QUÉBEC
PHYSICIANS'
HEALTH
PROGRAM

ANNUAL REPORT

2016_2017

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INTRODUCTION

The QPHP assisted 40% more people than in the previous year, either individually or in the scope of a workplace intervention, for a request made during the year. This substantial increase was due in part to the numbers of individuals encountered in institutions after a suicide.

In addition to that unpredictable phenomenon, there has been a 20% increase in requests for assistance from individuals, which reflect difficulties experienced in the workplace.

FACTORS CITED BY THE CLIENTELE IN 2016–2017

Three main factors emerged, which could explain a greater need for assistance.

1 SYSTEM PRESSURES

Most of the clients who consulted the QPHP in 2016–2017 spoke of the pressures of the healthcare system. In some cases, it was the primary reason for consultation.

For many physicians, directives to increase the number of patients they see or to speed up the pace of consultations has resulted in a fear of committing errors, as they fear their practise might become unsafe.

There are practically no job vacancies in institutions, which reduces mobility and makes it difficult for individuals to leave a conflictual workplace or to find a position that will offer the possibility of accommodations. Some physicians report an excessive workload when colleagues on sick leaves or maternity leaves are not replaced.

2 IMPACT OF COMPLAINTS

Among the situations mentioned by the clientele, a second factor stands out: the impact of complaints (within institutions or submitted to the regulatory authority). The shame experienced and the reputational damage among individuals who are perfectionists can lead to unforeseeable and even fatal reactions, especially when there has been media coverage. The QPHP has set up a specialized intervention process to provide close monitoring of affected individuals.

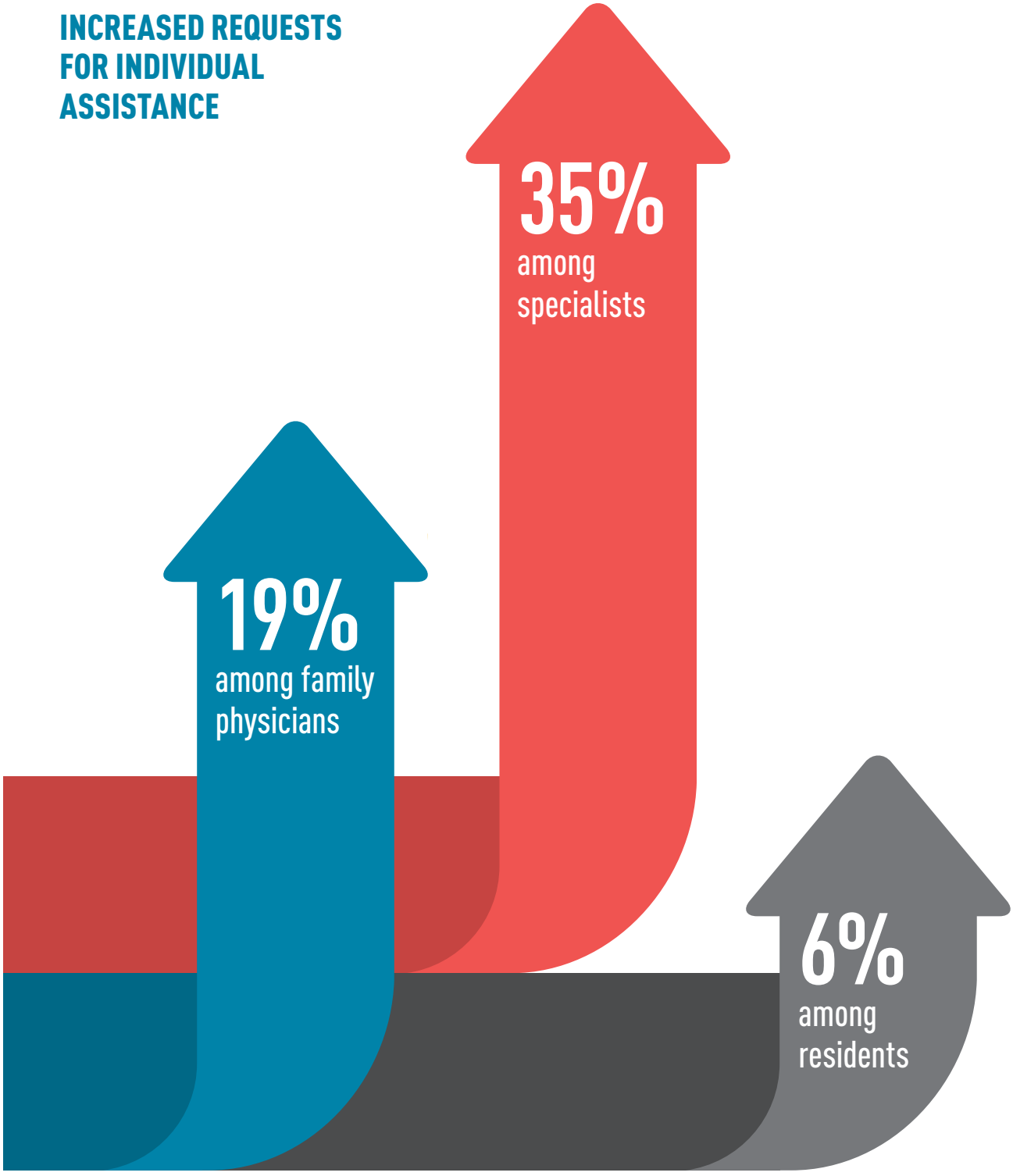
3 CRISIS IN THE WORKPLACE

Group interventions were another important development in 2016–2017. In 2016, the QPHP learned of six physicians who had committed suicide. In comparison, previously, there had been one or two suicides a year. Some workplaces have availed themselves of the QPHP's postvention programs adapted to physicians.

Postvention consists of a series of actions taken to provide support to individuals in the workplace after the suicide of a colleague. The suicide of a physician causes shockwaves not only among those who were close, but also among the team and everyone else in the institution. The provision of medical services can be disrupted, which is why it is important to assist those who have been affected, to ensure a quick and complete recovery of individuals and the services they provide.

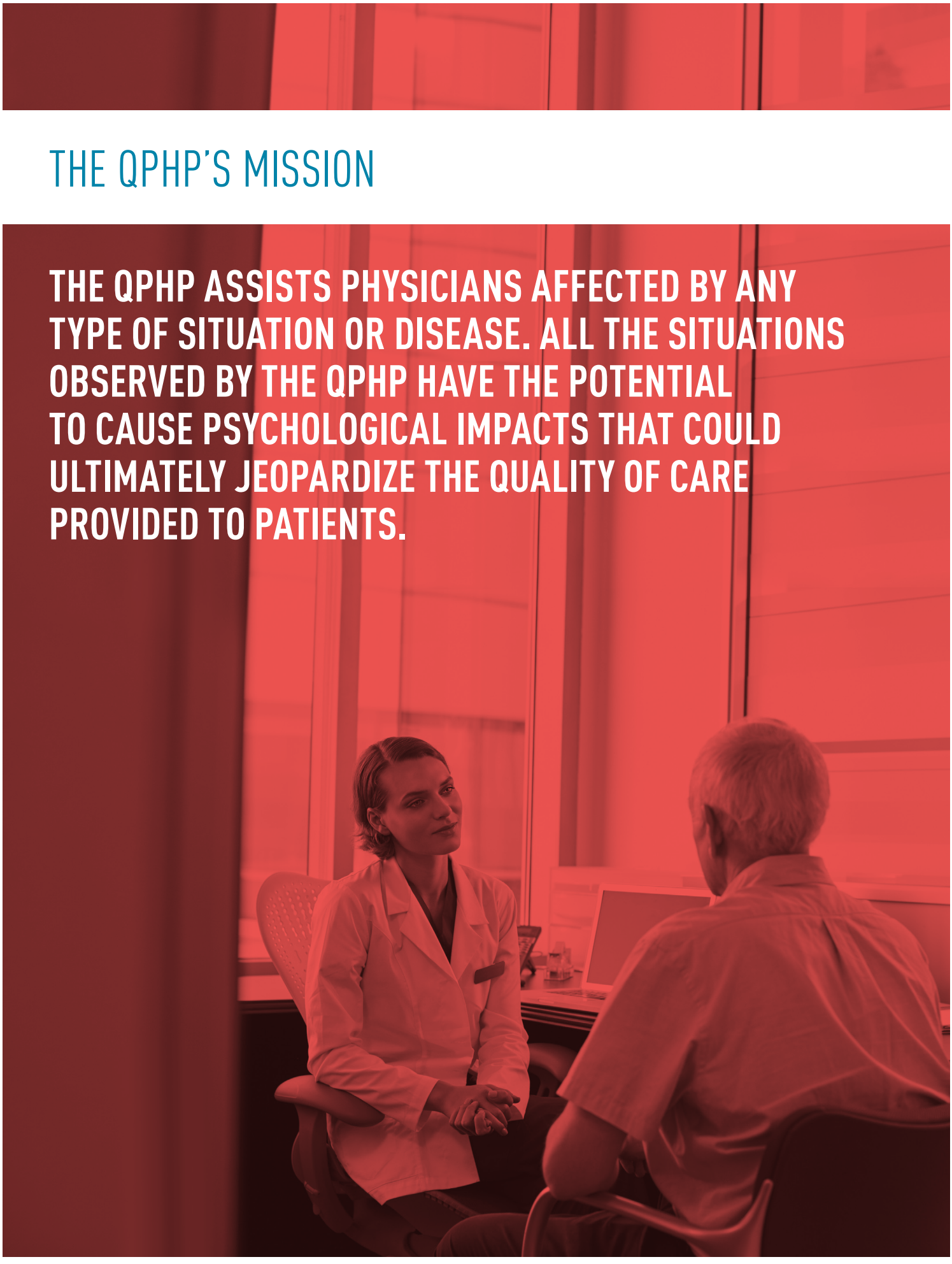
2016–2017 IN PERCENTAGES

INCREASED REQUESTS FOR INDIVIDUAL ASSISTANCE



THE QPHP'S MISSION

THE QPHP ASSISTS PHYSICIANS AFFECTED BY ANY TYPE OF SITUATION OR DISEASE. ALL THE SITUATIONS OBSERVED BY THE QPHP HAVE THE POTENTIAL TO CAUSE PSYCHOLOGICAL IMPACTS THAT COULD ULTIMATELY JEOPARDIZE THE QUALITY OF CARE PROVIDED TO PATIENTS.



PROBLEMS/SITUATIONS OBSERVED AT THE QPHP

PROFESSIONAL DIFFICULTIES

_ Burnout
_ Complaint or legal action
_ Academic failure or difficulties
_ Harassment or intimidation
_ Professional misconduct
_ Problems related to aging or retirement
_ Limitations to performing work
_ Work-related conflicts

MENTAL HEALTH PROBLEMS

_ Anxiety disorders
_ Mood disorders
_ Eating disorders

PERSONAL PROBLEMS

_ Family, conjugal problems
_ Financial stress
_ Physical disease
_ Bereavement
_ Neurodevelopmental conditions (ADHD, neuro-divergent traits)

BY ENSURING THAT PHYSICIANS ARE THEMSELVES IN GOOD HEALTH, THE QPHP PERFORMS A ROLE OF PUBLIC PROTECTION, AMONG OTHERS.

SUBSTANCE ABUSE/DEPENDENCE

_ Alcohol
_ Medication
_ Drugs
_ Sexuality
_ Gambling

PSYCHOSOCIAL RISKS

With its years of experience, the QPHP is now better able to identify the psychosocial risks related to the practice of medicine.

These risks are clustered into three categories:

1 CLINICAL ASPECT OF PRACTICE

_ Regrettable and unexpected events (the death of a patient), unfortunate outcomes
_ Real or perceived errors
_ Complaints
_ Law suits

2 ORGANIZATIONAL FACTORS

_ Overload caused by systematic issues (cuts, reorganization, mergers)
_ Administrative demands (computerization of medical practice, work organization, files, forms)
_ Conflicts
_ Absent colleagues not being replaced

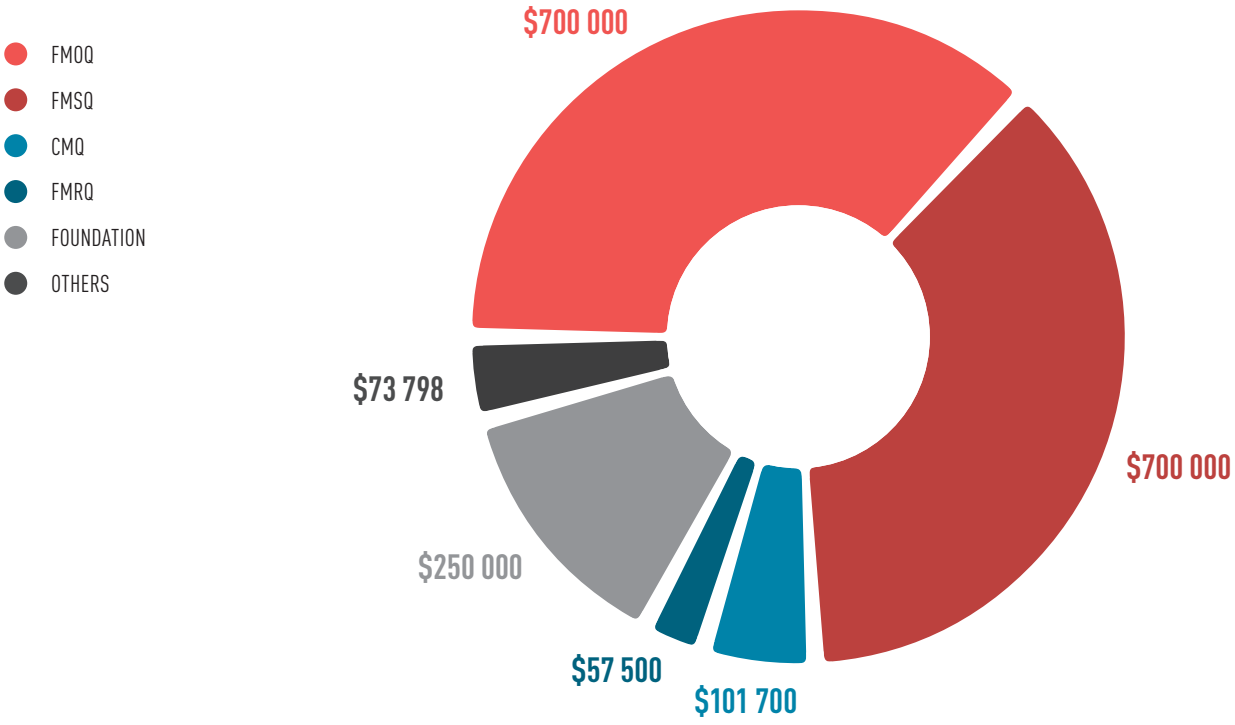
3 WORK-LIFE INTEGRATION FACTORS

_ Transition periods (births, retirement, child or spouse with health problems)
_ Disability, disease or limitation

THE QPHP'S STRUCTURE

The Québec Physicians' Health Program (QPHP) is a nonprofit organization founded in 1990 through an agreement between the FMOQ, FMSQ, FMRQ, CMQ and the AMLFC. These partners ensure the program's funding jointly with the QPHP Foundation.

THE QPHP'S 2016-2017 SOURCES OF REVENUE



TOTAL REVENUES: $1 882 998

BOARD OF DIRECTORS

The QPHP Board of Directors comprises five members from the founding organizations, and the executive director of the QPHP. The Board defines the QPHP's orientation and policies, with the goal of ensuring its growth and sound management. It never intervenes in requests for assistance, which remain strictly confidential.

MEMBERS OF THE BOARD FOR 2016-2017

Chair: **Dr. William J Barakett**	Fédération des médecins omnipracticiens du Québec (FMOQ)
Dr. Michèle Drouin	Fédération des médecins spécialistes du Québec (FMSQ)
Dr. Anne Magnan	Québec Physicians' Health Program (QPHP)
Céline Monette	Médecins francophones du Canada (MdFC)
Dr. Yves Robert	Collège des médecins du Québec (CMQ)
Dr. Cloé Rochefort-Beaudoin	Fédération des médecins résidents du Québec (FMRQ)

THE PROGRAM'S FOUNDERS OPTED TO RECRUIT PHYSICIANS TO COUNSEL PHYSICIANS IN DIFFICULTY. BY OFFERING A SERVICE THAT TAKES INTO ACCOUNT PHYSICIANS' RELUCTANCE TO CONSULT, THE QPHP MAKES IT EASIER FOR THEM TO REQUEST ASSISTANCE, THUS INCREASING USE OF THE SERVICE AND THE EFFECTIVENESS OF THE INTERVENTION.

TEAM

Under the authority of the executive director, Dr. Anne Magnan, nine physicians work part-time (for the equivalent of four full-time individuals). The QPHP team also includes five permanent employees, an administrative director, a communication director, an assistant to the executive director, a receptionist and an administrative secretary.

PHYSICIAN ADVISORS

Since its inception, the QPHP has supported the principle of physicians counselling client physicians in order to reduce the obstacles to consultation as much as possible. Clients consistently state that they feel understood with respect to their workplace situations.

The expertise of physician-advisors is based on their medical knowledge, their practical experience and their specialized training in physician health, which encompasses :

_ The psychosocial risks attached to the profession
_ The medical culture
_ Québec's university and organizational health structures
_ The ethical and medical-legal aspects of the profession
_ Strategies to manage the stress inherent in the practice of medicine
_ Best practices in return to work strategies

THE QPHP'S PHYSICIAN-ADVISORS

Dr. Richard Boulé
Dr. Suzanne Cummings
Dr. Adrienne Gaudet
Dr. Micheline Héroux
Dr. Claude Johnson
Dr. Claude Rajotte
Dr. Sandra Roman
Dr. Yves Tremblay
Dr. Marie-France Villiard

SERVICES

INTERVENTION

Given the high level of responsibility and standards of quality required in medical practice, each request for assistance to the QPHP is extremely important. The QPHP offers:

_ A **confidential** service
_ A **counselling** service provided by a medical colleague trained in physician health
_ **Referrals to resources** familiar with the problems and issues faced by physicians
_ **Services in three locations:** Montréal, Québec City and Sherbrooke
_ A response to requests **365 days a year**
_ Access to a physician-advisors, generally **the same day or within 24 hours**
_ Services for **individuals and groups**

CONFIDENTIALITY

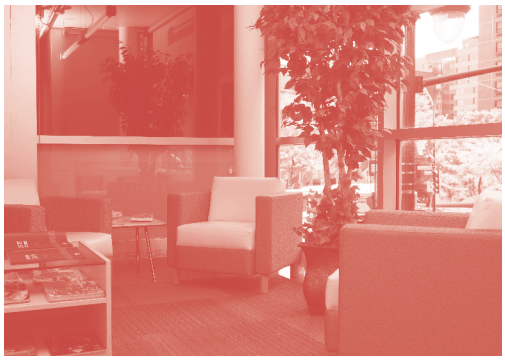
The Québec Physicians' Health Program is autonomous and operates entirely independently of medical organizations, the Collège des médecins and faculties of medicine.

A consultation by a physician with the QPHP is based on the principle of confidentiality, including whether or not the physician has ever consulted in the first place.

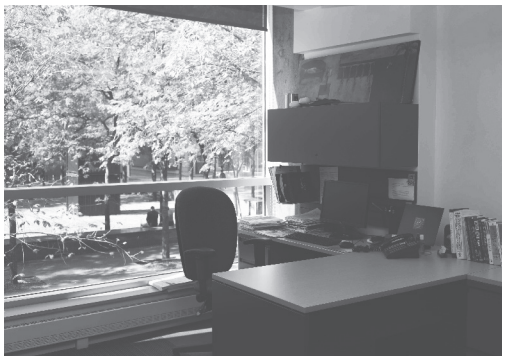
Whatever the context, the QPHP believes that clients must be aware of the content of their records before signing any authorization to divulge their information.

WAITING ROOMS (MONTRÉAL)

In conformance with its policy of confidentiality and discretion, the QPHP provides its clients with two waiting rooms.



OFFICES FOR CONSULTATIONS WITH THE PHYSICIAN-ADVISOR



THE QPHP'S CONTACT WITH A CLIENTELE EXCLUSIVELY MADE UP OF PHYSICIANS MAKES IT THE ONLY ACTIVE WITNESS TO THE STATE OF HEALTH OF THIS GROUP IN QUÉBEC.

PREVENTION

The QPHP is unfailingly vigilant with regard to the health problems experienced by physicians. Given the numbers of physicians experiencing difficulties seen by the QPHP, certain issues come up again and again, making it possible to better determine how physicians react when confronted with various situations.

Observation of the clientele has enabled the QPHP team to better identify the psychosocial risks inherent in the profession, to address problems and to help prevent them from worsening.

The **frequency of problems and the severity of their impact** guide the QPHP in prioritizing actions and implementing the most effective intervention procedures. Being alert to situations in which a physician may be at risk makes it possible to anticipate the pitfalls to which they are exposed and, when possible, to help them avoid them.

For example, it was found that physicians who have committed an error, or simply think they committed an error, are invariably overwhelmed by the situation. In some cases, their reactions may be both unexpected and fatal. The QPHP has introduced a specific intervention process for these physicians, in order to closely monitor them. Thus, prevention is built into the intervention.

Upon request and according to the type of problem, the QPHP disseminates information about physician health to audiences mainly composed of practicing or medical students, in order to raise their awareness of the risks specific to their profession, to prevent problems from worsening and to encourage them to consult the QPHP, if needed.

DIAGRAM OF THE QPHP'S SERVICES AND ACTIVITIES

SECTORS OF ACTIVITY	INTERVENTION			PREVENTION			RESEARCH
SERVICES OFFERED	Individual counselling services for psychological health problems	Counselling services to help a colleague in difficulty	Interventions related to crisis situations in the workplace	Identification of psychosocial risks related to the practice of medicine	Development of better health strategies for physicians	Sharing physicians' health strategies	Supporting scientific research into physician health
ACTIVITES	Overall assessment Counselling Referrals Support in rehabilitation/ re-integration into the workplace	Assessment of the situation Advice Guidance	Assessment Advice Guidance Postvention program	Prioritization of risk factors in terms of frequency and severity of impact	Development of approaches based on the literature and the QPHP's experience, to prevent or reduce the consequences related to psychosocial risks	Raising awareness of the importance of consulting a health professional if needed Dissemination of knowledge, scientific advances (articles, lectures, workshops, website), and physicians' best health strategies	Collaboration with researchers Networking and creating links between health researchers and physicians Promotion/ dissemination
IMMEDIATE RESULTS	Better understanding and use of resilience skills						
LONG-TERM RESULTS	Improving the quality of care provided to patients by helping physicians return to good health and optimize their professional functioning						

QPHP FOUNDATION

Quebec Physicians Health Program Foundation

The QPHP Foundation has been in existence since 2004. The funds gathered through its diverse fundraising activities are entirely dedicated to the physicians' health program. In 2015–2016, $250 000 was raised, which constituted 13% of the QPHP's total revenues.

THE FOUNDATION'S ACTIVITIES

_ Subscription campaign—an annual postal appeal to all physicians in Québec

_ The medical federations' golf tournament

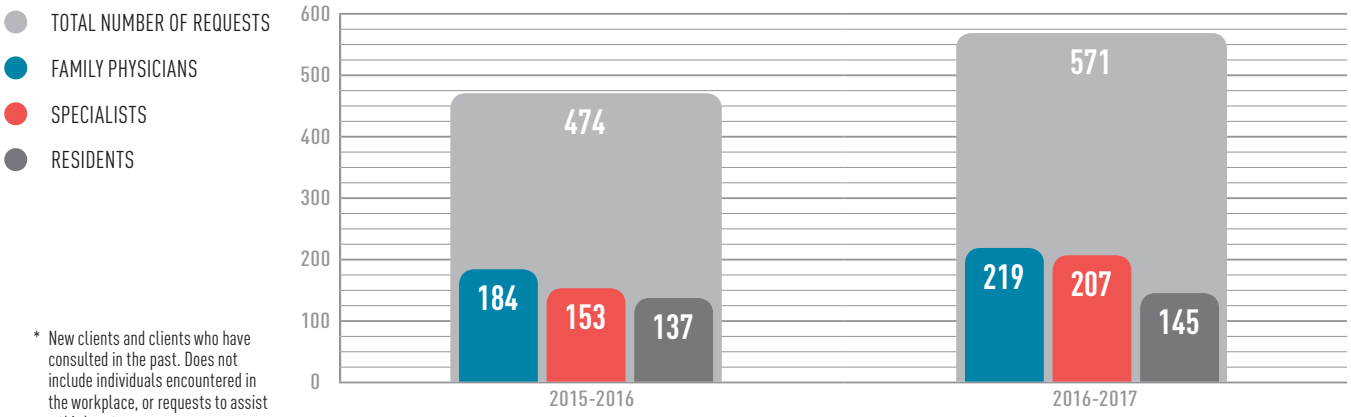
THE FOUNDATION'S BOARD OF DIRECTORS

Dr. William J. Barakett **Chairman**	Physician recognized for his commitment to colleagues in difficulty
Dr. Charles Bernard	Collège des médecins du Québec (CMQ)
Dr. Christopher Lemieux	Féderation des médecins résidents du Québec (FMRQ)
Dr. Diane Francoeur	Féderation des médecins spécialistes du Québec (FMSQ)
Dr. Louis Godin	Féderation des médecins omnipraticiens du Québec (FMOQ)
Dr. Anne Magnan	Québec Physicians' Health Program (QPHP)
Céline Monette	Médecins francophones du Canada (MdFC)
Dr. Muriel Narjoz-Mury	Physician recognized for her commitment to colleagues in difficulty
Dr. Claude Thibeault, **Vice-chair**	Physician recognized for his commitment to colleagues in difficulty

With the presence of their president on this Board of Directors, the major federations and other partners of the medical community reaffirm their support to the cause of physician health.

STATISTICS

COMPARISON OF NUMBERS OF NEW REQUESTS FOR INDIVIDUAL* ASSISTANCE: FAMILY PHYSICIANS, SPECIALISTS AND RESIDENTS



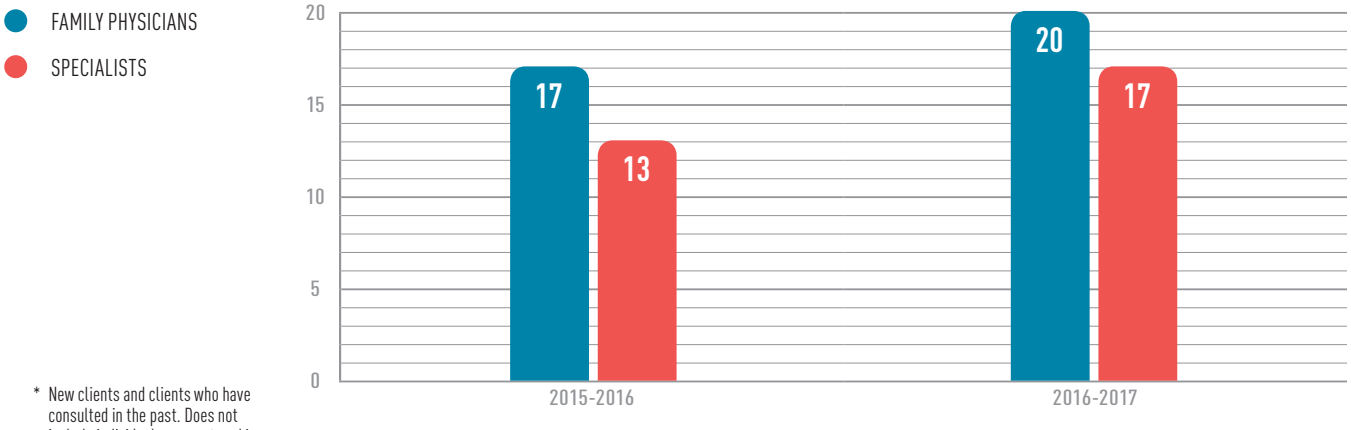
* New clients and clients who have consulted in the past. Does not include individuals encountered in the workplace, or requests to assist a third party.

In accordance with its client record management policy, the QPHP closes files one year after the last intervention. If the file remains inactive, it is destroyed one year after its closure.

When the numbers of individuals assisted in each financial year are added together, an overall increase of 20% across all clientele is noted. The rise is quite significant among specialists (35%) and, to a lesser extent, among family physicians (19%), while requests for assistance have remained stable among residents (6%).

ANNUAL PREVALENCE RATE OF REQUESTS FOR INDIVIDUAL ASSISTANCE—FAMILY PHYSICIANS AND SPECIALISTS*

Per 1000 physicians



* New clients and clients who have consulted in the past. Does not include individuals encountered in the workplace, or requests to assist a third party.

Rates are based on the number of requests to the QPHP, in terms of the numbers of physicians in the network (CMQ data from December 31 of each year).

Historically, there has always been a higher prevalence rate among family physicians. The QPHP hypothesizes that they find it easier to consult than their specialist colleagues. However, once we take into account individuals encountered in the workplace, the prevalence rate among specialists rose to 23 per 1000, while it remained at 20 per 1000 among family physicians. This can be partially explained by the number of suicides that affected the specialist cohort in the past year.

THERE IS EXTENSIVE DOCUMENTATION THAT DEATHS BY SUICIDE ARE MORE FREQUENT AMONG PHYSICIANS AND THAT THE BURNOUT RATE IS 36% HIGHER THAN THAT OF THE GENERAL PUBLIC.

BREAKDOWN OF THE CLIENTELE—INTERVENTIONS IN RESPONSE TO NEW INDIVIDUAL REQUESTS* AND WORKPLACE REQUESTS

	2015-2016	2016-2017
Family physicians	185	219
Specialists	159	270
Residents	137	188
Students	18	24
Sub-total of new individual and workplace requests for interventions	**499**	**701 (+40%)**
Clients requesting assistance for a third party	71	71
TOTAL OF NEW CLIENTS	**570**	**772**

* New clients and clients who have consulted in the past.

ANNUAL TOTAL OF CLIENTS ASSISTED

	2015-2016	2016-2017
Interventions in response to new individual and workplace requests	**499**	**701**
Clients requesting assistance for a third party	71	71
Clients under care—requests from previous years	**795**	**809**
ANNUAL TOTAL OF CLIENTS ASSISTED	**1 365**	**1 581 (+ 16%)**

Over the past four years, the numbers of clients assisted have been stable. In the last financial year, the same stability was observed among clients under care, and in requests to assist third parties and residents. However, a significant increase has been observed among family physicians and specialists when individual and workplace interventions are included.

AVERAGE AGE OF THE CLIENTELE

	QPHP		PHYSICIANS IN QUÉBEC**
	2015-2016	2016-2017	2016
Family physicians	44.5	44.7	51.5
Specialists	45.6	44.7	53.1
Residents	29.9	28.9	—
Students	25.6	26.1	—

** Average age for Québec: CMQ data as of December 31, 2016

These figures correspond to what has been reported in the literature about physician health.

PREVALENCE RATE OVER 3 YEARS*—COMPARISON BY REGION**

Per 1000 physicians

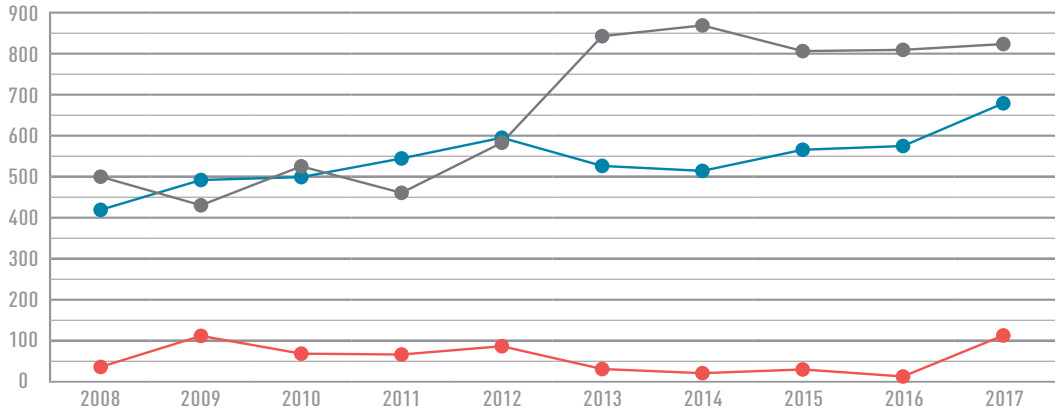
	PREVALENCE WITHIN THE PERIOD (3 YEARS)	
	2011-2014	2014-2017
Bas-St-Laurent • Gaspésie • Îles-de-la-Madeleine	37	52
Saguenay • Lac-St-Jean	41	37
Québec City	49	51
Mauricie • Centre du Québec (Bois-Francs)	39	54
Estrie	72	45
Laval	35	50
Montréal	42	53
Outaouais	37	44
Abitibi-Témiscamingue	36	54
Côte-Nord • Nord-du-Québec	67	43
Chaudière-Appalaches	37	34
Laurentides • Lanaudière	42	43
Montérégie	42	52
Outside of Québec	1	8
PROVINCIAL PREVALENCE	**42**	**48**

* New individual clients only; does not include individuals encountered in the workplace or requests to assist a third party.

** According to CMQ data as of December 31, 2016

COMPARISON OF INTERVENTION SERVICES

- INDIVIDUAL REQUESTS*
- WORKPLACE REQUESTS (INDIVIDUALS ENCOUNTERED)
- CONTINUING CARE FOR PREVIOUS REQUESTS

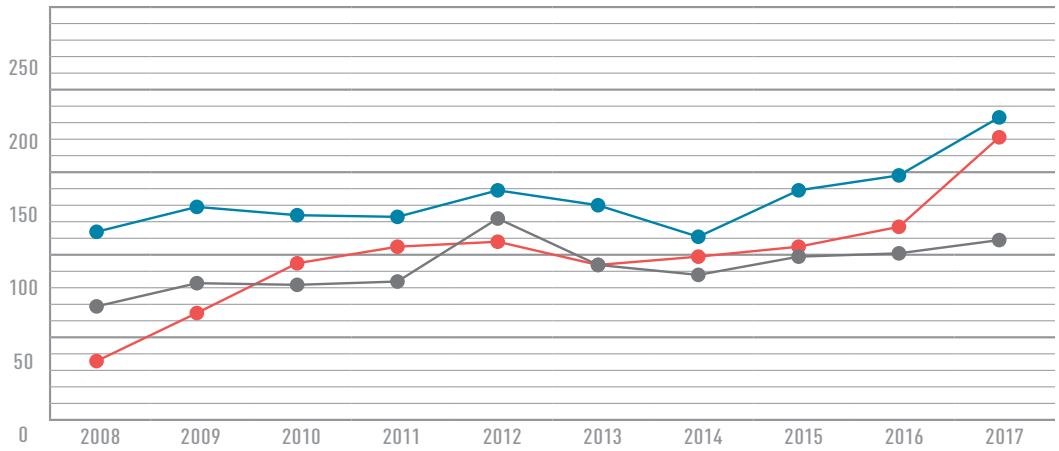


Note that the numbers of individuals requiring continuing care began to rise in 2011. While this peaked in 2014, with a noticeable progression between 2011 and 2013, the numbers of such cases have remained high since 2013. The QPHP has no explanation for this phenomenon. It could be that, previously, clients consulted for specific problems, which were rapidly resolved. And perhaps (and this has been reported by physician-advisors) needs are now more complex and persistent, in particular, because of the absence of mobility in practice settings.

* New clients and clients who have consulted in the past.

COMPARISON OF FAMILY PHYSICIANS, SPECIALISTS AND RESIDENTS (REQUESTS FOR INDIVIDUAL ASSISTANCE*)

- INDIVIDUAL REQUESTS: FAMILY PHYSICIANS
- INDIVIDUAL REQUESTS: SPECIALISTS
- INDIVIDUAL REQUESTS: RESIDENTS



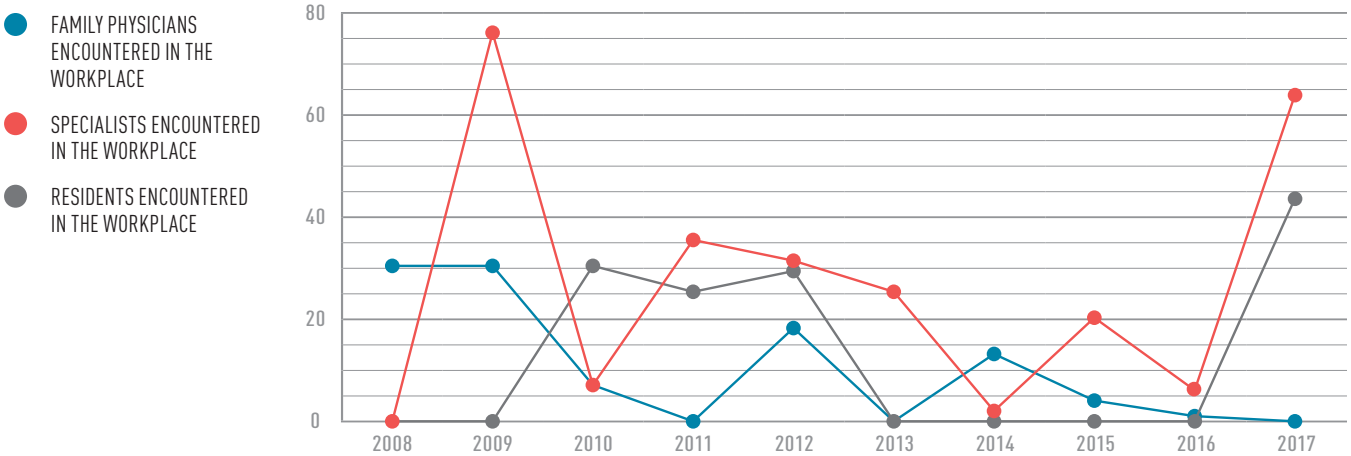
* New clients and clients who have consulted in the past. Does not include individuals encountered in the workplace, or requests to assist a third party.

The graph shows that, among family physicians, the growth in numbers of requests began in 2014–2015, while among specialists there was a considerable increase in the past year. We note that, compared to other clientele, requests from residents are quite stable

INDIVIDUALS ENCOUNTERED IN THE WORKPLACE

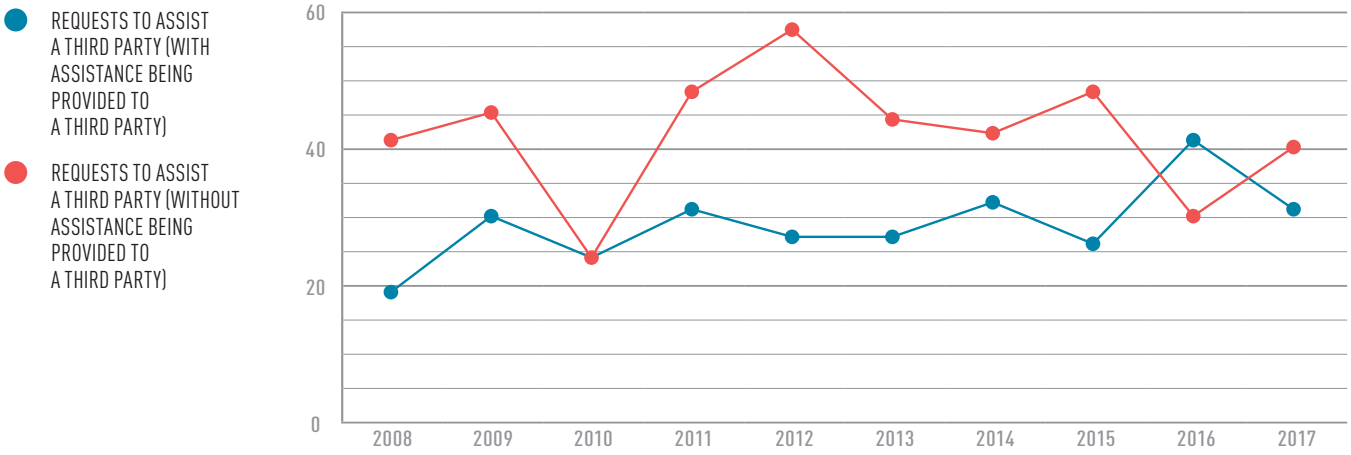
The diagram shows clearly that group requests can jump unexpectedly; it's the nature of this type of intervention. In 2006, the QPHP saw fewer than ten people in the scope of an institutional intervention, while in 2017, more than 100 physicians needed support in the context of an unexpected and unfortunate event.

COMPARISON BETWEEN FAMILY PHYSICIANS, SPECIALISTS AND RESIDENTS—INDIVIDUALS ENCOUNTERED IN THE WORKPLACE



We can see on this graph that group requests dealing with specialists and residents were much higher than those dealing with family physicians. The events that lead to a group intervention from the QPHP occur more often in hospitals.

ANNUAL TOTAL—REQUESTS TO ASSIST A THIRD PARTY



This type of request comes from physicians who want to support a colleague they are worried about and are seeking assistance to be properly equipped to do so. The primary objective in this type of situation is to help the person who has contacted the QPHP about how to approach a colleague whose behaviour may be problematic. Often, in such cases, after the former has talked to his or her colleague, the latter will ask for help from the QPHP. However, even if the physician does not call the QPHP, it is not necessarily a sign of failure, because he or she may have consulted a resource other than the QPHP (such as a psychologist, family physician, or the CMPA). In 2015–2016, requests for assistance following a colleague's intervention rose, but returned to the previous level afterward. In conjunction with the FMOQ and the FMSQ, two projects to facilitate approaching a colleague in difficulty are underway and will be implemented in 2018–2019.

THE COSTS OF THE QPHP

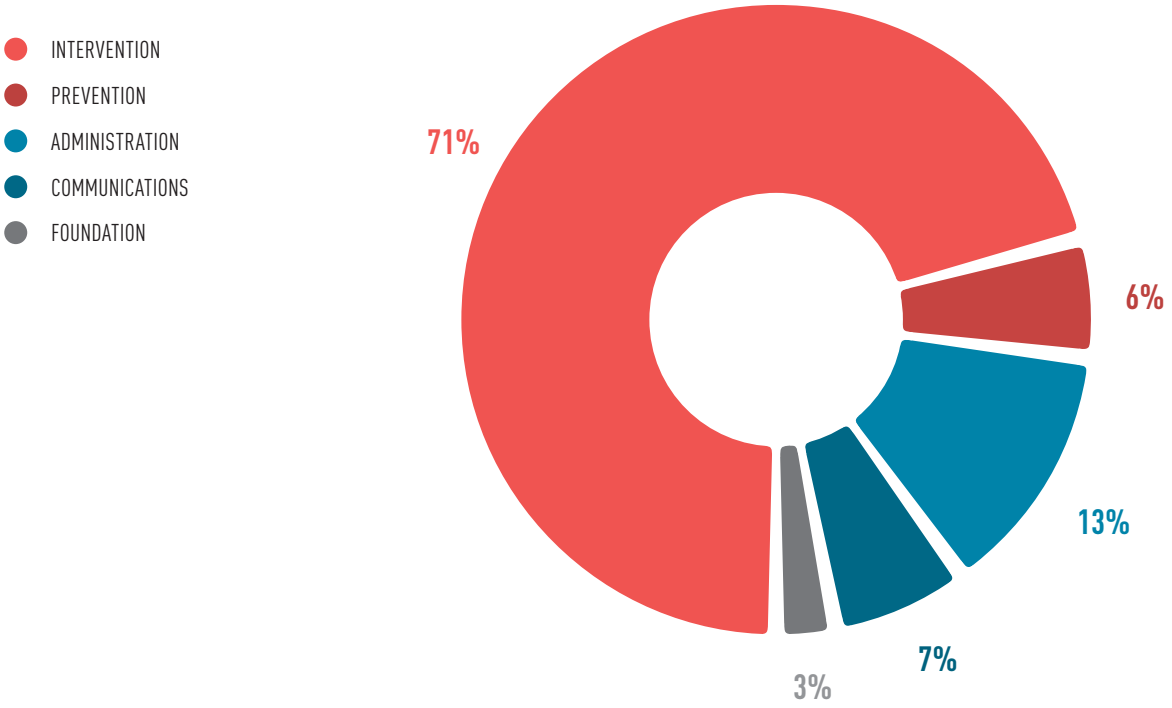
$76

PER CAPITA COST OF THE QPHP'S SERVICES

In Québec, the per capita cost of the QPHP's services is $76, out of a budget of $2 047 532. This amount is established by dividing the total budget by the number of physicians and residents enrolled in the Collège des médecins for that financial year. For 2016–2017, because of lower revenues, the organization absorbed a deficit of $164 534 from its reserves. In light of this situation, discussions with funding agencies have taken place over the year in order to adjust funding.

Interventions are the QPHP's biggest expense.

BREAKDOWN OF EXPENSES BY SECTOR OF ACTIVITY 2016–2017



4.7 hours

AVERAGE NUMBER OF HOURS PER CASE

QUÉBEC PHYSICIANS' HEALTH PROGRAM

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