Report on Mental Health Activities: focus on physician health

Prepared for the AFMC Board of Directors
Dr. Sarita Verma, Vice-President, Education
June 2018
Table of Contents

Executive Summary...........................................................................................................2
Open session with the AFMC Board .............................................................................4
Small Group Round Table Discussion.........................................................................6
AFMC – AMS J. Wendell McLeod Plenary.................................................................11
AFMC Learner Forum.....................................................................................................13
AFMC Strategic Policy Forum....................................................................................15
AFMC Next Steps..........................................................................................................17
AFMC Press Release.....................................................................................................18
Appendix A....................................................................................................................20
Appendix B.....................................................................................................................26
Appendix C.....................................................................................................................39
Executive Summary

It is estimated about half of Canadian physicians and medical trainees are burned out, with rates ranging as high as 75%, depending on the study. Doctors also face higher rates of suicide than the general population, with one doctor completing suicide each day in the United States. Some have attributed the problem to increasing system pressures on the profession, while others have pointed to decreasing respect within the profession as a major stressor. Increasing regulatory scrutiny of doctors with mental health difficulties also discourages those in distress from seeking help. Medical students and residents identified the transition between training and practice as a particularly vulnerable time. An average of 37% of medical students are burned out at any time. By the beginning of clerkship, that rate rises to about 50% – the same level as practicing physicians. This does not change as students become residents and as residents graduate into practice. Finally, organizational wellness is under siege: declining resources, increasing workloads and systemic barriers are making it less palatable to work in the University, hospital and ambulatory settings.

The Association of Faculties of Medicine of Canada (AFMC) dedicated a Board meeting to hear from leaders and learners about physician burnout, with a particular focus on the strategies to build resiliency among medical students, residents and faculty in medical schools. The AFMC recognizes that physician burnout is an important issue that must be dealt with openly and proactively because it affects both patient safety and physician well-being. Poor physician health leads to poor physician functioning, which can negatively impact the quality of patient care. In addition, burnout affects physicians’ ability to lead changes at the practice and health care system levels. When physicians ‘burn out’ they leave practice, which makes solving the ongoing challenges of physician shortages in Canada even more difficult. This has a direct effect on accessibility, quality and safety of health care in Canada.

In this regard, the following activities occurred between April 28 2017 and May 1, 2018:

1. The Saturday AFMC Open Board meeting was devoted to the topic of Physician Burnout: Building A Culture of Wellness and Resiliency in Medicine;
2. The key note by Ms. Margaret Trudeau on her experience with bi-polar disease entitled “Changing My Mind” as the AMS AFMC J Wendell McLeod speaker at the opening ceremonies of the CCME;
3. The AFMC Board press release “CANADIAN MEDICAL SCHOOLS AFFIRM THEIR SOCIAL ACCOUNTABILITY REGARDING PHYSICIAN HEALTH”;
4. The AFMC Learner Forum on “Promoting Wellness Among Learners: From Damage Control to Upstream Approaches” and;
5. The AFMC Strategic Policy Forum panel discussion on “Facing Canada’s Mental Health Crisis Through a Systems, a Patient and a Physician lens”.

Key Outcomes: As a result of these activities and an analysis of the reports, feedback and evaluations, the recommendations are to:

1. Establish a working group of leads from the Committee on Student Affairs and the Networks on Faculty Affairs, PG Affairs, Physician Health and Wellbeing, Professionalism and Faculty Development, chaired by a senior Associate Dean or Vice Dean of Education,
to develop a compendium of best practices in supporting wellness amongst physicians, identifying programs and structures at each medical school to report back to the AFMC Board;

2. Liaise with the other national medical organizations developing competencies and curricula in the area of physician health (CMA, RC, CFPC, CMPA, RDoC, CFMS, FMRQ, FMEQ) to promote their work at the medical schools and on the AFMC website;

3. The AFMC continue its commitment to faculty and student wellness as a key focus in supporting the Faculties of Medicine;

4. Support health human resource workforce planning that meets Canada’s mental health needs.
Open session with the AFMC Board

Since 2016, the AFMC Board has held open sessions to discuss areas of common concern and for pan-Canadian collaboration from the 17 medical schools and their partners. In 2016, the topic was: *Competency-Based Medical Education* and resulted in a position paper on that subject adopted by the consent agenda of the Board in 2017. The 2017 session was held on the topic of the *Social Accountability of Medical Schools in Addressing Indigenous Health*. In 2018 the Session was entitled of *Physician Burnout: Building a Culture of Wellness and Resiliency in Medicine*.

These sessions have in the past resulted in core work aligned to the AFMC Strategic Directions and have had important outcomes.

The Objectives of the 2018 session were to:

- Examine prevalence of physician burnout;
- Discuss the impact of three levels of poor well-being (learner, teacher and organizational) on the sustainability of the health care system;
- Discuss approaches to physician resiliency; and to
- Discuss how organizations can promote resiliency.

The session, in Halifax, Nova Scotia, was concomitant with the annual Canadian Conference on Medical Education (CCME) hosted by Dalhousie University and was attended by 95 participants from across all domains of the medical education continuum and key partners in Canada. The session closed with a commitment to engagement strategies across the partners and the AFMC communities for the long-term advancement of physician wellness in Canada.
The opening presentation was by Dr. Mamta Gautam. Dr. Gautam defined burnout as a syndrome of emotional exhaustion, chronic overstress. (Maslach) and in physicians as:

- A distinct work-related syndrome – demands exceed individual resources
- Most likely to occur in jobs that require extensive care of others
- Common among practicing physicians
- Not a psychiatric diagnosis, but can lead to serious consequences

Nearly half of all physicians (46%) experience burnout, more than any other type of worker. Emergency care (52%), critical care (53%), and family medicine (50%) experience the highest rates of burnout among health care providers. Dr. Gautam challenged the participants to think about the external, systemic and cultural drivers of burnout and the major impact on physicians with impaired job performance, professional conduct issues, physical illnesses, addictions and psychiatric illnesses, namely anxiety, depression and suicide. A key message was that the stigma of mental illness is a major problem for the profession.
There was then a roundtable discussion on the general context of the mental health of physicians in Canada with resident Melanie Bechard; medical student Henry Annan; Faculty Affairs Dean John Bohnen; Student Affairs Dean Melanie Lewis; PG Affairs Dean Carolyn Thomson, Vice Dean Education Leslie Flynn and moderated by Dean of Medicine (U of T) Trevor Young. These Participants reflected on the question: *What is causing physician burnout and what can we do about it?*

**Small Group Round Table Discussion**

The Board Session participants were divided into 10 small groups and asked to address three questions:

1. What is the role of the medical schools in this area?
2. Are there any exemplar practices in preventing and addressing burnout?
3. Please state one critical action medical schools should undertake in this area.
Below is the qualitative analysis using NVIVO software of the notes gathered from the small groups:

1. **What is the role of the medical schools in this area?**

   Four major themes emerged from the small group discussions regarding the role of medical schools in addressing physician burnout and well-being:

   a. **Culture change at all levels of medical training is needed**

      Participants noted that a significant shift in the culture from the start of medical education all the way into practice was needed to truly address physician wellbeing and burnout. In particular, groups discussed that leadership was needed from the top levels of medical schools to develop, modify, and expand systems that encourage physician wellness. Participants commented that improved flexibility should be embedded into medical training and practice that allows for medical learners and clinicians to take leave when needed, and that there needs to be more attention paid to workload for medical learners and faculty members alike. Participants also felt that the hidden curriculum was an issue and that a safe, supportive, and confidential environment is needed to promote disclosure of mistreatment. Further, some groups indicated frustration with how reports of mistreatment are handled currently and pointed to the fact that medical schools need to seriously address reports of mistreatment. Follow up on mistreatment while fostering kindness, respect, and emotional intelligence was seen as a key role of medical schools in shifting the overall culture of medical education and practice.

   b. **Normalize discussions of mental health and break down stigma**

      Most groups raised the issue that medical schools need to proactively work toward breaking down stigma around burnout and mental health. Suggestions for tackling this included things like incorporating regular discussions, debriefs, or storytelling sessions about mental health. Integrating physician wellness and mental health into the curriculum was also brought up, although there was less agreement on how and when this should be done; stakeholders pointed out that this should only be one piece of the puzzle. Another suggestion was that medical schools should enhance supports and training for faculty, and that faculty could then role model self-care.

   c. **Building bridges and facilitating access to existing services**

      Participants pointed out that, even where wellness and support services exist in medical schools, they may not be currently accessible. Participants pointed to logistical improvements, such as expanding hours of service for counseling and support services into evenings and weekends so that they are more accessible for learners and faculty. Groups also pointed out that better communication strategies about existing resources may be warranted so students and faculty are in fact aware of what is available to them. Providing mandatory or regularly scheduled sessions that are integrated into day-to-day medical education and practice was also seen as a way to facilitate access.
d. **Integrating wellness and mental health holistically and consistently**

Most groups also mentioned the need to integrate mental health holistically within medical education and practice. Participants cautioned against just plugging it into the curriculum somewhere, emphasizing that it needs to be integrated consistently and meaningfully across the UG/PG/practice continuum. This included developing peer support programs, regular check-ins or debriefs, and dedicating release time to build social relationships with peers and teams. Participants also mentioned how important it was to provide supports for learners and faculty that are located at distributed learning sites and ensuring that built-in opportunities to connect exist for these faculty and learners as well.

2. **Are there any exemplar practices in preventing and addressing burnout?**

   a. **Formal and informal opportunities for peer and collegial support**

   Participants largely discussed best practices that revolved around built-in and ongoing opportunities for support. This included regular check-ins and debriefs, as well as scheduled opportunities to build relationships with peers and mentors. Other best practices around this included storytelling and sharing of burnout & wellness stories within the community. Some mentioned that best practice may involve creating opt-out rather than opt-in programs for counseling and peer support, so that it is voluntary but most students will participate and it becomes ingrained within the culture of the medical school.

   b. **Resources from the Mental Health Commission and the Healer’s Art**

   Some groups identified existing resources from the Mental Health Commission of Canada and the Healer’s Art for first and second year medical students as a great starting point for integrating wellness into the medical education environment.

   c. **Emphasizing kindness and respect in medicine**

   Nearly all of the groups mentioned this in some capacity. Some participants pointed to the inclusion of the humanities in medicine to foster professionalism and wellness. Others commented on the need to intentionally integrate kindness, gentleness, and inclusion into the culture of our medical schools. Most groups considered the development of supportive and connected communities a best practice in preventing burnout.

3. **Please state one critical action medical schools should undertake in this area.**

   a. **Foster kindness and respect across all levels of learning and practice**

   Almost all groups felt that medical schools need to directly tackle culture change where positive behaviours (respect, compassion, professionalism) are reinforced and where kindness is valued over competition. Participants also mentioned teaching values and skills, such as resilience among medical students. Some participants mentioned the integration or expansion of a value-based curriculum. The importance of role modeling by faculty members was also emphasized, and offers an opportunity for faculty to show how they support one another and how they are supported by the school.
b. **Build wellness into systems and programs in medical schools**

Overwhelmingly, groups felt that a critical action that needs to be taken by medical schools is to build in more opportunities for support. This could be informal sessions to sit and talk or more formal peer mentoring. Participants emphasized that these steps should be built-in so that they are easy to access and part of the culture, but that they ultimately should be voluntary with learners and faculty having the choice to opt out. More than one group noted that more support is needed during residency, and medical schools should build in arms-length check-ins with their residents. Groups also noted that support for faculty members needs to be improved so that faculty are enabled to act as role models for wellness and self-care in learners. Another idea was to develop “communities of practice” that would be collaborative, compassionate teams with regular social engagement and events.

c. **Advocacy and involvement of other stakeholders**

One of the important actions for medical schools to take is to bring key stakeholders like government officials, policy makers, and hospital administration to the table. This includes bringing senior leadership and stakeholders on walkabouts so that they understand the realities of the current environment. Participants also mentioned that, to really consider physician wellness, medical schools need to advocate for physician resource needs.

d. **Conduct research about physician wellbeing**

Several groups pointed to the limited literature about physician wellness and burnout. Participants felt that medical schools need to take a role in collecting accurate qualitative & quantitative data around the issues of burnout/resilience and examine the systemic drivers of burnout. Another group mentioned the need for longitudinal studies about the role of resilience in burnout, as well as assessing other factors that impact physician wellness. Two groups also mentioned that medical schools should conduct cost-benefit analyses to examine the cost of doing something about burnout vs. the cost of not doing anything. This could help strengthen the case for physician wellness and support advocacy with government, policy makers, and hospital leadership.
Evaluation of the Board Session:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree/Disagree</th>
<th>Not sure</th>
<th>Agree/Strongly Agree</th>
<th>Total Respondents</th>
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<tbody>
<tr>
<td></td>
<td>Count</td>
<td>Percentage</td>
<td>Count</td>
<td>Percentage</td>
</tr>
<tr>
<td>I felt that the Board Session was well organized and the main points were well covered and clarified.</td>
<td>1</td>
<td>2.04%</td>
<td>1</td>
<td>2.04%</td>
</tr>
<tr>
<td>I felt that the speakers demonstrated comprehensive knowledge of the subject matter.</td>
<td>1</td>
<td>2.04%</td>
<td>2</td>
<td>4.08%</td>
</tr>
<tr>
<td>The objectives of this session were clear.</td>
<td>1</td>
<td>2.08%</td>
<td>4</td>
<td>8.33%</td>
</tr>
<tr>
<td>I felt that the material was informative and relative to my role.</td>
<td>1</td>
<td>2.08%</td>
<td>1</td>
<td>2.08%</td>
</tr>
<tr>
<td>I gained new knowledge and will be able to apply them to my institution, and to my academic or personal life.</td>
<td>2</td>
<td>4.26%</td>
<td>3</td>
<td>6.38%</td>
</tr>
</tbody>
</table>

Summary of Open-Ended Comments

- **Most valuable aspects of Board Session**
  - High quality, open discussion (13)
  - Small group discussions (10)
  - Hearing diverse perspectives, having a wide range of participants (9)
  - Panel (7)
  - Important topic/critical issues discussed (7)
  - Speaker: Mamta Gautam (5)

- **Areas for improvement of Board Session**
  - Bigger room (10)
  - Share next steps, concrete plan of action (5)
  - More time needed for questions, general discussion (4)
  - Include more perspectives and invite other important stakeholders as guests (hospital board members, politicians, etc.) (3)
  - Shorter panel/presentations (3)

The presentations for the Open Board session and slide deck are appended in **Appendix A**.
AFMC – AMS J. Wendell McLeod Plenary

Margaret Trudeau
Celebrated Canadian | Mental Health Advocate

Margaret Trudeau is a Canadian icon, celebrated both for her role in the public eye and as a respected mental-health issues advocate. From becoming a prime minister’s wife at a young age, to the loss of both her son and her former husband, to living with bipolar disorder, Margaret tirelessly shares her personal stories to remind others of the importance of nurturing the body, mind, and spirit. Margaret is the author of four books, including her bestselling title, Changing My Mind, which charts her life’s ups and downs, and her latest title, The Time of Your Life, which offers women an inspirational and practical approach to creating a healthy, happy, secure and satisfying future. Margaret sits on the Executive Advisory Board of the UBC Mental Health Institute as a community advocate, and she was for many years former the Honorary President of WaterAid, a charitable Canadian non-governmental agency that is dedicated to helping poor communities in developing countries build sustainable water-supply and sanitation services. She is also the proud mother to Prime Minister Justin Trudeau.

Margaret captured the plenary audience with a riveting tale of her history and experiences with bipolar disorder, substance use and addiction and being in the public eye.
Justin Mausz · 2018-04-28
How to be healthy, per @MargaretTrudeau:

1. Sleep
2. Eat healthy (watch out for sugar - it feeds the lizard brain)
3. Play outside, no matter what the weather

Brilliant.

Chelsea Ho... · 2018-04-29
So pleased to be in the beautiful Halifax breathing the sea air at #CCME18. Highlights thus far include @MargaretTrudeau’s candid and inspiring opening plenary about her experience with bipolar disorder.
AFMC Learner Forum
Promoting Wellness among Learners: From Damage Control to Upstream Approaches

Medicine has always been demanding, both during training and in practice. The volume of knowledge and skills to be acquired in a complex professional setting, combined with the emotional demands of working with ill people, can prove to be a significant burden and source of distress for many medical students and residents. Academic success, professional progress and personal development require good mental and physical health. Medical training and practice are demanding undertakings that bring trainees under significant stress, which can be normal, but can also lead to distress/burnout. For many trainees, the transition into medical education comes at the age where mental illness often presents. Additional individual factors, such as ethnic, gender, sexual, religious and political diversity, past experiences of conflict, violence or trauma, as well as resilience have implications for mental health during undergraduate and postgraduate medical education. Medical Faculties are becoming increasingly conscious of the role of the “hidden curriculum” as a catalyst for stress in medical learning. Among medical learners across the country, it is often felt that the best or even the only way to survive and succeed amidst the intense academic pressure is to give up all other activities that compete with academics for time—even those activities of great personal importance. Such decisions made in the interest of short-term survival frequently lead to longer-term sacrifices in healthy living, as habits developed in the formative years of medical school are carried into post-graduate training and, ultimately, one’s profession.

Learning Objectives were:

- To explore the issues underpinning the stressors on learners in medicine and solutions to the increasing concerns about student and resident wellness
- To describe best practices in providing support to learners
- To address the cultural and population differences in dealing with wellness and interpreting it from differing perspectives
- To nurture a safe learning environment for all learners by addressing systemic issues
- To recognize the factors leading to burnout among learners and examine solutions to prevent it

The Presidents of the four learner organizations spoke eloquently about the challenges with wellness, intimidation and harassment and their initiatives underway to address resiliency and process issues. The presentations are appended in Appendix B.
Joanna Holl... · 2018-04-29
“A sick doctor cannot doctor the sick”. @HG_Annan on wellness. #CCME18

Geny Moine... · 2018-04-29
standing room only at the AFMC_e Learner Forum #ccme18 : med ed community commited to creating a better future for learners @FMEQ @fmrq @CFMSFEMC @ResidentDoctors
AFMC Strategic Policy Forum

“Facing Canada’s Mental Health Crisis through a Systems, a Patient and a Physician Lens”

In any given year, one in five people in Canada experiences a mental health problem or illness and it affects almost everyone in some way.

- More than 6.7 million people in Canada are living with a mental health problem or illness today. By comparison 2.2 million people in Canada have Type 2 Diabetes.
- Mental health problems and illnesses hit early in people’s lives. More than 28% of people aged 20-29 experience a mental illness in a given year. By the time people reach 40 years of age, 1 in 2 people in Canada will have had or have a mental illness.
- If we include families and caregivers, mental health problems and illnesses impact almost everyone in some way.
- The economic cost to Canada is at least $50 billion per year. This represents 2.8% of Canada’s 2011 gross domestic product.
- Health care, social services and income support costs make up the biggest proportion of these costs. But it also cost business more than $6 billion in lost productivity (from absenteeism, presenteeism and turnover) in 2011.
- Over the next 30 years the total cost to the economy will have added up to more than 2.5 trillion.

Learning Objectives were:

1. Learn about Canada’s mental health situation- facts and realities;
2. Explore patient perspectives on how to teach and assess a person in crisis;
3. Discuss ways to integrate mental health into all levels of medical education;
4. Learn about addressing psychiatrist workforce supply to meet the needs of Canadians.

Moderated by Dr Margaret Steele, Dean of Medicine at Memorial University, the four panelists spoke about:

The System Challenges: The work of the Mental Health Commission of Canada: Louise Bradley; President and Chief Executive Officer

A Patient and Teacher Reflects: Stephanie Reidy

A Physician Caregiver Lens: Stories of Burnout and How to Treat Them. Dr. Maria Alexiadis

Workforce Planning: the shortage of psychiatrists in Canada. Dr. Pamela Forsythe, the Canadian Psychiatric Association. (Presentation appended in Appendix C)
Report on Mental Health Activities at AFMC Board and CCME April 28- May 1, 2018
AFMC Next Steps

As a result of the discussion at the Board meeting and the Forums the following recommendations are made to the AFMC Board:

1. To establish a working group of leads from the Committee on Student Affairs and the Networks on Faculty Affairs, PG Affairs, Physician Health and Wellbeing, Professionalism and Faculty Development, chaired by a senior Associate Dean or Vice Dean Education, to develop a compendium of best practices in supporting wellness amongst physicians identifying programs and structures at each medical school to report back to the AFMC Board;

2. To liaise with the other national organizations developing competencies and curricula in the area of physician health (CMA, RC, CFPC, CMPA, RDoC, CFMS, FMRQ, FMEQ) to promote their work at the medical schools and on the AFMC website;

3. That the AFMC continue its commitment to faculty and student wellness as a key focus in supporting the Faculties of Medicine;

4. To support health human resource workforce planning that meets Canada’s mental health needs.
AFMC Press Release

FOR IMMEDIATE RELEASE

CANADIAN MEDICAL SCHOOLS AFFIRM THEIR SOCIAL ACCOUNTABILITY REGARDING PHYSICIAN HEALTH

HALIFAX, NOVA SCOTIA, April 28, 2018 - The Association of Faculties of Medicine of Canada (AFMC) and the Dalhousie University Faculty of Medicine have an enduring commitment to social accountability. The AFMC dedicated a Board meeting today to hear from leaders and learners about physician burnout with a particular focus on the strategies to build resiliency among medical students, residents and faculty in medical schools. The AFMC and Dalhousie University Faculty of Medicine recognize that physician burnout is an important issue that must be dealt with openly and proactively because it affects both patient safety and physician well-being.

Poor physician health leads to poor physician functioning, which can negatively impact the quality of patient care. In addition, burnout affects physicians’ ability to lead changes at the practice and health care system levels. When physicians ‘burn out’ they leave practice, which makes solving the ongoing challenges of physician shortages in Canada even more difficult. This has a direct effect on accessibility, quality and safety of health care in Canada.

“Physician burnout is a system problem, not just an individual concern. The AFMC is committed to helping our learners and faculty members learn personal resilience skills, as well as taking realistic and compassionate approaches to combating physician burnout to ensure the sustainability of the profession,” stated Brian Postl, Chair of the AFMC Board.

“The wellness of our learners and faculty is of the highest importance to the Faculty of Medicine at Dalhousie. We are working in tandem with our students, residents and teachers to ensure there are programs of personal and professional support to build resilience to prevent burnout. This includes the recent creation of an Associate Dean of Resident Affairs – a role dedicated to supporting resident wellness programs – and other initiatives that promote resiliency among learners and practicing physicians,” said David Anderson, Dean of Medicine, Dalhousie University.

Health systems need to adopt realistic interventions that support medical student, resident, faculty and clinician satisfaction and well-being, and that preserve the long-term professional health of physicians. The AFMC reaffirms that it will share best practices and each medical school will undertake to offer prevention programs.

“The health care environment—with its demanding pace, time pressures, and emotional intensity—can put physicians at high risk for burnout,” stated Geneviève Moineau, AFMC President and CEO. “The AFMC is committed to ensuring a healthy workplace and learning environment for our students, residents and physicians.”
# Appendix A

**AFMC Open Board Session Presentation**

## Objectives

- Examine prevalence of physician burnout
- Discuss the impact of three levels of poor well-being (learner, teacher and organizational) on the sustainability of the health care system
- Discuss approaches to physician resiliency
- Discuss how organizations can promote resiliency

## Dean Trevor Young: Why are we doing this?

- AFMC commitment to social accountability
- Rising Prevalence of Burnout in Physicians
- Occupational Risks poorly addressed
- Impact on Self, Profession and Health System
- Medical Schools’ obligation to support learners and faculty
- Sustainability of the health care system depends on this.

## Physician Burnout: Building A Culture of Wellness and Resiliency in Medicine

**Mamta Gautam**  
MD, MBA, FRCPC, CCPE

## Faculty/Presenter Disclosure

- **Faculty:** Dr. Mamta Gautam  
- **Disclosure:** President and CEO, PEAK MD Inc

  - Relationships with commercial/pharma interests: NONE
  - Disclosure of commercial support: NONE
  - Potential for conflict of interest: NONE

  - Mitigating potential bias: NOT REQUIRED
  - The content of this discussion is not related to the services of commercial interest.
  - No therapeutic recommendations for medications will be made.
Report on Mental Health Activities at AFMC Board and CCME April 28- May 1, 2018

"Being a doctor today is harder than ever"

Physician burnout a major concern

CMAJ must address physician burnout,

Learning Objectives
- What is burnout?
- What is the scope of the problem?
- What is causing physician burnout?
- Why should we care?
- What can we do about it?
**BURNOUT**

A syndrome of emotional exhaustion, chronic over-stress. (Maslach)

- Distinct work-related syndrome – demands exceed individual resources
- Most likely to occur in jobs that require extensive care of others
- Common among practicing physicians
- Not a psychiatric diagnosis, but can lead to serious consequences

**BURNOUT**

Three stages of burnout:

- Emotional Exhaustion
- Depersonalization
- Reduced Personal Accomplishment

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**Review of Burnout Studies**

- 2007-8: CMA Survey – 48.6% of Canadian physicians had symptoms
- 2017 CMA survey – 28.3% (using 2-item MBI)

In US, according to Medscape:

- 2011 – 45.8% of physicians
- 2015 – 54% of physicians
- 2018 – 42% of physicians

**Review of Burnout Studies**

- Nearly half of all physicians (48%) experience burnout, more than any other type of workers.
- Emergency care (52%), critical care (53%), and family medicine (50%) experience the highest rates of burnout among health care providers.

Medscape Physician Lifestyle Report 2015

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**Possible Risk Factors**

- High Workload - demands exceed resources
- Age - inverse relation between age and burnout. Survivor bias.
- Gender – higher in women than men
- Spousal support – inverse relation between emotional exhaustion and support from partner

**Internal Drivers**

- Intellectual Defenses: Denial, minimization, rationalization, sublimation
- Personality traits: perfectionistic, self-critical, guilt, need for control
- High expectations of ourselves and others
- Sign of weakness, associated sense of shame and guilt
- Fear of failure, judgment, exposure
- Fear of loss of control, concerns re. future prognosis
External Drivers

- Workplace issues: Long hours, frequent call, frustration with administrative burden, paperwork, EMR, feeling undervalued, frustrations with referral networks, difficult patients, medicolegal issues
- Challenges in finding work-life balance
- Lack of control
- Doing things that are not ‘doctoring’
- Concerns dismissed, not taken seriously by colleagues
- Unsupportive or judgmental colleagues

Systems/Cultural Drivers

- Attitudes: The patient comes first. Never show weakness or emotion. Tough it out.
- Sets high expectations, perfectionism, self denial
- Withdrawal from practice – time away from patients and work, with increasing workloads,
- Lack of confidentiality and privacy – loss of autonomy
- Regulatory concerns – practice restrictions, limitations of privileges
- Insurance – discrimination or inability in obtaining insurance

Stigma as a Major Challenge

“Nowhere is the stigma of mental health greater than within medicine.”

M. Gautam, 2008

Consequences to the Physician

1. Impaired job performance and Professional Problems
2. Changing jobs, reducing work hours
3. Difficulty with Relationships
4. Physical Illnesses
5. Addictions
6. Psychiatric Illnesses – Anxiety, Depression, Suicide

Consequences to our Patients

- Quality of Care: patient safety and quality of care - increased rates of medical errors, riskier prescribing patterns, and lower patient adherence to chronic disease management plans
- Quality of Caring – communication, empathy, patient satisfaction

Consequences to the System

- Impact on morale and satisfaction
- Recruitment and Retention: dissatisfaction, making them more likely to leave clinical practice, retire early
- Leadership: Interest, energy and ability to lead changes in the practice or health care system
Even the healthiest and strongest of us can become unhealthy in an unhealthy environment.

What can we do to prevent burnout?

We need to stop blaming doctors and see this as a shared responsibility of:
- Individual physicians
- Healthcare systems

Panel Discussion

The View: A roundtable discussion on the general context of the mental health of physicians in Canada with Resident Melanie Bechard; Medical Student Henry Annan; Faculty Affairs Dean John Bohnen; Student Affairs Dean Melanie Lewis; PG Affairs Dean Carolyn Thomson, and Vice Dean Education Leslie Flynn.

Small Group Task

A facilitator has been assigned as well as a recorder to your table. Each table will take 5 minutes to make introductions. Then please discuss the topic freely and summarize with key finding in writing on the template provided and hand these to Dr. Sarita Verma. A Report will be generated from the work of the groups.

Small Group Work

Discussion Questions
- What is the role of the medical schools in this area?
- Are there any exemplary practices in preventing and addressing burnout?
- Please state one critical action medical schools should undertake in this area.
Feedback and Discussion

- What was said
- What was heard
- How to formulate the next steps?

Next Steps... Dr Brian Postl

- AFMC Statement on Physician Health
- Task Force of Committee on Student Affairs, Networks on Faculty/Clinical Affairs, PG Affairs, Faculty Development and Physician Health, Learners and Partners
- Best Practices Compendium
- Central Resources?
Appendix B

AFMC Learner Forum Presentations

<table>
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<th>Objectives</th>
<th>Context</th>
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<tr>
<td>- To explore the issues underpinning the stresses on learners in medicine and solutions to the increasing concerns about student and resident wellness.</td>
<td>- Medicine as a demanding profession.</td>
</tr>
<tr>
<td>- To describe best practices in providing support to learners.</td>
<td>- The volume of knowledge and skills combined with the emotional demands.</td>
</tr>
<tr>
<td>- To address the cultural and population differences in dealing with wellness and interpreting it from differing perspectives.</td>
<td>- Academic success, professional progress and personal development clashes.</td>
</tr>
<tr>
<td>- To nurture a safe learning environment for all learners by addressing systemic issues.</td>
<td>- Higher than average population of risk for distress/burnout.</td>
</tr>
<tr>
<td>- To recognize the factors leading to burnout among learners and examine solutions to prevent it.</td>
<td>- Influence of individual factors, such as ethnic, gender, sexual, religious and political diversity, past experiences of conflict, violence or trauma.</td>
</tr>
<tr>
<td></td>
<td>- Addressing the &quot;hidden curriculum&quot; as a catalyst for stress in medical learning.</td>
</tr>
<tr>
<td></td>
<td>- Physicians make sacrifices in healthy living, as habits developed in the formative years of medical school are carried into post-graduate training and, ultimately, one’s profession.</td>
</tr>
</tbody>
</table>

DISCLOSURE STATEMENT

I have no actual or potential conflict of interest in relation to this presentation.

Mr. Samuel Bergeron, President
Fédération medicale étudiante du Québec
Externe 2 / 4th year medical student
Université de Montréal - Campus Maurice-L'Écuyer
Email: president@fmeq.ca
Twitter: @SamB_Dgeron
Report on Mental Health Activities at AFMC Board and CCME April 28- May 1, 2018

Best practices supporting learners

FMEQ IN NUMBERS...

4200 students
4 faculties
6 cities, 7 campus

Our Mission
- Represent the four medical students associations of Quebec as one united and powerful voice.
- Defend and advocate for the interests of Quebec medical students on academic, political and social issues.
- Facilitate the communication and collaboration with the medical associations and their members.
- Establish partnerships and services specific to the needs of our members.

The Executive Board

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FINANCES & HUMAN RESOURCES
Pierre-Olivier Tremblay
Report on Mental Health Activities at AFMC Board and CCME April 28 - May 1, 2018

Wellness 500mg BID...

Medical students' initiatives
Faculties' initiatives
FMEQ’s initiatives for students

CaRMS Day

Clerks Wellness Day

Advocacy

National Lobby Day
Bill 20

Cannabis Legalization

Bill 130

Intimidation and Harassment

- FMEQ’s 2017 Paper on Intimidation in Clinical rotations
- Based on the FMEQ-CFMS 2015 wellness survey
- Investigations of the resources available on each campus
- Recommendations

Statistics

- n=251 across Quebec
- 40% of participants victim of harassment
- Over half (53%) witnessed acts of intimidation
- Only 18% reported the situation
- Main obstacles:
  - Fear of reprisals
  - Lack of access or unclear reporting procedures
  - “Gray zone” definition of intimidation
Recommendations on Intimidation and Harassment

1. Ensure that a clear and easily accessible process for reporting intimidation is available at all times in each faculty of medicine. To do this:
   A. Improve access to the reporting form for some faculties.
   B. Maintain the ability to file an alert anonymously
   C. Provide transparent feedback to the students involved
   D. Continue to send frequent messages to students (e-mails, conferences, etc.) on the process

Recommendations on Intimidation and Harassment

2. Ensure a standardized and objective process when applying for a grade review during an internship, where a student has experienced bullying and harassment issues
   A. Since the trust has often been broken between the student and the evaluators, ensure a grade review process with a panel of other faculty members where the student and the evaluators can be heard.

Recommendations on Intimidation and Harassment

3. Continue to raise awareness among students about intimidation and harassment issues and strategies to address them:
   A. Clearly define what constitutes intimidation and harassment early in the medical studies (preferably before the clinical.
   B. Provide more instructions to students on strategies for dealing with relational conflict through role plays and explore the possibility of involving clinical teachers in these role plays.
   C. Continue these activities throughout the studies, even during residency.
Recommendations on Intimidation and Harassment

4. Continue raising awareness about intimidation and harassment situations in clinical practice:

A. Involve all clinical settings/locations in abuse prevention strategies and awareness campaigns.

5. Ensure a transparent process by monitoring the reports so as to portray the problem and its evolution (improvement? increase/decrease in complaints? statistics, follow-up, etc.).

A. Share these statistics with the various relevant stakeholders, including the medical student associations.

6. Continue to encourage initiatives that promote the culture of student respect and student well-being:

A. Ensure that counseling resources are accessible in a timely manner to support students in their complaint process.

What are the best practices for student wellness?

✓ Intimidation and harassment-free environment for learners
✓ Clear reporting process (with anonymous reporting option)
✓ Multiple and diverse activities during the year promoting wellness
✓ Collaboration between faculties and student associations for wellness activities (Wellness Day, CaRMS preparation, etc.)
✓ Remind students (and ourselves) that we all have bad days sometimes

OUR PRIORITIES FOR 2017-2018

• Student Wellness
• CaRMS Process - UCMGs
• Political Advocacy
• Family Medicine Promotion

THANK YOU!

Follow us:
Facebook: Fédération médicale étudiante du Québec (FMEQ)
Twitter: @FMEQ
Instagram: @la_fmeq
Website: www.fmeq.ca

DISCLOSURE STATEMENT

I have no actual or potential conflict of interest in relation to this presentation.
Henry Annan
President, Canadian Federation of Medical Students (CFMS)

#KeepsmeWell: Songs from Generation Y

DISCLOSURE STATEMENT
I have no actual or potential conflict of interest in relation to this presentation

Dr. Christopher Lemieux, President
Fédération des médecins résidents du Québec

WHAT IS THE FMRQ?
The Fédération des médecins résidents du Québec (FMRQ) represents all Quebec medical residents, at both the provincial and federal levels.

The FMRQ's mission consists in the study, defense and advancement of the economic, social, moral, academic and professional interests of the unions and their members.

The FMRQ has 3,567 members, 2,085 women (58%) and 1,482 men (42%).

MANAGING stress TO PREVENT BURNOUT
Findings of the fmrq survey
Dr. Christopher Lemieux, President
Fédération des médecins résidents du Québec

- Learner forum
- Canadian Conference on Medical Education
- Sunday, April 29, 2018
**BACKGROUND**

**Stress and burnout: A major issue in medicine!**
- Significant increase in burnout among practicing physicians
- Doctors appear to be more susceptible than the general public to presenting burnout symptoms
- Several studies estimate that close to one physician in two develops burnout symptoms
- Burnout manifests itself quite early on in doctors' careers

**RESIDENCY AND BURNOUT**

**Specific residency-related issues**
- Acquisition of new competencies and ongoing evaluations
- Certification exams
- Competition for a position on completing residency
- Financial stress associated with student debt
- Biological age for forming a family
- Little control over practice and work schedules

**OBJECTIVES**

**The purpose of the survey was to:**
- Measure sources of stress during residency
- Measure the scope of the phenomenon of occupational burnout among medical residents
- Find out the factors contributing to burnout
- Guide the FMRQ in its consideration of the measures to be taken to attack the sources of stress, so as to prevent burnout in residency

**METHODOLOGY**

- Survey conducted between March 24 and April 11, 2017
- 947 respondents
- Response rate: 27%
- Margin of error: 2.7%

**FINDINGS OF THE FMRQ POLL**

Medical residents available until exhaustion!
Report on Mental Health Activities at AFMC Board and CCME April 28- May 1, 2018

Prevalence of burnout among medical residents
- With burnout symptoms: 45.2%
- Without burnout symptoms: 54.8%

Level of burnout by symptoms presented
- Emotional exhaustion: 45.2%
- Depersonalization or cynicism: 23.7%
- Loss of feeling of accomplishment or productivity: 13.3%

Level of burnout by number of symptoms presented
- Severe: 15%
- Moderate: 43%
- Low: 32%
- None: 4%

Burnout by source of stress
- With burnout symptoms
  - Self-esteem: 48%
  - Work-life integration: 48%
  - Excess: 48%
  - Medical errors: 33%
  - Residency evaluations: 30%
  - Work-personal life: 29%
  - Other: 60%
  - Unknown: 41%

Burnout and work environment
- With symptoms
  - I'm useless most of the time: 73%
  - I spend too much time at work that I don't have time to do all the work that needs to be done: 75%
  - I spend too much time at work that I don't have time to do all the work that needs to be done: 78%
  - I don't have time to do all the work that needs to be done: 49%

- Without symptoms
  - I'm useless most of the time: 89%
  - I spend too much time at work that I don't have time to do all the work that needs to be done: 69%
  - I spend too much time at work that I don't have time to do all the work that needs to be done: 69%
  - I don't have time to do all the work that needs to be done: 49%

I'm part of a team where members work together
- With symptoms: 73%
- Without symptoms: 58%

My efforts are generally recognized by my peers and in my evaluations
- With symptoms: 75%
- Without symptoms: 25%

Superior: physicians treat all medical residents equally
- With symptoms: 41%
- Without symptoms: 52%

I can't help how I do my work
- With symptoms: 22%
- Without symptoms: 42%
**Level of burnout and average hours worked**

- **Severe:** 77 hours per week
- **None:** 69 hours per week

**IN CONCLUSION**

This study highlighted the scope of the phenomenon of occupational burnout in residency in Quebec:

- 55% of medical residents in Quebec present burnout symptoms.
- Workload, number of hours of work, and lack of time appear to be factors with a negative impact on burnout.
- On the other hand, such elements as working in teams or feeling supported by one's peers can offset this impact.

**CONCLUSION**

**OBSERVATION**

What are we waiting for before we move to address face-on those sources of stress which have a direct impact on medical residents' mental health?

**RESIDENCY AND BURNOUT RECOMMENDATIONS**

**Where do we begin?**

- Identify problem
- Stakeholders involved
- Sources of stress
- Factors reducing the incidence of burnout

**Change elements in the organizational culture that contribute to stress and burnout**

- Equip medical residents and faculty with tools and practices to develop practicable solutions, so as to reduce sources of stress and burnout

**DISCLOSURE STATEMENT**

I have no actual or potential conflict of interest in relation to this presentation.
Well-Being

- Practice Efficiency
- Culture of Wellness
- Personal Resilience
Taking Action

- PGME / RDoC study inequities in the resident experience
- Results -> solutions
- Accessible wellness resources

Acknowledgements

- Mr. Irving Gold, Resident Doctors of Canada

Discussion and Questions
## Appendix C
### Strategic Policy Forum Presentation

### Objectives

Participants in this session will:
- Learn about Canada’s mental health situation—facts and realities;
- Explore patient perspectives on how to teach and assess a person in crisis;
- Discuss ways to integrate mental health into all levels of medical education;
- Learn about addressing psychiatrist workforce supply to meet the needs of Canadians.

### Facts

- One in five people in Canada experiences a mental health problem or illness and it affects almost everyone in some way.
- More than 0.7 million people in Canada are living with a mental health problem or illness today, by comparison 2.2 million people in Canada have type 2 diabetes.
- Mental health problems and illnesses hit early in people’s lives. More than 28% of people aged 20-29 experience a mental illness in a given year. By the time people reach 40 years of age, 1 in 2 people in Canada will have had or have a mental illness.
- If we include families and caregivers, mental health problems and illnesses impact almost everyone in some way.
- Over the next 30 years the total cost to the Canadian economy of mental health issues will have added up to more than $2.5 trillion.

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**DISCLOSURE STATEMENT**

I have no actual or potential conflict of interest in relation to this presentation.
DISCLOSURE STATEMENT

I have no actual or potential conflict of interest in relation to this presentation.

Stephanie Reidy
Advocate and Speaker on Mental Health in the Workplace

DISCLOSURE STATEMENT

I have no actual or potential conflict of interest in relation to this presentation.

Dr. Maria Alexiadis
Psychiatrist, Nova Scotia
Speaker of the Canadian Medical Association
Program Counsellor for the Doctors Nova Scotia Professional Support Program
Head of the Department Family Practice at the Centre Zone of the NSHA
DISCLOSURE STATEMENT

I have no actual or potential conflict of interest in relation to this presentation.

Challenges to meeting the need for psychiatrists across Canada

I use my personal story to illustrate the value of flexibility in attracting and retaining psychiatrists throughout their professional lifespan.

- Shared Stigma was not as big an issue for me as for some medical students who may express interest in psychiatry.
- Despite the increased attention that we now see in matters pertaining to mental health, within the medical community there remain some powerful negative messages.

Psychiatrists/100k

<table>
<thead>
<tr>
<th>Province/Territory</th>
<th>Physicians</th>
<th>Psychiatrists per 100k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northwest Territories</td>
<td>5.9</td>
<td>11.8</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>12</td>
<td>8.8</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>146</td>
<td>14.8</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>42</td>
<td>8.0</td>
</tr>
<tr>
<td>Quebec</td>
<td>1114</td>
<td>19.4</td>
</tr>
<tr>
<td>Ontario</td>
<td>1679</td>
<td>19.5</td>
</tr>
<tr>
<td>Manitoba</td>
<td>174</td>
<td>19.3</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>82</td>
<td>7.8</td>
</tr>
<tr>
<td>Alberta</td>
<td>303</td>
<td>9.1</td>
</tr>
<tr>
<td>British Columbia</td>
<td>311</td>
<td>16.1</td>
</tr>
<tr>
<td>Territories</td>
<td>2</td>
<td>1.7</td>
</tr>
<tr>
<td>CANADA</td>
<td>4558</td>
<td>12.7</td>
</tr>
</tbody>
</table>

Source: 2016 CMHA Report

Shared Stigma

- Cartoons and images abound – older men with beards and a couch.
- “not a real doctor”
- “medical management” means prescriber of psychotropic drugs but little other function within the team.
- Serving a small number of the “worsted well” in a psychotherapy practice removed from mainstream medicine.
Medical Students Share Public Misconceptions

- 26% of medical students in UK uncomfortable sitting next to a psychiatrist at a party (47% of public)
- 54% of public unaware that psychiatrists have a medical degree
- 46% of students and 60% of public thought that psychiatrists “know what you are thinking”

Deb and Lomax, 2013

Negative attitudes and beliefs of students

- Psychiatry is scientifically unsubstantiated and imprecise
- Fails to draw on students’ medical training
- Lacks prestige and the medical community
- Is of questionable benefit to patients
- Is emotionally demanding for the physician

Gowans et al CEF Vol. 14, No 8, August 2009

How is psychiatry presented at UGME level? – formal curriculum

Dalhousie 2015 scan for psychiatric content

<table>
<thead>
<tr>
<th>Core curriculum units</th>
<th>Direct mention</th>
<th>Indirect mention</th>
<th>No mention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6/57</td>
<td>9/57</td>
<td>42/57</td>
</tr>
</tbody>
</table>

Professional Competencies:

<table>
<thead>
<tr>
<th>Direct mention</th>
<th>Indirect mention</th>
<th>No mention</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/29</td>
<td>1/29</td>
<td>25/29</td>
</tr>
</tbody>
</table>

Taylor Berch, Dalhousie class of 2018

Still (thankfully) some are attracted to the field

- CaRMS 2017 Results
  
  6.2% of CMG chose psychiatry as their first discipline - 180 of 2870 applicants
  
  After first iteration 10 positions remained available of total of 138 unfilled

- Dal class of 1978 produced 5 psychiatrists out of 91 graduates – 4 women (1/3 class were female)

- Dal class of 2018 matched 6 graduates out of 108 to psychiatry – 4 to Dal, 2 elsewhere in Canada

Psychiatry Training positions

- Canadian citizens/permanent residents: 963
  
  - U of T 54
  
  - McGill 61/67
  
  - Dalhousie 37/40
  
  - U of T 167/111 (44 fellows)

- Regular Ministry funding: 929

- Non-ministry funding: 52

Graduate Mobility

- Chart 8: Graduate mobility: immigration at national level (2013-2017)
Residency Issues discourage movement outside of academic centres
- Training highlights subspecialty areas, not generalists
- On call doesn’t prepare for life as a staff, especially in smaller areas, without house staff
- After spending 5 years in an area many people have developed roots—partners, friendships, children and are reluctant to uproot
- Women in psychiatry—looking for innovative work sharing and payment possibilities
- Work life balance
- If you are good you get to stay on...

Remuneration Facts
- Poorly paid specialty, time based services, challenges working within interdisciplinary teams, lack of compensation for teaching for most preceptors outside of academic centre
- Increasing concern about learner debt load works against choosing psychiatry and other less well remunerated specialties
- Psychiatric research poorly funded so those attracted to clinician scientist / academic research positions may be discouraged from pursuing psychiatry and have few role models in the field.

Where we can make a difference
- Life expectancy and SMI—still 15 years lost—better access and collaboration with primary care
- Mental illness in the workplace - impact on the economy
- Addiction Medicine and psychiatry - better education, better interventions — not just about opioids
- Anxiety, depression, PTSD, early interventions for psychosis, silver tsunami - dementia

Funding psychiatric services

An Examples of Psychiatric Service Variables – Macro and Micro
- ICES report on involuntary psychiatric admissions in Ontario – steadily increase from 70.7% (2009) to 77.1% (2013), individuals with police contact in past week and immigrants both experienced greater likelihood of involuntary admission; 33.6% of involuntary admissions were released within 72 hr
- “We found that those who had a mental health visit in the week before admission with either a family doctor or psychiatrist were less likely to be involuntarily admitted. This indicates to us that involuntary hospitalization may to some extent, be an avoidable event if care provided in the community settings eases the psychiatric crisis that lead to involuntary hospitalization.” Paul Kirdyk

Will technological advances change our practice? … Likely
So what can we do to improve the psychiatric workforce supply?

- Address stigma around mental health throughout the medical school experience, provide early meaningful exposure to psychiatric issues – in case based learning, in communication skills, in clinical experiences, as research projects, support interest groups and other less formal opportunities to generate understanding about the rewards of working in this field.

- Use residency training to develop skilled generalists who can move comfortably into working in less heavily populated communities, to promote effective interprofessional teamwork, to contribute to efforts to improve mental health services at the community as well as the individual level.

So what can we do to improve the psychiatric workforce supply?

- Work with health authorities and other payers to develop more flexibility in how we remunerate psychiatrists – it shouldn’t be only FPS or salary.

- Address changes to work responsibilities to refresh rather than burn out physicians while recognizing their other personal commitments.

- Have systems that support transitioning into practice and retirement.

- Utilize technology and other ways to work effectively, limit the burden of “paperwork” and promote collaboration to maximize the skills of the psychiatrist team member.

Conclusion

Discussion and Questions