE		
AREA OF PRACTICE			Urban/suburban	53%	47%
General practitioner	56%	44%	Small town/rural	58%	42%
Medical specialist	56%	44%	Isolated/remote	63%	37%
Surgical specialist	46%	54%			
Other/Admin	50%	50%			

Table 29. Accessed wellness supports in the past five years by gender, age, area of practice, years in practice and community size.

*** Statistically significant using chi-square test of independence. See Appendix B for more details.

POSSIBLE REASONS FOR NOT SEEKING WELLNESS SUPPORT

When respondents were asked what may prevent some physicians from seeking wellness supports, having no time and believing the situation is not severe enough were identified as the two largest barriers, followed by being ashamed to seek help.

Having no time (55%; higher among medical residents at 75%), believing the situation is not severe enough (55%) and being ashamed to seek help (47%) are perceived as the main barriers to seeking wellness supports.

Three in 10 cite confidentiality as a barrier (higher among practising physicians at 30% vs. 24% among medical residents), while 21% believe risk of losing medical licence and ability to practise (higher among practising physicians at 22% vs. 16% among medical residents) could prevent physicians and medical residents from looking for wellness support. Twenty-one percent indicate other professional consequences (fewer career advancement opportunities, denied insurance, etc.) as a possible barrier (30% of medical residents compared with 20% of practising physicians). One in five (19%) cite lack of awareness of available services as a barrier.

POSSIBLE REASONS PHYSICIANS NOT SEEKING WELLNESS SUPPORT

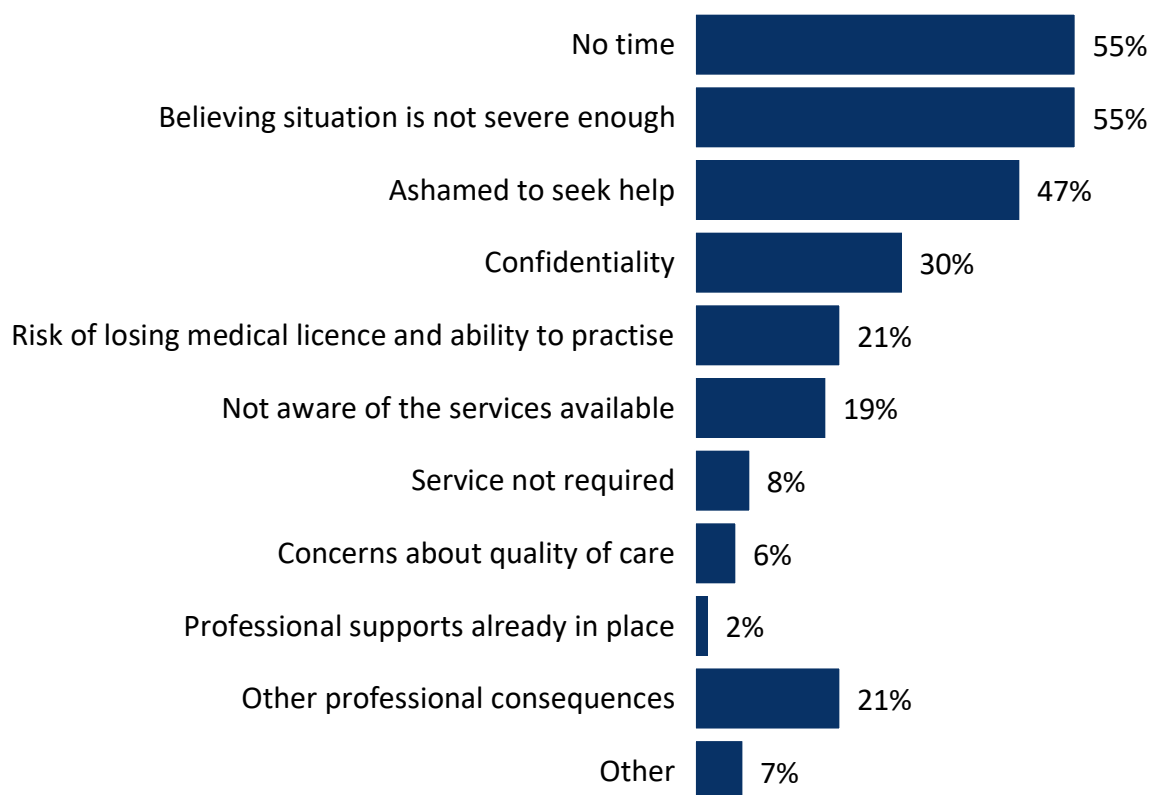


Figure 18. Responses to question 60. Some physicians may access resources for wellness supports (including mental health), while others manage in other ways when needed. What do you think are the main reasons some physicians may have for NOT seeking wellness supports (including mental health)? Select up to three reasons. Base: All respondents (n = 3864).

By gender, age, area of practice, years in practice and community size

Men are more likely than women to say that one of the main reasons physicians are reluctant to seek help is shame (51% vs. 44%). Women are more likely to cite a lack of time (61% vs. 45%), believing the situation is not severe enough (56% vs. 52%) and confidentiality (31% vs. 27%).

Younger respondents (<35 years old) are less likely to think that confidentiality is a barrier to seeking help (24%), and physicians 55+ years old (39%) are less likely to think a lack of time is a barrier.

Relatedly, physicians with over 30 years in practice are significantly less likely to say that a lack of time is a barrier (and are more likely to name being ashamed to seek help as a barrier).

General practitioners and medical specialists are more likely than surgical specialists and those working in other specialties/admin to think that a lack of time is an obstacle to seeking help.

Respondents practising in small town/rural and isolated/remote areas are more likely to think that confidentiality is a reason why physicians are reluctant to seek help (33% and 42%, respectively).

	No time	Believing situation is not severe enough	Ashamed to seek help	Confidentiality
GENDER				
Men	45%	52%	51%	27%
Women	61%	56%	44%	31%
AGE				
<35	73%	58%	47%	24%
35 to 54	60%	52%	44%	30%
55+	39%	57%	50%	32%
AREA OF PRACTICE				
General practitioner	58%	56%	48%	27%
Medical specialist	55%	54%	46%	31%
Surgical specialist	51%	53%	43%	34%
Other/Admin	49%	56%	48%	28%
YEARS IN PRACTICE				
5 or less	66%	55%	43%	30%
6 to 10	66%	53%	42%	29%
11 to 20	57%	54%	44%	28%
21 to 30	52%	52%	50%	32%
Over 30	34%	58%	50%	31%
COMMUNITY SIZE				
Urban/suburban	55%	54%	46%	28%
Small town/rural	54%	55%	48%	33%
Isolated/remote	56%	51%	41%	42%

Table 30. Main possible reasons (greater than 25%) physicians not seeking wellness support by gender, age, area of practice, years in practice and community size.

To understand the extent to which different subgroups see issues around privacy and risks to practice, an index was created. Those who selected at least one of “confidentiality,” “risk of losing medical licence and ability to practise” and “other professional consequences” were classified as “high” on the Professional Consequences Index (PCI). Overall, half (51%) of respondents score high on the PCI. There is no significant difference between practising physicians and medical residents (52% each).

By gender, age, area of practice, years in practice and community size

Women are *significantly* more likely than men to score high on the PCI, being more likely to fear professional consequences (**54%*** vs. 48%, respectively).

Medical specialists are *significantly* more likely than general practitioners to score high on the PCI (**55%*** vs. **48%***, respectively).

There are no significant differences by respondents' age, years in practice and community size.

	Professional Consequences Index (PCI) % HIGH		Professional Consequences Index (PCI) % HIGH
GENDER		YEARS IN PRACTICE	
Men	48%	5 or less	55%
Women	54%*	6 to 10	49%
AGE		11 to 20	52%
<35	50%	21 to 30	52%
35 to 54	52%	Over 30	50%
55+	51%	COMMUNITY SIZE	
AREA OF PRACTICE		Urban/suburban	51%
General practitioner	48%*	Small town/rural	52%
Medical specialist	55%*	Isolated/remote	56%
Surgical specialist	53%		
Other/Admin	50%		

Table 31. Professional Consequences Index by gender, age, area of practice, years in practice and community size.

SUBSTANCE USE

Very small proportions of respondents report regular substance use in the past year. Among those who do, alcohol is consumed most regularly. Very few turn to cannabis or tobacco or to unauthorized use of stimulants, opioids, etc. Overall reported consumption in the past year among respondents is significantly lower than that of the employed general population in Canada.

Two in 10 respondents (20%) say they have consumed alcohol at *least monthly* in the past year and 4% have consumed cannabis at the same level of frequency. Only 1% of respondents report consuming tobacco *daily/almost daily or weekly*.

Medical residents are *significantly* more likely to have consumed alcohol at *least monthly* in the past year compared with practising physicians (30%* vs. 18%, respectively). Consumption is also *significantly* higher among men (22%* vs. 17% of women) and those under 55 years old (24% of those <35 years old and 21%* of those 35 to 54 years old vs. 14% of those 55 years and older).

Similarly, medical residents are *significantly* more likely to have consumed cannabis *at least monthly* compared with practising physicians (9%* vs. 4%, respectively).

	AT LEAST MONTHLY IN THE PAST YEAR NET	Daily/almost daily or weekly	Monthly	Once or twice a year	Never
Alcohol (for men, five or more drinks in a day; for women, four or more drinks in a day)	20%	9%	11%	23%	58%
Cannabis (recreationally)	4%	2%	2%	10%	86%
Tobacco products	2%	1%	1%	3%	96%

Table 32. Responses to question 49. In the past year, how many times have you used the following substances for non-medical reasons? Note: Totals may not add up to 100% because of rounding. Base: All respondents consenting to the collection of sensitive data on suicidal ideation and substance use (n = 3750).

The CMA conducted a comparator survey among employed Canadians (excluding physicians and medical learners) that included many of the same measures at the same time the NPHS 2021 was fielded.¹⁴ This allows for direct comparison between respondents in the 2021 NPHS and the employed general population. When compared with the employed Canadian population, physicians and resident respondents of this survey are significantly less likely to report turning to substances in general: 34% of employed Canadians consumed alcohol and 29% consumed cannabis at *least monthly* in the past year; 24% smoked tobacco *daily/almost daily or weekly*.

¹⁴ Results from the same question asked among the general population (employed or currently in graduate school), Employed Canadian Population Comparator Survey. Fielded November 26 to December 10, 2021, via an online non-probability panel. A full report comparing the NPHS 2021 data with the Employed Canadians Survey dataset is forthcoming.

Very few respondents report having ever used other substances in the past year:

- One percent have ever taken stimulants (unauthorized, e.g., Ritalin, Dexedrine, Adderall, Vyvanse) vs. 13% of the employed general population.
- One percent have ever taken opioids (unauthorized) vs. 11% of the employed general population.
- Three percent have ever taken another substance (e.g., narcotics, benzodiazepine, cocaine, mushrooms) vs. 17% of the employed general population.

	EVER CONSUMED IN THE PAST YEAR NET	Daily/almost daily or weekly	Monthly	Once or twice a year	Never
Stimulants (unauthorized, e.g., Ritalin, Dexedrine, Adderall, Vyvanse)	1%	*	*	1%	99%
Opioids (unauthorized)	1%	*	*	1%	99%
Other (e.g., narcotics, benzodiazepine, cocaine, mushrooms)	3%	*	*	3%	97%

Table 33. Responses to question 49. In the past year, how many times have you used the following substances for non-medical reasons? Note: Totals may not add up to 100% because of rounding. Base: All respondents consenting to the collection of sensitive data on suicidal ideation and substance use (n = 3750).

*Less than 10 respondents

Section 4: Occupational factors

JOB SATISFACTION AND JOB-RELATED STRESS

Six in 10 respondents say they are satisfied with their job or training position, but they also say they feel a great deal of stress because of it.

Six in 10 (59%) agree or strongly agree that they are satisfied with their current job or training position and just over half (56%) agree or strongly agree that their professional values are aligned with those of their department or academic leaders. However, a similar proportion also agree or strongly agree that they feel a great deal of stress because of their job or training position (57%).

Medical residents are more likely to be satisfied with their job (64%* vs. 59% of practising physicians) and to agree or strongly agree that their professional values are aligned with those of their department or academic leaders (61%* vs. 54% of practising physicians). However, they are also more likely to agree or strongly agree that they feel stress from their job (66%* vs. 56% of practising physicians).

JOB SATISFACTION AND JOB-RELATED STRESS

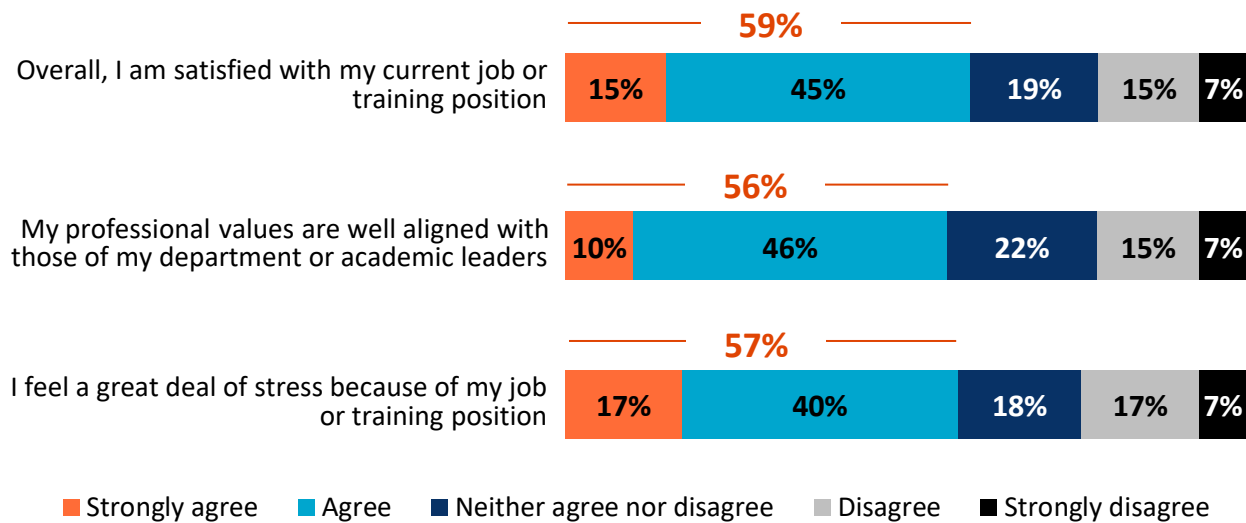


Figure 19. Responses to question 43, part of Mini-Z scale. To what extent do you agree or disagree with the following statements? Base: All respondents excluding not applicable for each statement: Overall I am satisfied with my job or training position (n = 3859); My professional values are well aligned with those of my department or academic leaders (n = 3699); I feel a great deal of stress because of my job/training position (n = 3840).

By gender, age, area of practice, years in practice and community size

Women are *significantly* less likely to be satisfied with their job or training position (**55%*** vs. 67% men) and less likely to feel their professional values are well aligned with those of their department or academic leaders (**53%*** vs. 59% men). They are *significantly* more likely to feel a great deal of stress because of their job (**64%*** vs 46% men).

Respondents aged 35 to 54 years are *significantly* less likely to be satisfied with their jobs (**53%*** vs. **66%*** of those aged 55+ years) and less likely to feel their professional values are well aligned with those of their department or academic leaders (**50%***). Those under 55 years of age are *significantly* more likely to feel a great deal of stress because of their job or training position (**66%*** for each of <35 years and 35 to 54 years vs. 41% of those 55 and older).

General practitioners, medical specialists and surgical specialists are *significantly* less likely to be satisfied with their jobs (**57%***, **61%*** and **54%***, respectively) than those in other specialties/administration positions (67%).

Physicians practising 11 to 20 years are *significantly* less likely to agree they are satisfied with their jobs (**52%*** vs. **70%*** of those practising for over 30 years). Those with over 30 years are also the least likely to say they feel a great deal of stress because of their job (**35%***).

Respondents practising in urban/suburban and small town/rural areas are *significantly* more likely to agree or strongly agree that their values are well aligned with those of their department or academic leaders (**56%*** and **54%*** respectively vs. 37% in isolated areas).

% "Strongly agree" + "Agree"	Satisfaction with current job or training position	My professional values are well aligned with those of my department or academic leaders	I feel a great deal of stress because of my job or training position
GENDER			
Men	67%	59%	46%
Women	55%*	53%*	64%*
AGE			
<35	63%	61%*	66%*
35 to 54	53%*	50%*	66%*
55+	66%*	59%*	41%
AREA OF PRACTICE			
General practitioner	57%*	56%	59%*
Medical specialist	61%*	56%	57%*
Surgical specialist	54%*	49%	59%*
Other/Admin	67%	56%	47%

% "Strongly agree" + "Agree"	Satisfaction with current job or training position	My professional values are well aligned with those of my department or academic leaders	I feel a great deal of stress because of my job or training position
YEARS IN PRACTICE			
5 or less	59%	53%	68%*
6 to 10	53%	50%	70%*
11 to 20	52%*	49%	64%*
21 to 30	58%	55%	56%*
Over 30	70%*	62%*	35%
COMMUNITY SIZE			
Urban/suburban	61%	56%*	56%
Small town/rural	57%	54%*	59%
Isolated/remote	51%	37%	64%

Table 34. Agreement with statements in question 43 by gender, age, area of practice, years in practice and community size.

*** Statistically significant using chi-squared test of independence. See Appendix B for more details.

CONTROL OVER WORKLOAD

Almost half of respondents consider the control they have over their workload to be poor or marginal.

Almost half of respondents claim to have a low level of control over their workload (46%: 15% poor control and 31% marginal control). Only 26% feel that their control over their workload is good or optimal.

Medical residents are *significantly* more likely to feel that their control over their workload is poor or marginal (64%* vs. 45% of practising physicians).

CONTROL OVER WORKLOAD

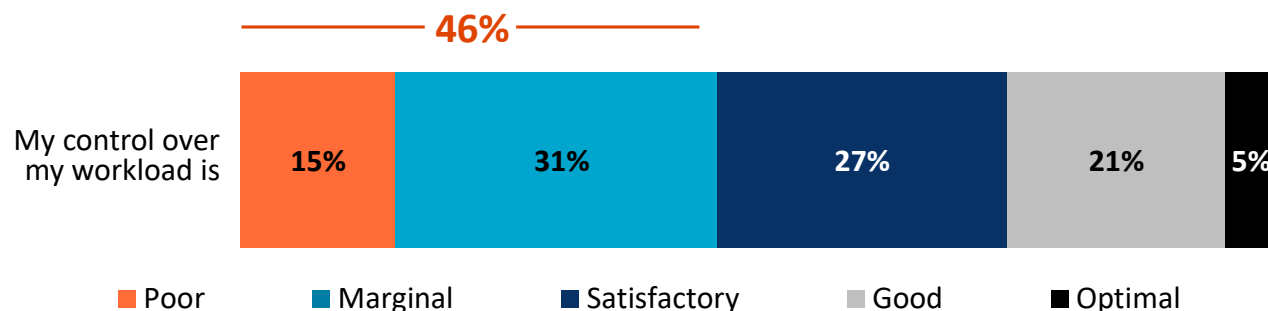


Figure 20. Responses to question 45, part of Mini-Z survey. How would you rate the following? Base: All respondents excluding not applicable for each statement: Sufficiency of time for documentation is (n = 3768); My control over my workload is (n = 3849); The degree to which my care team works efficiently together is (n = 3726).

By gender, age, area of practice, years in practice and community size

Women are more likely to say they have poor or marginal control over their workload (**51%*** vs. men 39%).

A greater percentage of those under 55 years of age say they have poor or marginal control compared with those who are older (**52%*** of those <35, **51%*** of those 35 to 54 vs. **38%*** of those 55+).

Years in practice also interacts with workload, with those practising 11 to 20 years *significantly* more likely (**53%***) to report poor or marginal control compared with those with over 30 years of practice (**33%***).

There is no significant difference by community size, but those in an isolated/remote area (56%) show a higher skew toward selecting poor or marginal control over workload compared with those practising in other areas (45% in small town/rural and 46% in urban/suburban areas).

	Control over workload % poor/marginal		Control over workload % poor/marginal
GENDER		YEARS IN PRACTICE	
Men	39%	5 or less	45%
Women	51%*	6 to 10	48%
AGE		11 to 20	53%*
<35	52%*	21 to 30	48%
35 to 54	51%*	Over 30	33%*
55+	38%	COMMUNITY SIZE	
AREA OF PRACTICE		Urban/suburban	46%
General practitioner	45%	Small town/rural	45%
Medical specialist	49%	Isolated/remote	56%
Surgical specialist	45%		
Other/Admin	43%		

Table 35. Poor + marginal control over workload by gender, age, area of practice, years in practice and community size.

****** Statistically significant using chi-square test of independence. See Appendix B for more details.

WORK–LIFE INTEGRATION

Half of respondents say they are dissatisfied with work–life integration.

Half of respondents (51%: 10% very dissatisfied and 41% dissatisfied) say they are dissatisfied with their work–life integration (i.e., meeting personal and professional obligations).

Medical residents are *significantly* more likely to say they are very dissatisfied/dissatisfied with their work–life integration (**56%*** vs. 50% of practising physicians).

WORK–LIFE INTEGRATION

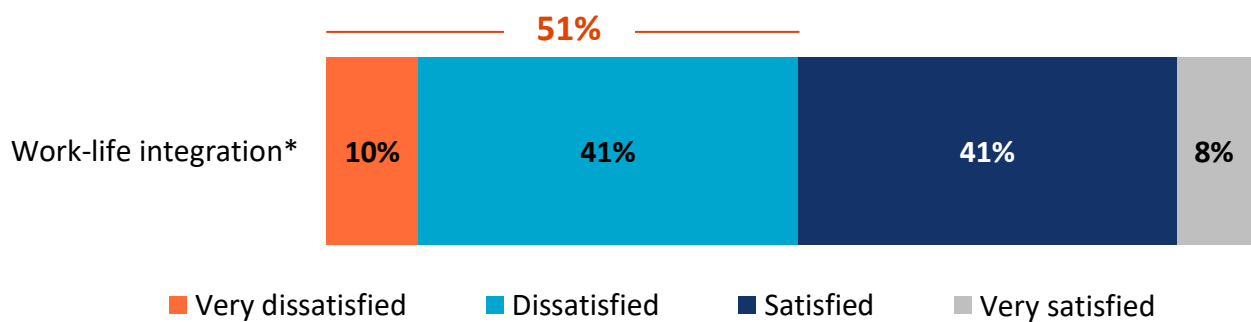


Figure 21. Responses to question 45aa. Please rate your degree of satisfaction with each of the following dimensions of your workplace. Base: Total answering: work–life integration (n = 3847) and efficiency and resources (n = 3626).

**i.e., meeting personal and professional obligations*

By gender, age, area of practice, years in practice and community size

Women are *significantly* more likely to be dissatisfied with their work–life integration (**56%*** vs. 43% among men).

Respondents aged 35 to 54 years are *significantly* more likely than those aged 55+ years to say they are dissatisfied with their work–life integration (**59%*** vs. **40%***, respectively).

Respondents practising as General Practitioners (**52%***), Medical Specialists (**51%***), and Surgical Specialists (**54%***) are *significantly* more likely than other/administration positions to be dissatisfied (42%).

Physicians practising from six to 10 years and 11 to 20 years are *significantly* more likely to be dissatisfied with work–life integration (**62%*** and **60%***, respectively, vs. **33%*** those with over 30 years in practice).

There is no significant difference by community size.

	Work life integration % very dissatisfied or dissatisfied		Work life integration % very dissatisfied or dissatisfied
GENDER		YEARS IN PRACTICE	
Men	43%	5 or less	54%
Women	56%*	6 to 10	62%*
AGE		11 to 20	60%*
<35	52%	21 to 30	51%
35 to 54	59%*	Over 30	33%*
55+	40%*	COMMUNITY SIZE	
AREA OF PRACTICE		Urban/suburban	51%
General practitioner	52%*	Small town/rural	51%
Medical specialist	51%*	Isolated/remote	59%
Surgical specialist	54%*		
Other/Admin	42%		

Table 36. Dissatisfied + very dissatisfied with each statement by gender, age, area of practice, years in practice and community size.

*** Statistically significant using chi-square test of independence. See Appendix B for more details.

EFFICIENCY AND RESOURCES

Six in 10 respondents say they are dissatisfied with efficiency and resources

Fifty-nine percent say they are dissatisfied (18% very dissatisfied, 41% dissatisfied) with efficiency and resources at work (e.g., use of scribes, availability of support staff, efficiency/use of EHR, appointment system and ordering systems). Practising physicians are *significantly* more likely to be dissatisfied with efficiency and resources (60%* compared with 52% of medical residents).

EFFICIENCY AND RESOURCES

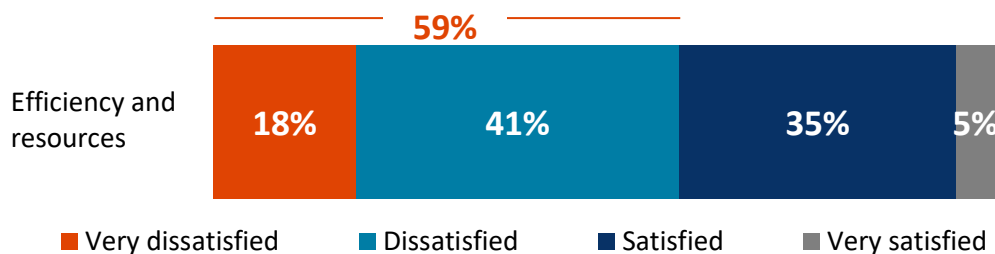


Figure 22. Responses to question 45aa. Please rate your degree of satisfaction with each of the following dimensions of your workplace. Base: Total answering: efficiency and resources (n = 3626).

By gender, age, area of practice, years in practice and community size

Women are *significantly* more likely to be dissatisfied with the efficiency and resources available in their workplace (**65%*** vs. 51% of men).

Respondents aged 35 to 54 years are *significantly* more likely than older age groups to say they are dissatisfied with efficiency and resources (**68%*** vs. **49%*** of those aged 55+ years).

Physicians practising six to 10 years and 11 to 20 years are *significantly* more likely to be dissatisfied with efficiency and resources (**72%*** and **69%***, respectively) than those more tenured (**46%*** of those practising 30 or more years in practice).

Those in urban/suburban areas (**59%***) and in small town/rural communities (**58%***) are *significantly* less likely to be dissatisfied with efficiency and resources compared with those in isolated communities (87%).

	Efficiency and resources % very dissatisfied or dissatisfied		Efficiency and resources % very dissatisfied or dissatisfied
GENDER		YEARS IN PRACTICE	
Men	51%	5 or less	63%
Women	65%*	6 to 10	72%*
AGE		11 to 20	69%*
<35	58%	21 to 30	57%
35 to 54	68%*	Over 30	46%*
55+	49%*	COMMUNITY SIZE	
AREA OF PRACTICE		Urban/suburban	59%*
General practitioner	57%	Small town/rural	58%*
Medical specialist	61%	Isolated/remote	87%
Surgical specialist	58%		
Other/Admin	61%		

Table 37. Dissatisfied + very dissatisfied with each statement by gender, age, area of practice, years in practice and community size.

**** Statistically significant using chi-square test of independence. See Appendix B for more details.**

ADMINISTRATIVE BURDEN: ELECTRONIC MEDICAL RECORDS (EMR)

Time spent on the EMR at home is seen as excessive or moderately high among half of respondents.

Half (49%) of respondents feel that the amount of time they spend on the EMR at home is “excessive” or “moderately high;” this is higher among practising physicians (50% vs. 43% of medical residents).

TIME SPENT ON EMR AT HOME

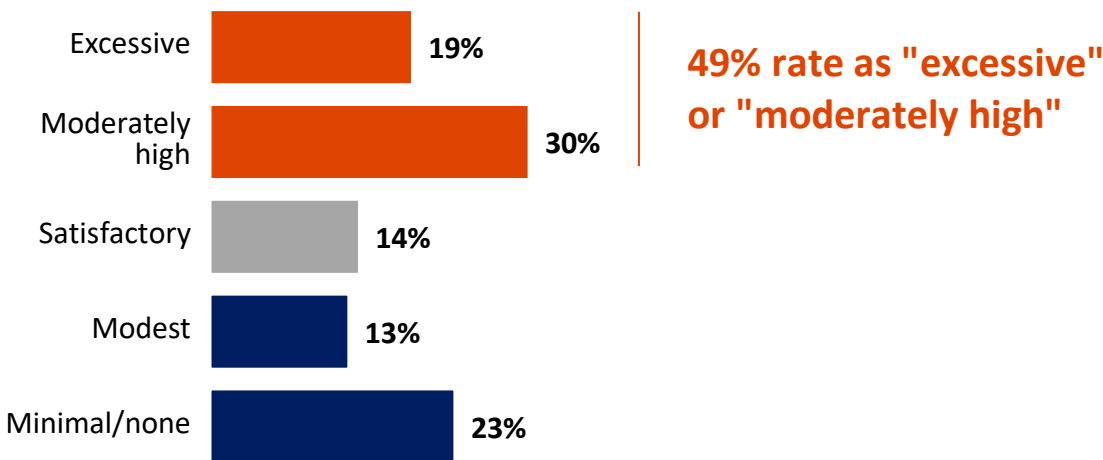


Figure 23. Responses to question 45a (part of Mini-Z scale). Please complete the following statement:
Base: All respondents excluding not applicable (n = 3306).

By gender, age, area of practice, years in practice and community size

Women are *significantly* more likely to feel that the time they spend on the EMR at home is “excessive” or “moderately high” (54%* vs. 41% of men).

General practitioners are *significantly* more likely to say the time they spend on the EMR at home is “excessive” or “moderately high” (61%* vs. 40%* of medical specialists, 39% of surgical specialists and 41% other/admin).

There are no significant differences by age or community size.

	My professional time spent on EMR at home % Rated “excessive” or “moderately high”		My professional time spent on EMR at home % Rated “excessive” or “moderately high”
GENDER		YEARS IN PRACTICE	
Men	41%	5 or less	58%*
Women	54%*	6 to 10	50%*
AGE		11 to 20	49%*
<35	48%	21 to 30	54%*
35 to 54	52%	Over 30	43%
55+	46%	COMMUNITY SIZE	
AREA OF PRACTICE		Urban/suburban	49%
General practitioner	61%*	Small town/rural	50%
Medical specialist	40%*	Isolated/remote	51%
Surgical specialist	39%		
Other/Admin	41%		

Table 38. Rated excessive or moderately high in question 45a by gender, age, area of practice, years in practice and community size.

*** Statistically significant using chi-square test of independence. See Appendix B for more details.

WORK HOURS

Physicians work more hours in an average week than the average Canadian employee.

Overall, respondents work on average 53.7 hours a week (total hours combined including patient care, administrative tasks and other duties/responsibilities).¹⁵ Practising physicians average about 52.4 hours of work a week: they spend, on average, about 35.5 hours a week on patient care, 10.0 hours on administrative tasks and 6.9 hours on other duties. Medical residents average about 65.9↑ hours of work a week, typically spending more time than practising physicians on patient care (48.0↑ hours a week, on average); their hours are similar to those of practising physicians on administrative tasks (10.2 hours) and other duties (7.8 hours).

¹⁵ Combined total hours for each of the following: 1) Patient care (including direct patient care, indirect patient care, and on-call work hours); 2) Administrative tasks (including electronic documentation time, email, prescriptions, ordering tests, etc.); 3) Other duties/responsibilities: Including teaching, committee work, research, leadership role, etc.

	All respondents	Practising physicians	Medical residents
	Mean hours	Mean hours	Mean hours
Patient care	36.7	35.5	48.0 ↑
Admin	10.0	10.0	10.2
Other duties	7.0	6.9	7.8
Total average	53.7	52.4	65.9 ↑

Table 39. Average hours worked by type of work, by practising physicians vs. medical residents.

↑↓ = significantly higher/lower than other subgroup(s). T-test for statistical significance used (95% confidence interval).

By gender, age, area of practice, years in practice and community size

Women put *significantly* more hours into administrative tasks than men (average **10.6↑** vs. 9.0) (probably because women are more likely to be general practitioners). On average, total hours spent by men and women are roughly similar (52.9 and 54.1 hours, respectively).

Surgical specialists are *significantly* more likely to be working a greater number of hours in a typical week compared with other types of physicians (**61.6↑** hours on average); they spend *significantly* more time on patient care (**46.3↑** hours compared with the average of 35.5 hours) specifically. General practitioners and physicians working in other/administration positions are spending more time, on average, on administrative tasks (**10.9↑** and **11.2↑** hours, respectively, compared with the average of 10 hours).

Physicians with over 30 years in practice are spending significantly less time working on average (**45.2↓** hours) than physicians practising less than 20 years (55.5 hours an average a week).

Respondents practising in isolated/remote and small town/rural communities work more hours on average per week (**59↑** and **55.6↑** hours, respectively, vs. 52.9 hours in urban/suburban areas), spending significantly more time on patient care and administrative tasks.

	Patient care	Administrative tasks	Other duties	Average # of hours worked
GENDER				
Men	37	9	6.9	52.9
Women	36.5	10.6 ↑	7.0	54.1
AREA OF PRACTICE				
General practitioner	36.1 ↓	10.9 ↑	4.9 ↓	51.8 ↓
Medical specialist	36.3	8.8	8.3	53.4
Surgical specialist	46.3 ↑	8.7	6.5	61.6 ↑
Other/Admin	32.9	11.2 ↑	10.3 ↑	54.4

	Patient care	Administrative tasks	Other duties	Average # of hours worked
YEARS IN PRACTICE				
5 or less	39	11.8 ↑	4.8 ↓	55.7
6 to 10	37.8	10.6	7	55.4
11 to 20	37.5	10.5	7.6 ↑	55.5
21 to 30	35.4	9.9	8.4 ↑	53.6
Over 30	30.9 ↓	8.3 ↓	6.0 ↓	45.2 ↓
COMMUNITY SIZE				
Urban/suburban	35.9	9.6	7.4 ↑	52.9
Small town/rural	40.7 ↑	10.3 ↑	4.6	55.6 ↑
Isolated/remote	40.8 ↑	12.0 ↑	6.2 ↑	59 ↑

Table 40. Average hours worked by gender, area of practice, years in practice and community size.

↑↓ = significantly higher/lower than other subgroup(s). T-test for statistical significance used (95% confidence interval).

ATMOSPHERE IN PRIMARY WORK AREA

Work environment is considered hectic or chaotic among four in 10 respondents.

Four in 10 respondents (39%) rate the atmosphere at their work as 1 or 2 on a scale of 1 to 5, where 1 is “hectic, chaotic,” 3 is “busy but reasonable” and 5 is “calm.” There is no difference between practising physicians and medical residents.

ATMOSPHERE IN PRIMARY WORK AREA

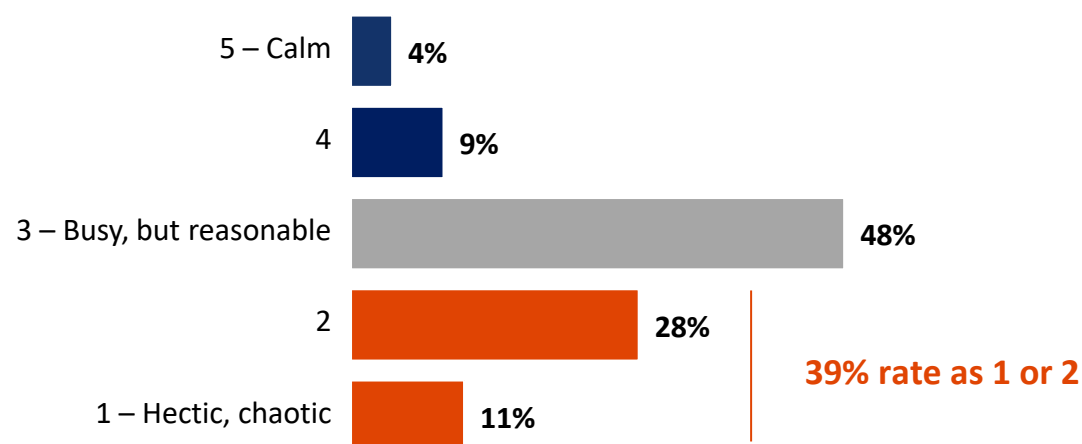


Figure 24. Responses to question 45b. Which number best describes the atmosphere in your primary work area?
Base: All respondents (n = 3864).

By gender, age, area of practice, years in practice and community size

Women are *significantly* more likely to rate their atmosphere at work as 1 or 2 on a scale of 1-hectic to 5-calm (**42%*** vs. 34% of men).

Respondents aged 35 to 54 years are *significantly* more likely to rate the atmosphere at their primary work area as 1 or 2 (**45%*** vs. **32%*** of those 55+ years old).

Medical specialists are *significantly* more likely than general practitioners to rate their atmosphere at work as 1 or 2 (**46%*** vs. **32%***, respectively).

Physicians practising between 11 and 20 years are *significantly* more likely to say their atmosphere at work as 1 or 2 (**46%*** vs. **29%*** of those who have been practising for more than 30 years).

Those working in larger urban/suburban areas and isolated/remote areas (**41%*** and **40%***, respectively) are *significantly* more likely to rate their workplace as 1 or 2 than those in small town/rural communities (32%).

	Atmosphere in primary work area % rated 1 or 2 hectic, chaotic		Atmosphere in primary work area % rated 1 or 2 hectic, chaotic
GENDER		YEARS IN PRACTICE	
Men	34%	5 or less	39%
Women	42%*	6 to 10	47%
AGE		11 to 20	46%*
<35	38%	21 to 30	38%
35 to 54	45%*	Over 30	29%*
55+	32%*	COMMUNITY SIZE	
AREA OF PRACTICE		Urban/suburban	41%*
General practitioner	32%*	Small town/rural	32%
Medical specialist	46%*	Isolated/remote	40%*
Surgical specialist	43%		
Other/Admin	38%		

Table 41. Atmosphere in primary work area by gender, age, area of practice, years in practice and community size.

**** Statistically significant using chi-square test of independence. See Appendix B for more details.**

PROFESSIONAL FULFILLMENT

One in five respondents score high on professional fulfillment.

Professional fulfillment is measured by the Professional Fulfillment Index, which includes question items on meaningfulness of work and contributing professionally in ways that are valued most, among others.¹⁶ Twenty-one percent of respondents score high on the Professional Fulfillment Index. The percentage of physicians with a high score was significantly greater among practising physicians (22%* vs. 14% of medical residents).

PROFESSIONAL FULFILLMENT INDEX

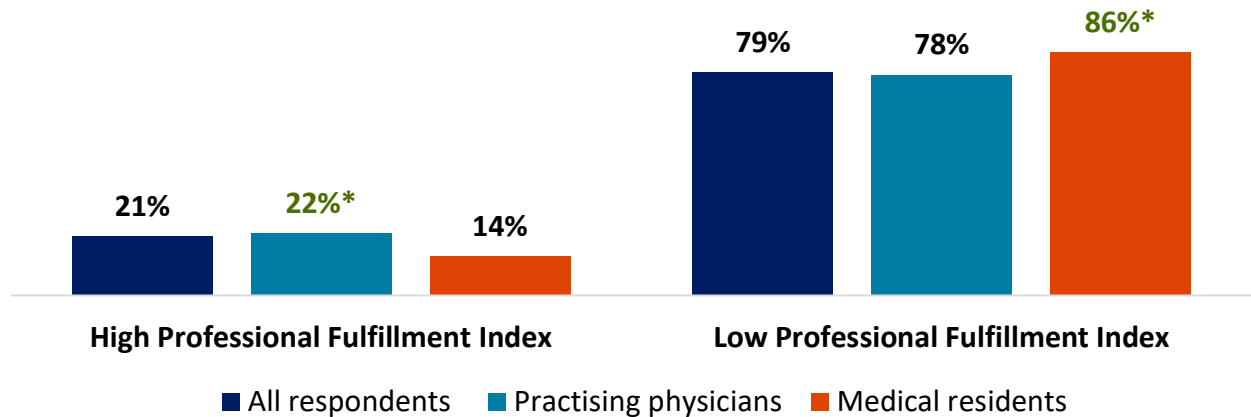


Figure 25. PROFESSIONAL FULFILLMENT INDEX. Dichotomous professional fulfillment subscale (6-item average) is recommended at an average item score cut-off point of >3.0. Base: All respondents, excluding those who did not agree to continue with the optional questions (n = 3864).

*** Statistically significant using chi-square test of independence. See Appendix B for more details.

¹⁶ The Professional Fulfillment Index (PFI) is measured using the dichotomous scale on the Professional Fulfillment subscale (6-item average). Items are scored 0 to 4 and treated as a continuous variable. Scale score is calculated by averaging the item scores. Dichotomous professional fulfillment is calculated at an average item score cut-point of >3.0.

By gender, age, area of practice, years in practice and community size

Men are *significantly* more likely to score “high” on the Professional Fulfillment Index (**27%*** vs. 17% of women).

Respondents who are under the age of 55 years (**17%*** of those aged 35 to 54 years and **14%*** of those under the age of 35 years) are *significantly* less likely to score “high” on the Professional Fulfillment Index than older respondents (30%).

General practitioners are *significantly* less likely to score “high” on the Professional Fulfillment Index than other areas of practice (18% vs. **21%*** of medical specialists, **24%*** of surgical specialists and **29%*** of other/admin physicians).

Physicians with 21 to 30 years of experience (**22%***) and over 30 years of practice (**34%***) are *significantly* more likely to score “high” on the Professional Fulfillment Index compared with those with 20 years of practice or less (14%–17%).

Respondents practising in in small town/rural (**17%***) and those in isolated/remote areas (**14%***) are *significantly* less likely to score “high” on professional fulfillment compared with those in urban/suburban communities (22%).

	High score on Professional Fulfillment Index		High score on Professional Fulfillment Index
GENDER		YEARS IN PRACTICE	
Men	27%*	5 or less	14%
Women	17%	6 to 10	14%
AGE		11 to 20	17%
<35	14%*	21 to 30	22%*
35 to 54	17%*	Over 30	34%*
55+	30%	COMMUNITY SIZE	
AREA OF PRACTICE		Urban/suburban	22%
General practitioner	18%	Small town/rural	17%*
Medical specialist	21%*	Isolated/remote	14%*
Surgical specialist	24%*		
Other/Admin	29%*		

Table 42. Score high on Professional Fulfillment Index by gender, age, area of practice, years in practice and community size.

**** Statistically significant using chi-square test of independence. See Appendix B for more details.**

BOX 4. PROFESSIONAL FUFILLMENT INDEX (PFI) BY PSYCHOLOGICAL FACTORS

Of those who are classified as **"languishing"** in mental health, none score high on professional fulfillment (0% vs. 6% of those who are "moderate" or 37% of those "flourishing" in mental health).

Physicians who report **burnout** are 4.5 times less likely to score high on professional fulfillment (8% vs. 36% of respondents who do not report burnout).

Those who have **moderate or severe anxiety** are six times less likely to be high on professional fulfillment (6% vs. 13% of those with mild and 36% of those with minimal levels of anxiety).

Physicians who score positive on **depression** are three times less likely than those who score negative to score high on professional fulfillment (10% vs. 31%, respectively).

PSYCHOLOGICAL SAFETY

Almost six in 10 respondents score high on feeling a sense of psychological safety on their team.

Psychological safety was assessed using Amy Edmondson's Psychological Safety and Learning Behavior in Work Teams measure.¹⁷ A majority of respondents (58%) score high on psychological safety, 39% score moderate and 3% score low. Practising physicians are more likely to score high on psychological safety (58% vs. 51% of medical residents), while medical residents are more likely to score moderate on the scale (47% vs. 39% of practising physicians). This difference is statistically significant when using the mean calculation of psychological safety (practising physicians mean of **24.74*** vs. medical residents 23.89).

PSYCHOLOGICAL SAFETY SCALE

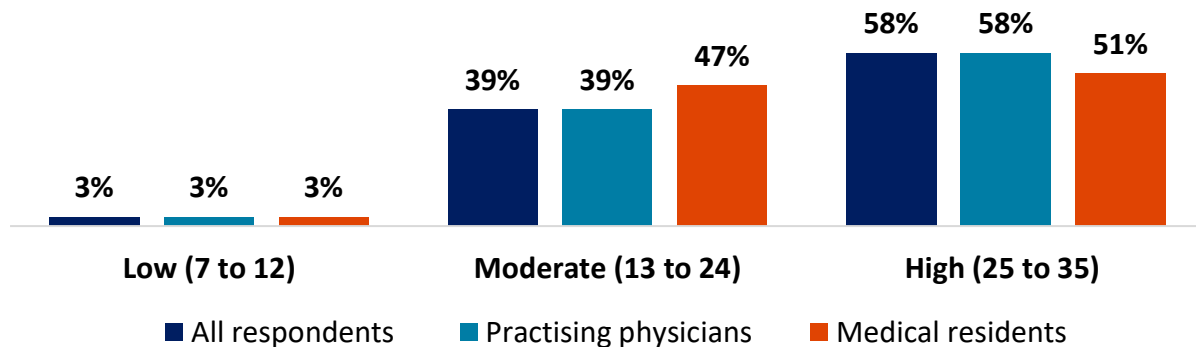


Figure 26. Psychological Safety: calculated total continuous score in tertiles. Base: All respondents (n = 3620), physicians (n = 3265), medical residents (n = 355), excluding not applicable.

¹⁷ Psychological Safety and Learning Behavior in Work Teams: seven items scored 1 to 5 with a range from 7 to 35. Scores are calculated into tertiles: 7 to 12, 13 to 24 and 25 to 35.

By gender, age, area of practice, years in practice and community size

Men are *significantly* more likely to score high on psychological safety (mean **25.47↑** vs. mean 24.21 women).

Respondents over the age of 55 years are *significantly* more likely to score a higher mean on psychological safety (mean **25.53↑**) compared with younger age groups.

Surgical specialists have a *significantly* lower mean psychological safety score (mean **23.23↓**) than all other area of practice.

Physicians with over 30 years of practice are *significantly* more likely to have a higher mean psychological safety score (**26.08↑**) than those with fewer years of practice. Those with six to 10 years of experience (mean **23.8↓**) and 11 to 20 years of practice (mean **23.98↓**) score *significantly* lower on the scale compared with those practising fewer years or more years.

Those in isolated/remote areas have a *significantly* lower mean score on psychological safety (mean **23.15↓** vs. those in urban/suburban areas – mean 24.76; and small town/rural areas – mean 24.5).

	High score on psychological safety
Overall mean: All physicians	24.65
GENDER	
Men	25.47 ↑
Women	24.21
AGE	
<35	24.56 ↓
35 to 54	24.07 ↓
55+	25.53
AREA OF PRACTICE	
General practitioner	25.22 ↑
Medical specialist	24.38 ↑
Surgical specialist	23.23 ↓
Other/Admin	24.91 ↑

	High score on psychological safety
YEARS IN PRACTICE	
5 or less	24.78
6 to 10	23.8 ↓
11 to 20	23.98 ↓
21 to 30	24.6
Over 30	26.08 ↑
COMMUNITY SIZE	
Urban/suburban	24.76 ↑
Small town/rural	24.5 ↑
Isolated/remote	23.15 ↓

Table 43. Psychological Safety Scale mean score by gender, age, area of practice, years in practice and community size.

↑↓ = significantly higher/lower than other subgroup(s). T-test for statistical significance used (95% confidence interval).

COLLEGIALLY AT WORK

About six in 10 respondents score high on the Collegiality Index.

Sixty-two percent of respondents score high on the Collegiality Index, which was calculated by summing four survey items related to perceived support, respect, cooperation and teamwork between colleagues at work. There is no difference between practising physicians and medical residents (62% vs. 60%, respectively).

COLLEGIALLY INDEX

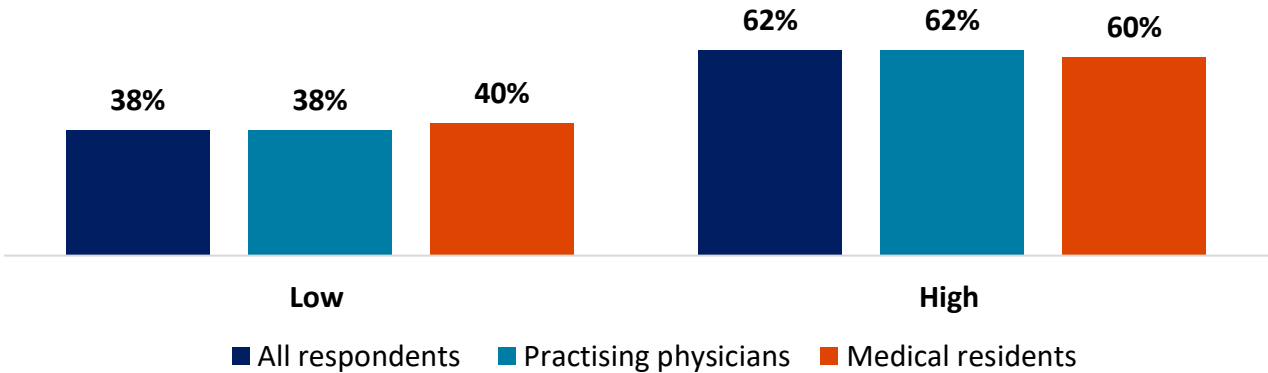


Figure 27. Collegiality Index: sum of four items; then dichotomized above/below mean of the sum. The four items included (agreement scale): In general, I find my colleagues to be supportive; People treat each other with respect in my work group; A spirit of cooperation and teamwork exists in my work group; Disputes or conflicts are resolved fairly in my work group. Base: excluding those who selected not applicable to at least one statement (n = 3703).

By gender, age, area of practice, years in practice and community size

Men are *significantly* more likely to score high on collegiality at work (67%* vs. women 58%).

Respondents 55+ years old (65%*) are *significantly* more likely to score high on collegiality at work compared with those 35 to 54 years old (57%*). The same is true for physicians practising over 30 years (68%*) compared with those 11 to 20 years in practice (57%*).

General practitioners are *significantly* more likely to score high (66%*) compared with surgical specialists (53%*).

Respondents practising in urban/suburban areas (63%*) are *significantly* more likely to score high on collegiality at work compared with those in isolated/remote areas (51%*).

	High on Collegiality Index		High on Collegiality Index
GENDER		YEARS IN PRACTICE	
Men	67%*	5 or less	65%
Women	58%	6 to 10	58%
AGE		11 to 20	57%*
<35	66%	21 to 30	60%
35 to 54	57%*	Over 30	68%*
55+	65%*	COMMUNITY SIZE	
AREA OF PRACTICE		Urban/suburban	63%*
General practitioner	66%*	Small town/rural	60%
Medical specialist	59%	Isolated/remote	51%*
Surgical specialist	53%*		
Other/Admin	61%		

Table 44. Collegiality Index score by gender, age, area of practice, years in practice and community size

EXPERIENCED INTIMIDATION, BULLYING, HARASSMENT AND/OR MICROAGGRESSIONS IN THE WORKPLACE

Eight in 10 respondents report having ever experienced intimidation, bullying, harassment and/or microaggressions in their workplace or training environment; four in 10 respondents report experiencing it “frequently” or “often.”

A total of 78% of respondents report having experienced intimidation, bullying, harassment and/or microaggressions in their workplace or training environment: 15% reported having these experiences “frequently” (at least once a week) or 25% “often” (a few times a month), and a further 38% report experience it “less often” (a few times a year).

The proportion of respondents who experience intimidation, bullying, harassment and/or microaggressions frequently (at least once a week) is similar among both practising physicians and medical residents (15% and 13%, respectively).

EXPERIENCED INTIMIDATION, BULLYING, HARASSMENT, MICROAGGRESSIONS IN WORKPLACE

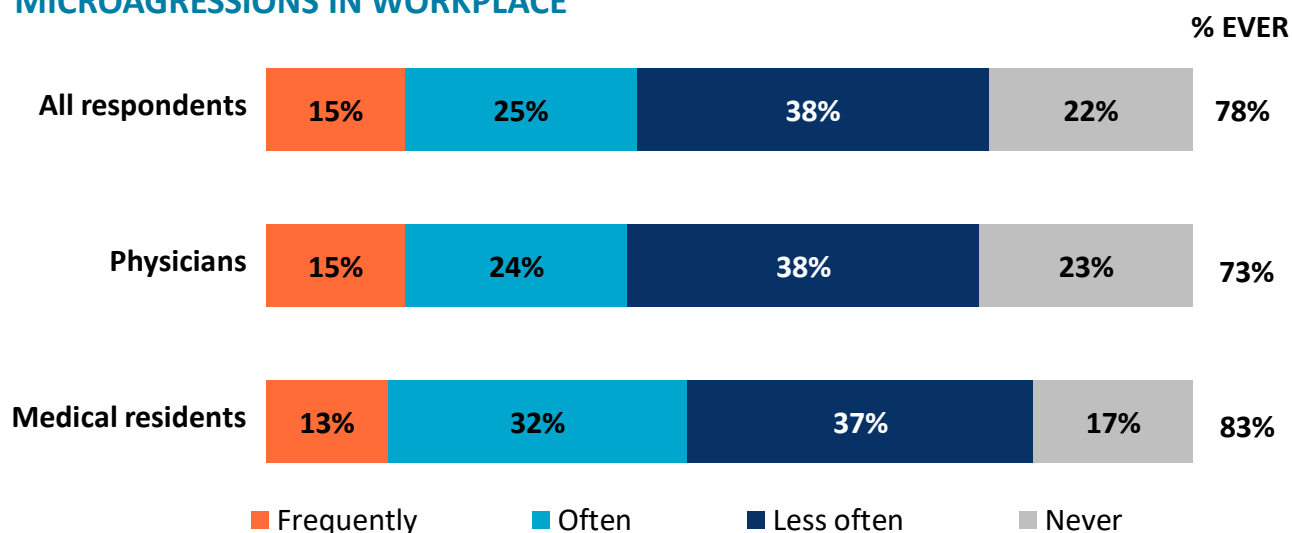


Figure 28. Responses to question 25. Have you ever personally experienced intimidation, bullying, harassment and/or microaggressions in the workplace or in a training environment? Base: All respondents (n = 3864), practising physicians (n = 3489), medical residents (n = 375).

**Frequently = every day, a few times a week, once a week; Often = a few times a month; Less often = a few times a year.
Ever = 100% minus "Never"*

By gender, age, area of practice, years in practice and community size

Women are *significantly* more likely to say they have experienced intimidation, bullying, harassment and/or microaggressions at least once a week (**17%*** vs. 11% men) and *significantly* less likely to say "never" (**16%*** vs. 31% men).

Those over the age of 55 years are *significantly* less likely to experience intimidation, bullying, harassment and/or microaggressions at least once a week than those 35–54 years old (**12%*** vs. **18%***, respectively).

Surgical specialists are *significantly* more likely to have experienced intimidation, bullying, harassment and/or microaggressions than those working in other settings (**24%*** vs. **12%*** of general practitioners, **16%*** of medical specialists and **13%*** of other/admin).

There were no differences according to community size.

	Experienced intimidation, bullying, harassment and/or microaggressions / % experience it “frequently” (at least once a week)	Experienced intimidation, bullying, harassment and/or microaggressions / % “never” experienced it
GENDER		
Men	11%	31%
Women	17%*	16%*
AGE		
<35	14%	19%
35-54	18%*	18%*
55+	12%*	30%*
AREA OF PRACTICE		
General practitioner	12%*	27%
Medical specialist	16%*	18%*
Surgical specialist	24%*	16%*
Other/Admin	13%*	22%*
YEARS IN PRACTICE		
5 or less	15%	17%*
6 to 10	21%	18%*
11 to 20	18%	18%*
21 to 30	14%	21%*
Over 30	11%	35%
COMMUNITY SIZE		
Urban/suburban	15%	23%
Small town/rural	15%	20%
Isolated/remote	17%	13%

Table 45. Experienced intimidation, bullying, harassment and/or microaggressions by gender, age, area of practice, years in practice and community size.

* Frequently = every day, a few times a week, once a week.

*** Statistically significant using chi-square test of independence. See Appendix B for more details.

BOX 5. EXPERIENCED INTIMIDATION, BULLYING, HARRASSMENT AND/OR MICROAGGRESSIONS BY PSYCHOLOGICAL FACTORS

Respondents who are classified as "**languishing**" in mental health are three times as likely compared with those who are "flourishing" to have experienced intimidation, bullying and/or harassment frequently (31% vs. 11%, respectively). Among those who are classified as "moderate" in mental health, 18% have had these experiences.

Those who are **burned out** are three times as likely to have experienced intimidation, bullying, harassment and/or microaggressions frequently (at least once a week) in their workplace or training environment (22% vs. 7% those who do not).

Those who experience **moderate or severe anxiety** are four times more likely to have experienced intimidation, bullying and/or harassment frequently (29%) compared with those with minimal anxiety (7%).

Respondents who score positive on **depression** are twice as likely as those who score negative to have experienced intimidation, bullying and/or harassment frequently (21% vs. 10%, respectively).

INVOLVED IN A COLLEGE COMPLAINT OR LAWSUIT

Four in 10 respondents have had a College complaint or lawsuit in their career.

Forty-three percent of respondents have had a College complaint or lawsuit at some point in their career.

INVOLVED IN A COLLEGE COMPLAINT OR LAWSUIT

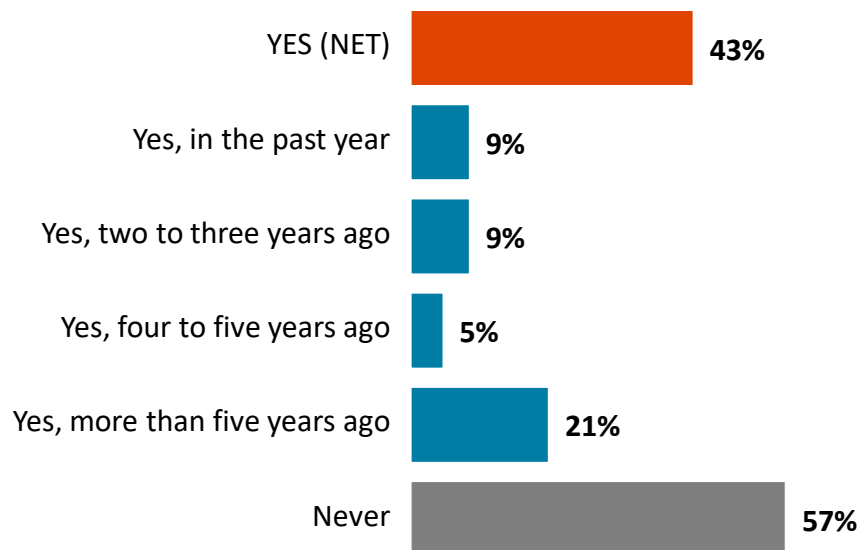


Figure 29. Responses to question 29. Have you been involved in a College complaint or lawsuit?
Base: All respondents (n = 3864).

By gender, age, area of practice, years in practice and community size

Men are *significantly* more likely to report having been involved in a College complaint or lawsuit (**53%*** vs. women 36%).

Respondents aged 35 to 54 years (**39%***) and 55+ years (**65%***) are *significantly* more likely to have had a College complaint in their career compared with those <35 years old (9%).

Medical specialists are *significantly* less likely to have been involved in a College complaint or lawsuit (**38%***) compared with surgical specialists (**60%***).

Physicians practising five or less years and six to 10 years of practice are significantly less likely to have been involved in a College complaint or lawsuit (**16%*** and **30%***, respectively) compared with those practising 21 to 30 and over 30 years (**54%*** and **68%***, respectively).

There is no difference by community size.

	% Involved in a College complaint or lawsuit ever		% Involved in a College complaint or lawsuit ever
GENDER		YEARS IN PRACTICE	
Men	53%*	5 or less	16%*
Women	36%	6 to 10	30%*
AGE		11 to 20	45%
<35	9%	21 to 30	54%*
35 to 54	39%*	Over 30	68%*
55+	65%*	COMMUNITY SIZE	
AREA OF PRACTICE		Urban/suburban	43%
General practitioner	43%	Small town/rural	46%
Medical specialist	38%*	Isolated/remote	43%
Surgical specialist	60%*		
Other/Admin	45%		

Table 46. Involved in a College complaint or lawsuit by gender, age, area of practice, years in practice and community size.

**** Statistically significant using chi-square test of independence. See Appendix B for more details.**

BOX 6. COLLEGE COMPLAINT BY PSYCHOLOGICAL FACTORS

Respondents who have had a College complaint in the past year are not any more likely than those who have never had a complaint to be classified as “languishing” in mental health (9% vs. 7%, respectively), score high on overall burnout (57% vs. 56%, respectively) or screen positive for depression (52% vs. 48%, respectively).

Subgroup analyses

Respondents with disabilities or those who are caregivers, either of children or of parents/family members/others, were included in an extended subgroup analysis as they were identified as a demographic that are more vulnerable to poorer outcomes. Details about these two subgroups are presented in this section.

PROFILE OF THOSE WITH DISABILITIES

Respondents living with disabilities experience worse outcomes across all psychological measures compared with those without disabilities, particularly individuals with mental health-related disabilities and those who are neurodivergent. This group also reports lower levels of perceived workplace collegiality and social support.

Respondents within the broader sample had the option to self-identify as a person living with a disability. Of the total sample, 77% say they do not have a disability. Among the 23% who identify as having a disability, the most prevalent disabilities include chronic long-term conditions, such as diabetes or multiple sclerosis (10%) and mental health conditions (8%). Additionally, 3% identify as having a neurodevelopment disorder (such as ADHD, autism or dyspraxia), 2% with a hearing or speech disability, 2% with a physical mobility disability and 2% with another form of disability.

LIVING WITH A DISABILITY

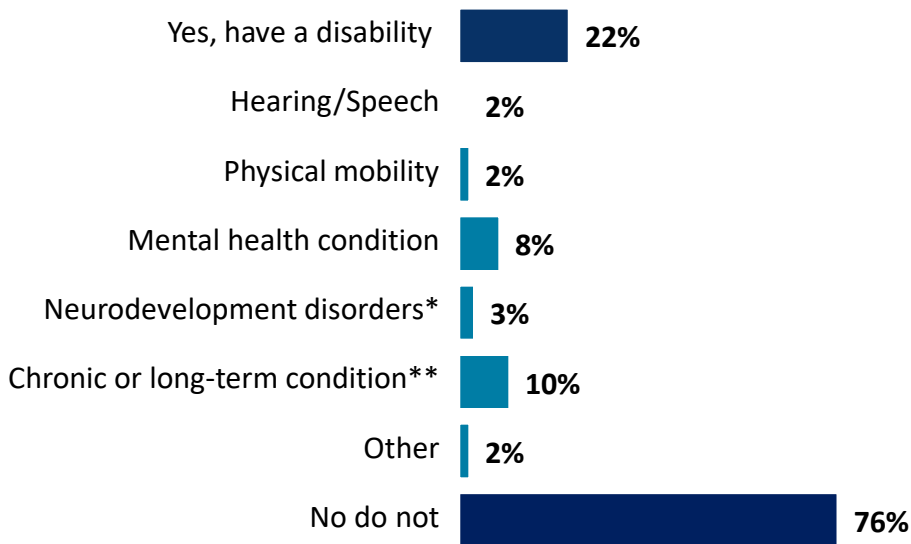


Figure 30. Responses to question 11. Do you consider yourself a person living with a disability, impairment or long-term condition related to any of the following? Base: All respondents (n = 3864).

* (ADHD, autism, dyspraxia, Tourette syndrome, others)
** (Diabetes, multiple sclerosis, heart conditions, epilepsy, chronic pain, others)

Breaking down those with disabilities by key demographic characteristics:

- Women (23%) are more likely than men (20%) to report having a disability, as are medical residents (25% vs. 22% of practising physicians).
- These groups are also more likely to report having a mental health condition (women 10%, medical residents 14%). Those aged 35 years and under are significantly more likely to report having a mental health condition (12%).
- By contrast, practising physicians (10%) and those aged 55 years or older (13%) are more likely to report having a chronic or long-term condition.

In comparing outcomes between those living with disabilities and those who are not, those living with disabilities have poorer mental health outcomes across all key psychological factors. They are significantly more likely to be “languishing” in their mental health (**12%*** vs. 6% of those not living with a disability), to be burned out (**61%*** vs. 39%), to screen positive for depression (**62%*** vs. 43%), to report having moderate or severe anxiety (**36%*** vs. 21%) and to report having considered suicide (lifetime) compared with those without disabilities (**56%*** vs. 29%).

In addition, those with mental health-related disabilities and those who are neurodiverse tend to have poorer outcomes on psychological measures compared with those with long-term chronic conditions (as illustrated in the table below).

Reporting on key differences among this subgroup, those with disabilities, are *significantly* less likely to score high on professional fulfilment (**15%*** compared to those living without a disability at 23%).

	Disability	No disability	Mental health condition	Neurodiverse	Long term chronic condition
Flourishing mental health	39%*	50%	22%	36%	45%
Languishing mental health	12%*	6%	19%	14%	9%
Overall burnout	61%*	39%	83%	81%	65%
Positive for depression	63%*	43%	83%	73%	54%
Severe or moderate anxiety	36%*	21%	53%	49%	31%
Suicidal ideation (lifetime)	56%*	30%	75%	60%	46%
Professional fulfilment (HIGH)	15%*	23%	8%	13%	18%
Psychological safety (HIGH)	49%	60%	43%	39%	50%
Social support (HIGH)	63%	75%	60%	63%	62%
Bullying/harassment/microaggressions	19%*	14%	21%	26%	17%

Table 47. Psychological factors by self-reported disability vs. no disability, and type of condition

**** Statistically significant using chi-square test of independence. See Appendix B for more details.**

Those living with disabilities are *significantly* less likely to score high on psychological safety (**49%*** vs. 60% of those not living with a disability) and *significantly* less likely to score high on social support including family, a significant other or friends (**63%*** vs. 75% of those without disabilities). They are also more likely to have experienced microaggressions at least once a week or more often (**19%*** vs. 14% of those with no disability). Future interventions, programs, initiatives, etc., should aim to improve the wellness of physicians living with disabilities who are at a particularly high risk of experiencing wellness challenges.

	Disability	No disability
In general, I find my colleagues to be supportive	78%	85%
People treat each other with respect in my work group	76%	84%
A spirit of cooperation and teamwork exists in my work group	72%	80%
Disputes or conflicts are resolved fairly in my work group	56%	65%
Working with members of this team, my unique skills and talents are valued and used	68%	77%
Members of this team are able to bring up problems and tough issues (including colleagues, nurses, admin)	64%	70%
No one on this team would deliberately act in a way that undermines my efforts (including colleagues, nurses, admin)	57%	65%
It is safe to take a risk in this team	39%	48%
If I make a mistake in this team, it is held against me	29%	24%
People on this team sometimes reject others for being different (including colleagues, nurses, admin)	32%	23%
It is difficult to ask other members of this team for help (including colleagues, nurses, admin)	25%	19%

Table 48. Statistical testing was not run for individual items, only for the Psychological Safety Scale.

Those living with disabilities are *significantly* less likely to score high on social support (**63%*** vs. 75% of those without disabilities). Future interventions, programs, initiatives, etc., should aim to improve the wellness of physicians living with disabilities.

	Disability	No disability
There is a special person who cares about my feelings	70%	77%
There is a special person with whom I can share joys and sorrows	68%	75%
There is a special person who is around when I am in need	66%	74%
I have a special person who is a real source of comfort to me	65%	72%
My family really tries to help me	55%	66%
I get the emotional help and support I need from my family	49%	60%
My family is willing to help me make decisions	51%	59%
I have friends with whom I can share my joys and sorrows	48%	58%
I can talk about my problems with my family	48%	57%
I can count on my friends when things go wrong	46%	57%
My friends really try to help me	43%	52%
I can talk about my problems with my friends	44%	51%

Table 49. Statistical testing was not run for individual items, only for the MSPSS.

PROFILE OF CAREGIVERS

Caregivers, either of children or of parents, other family members or friends, report worse outcomes across psychological measures than those without caregiving responsibilities. This group also reports lower levels of professional fulfilment and concerns around workload and environment.

Physicians were also given the opportunity to identify whether they act as a caregiver and/or have any dependents. Of the total sample, 53% say they do not have caregiving responsibilities. Among the 47% who say they are a caregiver, 40% indicate that they care for a child or children under 18 and 10% say they provide care for a parent, other family member or friend who has a long-term physical health or mental health issue. Three percent of respondents care for **both** a child and a parent, other family member or friend.

PARENT AND/OR CAREGIVER

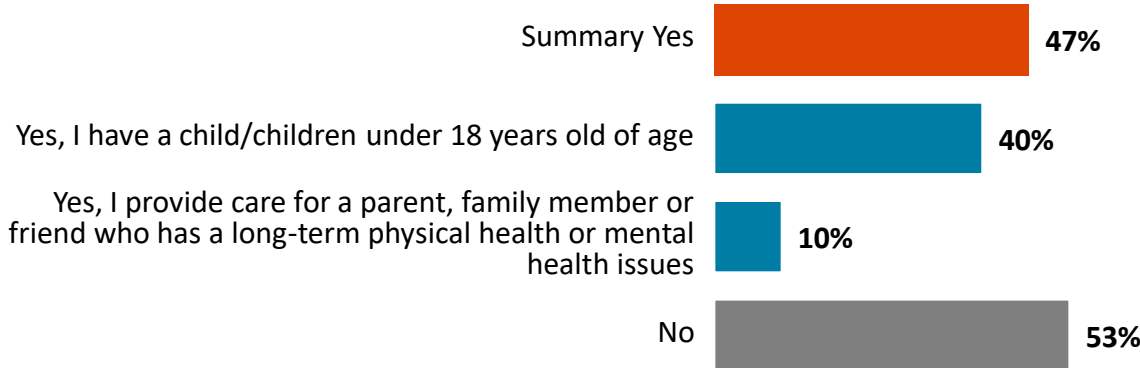


Figure 31. Responses to question 14. Do you have dependents for whom you are the primary caregiver?
Base: All respondents (n = 3864).

Breaking down caregivers by key demographic characteristics:

- **Women** (52%) are more likely than men (41%) to report being a caregiver of a child, parent, other family member or friend, as are practising physicians (51% vs. 15% of medical residents, probably because of the intersection of age).
- Notably, those who identify as a **member of an ethnic or racial group** are also more likely to be a caregiver (52% are a caregiver: 45% are a parent and 11% care for another) than those who identify as white only (45%: 39% are a parent and 9% care for another).
- Age is also a factor:
 - Respondents who are aged **35 to 54 years** are more likely to say they care for a parent (74% are a caregiver: 71% are a parent and 9% care for another) compared with those <35 years old (23% are a caregiver: 21% are a parent and 2% care for another) and those 55+ years old (23% are a caregiver: 9% are a parent and 16% care for another)
- As is years in practice:
 - Physicians **practising six to 20 years** are more likely to be a parent of a child under 18 years old (71% of those with six to 10 years and 75% of those with 11 to 20 years vs. 40% of those with five or less years, 38% of those 21 to 30 years and 5% of those with over 30 years of experience).

- Caregivers tend to have **poorer mental health outcomes across all key metrics** compared with those without any caregiving responsibilities. They are *significantly less likely to be “flourishing”* in mental health (**41%*** of parents vs. 47% of both parents and caregivers of another and 50% of those who are not parents or caregivers), more likely to be **burned out** (**61%*** of parents and 65% of both parents and caregivers of another vs. **47%*** of those who are not a parent or caregiver), to rate their **mental health “worse”** than before the pandemic (**69%*** of parents and **77%*** of both parents and caregivers of another vs. 54% of those who are not a parent or caregiver), to score **positive for depression** (**52%*** of parents and 61% of parents and caregivers of another vs. **44%*** of those who are not) and to report having **moderate or severe anxiety** (**29%*** of parents and 37% of both parents and caregivers of another vs. **22%*** of those who are not a parent or caregiver).

	Parent only	Both parent and caregiver of another ¹⁸	Not a parent or caregiver
Flourishing mental health	41%*	47%	50%
Languishing mental health	8%	13%	7%
Overall burnout	61%*	65%	47%*
Self-report worse mental health than before COVID	69%*	77%*	54%
Score positive for depression	52%*	61%	44%*
Severe and moderate anxiety	29%*	37%	22%*
Professional fulfillment (HIGH)	16%*	22%	24%

Table 50. Psychological factors by parent vs. parent and caregiver of another vs. neither.

Parent only: respondents who selected "Yes, I have child/children under 18 years of age."

Both parent and caregiver: respondents who selected "Yes, I have a child/children under 18 years of age" and "Yes, I provide care for a parent, family member or friend who has a long-term physical health or mental health issues."

*** Statistically significant using chi-square test of independence. See Appendix B for more details.*

Parents are *significantly* more likely to score lower on high professional fulfillment (**16%*** vs. 22% of both parents and caregivers of another vs. 24% of those who are not).

On the individual subscale items of professional fulfillment (comprising fulfillment, work exhaustion and disengagement), caregivers are consistently less likely to feel fulfilled and more likely to be exhausted and disengaged, particularly caregivers of both a parent or other family member plus a child.

¹⁸ Parent and caregiver of another: small base size $n = 94$.

	Parent only	Both parent and caregiver of another	Not a parent or caregiver
My work is meaningful to me	54%	57%	62%
I feel worthwhile at work or school	42%	47%	49%
My work is satisfying to me	38%	36%	48%
I'm contributing professionally in the ways I value most (e.g., patient care, research and leadership)	38%	42%	46%
I feel happy at work or school	23%	24%	33%
I feel in control when dealing with difficult problems at work or school	21%	23%	27%
Emotionally exhausted at work or school	39%	48%	28%
Physically exhausted at work or school	36%	47%	28%
A sense of dread when I think about work I have to do	34%	44%	26%
Lacking in enthusiasm at work or school	28%	38%	22%
Less connected with my colleagues	16%	22%	13%
Less interested in talking with my patients	13%	17%	10%
Less empathetic with my colleagues	10%	16%	7%
Less sensitive to others' feelings and emotions	10%	14%	7%
Less connected with my patients	9%	15%	7%
Less empathetic with my patients	9%	15%	6%

Table 51. Statistical testing was not run for individual items, only for the PFI by parent only vs. both parent and caregiver of another vs. neither.

Parent only: respondents who selected "Yes, I have child/children under 18 years of age."

Both parent and caregiver: respondents who selected "Yes, I have a child/children under 18 years of age" and "Yes, I provide care for a parent, family member or friend who has a long-term physical health or mental health issues."

When asked what barriers prevent them from having a healthy lifestyle, both “parents” and “both parents and caregivers” are significantly more likely than those without caregiving responsibilities to cite lack of time (74% and 81%, vs. 58%, respectively), heavy workload (65% and 71% vs. 56%), scheduling (60% and 57% vs. 54%) and other priorities (74% and 72% vs. 11%).

	Parent only	Both parent and caregiver of another	Not a parent or caregiver
Lack of time	74%	81%	58%
Heavy workload and/or stressful work environment	65%	71%	56%
Scheduling (e.g., long work hours)	60%	57%	54%
Other priorities (e.g., children)	74%	72%	11%

Table 52. Barriers preventing healthy lifestyle by parent only vs. both parent and caregiver of another vs. neither.

Parent only: respondents who selected "Yes, I have child/children under 18 years of age."

Both parent and caregiver: respondents who selected "Yes, I have a child/children under 18 years of age" and "Yes, I provide care for a parent, family member or friend who has a long-term physical health or mental health issues."

The data indicate that parents and caregivers experience more negative wellness outcomes compared with those who are not caregivers. These results can be used to help advocate for additional resources to support the wellness of caregivers, responsibilities for whom has increased throughout the pandemic.

Discussion

The National Physician Health (NPHS) Survey in 2021 is the second national wellness study conducted among physicians in Canada by the Canadian Medical Association (CMA). The primary objectives of the study are to track physicians' wellness over time since the initial baseline study in 2017 and to delve deeper into understanding factors related to physician wellness (i.e., behavioural and occupational factors). At the time of the survey (fall 2021), Canadians were still living under various COVID-19 provincial/territorial public health measures. The health system was strained by yet another rise in COVID-19 cases; hospitals were facing health human resource challenges;¹⁹ and average wait times between referral and medically necessary elective treatments increased significantly.²⁰

Many physicians faced the day-to-day realities of exceptionally challenging workplace environments. Further, the pandemic has increased family obligations, which may explain the increased strain on physicians who are parents and caregivers. An important, secondary goal arising from this context is to understand the impact of the pandemic on physician health and wellness and, as well, to determine whether specific demographic subgroups have been disproportionately affected. The results from this study can be used to support the inclusion of physician wellness initiatives in post-pandemic recovery planning. Prevention and treatment support can help to enhance physician wellness, career satisfaction and retention and ultimately improve the delivery of safe patient care.

Mental health has decreased during the pandemic among respondents.

In terms of overall mental health, fewer physicians are showing signs of “flourishing” mental health when compared with 2017; most appear to have slipped into “moderate” levels of mental health (at least in the aggregate) but some have fallen into “languishing” mental health. This is not surprising given the context: six in 10 respondents rate their mental health as being worse now than before the pandemic.

The most dramatic shift is in the near doubling of burnout.

The most striking finding of note from the 2021 NPHS is the increase in the rate of burnout among respondents. Overall burnout captured in this report is a condition consisting of two dimensions: emotional exhaustion and depersonalization. Over half of respondents are experiencing burnout, a *significant increase of 1.7 times* or 22 percentage points since 2017.

Other psychological factors that have seen notable and alarming increases include rates for positive screening for depression and recent suicidal ideation. Half of respondents screen positive for depression, an increase of 1.4 times or 13 percentage points compared with 2017. And recent suicidal ideation (in the past 12 months) is reported by 14% of respondents, an increase of 1.5 times or five percentage points since 2017.

¹⁹ Grimm CA. *Hospitals reported that the COVID-19 pandemic has significantly strained health care delivery.* 2021. [Results of a National Pulse Survey February 22–26, 2021.](#)

²⁰ Data for the study were collected between Jan. 15, 2021, and July 27, 2021.

Moir M, Barua B. *Waiting your turn wait times for health care in Canada, 2021 report.* [Fraser Institute.](#)

While medical residents are more likely to experience burnout, screen positive for depression and report recent suicidal ideation in the pre-pandemic and current contexts, practising physicians have seen larger percentage increases compared with pre-pandemic (2017) levels. In addition to occupational-related issues, personal factors such as social isolation along with continued uncertainty about the future and increased family obligations for some physicians have been additional stressors brought on by the pandemic.

Likelihood to reduce clinical work hours in the coming two years is higher among those with poor wellness outcomes.

A significant proportion of respondents (half) are thinking of reducing or modifying their clinical work hours in the next 24 months. Those who are more likely to be burned out, “languishing” in mental health, screen positive for depression, have moderate/severe anxiety and score low on professional fulfillment report greater a likelihood of reducing their clinical hours. While a growing shortage of physicians was certainly an issue pre-pandemic, the cost of increased burnout in the form of early retirements and reduced clinical hours due to the pandemic may be substantial in the coming years. Considering this, wellness should be considered as a pillar of future health human resource planning.

High administrative workload and lower satisfaction with work–life integration may be related to low professional fulfillment.

Overall, a majority of respondents score low on the Professional Fulfillment Index, which consists of sentiments around contentment, satisfaction and meaningfulness of work. Respondents who are low on professional fulfillment are significantly more likely to experience burnout and significantly less likely to be flourishing in their mental health, suggesting it may be a contributing factor to poor wellness outcomes.

Low professional fulfillment is probably related to a heavier workload, fatigue and a lack of work–life integration, rapidly changing policies and processes, and a shortage of human resources, all of which have been exacerbated by the pandemic. Moreover, those who score low on professional fulfillment more frequently report a likelihood of reducing their clinical work hours in the next 24 months (1.4 times more likely compared with those who score high on professional fulfillment).

The results from this study indicate that EMRs are probably contributing to longer work hours. While EMRs have been almost universally adopted by physicians,²¹ they present a key pain point that adds to work frustration, increases financial costs²² and interferes with personal life as many respondents in this study report spending moderate or excessive amounts of time on the EMR at home. Current EMR systems are plagued by issues around coordination and interoperability, which add to administrative tasks and reduce time spent with patients, which may lead to greater feelings of ineffectiveness and lower professional fulfillment.

²¹ Persaud N. A national electronic health record for primary care. *CMAJ*. 2019;191(2):E28–E29. <https://doi.org/10.1503/cmaj.181647>

²² Owens B. Family doctors call for guaranteed access to EMR data for research and quality improvement. *CMAJ*. 2018;190(2):E60–E61. <https://doi.org/10.1503/cmaj.109-5543>

There is a relatively high level of psychological safety but there is room for improvement.

Psychological safety leads to healthier teams and workplaces and is defined as “a shared belief held by members of a team that the team is safe for interpersonal risk taking.”²³ While many respondents score high on psychological safety, over four in 10 score moderate on the scale, suggesting there is room for improvement in this area. Those who are not burned out and those with higher levels of mental health are more likely to experience higher psychological safety, suggesting that a positive workplace culture may play a protective role against negative wellness outcomes. Similarly, those who do not experience psychological safety are much more likely to experience depression and anxiety.

There is culture shift toward prioritizing wellness.

A silver lining to the findings: COVID-19 has shone a light on the importance of mental health and well-being, and it appears that a culture shift is underway among physicians. Younger physicians (e.g., medical residents and those under 35 years of age) report prioritizing their personal wellness and seeking help to support their well-being, possibly an indication of the fading stigma associated with seeking mental health support.

At least in the aggregate, some of those who are at risk of psychological distress, who could benefit from wellness supports (e.g., women and younger physicians) are accessing them. These findings echo a separate cohort study carried out among Ontario physicians, wherein the researchers found that the COVID-19 pandemic was an impetus for greater use of mental health services among physicians.²⁴ This is also in line with results from research conducted among the general population showing that younger Canadians are more likely to talk about mental health and to seek out mental health resources compared with older generations.²⁵

Nevertheless, there are still significant barriers to overcome in terms of increasing access, overcoming stigma and emphasizing the need to seek out wellness supports. For some physicians, stigma and shame (among men and older people), or a belief that things aren't serious enough to necessitate seeking help (among women), may be preventing them from seeking out help. Confidentiality is also often cited as a reason why many physicians don't access supports. This is particularly the case among younger doctors and those practising in small town/rural areas and isolated/remote areas, who also worry about potential harm to their career.

²³ Edmondson A. Psychological safety and learning behavior in work teams. *Admin Sci Q*, 1999;44(2):350–383. <https://doi.org/10.2307/2666999>

²⁴ Myran DT, Cantor N, Rhodes E, et al. Physician health care visits for mental health and substance use during the COVID-19 pandemic in Ontario, Canada. *JAMA Netw Open*, 2022;5(1):e2143160. <https://doi.org/10.1001/jamanetworkopen.2021.43160>

²⁵ Ipsos. Feb. 28, 2022. Mental illness now considered by more Canadians as a disability. <https://www.ipsos.com/en-ca/mental-illness-considered-by-more-canadians-as-disability>. Ipsos. March 4, 2021. Six in ten Canadians (60%) currently experiencing mental health issues, but more than half (54%) haven't sought treatment. <https://www.ipsos.com/en-ca/news-polls/six-in-ten-canadians-currently-experiencing-mental-health-issues-but-more-than-half-havent-sought-treatment>

Greater at-risk subgroups

IMPORTANCE OF INTERSECTIONALITY

It is important to note that not all physicians have experienced the pandemic in the same way. This year's NPHS results reveal several higher at-risk subgroups who experience more negative wellness outcomes. These subgroups include medical residents; those under 35 years of age; those identifying as women; those with 6–10 years in practice; caregivers of a child and/or parent in the home; those living with disabilities; and those working in small town/rural or isolated/remote areas. According to intersectional theories, individuals hold multiple identities that interlock to shape their experiences, and intersectional identities can magnify or protect against work-related stress among physicians.²⁶ Physicians do not exist as members of only one of these categories; as such, greater attention needs to be paid to the interaction effect of membership in several of these at-risk groups (e.g., identifying as a woman, being under 35 years of age, *and* being a caregiver for a child at home).

MEDICAL RESIDENTS

Medical residents experience poorer wellness outcomes in general compared with practising physicians, and this was the case even before the pandemic.²⁷ Coming out of school, medical residents face steep learning curves, have growing responsibilities and work more intense hours in the first years of their medical training.²⁸ Other issues arising from the pandemic have further compounded their experiences, including adjustment to virtual learning, missing out on in-person clinical experiences and worries over possible gaps in their medical knowledge.²⁹

In a call to re-examine medical education in Canada, a commentary piece in *CMAJ* acknowledges that medical residents have been limited to working at one site in some parts of the country, have had reduced exposure to elective procedures and surgeries and may have received fewer learning opportunities than in the past.³⁰ As such, it is not surprising that medical residents report being less fulfilled professionally and are more likely to feel physically exhausted and have a sense of dread about their job.

It is reasonable to posit that the COVID-19 pandemic will leave an indelible mark on this generation of physicians, if not future ones. It will be critical to understand the experiences of this cohort that trained during the pandemic to better support them in their journey towards wellness.

WOMEN PHYSICIANS

Women physicians are also an at-risk group who score significantly lower on several psychological measures, which is consistent with findings from the 2017 NPHS. Although further reports will delve deeper, women tend to sit at the intersection of several subgroups who experience lower well-being outcomes. For instance, women physicians are more likely to be younger, more likely to be caregivers of either a child or parent at home, and relatedly also more likely to be in the earlier stages of their career (note that they make up two-thirds of the sample of general practitioners). The cumulative effect of these intersections has meant that women physicians are disproportionately experiencing burnout. Women are more likely to report being burned out, and they show

²⁶ Crenshaw K. Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. University of Chicago Legal Forum, 2015;1989(1). <https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8>

²⁷ Canadian Medical Association. [CMA National Physician Health Survey – A National Snapshot](#). 2018.

²⁸ Sturman N, Tan Z, Turner J. A steep learning curve": junior doctor perspectives on the transition from medical student to the health-care workplace. BMC Med Educ, 2017;17(1):92. <https://doi.org/10.1186/s12909-017-0931-2>

²⁹ Servin-Rojas M, Olivas-Martinez A, Dithurbide-Hernandez M, et al. Impact of the COVID-19 pandemic on the clinical training of last year medical students in Mexico: A cross-sectional nationwide study. BMC Med Educ. 2022;22(1):24. <https://doi.org/10.1186/s12909-021-03085-w>

³⁰ McCarthy C, Carayannopoulou K, Walton JM. COVID-19 and changes to postgraduate medical education in Canada. CMAJ, 2020;192(35):E1018–E1020. <https://doi.org/10.1503/cmaj.200882>

the highest percentage-point increase on this indicator from 2017 when compared with men (+26 vs. +14 percentage points among men). In addition, they are more likely than men to report the following:

- having “severe” or “moderate” anxiety
- having diminished mental health during the pandemic
- feeling fatigued at work/school on a regular basis
- being dissatisfied with work–life integration and efficiency and resources of their department
- their primary work area being chaotic
- the time spent on EMR at home being too high
- experiencing bullying, harassment and/or microaggressions “frequently” in the workplace

“SANDWICH” GENERATION

Physicians in the sandwich generation, practising six to 10 years and between the ages of 35 and 54 years, tend to experience the worst wellness outcomes compared with those who have been practising a greater number of years and those who are older. Although they are not as new to the medical profession as medical residents or those who have been practising for five years or less, they are still more likely to report wellness challenges compared with physicians with over twenty years of experience. By virtue of where they are in their personal lives, they tend to be parents and/or caregivers, which could contribute to poor wellness outcomes. As such, this in-between generation faces the challenges of being slightly more experienced professionally, and therefore possibly having more professional responsibilities, while simultaneously being a caregiver for younger child(ren) at home and juggling multiple duties.

Understandably, those who have been practising between six and 10 years have shown the largest decreases in “flourishing” mental health and social well-being from 2017. In fact, this group has shown some of the largest changes (when compared with physicians with fewer or more years in practice) on the following measures:

- more likely to report burnout
- more likely to have “severe” or “moderate” anxiety
- more likely to screen positive for depression
- more likely to indicate having had thoughts of suicide (lifetime)

CAREGIVERS

Not all at-risk groups are related purely to socio-demographic factors such as gender, age or career stage. Those who are caregivers, be it of a child(ren) and/or of a parent, are significantly more likely to report worse psychological outcomes across all key metrics compared with those without caregiving responsibilities. They are significantly less likely to be “flourishing” in mental health and more likely to be burned out, to rate their mental health “worse” than before the pandemic, to score positive for depression and to report having moderate or severe anxiety. While this group experiences greater responsibilities and burdens, the pandemic has made their experience even more challenging when combined with other work-related issues. It is not surprising, then, that caregivers report lower levels of professional fulfilment.

Demographically, caregivers skew women (52%), those aged 35 to 54 (74%–75%) and those who have been practising six to 10 years (72%).

LIVING WITH A DISABILITY

Another at-risk group identified in the data are those who indicate having a disability, comprising roughly 10% of the respondents. Physicians living with disabilities, specifically those with mental health-related disabilities and those who are neurodivergent, experience worse outcomes across all measures of mental health and wellness compared with those without disabilities. Respondents reporting living with a disability in mental health and/or neurodevelopment conditions tend to skew women, medical residents and those under 54 years old (younger respondents and women may be more likely to report).

Respondents living with a disability are significantly more likely to be “languishing” in their mental health, to be burned out, to screen positive for depression, to report having moderate or severe anxiety and to report having had thoughts of suicide (recent in past 12 months and lifetime). In addition, those with disabilities are more likely to score lower on professional fulfilment, psychological safety and social support. They also report feeling less supported by their colleagues and are more likely to say they have experienced bullying, harassment or microaggressions at least once a month or more often.

PRACTISING IN A SMALL TOWN/RURAL AREA OR ISOLATED/REMOTE COMMUNITY

Those living in small town/rural areas and isolated/remote communities are also an at-risk group. Their geographic location and the size of the community in which they practise may mean that even in the best of circumstances they lack some of the social connections and wellness supports that physicians practising in urban areas may tap into more easily. With limited staff in these areas, it may also be difficult to take any time off to prioritize their wellness. With the pandemic exacerbating an already-precarious situation wherein physicians were not adequately supported in their roles, it is no surprise that those living in small town/rural or isolated/remote areas are seeing worse outcomes compared to physicians in urban/suburban settings.

What are the next steps?

This report has outlined the main findings from the 2021 NPHS and has focused on highlighting basic, descriptive findings about Canadian physicians’ overall well-being.

In addition to the general findings, this report has uncovered some important areas for future analysis. Additional areas of research that will be explored in forthcoming reports include:

- **Deep dives within selected socio-demographic subgroups** to further explore the experiences of being medical professionals in the time of COVID-19.
- **Comparing the results of the 2021 NPHS with the results of an online survey for employed Canadians**, which was administered concurrently, allowing us to examine if some of the trends observed in this report also apply to the Canadian working population or if they are specific to physicians.
- **Regression analyses** will be carried out to identify the behavioural, occupational and cultural predictors of psychological outcomes. This includes not only looking into the risk factors that lead to poor outcomes but also examining protective factors that support physicians’ well-being.

In raising the issue about the current state of physician wellness, these data can be used to educate, advocate and build the case for additional wellness resources in training and practice environments. The data can also be used to help inform the development of new wellness initiatives, including targeted programs for the at-risk subgroups identified in this report.

Appendix A. Methodology details and study limitations

Summary profile of respondents by career stage and type of physician

	Practising physicians	Medical residents	General practitioners/ Family physicians	Medical specialists	Surgical specialists	Other/ Admin
GENDER IDENTITY	Women (59%)	Skews women (70%)	Highest skew to women (67%)	Skews women (56%)	Equally split: women (48%)/men (49%)	Skews women (53%)
AGE	45–64 years old (52%)	<44 years old (99%)	Younger, average age is 49 years old; most likely to be <44 years old (39%)	Average age is 51 years old	Average age is 52 years old	Average age is 54 years old; more likely to be 65+ (19%)
REGION	BC (20%), Prairies (25%), East (14%), Small town/rural (20%)	QC (31%) Urban/suburban (76%)	QC (16%) Urban/suburb (62%) Small town/rural (30%)	ON (27%) Urban/suburb (79%)	Urban/suburb (74%)	ON (30%) Urban/suburb (74%)
ETHNIC RACIAL IDENTITY	Identify as white (77%)	Identify as white (79%)	Identify as white (78%)	Identify as white (75%)	More likely to select white only (80%)	More likely to select white only (78%)
PRIMARY WORK SETTING	Community hospital, private office/clinic (40%)	Academic health centre (75%)	Private office/clinic (72%)	Community hospital (27%), academic health centre (45%)	Community hospital (40%), private office/clinic (23%), academic health centre (33%)	Community hospital (26%), academic health centre (38%), administrative office or corporate office (8%)
FEE STRUCTURE	–	–	Fee-for-service, sessional, blended; only group with capitation	Salary, sessional, blended, other	Fee-for-service, salary	Salary, sessional, blended, other

Table 53. Profile of physicians by stage of career and by type of physician.

Considerations on weighting data

The sample of physicians was not weighted. A comparison of the sample of respondents with CMA profile data shows there are differences in gender and region (see Table 54). As a part of the initial analysis, the data were weighted to determine how outcomes might be affected by the weighting. It was found that there were no major differences in outcomes when comparing the weighted and unweighted datasets. The decision was, therefore, made to leave the data unweighted to minimize the interaction of the weighting of a variable with the weighting of another variable.

Weighting of the data by random iterative method (RIM) would have produced a weighting efficiency of 76.5%, with a minimum respondent weight of 0.00 and a maximum respondent weight of 1.98.

	Counts	Unweighted percent	Weighting scheme
GENDER			
Men	1486	38%	55%
Women	2334	60%	45%
Other	12	0.3%	–
Prefer not to answer	32	1%	–
REGION			
Atlantic	525	14%	7%
Quebec	586	15%	23%
Ontario	1004	26%	36%
Prairies	963	25%	19%
BC and Territories	775	20%	14%
Prefer not to answer	11	0.3%	–

Table 54. Sample counts, unweighted proportions vs. weighting proportions.

Study limitations

As with any research, the execution of this study involved methodological decisions that have an impact on the representativeness of the findings. The main limitations of the study are as follows:

- This study was carried out by means of an **open online survey link** for broader participation beyond CMA's membership, meaning that any physician, resident or medical student who came across communications promoting the survey could access the open link. Internal measures were implemented to minimize the possibility that a participant could take a survey multiple times, such as screening out based on IP addresses and pattern matching to eliminate duplicate responses. Standard practices were also used to assess any potentially inconsistent response patterns.
- The **average time to complete the survey** was 30 minutes, which may have limited participation to those who would want to take or have the time to complete a survey of this length. That said, the survey obtained a large sample of completes, indicating the topic of the survey was relevant to its target population.

- This study also asked **sensitive questions** around issues such as drug use and suicidal ideation. Possible concerns around confidentiality of responses may have affected self-reporting of thoughts and behaviours. The CMA mitigated this risk through the study's approach, for example, identifying information was NOT collected, and a third party separate from the CMA mounted and analyzed the data.
- All research methodologies have their benefits and drawbacks. Both the CMA and Ipsos have considered the best way to balance representativeness, inclusiveness, convenience and time/budget considerations for this study. Nonetheless, **these limitations do not diminish the overall research findings** regarding the current state of physician wellness in Canada.

Appendix B. Statistical testing

Section 1. Psychological factors

Mental Health Continuum Short Form - Mental Health (MHC-SF Index created from question 64)

	Pearson chi-square value	df	p-value
Gender (flourishing)	12.611	2	0.002
Age (flourishing)	83.677	4	0.000
Years in practice (flourishing)	129.363	8	0.000
Age (languishing)	83.677	4	0.000

Mental Health Continuum Short Form - Well-being (MHC-SF Index created from question 64)

	Pearson chi-square value	df	p-value
Age (emotional well-being)	24.746	2	0.000
Years in practice (emotional well-being)	39.378	4	0.000
Age (social well-being)	61.968	2	0.000
Years in practice (social well-being)	92.198	4	0.000
Career stage (psychological well-being)	4.879	1	0.027
Gender (psychological well-being)	6.965	1	0.008
Age (psychological well-being)	54.777	2	0.000
Years in practice (psychological well-being)	76.758	4	0.000

Burnout among physicians (MBI 2-item Burnout)

	Pearson chi-square value	df	p-value
Career stage	4.703	1	0.030
Gender	84.707	1	0.000
Age	178.259	2	0.000
Area of practice	43.798	3	0.000
Years in practice	234.735	4	0.000
Community size	11.818	2	0.003

General Anxiety Disorder 7-Item Scale (rated moderate + severe)

	Pearson chi-square value	df	<i>p</i> -value
Career stage	15.007	1	0.000
Gender	30.882	1	0.000
Age	106.460	2	0.000
Years in practice	118.631	4	0.000

Depression screening (PHQ-2 Depression)

	Pearson chi-square value	df	<i>p</i> -value
Gender	17.897	1	0.000
Age	43.374	2	0.000
Years in practice	56.373	4	0.000
Community size	18.238	2	0.000

Suicidal ideation – lifetime (question 47)

	Pearson chi-square value	df	<i>p</i> -value
Gender	16.893	1	0.000
Age	17.532	2	0.000
Community size	20.390	2	0.000

Recent suicidal ideation (question 48)

	Pearson chi-square value	df	<i>p</i> -value
Career stage	10.111	1	0.001
Age	42.447	2	0.000
Years in practice	59.803	4	0.000

Section 2. Impact of COVID-19

Rating of mental health compared with before the pandemic (question 54)

	Pearson chi-square value	df	<i>p</i> -value
Career stage	8.293	1	0.004
Gender	54.117	1	0.000
Age	101.083	2	0.000
Years in practice	124.376	4	0.000

Frequency of feeling moral distress (question 56)

	Pearson chi-square value	df	<i>p</i> -value
Career stage	9.402	1	0.002
Gender	11.450	1	0.001
Age	69.486	2	0.000
Years in practice	57.938	4	0.000

Likelihood of reducing/modifying clinical work hours (question 57)

	Pearson chi-square value	df	<i>p</i> -value
Career stage	163.534	2	0.000
Age	161.426	4	0.000
Years in practice	92.705	8	0.000

Section 3. Behavioural factors and social support

Frequency of feeling fatigued at work/school (question 35)

	Pearson chi-square value	df	p-value
Career stage	41.469	1	0.000
Gender	123.306	1	0.000
Age	230.141	2	0.000
Area of practice	34.156	3	0.000
Years in practice	232.389	4	0.000
Community size	13.006	2	0.001

Frequency of feeling one gets optimal sleep (question 37)

	Pearson chi-square value	df	p-value
Area of practice	27.031	1	0.000
Gender	27.935	1	0.000
Age	137.450	2	0.000
Years in practice	144.981	4	0.000

Multidimensional Scale of Perceived Social Support (MSPSS)

	Pearson chi-square value	df	p-value
Age	25.237	4	0.000

Have a regular primary care physician (question 30)

	Pearson chi-square value	df	p-value
Career stage	45.475	1	0.000
Gender	4.156	1	0.041
Age	80.969	2	0.000
Years in practice	38.298	4	0.000
Community size	19.479	2	0.000

Wellness support offerings at current workplace – selected at least one support (question 40)

	Pearson chi-square value	df	<i>p</i> -value
Career stage	60.902	1	0.000
Age	16.825	2	0.000
Area of practice	59.048	3	0.000
Community size	13.485	2	0.001

Professional Consequences Index (selected one of three items in question 60)

	Pearson chi-square value	df	<i>p</i> -value
Gender	12.491	1	0.000
Area of practice	15.691	3	0.001

Wellness supports accessed in past five years (question 58)

	Pearson chi-square value	df	<i>p</i> -value
Career stage	12.014	1	0.001
Gender	137.511	1	0.000
Age	104.077	2	0.000
Years in practice	100.326	4	0.000

Section 4. Occupational factors

Satisfaction with current job or training position (question 43)

	Pearson chi-square value	df	p-value
Career stage	4.196	1	0.041
Gender	54.825	1	0.000
Age	59.295	2	0.000
Area of practice	24.464	3	0.000
Years in practice	72.237	4	0.000

My professional values are well aligned with those of my department or academic leaders (question 43)

	Pearson chi-square value	df	p-value
Career stage	6.949	1	0.008
Gender	0.805	0.703	0.921
Age	36.089	2	0.000
Years in practice	31.229	4	0.000
Community size	14.121	2	0.001

I feel a great deal of stress because of my job or training position (question 43)

	Pearson chi-square value	df	p-value
Career stage	14.885	1	0.000
Gender	111.810	1	0.000
Age	215.415	2	0.000
Area of practice	23.830	3	0.000
Years in practice	252.577	4	0.000

Control of workload (question 45)

	Pearson chi-square value	df	p-value
Area of practice	63.397	2	0.000
Gender	48.398	1	0.000
Age	63.397	2	0.000
Years in practice	76.678	4	0.000

Work-life integration (question 45aa)

	Pearson chi-square value	df	<i>p</i> -value
Career stage	4.337	1	0.037
Gender	58.861	1	0.000
Age	119.978	2	0.000
Area of practice	17.510	3	0.001
Years in practice	161.916	4	0.000

Efficiency and resources (question 45aa)

	Pearson chi-square value	df	<i>p</i> -value
Career stage		1	0.004
Gender	68.303	1	0.000
Age	110.362	2	0.000
Years in practice	127.089	4	0.000
Community size	34.642	2	0.000

Time spent on EMR at home (question 45a)

	Pearson chi-square value	df	<i>p</i> -value
Gender	56.483	2	0.000
Area of practice	164.078	6	0.000
Years in practice	42.132	8	0.000

Atmosphere in primary work area (question 45b)

	Pearson chi-square value	df	<i>p</i> -value
Gender	26.667	1	0.000
Age	58.005	2	0.000
Area of practice	65.411	3	0.000
Years in practice	66.135	4	0.000
Community size	22.794	2	0.000

Professional Fulfillment Index (Dichotomous Index)

	Pearson chi-square value	df	<i>p</i> -value
Career stage	12.005	1	0.001
Gender	53.28	1	0.000
Age	99.899	2	0.000
Area of practice	29.702	3	0.000
Years in practice	126.428	4	0.000
Community size	13.858	2	0.001

Collegiality at Work Index (based on items in question 24)

	Pearson chi-square value	df	<i>p</i> -value
Career stage	0.468	1	0.494
Gender	25.912	1	0.000
Age	26.370	2	0.000
Area of practice	30.005	3	0.000
Years in practice	32.724	4	0.000

Experienced intimidation, bullying, harassment, microaggressions in workplace (question 25)

	Pearson chi-square value	df	<i>p</i> -value
Career stage	14.229	3	0.003
Gender	147.245	3	0.000
Age	136.266	6	0.000
Years in practice	177.688	12	0.000

Involved in a college complaint or lawsuit (question 29)

	Pearson chi-square value	df	<i>p</i> -value
Gender	108.606	1	0.000
Area of practice	62.495	3	0.000
Years in practice	412.592	4	0.000
Age	582.307	2	0.000

SUBGROUP ANALYSES

Living with a disability

ITEMS WITH CHI-SQUARE TESTING	Pearson chi-square value	df	p-value
Mental health (flourishing/languishing)	50.884	2	0.000
Overall burnout	33.362	1	0.000
Depression	95.142	1	0.000
Anxiety	74.326	1	0.000
Suicidal (lifetime)	173.208	1	0.000
Professional fulfillment	19.204	1	0.000
Psychological support	43.674	2	0.000
MSPSS	39.840	2	0.000
Bullying/harassment/microaggressions	44.320	3	0.000
Collegiality index	26.456	1	0.000

Parent or caregiver

ITEMS WITH CHI-SQUARE TESTING	Pearson chi-square value	df	p-value
Mental health (flourishing/languishing)	32.630	6	0.000
Self-reported mental health worse than before COVID-19	85.464	3	0.000
Overall burnout	65.330	3	0.000
Depression	28.737	3	0.000
Anxiety	31.146	3	0.000
Professional fulfillment	37.733	3	0.000

Appendix C. Survey instrument

* Please note that through the development process and prior to survey opening, some questions were removed after the survey was scripted. In order to avoid breaks in the skip logic of the digital survey, we've opted to simply remove the associated questions from the appendix while leaving the Q# in their original order.

Introduction

CMA NATIONAL PHYSICIAN HEALTH SURVEY

Thank you for participating in the 2021 National Physician Health Survey. Your feedback will help the Canadian Medical Association (CMA) generate an up-to-date national data set on the health and wellness of Canadian practising physicians, medical residents and medical students.

Over the past two years, the medical profession has faced unprecedented levels of change, uncertainty, stress and strain. By sharing your experiences and highlighting the factors affecting your practice, daily interactions, lifestyle and mental health, you will help the CMA and other stakeholders identify the individual and system-level changes needed to better support health workers, create a healthier medical culture and guide a post-pandemic recovery.

Survey details

Please complete the survey by Nov. 15, 2021. It should take you less than 20 minutes; your time is greatly appreciated.

Please note that an “open” survey link is being used so the CMA can distribute the survey more widely and reach as many physicians as possible. This means you must complete the survey in one sitting.

Privacy

The information you share will remain strictly confidential and anonymous. You are under no obligation to participate in the survey and if you choose to participate, you are not required to answer every question. By completing the survey, you consent to your feedback being used as part of this study. See below for privacy policies.

Research ethics

This survey has received ethical approval from the University of Ottawa Research Ethics Board. If you have any questions about the ethical conduct of this study, please contact ethics@uottawa.ca.

Results

Overall findings from the survey will be shared publicly in the summer of 2022. Aggregated results will be posted on the CMA website and will be used by the CMA, researchers, educators, and health care organizations to inform physician health and wellness initiatives.

The CMA has engaged Ipsos, a third-party research firm, to collect and analyze the data. The information you share will remain strictly confidential and anonymous and will be used for research purposes only. All results will be communicated in aggregate (grouped) format. You are under no obligation to participate in the survey.

Before completing the survey, please read the following Ipsos and CMA privacy policies and click to accept.

- Ipsos privacy policy [HYPERLINK]
- I have read and acknowledge Ipsos' privacy policy
- CMA privacy policy [HYPERLINK]

I have read and acknowledge the CMA's privacy policy

[RESPONDENT MUST SELECT BOTH TO CONTINUE WITH SURVEY]

[SHOW NEXT SCREEN]

Will you be using a screen reader or assistive technology (e.g. Jaws, ZoomText or Dragon) to complete the survey?

- Yes [IF YES, RESPONDENT WILL RECEIVE GRID TYPE QUESTIONS AND NOT PROGRESSIVE GRIDS. SEE INSTRUCTIONS THROUGHOUT SURVEY]
 - No
-

SECTION 1. YOU AND YOUR PRACTICE

Q1. What is your career stage?

- Medical student
- Medical resident
- Practising physician
- Retired (not eligible) [THANK AND TERMINATE]

[TERMINATE MESSAGE: Thank you for your interest in participating in the 2021 CMA National Physician Health Survey. This survey is being conducted among practising physicians.

[IF PRACTISING PHYSICIANS OR MEDICAL RESIDENT IN Q1, ASK Q2; ELSE SKIP TO Q3]

Q2. Are you an international medical graduate?

- Yes
- No

Q3. Do you identify as...?

- Male
- Female
- Neither applies to me. I identify as (please specify):
- Prefer not to answer

Q5. To which age group do you belong?

- <25
- 25 – 34
- 35 – 44
- 45 – 54
- 55 – 64
- 65 – 74
- 75 years or older
- Prefer not to answer

Q6. Please indicate your primary province or territory of practice/work/school:

- British Columbia
- Alberta
- Saskatchewan
- Manitoba
- Ontario
- Quebec
- New Brunswick
- Nova Scotia
- Prince Edward Island
- Newfoundland & Labrador
- Northwest Territories
- Yukon
- Nunavut
- Prefer not to answer

Q7. Which option best describes the main area in which you currently practice/work/are doing your residency?

[LIST TYPE QUESTION]

- | | |
|-------------------------------------|---|
| • Administrative position | • Nuclear medicine |
| • Anatomical pathology | • Obstetrics and gynecology |
| • Anesthesiology | • Ophthalmology |
| • Cardiac surgery | • Orthopedic surgery |
| • Dermatology | • Otolaryngology-head and neck surgery |
| • Diagnostic radiology | • Pediatrics |
| • Emergency medicine | • Physical medicine and rehabilitation |
| • Family medicine, general practice | • Plastic surgery |
| • General pathology | • Psychiatry |
| • General surgery | • Public health and preventive medicine |
| • Hematological pathology | • Radiation oncology |
| • Internal medicine | • Urology |
| • Medical genetics and genomics | • Vascular surgery |
| • Medical microbiology | • Other (please specify): |
| • Neurology | • Prefer not to answer |
| • Neuropathology | • Not applicable |
| • Neurosurgery | |

[IF PRACTISING PHYSICIANS IN Q1, ASK Q8; ELSE SKIP TO INSTRUCTIONS BEFORE Q9]

Q8. For how many years have you been practising medicine?

- 5 or less years
- 6 to 10 years
- 11 to 15 years
- 16 to 20 years
- 21 to 25 years
- 26 to 30 years
- 31 years or more
- Prefer not to answer

[IF MEDICAL STUDENTS IN Q1, ASK Q9; ELSE SKIP TO INSTRUCTIONS BEFORE Q10]

Q9. Please indicate your current status:

- 1st year medical student
- 2nd year medical student
- 3rd year medical student
- 4th year medical student
- Other (please specify):
- Prefer not to answer

[IF MEDICAL RESIDENTS IN Q1, ASK Q10; ELSE SKIP TO Q11]

Q10. Please indicate your current status:

- PGY-1
- PGY-2
- PGY-3
- PGY-4
- PGY-5
- PGY -6 or greater
- Other (please specify):
- Prefer not to answer

Q11. Do you consider yourself a person living with a disability, impairment, or long-term condition related to any of the following? (select all that apply)

- Hearing
- Speech
- Physical or mobility
- Mental health condition
- Neurodevelopment disorders (ADHD, autism, dyspraxia, Tourette syndrome, others)
- Chronic or long-term condition (diabetes, multiple sclerosis, heart conditions, epilepsy, chronic pain, others)
- Other (please specify)
- No, I do not have a disability, impairment, or long-term condition
- Prefer not to answer

Q12. Do you identify as Indigenous?

- First Nations (North American Indian)
- Métis
- Inuk (Inuit)
- Other (please specify):
- No, I do not identify as Indigenous
- Prefer not to answer

Q13. How would you describe yourself? (select all that apply)

[MULTI-SELECT]

- White
- South Asian (East Indian, Pakistani, Sri Lankan, etc.)
- Chinese
- Black or African American
- Filipino
- Latin American
- Arab
- Southeast Asian (Vietnamese, Cambodian, Laotian, Thai, etc.)
- West Asian (Iranian, Afghan, etc.)
- Korean
- Japanese
- Mixed race
- Other (please specify): [NOT EXCLUSIVE]
- Prefer not to answer

Q14. Do you have dependents for whom you are the primary caregiver? (select all that apply)

- Yes, I have a child/children under 18 years old of age
- Yes, I provide care for a parent, family member or friend who has a long-term physical health or mental health issues
- No [EXCLUSIVE]
- Deleted

[IF MEDICAL STUDENT IN Q1, SKIP TO Q20a]

Q16. With respect to your main patient care/ practice setting, which of the following best describes the geographic population PRIMARILY served by you in your practice/residency?

- Urban/suburban
- Small town/rural
- Geographically isolated, remote
- Cannot identify a primary geographic population
- Prefer not to answer

Q17. Which of the following best describe(s) your primary work/ residency setting?

- Community hospital
- Private office or clinic
- Academic health centre
- Administrative office or corporate office
- Other (please specify):
- Prefer not to answer

Q18. Please indicate the predominant means by which you are paid for your professional services:

- Fee-for-service
- Capitation
- Salary
- Sessional/per diem/hourly
- Blended
- Other

[IF BLENDED IN Q18, ASK Q18A; ELSE SKIP TO Q20]

Q18a. Please specify your predominant model.

- Fee-for-service
- Capitation
- Salary
- Sessional/per diem/hourly
- Other

SECTION 2. YOUR DAILY WORK AND INTERACTIONS

[DO NOT ASK IF Q1 = MEDICAL STUDENT]

Q20. Please indicate how many hours in a typical week you usually spend on the following tasks:

Note: For any task(s) that you do not perform in a typical week, please ENTER "0". Please provide your best estimate.

- [CHANGE TO 168 HOURS AND PROVIDE A (DYNAMIC) SUM TOTAL AS A FOURTH **BOX** UNDER ALL THREE OF THE CATEGORIES. IF ADDS UP TO >168 HRS, SHOW ERROR MESSAGE "The total number of hours exceeds 168 hours in a week, please review your responses". ALLOW TO GO TO NEXT QUESTION REGARDLESS OF RESPONSE. IF LEAVE ANY CATEGORY EMPTY SHOW ERROR MESSAGE "Please enter a number. If none, enter "0"."]
- PATIENT CARE: Including direct patient care, indirect patient care, and on-call work hours
- [NUMERIC 0 TO 168] hours per week
- ADMINISTRATIVE TASKS: Including electronic documentation time, email, prescriptions, ordering tests, etc.
- [NUMERIC 0 TO 168] hours per week
- OTHER DUTIES/RESPONSIBILITIES: Including teaching, committee work, research, leadership role, etc.
- [NUMERIC 0 TO 168] hours per week
- TOTAL HOURS PER WEEK: [SUM TOTAL]
- [ASK IF Q1=MEDICAL STUDENT; IF Q1= CODES 2 OR 3, GO TO Q23]

Q20a. Please indicate how many hours in a typical week you usually spend on the following tasks:

Note: For any task(s) that you do not perform in a typical week, please ENTER "0". Please provide your best estimate.

- COURSE WORK/CLERKSHIP: Including class, reading, studying, clinical work, etc. [NUMERIC 0 TO 168] hours per week
- OTHER DUTIES/RESPONSIBILITIES: Including volunteering, additional work outside of medicine, committee work, research, leadership role, etc. [NUMERIC 0 TO 168] hours per week
- TOTAL HOURS PER WEEK: [SUM TOTAL]

[ASK ALL]

Q23. Please indicate how strongly you agree or disagree with the following statements:

Note: When you respond to each statement, the question will automatically move forward to the next statement. When it no longer moves forward, please click the "Next" button.

[PROGRESSIVE GRID. RANDOMIZE. IF YES IN Q.VIS, SHOW GRID QUESTION (SINGLE ANSWER PER ROW)]

- If I make a mistake in this team, it is held against me.
- Members of this team are able to bring up problems and tough issues (including colleagues, nurses, admin).
- People on this team sometimes reject others for being different (including colleagues, nurses, admin).
- It is safe to take a risk in this team.
- It is difficult to ask other members of this team for help (including colleagues, nurses, admin).
- No one on this team would deliberately act in a way that undermines my efforts (including colleagues, nurses, admin).
- Working with members of this team, my unique skills and talents are valued and used.

[SCALE. LEFT TO RIGHT]

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree
- Not applicable

Q24. To what extent do you agree with the following statements?

Note: When you respond to each statement, the question will automatically move forward to the next statement. When it no longer moves forward, please click the "Next" button.

[PROGRESSIVE GRID. RANDOMIZE. IF YES IN Q.VIS, SHOW GRID QUESTION (SINGLE ANSWER PER ROW)]

- In general, I find my colleagues to be supportive
- People treat each other with respect in my work group
- A spirit of cooperation and teamwork exists in my work group
- Disputes or conflicts are resolved fairly in my work group

[SCALE. LEFT TO RIGHT]

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree
- Not applicable

Q25. Have you ever personally experienced intimidation, bullying, harassment and/or microaggressions in the workplace or in a training environment?

- Everyday
- A few times a week
- Once a week
- A few times a month
- Once a month or less
- A few times a year
- Never

[IF MEDICAL STUDENT IN Q1, SKIP TO Q30]

Q29. Have you been involved in a college complaint or lawsuit? (Select all that apply)

[MULTI-SELECT]

- Yes, in the past year
- Yes, two to three years ago
- Yes, four to five years ago
- Yes, more than five years ago
- Never [EXCLUSIVE]

SECTION 3. YOUR HEALTH AND LIFESTYLE

Q30. Do you have a regular primary care physician (i.e., registered)?

- Yes
- No

Q35. How often do you feel fatigued at work/school?

- Never
- Rarely
- Sometimes
- Often
- Always

Q37. How often do you feel you are getting optimal sleep?

- Never
- Rarely
- Sometimes
- Often
- Always

Q38. What self-care activities do you do to support your well-being in your personal life, outside of work (excluding household duties / chores / responsibilities)?

[RANDOMIZE]

- | | |
|---|--|
| • Physical activity | • Stretching |
| • Healthy eating | • Gardening |
| • Optimal sleep | • Cooking or baking |
| • Spiritual practices (prayer, worship, etc.) | • Dance |
| • Mindfulness or meditation | • Art, such as painting or crafting |
| • Mindful breathing (e.g., box breathing) | • Volunteering |
| • Building resilience | • Reading |
| • Peer support | • Spending time with family and/or friends |
| • Self-compassion exercises | • Other (please specify) [ANCHOR] |
| • Practising gratitude (e.g., journaling) | • None of the above [EXCLUSIVE] |
| • Music | |

Q39. Which, if any, of the following barriers prevent you from maintaining a healthy lifestyle (e.g., being physically active, eating healthily, getting adequate sleep)? (Check all that apply.)

[RANDOMIZE]

- Shiftwork (e.g., inadequate recovery periods between shifts)
- Scheduling (e.g., long work hours)
- Heavy workload and/or stressful work environment
- No post-call day
- Psychological distress
- Other priorities (e.g., children)
- My workplace or training environment doesn't support these behaviours (e.g., minimal healthy food choices, lack of access to physical activity facilities)
- Lack of time
- Maintaining a healthy lifestyle is not a priority for me
- Other (please specify): [ANCHOR]
- No barriers, I am able to maintain a healthy lifestyle [EXCLUSIVE]

Q40. Which of the following does your current workplace offer to support your wellness (if any)?

[RANDOMIZE]

- Daycare services
 - Nutritious food options
 - Access to exercise facilities and/or activities
 - Access to a primary care physician
 - Access to psychological supports and/or peer support program
 - Back-up call, when I need time off for urgent life matters
 - Other wellness-related activities and/or incentives (please specify):
 - None of the above
-

SECTION 4. YOUR MENTAL HEALTH

Q41. Please indicate how often you have the following feelings about your work or training environment:

Note: When you respond to each statement, the question will automatically move forward to the next statement. When it no longer moves forward, please click the “Next” button.

[PROGRESSIVE GRID. RANDOMIZE. IF YES IN Q.VIS, SHOW GRID QUESTION (SINGLE ANSWER PER ROW)]

- I feel burned out from my work or training environment
- I have become more callous towards people since I took this job or started this training

[SCALE. LEFT TO RIGHT]

- Everyday
- A few times a week
- Once a week
- A few times a month
- Once a month or less
- A few times a year
- Never

Q42. How often have you been bothered by the following over the past two (2) weeks?

Note: When you respond to each item, the question will automatically move forward to the next item. When it no longer moves forward, please click the “Next” button.

[PROGRESSIVE GRID. RANDOMIZE. IF YES IN Q.VIS, SHOW GRID QUESTION (SINGLE ANSWER PER ROW)]

- Feeling nervous, anxious, or on edge
- Not being able to stop or control worrying
- Worrying too much about different things
- Trouble relaxing
- Being so restless that it’s hard to sit still
- Becoming easily annoyed or irritable
- Feeling afraid as if something awful might happen

[SCALE. LEFT TO RIGHT]

- Nearly every day
-

- More than half the days
- Several days
- Not at all

Q43. To what extent do you agree or disagree with the following statements?

Note: When you respond to each statement, the question will automatically move forward to the next statement. When it no longer moves forward, please click the “Next” button.

[ROWS. PROGRESSIVE. RANDOMIZE. IF YES IN Q.VIS, SHOW GRID QUESTION (SINGLE ANSWER PER ROW)]

- Overall, I am satisfied with my current job or training position.
- My professional values are well aligned with those of my department or academic leaders
- I feel a great deal of stress because of my job or training position
- The electronic medical record (EMR) adds to the frustration of my day

[SCALE. LEFT TO RIGHT]

- Agree strongly
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Not applicable

Q44. Using your own definition of “burnout”, please select one of the following statements below:

- (5) I enjoy my work. I have no symptoms of burnout.
- (4) I am under stress, and I don’t always have as much energy as I did in the past, but I don’t feel burned out.
- (3) I am definitely burning out and have one or more symptoms of burnout, (e.g., emotional exhaustion).
- (2) The symptoms of burnout that I am experiencing won’t go away. I think about work frustrations a lot.
- I feel completely burned out. I am at the point where I may need to seek help.

Q45. How would you rate the following?

Note: When you respond to each statement, the question will automatically move forward to the next statement. When it no longer moves forward, please click the “Next” button.

[ROWS. PROGRESSIVE. RANDOMIZE. IF YES IN Q.VIS, SHOW GRID QUESTION (SINGLE ANSWER PER ROW)]

- My control over my workload is...
- The degree to which my care team works efficiently together is
- Sufficiency of time for documentation is

[SCALE. COLUMNS. LEFT TO RIGHT]

- Poor
- Marginal
- Satisfactory
- Good
- Optimal
- Not applicable

Q45a. Please complete the following statement:

The amount of time I spend on the electronic medical record (EMR) at home is...

- Excessive
- Moderately high
- Satisfactory
- Modest
- Minimal/none
- Not applicable

Q45b. Which number best describes the atmosphere in your primary work area?

- 5-Calm
- 4
- 3-Busy, but reasonable
- 2
- 1-Hectic, chaotic

Q45aa. Please rate your degree of satisfaction with each of the following dimensions of your workplace.

Note: When you respond to each item, the question will automatically move forward to the next item. When it no longer moves forward, please click the “Next” button.

[RANDOMIZE. PROGRESSIVE GRID. IF YES IN Q.VIS, SHOW GRID QUESTION (SINGLE ANSWER PER ROW)]

- Work-life integration (i.e., meeting personal and professional obligations)
- Efficiency and resources (e.g., use of scribes, availability of support staff, efficiency/use of EHR, appointment system, and ordering systems)

[SCALE. LEFT TO RIGHT]

- Very dissatisfied
- Dissatisfied
- Satisfied
- Very satisfied
- Not applicable

Q46. During the past 12 months:

Note: When you respond to each item, the question will automatically move forward to the next items. When it no longer moves forward, please click the “Next” button. There are 14 statements in total.

[GRID. ROWS. CHANGE TO PROGRESSIVE GRID. IF YES IN Q.VIS, SHOW GRID QUESTION (SINGLE ANSWER PER ROW)]

- Was there ever a time lasting two weeks or more when you lost interest or pleasure in most things like hobbies, and/or work activities that usually give you pleasure?
- Was there ever a time when you felt down, depressed, or hopeless for two or more weeks in a row?

[COLUMNS]

- Yes
- No

[ON OWN PAGE]

Q47_intro. The next few questions may be deemed sensitive. These questions ask about substance use and suicidal ideation. The CMA and Ipsos are collecting such data in order to understand the prevalence of these behaviours and feelings among physicians.

A “Prefer not to answer” option will be available for you to select, if you choose not to answer a specific question.

Participation is completely voluntary and you may withdraw your consent at any time. Your answers from this survey will be combined with the answers from all other participants for reporting purposes, and your personal data will be held for no longer than 12 months.

- Do you accept the collection of sensitive data on suicidal ideation and substance use?
- Yes, I accept [CONTINUE]
- No, I do not accept [SKIP Q47-49 AND GO TO Q50]

Q47. Have you had thoughts of suicide? (select all that apply):

- Yes, before medical school
- Yes, during medical school
- Yes, during residency
- Yes, during medical practice
- No, I have never had thoughts of suicide [EXCLUSIVE]

Note: Should you have experienced any psychological or emotional discomfort during this survey, please contact your Provincial Physician Health Program or the CMA Wellness Support Line which offers free, confidential, 24/7 bilingual counselling and mental health supports to physicians, medical learners and their immediate families.

[IF NO IN Q47, SKIP TO Q49]

Q48. Have you had thoughts of suicide in the last 12 months?

- Yes
- No

Q49. In the past year, how many times have you used the following substances for non-medical reasons?

Note: When you respond to each item, the question will automatically move forward to the next item. When it no longer moves forward, please click the “Next” button.

[GRID. ROWS. RANDOMIZE. IF YES IN Q.VIS, SHOW GRID QUESTION (SINGLE ANSWER PER ROW)]

- Alcohol (for men, five or more drinks in a day; for women, four or more drinks in a day) [SHOW AS HOVER OVER: A drink is one can/bottle of beer or wine cooler, one glass of wine, one cocktail, or one shot of liquor]
- Stimulants (unauthorized, e.g., Ritalin, Dexedrine, Adderall, Vyvanse)
- Tobacco products
- Cannabis (recreational)
- Other (e.g., narcotics, benzodiazepine, cocaine, mushrooms)
- Opioids (unauthorized)

[SCALE]

- Never
- Once or twice
- Monthly
- Weekly
- Daily or almost daily

Q50. How true do you feel the following statements are about you at work or school during the past two weeks?

Note: When you respond to each item, the question will automatically move forward to the next item. When it no longer moves forward, please click the “Next” button.

[PROGRESSIVE GRID. RANDOMIZE. IF YES IN Q.VIS, SHOW GRID QUESTION (SINGLE ANSWER PER ROW)]

- I feel happy at work or school
- I feel worthwhile at work or school
- My work is satisfying to me
- I feel in control when dealing with difficult problems at work or school
- My work is meaningful to me
- I’m contributing professionally (e.g., patient care, research, and leadership) in the ways I value most

[SCALE. LEFT TO RIGHT]

- Not at all true
- Somewhat true
- Moderately true
- Very true
- Completely true

Q53a. How often do you feel supported by your social network?

- Always
- Very often
- Sometimes
- Rarely
- Never
- Not applicable

Q53b. Where is most of your support coming from? (select all that apply)

[MULTI-SELECT]

- Family
- Friends
- Colleagues
- Significant other
- Religious or spiritual community
- Other (please specify): [ANCHOR]
- None of the above [EXCLUSIVE]

Q54. Compared with before the COVID-19 pandemic, how would you rate your mental health now?

- Much better
- Somewhat better
- About the same
- Slightly worse
- Much worse

**Q55. What do you believe has contributed negatively to your mental health during the pandemic?
(select all that apply)**

[RANDOMIZE.MULTI-SELECT]

- Longer time with social restrictions/social isolation
- Continued uncertainty about the future
- Concerns about vaccine rollout
- Increased workload and/or lack of work-life integration
- Family issues and obligations
- Financial insecurity
- Long waitlists
- Challenges acquiring personal protective equipment (PPE)
- Interpersonal conflict
- Concerns about long-term care
- Lack of peer support
- Physical health struggles
- Adjustment to virtual care
- Adjustment to virtual learning
- College complaint or lawsuit
- Rapidly changing policies/processes
- Lack of human resources
- Decreased workload
- Other (please specify): [ANCHOR]
- None of the above [EXCLUSIVE]

Q56. Since the onset of the COVID-19 pandemic, how often have you felt morally distressed?

Moral distress is defined as psychological distress that results from events that go against one's values and moral beliefs. It occurs when one feels unable to take what they believe to be an ethically appropriate or right course of action because of institutionalized obstacles.

- Never
- Rarely
- Sometimes
- Very often
- Always

Q57. How likely is it that you will reduce or modify your clinical work hours in the next 24 months?

- Very unlikely
- Unlikely
- Not sure
- Likely
- Very likely

Q58. In the last five years, have you accessed any of the following wellness supports (including mental health and crisis supports)? (select all that apply)

[RANDOMIZE. MULTIPUNCH]

- Provincial Physician Health Program (PHP)
- Primary care physician
- Mentorship or coaching
- Employee Assistance Program (EAP)
- Other mental health professional (psychiatrist, psychologist, licensed counsellor, etc.) [ALWAYS SHOW AFTER EAP PROGRAM]
- CMA Wellness Support Line
- CMA Wellness Connection
- Local peer support program (i.e., not the Wellness Connection)
- Other (please specify) [ANCHOR]
- None of the above [EXCLUSIVE]

Q60. What do you think are the main reasons some physicians may have for NOT seeking wellness supports? (select up to three reasons)

[RANDOMIZE]

- Risk of losing medical licence and ability to practise
- Other professional consequences (fewer career advancement opportunities, denied insurance, etc.)
- Not aware of the services available
- Professional supports already in place
- Confidentiality
- No time
- Ashamed to seek help
- Concerns about quality of care
- Service not required
- Believing situation is not severe enough
- Other (please specify) [ANCHOR]

Q61. Do you have any additional comments to share related to your wellness?

[OPEN TEXT BOX]

- No further comments
- Q62_intro. Thank you. This concludes the main part of the survey. The CMA would like to offer physicians the opportunity to complete a few optional questions that would allow for more detailed analysis into the health and wellness of physicians. These optional questions would take approximately four (4) minutes to complete.
- Would you like to continue with these optional questions?
- Yes, I would like to continue.
- No, thank you. I would like to stop the survey now.

[IF YES, CONTINUE. IF NO, SKIP TO FINAL PARAGRAPH]

Q62. How often do you have the following feelings about your work or training program?

Note: When you respond to each statement, the question will automatically move forward to the next statement. When it no longer moves forward, please click the “Next” button. There are 22 statements in total.

[PROGRESSIVE GRID. RANDOMIZE. IF YES IN Q.VIS, SHOW GRID QUESTION (SINGLE ANSWER PER ROW)]

- I feel emotionally drained from my work or training program
- I feel used up at the end of the workday or school day
- I feel fatigued when I get up in the morning and have to face another day on the job or at school
- I feel like I’m at the end of my rope
- I feel frustrated by my job or training program
- I feel I’m working too hard on my job or training program
- Working with people directly puts too much stress on me
- I feel burned out from my work or training program
- Working with people all day is really a strain for me
- I feel I treat some patients as if they were impersonal objects
- I have become more callous towards people since I took this job or started this training program
- I worry that this job or training program is hardening me emotionally
- I don’t really care what happens to some patients
- I feel patients blame me for some of their problems
- I can easily understand how my patients feel about things
- I deal very effectively with the problems of my patients
- I feel I am positively influencing other people’s lives through my work or training program
- I feel very energetic
- I can easily create a relaxed atmosphere with my patients
- I feel exhilarated after working closely with my patients
- I feel I have accomplished many worthwhile things in this job or training program
- In my work or training program, I deal with emotional problems very calmly

[SCALE. LEFT TO RIGHT]

- Everyday
- A few times a week
- Once a week
- A few times a month
- Once a month or less
- A few times a year
- Never
- Not applicable

Q63. To what degree have you experienced the following?

During the past two weeks I have felt...

Note: When you respond to each statement, the question will automatically move forward to the next statement. When it no longer moves forward, please click the “Next” button. There are 4 statements in total.

[PROGRESSIVE GRID. RANDOMIZE. IF YES IN Q.VIS, SHOW GRID QUESTION (SINGLE ANSWER PER ROW)]

- A sense of dread when I think about work I have to do
- Physically exhausted at work or school
- Lacking in enthusiasm at work or school
- Emotionally exhausted at work or school

[SCALE. LEFT TO RIGHT]

- Not at all
- Very little
- Moderately
- A lot
- Extremely

Q63b. During the past two weeks my job has contributed to me feeling...

- Note: When you respond to each statement, the question will automatically move forward to the next statement. When it no longer moves forward, please click the “Next” button. There are 6 statements in total.

[PROGRESSIVE GRID. RANDOMIZE]

- Less empathetic with my patients
- Less empathetic with my colleagues
- Less sensitive to others' feelings/emotions
- Less interested in talking with my patients
- Less connected with my patients
- Less connected with my colleagues

[SCALE. LEFT TO RIGHT]

- Not at all
- Very little
- Moderately
- A lot
- Extremely

Q64. How often in the past month did you feel...?

Note: When you respond to each item, the question will automatically move forward to the next items. When it no longer moves forward, please click the “Next” button. There are 14 statements in total.

[PROGRESSIVE GRID. IF YES IN Q.VIS, SHOW GRID QUESTION (SINGLE ANSWER PER ROW)]

- Happy
- Interested in life
- Satisfied with your life
- That you had something important to contribute to society
- That you belonged to a community (like a social group, your neighbourhood, your city, your school)
- That our society is becoming a better place for people like you
- That people are basically good
- That the way our society works makes sense to you
- That you liked most parts of your personality
- Good at managing the responsibilities of your daily life
- That you had warm and trusting relationships with others
- That you had experiences that challenged you to grow and become a better person
- Confident to think or express your own ideas and opinions
- That your life has a sense of direction or meaning to it

[SCALE. LEFT TO RIGHT]

- Everyday
- Almost everyday
- About two or three times a week
- About once a week
- Once or twice
- Never

Q65. Read each statement carefully and indicate how you feel.

Note: When you respond to each statement, the question will automatically move forward to the next statement. When it no longer moves forward, please click the “Next” button. There are 12 statements in total.

This is the final question of the optional portion of the survey.

[PROGRESSIVE GRID. RANDOMIZE. IF YES IN Q.VIS, SHOW GRID QUESTION (SINGLE ANSWER PER ROW)]

- There is a special person who is around when I am in need.
- There is a special person with whom I can share joys and sorrows.
- My family really tries to help me.
- I get the emotional help and support I need from my family.
- I have a special person who is a real source of comfort to me.
- My friends really try to help me.
- I can count on my friends when things go wrong.
- I can talk about my problems with my family.
- I have friends with whom I can share my joys and sorrows.
- There is a special person who cares about my feelings.

- My family is willing to help me make decisions.
- I can talk about my problems with my friends.

[SCALE. LEFT TO RIGHT]

- Very strongly disagree
- Strongly disagree
- Mildly disagree
- Neutral
- Mildly agree
- Strongly agree
- Very strongly agree

[FINAL PARAGRAPH]

Thank you for taking the time to complete this survey. Should you have experienced any psychological or emotional discomfort during this survey, please contact your Provincial Physician Health Program or the CMA Wellness Support Line, which offers free, confidential, 24/7 bilingual counselling and mental health supports to physicians, medical learners and their immediate families.

