Research

Emergency physician burnout and attrition in Canada: a longitudinal study

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Abstract

Background: Canadian emergency staff have been dealing with record patient attendances, long wait times, bed blocking, and department overcrowding. We sought to report temporal trends in Canadian emergency physician burnout, and describe the impact of emergency medicine practice on physician well-being.

Methods: We undertook a longitudinal study on Canadian emergency physician wellness that enrolled participants in April 2020. Participants were invited to 3 follow-up surveys in November 2020, September 2022, and January 2025. The primary outcomes were emotional exhaustion, depersonalization, and personal accomplishment scores. We conducted a deductive qualitative thematic analysis of the 2025 survey free-text responses by applying the framework created with our 2022 survey, to identify interconnected themes explaining burnout causes, consequences, and mechanisms that physicians use to stay in the specialty.

Results: The response rate to the survey was 410/615 (67%) in January 2025, from respondents in all provinces or territories in Canada except Yukon and Nunavut. Of 410 participants, 41 (10%) had left the profession. Among those who remained in emergency medicine and completed the full survey, 69/351 (20%) had taken time off emergency medicine and 170/351 (48%) had reduced their clinical hours in emergency medicine. In total, 229/351 (65%) scored either high emotional exhaustion, high depersonalization, or both. Burnout levels in 2020, 2022, and 2025 remained unchanged. Respondents pointed to a broken health care system, unrealistic societal expectations, and insurmountable workplace challenges as reasons for burnout. The consequences were physician distress and leaving the profession. Mechanisms to continue in emergency medicine were reducing work hours, modifying work roles, and changing health care institutions.

Interpretation: Emergency physician burnout remains high, with almost half of respondents having reduced their work hours, and 10% having left the profession. Provincial, regional, and institutional health care leaders could reduce emergency physician burnout by following EM:POWER recommendations and instituting work models that facilitate reducing clinical hours and taking time away from emergency medicine when needed.

In April 2020, at the outset of the COVID-19 pandemic, our group initiated a longitudinal study on Canadian emergency medicine physician wellness, reporting high levels of burnout in 17% of participants.[1] Many considered that physician burnout would peak during the pandemic, with a return to baseline as the effects of the pandemic receded. However, the number of Canadian emergency department visits continues to increase yearly,[2] and Canadian emergency departments are in crisis.[3] Excessive wait times are associated with poor patient outcomes, including increased hospital length of stay and short-term mortality.[4] Patient crowding compromises patient care in terms of privacy, adequacy of history and examination, and patient safety.[5,6] The rate at which patients are leaving emergency departments without being assessed by a physician is increasing[7] and is associated with higher short-term mortality rates.[7]

Burnout is a response to chronic emotional and interpersonal stressors experienced in work.[8] It is measured through the dimensions of emotional exhaustion, depersonalization, and a sense of decreased personal accomplishment. Burnout leads to career choice regret, low job satisfaction, workforce depletion, depression, and potentially suicide.[9,10] Physician burnout also results in poor professionalism and medical errors.[9,10] After pandemic

restrictions lifted in 2022, we reported high emotional exhaustion or depersonalization levels in 74% of emergency physician respondents to our survey.[11]

We sought to estimate current trends in Canadian emergency physician burnout and to describe the impact of emergency medicine practice on physician well-being.

Methods

We report on the most recent iteration of a longitudinal, mixed-methods study that has followed a cohort of Canadian emergency physicians who enrolled in the study in April 2020.[1] The current survey is reported in adherence with the Checklist for Reporting of Survey Studies (CROSS) guidelines[12] and standards for trustworthiness in thematic analysis.[13]

The longitudinal study population

We initiated a national longitudinal survey at the outset of the COVID-19 pandemic, in April 2020.[1] We invited physicians working in Canadian emergency departments to enrol. On Apr. 4, 2020, we sent invitations to enrol in the longitudinal study to 20 emergency physician groups in 7 provinces (via members of the Network of Canadian Emergency Researchers), with 1 reminder sent a week later. Of the 1147 physicians working in these groups, 345 (30%) enrolled in the longitudinal study. We also sent enrolment invitations through every Canadian association that registers emergency physicians: the Society of Rural Physicians of Canada (450 physicians), Canadian Association of Emergency Physicians (1857 physicians), Association des médecins d'urgence du Québec (1358 physicians), and Association des spécialistes en médecine d'urgence du Québec (180 physicians). The survey was advertised through Twitter (now X) and Facebook and it was not possible to estimate response rates for social media or society distribution. In total, 615 participants enrolled in the study, working in every Canadian province and territory except Yukon. We invited all enrolled participants to complete follow-up surveys at 3 distinct time points: in November 2020,[14] September 2022,[11] and January 2025. Here we report the results of the third follow-up survey.

The 2025 survey

All participants enrolled in the longitudinal study were invited by text or email (according to their stated preference) to complete a confidential survey on Jan. 7, 2025. We sent 3 reminders to non-responders on Jan. 16, Jan. 22, and Feb. 11, 2025.

Participants recorded whether they were still working in emergency medicine, had taken take time off from working in emergency medicine since the start of the pandemic, or had reduced their clinical hours in emergency medicine since before the pandemic. They completed the Maslach Burnout Inventory (MBI) Human Services Survey for Medical Personnel[16] (Mind Garden, Inc.). The MBI is a valid and reliable tool for measuring burnout.[15] The MBI for medical personnel consists of 22 statements that are rated by the participant using a frequency scale with 7 options ranging from "never" to "every day." The MBI reports 3 dimensions on a continuum: emotional exhaustion, depersonalization, and personal accomplishment. A strength of the MBI is that it can be used to compare these dimension scores over time. The survey ended with an optional open-ended question: "Is there anything you would like to tell us about your experiences? (For example, are you feeling differently now compared to over the past 2 years?)" The survey was disseminated in both English and French, and participants could respond in either language.

Data analysis

We calculated the proportion of respondents who had left emergency medicine. We then removed these respondents from further analysis. We reported demographics with medians and proportions.

The prespecified MBI outcomes were emotional exhaustion, depersonalization, and low personal accomplishment levels among participants. We reported high burnout as either high emotional exhaustion (defined as a score ≥ 27), high depersonalization (a score ≥ 10), or both, because these are considered the core dimensions of burnout.[16–18] We performed multiple regression analysis to identify associations with emotional exhaustion, depersonalization, and personal accomplishment scores. Given previously reported associations,[1,14,19] we prespecified the independent variables as gender, age (as a continuous variable), and respondents having reduced their clinical hours in emergency medicine.

In April 2020, we used a 2-question abbreviated version of the MBI to measure burnout. In November 2020 and September 2022, we surveyed participants using the full MBI. We reported pairwise comparisons of MBI burnout scores among the November 2020, September 2022, and January 2025 surveys. We did not include April 2020 as we did not use the full MBI survey at that time. We performed the analyses using Stata version 19 (College Station, Texas).

Supervised by K.dW., 2 researchers (J.B. and A.S., first- and second-year medical students who identify as women) applied the thematic framework developed in our 2022 survey[11] to perform a deductive qualitative thematic analysis.[20] At the outset, K.dW., J.B., and A.S. discussed their life experiences and biases regarding burnout in the emergency department. Neither medical student researcher had started clerkship, and both were trained by K.dW. in qualitative analysis methods. K.dW. has worked as an emergency physician for 22 years in Canada and the United Kingdom. Both student researchers coded every text using the 2022 codebook (Appendix 1, available at www.cmaj.ca/lookup/doi/10.1503/cmaj.251863/tab-related-content), reviewing and discussing participant texts in small batches to agree on the final coding.

In brief, the 2022 framework contained the following themes: the health care system is broken, societal disinterest, workplace challenges, physician distress, and wanting to leave emergency medicine.[11] When new items arose that did not match an existing code, the student researchers discussed and agreed on new codes. Once coding was complete, the student researchers met to review whether additional themes should be added to the existing 2022 framework. Finally, K.dW., J.B., and A.S. reviewed

quotes, codes, and themes together, to agree on final adaptations to the existing 2022 framework, to better reflect the findings of the 2025 thematic analysis. The coding was performed using Dedoose Version 10 software (www.dedoose.com). We imported deidentified free-text answers and analyzed them in the language in which they were written (either French or English). Themes were presented to the investigator group (consisting of emergency physician qualitative researchers, quantitative researchers, wellness experts, a psychologist, a psychiatrist, and a methodologist) for a conceptual audit of the themes.

Ethics approval

The longitudinal study was approved by the Hamilton Integrated Research Ethics Board in 2020, including our serial follow-up surveys.

Results

Response rate

The response rate for this most recent survey among the participants registered in the longitudinal study was 410/615 (66.7%; Figure 1). Of the 410 respondents, 41 (10.0%, 95% confidence interval [CI] 7.5% to 13.3%) stated they had left emergency medicine (10 had retired, 25 moved to a different clinical specialty, and 6 had left clinical medicine).

2025 MBI survey scores

Of the 369 respondents who were still working in emergency medicine, 18 did not complete the full MBI survey and were excluded from further analysis, leaving 351 participants. At least 1 participant from every province and territory in Canada, except Yukon and Nunavut, responded (Table 1). The demographics were similar to those of the participants who registered for the longitudinal survey in April 2020, in which 49% identified as women, the median age was 41 years, and 54% worked in Ontario, 14% in Quebec, and 10% in British Colombia. Sixty-nine (19.7%, 95% CI 15.8% to 24.1%) had taken time off clinical emergency medicine since 2020, and 170 (48.4%, 95% CI 43.2% to 53.6%) had reduced their clinical hours from before the pandemic era.

In total, 163 respondents (46.4%, 95% CI 41.3% to 51.7%) had high emotional exhaustion, and 193 (55.0%, 95% CI 49.8% to 60.1%) had high depersonalization scores. Two hundred and twenty-nine (65.2%, 95% CI 60.1% to 70.0%) respondents had either high emotional exhaustion or high depersonalization scores, or both. After adjustment for age and reduced emergency department shifts, identifying as a woman was associated with a 3.6-point (95% CI 1.0 to 6.2) increase in the emotional exhaustion score and a reduction of 1.8 points (95% CI 0.4 to 3.3) in the personal accomplishment score. Emotional exhaustion scores reduced by 0.2 of a point (95% CI 0.0 to 0.3) per additional year of

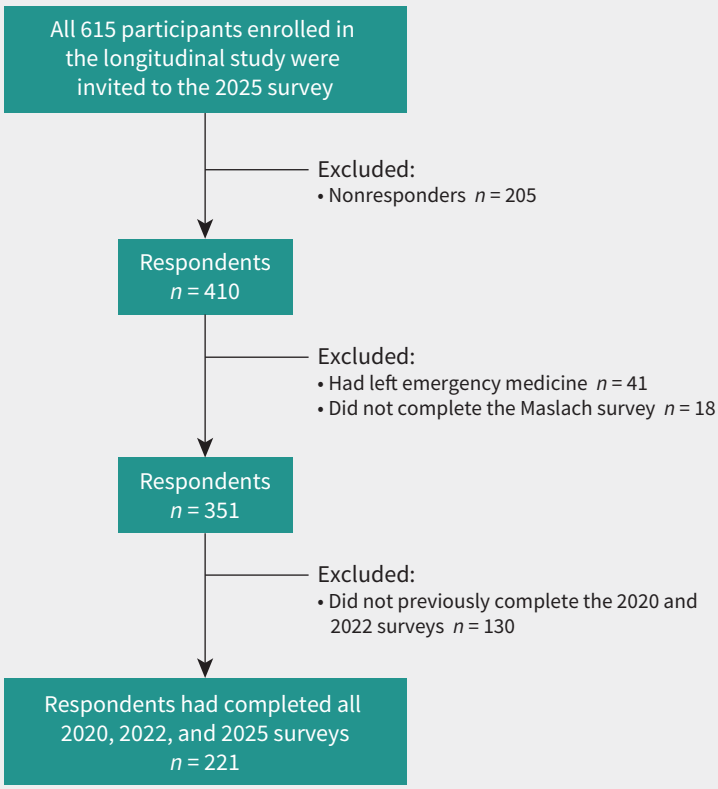

Figure 1: Flow chart outlining enrolment in the 2025 survey. See Related Content tab for accessible version.

Table 1: Demographic characteristics of respondents included in 2025 survey

Characteristic	No. (%)* of participants *n* = 351
Gender†	
Women	177 (50.4)
Men	174 (49.6)
Age at enrolment, yr, median (IQR)	42 (35–49)
Province of practice at enrolment	
Ontario	191 (54.4)
Quebec	41 (11.7)
British Columbia	33 (9.4)
Alberta	24 (6.8)
Manitoba	17 (4.8)
Nova Scotia	14 (4.0)
Saskatchewan	12 (3.4)
New Brunswick	8 (2.3)
Newfoundland and Labrador	8 (2.3)
Prince Edward Island	1 (0.3)
Northwest Territories	2 (0.6)
Took time off work since 2020	69 (19.7)
Reduced their shift load since 2020	170 (48.4)
Training route	
FRCPC or ABEM qualified	107 (30.5)
CCFP-EM qualified	129 (36.8)
CCFP	34 (9.7)
Other training	33 (9.4)
Not specified	48 (13.6)

Note: ABEM = American Board of Emergency Medicine, CCFP = Certification in the College of Family Physicians of Canada, CCFP-EM = Certificate of Added Competence in Emergency Medicine with the College of Family Physicians of Canada, FRCPC = Fellow of the Royal College of Physicians of Canada, IQR = interquartile range.
*Unless otherwise specified.
†No respondent identified as nonbinary.

age, depersonalization scores reduced by 0.3 (95% CI 0.2 to 0.4) per year of age, and personal accomplishment scores increased by 0.1 (95% CI 0.0 to 0.2) per year of age. Participants working reduced emergency department shifts had a 2.7-point (95% CI 0.2 to 5.3) increase in emotional exhaustion scores.

Survey score trends

In total, 221 respondents completed the 2020, 2022, and 2025 surveys (Table 2 and Figure 2). Emotional exhaustion, depersonalization, and low personal accomplishment scores were substantively unchanged across this time period.

Qualitative findings

In the 2025 survey, 187/351 (53%) respondents answered the optional free-text question. Unchanged from the 2022 survey, major themes were a broken health care system, the challenging workplace, physician distress, and wanting to leave emergency medicine. In 2022, participants complained that society was uninterested in the demise of emergency medicine. In 2025, participants stated they could no longer meet society's expectations, which had changed and were unrealistic. In our 2025 adapted framework, we removed societal disinterest and added unrealistic societal expectations (Figure 3; details in Appendix 1). In 2025, we found almost no references to the pandemic. In contrast to 2022, when few participants mentioned coping strategies, in 2025 many participants wrote about mechanisms they had used to persist in the job.

The prevailing theme was that the health care system is broken (Table 3 shows example quotes). We found repeated references to the emergency department making up for system inadequacies, with fewer resources and little support, and the expectation that the situation will worsen. For many, the future of emergency medicine was hopeless, with no possibility of recovery. Participants commented on a lack of accountability at every level of health care institution. Anger was directed toward hospital and political leaders, and occasionally toward patients.

New in 2025, participants perceived unrealistic societal expectations of emergency care, including that patients expected emergency physicians to manage nonemergent conditions day or night, sometimes in preference to seeing their family physician. The perception was that patients expect emergency physicians to rectify specialist issues (such as waits for imaging or to see specialists), social issues (such as appropriate residence or home care), or routine family medicine issues. Participants said they lacked control over many of these patient-related issues and that they felt unsupported by specialists, family physicians, and community services. Several commented that they were neither qualified nor trained to manage these types of presentations: "I cannot be all things to all people," "it is exhausting trying to provide the wrong care in the wrong place." Participants experienced being blamed by patients for systemic problems in the health care system, which was demoralizing.

Workplace challenges included extremely high patient volumes and long wait times, leading to patient assessments in corridors and waiting rooms, with resultant substandard care. Additional challenges included lack of primary care to follow up with patients, and reduced access to or long waits for specialist clinic appointments. Participants noted they rarely had access to the appropriate services to help resolve the root issues, contributing to poor job satisfaction.

Participants described personal distress, and exhaustion was a prominent sentiment. Some cited moral injury, hopelessness, powerlessness, and feeling used and unappreciated. The health care system was "destroying" them. Compared with 2022, there were no references to depression, being unable to feel joy, or emotional instability. Most were cognizant of their burnout.

A common theme was wanting to leave emergency medicine, and many participants accepted that the career was not sustainable. This included regretting choosing emergency medicine as a

Table 2: Comparison of burnout scores across years

Burnout dimension	2020 mean total score (SD)	2022 mean total score (SD), mean difference	2025 mean total score (SD), mean difference
Respondents who participated in all 3 surveys in 2020, 2022, and 2025, *n* = 221			
Emotional exhaustion	24.5 (12.3)	29.4 (12.9) 4.9 (3.3 to 6.4) 2020 to 2022	26.4 (12.3) −3.0 (−4.6 to −1.5) 2022 to 2025; 1.9 (0.3 to 3.4) 2020 to 2025
Depersonalization	10.8 (7.3)	12.9 (7.4) 2.1 (1.1 to 3.0) 2020 to 2022	11.9 (7.6) −1.0 (−2.0 to −0.1) 2022 to 2025; 1.0 (0.1 to 2.0) 2020 to 2025
Personal accomplishment	39.3 (5.8)	37.4 (7.1) −1.9 (−2.8 to −0.9) 2020 to 2022	38.1 (7.1) 0.6 (−0.3 to 1.5) 2022 to 2025; −1.2 (−2.1 to −0.3) 2020 to 2025
All respondents in each year	***n* = 416**	***n* = 383**	***n* = 351**
Emotional exhaustion	24.5 (12.2)	30.1 (13.2)	26.4 (12.2)
Depersonalization	10.9 (6.8)	13.3 (7.4)	11.8 (7.6)
Personal accomplishment	39.1 (6.2)	36.9 (7.2)	38.2 (6.9)
Respondents who participated in 2020 and 2022 surveys, *n* = 309			
Emotional exhaustion	24.4 (12.2)	29.7 (13.1) 5.3 (4.3 to 6.4)	–
Depersonalization	10.8 (6.9)	13.2 (7.4) 2.4 (1.8 to 3.0)	–
Personal accomplishment	39.2 (6.1)	36.9 (7.2) −2.3 (−3.4 to −1.2)	–
Respondents who participated in 2022 and 2025 surveys, *n* = 262			
Emotional exhaustion	–	30.1 (12.8)	27.0 (12.3) −3.1 (−4.2 to −2.0)
Depersonalization	–	13.2 (7.3)	12.1 (7.6) −1.1 (−1.8 to −0.4)
Personal accomplishment	–	37.1 (7.1)	38.0 (7.0) 0.9 (0.2 to 1.6)
Respondents who participated in 2020 and 2025 surveys, *n* = 260			
Emotional exhaustion	24.6 (12.2)	–	26.8 (12.3) 2.2 (1.0 to 3.5)
Depersonalization	11.0 (7.0)	–	12.2 (7.6) 1.2 (0.4 to 2.0)
Personal accomplishment	39.1 (6.0)	–	38.0 (7.1) −1.1 (−1.8 to −0.4)

Note: SD = standard deviation.

career and planning to leave the profession. Many participants talked about techniques to help them stay in emergency medicine. Prevailing strategies included reducing their shift load, taking on a new professional role, and changing health care organizations. Others described how a change in outlook helped them cope, such as accepting they have no control over these problems and letting go of what can't be fixed.

Interpretation

In January 2025, this longitudinal Canadian emergency physician survey found that 10% of respondents had left the specialty, half had reduced their clinical hours in emergency medicine, and 20% had taken time off emergency medicine. All burnout dimension levels were high, and substantively unchanged from the height of

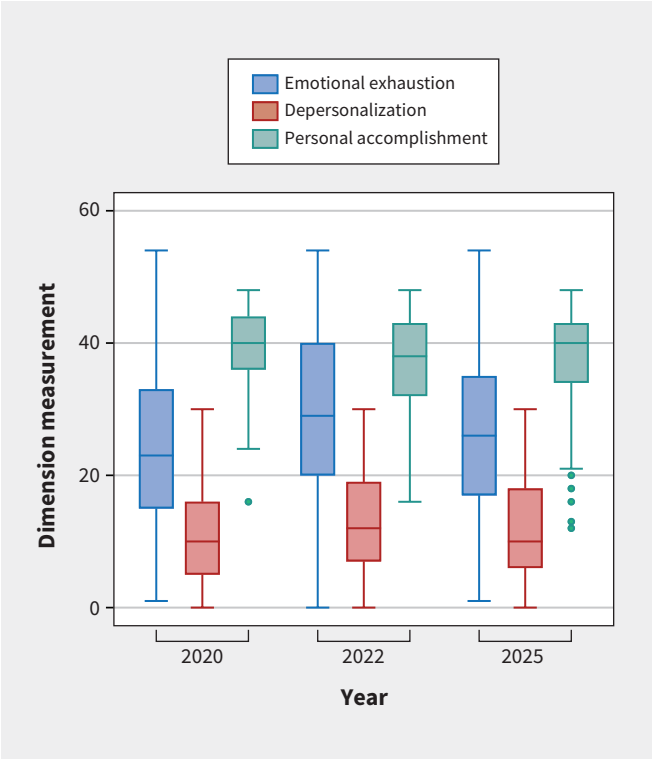

Figure 2: Maslach Burnout Inventory scores among participants who responded to the 2020, 2022, and 2025 surveys. For each group, the box indicates the interquartile range, the horizontal line represents the median, whiskers extend to the range of nonoutlier values, and individual points denote outliers.

the pandemic in November 2020. Women and younger participants reported higher levels of burnout, as did emergency physicians who had reduced their clinical hours.

We identified interconnected themes explaining the emergency physician experience, including the overall sentiment that the health care system is broken, unrealistic societal expectations of this broken system, insurmountable workplace challenges, physician distress, and leaving emergency medicine. Although most themes remained constant from the 2022 analysis, we noted a few important changes. Exhaustion was the most common feeling in 2025 and we found no references to depression, emotional instability, or inability to feel joy. Unlike in the 2022 survey, participants talked about what they did to make the job bearable: focus on what they could control, set boundaries, accept or detach from the new norm. Other strategies included reducing clinical hours, taking up nonemergency medicine roles, and changing institutions.

Our qualitative data give important insights into the potential sources of burnout. These included a medical system that feels no longer functional, in which patients repeatedly fall through gaps at all levels of health care and the emergency department is the only avenue to access help. However, emergency physicians do not have the tools to meaningfully address their patients' needs. Emergency department beds and rooms are taken up by admitted patients, meaning new patients are often assessed in public view, in the waiting room or corridor. Participants said inpatient and clinic specialty support was lacking. Additionally, participants described spending their time managing patient needs outside the emergency physician scope of practice: unaddressed social issues, primary care, and advocating for expedited specialist consultation.

There was a strong sense that the public has unrealistic expectations about what emergency physicians can fix. Participants described having given up trying to enact beneficial change because their hospital administration and the government had not responded. These experiences appear to be driving disengagement on an emotional, personal, and professional level, with many emergency physicians reducing their emergency medicine commitment, finding new ways to earn a living, and leaving the specialty. When exposed to chronic stress, with no way to effect change, humans resort to flight or freeze (leaving or stopping caring).

Our findings are congruent with those of the Canadian Medical Association's National Physician Health Survey, which showed similar burnout rates in physicians and learners over time, with emergency physicians reporting higher-than-average burnout scores.[21] It is now well established that women physicians experience higher emotional exhaustion and lower personal accomplishment levels than men physicians,[22,23] and this has been a consistent finding in our longitudinal cohort.[11,14] Women physicians leave the emergency medicine workforce at an earlier age[24] and report lower satisfaction[25] in emergency medicine than men physicians. Reducing workload is a common response to burnout[26] and may delay attrition from the workforce,[27] which explains our finding that physicians who had reduced their clinical hours were reporting worse burnout. Our results showing worse burnout with younger age were also reflected in a large US study.[28] This is concerning because burnout in younger physicians has an even stronger association with patient safety incidents than burnout in older physicians,[10] and loss of younger emergency physicians has a longer-term impact on the future workforce. We noted a subtle shift from depression, anhedonia, and emotional lability cited in 2022, to a focus on what can be controlled (changing organizations, reducing clinical shifts, taking on new work positions), which could be viewed as task-oriented coping.[29] Other respondents described detachment or acceptance.

Burnout levels remain high and should no longer be considered a pandemic phenomenon. Physician burnout is a patient safety risk,[30] is associated with low-quality care, and runs against the Quintuple Aim of a sustainable health care system.[31] Emergency physician loss is a crisis for the Canadian health care system and our results suggest attrition to the emergency workforce, which in turn exacerbates burnout among those who stay. Our qualitative framework identifies insurmountable health care system problems, a disconnect in society, and the constant challenges of the job as the causes for emergency physician burnout.

Addressing the lack of hospital and long-term care capacity; holding provincial, regional, and institutional leaders to account; and prioritizing emergency care could address serious gaps in patient care. In turn, this would translate into reduced levels of emergency physician burnout. Initiatives such as EM:POWER[32]

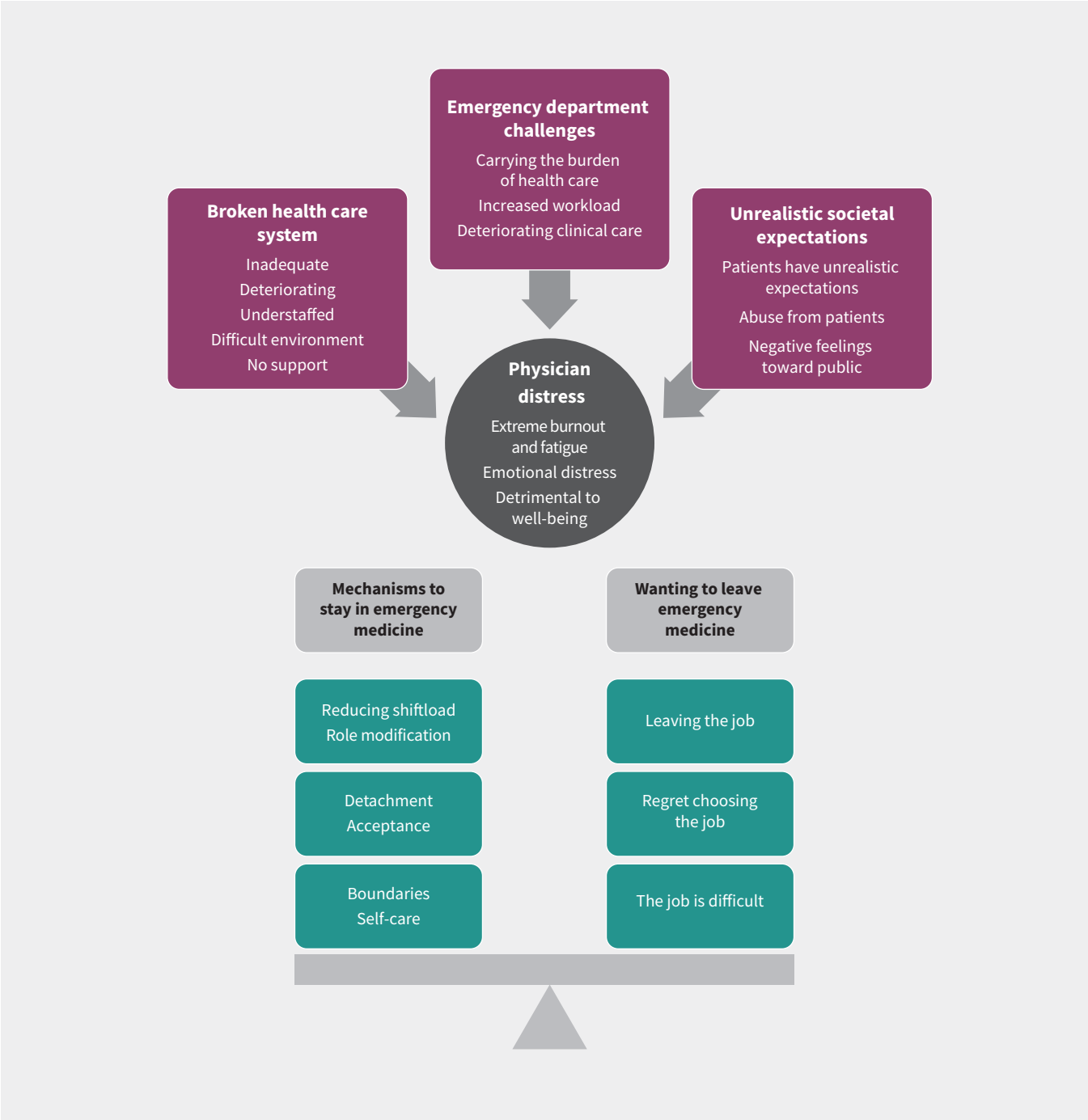

Figure 3: Diagram outlining findings from the 2025 thematic analysis. See Related Content tab for accessible version.

have set out a clear action plan to address such problems. Additional institutional initiatives could include investment in geriatric emergency care, provision of sufficient non–health care personnel to address patient needs day and night (food, communication, toileting, providing company, problem-solving), improved administrative support, scheduling that better matches circadian physiology, no longer expecting emergency physician groups to cover schedule gaps when they are short staffed, normalizing reducing clinical hours, and facilitating taking time off clinical emergency medicine.

Limitations

As with all survey research, responder bias is likely in this survey. We cannot generalize our findings to all Canadian emergency physicians. The initial cohort did not preferentially enrol burned-out physicians because we reported high burnout levels in only 17% of responders, using an abbreviated MBI in the first 3 months of the pandemic.[1] Not everyone enrolled in the study in 2020 completed the 2025 survey, which may bias our estimate of burnout, and only a small proportion of Canadian

Table 3 (part 1 of 2): 2025 survey themes with example quotes

Theme	Quotes
Health care system is broken	"Most of my frustration relates to systemic problems … the fact that we are being asked to fill in the gaps of our broken health care system, which should be addressed by politicians and administrators (*not* clinicians on the ground)." "Pretty much all my stress comes from working within a completely broken system that overburdens the emergency department and makes it the stopgap for the inadequacies of the system. The patients are left with almost no options to seek even basic care than to come to us." "I feel overwhelmed by the numbers, unsupported by administrators and health care and political leaders." "I find the leadership aspects of emergency work harder now. We are so short staffed: how to answer when a colleague asks 'is this sustainable?', when we both know it isn't, and we just keep trying to keep the place open." "This continues to be brutal. Under resourced. Undersupported. No end in sight." "Le contexte politique avec les coupures budgétaires, le manque de personnel alors qu'on demande toujours plus aux médecins n'est pas tenable." "Tired. Unsupported. Constant demands to do more and more with less and less."
Unrealistic societal expectations	"I have had so many more instances of aggression, racism, violence, or just people wanting to complain about things that I have no control over. There's so few instances where I feel like my work makes a difference." "People abuse the emergency department and the people working in it more than ever. They expect us to fix all their problems and be the solution to a broken health care system. I often don't feel like I am doing anything close to emergency medicine and cannot understand how people can't cope anymore with even simple ailments like a strained muscle or a cold." "Patient expectations and anxiety continue to climb and there seems too often to be a disconnect about what is an emergency and what the patient thinks is an emergency. Lack of quality access to primary care by physicians has led to sicker patients and more not-sick patients accessing ER to solve all their problems, even though it is not what I am trained to take care of. I cannot be all things to all people."
Workplace challenges	"Overall the job continues to feel harder and harder as walk-in clinics continue to shut down, primary care access has longer wait times than specialists, aging population is increasing the overall patient complexity, and we don't have the physician staff, nursing staff, allied staff, inpatient services, and physical resources required to do this job under these circumstances. My emergency department routinely has more admitted patients than there are actual beds in the department and has a 35% nursing vacancy rate." "Everything is harder. People are waiting so long and we can no longer influence this, it seems. Recently (Christmas and New Year) our wait times are up to 17 to 18 hours. There has been 60 to 70 or more in the waiting room. Sick or injured people are waiting way too long and it really bothers me." "I would have such better job satisfaction if I could see patients in a room rather than out of the waiting room. This in itself would make work way more enjoyable." "Patients with mental health and addictions come to us and we can do nothing to help them due to lack of community resources. We discharge them back to the streets, knowing that their quality of life is garbage and that they will be back tomorrow for the cycle to repeat." "I worry about the trajectory that I have seen in terms of deteriorating work environment, rising patient volumes, worsening staffing shortages, and less ability to decant issues to outpatient, specialist, or primary care resources that are increasingly vanishing." "We work terrible hours, get low-quality sleep, get paid less than doctors who never have to interact with patients, we're exposed to/victims of violence on a daily basis." "It is exhausting trying to provide the wrong care (primary care, surgeon's office is closed, cannot access outpatient imaging in a timely way, or just increased patient expectations to be seen immediately for any problem) in the wrong place."
Physician distress	"This job is getting harder. There is constant moral distress and the ask to do more with the same resources. It's draining to constantly be the default to a broken system." "You realize how you have sacrificed so much and missed so much life." "This job is getting harder every day. I feel like I am running on empty." "The health care system is destroying the people who work in it." "Working weekends, evenings, holidays with a seemingly terrible balance is not worth the suffering. Honestly dread going into work. I think the ED is one of the worst environments across any professions you can work in and it's getting worse. Either show up and just go through motions to collect a paycheque or try to make a difference in this challenging environment at the expense of all your sanity." "It's a relief to speak to the rare patient who seems to actually believe we are human beings. I feel used and treated like a means to an end by patients. I feel like they see me as an obstacle. I feel utterly defeated." "Je me sens moins empathique ou moins engagée avec les patients en général."

physicians are registered in this longitudinal study. We did not give a definition for taking time off emergency medicine, so we cannot draw detailed conclusions about those who indicated they had done so.

Conclusion

We found that most participating emergency physicians continue to experience high burnout levels comparable to those at the height of

Table 3 (part 2 of 2): 2025 survey themes with example quotes

Theme	Quotes
Wanting to leave emergency medicine	"I can no longer see how this career can be sustainable and I feel that most emergency medicine providers (both doctors and nurses or allied health care) are all looking for exit plans right now. I feel quite hopeless that things can ever get better." "I cannot see myself ever working full time again. And I will quit or retire as soon as I possibly can. In the beginning of COVID, you could push through, saying it was temporary, 'it's just another 2 weeks or another 3 weeks and yet another and so on, OK in a couple of months this will be different,' but the years have gone by." "I'm planning on leaving emergency [medicine] in the next 4 months. I've got young kids and the burden is the schedule, and fatigue from the job are too much." "I am going to step away from emergency department shifts this spring to see if I can refocus my CME, my educational goals and my plan for the future (as an emergency physician) and optimize my self-care (exercise, entertainment, sleep, etc.)." "I would leave if I could afford to, but I can't, so focus on the things that work and try to ignore or let go of the things that don't."
Mechanisms to stay in the job	"Most of my patients cannot be helped. They spend 8 to 12 hours in the waiting room and I no longer see that as my fault. I just don't think about it anymore." "I have accepted that I have limited capacity to deal with systemic issues so I just do what I can and I no longer try to change anything." "I have found other nonemergency work and cut my emergency hours by 50%. Emergency is hard work, not remunerated as well as it should be, and frankly hospital administration has contributed to the burnout." "Le meilleur moyen que j'ai trouvé pour m'épargner est de couper des shifts d'urgence et de faire autre chose qui est plus calme et dont je peux avoir du contrôle sur l'horaire et le stress inhérent." "I have a leadership role that has reduced my total hours in the ER. I feel this protects me somewhat from the very stressful and increasingly challenging emergency medicine environment. As a result, I have more recovery time between shifts to 'reset' and come back (to the next shift) with the best that I can offer." "I changed job locations. The hospital is *much* more agile and moves more quickly — innovation and change are normalized. This has been *huge* for my well-being." "I have spent the last years seriously appraising my choices in clinical practice; I have lost confidence and found it again. I have decreased the number of shifts and stopped nights. These changes have helped but so much of our identity is tied into our practice that these choices were hard to enact. I did not realize how much of me medicine would take."

Note: CME = continuing medical education, ED = emergency department, ER = emergency room.

the pandemic. Almost half of respondents have reduced their work hours and 10% have left the profession. Provincial, regional, and institutional health care leaders could reduce emergency physician burnout by following EM:POWER recommendations and instituting work models that facilitate reducing clinical hours and taking time away from emergency medicine when needed.

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