

Factors Affecting Physician Satisfaction and Wisconsin Medical Society Strategies to Drive Change

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ABSTRACT

Physicians' dissatisfaction in their work is increasing, which is affecting the stability of health care in America. The Wisconsin Medical Society (Society) surveyed 1016 Wisconsin physicians to determine the source of their dissatisfaction. The survey results indicate Wisconsin physicians are satisfied when it comes to practice environment, work-life balance, and income. In addition, they are extremely satisfied when it comes to rating their ability to provide high quality care, and they have identified some benefits related to the adoption of electronic health records. However, they are feeling burned out, very unsatisfied with the amount of time spent in direct patient care compared to indirect patient care, and that they are spending too much time on administrative and data entry tasks. In terms of future workforce, many physicians are either unsure or would not recommend the profession to a prospective medical student. Electronic health records serve as both a satisfier and dissatisfier and as a potential driver for future physician satisfaction interventions. Changes at the institutional, organizational, and individual levels potentially could address the identified dissatisfiers and build upon the satisfiers. The Society identifies 12 strategies to improve upon the physician experience.

INTRODUCTION

Physician professional satisfaction is crucial to the stability of the United States health care system, health care reform, and health outcomes, but physician satisfaction rates have experienced a dramatic decline in recent years.¹⁻⁵ Negative physician mental health and burnout rates increase when physicians are dissatisfied with their career, and those reporting higher dissatisfaction are more likely to reduce their work hours, leave their current practice, and retire early.² Physician burnout and dissatisfaction also are associated with lower patient satisfaction and reduced adherence to treatment plans, and they directly impact the quality of

care patients receive.⁵⁻⁸ Physician burnout is estimated to be between 25% and 60% across all specialties.^{2,9} Moreover, burnout is more common among physicians than any other profession.³ The importance of improving the physician experience via professional satisfaction is paramount, more so than ever.

A study released in 2010 surveyed 1735 allopathic and osteopathic physicians from the American Medical Association Physician Masterfile regarding their job satisfaction and stress rates and the subsequent implications on their self, their patients, and health care organizations. When physicians perceived higher stress, lower satisfaction rates, and/or burnout, they were more likely to have higher intentions of quitting their job (including early retirement), decreasing their work hours, changing their specialty or practice emphasis, and/or leaving direct patient care (either leave the health care field entirely or switch to a health care administrative role).¹⁰ Other researchers found that middle career physicians were more likely to be planning to leave their current practice out of frustration to pursue a career with no direct patient care or one outside the field of medicine altogether. Such departures are detrimental to health care as middle career physicians tend to be the most productive in terms of the amount of patient care provided. In turn, consequences can include amplification of the physician shortage, increased gaps in access to health care, disruptions in patient care, and added financial burdens on the health system or practices because of the need to replace the physician.²

It also has been suggested that younger and older physicians have the most career satisfaction, while mid-career physicians have the least, representing a U-shaped relationship. A study conducted at Mayo Clinic by Dyrbye et al surveyed 7288 physicians from the Medical Association Physician Masterfile in June 2011 regarding their career satisfaction and analyzed responses by age, region, income, and specialty. Early career physicians had more

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Table 1. Distribution of Specialties Among Respondents

Specialty	No. of Respondents	% of Respondents n=1016	No. of Society Members	% of Membership n=12,696
Family Med	200	19.69%	2671	21.04%
Internal Med	164	16.14%	1669	13.15%
Emergency Medicine	82	8.07%	764	6.02%
Pediatrics	75	7.38%	1144	9.01%
Anesthesiology	56	5.51%	880	6.93%
Psychiatry	50	4.92%	568	4.47%
Surgery	48	4.73%	590	4.65%
OB/Gyn	47	4.63%	647	5.1%
Orthopedics	44	4.33%	485	3.82%
General Practice/Other	33	3.25%	101	0.01%
Ophthalmology	25	2.46%	343	2.7%
Radiology	23	2.26%	805	6.34%
Dermatology	20	1.97%	205	1.61%
Oncology	20	1.97%	185	1.46%
Otolaryngology	19	1.87%	189	1.49%
Cardiology	18	1.77%	22	0.17%
Neurology	18	1.77%	269	2.12%
Pathology	12	1.18%	320	2.52%
Physical Med & Rehab	12	1.18%	196	1.54%
Allergy/Immunology	11	1.09%	74	0.58%
Endocrinology	8	0.79%	113	0.89%
Preventive Medicine	8	0.79%	71	0.56%
Urology	7	0.69%	164	1.29%
Plastic Surgery	6	0.59%	79	0.62%
Geriatrics	5	0.49%	43	0.34%
Neurological Surgery	4	0.39%	88	0.69%
Medical Genetics	1	0.09%	11	0.09%
Total	1016		12,696	

conflicts with work and home balance. Middle career physicians worked the most hours, took more overnight calls, had the lowest satisfaction, and the highest rates of emotional exhaustion and burnout with their specialty choice. They also were the least likely to recommend medicine as a career option to their children. Late career physicians had the lowest rates of distress and were generally the most satisfied. The cited grievances of middle career physicians existed in both men and women and across all specialties and practice types.²

Primary care physicians typically report higher rates of professional dissatisfaction,^{4,11} and it has been well documented that they have a higher risk of burnout compared to other specialties.^{2,3} One study found that more than half of general internists and family physicians exhibit symptoms of burnout, and physicians on the front line of health care access—including family medicine, general internal medicine, and emergency medicine—have the greatest risk of burnout.³ About one in six general internal medicine physicians leave the field, possibly due to dissatisfaction, compared to only one in 25 internal medicine subspecialty physicians.¹² Specifically, physicians working in primary care experience high stress due to time constraints, chaotic and stressful work environments, increasing administrative and regulatory burdens, an ever-expanding knowledge base, frag-

mented care delivery, and greater expectations of duties placed on the primary care system.¹³ In addition, primary care visits often can be disorganized, rushed, and overbooked, resulting in patients being unable to see their primary care physician when needed, placing more stress on the physician and system.⁴

In part, because of these known pressures and dissatisfaction rates, fewer graduating medical students are choosing to work in primary care.^{4,14,15}

A study conducted in 2009 surveyed 16,402 internal medicine residents regarding their perceived time spent on patient documentation compared to face-to-face patient interaction and the importance of the documentation. Over two-thirds of the residents perceived spending more than four hours per day on documentation. The majority felt they received feedback on their documentation less than 50% of the time, and only 58% felt that feedback on documentation was highly important.¹⁴ Fourth-year medical students surveyed at 11 US medical schools indicated the perceived high levels of paper-

work and charting, the need to bring work home, and the appeal of being a primary care physician as reasons why they did not choose an internal medicine career. In addition, the students expressed reservations about internists' quality of life and rewards compared to other fields.¹⁵

The Wisconsin Medical Society (Society) elected to survey Wisconsin physicians to determine if the concerns arising from these data also are evident in Wisconsin. Findings will be used to help inform the Society's advocacy and education efforts on behalf of physicians, and in dialogue with key stakeholders to bring to light challenges facing the profession.

SURVEY METHODS

In 2014, the Society conducted a survey to assess physician satisfaction in the state, paralleling a 2009 survey also administered by the Society. To the extent possible, data in this report are evaluated against the 2009 data. The 2014 survey instrument used similar questions to its 2009 predecessor, and exceptions are noted in this analysis where necessary. All surveys were distributed online and returned electronically. There were 40 survey questions across five categories. Each question typically solicited a Likert response to an objective statement. There also were open-field questions for anecdotal analyses.

Invitations to take part in the 2014 survey were e-mailed to 10,380 physicians for whom the Society has current e-mail addresses, including both members and non-members. Only completed surveys were analyzed. There were 1016 completed surveys with a response rate of 9.79%. This is about a half of a percent lower than the 2009 survey, when 10,070 physicians were solicited and 1044 responded, yielding a response rate of 10.37%.

Table 1 shows the rank-ordered distribution of specialties among the respondents and compares the respondents to the composition of the Society membership. Family medicine was the largest subgroup of respondents followed by internal medicine. Together these two groups accounted for 35.8% of the sample and comprise a similar majority in the Society's membership.

Respondents were asked if they work in a health care system with fewer or more than 25 physicians, a medical school, or a hospital.

Table 2 shows that 654 respondents (64%) worked for health care systems with more than 25 physicians. One hundred fifty-seven respondents (15%) worked in systems with fewer than 25 physicians. There were 101 respondents who worked in medical schools (10%); the remaining 73 worked in hospitals (7%).

Table 3 shows that respondents ranged in age from 28 to 83 years, with about 36% between 49 and 58 years. The average range was between 42 and 62 years with a mean of 52. Both the median and mode were 58.

Three hundred thirty-three (33%) respondents identified themselves as female; the remaining 683 (67%) identified themselves as male.

It should be noted that the demographic profile of survey respondents is very similar to the demographic profile of Society members.

SURVEY FINDINGS AND RELATED LITERATURE

The results of the 2014 survey were organized into two broad categories: factors contributing to physician dissatisfaction or "dissatisfiers" and factors contributing to physician satisfaction or "satisfiers." These were subcategorized based on naturally emerging themes, and the themes were further analyzed based on respondents' age, gender, primary employment affiliation, and specialty. An extensive literature review revealed that the Society survey results parallel and support other national data and research efforts.

Dissatisfiers

Decrease in Direct Patient Care

Direct patient care was defined as face-to-face time spent with patients obtaining history, performing exam, and crafting a care plan. One out of every two respondents reported being dissatisfied or very dissatisfied with the number of hours they are able to spend on direct patient care versus administrative tasks. This is a substantial increase compared to the 2009 survey results, when

Table 2. Primary Employment Affiliation

	n	n=1016
Health Care System With More Than 25	654	64.37%
Health Care System With Fewer Than 25	157	15.45%
Medical School	101	9.94%
Hospital	73	7.19%

Table 3. Age Characteristics of 2015 Respondents

Category	n
No Answer	9
Age Ranges	
28-38	115 ÷ 1007 = 11.42%
39-48	246 ÷ 1007 = 24.43%
49-58	362 ÷ 1007 = 35.95%
59-68	245 ÷ 1007 = 24.33%
69-78	36 ÷ 1007 = 3.57%
79-83	3 ÷ 1007 = 0.29%
Full Range	
28 – 83	1007
Mean	52 (f=39)
Median	58 (f=48)
Mode	58 (f=48)
Standard Deviation	10.06
Average Range	42–62

only one out of every three reported being dissatisfied or very dissatisfied. When asked if time spent in direct patient care has increased, decreased, or remained the same over the past year, 39% reported a decrease, 15% reported an increase, and 46% indicated it remained the same. This is a significant difference from the 2009 results in that more reported a decrease in direct patient care in 2014 compared to 2009 (39% vs 30%) and less reported an increase in direct patient care in 2014 compared to 2009 (15% vs 23%). Furthermore, only 32% of respondents reported feeling that they have significant or total control of the amount of time they spend in direct patient care.

Conversely, when asked about time spent over the past year specifically on indirect patient care, which was defined as electronic health records and other documentation, order entry, test interpretation, referrals and communication with care team, and billing, 74% reported an increase in 2014, whereas 3% reported a decrease, and 23% reported no change. Moreover, when asked about the amount of time spent in the past year on administrative tasks, which was defined as prior authorizations, insurance forms, paperwork, and meeting attendance, 65.5% of respondents reported an increase, 3% reported a decrease, and 31.5% reported no change. Sixty-eight percent of respondents reported feeling like they have no or only some control of the amount of time they spend in indirect patient care. No equivalent questions were asked in the 2009 survey. Respondents reported spending 25.2 hours per week on direct patient care, 11.9 on indirect

patient care, and 7.33 on administrative tasks. Well over 50% of physicians who worked for a health system or a medical school reported being dissatisfied with time spent on direct patient care compared to only 30% of those who worked at a hospital or private/public entity. Moreover, respondents working in the primary care fields of family medicine and internal medicine reported a dissatisfaction rate of 61% compared to 46% reported by all other specialties.

To demonstrate how a physician's workday is spent, one researcher observed and quantified the average physician responsibilities. On any given day, a primary care physician performs 18 in-person visits, 24 phone calls, 12 prescription refills, 17 e-mail messages, 20 lab reports, 11 imaging reports, and 14 consultation reports; all of these activities required the extensive use of an electronic health record.¹⁶ Other researchers have documented the large amounts of time physicians spent outside of the exam room, not interacting directly with patients. Gilchrist et al reported 39% of a physician's day, or three hours and eight minutes, is not in the exam room,¹⁷ whereas Gottschalk and Flocke reported 45%;¹⁸ most of this time is spent on documentation of patient interactions and necessary follow-up.^{17,18} Every minute a physician does not spend on direct patient care costs a practice \$4 to \$6 in lost revenue.¹¹ It has been documented that physicians spend 4.3 hours per week dealing with insurance issues, costing \$23 billion to \$31 billion annually for the time physicians, nurses, and other clerical staff spend on interacting with health plans. This issue has affected the training of physicians as well. Two times as many residents compared to previous reporting indicate they spend four or more hours on documentation work each day.¹¹

Electronic Health Records

More than 56% of respondents reported that their electronic health record (EHR) system has much or moderately worsened the physician-patient interaction, whereas only 21% reported that it much or moderately improved the interaction. Respondents working in primary care or employed at a health system or medical school were more likely to report that EHRs have much or moderately worsened the physician-patient interaction. Moreover, over 68% of respondents reported EHRs have made their overall workload much or moderately worse, and only 17% reported they much or moderately improved the workload. Respondents who were male, age 49 or over, or employed at a health care system or medical school were more likely to indicate that EHRs have much or moderately worsened their workload. Half of the respondents reported not having enough time to complete EHR work during the workday and having to finish it after hours, whereas 22% reported having time during the normal workday. More women, respondents working in primary care, and respondents working at medical schools or health systems reported having to complete EHRs after hours. When asked how much time they spend per week outside of the normal workday to complete

EHRs, 30% reported spending 0 to 2 hours, 22.5% reported 2 to 4 hours, 18% reported 4 to 6 hours, 13.6% reported 6 to 8 hours, and 12% reported more than 8 hours. Three out of four respondents reported feeling they have no to only some control in the amount of time they spend completing EHR work.

Literature suggests the current existence of EHR technology pointedly decreases physician satisfaction via multiple venues. A study completed by the RAND Corporation cited "poor EHR usability, time-consuming data entry, interference with face-to-face patient care, inefficient and less fulfilling work content, inability to exchange health information between EHR products, and degradation of clinical documentation" as major contributing professional dissatisfaction factors.¹⁹ Other research has found the data entry process of patient and billing information can consume up to 2 to 3 hours of a physician's day.⁴ It has been documented that up to two-thirds of a patient visit is spent on data entry instead of providing patient care. Quantified, on average each physician spends seven minutes per day refreshing locked computers, 10 minutes on re-signing into a computer, and 13 minutes signing-off on routine documents by clicking through multiple screens and confirming previously entered data. With the transition of electronic billing to the clinician, the creation of one electronic invoice requires 21 mouse clicks, eight mouse scrolls, and five screen changes, totaling at least one minute.¹¹

Professional Burnout and Chaotic Work-life

Professional burnout was defined as the exhaustion of motivation due to prolonged stress or frustration at work. Almost one out of four respondents reported they were either totally or significantly burned out. Approximately 25% more said they were moderately burned out. Over one third said they were somewhat burned out. Together, 82% of respondents reported some level of professional burnout with only 18% reporting no burnout at all. In terms of primary employment, physicians working in health systems or a medical school reported being burned out significantly more than those working in hospitals or private/public entities. Moreover, those working in primary care reported being more burned out than those in all other specialties. When asked to describe the professional work environment in which they currently practice, over half of respondents indicated it to be chaotic or hectic. Chaotic was defined as feeling chronically stressed, impacting their practice and quality of life. Hectic was defined as feeling stressed too often at work, but without it impacting their quality of life. The remainder of respondents reported feeling calm or reasonably busy. More women, primary care physicians, and respondents age 48 and under described their work environment as chaotic. Almost 70% of respondents reporting feeling they have no to only some control in the amount of time they spend on workday interruptions.

Shanafelt et al define professional burnout to be a syndrome characterized by a loss of enthusiasm for work (emotional exhaus-

tion), feelings of cynicism (depersonalization), and a low sense of personal accomplishment.²⁰ It has been suggested that physician burnout can influence quality of care, medical errors, and early retirement, along with personal damage to relationships, alcohol and drug use, and suicide contemplation.^{6,7,20} A sample of physicians from all specialties from the American Medical Association Physician Masterfile were surveyed to understand the factors contributing to satisfaction among US physicians. Taken individually, 37.9% of US physicians reported high emotional exhaustion, 29.4% had high depersonalization, and 12.4% had a low sense of personal accomplishment. In total, almost one out of every two (45.8%) physicians were considered to be experiencing at least one symptom of burnout, and those at the front line of care experienced higher rates of burnout compared to other specialties.³ Other researchers found the negative contributors to emotional exhaustion and depersonalization to be workload, constraining organizational structure, incivility, conflicts and violence, work-life conflict, low quality and safety standards, and negative work attitudes.²¹

Satisfiers

Practice and Work Environment

When asked about their current practice and work environment, over 75% of respondents said they were either very satisfied, mostly satisfied, or satisfied. This is similar to 2009 results—the main difference being that in 2014, 2.5% more said they were very satisfied. When examining the data based on primary employment affiliation, those who worked at hospitals had the highest satisfaction rate at 86%, while medical schools had the lowest at 71%. In terms of satisfaction regarding the internal culture and values of their employing organization matching their own, over 70% of physicians reported being very satisfied, mostly satisfied, or satisfied. Compared to 2009, this is a significant decrease from 83.5%. In addition, 30% of physicians in 2014 responded to this question with “dissatisfied” or “very dissatisfied” compared to 17% in 2009. However, due to differences in survey question wording, these results cannot be compared directly.

In terms of primary employment affiliation, respondents who worked at a system with less than 25 physicians were the most satisfied with the internal culture and value of their employing organization (82%), followed by those working at hospitals (80%). Among those employed at health care organizations with more than 25 physicians, medical schools, and private/public entities, the satisfaction rate was 67%.

According to the RAND Corporation study, physicians rate higher levels of satisfaction when the values of management and leadership at their place of work aligned with theirs, specifically in relation to values surrounding clinical care. Effective leadership was especially valued when management had clinical experience themselves and could relate to the needs of the physicians.

Physicians were not satisfied when they perceived poor collegiality, fairness, and respect among their colleagues, leadership, and organization.¹⁹ One systematic review found similar results in that there was a strong relationship between satisfaction and positive collegial support and interaction.²²

Work-life Balance and Compensation

Sixty-four percent of respondents reported being very satisfied, mostly satisfied, or satisfied with the number of hours per week worked versus their ability to pursue home life and other interests. In 2009, 59% of respondents reported the same. One difference between the two surveys is that there was a 2.6% decline in 2014 in the number of respondents reporting being very dissatisfied. However, when divided into primary employment affiliation and specialty, there is a variation in the responses. The highest satisfaction rates were from the respondents working at a private/public entity, followed by hospital employment at 81% and 72% respectively. Below average satisfaction rates came from those who work at a system with less than 25 physicians (63%), health care systems with more than 25 physicians (62%), and medical schools (52%). Those with specialties outside of primary care also have a higher satisfaction rate compared to those in primary care (68% vs 54%). Every three out of four respondents rated being very satisfied, mostly satisfied, or satisfied with their income relative to the number of hours they work. This is a significant difference from the 2009 survey when only 65% responded feeling similarly. The RAND Corporation study found income to be an important contributor to satisfaction levels based on income stability, fairness, and future payment reform; those with higher incomes also rated themselves as more satisfied.¹⁹ Other research has found similar associations between income level and satisfaction rates.²²

Ability to Provide Quality Care

When asked about their ability to provide the highest quality of care in their current practice, respondents overwhelmingly reported being able to do so. Seventy-eight percent reported being totally or significantly able to provide the highest quality of care. Adding the 27% that reported being moderately able to provide the highest quality of care brings this total to 95%. Five percent reported somewhat or not at all. Other research demonstrates that those who perceive themselves as providing higher quality care to their patients report higher levels of professional satisfaction. The converse of this is also true. When physicians are able to cite barriers in their practice that hinder their ability to provide quality care, their professional satisfaction decreases. Research also demonstrates that physician satisfaction directly relates to and impacts patient satisfaction.^{19,23}

Electronic Health Records

More than 80% of respondents have been using an EHR for three years or more. Half reported that EHRs have much or moderately improved their ability to provide the highest quality of care.

Those who were female, age 48 and under, were a primary care physician, or employed at a health care system with more than 25 employees, a hospital, or medical school were more likely to indicate that the EHR system has much or moderately improved their ability to provide the highest quality of care. Almost a third of the respondents indicated that EHRs have much or moderately worsened their ability to provide the highest quality of care.

Half of the respondents reported that the quality of chart notes in the EHR system has much or moderately improved their ability to communicate with other physicians when referring patients, although 35% reported the quality of the chart notes for this purpose to be much or moderately worse. In addition, almost 70% reported that the availability of chart notes has much or moderately improved their ability to communicate with physicians who refer patients to them.

Physicians often approve of the concept of EHRs in their ability to improve quality of care and access to patient data. Moreover, they are often optimistic that future EHRs will improve.¹⁹

DISCUSSION

It is clear from the survey results that Wisconsin physicians have many dissatisfiers to cope with on a daily basis. Almost 40% of respondents reported their retirement plans have changed due to the health care environment, though it was not specified if they would retire earlier or later than previously planned due to professional satisfaction. More respondents age 49 and over indicated their plans have changed compared those age 48 and under. Additionally, 59% of respondents said either they would not recommend or are unsure if they would recommend a career as a physician to prospective students. Women and those 48 and under were less likely to recommend a career as a physician.

However, the survey also highlighted many satisfiers and opportunities to improve professional satisfaction. When respondents were asked to rank the five factors that would most favorably impact their decision to continue working in the field of medicine, the five most-endorsed factors in order of highest rank were: (1) reasonable work-life balance, (2) reasonable income/reimbursement, (3) adequate time and resources in direct patient care, (4) ability to maintain autonomy, and (5) less insurance/administrative hassles. The top two already have been identified as satisfiers in the survey. Efforts can now be made to build upon these satisfiers and lessen the dissatisfiers.

Research and literature dedicated to improving physician satisfaction via evidence-based interventions is still emerging, and what is available can be grouped into three broad solution and action categories: (1) institutional changes, (2) work environment changes, and (3) individual-level changes. Instituting metrics such as known satisfaction predictors of control, time pressure, pace of work, and value alignment, with the correlated outcomes of satisfaction, stress, burnout, and desire to leave the field have been sug-

gested to improve physician satisfaction rates and decrease overall burnout at the macro or institutional level.^{24,25} Examining policies at the federal, state, and local levels could promote satisfaction by eliminating unintended barriers from regulations such as current limitations on who can order certain tests, renew prescriptions, and access patient data.¹¹

Preserving physician control and autonomy through developing and implementing appropriate practice models, such as expanding primary care teams, was determined to improve physician satisfaction at the organizational level.^{25,26} Promoting and utilizing appropriate care models, such as the patient-centered medical home, was found to reduce burnout by instituting participatory decision making and appropriate staffing levels for primary care teams.²⁷

The Healthy Work Place Study conducted by Linzer and colleagues hypothesized that workplace changes, discussed and recommended by directly prompted feedback on clinician perceptions and outcomes, would lead to a decrease in clinician stress and improved care for patients. They determined that burnout improved with workflow interventions such as altering current staff assignments in primary care teams and hiring additional staff. In addition, the application of quality improvement projects, such as new medication reconciliation processes, were found to improve burnout rates. Physician satisfaction improved when communication increased between physicians and staff.²⁴ Sinsky et al surveyed 23 high-performing care practices and found higher physician satisfaction rates due to proactive planned care via pre-visit questionnaires and lab tests, sharing of clerical tasks (eg, collaborative documentation by scribes and expanded data entry by assistants), sharing of clinical work by expanding nurse and medical assistant rooming protocols, expanding team communication through co-location and weekly huddles, and improving work flows and process standardization.⁴

Electronic health records are a large driver in work environment and workflow issues leading to high rates of dissatisfaction. Practices have worked to combat this dissatisfier by expanding data entry responsibilities to scribes or other members of the care team and the employment of work flow managers to guide in helping all staff work to the top of their license.^{4,19} Specifically adding inbox managers to filter out requests that do not require a physician, such as normal laboratory results and prescription renewals, and promoting quick in-person question and answering among staff versus e-mail allowed for the 90 minutes a day spent on inbox work to drop to just a few minutes.⁴

At the individual level, there is lack of attention to self-wellness by physicians, including poor attention to physical and mental health. Moreover, there is high stigma in the profession against seeking help, medical or otherwise. Physicians rarely reach out to their impaired colleagues and avoid seeking help for themselves for risk of medical licensing board action.²⁸ Gazelle et al suggested

that physician personality tendencies of perfectionism, denial of personal vulnerability, and delayed gratification further impact physician dissatisfaction. They propose the technique of coaching to enhance self-awareness, build upon and pull out individual strengths, examine new perspectives, question self-defeating thoughts and beliefs, along with aligning personal values to professional duties. The process of coaching applies mindfulness techniques, which has been found to be a successful method to reduce physician burnout.²⁹

Emerging research suggests that motivation for the profession is divided into extrinsic and intrinsic factors and argue that more focus and interventions should be on intrinsic motivation as it relates to professional satisfaction, including increasing self-awareness and structuring their work around their internal motivators to improve satisfaction.^{30,31} Moreover, research by Mayo Clinic found when academic researchers have less than 10% to 20% full-time equivalent to do what they care about most, burnout levels dramatically increased. Linzer et al suggested it to be cost-effective to provide at least one half day per week for physicians to dedicate time to what they are most passionate about.²⁵

Wisconsin Medical Society Strategies

The Wisconsin Medical Society serves over 12,500 physicians with a mission to improve the health of the people of Wisconsin by supporting and strengthening physicians' ability to practice high-quality patient care in a changing environment. Advocacy and professional satisfaction are at the core of the Society's work. Physician health and well-being is a leading priority of the organization. Informed by the findings of this survey and the current research and literature, the Society will begin to address this critical issue in collaboration with other key stakeholders by implementing the following strategies.

Society Advocacy Efforts

- Work collaboratively with health system leaders and practicing physicians to develop a method and/or process to routinely assess physician satisfaction. This indicator may inform performance, quality, work force, and the health and well-being of physicians and the professional team.
- Heighten awareness among state and national organizations working on models of transforming care delivery, efficiency, and effectiveness to the critical need of adding physician professional satisfaction as a key measure of success.
- Develop a set of "Physician Health and Well-being Principles" through the Society's Council structure. Principles will be used in dialogue with relevant health care stakeholder groups and guide the development of appropriate state and federal legislation and Society educational initiatives.
- Identify requirements in Meaningful Use that are negatively affecting the patient-physician relationship, physician satisfaction, and clinical outcomes and work toward reducing bar-

riers and implementing relevant change.

- Aid in the passage of Wisconsin legislation to reestablish a statewide professional wellness program, which will offer support and assistance to impaired professionals.
- Assess the need to establish a statewide physician reentry program, which will allow physicians who have left practice and are in good standing to retrain and reengage in the workforce.

Society Professional Development Efforts

- Charter a Physician Health and Well-being Task Force to advise Society leadership and staff on advocacy and educational priorities designed to favorably impact physician satisfaction.
- Expand the Society's Leading Healthy Work Systems program through health care system engagement and strategic partnerships. This program is designed to support physicians in transforming their work life to better serve patients, lead interprofessional teams, and enjoy a more balanced and rewarding life as healers.
- Continue to offer and expand Performance Improvement Continuing Medical Education (PI CME) modules to assist physicians in fulfilling their licensure and specialty board requirements, while aligning these efforts with relevant quality improvement and payment incentive programs.
- In conjunction with health system input, develop a toolkit of educational offerings, resources, or services that address areas of dissatisfaction for physicians in clinical documentation, workflow, and/or efficient use of the electronic health record system in their day-to-day practice.
- Partner with entities that have proven expertise and programs supporting the health and well-being of physicians and that focus on intrinsic factors and motivation such as mindfulness techniques.
- Provide opportunities and venues through the Society or within local communities for physicians (and their families) to network and build collegiality across systems, specialties, and geographies.

CONCLUSION

The Wisconsin Medical Society's physician satisfaction survey clearly demonstrates rising dissatisfaction and burnout among Wisconsin's physicians—a trend that has serious implications for patients and the profession, and one that also is evident in the existing literature. As such, the Society has and will continue to use this data to develop and implement strategies to help reverse this growing problem.

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