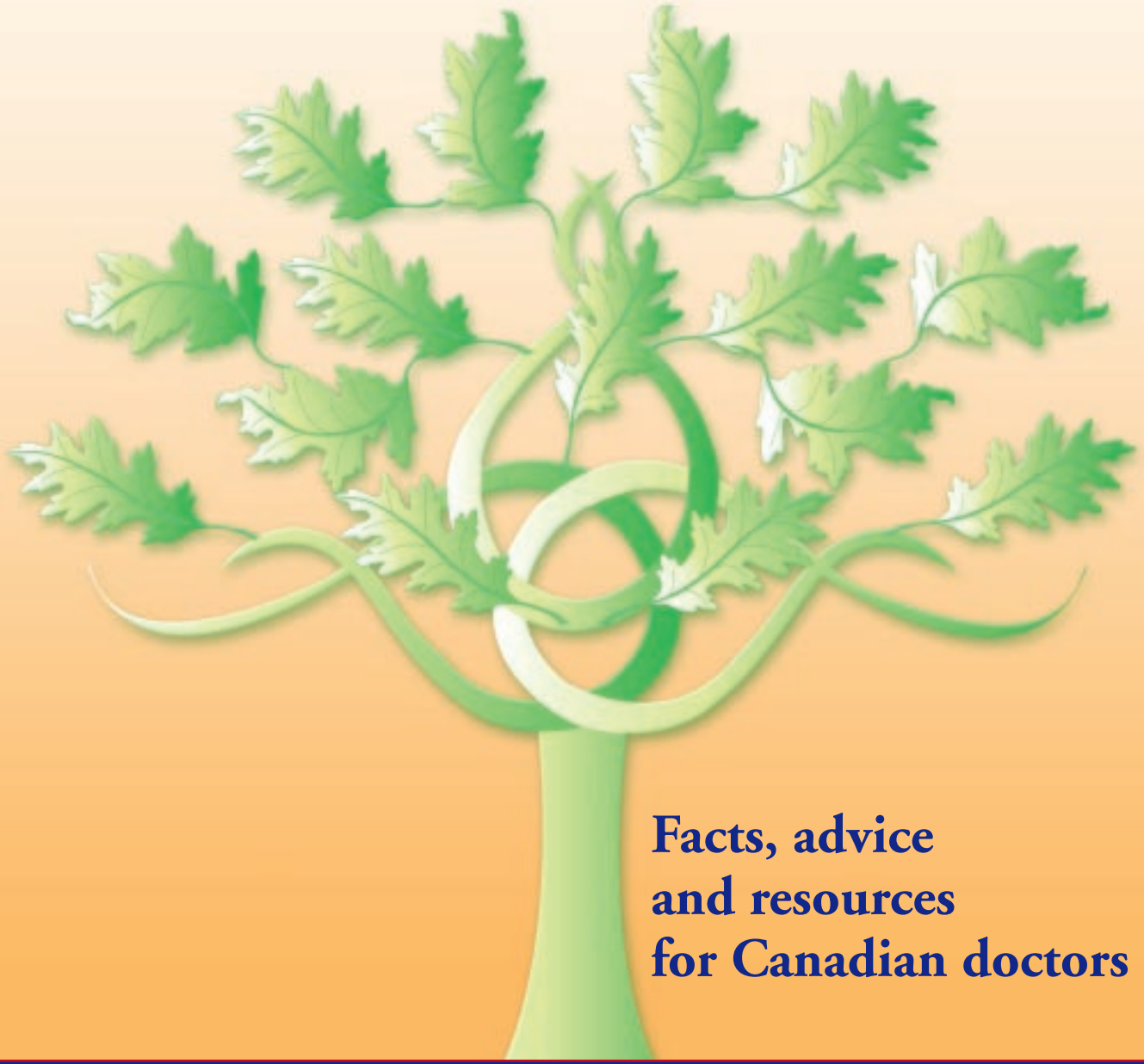
CMA Guide to

Physician Health and Well-Being



Facts, advice
and resources
for Canadian doctors

Association Médicale Canadienne
Canadian Medical Association

Editor-in-chief: Dr. Michael Myers
Associate Editors: Drs. Todd Watkins and Gisele Microys

Published by the Canadian Medical Association

National Library of Canada Cataloguing in Publication

CMA guide to physician health and well-being : facts, advice and resources for Canadian doctors.

Issued also in French under title: Guide de l'AMC sur la santé et le mieux-être des médecins.
Includes bibliographical references.
ISBN 1-894391-04-7

1. Physicians--Mental health. 2. Physicians--Health and hygiene. 3. Physicians--Health and hygiene--Canada. 4. Physicians--Mental health services--Canada. 5. Physicians--Services for--Canada. I. Canadian Medical Association.

RC451.4.P5C52 2003 610.69'52'019 C2003-900300-0

Ordering information and additional copies are available from:
Member Service Centre
Canadian Medical Association
1867 Alta Vista Dr.
Ottawa ON K1G 3Y6
Tel: 888 855-2555 or 613 731-8610 x2307
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Now is an exciting time to be involved in the field of physician health and well-being

A highly successful international conference on the topic in Vancouver this past October, a growing body of evidence-based research, a heightened health awareness among Canadian physicians, and this publication are all testament to this. There is consensus building among medical students and physicians, their loved ones, medical associations, provincial Colleges of Physicians and Surgeons, physician health specialists and even the general public that there are serious problems in how we teach the doctors of tomorrow and how we practise front-line medicine. We physicians are a population at risk for illness and family breakdown.

The theme of the recent conjoint Canadian Medical Association and American Medical Association conference on physician health was "Steering the Course: Self, Service and Leadership." As a member of the planning committee for that conference, let me explain what we intended to capture in these overlapping concepts.

Self: How well do we take care of ourselves — physically, emotionally, spiritually? How can we improve as role models so that both our students and our families are left a legacy of "doing it right"?

Service: How can we extend our reach to colleagues in distress so that we reduce suffering and isolation and diminish morbidity and lost productivity due to illness? How do we identify those doctors living with life-threatening conditions, such as substance dependence and severe mood disorders, who are undiagnosed, untreated, undertreated or self-treated? What are the limits and boundaries of our intercollegial responsibility — and how do we reach out and help, while simultaneously respecting each other's rights to autonomy, privacy and simple dignity?

Leadership: How can we become both more interested and proficient at leading in our work setting, our educational centres and our associations? What are the means — advanced degrees, continuing education course work, Internet offerings, workshops, mentoring — we can use to stimulate and nurture others into becoming leaders? What are the rewards and pitfalls of these quests and the impact on our self-regard, our families and our patients?

When I look to some of the challenges ahead, many are in the area of prevention.

Primary prevention

We need to continue to study and delineate risk factors in medical education and practice. Given the changing dynamics and demands of medical practice, do we need to change the criteria used to select medical students? How sensitive are we to the genetic and developmental vulnerabilities of our medical school applicants, and how much do we accept the elusive "woundedness" of some, in addition to their intellectual achievements on paper and how well they perform at interview?

Regarding our teaching methods, we must identify and deal with professors whose styles are outdated, coercive, shaming or abusive. We continue to lose gifted individuals whose life-stage commitments to child-bearing and child rearing conflict with the imperative of academic productivity.

We also need sweeping reform in the culture of medical practice. We physicians are used to hard work and self-sacrifice in the service of our patients, education and research. But many of us are being exploited for what should be noble or admirable qualities. The public's expectations of its doctors are often unrealistic. I believe that this needs attention.

Secondary prevention

Our initiatives in educating medical students and physicians about self-care and family-care must continue. But these will fail if we don't make overdue systemic changes in primary prevention. Further, we must eliminate stigma. Its effects are

Dr. Michael Myers

pernicious when doctors fall ill — stigma reinforces denial of symptoms and delays help-seeking, it drives self-medicating and noncompliance with treatment, it augments suffering and exclusion and it kills by self-neglect and suicide. We need to find ways of recognizing possible illness in our trainees and colleagues and improve our strategies (and impart these to others) for reaching out to them in a sensitive and helpful way. Provincial health programs and other resources need to be advertised and "user-friendly." And we need to listen to the voices of doctors' loved ones, not only to inform our diagnoses and enrich our treatment plans, but also to provide the support and care that they might need.

Tertiary prevention

If we are going to really heal and keep Canadian physicians healthy and in remission, we need state-of-the-art treatment. This means a cadre of family physicians across this nation who are interested in and dedicated to looking after their physician colleagues. We need physicians who practise both the science and art of medicine, who treat their colleagues with respect and thoroughness and who allow their physician-patients to be patients. This also includes specialists in addiction medicine, psychiatrists and other mental health professionals with expertise in physician health, subspecialists in mood disorders, rehabilitation and occupational health, eating disorders and forensic issues and good (and affordable) treatment facilities.

We need to work closely with our Colleges of Physicians and Surgeons to assist and educate and to address the perception of so many rank-and-file physicians that their provincial College is out of touch with reality. We need to fight for more funding for research in many areas but especially epidemiological studies on illness and treatment nonadherence in physicians. And I hope to see improvement in our relations with disability insurers and what I call humanizing the medical workplace for partially disabled physicians.

It is an honor to be invited to be editor-in-chief of this publication. I am proud to be a part of the contingent of dedicated colleagues and CMA staff who work in this field and who have contributed so generously to this production.

Dr. Michael Myers, Clinical Professor, Dept. of Psychiatry, University of British Columbia

Awareness of physician wellness issues growing

Is stress over the state of our health care system taking its toll on physicians? Where once drug and alcohol problems were the main reasons for calls to physician support programs, experts now say they're seeing an increase in requests for help coping with depression and anxiety.

"We're having a difficult time with the government here," says **Dr. Paul Farnan**, the newly appointed clinical coordinator of the Physician Support Program (PSP) of BC. "[Doctors are] trying to ensure patients will get services while they themselves are being bad-mouthed by the government … it leads to a lot of stress." In 2001, the PSP had just over 100 new cases out of about 300 calls.

In his inaugural speech at this year's Canadian Medical Association (CMA) meeting in Saint John, NB, CMA President **Dr. Dana Hanson** identified physician health and well-being as one of his key priorities. "The reality of today's practice environment has brought with it an increase in stress-related illnesses," he said. "Depression, burnout, family and financial crisis are all on the rise. As I have travelled across Canada, I have found it deeply troubling to hear colleagues say: 'I hate to go to work now' or 'I am certain we take much better care of our patients than anyone takes care of us.'

The goal must be to "nurture a positive and open attitude toward physician health and well-being… We need to find the right balance between our professional and our private lives. We need to coordinate divisional services, offer better help and get rid of the stigma that comes with asking for help."

Currently, the issue is highlighted via the biennial International Conference on Physician Health, co-sponsored by the CMA and American Medical Association. The larger provinces, such as Ontario and Alberta, also offer formal services geared toward physician health, variously supported by medical associations and other associations. Smaller provinces have slightly different approaches: Nova Scotia and Newfoundland and Labrador have multiprofessional support programs; New Brunswick has a volunteer committee; Prince Edward Island is in flux; there's no specific program in the Northwest Territories; and the Yukon is covered by the Physician and Family Support Program (PFSP) on contract by the Alberta Medical Association.

Most programs cater to physicians at all stages of their careers, as well as to their family members, providing support for everything from mental health and substance abuse problems to financial and legal problems. The new Canadian Physician Health Network (see page 27) was formed with an eye to coordinating and fostering the development of provincial physician health programs. "The health care doctors provide is only as good as their health," Farnan stresses. In 2001, 28% of calls to the BC PSP were psychiatric and mental health related, 23% personal, 12% behavioural (aggression, anger), 12%–13% addiction related and the remainder a combination. "The stigma of mental illness and addiction is extremely difficult for anyone to deal with in society, and for physicians it's even worse," he says.

About 85% of the calls to the Alberta Medical Association's PFSP are referred to an employee assistance provider, according to **Dr. Gisele Microys**, clinical director of the program and chair of the Canadian Physician Health Network. Microys says the program works because it takes into consideration the issues physicians grapple with, such as denial, delayed help seeking and confidentiality. In 2001, the program had 361 calls dealing with marital concerns (the most common), work stress, burnout, alcohol and drugs. Efforts are made to fast-track physicians and their family members, and mail-outs are done to encourage use of the service.

Doctors' identities are frequently wrapped up in being a doctor," says Microys, "on account of this we tend to limit our interests and can be seen as idiot savants of a sort," she jokes, "There's a need to humanize medicine, allow for balance in our lives. Some areas in need of attention ... we're supposedly government employees but do not receive indexed pensions. Hence many docs feel they have to work until they drop with the "white coat" painted on and no way out." She notes that doctors feel they have

less control over the health care system and are frustrated with increasing bureaucracy and an inability to get the care they want quickly for their patients.

BC physician **Dr. Michael Myers**, known as the "doctor's doctor" to his colleagues, cautions physicians to take out insurance "today because you never know. You may get wobbly." Myers is past-president of the Canadian Psychiatric Association (CPA), serves as a consultant to the BC PSP and is chair of the section on physician health at the CPA. He considers the support programs currently in place to be solid, but he says more psychiatrists with doctor-treating expertise are needed.

Although some mental health issues physicians grapple with have their origin in the biopsychosocial sphere, others are the result of overwork and stress, a scenario that inevitably results in strife at home. One doctor Myers counselled sought help because his son was addicted to heroin. Fearful of having "brilliant clinician, lousy father" carved on his gravestone, he made some radical lifestyle changes to help improve the situation. Myers reinforces that sometimes challenges can be a blessing in disguise and is encouraged by the fact that doctors are seeking help at an earlier stage in life.

In Ontario, the number of physicians seeking help is increasing, according to **Dr. Michael Kaufmann**, medical director of the Ontario Medical Association (OMA) Physician Health Program, although this may be secondary to promotional efforts in certain geographic areas. There were about 150 calls in 2001, a number that was surpassed in 2002. The "program designed by physicians, for physicians" provides intervention coordination, referral for assessment and treatment, recovery monitoring and advocacy.

Doctors are worried by lack of resources, and "the pressure on doctors' time is seen to be adding to the stress, leaving less time to look at health maintenance activities," says Kaufmann. About one-third of calls to the Ontario program are addiction related, and the remainder are psychiatric. He notes that, recently, there has been an increase in calls about gambling. Although he sees a continuing stigma when it comes to seeking help, he also sees a greater willingness by interest groups to discuss physician health.

Dr. André Lapierre has been director of the Quebec Physician Support Program for 12 years. He has also seen a steady rise in the number of calls, to about 200 annually. Since the early 1990s, about 75% of the calls have been about mental health (depression, burnout, stress and anxiety). He notes a lowering of the mean age of callers, from about 45 in 1990 to about 40 now, as well as more calls from women, general practitioners and residents.

The good news is there is increasing recognition of the importance of physician health, says Kingston, Ont., physician **Dr. Raju Hajela**, past-president of the Canadian Society of Addiction Medicine and current chair of the OMA Physician Health Program Advisory Committee. "We're starting to recognize that [as doctors] we need to look after ourselves. In the past, we were expected to be invincible, and there is still that expectation to produce, produce, produce — to be available to everybody."

Hajela helps physicians vent their frustrations over a sick system, workforce issues, funding concerns and having to "operate according to evidence-based decision making when the powers that be function according to decision-based evidence making." He says there has been no change over the years in the prevalence of addiction; doctors face an 8%–9% risk of having a drug or alcohol-related problem in their lifetime. Marital discord is also a major problem among physicians, mainly because doctors have a need to control and high expectations of themselves and their families, says Hajela. "The standing joke is that every physician needs a good wife, even the female physicians, to look after the home front."

However, the traditional role of the doctor has changed over the years, with younger doctors not working as many hours, more likely to look after themselves and desiring a more balanced life. Although it raises staffing issues, it is a healthy trend, he says. He also sees more support for doctors to come forward, both on a personal and organizational level, and a slight lessening of stigma. Hajela says efforts must now focus on breaking down silos between different specialties, improving communication, further decreasing stigma and boosting education and resources in the area of physician support.

"Healthy doctors are more productive and less likely to be disabled…It can be a win–win situation."

Gillian Wansbrough,
Medical writer, Toronto

"*Engrossed late and soon in professional cares … you may so lay waste that you may find, too late, with hearts given way, that there is no place in your habit-stricken souls for those gentler influences which make life worth living.*" — Dr. William Osler, 1899

"*If we don't look after the health care of our providers, they can't look after the health care of [us].*" — Commissioner Roy Romanow, Royal Commission on the Future of Health Care in Canada, August, 2002

The fact that it is important for practising physicians to effectively manage the professional and personal stressors associated with being a doctor has been emphasized only recently. The need for physicians to maintain their own health and well-being and thereby maximize their ability to provide quality health care to patients is now considered extremely important. Although many sources of stress are inherent to any demanding profession, the current medical practice environment is creating new demands on physicians that place their health and well-being, and that of their families, at increased risk. It has also been recognized that specific challenges face female physicians and medical students and residents. With recognition of these problems and challenges has come an understanding that physicians need to monitor their own health and strive to adopt healthy lifestyles.

Being a physician can be harmful to your health

The very traits that make good physicians make bad patients, delegates attending the 2002 AMA/CMA International Conference on Physician Health in Vancouver heard time and again.

Many physicians have compulsive personality traits, says Dr. David Dodd, director emeritus of the Tennessee Physician Health Program. These include a restricted ability to express warm and tender emotions; perfectionism; insistence that others submit to one's way of doing things; excessive devotion to work and productivity, to the exclusion of pleasure and interpersonal relationships; and indecisiveness and chronic self-doubt. Dodd says 80% of physicians have 3 of these 5 traits; 20% have 4 of 5. Excessively high standards result in feelings of shame and guilt for not being good enough, even for being ill.

"These traits keep us conscientious and are reinforced by education," says Dr. Patti Tighe, head of the Physician Health Committee at Northwestern Memorial Hospital in Chicago. "But when we're sick, these traits threaten us. We're uncooperative patients."

Add the risk factors that go along with medical practice — sleep deprivation, excessive work and patient demands, potential litigation, witnessing trauma and human suffering, and job dissatisfaction — and the conclusion is clear, according to William Swiggart, a counsellor at the Vanderbilt University Medical Center in Nashville. "Being a physician is harmful to your health."

Organizers of physician health and wellness programs must consider the reality that physicians make lousy patients and that physicians are not health-maintenance oriented, says Tighe. "Our identity is as healers and fixers, not as preventers of symptoms."

Physicians dread being patients because they feel helpless and vulnerable, she adds. "They do want to be taken care of, but feel guilty at accepting care and shame for needing it." Accordingly, physicians tend to be overcontrolling and noncompliant patients, and as a result, they often get poor quality, on-the-

Today's physician health programs, which include early identification, intervention, evaluation, treatment and long-term monitoring, have impressive success rates. About 90% of all physicians return to practice.

fly care from colleagues. A survey of 795 physicians (response rate 34%) in the province of Barcelona, Spain, found that 33% had provided abnormal care to their colleagues, 39% reported that their colleagues were very difficult to care for, 34% feared not acting correctly and 86% didn't charge for the consultation.

Physicians live longer than other professionals[1] — on average, 73 years compared with 70.9 years — but that doesn't mean they're immune to illness. "The popular myth is that physicians don't get sick and when they do, it's a rare disease," says Dr. Olaf Aasland, director of the Norwegian Medical Association Research Institute. A survey of Norwegian physicians found that 80% reported being ill in the previous year, and the most common illnesses were influenza (36.8%) and respiratory tract problems (24.6%). But the leading causes of illness requiring more than 2 weeks' sick leave were burnout and depressive disorders.

"It's difficult for physicians to take the role of patient when necessary," says Aasland, since they are generally reluctant to access health resources. The Spain survey also found that 49% of respondents had no family physician and only 52% had a clinical history with a family physician. Of those who did seek help, only 48% of respondents said they followed their FP's instructions. Meanwhile, 82% said they self-prescribed and 6% had self-treated stress with medication. Their record in preventive medicine was also poor: 47% reported having no periodic health test and 41.5% didn't have up-to-date vaccines (11% of physicians' children were in the same state).

"Doctors are trained to be on one side of the bed or desk," said study coauthor Dr. Antoni Arteman of the Barcelona Medical Association. "They refuse to act like patients … they refuse to follow medical procedures or recommendations that they don't agree with."

This is why physicians need special programs; unfortunately, there has been a traditional stigma around seeking help. One reason may be because early physician intervention programs often focused on alcohol and drug abuse, and resulted in probation or loss of licence. John Ulwelling of the US Foundation for Medical Excellence cited an example of the enormous stigma and stress associated with probation: of the 40 Oregon physicians on probation in 1976–77 when there were virtually no treatment programs, 8 committed suicide and 2 others attempted to kill themselves. The attitude among professional medical associations was that impaired physicians should have "their licences ripped off the wall." In short, Ulwelling said, "we had a mess."

Slowly, things started to change. Treatment programs opened, and physicians gained expertise in treating their colleagues. Today's physician health programs, which include early identification, intervention, evaluation, treatment and long-term monitoring, have impressive success rates. About 90% of all physicians return to practice, says Ulwelling. These programs usually meet the needs of physicians who are physically or mentally ill, including those who violate sexual boundaries, who misprescribe classified drugs, who are disruptive or who suffer from mood disorders (unipolar depression and bipolar illness most commonly go unreported).

The new challenge, said Ulwelling, is to prevent problems in the first place through promotion of physician well-being. We need to reach a "larger number of physicians who have been greatly discombobulated by the enormous changes in health care in the past 15 years."

Physicians today are at a particularly high risk of overwork, burnout and more serious impairment. Restructuring, financial constraints, a growing and aging population and the acceleration of information technology all mean that "increased demands are falling on the backs of [physicians] for increased productivity, documentation, vigilance to prevent error and mastery of expanding areas of knowledge and technology. The load we are carrying increasingly exceeds our carrying capacity," says Ulwelling.

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Barbara Sibbald,
Medical journalist, CMA

Burnout — "an erosion of the soul"

Burnout caused by professional stress and demanding workloads may be affecting nearly half of all physicians, a recent study indicates.

"Burnout's natural home is in the caring profession," says Robert Boudreau, a Faculty of Management professor at the University of Lethbridge and author of a 2002 study of Alberta physicians. Preliminary results from the survey of 1161 physicians (response rate 17.6%) indicate that 48.6% are in the advanced stages of burnout as measured by the Modified Maslach Burnout Inventory. By comparison, 31% of Alberta nurses and 32% of US physicians (sample size of 216 physicians) are in this advanced stage of stress.

Boudreau defines burnout as a situation where the demands at the workplace tax or exceed individual resources — the way of life for many physicians whose medical practices are increasingly complex and demanding. Nearly two-thirds of Canada's physicians (64%) have a workload they consider too heavy and more than half (58%) say their family and personal life has suffered because they chose medicine as a profession, according to CMA's 2001 Physician Resource Questionnaire.[1] In addition,

- 57% said patients' expectations are unreasonably high,
- 29% said they are on call too often,
- 33% said a lack of locums affects their ability to take vacations,
- 64% said it is difficult to get appropriate resources on behalf of patients and
- 46% said the opportunities to change specialty or career path are limited.

Despite evidence pointing to high levels of professional stress, physicians have no advantage over the general population, where less than one-quarter of people know how to cope with stress.

"Excess stress can lead to illness," says Dr. Patti Tighe, head of the Physician Health Committee at Northwestern Memorial Hospital in Chicago. And because stress is exacerbated by genetic predisposition, personality traits, mood (especially depression) and early life experiences such as conditional love, management of stress is individual.

"No one thing will work for everyone," says Boudreau. However, the strategy many physicians adopt is avoidance — they leave their jobs, cut back on hours or change employment.

Physician burnout is characterized by emotional exhaustion, cynicism, perceived clinical ineffectiveness and a sense of depersonalization in relationships with coworkers, patients or both. Burnout has been linked to impaired job performance, irritability and marital difficulties. It has also been associated with poor health — including headaches, sleep disturbances, fatigue, hypertension, anxiety, depression and myocardial infarction — and may contribute to alcoholism and drug addiction.[2] More poignantly, burnout has been described as "an erosion of the soul"[3] that results from the dislocation between what people are doing and what they are expected to do.

Preventing burnout by promoting physician well-being is the impetus behind two new US initiatives. The Joint Commission on Accreditation of Healthcare Organizations now calls for a "process" to address physician well-being that is separate from disciplinary processes. Another initiative comes from the Accreditation Council of Graduate Medical Education (ACGME), which is restricting the number of hours residents can work to a maximum of 80 per week.

But restricting the hours of work may actually increase stress "if the expectations are the same but there are fewer hours," argues Dr. Eric Endean, chief of surgery at the University of Kentucky in Lexington. In a pilot study involving university teaching programs in Kentucky, Georgia and Michigan, surgical residents identified their top stressor as ineffective use of time (average 3.56 on a scale of 1 to 5); their top priorities were family (27%) and career (19%). These findings, says Endean, are consistent with burnout. "Decreasing work hours is not the solution. Fatigue may not be the most important cause of stress."

What is needed, he says, is education about how

to cope with stress. Although Endean cites a US study of 540 residents in which more than 300 reported high stress, he acknowledges that medical training currently offers little to help residents cope. Accordingly, an "unhealthy response" such as depression, drug dependency, divorce, rage, self-destructive behaviour or burnout may result. Preliminary results from a pilot study in which residents take seminars on time management, stress management and goal setting indicate that such education is effective.

Female physicians who are balancing the demands of work, child care and domestic management are also vulnerable to burnout. According to the US Physician Worklife Study, female physicians are 60% more likely than their male colleagues to report burnout.[4] The likelihood of burnout increased 12%–15% for each additional 5 hours worked above 40 hours per week.

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Barbara Sibbald,
Medical journalist, CMA

Personal strategies for preventing burnout

Influence happiness through personal values and choices

Self-awareness

Spend time with family and friends

Spend time on religious or spiritual activities

Take care of yourself (nutrition, exercise, sleep)

Adopt a healthy philosophical outlook

Find a supportive spouse or partner

Attend stress workshops, crisis counselling or coaching

Work strategies for preventing burnout

Control your environment and workload

- Shared call
- Flextime or job redesign
- Build your team

Find meaning in work and set limits

Find a mentor

Have adequate administrative support systems

Advice on preventing burnout from Dr. Anderson Spickard Jr., Vanderbilt University Medical Center in Nashville, and Robert Boudreau, University of Lethbridge Faculty of Management

The health of women physicians

As more women enter the practice of medicine in Canada, there is an ever-increasing interest in how this unique group compares with other women, women in other professions and male physicians. There is also a growing need to address professional and health-related issues that are unique to this group. For example, the stresses associated with balancing the responsibilities of spouse, mother and physician may adversely affect female physicians' mental health. It is important to monitor trends among female physicians and increase awareness of health-related issues so that wellness strategies and disease prevention programs can be established for this growing group of health care providers.

What the studies reveal

The Women Physicians' Health Study[1-3] is a cross-sectional questionnaire-based survey of women physicians, aged 30 to 70 years, selected from the American Medical Association's Physician Masterfile. Women made up 19.4% of practising physicians in the United States in 1994, 24% in 2000, and it is projected that, by the year 2010, women will comprise 29.4% of the physician workforce.[4] In 2002, 29.8% of physicians in Canada were women.[5] By 2021, it is believed that women will make up approximately 43.5% of the physician workforce in Canada.[6]

Women in the Women Physicians' Health Study reported healthy personal habits that exceeded national health-behaviour goals.[2] The fact that health-conscious behaviours were correlated with self-reported prevention-related counselling and screening practices led the researchers to argue that "if we value disease prevention, and if physicians' personal health practices are consistent predictors of their likelihood to be more active preventionists, we ought to try to cultivate healthy physicians."[3]

Some studies indicate that female physicians may also be more health conscious than their male counterparts. Results of the 2001 OMA Physician Health Program's Physician Resource Network Baseline Survey,[7] which drew its data from responses of physicians in 2 regions of Ontario, showed that female physicians were slightly more likely than male physicians (57% v. 41%) to have seen their family physician within the previous year and to have engaged in exercise or a physical activity at least once weekly (88% v. 77%).[7]

Roles as mother and spouse

Spouses and children are an integral part of the lives of many female physicians, despite the stresses associated with balancing family and career responsibilities. According to Statistics Canada, in 1992, women who were employed full time and whose youngest child was under the age of 6 spent an average of 5.4 hours per day on child care and domestic work.[8] The same census data indicated that women in the workforce lost 6 days of paid work per year due to family and personal responsibilities, whereas men lost 1 day per year. Most surveys of women in medicine confirm that the division of labour is similar to the norms for Canada.

In her book *Fruitful*,[9] Anne Roiphe explores the contradictions that "middle- and upper-class mothers who have education and professions" live. She states that after 30 years of "feminist consciousness," we know that paid work outside of home is essential for a woman's self-esteem, income and marriage. At the same time, however, most women still measure their worth, to some extent, on their ability to care for their families. Women, more than men, look to family for affirmation. However, it is a challenge to care for vulnerable family members, raise children and succeed professionally within the contexts of the "traditional" family unit. Women who work outside of the home often feel that they must "pay for" the privilege of having both a successful career and a supportive family. Many worry that their hard work and varied commitments, which often take them away from their families, may harm the children they innately want to protect. Roiphe describes some of the conflicting emotions of a working mother:

"*I want to warn her of this and that. I try. She pays no attention to me. I want to follow her around, remind her to eat well, to sleep enough. I try. She smiles at me. I know that I should pay attention to my own waiting work. ... I am a mother feminist. I ask myself if that is a contradiction…*"[9] p. 232

The pressures many women feel to be the "perfect mother" and the "best doctor" indicate a need to continue to modify our expectations. This is not to say that male physicians do not struggle with dual roles as well, but there are particular pressures for many women that cannot be ignored.

Mental health of women physicians

An alarming study with respect to women physicians' mental health, conducted by North and Ryall, reported that more than half of women physicians may experience a psychiatric illness during their lifetime.[10] Depression rates were high, and suicide rates were alarmingly high. Similarly, in a systematic review of original articles of population-based studies, Lindeman et al[11] report the relative risk for suicide mortality in female physicians to be 2.5–5.7 and in male physicians to be 1.1–3.4, as compared to the general population. These data highlight the need to address physicians' stress and mental health issues more effectively.

Ann Davidson, who recently studied the health of women physicians in Ontario, notes that women in medicine feel "the additional stress of working within a vocation that has tended to uphold professional achievement and scientific mastery over personal, family, and relationship needs,"[12] and she underlines the importance mentors can play as a source of support. The loneliness and isolation that many women physicians experience in the pursuit of their careers can have a significant impact on their mental health, and mentors can help them to cope.

A plan for prevention

A study similar to the US Women Physicians' Health Study might well be considered in Canada. With more information about the health problems faced by women in medicine, specific wellness and disease prevention programs could be developed, both locally and nationally. The Ontario Medical Association now has an electronic mentorship program for medical women ("Physicians leading physicians — women leading women"). Other mentorship programs, particularly on the Internet, might be developed in other provinces to help women deal with some of the challenges they face.

The Canadian Medical Association currently provides physician support through a joint AMA/CMA International Physician Health Conference, and several of the provincial divisions are conducting their own wellness initiatives as well. For a list of the resources currently available to physicians in Canada see page 27.

The importance of awareness to the prevention of health-related problems cannot be overstated. The stigma of mental illness is felt keenly, even among physicians, but we must begin among ourselves the difficult task of speaking about the unique stresses we face in our lives as physicians. We must do this as we exercise, read, knit, write, reflect and laugh. We must look for time for each other and time for ourselves. We must continue to practice what we preach.

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Dr. Gail Beck,
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A resident's perspective on well-being

We've all heard the stories, the ones that begin with "back when I was a resident" or "you think you have it bad?" Inevitably, these lines are followed by descriptions of 1-in-1 call for months on end, taking call while hooked up to an intravenous pole or completing residency without ever going on vacation. With these descriptions of the 'normal' level of commitment required to become a good doctor, it is easy to understand why many residents believe they have to give up all other activities while in residency training. Many established physicians also report that although this intensive training may have been the cause of their depression, inability to relax or failed marriage, such training was in fact required to make them good doctors.

If this type of training is necessary to become a doctor, we should ask Health Canada to place signs on the doors to medical school: "*Warning: medicine can be hazardous to your health.*"

Despite increasing awareness of the effects an unbalanced lifestyle can have, stress-related morbidity among residents and other physicians remains high. Studies continue to report the complications of stress, such as burnout, depression and other psychiatric morbidities, at much higher levels in physicians than in the general public and other professionals.[1] Alarmingly, even higher rates of depression are reported among residents.[2–5] In addition, all physicians, by virtue of their profession, are at a much greater risk for suicide.[6]

But many physicians continue to turn a blind eye to the facts. Some still believe that their colleagues do not get sick — that mental illness is someone's fault or a weakness of character. Their perceptions keep doctors in denial of the fact that current practice and training standards are not healthy. It is time to break the code of silence and admit that physicians do get sick. Only then can we begin to remove the stigma and make our profession well.

Cause for concern: resident-specific issues

Residents may perceive that they have minimal control over their lives and livelihoods during residency training. Long work hours at the hospital coupled with educational commitments after hours result in reduced personal time. This may result in poor self-care, strained relationships, feelings of inadequacy and other sequelae.

Why are so many residents unwell? What is so stressful about residency? Although it may seem trite to point out that residency is particularly stressful, it is important to remind ourselves why this is the case.

- **The supervisor–trainee relationship** is fraught with stressful points including continuous evaluations and issues of intimidation and harassment.
- **Financial burdens:** It is not uncommon for residents to begin their training owing more than $100 000.
- **Information explosion:** knowledge is doubling every 5 years, so what we as residents are learning at the beginning of our training may no longer be true when we complete the program.
- **Physician shortages:** Because almost every community needs more doctors, new graduates are walking into overfilled, highly demanding, stressful practices.
- **Patient acuity:** As the practice of medicine changes and more care is provided outside of the hospital, patient acuity in the hospitals where residents train increases.
- **Career choices:** To get into their program of choice, medical students are being forced to choose the right electives so they will be competitive in their chosen area. However, if they realize they have not made the right choice of specialty, it is now harder than ever to change career paths.

Although many trainees before us have gone through residency and survived, there is a cost associated with the endurance required to make it through. It is time to change the system from a "survival of the fittest" philosophy to an environment that nurtures intelligent people and produces competent, well-balanced physicians. Residency should be some of the best years of your life. It

Dr. Laura Musselman

should also be the beginning of a fulfilling career — a career that challenges but also allows for interests outside of the profession.

Unfortunately, the very design of residency programs ensures that by the end of training a percentage of graduates will be stressed, burned out, depressed or abusing substances. In addition to the stressors associated with the 25- to 40-year-old demographic, residents must contend with 2 additional sets of stressors.[7] The first relates to the inherent characteristics, which on one hand make them excellent medical school candidates, but on the other put them at an increased risk for the sequelae of poor stress management. These include chronic self-doubt, ability to delay gratification indefinitely and need for perfection and control. The second set of stressors is systemic in nature; these training-related stressors can be classified into 3 main categories:

Biological: Long work and study hours lead to sleep deprivation, poor eating habits and a low level of fitness.

Situational: Stressors include isolation (from family, friends and colleagues), limited time for relaxation and entertainment, patient care issues (e.g., inadequate support from allied health professionals, difficult patients, complex presentations) and financial issues.

Professional: Including poor trainee–supervisor relationships, occupational hazards (e.g., blood borne infections, violent patients), balancing the role of service provider, educator and learner (dealing with excessive work loads coupled with nonoptimal learning conditions) and career planning issues.

Of course, once residents finish residency, more challenges await them. It is important that residents, as they become established doctors, work to maintain the healthy balance between work and home life that they struggled to cultivate during their training.

The shift toward increased balance

The good news is that medical culture is slowly beginning to change, and a strong voice in the push for change is coming from new doctors. With each new cohort of residents, interest in finding a healthy balance between work and personal time increases. It is encouraging that many of today's residents believe you can be a good doctor and be a dedicated pianist or potter. In fact, you might even be a better doctor and person because of it.

Residents have been leaders in the field of physician health and advocates for change. Students and residents were the first to publish position papers on well-being and to put the issue at the forefront of their organizations' mandates. Resident associations have made it a priority to inform residents and their families about wellness issues and have developed programs aimed at promoting balanced lifestyles and overall physician health.

Contracts are one way of changing the current culture. Provincial housestaff organizations across the country have successfully negotiated changes to collective agreements. Contractual provisions limiting maximum hours of work and workload have been critical in ensuring some balance in residency training. However, contracts can only provide the legal framework for potential protection. It is essential that the hospitals that negotiate these contracts mandate that the terms be enforced from the top down.

The examples of healthy lifestyles that residents have set are beginning to make established physicians reflect on their current situations. They have begun to acknowledge that how they trained and how they practice may not be the best. Medical organizations, including the Canadian Medical Association, have recently made it a priority to further educate physicians about these issues and to promote prevention and treatment options.[8]

To help residents and their families stay healthy, many resources have been made available to residents through their provincial housestaff organizations. These include, but are not limited to:

- support lines including a 24-hour helpline

- family doctor referral lists
- social events to meet other residents, decrease isolation and increase morale among coworkers
- resource materials for partners and residents (books, videos, support group access)
- selected expert speakers in the area of physician health
- financial planning seminars
- extended disability insurance coverage

Although these services are helpful, we also need systemic structural and cultural changes in the practice of medicine, for both residents and established physicians. Without a shift in the current paradigm, even the best intentions will fail. A more appropriate structure must be developed that will allow people to live balanced lives. Recommendations from other organizations include: group practice, job sharing, more flexible payment mechanisms, shared call, 'stop-clock' or slowed promotion tracks and mentoring networks. For more practical tips, see Peterkin[8] and information provided on provincial housestaff organizations' Web sites (find links through www.cair.ca).

Healthy doctors — the profession's future

"*…some level of impairment to residents is a common and predictable sequelae to the time they spend at traditionally 'catastrophic levels of stress'…*"[10]

It is time to ensure that observations like this are no longer valid. We must make wellness issues a priority and begin to incorporate healthy styles of learning into the curriculum so that the current unhealthy socialization process in medicine is stopped. Residents will continue to be involved on the front lines to ensure that the practice of medicine becomes a healthier endeavour, not only for patients, but also for physicians.

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A number of effective strategies and programs exist to promote physician health and to help physicians in need of assistance. Research is ongoing to help define the stressors facing physicians and their families in today's environment and to identify the most effective treatment strategies. Across Canada, assistance programs have been established that offer a variety of preventive and treatment services to physicians and their families. These programs deal with a variety of psychological and family issues, as well as problems related to addictions, stress and burnout.

Canadian physician health programs: an overview

In the last few decades, throughout North America, the physician health initiative has been evolving. One element of that initiative has been the development of physician support programs, often known by the name Physician Health Program, amongst others. In the US, these programs began as committees made up of volunteer doctors who had sometimes experienced personal problems themselves, usually drug or alcohol addiction, and who wanted to help their colleagues. Many of those volunteer-based committees have grown into robust and comprehensive services for doctors. The same thing is happening in Canada.

Today, doctors call their provincial support programs for a variety of reasons beyond drug and alcohol problems. These include stress and burnout, psychological disorders, family and relationship problems, medico-legal problems and much more.

Confidential Canadian physician support programs exist in every province, in some form, to serve the more than 1500 callers nationwide in need of help each year. These programs are similar in many ways, and at the same time, as diverse and innovative as the people and organizations that have created them. Three basic models can be identified to describe Canadian programs:

- Volunteer committees providing peer support (Saskatchewan, New Brunswick, PEI)
- Professionally staffed, comprehensive programs offering a range of services to doctors, trainees and their families based on available community resources (BC, Manitoba, Ontario, Quebec, Nova Scotia, Newfoundland and Labrador)
- Professionally staffed, comprehensive program based upon an employee assistance program model that utilizes a professional counselling service along with other resources (Alberta and Yukon)

Where physician support committees still exist, such as the Saskatchewan Physician At Risk Committee of the Saskatchewan Medical Association, volunteer members help colleagues suffering from drug, alcohol or other personal problems by reaching out to them in a personal way. They will meet with a doctor in their own home or office, often sharing their own experience and strength in a manner that only someone who has “been there” can understand.

The Physicians at Risk Program of the Manitoba Medical Association continues to make use of peer volunteers and also employs a physician coordinator on a part-time basis. One of the particular strengths of the Manitoba program is its support group, available to spouses of doctors in recovery from drug and alcohol problems.

The Physician Support Program (PSP) of British Columbia is an example of a program that is jointly funded by the regulatory body (College of Physicians and Surgeons of British Columbia) and the

medical association (British Columbia Medical Association). However, it operates confidentially, at arm's length from both, under the guidance of its Clinical Coordinator and a governing committee. The PSP is also staffed by 2 triage physicians and an assistant clinical coordinator who is devoted to the difficult task of providing follow-up for the many doctors who call the program for help. The PSP originally responded primarily to doctors suffering from drug and alcohol problems, but, like most other Canadian programs, now responds to the variety of personal and emotional problems experienced by doctors and their families. The PSP is also sensitive to the needs of physicians in training, both medical students and residents.

The Ontario Medical Association's Physician Health Program (PHP) is the largest of its kind in Canada, employing a medical director, program manager, 2 case managers and other administrative support staff, all on a full-time basis. A particular strength of the PHP is the case management model used to provide monitoring and advocacy for doctors in recovery from drug and alcohol problems, as well as a new program to provide the same service to those with psychiatric disorders. The PHP is also creating resource networks around the province guided by regional physician coordinators who recruit expert clinicians that are available to support doctors, trainees and their families who may be experiencing a wide range of personal health problems.

The Programme D'Aide aux Médecins du Québec (Quebec Physician Health Program [PHP]) is unique in the country in that it is supported by multiple medical professional organizations. The program has a full-time medical director based in Montréal and other part-time professional staff located in 2 other major regions of the province. The Quebec PHP responds 7 days per week to all of the personal, behavioural, drug and alcohol problems and mental health problems that doctors and their immediate family members present with. In Quebec, there is also a special emphasis on being available to serve physicians in training (residents).

Professional support programs in Nova Scotia and Newfoundland and Labrador have distinguished themselves by providing support services to other health professions, such as dentists and veterinarians. These programs also have dedicated professional staff and respond to all of the problems medical and other health professionals face, from burnout to depression to substance use disorders.

The Physician and Family Support Program (PFSP) of the Alberta Medical Association, which also serves the Yukon, is unique in Canada in that it employs an employee assistance program model. A service provider, under contract to the PFSP, answers a toll-free number 24 hours a day, 7 days a week. Callers are then assessed by trained physicians and referred to appropriate resources. These can include psychiatrists, family doctors as well as medico-legal and arbitration services. Most callers access a limited number of counselling sessions offered by the program's service provider without direct charge to the client. This service, primarily focused on stress and family-related problems, has been very popular and is often used by Alberta doctors and their families.

Most provincial support programs are very capable of the "traditional" services, such as intervention, assessment and referral for doctors suffering from drug and alcohol problems and other conditions that impair judgement and the ability to practise medicine with skill and safety to patients. But today, Canadian physician health programs are evolving beyond these necessary response capabilities to provide programming focused on health promotion and illness prevention. Almost every provincial program offers lectures, workshops and seminars on these topics for medical students, residents and community physicians of all kinds. Some programs also plan and sponsor physician and family wellness days, which are innovative and increasingly popular.

The full range of services offered by Canadian physician health programs is growing quickly, limited only by the imagination of those who work for them. Physician health policies for hospitals and clinics, financial counselling and assistance for doctors in need, career and life coaching, support for doctors infected with blood-borne pathogens and research into matters of physician health and well-being are but a few of the initiatives already under way across Canada.

Canadian physician support programs are robust, vigorous supporters of the nation's doctors and their families and are playing an ever-increasing and important role in the country's physician health initiative.

Dr. Michael Kaufmann,
Director, OMA Physician Health Program

Tolerance for disruptive behaviour waning

"If you can't get it right, then just get out!"

Dr. Joseph Molea

The shout reverberates in the operating room, almost but not quite drowning out the clatter of instruments and an overturned tray crashing to the floor. Stories abound of physicians throwing tantrums and unleashing diatribes of profanity at colleagues, nurses and even patients, but outbursts by so-called "disruptive physicians" are being recognized as potential markers of serious personality disorders.

Participants at the 2002 International Conference on Physician Health in Vancouver heard several descriptions of what constitutes disruptive behaviour, and were warned not to dismiss uncharacteristic outbursts as mere reactions to extreme situations.

"The causes of physician impairment, though obscure, must be identified and not just written off to stress," states Dr. Joseph Molea, executive director of the Tampa-based HealthCare Connection addiction treatment centre. "For this reason, a caution must be raised regarding the seemingly compassionate step of 'collegial intervention' as a first step in addressing such behaviour."

Identifying and confronting a colleague for disruptive behaviour can be a daunting challenge since the individual is often a high achiever who is friendly and outgoing. "The ability of some [disruptive physicians] to produce is often prodigious and makes them the sacred cows within an organization," states Molea. "Such physicians can be quite charming and engaging when they choose to be. They are single-minded in their approach to a perceived problem and are often successful at achieving set goals." Such contradictory characteristics, he adds, "make it difficult for physician managers to confront the issue when complaints do arise."

However, disruptive behaviour must be addressed because the potential harm to patient safety is so great. Molea believes a hospital's best defence is a clear set of bylaws that provides a framework for self-governance and enables the medical staff to discharge its responsibilities. Bylaws should include policies on appropriate behaviour and conduct, plus strategies to follow if the conduct guidelines are contravened — and a confidential record of incidents attributed to problem individuals should be kept.

Policies should define negative and unethical behaviours, but also include a list of positive behaviours that can be emulated.

The philosophies of administrative and medical staff leaders "are central determinants in creating a culture that can either contain and minimize the systemic effects of disruptive behaviours or invite and exacerbate them," Dr. Glenn Siegel of Illinois-based Professionals At Risk Treatment Services, told the conference.

Experts agree that the broad scope of "disruptive behaviour" in physicians can make problems

more difficult to identify and deal with. Molea says more than 80% of physicians who demonstrate new-onset disruptive behaviour are also struggling with some kind of chemical dependency. While others downplay the substance-abuse connection, they agree that tantrums, threatening behaviour and other outbursts should be taken seriously and addressed officially.

What constitutes "disruptive" behaviour?

Disruptive behaviour can be communicated not only through explicit words or actions, but also through tone, innuendo and body language. The perpetrator may actively disguise communication to avoid consequences. Here are some examples:

- Swearing or foul language
- Use of racial, religious, gender epithets
- Jokes or witticisms that make fun of self or other people
- Sexual talk
- Insults and verbal put-downs
- Staring or glaring
- Stalking
- Unnecessary physical contact
- Menacing gestures
- Demeaning tone
- Yelling
- Throwing objects

"Disruptive behaviour may be a symptom of another problem," according to the American Medical Association's Physicians' Guide to Medical Staff Organizational Bylaws. "A medical staff wellness committee or other nondisciplinary mechanism should be instituted to assist members exhibiting disruptive behaviour."

It would be difficult to track every tirade or tantrum by a physician, and not all of this behaviour is a marker for some deep-seated problem. There is even some anecdotal evidence that medical system stressors are contributing to increased disruptive behaviour. The AMA guide warns of the need to match "corrective action" to the severity of the disruptive behaviour and even cautions against categorizing "frank and communicative criticism of an institution" as being disruptive.

"Doing the necessary early and complete evaluation for mental health issues with someone who has exhibited problem behaviour means you're ruling out the worst first," explains Molea. "There's no doubt that physicians have a lot of reasons to be stressed these days, and if it ends up that a work environment is the source of problems, we will often say 'You know, maybe you shouldn't go back to work there'."

Steve Wharry,
Medical journalist, CMA

Back to school for health

The University of Ottawa didn't get serious about physician health until something serious happened — the attempted suicide of a highly respected clinician, teacher and researcher. Within a few years, the university became the first in Canada to launch a physician wellness program for its medical school faculty.

Founding director Dr. Mamta Gautam, an Ottawa psychiatrist who specializes in physician health and wellness, says the university began by documenting the need. A 1999 survey of 5 medical departments found that University of Ottawa physicians were working about 59 hours a week. Of respondents, 48% reported low job satisfaction (compared with 58% for the general population), about 50% said they thought about leaving academic medicine every week and 30% thought of leaving medicine altogether. Looking back at the 3 months preceding the survey, 25% indicated they were under high stress, 20% had poor emotional health, 12% thought of suicide and 7% (about 10 physicians) had planned a suicide attempt. "This was an astounding number," said Gautam. "It left the faculty realizing something needed to be done and wondering what to do."

Her proposal for a faculty wellness program was accepted, and it was running within a year. Its mandate is to promote maximum wellness by addressing issues of education, prevention, research, resources and intervention for stress and burnout, anxiety, conflict, bereavement, relationships, finances and time management. It also provides support during litigation or complaint processes.

Gautam devised an innovative Connector Program to reach faculty at all 5 teaching hospitals. Each hospital's contact person has a referral list of specialists, including psychiatrists, social workers, family law lawyers and financial consultants, who are available on an urgent basis. "The issue often is simply knowing where to go to find people with physician expertise," says Gautam. But expediency is essential.

The service is confidential and anonymous. A physician whose ability is impaired is reported only for noncompliance with treatment, and "we've never had that happen," says Gautam. Most physicians who are told they need to get well and can't practise are relieved that responsibility has been taken from them. The program employs the "neighbourhood watch" concept of looking out for colleagues. This can be difficult because if your "neighbour" goes off on sick leave, you'll have more work to do.

Other preventive strategies focus on diversions. The program, now run by Dr. Derek Puddester, distributes a guide to onsite exercise facilities, has helped establish exercise groups for walkers, runners and bikers, and set up book, movie and music appreciation clubs. In spring 2003, the program will hold its first Humanities in Medicine Day to explore and celebrate the nonscience aspects of medicine. Another goal of the program is to promote camaraderie. "We're generating a spirit of collegiality rather than competition," says Gautam.

Gautam also introduced Physician Appreciation Day, which was officially proclaimed by the city of Ottawa as Oct. 16. "Although we have a lot of privileges in medicine, we also appreciate knowing that our work is valued," says Gautam.

Tips for starting a successful university-based wellness program

- Document the need
- Get buy-in from the dean (or it won't happen)
- Obtain senate approval and a place on the organization chart
- Get a budget, terms of reference and a mandate
- Ask the dean to invite prospective committee members
- Recruit committee members from all specialties, and include junior faculty
- Recruit a respected committee leader (not a psychiatrist) to destigmatize illness

Source: Dr. Mamta Gautam, University of Ottawa

Barbara Sibbald,
Medical journalist, CMA

Leadership

In 1998, the Canadian Medical Association published its policy on physician health and well-being as an acknowledgement of the need to address this issue in a substantive fashion. That document stresses the need for physicians to manage professional and personal stress to maintain their own health. The policy contains a number of recommendations to various accrediting bodies, educational institutions and medical organizations so there would be a continued emphasis on health and well-being issues. It is clear that each of these types of organizations has a role to play in promoting and maintaining physician health and well-being and in helping physicians in need.

In 2002, CMA President Dr. Dana Hanson emphasized that physician well-being would be an important priority during his term.

Do you practise in an unhealthy workplace?

Given the amount of time we spend at our jobs, the workplace is undoubtedly a key determinant of health. Too-heavy workloads coupled with too little job control, or too much effort coupled with too little reward, may result in illness and injury.

According to Occupational Health and Safety Canada, an unhealthy workplace can triple the chance of cardiovascular problems, double the chance of substance abuse and lead to more injuries, infections, back pain and mental health problems.[1]

Alarmingly, health professionals are the least likely of all workers to describe their work environment as healthy. Furthermore, their job satisfaction is below the national average. According to a Canadian Policy Research Networks discussion paper, this negative work experience undermines the provision of patient care.[2] Drawing from myriad studies, the researchers conclude that "the conditions that contribute to motivated, committed, knowledgeable and well-resourced employees are also those that guarantee optimum organization performance."

Unfortunately, physicians don't often strive to improve the work environment because they view themselves as nontraditional employees. They may be paid differently or have affiliations with several institutions and usually don't think of themselves as being part of the organization — even if they are putting in 60 hours a week.

Robin Robertson, manager of the Alberta Medical Association's Physician and Family Support Program, feels that physicians need to buy into the organization first, and then become motivated to help make the workplace healthier.

What will motivate physicians to buy in? "It's not about contractual relationships," says Robertson, "it's about culture, rewards and people." A Canadian Policy Research Networks survey of 2500 employees found that "good" jobs were based on mutual trust, good communication and employee commitment and influence.[3] In turn, a strong employment relationship is associated with high job satisfaction, opportunity for skill development, lower turnover, lower absenteeism, higher morale and higher productivity.

Ensuring the long-term health of an organization begins with gathering concrete information. Ways to measure the health of a workplace include productivity, abesenteeism, retention and turnover, injury rates and employee satisfaction surveys. Other indicators are assistance program access, stress and burnout levels, as measured by paid and unpaid leave, and the ability to recruit.

Robertson encourages physicians to get involved at the most fundamental level, which is defining an organization's strategy — what it does and does not do — since this affects resource allocation (including

staffing), structure and process. Then, when inevitable organizational changes come, at least physicians will understand why.

It's also important to develop a positive workplace, says Robertson, to encourage team spirit. Among health care workers, emotions determine 50%–70% of the workplace climate, which in turn determines 30%–60% of organization performance.[4] Incentives, or influences, may be as simple as a free parking spot or a physician lounge. "People need to think the organization sees them as important," says Robertson.

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Barbara Sibbald,
Medical journalist, CMA

Cost of a noneffective, unhealthy workplace

A ballpark, subjective measure — probably an underestimate — but a good place to start. Subsequent measures can be made through surveys, burnout rates, absenteeism, etc.

1. What percentage of employees do you think are experiencing work stress in your organization at one time?
   10% (lowest possible) _____ 90% (highest possible)

2. Multiply that % by the number of employees in your organization
   _____% × (number of employees) = (a)

3. Estimate of average annual salary = $(b)

4. Multiply (a) × $(b) = $(c)

5. Estimate the reduction in productivity (i.e., 37.5%) = (d)
   (d) × $(c) = $(e)

This $(e) is an estimate of costs of reduced productivity resulting from personal problems, ineffective and unhealthy workplaces. In most cases, you could save 5–15 cents on every dollar — money that could be used for patient care or employee programs.

Courtesy of Robin Robertson,
Program manager, AMA Physician and Family Support Program

Physician health programs compulsory in US hospitals

Hospitals in the United States are scrambling to establish physician health programs to meet new standards for national accreditation.

In January 2001, the Joint Committee for the Accreditation of Health Organizations (JCAHO) set out new standards that require hospitals to establish a "process to identify and manage matters of individual physician health that is separate from the medical staff disciplinary function." Accreditation depends on them. At this time, the Canadian Council on Health Services Accreditation has no similar requirement.

Dr. Patti Tighe, head of the physician health committee at Chicago's Northwestern Memorial Hospital and author of the standards, says they are a "huge step for physician wellness." They're about "putting yourself first, staying healthy and paying prompt attention to illness. If you do that, no one gets impaired."

By using the word "process," JACHO acknowledges the challenge of setting up a full functioning committee in smaller hospitals. In Maryland, all 68 hospitals have some physician health activities, but they range from limited programs that are mostly referral services to five full-range programs that receive reports, investigate, evaluate, refer, monitor and educate. However, "if you have one good, competent physician who cares, that may be enough," says Robert White, manager of the University of Maryland Medical Center Employee Assistance Program.

The accreditation standards also require health organizations to educate medical staff to recognize illness and impairment in colleagues; to make provision for both referral and self-referral; to ensure confidentiality; to evaluate the credibility of complaints, allegations or concerns; to monitor the affected physician; and to report to medical staff any situation where a physician is providing unsafe treatment.

Overlap between hospital and state-run physician health programs is seen as a good thing. Provincial or state-wide programs benefit physicians outside of institutional settings; all but 3 US states have programs, as do all Canadian jurisdictions except the Northwest Territories (see page 27). And hospital-based programs provide another layer of advocacy and support.

"Hospitals are our eyes and ears," says Mike Llufrio, head of the Maryland State Medical Society's physician program. "Hospitals are big dysfunctional families that can wreak havoc in the lives of doctors. We must educate institutions and individuals to intervene sooner."

As the licensing or governing bodies, state medical associations have to be impairment focused, but "hospitals have the opportunity to focus elsewhere," adds Tighe. Hospitals can refer to a state medical association if there is a need for an unbiased third party, if noncompliance is an issue or if the doctor needs to be reported to the medical board.

Many US hospitals are choosing to implement physician health programs through established employee assistance programs. EAPs offer a range of expert services, such as financial advice, marital counselling and referral, in addition to evaluation, monitoring and record keeping.

Advice on establishing a hospital physician health program

- **Have a dedicated committee of 8–20 people.** Exclude members of peer review and credential committees, persons in authority such as chiefs of staff and those involved in the disciplinary function. Include department representatives, recovering physicians (at least 2 years post-recovery) and EAP advisory members, and rotate the membership. Invite experts, such as lawyers, as needed.

- **Establish a formal structure.** To be a strong advocate and to enhance effectiveness and acceptance, your committee needs a place in the institution's bylaws and a budget. Plan for a

part-time committee chair and administrative support. The committee chair should not do assessment and referrals because many physicians find it difficult to believe that a colleague can care for them; use a psychiatrist on a part-time basis instead.

- **Establish relationships with treatment providers.** These include local outpatient and inpatient providers, larger programs such as Ontario's Homewood Health Centre and the Betty Ford Center, and 12-step groups, including Caduceus (AA for professionals).

- **Report cases when necessary.** The possibility of reporting can be used as leverage to encourage someone in denial to take the right step. Not reporting is tantamount to enabling.

- **Support intervention.** Under the EAP model, a supervisor refers the case for expert evaluation, and the physician is referred for treatment and is monitored throughout rehabilitation or disciplinary action to ensure the safety of both the physician and patients. Report lack of cooperation.

- **Know the legal issues in your state or province.** They may include mandatory reporting, confidentiality and immunity from civil suit.

- **Maintain confidentiality and records.** Committee minutes must not include names. EAP files, which are protected by federal regulations, include the clinical details and are necessary to document recovery and compliance. Only policy meeting minutes (not committee meeting minutes) and an annual statistical report are circulated to medical staff.

- **Be visible.** Promote the program through house staff and resident orientation, medical staff meetings, the hospital intranet and newsletter, inservice training, nursing unit meetings or a series of grand rounds led by a respected staff member. Promote the program name and contact numbers on fridge magnets, coffee cups and the like. Include the name of the program and committee members on all written material.

- **Undertake special projects.** Consider retreats or education programs on personal development topics such as coping with medical malpractice, aging, recognizing stressers, coping skills and care of self. Offer informal discussion groups so physicians can share ideas, feelings and values. Fitness facilities, primary care projects, free flu shot clinics and nutritional labelling on cafeteria food all send the right messages.

- **Build on the work of others.** For a sample, visit the Vanderbilt Physician Wellness Web site (www.vanderbilt.edu/HRS/wellness/eappw.htm)

Barbara Sibbald,
Medical journalist, CMA

When the College calls

You get a call from the College of Physicians and Surgeons of Canada, and you're understandably apprehensive. What does it mean? Should you be worried?

Officials from 3 Colleges — Dr. Don Chadsey, deputy registrar in Alberta; Dr. Cameron Little, registrar in Nova Scotia; and Dr. Dody Bienenstock, registrar in Ontario — offer some insight into what happens when the College calls.

Is the College out to "get doctors"?

Contrary to the image the Colleges may have, "our purpose in life is absolutely not to make physicians' lives miserable," says Chadsey. "We view complaints as opportunities for change and improvement where there's been a deficiency." The medical act of each province outlines the roles of the Colleges, including establishing and maintaining standards of medical practice, as well as disciplinary procedures.

Who runs the College?

The Colleges are governed by boards or councils. Members include physicians who typically are elected by their peers on a regional basis, physicians who are appointed by the province's medical schools and non-physicians appointed by the provincial government.

Why would the College contact me?

"Maybe we're calling to tell you that you accidentally overpaid us this year and we want to send you a cheque," says Chadsey. But more worrisome is the call precipitated by a complaint. "People complain about everything," says Little. "They complain about having to wait, they complain about rudeness, that they didn't get good care, that their mother or father is not getting good care, that the doctor looked too busy, that the doctor didn't communicate, that he didn't follow up on tests."

Poor communication is at the root of many complaints — maybe as much as 80%, Chadsey estimates. A patient might complain because the doctor didn't listen to him; however, if a patient is given good information by the doctor in advance, he might not complain to the College even if he suffers an unwelcome side-effect to medication, such as impotence from an antihypertensive medication.

Although they attract the most attention, only a small percentage of complaints concern sexual misconduct. In Alberta, for example, of 700 complaints received each year, only about a dozen or so pertain to allegations of sexual misconduct.

What should I do if the College calls?

Cooperate fully, but don't worry; many complaints from the public are resolved over the telephone. In Ontario, telephone calls resolve about 42% of more than 4000 phone complaints received annually. College investigators may resolve issues by providing the complainant with policy information or by passing information from the physician to the patient. For example, a patient might complain that a physician is reluctant to hand over medical records, in which case the College reminds the doctor that patients have a right to access their record, says Little.

If verbal resolution is not possible, the patient usually is asked to put the complaint in writing. Many colleges, like Nova Scotia's, have a form to help complainants focus on the real issue.

The physician is typically sent a copy of a written complaint and given ample opportunity to respond.

Can the college target me just because I'm over 65 years of age?

In general, age is not a basis for a complaint. "The question is, 'Is the doctor competent?'" says Chadsey. Most surgeons, for instance, have stopped performing operations by the time they are 70, and many hospitals will not extend privileges to physicians of that age. However, "there are family physicians who are very alert and can [practise] well into their 70s," says Little.

Ontario has an innovative peer assessment program; once a physician reaches age 70, another physician reviews his or her practice every 5 years. Very few people who undergo such a peer assessment find fault with it, says Bienenstock. "Many

people say, 'Wow, I was really scared of it and it turned out to be most helpful'."

When should I seek advice from a lawyer?

It's a good idea to contact the Canadian Medical Protective Association (CMPA) — the profession's medical mutual defence organization — as soon as you learn that there's a complaint against you. In some cases, it's advisable to contact the CMPA even if there's only a threat of a complaint. "Some doctors think they should only call the CMPA if it's a serious complaint, but I think that's probably not wise," says Little. The CMPA advises physicians not to answer any letters of complaint from patients, lawyers or others until the CMPA has been consulted. As well as providing advice and legal assistance, the CMPA pays legal expenses of CMPA-approved lawyers and covers court awards, settlements and costs.

How can I check on the progress of a complaint against me?

Although the College keeps the physician informed of the progress of a complaint, the physician is welcome to contact the College as well. "It's a 2-way street. You can call and ask, 'How's it going?' and the investigator will keep you up to date if there are any changes or progress," says Bienenstock.

What kinds of penalties might I face?

The College may counsel or caution, issue a reprimand or require a physician to undergo re-education or treatment. If the investigations committee decides there's sufficient information and evidence to indicate that a physician is incompetent or has acted unprofessionally, the matter will be referred to a hearing committee. This committee holds quasi-judicial proceedings that include sworn testimony from witnesses. In many provinces, disciplinary hearings are open to the public. The hearing committee decides whether the College has proven the charges against the physician; if so, the College can impose penalties ranging from a reprimand to removal of the physician from practice. The College is not a court of law, however; it cannot find a physician guilty of negligence or order financial compensation to a patient.

Can the College discipline me because I have a mental illness or an addiction?

Not likely, but you will be encouraged to seek treatment. A complaint about a physician who is addicted to alcohol or drugs is not handled as a complaint. "It's handled as an illness and the physician is sent to assessment and treatment," says Chadsey. However, if you refuse treatment, the College might suspend your licence temporarily. Disciplinary action might be involved if addiction has resulted in poor patient care.

Do the Colleges have rehabilitation programs?

Each College is involved in or has access to a physician health program that anyone can call anonymously. The programs are funded by the profession. Most addicted physicians recognize their need for rehabilitation. "Just simply by talking to them, they would be prepared to say, 'You're right, I need to do something about this'," says Bienenstock.

What recourse do I have if I disagree with the College's decision?

A physician can request a review of the complaints committee's decision. The review might be undertaken by a senior member of the administrative team, such as the registrar. Decisions of hearing committees can be appealed to the province's appeal court.

Am I guaranteed confidentiality when there's a complaint against me?

The Colleges take confidentiality very seriously. "Unless the complaint is referred to discipline and allegations have been made public, this is by law absolutely confidential," says Bienenstock. Nova Scotia's Little agrees: "We don't comment on any complaint."

Can I "fire" a patient who threatens to complain about me?

Yes, but indicate your intentions in writing, and give the patient a reasonable amount of time to find another doctor. Nova Scotia physicians are advised to tell patients why they're being "discharged," to offer to help them find another doctor and to give them time to move to another practitioner. Ontario physicians are advised to communicate to patients that the relationship is not going to work and to give them a reasonable amount of time to find a new physician. In Alberta, physicians are responsible until the patient gets settled with someone else.

Pauline Anderson,
Medical writer, Toronto

The Canadian Physician Health Network

The Canadian Physician Health Network (CPHN) was created as an informal alliance in 2001. The CPHN has representation from each of the provincial and territorial support programs, the CMA and its divisions, the Canadian Association of Internes and Residents and the Canadian Federation of Medical Students. The aim of the network is to provide an environment for mutual support, the sharing and promotion of ideas and innovation in the area of physician health and well-being.

The network held its first annual meeting in Saint John, NB, in August 2002 in conjunction with the annual CMA general council meeting. The chair of the CPHN is Dr. Gisele Microys, a GP-psychotherapist and consulting physician of the Physician and Family Support Program of the Alberta Medical Association.

What follows is a practical guide and directory of the provincial and territorial physician health programs that form the basis for the physician health network. Information about each program is up-to-date as of the end of 2002. Physicians and their families in the Yukon are served by the Alberta support program and those in the Northwest Territories can take advantage of the Saskatchewan program.

Prince Edward Island
Physician Support Program

Phone number: 1 888 368-7303 (toll-free within 902 area code)

Hours: 8 am to 5 pm

Email address: mlowther@medicalsocietypei.com

Web site: www.mspei.pe.ca

Who can participate:
- Physicians
- Medical students and residents

Types of problems dealt with: Not defined

Services provided:
- Intervention
- Referral for management

Types of preventive/educational activities:
- Regular continuing medical education on stress and burnout

Process of contact: Through Marilyn Lowther, executive director of MSPEI

Language of service: English

Cost: None

Supporting organization: Medical Society of PEI

Director: Marilyn Lowther

Confidentiality policy: All work is confidential and available to committee members only.

Newfoundland and Labrador
Professionals' Assistance Program

Phone number: 1 800 563-9133

Hours: Variable — confidential message left at any time

Email address: rmlahey@roadrunner.nf.net

Web site: None

Who can participate:
- Physicians
- Medical students and residents
- Families of physicians, medical students and relatives

Types of problems dealt with:
- Stress
- Relationship issues
- Substance abuse
- Career issues
- Financial issues

Services provided:
- Assessment
- Referrals
- Counselling
- Interventions
- Wellness initiatives

Type of preventive/educational activities:
- Seminars on wellness and well-being issues
- Meetings with program directors, house staff (e.g., on resident stress)

Process of contact: Direct call to clinical coordinator by client or concerned colleague. No formal program for emergencies.

Language of service: English

Cost: No cost to access or follow-up with clinical coordinator (registered social worker), but no funds to assist with private counselling.

Supporting organizations: Newfoundland and Labrador Medical Assoc., Newfoundland Dental Assoc., Newfoundland Pharmaceutical Assoc.; Law Society of Newfoundland

Directors:
- Professionals' Assistance Committee comprised of 3 physicians, 2 dentists, 2 pharmacists and 2 lawyers
- Physicians: Dr. Susan King (Chair), Dr. Sylvia Clarke, 1 vacancy

Confidentiality policy: All contact with clinical coordinator is confidential (with standard exceptions). Does not report to licensing authority.

New Brunswick
Physician Health Program

Phone numbers:
- Chair of Physician Health Committee 506 635-8410
- New Brunswick Medical Society office 506 458-8860

Hours: 24-hour answering machine

Email address: nbms@nbnet.nb.ca

Web site: www.nbms.nb.ca

Who can participate: Physicians and family members

Problems addressed:
- Substance use disorders
- Mental health issues

Services provided:
- Interventions and advice on interventions
- Referrals for treatment
- Post-treatment follow-up and monitoring
- Loans to physicians in treatment

Types of preventive/educational activities:
- Workshops for committee members
- Local CME programs for members by request through the Community Hospital Program

Process of contact: Through chair of the Physician Health Committee or regional contacts

Language of service: English and French contacts available

Cost: No direct cost to user; cost of program covered through NB Medical Society membership dues

Supporting organization: New Brunswick Medical Society

Name of director: Dr. Ed Lund, chair of Physician Health Committee

Confidentiality policy: The committee acts as a confidential advocate for as long as it is satisfied that a physician is not a risk to the public.

Nova Scotia
Professional Support Program

Phone number: 902 468-8215

Hours: 24-hour helpline

Email address: robert.fredrickson@doctorsns.com or jan.goodwin@doctorsns.com

Web site: Under development

Who can participate:
- Physicians
- Dentists and veterinarians
- Residents
- Families of physicians, dentists, veterinarians and residents

Types of problems dealt with:
- Relationship issues
- Career issues
- Burnout
- Depression
- Legal issues
- Financial issues
- Substance use disorders

Types of services provided:
- Case management
- Interventions
- Advocacy
- Limited financial assistance for initial therapeutic interventions

Types of preventive/educational activities:
- Seminars and refresher courses
- Educational programs around the province
- CME credited and sponsored programs

Process of contact: 24-hour helpline; response in 12–24 hours (usually immediately); appointment within 48 hours (usually before) but depends on situation and client's schedule.

Language of service: English

Cost: None. Financial aid available to seek legal advice or financial advice or counselling that may not be covered by private or public plans.

Supporting organizations: Medical Society of Nova Scotia, Nova Scotia Dental Association, Nova Scotia Veterinary Association, Professional Association of Residents In the Maritime Provinces (PARI-MP)

Directors: Robert E. Fredrickson, MD, and Janice R. Goodwin, MD, coordinators

Confidentiality policy: Charts are totally confidential

Quebec

Quebec Physicians Health Program

Phone numbers: 514 397-0888 or 1 800 387-4166

Hours: 9:00 am to 4:45 pm. After working hours and on weekends, an on-call physician is still available. During the night, physicians can leave a message.

Email address: info@qphp.org

Web site: www.qphp.org

Who can participate: Physicians, residents, students, family members

Types of problems dealt with:

- Mental health problems (e.g., burnout, adjustment disorder, anxiety, bereavement)
- Substance abuse, addiction and behavioural problems (e.g., alcohol, drugs, gambling)
- Stress
- Personal, marital or family problems
- Sexuality in the patient–physician relationship
- Sexual or mental harassment and violence
- Financial difficulties or legal problems

Process of contact: The first evaluation is done over the phone or at the time of first encounter, and the formal assessment by an expert is scheduled within 1–15 days.

Language of service: French and English

Cost: No cost for services delivered by the QPHP physicians. Other medical resources are paid by the Quebec Health System. All other necessary resources are paid by the participant physician.

Supporting organizations: Federation of General Practicioners, Federation of Specialists, Federation of Residents, Association des médecins de langue française du Canada, Collège des médecins du Québec, la Fondation médecins du Québec

Director: Dr. André Lapierre

Confidentiality policy: Confidentiality and discretion are the two mainstays of the program's survival and the guarantee of its integrity. These two commitments must be taken into account when setting up a personal file, transmitting information to a third party and storing data for use in studies and research. No information shall be transmitted to a third party without the express authorization of the physician, resident or student concerned.

Ontario
Physician Health Program

Phone number:
- In-province: 1 800 851-6606
- Throughout Canada: 1 800 268-7215 x2972

Hours: 8 am to 5 pm, Monday through Friday

Email address: michael_kaufmann@oma.org; sarah_hutchison@oma.org

Web site: www.phpoma.org

Who can participate:
- Physicians and family members
- Students, interns and residents
- Veterinarians

Types of problems dealt with:
- Substance use disorders
- Psychiatric problems
- Stress
- Emotional
- Marital
- Behavioural problems
- Family problems

Types of services provided:
- Telephone advice and support for physicians, veterinarians, their families and concerned colleagues
- Preliminary assessment
- Intervention coordination
- Referral for counselling and clinical services
- Recovery monitoring
- Case management and advocacy

Types of preventive/educational activities:
- Community outreach through presentations and CME education (includes medical students, residents, academic physicians and hospitals)
- Bimonthly articles in the Ontario Medical Review on physician health and wellness
- Physician "Wellness" days

Process of contact: Physician Health Program (PHP) staff will respond by telephone, email or in person, depending on the situation and the request of the individual. The PHP does not at this time provide after hours service, but appointments are available outside office hours.

Language of service: English

Cost to participant: Laboratory fees

Supporting organization: Ontario Medical Association

Director: Dr. Michael Kaufmann

Associate director: Sarah Hutchison

Confidentiality policy: This is a confidential service. Information and advice will be provided to any caller regardless of whether or not he or she provides identifying information. The PHP will maintain participant information as confidential with the following exceptions:
- Information supporting a direct intervention involving the medical director must be documented in writing by those willing to provide it and must not be anonymous.
- Participants contractually monitored with substance abuse disorders or psychiatric disorders who are noncompliant with the process may be reported to the regulatory body under certain, specified circumstances.
- Reports to the appropriate agencies required by Ontario law concerning child abuse and neglect, impaired driving and sexual abuse of patients.
- An obligation to notify law enforcement authorities when it is believed that a caller intends to do serious harm to another person or persons.

Manitoba
Physician at Risk Program

Phone number: 204 237-8320

Hours: Hotline checked daily

Email address: None

Web site: None

Who can participate:
- Physicians
- Medical students and residents
- Families of physicians, medical students and residents

Problems addressed:
- Psychiatric
- Substance abuse
- Stress
- Codependency issues

Services provided:
- Intervention and advice
- Coordinating treatment
- Follow-up for physicians and their significant others
- Emergencies are not dealt with

Types of preventive/educational activities:
- Articles in Manitoba Medical Association newsletter occasionally

Process of contact:
- Hotline
- Referral from College of Physicians and Surgeons of Manitoba
- Direct contact with coordinator

Language of service: English

Cost: None

Supporting organization: Manitoba Medical Association

Director: Dr. Derek Fewer, program chair

Confidentiality policy: No records kept. Only aggregate reporting to Manitoba Medical Association Board.

Saskatchewan
Physicians at Risk Committee

Phone numbers:
- SMA office at 1 800 667-3781 (in-province only)
- 306 244-2196
- SPARC committee members:
  - Dr. R. Kozakavich, Saskatoon, 652-3624
  - Dr. V. Gooding, Saskatoon, 653-0002
  - Dr. P. Good, Regina, 522-6649
  - Dr. V. Bennett, Saskatoon, 966-8230
  - Dr. P. Butt, Saskatoon, 665-2898
  - Dr. K. Dautremont, Moose Jaw, 692-0200
  - Dr. T. Smith-Windsor, Prince Albert, 953-1664
  - Dr. Larry Howie, Saskatoon, 477-1000
  - Dr. L. Bettin, PAIRS, Saskatoon
  - Ms. Y. Asai, SMS, Saskatoon
  - Ms. J. Kostiuk, SPARC Coordinator, Saskatoon, 244-2196 or 1 800 667-3781

Hours:
- 8 am to 5 pm at the Saskatchewan Medical Association office
- Contact committee members at any time

Email address: sma@sma.sk.ca

Web site: www.sma.sk.ca

Who can participate:
- SMA members and families
- Medical students and residents

Problems addressed:
- Substance abuse and addictions
- Stress disorders
- Depressive/bipolar disorders

Services provided:
- Assessments
- Referrals
- Interventions and case management
- Family support

Types of preventive/educational activities:
- Undergraduate lectures
- SPARC presence at CMA events

Process of contact:
- Referral from College of Physicians and Surgeons of Saskatchewan
- Phone calls to SMA office
- Phone calls to SPARC members

In emergencies or for initial assessment, two SPARC members interview the physician involved within about 24 hours to set up an interview within 72 hours. If there is a question of physician, family or patient safety, the physician is removed from the workplace and immediate referral is arranged. If the physician is resistant, the College of Physicians and Surgeons is notified.

Language of service: English

Cost: None

Supporting organization: Saskatchewan Medical Association

Director: Dr. Ron Kozakavich, chair of SPARC

Confidentiality policy: SPARC contacts and deliberations are confidential unless a physician is deemed to be both unsafe and noncompliant by at least 2 SPARC members, at which time the College of Physicians and Surgeons is notified. Only SPARC members who have had direct contact with an individual and SMA secretarial support are aware of specific identities.

Alberta
Physician and Family Support Program

Phone number: Toll-free 1 877 767-4637 anytime, from anywhere in North America, or 403 850-1809

Hours: 24 hours a day

Email address: robin.robertson@albertadoctors.org

Web site: www.albertadoctors.org (Benefits and Services)

Who can participate:
- Eligible Alberta physicians, residents and medical students
- Immediate family members (spouse/partner and dependant children)

Types of problems dealt with:
- Family and relationship problems
- Work-related and career concerns
- Stress, anxiety, depression
- Personal health concerns
- Addictions (e.g., alcohol, drugs, gambling)
- Child- and elder-care issues
- Sexual harassment or abuse
- Financial concerns
- Grief and loss
- Personal support for change (e.g., retirement)
- Trauma and critical incidents
- Concerns about a colleague (e.g., impairment, disruptive behaviour)
- Medico-legal peer support

Services provided:
- Assessment and referral to counselling resources; general practitioners; conflict resolution, mediators, arbitrators; financial advisors; substance abuse treatment; psychiatrists; practice management advisors; medico-legal peer support network
- Interventions
- Prevention and education services

Types of preventive/educational activities:
- Workshops: Insights Discovery (1 day); Emotional Intelligence (1 day); TLC for the Doctor's Soul (1 day)
- Seminars: Physicians Treating Physicians (half day); Healthy Business Partnerships (half day); Thriving/Surviving Significant Change (1 day)
- Retreats/Weekends: Reclaiming Equilibrium (Fri. evening to Sun. afternoon); Family Retreat (Weekend); Enriching Your Couple Relationship (Fri. evening to Sun. afternoon); plus custom presentations and sessions by request from physician-related groups.

Process of contact: Your call will be answered by a staff member at Kelly, Luttmer & Associates Ltd. You will be asked for your name, a contact phone number and a convenient time for an assessment physician to call you back within 1 hour. When the assessment physician calls, you will discuss your concerns and decide on the best referral(s) for you and/or your family. PFSP's assessment physicians are familiar with the special circumstances surrounding physician health and lifestyle issues.

Language of service: English

Cost: PFSP covers up to 6 sessions for the physician and up to 6 sessions for the family in a 12-month period at no direct cost.

Supporting organization: Alberta Medical Association

Directors: Robin Robertson, manager and prevention and education director, and Dr. Gisele Microys, consulting physician

Confidentiality policy: Information is not shared with anyone outside the program without the informed, voluntary and written consent of client. There are 2 exceptions when we must report to others, whether or not consent is given: when there is suspicion of current child abuse and if there is threat of serious injury to self or others. Utmost care is taken to ensure anonymity as clients come and go from appointments.

British Columbia
Physician Support Program of British Columbia

Phone number: 1 800 663-6729 (in-province only)
Direct line: 604 742-0747
Fax: 604 742-0744

Hours: Hotline is monitored from 9 am to 5 pm, Monday to Friday (excluding statutory holidays)

Email address: psp@radiant.net

Web site: www.physiciansupportprogram.ca

Who can participate:
- Physicians and physicians in training
- Family members

Types of problems dealt with:
- Psychiatric
- Behavioural
- Substance abuse
- Personal or marital
- Physical
- Financial
- Medico-legal

Types of services provided:
- Triage and initial assessment, as well as initial telephone counselling
- Facilitate access to appropriate resources
- Perform interventions or facilitate interventions
- Facilitate access to outpatient counselling, residential treatment programs or support groups
- Administrative assistance with applications for out-of-province services, when required
- Maintain ongoing telephone contact/support of callers, where indicated
- Act as a resource for chiefs of staff, department heads and medical directors

Types of preventive/educational activities:
- Publication and distribution of information pamphlets and brochures
- Regular educational presentations to physicians, physicians in training, their families and physician administrators
- Web site
- Annual education conference

Process of contact: Initial contact by calling the Physician Support Program confidential hotline. Administrative coordinator arranges for duty PSP physician to return the call (ideally, the same working day). For out-of-hours' emergency situations, we rely on the emergency medical services of the province (e.g., family physicians, emergency rooms, ambulance services).

Language of service: English

Cost: No up-front cost for services that are provided directly by PSP staff. Frequently, costs for services that the caller is referred to are covered by the provincial health care plan. A caller may become responsible for the costs of some services that are not insured directly by the provincial plan (e.g., psychologist consultations). The caller may or may not have additional private insurance that will cover these uninsured fees.

Supporting organizations: The British Columbia Medical Association and the College of Physicians and Surgeons of British Columbia contribute equal amounts to cofund the Program.

Director: Dr. Paul A. Farnan, clinical coordinator

Confidentiality policy: We respect the confidentiality and privacy of those persons who contact our program and have no automatic reporting arrangement with any licensing body. There are some exceptional legal and ethical circumstances where reporting is mandated; these exceptions can be discussed between the caller and the clinical coordinator.

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