



Mental Health
Commission
of Canada

Commission de
la santé mentale
du Canada

Physician Mental Health & Wellness

June 10, 2019

Dr. Vicky Stergiopoulos

Dr. Tania Tajirian

Dr. Treena Wilkie

Dr. Juveria Zaheer



Mental Health
Commission
of Canada

Commission de
la santé mentale
du Canada

**Thank you for joining us today!
The webinar will begin shortly.**

Audio is provided in broadcast mode **through your computer speakers**. Please ensure your computer speakers are turned on and turned up.

If you are experiencing technical difficulties please contact Adobe Connect at: **1-800-422-3623** or **click [here](#)**



@mhcc_ #workplaceMH #StandardCda

Guest Speakers



Vicky Stergiopoulos, Clinician Scientist & Physician-in-Chief, CAMH



Tania Tajirian, Chief Medical Information Officer, CAMH



Treena Wilkie Deputy Physician in Chief, Medical Affairs and Practice, CAMH



Juveria Zaheer, Clinician Scientist, CAMH



Objectives

Review the prevalence and factors associated with physician burnout

Describe individual, team and organizational level strategies to improve physician well-being, engagement and excellence.

Review opportunities to support professional practice and leadership development of physician

Discuss the opportunity to decrease physician burnout by optimizing the use of electronic health records.

Physician suicide: what can be done?

Background and context

- Increasing recognition of physician support needs internationally.
- High prevalence of burnout across medical specialties internationally
- 2017 CMA National Physician Health Survey
 - More than 25% of physicians reported high levels of burnout
 - One third screened positive for depression

Burnout is a syndrome of depersonalization, emotional exhaustion, and a sense of low personal accomplishment that leads to decreased effectiveness at work

Does **Burnout** Matter?

- **Burnout can impact:**
 - Quality of care, medical errors
 - Level of empathy towards patients
 - Team dynamics (hostility towards co-workers, less optimal functioning)
 - Decline in job satisfaction
 - Premature retirement
- **On the personal front, burnout is associated with:**
 - Sleep difficulties
 - Relationship problems
 - Poor mental health
 - Substance use
 - Suicide

2010

Balch et al, 2009; Shanafelt et al,

Personal



Sleep disturbance



Relationship problems



Low Mood



Anxiety



Substance Use

Professional



Impact on quality of patient care



Unprofessional behaviour



Decreased work effort



Higher physician turnover



Decreased efficiency of practice

Economic Costs of **Burnout**

- Estimated cost for all physicians in Canada ~ \$213,000,000
- Estimated cost for all physicians in the US ~ \$4.9 billion /year (range \$3.1-6.2 billion)
- While not the only wellness consideration, 'burnout' represents a key driver and consideration for wellness strategies

Dewa, 2014; Han & Goh

Factors Associated with **Burnout**

- Doing more with less – work overload
- Spending more time with technology and other clerical tasks and less time focused on patients
- Organizational commitment and culture
- Support from Chief
- Control over work schedule
- Physician participation in decision making

Barriers to Recognizing the Issues

- Burnout / illness seen as a weakness to cope
- Culture of immunity and invulnerability to illness
- Salary driven motives
- E.g.: taking all assigned call shifts for compensation (“doing it to ourselves”)

“Burnout at its deepest level is not the result of some train wreck of examinations, long call shifts, or poor clinical evaluations. It is the sum total of hundreds and thousands of tiny betrayals of purpose, each one so minute that it hardly attracts notice. When a great ship steams across the ocean, even tiny ripples can accumulate over time, precipitating a dramatic shift in course.”

Gunderson, The Atlantic, 2014

From Burnout to Well-Being



What is Resilience?

- “The capacity to recover quickly from difficulties; toughness”.
- “As a character trait, resilience is a person's mental ability to recover quickly from misfortune, illness or depression.
... Resilient people develop a mental capacity that allows them to adapt with ease during adversity, bending like bamboo instead of breaking.”

Strategies to Support Physician Well-Being

- Education, awareness raising
- Proactive engagement
- Teaching and promoting resilience
- Mindfulness sessions
- Web based CBT
- Cultivating community at work

Organizational approaches to well being are more effective than individual directed interventions

Panagioti et al, 2017

Physician Well-Being

Approaches / considerations when engaging physicians:

Communicate early / engage early

Formal and informal gatherings

Peer led activities / support

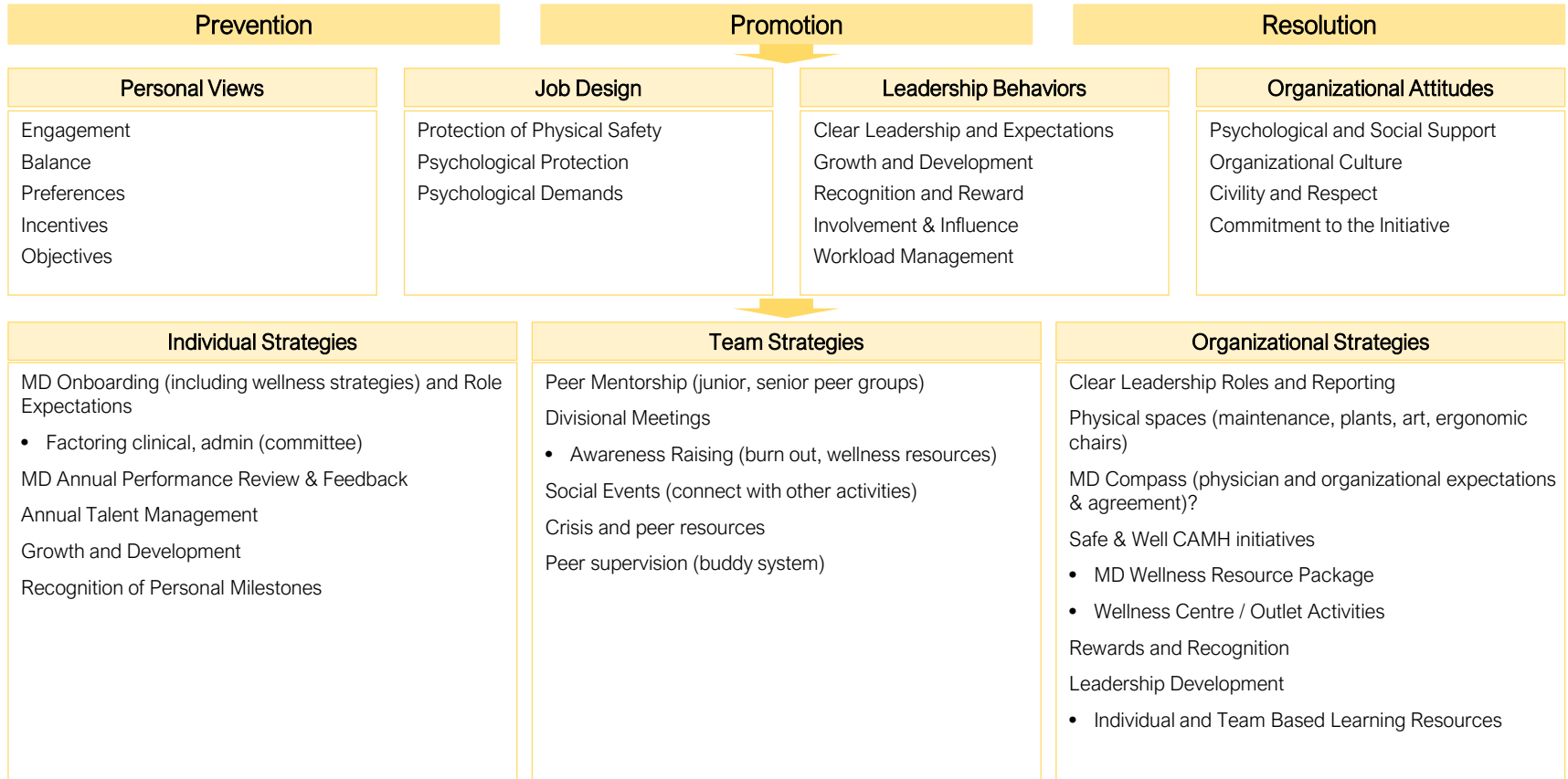
Executive involvement and support

CAMH – Who We Are



- Largest Mental Health and Addictions hospital in Canada
- University of Toronto-affiliated teaching hospital
- 3 main sites with 30+ locations
- 90 distinct services between an emergency department, inpatient, outpatient, day treatment and partial hospitalization models
- HIMSS Stage 7

CAMH Physician Wellness and Engagement Framework



Getting Started- Physician Survey

Participants

108

Response Rate
46%
of Staff Physicians

Burn-out

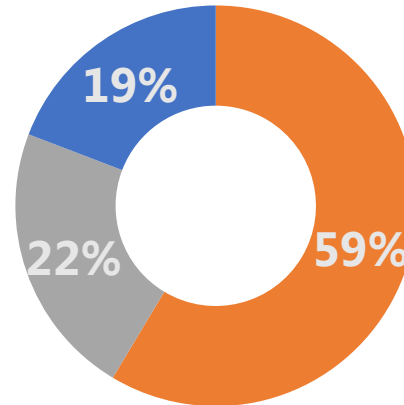
21.4%

Experience burn-out a few
times a **week**

50%

Experience burn-out a few
times a **month**

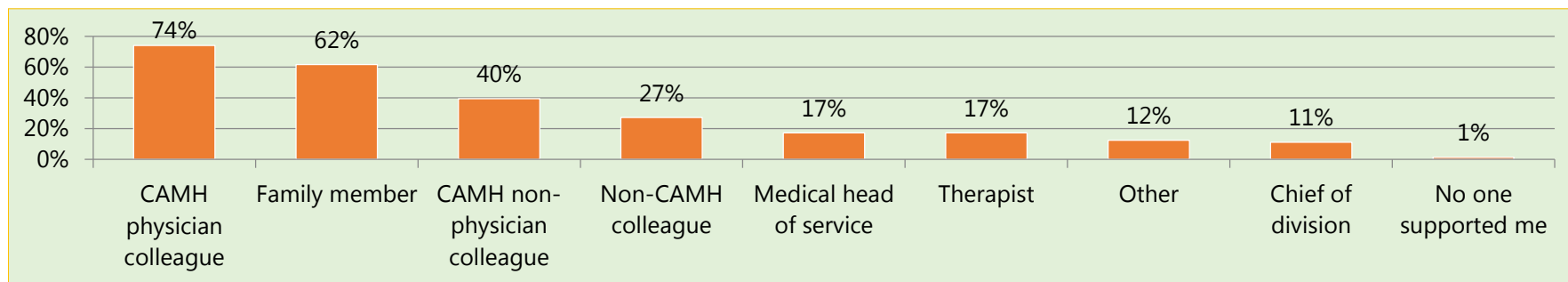
In the past 12 months, have you been negatively impacted by emotionally stressful events at work?



■ Yes, more than once ■ Yes, once ■ No, I haven't

Summary of Support Needs

If you have been negatively impacted by emotionally stressful events, who has supported you?



Receiving Support

Strongest preference is to receive support from a **CAMH physician colleague** following an emotionally stressful event

31.1%

Immediately
following the event

22.2%

Within **1 day**
of the event

27.8%

Within **1 week**
of the event

Emerging Themes

- **Developing a culture of safety and wellbeing**
 - Emphasizing teamwork, embracing complexity, avoiding blame
 - **Leadership Accountability**
 - Communicating effectively, supporting both excellence and wellbeing of staff and physicians
 - **Formal processes and supports to support wellbeing**
 - Putting centralized structures and supports in place, communicating regularly on available resources
-

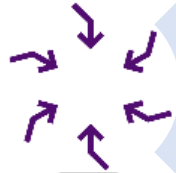
Organizational responses

Appreciative Inquiry

- Not focusing on getting rid of physician burnout, but rather supporting physician wellness and system transformation



Physician Wellness



Addressing contributors to physician burnout

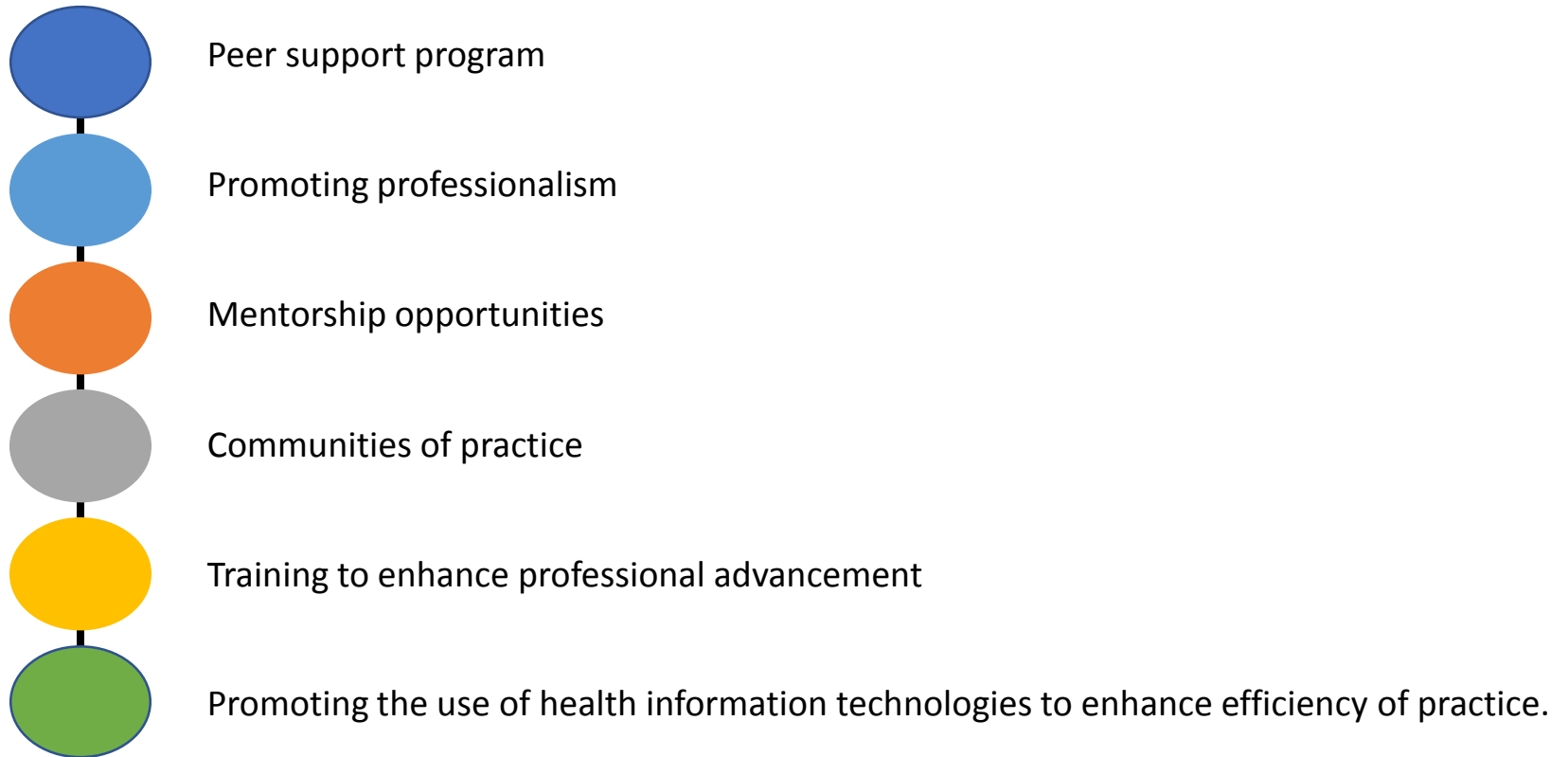


Promote engagement and professional success

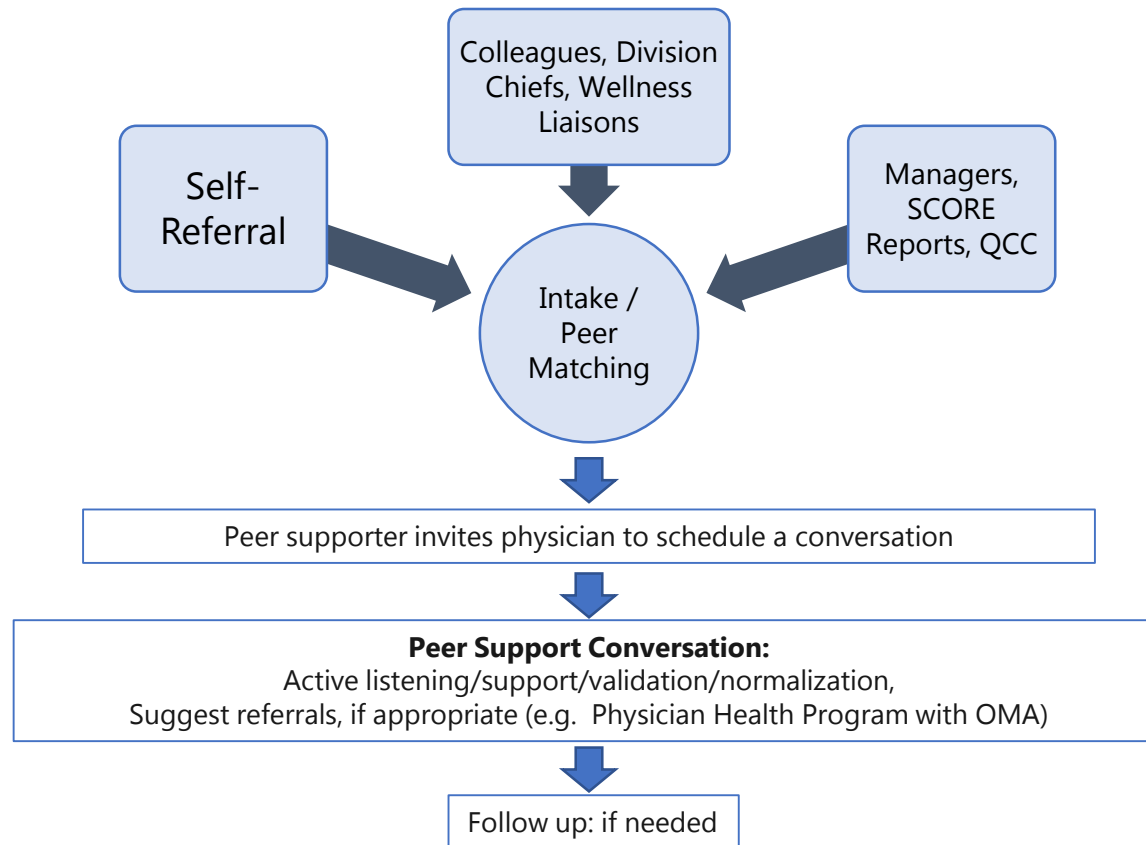
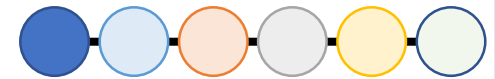


Focus on the joy of medicine

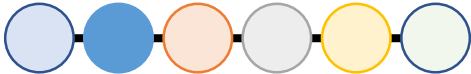
Physician Engagement, Wellness and Excellence Initiatives



Overview of Peer Support for Physicians



Promoting Professionalism



Establish a welcoming culture that promotes openness, transparency and teamwork

Enhanced focus on early conversations to provide feedback



Organizational focus on the physician onboarding process

Mentoring Program



Facilitate “pairings”, usually between junior and more senior colleagues

- Encouragement and support
- Sponsorship
- Information sharing/systems navigation
- Constructive feedback
- Role modelling



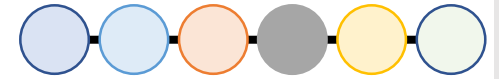
Embed the discussion within each reappointment meeting between chiefs and physicians

Mentorship Lead physician will pro-actively liaise with each new physician during the on-boarding process at CAMH

Physician Wellness Office will serve as a resource for any physician to access mentorship services of their own accord

To mobilize our physicians to request mentorship, we have created several pathways:

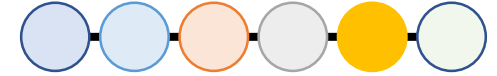
Communities of Practice



- Junior Faculty Club (Early Career Physicians)
- Late Career Physicians
- Women in Psychiatry
- Queer in Psychiatry (QuIP)
- International Medical Graduates



Advancement and Training



Online and in-person courses available for emerging leaders

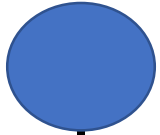


Development of a curriculum for Medical Heads based on LEADs framework

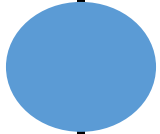


Group educational initiatives for leaders

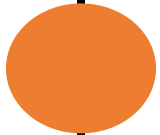
Initiatives



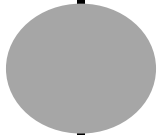
Peer support program



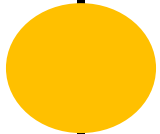
Promoting professionalism



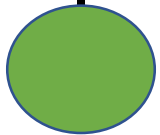
Mentorship opportunities



Communities of practice



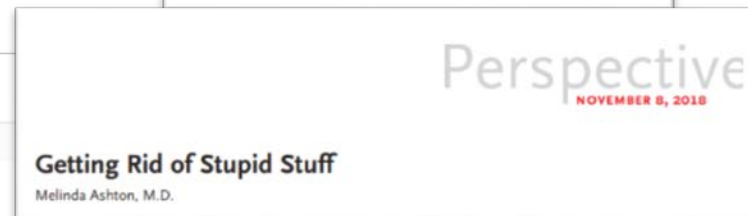
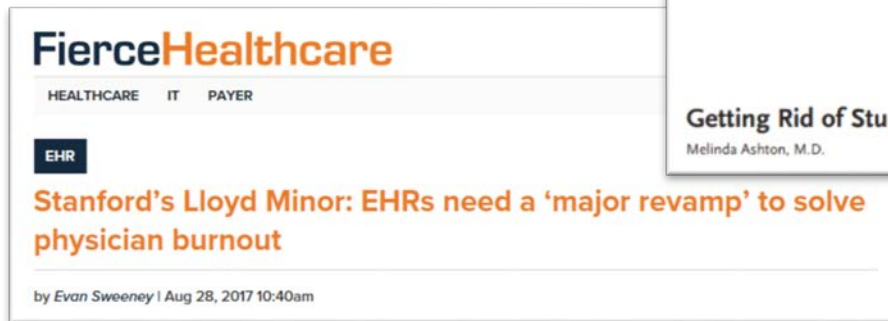
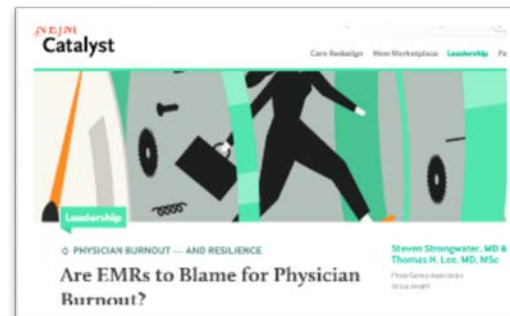
Training to enhance professional advancement



Promoting the use of health information technologies to enhance efficiency of practice.

The role of EHRs

What is the Role of EHR?



EHRs

Plan:

Provide fast access to patient information

Support clinical decision making

Support patient journey through transitions of care

Improve patient safety and quality of care

Current Status:

Administrative burden 11

Desk top Medicine 2,3

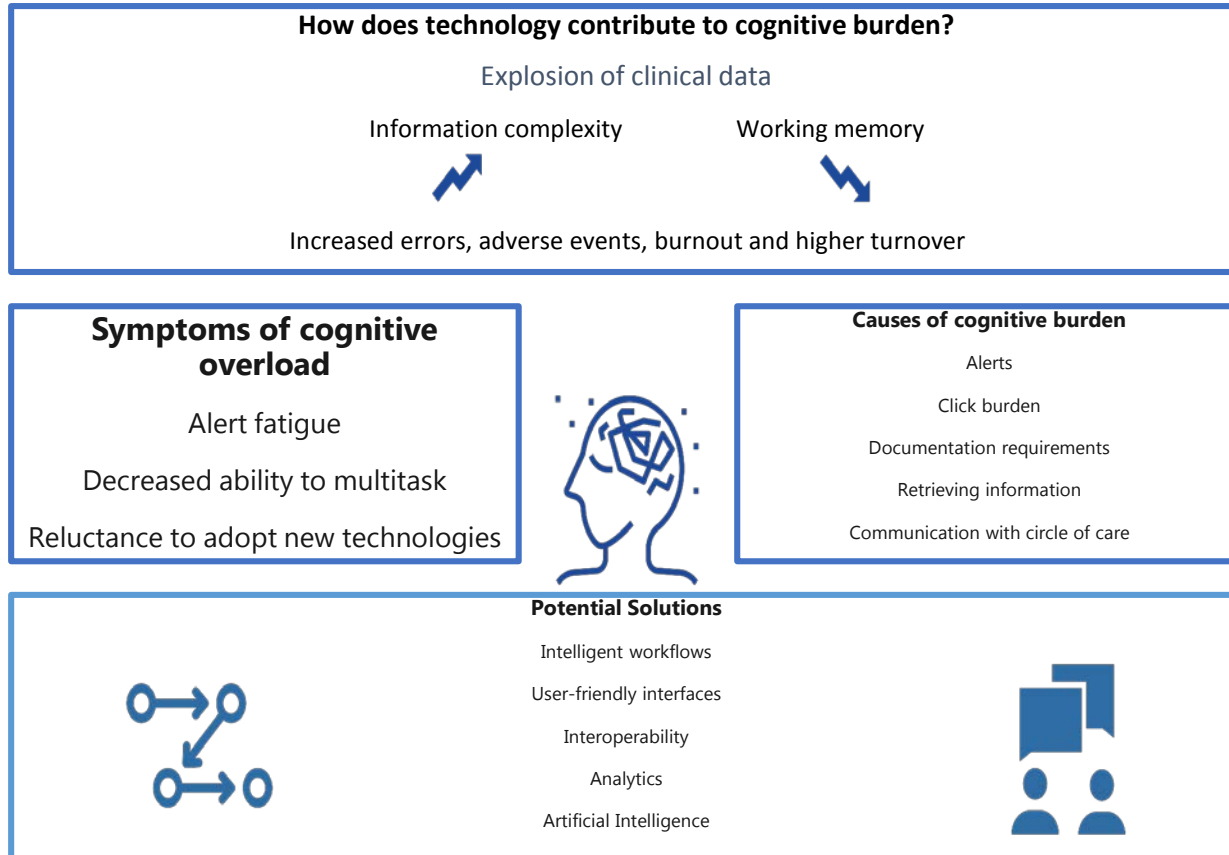
Data entry clerks (digital storage) 1,8

Burnout (joy of medicine) 1,8.9,11



<http://fortune.com/longform/medical-records/>

Drawbacks of HIT



Top Three Strategies



Increase Efficiency

- Personalization (workflows and order sets) ¹⁰
- Speech recognition strategies ⁹
- Mobile solutions¹⁰
- Get rid of “pebbles in your shoes” ¹²
- Evaluate and monitor data / Identify “super-users”

Increase Proficiency

- Provide ongoing flexible training ⁷
- Promote documentation best-practices (note bloat) ¹
- Reduce after hours (Pajama time) ^{5,6}
- SWAT teams ⁴

Communication Strategy

- Monthly Newsletters (email fatigue)
- Physician think tanks

Data Rich = Data Driven

Better physician experience = Better patient outcomes

References

- 1-Downing NL, Bates DW, Longhurst CA. Physician Burnout in the Electronic Health Record Era: Are We Ignoring the Real Cause?. *Ann Intern Med.*;169:50–51
- 2- Tai-Seale M, Olson CW, Li J, et al. Electronic health record logs indicate that physicians split time evenly between seeing patients and desktop medicine. *Health Aff (Millwood)*. 2017;36:655-62.
- 3 -Sinsky C, Colligan L, Li L, et al. Allocation of physician time in ambulatory practice: a time and motion study in 4 specialties. *Ann Intern Med*. 2016;165:753-60
- 4- Sieja A, Markley K, Pell J, Gonzalez C, Redig B, Kneeland P, linC. Optimization Sprints: Improving Clinician Satisfaction and Teamwork by Rapidly Reducing Electronic Health Record Burden. *Mayo Clinic proceedings*.2019 vol:94 iss:5 pg:793 -802
- 5- Gardner R, Cooper E, Haskell J, Harris D, Paplau S, Kroth P, Linzer M. Physician stress and burnout: the impact of health information technology. *AMIA*. 2019.vol:26 iss:2 pg:106 -114
- 6- Robertson S, Robinson M. Electronic Health Record Effects on Work-Life Balance and Burnout Within the I3 Population Collaborative. *The journal of graduate medical education*.2017 vol:9 iss:4 pg:479 -484
- 7-Robinson, Kenneth. Novel electronic health record (EHR) education intervention in large healthcare organization improves quality, efficiency, time, and impact on burnout. *Medicine*. vol:97 iss:38 pg:e12319 -e12319
- 8-Collier R. Electronic health records contributing to physician burnout. *CMAJ*. 2017 vol:189 iss:45 pg:E1405 -E1406
- 9-Collier R. Rethinking EHR interfaces to reduce click fatigue and physician burnout. *CMAJ*. 2018 vol:190 iss:33 pg:E994 -E995
- 10- Guo U, Chen L, Mehta P. Electronic health record innovations: Helping physicians - One less click at a time. *Health information management journal*. 2017 vol:46 iss:3 pg:140 -144
- 11- Shanafelt TD,Dyrbye LN, West CP. Addressing Physician Burnout: The Way Forward. *JAMA*. 2017 Mar 7;317(9):901-902
- 12- Ashton M.Getting Rid of Stupid Stuff. *N Engl J Med* 2018; 379:1789-1791

Physician Suicide

Physician suicide: What can be done?

- What do we know about the **risk for suicide** in physicians?
- How can we understand the **root causes** and **risk factors** for suicide in physicians?
- **What can we do to help?**

What do we know about the risk for suicide in physicians?

- 300-400 physicians die by suicide each year in the United States – approximately **one physician per day**¹
 - The rate is 1.41 times higher for males and 2.27 times higher for females than the general population¹
- Increasing **suicidal ideation** begins in **medical school**, and persists through **residency training** and beyond^{2,3,4}
 - Recent meta-analysis shows prevalence of suicidal ideation among medical students was 11.1% (7.4% in the past two weeks; 24.2% within the past year).^{3,4}
 - In one meta-analysis, nearly 1 in 3 resident physicians met criteria for major depressive disorder.⁵
- **Paradox of physician suicide:** Although physicians tend to have healthier lifestyles than those of the general public and thus to live longer, suicide rates among doctors are higher than those in the general population.⁶

NATIONAL POST

Suicide rates for doctors are shockingly high. The stigma of mental illness prevents them from getting help

WOUNDED HEALERS

By Sharon Kirkey

How can we understand the root causes and risks for suicide in physicians?

In general,

- Death by **suicide is a tragedy** not only affecting those who die, but their **families, friends,** and **communities**
- Suicide is a complex outcome, with **biological, social, psychological,** and **cultural** underpinnings
- Experiencing **suicidal thoughts** or engaging in **suicidal behaviour** not only increases someone's risk **for suicide,** but are **distressing** and **debilitating** on their own.

For physicians specifically,

- Risk factors for suicidal behaviour or death by suicide are **similar to those in the general population** – for example, previous history of suicidal behaviour, family history of suicide, depressive symptoms, substance use
- However, there are also factors **specific to physicians** which may explain the higher rates of suicidal ideation and behaviour in this population.

How can we understand the root causes and risks for suicide in physicians?



Michael Myers is professor of clinical psychiatry at SUNY Downstate Medical Center in Brooklyn, New York. He is a specialist in physician health.

the**bmj**opinion

The complexity of physician suicide
August 31, 2018

*“Physicians take their own lives when many diverse and **overwhelming forces** come together all at once—a **perfect storm of biopsychosocial factors**. There is no one reason why a physician might die by suicide and many factors can be at play. It is important that **we are aware of these factors** and understand them, so that we can try and **support our colleagues**.”*

How can we understand the root causes and risks for suicide in physicians?

Biological Factors

- Physicians may have a higher prevalence of depression than non-physicians ⁶;
 - Twenty-eight percent of residents experience a major depressive episode during training versus 7–8 percent of similarly aged individuals in the U.S. general population. ⁸
- Higher frequency of alcoholism in female physicians than women in the general population ⁶
- Higher rates of substance use in certain specialties (exposure or temperament driven) ⁶
- Sleep disturbance ⁸

How can we understand the root causes and risks for suicide in physicians?

Psychological Factors

From NEJM 2005:

- “It has also been noted that physicians tend to neglect their own need for psychiatric, emotional, or medical help and are more critical than most people of both others and themselves. They are more likely to blame themselves for their own illnesses. And they are apparently more susceptible to depression caused by adverse life events, such as the death of a relative, divorce, or the loss of a job.”⁶

How can we understand the root causes and risks for suicide in physicians?

Social/Cultural Factors

- Social isolation and disturbances of social networks related to scheduling, professional identity.⁶
- Experiences of trauma, bullying, gendered harassment, burnout.⁶
- Regulatory complaints are associated with increased rates of suicidal ideation.³
 - In a survey study from the UK, those with a past or current regulatory complaint were more likely to report suicidal ideation (9.3-13.4%, compared to 2.5% without a complaint)
- Access to and choice of lethal means for suicide^{1,3,6}
- Physicians who took their lives were less likely to be receiving mental health treatment compared with nonphysicians who took their lives even though depression was found to be a significant risk factor at approximately the same rate in both groups.⁷

“Suicidal physicians encounter additional barriers to care, compared with the general population. Whereas both groups face concerns about stigma, lack of time and lack of access to care, physicians have the added burden of concerns regarding confidentiality, and fear of discrimination in licensing and applications for hospital privileges.”³ CMAJ, 2019
- Some specialties have higher risk than others (psychiatry, anaesthesiology)⁶

What can we do to help?

In general

- Developing evidence-based strategies for suicide prevention is challenging because suicide is a rare, multi-factorial outcome rather than simply a consequence of mental illness

Best Evidence:

- Restricting access to lethal means can clearly prevent suicide
- Significant results of school-based awareness programs in reducing suicide attempts and ideation
- Anti-suicidal effects of clozapine (schizophrenia) and lithium (all affective disorders)
- Pharmacological and psychological treatments of depression, BPD
- Physician education in primary care

Promising Evidence (requires further study)

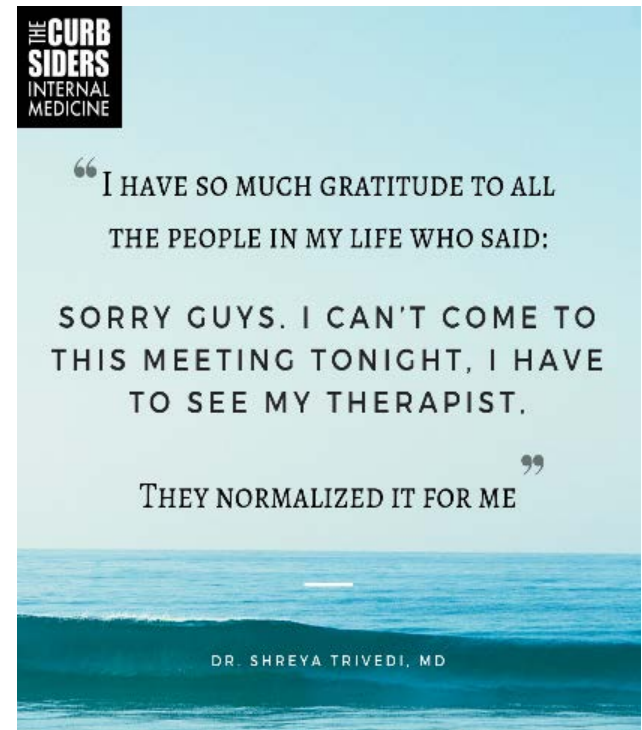
- Gatekeeper training
- Media regulation
- Internet-based intervention and helplines
- Screening in primary care
- Ketamine

What can we do to help?

For physicians specifically,

There is a lack of evidence specific to physicians, but we can look at the literature on suicide prevention and physician mental health to guide us in an approach

1. Raising awareness and addressing stigma
2. Supporting access to high-quality mental health care while addressing fear of consequences
3. Structural / systemic approaches – identification and support for those at risk, humane training and working conditions, support through college and legal issues



Source: *The Curbsiders Podcast: 29 Depression and Suicide: Occupational Hazards of Practicing Medicine*

Suggested Reading / Listening

Rebecca Black: Preventing suicides among doctors:

<https://blogs.bmj.com/bmj/2019/03/25/rebecca-black-preventing-suicides-among-doctors/>

“I have been a widow for ten months now. My husband Tom Black, a GP, died by suicide on the 14 May last year. I am also a GP and am keen to talk about it to help open up our conversations about mental illness and suicide in doctors.”

Sickboy Podcast: The sad doctor featuring Dr. Michelle Marlborough:

<http://sickboy podcast.com/blog/2018/4/23/the-sad-doctor-depression>

“Dr. Pamela Wible is an American physician who devotes herself to the prevention physician suicide. She has said one of my favourite things about the issue of physician illness and the driving systemic factors: “Nobody says to them, ‘You’re working inhumane hours’ or ‘This sleep deprivation you’ve been dealing with for seven years is dangerous.’ Nobody says that. It’s not going to be meditation or yoga that solves this. If you’re in the coal mine and your canary dies, you don’t take deep breaths and do resiliency modules online. You get out of the coal mine.”

We need to look after each other. We need to speak up. We need to address what maintains illness and what may prevent our peers from seeking help.”

References

1. Schernhammer ES, Colditz GA. Suicide rates among physicians: a quantitative and gender assessment (meta-analysis). *Am J Psychiatry*. 2004 Dec; 161(12):2295-302.
 2. Goldman ML, Shah RN, Bernstein CA. Depression and suicide among physician trainees: recommendations for a national response. *JAMA Psychiatry*. 2015;72(5):411–412.
 3. Albuquerque J, Tulk S. Physician suicide. *CMAJ*. 2019 May; 191(18) E505.
 4. Rotenstein LS, Ramos MA, Torre M et al. Prevalence of depression, depressive symptoms, and suicidal ideation among medical students: a systematic review and meta-analysis. *JAMA*. 2016; 316(22):2214-2223.
 5. Mata DA, Ramos MA, Bansal N, et al. Prevalence of depression and depressive symptoms among resident physicians: a systematic review and meta-analysis. *JAMA*. 2015; 314(22):2373-2383.
 6. Schernhammer ES. Taking their own lives — the high rate of physician suicide. *New England Journal of Medicine*. 2005; 352(24). 2473-2476.
 7. Gold KJ, Sen A, Schwenk TL. Details on suicide among US physicians: data from the national violent death reporting system. *General Hospital Psychiatry*. 35(1), 45-49.
 8. Guille, C., Zhao, Z., Krystal, J., Nichols, B., Brady, K., & Sen, S. (2015). Web-Based Cognitive Behavioral Therapy Intervention for the Prevention of Suicidal Ideation in Medical Interns. *JAMA Psychiatry*, 72(12), 1192-8.
 9. Bourne T, Wynants L, Peters M, et al. The impact of complaints procedures on the welfare, health and clinical practise of 7926 doctors in the UK: a cross-sectional survey. *BMJ Open* 2015;5:e006687.
-

Thank You

camh

Questions



Mental Health
Commission
of Canada

Commission de
la santé mentale
du Canada

How did we do?

Please fill out the survey
that opens **after** you leave
the webinar





Mental Health Commission of Canada

Suite 1210, 350 Albert Street
Ottawa, ON K1R 1A4

Tel: 613.683.3755
Fax: 613.798.2989

mhccinfo@mentalhealthcommission.ca
www.mentalhealthcommission.ca

[@MHCC_](https://twitter.com/MHCC_) [f/theMHCC](https://www.facebook.com/theMHCC) [/1MHCC](https://www.youtube.com/channel/UC1MHCC) [@theMHCC](https://www.instagram.com/theMHCC)
[in/Mental Health Commission of Canada](https://www.linkedin.com/company/Mental-Health-Commission-of-Canada)