



MASSACHUSETTS
MEDICAL SOCIETY

Every physician matters, each patient counts.

Supporting MMS Physicians' Well-Being Report: Recommendations to Address the On-Going Crisis

March 2023

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Executive Summary

High-quality patient care relies on the occupational well-being of the physicians providing that care. Physician well-being has been an important topic for physicians and the health care system for many years.¹ In settings where physicians' job demands consistently outpace resources, burnout increases. Abundant evidence indicates that it is the system, not the individual alone, that primarily drives burnout.² By the same token, evidence suggests that occupational well-being can be improved through organizational interventions that reduce the mismatch between job demands and resources. In fact, prior to the COVID-19 pandemic, the attention on reducing physician burnout and the corresponding actions appeared to be leading to reduced rates of burnout.³ Unfortunately, the trend appears to have reversed during the pandemic, with worsening physician burnout and ever more concerns about burnout's impact on the physician workforce.

The Massachusetts Medical Society (MMS) developed this survey to assess physician burnout and to identify specific drivers of work-related stress for MMS members of various demographic groups in order to provide general insights regarding the state of physician well-being in Massachusetts.

This survey showed concerning levels of burnout and intent to leave among MMS members, with certain demographics at greater risk for occupational distress and departure from medicine. These results raise serious concerns regarding the stability and well-being of our physician workforce, highlighting the need for fundamental systems changes.

To address these challenges, we must begin by understanding the key drivers of burnout, and we must develop solutions that address its underlying causes. This report is intended to serve as a springboard for action by illuminating some of these challenges and their drivers and providing specific recommendations for moving forward.

¹[https://www.mayoclinicproceedings.org/article/S0025-6196\(21\)00480-8/fulltext](https://www.mayoclinicproceedings.org/article/S0025-6196(21)00480-8/fulltext)

²<https://www.ncbi.nlm.nih.gov/books/NBK552615>

³[https://www.mayoclinicproceedings.org/article/S0025-6196\(18\)30938-8/fulltext](https://www.mayoclinicproceedings.org/article/S0025-6196(18)30938-8/fulltext)

Key Findings

- » **Burnout is a serious concern for Massachusetts physicians**
 - Overall, 55% of respondents experienced symptoms that reach the threshold for burnout.
- » **Many physicians have already reduced, or intend to reduce their clinical effort**
 - More than 50% of respondents had already reduced or were “Definitely” or “Likely” to reduce their clinical hours over the 12 months following survey dissemination (June 2022).
 - About one in four respondents planned to leave medicine in the next two years.
- » **There is room for improvement in workplace support and culture for physicians**
 - Only one in three respondents felt their work schedule allowed enough time for their personal and/or family life.
 - Only one in four respondents felt their workplace provided useful resources that supported their physical health and well-being.
 - Roughly half of respondents felt they matter to their organization, whereas 15% of respondents felt they matter “Not at All” and 36% felt they matter “Somewhat.”
- » **Occupational well-being and its drivers vary by demographic category**
 - Burnout, intent to leave or reduce hours, workplace perceptions, and workplace stressors all varied depending on respondents’ gender, race, ethnicity, years in practice, and practice type.
 - The data suggest that more attention is needed with respect to the occupational well-being of particular groups, including women physicians, physicians of color, underrepresented physicians, and younger physicians.
- » **Sexism and racism represent important workplace stressors for all genders and races**
 - Almost a quarter of all respondents (regardless of gender) reported that gender inequities and/or structural sexism cause workplace stress.
 - Almost a quarter of all respondents (regardless of race/ethnicity) reported that racial inequities and/or structural racism cause workplace stress. Among respondents who identified as Black/African American, 86% cited racial inequities and/or structural racism as their #1 work stressor.
 - Among the 22 respondents who identified as Hispanic/Latino/Latinx, 41% cited racial inequities and/or structural racism as a work stressor.
- » **The primary workplace stressors reported by physicians relate to systems issues, including the need for improved workplace support and culture**
 - The top five work stressors* for respondents were as follows:
 - Increased documentation requirements not always related to clinical care (80.9%).
 - Lack of support staff for non-medical tasks (64.2%).
 - Prior Authorization (PA) requirements (58.2%).
 - Overreach of non-medical administrators in medical decision-making and resource allocation (57.3%).
 - Turnover of clinical and/or non-clinical staff (56.6%).

*Stressor order varied by gender, race, and ethnicity. See “work stressors by demographics” page 31.

Introduction

Increasing burnout among physicians represents a well-recognized and growing threat to patient care, to physicians themselves, and to the health care industry. As detailed in the Massachusetts Medical Society's report: [*A Crisis in Health Care: A Call to Action on Physician Burnout*](#), this phenomenon existed long before the COVID-19 pandemic and was driven by rapid changes in health care and the professional environment. The crisis has only accelerated during the pandemic.

When physicians' job demands chronically exceed available resources, physicians eventually become burned out and experience emotional exhaustion, cynicism, and a loss of a sense of efficacy in their work. Factors contributing to physician burnout include increased administrative burden, workforce shortages, escalating practice costs, overreach of non-medical administrators, and historic levels of inflation. In Massachusetts, as elsewhere, these challenges are compounded by financial instability caused by uncertain revenues, resulting, for example, from lower reimbursement for patients insured through MassHealth and from continuous threats of Medicare payment reductions. Such factors collectively undermine practice sustainability as well as the well-being of the health care work force, and thus have negative implications for patient access to much-needed high-quality health care.

The importance of understanding and addressing physician burnout is further underscored by the Physicians Foundation's 2022 *Survey of America's Physicians: Part 3, Assessing the State of Physician Practice and the Strategies*. This report documents an alarming loss of physician morale and details how the above factors and more have led to a system where physicians feel unable to do their jobs to the best of their ability, and where many plan to leave the profession.

The Massachusetts Medical Society (MMS) extensively invested in efforts to support physician wellness. In 2018, the MMS and the Massachusetts Health and Hospital Association (MHA) created a [*first-of-its-kind Joint Task Force on Physician Burnout*](#). The task force's mission is to identify and prioritize effective strategies to mitigate burnout and to advocate for statewide adoption of identified strategies and practices. The task force has worked actively to raise awareness around the prevalent reality of physician burnout, and to identify strategies that will improve the system. The MMS-MHA Joint Task Force on Physician Burnout has published white papers, held educational programs, and convened key meetings with state agencies to spread awareness of and seek to reduce physician burnout. Examples of this work include a manuscript entitled [*A Crisis in Health Care: A Call to Action on Physician Burnout*](#); educational efforts, including convening a landmark [*Medical Student and Residency Program Burnout Roundtable*](#); and numerous [*additional accomplishments*](#). Finally, the MMS offers extensive educational programming on topics including psychoeducation, burnout prevention, and mindfulness and compassion during tumultuous times.

This report explores self-reported physician well-being in Massachusetts, including drivers of stress, the rate of burnout and intent to leave, and perceptions of workplace support and culture. Although similar work has been done at a national level, it has never been completed on a broad scale in Massachusetts. Recommendations are offered. Discussion will continue.

Methodology and Response Rate

In late spring 2022, MMS staff crafted a survey, working from the “Coping with COVID-19 for Caregivers Survey” from the American Medical Association (AMA) and expanding it to resonate for Massachusetts. MMS staff further worked with Susannah G. Rowe, MD, MPH, FACS, to refine a survey tool designed to assess physician stressors and wellness. The survey was pilot tested for clarity and purpose and was updated accordingly, based on feedback from members from MMS committees, task forces and sections, including the Women Physicians Section Governing Council, the Committee on Women’s Health, the MMS-MHA Joint Task Force on Physician Burnout, and the Committee on Mental Health and Substance Use.

The survey was emailed directly to MMS members twice in the summer of 2022 (responders were deleted from second mailing), and the survey was promoted twice to MMS members via the MMS weekly newsletter, *Vital Signs This Week*.

Participants

Surveys were sent to 20,952 members in the categories of Students, Residents, Physicians, and Senior Physicians. Medical Students, although emailed, were not identified/ included in this survey.

Demographics

The survey asked for demographic information as follows:

- » For Years of Practice, the survey asked respondents to choose one of the following: <5 years, 5–10, 11–15, 16–20, 21–25, 26–30, or 30+.
- » For Type of Practice, respondents were asked to choose one of the following: Group Practice Owner, Co-Owner, Shareholder, Partnership, Group Practice Employee, Hospital Employee, Federally Qualified Health Center Employee, Solo Practice, Resident, Fellow, Teaching or Academic Medicine, Administration, or Research.

- » For Gender, respondents were asked to choose one of the following: Female, Male, Self-Defined Gender, or Prefer Not to Answer.
- » For Race, respondents were asked to check all that apply from the following: Asian, Black/African American, Native American or Alaska Native, Native Hawaiian or Other Pacific Islander, Prefer Not to Answer, White, or Other (Please Specify).
- » For ethnicity, respondents were asked to choose one of the following: Hispanic/Latino/Latinx or Not Hispanic/ Latino/Latinx.

Outcome Measures

Respondents were asked to choose from a list of responses to gauge their degree of burnout symptoms using their own definition of burnout. This question was based on a single-item burnout question adapted from the AMA “Coping with COVID-19 for Caregivers Survey” with the additional response “I don’t feel burned out, but I am looking to improve balance in my life.” Survey respondents were also asked if they have reduced, or plan to reduce, hours devoted to clinical care over the next twelve months, and were asked to rate the likelihood that they would leave medicine in the next two years.

Workplace Support and Culture

Respondents were asked to choose which of three statements best described the support and culture at their workplace. The statements were based on recommendations provided by content experts as well as members of the MMS committees, task forces, and sections mentioned in the methodology section:

- » “I matter to my organization.” Whereas other surveys have used the phrase “valued by” rather than “matter to,” for the purposes of this survey, it was decided that using the phrase “matter to” provided a more holistic approach to the question and was therefore more appropriate.

Methodology and Response Rate *(continued)*

- » “My workplace provides useful resources that support my physical health and well-being.”
- » “My work schedule allows enough time for my personal and/or family life.”

Drivers

A list of potential work stressors was developed, based on feedback provided by content experts as well as members of the MMS committees, task forces, and sections. Respondents were asked to indicate which of those stressors contribute to stress in their work lives. Respondents could “Check all that apply.” Respondents were also given the option to answer “Other,” if they did not see a stressor listed, and to provide written detail.

Qualitative Data

Survey respondents also had the chance to voice their opinions about wellness through free text responses to the open-ended question: “What are three things that the MMS can do to support physicians during this time?”

Data Analysis

Demographics Data are reported for female and male genders. In the interests of protecting confidentiality due to small sample size, data for respondents who self-reported genders other than female and male are not shared. Data are reported for each race category separately, such that people who identified as more than one race will appear more than once in the dataset. Data are reported for ethnicity as a binary variable, and for years in practice and practice type as categorical variables.

Outcomes The three primary outcomes of burnout, intent to leave, and reduction of work hours were analyzed overall and, where possible, by gender, race, years in practice, and practice type. The overall burnout percentage was calculated by combining three response percentages: (1) I am beginning to burn out and have one or more symptoms of burnout, (2) The symptoms of burnout that I am experiencing won’t go away, and (3) I feel completely burned out. The “intent to leave” responses were provided as a 5-point Likert scale and then dichotomized in graphs by combining those respondents who stated they were “Likely” to leave in the next two years, and those who stated they were “Definitely” leaving medicine in the next two years.

Workplace Support and Culture Questions Data are reported overall and by demographics.

Drivers Free text comments regarding “Other” work stressors were reviewed and post-coded. All write-in responses fell into one of the existing categories, so these responses were grouped into these categories accordingly. Work stressors were ordered according to frequency of responses, and the top five stressors are highlighted in the attached graphs. Where possible, stressors were analyzed by gender, race, years in practice, and practice type.

Qualitative Responses to the Open-Ended Question about What MMS Can Do to Support Physicians Free text responses were reviewed by MMS staff and were used to help inform the attached recommendations. For confidentiality reasons, these responses are not shared in this report.

Methodology and Response Rate *(continued)*

Response Rate

20,952 members were sent an emailed survey, 10,336 members opened the email, and 575 physician members responded to at least one question. Of the 575 respondents, only 568 answered the “please specify your gender” request. Of those respondents who answered, 281 (49.5%) were women, 267 were men (47%),

18 (3.2%) preferred not to answer, and 2 identified as self-defined gender. Demographic descriptions of survey respondents are shown in the demographics section of survey results at the end of the report.

Findings

Burnout (Overall)

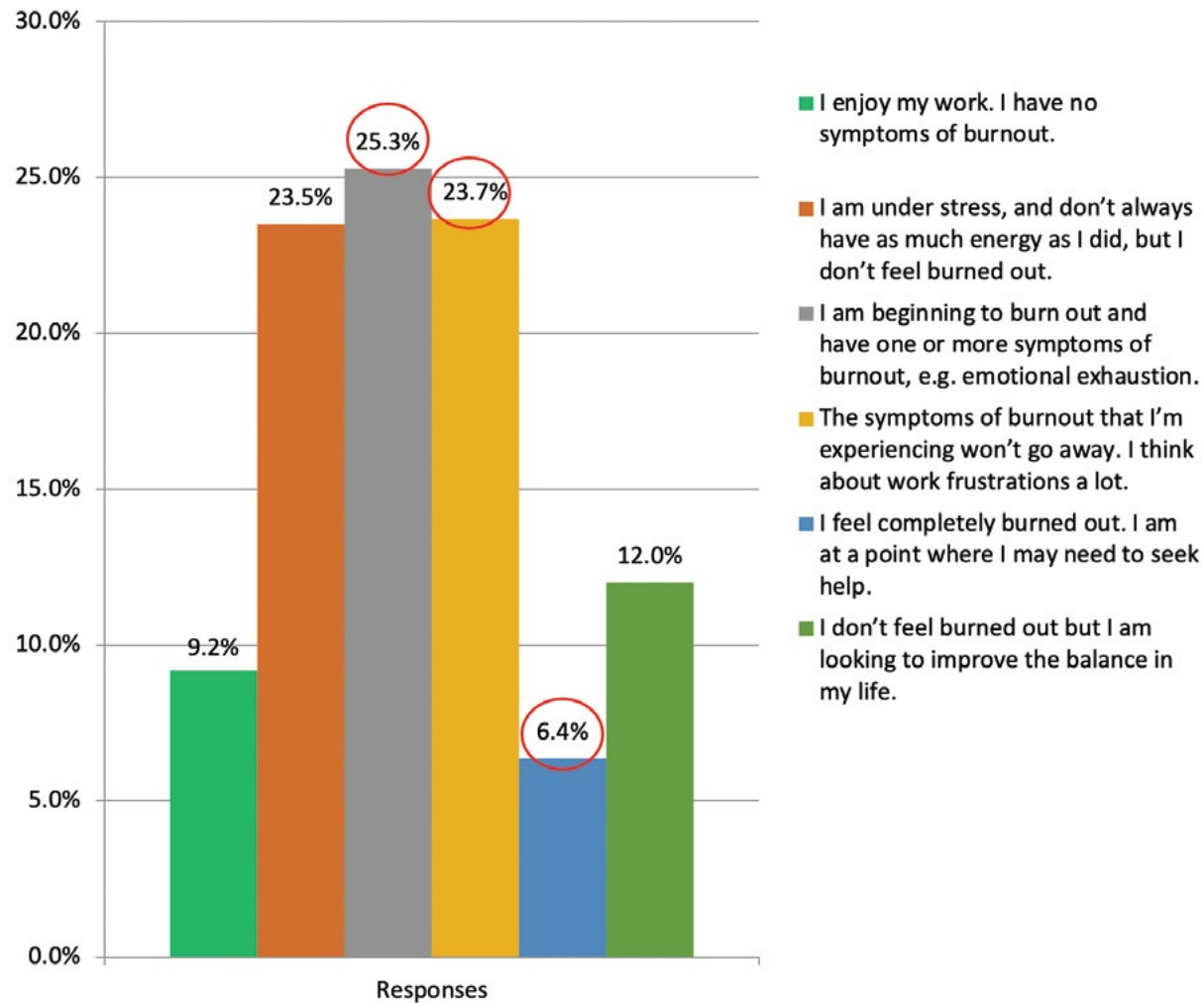
Using their own definition of burnout, 55% of respondents overall experienced symptoms that reached the threshold for burnout* (see methodology section for overall burnout percentage calculation.)

Fewer than 10% of respondents noted that they have no symptoms of burnout, and another 12% indicated that they didn't feel burned out but were looking to improve the balance in their lives.

Approximately a quarter of respondents noted that they were beginning to burnout, and almost 7% of respondents noted that they were completely burned out.

Burnout is a Concern for Massachusetts Physicians and Their Patients

Using your own definition of "burnout," please choose one of the answers below.



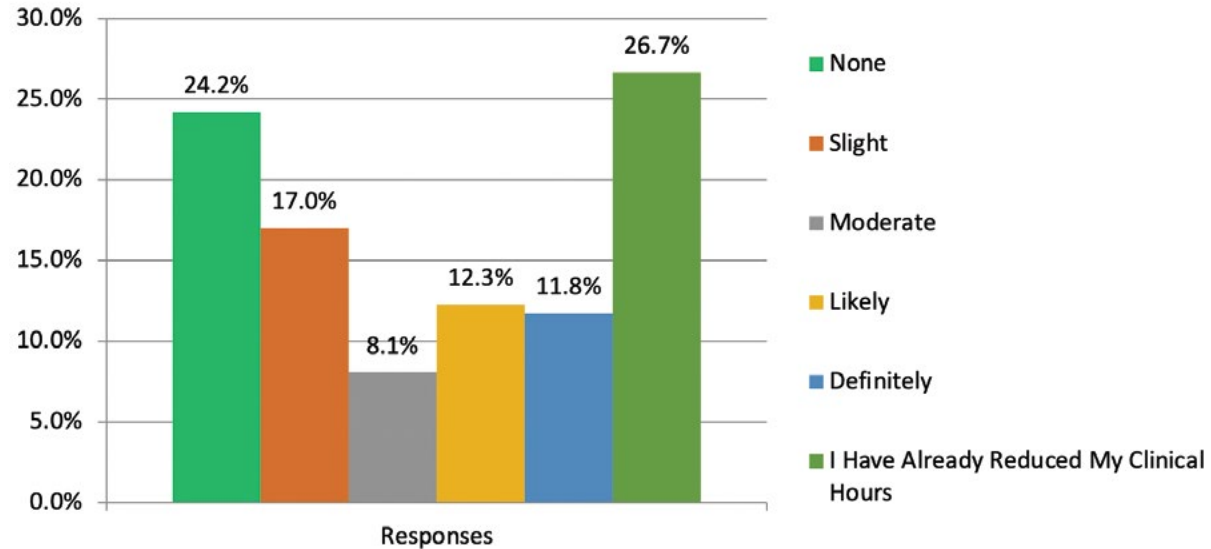
Findings

Anticipated Reduction of Hours Devoted to Clinical Care

Roughly 27% of respondents had already reduced their clinical hours. Additionally, about 24% of survey respondents were “Definitely” or “Likely” to reduce their clinical hours during the next twelve months.

Many Physicians Have Already Reduced, or Intend to Reduce Their Clinical Effort or Leave Medicine

What is the likelihood that you will reduce the number of hours you devote to clinical care over the next 12 months?



Findings

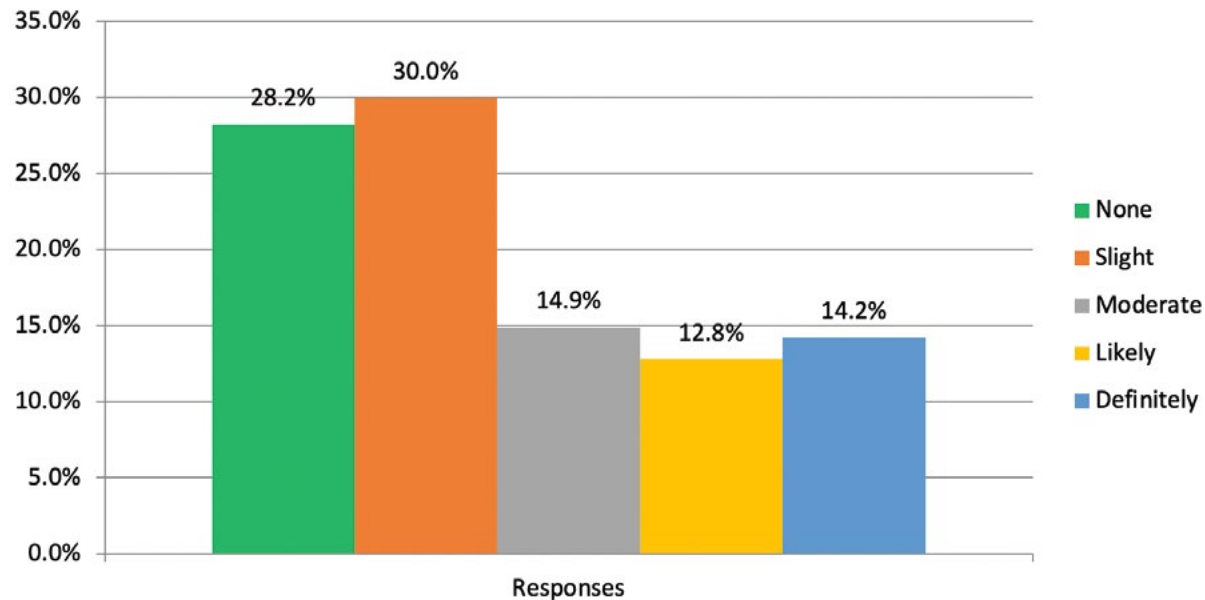
Many Physicians Have Already Reduced, or Intend to Reduce Their Clinical Effort or Leave Medicine (continued)

Likelihood to Leave Medicine in the Next Two Years

At the time of the survey, 27% of respondents said they were expecting to leave medicine in the next two years. This equates to a little over one in four respondents expecting to leave medicine in the next two years.

This figure comes from combining those respondents who stated they were “Likely” to leave medicine in the next two years (12.8%) and those who stated they were “Definitely” going to leave in the next two years (14.2%).

What is the likelihood you will leave medicine in the next two years?



Findings

There is Room for Improvement in Workplace Support and Culture for All Physicians

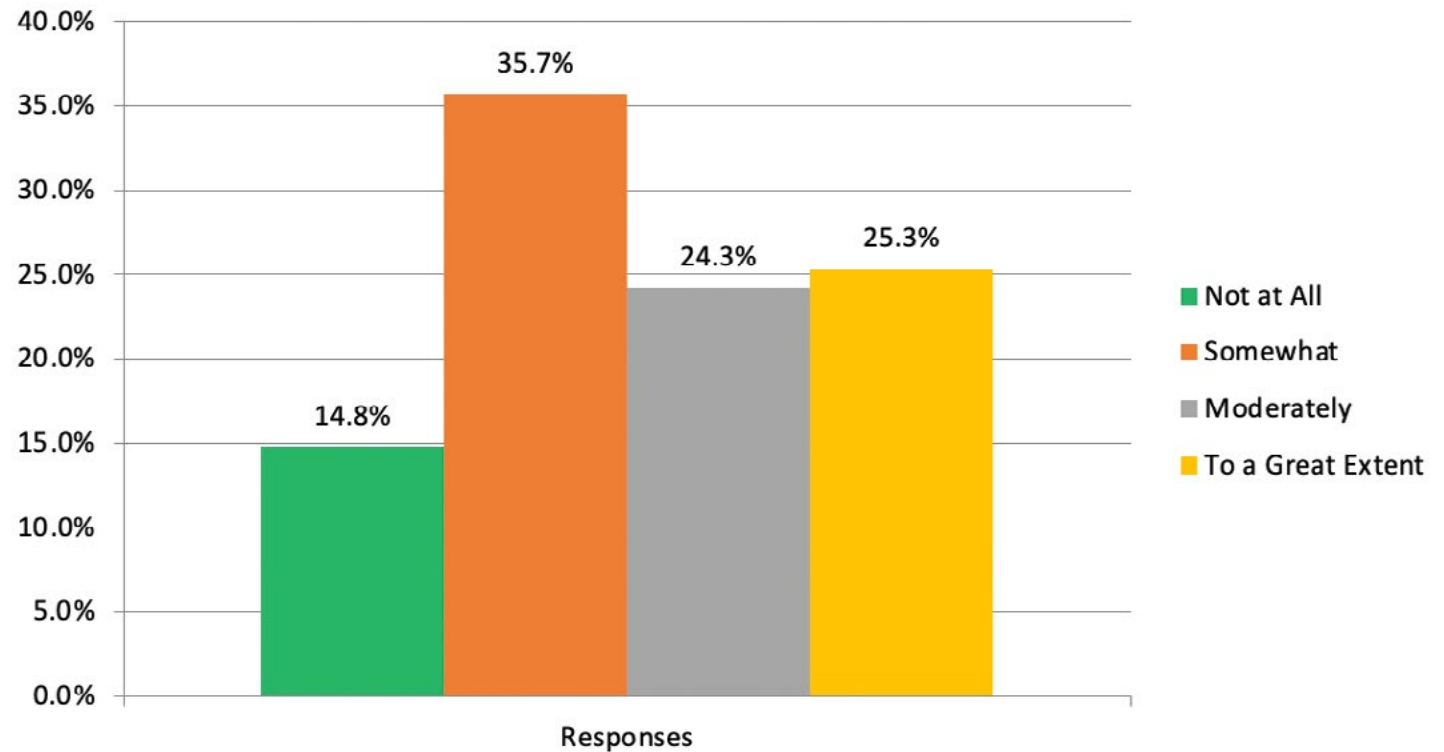
The Perception of Matter to the Organization

About 50% of respondents reported feeling they “matter” to their organization.

Only a little over a quarter of respondents (25.3%) felt they matter “To a Great Extent” to their organization.

Almost 15% of respondents felt they matter “Not at All” to their organization.

I matter to my organization.



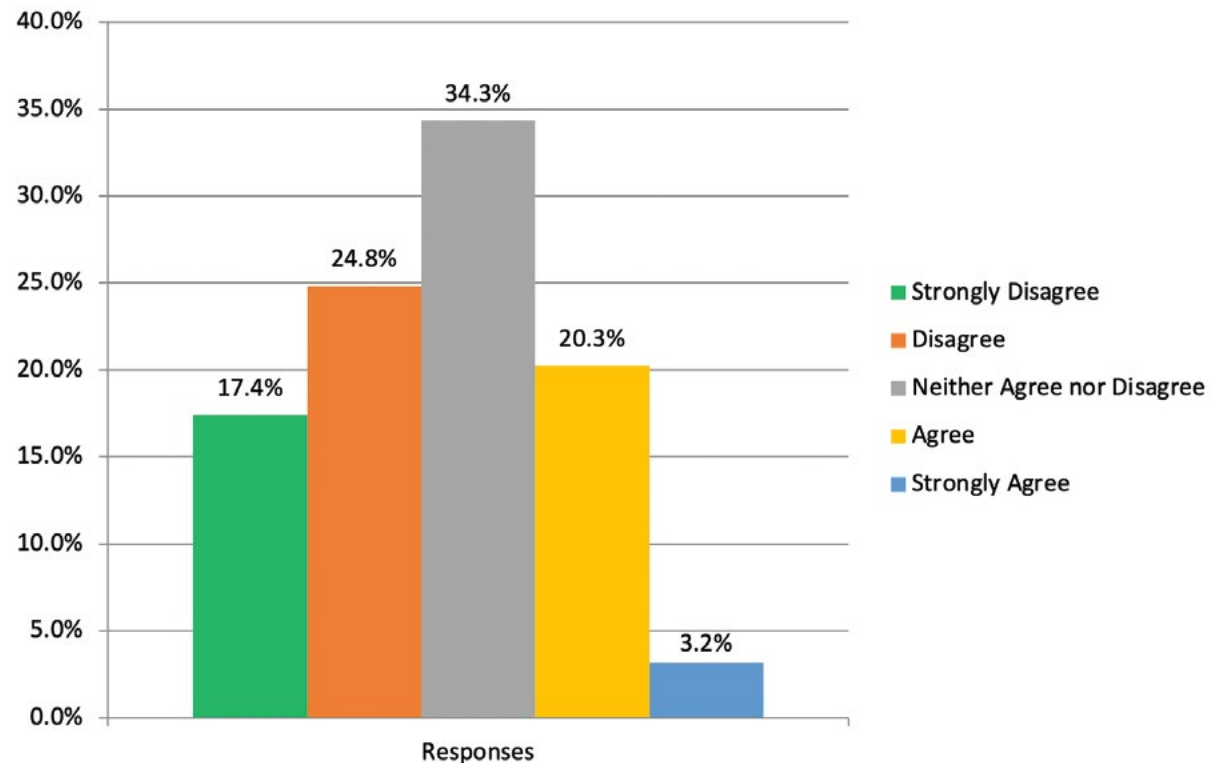
Findings

There is Room for Improvement in Workplace Support and Culture for All Physicians *(continued)*

Workplace Supports

42% of respondents disagreed that their workplace provided useful resources that support their personal health and well-being, compared with 24% who agreed their workplace provided useful resources.

My workplace provides useful resources that support my physical health and well-being.



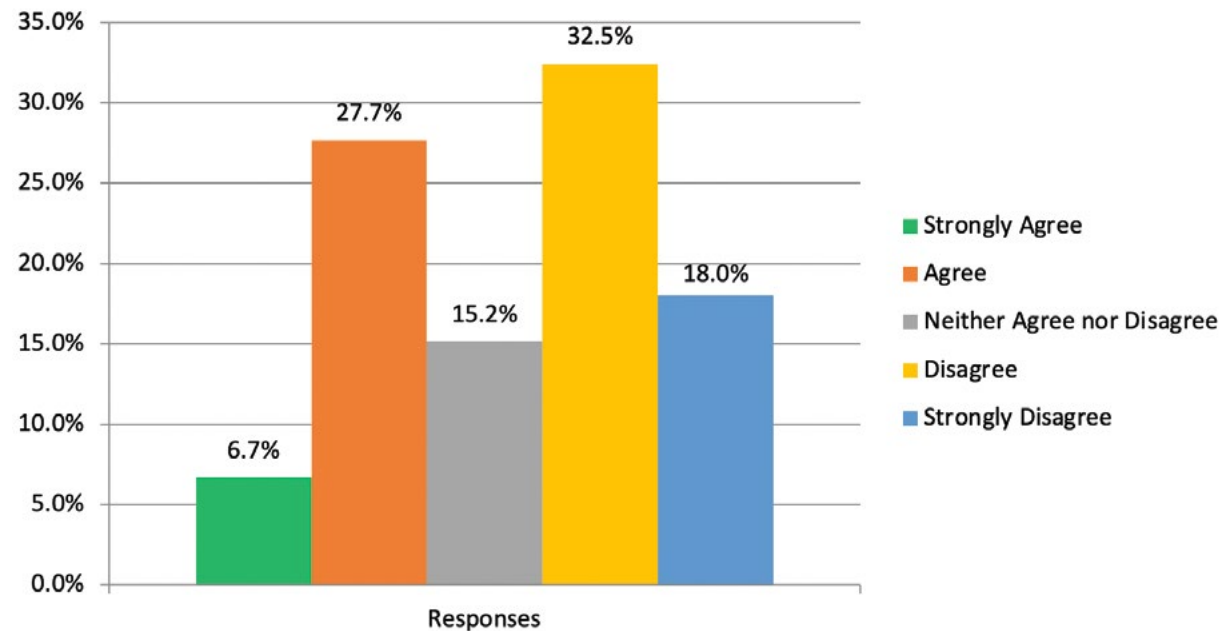
Findings

There is Room for Improvement in Workplace Support and Culture for All Physicians *(continued)*

Work Schedule

50% of respondents largely disagreed that their work schedule allowed enough time for their personal and/or family life. (32.5% “Disagreed” and 18% “Strongly Disagreed”).

My work schedule allows enough time for my personal and/or family life.



Findings

Occupational Well-Being and Its Drivers Vary by Demographic Category

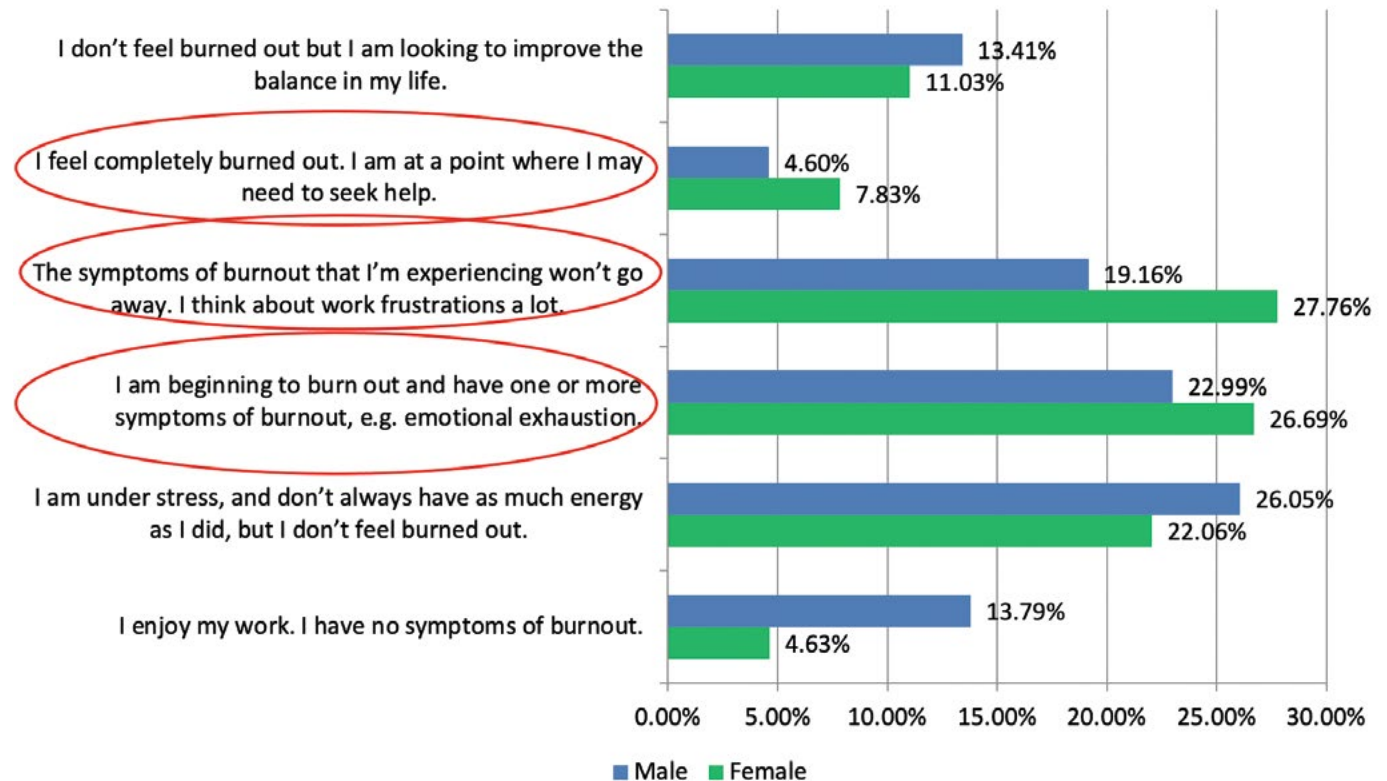
Burnout by Demographic Group By Gender

About 63% of female respondents experienced symptoms of burnout.* By comparison, almost 47% of male respondents reported experiencing burnout.

About 5% of female respondents reported they were enjoying work with no symptoms of burnout, while 14% of male respondents reported they were feeling that way.

At the other extreme, the percentage of female respondents who felt completely burned out (7.8%) was almost double that of male respondents (4.6%). Notably, fewer women (4.6%) than men (13.8%) responded that they “enjoy their work and have no symptoms of burnout.”

Using your own definition of “burnout,” please choose one of the answers below.



Findings

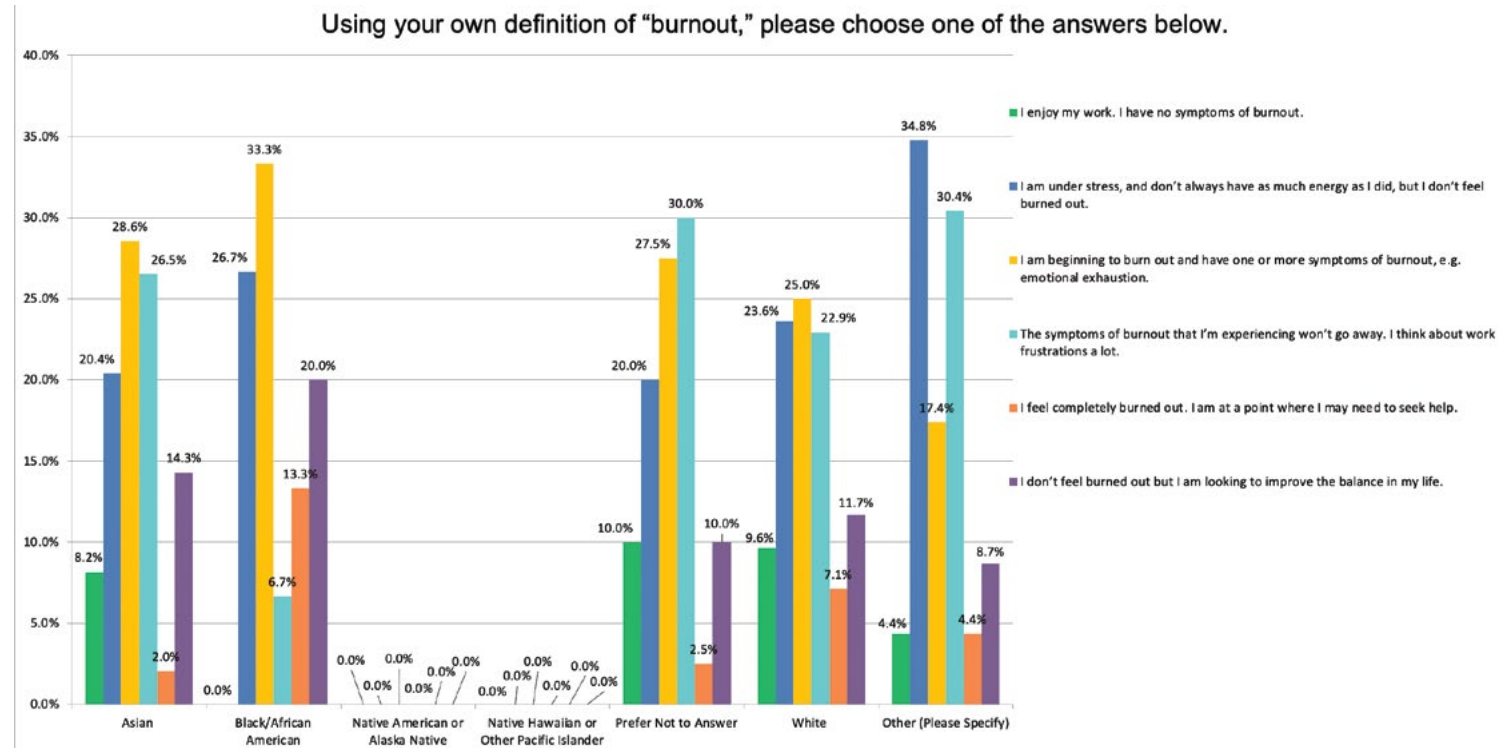
Occupational Well-Being and Its Drivers Vary by Demographic Category (continued)

By Race

57.1% of Asian respondents reported symptoms of burnout, compared with 53.3% of Black/African American respondents and 55.0% of White respondents.

There were no responses from Native American/Alaska Native or Native Hawaiian or Other Pacific Islanders.

60.0% of respondents who preferred not to answer and 52.2% of "Other" respondents reported symptoms of burnout.



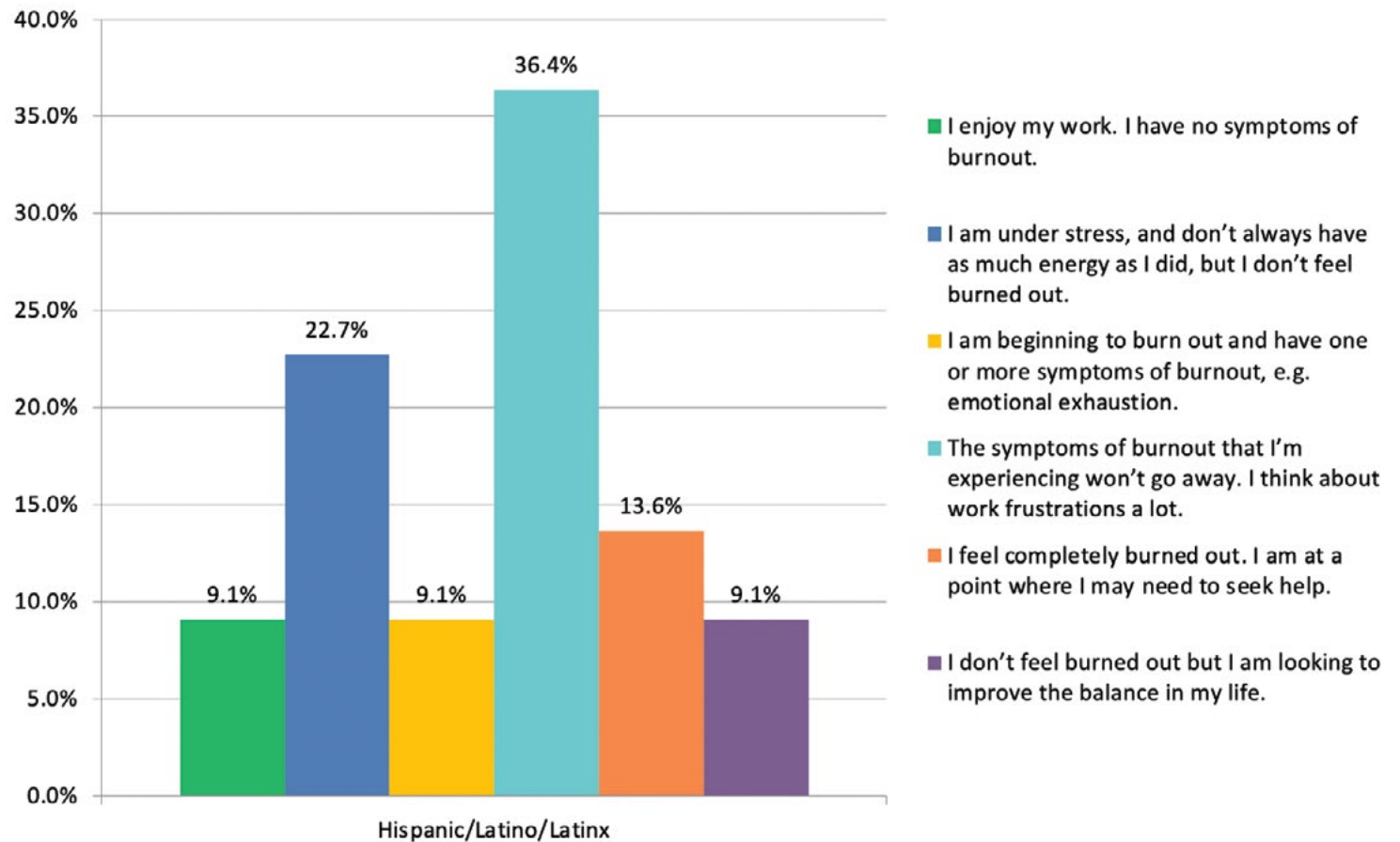
Findings

Occupational Well-Being and Its Drivers Vary by Demographic Category (continued)

By Ethnicity

59.1% of Hispanic/Latino/Latinx reported symptoms of burnout compared with 55.5% of those who did not identify as Hispanic/Latino/Latinx.

Using your own definition of “burnout,” please choose one of the answers below.



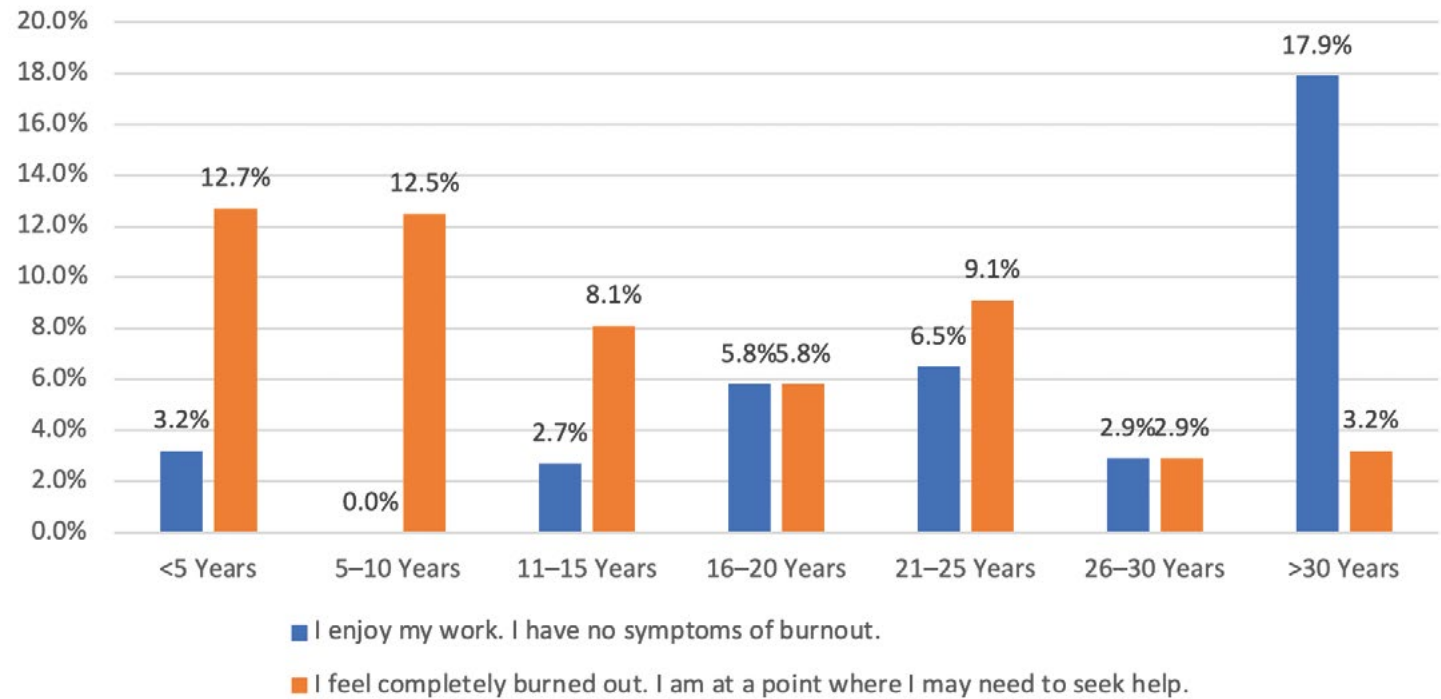
Findings

Occupational Well-Being and Its Drivers Vary by Demographic Category (continued)

By Years in Practice

Notably, only 3.2% percent of those working fewer than five years, and 0% of those who had been in practice for five to ten years responded “I enjoy my work. I have no symptoms of burnout.” In contrast, 12.7% of those working fewer than five years and 12.5% of those working five to ten years felt completely burned out.

Those in practice for more than 30 years had the highest level of work enjoyment (17.9%).



Findings

By Practice Type

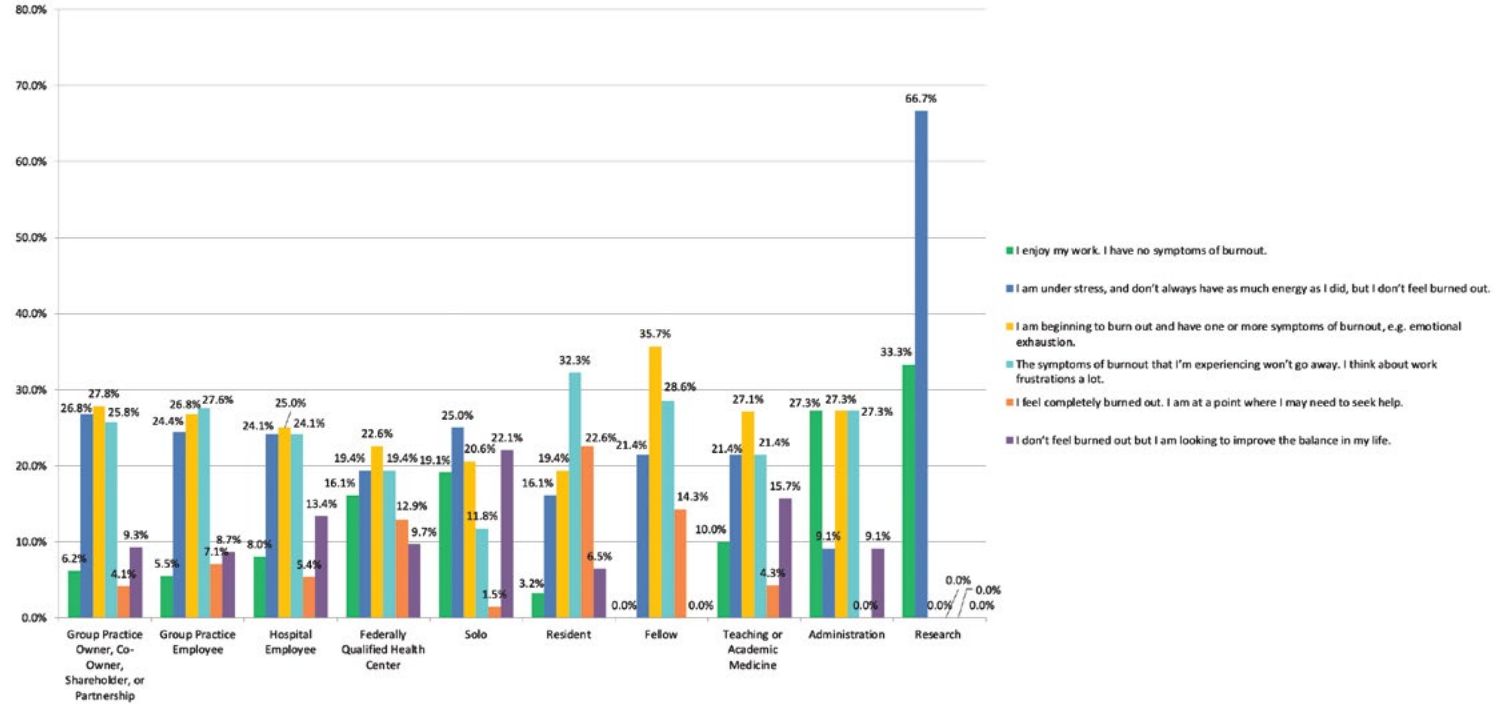
A total of 74.2% of Residents and 78.6% of Fellows reported symptoms of burnout compared with 61.4% of Group Practice Employees and 57.7% of Group Practice Owners.

Federally Qualified Health Center Employees and Hospital Employees reported similar burnout rates of 54.8% and 54.5% respectively.

Notably, 13.4% of Hospital Employees and 22.1% of Solo practice identified “I don’t feel burned out but I am looking to improve the balance in my life.”

Occupational Well-Being and Its Drivers Vary by Demographic Category (continued)

Using your own definition of “burnout,” please choose one of the answers below.



Findings

By Gender

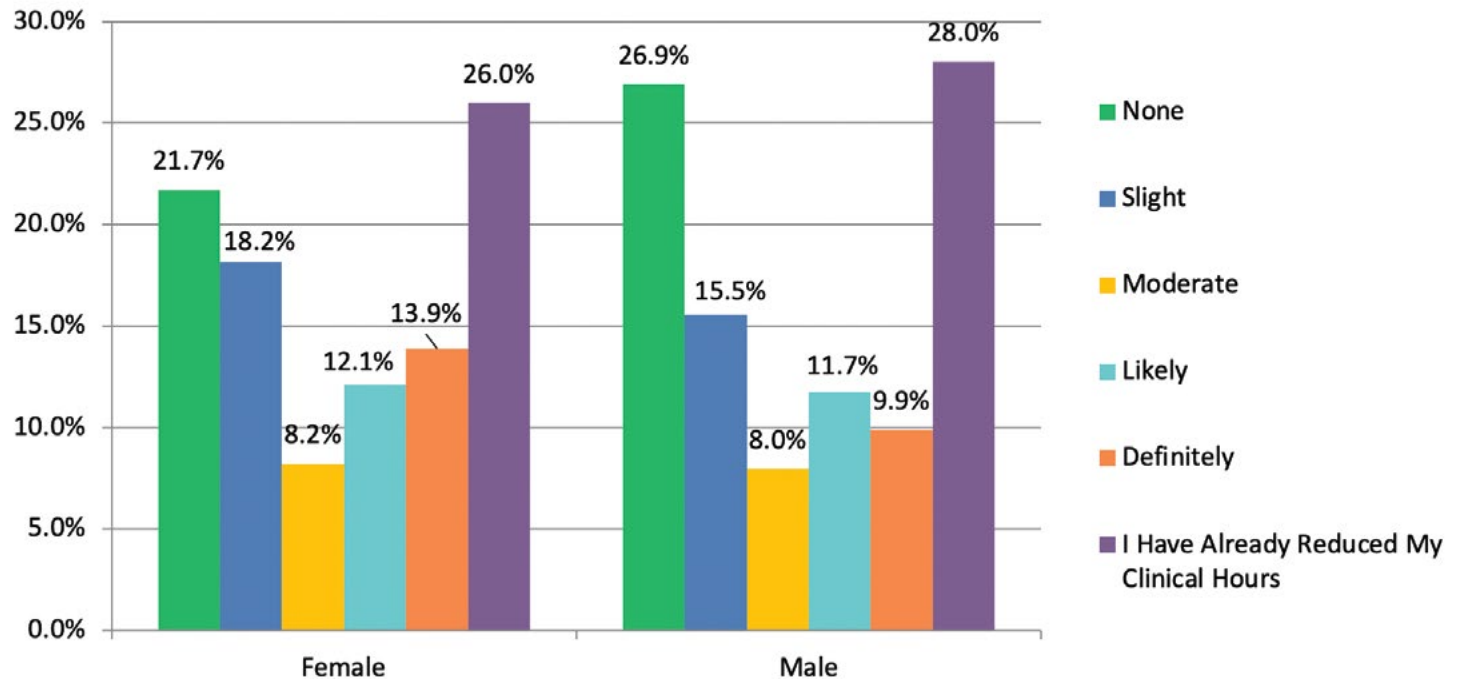
Women were more likely than men to plan to reduce their hours but less likely to say they plan to leave medicine in the next two years.

Reduced Clinical Hours

A higher percentage of female respondents (13.9%) reported they were “Definitely” going to reduce their clinical hours compared with male respondents (9.9%). In contrast, slightly fewer female respondents (26%) had already reduced their clinical hours versus male respondents (28%).

Reductions in Clinical Effort by Demographic Group

What is the likelihood that you will reduce the number of hours you devote to clinical care over the next 12 months?



Findings

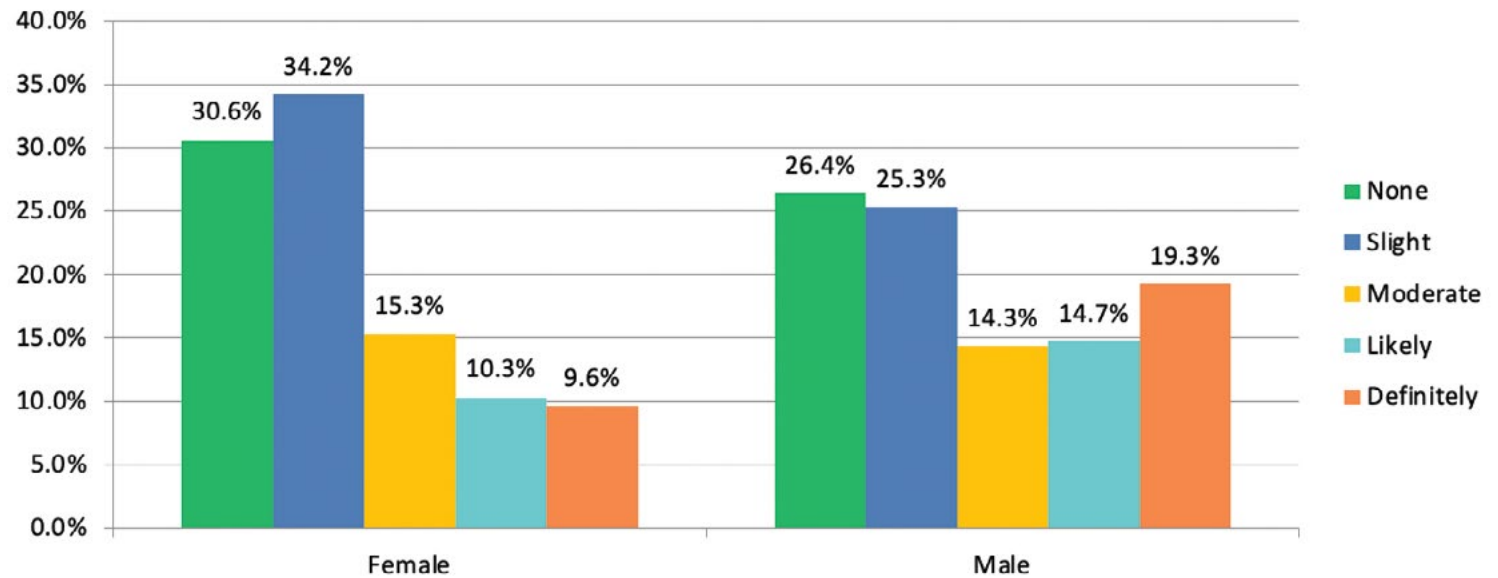
Reductions in Clinical Effort by Demographic Group (continued)

Intent to Leave Medicine

When asked whether they would “Definitely” or “Likely” leave medicine in the next two years, female respondents were less likely to report an intention to leave than male respondents (19.9% versus 34%)*.

*This figure comes from combining those respondents who stated they would “Likely” leave medicine in the next two years and those who stated they would “Definitely” leave medicine in the next two years, separated by gender.

What is the likelihood you will leave medicine in the next two years?



Reductions in Clinical Effort by Demographic Group (continued)

Findings

By Race and Ethnicity

Reduced Clinical Hours

Asians: 20.4% had already reduced hours, and 20.4% reported they were “Likely” and “Definitely” going to reduce hours.

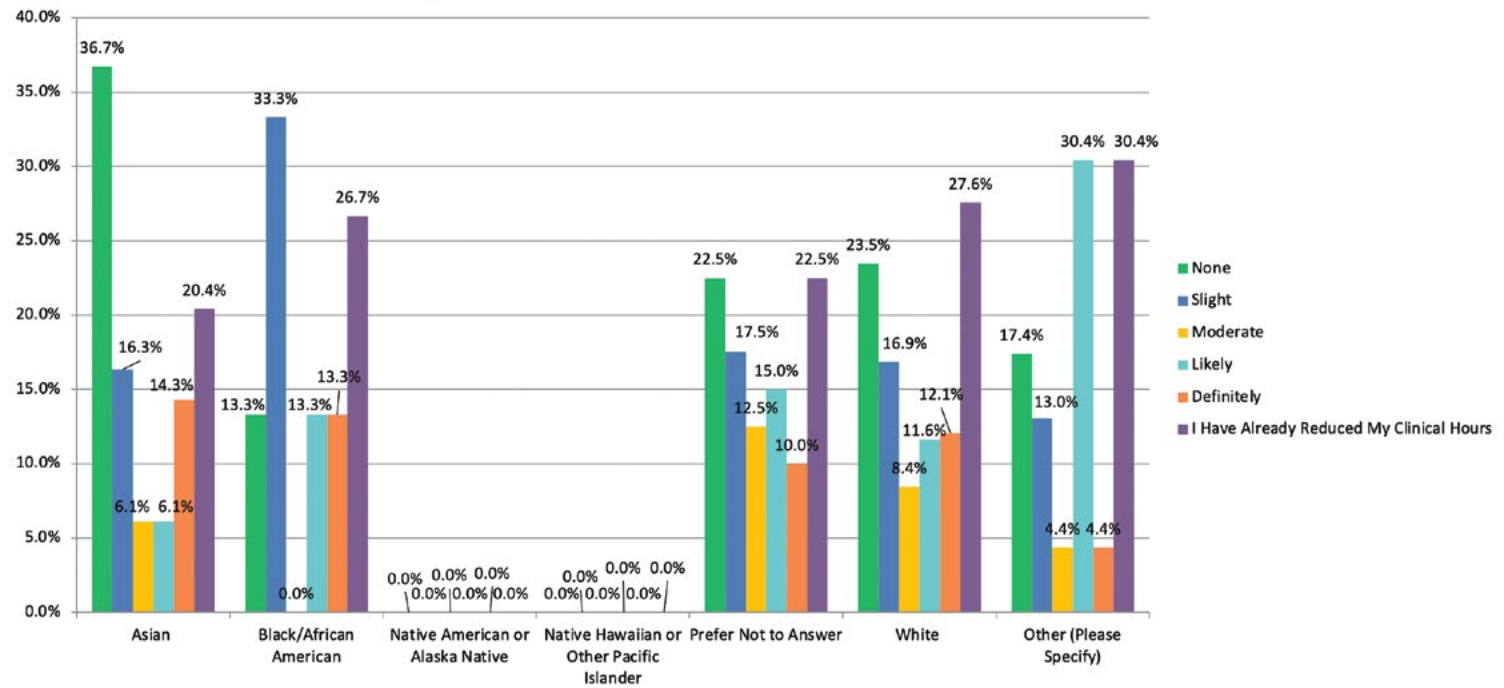
Black/African American: 26.7% had already reduced hours, and 26.6% were “Likely” and “Definitely” going to reduce hours.

White: 27.6% had already reduced hours, and 23.7% were “Likely” and “Definitely” going to reduce hours.

Other: 30.4% had already reduced hours, and 34.8% were “Likely” and “Definitely” going to reduce hours.

Prefer Not to Answer Race: 22.5% had already reduced hours, and 25.0% were “Likely” and “Definitely” going to reduce hours.

What is the likelihood that you will reduce the number of hours you devote to clinical care over the next 12 months?

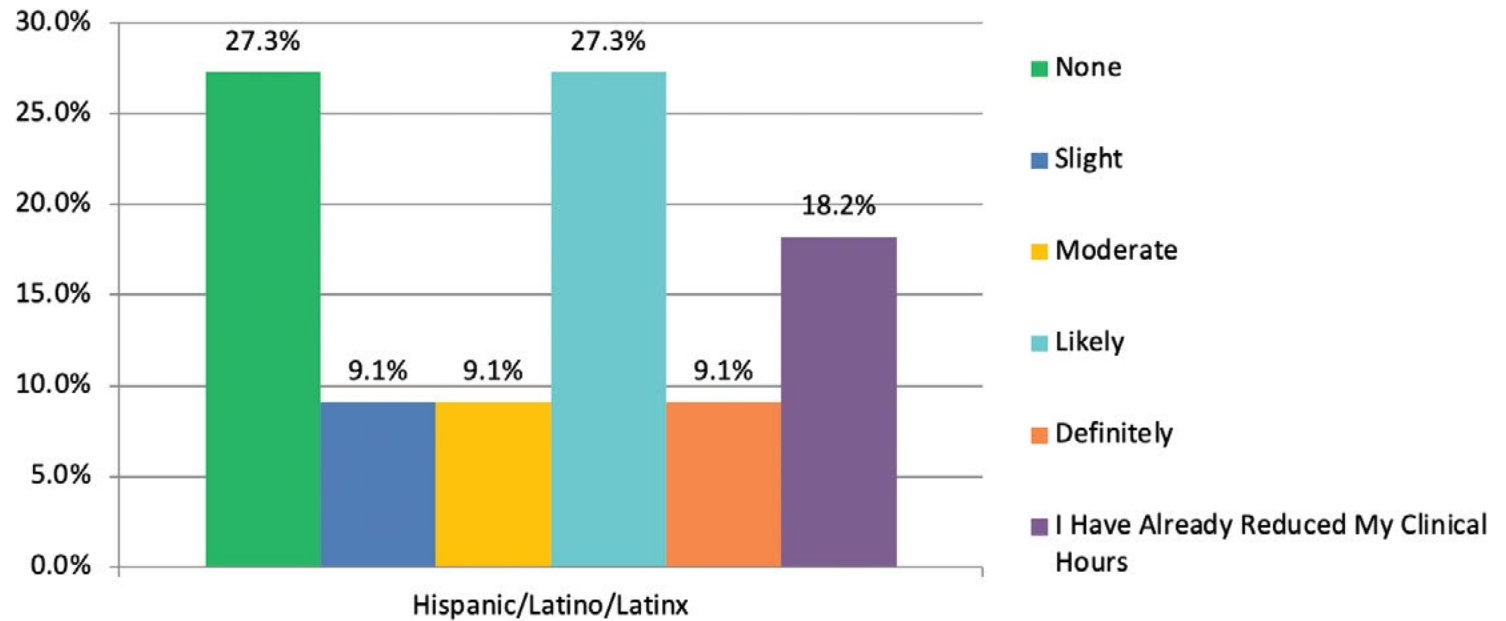


Findings

Reductions in Clinical Effort by Demographic Group (continued)

Hispanic/Latino/Latinx:
18.2% had already reduced hours, and 36.4% were “Likely” and “Definitely” going to reduce hours.

What is the likelihood that you will reduce the number of hours you devote to clinical care over the next 12 months?



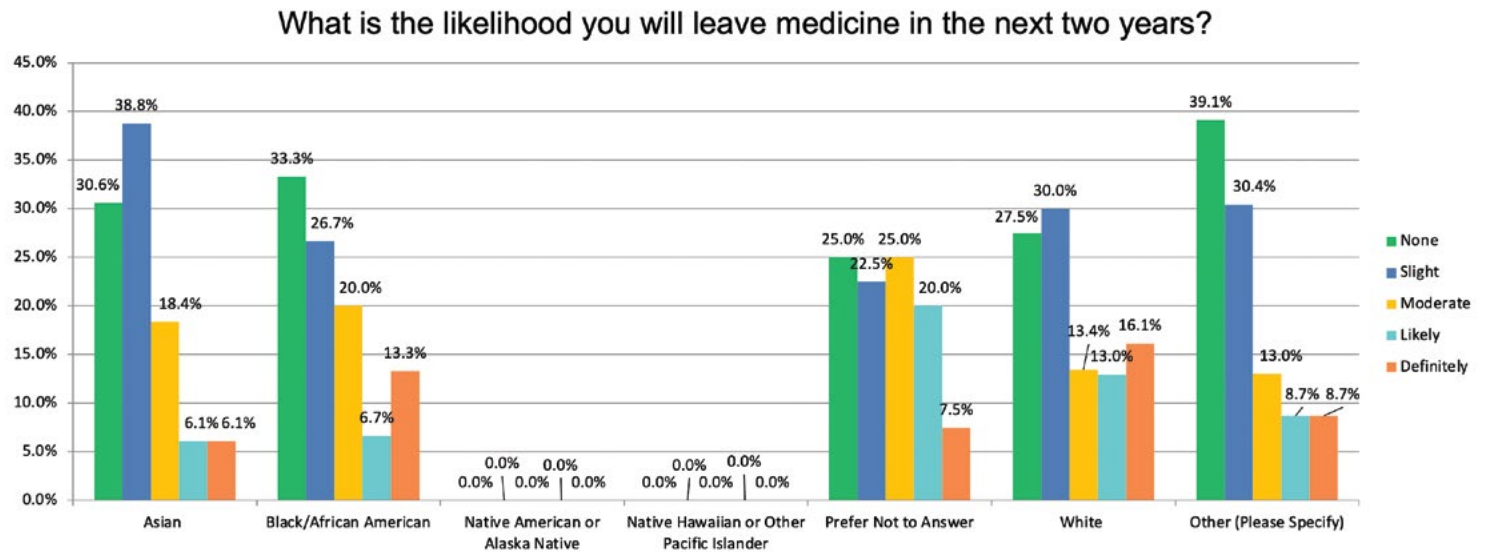
Reductions in Clinical Effort by Demographic Group (continued)

Findings

Intent to Leave Medicine

The percentages of respondents reporting that they were "Likely" or "Definitely" leaving medicine within two years varied by race, as follows:

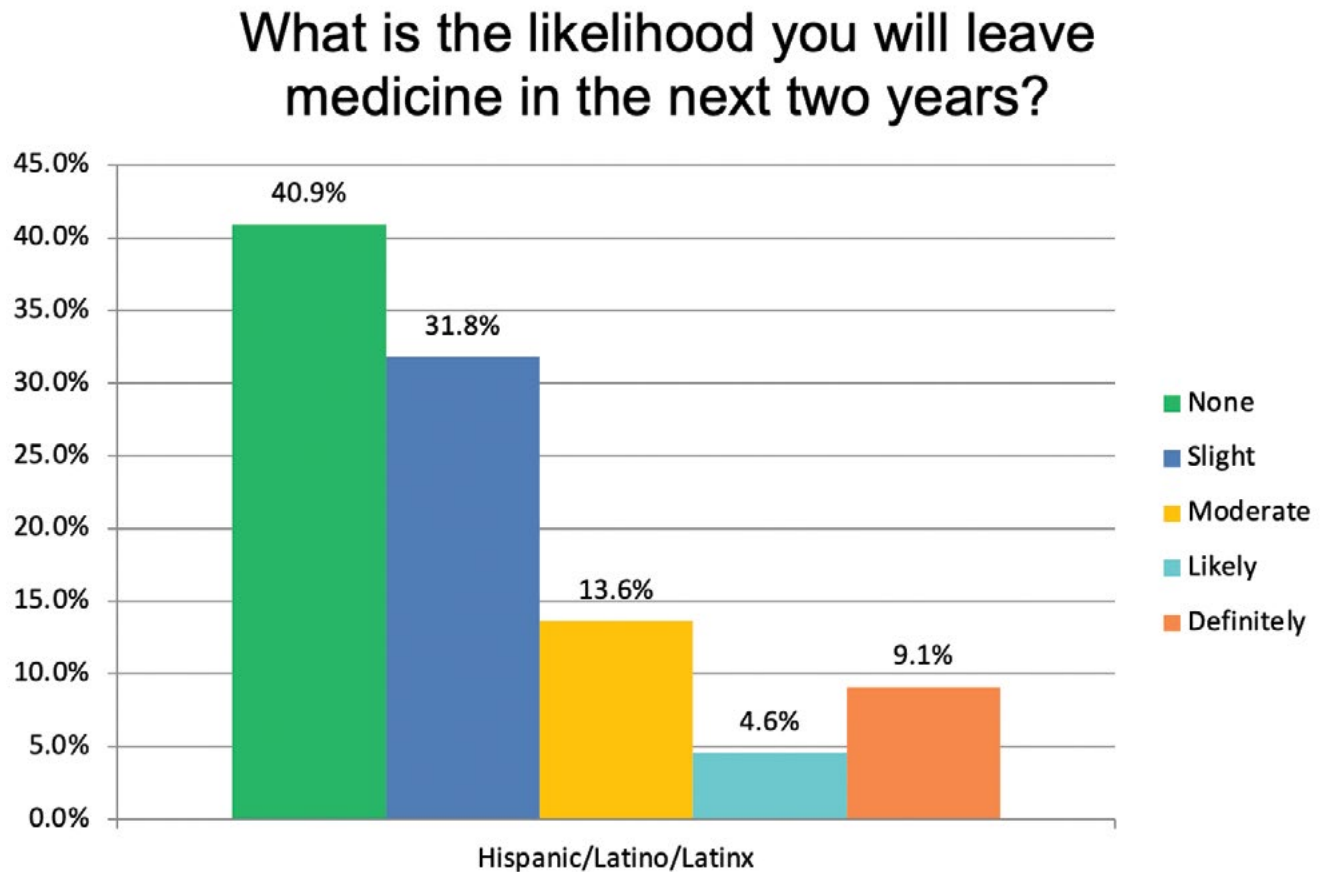
- 12.2% of Asian respondents.
- 20.0% of Black/African American respondents.
- 29.1% of White respondents.
- 27.5% of respondents who did not share information about race/ethnicity.



Reductions in Clinical Effort by Demographic Group (continued)

Findings

- 13.7% of Hispanic/Latino/Latinx respondents indicated they are “Likely” or “Definitely” to leave medicine in the next two years.



Findings

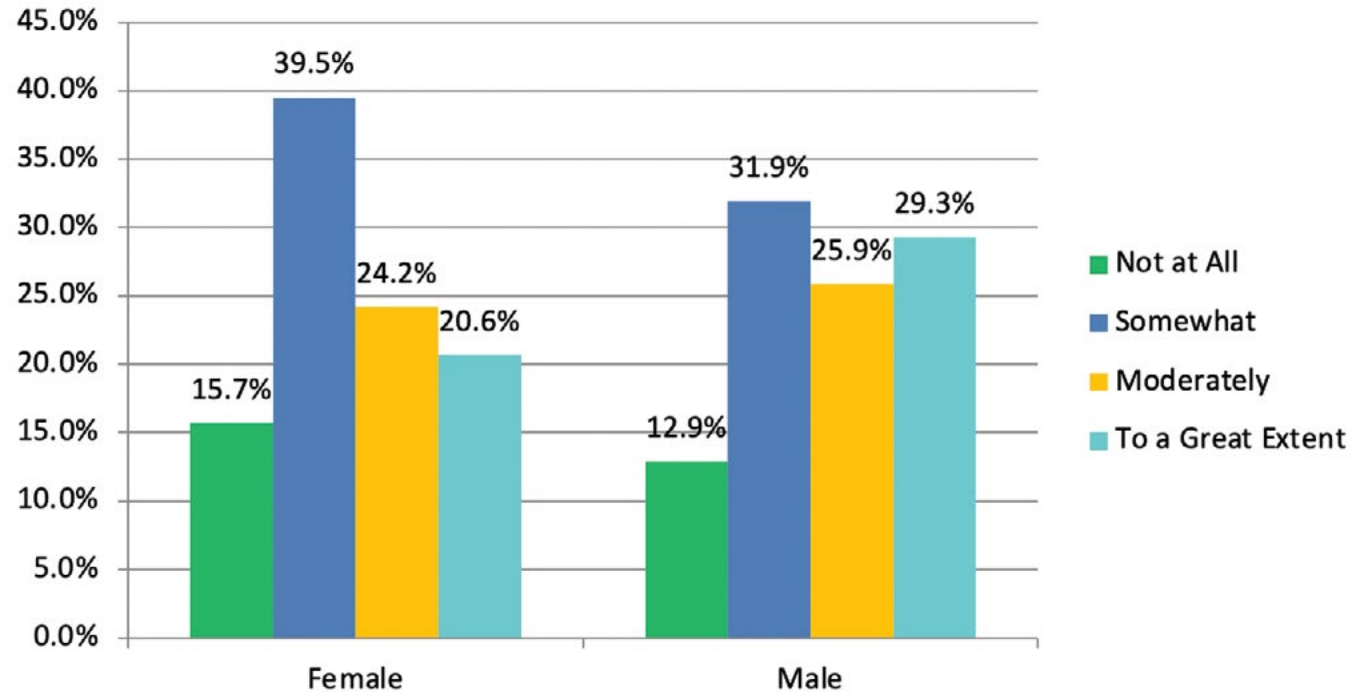
Perceptions of Workplace Support and Culture by Demographic Group

By Gender

In general, women rated workplace support and culture less favorably than men.

The percentage of female respondents (15.7%) who felt they did not matter at all to their organization was slightly higher than the percentage of male respondents who felt that way (12.9%).

I matter to my organization.



Findings

Perceptions of Workplace Support and Culture by Demographic Group (continued)

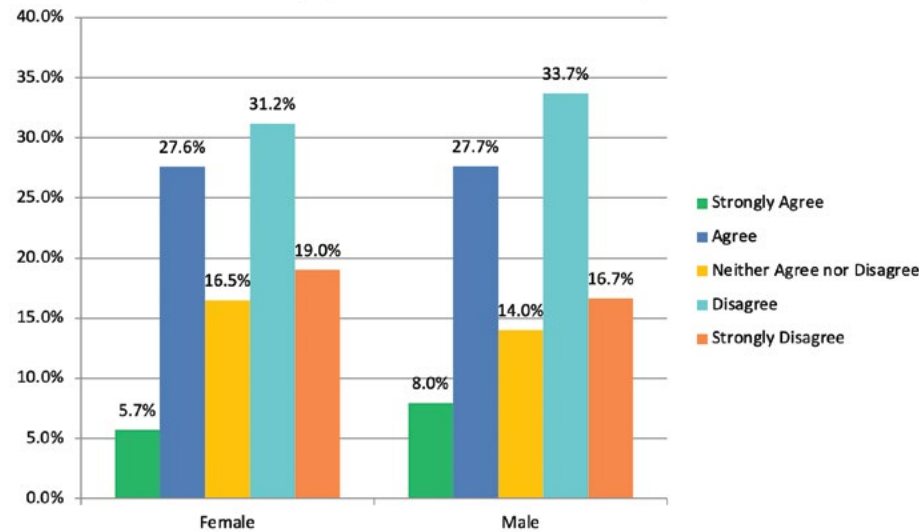
Work Schedule versus Family Life

- 50% of female and male respondents “Strongly Disagreed” and “Disagreed” that their work schedule allows enough time for personal and or family life.

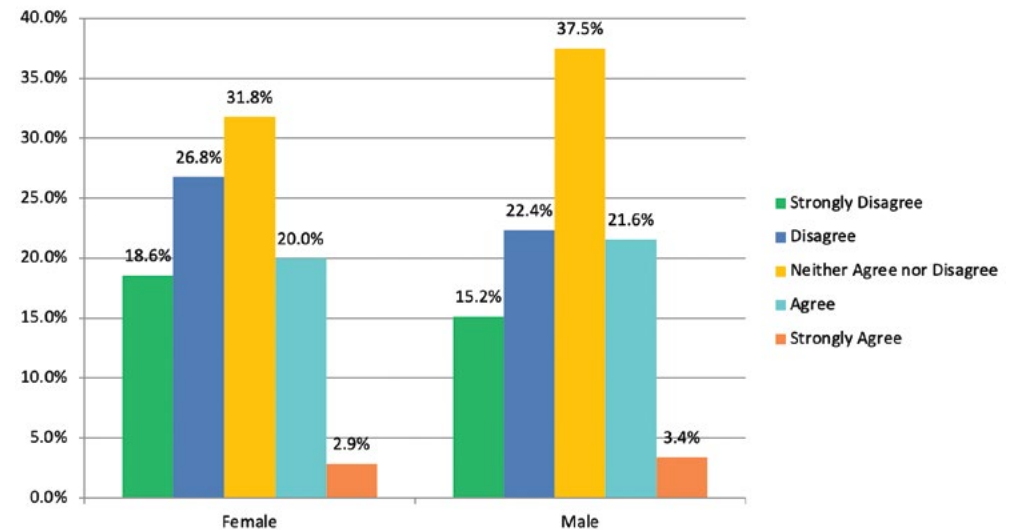
Workplace Provides Useful Resources

- 22.9% of female respondents “Strongly Agreed” or “Agreed” that their workplace provided useful resources that supported their personal health and well-being compared with 25% of male respondents.

My work schedule allows enough time for my personal and/or family life.



My workplace provides useful resources that support my physical health and well-being.



Findings

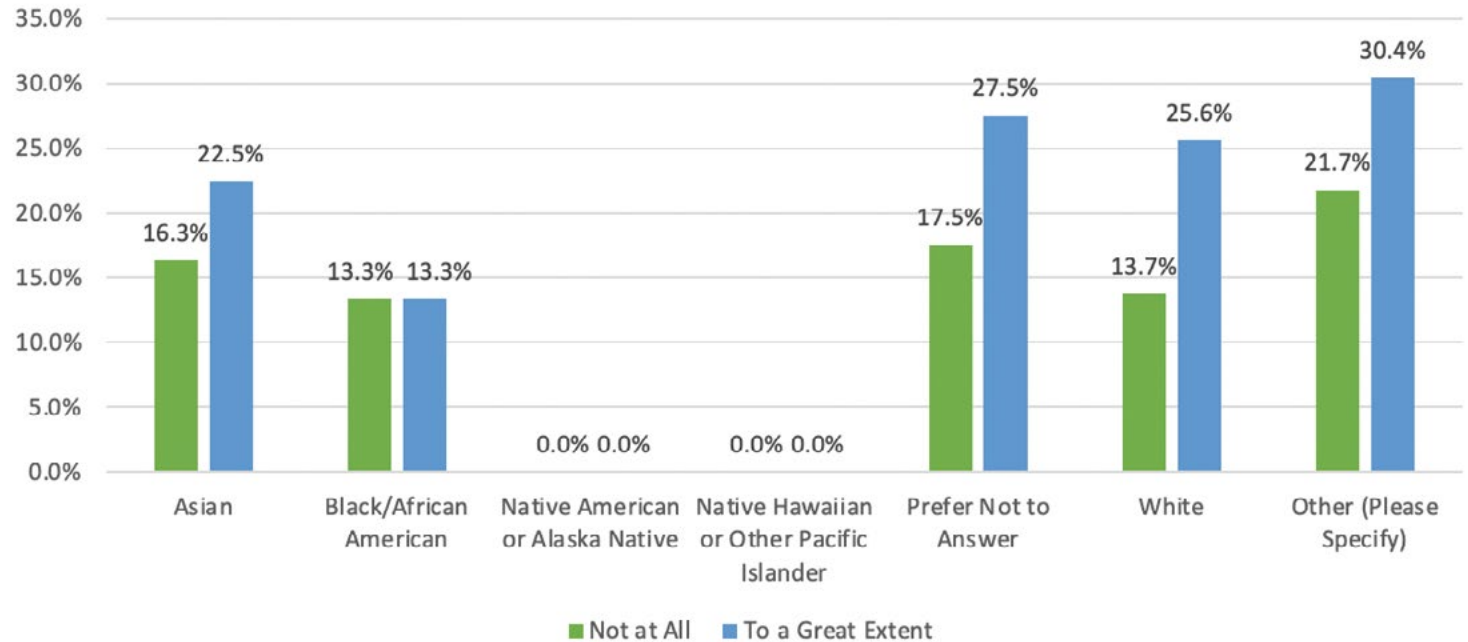
Perceptions of Workplace Support and Culture by Demographic Group (continued)

By Race and Ethnicity

In general, physicians of color were less likely than White physicians to feel they matter to their organization.

- 22.5% of Asian respondents and 13.3% of Black/African American respondents felt they matter “to a great extent” to their organization compared with (25.6%) of white respondents who felt that way.
- 16.3% of Asian respondents and 13.3% of Black/African American respondents felt they matter “Not at All” to their organization compared with 13.7% of White respondents who felt that way.

I matter to my organization.



Findings

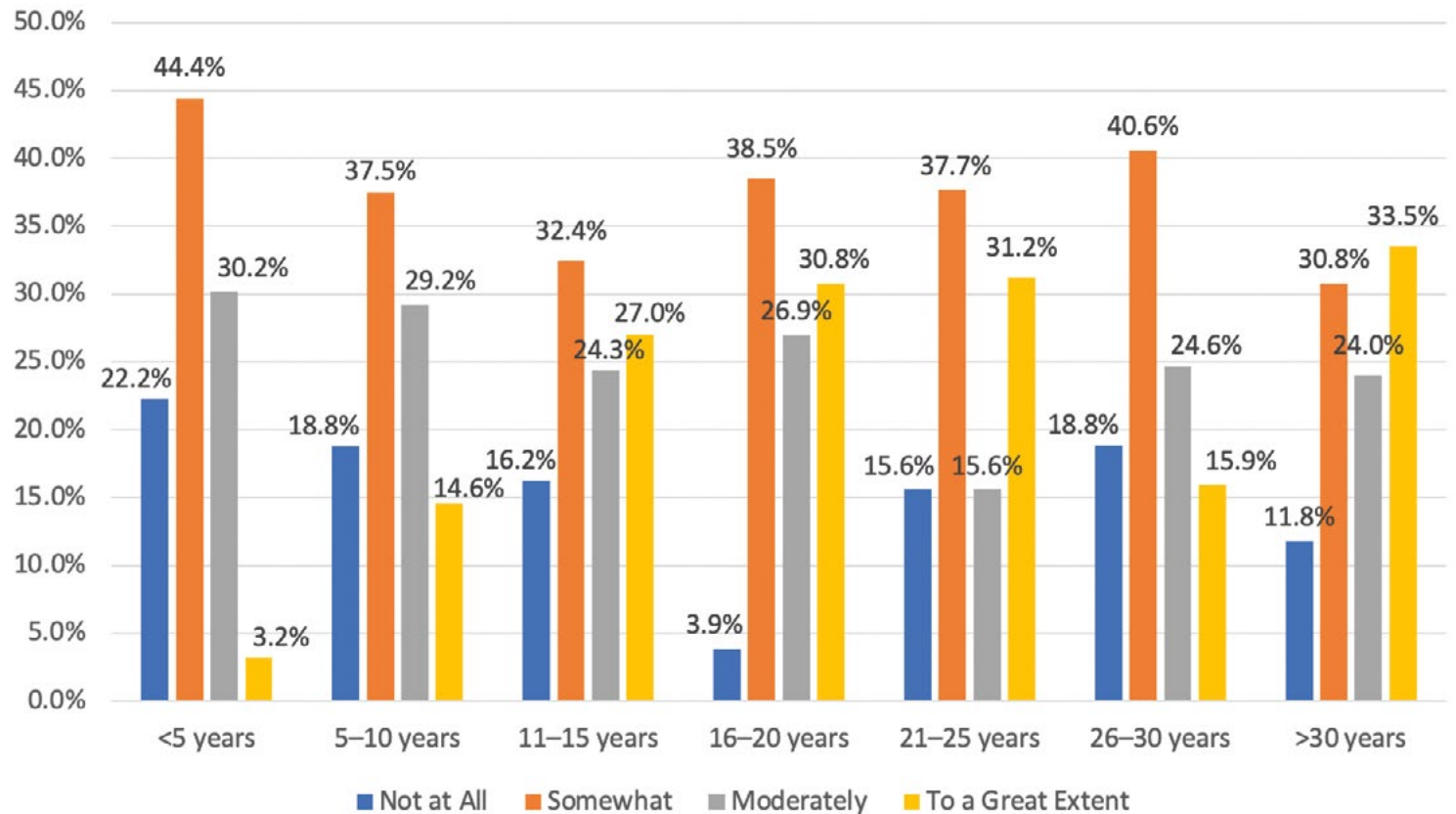
Perceptions of Workplace Support and Culture by Demographic Group (continued)

By Years in Practice

In general, older physicians were more likely to feel they matter to their organization than younger physicians.

- Physicians in practice 16 to 20 years and 21 to 25 years were most likely to feel they matter "To a Great Extent" (30.8% and 31.2%, respectively) compared with those in practice for fewer years.
- Significantly, respondents in practice for fewer than five years and those in practice for five to ten years felt they matter "Not at All" to their organization (22.2% and 18.8%).

I matter to my organization.



Perceptions of Workplace Support and Culture by Demographic Group (continued)

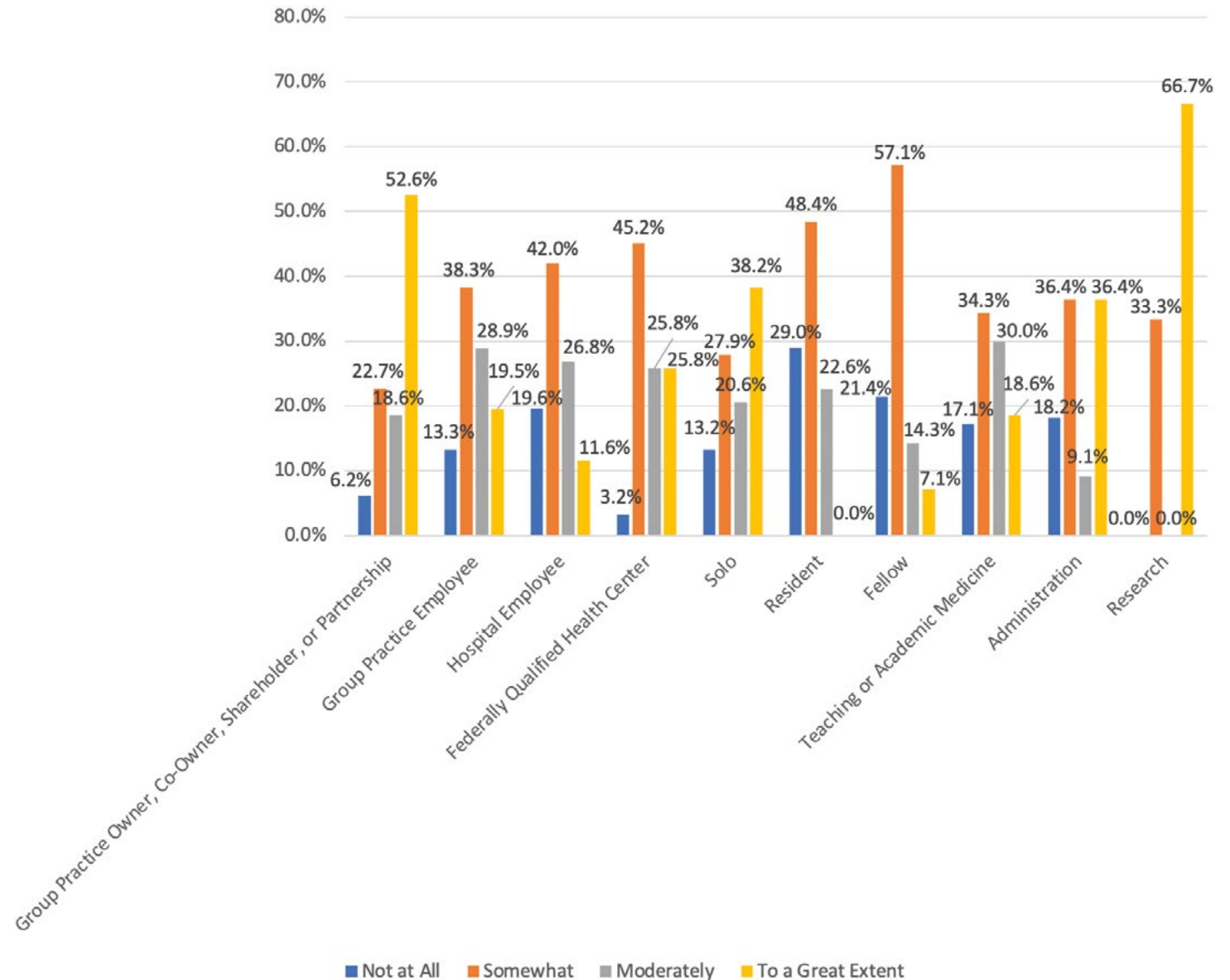
Findings

By Practice Type

In general, physicians with an ownership stake in their practice were more likely to feel they matter to their organization than other physicians.

- The categories of Group Practice Owner, Co-Owner, Shareholder, and Partnership had the highest percentage of respondents who felt they matter to their organization (52.6%) followed by those in Solo practice (38.2%) and Administration (36.4%).
- Among hospital employees, only 11.6% felt they matter "To a Great Extent" to their organization, and almost 20% felt they matter "Not at All."
- Notably, 0% of residents felt they matter to their organization "To a Great Extent," and 29% felt they matter "Not at All."

I matter to my organization.



The Primary Workplace Stressors Reported by Physicians Relate to Systems Issues, Although the Priorities Vary by Gender

Findings

Top Five Work Stressors

The top five work stressors with corresponding endorsement rates were:

- Increased requirements for documentation/charting (not always related to clinical care), (80.9%).
- Lack of support for non-medical tasks, (64.2%).
- Prior Authorization requirements, (58.2%).
- Overreach of non-medical administrators in medical decision-making and resource allocation, (57.3%).
- Turnover of clinical and/or non-clinical support staff, (56.6%).

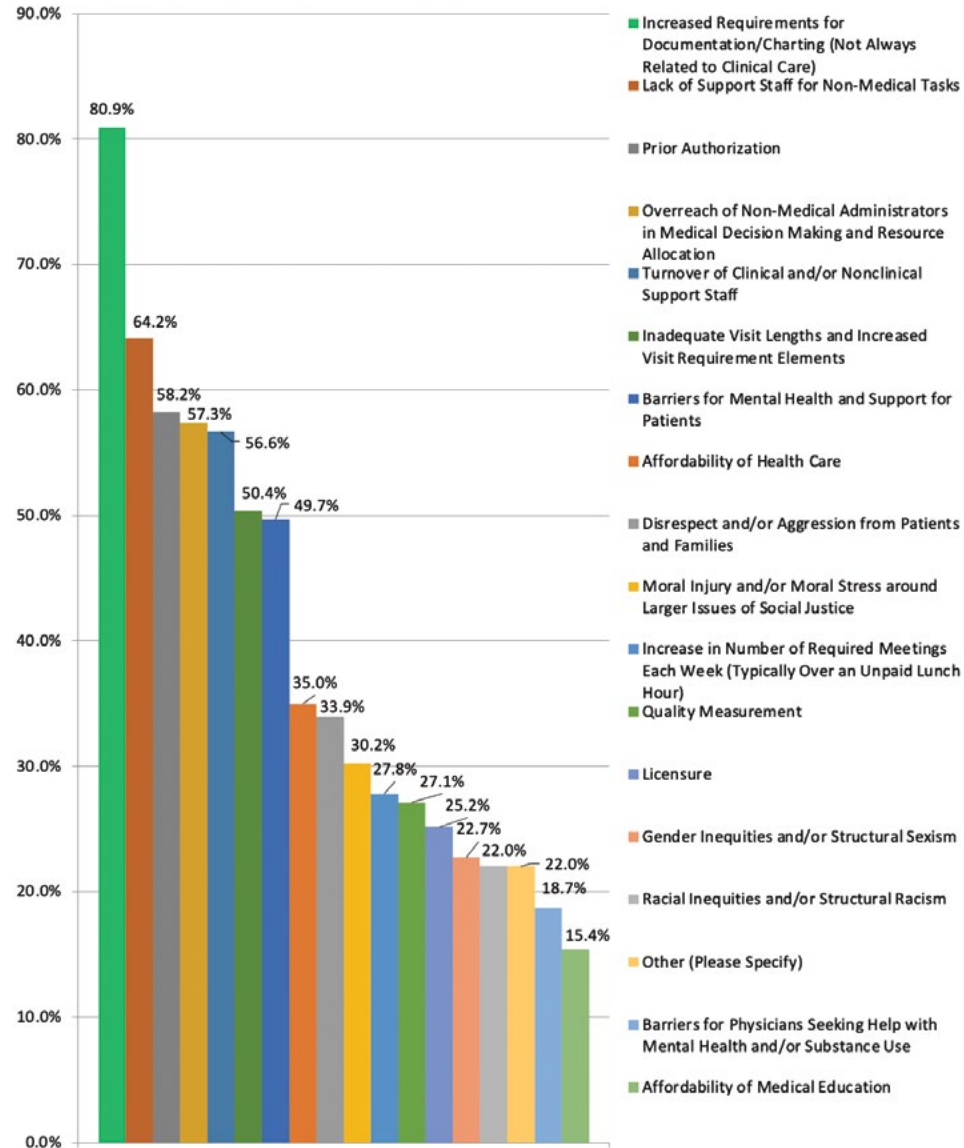
Additional Work Stressors

Aside from the top stressors previously noted, other frequently cited stressors included:

- Inadequate visit lengths and increased visit requirements (50.4%).
- Barriers to mental health and support for patients (49.7%).
- Affordability of health care (35.0%).
- Disrespect and/or aggression from patients and families (33.9%).

Work stressors are listed in descending order by percentage of responses. Each work stressor listed received at least a 15% response rate. Not one stressor listed was not considered a stressor by the respondent group.

Which of these contribute to stress in your work life?
Check all that apply.



Findings

The Primary Workplace Stressors Reported by Physicians Relate to Systems Issues, Although the Priorities Vary by Gender *(continued)*

Top Five Work Stressors by Gender

The top stressor for both female and male respondents was “Increased requirements for documentation/charting (not always related to clinical care).”

Three top-five stressors were cited by both female and male respondents:

- Lack of support staff for non-medical tasks (#2 stressor for females and #4 for males).
- Turnover of clinical and/or non-clinical staff (#3 stressor for females and #5 for males).
- Prior Authorization requirements (#5 stressor for females and #2 for males).

Female physicians listed “Inadequate visit lengths and increased visit requirements” as a top-five stressor (#4), whereas men did not. Male physicians listed “Overreach of non-medical administrators in medical decision-making and resource allocation” as a top-five stressor (#3), whereas female physicians did not.

	Female	Male
Work Stressor 1	Increased requirements for documentation/charting (not always related to clinical care)	Increased requirements for documentation/charting (not always related to clinical care)
Work Stressor 2	Lack of support staff for non-medical tasks	Prior Authorization
Work Stressor 3	Turnover of clinical and/or non-clinical staff	Overreach of non-medical administrators in medical decision making and resource allocation
Work Stressor 4	Increased visit lengths and increased visit requirement elements	Lack of support staff for non-medical tasks
Work Stressor 5	Prior Authorization	Turnover of clinical and/or non-clinical staff

Sexism and Racism Represent Important Workplace Stressors for All Genders and Races

Sexism

Among respondents of all genders, 22.7% reported that gender inequities and/or structural sexism represent workplace stressors.

Among women respondents, 35.9% cited gender inequities as an important source of work stress versus 9.8% of men.

Racism

Among respondents of all races and ethnicities, 22.0% reported that racial inequities and/or structural racism represent workplace stressors.

Among the 14 respondents who identified as Black/African American, 86% cited racial inequities and/or structural racism as their #1 work stressor.

Among the 22 respondents who identified as Hispanic/Latino/Latinx, 41% cited racial inequities and/or structural racism as a work stressor.

Discussion and Recommendations

This survey of MMS members, titled *Supporting MMS Physicians' Well-Being Report*, showed that 55 percent of Massachusetts physicians responding to the survey are experiencing symptoms of burnout, about one in four physicians have already reduced their clinical care hours, and about one in four physicians plan to leave medicine in the next two years. The survey highlights important disparities by gender and race as well as variability by practice environments and years of practice. These findings are in general agreement with recent national data on physician burnout.⁴ As was stated in the report introduction, the current situation is inherently unsustainable.

As with other reports,⁵ most of the drivers identified in this survey relate to systems-level, payer, and organizational factors. As such, their mitigation relies primarily on organizational and systems-level approaches to work processes, operational supports, and job demands. The survey also found variability and room for improvement in regard to workplace culture and support for physicians, specifically whether physicians felt that they matter to their organization, whether their workplace provided useful resources that support their personal health and well-being, whether their work schedule allowed enough time for their personal and/or family life, and the degree to which racism and sexism creates job stressors.

These survey findings closely align with prior national, regional, organizational, and MMS-level data on the occupational well-being of physicians. The results highlight the need for improved processes and additional support for

physicians and serve to validate the current efforts of the MMS, offering potential insights into future work.

Inspired and informed by the findings of this survey, by on-going initiatives of the Massachusetts Medical Society and partner organizations, and by the preponderance of national data on clinician well-being, the Massachusetts Medical Society proposes the following recommendations.

Reduce Stressors

1. Improve Electronic Health Record Documentation and Processes

Not surprisingly, the Electronic Health Record (EHR) tops the list of stressors. Frustrating computer interfaces — developed for billing, coding, and reimbursement, but used to track patient visits and treatment plans — have crowded out the physician's ability to engage with patients, undermining patient encounters for both physicians and patients.

As noted in our report *A Crisis in Health Care: A Call to Action on Physician Burnout*,⁶ the quantity of mandatory measurement and documentation, imposed by current EHRs due to regulatory and payer requirements, means that physicians typically spend up to two hours doing computer work for every hour spent face-to-face with a patient, including numerous hours after work (so-called “pajama time”) completing online administrative tasks that do little if anything to advance the goals of patient care.

⁴https://www.medscape.com/slideshow/2023-lifestyle-burnout-6016058?reg=1&utm_source=newsletter&utm_medium=email&utm_campaign=newsletter_axiosvitals&stream=top#2

⁵https://www.medscape.com/slideshow/2023-lifestyle-burnout-6016058?reg=1&utm_source=newsletter&utm_medium=email&utm_campaign=newsletter_axiosvitals&stream=top#2

⁶<https://www.massmed.org/Publications/Research,-Studies,-and-Reports/Physician-Burnout-Report-2018>

Discussion and Recommendations (*continued*)

We support the EHR recommendations proposed in our report *A Crisis in Health Care: A Call to Action on Physician Burnout*, including the following:

- » Improve interoperability coupled with stakeholder investment.
- » Utilize application programming interfaces (APIs) by vendors.
- » Dramatically increase physician engagement in the design, implementation, and customization of EHRs⁷.
- » Obtain ongoing commitment from payers and health care organizations to reduce the physicians' burden of documentation and measurement.⁸
- » Encourage use of medical scribes,⁹ voice recognition technology, workflow improvements, artificial intelligence options, and implementation of electronic prior authorization within institutions and provider organizations to streamline physician work.

2. Address Workforce/Staffing Issues

Many respondents cited concerns about workforce shortages, including “lack of support staff for non-medical tasks” and “turnover of clinical and/or non-clinical staff.” The lack of an adequate and representative workforce, coupled with increased labor costs and increased volume/demand for services,¹⁰ exacerbates stressors on physicians and their practices.

We recommend that institution and provider organizations create opportunities for a full complement of support staff for hospitals and physician practices, including:

- » Innovative pipeline programs with community colleges and high schools that offer professional training, financial support, and career services.

- » Improved financial support for care team members (PAs, MAs) including tuition assistance, loan forgiveness, and scholarships.
- » Development of favorable work policies that provide flexibility and a supportive employee wellness culture.
- » Implementation of retention initiatives.
- » Coordination among MMS, the governor, the state, and the healthcare community to address workforce challenges, including exploring funding mechanisms for these efforts.

3. Support Financial Viability of Physician Practices

Although not specifically cited as a top-five workplace stressor, financial viability is essential to creating a functional work environment. The above challenges are compounded by financial instability caused by uncertain revenues, continuous administrative burdens, and rising labor costs. For example, low reimbursement for patients insured through MassHealth and continuous threats of Medicare payment reductions for physician practices create instability for practices. These factors collectively undermine practice stability. There is a need for sustainable practice environments.

We recommend:

- » Advocating for sustainable payer reimbursements.
- » Developing workforce solutions that ensure suitable staffing levels (see recommendations above.)
- » Reducing administrative burdens, including the burdens of prior authorization and quality measurement.
- » Convening stakeholders to address affordability of health care for patients.

⁷<https://www.massmed.org/Publications/Research,-Studies,-and-Reports/Changing-EHR-Physician-Burnout>

⁸<https://www.massmed.org/Publications/Research,-Studies,-and-Reports/Physician-Burnout-Report-2018>

⁹<https://jamanetwork.com/journals/jama/fullarticle/2725222>

¹⁰<https://www.wbur.org/news/2022/10/31/massachusetts-hospital-staffing-crisis-report>

Discussion and Recommendations (*continued*)

4. Address Excessive Administrative Hassles

Prior Authorization Burdens

Physician practices are reaching a crisis point and identifying administrative burdens — particularly Prior Authorization — is one of the biggest challenges to providing high-quality and cost-effective care.¹¹ Prior authorizations take up considerable physician time and staff effort, leaving less time dedicated to patients and their care.

Each health plan has different requirements for determining which services require prior authorizations, under which circumstances they must be submitted, how to submit them, and what information to include.

According to a 2021 American Medical Association Prior Authorization survey, practices complete on average 41 prior authorizations per week, spending an average of almost two business days (13 hours) on them. Forty percent of physicians must hire staff to work exclusively on prior authorizations. Most importantly, prior authorizations can harm patients. In that same survey, 95% of physicians reported that prior authorizations delayed access to necessary care, and 34% of physicians reported that prior authorizations had led to a serious adverse event for a patient.

The MMS supports a range of reforms aimed at reducing administrative complexities, particularly prior authorizations.

We recommend:

- » A revamping of prior authorization requirements to ensure timely access to care, continuity of care, and a reduction of burdensome tasks. We support the following initiatives:

- Improve access to care and continuity of care for patients.
 - Prohibit prior authorizations for generic medications and medications and treatments that currently have low denial rates, low variation in utilization, or an evidence base to treat chronic illness.
 - Require prior authorization to be valid for the duration of treatment or at least 1 year.
 - Require insurers to honor the patient's prior authorization from another insurer for at least 90 days.
- Promote transparency and fairness in the Prior Authorization process.
 - Require public prior authorization data from insurers as it relates to approvals, denials, appeals, wait times, and more.
 - Require the Health Policy Commission to issue a report on the impact of prior authorization on patient access to care, administrative burden, and system cost.
 - Prohibit retrospective denials if care is preauthorized.
 - Require carriers to notify affected individuals about any new prior authorization requirements.
- Improve timely access to care and administrative efficiency.
 - Establish a 24-hour response time for urgent care.
 - Require insurers to adopt software to facilitate automated, electronic processing of prior authorizations, and require the Division of Insurance (DOI) to implement standardized prior authorization forms.
 - Require insurers to provide a quick and easy process for physicians to determine which medications are approved on their formulary, as well as what the patient copay is and what alternative medications are covered.

¹¹2022 Physicians Foundation Survey of America's Physicians Part Three of Three.

Discussion and Recommendations (*continued*)

5. *Align and Reduce Quality Measures*

Payers have added to their quality measure sets in increasingly divergent ways, requiring reporting on differing metrics and in differing manners. The large number of quality measures, with reporting requirements that may vary by payer, creates a significant administrative burden and makes it difficult for physicians to improve the quality of their health care delivery in a focused fashion.

The MMS appreciates the convening of the Executive Office of Health and Human Services' Quality Measure Alignment Task Force and the opportunity to participate in its work. Whereas the task force has made great progress in recommending a core measure set to meaningfully reduce administrative burden, more needs to be done.

We recommend the following initiatives:

- » Require payers to adopt the EOHHS Quality Measure Alignment Task Force core measure set.
- » Require consistency across payers, in terms of their metrics, and standardization of the reporting process.
- » Require that equity measures be uniformly adopted by payers to reduce burden and increase improvement in process and outcomes.
- » Limit total quality/equity metrics to 15.

Improved and Increased Support

1. *Improve Workplace Support and Culture for All Physicians*

Health care organizations must devote resources to intentionally creating a healthy work environment and culture for all its workers, monitoring the well-being of its workforce, understanding key drivers of well-being, and measuring the

impact of well-being initiatives. Achieving these goals requires an understanding of specific work stressors faced by physicians, as well as the common stressors faced by all employees.

At the present time, surveys remain the gold standard for measuring occupational well-being and its drivers. Therefore, organizations should periodically survey their workforce, including physician-specific questions for physicians, in order to understand the prevalence and drivers of burnout and occupational well-being.

Further, organizations should create a culture of support, including flexibility, respect for autonomy, dedication to inclusion, and attention to key constituents, as addressed here.

Leadership sets the tone for a culture of well-being. For decisions at every level, institutions and provider organizations need to consider potential impacts on the well-being of its workforce. Leaders are responsible for establishing a supportive culture and working conditions to ensure the clinical team and the full workforce feel valued and feel that they matter. In the December 3–4, 2022, *Wall Street Journal* article, “The Power of Mattering at Work,” it is noted that U.S. Surgeon General Vivek Murthy, MD, recently issued a report¹² calling for workplaces to better protect employee mental health and well-being. Among the essentials for well-being at work, the report cites mattering as a key component, defining “mattering” as the belief that you are valued and important to others. “People want to know that they matter to those around them, and that their work makes a difference in the lives of others.” Mattering also means inclusion in key administrative and financial decisions, respect for professional expertise, and appropriate professional autonomy.

Finally, demographic variability in occupational well-being points to the need to prioritize interventions for specific

¹²<https://www.hhs.gov/about/news/2022/10/20/us-surgeon-general-releases-new-framework-mental-health-well-being-workplace.html>

Discussion and Recommendations (*continued*)

groups of physicians. Consistent with national data, women in our survey reported worse occupational well-being than men. Additionally, the data raise concerns for residents and younger physicians. Whereas deliberate attention should be directed across systems and provider organizations, the survey identifies the need for immediate attention to the wellness of women, residents, and early career physicians.

We recommend institutions and provider organizations:

- » Foster a supportive work culture through:
 - Active listening and action, and by offering flexibility, autonomy, and time dedicated to areas of practice that bring meaning.
 - Including physicians in clinical and resource-allocation decisions to secure ideas and gain buy in and to help prevent the experience of overreach of non-medical administrators (another stressor).
 - Implementing periodic physician and all-employee surveys to measure burnout and well-being.
 - Actively responding to survey findings by addressing work stressors, investing in ongoing operational improvements geared toward employee well-being and satisfaction, and developing more supportive workplace culture and policies.

2. Support Physician Health and Well-Being

As demonstrated in this survey, physician burnout is a troubling and increasing trend that requires thoughtful and comprehensive intervention. Efforts must be undertaken to mitigate burnout through improvement to physicians' work experience. In addition, we need policy changes that

proactively support mental health treatment and that support physicians experiencing burnout and related challenges.

We recommend:

- » Institutions — including physician associations, hospitals, and licensing bodies — should take deliberate steps to facilitate appropriate treatment and support without stigma or unnecessary constraints on physicians' ability to practice.
- » In April 2018, the Federation of State Medical Boards (FSMB) adopted as policy the recommendations of its Workgroup on Physician Wellness and Burnout.¹³ The FSMB calls for reconsidering "probing questions" about a physician's mental health, addiction, or substance use on applications for medical licensure or renewal, because such questions likely discourage physicians from seeking treatment.
- » Build awareness that the Massachusetts Board of Registration in Medicine has since amended its application for licensure to limit questions to the presence or absence of current impairments that impact physician practice and competence, in the same manner as questions about physical health.
- » Consider following the FSMB recommendation: The FSMB further calls for state medical boards to offer "safe haven" non-reporting to applicants for licensure who are receiving appropriate treatment for mental health or substance use. Such non-reporting would be based on monitoring and good standing with the recommendations of the state physician health program. [Section 5F of Chapter 112 of the Massachusetts General Laws](#) currently offers a limited safe-haven for those in compliance with the requirements of a drug or alcohol program, but does not allow for reporting exemptions more broadly for the treatment of mental health conditions.

¹³ <https://www.fsmb.org/siteassets/advocacy/policies/policy-on-wellness-and-burnout.pdf>

Discussion and Recommendations (*continued*)

- » Organizations should follow the guidance provided by the FSMB recommendations for hospitals, provider organizations and insurers as well.¹⁴
- » Update credentialing and recredentialing forms: The Joint Commission, along with other leading healthcare organizations, encourages organizations during credentialing or recredentialing to refrain from asking if clinicians have ever been diagnosed with, or treated for, a mental health disorder. Alternatives include asking about current impairment only, asking for an attestation of good health, or not asking the mental health question at all. For example, The Lorna Breen Foundation suggests the following model language: “Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical, and professional manner?”

3. Address Sexism and Racism in the Workplace

Racism and sexism were cited as workplace stressors for people of all genders, ethnicities, and races. Strikingly, among the 14 respondents who identified as Black/African American, 86% cited racial inequities and/or structural racism as their #1 work stressor. More than a third of people identifying as Hispanic/Latino/Latinx cited racial inequities and/or structural racism as a work stressor. Approximately a third of women cited gender inequities as an important source of work stress.

We recommend these actions for institutions and provider organizations:

- » Elevate equity as a foundational principle underlying all strategic and operational decisions.

- » Acknowledge the fact that racism and sexism negatively impact people of all genders and races in the workplace. Actively address behaviors and systems rooted in racism and sexism.
- » Collect data on diversity and representation of women and other individuals from backgrounds underrepresented in medicine with particular attention to young physicians and residents to appreciate and understand the community of clinicians.
- » Reevaluate and dismantle entrenched hierarchical workplace structures and training processes that ingrain, amplify, and perpetuate impacts of historical bias.
- » Commit to pay equity. Develop guidelines and policies to promote equitable compensation. Regularly assess compensation (including all forms of compensation) for gender and racial inequities and eliminate differences. Establish processes and infrastructure to identify and address areas of support needed for physicians who are historically under-resourced.
- » Develop educational programs on topics such as mitigating bias, cultivating an inclusive workplace, creating a bystander culture, and identifying and rectifying microaggressions.
- » Strive to retain women and physicians from underrepresented groups by continuing to explore key drivers of occupational distress by identity and by prioritizing interventions that directly address the primary causes of occupational distress for women and underrepresented groups in medicine.
- » Implement mentorship programs and training to guide physicians from backgrounds underrepresented in medicine toward leadership positions in the workplace.
- » Address retention, recruitment, and pipeline challenges to increase diversity among Massachusetts physicians.

¹⁴<https://www.fsmb.org/siteassets/advocacy/policies/policy-on-wellness-and-burnout.pdf>

Recommendations

Reduce Stressors

1. Improve Electronic Health Record Documentation and Processes

We support the Electronic Health Record (EHR) recommendations proposed in our report *A Crisis in Health Care: A Call to Action on Physician Burnout*, including the following:

- » Reform certification standards by the federal government.
- » Improve interoperability coupled with stakeholder investment.
- » Utilize programming interfaces (APIs) by vendors.
- » Dramatically increase physician engagement in the design, implementation, and customization of EHRs.¹⁵
- » Obtain ongoing commitment from payers and health care organizations to reduce the physicians' burden of documentation and measurement.¹⁶
- » Encourage use of medical scribes,¹⁷ voice recognition technology, workflow improvements, artificial intelligence options, and implementation of electronic prior authorization within institutions and provider organizations to streamline physician work.

2. Address Workforce/Staffing Issues

We recommend these actions for institutions and provider organizations:

- » Create opportunities for a full complement of support staff for hospitals and physician practices, including the following:
 - Innovative pipeline programs with community colleges and high schools that offer professional training, financial supports, and career services.

¹⁵<https://www.massmed.org/Publications/Research,-Studies,-and-Reports/Changing-EHR-Physician-Burnout>

¹⁶<https://www.massmed.org/Publications/Research,-Studies,-and-Reports/Physician-Burnout-Report-2018>

¹⁷<https://jamanetwork.com/journals/jama/fullarticle/2725222>

- Improved financial support for care team members, including tuition assistance, loan forgiveness, and scholarships.
- Development of favorable work policies that provide flexibility and a supportive employee wellness culture.
- Implementation of retention initiatives.
- Coordination among MMS, the Governor, the state, and the healthcare community to address workforce challenges, including exploring funding mechanisms for these efforts.

3. Support Financial Viability of Physician Practices

We recommend:

- » Advocating for sustainable payer reimbursements.
- » Developing workforce solutions that ensure suitable staffing levels.
- » Reducing administrative burdens, including the burdens of prior authorization and quality measurement.
- » Convening stakeholders to address affordability of health care for patients.

4. Address Excessive Administrative Hassles

Prior Authorization Burdens

The MMS supports a range of reforms aimed at reducing administrative complexities, particularly prior authorizations.

Recommendations *(continued)*

We recommend:

» Prior Authorization

- There needs to be a revamping of prior authorization requirements to ensure timely access to care, continuity of care, and a reduction of burdensome tasks.

» We support the following initiatives:

Improve access to care and continuity of care for patients.

- Prohibit prior authorization for generic medications and medications and treatments that currently have low denial rates, low variation in utilization, or an evidence base to treat chronic illness.
- Require prior authorizations to be valid for the duration of treatment or at least one year.
- Require insurers to honor the patient's prior authorization from another insurer for at least 90 days.

» Promote transparency and fairness in the PA process.

- Require public prior authorization data from insurers as it relates to approvals, denials, appeals, wait times, and more.
- Requires the Health Policy Commission to issue a report on the impact of prior authorization on patient access to care, administrative burden, and system cost.
- Prohibit retrospective denials if care is preauthorized.
- Require carriers to notify affected individuals about any new prior authorization requirements.

» Improve timely access to care and administrative efficiency.

- Establish a 24-hour response time for urgent care.
- Require insurers to adopt software to facilitate automated, electronic processing of prior authorizations, and require the Division of Insurance (DOI) to implement standardized prior authorization forms.
- Require insurers to provide a quick and easy process for physicians to determine which medications are approved on their formulary, as well as what the patient copay is and what alternative medications are covered.

Align and Reduce Quality Measures

We recommend the following initiatives:

- » Require payers to adopt the EOHHS Quality Measure Alignment Task Force core measure set.
- » Require consistency across payers, in terms of their metrics, and standardization of the reporting process.
- » Require that equity measures be uniformly adopted by payers to reduce the burden and increase improvement in process and outcomes.
- » Limit total quality/equity metrics to 15.

Recommendations (continued)

Improved and Increased Support

1. Improve Workplace Support and Culture for All Physicians

We recommend institutions and provider organizations:

- » Foster a supportive work culture through:
 - Active listening and action, and by offering flexibility, autonomy, and time dedicated to areas of practice that bring meaning.
 - Including physicians in clinical and resource-allocation decisions to secure ideas and gain buy in and to help prevent the experience of overreach of non-medical administrators (another stressor).
 - Implementing periodic physician and all-employee surveys to measure burnout and well-being.
 - Actively responding to survey findings: addressing work stressors, investing in ongoing operational improvements geared toward employee well-being and satisfaction, and developing more supportive workplace culture and policies.
 - Intentionally address disparities in occupational well-being by 1) investigating drivers of disparity and 2) prioritizing interventions that specifically address key challenges faced by those from demographics with reduced occupational well-being, including women, residents, and early career physicians.

2. Support Physician Health and Well-Being

We recommend:

- » Institutions — including physician associations, hospitals, and licensing bodies — should take deliberate steps to facilitate appropriate treatment and support without stigma or unnecessary constraints on physicians' ability to practice.
- » In April 2018, the Federation of State Medical Boards (FSMB) adopted as policy the recommendations of its Workgroup on Physician Wellness and Burnout.¹⁸ The FSMB calls for reconsidering “probing questions” about a physician’s mental health, addiction, or substance use on applications for medical licensure or renewal, because such questions likely discourage physicians from seeking treatment.
- » The Massachusetts Board of Registration in Medicine has since amended its application for licensure to limit questions to the presence or absence of current impairments that impact physician practice and competence, in the same manner as questions about physical health.
- » The FSMB further calls for state medical boards to offer “safe haven” non-reporting to applicants for licensure who are receiving appropriate treatment for mental health or substance use. Such non-reporting would be based on monitoring and good standing with the recommendations of the state physician health program. [Section 5F of Chapter 112 of the Massachusetts General Laws](#) currently offers a limited safe-haven for those in compliance with the requirements of a drug or alcohol program, but does not allow for reporting exemptions more broadly for the treatment of mental health conditions.

¹⁸<https://www.fsmb.org/siteassets/advocacy/policies/policy-on-wellness-and-burnout.pdf>

Recommendations (*continued*)

- » Organizations should follow the guidance provided by the FSMB recommendations for hospitals, provider organizations and insurers as well.¹⁹
 - The Joint Commission, along with other leading healthcare organizations, encourages organizations during credentialing or recredentialing to refrain from asking if clinicians have ever been diagnosed with, or treated for, a mental health disorder. Alternatives include asking about current impairment only, asking for an attestation of good health, or not asking the mental health question at all. For example, The Lorna Breen Foundation suggests the following model language: “Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical, and professional manner?”

3. Address Sexism and Racism in the Workplace

Recommended actions for institutions and provider organizations:

- » Elevate equity as a foundational principle underlying all strategic and operational decisions.
 - » Acknowledge the fact that racism and sexism negatively impact people of all genders and races in the workplace. Actively address behaviors and systems rooted in racism and sexism.
 - Collect data on diversity and representation of women and other individuals from backgrounds underrepresented in medicine with particular attention to young physicians and residents.
- Reevaluate and dismantle entrenched hierarchical workplace structures and training processes that ingrain, amplify, and perpetuate impacts of historical bias.
 - Commit to pay equity. Develop guidelines and policies to promote equitable compensation. Regularly assess compensation (including all forms of compensation) for gender and racial inequities and eliminate differences. Establish processes and infrastructure to identify and address areas of support needed for physicians who are historically under-resourced.
 - Develop educational programs on topics such as mitigating bias, cultivating an inclusive workplace, creating a bystander culture, and identifying and rectifying microaggressions.
 - Strive to retain women and physicians from underrepresented groups by continuing to explore key drivers of occupational distress by identity and by prioritizing interventions that directly address the primary causes of occupational distress for women and underrepresented groups in medicine.
 - Implement mentorship programs and training to guide physicians from backgrounds underrepresented in medicine toward leadership positions in the workplace.
 - Address retention, recruitment, and pipeline challenges to increase diversity among Massachusetts physicians.

¹⁹<https://www.fsmb.org/siteassets/advocacy/policies/policy-on-wellness-and-burnout.pdf>

Limitations

As is typical for large physician surveys, the response rate for this one was low.²⁰ Whereas the findings of this survey are in general agreement with large national studies of physician burnout, the low response rate and different response rates for different demographic groups limit the generalizability of the findings. Thus, these results may not be reflective of the entire population of Massachusetts Medical Society physicians. Due to small sample size, the data shared in this report are limited to two genders. Differences by race

and ethnicity, although aligned with other studies, may not reflect true differences among MMS members due to low numbers of physicians of color and underrepresented physician respondents. Data were not available for the intersection of race and gender. Also, of the MMS physicians completing the survey, almost 40 percent had been in practice for more than 30 years, reflecting a slightly older median age among survey respondents compared with physicians state-wide.

²⁰[https://www.mayoclinicproceedings.org/article/S0025-6196\(22\)00515-8/fulltext#%20](https://www.mayoclinicproceedings.org/article/S0025-6196(22)00515-8/fulltext#%20)

Conclusion and Acknowledgments

The Massachusetts Medical Society's *Supporting MMS Physicians' Well-Being Report* provides insight into the state of Massachusetts physicians by gender, and racial and ethnic identity, practice type, and length of time in practice. Recommendations are offered. Actions must be taken to address this critical workforce challenge.

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Acknowledgments

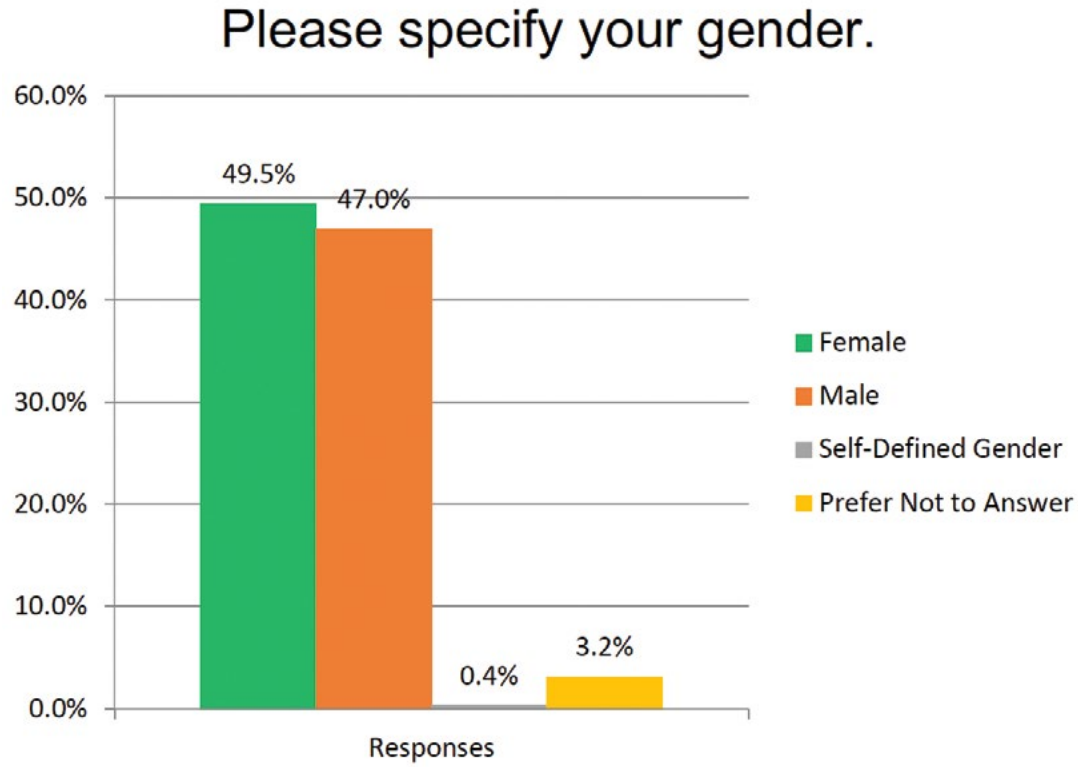
The Massachusetts Medical Society would like to extend a special thanks and gratitude to all individuals, organizations, and groups that contributed to the design, dissemination, and analysis of the *Supporting MMS Physicians' Well-Being Survey and Report*. Special thanks are extended to the MMS Women Physicians Section Governing Council, the MMS Committee on Women's Health, the Massachusetts Medical Society–Massachusetts Health and Hospital Association Joint Taskforce on Physician Burnout, and the Committee on Mental Health and Substance Use for their input on the survey instrument and results. Special thanks are also extended to MMS Executive Vice President Lois Cornell; Charles Alagero, General Counsel and VP of Advocacy and Member Relations; Casey Rojas, JD, Federal Relations and Health Equity Manager; Leda Anderson, Director, Advocacy and Government Relations; Katherine Udden, MMS Director of Communications; and Bissan Biary, MMS Practice Solutions Specialist for their input and thoughtful review of the results in this report. The Society would also like to thank Nancy Nankivil and Kyra Cappelucci from the American Medical Association for their assistance with the AMA survey development. Finally, the MMS would like to thank all members who took the time to complete the survey and provide comprehensive comments.

Demographics

Demographics: Overview

There was a total of 575 MMS physician member respondents.

There were slightly more female respondents (281, 49.5%) than male respondents (267, 47%). Of the 575 respondents, only 568 answered the "Please specify your gender." Of those respondents who answered, 281 (49.5%) were women, 267 (47%) were men, 18 (3.2%) Preferred Not to Answer, and 2 identified as Self-Defined Gender.

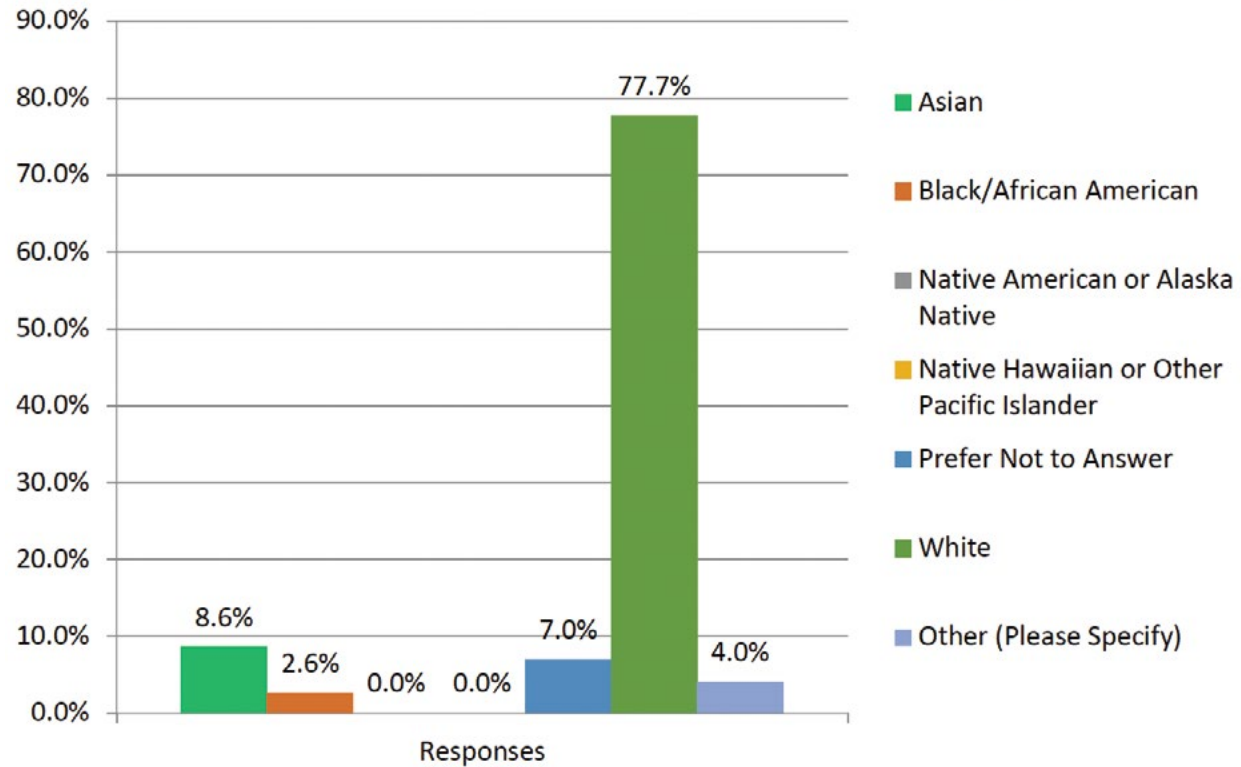


Demographics (continued)

The respondents identified as Asian (9%), Black/African American (2.6%), and as White (77.7%). 11% responded "Prefer Not to Answer" and "Other" for race.

No respondent identified as Native American or Alaska Native, Native Hawaiian, or Other Pacific Islander.

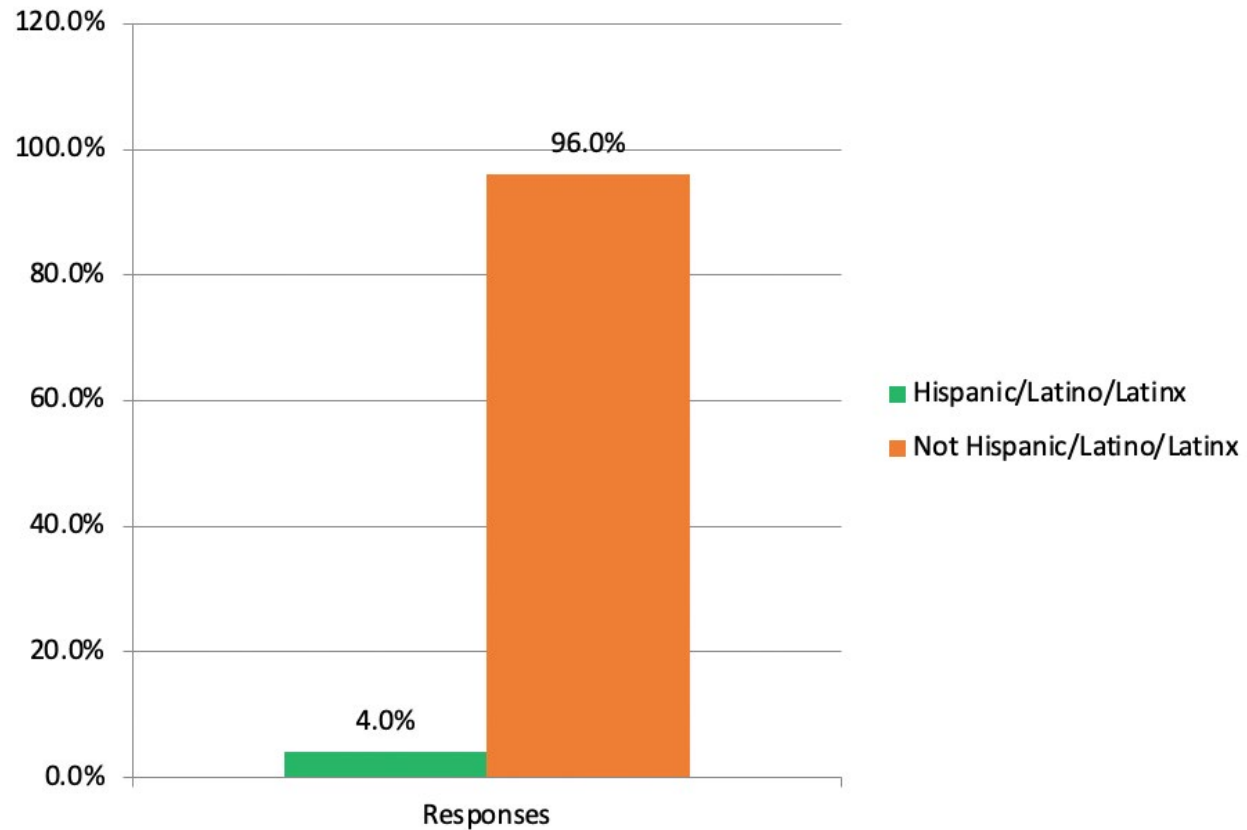
What is your race? Check all that apply.



Demographics (continued)

96% identified as not Hispanic/Latino/Latinx.

Are you Hispanic/Latino/Latinx?



Demographics (continued)

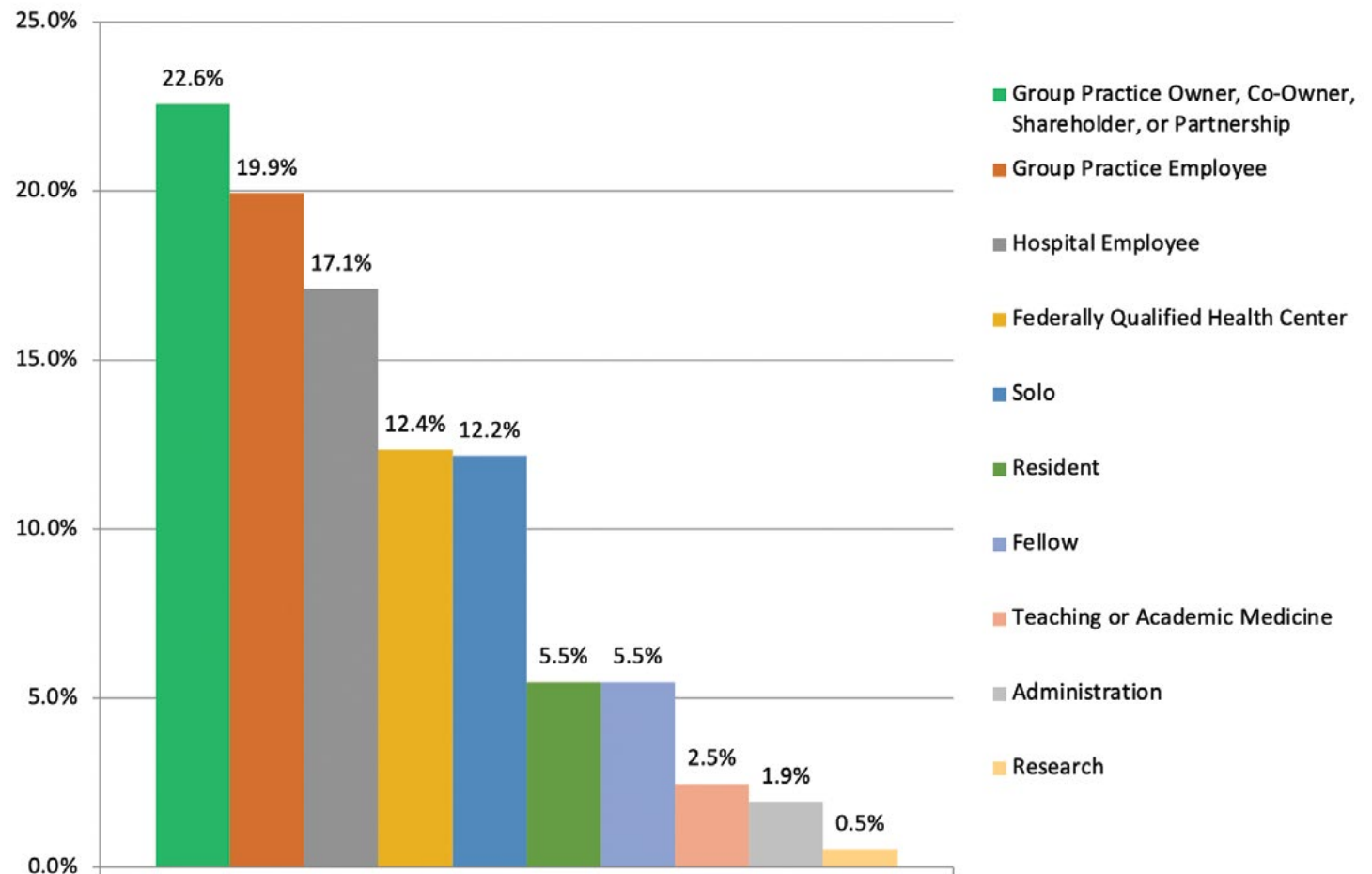
Demographics: Primary Form of Medical Practice

The top three responses were Group Practice Owner, Co-Owner, Shareholder or Partnership (22.6%), Group Practice Employee (19.9%), and Hospital Employee (17.1%).

Solo Practitioners accounted for (12.2%) of responses.

Residents and Fellows combined accounted for roughly 10% of responses.

Which of the following best describes your primary form of medical practice?



Demographics (continued)

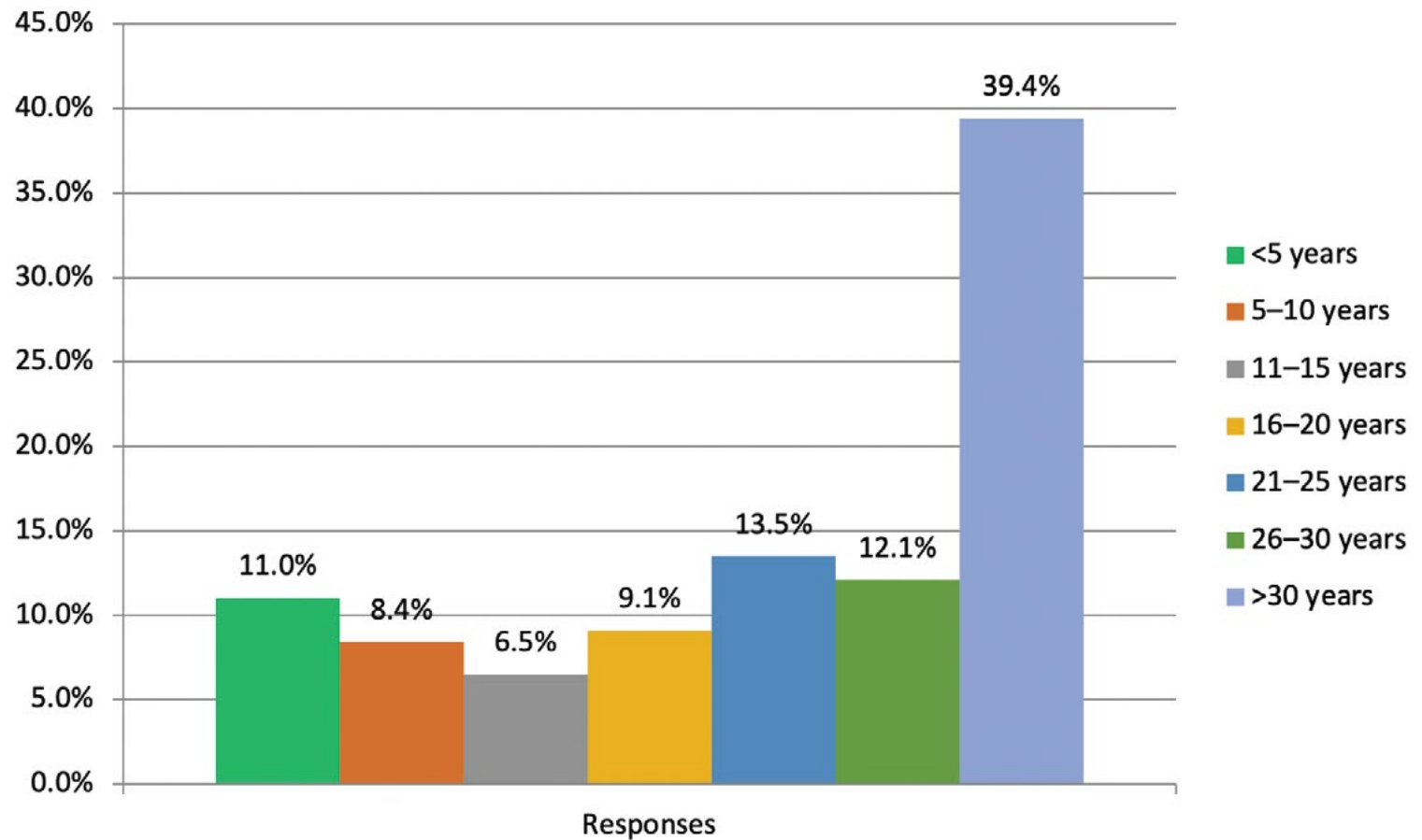
Demographics: Length of Time in Practice

Roughly 60% of respondents had been in practice for less than or equal to 30 years.

The largest single group of respondents had been in practice for more than 30 years (39.4%). The next largest group of responses came from those who had been in practice for 21 to 25 years (13.5%).

All other years in practice responses varied from roughly 7% to 12% of the total response rate.

How long have you been in practice?



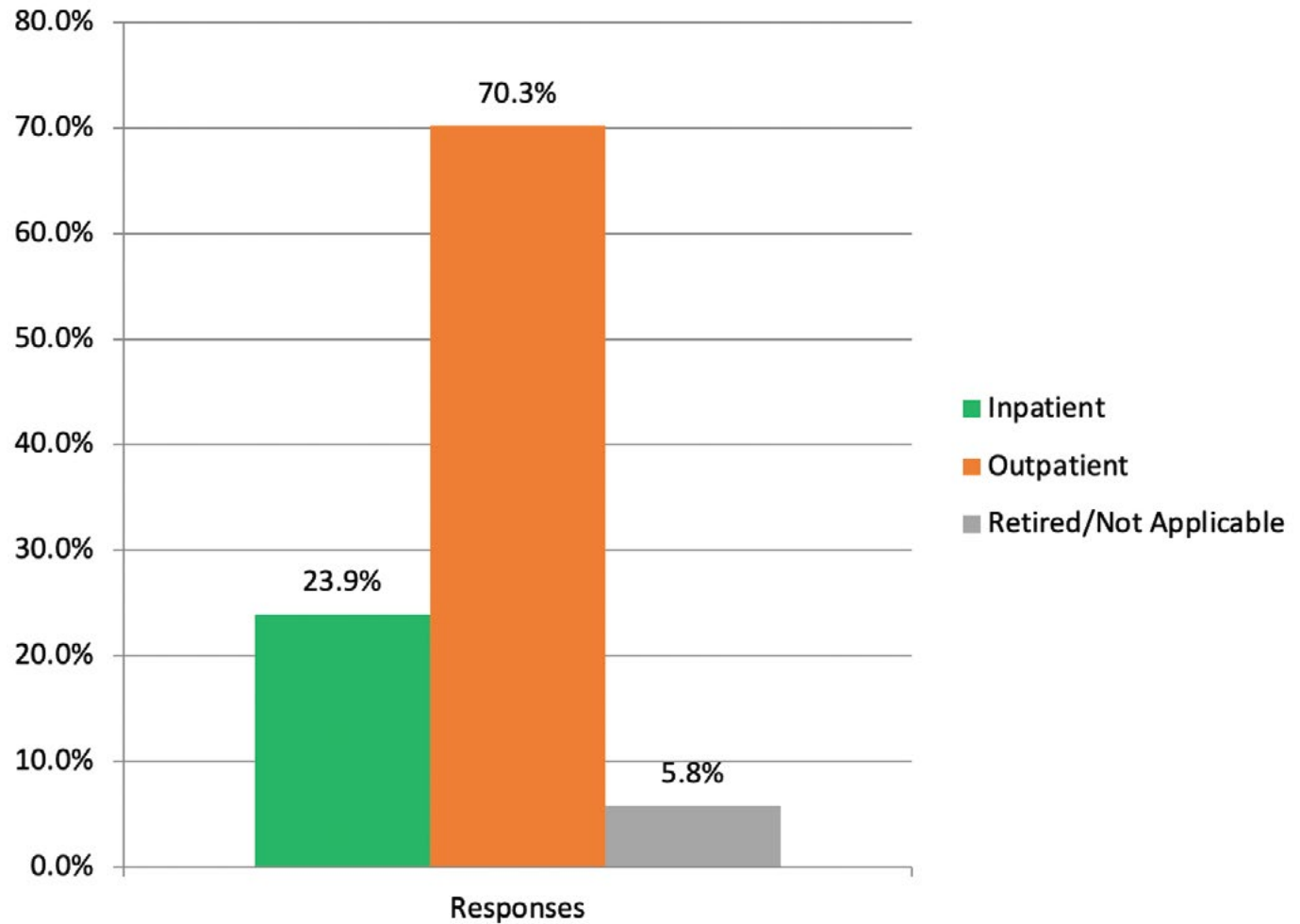
Demographics (*continued*)

Demographics: Practice Settings and Specialties

Most respondents practice in an outpatient setting (70.3%).

The survey provided a response for retired physicians. Some did choose to respond as retired.

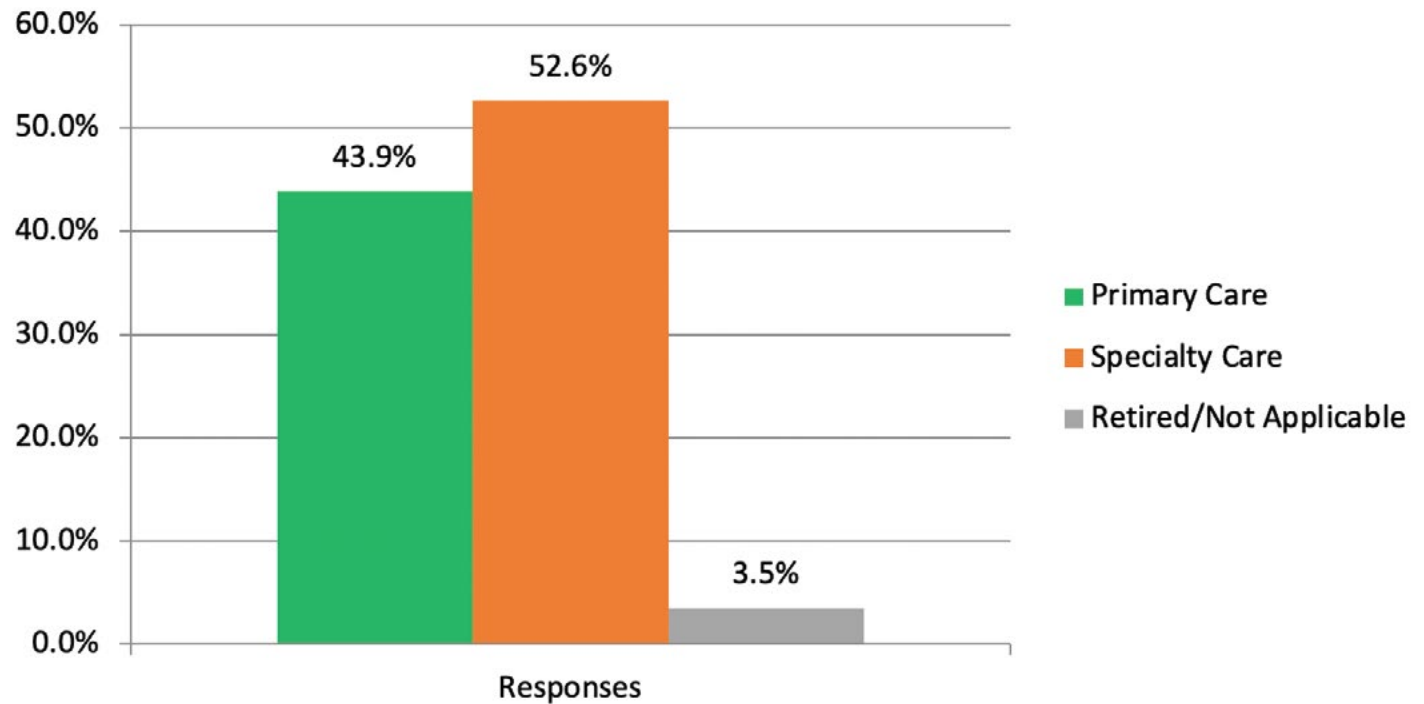
Please indicate your practice setting.
Check all that apply.



Demographics (continued)

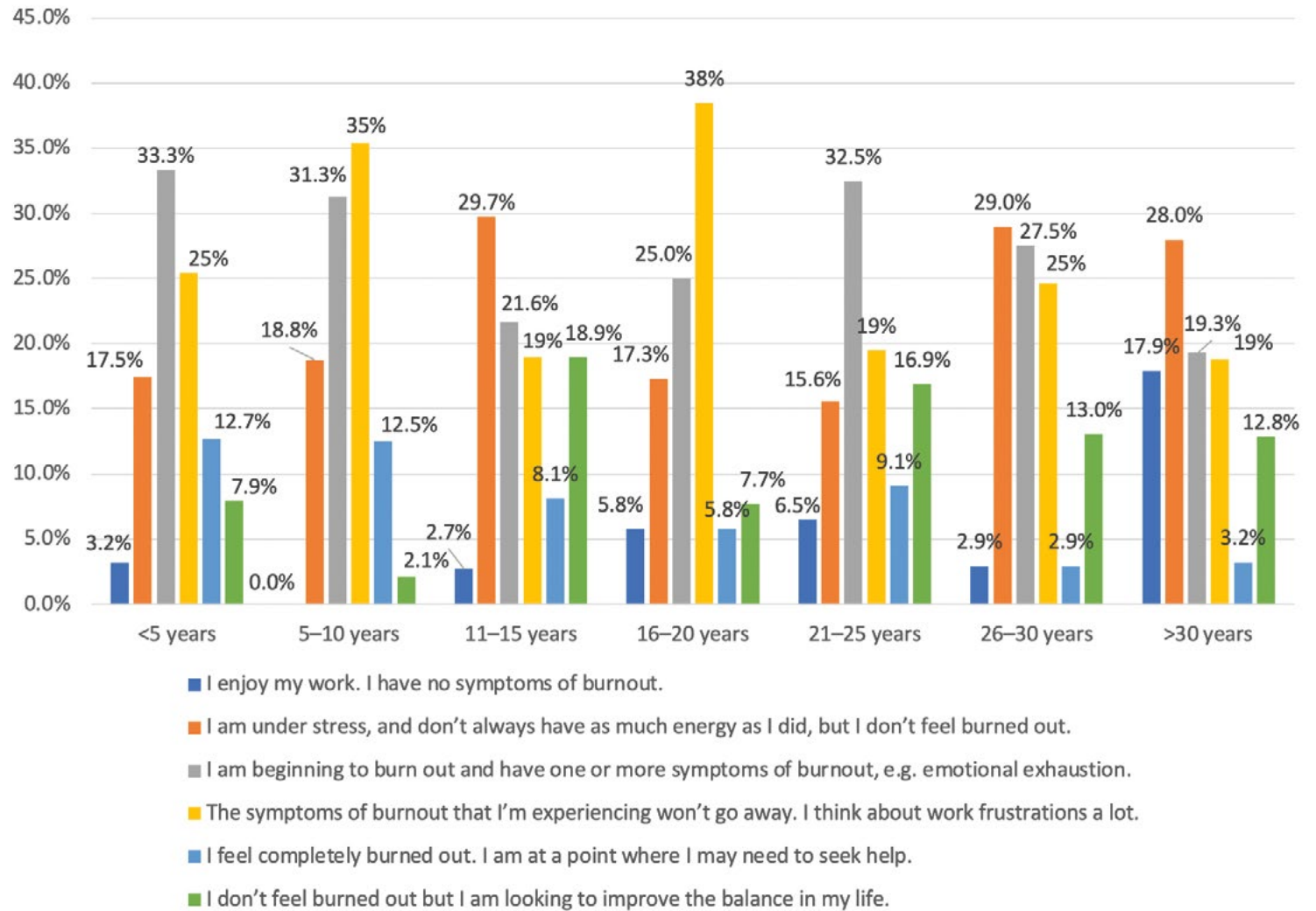
More respondents practiced in specialty care than in primary care (53% versus 44%).

Please indicate whether you practice in primary care (defined as IM, PED, OB, FP) or specialty care.



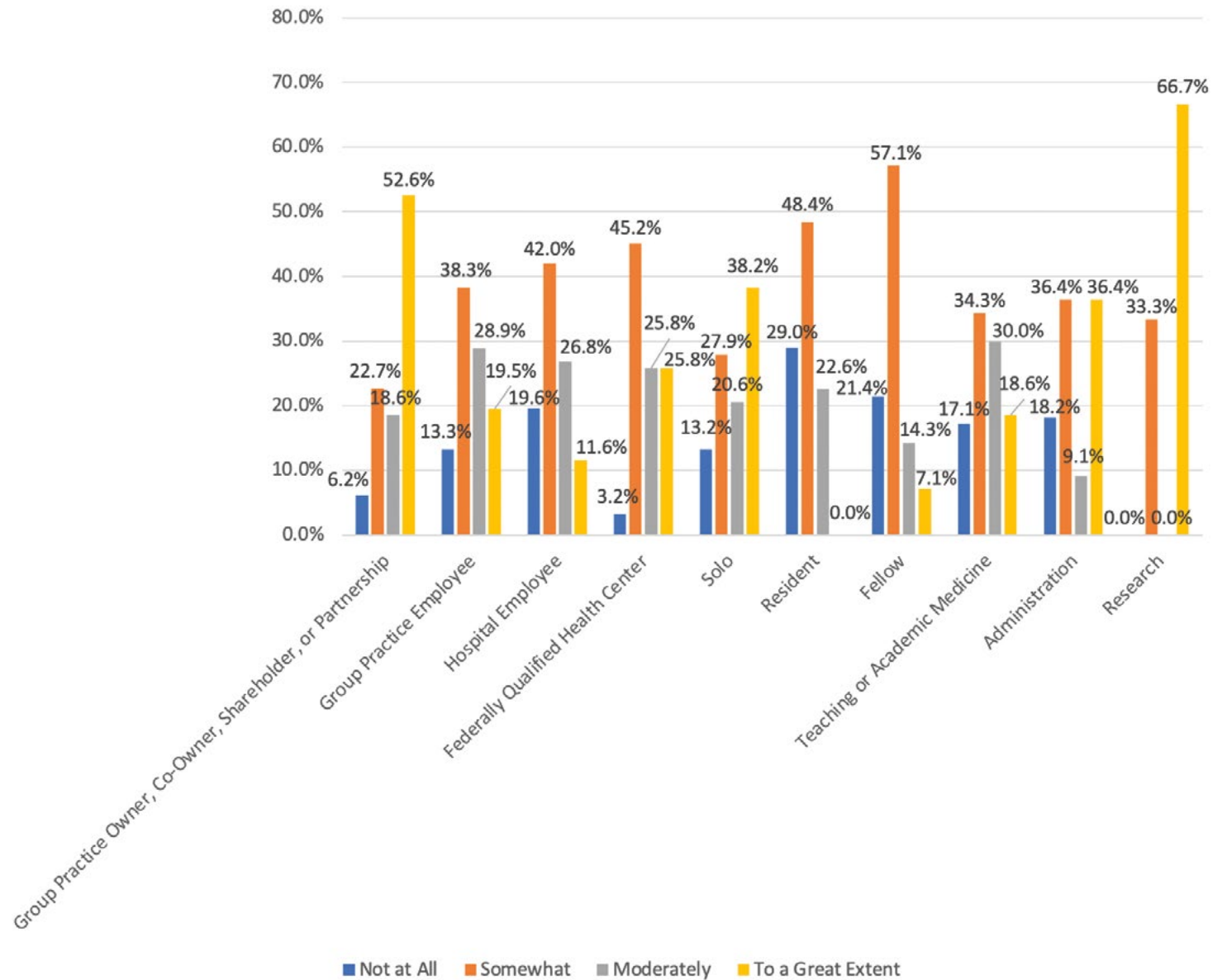
Appendix

Using your own definition of burnout...



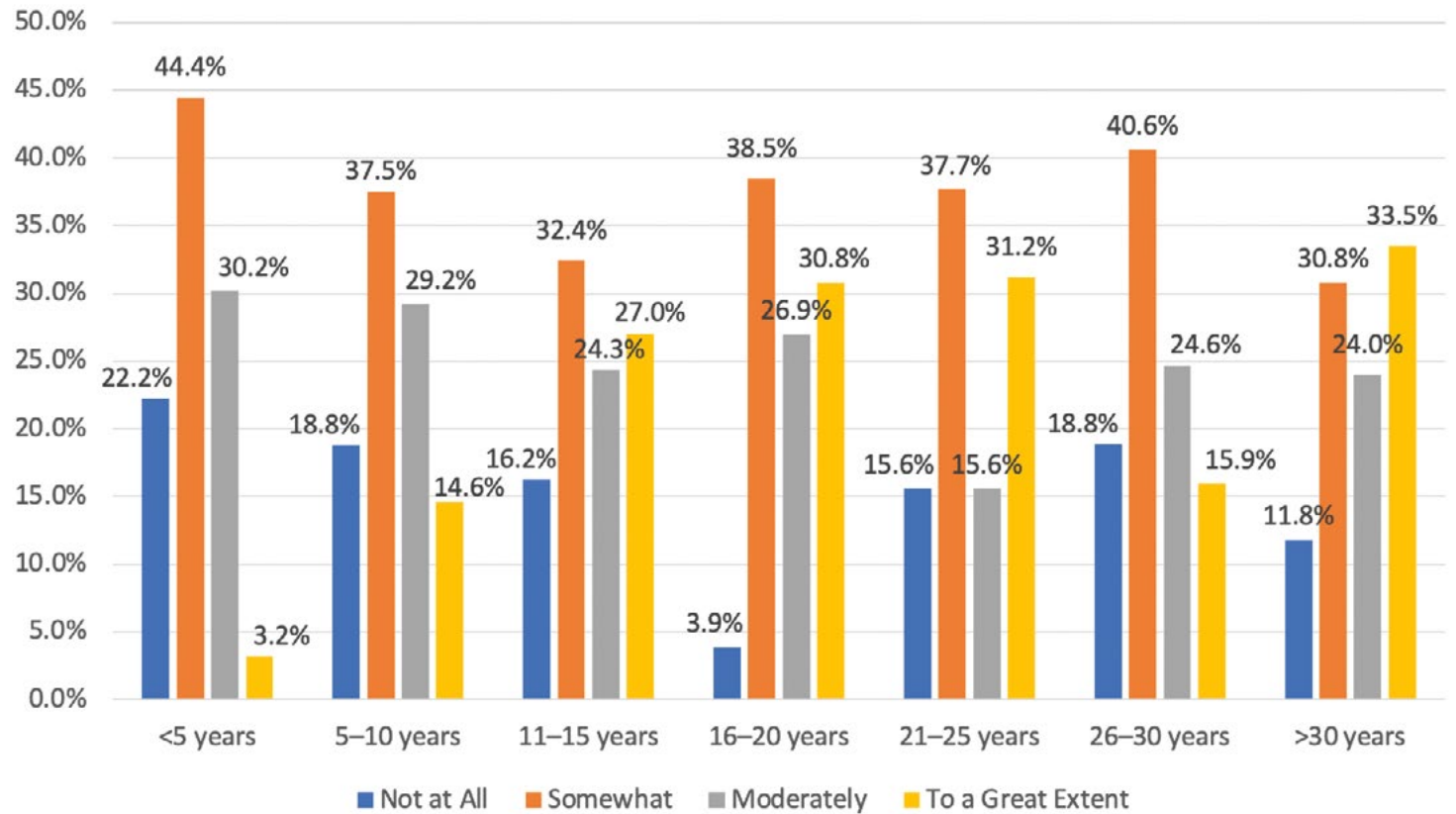
Appendix (continued)

I matter to my organization.

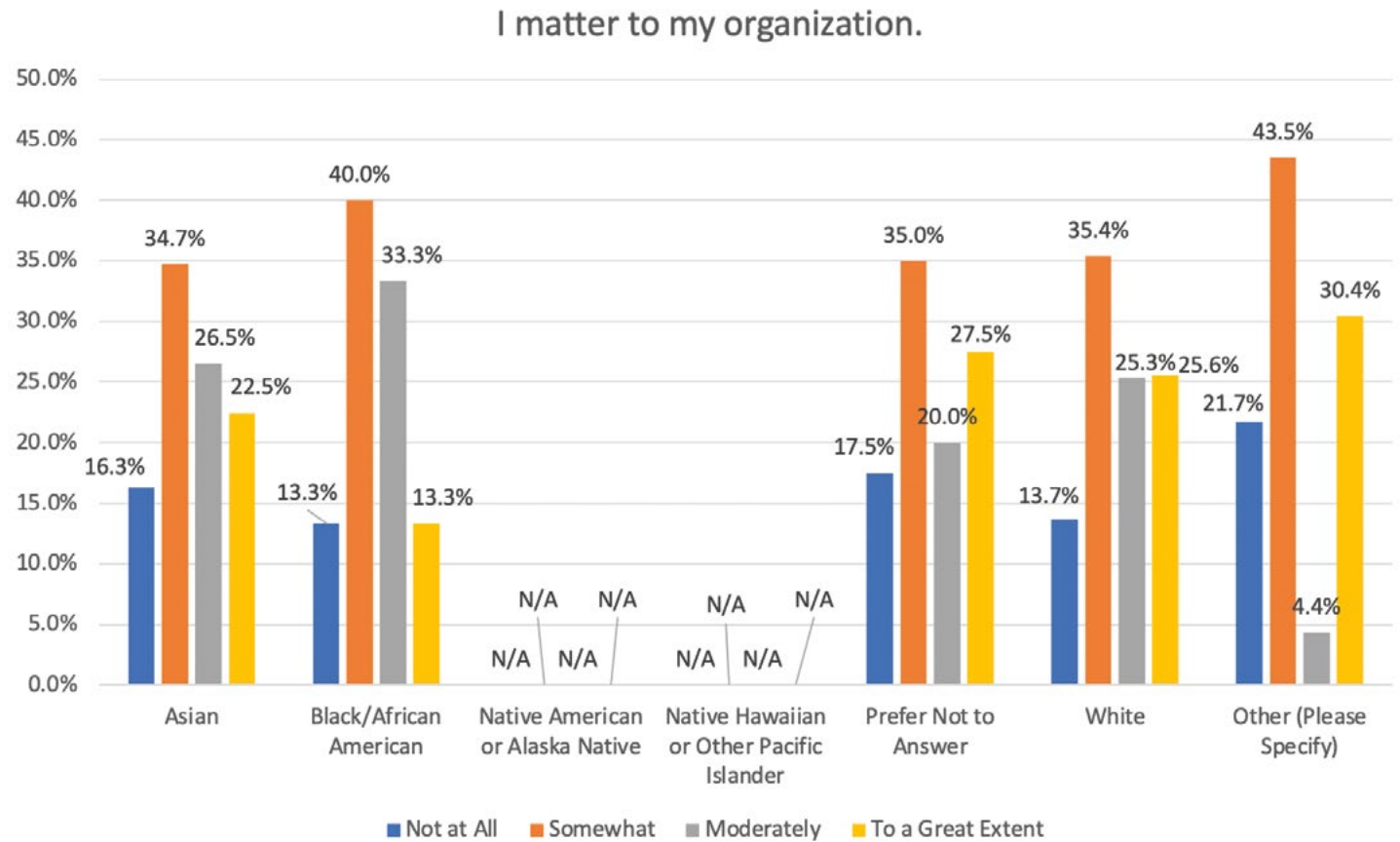


Appendix (continued)

I matter to my organization.



Appendix (continued)





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