

Doctors' Health Matters ♦ Finding the Balance

Editor: Dr. Mamta Gautam

17–19 November 2008, BMA House, London, UK

Physician health becomes a global movement

The 2008 international conference for physician health, co-hosted by the Canadian, British and American medical associations, kicked off with a significant expansion of research and grew into a nascent movement to build a network of support for physician health programs and doctors' health worldwide.

Drs. Todd Watkins and Mamta Gautam, leaders of the CMA Centre for Physician Health and Well-being, led an enthusiastically received initiative to create an international alliance on physician health. This was a fitting conclusion to the conference, which featured international panel presentations and quality research building on and surpassing the high standards set in preceding meetings. Three hundred delegates from 20 countries attended sessions exploring all areas of physician health from work–life balance to burnout and substance abuse. A number of research studies from across Canada were represented.

Sustainability

CMA president, Dr. Robert Ouellet, joined Watkins in remarking on the important link between healthy physicians and a sustainable health care system, and noted the CMA has had “some success” in making governments aware of this. “Sustaining the health of Canada’s physicians is all about sustaining Canada’s health care system,” Watkins said, adding that the current serious physician shortage is putting real pressure on the system.

A presentation from the Quebec Physicians’ Health Program illustrated how demands on that program have grown consistently, partly due to the pressures of a more challenging work environment and decreasing resources. Dr. Serge Daneault of Montréal described what he termed “physician suffering” as a result of being overworked and exhausted, having feelings of powerlessness and being trapped into making difficult decisions.

At capacity

Watkins noted that provincial physician assistance programs



Delegates making healthy food choices

across Canada are operating at capacity, even though new data presented at the meeting show that Canadian physicians are generally healthy and satisfied with their health status (see story page 3). He attributed this paradox to the change in physician culture and reduction in stigma attached to physician illness, which means doctors are more aware of assistance programs and are making use of them to seek help.

Worldwide, physician assistance programs are evolving and facing new challenges. While the BMA has had a physician assistance hotline in place for some time, Sir Liam Donaldson, chief medical officer for the United Kingdom’s department of health announced the first pilot program by the National Health Service (NHS) to specifically assist sick doctors in London. He said the new program came about only because the NHS belatedly acknowledged that physicians have unique requirements that cannot be met by programs intended for all NHS employees.

On the downside, Dr. Michael Gendel, past president of the US Federation of State Physician Health Programs, noted that the expansion of such programs to virtually every US

continued on page 2

Conference a success on many levels



Dr. Mamta Gautam

I recall the early 1990s, when a handful of us would gather to talk about physician health. I could never have imagined it becoming such a key area of interest, for so many people, organizations and health care systems, both nationally and globally.

Held for the first time outside North America, the conference's international aspect is what makes it truly remarkable. While many colleagues from Canada, the United States, Norway, Sweden, Australia, New Zealand, Spain and the United Kingdom have consistently participated, the London location enabled many of them to bring along more of their colleagues and allowed for a new presence from other European countries, such as France, Belgium, Finland, Serbia, Ireland and the Netherlands. Some delegates flew all the way from Israel, Japan and Brazil.

The CMA's Dr. Todd Watkins spoke eloquently, reminding us all that "this area is too important for competition" and urging that "this is the time to pull together in a united effort." This set the stage for 3 days full of new shared information, collegiality and collaboration. The conference showcased progress in many areas; there is greater appreciation that doctors' health affects their medical practices and that efforts to improve physician health must be continued.

A special November 2008 issue of the *British Medical Journal*, "Finding a balance: doctors' health and work" (see story page 6) highlighted the notably increased research in this area. Although early anecdotal evidence helped create awareness and understanding of crucial physician health matters, such powerful research results are crucial to further define the issues scientifically and support the creation and maintenance of programs to address them.

Data from the 2008 Canadian Physician Health Survey were presented, showing that Canadian doctors are relatively healthy. These data may demonstrate some positive results of

our work to date in revealing an early trend toward better health and resilience. A study of Norwegian doctors attending an educational program showed a decrease in burnout after the counseling intervention.

There was an enthusiastic buzz at the conference. Attendees were excited to be there, stimulated by new ideas, programs and interventions. Nowhere was this more apparent than at the launch of the International Alliance for Physician Health (IAPH). We expected perhaps 5 or 10 colleagues to come to the meeting at the end of a full day and were thrilled to have almost 100 people from around the world attend (standing room only!) — all interested in creating such an alliance and eager to discuss how it could work and define the next steps.

We look forward to the work of this alliance. Although the causes of stress that negatively affect physician health may vary depending on the country, the reality of the impact is the same. The IAPH will serve as the umbrella organization that unites, supports and promotes experts in the area of physician health and their networks to work together to maximize their contributions, share resources and leverage ideas in an ongoing process to advocate for doctors' well-being.

This field has evolved over the past 40 years, from the early 1960s, when energy was devoted primarily to treating physician with addictions, to the treatment of mental health problems, then physical and sexual difficulties and, more recently, difficult behaviour. The international conference on physician health was launched over 20 years ago by the American Medical Association in conjunction with the CMA. It has brought together interested experts on a biennial basis and encouraged many countries to share information and create policies and programs to address physician health. Continued collaborative efforts will yield healthier doctors and healthier populations globally. Look for details on the 2010 conference to be held in the United States.

Dr. Gautam is chair of the expert advisory group to the CMA Centre on Physician Health and Well-being.

continued from page 1

state suffered its first major setback earlier this year with the collapse of the California program as the result of an ongoing political dispute with the state licensing agency.

"Disruptive behaviour" and the myriad reasons why more of these cases are requiring intervention by physician health programs was a prominent con-

ference theme. Watkins noted this "area of unfortunate growth," and said upwards of 20% of new cases seen by physician health programs in Canada are related to disruptive behaviour. To assist, the CMA has developed an education module for physician leaders dealing with the issue as part of its Physician Manager Institute.

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Canadian physicians healthy — national survey finds

Preliminary findings from the 2008 Canadian Physician Health Study (CPHS), the first national study of Canadian physician health, shows that doctors are generally a healthy group, with self-rated health and lifestyle habits exceeding those of the general population and with 66% of respondents indicating that their general health was excellent or very good, and only 9% rating it in fair or poor. The study also showed improved general satisfaction with being a physician.

The study was conducted by the Canadian Medical Association (CMA) and led by a research team headed by Dr. Erica Frank, Canada Research Chair in Preventative Medicine and Population Health at the University of British Columbia. A randomized sample of 8100 practising Canadian physicians was surveyed early in 2008, with a response rate of 41% (3320).

Mental health

Three-quarters of respondents said mental health had not made it difficult to work in the past month. However, a significant number of respondents (up to 25%) do face some form of mental health challenge that makes it difficult for them to work. In fact, 21% indicated that in the past year they had suffered 2 or more weeks of anhedonia, and 23% said they had been depressed for a similar period.

We know that 1 in 5 Canadians will face a mental illness sometime in their lifetime and clearly physicians are not immune. The research team stated that the CPHS data will require more analysis, with the further goal of more qualitative assessment of the mental health of physicians.

Physicians have been criticized for self-medicating and not having their own family doctor. According to this survey, although 61% of respondents said they have had a checkup within the last two years (83% for female physicians), 58% agreed or strongly agreed that, if they can, they will take care of their own medical needs. In addition, although 85% said they know of resources they would use if they needed help for a physical problem, that figure is only 69% when it comes to mental health problems. This is troubling and suggests that stigma within the profession remains a barrier to access to mental health services for doctors.

Regarding work–life balance, 57% of respondents agreed or strongly agreed they had a good balance of work and other activities in their life, while only 4% strongly disagreed. Three-quarters agreed or strongly agreed they were perceived as being more professional when they live a more balanced life.

The vast majority (86%) indicated they had disability insurance, with 9% reporting ever having been denied disability insurance; a similar high percentage agreed or strongly agreed that having such insurance was important to them.

Almost a third (30%) disagreed or strongly disagreed that their work environment generally encourages good health and

80% agreed or strongly agreed they would work when they are ill if they can.

Health behaviours

The survey asked a number of questions about personal lifestyle habits. Not surprising, the rate of smoking among doctors is very low, with only 3% indicating that they still smoke on a daily basis — far fewer than in the general population.

Alcohol consumption also tended to be lower than that seen in the general population, with half of respondents indicating they drink alcohol once a week or less. Most (86%) said they limit their alcohol consumption to 2 or fewer drinks at a time on average. Binge drinking is also rare.

In terms of exercise and consumption of fruits and vegetables, this physician population reported healthy diet and exercise behaviours. Physicians also scored well in terms of taking preventive measures — such as screening tests — to maintain their health. Few doctors were obese — 8% v. 23% of the general population — but Frank noted that many in the surveyed group were overweight.

The demographic mix of survey respondents mirrored the current practising physician population well: 34% were female, 79% graduated from a Canadian medical school and respondents work in a variety of geographic and practice settings.

The overall response rate was 41%; Frank said this is better than the usual response to CMA surveys, and internal validation supports the validity of the findings for the Canadian physician population as a whole. In terms of the response rate, she said, “Frankly, it’s the best we’re going to get.” In addition, she noted the overall findings are not surprising and are in keeping with earlier studies she has done of US women physicians and medical students.

The data will help us to better understand this “healthy denominator” of physicians and work further to define the characteristics of the resilient physician. Yet, there remains concern about the “numerator,” that is, physicians who require the assistance of physician health programs across the country, in growing numbers.

This study establishes a new and important baseline for the health of Canadian doctors. The data will inform the future development of resources and services by the physician health community and assist the CMA in achieving and sustaining its vision of a vibrant medical profession.

The CPHS was made possible through financial contributions from Health Canada, the Royal College of Physicians and Surgeons of Canada and the Canadian Medical Foundation, with additional support from the British Columbia Medical Association, the Physician Health Program of British Columbia and the Healthy Heart Society of British Columbia.



Dr. Erica Frank

Published studies confirm value of intervention programs

A landmark feature of the conference was the simultaneous publication in the *British Medical Journal* of 4 peer-reviewed physician health research articles. These publications confirmed the efficacy of physician health programs in Canada, the United States and Norway in assisting physicians with substance abuse problems or burnout, and demonstrated the maturity and quality of research in this field.



BMA House where the international conference was held

The four articles are

- Alcohol consumption and alcohol counselling behaviour among US medical students: cohort study
- Counselling for burnout in Norwegian doctors: one year cohort study
- Characteristics and outcomes of doctors in a substance dependence monitoring programme in Canada: prospective descriptive study
- Five year outcomes in a cohort study of physicians treated for substance use disorders in the United States

The key message from the three intervention trials is that these programs help physicians deal with stress or overcome abuse problems.

The study of US medical students showed their rates of binge drinking were slightly lower than their general population peers, and those who received training in alcohol counselling felt far more confident about discussing this issue with patients.

The Norwegian study involved 227 physician participants in the Villa Sana program, involving a brief counselling intervention to help deal with self-perceived stress and burnout. Counselling was either a day-long individual session or group therapy for a week; the main outcome measures were levels of burnout and predictors of reduction in emotional exhaustion. Among the 185 physicians who completed 1 year of follow up, the mean level of emotional exhaustion was significantly reduced to a level found in a representative sample of 390 Norwegian doctors. Reductions were also seen in the amount of full-time sick leave taken and in hours worked per week, compared with baseline measures taken before they completed the program.

The Canadian trial, headed by Joan Brewster, assistant professor, Dalla Lana School of Public Health, University of Toronto, tracked 100 doctors consecutively admitted to the Ontario Physician Health Program for monitoring of substance dependence (primarily alcohol or opioids) since 1995. Physicians were tracked until they completed the monitoring process or left the program and the main outcome measure was relapse during years of follow up. Treatment was an abstinence-based residential program followed by contractual monitoring that included random urine testing, monitoring in the workplace, visits to treating physicians and attendance at support group meetings.

During the monitoring period, 71% of participants had no known relapse and another 14% completed the program after some form of relapse, for a total success rate of 85%. In light of these findings, Brewster and colleagues concluded, "A structured monitoring program ... with regulatory contingencies for lack of adherence, can produce successful results."

The descriptive study, conducted by Dr. Thomas McLellan of the Treatment Research Institute, Philadelphia, and colleagues, tracked 904 physicians admitted to one of 16 physician health programs in the United States for substance dependence. The main outcome measures of this 5-year study were completion of the program, continued substance use, and occupational status. At the end of the study period, 78.7% of physicians who completed a treatment program were licensed and working; 10.8% had had their licence revoked. "On the basis of these data ... physician health programmes seem to provide the best available measures for protecting patients and for recovering physicians' careers."

The full articles are on the BMJ website at www.bmj.com/content/vol337/issue7679/

Staying healthy in a challenging environment

The medical profession continually faces political and social challenges that can create a stressful environment. We must counter this by focusing on the positive aspects of being a physician and reaffirming the motivations that have led us to care for patients in the first place.

This was a key message of the conference opening plenary session on the impact of organizational change and the shifting political landscape within which physicians operate.

Janet Grant, professor of education in medicine at the Open University, United Kingdom, was on a panel of speakers who reflected on how physicians have lost control of the education process. This is causing deterioration in relations between senior and junior doctors and between physicians and their patients. Grant described the current political imperative to define professions as “merely a set of competencies” and the current view of professional autonomy as “socially unacceptable elitism.”

The impact of described reforms in the National Health System, hospital management systems and medical education on British physicians would be relevant to many physicians operating in Canadian and other international systems.

Olaf Aasland, director of the Research Institute of the Norwegian Medical Association, tempered these comments by saying, “I’m afraid that many sociologists would say the con-

trol we think we have and that we are afraid of losing is already long gone.”

To maintain a resilient medical profession, Aasland said, there is a need to focus on positive messages, such as the fact that physicians are generally healthier and live longer than the general population, tend to take good care of themselves and each other and are open to change. “The health of doctors is really a story of success,” he said. “Let us not be remembered as the generation of unhappy and sick doctors.”

Aasland’s optimism was mirrored by speakers and delegates who spoke of the importance of maintaining collegiality among physicians and providing a supportive community for those in need.

“We must be a caring community for one another.”

— Dr. Nancy Nielsen, president,
American Medical Association

Dr. Nielsen emphasized that, to be healthy, physicians must uncover what they value on an individual level. At the organizational level, physicians, as a national resource, must discover the conditions that allow them to find joy in their work so that their contributions will be those of a profession and not simply an occupation.

Growing awareness of stress associated with complaints

There is a growing awareness within the medical profession worldwide of the stress and anxiety associated with the threat of a lawsuit or a complaint to a regulatory body. There also appears to be increasing willingness on the part of medical groups to deal with this by offering support for doctors.

The tone of a 2-hour plenary session dealing with the subject of complaints and litigation was set by a harrowing account by a British general practitioner, Dr. Paul Davis, of his 3.5-year experience dealing with a complaint to the General Medical Council (the equivalent of the Canadian provincial regulatory colleges) and the subsequent threat of a lawsuit and belated media coverage following the death of a patient in his care.

Although the GMC complaint was resolved and the lawsuit settled with no admission of guilt, Davis acknowledged, “I am not the doctor I was before.” Despite receiving professional help, Davis said, he continues to have situational anxiety. He double-checks with his colleagues more often than before and does not think he could go through the process again.

Polled about their views, conference delegates said they believed that a complaint to a regulatory authority is the most stressful situation faced by a physician. This was confirmed by Dr. Douglas Bell, managing director of physician services for the Canadian Medical Protective Association (CMPA).

Bell said Canadian physicians who have faced civil action or dealt with a complaint to a college or a preliminary investigation rate a college complaint or investigation as more stressful than court action. Of those who have faced a college investigation, he said, 67% rate this as stressful or very stressful.

According to Bell, the CMPA has recently taken steps and plans to do more to help physicians deal with the stress and anxiety associated with these situations. The CMPA has created a Physician Support Committee and is working to make physicians who contact them aware of resources offered by provincial health programs when needed.

Bell said there is a need to lift the “cone of silence” surrounding physician stress in this context and normalize it. He emphasized that when the CMPA advises physicians not to talk about their case to others, this only refers to the details of the case. It does not mean they should not seek support from family, colleagues and their family physician.

Dr. Ronald Hofeldt, an Oregon psychiatrist who works with physicians facing lawsuits, emphasized that with timely assistance and proper coaching, physicians are actually well equipped to manage the process of being a defendant in a lawsuit. A well-prepared physician, he said, will better understand the stress involved and be more resilient throughout the process.

Research that matters: summaries of presented papers

Conference concurrent sessions gave delegates an opportunity to hear results of research in several areas of physician health. Summaries of just a few of the papers are presented here. A more comprehensive list is available on the British Medical Association and Canadian Medical Association websites.

Mental illness

Relapse rates in physicians monitored for bipolar disorder and recurrent unipolar depression

Why the research was done: To evaluate relapse rates among physicians with bipolar disorder or depression who are working and being monitored by a physician health program.

How the research was done: Fifty working physicians who had a primary diagnosis of bipolar disorder or unipolar depression who were referred for monitoring by a regulatory board or their workplace to the Ontario Medical Association Physician Health Program were evaluated; the primary outcome was time to relapse or time to stopping work.

Main findings: The rate of relapse was significant and about the same as that seen in the general psychiatric population: 54% of physicians experienced a relapse during the mean 2-year monitoring period and 32% of the 50 physicians stopped work due to relapse. Physicians with psychiatric comorbidities were more prone to relapse and stopping work.

What it means: Those conducting monitoring programs and those who treat doctors with recurrent mood disorders may wish to give special consideration to follow-up, particularly when there is psychiatric comorbidity.

Tobacco use

Tobacco use by physicians in a physician health program — implications for treatment and monitoring

Why the research was done: No specific studies have looked at tobacco use among physicians with substance abuse problems or mental illness and the implications of this use.

How the research was done: A retrospective analysis of 1319 physicians enrolled in the Colorado Physician Health Program between 2000 and 2007 was undertaken to look at the correlation between physician tobacco use and reason for referral, and a cohort of 39 physicians treated in 2007 was analyzed to evaluate treatment and outcomes.

Main findings: More than a third of all physicians in the study were smokers (three times the national average for physicians but on par with substance abusers in the general population). All nine of the 17 physicians who relapsed during monitoring were current tobacco users.

What it means: Tobacco use is a risk factor for relapse to drug and alcohol use. Physician health programs should take it seriously and institute tobacco-free treatment facilities to promote better recovery rates. (See page 3.)

Retirement

Retired physicians in Norway — a survey study

Why was the research done: There are limited data available on retired physicians and their health and well-being.

How the research was done: A 43-item questionnaire was mailed to all Norwegian physicians who retired in 2007; 900 responses were available for analysis (56% response rate).

Main findings: Almost 94% of respondents (age range 61–94 years) said they were in good health and more than a third said they were still working part time. Just under half said they had made plans before retirement that were successfully carried out.

What it means: Norwegian physicians seem to be coping well with retirement in good health and a high level of activity.

Sick Leave

The elephant in primary care consulting rooms

Why the research was done: Limited information is available on what general practitioners (GPs) in the United Kingdom do when they have short-term illnesses.

How the research was done: A mail-in questionnaire dealing with short-term illness and taking leave while sick was developed, validated and sent to a group of 459 physicians (response rate 61%).

Main findings: Three-quarters of the GPs said they had taken no sick time in the previous year and the average, self-reported sick leave was 2.9 working days (significantly lower than the 6.8 days reported by the United Kingdom general public). In responding to hypothetical situations, almost three-quarters said they would continue to work when sick, mainly because of their responsibility to colleagues.

What it means: British GPs do not take adequate time off when unwell with short-term illnesses. (See page 3.)

Physician health posters

Stress among junior doctors in Australia and New Zealand

Main findings: A national survey of interns and residents in Australia shows a high degree of satisfaction with career choice but high levels of stress and some poor lifestyle habits.

Design: A confidential online survey, consisting of 96 items, administered to interns and residents in Australia and New Zealand between February and April 2008. The survey was intended to raise awareness of doctor's health issues; 914 surveys were fully completed.

From: Australian Medical Association Council of Doctors-in-Training, Barton ACT, Australia

Seniority equals sloth

Main findings: The number of steps taken by cardiologists and student and resident members of a hospital cardiology team is inversely related to the seniority of the physician.

Design: Each member of the physician cardiology team was asked to wear a pedometer during the working day, for five days, with total number of steps recorded.

From: John Radcliffe Hospital, Oxford, United Kingdom

Physician perceptions about wellness

Main findings: Although recognizing the importance of individual good health for improving patient care, some physicians still resent colleagues for taking time off work when sick.

Design: In-depth interviews were conducted with 42 physicians from different specialties to identify key sources of work stress, coupled with field observations of physician-patient interactions and a mail survey of 1178 physicians asking about patient load and perceptions of workload.

From: University of Calgary, Calgary, Alberta, Canada

Work-related hazards in Finland

Main findings: Perceptions around the four most common work-related hazards for Finnish doctors, including severe burnout and violence at work, decreased significantly between 1997 and 2007.

Design: Two mail surveys about perceived level of risk at work for 13 hazards were conducted among a representative

the risks of wearing masks

dare to care

signs of addiction

Watch for any pattern or cluster of these observable behaviors:

- Unexpected professional behavior
- Decreased performance
- Diverting drugs
- Increased irritability
- Charting irregularities
- Missing in action
- Unusual orders from pharmacy
- Dilated or constricted pupils
- Nodding off during a case
- Slurred speech
- Dangerous to leave alone on case
- Pocketing drugs
- Isolating or withdrawing from peers
- Often late
- Mood alterations (unexplained anger)
- Overreacting to criticism
- Wearing long sleeves all the time
- Frequent home crises
- Frequent bathroom breaks
- Forgetful, unpredictable
- Taking frequent extra calls
- Tremors, shakes
- Increasing difficulty with peers, supervisors and/or authority

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ALBERTA MEDICAL ASSOCIATION Physician and Family Support Program

We would like to acknowledge the resources provided by the Working Masks Program and by AG Academic Center at the University of Alberta for this project. For more information contact: 416@med.ualberta.ca

AMA campaign featured as a poster

cross-section of Finnish doctors in 1997 and 2006 with responses from 3313 and 2841 doctors, respectively.

From: University of Kuopio, Kuopio and Finnish Institute of Occupational Health, National Research and Development Centre for Welfare and Health and Finnish Medical Association, Helsinki, Finland

Body fluid exposures

Main findings: Accidental exposure to blood and body fluids is three times more common among interns and residents than senior physicians.

Design: A 3-year study was conducted using data from the Exposure Prevention Information Network from 4 teaching hospitals in the United Kingdom with an annual average medical staff of 629 physicians and 238 interns and residents.

From: Imperial College Healthcare NHS Trust, London and Plymouth Hospitals NHS Trust, Plymouth, United Kingdom

A personal health kit for students

Main findings: A personal health kit containing such items as a pedometer, a book of healthy recipes, a Frisbee and condoms is well accepted by medical students and perceived as helping encourage healthy habits.

Design: Students entering medical school ($n = 194$) were provided with a personal health kit, then asked to complete a written questionnaire assessing its usefulness two weeks and one year after receiving it.

From: Université de Sherbrooke, Sherbrooke, Quebec and Université de Moncton, Moncton, New Brunswick, Canada

Physician Health Programs

Provincial

Physician Health Program of British Columbia

Toll free: 800 663-6729 (Canada wide) or
604 742-0747
info@physicianhealth.com
www.physicianhealth.com

Alberta Physician and Family Support Program

(provides services to the Yukon)
Toll free: 877 767-4637 (Canada wide) or
403 228-2880
pfsp@albertadoctors.org
www.albertadoctors.org (under Benefits and Services,
Physician and Family Support Program)

Saskatchewan Physician Support Program

Toll free: 800 667-3781 SMA Office (in province only) or
306 244-2196
SPSP Committee members can be found on the "members
only" section of the website
brenda@sma.sk.ca
www.sma.sk.ca/programs/physicianhealth.aspx

Manitoba Physician at Risk Program

204 237-8320

Physician Health Program, Ontario Medical Association

Toll free: 800 851-6606 (in province only) or
800 268-7215 x2972 (Canada wide)
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Quebec Physicians' Health Program

Toll free: 800 387-4166 (Canada wide) or
514 397-0888
info@pamq.org
www.qphp.org

Nova Scotia Professional Support Program

902 468-8215
robert.fredrickson@doctorsns.com,
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New Brunswick Physician Health Program

888 453-7272 (24-hour voice messaging)
Messages returned daytime hours, weekdays
New Brunswick Medical Society: 506 458-8860
lricharddespres@nbms.nb.ca
www.nbms.nb.ca

Prince Edward Island Physician Support Program

Toll free: 877 626-3955 (within 902 area code) or
902 626-3955
airwin@medicalsocietypei.com
www.mspei.org

Newfoundland and Labrador Professionals' Assistance Program

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709 754-3007
rmlahey@nl.rogers.com

Other

University of Ottawa Faculty Wellness Program

613 562-5800 x8507
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Canadian Association of Internes and Residents

613 234-6448
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Canadian Federation of Medical Students

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