
GUIDE FOR COMMON INDICATORS FOR CANADIAN PHYSICIAN HEALTH PROGRAMS

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GUIDE FOR COMMON INDICATORS FOR CANADIAN PHYSICIAN HEALTH PROGRAMS

Introduction:

This Guide was developed for use by Canadian physician health programs (PHPs) in order to standardize data collection regarding services offered by programs, to whom the services are offered, and outcome of service delivery. Measures of clinical outcome are complex and depend on presenting problems and services offered. The outcome variables suggested in the Guide are preliminary and are not intended to serve as a basis for evaluating the activities of PHPs. If standardized tests are used on intake, measurement of client outcome is facilitated by use of the same tests when PHP service is completed.

In each section, a brief rationale for the collection of variables is given, and explanations of terms used are provided for consistency. PHPs were initially developed to offer services to physicians, but many programs now offer services to other professions. While other professions that are currently served by Canadian PHPs are included in the variable “service group,” all other data is structured and defined as it relates to physicians.

It is a goal for collection of Common Indicators that information about the individuals who contact PHPs should be recorded to give a complete picture of the range of PHP activities. For the purpose of data collection and analysis, it is important that the core data variables for each case be recorded. The use of the guide is voluntary and it may not be practical for each program to collect every variable; when a variable is collected it is important that the appropriate value be selected and that a default entry not be made. That is, for a variable where response categories are Yes/No, a missing value is not the same as a “No” response.

An important first step for PHPs is to be able to identify both the number of individuals to whom the program provides service and the nature of and context in which the service is provided. It is recognized that programs provide a variety of services and it is helpful to distinguish between services that relate to the provision of information, advice and education relating generally to physician health or program activities, versus services that are clinical in nature. The guide refers to both individuals and clients where an “individual” is defined as a person who may be calling a PHP for information or assistance that may or may not be related to a particular physician (or other service group). The distinction between “individual” and “client” is related to the service provided by the PHP. For example, an individual would not receive a service beyond information and education whereas a client (i.e. a physician) may receive any clinical service provided by a PHP.

A framework that is being advanced with this guide is the reporting of PHP program activity by the service provided. In this way, PHPs can clearly distinguish and compare clinical and non-clinical services. For example, at the service level, information, education and prevention are categorized as non-clinical services, and assessment, intervention, clinical referrals, case management, monitoring and advocacy related to an individual physician’s health are clinical services. The grouping of the range of non-clinical services are called “Contacts” and the grouping of the range of clinical services are called “Cases”. In this way, a PHP is able to report on the number of “Contacts” vs. “Cases” and then provide further detail about the number and level of services provided in each of these two service areas.

SECTION I. VARIABLES TO BE COLLECTED FOR ALL CONTACTS AND CASES:

The variables below should be collected for each individual and/or client to whom any service is provided, including information and education. A “Contact” is established when an individual or client receives information, education or prevention related service from a PHP. A “Case” is established when a PHP client (physician, resident, student, family member) receives a clinical service from the program.

1. Unique identifier:

For each case or contact, a unique identifier is required for internal PHP use. This will allow linking of the common indicator variables and other measures to the services provided by the PHP. This unique identifier may take any form convenient to the individual PHP, including numeric, alpha-numeric or alpha character descriptions.

2. Open Date:

Date when individual first seeks services from the PHP.

Collection of Open date enables the PHP to tabulate the number of services provided to individuals in a given time period, such as a quarter or year. National summaries and comparisons among PHPs can also be made.

Open Date FORMAT: Year/Month/Day

3. Close Date:

Date when service provision is ended. Collection of this information allows calculation of duration of client contact or service delivery. Given the nature of some non-clinical services, the open and close dates for some contacts will be either the same date or in close range.

Close Date FORMAT: Year/Month/Day

4. Service group:

Group to which the individual calling the PHP, or the potential client, belongs. For further clarification, this includes a student, resident or retired individuals within a service group. While PHPs were developed to provide service to physicians and their families, some have expanded to provide service to other professional groups. The value list below reflects only those professions to whom Canadian PHPs provide services in 2005. It may be necessary to expand this list as programs report additional information in the “other professional” category.

Calls can also come from persons who are not health professionals, such as educators, researchers, or the general public. This variable does not specify the individual caller’s relationship to the client or potential client. For example, a call from a physician’s wife would be recorded under the “physician” service group. Currently several Canadian PHPs provide services to other professions which include dentists, pharmacists, veterinarians and lawyers.

Service Group VALUES:

Professional Clients:
1. Physician
2. Dentist
3. Pharmacist
4. Veterinarian
5. Lawyer
6. Other Profession
Others:
7. Professional educator, researcher or student
8. General Public
9. Other

5. Caller Role - Relationship of caller to Service Group:

This link between the caller role and the service group provides information about who is calling with respect to a particular service group. This will enable programs to answer and compare who and how individuals access program services.

Caller Role VALUES:

1. Client/Self	<i>Member of a Professional Service Group</i>
2. Spouse/partner/family member	<i>Related to a member of a Professional Service Group</i>
3. Professional relationship	<i>Includes colleague, supervisor, professional association</i>
4. Regulatory body	<i>Professional licensing body such as the College of Physicians and Surgeons</i>
5. Treating clinician	<i>A registered health professional from whom the client is receiving clinical services</i>
6. Member of the public	<i>Includes patients of the client</i>
7. Other relationship	<i>e.g. friend, boyfriend, girlfriend</i>

6. Source for Contact:

How the individual/client learned about the PHP services. This will provide valuable information that could guide future promotional strategies undertaken by PHPs.

Contact Source VALUES:

How did you learn about the PHP?

1. Personal information	<i>Advised about the program by a family member or friend.</i>
2. Professional information	<i>Advised about the program through a professional source such as a colleague, employer, professional association.</i>
3. Internet reference	<i>Found out about the program through internet search or link from other website</i>
4. Educational presentation by PHP	<i>Rounds, class, seminar, or workshop given by PHP to educate students or physicians about physician health and the PHP.</i>
5. Medical school information	<i>Information gained at medical school through classes, presentations, student health committees etc. Excludes presentations by PHP which are recorded above.</i>
6. Professional Literature	<i>Information gained from medical newsletter, magazine or professional journal</i>
7. Other referral source	<i>Specify</i>

7. Presenting problem:

This is the reason the individual contacted the PHP and it is recorded based on the assessment of the PHP at the point of first contact. Presenting problems are organized into the seven groups described in Table 1- Primary category presenting problem. Within each primary category, additional detail about the problem can be provided by making one or more selections in Table 2 – Detailed Problem(s).

Psychiatric diagnoses are recorded only if the individual has been diagnosed according to DSMIV criteria, presenting with an existing diagnosis. This grouping should not be selected if the client has self-diagnosed. Further it is not intended to capture an on-the-spot intake diagnosis. A separate list is provided for mental health problems not formally diagnosed according to DSMIV criteria.

Designate **one** category of problem as the “Primary” presenting problem, and indicate as many problems or sub-categories as apply in Table 2. When a standardized measurement scale is used to measure or diagnose a client’s presenting problem, indicate the problem(s) here, and list the scale(s) used in variable #10.

Table 1 – Primary category presenting problem VALUES:

Designate **one** primary category of the seven below:

1. Addictive Disorders	<i>Includes substance abuse, dependence, gambling, sexually compulsive behaviours, and dual disorders</i>
2. Psychiatric Disorders (DSM criteria met)	<i>Past or current psychiatric diagnosis at time of presenting to PHP</i>
3. Mental Health (no formal Dx)	<i>Stress, anxiety, depression, and other emotional problems, not formally diagnosed by DSM criteria</i>
4. Occupational issues	<i>All presenting problems that relate to the workplace including harassment, abuse, complaints, audits, relationships</i>
5. Family/Relationship	<i>Problems in relationships with spouse, partner, children. Caregiver issues and other family problems</i>
6. Physical/Mental/Cognitive	<i>Physical disabilities, blood borne pathogens, chronic pain, other chronic conditions incl. Cognitive issues</i>
7. Other personal (non-occupational)	<i>Problems experienced in personal life including abuse, civil litigation, financial, grief and support</i>

Table 2 – Detailed presenting problem(s):

After designating one primary category above, identify any relevant subcategories within the primary problem grouping. Where relevant and applicable, give the duration of the problem.

Problem Category	Check all that apply √	Problem Duration (months)	Sub-category definition
Addictive Disorders			
1.1 Substance abuse			<i>Problem drug use that meets DSM diagnostic criteria for abuse (See also table to record drug use in Variable #13)</i>
1.2 Substance dependence			<i>Dependence on a drug. Meets DSM diagnostic criteria at time of contact (See also table to record drug use in Variable #13)</i>
1.3 Gambling			<i>Difficulties with lack of control over gambling behaviour that is producing problems for the client.</i>
1.4 Sexually compulsive behaviour			<i>Difficulties with lack of control over sexual behaviour that is producing problems for the client.</i>
1.5 Dual disorders			<i>Co-occurrence of at least one addictive problem and at least one psychiatric/psychological problem.</i>
1.6 Other addictive behaviours			<i>Specify</i>
Psychiatric (DSM criteria met)			
2.1 Mood disorders			<i>Including major depression, dysthymia, bipolar disorder, schizo-affective disorder</i>
2.2 Anxiety disorders			<i>Anxiety including panic disorder, GAD, acute stress disorder, PTSD, OCD etc.</i>
2.3 Personality disorders			<i>Pattern of experience and behaviour that is pervasive and inflexible; examples include borderline, narcissistic, antisocial, paranoid personality disorders</i>
2.4 Eating disorders			<i>Severe disturbances in eating behaviour – e.g. anorexia nervosa and bulimia nervosa</i>
2.5 Other psychiatric problem(s)			<i>Please specify according to DSM diagnostic criteria</i>

Problem Category	Check all that apply √	Problem Duration (months)	Sub-category definition
Mental Health (no formal Dx)			
3.1 Anxiety, stress			<i>Disturbed function or reaction of individual as a result of adverse stimuli, or self-identified anxiety</i>
3.2 Depression			<i>Self-identified low mood</i>
3.3 Grief, loss			<i>Reaction to a major loss in life</i>
3.3 Suicidal ideation			<i>Troubling thoughts of suicide</i>
3.4 Suicide attempt			<i>Client has attempted suicide</i>
3.5 Other mental health			<i>Specify</i>
Occupational Issues			
4.1 Emotional abuse – subject of			<i>Subject of verbal abuse or harassment causing emotional distress in the workplace involving supervisors, colleagues or patients.</i>
4.2 Sexual abuse – subject of			<i>Subject of sexual suggestions or innuendo and/or physical touching in the workplace</i>
4.3 Physical abuse- subject of			<i>Subject of hitting or other physical violence in the workplace.</i>
4.4 Emotional abuse – perpetrator of			<i>Perpetrator of verbal abuse or harassment causing emotional distress in the workplace involving patients or colleagues.</i>
4.5 Sexual abuse – perpetrator of			<i>Perpetrator of sexual suggestions or innuendo and/or physical touching in the workplace involving patients or colleagues</i>
4.6 Physical abuse – perpetrator of			<i>Perpetrator of hitting or other physical violence in the workplace involving patients or colleagues.</i>
4.7 Disruptive behaviour – perpetrator of			<i>Causing disruption in the workplace by lack of cooperation with colleagues and/or co-workers</i>
4.8 Workplace relationships			<i>Distress related to difficulties in getting along with one or more co-workers.</i>
4.9 Occupational stress or burnout			<i>Burnout and problems related to workload, scheduling, shifts, insufficient resources</i>
4.10 Occupation or job change			<i>Requires guidance in change of job or occupation.</i>
4.11 Retirement			<i>Help with planning retirement, or difficulties in dealing with life changes accompanying retirement.</i>
4.12 Other occupational issues			<i>Specify</i>
Legal and Licensing Issues			
4.13 Audit			<i>Random practice audit – generally as arising from Peer Assessment Programs or College Quality Assurance programs</i>
4.14 Regulatory complaint			<i>Patient complaint received by College giving rise to investigation</i>
4.15 Professional boundary issues			<i>Inappropriate boundaries with patients</i>
4.16 Other regulatory issues			<i>Examples include Registration considerations, seeking reinstatement of privileges or changing existing licensing restrictions</i>
4.17 Practice related financial problems			<i>Concerns related to management of practice finances or due to practice audits/repayments (e.g. Medical Review Committee, Revenue Canada)</i>
4.18 Civil suit related to practice			<i>Arising from patient who has pursued civil litigation related to allegations of substandard treatment – patient or other party seeking damages</i>
4.19 Criminal charges related to practice			<i>Arising from charges related to sexual abuse of a patient, fraud, narcotics offences</i>

Problem Category	Check all that apply √	Problem Duration (months)	Sub-category definition
4.20 Other legal & licensing issues			<i>Specify</i>
Family – Relationship			
5.1 Marital/partner/relationship			<i>Problems with spouse, partner, or romantic relationship, including separation or divorce</i>
5.2 Parenting			<i>Problems in dealing with children.</i>
5.3 Caregiver of parents, others			<i>Problems relating to caring for parents or other relatives who need care, including time management, arranging of care, and emotional issues</i>
5.4 Domestic violence			<i>Experience of physical abuse in the home, victim or perpetrator</i>
5.5 Other family problems			<i>Specify</i>
Physical / Medical / Cognitive			
6.1 Physical disability			<i>Chronic physical disability that interferes with work or other aspects of life.</i>
6.2 Blood borne pathogen			<i>e.g. HIV, Hep C, Hep B</i>
6.3 Chronic pain			<i>Chronic pain that interferes with work or other aspects of life</i>
6.5 Other medical problem(s)			<i>Specify</i>
6.6 Ageing			
6.7 Neuro-degenerative illnesses			<i>e.g. multiple sclerosis, Alzheimer's</i>
6.8 Other cognitive issues			<i>Specify</i>
Other Personal (Non-occupational)			
7.1 Emotional abuse – subject of			<i>Subject of verbal abuse or harassment causing emotional distress outside of workplace setting.</i>
7.2 Sexual abuse – subject of			<i>Subject of unwanted sexual verbal suggestions or innuendo and/or physical touching outside of workplace setting</i>
7.3 Physical abuse – subject of			<i>Subject of hitting or other physical violence that does not involve spouse/partner (refer to domestic violence 5.4) outside of workplace setting</i>
7.4 Emotional abuse – perpetrator of			<i>Perpetrator of verbal abuse or harassment causing emotional distress outside of workplace setting</i>
7.5 Sexual abuse – perpetrator of			<i>Perpetrator of unwanted sexual verbal suggestions or innuendo and/or physical touching outside of workplace setting</i>
7.6 Physical abuse – perpetrator of			<i>Perpetrator of hitting or other physical violence that does not involve spouse/partner (refer to domestic violence 5.4) outside of workplace setting</i>
7.7 Personal financial problems			
7.8 Civil legal issues			<i>May include lawsuits not related to practice – divorce proceedings, child custody etc</i>
7.9 Criminal legal issues			<i>Criminal charges not related to practice such as DUI, Assault etc.</i>
7.10 Other personal			<i>Specify</i>

8. Service provided:

This section records services provided by the PHP. Several different services may be provided to an individual or client, and all should be recorded in the format below. This variable includes only services provided or actions taken directly by the PHP, not those for which an individual or client is referred elsewhere. For example, if a client is given financial advice by the PHP, record it here; if a client is referred elsewhere for this service, record it here as "Referred elsewhere" and record the specific service below under referrals in Variable #16.

Service Provided VALUES:

Service Provided Category	Check all that apply √	Sub-category definition
Non-Clinical services:		
1.0 Information & Education:		
1.1 Information on PHP services		<i>Information is given about the services provided by the PHP, verbally or by providing material or referral to a website</i>
1.2 Information on Physician health issues		<i>Information is given information about physician health issues in general. This can be done verbally or by supplying material, or through referral to literature or other resources on the subject</i>
1.3 Education		<i>PHP provides one or more lectures to a group of students, residents, physicians or others on physician health issues</i>
1.4 Wellness Retreat or Workshop		<i>Request for an educational program to be offered or facilitated by PHP. If a caller requests information about a wellness retreat or workshop not provided by the PHP then the service recorded would be "Referral elsewhere for services"</i>
2.0 Referral Elsewhere for service (Clinical or non-Clinical)		
		<i>Referral for information, advice, counselling, assessment, treatment, support group, or any other service – (Complete referral information under Variable #16)</i>
Clinical Services provided by PHP:		
Interventions		
3.1 Direct intervention by PHP staff		<i>At least one member of the PHP staff, and possibly others involved with the client, directly confront the client regarding problems. Intervention may lead to client being assessed or treated, and becoming a PHP case</i>
3.2 Intervention facilitated by PHP staff		<i>PHP provides information to those who plan to confront the client, but no PHP Staff member participates directly in the intervention</i>
Direct Services by PHP		
4.1 Brief advice		<i>One hour or less of individual advice on personal or professional issues</i>
4.2 Triage assessment		<i>Brief questioning to determine the nature of the problem, to determine where client should be referred</i>
4.3 Formal assessment		<i>In-depth assessment, possibly involving physiological and/or psychological tests, possibly resulting in a diagnosis</i>
4.4 Case co-ordination/management		<i>Ongoing contact with client, tracking treatments, services, and progress</i>
4.5 Monitoring contract		<i>Formal treatment contract for a fixed duration, specifying services provided to client and client's responsibilities, with specified conditions for breaking the contract</i>
4.6 Monitoring: drug screen only		<i>Limited duration contract for drug screening, with specified conditions for breaking the contract</i>
4.7 Protective drugs		<i>Recommendation prescription of protective drugs, eg. Antabuse</i>
4.8 Planned follow-up		<i>Follow-up with client after a specified period of time, possibly following treatment or other services. Follow-up is to see how client is doing and whether further services are required, distinct from case management, and not including a formal contract</i>
4.9 Counselling/ psychotherapy by PHP		<i>More than one session of advice, counselling, or psychotherapy regarding personal, career, or professional issues</i>

Service Provided Category	Check all that apply √	Sub-category definition
4.10 Peer support network through PHP		<i>Peer support group or network offered by the PHP, distinct from an outside group or network to which the client is referred</i>
4.11 Other service		<i>Specify</i>

9. Reason for termination of contact with PHP:

Primary reason that contact with contact or case was completed or concluded. Select **one**.

Reason for termination VALUES:

1. Successful completion of service	<i>Service provided by PHP</i>
2. Transfer to other service provider	<i>No further contact with PHP</i>
3. Client refused further contact with PHP	
4. Client moved out of province	
5. Client cannot be located	
6. Client is deceased	
7. Case closed due to expiry	
8. Other reason	<i>Specify</i>

SECTION II. VARIABLES TO BE COLLECTED FROM INDIVIDUALS (CLIENTS) WHO BECOME CASES:**10. Standardized tests used in identifying presenting problem:**

If standardized tests are used by the PHP in diagnosing or exploring client's presenting problem, record the name of the test, and the score on intake or initial assessment, below. It is beyond the scope of this guide to recommend specific tests but only to recommend that if tests are used, scores should be recorded here when initially administered, and as progress and outcome measures (Section VII) after service completion if practicable. Examples of tests you may wish to consider at intake and to gauge progress and outcome include; the Maslach Burnout Inventory,¹ the Beck Depression Inventory,² the Addiction Severity Index,³ the Health Survey SF-12,⁴ the General Health Questionnaire (GHQ),⁵ the Annual Satisfaction Index,⁶ the Social and Occupation functioning assessment scale (SOFAS),⁷ and the Global Assessment of Functioning scale (GAF).⁸ In addition, examples of tests that might be used at intake are the CAGE,⁹ MAST,¹⁰ DAST,¹¹ and AUDIT.¹²

SPECIFY TEST USED	SCORE	DATE ADMINISTERED

11. Medication and drug use profile:

The following table includes a list of the commonly used medications and other drugs. This is intended to record the client's medication and drug use at the time of receiving services from the PHP. If the client's presenting problem is problematic use of substances, record information in the "problem drugs" variable (#13).

Medication and Drug Use VALUES:

Drug	Check all that apply ✓	Duration of use(months)
1. Prescribed drugs for chronic conditions (e.g. diabetes, heart, blood pressure, etc.) (Specify)		
2. Antidepressants		
3. Antipsychotics		
4. Anticonvulsants & Lithium		
5. Minor tranquilizers (Benzodiazepines, valium)		
6. Other sleep agents		
7. Rx. Analgesics including opioids		
8. Birth control medication		
9. Other regularly prescribed medication (Specify)		
10. Antihistamines and decongestants		
11. Analgesics OTC (over the counter)		
12. Antacids		
13. Vitamins & supplements		
14. Herbal remedies		
15. Smoking cessation products (patch or gum)		
16. Other OTC medications		
17. Alcohol		
18. Steroids		
19. Illicit drugs (Specify)		
20. Other drugs (Specify)		

12. Smoking status:**Smoking status VALUES:**

1. Never	<i>Has ever smoked less than 100 cigarettes in total</i>
2. Past/Former	<i>Has smoked nothing for at least one month</i>
3. Current occasional smoker	<i>Smokes less frequently than every day</i>
4. Current daily smoker	<i>Smokes every day</i>

13. Problem Drugs (If Client's presenting problem is substance abuse or substance dependence):

Indicate the "primary" drug(s) of choice and other drugs with which the client has problems. The preferred drug will usually be one drug, but may sometimes be a combination such as alcohol and benzodiazepines where both drugs are equally favoured and both should be recorded. The last Column applies to other drugs which the individual uses problematically.

Drug of Choice VALUES:

DRUG	Preferred Drug(s) ✓	Duration of Use (months)	Other problem drugs ✓
1. Alcohol			
2. Opioids			
3. Minor tranquilizers (benzodiazepines; e.g. valium)			
4. Marijuana/hashish			
5. Cocaine/crack			
6. Amphetamines/stimulants			
7. Non-benzodiazepine sedative-hypnotics (e.g. barbiturates)			
8. Hallucinogens			
9. Solvents/inhalants			
10. Dissociative anesthetic (e.g. ketamine)			
11. Antihistamines and/or decongestants			
12. Steroids (anabolic)			
13. Other specify: _____			

14. Case referral source:

The referral source answers the question "Who asked you to call the PHP"

Case referral source VALUES: (May be more than one)

Case Referral Source	Check all that apply ✓	Definition
1.0 Self:		<i>The client contacted the PHP independently without pressure from another person or organization (as far as is known by the PHP)</i>
Personal Relationship to client:		
2.1 Spouse/Partner		
2.2 Other family member		
2.3 Personal physician		<i>Family physician of the client or other physician treating the client</i>
2.4 Other regulated health professional		<i>Includes only those health professionals providing health care to the client.</i>
2.5 Other professional or service provider		<i>Professional such as lawyer or financial adviser providing personal service or advice to the client.</i>
2.6 Other personal relationship		<i>e.g. friend, boyfriend, girlfriend</i>

Case Referral Source	Check all that apply ✓	Definition
Professional relationship to client:		
3.1 Employment		<i>Client's work supervisor, including hospital administrator; Chief of Staff</i>
3.2 Colleague		<i>Physician who works with the client in a professional relationship, but is not the client's supervisor. Includes a physician colleague who is a friend</i>
3.3 Any other co-worker		<i>Any non-physician co-worker of the client, including, nurses, other professionals, clerical staff, etc.</i>
3.4 Professional regulatory body		<i>Professional licensing body such as College of Physicians</i>
3.5 Professional association		<i>National, provincial, or local professional medical association.</i>
3.6 House staff organization or hospital Committee		
3.7 Resident organization		<i>National, provincial, local, or hospital resident organization (e.g. CAIR, PAIRO)</i>
3.8 Student organization		<i>National, provincial, or university medical student organization (e.g. Federation of Medical Students)</i>

15. Regulatory involvement:

This variable indicates whether the regulatory body (Provincial licensing body – i.e. College of Physicians and Surgeons) is involved with the case, and whether the individual is involved with the regulatory body in any way. The involvement indicated here is not the same as having been referred by the regulatory body, which may be indicated by referral source (Variable #14). A client may be involved with the regulatory body, but referred by someone else.

Regulatory involvement VALUES:

1. Involvement related to presenting problem	<i>The client's involvement with the regulatory body is directly related to the presenting problem. The regulatory body may request a report on the client's presenting problem, or any issues with compliance in assessment and/or treatment.</i>
2. Involvement not related to Presenting problem	<i>The client has issues (complaints, investigations, discipline etc) with the regulatory body that are not related to the presenting problem.</i>
3. No regulatory body involvement	<i>At the time the client presents to the PHP for a service, there is no regulatory involvement.</i>

16. Where referred for service:

When a client (case) is referred outside the PHP for treatment or service, record it here. A case may be referred to more than one service. This variable does not record the specific treatment provided by the service referred to. For example, a client may be referred for individual counselling or to an addiction treatment program. That referral is recorded here but the specific therapy provided by the therapist or program is not recorded.

Where referred VALUES: (May be more than one)

Where Referred	Check all that apply ✓	Sub-category definition
Assessment and treatment:		
1.1 Multidisciplinary assessment service		<i>Assessment that may include psychiatric assessment, psychological and neurological testing, physiological measures, social assessment, etc. Purpose is to determine the primary problem or diagnosis and the best approach to treatment</i>

Where Referred	Check all that apply ✓	Sub-category definition
1.2 Problem specific assessment		<i>Assessment of the severity or a particular problem, to determine what treatment services are required</i>
1.3 Inpatient treatment		<i>Any form of residential treatment in a hospital, treatment facility or other inpatient facility</i>
1.4 Outpatient treatment		<i>Any form of outpatient treatment program in a hospital, facility, clinic etc</i>
1.5 Other		<i>Specify</i>
Addiction-related services:		
2.1 Detox		
2.2 Caduceus group		
2.3 12-step group		<i>e.g. AA, NA, SA, CA, Adult Children of Alcoholics</i>
2.4 Self-help group		<i>Other than 12-step, e.g. Al-Anon, Narc-Anon, Women for Sobriety</i>
2.5 Addiction treatment program		<i>Multidisciplinary addiction treatment program which may be inpatient, day program, or other outpatient (indicate inpatient or outpatient above in conjunction with this value)</i>
2.6 Individual Addiction specialist		<i>Addiction physician or other health professional who specializes in treating individuals with addiction problems.</i>
2.7 Therapeutic community		<i>Longstanding treatment community e.g. Stonehenge – Guelph</i>
2.8 Other Addiction-related service		<i>Specify</i>
Medical treatment		
3.1 Family physician		
3.2 Psychiatrist		
3.3 Other specialist physician		
3.4 Hospital emergency department		
3.5 Other medical treatment		<i>Specify</i>
Counselling and group therapy		
4.1 Individual counselling		
4.2 Group therapy		
4.3 Couple/family counselling		
4.4 Spousal/partner support group		
4.5 Non-traditional/alternative healer		
4.6 Other counselling		<i>Specify</i>
Other personal services:		
5.1 Child care assistance		
5.2 Community agency		<i>For example, United Way, John Howard Society,</i>
5.3 Occupational/professional counselling		
5.4 Legal services		
5.5 MD management		
5.6 Financial counselling		
5.7 Ombudsman		
5.8 CMPA		
5.9 Other personal service		<i>Specify</i>
Assistance from the profession:		
6.1 Professional association		
6.2 Undergrad/postgrad Medical society		
6.3 Rural Physician Action Plan		
6.4 Compassionate expense fund		
6.5 Other professional service		<i>Specify. e.g. educational course</i>

SECTION III. CASE CHARACTERISTICS (PERSONAL)

Personal and professional case characteristics are recorded as they present when the client is first provided service by the PHP. A major research purpose of using Common Indicators is to examine the characteristics of clients presenting to Canadian PHPs.

17. Age: Year of birth.

It is important to record year of birth rather than age at intake, as year of birth does not change.

Age VALUE: Year of birth

18. Gender:**Gender VALUES:**

1. Male
2. Female
3. Unknown/Other

19. Current relationship status:**Relationship status VALUES:**

1. Married/partnered/common law
2. Single/separated/divorced/widowed

20. Spouse a physician?**Spouse a physician? VALUES:**

1. Yes
2. No
3. Unknown

21. Marital History:

of previous marriages

22. Caregiver roles:

Caregiver roles are where the client has the primary responsibility for caring for another person, or shares the responsibility equally with a partner. That is, the client has at least 50% responsibility for care.

Caregiver roles VALUES: *(May be more than one)*

1. Children	<i>Client's children or step-children</i>
2. Parents	<i>Client's parents or parents-in-law</i>
3. Other	<i>Any other individuals for whom the client has caregiver responsibility</i>
4. None	

23. Number of children:

Number of children VALUE: number

24. Number of children living with client at least 25% of time:

Number of children living with client at least 25% of time VALUE: number

25. Ages of children:

Age at time of client's first contact with PHP.

Child	Age
1	
2	
3	
4	
5	

26. Active spiritual practice:**Active spiritual practice VALUES:**

1. Yes	<i>Involvement in an organized religion, with regular attendance at services, and observance of practices. Daily meditation practice, Yoga etc or other form of active spiritual practice</i>
2. No	

27. Regular physical activity?

1. Yes	<i>Participates in a physical activity 3 or more times per week for at least 20 minutes duration each time</i>
2. No	

28. Overall health status:

Client's self-reported overall health status at time of PHP service.

Health Status VALUES:

1. Excellent
2. Good
3. Fair
4. Poor

29. Regular family physician?**Regular family physician VALUES:**

1. Yes	<i>Regular family physician refers to a physician to whom the client entrusts their primary health care needs, and where a doctor-patient relationship has been clearly established</i>
2. No	

30. If Yes, seen physician in past year?

1. Yes	<i>Has kept an appointment with the family physician in the past year</i>
2. No	

SECTION IV - CASE CHARACTERISTICS (PROFESSIONAL)

Personal and professional case characteristics are recorded as they present when the client is first provided service by the PHP. A major research purpose of using Common Indicators is to examine the characteristics of clients presenting to Canadian PHPs.

31. Career stage:

Reflects the career stage of the client at the time that they first contact the program for services.

Career stage VALUES:

1. Independent practice	<i>Holds a licence for independent practice issued by a Canadian College of Physicians and Surgeons</i>
2. Resident/postgraduate fellows	<i>Enrolled in a postgraduate medical school program through an accredited medical school and holds an educational licence issued by a Canadian College of Physician and Surgeons</i>
3. International Medical Graduate (IMG)	<i>Has completed a medical degree in a country outside Canada and currently does not hold either a licence for independent practice or an educational licence</i>
4. Unlicensed professional	<i>Does not currently hold an independent or educational licence but has been licensed to practice in the past. Licence to practice medicine has been revoked or client has formally withdrawn/resigned from medical practice</i>
5. Student	<i>Is a medical student in an accredited medical school</i>
6. Retired	<i>A physician who has practised in Canada and held an independent practice licence, but no longer practices.</i>
7. Other <i>Specify</i>	

32. Where professional education obtained:

In which country did the physician obtain his/her medical degree?

Country of MD education VALUES:

1. Canada
2. USA
3. Other

33. Medical school of graduation, if Canada:

If client graduated from medical school in Canada, specify school of graduation.

Medical School VALUES: Specify school

34. Year of medical/professional graduation:

Year that physician graduated from medical school; NOT the year that the physician began the practice of medicine.

VALUE: year

35. Total number of years in practice:

Total number of years practising medicine. If retired or not practising, record the total number of years in practice at the time of retirement.

VALUE: years

36. Other advanced degree:

Degree other than graduation in profession. May occur prior to/or following MD professional education.

Advanced Degree VALUES:

1. Public Health Masters	<i>MPH, MSc, MHSc</i>
2. Business Masters	<i>MBA</i>
3. Academic doctorate	<i>PhD</i>
4. Law	<i>LLB, LLM</i>
5. Other	<i>Specify</i>

37. Specialty certification (primary specialty practiced):

Select only **one** – the primary area in which the physician practices.

Specialty certification VALUES:

General Practice	
	1.1 General practice
	1.2 Family Practice
Clinical Specialists	
	2.1 Anaesthesia
	2.2 Community Medicine
	2.3 Dermatology
	2.4 Diagnostic Radiology
	2.5 Emergency Medicine
	2.6 Internal Medicine (e.g. <i>Cardiology, Clinical Immunology & Allergy, Endocrinology, Gastroenterology, Geriatrics, Haematology, Infectious Diseases, Medical Oncology, Nephrology, Respiratory Medicine Rheumatology</i>)
	2.7 Medical Genetics
	2.8 Neurology
	2.9 Nuclear medicine
	2.10 Occupational medicine
	2.11 Paediatrics
	2.12 Physical Medicine/Rehabilitation
	2.13 Psychiatry
	2.14 Radiation Oncology
Laboratory Specialists	
	3.1 Pathology (e.g. <i>Anatomical pathology, General/clinical pathology, Haematologic pathology, neuropathology</i>)
	3.2 Laboratory Medicine (e.g. <i>Medical biochemistry, Medical microbiology</i>)
Surgical Specialists	
	4.1 Cardiovascular/Thoracic surgery
	4.2 General Surgery
	4.3 Neurosurgery,
	4.4 Obstetrics/gynaecology
	4.5 Ophthalmology
	4.6 Otolaryngology
	4.7 Orthopaedic surgery
	4.8 Plastic Surgery
	4.9 Urology
5.0 Other	<i>Specify</i>

38. Certified in Addiction Medicine (may be more than one):**Addiction medicine certification VALUES:**

	Check all that apply ✓	
1. CSAM		<i>Canadian Society of Addiction medicine certification</i>
2. ASAM		<i>American Society of Addiction medicine certification</i>
3. Other		<i>Specify</i>
4. Not certified		

39. Practice Addiction Medicine:

At least 20% of the physicians' practice is focused on patients whose primary presenting problem is substance dependence or substance abuse.

Practice addiction medicine VALUES:

1. Yes
2. No

40. Prescribing privileges:

Current status of narcotic and controlled drug prescribing privileges:

Prescribing privileges VALUES:

1. Unrestricted	<i>No restrictions on the ability to prescribe narcotics, controlled drugs, benzodiazepines or other targeted substances under Controlled Drugs and Substances Act</i>
2. Restricted	<i>Formal restrictions to limit or prohibit prescription of one or more drug(s) in the categories of narcotics, controlled drugs, benzodiazepines or other targeted substances. Formal restrictions may be placed on the physician by the College of Physicians in the form of practice restriction or notification to Health Canada.</i>
3. Revoked	<i>Formal notice that physician is prohibited from prescribing drug(s) in the categories of narcotics, controlled drugs, benzodiazepines or other targeted substances. Notice provided by Health Canada to pharmacies in Canada.</i>

41. Employment status:

At the time of obtaining service from the PHP:

Employment status VALUES:

1. Working in the profession	<i>Practising as an MD (including residency program or student)</i>
2. Parental leave	<i>Maternal/Paternal leave</i>
3. Sabbatical/educational leave	
4. Ill/Disabled	<i>e.g. medical leave</i>
5. Not employed in medicine	<i>Not working in the medical profession</i>
6. Other	<i>Specify (includes retired and unemployed)</i>

42. Work hours per week:

If currently working in the profession, number of hours (excluding on-call)

Work hours VALUES: number of hours

43. On call hours:

If currently working in the profession, Range and **average on-call** work hours per month for those who do call. This does not presume a regular 9 – 5 work schedule, but is intended to capture on call hours outside of the physician’s own regular schedule.

Average on-call hours VALUES:

1. Up to 50 hours per month
2. 51- 120 hours per month
3. 121- 180 hours per month
4. 181- 240 hours per month
5. More than 240 hours per month
6. No on-call

44. Practice setting:

If currently working in the profession, designate a **primary** practice setting and check all that apply.

Practice setting VALUES:

	Primary Practice Setting ✓	Check all that apply ✓	
1. Solo clinical			<i>Independent clinical practice – does not practice with other physicians/health professionals</i>
2. Group clinical			<i>Practice in association with at least one physician and/or other health professionals - includes workplace settings like community clinics/CHC, may include walk-in clinics</i>
3. Hospital based clinical			<i>Includes emergency department, community hospital, academic health science centres</i>
4. Locum			<i>May be either in solo or group setting. Defined by temporary work arrangement.</i>
5. Other clinical			<i>Research unit, nursing homes/homes for the aged</i>
6. Non clinical			<i>Non clinical includes settings such as university, research, professional association etc. administrative office</i>

45. Practice Activity:

If currently working within the profession, designate **one** primary practice activity

Practice Activity VALUES:

1. Direct patient care	<i>Provide direct patient care</i>
2. Managing practice	<i>Management of private practice group/facility</i>
3. Research	
4. Administration	<i>Hospital based practice</i>
5. Teaching/Continuing medical education	
6. Other	<i>Specify</i>

46. Type of income:

If working within the profession, designate **one** primary source of income in past twelve months of medical practice

Type of Income VALUES:

1. Fee For Service	<i>Income based on billing to provincial plan for reimbursement</i>
2. Salary	<i>Income as a salaried employee – i.e. Community clinic, government agency</i>
3. Capitation	<i>Income as a flat fee for taking care of enrolled patients</i>
4. Sessional/per diem/hourly	<i>Income based on hourly, sessional or per diem rates to 3rd party</i>
5. Service contracts	<i>Income based on contracts negotiated with 3rd party payer</i>
6. Other	<i>Income not captured in payment method described above.</i>

47. Satisfaction with work situation:

Client’s self-reported satisfaction with work situation at time of beginning PHP service.

Work Satisfaction VALUES:

1. Very satisfied
2. Somewhat satisfied
3. Somewhat dissatisfied
4. Very dissatisfied

48. Changes in work situation:

Recent changes in client’s work situation (at time of beginning PHP service). These changes can include changes in place of employment, changes within an employing organization, changes in workload, changes in close colleagues or supervisors.

Changes in work situation VALUES:

1. In past six months or less
2. In past 7 – 12 months
3. No changes in past year

49. Community size:

Size of community in which client’s primary practice is located.

Community Size VALUES:

1. Urban core areas	<i>Continuously built up areas 100,000 persons or more.</i>
2. Suburban areas	<i>Areas with access to Urban Core Areas. Suburban areas include Large Towns, Small Towns and Isolated Rural Areas with access to Urban Core Areas</i>
3. Small Cities	<i>City with population of greater than 50,000 without an adjacent suburban area</i>
4. Large Town areas	<i>Towns with populations between 10,000-49,000 and surrounding rural areas with access to these towns</i>
5. Small Towns and Isolated Rural Areas	<i>Towns with populations below 10,000 and other isolated rural areas</i>

SECTION V - CLIENT & FAMILY HISTORY OF PROBLEMS**50. Client history and previous treatment or management:**

Problems the client has suffered in the past. The primary problem category should be indicated and subcategories can be indicated by inserting the appropriate number from the list in Variable #7. (*Specify as many previous problems as are applicable*).

For each type of problem, specify the treatment received by inserting the number from the list in Variable #16. Also, indicate when treatment was experienced, listing more than one year when problems recurred. (*Specify as many treatments as are applicable*). Referring to values in Variable #16, it is recognized that in many cases the PHP will not have provided prior services.

Previous client history and treatment VALUES: Refer to Variable #7 and Variable #13 values

For example:

Problem Ref. # (From Variable #7)	Treatment Ref # (From Variable #16) Year	Treated
1.2 (Substance dependence)	2.5 (Addiction treatment program)	1972; 1985

51. History of problems in family:

Not all problems are relevant or significant for every case. When a problem in the family is identified, indicate the problem and the family member to which it applies (e.g. mother, brother, etc.). (*Specify as many problems and family members as are applicable*)

Family Member VALUES for use in table below:

1. Mother
2. Father
3. Sibling
4. Child
5. Aunt(s) and/or Uncle(s)
6. Grandparent(s)
7. Spouse/partner

Refer to Variable #7 for values of problem referred to.

For example:

Problem Ref. # (From Variable #7)	Family Member
1.2 (Substance dependence)	2. Father; 3. Sister
3.2 (Depression)	7. Spouse

SECTION VI - CASE PROGRESS, OUTCOME, AND TERMINATION

Measurement of progress and outcome depends on presenting problem, and measures will vary widely. Below are some general measures, and suggestions regarding more detailed measures.

REFERRAL ACCEPTANCE:

If a client is referred for service outside the PHP, this question records whether the referral was accepted.

52. Referral accepted:

Client accepted the referral for appointment, institution, or group

Referral accepted VALUES:

1. Yes
2. No
3. Unknown

PROGRESS FOR ADDICTIVE DISORDERS:**53. Relapse:**

Known relapse during case management or monitoring for addictive disorders, where relapse is understood as any return to drug use, including a single episode, while involved with PHP. Answer this question when the client file is closed.

Relapse VALUES:

1. Yes
2. No
3. Unknown

When a relapse occurs while case is still open, a Relapse Questionnaire may be completed giving more details for each incident. A version of the Relapse Questionnaire used by the Ontario PHP is provided in Appendix 1.

PROGRESS FOR PSYCHIATRIC DISORDERS:**54. Recurrence:**

Known recurrence of psychiatric disorder during case management or monitoring for a psychiatric disorder where recurrence is defined as a return of symptoms or a significant increase in symptoms following a period of stability. It is important to note whether the recurrence is related to the same diagnosis or a different diagnosis within two months of the last treatment. Answer this question when the client file is closed.

Recurrence VALUES:

1. Yes
2. No
3. Unknown

When a recurrence occurs while case is still open, a Recurrence Questionnaire may be completed giving more details for each incident. A version of the Recurrence Questionnaire developed by the Ontario PHP is provided in Appendix 2.

FOR SPECIFIC PROBLEMS WHERE THERE IS A STANDARDIZED TEST:**55. Standardized test scoring:**

A useful measure of progress and outcome is a comparison of the client's score on a standardized test or instrument at a later date or upon leaving the PHP with the score measured on entering the PHP. The table below can be used to record

scores on tests that repeat those administered on intake, throughout program contact, or as the client leaves the program (Refer to Question#10 for examples of suggested tests). Test scores during and on completion of the PHP program are useful even if the test was not administered on intake. The “Date Administered” column allows comparisons with open and close dates, and facilitates progress measurement by the use of standardized tests throughout the program. For example, a given test may be administered annually to a monitored client.

SPECIFY TEST USED	SCORE	DATE ADMINISTERED

AT TIME OF TERMINATION OF CASE CONTACT:

56. PHP rating of outcome:

Overall description of outcome of service, as perceived by the PHP person most in contact with the case at the time of termination of contact.

Outcome rating VALUES:

1. Problem completely resolved
2. Problem improved
3. Little improvement
4. No improvement
5. Problem worsened
6. Unknown

57. Client satisfaction:

Client satisfaction with PHP service following completion of service, if known. This measure increases may be collected directly from the client by the PHP, or by using an objective process outside the PHP following completion of service.

Client satisfaction VALUES:

1. Very satisfied
2. Somewhat satisfied
3. Somewhat dissatisfied
4. Very dissatisfied

FOR WORK-RELATED PROBLEMS:

58. Satisfaction with work situation:

Client’s self-reported satisfaction with work situation at time of termination of PHP contact. Collecting these data in the same way on intake and on termination allows comparison of client’s satisfaction at the end of PHP contact with that on intake.

Work Satisfaction VALUES:

1. Very satisfied
2. Somewhat satisfied
3. Somewhat dissatisfied
4. Very dissatisfied

IN CASE OF CLIENT DEATH:**59. Date of death:**

In some cases this will be the same as a termination date.

Date of death VALUE: date

60. Cause of Death:**Cause of death VALUES:**

1. Natural causes	
2. Suicide	
3. Violent death	
4. Accidental death	
5. Other cause of death	<i>Specify</i>
6. Unknown	

61. Was the cause of death related to the presenting problem?**VALUES:**

1. Yes
2. No

References:

1. Maslach C, Jackson SE, Leiter MP. Maslach burnout inventory manual. 3rd ed. Palo Alto, CA: Consulting Psychologists Press; 1996. Available from: <http://www.cpp.com/detail/detailprod.asp?pc=35>.
2. Beck AT, Steer RA, Brown GK. Beck depression inventory-II (BDI-II). Toronto, ON: Psychological Corporation, Canada; n.d. Available from: http://harcourtassessment.com/cgi-bin/MsmGo.exe?grab_id=73&page_id=6554624&query=beck%2A&hiword=beck%2A+.
3. McLellan AT. Addiction severity index. 5th ed. Philadelphia, PA: Treatment Research Institute, n.d. [cited 2005 Jul 20]. Available from: http://www.tresearch.org/resources/instruments/ASI_5.pdf. [6th ed under development].
4. Ware JE. SF-12v2™ health survey. Lincoln, RI: QualityMetric Incorporated; n.d. [cited 2005 Jul 20]. Available from: <http://www.sf-36.org/tools/sf12.shtml>
5. Goldberg D. General health questionnaire (GHQ). Swindon, Wiltshire, UK: nferNelson; n.d. Available from: http://www.nfer-nelson.co.uk/catalogue/catalogue_detail.asp?catid=98&id=1124#Prices.
6. Annual Satisfaction Index. Adapted from Talbott Recovery Campus.
7. Social and occupational functioning assessment scale (SOFAS). In: American Psychiatric Association. Task Force on DSM-IV. Diagnostic and statistical manual of mental disorders : DSM-IV-TR. 4th ed., text revision. Washington, DC: American Psychiatric Association; 2000. p. 817-818.
8. Axis V: global assessment of functioning. In: American Psychiatric Association. Task Force on DSM-IV. Diagnostic and statistical manual of mental disorders : DSM-IV-TR. 4th ed., text revision. Washington, DC: American Psychiatric Association; 2000. p. 32-34.
9. Ewing JA. Detecting alcoholism. The CAGE questionnaire. JAMA. 1984 Oct 12;252(14):1905-7.
10. Selzer ML. The Michigan alcoholism screening test: the quest for a new diagnostic instrument [MAST]. Am J Psychiatry 1971 Jun;127(12):1653-8. Available from: Melvin L. Selzer, M.D., 6967 Paseo Laredo, LaJolla, CA 92037; Phone: 858-459-1035 ; E-mail: jmslzs@aol.com.
11. Skinner HA. The drug abuse screening test [DAST]. Addict Behav 1982;7(4):363-71. Available from: Marketing and Sales Services, Centre for Addiction and Mental Health, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1; Phone: 1-800-661-1111 or 416-595-6059.
12. Babor TF, Higgins-Biddle JC, Saunders JB, Monteiro MG. AUDIT : the alcohol use disorders identification test : guidelines for use in primary care. 2nd ed. Geneva, Switzerland : World Health Organization, Dept. of Mental Health and Substance Dependence; 2001. [cited 2005 Jul 26]. Available from: http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf.

Appendix 1

PHYSICIAN RELAPSE QUESTIONNAIRE FOR SUBSTANCE USE DISORDERS

Participant Identifier: _____

Date of relapse: Year Month: Day: Is above relapse date an estimate?: YES NO**At Time of Relapse:**Duration of continuous abstinence prior to relapse: Months **or** Unknown: **DESCRIPTION OF RELAPSE:****What drug(s) were used:**

1	ALCOHOL
2	OPIOIDS
3	MINOR TRANQUILIZERS (Benzodiazepines; e.g. Valium)
4	MARIJUANA/HASHISH (CANNABIS)
5	COCAINE/CRACK
6	AMPHETAMINES/STIMULANTS
7	NON-BENZODIAZEPINE SEDATIVE-HYPNOTICS (e.g. Barbiturates)
8	HALLUCINOGENS
9	SOLVENTS/INHALANTS
10	DISSOCIATIVE ANESTHETIC
11	ANTIHISTAMINES and/or DECONGESTANTS
12	STEROIDS (Anabolic)
13	OTHER Specify:

Duration of use (check one): Single use
 One day or less
 More than one day: Days
 Unknown

Description (check one): Lapse (Self-limited use, one day or less)
 Minor relapse (Self-limited use, remained in contact with program)
 Major relapse (Longer-term use, loss of connection to program)

Was client re-assessed? YES NOWas re-treatment obtained? YES NO**WORKPLACE CONSEQUENCES:****How was work affected?**

Work not affected
 Work temporarily interrupted
 Work stopped
 N/A

REGULATORY CONSEQUENCES

Were there any regulatory consequences from the licensing body for the relapse? YES NO

PHP CONSEQUENCES

As a results of the relapse, did the PHP change its treatment of the client? YES NO

If yes, what was the PHP Response to Relapse (Check all that apply):

- None
- Increase contact with monitor
- Increase frequency of urine testing
- Increase contact with Addiction Medicine physician
- Increase attendance at Mutual Help group
- Increase Health Professionals Support Group
- Increase or add therapy or counselling (Specify): _____
- Other activity change (Specify): _____
- Reset Contract Date - New Date: Year Month: Day:
- Terminated
- Other (Specify): _____

OTHER CONSEQUENCES TO RELAPSE

LIFE AREA	CONSEQUENCE OCCURRED?
Physical Health	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN
Marriage or Relationship	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN
Legal (Non-regulatory)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN
Other	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN

Overall outcome of Relapse:

- Satisfactory (Back on track without major consequences; continuation in PHP)
- Minor Setback (Back on track with adjustments in program, continuation in PHP)
- Major Setback (Major consequences or re-treatment, or reset PHP contact)
- Poor Outcome (Possible or known continued use; not in contact with PHP)
- Deceased

Comments:

Appendix 2

PHYSICIAN QUESTIONNAIRE FOR RECURRENCE OF PSYCHIATRIC DISORDER

Participant Identifier: _____

Date of recurrence: Year Month: Day: Is above recurrence date an estimate?: YES NO**At Time of Recurrence:****Was client re-assessed?** YES NO**Was recurrence related to current diagnosis?** YES NO**If NO, what is the diagnosis (Specify)** _____

(Use codes from Variable #7, Table 2 - Section 2)

Was further treatment obtained? YES NO**WORKPLACE CONSEQUENCES:****How was work affected?**

- Work not affected
- Work temporarily interrupted
- Work stopped
- N/A

REGULATORY CONSEQUENCES**Were there any regulatory consequences from the licensing body for the recurrence?** YES NO**PHP CONSEQUENCES****As a result of the recurrence, did the PHP change its treatment of the client?** YES NO**If yes, what was the PHP Response to Recurrence (Check all that apply):**

- None
- Increase contact with monitor
- Addition of urine testing
- Increase contact with psychiatrist
- Increase Health Professionals Support Group
- Increase or add therapy or counselling (Specify): _____
- Other activity change (Specify): _____
- Reset Contract Date - New Date: Year Month: Day:
- Terminated
- Other (Specify): _____

OTHER CONSEQUENCES

LIFE AREA	CONSEQUENCE OCCURRED?
Physical Health	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN
Marriage or Relationship	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN
Legal (Non-regulatory)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN
Other	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN

Overall outcome of Relapse:

- Satisfactory (Back on track without major consequences; continuation in PHP)
- Satisfactory (Back on track without major consequences; continuation in PHP)
- Minor Setback (Back on track with adjustments in program, continuation in PHP)
- Major Setback (Major consequences or re-treatment, or reset PHP contact)
- Poor Outcome (Serious unremitting course, deterioration, etc. not in contact with PHP)
- Deceased

Comments:

Appendix 3

ANNUAL SATISFACTION INDEX

Unique Identifier: _____

Date questionnaire completed: Year Month: Day: *Complete the index below based on overall satisfaction with life areas during the past year. For each life area, circle the appropriate number.*

<u>LIFE AREA</u>	<u>SATISFACTION RATING</u>			
	Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied
1. Your physical health	4	3	2	1
2. Your emotional health	4	3	2	1
3. Your ability to think clearly and your memory	4	3	2	1
4. Your attitudes in general	4	3	2	1
5. Your social life	4	3	2	1
6. Your relationship with your spouse or significant other	4	3	2	1
7. Your family life	4	3	2	1
8. Your professional life	4	3	2	1
9. Your financial status	4	3	2	1
10. Your self-esteem	4	3	2	1
11. Your sense of inner peace	4	3	2	1
12. Your ability to achieve balance in life	4	3	2	1
13. Your spiritual health	4	3	2	1
14. Your progress in recovery	4	3	2	1
15. Your lifestyle (diet, exercise)	4	3	2	1
16. Your leisure life	4	3	2	1
17. Your overall life satisfaction	4	3	2	1

**SUMMARY VARIABLE LIST FOR
COMMON INDICATORS
FOR CANADIAN PHYSICIAN HEALTH PROGRAMS**

August 2005

SECTION I. VARIABLES TO BE COLLECTED FOR ALL CONTACTS AND CASES:

The variables below should be collected for each individual and/or client to whom any service is provided, including information and education. A “Contact” is established when an individual or client receives information, education or prevention related service from a PHP. A “Case” is established when a PHP client (physician, resident, student, family member) receives a clinical service from the program.

Page numbers refer to the *Guide for Common Indicators for Canadian Physician Health Programs*.

1. Unique identifier (page 5):

A unique identifier may take any form convenient to the individual PHP, including numeric, alpha-numeric or alpha character descriptions.

2. Open Date (page 5):

Date when individual first seeks services from the PHP. Recorded in the format of Year/Month/Day.

3. Close Date (page 5):

Date when service provision is ended. Recorded in the format of Year/Month/Day.

4. Service group (page 5):

Group to which the individual calling the PHP, or the potential client, belongs. For further clarification, this includes a student, resident or retired individuals within a service group. While other professions that are currently served by Canadian PHPs are included in the variable “service group”, all other data/variables are structured and defined as it relates to physicians. Calls also come from persons who are not health professionals, such as educators, researchers, or the general public. This variable does not specify the individual caller’s relationship to the client or potential client. For example, a call from a physician’s wife would be recorded under the “physician” service group.

5. Caller Role - Relationship of caller to Service Group (page 6):

This link between the caller role and the service group provides information about who is calling with respect to a particular service group.

6. Source for Contact (page 6):

How the individual/client learned about the PHP services.

7. Presenting problem (page 7):

This is the reason the individual contacted the PHP and it is recorded based on the assessment of the PHP at the point of first contact. Presenting problems are organized into the seven primary presenting problem categories. Within each primary category, more detailed information about the problem can be recorded, including problem duration (in months).

A psychiatric diagnosis is recorded only if the individual has been diagnosed according to DSMIV criteria, and is presenting with an existing diagnosis. A separate list is provided for mental health problems not formally diagnosed according to DSMIV criteria.

8. Service provided (page 10):

This section records services provided by the PHP. Several different services may be provided to an individual or client, and all should be recorded. This variable includes only services provided or actions taken directly by the PHP, not those for which an individual or client is referred elsewhere. If the individual/client is referred elsewhere, this is recorded under variable #16.

9. Reason for termination of contact with PHP (page 11):

Primary reason that contact with contact or case was completed or concluded.

SECTION II. VARIABLES TO BE COLLECTED FROM INDIVIDUALS (CLIENTS) WHO BECOME CASES:**10. Standardized tests used in identifying presenting problem (page 12):**

If standardized tests are used by the PHP in diagnosing or exploring client's presenting problem, record the name of the test, and the score on intake or initial assessment.

11. Medication and drug use profile (page 12):

This is intended to record the client's medication and drug use at the time of receiving services from the PHP. If the client's presenting problem is problematic use of substances, record information in the 'problem drugs' variable #13.

12. Smoking status (page 13):

This records the client's smoking status at the time that they contact the PHP.

13. Problem Drugs (If Client's presenting problem is substance abuse or substance dependence) (page 13):

Indicate the 'primary' drug(s) of choice and other drugs with which the client has problems. The preferred drug will usually be one drug, but may sometimes be a combination such as alcohol and benzodiazepines, where both drugs are equally favoured and both should be recorded. Also, record other drugs that the individual uses problematically.

14. Case referral source (page 13):

The referral source answers the question "Who asked you to call the PHP"

15. Regulatory involvement (page 14):

This variable indicates whether and/or how the regulatory body (College of Physicians and Surgeons) is involved with the case. This involvement is distinct from a referral from a regulatory body to the PHP, which is recorded by referral source (variable #14). A client may be involved with the regulatory body, but referred by someone else.

16. Where referred for service (page 14):

This variable captures when a client (case) is referred outside the PHP for treatment or service. A case may be referred to more than one service. This variable does not record the specific treatment provided by the service referred to. For example, a client may be referred for individual counselling or to an addiction treatment program and while the referral is recorded here, the specific therapy provided by the therapist or program is not recorded.

SECTION III. CASE CHARACTERISTICS (PERSONAL)

Personal and professional case characteristics are recorded as they present when the client is first provided service by the PHP.

17. Age: Year of birth (page 16).

It is important to record year of birth rather than age at intake, as year of birth does not change.

18. Gender (page 16):**19. Current relationship status (page 16):**

This is to record the relationship status of the individual at the point that they seek a service from the PHP and to distinguish between married/partnered and single status.

20. Spouse a physician? (page 16)

For the individual seeking a service, to record if their spouse is a physician.

21. Marital History (page 16)

of previous marriages

22. Caregiver roles (page 16):

Caregiver roles are where the client has the primary responsibility for caring for another person, or shares the responsibility equally with a partner. That is, the client has at least 50% responsibility for care.

23. Number of children (page 16):

Record as a single numeric value.

24. Number of children living with client at least 25% of time (page 16):

The number of children who live with the client at least 25% of the time.

25. Ages of children (page 17):

For each child, record their age at the time of the client's first contact with the PHP.

26. Active spiritual practice (page 17):

Active spiritual practice is defined primarily by the client and would include for example, involvement in organized religion, daily meditation practice, yoga etc.

27. Regular physical activity? (page 17)

Regular physical activity is defined as participating in physical activity 3 or more times per week, for at least 20 minutes each time.

28. Overall health status: (page 17)

Client's self-reported overall health status at time of PHP service.

29. Regular family physician? (page 17)

Regular family physician is defined as a physician with whom the client entrusts their primary health care needs and where there exists a clearly established doctor-patient relationship.

30. If Yes, seen physician in past year? (page 17)**SECTION IV - CASE CHARACTERISTICS (PROFESSIONAL)**

Personal and professional case characteristics are recorded as they present when the client is first provided service by the PHP.

31. Career stage (page 18):

Reflects the career stage of the client at the time that they first contact the program for services. The career stages reflect the range of licensing stages for an individual physician.

32. Where professional education obtained (page 18):

In which country did the physician obtain his/her medical degree?

33. Medical school of graduation, if Canada (page 18):

If client graduated from medical school in Canada, specify school of graduation.

34. Year of medical/professional graduation (page 18):

Year that physician graduated from medical school; NOT the year that the physician began the practice of medicine.

35. Total number of years in practice (page 18):

Total number of years practising medicine. If retired or not practising, record the total number of years in practice at the time of retirement.

36. Other advanced degree (page 19):

Degree other than graduation in profession. May occur prior to/or following MD professional education.

37. Specialty certification (primary specialty practiced) (page 19):

Select only **one** – the primary area in which the physician practices and holds Royal College of Physicians and Surgeons certification.

38. Certified in Addiction Medicine (may be more than one) (page 20):

Addiction medicine is not captured by specialty certification (variable #37) and this variable records formal certification in this area.

39. Practice Addiction Medicine (page 20):

At least 20% of the physicians' practice is focused on patients whose primary presenting problem is substance dependence or substance abuse.

40. Prescribing privileges (page 20):

Current status of narcotic and controlled drug prescribing privileges.

41. Employment status (page 20):

The employment status of the client at the time of obtaining service from the PHP.

42. Work hours per week (page 20):

If currently working in the profession, number of hours (excluding on-call)

43. On call hours (page 21):

If currently working in the profession, Range and **average on-call** work hours per month for those who do call. This does not presume a regular 9 – 5 work schedule, but is intended to capture on call hours outside of the physician's own regular schedule.

44. Practice setting (page 21):

If currently working in the profession, designate a **primary** practice setting and other settings that are applicable.

45. Practice Activity (page 21):

If currently working within the profession, designate **one** primary practice activity.

46. Type of income (page 22):

If working within the profession, designate **one** primary source of income in past twelve months of medical practice

47. Satisfaction with work situation (page 22):

Client's self-reported satisfaction with work situation at time of beginning PHP service.

48. Changes in work situation (page 22):

Recent changes in client's work situation (at time of beginning PHP service). These changes can include changes in place of employment, changes within an employing organization, changes in workload, changes in close colleagues or supervisors.

49. Community size (page 22):

Size of community in which client's primary practice is located.

SECTION V - CLIENT & FAMILY HISTORY OF PROBLEMS
50. Client history and previous treatment or management (page 23):

Problems the client has suffered in the past. The primary problem category should be indicated along with any relevant subcategories from the list in variable #7. For each type of problem, specify both the treatment received by inserting the number from the list in variable #16, and when treatment was experienced, listing more than one year when problems recurred. For the values in variable #16 ('where referred for service'), it is recognized that in many cases the PHP will not have provided prior services.

51. History of problems in family (page 23):

Not all problems are relevant or significant for every case. When a problem in the family is identified, indicate the problem and the family member to which it applies (e.g. mother, brother, etc.). Specify as many problems and family members as are applicable. Refer to variable #7 for values of problem referred to.

SECTION VI - CASE PROGRESS, OUTCOME, AND TERMINATION

Measurement of progress and outcome depends on presenting problem, and measures will vary widely. Below are some general measures, and suggestions regarding more detailed measures.

REFERRAL ACCEPTANCE:**52. Referral accepted (page 24):**

Client accepted the referral for appointment, institution, or group

PROGRESS FOR ADDICTIVE DISORDERS:**53. Relapse (page 24):**

Known relapse during case management or monitoring for addictive disorders, where relapse is understood as any return to drug use, including a single episode, while involved with PHP. Answer this question when the client file is closed.

When a relapse occurs while case is still open, a Relapse Questionnaire may be completed giving more details for each incident. A version of the Relapse Questionnaire used by the Ontario PHP is provided in Appendix 1.

PROGRESS FOR PSYCHIATRIC DISORDERS:**54. Recurrence (page 24):**

Known recurrence of psychiatric disorder during case management or monitoring for a psychiatric disorder where recurrence is defined as a return of symptoms or a significant increase in symptoms following a period of stability. It is important to note whether the recurrence is related to the same diagnosis or a different diagnosis within two months of the last treatment. Answer this question when the client file is closed.

When a recurrence occurs while case is still open, a Recurrence Questionnaire may be completed giving more details for each incident. A version of the Recurrence Questionnaire developed by the Ontario PHP is provided in Appendix 2.

FOR SPECIFIC PROBLEMS WHERE THERE IS A STANDARDIZED TEST:**55. Standardized test Scoring (page 24):**

A useful measure of progress and outcome is a comparison of the client's score on a standardized test or instrument at a later date or upon leaving the PHP with the score measured on entering the PHP. Record scores and the date administered for tests that are repeated after intake, throughout program contact, or as the client leaves the program. Test scores during and on completion of the PHP program are useful even if the test was not administered on intake.

AT TIME OF TERMINATION OF CASE CONTACT:**56. PHP rating of outcome (page 25):**

Overall description of outcome of service, as perceived by the PHP person most in contact with the case at the time of termination of contact.

57. Client satisfaction (page 25):

Client satisfaction with PHP service following completion of service, if known.

FOR WORK-RELATED PROBLEMS:**58. Satisfaction with work situation (page 25):**

Client's self-reported satisfaction with work situation at time of termination of PHP contact.

IN CASE OF CLIENT DEATH:

59. Date of death (page 26):

In some cases this will be the same as a termination date.

60. Cause of Death (page 26):

61. Was the cause of death related to the presenting problem? (page 26)

RESEARCH BACKGROUND

GUIDE FOR COMMON INDICATORS FOR
CANADIAN PHYSICIAN HEALTH PROGRAMS

Introduction:**Importance of research on physician health:**

While physician health programs (PHPs) have existed in Canada since the mid-1970's, there has been little research on their activities beyond the record-keeping of individual programs. The few previously published Canadian studies are descriptions of relatively small samples of physicians participating in a single program.¹⁻³ Nevertheless, Canadian and International physician organizations continue to call for increased research on physician health programs. The 1998 Canadian Medical Association (CMA) position paper on Physician Health and Well-Being⁴ recommended that "... ongoing evaluation of support and assistance strategies and programs be carried out." The more recent development of the CMA Centre for Physician Health and Well-Being⁵ provided support for Canadian research on PHPs by a research funding process. One project funded was the development of the Guide for Common Indicators. In addition, a report prepared for the Centre in 2002 recommended increased research on physician health and PHPs.⁶ The Canadian Psychiatric Association's Position Paper on Treatment of the Mentally Ill Physician supports research on the mentally ill physicians.⁷

In the US, a physician health research conference in 1996 set a research agenda for physician health which included comparisons among PHPs and "elaboration of research methodologies."⁸ Internationally, the Manifesto of Barcelona⁹ in 2001 called for research into issues in physician health in Europe. Despite this official acknowledgement and good intentions, there is still a lack of substantive evidence on many issues related to physician health, including the work of PHPs.¹⁰

Research on PHPs:

In addition to the few Canadian studies mentioned above, some US PHPs and large treatment facilities that specialize in treating physicians have published data on their programs and their participants.¹¹⁻¹⁶ Although findings from disparate programs are of interest, they cannot provide a broad picture of physician health and its treatment in PHPs. In addition to selection and reporting biases, comparisons among programs and regions are made difficult by the fact that different data collection methods are used, and measures may not be directly comparable. Also, small programs from less populous provinces and territories cannot accumulate enough participants to conduct research on physician health and their programs.

In the US, a project has begun to encourage state PHPs to collect uniform intake and assessment data from all participants. A questionnaire and assessment instrument was developed by the research committee of the Federation of State Physician Health Programs (FSPHP), initiated by the PHP in Colorado. This group is encouraging other states to adopt the computerized questionnaire, but not all states have bought into the approach. The initiative is hampered by lack of funding and a lack of a long term research plan. To date, no results have been published from this project.

The Guide for Common Indicators for Canadian Physician Health Programs was developed as a first step toward standardized data collection for Canadian PHPs. With the development of the Guide, Canada is in a position to take the lead in research on physician health and the work of PHPs if the Guide is implemented and a science-based research agenda is put forward and followed.

Purpose of this document:

This Research Background is intended to accompany the Guide for Common Indicators for Canadian Physician Health Programs. For each group of variables, it provides a brief summary of research literature and the importance of collecting data on the issues. The research summarized here focuses on research questions that could be addressed if Canadian PHPs were to implement the Guide. Specifically, this is not a review of the entire literature on physician health. It is a review of material that relates to the issues that will be raised by collection of the variables in the Guide. Where applicable, the variables mentioned here refer to the variable number and page number in the Guide.

SECTION I. VARIABLES TO BE COLLECTED FOR ALL CONTACTS AND CASES:

The unique identifier generated by the PHP will allow linking of the common indicator variables and other measures to the services provided by the PHP. This unique identifier may take any form convenient to the individual PHP, and is for internal use by the PHP. It is included here to assist PHPs in database planning.

1. Unique identifier (page 5)**Contacts with PHPs: how many, who, and when:**

This group of variables represents the basic data of how many people contact the PHPs, when they contact the PHPs, and who the callers are in a general sense. These broad descriptive data will allow collection of national statistics on the number of Canadian physicians using PHPs, and how many individuals of other

- 2. Open Date (page 5)**
- 3. Close Date (page 5)**
- 4. Service Group (page 5)**
- 5. Caller Role (page 6)**

professions are provided service by PHPs. Collection of the date of contact will allow identification of seasonal variations and trends over years. There are scattered research reports of trends in single programs or jurisdictions, but there is no previous report of the collection of these data within an entire country.

By definition, PHPs were formed to help physicians who have addiction, mental health, or other health problems. However, several Canadian PHPs now offer services to other professionals such as pharmacists, veterinarians, and lawyers.¹⁷ Recording the service group will allow national comparisons of the numbers of members of various professions served by PHPs. While many callers will be members of the service group themselves (e.g. physicians), others with varying relationships to the service group may also call the PHP. PHPs often offer services to family members,¹⁷ but callers also may include colleagues or clinicians treating the service group member, among others.

How a contact learned about the PHP:

This variable is critically important to PHPs in planning the dissemination of information about their programs. For example, if a large proportion of callers learned about the program from the internet, or from educational presentations by the PHP, these could become important avenues for informing professionals about the program.

6. Source for Contact (page 6)

Why physicians contact PHPs:

North American PHPs were originally formed to deal with alcohol and drug problems,¹⁸ but they now deal with a wide range of personal and professional problems.¹⁷ For example, in 2004 only about one quarter of calls to the Ontario PHP were regarding substance use or a combination of substance use and psychiatric disorders.¹⁹ Nevertheless, publications describing the activities and participants in North American PHPs deal almost exclusively with physicians "impaired" by alcohol and drug problems.^{1-3,11-16,20,21} An important contribution to the research literature would be a description of Canadian physician participants with problems other than alcohol and other drugs, and the services offered to these physicians by PHPs. Currently there are no data on physicians who present with mental health, occupational, or family problems, how PHPs help them, and whether they are satisfied with the services received.

7. Presenting problem (page 6)

It should be clearly understood that the application of Common Indicators to collection of data regarding problems presenting to Canadian PHPs will not give information about the prevalence of these problems among the population of Canadian physicians. Instead, the data collected will indicate the kinds of problems for which physicians seek help from PHPs, and how the PHPs help them. Physicians turning to PHPs are not a random sample of Canadian physicians, and many who have health problems will seek help elsewhere. Nevertheless, application of the Guide may produce some data on trends in the types of health problems physicians are concerned about.

Types of presenting problems:

Addictive Disorders: The majority of published research on PHPs is related to problems with alcohol and other drugs. In contrast to early reports that physicians are more likely than others to have such problems,²² more recent research shows that drug problems occur among physicians with about the same frequency as the general population^{23,24} and other professionals,²⁵ and less frequently among women physicians.^{26,67} Nevertheless, PHPs originated in response to alcohol and drug problems among physicians¹⁸ and in past decades many programs dealt with these problems exclusively. Programs were called "Impaired Physician Programs."¹⁵ However, among programs that address physician health problems other than substance abuse and dependence, the proportion of cases that present with drug-related problems has been declining. For example, only about one quarter of participants in the Ontario PHP in 2004 presented with substance use disorder or substance use disorder combined with psychiatric disorders.¹⁹

Although there are many publications regarding physician PHP clients who have problems with alcohol or other drugs, most are descriptive and all apply to one program only. Except for one recent study,²¹ few have carried out detailed analyses of risk factors and relationships with outcome. Also, the relationship of alcohol and other drug problems to other presenting problems is not known. These knowledge gaps could be addressed with collection of relevant variables in sufficient numbers.

When physicians have problems with alcohol or other drugs, the most common service offered by PHPs is contractual monitoring, accompanied by a range of support services, counselling, and advocacy.^{19,21} It is not known what factors are related to success in monitoring, or whether physicians with these problems can benefit from alternative services. If comparable data are collected by PHPs that offer a range of services, research on these questions can begin.

While there are clinical reports, there are no systematic research studies of physicians with gambling addiction or sexually compulsive behaviour.

Psychiatric Disorders: There are numerous clinical reports of psychiatric problems and treatment among physicians.²⁹ However, there are few studies of the prevalence of psychiatric disorders in physician populations. In the UK, managers, physicians, nurses, and other professions in the National Health Service were found to have a higher prevalence of “minor psychiatric disorders” than the general population.³⁰ Among US female physicians, 19.5% had a self-reported history of depression, similar to the findings of studies of women in the general population.³¹ In the 1992 survey of Canadian physicians, 21% reported ever having sought counselling for emotional problems, more than pharmacists but less than lawyers.²⁵ Most studies have concentrated on mood and anxiety disorders, the most common diagnoses, and there is little study of other disorders. Studies of physicians presenting to PHPs have usually discussed psychiatric disorders in the context of their co-occurrence with substance use problems, or dual disorders. Betts reported on physicians with a variety of psychiatric disorders participating in the North Carolina PHP.³² When treated and monitored, two thirds of these physicians had successful outcomes in the program.

In view of the growing emphasis of PHPs on problems other than substance abuse, it is important to examine psychiatric disorders, and their relationship with other problems, in this population of physicians.

Mental Health: In the framework of presenting problems in the Guide for Common Indicators, Mental Health issues are separated from Psychiatric Disorders by the application of DSM diagnoses to the latter. Mental health issues include stress, anxiety, and depression that are not diagnosed according to DSM criteria. The research issues regarding these problems are the same as for psychiatric disorders, and there has been little study of these problems among PHP clients.

Overall, physicians have been found to have higher rates of suicide than the general population.^{33,34} However, there are methodological problems with studies of physician suicide that make statistics unreliable.³⁵ A recent US consensus statement on depression and suicide in physicians encouraged reducing barriers to physicians seeking help for mental health problems.³⁶ Research on these problems among Canadian PHP participants will help to develop new approaches and point prevention and ways to make help more accessible for these physicians.

Occupational Issues: Physicians commonly report a high degree of occupational stress. On the CMA’s Physician Resource Questionnaire, physicians report a high level of occupational stress and dissatisfaction with the conditions under which they practice.³⁷ In the Ontario Medical Association’s 2001 survey of Ontario physicians, about 46% of respondents reported finding medical practice very or extremely stressful.³⁸ A recent study of Alberta physician reported that almost half of respondents were in advanced stages of burnout, but the response rate to this survey was low.³⁹ A similar level of burnout was found in the 2003 CMA PRQ study.⁴⁰

Occupational stress can result from loss of sleep due to long work and on-call hours,^{37,41} although much of the literature on this issue focuses on resident physicians.⁴² In the US, limits have been placed on the work hours of residents due to concern about work performance.⁴³

Regarding career satisfaction, the US study of women physicians reported that 49% of female physicians were always or almost always satisfied with their careers.⁴⁴ In this study, 69% said they would choose the same career again. Among Canadian physicians in 1992, 68% said they would choose the same career again.²⁵ There is variability among specialties in the level of career satisfaction reported,⁴⁵ and controversy over whether dissatisfaction among physicians is increasing.^{46,47}

Other problems originating in the workplace include harassment,⁴⁸ sexual harassment,⁴⁹ and violence and abuse from patients.⁵⁰ In addition, physicians themselves may commit sexual offences.⁵¹ In addition, there is increasing concern about behaviourally disruptive physicians.⁵²

While occupational and workplace problems are commonly reported and increasingly seen at PHPs, there is little research on the characteristics of physicians who present with these problems, the services offered to them by PHPs, or their outcomes.

Family/relationship: Many clinical studies report the problems of physician marriages, which can be strained by long hours of work and conflicting priorities.^{53,54} The prevalence of domestic violence among physicians is reportedly quite low, but, in the US Women Physicians Health Study, it was related to other medical and psychiatric difficulties.⁵⁵ Among physicians using the services of PHPs, it is not known how many present with family problems, or what services are offered to them by the PHPs. *For more information on family and relationship problems, see the section below on Case Characteristics (Personal).*

Physical/mental/cognitive: There is no published research on PHP actions in dealing with physical health problems such as blood-borne pathogens or other medical problems. In many jurisdictions, PHPs do not address these issues, although some PHPs are broadening their scope to include them. Some concern about cognitive impairment of physicians has been raised in the context of professional competency.⁵⁶ Also, these problems may arise as physicians age.⁵⁷ As it is relatively new for PHPs to address these issues, it is important to have a firm grounding for carrying out research on this work.

Services provided by Canadian PHPs:

Canadian PHPs offer a wide range of services to their clients and participants, including education, information, assessment and referral, counselling, case management, and monitoring under contract.¹⁷ No systematic information is available indicating which services are most commonly offered for which presenting problems, or which services are offered internally by PHPs themselves and which are provided by referral to outside providers. This information is essential to understanding the activities of Canadian PHPs.

Reasons for termination of contact not only elaborates on the activities of PHPs, but can be used when selecting cases for research on outcome. For example, one could examine intake data or outcomes for those who successfully completed service, or for those who were lost to further contact.

- 8. Service provided (page 10)
- 9. Reason for termination of contact with PHP (page 11)

SECTION II. VARIABLES TO BE COLLECTED FROM INDIVIDUALS (CLIENTS) WHO BECOME CASES:**Standardized and diagnostic tests:**

A wide range of standardized tests can be used in the initial assessment of PHP participants, and in monitoring progress and outcome. In the *Guide* (page 12), several examples are given, with references to the test manuals. The use of standardized tests facilitates objective measurement of progress, as scores throughout monitoring, or on completion of a program, can be compared with those on entry, when appropriate for the test. The advantage to using standardized tests is that scores can be compared with published norms, as well as with participants' own scores at different times. As the choice of appropriate test depends on the presenting problem and the preferences of the PHP, they cannot be summarized here. Consult the references given in the *Guide*, or published materials, for other specific tests.

- 10. Standardized tests used in identifying presenting problem (page 12)

Participants' use of medications and drugs, other than substance use and dependence:

PHPs have typically collected detailed information on drugs used dependently or problematically by their participants, but little or no information has been published on other medications or drugs used by participants, or by those presenting with problems other than substance-related. Collection of this information has the potential to illuminate new aspects of presenting problems and possible risk factors. In addition, use of medications may point to health problems that would not be otherwise recorded.

Smoking rates among North American physicians are currently less than 5%,^{26,58} while PHPs report smoking rates among their clients of up to 50%.^{21,59} Although smoking status is related to less favourable outcomes among non-physician psychiatric patients, a recent study of risk factors for relapse among physicians monitored for substance use problems by a PHP found no relationship to smoking status.²¹

- 11. Medication and drug use profile (page 12)
- 12. Smoking status (page 13)

Problem Drugs:

This variable is to be used if clients present with substance abuse or substance dependence problems. Most publications on PHP clients and services have addressed those who have problems with alcohol and other drugs. While there is concern that physicians are disproportionately likely to develop problems with opioids or other drugs to which they have increased access, particularly among some specialties,^{15,60-62} by far the most common problematic drug or drug of choice reported among PHP clients is alcohol.^{12,15,21,59,62,63} One recent study found that use of a "major" opioid drug was a predictor of relapse during monitoring for substance abuse.²¹ More research is needed to examine risk factors associated with the use of particular drugs, and the outcomes associated with drug use and PHP services.

- 13. Problem Drugs (page 13)

Who asked the physician to call the PHP:

Referral source tells how a physician came to the program. Was he or she pushed by an employer, the licensing body, a spouse, or did they come on their own initiative? Collecting data on referral source and regulatory involvement allows description of factors that send clients to PHPs, but correlation of this information with presenting problem will answer questions about which problems are more likely to come to the attention of regulatory bodies and which are more likely to be self-referred. There is no existing research literature specifically on this issue and data illuminating the question will be an advance in knowledge. In addition, it is not known whether referral source is related to outcome, although one US study compared characteristics and outcomes for physicians in treatment voluntarily with those monitored by the licensing board.⁶⁴ While the physicians in the two groups had differing personal and

- 14. Case referral source (page 13)
- 15. Regulatory involvement (page 14)

professional characteristics, their short-term outcomes did not differ. As defined in the Guide, involvement with a regulatory body may be recorded as related to the client's presenting problem or unrelated. This distinction may be critical for examining the role of coercion in the use of PHPs, as distinct from physicians presenting with co-existing problems.

Services provided outside the PHP:

Canadian PHPs provide a wide variety of services, some "in house" and others by referral to individuals or agencies outside the PHP.¹⁷

The critical research question of relating outcome to type of service received requires the recording of this variable. Surprisingly, there is little published research on this topic. Publications regarding treatment of physician health problems have tended to report data from one treatment facility or one treatment approach. Implementing the Guide in Canadian PHPs offers the possibility of comparing outcomes for physicians who are referred to different types of services for the same presenting problem, an opportunity that does not often present itself when studying the clients of a single PHP.

16. Where referred for service (page 14)

SECTION III. CASE CHARACTERISTICS (PERSONAL)

Demographics and life situation:

Physician clients of PHPs who have problems with alcohol and other drugs tend to be in mid-life,^{1,12,15,16,21,59} but there are few published studies of the age of physicians in PHPs with other types of presenting problems. In the US Women Physicians' Health Study, younger women reported higher levels of work-related stress associated with less control over their work.⁴⁴ The age at which problems develop may have important implications for examination of risk factors, and preventing problems.

Women are generally under-represented in the client populations of PHPs, but most studies deal only with drug-related problems.^{1,12,15,19,21} It is not known whether this represents a lower prevalence of problems among women, or a reluctance to bring problems to a PHP. One US study reported that women physicians in treatment are more secretive about their substance use.⁶⁶ The US Women Physicians' Health Study found that female physicians follow relatively personal behaviours,²⁶ as did a survey of drug use by Ontario women physicians conducted in 2003⁶⁷ and a 1992 survey of Québec women physicians.⁶⁸ Nevertheless, particular issues have been identified as problematic for women physicians, including work stress⁶⁹ and abuse and harassment at work.^{49,70,71} Women with caregiver roles report more stress, but most would choose to become a physician again.⁴⁴

A great deal has been written about medical marriages, which can suffer due to long work hours and conflicting priorities for physicians.^{53,54} In addition, marital difficulties among physicians have been related to mood disorders.⁷³ On the other hand, a supportive spouse and absence of role conflict have been found to be related to marital and parental satisfaction of physicians.⁷⁴ Little has been written about marriage and family issues in PHPs. It is not known how marital status and caregiver roles relate to presenting problems among physicians, or to outcomes for clients of PHPs.

- 17. Age (page 16)
- 18. Gender (page 16)
- 19. Relationship status (page 16)
- 20. Spouse a physician (page 16)
- 21. Marital history (page 16)
- 22. Caregiver roles (page 16)
- 23. Number of children (page 16)
- 24. Number of children living with client (page 16)
- 25. Ages of children (page 17)

Health status and self-care:

In the US Women Physicians' Health Study, "devout" physicians were more likely to report that they would become a physician again,⁴⁴ and, among Canadian physicians in 1992, attendance at religious services was associated with decreased use of tobacco, alcohol, and illicit drugs.²⁵ However, there are no data on the religious practices of physicians using the services of PHPs, and relationship to presenting problem, services, or outcome.

In 1992, 45% of Canadian physicians reported having a personal physician who provides regular care, significantly lower than the proportion of pharmacists (65%) and lawyers (66%) in the same study who indicated they have a physician.²⁵ Among Québec physicians in 1992, almost half of female physicians reported having a regular physician, while little more than one quarter of male physicians reported the same condition.⁶⁸ Although it is commonly stated that physicians are less likely than others to have a regular personal physician, there are no studies relating the presence of a personal physician to health outcomes in physicians.

- 26. Active spiritual practice (page 17)
- 27. Regular physical activity (page 17)
- 28. Overall health status (page 17)
- 29. Regular family physician (page 17)
- 30. Seen physician in past year (page 17)

SECTION IV - CASE CHARACTERISTICS (PROFESSIONAL)**Physician education and career stage:**

Little is known about the relationship of physician education to the development of problems. Canadian PHPs provide services mostly to practising physicians, but most also offer services to residents and medical students.^{17,19} In addition, medical schools and resident organizations provide services for students and residents who need help.⁷⁵

As mentioned above in discussing age, problems with alcohol and other drugs tend to develop in mid-life. Medical interns and residents may have particular problems with stress and mental health issues^{76,77} and medical students are particularly likely to report being recipients of abuse.^{48,71,78} Retirement is perceived positively by most physicians, but there are challenges and adjustments to be made at this time.³⁶ In addition, older physicians may face challenges of fatigue and declining memory abilities.⁷⁹ Number of years in practice and year of graduation are closely correlated with age and career stage.

While foreign medical graduates face difficulties in beginning practice in Canada, where physicians are educated has never been studied in relation to physician health and wellness. Canadian medical schools are increasing their emphasis on training in self-care and wellness, but no study has related the school where physicians graduated to subsequent health problems.

Specialty:

Among programs serving physicians who have problems with alcohol and other drugs, the specialties of anaesthesia and psychiatry are often reported to be over-represented,^{15,20,21,59,61,62} and paediatricians may be under-represented.⁸⁰ High levels of stress are frequently reported among emergency physicians.⁸¹ However, the evidence regarding the association of drug use or emotional problems with physicians of different specialties is equivocal.^{82,83} Surveys of practising physicians have not found consistent specialty differences, and over-representation of particular specialties in PHPs can be due to reasons other than elevated prevalence of problems.²² For example, some PHPs may acquire a reputation for serving particular specialists, such as anaesthetists, or licensing boards or others may be more likely to refer physicians of particular specialties to PHPs.

Drug-related practice:

Physicians who practice addiction medicine are more likely than other physicians to have had drug problems in the past themselves.²⁵ However, it is not known whether physician who practice addiction medicine are more or less likely to use the services of PHPs.

Physicians who develop problems with drugs available only on prescription may have their prescribing privileges restricted or revoked, and some PHPs report a high proportion of clients who have such restrictions.^{20,84} It is not known whether these restrictions are related to other problems physicians may have, or to treatment outcome for these physicians.

Practice and employment variables:

Long hours of work and on call hours have been associated with stress, particularly among resident physicians.⁴² However, in a survey of Canadian physicians' drug use, Brewster found that those who worked the longest hours used drugs less frequently than those who worked shorter hours.²⁵ Special stresses have been attributed to physicians who practice in isolation, either in solo practice or in rural communities.⁸⁵ In general, there is little empirical research relating employment and practice activities to physician health and the use of the services of PHPs.

Work satisfaction:

In general, surveys of practicing physicians have found that most would choose to become physicians again.^{25,44} However, Canadian physicians responding to the CMA's Physician Resource Questionnaire report a high level of occupational stress and dissatisfaction.³⁷ Recent changes in work situation may indicate dissatisfaction with work. Dissatisfaction with work, and occupational stress, are themselves problems for which physician may seek help

- 31. Career stage (page 18)
- 32. Where professional education obtained (page 18)
- 33. Medical school of graduation, if Canada (page 18)
- 34. Year of medical/professional graduation (page 18)
- 35. Total number of years in practice (page 18)
- 36. Other advanced degree (page 18)

- 37. Specialty certification (page 19)

- 38. Certified in Addiction Medicine (page 20)
- 39. Practice Addiction Medicine (page 20)
- 40. Prescribing privileges (page 20)

- 41. Employment status (page 20)
- 42. Work hours per week (page 20)
- 43. On call hours (page 21)
- 44. Practice setting (page 21)
- 45. Practice Activity (page 21)
- 46. Type of income (page 22)
- 49. Community size (page 22)

- 47. Satisfaction with work (page 22)
- 48. Changes in work situation (page 22)

from PHPs. The relationship between these variables and the development of other types of problems has not been explored.

SECTION V - CLIENT & FAMILY HISTORY OF PROBLEMS

Physicians being helped by PHPs for problems with alcohol and other drugs report a high rate of previous treatment for substance abuse and psychiatric problems.^{15,59} In the Ontario PHP, they also report relatively high levels of abuse experience (both as victim and perpetrator).⁵⁹ High levels of family history of substance abuse are also reported.^{21,59} Family history of substance use disorder was found to increase the risk of relapse in a recent study of physicians monitored for substance use disorder.²¹ In a non-clinical population, Canadian physicians who had direct relatives and/or a spouse who had problems with alcohol or other drugs were more likely to use drugs.²⁵ In the general population, childhood sexual and physical abuse are clearly associated with the subsequent development of substance abuse problems.^{86,87} Nevertheless, there has not been much study of the specific association of personal and family history of problems and the problems that physicians bring to PHPs.

50. Client history and previous treatment (page 23)
51. History of problems in family (page 23)

SECTION VI - CASE PROGRESS, OUTCOME, AND TERMINATION

Reports of progress and outcome for physician in PHPs have so far been confined to programs addressing problems with alcohol and other drugs. In general, physicians do well in these programs, with a combination of case management and monitoring. Many programs report success rates of 90% or more,^{20,63,84,88} although these reports do not necessarily share consistent definitions of success. One requirement for all is abstinence from drug use. There are no reports of outcomes for physicians who bring problems other than substance abuse to PHPs, and consistent data are needed to examine these.

Another approach to outcome measurement is demonstrated by a recent publication of physicians' measured satisfaction with the PHP services.⁸⁹ These authors found that physicians who had good clinical outcomes reported a higher level of satisfaction with PHP services. One recent study related various characteristics of physician in treatment for substance abuse to the risk of relapse.²¹ The occurrence of any relapse during monitoring was independently related to the presence of a coexisting psychiatric diagnosis, use of a "major" opioid, or existence of a family history of substance abuse. Risk increased with the presence of more than one of these risk factors.

There is a need to continue research on predictors of progress and outcome in physician health programs, to inform education and prevention efforts as well as decisions about services to be offered to physician clients of PHPs. Such research is best carried out with the numbers of clients that can be studied by inclusion of more than one PHP. But a prerequisite for this is consistent data definitions and indicators so that a shared understanding is reflected in the collaborative studies.

REFERENCES

- 1 Glaser FB, Brewster JM, Sisson BV. Alcohol and drug problems in Ontario physicians: Characteristics of the physician sample. *Canadian Family Physician*, 1986(May), *32*: 993-999.
- 2 Graham D, Rayson J. The physician support program of British Columbia. *British Columbia Medical Journal*, 1995, *37*(1): 23-25.
- 3 Henderson HW. Addicted doctors: Responding to their needs. *Canadian Family Physician*, 1983(Sep), *29*: 1691-1699.
- 4 Canadian Medical Association. Policy on Physician Health and Well-Being. Available: http://www.cma.ca/index.cfm/ci_id/3211/la_id/1.htm Accessed August 10, 2005
- 5 Canadian Medical Association Centre for Physician Health and Well-Being http://www.cma.ca/index.cfm/ci_id/25541/la_id/1.htm Accessed August 1, 2005
- 6 Brewster JM, Robertson RC. *Physician health in Canada: Current status and recommendations for action*. Prepared for Canadian Medical Association Centre for Physician Health and Well-being, October, 2002.
- 7 Myers M. Treatment of the mentally ill physician. CPA Position Paper. *Canadian Journal of Psychiatry*, 1996, *42*(6): Insert.
- 8 Dilts S, Goldman L, Shore J. Physician health research conference (Estes Park, Colorado – September 15-17, 1996): Progress report one year later. *Psychiatric Quarterly*, 1999 (Summer), *70*(2): 93-106.
- 9 PAIMM (Integral Care Programme for Sick Physicians). *Manifesto of Barcelona*. Consensus statement: 1st European Meeting PAIMM 2001. Barcelona, November 8, 2001. Available: <http://paimm.fgalatea.org/eng/manifest.htm> Accessed August 10, 2005
- 10 Brown R, Schneidman B. Physicians' health programs – What's happening in the USA? *Medical Journal of Australia*, 2004 (Oct 4), *181*(7): 390-391.
- 11 Bohigian GM, Croughan JL, Sanders K, Evans ML, Bondurant R, Platt K. Substance abuse and dependence in physicians: The Missouri physicians' health program. *Southern Medical Journal*, 1996(Nov), *89*(11): 1078-1080.
- 12 Bohigian GM, Bondurant R, Croughan J. The impaired and disruptive physician: The Missouri Physicians' Health Program – an update (1995 – 2002). *Journal of Addictive Diseases*, 2005, *24*(1): 13-23.
- 13 Pelton C, Lang DA, Nye GS, Jara G. Physician diversion program experience with successful graduates. *Journal of Psychoactive Drugs*, 1993(Apr-Jun), *25*(2): 159-164.
- 14 Reading EG. Nine years experience with chemically dependent physicians: The New Jersey experience. *Maryland Medical Journal*, 1992(Apr), *41*(4): 325-329.
- 15 Talbott GD, Gallegos KV, Wilson PO, Porter TL. The Medical Association of Georgia's Impaired Physicians Program: Review of the first 1000 physicians: Analysis of specialty. *Journal of the American Medical Association*, 1987(Jun 5), *257*(21): 2927-2930.
- 16 Gossop M, Stephens S, Stewart D, Marshall J, Bearn J, Strang J. Health care professionals referred for treatment of alcohol and drug problems. *Alcohol & Alcoholism*, 2001, *36*(2): 160-164.
- 17 Myers M, Watkins T, Microys G. *CMA Guide to Physician Health and Well-Being*. Canadian Medical Association, 2003. Available: <http://www.cma.ca/multimedia/staticContent/HTML/NO/12/PhysicianHealth/resources/guide-PHWB.pdf> Accessed August 10, 2005
- 18 Stimson, Gerry V. Recent developments in professional control: The impaired physician movement in the USA. *Sociology of Health and Illness*, 1985, *7*: 141-166.
- 19 Ontario Medical Association Physician Health Program. Annual Report, 2004. Toronto: Ontario Physician Health Program, 2004.
- 20 Gallegos KV, Lubin BH, Bowers C, Blevins JW, Talbott GD, Wilson PO. Relapse and recovery: Five to ten year follow-up study of chemically dependent physicians – The Georgia experience. *MMJ*, 1992 (April), *41*(4): 315-319.
- 21 Domino KB, Hornbein TF, Polissar NL, Renner G, Johnson J, Alberti S, Hanks L. Risk factors for relapse in health care professionals with substance use disorders. *Journal of the American Medical Association*, 2005 (March 23/30), *293*(12): 1453-1460.
- 22 Brewster JM. Prevalence of alcohol and other drug use among physicians. *Journal of the American Medical Association*, 1986 (April 11), *255*(14): 1913-1920.
- 23 Hughes PH, Brandenburg N, Baldwin DC, Storr CL, Williams KM, Anthony JC, Sheehan DV. Prevalence of substance use among US physicians. *Journal of the American Medical Association*, 1992 (May 6), *267*(17): 2333-2339.
- 24 McAuliffe WE, Rohman M, Santagelo S, Feldman B, Magnuson E, Sobol A, Weissman J. Psychoactive drug use among practicing physicians and medical students. *New England Journal of Medicine*, 1986 (Sep 25), *351*(13): 805-810.
- 25 Brewster JM. *Drug use among Canadian Professionals: Executive Summary of Final Report*. Ottawa: Health and Welfare Canada, 1994.
- 26 Frank E, Brogan DJ, Mokdad AH, Simoes EJ, Kahn HS, Greenberg RS. Health-related behaviours of women physicians vs. other women in the United States. *Archives of Internal Medicine*, 1998, *158*: 342-348.
- 29 Gautam M. Depression and anxiety. In Goldman LS, Myers M, Dickstein LJ. (Eds) *The Handbook of Physician Health: The essential guide to understanding the health care needs of physicians*. Chicago: American Medical Association, 2000.
- 30 Wall TD, Bolden RI, Borrilla CS, Carter AJ, Golya DA, Hardy GE et al. Minor psychiatric disorder in NHS trust staff: Occupational and gender differences. *British Journal of Psychiatry*, 1997 (Dec), *171*(12): 519-523.

- 31 Frank E, Dingle AD. Self-reported depression and suicide attempts among US women physicians. *American Journal of Psychiatry*, 1999, **156**: 1887-1894.
- 32 Betts WC. Psychiatric diagnoses in North Carolina Physicians Health Program participants. *North Carolina Medical Journal*, 1996 (July/August), **57**(4): 214-215.
- 33 Schernhammer ES, Colditz GA. Suicide rates among physicians: A quantitative and gender assessment (meta-analysis). *American Journal of Psychiatry*, 2004 (Dec), **161**(12): 2295-2302.
- 34 Aasland OG, Ekeberg O, Schweder T. Suicide rates from 1960 to 1989 in Norwegian physicians compared with other educational groups. *Social Science & Medicine*, 2001, **52**(2): 259-266.
- 35 Silverman MM. Physicians and suicide. In Goldman LS, Myers M, Dickstein LJ. (Eds) *The Handbook of Physician Health: The essential guide to understanding the health care needs of physicians*. Chicago: American Medical Association, 2000.
- 36 Center C, Davis M, Detre T, Ford DE, Hansbrough W, Hendin H et al. Confronting depression and suicide in physicians: A consensus statement. *Journal of the American Medical Association*, 2003 (June 18); **289**(23): 3161-3166.
- 37 Sullivan P, Buske L. Results from CMA's huge 1998 physician survey point to a dispirited profession. *Canadian Medical Association Journal*, 1998 (Sep 8): **159**(5): 525-528.
- 38 OMA Human Resources Committee. OMA position paper on physician workforce policy and planning. *Ontario Medical Review*, 2002, **69**(4): 17-28.
- 39 Boudreau R, Wedel R, Robertson RC. Physician burnout in Wild Rose Country: Early returns and reflections. Presented at the AMA/CMA International Conference on Physician Health. Vancouver, BC, October 19, 2002.
- 40 Canadian Medical Association Centre for Physician Health and Well-Being. CMA study on physician burnout. Available: http://www.cma.ca/index.cfm/ci_id/9366/la_id/1.htm Accessed August 10, 2005
- 41 Slade S, Busing N. Weekly work hours and clinical activities of Canadian family physicians: Results of the 1997/98 National Family Physician Survey of the College of Family Physicians of Canada. *Canadian Medical Association Journal*, 2002 (may 28), **166**(1): 1407-1411.
- 42 Veasey S, Rosen R, Barzansky B, Rosen I, Owens J. Sleep loss and fatigue in residency training: A reappraisal. *Journal of the American Medical Association*, 2002 (Sep 4), **288**(9): 1116-1124.
- 43 Philibert I, Friedmann P, Williams WT. New requirements for resident duty hours. *Journal of the American Medical Association*, 2002 (Sep 4), **288**(9): 1112-1114.
- 44 Frank E, McMurray JE, Linzer M, Elon L. for the Society of General Internal Medicine Career Satisfaction Study Group. Career satisfaction of US women physicians: Results from the Women Physicians' Health Study. *Archives of Internal Medicine*, 1999 (July 12), **159**: 1417-1426.
- 45 Leigh JP, Kravitz RI, Schembri M, Samuels SJ, Mobley S. Physician career satisfaction across specialties. *Archives of Internal Medicine*, 2002 (July 22), **162**:1577-1584.
- 46 Landon BE, Reschovsky J, Blumenthal D. Changes in career satisfaction among primary care and specialist physicians, 1997 – 2001. *Journal of the American Medical Association*, 2003 (Jan 22/29), **289**(4): 442-449.
- 47 Zuger A. Dissatisfaction with medical practice. *New England Journal of Medicine*, 2004 (Jan 1), **350**(1): 69-75.
- 48 Richman JA, Flaherty JA, Rospenda KM. Perceived workplace harassment experiences and problem drinking among physicians: Broadening the stress/alienation paradigm. *Addiction*, 1996, **91**(3): 391-403.
- 49 Frank E, Brogan D, Schifman M. Prevalence and correlates of harassment among US women physicians. *Archives of Internal Medicine*, 1998 (Feb 23), **158**: 352-358.
- 50 Kmietowicz Z. Half of doctors experience violence or abuse from patients. *British Medical Journal*, 2003 **327**: 889.
- 51 Langevin R, Glancy GD, Curnoe S, Bain J. Physicians who commit sexual offences: Are they different from other sex offenders? *Canadian Journal of Psychiatry*, 1999, **44**: 775-786.
- 52 Kaufmann M. Recognition and management of the behaviourally disruptive physician. *Ontario Medical Review*, 2001 (April): 53-55.
- 53 Myers MF. *Doctors' Marriages (Second Edition): A look at the problems and their solutions*. New York: Plenum, 1998.
- 54 Myers M. Physicians and intimate relationships. In Goldman LS, Myers M, Dickstein LJ. (Eds) *The Handbook of Physician Health: The essential guide to understanding the health care needs of physicians*. Chicago: American Medical Association, 2000.
- 55 Doyle JP, Frank E, Saltzman LE, McMahan PM, Fielding BD. Domestic violence and sexual abuse in women physicians: Associated medical, psychiatric, and professional difficulties. *Journal of Women's Health and Gender-Based Medicine*, 1999 (September), **8**(7): 955-965.
- 56 Turnbull J, Carbotte R, Hanna E, Norman G, Cunnington J, Ferguson B, Kaigas T. Cognitive difficulty in physicians. *Academic Medicine*, 2000 (February), **75**(2): 177-181.
- 57 Goldstein MZ. The aging physician. In Goldman LS, Myers M, Dickstein LJ. (Eds) *The Handbook of Physician Health: The essential guide to understanding the health care needs of physicians*. Chicago: American Medical Association, 2000.
- 58 Brewster JM, Ferrence R, Victor JC, Ashley MJ, Cohen J, Selby P, Tremblay M. Practices of Canadian family physicians and pediatricians in advising parents who smoke. 4th National Conference on Tobacco or Health, Ottawa, June 19 – 22, 2005.

- 59 Brewster JM, Kaufmann IM, Hutchison S. Ontario's Physician Health Program: The first 100 monitored participants. Ontario PHP, unpublished, 2003.
- 60 Booth JV, Grossman D, Moore J, Lineberger C, Reynolds JD, Reves JG, Sheffield D. Substance abuse among physicians: A survey of academic anesthesiology programs. *Anesthesia & Analgesia*, 2002, *95*: 1024-1030.
- 61 Paris RT, Canavan DI. Physician substance abuse impairment: Anesthesiologists vs. other specialties. *Journal of Addictive Diseases*, 1999, *18*(1): 1-7.
- 62 Vanderberry RC. Positioning a safety net for physicians and their patients. *North Carolina Medical Journal*, 1996 (July/August), *57*(4): 195-198.
- 63 Ganley OH, Pendergast WJ, Wilkerson MW, Mattingly DE. Outcome study of substance impaired physicians and physician assistants under contract with North Carolina Physicians Health Program for the period 1995 – 2000. *Journal of Addictive Diseases*, 2005, *24*(1): 1-12.
- 64 Nelson HD, Matthews AM, Girard DE, Bloom JD. Substance-impaired physicians: Probationary and voluntary treatment programs compared. *Western Journal of Medicine*, 1996, *165*: 31-36.
- 66 McGovern M, Angres D, Shaw M, Rawal P. Gender of physicians with substance use disorders: Clinical characteristics, treatment utilization, and post-treatment functioning. *Substance Use & Misuse*, 2003, *38*(7): 993-1001.
- 67 Moukas E, Davidson A, Kaufmann M. OMA Physician Health Program explores help-seeking behaviours of women physicians. *Ontario Medical Review*, 2003 (Nov): 41-43.
- 68 De Koninck M, Guay H, Bourbonnais R, Bergeron P. Physical, mental, and reproductive health of Québec women physicians. *Journal of the American Medical Women's Association*, 1995 (March/April), *50*(2): 59-63.
- 69 Gross EB. Gender differences in physician stress: Why the discrepant findings? *Women & Health*, 1997, *26*(3): 1-14.
- 70 Stewart DE, Ahmad F, Cheung AM, Bergman B, Dell DL. Women physicians and stress. *Journal of Women's Health & Gender-Based Medicine*, 2000, *9*(2): 185-190.
- 71 Moscarello R, Margittai KJ, Rossi M. Differences in abuse reported by male and female Canadian medical students. *Canadian Medical Association Journal*, 1994 (Feb 1), *150*(3): 357-363.
- 73 Myers MF. Mood disorders and doctors' marriages. *BC Medical Journal*, 19998 (April), *40*(4): 162-164.
- 74 Warde CM, Moonesinghe K, Allen W, Gelberg L. Marital and parental satisfaction of married physicians with children. *Journal of General Internal Medicine*, 1999, *14*: 157-165.
- 75 <http://www.pairo.org/> Accessed August 10, 2005
- 76 Bellini LM, Baime M, Shea JA. Variation in mood and empathy during internship. *Journal of the American Medical Association*, 2002 (June 19), *287*(23): 3143-3146.
- 77 Earle L, Kelly L. Coping strategies, depression, and anxiety among Ontario family medicine residents. *Canadian Family Physician*, 2005 (Feb), *51*: 242-243.
- 78 Silver HK, Glick AD. Medical student abuse: Incidence, severity, and significance. *Journal of the American Medical Association*, 1990 (Jan 26), *263*(4): 527-532.
- 79 Draper B, Winfield S, Luscombe G. The older psychiatrist and retirement. *International Journal of Geriatric Psychiatry*, 1997, *12*: 233-239.
- 80 Massachusetts Medical Society, Physician Health Services. Annual Report, 2003. Waltham, MA: Massachusetts Medical Society, 2003.
- 81 Doan-Wiggins L, Zun L, Cooper MA, Meyers DL, Chen EH. Practice satisfaction, occupational stress, and attrition of emergency physicians. *Academic Emergency Medicine*, 1995 (June), *2*(6): 556-563.
- 82 Hughes PH, Baldwin DC, Sheehan DV, Conard S, Storr CL. Resident physician substance use, by specialty. *American Journal of Psychiatry*, 1992 (Oct), *149*(10): 1348-1354.
- 83 Lutsky I, Hopwood M, Abram SE, Carletty JM, Hoffman RG, Kampine JP. Use of psychoactive substances in three medical specialties: Anaesthesia, medicine and surgery. *Canadian Journal of Anaesthesia*, 1994 (July), *41*(7): 561-567.
- 84 Shore JH. The Oregon experience with impaired physicians on probation: An eight-year follow-up. *Journal of the American Medical Association*, 1987 (June 5), *257*(21): 2931-2934.
- 85 Thomassen HV, Lavanchy M, Connelly I, Berkowitz J, Grzybowski S. Mental health, job satisfaction, and intention to relocate. *Canadian Family Physician*, 2001 (April), *47*: 737-744.
- 86 Moncrieff J, Farmer R. Sexual abuse and the subsequent development of alcohol problems. *Alcohol & Alcoholism*, 1998, *33*(6): 592-601.
- 87 Simpson TL, Miller WR. Concomitance between childhood sexual abuse and physical abuse and substance use problems. *Clinical Psychology Review*, 2002, *22*: 27-77.
- 88 Waterhouse GJ, Roback HB, Moore RF, Martin PR. Perspectives of treatment efficacy with the substance dependent physician: A national survey. *Journal of Addictive Diseases*, 1997, *16*(1): 123-138.
- 89 Knight JR, Sanchez LT, Sherritt L, Bresnahan LR, Silveria JM, Fromson JA. Monitoring physician drug problems: Attitudes of participants. *Journal of Addictive Diseases*, 2002, *21*(4): 27-36.