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Executive summary

A physician mental health strategy is one of the four pillars of the Canadian Medical Association’s (CMA) mental health plan, but is also a stand-alone strategy reflecting the CMA’s long-standing interest and leadership in the health and well-being of Canadian physicians. The strategy proposes a framework for a multi-year, collaborative endeavour that the CMA will pursue to optimize the mental health of physicians, residents and medical students.

The need for a strategy is evident from the burden of mental health issues and illness among practising physicians and trainees. Although the overall physical health of physicians is quite good, a significant proportion experience distress associated with mental or emotional issues. Physicians’ rates of depression and alcohol misuse are similar to those of the general population and their rate of suicide exceeds that of the general public. Physicians experience numerous types of stressors related to the nature of medical work, as well as systemic issues associated with the structure and functioning of our health care system. Although increasing efforts have been made to provide services and programs to promote and protect the mental health of physicians, a range of barriers continues to exist. These include the culture and stigma surrounding mental illness, as well as confidentiality and licensing concerns. Physicians with mental illness tend to be treated differently than physicians with physical illness and an insufficient distinction is often made between mental illness and inability to practise medicine.

The four strategic directions, outlined in the following diagram and described in more detail in this strategy, will be used to guide CMA action in the coming years. Considering the magnitude of mental health-related issues
affecting physicians and the challenges to addressing them, a concerted and sustained effort will be required that engages a range of potential partners and funders.

This strategy provides a framework for conceptualizing the many interdependent initiatives that will need to be addressed. As an initial set of actions, the CMA, in collaboration with the provincial and territorial medical associations, the Canadian Physician Health Network, the Canadian Medical Foundation and national organizations of residents and medical students, will pursue a preliminary set of five projects:

I. Develop a comprehensive social marketing campaign to address awareness, knowledge, attitudes and behaviours regarding physician mental health issues.

II. Establish a primary prevention pilot program offering curriculum and skills to build and enhance resiliency.

III. Improve access to care for physicians beginning with a personal physician for every doctor.

IV. Engage regulatory bodies in examining how physician mental health issues and illness are addressed by these bodies.

V. Establish research and evaluation components for each of these four priority projects.
Introduction

A Mental Health Strategy for Physicians in Canada, a key component of the Canadian Medical Association’s (CMA) overall plan for mental health, is focused on promoting and protecting the mental health of Canada’s physicians. The development of this strategy builds on the CMA’s long-standing interest and leadership in this area reflected in previous policies and resources: creating and ongoing expansion of the Centre for Physician Health and Well-Being; planning, organizing and hosting national and international conferences on physician health; launching the International Alliance on Physician Health (IAPH); and facilitating and participating in the Canadian Physician Health Network (CPHN), a national network of organizations interested in advancing the health and well-being of Canadian physicians. The development of this strategy also coincides with increased interest in mental health issues in this country, including the creation of the Mental Health Commission of Canada (MHCC).

Although the few Canadian studies that exist show that the physical health of physicians is quite good compared with that of the general public, physicians experience significant rates of mental health issues (e.g., burnout, stress, distress, behavioural problems, etc.) and mental illness (e.g., depression, suicide, substance use disorders and other psychiatric disorders). Starting in medical school, through residency training and throughout their careers as practising health care professionals, physicians are exposed to numerous stressors, some of which reflect systemic challenges in the structure and functioning of our health care systems. In addition, physicians can experience professional culture impediments to acknowledging and identifying mental health issues or illness and obtaining access to care. Although considerable effort has been made to provide services to physicians, a more comprehensive and ongoing approach to the mental health needs of physicians is required.

The purpose of this strategy is to lay out a comprehensive approach to improving and protecting the mental health of Canada’s physicians, residents and medical students. While focused on the CMA, this strategy will likely be relevant to many individuals and groups including physicians and medical trainees, medical educators, national associations, specialty societies, governments, insurance companies, medical protective associations, regulatory bodies, provincial associations and researchers.
The health of physicians

Over the past 25 years, there has been growing interest in the area of physician health and increasing awareness and recognition of stress, burnout, illness and impairment among physicians. It is crucial to understand and address these issues, as that will allow us to optimize physicians’ health and ensure recruitment and retention of our physician workforce, as well as sustainability of the medical system. Although anecdotal evidence abounds, there is a paucity of studies on the health of Canadian physicians, and the few available have relatively low response rates and rely on self-reporting of health and health behaviours. Data gathered to date must be interpreted within this context.

A recent survey of Canadian physicians found that over 90% of respondents self-reported being in good to excellent health, yet just over 20% of physicians had felt unable to experience joy or had felt depressed for at least two weeks in the preceding year. In addition, although most physicians reported that neither their physical nor mental health made it difficult to work in the past month, over a quarter (26%) stated that their mental health made it difficult to work at least some of the time in the past year. Prevalences of depression and sadness were higher among women than men. An earlier study of lifetime depression rates among female physicians in the United States (US) reported rates (19.5%) that were comparable to those in the general population. These data suggest that physicians may not recognize or acknowledge the important impact of mental health (including exhaustion, overwork, stress, anxiety) on their overall health. This can be an important barrier to seeking assistance and to improved mental health.

Suicide rates among physicians in the US and other countries are higher than those of the general population — about 70% higher for men and 2.5–4 times higher for women. In North America overall, the prevalence of alcohol problems among physicians is believed to be similar to that of the general population, although self-medicating with prescription drugs in times of stress is believed to be higher.

Medical students’ and residents’ health

Like practising physicians, most residents and medical students report high levels of overall health, although a significant minority experience mental health issues.

In a survey of Canadian residents, most respondents (> 80%) self-reported their mental health as good to excellent, yet just under 20% rated it fair to poor. Almost a third (30%) of residents reported having experienced a mental health problem. A systematic review of mental health studies of medical students in the US and Canada found consistently higher rates of psychological distress in medical students compared with both the general population and age-matched peers. A later study at seven US medical schools observed rates of burnout of 49.6% and suicidal ideation among 11% of students. A cohort study of 16 US medical schools observed that a third of the medical students drank excessively. In a recent multicentre study of US medical students and residents, 12% of participants had probable major depression and a further 9% had probable mild to moderate depression.
Rates of depression tended to be higher among medical students than residents and among females compared with males. Nearly 6% of participants reported suicidal ideation.

**Sources of stress**

There are a number of intrinsic and extrinsic stressors for physicians. Stressors intrinsic to providing medical care include working with emotionally intense issues, suffering, fear, failure and death. Night-call duties, long working hours and poor ergonomics are additional physical stressors. System changes with resource constraints, increased consumerism and physician role changes are additional sources of stress.

Working conditions and related stressors are commonly identified by Canadian physicians and residents. Among Canadian physicians, 30% disagreed with a statement that their work environment encourages them to be healthy. Physicians in an Alberta-based survey indicated that stress is affecting their health with severe (6%) or moderate (48%) impact. In a study of Quebec ophthalmologists, more than a third (35%) reported high levels of burnout and psychological distress, with the main occupational stressors being a growth in demand for services, shortage of ophthalmologists, amount of work to be done, budgetary pressures and repeated training of new work teams.

Among Canadian residents, a third reported their life as “quite a bit” to “extremely” stressful. Time pressure was the most commonly identified source of stress among those experiencing a high-stress residency, although nursing staff and staff physicians were the most frequent sources of intimidation and harassment. Other stressors include personal finances, career, decision-making and new responsibilities. There is limited information on stressors among Canadian medical students, although studies elsewhere have found students to be most stressed during the transition to clinical work and suggest that levels of stress decrease with increased level of training.

**Summary**

The self-reported physical health of Canadian physicians and residents is quite good. However, a range of mental health issues and illnesses occur among physicians at least as commonly as they do in the general population and some conditions occur more frequently. Mental health issues and illness, such as distress, depression, substance misuse and suicidal ideation, are also frequent among students and residents. The next section of this document provides a brief overview of existing mental-health-related programs and services for physicians.
There is a potential continuum of services and programs to influence and respond to mental health issues and illness in practising physicians, residents and students. These work to improve the health of the individual physician and have a positive impact on their patients and their practice, as well as their families. The continuum ranges from upstream efforts to create more health-promoting environments and the prevention of mental health issues before they occur, through early intervention to treatment.

The Table 1 provides brief descriptions and examples for different points in this continuum.

Opportunities for prevention and the interventions required for mental health issues and illness overlap, but are not identical. Health promoting environments and primary preventive interventions that reduce stress and encourage more healthy coping strategies should benefit both sets of conditions. For those with existing conditions, interventions can prevent exacerbation of stress and burnout, but it is more difficult to prevent exacerbation of psychiatric illness beyond early identification and response. Nevertheless, steps such as ensuring regular sleep (e.g., no call duties) may help prevent exacerbation of psychiatric illnesses.

The field of physician health has evolved over the past 40 years. In the early 1960s, the focus was primarily

### Table 1

<table>
<thead>
<tr>
<th>Level of intervention</th>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health promotion</td>
<td>Attention to systemic and work environment issues to provide a health enhancing impact</td>
<td>Balancing work hours and workload; increasing support staff; providing recreational facilities; including personal health practices, such as exercise, nutrition and adequate sleep in training and practice</td>
</tr>
<tr>
<td>Primary prevention</td>
<td>Attention to potential risks for developing problems, typically at an individual level</td>
<td>Resiliency training, stress-reduction groups, fatigue management programs; enhancing teamwork and collaborative care; workshops on achieving work–life balance</td>
</tr>
<tr>
<td>Secondary prevention</td>
<td>Attention to early detection of and intervention for problems that are developing</td>
<td>Easy access to assessment and counseling services, workshops on coping with adverse events, litigation, career transitions, dealing with change, dealing with difficult behaviour</td>
</tr>
<tr>
<td>Tertiary prevention</td>
<td>Attention to providing treatment for established problems</td>
<td>Intensive outpatient counseling, inpatient treatment, medication, return to work programs, case coordination/management</td>
</tr>
</tbody>
</table>
on identifying, treating and monitoring colleagues who were misusing drugs and alcohol. During that time, there was growing awareness that a proportion of this population was also dealing with stress, burnout and mental illness, such as anxiety, depression and bipolar disorder. This prompted the emergence of a small number of physician health programs across Canada to provide assistance to these physicians.

Over the past decade, the physician health community has worked hard to destigmatize physician ill health, create enhanced resources to support physicians and increase awareness and use of these resources. Many of these initiatives have been led by organizations such as the CMA Centre for Physician Health and Well-being, the physician health programs (PHP) and other members of the CPHN or key researchers in this area — all interested in and committed to physician health. Some of these were developed ad hoc, arising out of a newly defined need in a specific place at a specific time. The more established PHPs now offer programs at all levels, including health promotion, early intervention, monitoring and treatment. The CPHN is working toward a national system to define common indicators, standardize data collection and establish comprehensive service delivery across the country. This temporal development is encouraging, and continued collaborative efforts will yield healthier doctors and healthier communities nationally.

All Canadian provinces have PHPs to help physicians with mental health problems. The PHPs take calls not only from physicians, but also from their families and colleagues. The extent of staffing varies from physician counselors to case managers of varying backgrounds. Following a preliminary assessment, the PHP will refer a physician to specific services. Physicians with psychiatric or drug-dependence problems are referred outside the PHP, although PHPs can become involved in monitoring physicians. Physicians may also be referred for individual therapy, family therapy or marriage counseling. Even after external referral for treatment, the PHP case manager continues to coordinate and manage overall care. Most PHPs will take referrals from licensing bodies, and some report non-compliance with monitoring contracts to these bodies.

The outcomes for physicians treated for substance use disorders in state PHPs in the US have been quite favourable, although this likely represents a select population of treated physicians. Ontario’s PHP recently reported an 85% successful completion rate for treatment of physicians with substance dependence involving five years of monitoring. Results across multiple Canadian PHPs are not available, as proposals for collecting common data have not yet been fully implemented. The PHPs are linked through the CPHN, which aims “to provide an environment for mutual support, the sharing and promotion of ideas and innovation in the area of physician health and well-being.”

In addition to PHPs, physicians, residents and students may seek assistance and treatment from the same range of options available to the general public. Little is known about the long-term outcome of physicians returning to work after recovery from severe, recurrent depression or after an episode of bipolar disorder. Preliminary research suggests that this subgroup of physicians may warrant special attention.

Few health promotion programs are targeted at Canadian physicians, although there are healthy workplace programs in many hospitals and some other health care workplaces. The CMA is participating with 11 other national partners in a Quality Worklife Quality Healthcare Collaborative, which is striving to create healthier workplaces and, ultimately, to improve patient/client and system outcomes.

The PHPs are increasingly providing assistance to physicians suffering from burnout, occupational stress and fatigue. They also provide educational seminars and displays at medical organization meetings and outreach to medical students and residents to raise awareness of issues and the services they provide. Many medical schools have created wellness programs for their faculty and offer some form of wellness teaching in their curricula. Some are sponsoring “wellness weeks” or other awareness/activity events. The Canadian Federation of Medical Students is also in the process of developing a “wellness package.”

Other options such as “life coaching” are emerging, particularly for those without meaningful psychopathol-
ogy to build on personal strengths and help them thrive personally and professionally. An early intervention model from Norway called Vila Sana is designed “to prevent burnout, enhance mental health and quality of life, and strengthen personal professional awareness and identify”; it comprises either single-day or week-long sessions. At one-year follow-up, participating physicians had reduced emotional exhaustion, fewer were on full-time sick leave, and there was an increase in the proportion that had undergone psychotherapy. These positive outcomes contrast with an earlier systematic review of interventions for burnout among medical students, residents and physicians that did not identify any effective interventions.

Gaps and challenges in responding to mental health needs of physicians

Consideration of the burden of mental health issues and mental health illness among physicians and the extent of programs and services that are currently available reveals several themes. First, there is relatively limited information available regarding the mental health status of practising physicians and trainees. Although it is an important start, much of our information is based on occasional surveys with typically low response rates, and most information is from other countries. While there is consistency in the picture they portray regarding the burden of mental health issues in this and other countries, existing studies provide little deep understanding of the interplay of causal factors or the relative effectiveness of interventions.

Physicians are a critical component of our health care systems. However, those systems are not necessarily healthy to those who work within them. Providing care in less functional or limited resource settings can add considerable stress to physicians. Punitive and humiliating experiences in training and in practice contribute to the stress load.

Part of the challenge in assessing and responding to the mental health needs of physicians is the multitude of system factors. These include medical schools and graduate training programs, regulatory bodies, researchers and their funders, insurers, professional associations and health care organizations. Each has its own perspective and potential contribution to the promotion and protection of physicians’ mental health. To date, considerable effort, dedication and leadership has gone into providing individual care to physicians, establishing PHPs and ensuring service innovation in particular settings. Building on these efforts, it will be necessary to continue to work to create a more coordinated system of promotion, prevention and care.

As a target population for a set of interventions, physicians are diverse and isolated. That isolation can be geographic, as well as professional. Many physicians are self-employed and work in solo or small-team settings with limited supports. Even in large health care institutions, physicians typically have privileges, but are not fully integrated members of the institution. Being predominantly self-employed, physicians may not have comprehensive health coverage or paid sick leave, so taking time off work to seek care or recovery translates into immediate income loss and costs.

There is an overall societal stigma for those suffering from mental illness and this is a major area of interest of the MHCC. Stigma is a social process characterized by exclusion, rejection, blame or devaluation resulting from an adverse social judgement about a person or group. For any illness, there is a cultural pressure among physicians to not be sick so that one can provide care, with the result that physicians try to control their own illness and treatment. For mental health issues, this perspective is intensified and there is considerable stigma attached to physicians acknowledging mental health issues or illness, as well as seeking assistance.

The stigma creates a challenge to early identification and early intervention. Physicians are concerned about the responses of their peers, regulatory bodies and privilege-granting bodies, as well as access to health and disability insurance. For example, in a postal survey of physicians in the United Kingdom (UK), career implications
was the most commonly cited reason for failure to disclose that they had a mental illness. A survey of US physicians observed that those with moderate to severe depression scores, when compared with those with minimal to mild depression, were more likely to self-prescribe antidepressants and avoid seeking treatment due to concerns about confidentiality. Studies of medical students and residents have revealed concern about how medical schools and graduate programs may react if they seek help.

Potential embarrassment is a barrier to seeking care as physicians worry that they will be perceived to be overreacting to a trivial illness, worry that their self-diagnosis may be wrong and be reluctant to seek assistance for less-defined illnesses such as stress, sexual difficulty, or alcohol dependence. Although most Canadian physicians have someone they regard as their family doctor, studies of those physicians find that they still self-diagnose and self-treat and engage in informal health care such as “corridor consults.” Providing care to physician colleagues can also be stressful and challenging and is an area where formal training has not been explicitly or systematically provided.

With their experience, physicians have a heightened awareness of the implications of seeking treatment and receiving a diagnosis. They will likely have witnessed instances of failed confidentiality or obligatory reporting. Health care organizations and regulatory bodies have adopted a punitive approach to physicians with mental illness more often than a supportive response, which may have a deterrent effect on physicians seeking help. Of particular concern is that screening questions used by many insurers and regulatory bodies are based on the presence of a diagnosis or having sought care rather than the existence of an impairment. Any disorder that interferes with the ability to engage safely in professional activities constitutes an impairment. Impaired physicians require care and modification or suspension of their medical duties. However, the presence or previous presence of symptoms/illness does not automatically mean impairment. As noted by the Canadian Psychiatric Association, “Physicians can be mentally ill and not occupationally impaired. In other words, their depression, eating disorder, alcoholism, or obsessive-compulsive disorder has not progressed to the point that it affects their medical judgement, competence, safety, or manner.” The application of principles of occupational medicine (e.g., assessment of ability to return to work) and the management of chronic diseases are highly relevant to addressing the needs of physicians with mental illness.

The distinction between illness and impairment may, however, not be universally applied. An analysis of US medical licensing boards’ practices in 2006, compared with those in the 1990s, found that applicants were more likely to be asked about past rather than current histories of mental illness and substance use. In a survey of US medical licensing boards, over a third of responding boards indicated that the diagnosis of mental illness by itself was sufficient for sanctioning physicians and that they treat physicians receiving psychiatric care differently from physicians receiving medical care. No comparable data are available for Canadian regulatory bodies.

Despite the presence of treatment options for ill physicians, the combination of shame, adverse experiences of colleagues and lack of knowledge of available services is a considerable barrier to seeking care. Concerns are not ungrounded. For example, although a focus group of 116 UK physicians who had experienced mental illness described greater empathy with patients and better understanding of mental ill health, negative themes included loss of career, being ostracized by colleagues, being seen as weak, incapable or lazy, or no longer being seen as a “proper doctor.”
Developing a mental health strategy for physicians

The urgent need for a mental health strategy for physicians is clear, although there will be challenges in developing a strategy of this magnitude. Viewing physicians collectively, mental health issues and illness are a community-wide problem and, thus, require a comprehensive set of responses. This section outlines:

- A vision for what is to be achieved
- The need for the involvement of many
- The main components or pillars of the response, including priorities for initial actions

Vision

The overall intent of this strategy is to achieve optimal mental health for all physicians. Mental health is a key aspect of comprehensive physician health and well-being, as advocated by the CMA Centre for Physician Health and Well-being. The Senate Standing Committee on Social Affairs, Science and Technology chose the phrase “out of the shadows” to capture the need to address the often hidden and unmet mental health needs of Canadians. Consistent with that spirit and intent, there is a similar need to cast a strong light on and respond to the significant mental-health-related issues and concerns facing physicians.

The need for a collaborative approach

Considering the long-standing commitment to physician health issues of the CMA and its provincial/territorial partners, there is a clear mandate and responsibility to provide leadership to promote and protect the mental health of physicians. However, this cannot be done alone. The existing gaps and challenges outlined in this strategy are predominantly systemic in nature and will take the contribution and collaboration of many parties to make the changes that are necessary. As such, the CMA, provincial/territorial medical associations (PTMAs) and the CPHN will need to work collaboratively and engage and work with many other organizations to achieve change. Similarly, many organizations and settings are best suited to take the lead in assessing how they can best improve on the status quo.

The following list of ways that various system actors may be able to contribute to positive change is provided for illustrative, not prescriptive, reasons. Knowing their own milieu best, these actors may have better suggestions for moving forward.

Physician/professional associations

- Make a commitment to long-term, sustained effort, including a commitment to support and develop resources for PHPs.
- Develop an educational strategy that includes resiliency training for physicians.
- Provide leadership in identifying a need for change, raising awareness, advocating supportive policies and a range of effective services and programs and fostering collaborative problem-solving and action among key stakeholders.
- Foster networking and mutual support among physicians.
- Address stigma within the physician culture.
- Advocate and contribute to building more effectively designed health care system that will provide better health care, as well as a healthier work environment.

Physicians

- Engage in creating a more supportive community.
- Reduce stigma — take personal responsibility for own activities that may contribute to stigma.
• Provide support to others in need including willingness to provide care to colleagues.

Medical schools and graduate programs
• Foster networking and mutual support among students and residents.
• Address stigma within the training environment and eliminate the “hidden curriculum.”
• Support positive learning experiences.
• Support a continuum of programs and services to address mental health issues and illness, including healthy approaches to resilience and coping.

Health care organizations
• Foster health promoting workplaces (e.g., Quality Worklife Quality Healthcare Collaborative).
• Foster approaches to improving quality of care and patient safety (vs blame/mistake driven environment).
• Address stigmatizing policies and behaviours regarding mental illness of patients and staff.

Governments
• Work with employers and health care providers to create more effective health care structures to provide better care and better working conditions.
• Work with the CMA and partner associations to provide more comprehensive benefits for physicians.
• Provide funding to address more comprehensively the mental health needs of physicians (e.g., assessing needs, providing services across a continuum, evaluating programs, conducting research).

Researchers
• Partner with physician organizations and others to identify priority research questions, conduct research and disseminate findings regarding the occurrence, prevention and interventions for mental health issues and illness in physicians, residents and students.

Regulatory bodies
• Consider how existing policies, screening questions, investigations and public communication of decisions may reinforce the existing stigma that remains a barrier to the early identification of, and intervention for, mental health issues and illness among physicians.
• Review their approach to mental health issues in physicians to ensure that it focuses on impairment and not the mere presence of a diagnostic label or seeking of care.
• Create a regulatory environment that protects the public while removing the barriers that currently exist for physicians seeking diagnosis and treatment for mental illness. Working with medical associations, PHPs and governments, a licensure process could be established that creates a “safety net” for both the public and those who care for the public.

Insurers
• Reduce existing barriers when physicians make claims for mental health-related issues (e.g., perceptions that mental health illnesses are not taken seriously, requirements for specialist opinions, etc.).
• Appreciate the physician’s working conditions and the level of complexity of tasks and mental health required to do the work of a physician.

Focusing specifically on what the CMA and its partner PTMAs can do, the next subsection describes the four strategic directions or pillars that comprise this strategy.
Strategic directions

We have outlined a situation of recurring themes including stigma, physician culture, stressful working and training environments, information gaps and an underdeveloped continuum of preventive and treatment services. Four strategic directions will guide the work of the CMA in the coming years to protect and promote the health of physicians (including medical students and residents) in Canada:

1. Increase awareness, knowledge and skills regarding physician mental health issues.
2. Improve access to a range of mental health services and programs for physicians.
3. Create learning and work environments that support the mental health of physicians.
4. Monitor, evaluate and research physician mental health needs, services and policies.

These four strategic directions provide focus for a comprehensive set of actions that the CMA and its partners can pursue to promote and protect the mental health of physicians. Intrinsic to planning and taking action in these strategic directions, consideration must also be given to addressing the intended target audience (i.e., students, residents, practising physicians), the level of action (i.e., national, provincial/territorial or local/regional) and the participation of particular partners. There may also be intermediary-type organizations that the CMA and its partners will wish to engage (e.g., regulatory bodies) for the ultimate benefit of one or more of the target audiences. For example, to increase “awareness, knowledge and skills,” there will be a need to consider questions such as:

- What are roles at national, provincial/territorial and local levels?
What are the similarities and key differences in developing messages and their communication to students vs residents vs practising physicians?

Who are the key partners who should be engaged from the beginning in planning this group of interventions?

Which groups are potential “intermediaries” that could help reach priority target groups (e.g., medical schools to reach students)?

How might this particular set of activities need to link/sequence/reinforce actions that are part of other strategic directions?

A planning “cube” is required to capture these different dimensions. Cube-based models have been beneficial in conceptualizing and planning interventions across multiple dimensions. It will facilitate the analysis and planning that will need to drill down to particular “cells” or groups of cells of the cube while still maintaining a perspective on the overall strategy.

The following subsections describe each of the strategic directions in more detail.

**Increase awareness, knowledge and skills regarding physician mental health issues**

Improving the mental health of physicians will require considerable change in the behaviour of physicians, both individually and collectively.

**Priority project** A comprehensive social marketing campaign

**Key concepts to be addressed**

- Establish own health as a priority.
- Increase awareness of risks and signs of problems, the effectiveness of interventions and treatment and the critical distinction between illness and impairment.
• Address the effects of stigma on physicians’ health (e.g., not seeking early assistance).
• Disseminate effective practices and coping strategies.
• Seek help for self and others.

These are multifaceted messages pushing against well-ingrained attitudes and sociocultural norms for a highly sophisticated audience. As such, a comprehensive social marketing campaign is required to facilitate behaviour change in the target population(s). Health-related social marketing has been defined as “the systematic application of marketing, alongside other concepts and techniques, to achieve specific behavioural goals, to improve health and to reduce inequalities.” Social marketing is not simply a promotion or communication activity, but rather employs a conceptual framework that includes “exchange theory, audience segmentation, competition, ‘the marketing mix,’ consumer orientation and continuous monitoring.”

Fundamental to any social marketing initiative is a research component. There must be an understanding of the target audience’s wants and needs to guide planning of the interventions, as well as evaluating and monitoring audiences’ responses to all aspects of the interventions. The social marketing plan must empower, inspire and motivate change among physicians. Involvement of innovative and creative social marketing professionals is highly advisable to pursue this component of the strategy.

Several issues will need to be considered in pursuing this strategic direction. From an efficiency perspective, coordination with national leadership working with input from provincial and partner associations is attractive, but depends on whether audience needs and responses to interventions are sufficiently similar across the country. Another potential efficiency issue is the extent of overlap between issues and interventions for medical students, residents and physicians. Although there are similar underlying cultural issues, there are significant differences in the age, life stage and nature of stressors among these three groups.

The social marketing plan does not exist in isolation from the other strategic directions of the overall mental health strategy. Therefore, the necessary links and sequencing must be integrated. For example, some of the key messages (e.g., distinction between illness and impairment, impact of stigma) may be useful foundations for engaging with regulatory bodies. Similarly, because an increase in help-seeking behaviours may occur following some messages, the impact on existing services must be considered.

There will obviously be a cost to pursuing and implementing a well conceived social marketing plan. Because the general public is not the target audience, the need to purchase expensive public media will be avoided. Nevertheless, a range of potential funding sources and partnerships beyond national and PTMA budgets should be considered (e.g., federal, provincial governments, MHCC, in-kind contributions from journals, conference promoters, etc.).

**Improve access to a range of mental health services and programs for physicians**

**Priority projects**
• Establish primary prevention pilot program offering curriculum and skills to build and enhance resiliency.
• Support access to a personal physician for every physician.
Key concepts to be addressed

- Offer accessible curriculum and skills to build resiliency.
- Encourage a primary care physician for every physician.

At the level of individual programs, a potential priority project would be to pursue, in cooperation with PTMAs, a primary prevention pilot program, whereby physicians are offered a curriculum to access education, tools and skills to build and enhance resilience. This would build on the work of Norway’s Villa Sana Resource Centre that runs both one-day individual counseling sessions, as well as group-based one-week courses “to prevent burnout, enhance mental health and quality of life and strengthen professional awareness and identity.” A one-year follow-up of over 200 participating physicians revealed reductions in the level of mental exhaustion to a level similar to a representative sample of all Norwegian physicians. The CMA and its partners could pilot and evaluate a model that builds on the Norwegian experience, but with an even greater emphasis on preventing burnout and exhaustion before they occur to enhance the mental health and quality of life of Canadian physicians and strengthen their personal and professional resources.

Another individual-level intervention would be to encourage a primary care physician for every physician. Achieving this objective depends on the number of physicians willing and able to function in this role and individual physicians actively and appropriately engaging in this relationship. Most physicians report that they have a primary care physician, but more physicians need to be available to take on physicians as patients and be encouraged to do so. Providing care to colleagues has unique aspects and demands. The best practices for providing care in such a relationship could be identified, and a range of training and support provided. Mechanisms are also required to match primary care physicians who would be willing to provide care to physician colleagues with those seeking such services. Such a service would likely need to be deployed at a local or provincial/territorial level, although the CMA could facilitate information sharing regarding existing models (e.g., Ottawa’s Code 99 program). An additional dimension that must be addressed is the expectations of the physician as patient. Many of these issues must be considered for incorporation in the social marketing plan.

In addition to developing and implementing specific individual-level programs and services, there is also a need for a systematic analysis of interventions and prioritizing the gaps. In the longer term, it would be desirable to move toward the ability to assess the range of interventions and be able to identify and prioritize gaps to address with new interventions. This systems thinking would benefit from well-developed collaborative partnerships at provincial/territorial and/or local levels and a continuum of effective intervention models/programs and tools to conduct the information gathering, gap analysis and priority setting. While identified here as a longer-term initiative, particular regions or settings (e.g., medical schools) may be ready to pursue this approach. As an initial step, the CMA could function as a clearinghouse for effective interventions and best practices.

As previously noted, there is limited information on effective health promotion and primary prevention strategies to promote mental health of physicians, as many current initiatives have not been evaluated. Therefore, it is not possible to provide specific recommendations regarding particular interventions. There is clearly a need to evaluate the various pilot interventions that are occurring (e.g., in medical schools) and this issue is addressed in more detail in another strategic direction.

Create learning and working environments that support the mental health of physicians

Priority project: Engage regulatory bodies in examining how they address physician mental health issues and illness
Key concepts to be addressed

- Reduce the harm caused by stigma and obstacles to care, such as delayed diagnosis and treatment (licensing bodies, insurers, privilege granting bodies, peers).
- Improve work-life of physicians, residents and students.

As previously described, studies of US medical licensing bodies have demonstrated a trend toward more stigmatizing behaviours over time, and there is a perception of a similar trend here in Canada. Regulatory bodies must be sensitized to the distinction between illness and impairment. There is no question that physician impairment, regardless of the reason, is a critical issue for which regulatory bodies have a clear responsibility. However, there is also a need to avoid stigmatizing behaviour by those bodies. Considering that mental health issues and illness among physicians are relatively common, efforts must be made to seek an optimal balance between addressing physicians who may be experiencing impairment due to their illness and not establishing barriers to physicians seeking help. It is crucial that this be done in a manner that respects the confidentiality of the individual’s health care and privacy rights. Considerable analysis of this issue has been carried out in other countries and will likely be informative to our efforts.

Before engaging the regulatory bodies, a number of background steps are required that fall within the purview of the research and evaluation strategic direction:

- Assess and document potentially stigmatizing behaviours/policies of regulatory bodies.
- Seek anecdotal experiences from physicians regarding the adverse impact on physicians of regulatory bodies’ actions/policies (e.g., delays in diagnosis and care, suicide, etc.). The intent here is to make the statistics “real.”
- Seek input from others who may have perspectives/experiences with regulatory body processes/decisions (e.g., CMPA).
- Identify best practices in regulatory bodies in and outside Canada that seek an appropriate balance between protecting the public and encouraging physicians with mental health issues/illness to seek care.
- Follow the initiative taken by the American Medical Association (AMA) and work in conjunction with the AMA to develop a template that offers model language for provincial medical licensure applications that is non-discriminatory to physicians and does not create barriers to appropriate diagnosis and treatment of mental illness.
- Develop a comprehensive awareness/advocacy plan ensuring strategic synergies with other interventions (e.g., social marketing campaign, MHCC work, etc.).

With this preparatory work in place, the next step will be to engage the regulatory bodies. A unified national approach will be undertaken, acknowledging that discussions may advance more quickly in some provinces and territories and successes in these jurisdictions could serve as examples to the others.

Multiple other sources of stigmatizing behaviour toward physicians exist. Learning and working environments can support mental health, but can also be a source of stress and can reinforce adverse behaviours. Other physicians are an important group and the social marketing plan is intended to address these behaviours. Although many physicians are self-employed, they are often dependent on privileges extended by facilities and health authorities. These settings can be another source of stigmatizing behaviour that may not distinguish between illness and impairment. These target audiences are much more numerous than regulatory bodies, which poses a greater logistical challenge for advocacy efforts. It may be preferable to seek experience and progress working with the regulatory bodies first, then adjust the approach to address privilege-granting organizations. Progress with the regulatory bodies can also be used in efforts with these organizations (i.e., “if the College’s policy is ‘x’,
shouldn’t your organization be the same?”). Depending on local circumstances, PTMAs and partners may need to engage specific organizations as part of their advocacy efforts. In addition, the CMA would continue to participate in the Quality Worklife Quality Healthcare Collaborative.

Improving the work-life of physicians and students must be addressed, and this overlaps conceptually with promoting healthy environments. As noted earlier, many initiatives are being piloted in medical schools, at both undergraduate and postgraduate levels, although evaluation of the impact of these interventions is incomplete. Further evaluations are required and findings must be disseminated.

A key area of interest of the CMA and PTMAs is improving the structure and functioning of Canada’s health care systems. CMA’s vision for “health care transformation” will create system improvements that could have a direct and positive impact on the mental health of physicians. An implicit benefit of such changes will be greater support for and reduced stressors on physicians. Therefore, improving and protecting the mental health of physicians should be identified as an explicit additional benefit, where appropriate, for broader restructuring efforts.

Monitor, evaluate and research physician mental health needs, services and policies

Considering the importance of physicians to the functioning of health care systems, there is a relative paucity of information on their health. Although the number of relevant studies has increased in recent years, most information on the extent of mental health issues and illness among physicians is survey-based and response rates are typically low. Limited information is available regarding the impact or effectiveness of existing programs and services. Nevertheless, there is sufficient information currently to inform the development and implementation of the initial projects described in the preceding subsections.

Priority project: Research and evaluation for each of the 4 priority projects

Key concepts to be addressed

- Social marketing initiative: understand target audiences’ wants and needs sufficiently to guide planning of interventions; evaluate and monitor the interventions to gauge the audiences’ responses to all aspects of the intervention.
- Primary care physician for every physician: monitor the proportion of physicians with a primary care physician; assess the level of engagement of individual physicians with their primary care doctor; assess the level of confidence of primary care physicians in providing care to colleagues.
- Early assessment and evaluation of the primary prevention pilot program to build and enhance resiliency: evidence-informed design of pilot and assessment of impact.
- Engagement strategy with regulatory bodies: conduct of policy analysis.

In addition to conducting supportive research and evaluation components for each of the four priority projects, multiple additional areas could be pursued as part of this strategic direction, including but not limited to:

- Assessing physicians’ needs (a function of burden of condition, existing services and evidence of effectiveness)
- Evaluating existing programs and interventions
- Advocating research funding for physician’s mental health issues
- Seeking common PHP data to describe existing services

There is insufficient information to identify specific, additional priorities from the list above at this time. One approach would be for the CMA to conduct a workshop or some other collaborative process among existing
networks of contacts, such as PHP programs, researchers and research users, to brainstorm and prioritize a list of potential projects, lead organizations, resource requirements and potential funding sources.

Moving forward

Initial priorities for action

- Develop a comprehensive social marketing campaign.
- Establish a primary prevention pilot project offering curriculum to build and enhance resiliency.
- Improve access to and effective use of personal physicians for every physician.
- Engage the regulatory bodies.
- Provide research and evaluation support to each of the other projects.

Implementing a comprehensive, collaborative multi-year approach to physicians’ mental health is a considerable, but needed undertaking. This strategy provides a framework for conceptualizing the many interdependent initiatives that need to be pursued. The initial focus should be on key foundational items that will facilitate progress on other items that can be pursued at a later time. Four initial priorities are proposed.

I. Comprehensive social marketing campaign

A well-planned, social marketing campaign will address knowledge gaps, misinformation and less-effective behaviours among physicians. Acquiring the assistance of a strong, professional and innovative social marketing team with a proven track record in this field is strongly advised. The plan developed by this team would be expected to involve the CMA and partners closely and would likely provide greater clarity regarding the sequencing and conduct of other steps in this strategy.

II. Primary prevention program to build and enhance resiliency

A professional development pilot project will focus on primary prevention and offer a curriculum and tools for building resiliency in physicians. The Norwegian model is one option, but an analysis of other potential options would be expected to be part of a funding proposal.

III. Personal physician for every physician

Enhanced personal care and mental health for physicians is contingent on every physician having his or her own family physician. This would require identifying best practices and providing training for physicians serving in this role, as well as the provision of registry/matching services. Again, aspects of the social marketing plan would likely complement this initiative; collaboration and integration of efforts are required.

IV. Engaging the regulatory bodies

Engagement with the regulatory bodies needs to be preceded by a comprehensive policy analysis to fully understand the issues and associated options. It would be advantageous for the engagement efforts to occur after the social marketing plan has begun to be implemented as some of the messaging would be relevant (e.g., adverse effects of stigmatization within the profession, distinctions between impairment and illness, etc.). Nevertheless, the initial policy analysis is a precursor to engagement efforts and can be initiated in parallel to the early social marketing work.
V. Providing research and evaluation support to the above projects

The planning and implementation of each of the above projects will require supporting research and/or policy analysis, which will have capacity implications. There is also ongoing work to better understand physician mental health needs and evaluate existing and future interventions.

Sustained commitment

To begin to support a systems approach to a range of health promotion, assessment and care options for physicians, it is recommended that the CMA serve as a clearinghouse for effective interventions along this continuum. This could also link with the CMA’s broader partnership with the MHCC regarding best practices.

Each of these four priorities for initial action represents multiyear projects. Sustained commitment will be required from the CMA and its partners to lead and support these initiatives.

References

Appendix 1: Mental health services for Canadian physicians: executive summary

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12 October 2009

Abstract
There is growing concern about the prevalence of mental health disorders among all Canadians and whether adequate treatment is available. Although physicians are a relatively healthy group overall, their level of distress is significant and they are no less likely to develop psychiatric disorders than other Canadians. The Canadian Medical Association has taken a leadership role in supporting services for Canadian physicians with mental health problems through the Canadian Physician Health Network (CPHN) and other means. This report summarizes the extent of the problem, services available and barriers to the use of these services. It is based on published material and interviews with key informants who are knowledgeable about Canadian services for physicians with mental health problems. In this report, “mental illness” includes drug- and alcohol-related problems in addition to other psychiatric diagnoses and occupational stress. Although mental illness is a disease that manifests itself in individuals, prevention programs and interventions must extend beyond individual approaches and make systemic changes to produce healthier physicians.

Recommendations

Prevention
Prevention programs in medical schools, residency programs and healthy workplaces vary considerably, with no coordination among sites. Few of these programs are systematically evaluated. Health promotion and prevention should move beyond individual approaches and make systemic changes to prevent mental health problems.

Recommendations
• Prevention initiatives should address health system and workplace issues, in addition to programs for individuals feeling distress.
• Physicians at all career levels should be encouraged to lead healthy life-styles and engage in self-care, including having their own family physician or general practitioner.
• Medical schools and resident organizations should coordinate approaches with one another.

Treatment programs and access to treatment
Physician health programs (PHPs) exist in every province, are well developed and have their own coordinating organization, the Canadian Physician Health Network (CPHN). However, the services they offer vary and range from brief counseling and referral to long-term post-treatment monitoring. Additional treatment options, available from a variety of providers not involving PHPs, also range from brief counseling to intensive treatment and long-term support.
**Recommendations**

- Record-free, confidential early intervention programs should be developed for physicians at all career stages.
- Available programs should be widely advertised and freely available, as lack of awareness is a significant barrier.
- Efforts should be made to reduce the stigma of illness and help-seeking in the medical profession and to work with licensing bodies and insurance companies to address and reduce the consequences of having been treated and monitored. Viewing stress among physicians in relation to aspects of the occupation rather than solely as an individual problem would help reduce stigma.
- Treatment and monitoring programs should clearly distinguish between supportive help and disciplinary consequences.

**Research**

Although an abundance of clinical anecdotal information has been gathered, quantitative data on the mental health of Canadian physicians are lacking.

**Recommendations**

- National studies should be conducted to examine the mental health of Canadian physicians, medical students and residents, including their perception of the need for and use of mental health services.
- Common data should be collected by the PHPs to facilitate research on these significant programs.
- Existing and future prevention, treatment and monitoring programs should include evaluation plans and regular evaluations.
- The CMA should lobby funding organizations, including the Canadian Institutes of Health Research, for increased funding for physician mental health research.
- The relationship between mental health problems among physicians and physician practice must be studied, as an assumption of “impaired practice” due to mental health problems underlies some existing approaches.
Appendix 2: Mental health and stigma in the medical profession: executive summary

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Abstract
This review of the literature on the stigma of mental illness in the medical profession will inform effective strategies to tackle this important problem that often prevents physicians in need from acknowledging their symptoms and seeking help. This information may also facilitate essential change in the culture of medicine, so that the punitive, discriminatory responses associated with physician mental illness and physicians seeking help are eliminated and replaced by an atmosphere that encourages and supports individual responsibility and collegial support for physician wellness.

Introduction and definitions
Stigma is typically a social process that involves exclusion, rejection, blame or devaluation resulting from an adverse social judgement about a person or group. Stigma is a powerful deterrent that may discourage physicians from recognizing that they are suffering from mental illness or substance abuse problems and deter them from seeking help and successfully completing a treatment program.

Concerns about doctors’ health or ill-health tend to focus mainly on mental illness and substance abuse. Impairment is often defined as “any physical, mental or behavioral disorder that interferes with the ability to engage safely in professional activities.”1 Of particular importance is the distinction between physicians who are diagnosed with a mental illness or substance abuse problem and those who are impaired. Mental illness is not synonymous with impairment, and mentally ill physicians receiving appropriate treatment can provide safe, high-quality care to patients.

Examining the evidence
Evidence from the literature demonstrates that physician mental illness and stigma are important topics of inquiry. Below, evidence is presented on the prevalence of mental illness and substance abuse in the medical profession, the consequences for mentally ill physicians and the impact this illness may have on patient care depending on whether the physician is effectively treated.

Evidence of mental illness, substance abuse and impairment among physicians: Doctors generally have better physical health than the average population, but poorer mental health than others. It is generally agreed that approximately one in ten physicians will develop a substance-related disorder at some point in their life and the prevalence of depression appears comparable to that in the general population. The exact number of impaired physicians in North America is unknown, and reported prevalence rates vary widely.

Evidence that certain factors may predispose physicians to mental illness and substance abuse: A combination of factors in physicians’ background, personality, training and work experiences may contribute to and predispose them to substance abuse and mental illness. People with certain personality traits appear to be attracted to and disproportionately accepted into medical school. These traits may contribute to their success in their medical careers, but also lead to later emotional difficulties and breakdown. Physicians report feeling pressure from patients and colleagues to appear healthy even when they are not, and believe that good health in
doctors is often equated with medical competence. It has also been suggested that because medical organizations are not as supportive as they could be, they may contribute further to depression and suicide among doctors.

Evidence that impaired physicians who have received appropriate treatment can be effective and safe health care providers: A number of rigorous studies have assessed the extent to which doctors who receive appropriate treatment for substance abuse can return to work and be effective and safe health care providers. Evidence shows that physicians with substance addictions, who enter intensive treatment that is followed by comprehensive long-term after care and monitoring, have long-term success rates of 70%–90%.

There are few data regarding the effectiveness of treatment or recovery rates for physicians suffering from depression or other forms of mental illness not related to substance addictions, even though the therapeutic options are generally plentiful and effective. More studies are needed to evaluate the effectiveness of treatment of mental health disorders that are purely psychological.

Evidence that physicians living with addictions or mental illness who go untreated may provide poorer quality patient care and make more medical errors: Physicians’ fitness to work is related to patient safety, where substandard performance may result in patients being harmed. Physicians living with addictions or mental illness who go untreated may find that their ability to practise medicine is impaired. For example, evidence shows that physician impairment may have serious consequences for patient care in terms of doctors’ prescribing habits, discharge decisions, patient communication, test ordering, patient compliance and patient satisfaction with care.

Evidence that physicians living with addictions or mental illness who go untreated may suffer more severe, long-term, even fatal outcomes: It is often difficult to identify mentally ill or addicted physicians because they typically suppress and deny that any problem exists. Because the early symptoms are often nonspecific, addictions and mental illness among physicians are almost always in an advanced stage before warning signs become obvious to others around them. Depression and substance abuse not only affect physicians’ workplace behaviour, but may also alter clinical performance and contribute to further substance abuse, broken relationships and a decline in physical health. Suicide is the most tragic outcome for the ill or impaired physician and the two greatest risk factors associated with suicide are often identified as mental illness and substance abuse.

How does stigma thrive?

It is often difficult to identify impaired physicians because their manifestations are so highly varied and also characteristic of healthy, productive doctors. Stigma thrives as a result of the culture of medicine and medical training, perceptions of physicians and their colleagues and the expectations and responses of health care systems and organizations.

The culture of medicine and medical training: The culture of medicine and medical school perpetuates and prevents physicians from acknowledging symptoms of mental illness in themselves or their colleagues and the fact that good physicians may live with a mental illness. Medical students quickly learn to place a low priority on their own health and to appear healthy and physically well even when they are ill.

Perceptions of physicians and their colleagues: Physicians are reluctant to recognize or talk openly about any psychological problem, and colleagues are reluctant to help one another in need. Colleagues may delay reporting their concern about a fellow physician as a way of protecting their possibly impaired colleague from the adverse consequences of stigma, shame, income loss and licensure actions. They may be afraid of being wrong in their assessment of the situation and unaware of the steps to take or the resources available. Many doctors find themselves facing the ethical dilemma of having to choose between protecting the privacy of their impaired colleague and the safety of patients; often, preserving confidentiality of the colleague’s situation wins out.

Expectations of health care systems and organizations: Concerns about physicians’ mental ill health and substance abuse have traditionally been expressed in terms of disciplinary responses to ensure the safety of
patients rather than in terms of treatment for the affected physician. Health care systems and health care organizations often contribute to a punitive environment rather than providing a supportive response to physicians living with a mental illness, which may be a strong deterrent for physicians seeking help.

**What needs to change?**

Research shows that, to be effective, anti-stigma programs must work on multiple levels by targeting individuals, structures and systems. Education appears to be an important strategy, where it is essential to raise awareness of the issues and promote the view that prejudicial attitudes toward mental illness are socially unacceptable. Several strategic areas for change were examined, including medical schools’ and the medical profession’s attitudes, understanding and responses to physicians with mental illness and recovering physicians, as well as those of the health care systems and organizations where physicians work.

**Medical schools and medical school training:** Many doctors who develop addiction problems later in their careers likely exhibited vulnerabilities earlier on in medical school. Medical students and residents need to be taught to recognize signs of distress in themselves and their colleagues, recognize when help is needed and feel safe and supported in seeking or offering help. Medical schools and residency programs also need to assess how they influence and shape students’ attitudes toward self-care and wellness.

**Physicians and the medical profession:** The effectiveness of the medical profession in identifying and intervening on behalf of its members needs to change. There must be a shift in the culture of medicine that encourages physicians to seek help for themselves and their colleagues when they are at risk. The medical community must also learn to better support its recovering members. Doctors generally need to be informed about the availability of qualified resources that can be obtained promptly, confidentially and without involving disciplinary bodies.

**Health care systems and health care organizations:** There must be a shift to eliminate the punitive, discriminatory responses associated with physician mental illness and physicians seeking help. Instead, there should be encouragement and support for individual responsibility and collegial support for physician wellness. A more proactive approach to physician health and well being must be taken that encourages and supports individual responsibility for wellness and that promotes and supports early intervention when health and performance deteriorate.

**Recommendations**

1. Medical schools, the medical profession and health care systems and organizations must be educated about and encouraged to adopt a proactive approach to promoting and supporting physician health and wellness.

2. Medical schools, the medical profession and health care systems and organizations must be educated about and encouraged to promote health and wellness awareness and effective wellness and coping practices among physicians for themselves and their colleagues.

3. Medical schools, the medical profession and health care systems and organizations must be educated about the risk, signs and symptoms of mental illness and substance abuse in physicians and their colleagues.

4. Medical schools, the medical profession and health care systems and organizations must be educated about and encouraged to promote the availability and use of resources for physicians in need.

5. Medical schools, the medical profession and health care systems and organizations must be educated about and encouraged to promote the personal, patient and career benefits of physicians obtaining appropriate treatment.
6. Medical schools, the medical profession and health care systems and organizations must be educated about the negative consequences of stigmatizing mental illness in terms of recognizing symptoms and seeking help.

7. Medical schools, the medical profession and health care systems and organizations must be educated about and encouraged to promote the critical distinction between mental illness and impairment.

8. Medical schools, the medical profession and health care systems and organizations, including regulatory authorities, must be educated about and encouraged to promote the view that identifying physicians in need is completely separate from disciplinary responses.

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Reference