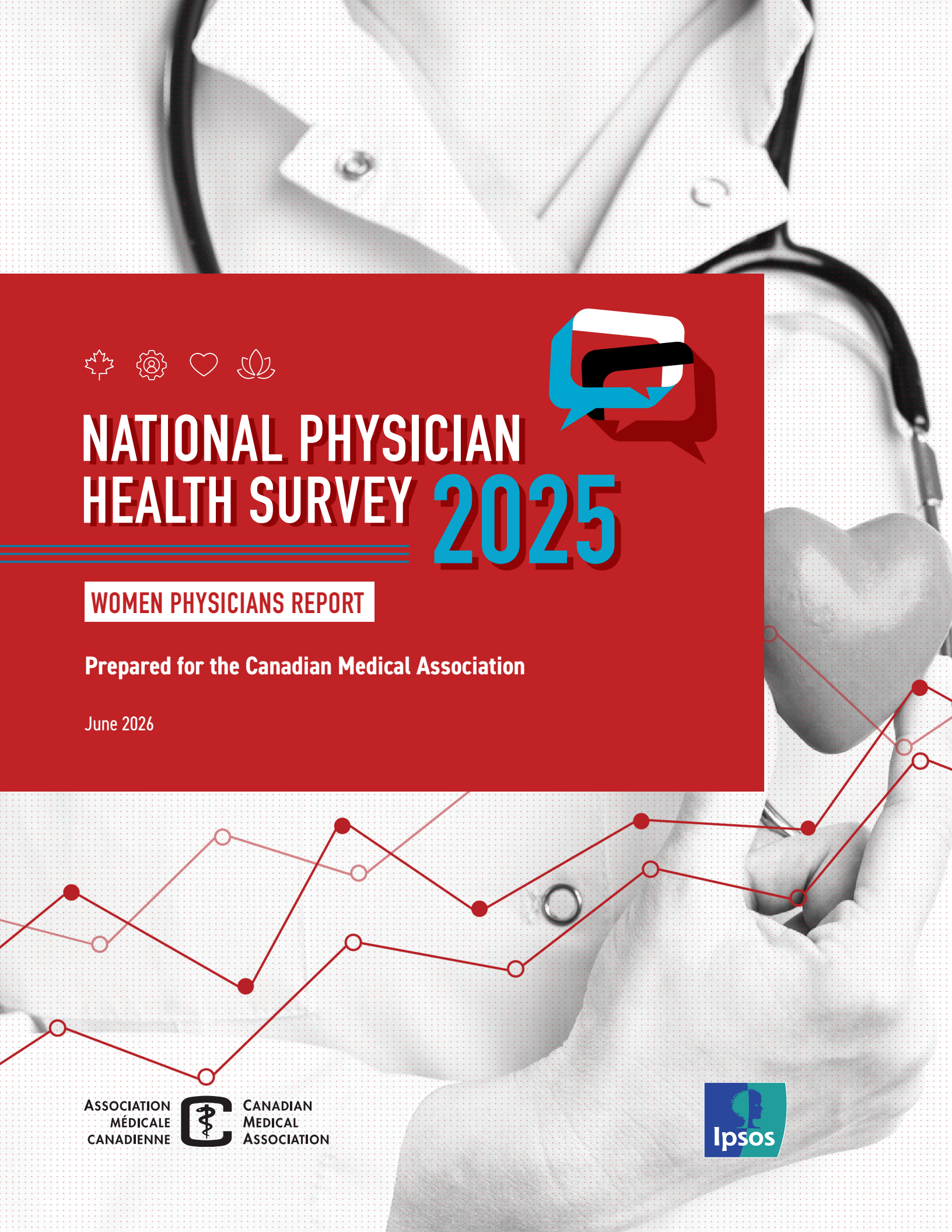

NATIONAL PHYSICIAN HEALTH SURVEY 2025

WOMEN PHYSICIANS REPORT

Prepared for the Canadian Medical Association

June 2026

ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

Ipsos

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Third National Physician Health Survey

This document is also available in French under the title: ***Sondage national de l'AMC sur la santé des médecins de 2025 – Rapport sur les femmes médecin***.

The Canadian Medical Association (CMA) acknowledges that our head office in Ottawa, Ontario, is located on the never surrendered homeland of the Anishinabe Algonquin Nation, a land of spirit and purity, of healing plants and sacred waters, provided to the People by Creator since time immemorial. With great humility, we offer gratitude for the commitment the Anishinabe Algonquin have always held in keeping the 'Song of a Healthy Nation' alive for all people of this beautiful land. The request we make to the People of the Host Nation is that they bless our efforts here, in the heart of their territory, to become an inextinguishable light in the field of health and wellness.

The CMA leads a national movement with physicians and medical learners who believe in a better future of health. Our ambition is a sustainable, accessible health system where patients are partners, a culture of medicine that elevates equity, diversity and well-being, and supportive communities where everyone has the chance to be healthy. We drive change through advocacy, giving and knowledge sharing — guided by values of collaboration and inclusion. For general questions or comments, we can be reached by phone at 613-731-8610 or through our general inquiries contact form. Our media team can be reached at mediainquiries@cma.ca.

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The data and analysis were shared with and reviewed by the Federation of Medical Women of Canada.

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INTRODUCTION

About the study

With the objective of informing decision-making regarding physician health initiatives, the Canadian Medical Association (CMA) conducts the National Physician Health Survey (NPHS) to provide insight into health and wellness challenges facing physicians and medical learners in Canada. The 2025 NPHS is the third iteration of the survey, following waves that gathered baseline data in 2017 and pandemic-era insights in 2021.[1,2] It comes at a pivotal moment as the profession navigates ongoing workforce challenges, emerging technologies and evolving workforce safety concerns.

The goal of the 2025 NPHS is to provide current, relevant data that can guide organizations, researchers, educators and policy-makers in strengthening physicians' wellness initiatives. The survey takes an equity-focused approach, tracking outcomes across key demographic groups and identifying opportunities for system-level changes to support physician health.

This document presents the results of the 2025 NPHS for women respondents (*n* = 1,993).

For the national results, full details on the methodology, study limitations, the questionnaire and other considerations, see the CMA 2025 National Physician Health Survey.[3]

EXECUTIVE SUMMARY

The *CMA 2025 National Physician Health Survey: Women Physicians Report* presents findings from physicians who identify as women. Overall, women physicians report less favourable outcomes than men physicians across key wellness measures. Nearly half of women physicians (49% vs. 41% among men) report symptoms of burnout, including high emotional exhaustion (45% vs. 36%) and depersonalization (26% vs. 23%), rates that are significantly higher than among men physicians. Mental health indicators reveal additional concerns: more than one-third of women physicians (37% vs. 29% among men) report lifetime suicidal ideation, and one-quarter (25% vs. 18%) report frequent moral distress at work; both of these rates significantly exceed those among men physicians. Two-thirds of women physicians (67%) report frequent fatigue at work or school, significantly higher than the rate among men physicians (52%). Fewer than six in 10 women physicians (57%) report satisfaction with their work–life integration, significantly lower than the rate among men physicians (65%). Professional fulfillment remains low, with only one in four women physicians (26%) scoring high, compared with more than one-third of men physicians (36%).

In parallel with these outcomes, women physicians report high workplace demands and a substantial administrative burden. They report working an average of 52.8 hours per week and spend significantly more time on administrative tasks than men physicians (10.7 vs. 9.8 hours per week). Two-thirds of women physicians (67%) report excessive or moderately high after-hours EMR work, significantly higher than the rate among men physicians (58%). More than four in five women physicians (83%) indicate that false health information[a] negatively impacts their work, compared with fewer than seven in 10 men physicians (69%). These pressures coexist with lower perceived workplace safety and collegiality: women physicians are significantly less likely than men to feel psychologically safe (62% vs. 68%) or culturally safe (72% vs. 78%) and are less likely to report high collegiality (64% vs. 71%).

Mistreatment is widespread. Nearly eight in 10 women physicians (78%) report having experienced intimidation, bullying, harassment, microaggressions and/or discrimination, significantly higher than men physicians (68%). Among women physicians who have experienced bullying, nearly two-thirds (65%) cite gender expression or identity as the reason for being targeted, compared with just 11% of men physicians. Patients and their families or friends (59%) and fellow physicians (57%) are the most frequently reported sources of intimidation, bullying, harassment, microaggressions and/or discrimination, and women physicians are significantly more likely than men to report being targeted by another physician (57% vs. 48%). Women physicians are also more likely than men to have witnessed intimidation, bullying, harassment, microaggressions and/or discrimination in their workplace (79% vs. 73%) and, when witnessing such incidents, to report having supported the individual being targeted (75% vs. 66%).

Experiences among women physicians vary considerably across key demographic groups. Career stage is a strong differentiator: early- and mid-career women physicians consistently report worse outcomes than those late in their career, including higher burnout, fatigue, moral distress and lifetime suicidal ideation, as well as a greater likelihood of having ever experienced intimidation, bullying, harassment, microaggressions and/or discrimination. These groups also report lower professional fulfillment, lower collegiality and higher dissatisfaction with their work–life integration. Women physicians who self-identify as having a disability experience markedly poorer outcomes across nearly all domains, including burnout, suicidal ideation, fatigue, professional fulfillment and workplace safety, and they are more likely to experience intimidation, bullying, harassment, microaggressions and/or discrimination. Caregiver status further differentiates experiences: women physicians with caregiving responsibilities, particularly those providing care for both children and parents, report higher moral distress, greater

[a] The survey question was worded as “health misinformation”; the terms are used interchangeably in this report reflecting shift in language around the issue.

after-hours EMR burden and lower satisfaction with their work–life integration, while women physicians who are not caregivers report longer work hours and higher lifetime suicidal ideation. Differences by ethnic and racial identity are also evident: women physicians who do not self-identify as white report longer work hours and lower cultural safety and collegiality, and they are more likely to have ever experienced intimidation, bullying, harassment, microaggressions and/or discrimination, with distinct patterns in perceived reasons for mistreatment. Taken together, these findings highlight how gender intersects with career stage, disability status, caregiver responsibilities and racial/ethnic identity to shape women physicians' well-being and workplace experiences.

Amid these challenges, women physicians demonstrate high engagement with wellness supports. Nearly three-quarters (72%) have accessed at least one wellness support in the past five years, significantly higher than the rate among men physicians (53%). In addition, women physicians clearly articulate priorities for system improvement as essential for recruitment and retention: 80% identify lower administrative burden (vs. 73% men), followed by access to locums (54% vs. 41%), team-based care (48% vs. 42%) and culturally safe work environments (44% vs. 35%). Women physicians also more frequently identify system-level supports that would benefit well-being, including back-up staff (51% vs. 41%) and mental health supports (37% vs. 29%). Notably, women physicians are less likely than men to report intentions to leave medicine or retire early (11% vs. 17%), although this varies substantially by career stage and other demographic factors.

Across nearly all domains, women physicians report significantly poorer wellness outcomes and more challenging workplace experiences than men physicians, alongside higher engagement with wellness supports and stronger endorsement of structural solutions. Collectively these differences reflect system-level inequities, organizations' structural issues and inequalities in the culture of medical work. They underscore the importance of immediate, targeted, system-level interventions to improve working conditions, workplace safety and long-term physician retention.

METHODOLOGY

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 the CMA website, as well as support from external parties who distributed the link to their own networks. An open link survey methodology was used to ensure that physicians beyond the CMA membership were invited. Efforts were taken to make the reach as broad and representative as possible.

The survey was open from March 11 to April 15, 2025. Participation in this study was voluntary.

A total of 3,310 practising physicians and medical residents completed the 2025 NPHS (*n* = 2,942 practising physicians, *n* = 337 medical residents, *n* = 31 fellows), including 1,993 women, 1,226 men, 32 other and 59 who preferred not to answer. This report presents the results of women respondents. Throughout this report, the 1,993 women respondents are compared with the 1,226 men respondents. Those who identified as other or preferred not to answer were not included because of small sample size.

This report uses the terms "women" and "men" because the analysis is based on physicians' self-identified gender.

TABLE 1. Respondent sample counts and proportions.

TOTAL SAMPLE

	WOMEN		MEN	
TOTAL sample	1,993	100%	1,226	100%

PHYSICIAN STAGE[b]

	WOMEN		MEN	
Practising physician	1,764	89%	1,105	90%
Medical resident	229	11%	121	10%

YEARS IN PRACTICE

	WOMEN		MEN	
5 or less	266	15%	110	10%
6 to 10	242	14%	120	11%
11 to 20	522	30%	236	21%
21 to 30	434	25%	252	23%
31 or more	300	17%	384	35%

COMMUNITY SIZE

	WOMEN		MEN	
Urban/suburban	1,463	73%	953	78%
Small town / rural	422	21%	227	19%
Isolated/remote	53	3%	23	2%
Cannot identify / prefer not to answer	51	3%	21	2%

DISABILITY[c]

	WOMEN		MEN	
Self-identifies as having disability	479	24%	196	16%
Does not self-identify as having a disability	1,465	74%	1,003	82%

CAREGIVER STATUS[d]

	WOMEN		MEN	
Caregiver of parent(s) and/or child(ren)	1,165	58%	614	50%
Not a caregiver	828	42%	612	50%
Caregiver of child(ren)	930	47%	514	42%
Caregiver of parent(s)	122	6%	57	5%
Caregiver of both parent(s) and child(ren)	113	6%	43	4%

ETHNIC AND RACIAL IDENTITY[e]

	WOMEN		MEN	
Asian	211	11%	153	12%
Black	46	2%	35	3%
Latin/Hispanic	17	1%	26	2%
Middle Eastern	50	3%	49	4%
White	1,545	78%	856	70%
Mixed race	73	4%	46	4%
Identify as Indigenous	73	4%	34	3%
Does not identify as Indigenous	1,901	95%	1,171	96%
Not specified above	68	3%	51	4%

[b] Percentages may not sum to 100% as "Prefer not to answer" responses are not shown.
[c] Percentages may not sum to 100% as "Prefer not to answer" responses are not shown.
[d] As these results are from a multi-response question, percentages may not sum to 100%.
[e] As these results are from a multi-response question, percentages may not sum to 100%. In addition, "Prefer not to answer" responses are excluded. For the purpose of analysis in this report, the data for respondents who do not self-identify as white have been combined because of small sample sizes.

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.

As part of the initial analysis, the data were weighted to determine how outcomes might be affected by the weighting. Outcomes from this weighted dataset were then compared with the unweighted results. 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. For more information about considerations around weighting, refer to the CMA 2025 National Physician Health Survey.[3]

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.), workplace indicators, physical, psychological and cultural safety indicators, and workforce sustainability 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)[f], anxiety symptoms (General Anxiety Disorder 7-Item Scale), depression screening (Patient Health Questionnaire–2), professional fulfillment (Professional Fulfillment Index) and suicidal ideation.[4,5,6,7,8]

Workplace indicators included task-specific work hours, percentage of hours spent on unnecessary tasks, administrative burden (e.g., electronic medical records), level of fatigue, work–life integration, job satisfaction, professional fulfillment, negative impact of false health information, comfort answering licensing questions on mental health, and preparedness for career transition.

Physical, psychological and cultural safety indicators included perceptions of physical, psychological and cultural safety; agreement with safety concern attributes; experiences and witnessing situations of intimidation, bullying, harassment, microaggressions and/or discrimination in the workplace; sources and reasons for bullying; interpersonal conflict; disrespectful, demeaning or condescending communication styles; collegiality at work; leadership assessments of supervisor/managers and senior leadership; and training received.

Workforce sustainability factors included modification of clinical hours, plans to reduce or increase clinical hours, reasons for reducing clinical hours, and likelihood of leaving practice or retiring earlier than expected.

Please refer to Appendix A of the CMA 2025 National Physician Health Survey[3] for the full survey instrument.

NOTES TO READER

Unless otherwise indicated, all questions reported exclude "don't know" and/or "not applicable" and/or "prefer not to answer" responses, and thus base sizes may vary from question to question.

In this report, the term "physicians" is used when referring to the combined responses from practising physicians, medical residents and fellows.

[f] 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.

This report uses the terms "women" and "men" because the analysis is based on physicians' self-identified gender.

This report presents a comparison of data for women physicians with the results of men physicians.

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

- A chi-square test was carried out on many measures.[g] Specific outputs of the statistical testing (chi-square value, degrees of freedom, p-value) are available upon request.
- 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 multiselect to help guide the interpretation of the data.
- 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. When interpreting these highlights: if both higher (green) and lower (red) subgroups appear in a comparison, the significant differences are between those highlighted groups specifically. If only one subgroup is highlighted (either green or red), it is significantly different from all other subgroups shown.

The term "significant" is clearly stated when 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 "directionally higher" or "directionally lower" or "more likely" or "less likely" are used, and the results are not colour coded.

Some results do not add to 100% because of rounding or because the question would have allowed the selection of multiple responses. Numerical data provided in this report were rounded to the nearest integer in accordance with standard mathematical rounding rules. For values with a decimal part of 0.5 or higher, the number was rounded up, whereas values with a decimal point of less than 0.5 were rounded down. The reader should bear the impact of rounding in mind while summing the values.

For this report, select demographic variables were chosen for analysis on the basis of CMA priorities. These include years in practice (early career: five years or less; mid-career: six to 20 years; late career: 21 years or more), disability status (self-identifies as having a disability vs. does not self-identify as having a disability), caregiver status (child caregiver: caregiver of child(ren) only; parent caregiver: caregiver of parent(s) only; multigenerational caregiver: caregiver of both parent(s) and child(ren); family caregiver[h]: caregiver of parent(s) and/or child(ren); non-caregiver: not a caregiver), and ethnic and racial identity (white vs. does not self-identify as white only).

Although the survey collected demographic data across multiple dimensions, the analysis presented in this report focuses on differences among women respondents by these selected variables only where statistically significant and relevant differences were identified. Where demographic comparisons are not mentioned, this indicates that no statistically significant differences were observed among women respondents for that measure.

In "A closer look at other demographic characteristics among women physicians" sections, the term "workplace hostility" is used for brevity to represent "intimidation, bullying, harassment, microaggressions and/or discrimination in the workplace or in a training environment."

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[g] Chi-square tests were carried out as follows:
- 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).

[h] Family caregiver reflects the net of respondents who provide care to a parent and/or a child. It includes child caregivers, parent caregivers and multigenerational caregivers.

SURVEY RESULTS

SECTION 1
PSYCHOLOGICAL FACTORS

BURNOUT[i,5]

Forty-nine percent of women physicians report symptoms of burnout, that is, they report a high level on at least one burnout indicator of depersonalization (26%) or emotional exhaustion (45%).

The prevalence of overall burnout is *significantly* higher among women physicians than among men physicians (**49%*** vs. **41%***), on both depersonalization (**26%*** vs. **23%***) and emotional exhaustion (**45%*** vs. **36%***).

NEARLY HALF OF WOMEN PHYSICIANS ARE EXPERIENCING SYMPTOMS OF BURNOUT, A PROPORTION *SIGNIFICANTLY* HIGHER THAN THE PROPORTION OF MEN PHYSICIANS.

TABLE 2. Maslach Burnout Inventory two-item scale by gender. Base: women (*n* = 1,993); men (*n* = 1,226).

	WOMEN	MEN
High depersonalization	26%*	23%*
High emotional exhaustion	45%*	36%*
High overall burnout	49%*	41%*

** Statistically significant using chi-square test of independence.

[i] Maslach Burnout Inventory Two-Item Scale. Scoring: 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 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).

A closer look at other demographic characteristics among women physicians

Early- and mid-career women physicians are *significantly* more likely than those late in their career to report high overall burnout (**56%↑** early, **54%↑** mid vs. **40%↓** late).

Women physicians who self-identify as having a disability are *significantly* more likely than those who do not to report high overall burnout (**58%↑** vs. **46%↓**).

SUICIDAL IDEATION

Thirty-seven percent of women physicians have had thoughts of suicide at some point in their life.

Women physicians report a *significantly* higher rate of lifetime suicidal ideation than men physicians (**37%↑** vs. **29%↓**).

MORE THAN ONE-THIRD OF WOMEN PHYSICIANS REPORT HAVING HAD THOUGHTS OF SUICIDE AT SOME POINT IN THEIR LIVES, *SIGNIFICANTLY* EXCEEDING THE RATE AMONG MEN PHYSICIANS.

TABLE 3. Suicidal ideation (lifetime) by gender. Base: respondents consenting to the collection of sensitive data, women (*n* = 1,903); men (*n* = 1,154).

	WOMEN	MEN
Suicidal ideation (lifetime)[j]	**37%↑**	**29%↓**

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

A closer look at other demographic characteristics among women physicians

Mid-career women physicians report *significantly* higher rates of lifetime suicidal ideation than those late in their career (**37%↑** vs. **32%↓**).

Among women physicians, those who self-identify as having a disability report *significantly* higher rates of lifetime suicidal ideation than those who do not (**56%↑** vs. **30%↓**).

Looking at caregiver status, women physicians who are non-caregivers report *significantly* higher rates of lifetime suicidal ideation (**40%↑**) than child caregivers (**33%↓**) or family caregivers (**34%↓**).

[j] Lifetime suicidal ideation was not chosen to be run on chi-square; therefore, the statistical testing done was based on *t*-testing.

FEELING MORAL DISTRESS

Twenty-five percent of women physicians say they feel moral distress in their work "always" or "very often." Another 39% say they feel moral distress "sometimes," and 35% feel this way either "rarely" or "never."

Women physicians are *significantly* more likely to frequently (always or very often) experience moral distress at work than men physicians (**25%*** vs. **18%***).

ONE IN FOUR WOMEN PHYSICIANS EXPERIENCE MORAL DISTRESS AT WORK "ALWAYS" OR "VERY OFTEN," A RATE *SIGNIFICANTLY* HIGHER THAN THE RATE AMONG MEN PHYSICIANS.

TABLE 4. Frequency of feeling morally distressed by gender. Base: All respondents, women (*n* = 1,993); men (*n* = 1,226).

	WOMEN	MEN
% very often / always	25%*	18%*
% sometimes	39%*	32%*
% rarely/never	35%*	51%*

** Statistically significant using chi-square test of independence.

A closer look at other demographic characteristics among women physicians

Women physicians early in their career (**29%↑**) and in mid-career (**29%↑**) are *significantly* more likely than those late in their career to report frequent (always or very often) moral distress (**21%↓**).

Among women physicians, frequent moral distress rates are *significantly* higher for those who self-identify as having a disability than for those who do not (**35%↑** vs. **22%↓**).

Looking at caregiver status, women physicians who are family caregivers or child caregivers (**27%↑** for both) report a *significantly* higher frequency of moral distress than those who are non-caregivers (**22%↓**).

SECTION 2
WORKPLACE FACTORS

WORK HOURS

On average, women physicians report working 52.8 hours per week[k]: 35.2 hours on patient care, 10.7 hours on administrative tasks and 8.7 hours on other duties.

Compared with men physicians, women physicians spend *significantly* more time on administrative tasks (**10.7↑** vs. **9.8↓**), while reporting similar total work hours (52.8 vs. 52.3) and patient care hours (35.2 vs. 36.0).

WOMEN PHYSICIANS SPEND *SIGNIFICANTLY* MORE TIME ON ADMINISTRATIVE TASKS THAN MEN PHYSICIANS, ALTHOUGH THEY SPEND A SIMILAR AMOUNT OF TIME ON PATIENT CARE.

TABLE 5. Average hours worked by gender. Base: All respondents, excluding those report 0 total hours, women (*n* = 1,988); men (*n* = 1,226).

	WOMEN	MEN
Patient care	35.2	36.0
Administrative tasks	**10.7↑**	**9.8↓**
Other duties	8.7	8.8
Average no. of hours worked	52.8	52.3

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

[k] 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 (electronic documentation time, email, prescriptions, ordering tests, etc.);
(3) other duties/responsibilities (teaching, committee work, research, leadership role, etc.)

A closer look at other demographic characteristics among women physicians

Women physicians early in their career (**53.9↑**) and in mid-career (**52.2↑**) report a *significantly* higher overall number of weekly work hours than those late in their career (**49.5↓**). Those early in their career (**36.9↑**) and in mid-career (**34.5↑**) spend significantly more time on patient care than those late in their career (**31.8↓**).

Among women physicians, those who self-identify as having a disability (**51.1↓**) report a *significantly* lower number of total work hours than those who do not self-identify as having a disability (**53.3↑**).

In terms of caregiver status, women physicians who are non-caregivers report *significantly* higher total work hours (**54.4↑**) than child caregivers (**51.4↓**) or family caregivers (**51.7↓**). Specifically, non-caregivers devote *significantly* more time to patient care (**37.1↑**) than child caregivers (**34.1↓**), parent caregivers (**31.7↓**) or family caregivers (**33.9↓**).

Women physicians who do not self-identify as white only report *significantly* higher total work hours (**56.8↑** vs. **51.6↓**) and patient care hours (**38.2↑** vs. **34.4↓**) than those who self-identify as white only.

ADMINISTRATIVE BURDEN: RELATED TO ELECTRONIC MEDICAL RECORDS (EMR)

Sixty-seven percent of women physicians report that the time they spend working on the EMR outside of regular working hours is "excessive" or "moderately high."

Compared with men physicians, women physicians are *significantly* more likely to say the amount of time they spend on the EMR outside of working hours is "excessive" or "moderately high" (**67%*** vs. **58%*** among men).

TWO-THIRDS OF WOMEN PHYSICIANS INDICATE THE TIME THEY SPEND ON EMR OUTSIDE REGULAR WORKING HOURS IS "EXCESSIVE" OR "MODERATELY HIGH," *SIGNIFICANTLY* HIGHER THAN THE PROPORTION OF MEN PHYSICIANS.

TABLE 6. Administrative burden (excessive + moderately high) by gender. Base: Women (*n* = 1,839); men (*n* = 1,132).

	WOMEN	MEN
% excessive or moderately high	67%*	58%*

** Statistically significant using chi-square test of independence.

A closer look at other demographic characteristics among women physicians

Among women physicians, multigenerational caregivers (**77%↑**) are *significantly* more likely to indicate that the time they spend on the EMR outside of regular working hours is excessive or moderately high, compared with those who are child caregivers (**68%↓**) or non-caregivers (**66%↓**).

LEVEL OF FATIGUE

Sixty-seven percent of women physicians report they frequently (19% "always" or 48% "often") feel fatigued at work/school. A smaller proportion say they "sometimes" feel fatigued at work/school and only 7% say "rarely/never" (6% rarely and 1% never).

Women physicians are *significantly* more likely than men physicians to say they frequently (always/often) feel fatigued at work/school (**67%*** vs. **52%***).

TWO-THIRDS OF WOMEN PHYSICIANS SAY THEY "ALWAYS" OR "OFTEN" FEEL FATIGUED AT WORK/SCHOOL, A *SIGNIFICANTLY* HIGHER RATE THAN AMONG MEN PHYSICIANS.

TABLE 7. Responses to question: How often do you feel fatigued at work/school by gender. Base: Women (*n* = 1,993); men (*n* = 1,226).

	WOMEN	MEN
% always/often	67%*	52%*
% sometimes	26%*	33%*
% rarely/never	7%*	15%*

** Statistically significant using chi-square test of independence.

A closer look at other demographic characteristics among women physicians

Women physicians early in their career (**77%↑**) and in mid-career (**72%↑**) are *significantly* more likely to say they frequently (always/often) feel fatigued at work/school than those late in their career (**56%↓**).

Women physicians who self-identify as having a disability are *significantly* more likely to be frequently fatigued than women physicians who do not (**76%↑** vs. **64%↓**).

Women who do not self-identify as white only are *significantly* less likely to be frequently fatigued than those who self-identify as white only (**59%↓** vs. **69%↑**).

WORK-LIFE INTEGRATION

Fifty-seven percent of women physicians are satisfied with their work–life integration, with the remaining four in 10 (43%) dissatisfied.

Women physicians are *significantly* less likely than men physicians to be satisfied with their work–life integration (**57%*** vs. **65%***).

SIX IN 10 WOMEN PHYSICIANS ARE SATISFIED WITH THEIR WORK-LIFE INTEGRATION, A *SIGNIFICANTLY* LOWER RATE THAN AMONG MEN PHYSICIANS.

TABLE 8. Responses to question: Please rate your degree of satisfaction with work–life integration by gender. Base: Women (*n* = 1,985); men (*n* = 1,222).

	WOMEN	MEN
% very satisfied / satisfied	57%*	65%*
% very dissatisfied / dissatisfied	43%*	35%*

** Statistically significant using chi-square test of independence.

A closer look at other demographic characteristics among women physicians

Late-career women physicians are *significantly* more likely than those in mid-career to report high satisfaction with their work–life integration (**62%↑** vs. **53%↓**).

Women physicians who self-identify as having a disability are *significantly* less likely than those who do not self-identify as having a disability to report high satisfaction with their work–life integration (**45%↓** vs. **61%↑**).

Women physicians who are child caregivers (**57%↑**) or are non-caregivers (**59%↑**) are *significantly* more likely to report high satisfaction with their work–life integration than multigenerational caregivers (**45%↓**).

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.[I,8] Twenty-six percent of women physicians score high on the Professional Fulfillment Index, while 74% score low.

Compared with men physicians, women physicians are *significantly* less likely to score high on the Professional Fulfillment Index (**26%*** vs. **36%***).

ONE IN FOUR WOMEN PHYSICIANS SCORE HIGH ON PROFESSIONAL FULFILLMENT, A *SIGNIFICANTLY* LOWER RATE THAN AMONG MEN PHYSICIANS.

TABLE 9. Professional Fulfillment Index by gender. Base: women (*n* = 1,993); men (*n* = 1,226).

	WOMEN	MEN
High Professional Fulfillment Index score	26%*	36%*
Low Professional Fulfillment Index score	74%*	64%*

** Statistically significant using chi-square test of independence.

[I] 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 item scores. Dichotomous professional fulfillment is calculated at an average item score cut-point of >3.0.

A closer look at other demographic characteristics among women physicians

Late-career women physicians (**33%↑**) are *significantly* more likely to score high on the Professional Fulfillment Index than early- or mid-career women physicians (both **23%↓**).

Women physicians who self-identify as having a disability are *significantly* less likely to score high on the Professional Fulfillment Index than women physicians who do not self-identify as having a disability (**20%↓** vs. **29%↑**).

NEGATIVE IMPACT OF FALSE HEALTH INFORMATION

Eighty-three percent of women physicians report that false health information negatively impacts their work, either to a great extent (31%) or somewhat (52%).

Compared with men physicians, women physicians are *significantly* more likely to be affected by false health information (**83%*** vs. **69%***).

OVER FOUR IN FIVE WOMEN PHYSICIANS BELIEVE THAT THEIR WORK IS NEGATIVELY AFFECTED BY FALSE HEALTH INFORMATION, A *SIGNIFICANTLY* HIGHER RATE THAN AMONG MEN PHYSICIANS.

TABLE 10. Negative impact of health misinformation (a great extent + somewhat) by gender. Base: Women (*n* = 1,993); men (*n* = 1,226).

	WOMEN	MEN
% great extent / somewhat	83%*	69%*

** Statistically significant using chi-square test of independence.

A closer look at other demographic characteristics among women physicians

Early-career (**88%↑**) and mid-career (**85%↑**) women physicians are *significantly* more likely to indicate that misinformation negatively impacts their work than those late in their career (**79%↓**).

Women physicians who self-identify as having a disability are *significantly* more likely to indicate misinformation negatively impacts their work than women physicians who do not self-identify as having a disability (**86%↑** vs. **82%↓**).

Women physicians who do not self-identify as white only are *significantly* less likely to indicate misinformation negatively impacts their work than those who self-identify as white only (**78%↓** vs. **84%↑**).

SECTION 3
PSYCHOLOGICAL AND CULTURAL SAFETY FACTORS

PSYCHOLOGICAL AND CULTURAL SAFETY IN LEARNING OR PRACTICE ENVIRONMENT

Sixty-two percent of women physicians say they feel psychologically safe at their workplace, and roughly seven in 10 (72%) feel culturally safe.

Compared with men physicians, women physicians are *significantly* less likely to feel psychologically (**62%*** vs. **68%***) and culturally (**72%*** vs. **78%***) safe.

WOMEN PHYSICIANS ARE *SIGNIFICANTLY* LESS LIKELY THAN MEN PHYSICIANS TO REPORT FEELING PSYCHOLOGICALLY AND CULTURALLY SAFE AT WORK.

TABLE 11. Psychological and cultural safety (strongly agree + agree) by gender. Base: All respondents, base sizes vary depending on safety indicator.

	WOMEN	MEN
Psychological safety	62%*	68%*
Cultural safety	72%*	78%*

** Statistically significant using chi-square test of independence.

A closer look at other demographic characteristics among women physicians

Women physicians early (**68%↑**) and late (**64%↑**) in their career are *significantly* more likely to indicate high psychological safety than those in mid-career (**59%↓**).

Late-career women physicians are significantly more likely to indicate high cultural safety than those in mid-career (**77%↑** vs. **69%↓**).

Women physicians who self-identify as having a disability are *significantly* less likely than those who do not self-identify as having a disability to indicate high psychological (**52%↓** vs. **67%↑**) or cultural safety (**65%↓** vs. **75%↑**).

Women physicians who self-identify as white only are *significantly* more likely to indicate high cultural safety than those who do not self-identify as white only (**74%↑** vs. **64%↓**).

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

Seventy-eight percent of women physicians report having experienced intimidation, bullying, harassment, microaggressions and/or discrimination in their workplace or training environment at least once. A much smaller proportion (16%) report experiencing these behaviours at least once a week.

Compared with men physicians, women physicians are *significantly* more likely to report having ever experienced intimidation, bullying, harassment and or microaggressions (**78%*** vs. **68%***).

FOUR IN FIVE WOMEN PHYSICIANS REPORT HAVING EVER EXPERIENCED INTIMIDATION, BULLYING, HARASSMENT, MICROAGGRESSIONS AND/OR DISCRIMINATION, A *SIGNIFICANTLY* HIGHER RATE THAN AMONG MEN PHYSICIANS.

TABLE 12. Experienced intimidation, bullying, harassment, microaggressions and/or discrimination by gender. Base: Women (*n* = 1,938); men (*n* = 1,194).

	WOMEN	MEN
Ever experienced (NET)[m]	**78%***	**68%***
At least once a week	16%	12%
A few times a month	12%	9%
Once a month or less	11%	9%
A few times a year or less	39%	39%
Never	**22%***	**32%***

** Statistically significant using chi-square test of independence.

[m] Chi-square was run **only** for the following categories: Ever experienced (NET), and Never.

A closer look at other demographic characteristics among women physicians

Early-career (**81%↑**) and mid-career (**79%↑**) women physicians are *significantly* more likely to have ever experienced workplace hostility than those late in their career (**74%↓**). Mid-career women physicians are *significantly* more likely than those late in their career to have experienced workplace hostility at least weekly (**17%↑** vs. **14%↓**).

Women physicians who self-identify as having a disability are *significantly* more likely to have ever experienced workplace hostility than those who do not (**82%↑** vs. **76%↓**). Those who self-identify as having a disability are *significantly* more likely to have experienced workplace hostility at least weekly than those who do not self-identify as having one (**25%↑** vs. **13%↓**).

Women physicians who do not self-identify as white only are *significantly* more likely to have ever experienced workplace hostility than those who self-identify as white only (**87%↑** vs. **75%↓**).

SOURCES OF BULLYING

Among the women physicians who indicate experiencing bullying, the most frequently mentioned sources are a patient or a patient's family member or friend (59%) or a physician (57%). Other sources include the health care system (29%), other health care providers (29%) and senior leaders or administrators (26%).

SIX IN 10 WOMEN PHYSICIANS EXPERIENCING BULLYING INDICATE BEING TARGETED BY A PATIENT, A PATIENT'S FAMILY MEMBER OR FRIEND, OR ANOTHER PHYSICIAN.

Compared with men physicians, women physicians are *significantly* more likely to indicate being targeted by a physician (**57%↑** vs. **48%↓**) or other health care provider (**29%↑** vs. **24%↓**).

TABLE 13. Sources of bullying by gender. Base: All respondents acknowledging receiving bullying; women (*n* = 1,492); and men (*n* = 803).

	WOMEN	MEN
Patient or patient's family member or friend	59%	56%
Physician	**57%↑**	**48%↓**
The health care system (i.e., organizational structure and/or policies)	29%	31%
Other health care provider	**29%↑**	**24%↓**
Senior leader or other administrator (e.g., manager/director)	26%	28%
Medical learner	7%	6%
Other	**5%↑**	**4%↓**

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

A closer look at other demographic characteristics among women physicians

Among women physicians who have experienced workplace hostility, those early in their career (**71%↑**) are most likely to report they have been targeted by a patient or a patient's family member or friend, followed by those in mid-career (**61%↑**), with both groups *significantly* more likely than those late in their career (**53%↓**). Early-career (**32% ↑**) and mid-career (**30%↑**) women physicians are *significantly* more likely to cite another health care provider than those late in their career (**19%↓**). Those in mid-career (**30%↑**) and late in their career (**29%↑**) are significantly more likely to mention a senior leader or other administrator than those early in their career (**20%↓**).

Women physicians who self-identify as having a disability are *significantly* more likely than those who do not self-identify as having a disability to cite another physician (**64%↑** vs. **54%↓**), another health care provider (**35%↑** vs. **27%↓**), the health care system (**35%↑** vs. **27%↓**), a senior leader or other administrator (**33%↑** vs. **24%↓**), a medical learner (**10%↑** vs. **6%↓**) or others (**9%↑** vs. **4%↓**) as sources of workplace hostility.

Women physicians who do not self-identify as white only are *significantly* more likely than those who self-identify as white only to report they have experienced workplace hostility from a patient or a patient's family member or friend (**67%↑** vs. **57%↓**) or another health care provider (**34%↑** vs. **27%↓**).

REASONS FOR BULLYING

Nearly two-thirds of women physicians who have experienced bullying cite their gender expression/identity (65%) as the reason they were targeted, followed by their age (29%) and ethnicity/culture (22%).

Women physicians are *significantly* more likely than men physicians to report being targeted because of their gender expression/identity (**65%↑** vs. **11%↓**), age (**29%↑** vs. **20%↓**), physical appearance (**10%↑** vs. **7%↓**), disability or mental health condition (**7%↑** vs. **4%↓**) and family status (**5%↑** vs. **3%↓**). On the other hand, women are *significantly* less likely than men to cite ethnicity/culture (**22%↓** vs. **36%↑**), personal beliefs (**15%↓** vs. **31%↑**), socioeconomic status (**4%↓** vs. **8%↑**) and sexuality (**1%↓** vs. **6%↑**).

WOMEN PHYSICIANS WHO HAVE EXPERIENCED THESE BEHAVIOURS ARE MOST LIKELY TO CITE THEIR GENDER EXPRESSION OR IDENTITY AS THE REASON THEY WERE BULLIED, *SIGNIFICANTLY* MORE LIKELY THAN MEN PHYSICIANS.

TABLE 14. Responses to question: Thinking of the incident, do you think you were targeted because of any of the following aspects about yourself? Base: All respondents acknowledging receiving bullying; women (*n* = 1,395); and men (*n* = 659).

	WOMEN	MEN
Gender expression/identity	**65%↑**	**11%↓**
Age	**29%↑**	**20%↓**
Ethnicity/culture	**22%↓**	**36%↑**
Personal beliefs	**15%↓**	**31%↑**
Role/position in the workplace	10%	11%
Physical appearance	**10%↑**	**7%↓**
Disability or mental health condition	**7%↑**	**4%↓**
Your socioeconomic status	**4%↓**	**8%↑**
Family status	**5%↑**	**3%↓**
Sexuality	**1%↓**	**6%↑**
Nothing/none	4%	6%
Don't know	1%	1%

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

A closer look at other demographic characteristics among women physicians

Among women physicians who have experienced workplace hostility, those early in their career (**77%↑**) or in mid-career (**69%↑**) are *significantly* more likely than those late in their career (**55%↓**) to believe they have been targeted because of their gender expression/identity. Women physicians early in their career (**57%↑**) are most likely to believe they have been targeted because of their age, followed by those in mid-career (**27%↑**), with both groups *significantly* more likely than those late in their career (**16%↓**). Those late in their career (**20%↑**) are *significantly* more likely than those in mid-career (**13%↓**) or early in their career (**12%↓**) to mention personal beliefs. Those in mid-career are *significantly* more likely than those late in their career to mention their family status as the reason for being targeted (**7%↑** vs. **3%↓**).

Women physicians who self-identify as having a disability are *significantly* more likely than those who do not self-identify as having a disability to believe they have been targeted for the following reasons: age (**35%↑** vs. **27%↓**), physical appearance (**15%↑** vs. **8%↓**), disability or mental health condition (**21%↑** vs. **2%↓**) and socioeconomic status (**7%↑** vs. **4%↓**).

Women physicians who do not self-identify as white only are *significantly* more likely than those who identify as white only to believe they have been targeted because their ethnicity/culture (**70%↑** vs. **6%↓**) and personal beliefs (**18%↑** vs. **13%↓**). Women physicians who do not self-identify as white only are *significantly* less likely than those who self-identify as white only to believe they have been targeted because of their gender expression/identity (**59%↓** vs. **67%↑**), role/position in the workplace (**7%↓** vs. **11%↑**) and socioeconomic status (**1%↓** vs. **5%↑**).

WITNESSED INTIMIDATION, BULLYING, HARASSMENT, MICROAGGRESSION AND/OR DISCRIMINATION

Seventy-nine percent of women physicians have ever witnessed intimidation, bullying, harassment, microaggression and/or discrimination: 16% on a weekly basis, 14% a few times a month, 12% once a month or less and 36% a few times a year or less.

Compared with men physicians, women physicians are *significantly* more likely to have ever witnessed intimidation, bullying, harassment, microaggression and/or discrimination (**79%*** vs. **73%***).

EIGHT IN 10 WOMEN PHYSICIANS HAVE WITNESSED INTIMIDATION, BULLYING, HARASSMENT, MICROAGGRESSION AND/OR DISCRIMINATION IN THEIR WORKPLACE, A *SIGNIFICANTLY* HIGHER RATE THAN AMONG MEN PHYSICIANS.

TABLE 15. Response to question: How often do you witness a colleague experience intimidation, bullying, harassment, microaggression and/or discrimination in the workplace or training environment?
Base: Women (*n* = 1,909); men (*n* = 1,179).

	WOMEN	MEN
Ever witnessed (NET)[n]	**79%***	**73%***
At least weekly	16%	14%
A few times a month	14%	11%
Once a month or less	12%	9%
A few times a year or less	36%	38%
Never	**21%***	**27%***

** Statistically significant using chi-square test of independence.

A closer look at other demographic characteristics among women physicians

Early-career (**84%↑**) and mid-career (**80%↑**) women physicians are *significantly* more likely to have ever witnessed workplace hostility than those late in their career (**72%↓**). Specifically, those in mid-career are *significantly* more likely than those late in their career to have witnessed it at least weekly (**17%↑** vs. **13%↓**).

Women physicians who self-identify as having a disability are *significantly* more likely to have witnessed workplace hostility at least weekly than those who do not self-identify as having disability (**22%↑** vs. **14%↓**).

Women physicians who do not self-identify as white only are *significantly* more likely to have ever witnessed workplace hostility than those who self-identify as white only (**82%↑** vs. **77%↓**).

[n] Chi-square was run **only** for the following categories: Ever witnessed (NET), and Never

RESPONSE TO THE SITUATION

Among women physicians who witnessed bullying, three in four (75%) indicated they supported the individual who was being bullied. A smaller proportion addressed it directly with the perpetrator (24%), reported the situation through established processes (19%) or took another action (6%). Just over one in 10 (13%) reported not doing anything.

Among those who reported having witnessed a colleague experience bullying, women were *significantly* more likely than men to say they supported the individual (**75%↑** vs. **66%↓**).

THREE IN FOUR WOMEN PHYSICIANS WHO WITNESSED INTIMIDATION, BULLYING, HARASSMENT, MICROAGGRESSION AND/OR DISCRIMINATION SAY THAT THEY SUPPORTED THE INDIVIDUAL BEING TARGETED, A PROPORTION *SIGNIFICANTLY* HIGHER THAN AMONG MEN PHYSICIANS.

TABLE 16. Response to witnessing intimidation, bullying, harassment, microaggressions and/or discrimination by gender. Base: All respondents who have witnessed a colleague experience bullying; women (*n* = 1,438); and men (*n* = 805).

	WOMEN	MEN
I supported the individual	**75%↑**	**66%↓**
I directly addressed it with the perpetrator(s)	24%	27%
I reported the situation through established processes	19%	18%
Other	**6%↑**	**3%↓**
I could not or did not do anything	**13%↓**	**17%↑**

** Statistically significant using chi-square test of independence.

A closer look at other demographic characteristics among women physicians

Mid-career (**28%↑**) and late-career women physicians (**29%↑**) are *significantly* more likely to say they addressed it directly with the perpetrator(s) than those early in their career (**20%↓**). Early-career women physicians are *significantly* more likely to say they could not or did not do anything than those late in their career (**16%↑** vs. **9%↓**).

EXPERIENCED DISRESPECTFUL, DEMEANING AND/OR CONDESCENDING COMMUNICATION STYLE

A total of 84% of women physicians report having experienced a disrespectful, demeaning and/or condescending communication style in their workplace or training environment: 20% report having these experiences "frequently" (at least weekly), 29% experience it a few times a month/once a month or less and 36% report experiencing it less often (a few times a year or less).

Compared with men physicians, women physicians are *significantly* more likely to have ever experienced a disrespectful, demeaning and/or condescending communication style in their workplace or training environment (**84%*** vs. **78%***).

OVER EIGHT IN 10 WOMEN PHYSICIANS REPORT HAVING EVER EXPERIENCED A DISRESPECTFUL, DEMEANING AND/OR CONDESCENDING COMMUNICATION STYLE; ONE IN TWO REPORT EXPERIENCING IT MORE FREQUENTLY THAN A FEW TIMES A YEAR.

TABLE 17. Frequency of experiencing disrespectful communication at work by gender. Base: Women (*n* = 1,959); men (*n* = 1,209).

	WOMEN	MEN
Ever witnessed (NET)°	**84%***	**78%***
At least weekly	20%	17%
A few times a month	15%	13%
Once a month or less	13%	12%
A few times a year or less	36%	36%
Never	**16%***	**22%***

** Statistically significant using chi-square test of independence.

A closer look at other demographic characteristics among women physicians

Early-career (**86%↑**) and mid-career (**87%↑**) women physicians are *significantly* more likely to have ever experienced a disrespectful, demeaning and/or condescending communication style than those late in their career (**78%↓**). Specifically, those in mid-career (**23%↑**) are *significantly* more likely to have experienced it at least weekly compared with those early (**16%↓**) and late (**15%↓**) in their career.

Women physicians who self-identify as having a disability are *significantly* more likely to have experienced a disrespectful, demeaning and/or condescending communication style at least weekly than those who do not self-identify as having one (**25%↑** vs. **18%↓**).

° Chi-square was run **only** for the following categories: Ever witnessed (NET), and Never.

COLLEGIALITY AT WORK[p]

Sixty-four percent of women physicians 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.

Compared with men physicians, women physicians are *significantly* less likely to score high on collegiality (**64%*** vs. **71%***).

CLOSE TO TWO-THIRDS OF WOMEN PHYSICIANS SCORE HIGH ON THE COLLEGIALITY INDEX; COMPARED WITH MEN PHYSICIANS, THEY ARE *SIGNIFICANTLY* LESS LIKELY TO SCORE HIGH.

TABLE 18. Collegiality Index score by gender. Base: Women (*n* = 1,993); men (*n* = 1,226).

	WOMEN	MEN
High Collegiality Index score	64%*	71%*

** Statistically significant using chi-square test of independence.

A closer look at other demographic characteristics among women physicians

Women physicians in mid-career (**60%↓**) are *significantly* less likely than those early or late in their career (both **68%↑**) to score high on collegiality.

Women physicians who self-identify as having a disability (**56%↓**) are *significantly* less likely than those who do not self-identify as having a disability (**66%↑**) to score high on collegiality.

Women physicians who do not self-identify as white only (**59%↓**) are *significantly* less likely than those who self-identify as white only (**65%↑**) to score high on collegiality.

[p] Collegiality Index: sum of four items; then dichotomized above/below the mean of the sum. The four items included the following (agreement scale): in general, I find my colleagues to be supportive; the people I work with treat each other with respect regardless of unique individual identities, differences and preferences; communication is open and honest among my colleagues; people from all backgrounds are treated fairly in my learning or practice environment.

TRAINING RECEIVED

Eighty-two percent of women physicians have received at least one type of training, and 18% have not received any type of training.

Compared with men physicians, women physicians are *significantly* more likely to have received any form of training (**82%*** vs. **78%***).

FOUR-FIFTHS OF WOMEN PHYSICIANS HAVE RECEIVED AT LEAST ONE OF THE LISTED TRAININGS,[q] A *SIGNIFICANTLY* HIGHER PROPORTION THAN AMONG MEN PHYSICIANS.

TABLE 19. Received training by gender. Base: Women (*n* = 1,993); men (*n* = 1,226).

	WOMEN	MEN
Have received any training	82%*	78%*
Have not received any training	18%*	22%*

** Statistically significant using chi-square test of independence.

A closer look at other demographic characteristics among women physicians

Early-career women physicians (**88%↑**) are *significantly* more likely to have received any training than those late in their career (**78%↓**) or in mid-career (**81%↓**).

Women physicians who do not self-identify as white only (**87%↑**) are *significantly* more likely to have received any training than those who self-identify as white only (**81%↓**).

[q] Trainings included in the measure were cultural safety, psychological safety, physical safety, anti-racism, Indigenous cultural competency and/or safety, and unconscious bias.

SECTION 4
WORKFORCE SUSTAINABILITY FACTORS

LIKELIHOOD TO LEAVE OR RETIRE EARLIER THAN EXPECTED

Eleven percent of women physicians report being likely to leave medicine or retire earlier than expected.

Compared with men physicians, women physicians are *significantly* less likely to leave medicine or retire earlier (**11%*** vs. **17%***).

ONE IN 10 WOMEN PHYSICIANS INDICATE A LIKELIHOOD TO LEAVE MEDICINE OR RETIRE EARLIER THAN EXPECTED, A *SIGNIFICANTLY* LOWER PROPORTION THAN AMONG MEN PHYSICIANS.

TABLE 20. Likelihood to leave medicine by gender (very likely + likely). Base: Women (*n* = 1,993); men (*n* = 1,226).

	WOMEN	MEN
% who selected very likely + likely to leave medicine or retire early	11%*	17%*

** Statistically significant using chi-square test of independence.

A closer look at other demographic characteristics among women physicians

Among women physicians, those late in their career (**22%↑**) are *significantly* more likely to leave medicine or retire earlier than expected than those in mid-career (**7%↓**) or early in their career (**2%↓**), with those in mid-career *significantly* more likely than those early in their career.

Women physicians who self-identify as having a disability are *significantly* more likely to leave medicine/retire early than those who do not self-identify as having one (**17%↑** vs. **9%↓**).

Women physicians who do not self-identify as white only (**7%↓**) are *significantly* less likely to leave medicine/retire early than women physicians who self-identify as white only (**12%↑**).

SECTION 5
ACCESSING WELLNESS SUPPORTS

WELLNESS SUPPORTS ACCESSED IN THE PAST FIVE YEARS

Seventy-two percent of women physicians have used at least one of the listed wellness supports in the past five years. The following supports were the most likely to be cited: primary care physician (45%), other mental health professional (40%), mentorship or coaching (22%) or provincial physician health program (22%).

Compared with men physicians, women physicians are *significantly* more likely to have used at least one support in the past five years (**72%*** vs. **53%***). With respect to individual wellness supports, women physicians are more likely to have used a primary care physician (45% vs. 34%), other mental health professional (40% vs. 21%), mentorship or coaching (22% vs. 14%) and provincial physician health program (22% vs. 14%).

WHEN ASKED ABOUT THE TYPE OF WELLNESS SUPPORTS THEY HAVE ACCESSED IN THE PAST FIVE YEARS, SEVEN IN 10 WOMEN PHYSICIANS INDICATE THEY HAVE ACCESSED AT LEAST ONE OF THE LISTED SUPPORTS, A *SIGNIFICANTLY* HIGHER PROPORTION THAN AMONG MEN PHYSICIANS.

TABLE 21. Wellness supports accessed in past five years by gender. Base: Women (*n* = 1,993); men (*n* = 1,226).

	WOMEN	MEN
Used at least one support in the past five years (NET)[r]	**72%***	**53%***
Primary care physician	45%	34%
Other mental health professional	40%	21%
Mentorship or coaching	22%	14%
Provincial physician health program (PHP)	22%	14%
Local peer support program	7%	6%
Employee assistance program (EAP)	6%	4%
CMA Wellness Connection or Physician Wellness Hub	4%	3%
Other	5%	3%
None of the above	**28%***	**47%***

** Statistically significant using chi-square test of independence.

[r] Chi-square was run **only** for the following categories: Used at least one support in the past five years (NET), and None of the above.

A closer look at other demographic characteristics among women physicians

Early-career (**81%↑**) and mid-career (**76%↑**) women physicians are *significantly* more likely to have used at least one support than those late in their career (**63%↓**). With respect to individual wellness supports, those early in their career and in mid-career are *significantly* more likely than those late in their career to have accessed a primary care physician (**50%↑** early, **47%↑** mid vs. **37%↓** late), other mental health professional (**51%↑** early, **45%↑** mid vs. **28%↓** late) or mentorship/coaching (**25%↑**early, **26%↑** mid vs. **15%↓** late). Women physicians in mid-career are *significantly* more likely than those late in their career to have accessed a provincial physician health program (PHP; **26%↑** vs. **20%↓**), an employee assistance program (EAP; **7%↑** vs. **3%↓**) or the CMA Wellness Connection or Physician Wellness Hub (**5%↑** vs. **3%↓**). Those late in their career are *significantly* more likely to have accessed other types of support than those early in their career (**7%↑** vs. **3%↓**).

Women physicians who self-identify as having a disability are *significantly* more likely to have used at least one support than those who do not self-identify as having one (**84%↑** vs. **68%↓**). Specifically, those who self-identify as having a disability are *significantly* more likely to have accessed another mental health professional (**59%↑** vs. **34%↓**), primary care physician (**58%↑** vs. **41%↓**), PHP (**28%↑** vs. **20%↓**), EAP (**9%↑** vs. **4%↓**) and other type of support (**7%↑** vs. **4%↓**).

Women physicians who do not self-identify as white only are *significantly* more likely to have used a local peer support program than those who self-identify as white only (**9%↑** vs. **6%↓**).

SECTION 6
POTENTIAL SOLUTIONS

SOLUTIONS TO PROMOTE RECRUITMENT AND RETENTION

Eighty percent of women physicians mentioned lower administrative burden as a solution to promote recruitment and retention, followed by access to locums to allow for coverage (54%) and financial incentives (52%).

Compared with men physicians, women physicians are *significantly* more likely to mention lower administrative burden (**80%↑** vs. **73%↓**), access to locums to allow for coverage (**54%↑** vs. **41%↓**), team-based care (**48%↑** vs. **42%↓**) and physically, psychologically and culturally safe work environments (**44%↑** vs. **35%↓**) as solutions to promote recruitment and retention of physicians. Women are *significantly* less likely than men to mention financial incentives (**52%↓** vs. **62%↑**) and national or multi-jurisdictional licensure (**34%↓** vs. **39%↑**).

WOMEN PHYSICIANS ARE MOST LIKELY TO MENTION LOWER ADMINISTRATIVE BURDEN, ACCESS TO LOCUMS TO ALLOW FOR COVERAGE, AND FINANCIAL INCENTIVES AS SOLUTIONS TO PROMOTE RECRUITMENT AND RETENTION.

TABLE 22. Solution(s) that promote the recruitment and retention of physicians by gender. Base: Women (*n* = 1,993); men (*n* = 1,226).

	WOMEN	MEN
Lower administrative burden	**80%↑**	**73%↓**
Access to locums to allow for coverage	**54%↑**	**41%↓**
Financial incentives	**52%↓**	**62%↑**
Team-based care	**48%↑**	**42%↓**
Physically, psychologically and culturally safe work environments	**44%↑**	**35%↓**
Connected health systems / improving interoperability	40%	38%

	WOMEN	MEN
National or multi-jurisdictional licensure	34%↓	39%↑
Use of AI and machine learning in practice	20%	23%
Supports for family/spouse	18%	20%
Easy/confidential access to mental health services	13%	12%
More wellness programming	13%	11%
Training and development	10%	11%
Leadership and advocacy skills training	9%	10%

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

A closer look at other demographic characteristics among women physicians

Early-career women physicians are *significantly* more likely than those in mid-career to mention lower administrative burden as a solution to promote recruitment and retention (**84%↑** vs. **78%↓**). Those early in their career are *significantly* more likely to mention financial incentives than those late in their career (**57%↑** vs. **48%↓**). Those late in their career (**56%↑**) are *significantly* more likely to mention team-based care than those early in their career (**42%↓**) and in mid-career (**48%↓**). Early-career women physicians are *significantly* more likely to mention connected health systems and interoperability than those late in their career (**46%↑** vs. **41%↓**). Those early (**39%↑**) or late (**36%↑**) in their career are *significantly* more likely to mention national/multi-jurisdictional licensure than those in mid-career (**29%**). Those early in their career (**20%↑**) and in mid-career (also **20%↑**) are *significantly* more likely to mention assistance for family/spouse than those late in their career (**11%↓**). Those in mid-career are *significantly* more likely to mention easy/confidential access to mental health services than those late in their career (**14↑%** vs. **10%↓**).

Women physicians who self-identify as having a disability are *significantly* more likely than those who do not to mention physically, psychologically and culturally safe work environments (**48%↑** vs. **42%↓**), more wellness programming (**17%↑** vs. **12%↓**) and easy/confidential access to mental health services (**19%↑** vs. **11%↓**) as potential solutions. Conversely, women physicians who self-identify as having a disability are *significantly* less likely to mention team-based care (**40%↓** vs. **51%↑**) than those who do not.

Women physicians who do not self-identify as white only are *significantly* more likely than those who do to mention safe work environments (**49%↑** vs. **42%↓**), financial incentives (**60%↑** vs. **49%↓**), national/multi-jurisdictional licensure (**42%↑** vs. **31%↓**), training and development (**13%↑** vs. **9%↓**) and assistance for family/spouse (**21%↑** vs. **16%↓**) as potential solutions. Conversely, women physicians who do not self-identify as white only are *significantly* less likely than those who do to mention lower administrative burden (**75%↓** vs. **81%↑**), access to locums to allow for coverage **(50%↓** vs. **55%↑**) and team-based care (**42%↓** vs. **50%↑**).

DISCUSSION

The *CMA 2025 National Physician Health Survey: Women Physicians Report* provides timely insights into the experiences and well-being of women physicians in Canada. Given the importance of equity in the medical profession, understanding the conditions shaping women physicians' well-being is important in its own right, as well as for workforce planning and a well-functioning health system. The findings in this report describe a physician workforce facing sustained pressures alongside areas of engagement and responsiveness, underscoring the value of examining how workplace structures, demands and supports influence women physicians' experiences.

Across multiple indicators, women physicians report less favourable wellness outcomes than men physicians. Higher levels of burnout (49% vs. 41%), fatigue (67% vs. 52%), moral distress (25% vs. 18%), and lifetime suicidal ideation (37% vs. 29%) are observed alongside lower professional fulfillment (26% vs. 36%) and satisfaction with work–life integration (57% vs. 65%). At the same time, women physicians demonstrate greater awareness of and openness about the need for additional supports to sustain well-being. Together, these findings suggest that while women physicians experience greater strain across several dimensions of well-being, they may also be more likely to articulate the role of workplace conditions and supports in shaping wellness, highlighting opportunities for system-level interventions that align with expressed needs.

Alongside observed wellness challenges, underlying structural drivers like workplace demands and administrative burden are prominent features negatively impacting women physicians' work. Women physicians spend more time on administrative tasks than men physicians (10.7 vs. 9.8 hours per week) and are more likely to report excessive or moderately high after-hours EMR work (67% vs. 58%). This is concerning, as the majority of physicians in recent research agree that administrative workload interferes with their work–life integration, reduces professional fulfillment and contributes to burnout.[9] In addition, a higher proportion of women physicians report that false health information negatively impacts their work (83% vs. 69%). Taken together, these findings reflect sustained workload pressures that extend beyond direct patient care.

Women physicians also report lower levels of perceived psychological safety (62% vs. 68%), cultural safety (72% vs. 78%) and collegiality (64% vs. 71%). Experiences of intimidation, bullying, harassment, microaggressions and/or discrimination are widespread among women physicians and occur at significantly higher rates than among men physicians (78% vs. 68%). Among women physicians who report these experiences, gender expression or identity is the most frequently cited reason for being targeted (65% vs. 11% among men). Patients and their families or friends (59%) and fellow physicians (57%) are the most commonly reported sources, with women physicians more likely than men to report being targeted by another physician (57% vs. 48%). Women physicians are also more likely to report having witnessed intimidation, bullying, harassment, microaggressions and/or discrimination in their workplace (79% vs. 73%) and to report having supported the individual being targeted (75% vs. 66%), indicating greater exposure to and engagement with these experiences.

The above-mentioned challenges experienced by women physicians, such as administrative burden, after-hours EMR work, lower levels of safety and elevated rates of workplace hostility, arise from how systems are designed and policies are implemented, or in some cases, not implemented. These systems and policies were established at a time when the demographic profile of the average physician differed significantly from that of the workforce of today. This misalignment reflects persistent cultural and institutional issues that need to be addressed.

When it comes to help-seeking behaviours, women physicians demonstrate high engagement with wellness supports. A substantially higher proportion have accessed at least one wellness support in the past five years (72% vs. 53% of men physicians). While women may be more willing to seek support for their well-being, these findings may also indicate a greater need for support because of their increased exposure to workplace strains.

Women physicians more frequently endorse system-level supports such as reduced administrative burden (80% vs. 73%), access to locums (54% vs. 41%), team-based care (48% vs. 42%) and physically, psychologically and culturally safe work environments (44% vs. 35%). Notably, many of the solutions prioritized by women physicians directly correspond to the challenges they are more likely to experience, such as excessive administrative workload and unsafe work environments, demonstrating alignment between lived experience and desired solutions. Beyond reflecting unmet needs, this pattern may also suggest that women physicians are more willing to recognize and articulate the need for additional wellness supports and services, underscoring opportunities for system-level responses that align closely with expressed priorities.

Women physicians are also more likely than men physicians to have received at least one training (82% vs. 78%) in areas such as cultural, psychological and physical safety; anti-racism; Indigenous cultural competency and/or safety; and unconscious bias. With approximately eight in 10 physicians of both genders having received any form of training, this represents an encouraging step toward fostering more supportive and inclusive professional environments.

Differences across demographic groups highlight the fact that women physicians' experiences are not uniform and are shaped by intersecting professional and personal factors. Career stage is a key differentiator, with early- and mid-career women physicians reporting consistently less favourable outcomes than those late in their career. These include higher burnout (56% early, 54% mid vs. 40% late), fatigue (77%, 72% vs. 56%), moral distress (29%, 29% vs. 21%) and lifetime suicidal ideation (37% mid vs. 32% late), more frequent experiences of intimidation, bullying, harassment, microaggressions and/or discrimination, and lower professional fulfillment (23% early and mid vs. 33% late), collegiality (60% mid vs. 68% early and late) and satisfaction with work–life integration (53% mid vs. 62% late). These patterns suggest that periods of career establishment and peak clinical responsibility may coincide with heightened exposure to workplace pressures.

Disability status is associated with particularly pronounced inequities. Women physicians who self-identify as having a disability report poorer outcomes across nearly all measured domains, including higher burnout (58% vs. 46%), higher lifetime suicidal ideation (56% vs. 30%), higher fatigue (76% vs. 64%), lower professional fulfillment (20% vs. 29%) and lower psychological safety (52% vs. 67%). They are also more likely to report frequent experiences of intimidation, bullying, harassment, microaggressions and/or discrimination (25% vs. 13%), pointing to persistent barriers related to accommodation, accessibility, stigma and institutional support within medical workplaces.

Caregiving responsibilities further differentiate women physicians' experiences. Those with caregiving roles, particularly those providing care for both children and parents, report higher moral distress (27% vs. 22% among non-caregivers), greater after-hours EMR burden (77% vs. 66%) and lower satisfaction with their work–life integration (45% vs. 59%). In contrast, women physicians without caregiving responsibilities report longer work hours (54.4 vs. 51.7 hours per week among family caregivers) and higher lifetime suicidal ideation (40% vs. 33%–34% among caregivers). These findings illustrate the complex ways in which caregiving responsibilities intersect with workload expectations and available supports.

Ethnic and racial identity also shapes workplace experiences among women physicians. Women physicians who do not self-identify as white only report higher work hours (56.8 vs. 51.6 hours per week), lower cultural safety (64% vs. 74%) and collegiality (59% vs. 65%) and more frequent experiences of intimidation, bullying, harassment, microaggressions and/or discrimination (87% vs. 75%). They are also more likely to identify race, ethnicity or culture as a reason for being targeted, underscoring the intersecting effects of gender and racial identity and the importance of culturally safe and inclusive workplace environments.

Overall, the findings point to the importance of system-level approaches that reflect the expressed needs and experiences of women physicians. Addressing workload design, administrative burden, workplace safety and access to supports may help strengthen well-being and support the sustainability of the physician workforce, particularly for groups facing compounding pressures across career stage, disability status, caregiving responsibilities, and ethnic or racial identity. Action is urgently needed to address the concerning status of women physicians, particularly across the intersecting factors identified in this report: career stage, disability, caregiving roles and racial/ethnic identity. Meaningful change will require coordinated, system-level responses across — among others — employers, health systems, regulators, researchers, faculties of medicine, medical associations and government. Additional guidance can be found in the CMA's Physician health and safety policy.[10]

CONCLUSION

The 2025 National Physician Health Survey highlights the fact that women physicians experience substantial pressures, including higher rates of burnout, fatigue, moral distress and experiences of intimidation, bullying, harassment, microaggressions and/or discrimination, alongside lower professional fulfillment and satisfaction with work–life integration, compared with men physicians. At the same time, women physicians demonstrate important strengths through high engagement with wellness supports and a clear awareness of system-level interventions that would improve physicians' well-being, including team-based care and physically, psychologically and culturally safe work environments. To support women physicians' wellness and promote a sustainable health care system, coordinated initiatives and actions are immediately needed. These should focus on reducing administrative and EMR burden, strengthening workplace safety and creating equitable professional environments. Interventions should respond to the diverse needs of women physicians across career stages, caregiving roles, disability status and ethnic and racial identities.

Limitations and future research

As with any research, the execution of this study involved methodological decisions that have an impact on the representativeness of the findings. For more information on the main limitations of the study, see the CMA 2025 National Physician Health Survey.[3]

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