The wellness program for medical faculty at the University of Ottawa: a work in progress

Noni E. MacDonald, Simon Davidson

Review

Synthèse

Dr. MacDonald was formerly with the Department of Pediatrics, University of Ottawa, Ottawa, Ont. She is now Dean of the Faculty of Medicine, Dalhousie University, Halifax, NS. Dr. Davidson is with the Departments of Psychiatry and Pediatrics, University of Ottawa, Ottawa, Ont.

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These are the duties of a physician:
First... to heal his mind and to give help to himself before giving it to anyone else.
— Epitaph of an Athenian physician, 2 AD

Suicide, alcohol abuse, drug abuse and marital discord can be the unfortunate outcomes of workplace distress. The medical profession is not immune. Researchers have long recognized that physicians may have even higher risks for these problems than nonphysicians.[1–5] In a 1993 survey of Canadian physicians carried out by the *Medical Post*, 76% of those surveyed reported experiencing negative stress, 65% reported increasing stress over the previous 5 years, 31% had been depressed, and 7% had thought of suicide.[6] Much attention has been focused on interventions for the impaired physician in practice,[7–9] but scant attention has been paid to the stresses and needs of academic physicians. The lack of protection against the wrath of distress even in the "ivory tower" was brought home to the medical faculty at the University of Ottawa by a serious mental health problem that beset a highly respected faculty member several years ago.

In response to this crisis, the Task Force on Faculty Stress was formed in 1995 under the auspices of the then dean of medicine, with the 2 of us as cochairs. This project has been supported and enhanced through the efforts of the current dean. The goals of the task force were:

- to increase faculty awareness of stress and strategies for wellness;
- to develop an early detection, outreach and intervention program that faculty would use; and
- to develop department and faculty interventions to decrease work-related distress, including a shift to a better balance between work and family life.

In this article we describe the development of the first 2 phases of the wellness program.

Task force membership

The dean of medicine and the 2 cochairs of the task force selected the initial members of the task force to take into account concerns raised by faculty members during informal focus group discussions. Faculty members indicated that the task force would not be credible if it was based within only one department, such as psychiatry, if it had solely professional stress experts, or if the task force members had not experienced the stress of academic medicine. Furthermore, many faculty members also noted that there must be high-level support for the task force (from the dean of medicine, department chairs and division heads) if changes were to occur. Members were invited from basic science and clinical departments. Although some were experts in professional stress management, most were not. All were respected leaders in their discipline, all were concerned about faculty stress, and all had first-hand knowledge of the stressors in academic medicine. The value and importance of having junior faculty involved was also recognized: a senior resident, a fellow and a junior faculty member agreed to join the task force. Faculty involvement with the task force has been entirely volunteer.

The letters from the dean inviting people to join the task force as well as his letters to department chairs outlining the plan were crucial in developing acceptance of the task force. Furthermore, support for the task force, including financial con-

tributions, was sought from the chief executive officers of all the major teaching hospitals affiliated with the University of Ottawa.

The task force initially worked on developing the goals and the intervention strategies. Many became "nonexpert" tutors for workshops and other educational interventions. All members of the task force championed the area of positive stress management for their departments and divisions by initiating discussions on stress at departmental meetings as well as with individual faculty members and by acting as role models. The development of these program champions from a wide range of senior faculty opinion leaders together with the spur from the initial serious mental health problem provided the energy to carry the program through its start-up phase.

Increasing faculty awareness of stress and strategies for wellness

A two-pronged strategy was developed to increase faculty awareness of stress and strategies for wellness. One prong involved raising the profile of stress for department chairs and senior faculty members through presentations to Faculty Council, department and division heads, and the Postgraduate Medical Education Committee as well as informal discussions with senior faculty whenever the opportunity arose. The task force knew from focus group discussions that, for the program to become widely respected and accepted, senior faculty members had to be seen to value it and, through their leadership roles, reshape service, education and research roles to minimize distress.

The second prong involved a series of faculty-wide workshops, seminars and continuing medical education presentations by task force members. Presentations then and now are tailored to the audience and time frame. All have included clinical vignettes culled from the personal experiences of task force members. Each presentation highlights stressors and distress and serves as a reality check for many faculty members. In addition to didactic components on the recognition of stress, early signs of distress and strategies for wellness, all sessions have included an interactive component during which faculty members can provide feedback and raise concerns through written questionnaires, interactive computer touchpads and open discussion. Several stressors have been highlighted repeatedly by many faculty members (Table 1).

Through feedback we learned that many faculty members were personally aware of colleagues who were in distress, but most did not feel comfortable about intervening owing to a lack of knowledge about what to do and how, a lack of awareness of available support resources and concerns about privacy. These reasons for not intervening are not surprising, since physicians are well known to take poor care of themselves and often poor care of fellow physicians.[5,11,12] Most faculty members, when first questioned at seminars or rounds, did not have a family physician. Many physicians focus on providing care to others and teaching about caregiving but are reluctant and unskilled in seeking and accepting help for themselves.[9] All too often, informal corridor consultations are sought and prescriptions given.[9] This occurs even in academic centres, where any medical student would fail a rotation for providing such care for a "regular patient" (i.e., no formal history or examination, no discussion or investigation of the problem, no follow-up plan and no written record).

Developing an early detection, outreach and intervention program

Faculty concerns about privacy and confidentiality are well founded. The speed with which the news spread of the initial serious mental health problem underlined this issue. Faculty members are thus faced with a dilemma: "If I get help within the faculty, I probably will not be able to keep this private, yet I want excellence of care and know that many faculty are in their position because they are leaders in their field." Furthermore, many faculty members perceived that services designated for the medical profession in Ontario and offered outside the faculty through the Ontario Medical Association and the College of Physicians and Surgeons of Ontario focused more on severe impairment than on the "minor" daily stresses and "milder" distress that occur within the faculty. Thus, many were reluctant to refer a colleague or to use these services themselves. Faculty members also stated clearly that they wanted to be cared for by experts in their problem, yet were reluctant to seek help outside the faculty because they did not "know" the expert. Thus, the task force members felt that the support program would have to ensure both privacy and verified expertise for faculty to use it.

Another area of concern raised by task force members was speed of access. Long delays might exacerbate the fac-

Table 1: Major stressors and concerns identified by medical faculty members at the University of Ottawa

Conflict between research, clinical and family responsibilities
High and increasing clinical responsibilities, increased call, fewer trainees
Cutbacks in hospitals have led to increased indirect patient demands on physicians
Shrinking medical research money
Not feeling valued by academic departments, hospital administration, peers, patients or general public
Fear of patients, angry patients, fear of potential for lawsuits
Marital discord, family breakdown
Increased teaching responsibilities with problem-based-learning curriculum
Retirement issues: adequate money, marital conflict, loss of self-esteem
Career fear, "imposter phenomenon"[10]

ulty member's distress, leading to functional deterioration while awaiting assessment and intervention. This would have a negative ripple effect on patient care, teaching and research responsibilities of other faculty members.

Borrowing from an intervention program developed by us in the early 1980s for University of Ottawa pediatric residents in distress and from a hospital-based support program in family medicine at the Sir Mortimer B. Davis–Jewish General Hospital, Montreal,[9,13] the task force developed a faculty outreach program entitled the Neighbourhood Watch and Connector Program (Fig. 1). The outreach program also took into account faculty needs and concerns around privacy, expertise and speed of access.

With the Neighbourhood Watch and Connector Program, faculty members are informed about markers of distress through workshops, seminars and continuing medical education presentations. The program emphasizes the importance of watching for signs of distress in oneself and in others as well as the benefits of early detection and intervention. Faculty members who recognize that they or a colleague are becoming distressed and need help contact 1 of 5 "connectors," all experienced clinical psychiatrists. All calls to a connector are strictly confidential. The name of the faculty member in distress is not divulged to the connector unless confidentiality is not an issue.

The connector determines with a few brief questions the optimal expert referral for assessment and intervention, for example the type of professional intervention needed, the type of problem, and the caller's preferred sex of the expert, language and site for care. The caller is then asked to contact the connector again later that day. In the interim, the connector contacts an expert who meets the criteria. All the experts on the connector referral list have been screened by the Connector Committee for their expertise and for their agreement to see a faculty member within 48 to 72 hours. The list includes such professionals as community and faculty psychiatrists, psychologists, social workers, family physicians, marriage counsellors, family mediation lawyers, tax accountants, bankruptcy experts and retirement counsellors. The expert, when contacted, is told that a member of the University of Ottawa Faculty of Medicine is in crisis and will be calling within 2 days for an appointment. When the faculty member calls back, the connector gives him or her the name and number of the expert. If the connection is for a colleague and the "referring" faculty member needs advice or help on how to intervene with the colleague, the connector will also discuss useful strategies and techniques to encourage the colleague to make the connection. The faculty member must pay for any services not covered by the Ontario Health Insurance Plan, such as referral to a lawyer, accountant or social worker.

Frequently, faculty members have concerns about a colleague but are unsure whether help is required. The connector can clarify the need for help. In some cases in which help is deemed to be necessary, the faculty member has not yet discussed the concern with the colleague and is uncomfortable about doing it or unsure of how to do it. The connector assists the faculty member to develop options and a preferred method so that the connection can be completed successfully. As well, all educational programs on stress for the faculty include this information. When a faculty member calls a connector, during the course of the conversation the connector reiterates the benefit and value of recognizing stress and of getting help, especially of getting it early.

The Neighbourhood Watch and Connector Program was promoted to the faculty through flyers, which included the names and telephone numbers of the 5 connectors, posted on bulletin boards at all of the major affiliated

NEIGHBOURHOOD WATCH AND CONNECTOR PROGRAM

Faculty of Medicine
University of Ottawa

- Recognition many faculty under stress.
  e.g. workload
  research grants
  patient complaints
  family discord
  personal problems: addiction, suicide ideation, depression
  patient–physician boundaries
- Faculty member may be reluctant to seek help with the faculty owing to privacy issues.
- At each site on the medical campus there is a contact person (a "connector") whose only role is to get sufficient information so as to facilitate the connection to a community-based specialist, e.g., psychiatrist, marriage counsellor, family therapist, etc., as needed. The role is not to provide assessment and treatment.
- All inquiries are confidential and will be handled discreetly and as quickly as possible. Names need not be revealed.
- **FOR INFORMATION FOR YOURSELF OR A COLLEAGUE CONTACT**:

Health Sciences Centre	Name Telephone number
Children's Hospital of Eastern Ontario	Name Telephone number
Ottawa Hospital (General Campus)	Name Telephone number
Ottawa Hospital (Civic Campus)	Name Telephone number
Royal Ottawa Hospital	Name Telephone number

Faculty members should feel free to contact people in any of the centres.

Fig. 1: Flyer promoting the Neighbourhood Watch and Connector Program for medical faculty at the University of Ottawa.

teaching hospitals and at the Faculty of Medicine building (Fig. 1). The flyer is signed by the dean of medicine and the cochairs of the task force. This information is also sent to all department chairs on a yearly basis.

Preliminary results

The Neighbourhood Watch and Connector Program was implemented in 1996. During the first 4 months of the program, over 40 connections were made. Initially, the task force expected that the number of connections would decrease rapidly after the first flurry of requests. However, the number of requests for help still run at about 60 to 80 per year. Clearly, this program has tapped into previously unmet needs. Furthermore, connection requests have not been just for mental health issues: financial problems and other nonmedical stressors have also often been major concerns. A precise examination of the data on connections is not possible because the program is anonymous. In addition, some faculty members may have called more than once.

With hospital and health care restructuring, the importance of this program has been underscored. It continues to be strongly supported by the dean.

Over time, there have been changes in leadership in the faculty. The initial goals of the task force have been achieved. The structure, role and functioning of the task force are being renegotiated with the dean, as the task force moves into a period of renewal and consolidation.

"And miles to go before we sleep"

The Task Force on Faculty Stress has completed only the first part of the development of the full program, that is, a start on increasing faculty awareness of stress and distress and the development of a personal support program for those in distress through the Neighbourhood Watch and Connector Program. The cochairs and members of the task force have done this at the same time as carrying out their "regular" work. All have recognized that much more work is needed, but this will require protected time. Numerous strategies and options are being explored. Requests for seminars on the program from other faculties of medicine, medical societies and other groups continue to come in. A formal research project to evaluate specific stressors in 5 clinical departments in the Faculty of Medicine is underway. Clearly, this is an understudied area. To ensure that faculty members can strive for excellence in clinical care, research and teaching while living a balanced and fulfilling life, we must work toward optimizing positive workplace stress and minimizing distress.

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Correspondence to: *Dr. Noni E. MacDonald, Faculty of Medicine, Dalhousie University, Rm. C-205, 5849 University Ave., Halifax NS B3H 4H7; fax 902 494-7119; noni.macdonald@dal.ca*