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**PHYSICIAN WELLNESS:  
PRIORITIES and PRACTICES FOR ACTION**

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Newfoundland and Labrador Medical Association  
Position Paper

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### I. INTRODUCTION

In 2013, the Newfoundland and Labrador Medical Association (NLMA) committed to moving forward with an enhanced physician health program that provides health promotion, prevention, and intervention services related to the physical and mental health of physicians.

As part of its work in developing a comprehensive and effective physician care program, the NLMA undertook a physician survey and a literature review to identify key principles that will help the membership understand the purpose and value of the NLMA's initiatives. The NLMA's use of an evidence-based approach to support program development adds value and ensures respect for excellence in medical practice.

In this position paper, the NLMA recognizes the importance of promoting and maintaining physician health. The paper presents current research findings, documents the effect physician illness and lack of appropriate care has on patient well-being and career reputation, and outlines recommendations for action based on best practices.

### II. OPPORTUNITY FOR ACTION

In March 2013, approximately 500 NLMA members responded to a survey on physician health. That survey complemented earlier research the Association had conducted through a series of member focus groups. The survey and research findings identified the need for improved services to help physicians with work-life balance, in particular issues around resiliency, stress and burnout.

Members informed the NLMA that they need help with time management, relationships and family. The need for help with workplace issues was also identified, specifically help with disruptive behavior, conflict and inter-professional relationships. Mental health and illness were priority areas for most who responded, as was access to primary care, health promotion and disease prevention. More than 80% of members who participated in the survey indicated that accessing confidential counselling supports delivered by qualified providers was of great importance.

In response, the Association created the re-branded NLMA Physician Care Network, which serves as the umbrella for new physician health and wellness programs. The first program launched under the Network was the *inConfidence Member and Family Assistance Program*, which provides physicians with access to work/life consultants complimented by a rich repository of online resources. It was followed up with the launch of the *MDLink* program, which connects physician-patients with physician-providers in their own community or a neighboring one. It is based on models that have been developed elsewhere in Canada and modified for local use, such as the "Code 99" program in Ontario. The annual *Safe Harbour* program was also established to give physicians an opportunity to attend a weekend wellness retreat to learn about techniques and practices that will lead to a fulfilling career and balanced life.

The NLMA's efforts are supported by recommendations arising from research and put forward by the Royal College of Physicians and Surgeons of Canada (RCPSC) and the Canadian Medical Association (CMA): that 95% of all Canadians should have a family physician by 2012 and that every practicing physician also have a primary care provider (PCP)(RCPSC & CMA, 2009).

Access to primary health care often results in better health outcomes; as a result, the stakes are understandably high when it comes to physician health and its effect on patient wellbeing (Sanders, 2013). Since physicians, like their patients, are susceptible to the same illnesses (Gendel et al, 2012), it makes sense for the CMA to recommend every practicing physician have a family physician (CMA, 1998). Despite this recommendation, NLMA research also found that physicians often find it more difficult to access independent primary care compared to the general population (Kay et al, 2008). The reasons for this vary among physicians. Some do not like to see themselves as patients (Richards, 2005); some are not good patients because they are doctors (Fromme et al, 2004). Other reasons are systemic in nature: as providers, many physicians have not been trained to treat other physicians, or they are not comfortable in that role. As patients, physicians have concerns about confidentiality, or they are unable to access care outside of their own working hours (Puddester, 2014a).

Like any other member of the community at large, physicians need appropriate primary care (Kay et al, 2004). Physicians often ignore this advice (Gendel et al, 2012), relying instead on self-diagnosis, and they self-treat, delay, or avoid personal medical care altogether (Bradley, 2009; Roman, 2011). The existing literature on physician health, wellness programs, and personal health reveals a variety of other concerns documented in both research reports and popular media.

### **III. PHYSICIAN HEALTH CHALLENGES**

In its 2012 NLMA Member Survey, the NLMA found that the majority of respondents provided positive self-assessments of their physical health and mental well-being, with most reporting good eating habits. Relative to these aspects of health and well-being, members provided somewhat lower ratings in relation to their physical activity levels. Many also engaged in preventative health practices, and most have had a medical check-up in the last 12 months. Despite this finding, there is a sizable minority who have not had a check-up within this timeframe and who also reported not having a family physician. This subset of members feel they either do not require the services of a family physician or have elected to manage their own health needs. The 2012 survey results also showed that physicians rank, in terms of priority, mental health issues (depression, burnout) first, followed closely by access to skilled and confidential health services, and work/life balance.

Following this study, the NLMA carried out additional research using key informant interviews and focus groups. The focus groups held in January 2013 showed NLMA members place a high importance on health promotion (nutrition, physical activity), mental health, and interventions that encourage physicians to take care of their own physical health. Members also felt strongly that a physician health program must be both designed and delivered by physicians in order to give the program credibility and trust. This work informed the development and implementation of the 2013 NLMA Physician Health Survey to seek further data. Some key results:

- 55% of members rate facilitated access to primary care providers as critically or very important
- 50% said they would access the program for support with mental health issues such as anxiety or depression
- 60% said they would access services to assist with resiliency, stress and burnout
- 40% said they would use the program to access primary care.

The Canadian experience is comparable to that of physicians in Newfoundland and Labrador. Overall, Canadian physicians are generally healthy compared to the general population. According to the Canadian Physician Health Survey (Frank & Segura, 2009), 90% of respondents said they were in good to excellent health and most said they lead healthy lifestyles. However, a significant concern arising from this study is the poor mental health status of physicians generally. Nearly half of the study's respondents reported issues with burnout and mental stress, along with a lack of self-care. Twenty-five percent of physicians reported reduced work activity due to long term health conditions and 5% reported experiencing poor physical or mental health that kept them from managing their workload more than half the time in the previous month. In fact, only 11% would not work if they were ill.

Physician burnout is associated with poor outcomes for both doctor and patient, including higher risk for physician suicide, unprofessional conduct/behavior towards patients, higher risk for medical errors, and lower quality of care for patients. Wallace, Lemaire and Ghali (2009) and Puddester, cited in Stall et al (2014), also argue that physician wellness is also an indicator for health system performance, and that poor physician health affects the efficiency and productivity of the health sector by increasing the costs of the health system, especially when physicians leave practice through suicide, early retirement, or career change.

Sinha (2008) found chronic stress was a significant risk factor in the development of substance use and addiction. The respondents in the 2013 NLMA Physician Survey ranked mental health, physical health and addictions and related disorders as the top priority areas of a physician health program. These findings parallel similar concerns reported in Gooding and Senger's 2009 survey of Canadian physicians:

- 1 out of every 10 physicians will become dependent on alcohol or psychoactive drugs sufficient to impair the practice of medicine
- 1 out of every 100 physicians will become dependent on narcotics.

Gooding and Senger (2009) also found this risk is not limited only to practicing physicians, as students and residents report engaging in risky behaviors or experiencing adverse outcomes due to poor mental health:

- Approximately 40% of residents reported impaired performance secondary to anxiety or depression
- Medical residents are 5.5 times more likely to use sleeping pills, stimulants and other drugs
- Physicians under the age of 40 have three times the suicide risk of the general population
- Suicide is the second leading cause of death in medical students
- Approximately 50% of first time marriages for those under age 35 end in divorce
- Up to 40% of residents report problems with their relationships.

The literature also recognizes gender has a relevant influence on a physician's health and the risk for

self-harm through addiction or suicide. The Saskatchewan Medical Association reported that on average, male physicians work between 68 and 80 hours a week. While female physicians work about 90% of what their male colleagues do daily, female doctors also look after the majority of home and family responsibilities. For both male and female physicians, the cost is high:

*The suicide rate for physicians is twice that of the general population. The suicide rate of physician's wives is higher than the rate for wives of any other professional group. (...) Approximately 50 per cent of first time marriages for those under the age of 35 end in divorce. Physicians under the age of 45 consistently indicate that their most toxic stressor is the struggle with work/family imbalance and its effect on home life (SMA, nd).*

Miller and McGowan (2000) in their analysis of US data, concluded female physicians are especially vulnerable, saying: "Suicide rates for women physicians are approximately four times that of women in the general population. The rates for male and female physicians are roughly equal, whereas women in the general population are much less likely than men to complete suicide."

Kaufmann (2000) suggests a work culture focused on self-denial contributes to poor physician wellbeing:

*Medical training includes significant experience of self-denial. Physicians learn to go without sleep, meals, recreation and time with family and friends as a matter of routine while acquiring the vast amount of knowledge and skill required to practice medicine. Many will continue to deny their own personal needs while serving those of others in medical practice. This pattern of behavior may be deadly for a doctor prone to suicide.*

Kaufmann also concludes it is the fear of income loss and damage to reputation coupled with stigma that keeps physicians from seeking help in the early stages of burnout. Physicians often face pressure from both their colleagues and own communities to be healthy. Acknowledging the medical needs of a colleague may be considered taboo (Thompson et al, 2001). Given the foregoing, it is significant that Gooding and Senger (2009) found "physicians consistently indicate that the most toxic stressor is the struggle with work/family imbalance and its effect on home life." Frank and Segura (2009) reported almost one-third of respondents in their Canadian Physician Health Survey said their work environment presented a barrier to them maintaining good health. Physicians believe they are seen as more professional if they themselves lead healthy lifestyles, but less than half reported actually achieving that balance.

#### **IV. BARRIERS TO PHYSICIAN SELF-CARE**

Physicians understand the value of self-care, such as work-life balance and maintaining good health habits, but structural and/or social barriers may keep them from doing so (Chen et al, 2008). Key factors include

- identifying the required medical expertise
- acquiring an independent family physician
- having confidence in their provider's discretion, and

- overcoming resistance to seeking help.

The literature suggests that at the simplest level, the issue is that doctors do not know where to source information about their health concerns and problems in a way that meets their needs for discretion or ease of access (outside working hours, for example). Lack of training in how to treat physicians is another factor. Treating the physician-patient requires some delicacy with respect to role and expertise (Rogers, 1998; Kay et al, 2008; Fox et al, 2009).

The 2013 NLMA survey revealed 28% of NLMA members do not have a family physician. Those who do not have a family physician indicated that it was because they:

- haven't needed one (45%);
- manage their own health care (33%); or,
- don't have time to find a family physician (12%).

When asked the last time they had had a medical check-up, 40% of the physicians indicated it was longer than a year.

The NLMA survey findings are comparable to the findings of the 2008 Canadian Physician Health Survey (Frank & Segura, 2009). The survey found nearly 33% of Canadian physicians were not registered with a primary care provider (PCP), while 25 per cent of physicians with a PCP were registered with a close colleague and 7.5% with a family member or acquaintance. Other research suggests it is quite common for physicians to not have an independent PCP (Wachtel et al, 2005). Physicians often find it more difficult to access independent primary care compared to the general population, and are among the lowest users of formal health services (defined as office visits to a PCP).

A physician's willingness to seek help is often tangled with their concerns regarding provider confidentiality. For physicians who may be struggling with a substance use issue or a mental health problem, the security of their personal health data is a primary concern. This concern is not without foundation as there have been several recent incidents relating to breaches of patient information by unauthorized personnel in this province as well as in other parts of Canada. The tight-knit communities within the medical profession can make it difficult to assure confidentiality (Rosvold & Tyssen, 2005). Many physicians fear their PCPs will discuss their care with peers, that office staff might have access to personal health information, or that other details might be disclosed within their workplace (Davidson & Schattner, 2003; Kay et al, 2008; BMA, 2010).

For physicians, the loss of privacy may come with a far greater penalty, the loss of reputation and the confidence of their patients. Concerns with privacy breaches and the possible lack of confidentiality may cause physicians to delay treatment or to be selective in their medical history with their PCP. Physicians may also not disclose particular medical issues, as they fear disclosure will also risk their license to practice. In 2010, the Canadian Medical Protective Association (CMPA) reported several regulatory boards in Canada have made collecting certain kinds of health information part of the medical license renewal process. The rationale is public safety, but in its report, the CMPA said:

*Mandatory disclosure and punitive approaches to identifying physicians' personal health issues are not likely to promote patient safety. They may actually serve as an impetus for physicians to hide their condition if they feel that the repercussions of reporting will affect their long-term professional career and*

*personal livelihood. This result would hinder rather than support patient safety. A nonjudgmental system, which promotes self-reporting and encourages physicians to seek appropriate treatment, would be a more beneficial alternative (CMPA, 2010).*

In Newfoundland and Labrador, the barriers physicians face in seeking care include those discussed previously and also the following: isolation of practitioners in rural and remote areas, lack of confidentiality for trainees, difficulties in getting away from the office/clinic when coverage is limited, the geographic challenges of travel, transportation and climate, the issues of declining populations, shrinking communities and aging populations. International medical graduates (IMGs) may also fear losing their immigration status if they seek care and this results in dismissal from the program.

## V. RISKS AND CONSEQUENCES

The lack of a primary care physician offers risk on several levels encompassing harm to the physician and harm to the patient. The physician in need of care may rely on self-treatment, increasing the risk for missed diagnosis, substance use, and harm to the patient. Singly or together, these risks can affect the physician's ability to practice medicine and therefore earn an income.

### 5.1 Self-treatment

The Canadian Physician Health Survey (Frank & Segura, 2009) reported that almost half of physicians agreed that, if necessary, they would look after their own medical needs. One US study found self-diagnosis, self-referral and self-treatment was the most common response for the one-third of doctors who lacked access to primary care (Gross et al, 2000). A third study in 2011 found that more than half of physicians prescribed medication for themselves including antibiotics, pain killers, and sleep aids (Montgomery et al, 2011).

Frank and Segura (2009) in their research found physicians tended to self-diagnose and treat, delay, or avoid personal medical care altogether. As well, a survey of Ottawa-area physicians reported that rates for self-prescribing and prescribing to family members were 47 per cent and 58 per cent, respectively, suggesting that access to primary care is not just a physician issue but a family one too (Puddester & Donohue, 2004).

One risk with self-treatment is that the health issue remains undocumented; without a primary care provider, especially when the issue relates to substance abuse or poor mental health, there is no record of treatment and this means data about the context of the problem are limited. Physicians who rely on self-treatment run the risk of being in conflict with medical practice regulators, almost all of whom have policies stating members cannot self-treat.

### 5.2 Risk to self

In its review, the NLMA found that self-treatment by physicians is a potentially dangerous practice. The key issue is the lack of objectivity, which can affect how accurately the practitioner can evaluate the symptoms (Richards, 1999; Rosvold & Tyssen, 2005). Despite recommendations against self-treatment in both the professional and academic literature (Davidson & Schattner, 2003; Fromme et al, 2004), self-treatment is common among physicians (Gendel et al, 2012; Arnold 1997; Forsythe et

al, 1999; Kay et al, 2010). According to Fromme et al (2003), existing research suggests between 42% and 82% of physicians treat themselves in some manner. The literature recognizes self-prescribing among physicians poses a risk to their health, and by extension, the health of the public. However, self-prescribing should not solely be viewed as a cause of physician impairment, but a systemic issue arising from the barriers they face in accessing primary care (Chen et al, 2008; Rosvold & Tyssen, 2005).

### 5.3 Risk to patients

Physician well-being, or lack thereof, also has an effect on the patient with respect to the physician's ability to recommend changes in lifestyle such as the adoption of new behaviors re: health (recovery and maintenance) (Taub et al, 2006; Frank & Segura, 2009). International research findings suggest physicians who themselves have unhealthy weight or who smoke or drink to excess are less likely to address similar issues in their patients (Mote, 2012). Although a person's health matters in any work environment, when it comes to physicians, the importance of personal health is significantly higher given the intrinsic link to critical decisions regarding the health of others (Uncu et al, 2006). A physician's poor physical and mental health can potentially have a negative effect on patient outcomes and the overall quality of care they provide (Shanafelt et al, 2002; Taub et al, 2006).

The NLMA is deeply concerned that poor physician health can lead to the provision of poor or substandard patient care. Stress, chronic ill-health, and poor coping mechanisms may result in increased clinical errors (Miller & McGowen, 2000; Taub et al, 2006; Wallace et al, 2008). While physicians may fear seeking help will result in their losing their medical license, there is also the potential for loss of license arising from negative patient outcomes resulting from poor professional practice connected to physician ill-health (Stall et al, 2014).

## VI. PROMOTING PHYSICIAN WELLNESS

In their 2009 study, Wallace et al, described the work culture of medicine as one that supported neglect of self-care and indifference to personal wellness. The researchers argued that shifting the work culture to focus on physician well-being and self-care would lead to increased job satisfaction and decreased stress, emotional exhaustion, and burnout. Physician wellness programs that support those outcomes are now available across Canada to physicians, residents, medical students, and their families through the Canadian Medical Association and its provincial counterparts. One recent example is *Well Doc?*, a program delivered in Alberta (Lemaire, 2014) that is based on the research findings of Wallace et al (2009). There is also CanMEDS Professional, a comprehensive program that guides physician through the professional dimensions of their work including ethical practices, accountability to regulatory bodies, and maintaining physician wellness. In particular, the module on physician wellness addresses compassion fatigue, burnout and stress, and developing a plan for resiliency. The creation of the Canadian Physician Health Institute also supports these programs through three main strategies:

- supporting physician access to health care;
- improving awareness regarding the importance of physician wellness and well-being; and,
- challenging stigma associated with mental health issues.



The Internet offers the opportunity for ongoing professional and personal development for improving physician wellness through web-based learning (MacDonald et al, 2009). The shift to on-line learning allows the content to go to the learner rather than the clinician learner having to leave their practice. The on-line model allows maximum flexibility, adaptability, and speed while providing physicians with quick and anonymous access to resources, services, and support for personal health care issues such as depression, suicide, stress, anxiety, burnout, and substance abuse. For example, the Canadian Medical Protective Association's initiative "Sharing Experiences" allows "physicians to benefit from the insights and coping strategies of their colleagues, and to realize that they are not unique or alone when confronted with such problems."

### CONCLUSION

While ongoing education and promotion of physician wellness is important, implementing evidence-based practices is necessary to ensure personal and systemic changes in the long term. In Canada, best practices for promoting and supporting physician wellness focus on ensuring:

- Physicians have a primary care provider
- Regulators have policies against self-treatment
- Standards are in place for Undergraduate Medical Education (UGME) and Postgraduate Medical Education (PGME)
- Medical students can avail of student/resident health programs
- Physicians have access and use accredited Employee Assistance Programs (EAPs).

As demonstrated in the review of literature, physicians who have an independent PCP, and who are compliant with preventive health behaviors, demonstrate the benefits and value of improving physicians' access to primary care (Gross et al, 2000; McCall et al, 1999). As well, the literature suggests additional education for physicians on how best to treat other physician-patients and how to maintain personal well-being is also helpful (Domeyer-Klenske & Rosenbaum, 2012; Puddester et al, 2009).

Physicians and their associations need effective strategies to challenge the prevailing culture of self-reliance (Kay et al, 2008); Davidson & Schattner, 2003). These strategies, combined with implementation of best practices, can benefit from increased collaboration with regulators and medical schools, ongoing monitoring and reporting, and the development, implementation, and regular review of policies and procedures to guide association programs and to ensure success overall.

The data collected by the NLMA in its 2012 Members' Survey and 2013 Physician Health Survey provide a benchmark for the organization against which to measure the success of its interventions and promotion efforts. The NLMA, building on the feedback from its members, has already identified a number of approaches to improve and support physician wellness as outlined in the introduction and challenges sections of this discussion paper. These approaches also include a communication plan to guide the promotion of its wellness and intervention programs and a social marketing campaign to educate physicians on the importance of seeking a PCP.

Based on the findings of the NLMA surveys and the themes arising from the literature review, it would be important for the NLMA to focus also on the following areas to continue building on its efforts to support physician wellness:

- Collaborating with Memorial University's School of Medicine to develop and implement a wellness curriculum to focus on medical student and resident wellness
- Collaborating with Memorial University's School of Medicine to develop and implement a CME module on physicians treating other physicians
- Collaborating with the College of Physicians and Surgeons of Newfoundland and Labrador re: promoting and implementing an appropriate regulatory response to physician health concerns
- Collaborating with the College of Physicians and Surgeons of Newfoundland and Labrador and the Department of Health and Community Services to ensure the legal requirements are met for ensuring privacy and security of personal health information and medical records.

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