UNDERSTANDING PHYSICIAN HEALTH APPROACHES IN CANADA

by

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ABSTRACT

In Canada, Medical Regulatory Authorities (MRAs) and provincial/territorial Medical Associations (MAs) have developed approaches to support, manage or regulate physician health. These approaches have proliferated despite an international body of literature documenting several critical issues related to physician health. This study used sequential, multiple methods across two phases to explore physician health approaches in Canada and the perspectives of MRAs and MAs in Canada on the issues in physician health. The first phase used content analysis to explore the publicly available descriptions of physician health approaches and perspectives of MRAs and MAs. The second phase interviewed MRAs and MAs to better understand their approaches and perspectives. There were layers of complexity in their roles that demanded nuanced approaches. Both MRAs and MAs were also limited by their role in a complex adaptive system. Physician health is a complex, multifaceted issue that requires systemic solutions to effect change.

LIST OF ABBREVIATIONS USED

AMA	Alberta Medical Association
BBV	Bloodborne Virus
CMA	Canadian Medical Association
CMQ	Collège des Médecins du Québec
CMPA	Canadian Medical Protective Association
CPSA	College of Physicians and Surgeons of Alberta
CPSBC	College of Physicians and Surgeons of British Columbia
CPSM	College of Physicians and Surgeons of Manitoba
CPSNB	College of Physicians and Surgeons of New Brunswick
CPSNL	College of Physicians and Surgeons of Newfoundland and Labrador
CPSNS	College of Physicians and Surgeons of Nova Scotia
CPSO	College of Physicians and Surgeons of Ontario
CPSPEI	College of Physicians and Surgeons of PEI
CPSS	College of Physicians and Surgeons of Saskatchewan
DBC	Doctors BC
DMB	Doctors Manitoba
DNS	Doctors Nova Scotia
EDI	Equity, Diversity and Inclusion
FMRAC	Federation of Medical Regulatory Authorities of Canada
FSPHP	Federation of State Physician Health Programs
GMC	General Medical Council
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HPN	Health Professions, Government of Nunavut
MA	Medical Association
MOU	Memorandum of Understanding
MRA	Medical Regulatory Authority
MSPEI	Medical Society of PEI
NHS	National Health Service
NBMS	New Brunswick Medical Society

NLMA	Newfoundland and Labrador Medical Society
NWTMA	Northwest Territories Medical Association
OMA	Ontario Medical Association
PEI	Prince Edward Island
PHA	Physician Health Approach
PHMP	Physician Health Monitoring Program
PHP	Physician Health Program
PLNWT	Professional Licensing, Government of the Northwest Territories
PSA	Professional Standards Authority
PTMA	Provincial and Territorial Medical Association
SMA	Saskatchewan Medical Association
SUD	Substance Use Disorder
UK	United Kingdom
US	United States
YMA	Yukon Medical Association
YMC	Yukon Medical Council

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CHAPTER 1: INTRODUCTION

1.1 Background

Physician health includes the full spectrum of health ranging from wellness to illness and is a growing concern for healthcare systems. On one end, physician wellness is a "multifaceted" construct that includes "physical, mental and emotional health and wellbeing" (Wallace et al., 2009, p. 1714). Physician wellness has been argued to be the missing quality indicator in healthcare given the impact of physician stress, job satisfaction, and burnout on workforce shortages and patient care standards (Wallace et al., 2009). Towards the other end of the spectrum is illness. Physicians are as susceptible to illness as the general population, if not more susceptible in some instances, given the demands of their profession. Illnesses like substance abuse and other mental illnesses may also lead to the impairment of a physician's ability to practice medicine safely. A survey of American physicians found those suffering from substance use disorders or dependence were more likely to report major medical errors in the previous three months (Oreskovich, 2012, 2015). Physician health, whether impacting standards or impairing practice, may culminate in a risk to patient safety.

Given the growing emphasis on physician health and the potential risks to the public, physician health approaches (PHAs) emerged in the 1970s (DuPont et al., 2009A, Federation of State Physician Health Programs, 2019; Platman et al., 2013). PHAs may be formalized as a physician health program (PHP), a legislated process to evaluate fitness to practise, or may simply relate to an organizational policy to approach unwell, ill or impaired physicians. PHAs provide a range of services, from advocacy, support, and prevention to management through biological monitoring and regulation of their medical license. In Canada, PHAs are operated by provincial Medical Regulatory Authorities (MRAs) and Medical Associations (MAs), either

independently or collaboratively. MRAs in Canada have a legislated duty to serve and protect the public interest in the medical profession, which by extension includes regulating physician health to minimize risk. MAs, as advocates for the profession, serve as the representative for physicians in the province and are invested in ensuring the health of their members. Regardless of the service provider, PHAs aim to provide non-disciplinary, supportive, and sometimes therapeutic alternatives for unwell physicians that minimize the risk of harm to patients while enabling physicians to stay in the healthcare workforce.

1.2 Importance of this Research

There is demand among Canadian physicians for comprehensive approaches to physician health; a 2018 Physician Health Survey by the Canadian Medical Association (CMA) found that 15% of physicians had accessed a PHP in the last 5 years. Given the number of physicians in Canada in 2018, this equates to approximately 13,000 physicians in the country (Canadian Institute for Health Information, 2019). Moreover, in 2018, the CMA, together with Scotiabank and MD Financial, pledged $115 million over ten years towards physician health initiatives in Canada (CMA, 2018B). There is a need for support and PHAs from physicians and a significant amount being invested into physician health in Canada. This was known before the COVID-19 pandemic, which has undoubtedly heightened the need for effective and comprehensive PHAs in Canada.

However, there are limited studies exploring or comparing established approaches to physician health in Canada. Brewster et al. (2008) examined the characteristics and outcomes of physicians monitored for substance use disorders in Ontario run by the Ontario Medical Association. Albuquerque et al. (2009) analyzed the recurrence rates of major depression and bipolar disorder in physicians monitored under the same Ontario program. Outside of Canada,

studies include a retrospective chart review to understand demographics of participants in Spain and the outcomes of those self-referred versus mandated referral (Braquehais et al., 2014 and 2016). In the United States (US), researchers used a Likert-type survey to assess the satisfaction of PHP participants (Knight et al., 2002). An Australian team used thematic analysis to understand the perspectives of physicians with physician-patients who reported their patient to the regulator (Bismark et al., 2016). One American team completed a survey of American PHPs to characterise their approaches and outcomes in 2009 (DuPont et al.). No similarly comprehensive account of Canadian PHAs exists in the literature.

Moreover, the literature highlights several issues with respect to PHAs. Some commentators have argued regulatory oversight of PHPs amounts to coercion, as physicians are often *required* to voluntarily participate, or else are referred to a regulator's disciplinary process. For example, one regulatory authority in Canada states "if a regulated member refuses to participate in the [Physician Health Monitoring Program] despite a health condition which may affect his or her practice, then this may be grounds for a complaint" (College of Physicians and Surgeons of Alberta, 2020, p. 1). Given this requirement for voluntary participation, it remains unexplored how Canadian PHAs approach the issue coercion.

Stigma may also be present in PHAs towards particular illnesses. In America, a survey of MRAs found thirteen out of 35 medical boards believed the diagnosis of a mental health condition was sufficient for disciplinary action (Hendin et al., 2007). In addition, since the 1990s, physicians with a bloodborne virus (BBVs) like human immunodeficiency virus (HIV) have been subject to more rigorous and differential approaches within or outside of a typical PHA. These structures include dedicated policies, oversight by expert review panels, testing

regimes, and stress the ethical and legal obligations of physicians to know and report their serological status. How Canadian PHAs manage stigma is unknown.

Additional issues documented in the literature include a potential lack of due process and procedural fairness (Boyd and Knight, 2012; Boyd, 2015; Lenzer 2016), the impact of the "culture of medicine" which pressures physicians to be above the illnesses afflicting their patients (Wallace, 2012), and the imperfection of self-regulation (Wynia, 2010) on the effectiveness of PHAs. The lack of due process in some jurisdictions has led to legal action against PHAs or PHA operators and may culminate in a conflict of interest. The combined impact of the culture of medicine and of self-regulation contributes to a 'conspiracy of silence' within the profession, with studies evidencing the "culture of 'gaze aversion'" and a "loyalty to colleagues" that keeps unwell and impaired physicians in practice (Platman et al., 2013; Bismark et al., 2014, p. 402). The complex context in which PHAs operate coupled with the lack of understanding of how they operate warrants investigation.

Ultimately, these issues notwithstanding, physicians who are unwell or impaired by illness may jeopardize patient safety and the integrity of the medical profession if left unsupported, unmanaged and under regulated. Given the risk of patient harm and the implications to the physician workforce, both MRAs and MAs are engaged in supporting and regulating physician health. It serves the interest of both MRAs and MAs to have effective PHAs in place. However, different approaches have emerged across the country, and it is unclear how these approaches accommodate issues like voluntariness, stigmatized illnesses, due process and the culture of medicine, and how different PHAs lead to different outcomes for physicians and patients. Given the considerable amount of funding available in Canada to support physician wellness, an understanding of the variable approaches in the context of their outcomes, such as

the maintenance of physicians in the workforce, will support the identification of best practice approaches to physician health and may inform how to best invest in physician health. This thesis will fill a gap in the current literature on PHPs in Canada by describing established PHAs offered by MRAs and MAs in Canada with the aim of contributing to improved outcomes for both unwell and ill physicians and their patients.

1.3 Thesis Aims and Objectives

The overarching aim of this thesis was to explore PHAs in Canada, in an effort to describe (1) diverse approaches to physician health established across Canada by both MRAs and MAs, (2) dominant perspectives on physician health and illness, and (3) how MRAs and MAs view the outcomes of these approaches. To achieve these aims, I proceeded in two phases. The objective of Phase I was to comparatively describe the stated approaches to physician health and perspectives of MRAs and MAs in Canada. I therefore conducted a quantitative and qualitative content analysis of all Canadian PHAs based on the publicly available documents describing their PHA. Phase II then proceeded to semi-structured interviews with representatives from Canadian MRAs and MAs responsible for developing and delivering PHAs. The objective of Phase II was to further understand the established approaches of PHAs in Canada and the perspectives on physician health on which they are founded. In addition, Phase II interviews queried the views of MAs and MRAs on the identified issues and on the complexities of managing and regulating physician health in Canada. I used the foundational understanding of PHAs achieved in Phase I as a basis for analysis in Phase II.

1.4 Overview

This thesis is divided into six chapters. Chapter 1 provided background on physician health and the importance of this study given the need for PHAs and the level of investment

presently available to support physician health in Canada. Chapter 1 also highlighted the issues documented related to PHAs and the gaps in our understanding of these issues in the Canadian context. This Chapter then presented the thesis aims and objectives to address these gaps and will proceed with an outline of the remainder of the thesis.

Chapter 2 presents the literature review. Section 2.1 provides a more detailed background on physician health, charting the history of discourses on physician health from the 1800s to present day and recent statistics on physician health. Section 2.2 then outlines our understanding of PHA models based on the literature in Canada. Section 2.2 also compares Canadian approaches to PHAs to those established in the US and the UK in sub-section 2.2.2. In section 2.3, the literature analyzing PHAs is summarized, highlighting the potential issues of (1) coercion, (2) stigma, (3) due process, oversight and conflicts of interest, and (4) the context issues of medicine's culture and self-regulation. Chapter 2 concludes with a summary of the literature.

Chapter 3 outlines the methodological underpinnings of the thesis and the methods used to achieve the thesis's objectives. Section 3.1 reminds the reader of the thesis's research aims and objectives, and section 3.2 details the methodology adopted in this thesis. Pragmatism as a philosophical worldview is described in section 3.2.1, the design in 3.2.2, and my position as a researcher in relation to physician health is summarized in 3.2.3. Section 3.3 defines the methods used in Phase I and II. Section 3.4 describes the methods used to provide quality and rigor to the research.

Chapters 4 and 5 present the results from Phase I and II respectively. Chapter 4 begins with a quantitative description of the content related to PHAs in Canada, and then proceeds to the qualitative account of PHAs and perspectives on physician health in Canada. Chapter 5 starts

with a summary of the participants, and then details the thematic meaning generated from the MRA and MA transcripts. Both chapters conclude with a summary of the findings in the phase.

Chapter 6 concludes the thesis. The chapter opens with a summary of the main findings in Phase I and II. Section 6.2 then positions the findings in the context of the literature and section 6.3 summarizes the challenges and limitations in the thesis design, highlighting areas to focus future research. Section 6.4 details the implications for PHAs in Canada, and section 6.5 concludes the thesis.

CHAPTER 2: LITERATURE REVIEW

The literature review aimed to answer two overarching questions, (1) how has physician health been described in the literature? and (2) how is physician health currently being supported, managed, or regulated? To gain a broad understanding of PHAs, the literature review included the study of PHAs in Canada, as well as the US and the UK. These additional jurisdictions were included based on their role in the history of PHAs (US) and their consideration as best practice (UK). The literature review was initially conducted on English-language databases PubMed and Google Scholar, and targeted searches of organizations known to me through my work at the College of Physicians and Surgeons of Nova Scotia (e.g., the Canadian Medical Association, American Medical Association, and the British Medical Association) using key words such as "physician health", "physician wellness", "physician illness", "physician health programs", "physician impairment", as well as popular physician health topics such as "physician burnout", "physician substance abuse" and "physician bloodborne viruses". The literature review was conducted from November 2020 to June 2021 in a snowballing approach, with additional studies obtained using bibliographic hand searching.

This thesis initially focused on exploring physician health programs (PHPs), however over the course of the literature review and initial document scan it was deemed necessary to broaden the scope to any approach to physician health, including outside the confines of formalized program. For the purposes of this thesis, PHAs have been defined as any policy, process, program, or governance that supports (e.g., provides counselling, peer support, preventative services, advocacy, education, etc.), manages (e.g., conducts assessment, monitors or case manages, refers to treatment), or regulates (e.g., restricts license or determines fitness to

practise, an occupational health term that focuses on the impact of impairment to their ability to perform their work) of an ill or unwell physician. As well, given the range of topics related to physician health, I have defined physician health as a spectrum ranging from wellness, illness and impairment. The following section will summarize the key findings from this review, beginning first with an overview of the evolution of perspectives on physician health in the literature, followed by a summary of the physician health models and services in Canada, US and the UK, and concluding with an analysis of these models and the issues identified in the literature.

2.1 Descriptions of Physician Health

The following section details the discourses on physician health in the literature, from the 1800s to modern day, and concludes with an overview of the current state of physician health. This section sets the stage for later analysis chapters, as it introduces essential themes in physician health that persist today.

2.1.1 A History of Discourses on Physician Health

The first stories of physician health, which focused initially on suicide and mental illness, highlighted the heightened demands of the profession. The higher rates of suicide in physicians have been observed as far back as 1858, and the first American scientific article addressing the topic was published in 1897 (Center et al., 2003; Legha, 2012). This early editorial emphasized the unique forces impacting physicians, citing long hours and the “many ethical and moral burdens” contributing to the “special reasons for discontent” (as cited in Legha, 2012, pp. 219-220). Articles in reply to this first paper concluded suicide was an understandable outcome and a “occupational hazard” given the working conditions, underscoring the disenfranchisement of physicians at the time (Legha, 2012, p. 229). Moreover, it was suggested in these early responses

that others in a “lesser profession would not fare as well” (Legha, 2012, p. 221). This sentiment established a precarious ideal of the moral and selfless physician who places their patients above their own health (Legha, 2012).

However, as the profession moved into the Golden Age of medicine, an era characterised by growing status and prestige lasting from the early 1900s to 1970s, physician suicide evolved to be considered merely a result of an individual’s own psychology and *not* a reflection of the profession (Legha, 2012). The Golden Age established a narrative of physician illness that persists today whereby physicians should be “above the mental illness that might grip their patients” (Legha, 2012, p. 221). As the working environment and renumeration for physicians improved (Hurley and Grant, 2013), suicide could no longer be explained by extenuating circumstances. Physician suicide became “a reprehensible crime committed by those in society considered to be its best and brightest” (Legha, 2012, p. 221). In some ways this is an extension of the ideal established in the initial discourse around physician suicide, where physicians were supposed to meet their patient’s needs despite their own illnesses or impairments.

In the 1950s, studies began highlighting a small but consistent number of physicians suffering from substance abuse (American Medical Association, 1973; Legha 2012). Some of these early studies deemed addiction an “occupational hazard”, emphasizing circumstance and the availability of substances such as narcotics (American Medical Association, 1973, p. 684). However, these reports also drew attention to the individual, such as the susceptibility of a “predisposing personality” when presented with readily available narcotics, as well as the tendency for physicians to consume more “tranquilizers, sedatives and stimulants” than the general population despite similar tobacco and alcohol consumption rates (American Medical Association, 1973, p. 684). Thus, in 1973, the American Medical Association authored a paper

titled *The Sick Physician: Impairment by Psychiatric Disorders, Including Alcoholism and Drug Dependence* (American Medical Association, 1973; DuPont et al., 2009A; Platman et al., 2013). This report widened the physician health lens from suicide to psychiatric conditions and substance abuse and was a call to action for medicine, citing the "denial" often seen in physicians which was compounded by "'the conspiracy of silence' within the profession itself" that puts patient safety at risk (Platman et al., 2013, p. 435).

The Sick Physician also signalled a turning point in how the profession engaged with ill physicians. By explicitly linking the impairment of the "ill physician's judgement and ability to practice" and the "risk to the safety of the patient", in the *Sick Physician* the American Medical Association created a hierarchy of responsibilities in medicine to manage the ill physician and ensure patient safety. Beginning with the physician-patient themselves, the Association recognised that the ill physician often denies their illness, "avoids medical assistance and minimizes [their] problems outright" (American Medical Association, 1973, p. 687). Thus, the onus fell on the workplace and organized medicine to ensure physicians had support, with referral to a regulatory authority in the event of noncompliance or resistance to treatment (American Medical Association, 1973, p. 687). Prior to *The Sick Physician,* the only path for physicians with substance abuse would have been disciplinary proceedings (American Medical Association, 1972). Within twenty years of *The Sick Physician* being published*,* almost every state in America and some Canadian provinces had created an approach to physician health, such as British Colombia's Physician Health Program which was founded in 1979 (Platman et al., 2013; Physician Health Program of British Columbia, 2015).

In the 1990s, a fourth notable class of illnesses afflicting physicians juxtaposed the concept of the infallible physicians: bloodborne viruses (BBVs), specifically human

immunodeficiency virus (HIV), hepatitis C virus (HCV), and hepatitis B virus (HBV). The first transmission case of HIV from healthcare worker (HCW) to patient was identified in July 1990, when a Florida dentist infected five of his patients (Flanagan, 1993; Glantz et al., 1992). Although there were over 35 cases of patient-to-HCW transmission by 1990, that physicians could transmit BBVs to patients sparked public alarm to such an extent that the United States Congress became engaged with the issue (Flanagan, 1993; Glantz et al., 1992). A year following the incident, the Centres for Disease Control (CDC) issued guidance requiring physicians who engage in exposure prone procedures (EPPs) to know their serologic status, have their practice reviewed by an expert review panel (ERPs), and disclose their status to patients (Flanagan, 1993; Glantz et al., 1992). However, shortly after this guidance was issued the US senate "voted 81 to 18 to impose a $10,000 fine and a ten-year jail sentence on any HIV-infected physician who treated patients without disclosing their HIV status" (Glantz et al., 1992, p. 43). Although this amendment was ultimately rejected, legislation was passed that required states to adopt the CDC guidelines or equivalent (Flanagan, 1993). These guidelines informed BBV policies across America and were followed by similar guidelines in Canada in 1998 (Public Health Agency of Canada, 2019). While very few American states and none of the Canadian provinces adopted the disclosure policy set out by the CDC, oversight of physicians by ERPs and the categorisation of duties as EPPs have been mainstays in the BBV policies of present day (Public Health Agency of Canada, 2019; Henderson et al., 2020).

Moving into modern day, the discussion of physician wellness recalls the themes first identified in the 1800s. Since the 2000s, the demands of the medical profession and their impact on burnout have emerged as a dominant topic in the discourse of physician wellness. A scoping review of English peer-reviewed literature regarding the mental health of physicians and medical

students from 2008 to 2018 found 76% of the literature focused on burnout (Mihailescu and Neiterman, 2019). The topic of burnout is often approached through the lens of the implications to the workforce. Given estimates range from 20% to over 50% of physicians who are burnt out, "poor well-being among physicians is prevalent enough to constitute an international workforce crisis" (Brady et al., 2018, p. 99). Burnout is characterised by a variety of themes ranging from the positive presence of well-being to the absence of negative features like stress and distress, and often includes aspects that go "beyond mere job satisfaction" (Brady et al., 2018, p. 99). The main measure of burnout is the Maslach Burnout Inventory, which evaluates burnout along three axes: emotional exhaustion, depersonalization or cynicism, and a lack of personal accomplishment (Wiederhold et al., 2018). The rise in burnout in physicians has been attributed to several factors, such as the "asymmetrical relationship between the 'giver' and the 'receiver'" and the "gap between demands and resources" in medicine (Wiederhold et al., 2018, p. 253). These themes echo those raised in the initial commentaries on physician suicide, with the modern practice of medicine adding additional constraints like a "decline in compensation, malpractice litigation, and erosion of professional autonomy" (Dunn et al., 2007, p. 1544).

The treatment of burnout in the literature exemplifies the tension in physician health literature. Initially, burnout was considered "primarily a mental phenomenon" (Brady et al., 2018 p. 99). More recently, understandings of burnout have evolved to include "measures of integrated well-being in general-life" (Brady et al. 2018, p. 103), recognising the role of the work and wider environment in the phenomenon. The Golden Age focus on illness being the fault of an individual in contrast with early understanding that the medical profession faces unique and substantial pressures is a persistent friction in the topic of physician illness today. Additionally, given one of the signs of a burnt out physician is one who is overloaded with work at the expense

of their well-being, they are the epitome of the ideal physician who prioritizes patient care over their own care. Thus, in the history of physician unwellness, there are some timeless themes in physician health which have existed since the discourse on physician suicide in the 1800s.

Contrastingly, the case of BBVs introduced the topic of risk to the discussion on physician illness, which partly reflects the history of BBVs. The transmission of HIV from the Florida dentist occurred in the midst of the AIDS epidemic. One of his patients who was infected and later developed AIDS was 23, and near the end of her life testified in front of US Congress (Flanagan, 1993; Glantz et al., 1992). Her testimony was "political dynamite" and set the tone for the attitude towards BBV risk that persist today (Glantz et al., 1992, p. 44). In society, risk is both "an indication of probability" and an "ideological apparatus" (Webber et al., 2016, p. 361). Risk reflects the likelihood an act will result in harm and the gravity of harm, but the riskiness of an act cannot be completely separated from the "symbolic or moral concerns" the act is associated with (Webber et al., 2016, p. 361). And particularly at the time of the epidemic, BBVs were associated with "deviant" behaviours and individuals: "drug users, people of colour, men who have sex with men and sex workers" (Webber et al., 2016, p. 363). However, since the Golden Age, physicians were considered society's "best and brightest" (Legha, 2012, p. 221). Thus, it may be due to this "immorality" associated with BBVs that the emergent guidelines emphasized the ethical obligations of HCWs to manage the risk of transmission to patients (Henderson et al., 2020; Public Health Agency of Canada, 2019). It is notable that with the advent of modern treatments and vaccinations, since 2010 there have only been 5 cases of BBV transmission globally (Henderson et al., 2020).

2.1.2 The Current State of Physician Health

The present-day statistics on physician health suggest the prevalence of physician unwellness, illness and impairment are consistent, if not increasing in the case of some conditions. For example, substance use disorders, a focus of many PHPs, may be growing in prevalence. In the 1990s, studies found a prevalence for physicians of approximately 10% to 12%, like that seen in the general population (Hughes, 1992; as cited in DuPont et al., 2009A). However, more recent studies surveying American physicians via similar methods have found a point prevalence of substance use and dependence disorders of approximately 15% (Oreskovich, 2012, 2015). As well, studies continue to show that despite similar lifetime use rates of substances as the general population, physicians have higher abuse rates of substances like opiates, sedatives, and alcohol (American Medical Association, 1973; Cottler et al., 2013).

It is encouraging that although there is the common thread of the environment in physician suicide and burnout, there has been no increase in the rate of suicide despite the rise in burnout (Kuhn and Flanagan, 2017). Rates of suicide among physicians remain higher than the general population (Centre et al., 2003; Lenzer, 2016). When compared to the general public, the relative risks for suicide in physicians were found to range from 1.1 to 3.4 in males and from 2.5 to 5.7 in female physicians (Centre et al., 2003). These rates subvert those normally seen in the general population. In the general population, the suicide rate for males may be up to four times higher, whereas in physicians, the rate in females is similar to that of males (Centre et al., 2003). Moreover, a psychological autopsy study in the US showed most physicians who have committed suicide were not accessing treatment at the time of their death (Hendin et al., 2007). Ultimately, physician health remains a relevant and significant issue for the profession. Given the risk of patient harm and the impact to the workforce, both regulatory authorities and

organized medicine are implicated in the support, management, and regulation of physician health. With this knowledge, the review will now consider the approaches adopted by Canada, the United States and the United Kingdom to supporting, managing and regulating physician health.

2.2 Physician Health Approaches

This section of the literature review will cover various established models to approaching physician health. PHAs of the modern era manage more than substance abuse and other psychiatric disorders. PHAs now encompass "a range of conditions" that "impede physicians from practicing medicine" safely and competently (Taub et al., 2006, p. 78). This can include substance abuse and other psychiatric conditions such as bipolar disorder, depression, anxiety and trauma-related disorders, eating disorders, pain and cognitive impairment (Federation of State Physician Health Programs, 2019). Moreover, services provided by such programs now include not only biological monitoring and fitness to practise determination but often wellness support and prevention, advocacy, education, family services and case management services (Bailey and Jefferies, 2012). The services offered and the extent to which a program provides more comprehensive services depends on the mandate of the operator delivering these services, resulting in different PHA models. The models reviewed in this section are limited to Canada, the US and the UK. However, PHAs can also be found in Australia, New Zealand, Spain, Switzerland, Norway, and Finland (Braquehais, 2014; Brooks et al., 2013).

2.2.1 Physician Health Approaches in Canada

The following section will provide an overview of the physician health approaches in Canada, beginning with an introduction to two key stakeholders in physician health: Medical Regulatory Authorities (MRAs) and Medical Associations (MAs). In Canada, physicians are

regulated at the provincial level by MRAs, known as the College of Physicians and Surgeons of the respective province. MRAs exist in every province and territory (Federation of Medical Regulatory Authorities of Canada, 2016). MRAs in Canada have legislated duties to regulate medicine with the primary mandate to protect the public. For example, in Nova Scotia, the Medical Act of 2011 Section 5 sets out the following duties for the College of Physicians and Surgeons of Nova Scotia:

> In order to (a) serve and protect the public interest in the practice of medicine; and (b) subject to clause (a), preserve the integrity of the medical profession and maintain the confidence of the public and the profession in the ability of the College to regulate the practice of medicine, the College shall (c) regulate the practice of medicine…

The main regulatory activities of a MRA therefore includes the licensing of physicians (also known as registrants of the College) as well as the performance of registrants, which is often disciplinary in nature by a group of peers (Epps, 2011). This disciplinary function is an essential part of their mandate and is arguably the function for which they are most known. Regulation itself is essential given inherent imbalance of power between physicians and patients, and the resulting need to protect the patients (or consumers) in such circumstances (Epps, 2011). Moreover, charged with the protection of the public, regulatory authorities must take action to minimize the risk of harm in the practice of medicine. This includes setting out Standards of Practice, which are duties required of physicians, such as a Duty to Report either yourself or a physician colleague who may pose a risk of harm to the public. MRAs in Canada are required by legislation to protect the public and must therefore "ensure that the appropriate mechanisms are in place to accomplish this goal" (Bailey and Jefferies, 2012, p.14). This implicates MRAs in the

regulation of physician health, and legal scholars in Canada have determined that an approach to physician health "is most defensible if it is one that engenders and maintains public confidence in the profession" (Bailey and Jefferies, 2012, p. 64).

In contrast, MAs in Canada are member associations. For example, in Nova Scotia, Doctors Nova Scotia (DNS) "is the collective voice of physicians in Nova Scotia" and to serve their members, "negotiates physician remuneration with the provincial government", and "acts as the medical profession's united voice" (DNS, n.d., n.p.). MAs exist in Canada at both a national and provincial level. Both play a role in PHAs. Provincial and Territorial MAs (PTMAs) "are autonomous divisions" of the Canadian Medical Association (CMA), with responsibilities specific to their provincial jurisdiction and which "unite at the national level to more effectively handle issues common to all" (CMA, 2022, n.p.). Most PTMAs in Canada are compulsory, meaning physicians must be a member of the association (Doctors Manitoba, 2014). With respect to PHAs, most PHAs are delivered at the local level, however the CMA supports the PTMAs with access to funding. The CMA, together with Scotiabank and MD Financial Management have allotted $115 million over ten years to support physician health and wellness initiatives (CMA, 2018).

Between these two stakeholders, provincial PHAs in Canada have been found in one of three models. The first model is an approach run exclusively by the MA (Bailey and Jefferies, 2012; Federation of State Physician Health Programs 2005; Federation of State Physician Health Programs, 2019). This is the model adopted by the Canadian province of Ontario. The Ontario Medical Association (OMA) provides a suite of services in the form of a physician health program (PHP) for physicians, residents and medical students, including case management and

support for conditions and issues ranging from substance abuse to boundary and marital issues (Bailey and Jefferies, 2012; OMA, n.d.). The Ontario PHP is funded exclusively by the OMA, with reporting thresholds established and oversight provided by the MRA in Ontario. The OMA PHP is one of the largest programs by participants in Canada (Brewster et al., 2008).

A second model is where both the MRA and MA provide support (Bailey and Jefferies, 2012; Federation of State Physician Health Programs 2005; Federation of State Physician Health Programs, 2019). This model can be seen in Alberta, where the College of Physicians and Surgeons of Alberta (CPSA) and the Alberta Medical Association (AMA) deliver PHP services in a co-management model, with services provided by the AMA and a monitoring arm managed by CPSA (Bailey and Jefferies, 2012). This model was recommended by the Health Law Institute of the University of Alberta, in a 2012 report commissioned by CPSA and AMA titled *Physicians with Health Conditions: Law and Policy Reform to Protect the Public and Physician-Patients* (Bailey and Jefferies, 2012). This report had the objective "to assist these entities as they work together and with other stakeholders in Alberta" (Bailey and Jefferies, 2012, p.10). This model was proposed as in the Institute's view, a program run entirely by a MA would require regulators to "assume the legal risks of relinquishing direct oversight and involvement in biological monitoring" (Bailey and Jefferies, 2012, p. 71).

A third model is when a third party or independent organization delivers the PHA through contract with a MA or MRA (Bailey and Jefferies, 2012; Federation of State Physician Health Programs 2005; Federation of State Physician Health Programs, 2019). This is the model that was adopted by the Canadian province of British Columbia up until 2015 (Bailey and Jefferies, 2012; Physician Health Program of British Columbia [PHP of BC], 2015). The PHP of BC was founded in 1979 and was jointly funded by the College of Physicians and Surgeons of

British Columbia (CPSBC), Doctors of BC (DBC), and the Ministry of Health (Bailey and Jefferies, 2012). Initially, the program was intended to support physicians with substance abuse disorders (Bailey and Jefferies, 2012). However, it grew to support physician health issues such as more general mental health, as well as other support services related to careers, finances, and workplace conflict (Bailey and Jefferies, 2012). In 2015 however, the CPSBC withdrew its funding, and the program is now solely funded by the provincial government via the Master Agreement with physicians and overseen by a joint steering committee featuring representatives from the Ministry of Health and DBC (PHP of BC, 2015; PHP of BC, 2020). Thus, in Canada, provinces adopt either the first or second model.

2.2.2 Physician Health Approaches in the United States and United Kingdom

PHAs in the US and UK are reviewed briefly here in order to compare the PHAs in Canada. In the US, MRAs and MAs serve similar purposes. MRAs in the US are known as Medical Boards and operate as branches of state government, tasked with "... maintain[ing] the societal contract through the licensure process" (as cited in Bailey and Jefferies, 2012, p. 34). While MAs in US serve a similar advocacy role as MAs in Canada, Medical Boards "have a policing function that is not necessarily shared to the same extent by Canadian medical regulatory colleges" (Bailey and Jefferies, 2012, p. 34). Disciplinary action against US physicians is "more commonplace" given the differences in licensure policy and the litigious nature of the US (Alam et al., 2012, p. 170). Nonetheless, given the similar localised regulatory and associative structure, and given both the US and Canada "rely heavily on licensure to assess the fitness of physicians" (Bailey and Jefferies, 20120, p. 34), America is a reasonable comparator.

Like in Canada, there are three general models for PHAs in the United States: ones run by a MA, by a MRA, or as an independent entity under contract with either the MA or MRA. PHAs in America are as prevalent as those in Canada; PHAs exist in every state (Bailey and Jefferies, 2012; Brewster et al., 2008). Notably, a 2009 survey of PHPs in the US by DuPont et al. (2009A) found 54% were operated as independent foundations, in contrast to Canada where this model no longer exists. PHAs provided by MAs or MRAs thereafter were 35% and 13%, respectively. PHAs in the US place emphasis on substance use disorder. The same survey by DuPont et al. (2009A) found all surveyed PHPs shared the main goal to identify cases of substance use early, thoroughly assess, refer to abstinence-based treatments, and monitor individuals. However, only 12% of PHAs were dedicated solely to substance use. The majority (85%) also worked with mental and physical illnesses (DuPont et al., 2009A). PHAs in the US were staffed by an average of 5 full-time equivalents, with an average annual operating budget of $538,000, although this ranged from $21,250 to $1.5 million (DuPont et al., 2009A).

There are a number of editorials and studies on the approach to physician health in America (Boyd, 2015; Boyd and Knight, 2012; DuPont and Skipper, 2012; Hendin et al., 2007; Lawson and Boyd; 2018; Miles, 1998, Platman et al., 2013). In their jurisdictional scan, the Health Law Institute of Alberta in their 2012 report noted that:

> A survey of the literature suggests that the American approach to the regulation of physicians and physician health and wellness is transforming from something that was initially addictions-focused and solely focused on patient-protection, to an issue that must be addressed in a holistic manner, covering all forms of physician impairment and working to create a healthy population of physicians better able to serve the public. (p. 34)

The issues raised in the literature in America will be discussed in the section 2.3 of this thesis.

Contrastingly, the UK has a different regulatory approach and a different overall approach to PHAs. Physicians in the UK are licensed and regulated by the national General Medical Council (GMC). Per the Medical Act 1983, the GMC's role is to "protect patients and improve medical education and practice across the UK" which includes taking actions to prevent a doctor from putting patients and the public confidence at risk (GMC, 2021). However, the GMC is also subject to oversight by the Professional Standards Authority (PSA), an independent organization accountable to the UK parliament with the mandate to improve the protection of the public (PSA, n.d.). In 2009, a PSA report set the standard for the involvement of UK regulators in the topic of health. Titled "Health Conditions: Report to the Four UK Health Departments", the PSA addressed the potentially discriminating issue of regulators evaluating and requesting information on registrant's health (Council for Healthcare Regulatory Excellence, 2009). The PSA determined there is a role for regulators to engage with the topic of a registrant's health but only insofar as it relates to fitness to practise (Council for Healthcare Regulatory Excellence, 2009). Therefore, the GMC evaluates and conducts health assessments only in the context of a fitness to practise assessment (GMC, 2021). Moreover, since the introduction of Responsible Officers with the *Medical Professionals Regulations 2010*, the GMC has further distanced itself from the issue of physician health. A responsible officer is a senior licensed physician in every health organization with the dual aim of supporting the annual appraisal process and assuring the fitness to practise of physicians locally (Department of Health, 2010). As a result, there are only limited circumstances where a doctor must be referred to the GMC, for example if the risk of patient harm due to the illness is unknown to the responsible officer and the physician is noncompliant with treatment. Otherwise, from the regulatory perspective, the health of a physician is managed and monitored locally. Additionally, the British Medical Association offers

a peer support program which provides support to physician members but is not as comprehensive as some of the programs provided by organized medicine in North America. Instead, more support services come from the National Health Services (NHS), the national healthcare system in the United Kingdom, under the Practitioner Health Programme, a "confidential, free, self-referral NHS service for doctors and dentists with mental illness and addiction problem" (Practitioner Health Services, 2018, p. 2). Thus, the most comparable approach to those in North America is a suite of services offered by the workplace in the UK, as opposed to the MA or MRA like in Canada and the US.

In sum, there are varied approaches to physician health across Canada, the US and the UK. The role of regulators in physician health is a key differentiator across the three jurisdictions. In Canada, legal scholars determined this is squarely in their jurisdiction, and as a result are more often involved in establishing PHAs. In contrast, in the United States, the dominant model suggests some separation from the regulator, with most programmes delivered by an independent body. In the UK, physician health is managed at the local level, with devolved authority through legislative mechanisms. Moreover, more comprehensive programming is provided by the workplace in the UK, as opposed to by the MA or MRA. Finally, as highlighted in the overview of models in the US, there are several issues raised in the international literature. The next section will summarize these issues.

2.3 Analysis of Physician Health Approaches

This section will evaluate the literature analyzing and criticizing PHAs. In North America, PHAs have widely been perceived to be successful rehabilitation programs particularly for those recovering from substance abuse, with recovery rates (meaning the participants continued their roles in the workforce) in American and Canadian PHAs ranging from 70% to

85%, (DuPont, 2009B; McLellan, 2008; Brewster, 2008). Similar rates have been reported by the NHS's PHP in the UK (Practitioner Health Service, 2018). Additionally, a matched cohort study found physicians under monitoring had a reduced relative risk of malpractice claims than their match cohort (Brooks et al., 2013). Demographically, the data suggests more men are accessing PHPs (Brewster et al., 2008) however women may be more likely to self-report to a PHP (Braquehais et al., 2015). One retrospective cross-sectional review also found residents present to a PHP at a higher proportion than attending physicians (Parry et al., 2018). Moreover, although only a single study, a cross-sectional survey using Likert-type ratings of physicians participating in the Massachusetts Medical Society's PHP found 83% satisfaction amongst participants, which even to the authors was "mildly surprising" (Knight et al., 2002, p.33). PHPs have been recognised as one of the most effective models of recovery and as evidence that substance use disorders can be "treated successfully" in the long term (DuPont et al., 2009B, p. 170). However, there are some significant controversies, both in the operations of PHAs and in the context of medicine, that must be considered and which have not been qualitatively assessed in the Canadian jurisdiction.

2.3.1 Coercion

One of the main issues in the literature on PHAs is the extent to which physicians are coerced into participating given the role licensing bodies like MRAs play in PHAs. The issue of coercion is well documented from the time PHAs were first formalized. In the seminal *Sick Physician* report, it was noted "an element of coercion is often necessary" given the ill physician is usually myopic with respect to their impairment (American Medical Association, 1973, p. 687). More recently, in the survey of PHAs in America by DuPont et al. (2009A), the authors noted "essentially all these physicians were coerced into signing a PHP contract and entering

treatment" (p. 5). As a result, some have called for the "systemic analysis of the ethical and management issues that arise in standard PHP practice" (Boyd and Knight, 2012, p. 1) and the national oversight of PHPs (Knight, 2015). Others recommend distancing PHAs from MRAs, which regulate the license of physicians and may be main source of coercion. For example, the Federation of State Physician Health Programs (FSPHPs), a non-profit which claims to represent the "best practices developed by PHPs across the United States and Canada" (FSPHP, 2019, p. 6) published guidelines in 2019 that stated full regulatory oversight "derails the mission of the PHP, decreases efficacy, and discourages early referral for care" (FSPHP, 2019, p. 14).

The use of a license as leverage is not a phenomenon limited to medicine. Other safety sensitive occupations use similar means, such as pilots (Monahan and Bonnie, 2014). Legally and ethically, in the views of some scholars, the use of coercion is justified given the social contract of medicine and the privilege afforded by their license (Candilis, 2016; Monahan and Bonnie, 2004). One pair of scholars, Monahan and Bonnie, deemed the use mandated treated "uncontroversial" given a physician's license "does not amount to a moral entitlement, and the 'right' to hold such a license is uniformly understood to be highly conditional" (2014, p. 137). Moreover, Monahan and Bonnie stated: "In balancing the risk of unfairly withholding the professional's license and the risk of under protecting the public, there is no doubt that the risk of error is properly placed on the licensee" (2014, p.137). Similarly, one editorial described the role of the social contract as follows (Candilis, 2016):

> The social contract is an agreement entered by professionals and governments (as public representatives) that secures a benefit, a right, to the public. The possibility of mandated board intervention is part of that social contract. The social contract—through licensure

> and credentialing agreements—confers a benefit to society: the right of individual citizens to expect safe medical practice. (p. 79)

The success rates of PHPs have also been highlighted as a justification for any coercion (as cited in Boyd and Knight, 2012; DuPont et al., 2009A). These high success rates and lack of relapses led one team of researchers to conclude rather than being a defining characteristic of addiction, the "inevitable relapse" may be a defining characteristic of the acute care model" (p.167). Notably, in their 2009 survey, DuPont et al., also found that while "only 31% entered care through a formal stipulation or mandate from a regulatory or licensing authority" it was "safe to say that all were coerced, with the remainder entering care due to some combination of informal pressures by colleagues or family" (p. 3). The element of coercion in these programs may be greater than simply the role of MRAs and the use of licensure as leverage.

2.3.2 Stigma

A second major issue highlighted in the literature is the potential for stigma in PHAs. Stigma can be delineated into "three mechanisms of action: prejudice, stereotypes, and discrimination", reflecting the emotions, thoughts and behaviours that culminate into stigma (Wagner et al., 2014, p. 2398). One way stigma manifests in PHAs is the confusion of illness and impairment. Impairment, a state which can be defined as "the inability to practice medicine with reasonable skill and safety" due to illness is a state distinct from simply being ill (FSPHP, 2008, p. 1). There is a continuum between illness and impairment, "with illness typically predating impairment, often by many years" (FSPHP, 2008, p. 1). However, a survey by the Federation of State Medical Boards found thirteen out of 35 medical boards felt "diagnosis of mental illness by itself was sufficient for sanctioning physicians" (Hendin et al., 2007, p. 6). Moreover, one study found that 40% of the general public self-diagnosed themselves as impaired when they used the

broad definitions of impairment included on state medical board websites, which included for example whether someone has intimidated someone else at work, their personal hygiene has deteriorated, or have been easily agitated (Lawson and Boyd, 2018). The consequence of such attitudes towards illness often delays physicians in obtaining the care they need (FSPHP, 2008; Hendin et al., 2006; Miles, 1998). Treating illnesses like impairments further perpetuates the problem of denial and silence surrounding physician illness and is a barrier for the development and effectiveness of physician health programs.

The equating of illness and impairment also highlights stigma against specific illnesses. The potential stigma against mental illness in PHPs is evident whereby the presence of mental illness can trigger a disciplinary response (Hendin et al., 2007). The stigma towards mental illness has therefore received some attention. In their report to the MRA and medical association of Alberta, the Health Law Institute of the University of Alberta recommended that:

> "…Instances of certain conditions being singled out should be eliminated. These distinctions not only fail to address the aim of protecting the public, but also, of arguably equal concern, may well contribute to the stigma associated with certain conditions such as mental health issues" (p. 75).

However, overlooked within this report and by much of the literature on discrimination and stigma in PHPs is the treatment of physicians with BBVs. If differential treatment is one of the hallmarks of stigma, it is notable that absent within any of the PHPs across the US, Canada and the UK is one which incorporates (or at least, does not differentiate) BBVs from the standard PHP. Moreover, at a societal level, despite the advent of treatment and vaccinations enabling the elimination or reduction of viral loads to undetectable or transmittable levels, there remains significant stigma. A US survey in 1991 found more than 90% of the public would want their

physician to disclose their HIV status (as cited in Glantz et al., 1992). A more recent survey in 2005 found still 89% of public believe the disclosure of HIV status should be mandatory, and 82% believe it should be mandatory to disclose HBV or HCV (Tuboku-Metzger et al., 2005). There is even evidence the healthcare system itself still contributes to the perpetuation of stigma for the general BBV patient (Chambers et al., 2015). Thus, it is likely that the societal perception of BBVs has invaded the BBV guidelines. If an effective PHA is one which safeguards public safety, given the limited risk from BBVs to the public at present due to modern treatments and immunizations, BBV policies should have evolved from their original frameworks.

2.3.3 Due process, Oversight and Conflicts of Interest

A third issue identified in the literature is with respect to the lack of due process (such as the inability to appeal a diagnosis or health assessment), a lack of oversight, and the resulting potential for conflicts of interest (Boyd and Knight, 2012; Boyd, 2015; Lenzer 2016). In both Canada and the United States, legal actions have been brought against MRAs or PHPs, respectively, for matters related to due process, or the resolution of matters in accordance with rules and principles. In Canada, in *College of Physicians & Surgeons of Alberta* [CPSA] *v. Collett* (2019), CPSA's decision to suspend a 74-year-old physician's license was successfully appealed in the Court of Appeal of Alberta. Dr Collett argued there he was not incapacitated, that CPSA did not grant him procedural unfairness, and that CPSA a reasonable person would conclude CPAS was bias against him. The Court of Appeal found that Collett did not meet the statutory definition of incapacitated per the province's *Health Profession Act,* that it was inadequate and unfair to provide two business days for Dr Collett to make "the life-altering decision" to withdraw from the practice of medicine but did not find sufficient evidence of bias. In the US, a class action was brought against the Michigan PHP on the lack of due process (as

cited in Boyd, 2015). The lack of oversight of programs may be contributing to the lack of due process, and as a result one commentator calls for national oversight of approaches, stating (Boyd, 2015):

> Although many physician health programs try hard to do what is in the best interests of the physicians with whom they work, as well as the general public, external oversight for all PHPs would ensure the procedures they are using are adequate to ensure fairness.

Moreover, whether or not this is due to the lack of due process, one commentator in the British Medical Journal highlighted the impact of these processes on physicians, which may be "driving some to suicide" (Lenzer, 2016, p. 1). A 2014 report for the GMC of the United Kingdom reviewed cases of suicide or suspected suicide physicians under the fitness to practise process between 2005 and 2013 and concluded "the GMC referral itself is very often a compounding factor" to physician suicide (p. 32).

The lack of due process and oversight may also culminate in bias and conflicts of interest (Boyd, 2015; Boyd and Knight, 2012; Lenzer, 2016). For example, an audit of the PHP in North Carolina found that (as cited in Boyd, 2015):

> The Program created the appearance of conflicts of interest by allowing treatment centers that receive Program referrals to fund its retreats, paying scholarships for physicians who could not afford treatment directly to treatment centers, and allowing the centers to provide both patient evaluations and treatments. (p. 432)

Conflicts may also arise in the internal conduct of physician health assessments, if assessments are conducted in house, or in the way a PHP refers a physician to an independent or outside assessor, introducing bias to the determination of the physician's fitness (Boyd and Knight,

2012). Thus, the lack of due process, oversight and potential conflict of interests may culminate in legal action against PHAs and PHA operators, and may be a compounding factor for a vulnerable, sick physician.

2.3.4 The Context of Medicine and Self-regulation

A fourth and final pair of issues in PHAs is the culture of medicine, as evidenced in the experience of being a sick physician, and the concept of self-regulation. These issues differ from the previous three as they derive more from the context in which PHAs operate as opposed to an issue within the approach itself. As alluded to in previous sections, the culture of medicine plays an important role in perpetuating physician illness. As cited in Wallace (2012):

> Sometimes we work exhausted, or, perhaps, more ill than our patients. Covertly, we get the message. We are to rise above any human frailty. It isn't a conscious process; it is, rather, who we have become. Resilience isn't taught but it is expected, and we come to expect it in ourselves and each other. Therefore, to admit a problem is to admit that we are, somehow, less than and not equal to our peers. We feel shame and we fear being judged and stigmatized so we tend to suffer in silence and carry on in a profession that prides itself on stoicism and bravado (p. 6).

The fear of judgement contributes to the 'conspiracy of silence' and may prevent physicians from coming forward to seek help as a physician-patient. The experience of being a physician patient is a unique one. As seen in the following excerpt, there is often a distinct mismatch in the experience of the patient and that of the physician (as cited in Hahn, 1985):

> Between the last full moon and this, in the space of a single lunar month, I had come near to death, and been saved at the last moment; had had my mangled flesh sewn together

> and united; had "lost" my leg (for an eternity?) in a limbo of non-feeling; had recovered it, as by a miracle, when recovery had seemed impossible. I had had the foundations of my inner world shaken-nay, I had had them utterly destroyed - Oliver Sacks, physician
>
> Recovery uneventful. - Dr. Swan, surgeon (medical chart of Oliver Sacks) (p. 87)

Illness and unwellness are universal, and physicians are no different from the general population in terms of their likelihood to experience illness. However, the experience of becoming a physician-patient is a collision of two worlds. Numerous physicians have attempted to explain how their illness conflicts with their physician identity, highlighting "the resistance of doctors to forgive themselves their own frailty" (Wilson et al., 2019, p. 20). Physicians report their medical training disrupts their ability to experience the emotions that result from illness, with recurrent themes of "denial, self-stigmatisation, shame, and concerns about their professional reputation and competence" as well as "feelings of fear, failure, and guilt" (Wilson et al., 2019, p. 20). In terms of academic literature examining the experience of being an ill physician, there is "virtually no information" on physician's medical care (Wallace, 2012, p. 6). The limited information available is restricted to medical students, which reports that of those who "screened positive for depression in their study, only 22 percent were using mental health services and only 42 percent of those with suicidal ideation were receiving treatment" (Wallace, 2012, p. 6). There are evidently significant barriers to physicians seeking help which may be resulting from the culture of medicine.

Related is the impact of self-regulation and medical professionalism. Self-regulation is a privilege afforded to the medical profession on "premised, in part, on the 'social contract' between the public and physicians" where in return for this privilege, society in return, is guaranteed 'high standards of competence and moral responsibility'" (as cited in Bailey and

Jefferies, 2012, p.8). Self-regulation is an essential component of medical professionalism, which "holds that medical practitioners, working together, are best suited to establish the standards and values that govern their practice and to monitor each others' [sic] adherence to these standards" (Wynia, 2010, p. 210). Self-regulation and professionalism are particularly relevant in the case of referrals or reports to PHAs. While PHAs receive some mandated referrals, which as outlined previously are controversial, referral can also be received via physicians themselves, from colleagues, or from a physician providing care to the sick physician, known as the treating physician (Bismark et al., 2016; DuPont et al., 2009A). Under self-regulation, physicians are subject to a duty, either under a specific standard of practice (a duty imposed by a MRA that physicians are required to adhere to) or otherwise in legislation, to report to the MRA physician colleagues, physician-patients or themselves, who are or may present a risk to the public. However, in a survey of 1120 physicians in the United States (DesRoches et al., 2010), a third of physicians "were not completely certain of their obligation to report a colleague who is impaired" (Wynia, 2010, p. 210). Moreover, in Australia, where there is a legislated duty to report, researchers interviewing treating physicians who had reported their physician-patient found a third were uncertain "whether mandatory reporting laws are an effective mechanism" to minimize the risk to public (Biskmark et al., 2016, p.8). If PHAs were originally designed to support physicians and prevent harm to the public, they may be hampered by the unlikelihood of physicians to self-report or report each other.

2.4 Summary

The nuance of physician illness has been a documented as far back as the 1800s. From suicide to burnout, physician health is an important issue that implicates both regulatory authorities and medical associations, and features themes such as the infallible physician to the

incompatible notion of a physician with a “deviant” condition like HIV. In response to this issue, PHPs and other physician health policies have emerged, which aim to regulate, manage, and support physicians through their illness and impairment. There are several different models to approach physician health, although they all derive their authority from similar regulatory authorities and statutes which prioritise patient safety. However, given this complex context, these programs may be coercive, stigmatising and may not be sufficiently robust in their approaches. Moreover, the context of medicine and limits in self-regulation adds additional complexities to the operations of PHAs. No study in Canada has yet explored the approaches to physician health across the country or the organization’s understanding of these issues. In addition to understanding the origins of these differential programs, this project will also consider how these programs resolve such issues by their framing of, and approaches to, physician health.

CHAPTER 3: METHODOLOGY & METHODS

This chapter outlines the methodological underpinnings of the thesis and the methods used to answer the research questions. First, the chapter will review the research purpose and questions, followed by an overview of the methodology, including the worldview I adopted and my position as a researcher in relation to physician health. The chapter will then detail the recruitment, data collection and analysis methods for Phases I and II and conclude with an outline of the measures taken to provide rigour and quality.

3.1 Thesis Aims and Objectives

The overarching aim of this thesis was to explore PHAs in Canada to describe (1) the diverse approaches to physician health, (2) the perspectives on physician health and (3) how MRAs and MAs view the outcomes of these approaches. To achieve these aims, I proceeded in two phases, the latter informed by the former. The objective of Phase I was to comparatively describe the stated approaches to physician health and perspectives of MRAs and MAs in Canada. I therefore conducted a quantitative and qualitative content analysis of all Canadian PHAs based on the publicly available descriptions. With the foundation and understanding of Phase I, I then conducted semi-structured interviews with representatives from Canadian MRAs and MAs responsible for developing and delivering PHAs. The objective of Phase II was to further understand the perspectives of these two key stakeholders on the topic of physician health, and how these perspectives have informed their approach to and outcomes of their PHAs. Thus, interviews queried the views of MAs and MRAs on the identified issues and on the complexities of managing and regulating physician health. In addition, the interviews aimed to better understand their operations and their approach outcomes; in essence, how their

understanding of the issue of physician illness has informed and impacted their policies and the outcomes of their approaches.

3.2 Methodology

There is limited academic research into PHAs in Canada. Moreover, PHAs have proliferated across Canada, as well as other international jurisdictions, despite potential issues like coercion, stigma, the lack of due process and the culture of medicine (Boyd, 2015 Hendin et al., 2007; Lawson and Boyd, 2018; Lenzer, 2016; Miles, 1998; Wallace, 2010). No study has evaluated the approach and understanding of PHAs in Canada. Therefore, given a limited understanding in the context of such fundamental issues, the project adopted a pragmatic worldview, a qualitative description design, and sequential multi-method approach to address the research questions and to fill a gap in the literature.

3.2.1 Pragmatism

Pragmatism as a philosophy emerged in the late nineteenth century in the United States and is a more fulsome worldview than simply what 'works' or is efficient in practice (Morgan, 2014). Pragmatism as a philosophical system finds meaning in the outcomes of actions and the context in which these actions transpire; for pragmatists, "actions cannot be separated from the situations and contexts in which they occur" and "are linked to consequences in ways that are open to change" and which depend on both individual and societal worldviews (Morgan, 2014, p. 2-3). This means there is no "objective concept of truth" and instead individuals have beliefs, some of which are shared with others in society, that inform decisions and evolve as situations evolve (Morgan, 2014, p 3). Essentially, pragmatism contends "there is no way that any human action can ever be separated from past experiences and the beliefs that have arisen from those experiences" (Morgan, 2014, p. 2). Thus, in the context of PHAs, pragmatism is an appropriate

lens in which to view the approaches (actions) and perspectives (beliefs) of the MAs and MRAs implementing these critical approaches within the context of the medical professionalism and their outcomes. Moreover, given pragmatic worldviews are strongly suited for outcome-driven research projects and may rely on multiple methods to address research questions (Creswell, 2013), I was drawn to this philosophical framework. A pragmatic approach that focused on "conducting research that best addresses the research problem" was best suited to meet my aims in exploring PHAs (Creswell, 2013, p. 28).

3.2.2 Qualitative Description Design

Absent in the literature was a qualitative inquiry into PHAs in Canada. A qualitative description design is best suited for qualitative inquiries that are qualitative in nature but do not "fit within a traditional qualitative approach" such as ethnography, phenomenology, or grounded theory (Bradshaw et al., 2017, p. 1). Instead, qualitative description designs "seek to discover and understand a phenomenon, a process, or the perspectives" of those involved (Bradshaw et al, 2017, p. 1). Given the desire to explore and describe PHAs in Canada, including the approaches, perspectives and outcomes, a qualitative description design was most appropriate for this study.

3.2.3 Reflexivity

Reflexivity plays a critical role in qualitative research. Reflexivity refers to the position of the researcher within qualitative work and has evolved from an implicit or even omniscient reference to one which is explicitly outlined (Creswell, 2013). Reflexivity provides some insight into the researcher's self-awareness and how their own biases, values and experiences may have impacted the study (Creswell, 2013). This section will outline my own position as a researcher in relation to the study and the topic of physician health.

The origin of this study was a request by the College of Physicians and Surgeons of Nova Scotia (CPSNS) to help them understand best practice approaches to managing physician health from a regulatory point of view. I therefore conduct this study to better understand PHAs in Canada in order to inform my recommendations. I have had the freedom to design and conduct the study as I saw fit, however CPSNS has been a resource to me throughout, providing a sounding board and a pilot for interview questions, supporting the identification of key components in my approach, and lending credibility to my study (further details on the changes made after pilot testing are outlined in sections below). However, working for one of the two key stakeholders also limited objectivity. In order to ensure informed consent, I was required to outline my contract and role at CPSNS in my interview invites, informed consent documents, and in the interview preamble and manifested different in each set of interviews.

When interviewing MRAs, I raised my role during the course of the interviews, often as a frame or context for why I was interested in a certain question (e.g., "I am interested in what success looks like and how it is measured, because this is something we've discussed at the College") or to provide my own experience with a particular issue (e.g., "We are aware that we may be implying someone's health diagnosis when we publicized their license restrictions, how do you approach this?"). As an insider in some senses, I aimed to build rapport and trust with my interviewees, particularly as I had questions in my guide relating to coercion, stigma, and conflicts of interest. While not intending to lead the interviewee to any answer, I hoped to demonstrate a working understanding of the challenges in PHAs. My position at CPSNS presented differently when interviewing MAs. Instead of being embedded among questions, I took time at the end of my preamble to explain why I was interested in speaking with MAs and not only MRAs. Not only would it have been a clear gap given the extent of programming they

do provide, but I would also state I did not believe physician health could be comprehensively addressed by any one stakeholder in the complex adaptive system that is healthcare. In both cases, my experience was used to provide background, establish my relationship to the topics, or establish the relevance of my questions. In summary, though the CPSNS has no legal or functional bearing outside of the province, my role there was nonetheless an underpinning and explicitly recognized theme throughout the course of Phase II.

Personally, with respect to my own experience and views on physician health, I came to the work at CPSNS with a background in corporate due diligence. This informed my study design and influenced my selection of methods that felt familiar to me. Since this project will inform my work at CPSNS, I wanted to approach the academic project similarly to how I would approach a problem in a work environment. Moreover, I am not a physician myself. Though in some ways I held 'insider' status with respect to working for a MRA, I was an 'outsider' for not being a physician myself (like many of my participants) and could not relate to the realities and strain of practicing medicine. However, throughout my life, I have been personally impacted supporting members of my immediate family living with their own health conditions. While I may not have understood the full context in which physicians practice, I sympathized with the human experience of having your health become a defining element of your day-to-day life. Physicians are humans too, but their profession and resulting position in society has a profound effect on their ability to be human. I brought both personal and professional experiences to the project and which informed my worldview, methods, and may have influenced the analysis and interpretation of data. Finally, my role at CPSNS and my own views as a researcher, such as my conceptualizing of the spectrum of health, may have influenced the results of this study. It is reasonable to assume another researcher, with a different background or without a role with one

of the stakeholders of interest, may have had different results. Further details on my methods to assure quality and rigour can be found in section 3.4 of this chapter.

3.3 Methods

3.3.1 Phase I: Content Analysis of Physician Health Approaches

Overview. An analysis of Canadian physician health documents was conducted to describe the current approaches and perspectives in Canadian PHAs. Content was extracted from the descriptions on publicly available websites or documents and was then examined to describe the administrative and operational services, as well as the differentiation or specialization for specific illnesses (e.g., like for BBVs). A content extraction template was developed to support the systematic collection of content across variable organizations. The content extraction template was pilot tested within the College in Nova Scotia and revised accordingly. The content extraction template was also reviewed and piloted with an external researcher to ensure replicability. Following extraction, content analysis was conducted using both quantitative and qualitative methods. The content was statistically described (e.g., total number of components, total number of documents extracted, etc.), and the text descriptions of the approaches were both quantitively and qualitatively analyzed, illuminating both stated and implicit perspectives within the respective polices.

Sample. Every website of the provincial/territorial chapter of the Canadian Medical Association and provincial/territorial members of the Federation of Medical Regulatory Authorities of Canada was included (n=24, with 11 MAs [there are no local chapters in Nunavut and Quebec] and 13 MRAs). The aim was to obtain an understanding of the range of models and approaches to physician illness across Canada, and so no province/territory was excluded. In

addition, with the invitations for Phase II, a request for additional information (documents, policies, etc.) was included, to supplement the publicly available information.

Data Collection and Analysis. To facilitate the unitizing of data, a content extraction template was developed. Unitizing in content analysis supports the systematic collection of data across different document sources (Krippendorf, 2013). The initial content extraction template was based on the components of PHAs identified in the literature (Bailey and Jefferies, 2012; Federation of State Physician Health Programs, 2019) and was pilot tested with the College in Nova Scotia and with a peer for credibility. The template was then revised to include funding, partnerships and outcomes, all of which were identified in the pilot process as missing. In total, the final template therefore included free text references to the following areas: overall aims, mission and philosophy; oversight and governance; intake processes; quality assurance mechanisms; confidentiality and privacy; funding; reporting, duty to report or other ethical duties; health assessment or fitness to practise processes; referral to treatment; wellness, prevention, advocacy, education and support; monitoring; references to specific illnesses (in particular substance-use disorders and bloodborne viruses); partnerships; and outcomes. Table 1 lists each component and the component's description. Content was collected from the respective websites of the MRAs and MAs in the manner outlined in Figure 1. In effort to ensure extraction from as many organizations as possible, if the content spoke to an approach or perspective on physician health, it was extracted. Figure 2 outlines the process in which the content analysis was conducted.

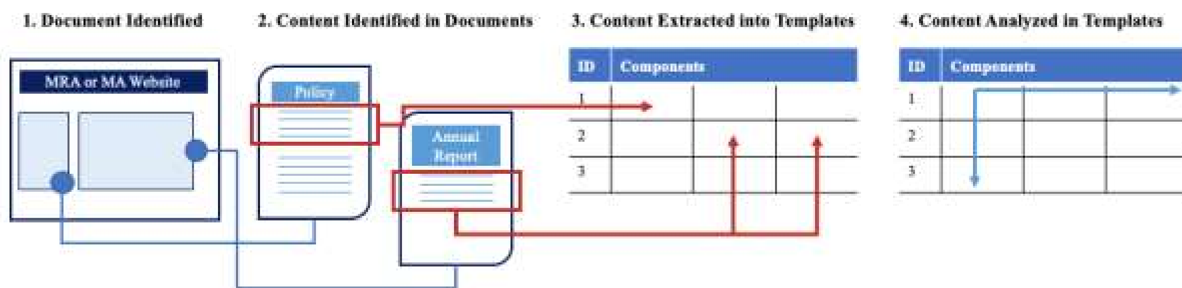
Table 1 *Summary of Components and Component Descriptions used in the Content Extraction Template*

Component	Description
Overall Mission, Aims or Philosophy	How the association/authority approaches physician health and frames the importance of physician health.
Oversight and Governance	How the association/authority oversees or governs physician health. This component may include reference to organization's strategy (as this results from oversight/governance processes).
Intake Processes	How the program accepts individuals, applies the policy to individuals, or defines eligibility.
Quality Assurance Mechanisms	How the association/authority reviews and manages outcomes (for patients or physician). May include methods taken to assure safety (not monitoring).
Confidentiality & Privacy	How the association/authority manages confidentiality and privacy.
Funding	How the association/authority or participants fund or pay for the approach.
Reporting, Duties to Report or other ethical duties	What duties or reporting requirements the association/authority references/requires (what they "must" do).
Health Assessment or Fitness to practise Processes	How the association/authority assesses and determines health or fitness to practise, including third-party assessments.
Referral to Treatment	How the association/authority manages referrals to treatment.
Wellness, Prevention, Advocacy. Education and Support	What specifically the association/authority offers in terms of wellness, prevention, advocacy, education and support.
Monitoring Services	How the association/authority states it monitors physicians.
References to Specific Illnesses	Any processes or perspectives related to a specific illness (e.g., bloodborne viruses or substance use disorders).
Reference to Partners/Partnerships	Reference to partners / partnership programs
Outcomes	Reference to results, outcomes, etc.

Figure 1 *Approach to Content Extractions from Medical Regulatory Authorities and Medical Associations*

Step	Process
1	Review any obvious reference to physician health / physician health or wellness program on home page of organization.
2	Review reference under "Physicians"/"For Registrants"/"For Physicians"/"Member Benefits"/"Programs".
3	Review "About Us" for references to policies, committees related to physician health.
4	[For regulatory authorities] Review Code of Ethics for reference to physician health
5	[For regulatory authorities] Review Committee Terms of Reference for reference to physician health / physician health programs (May be under Investigations, Discipline, Competence or Quality Assurance)
6	[For regulatory authorities] Review "Standards of practice" and "Guidelines" [Often referenced on home pages] for Duties to Report (Colleague / Self) and Bloodborne Pathogens
7	Review available annual reports for references to physician health programs
8	Search on website for "health", "wellness", or "physician health", "incapacity", "substance abuse", “substance use disorder”, “bloodborne viruses”, etc.

Figure 2 *Content Analysis Process Adopted in Phase I*



Note. Content analysis was conducted by the following process. (1) Documents were first identified on the MRA or MA website, (2) documents were reviewed and content relevant to their physician health approach or a perspective (opinion, attitude, etc.) on physician health were

identified, (3) content was extracted into the templates (4) content was analyzed by document and by component for immersion and code identification.

The extracted content was analyzed both quantitatively and qualitatively. Quantitatively, I used descriptive statistical measures that summarized the number and type of documents extracted and the presence or absence of components within the content (as in Hall and Steiner's 2020 policy analysis; Krippendorf 2019). Qualitatively, a blend of both conventional and summative content analysis was conducted, a method which combines latent and manifest content analysis as outlined by Hsieh and Shannon (2005). Conventional content analysis includes: (1) immersion in the data leading to the identification of an initial coding scheme, (2) the application of a hierarchical coding structure, and (3) the development of definitions within each category, subcategory, and code model (Hsieh and Shannon, 2005). Summative content analysis is like quantitative content analysis, as it includes word frequency counts of identified keywords, but goes further to analyze how word usage varies by author (Forman and Damschroder, 2008; Hsieh and Shannon, 2005). Coding in content analysis serves the purpose of organizing "large quantities of text into much fewer content categories" and may then be categorized and related (Hsieh and Shannon, 2005, p. 1285). This paper used the initial immersion and inductive process of conventional analysis to generate an initial coding scheme and structure from the content, reviewing first by document and then by component for each organization. I then conducted summative analysis using NVivo 12 for Mac to determine the code usage across organizations. The benefit of using both methods of content analysis is the identification of key themes within the documents in the absence of prior research, as well as the understanding of how those keywords presented within the context of the PHA operator. The

deliverable of this phase was a quantitative and qualitative summary of the approaches and perspectives of PHAs in Canada.

3.3.2 Phase II: Semi-Structured interviews with Canadian MRAs and MAs

Overview. The aim of this phase was to further understand the approaches taken in each province and territory, and why there are different approaches to the support, management, and regulation of physician health in the same national context. Semi-structured interviews provide a balance of systematic information gathering and the flexibility of open-ended questions. With the background and understanding of Phase I, the interviews further explored their operations beyond their documented practices and any components not described in the public domain. The interviews also further explored the views and approaches of the two key stakeholders on the issues in physician health, and the complexities in managing and regulating physician health identified in the literature.

Recruitment. As in Phase I, every provincial/territorial chapter of the Canadian Medical Association and provincial/territorial member of the Federation of Medical Regulatory Authorities of Canada was contacted for participation (n=24). No provincial or territorial association or authority was excluded, as for example, their perspective on the issue may have informed the absence of a formal or informal approach. Emails were sent based on a standardized template (Appendix 1) to the individual of highest authority (Registrar or CEO) within the organization to ensure organizational consent, and they were requested to identify 1-2 individuals who directly support or manage their approach to physician health. To ensure timeliness of transcription and availability to conduct interviews, emails were sent in five waves. Follow ups were sent three weeks following initial emails.

Data Collection and Analysis. Two semi-structured interview instruments were prepared, one for the MRAs and one for MAs (Appendix 2 and 3). Both instruments followed the same interview arc divided into two parts. The first part began with an overview of the approach in general, how it has evolved and how the approach defines success and makes decisions, followed by how the stakeholder collaborates with system partners and how it approaches confidentiality. The second part dove into the issues that were identified in the literature in Phase I, such as regulatory involvement potentially amounting to coercion, the potential for stigma by differential treatment or treating all illnesses as impairments, and finally the risk of conflict of interest. The instrument was reviewed with CPSNS prior to distribution and modified based on feedback before administration to include questions on what is next for the interviewee's PHA, how COVID-19 has impacted the approach, and further elaborations into how the approach has evolved and defines success. Interviews were held virtually via MSTeams or the participants platform of choice from November 2021 to February 2022 and transcribed verbatim by me. Interviews were audio recorded via Voice Memos on iPhone. Transcripts were provided for member checking prior to analysis.

The interviews were analyzed thematically to explore explicit and implicit perspectives on physician health and physician health approaches. Thematic analysis was conducted using the tenants of reflexive thematic analysis outlined in Braun and Clarke (2022). The recursive phases of thematic analysis include (1) dataset familiarization, (2) data coding, (3) initial theme generation, (4) theme development and review, (5) theme refining, defining, and naming, and finally (6) producing the report (Braun and Clarke, 2022). For data familiarization, transcripts were read in full for immersion, with handwritten notes to capture emerging codes. Given the distinctive nature of MRA interviews versus MA interviews, it was then decided that initial

coding and theming would be conducted separately for the two groups. Using the framework of codes developed in Phase 1, the two groups were each respectively reviewed in one sitting, and then reviewed a second time in a variable order, to disrupt any patterned thinking or coding framed by the first transcripts. In the second review, codes were ordered into hierarchy of initial themes, which formed the baseline for theme generation. The initial themes of MRAs and MAs were then compared and contrasted to develop, refine and define the emergent themes, with emphasis on finding shared meaning across the dataset. Using a pragmatic worldview, the analysis identified the implicit and explicit opinions, understandings and perspectives on physician health, within the context of the interviewee's organization or authority, and how this effected the outcomes of the PHA. The differences between the published practices and philosophies (Phase I) and the stated practices (Phase II) were also considered. The deliverable for this phase of work was a descriptive account of the perspectives of key stakeholders engaged in the support, management, and regulation of physician health.

3.4 Quality & Rigor

Multiple methods were employed in this study to ensure quality and rigor. At a study design-level, the use of multiple methods to triangulate findings provided credibility and trustworthiness, as well as dependability given the iterative and sequential approach. There were also strategies employed within each phase to ensure trustworthiness and credibility. In Phase I, the data extraction template was pilot tested with the College in Nova Scotia for credibility and a peer piloted the use of the template to ensure replicability. In Phase II, the interview instrument was reviewed with the College in Nova Scotia for credibility and modified based on feedback before administration. Transcripts were also provided to participants for member checking, with 85% of participants providing confirmation of their interview. Confidentiality of participants was

also a concern in Phase II. Although I was assured my participants understood the potential risk and I provided member checking to ensure their comfort with their statements, I also took steps to further assure their confidentiality. Selected excerpts were reviewed to ensure the participant would not be readily identified and any details I deemed too sensitive relating to the program or an individual were not disclosed. Finally, to ensure credibility and trustworthiness of the findings, given my role at the College and personal relation to the topic, I used reflexive memos to capture my reflections on theme development and evolution.

CHAPTER 4: PHASE I RESULTS

This chapter reports the results from the Phase I content analysis. The objective of Phase I was to comparatively describe the stated services of PHAs and perspectives on physician health in Canada. I conducted both quantitative (Hall and Steiner, 2020; Krippendorf, 2019) and qualitative content analysis (Hsiesh and Shannon, 2005) of all Canadian PHAs operated by MRAs and MAs based on descriptions published in publicly available documentation. A descriptive summary of the documents extracted will be reported first, to aid in orienting the reader to the findings. The qualitative content analysis is then presented to further unpack published approaches to, and perspectives on, physician health in Canada. The chapter concludes with a summary of the results.

4.1 Description of Content Extracted

The objective of the quantitative content analysis was to better understand the content and achieve a foundational understanding of the type of content extracted before proceeding to the qualitative content analysis. Content was extracted in the form of a document, and the content of the document was then organized into the template for analysis. As summarized in Table 2, a total of 258 documents were extracted across the identified MRAs and MAs in 10 provinces and 1 territory. For the purposes of Phase I, the documents identified included policy documents, website pages related to physician health approaches, blog or magazine articles written by the organization, annual reports, and strategic plan documents. Content was identified in the manner outlined in Figure 1 (Chapter 3), including any obvious references to physician health on the organization's website, followed by successive reviews under registrant or member sections, and searches on the website for terms like “health”, “wellness”, and "physician health”. The highest number of documents was obtained from Doctors Nova Scotia (DNS),

Newfoundland and Labrador Medical Society (NLMA) and College of Physicians and Surgeons of Manitoba (CPSM). No content was extracted for the Yukon Medical Association (YMA), the Nunavut Health Professions (HPN), or the Northwest Territories, due to the absence of references to physician health or dedicated websites, leaving a total sample size of 20, with 11 MRAs and 9 MAs. There were limited documents extracted from the Collège des Médecins du Québec (CMQ), as most of the resources on the regulator's website were in French, which was beyond my basic understanding of the language, as well as the Yukon Medical Council (YMC), which was limited to a few policies, and the New Brunswick Medical Society (NBMS) which required a member log-in to see detailed descriptions of their services. Table 3 summarizes the document type by organization. For the MRAs, a total of 136 documents were extracted. Most documents extracted were registrant communications (n=50), policy documents (n=37) or annual reports (n=33). For the MAs, a total of 122 documents were extracted into the data extraction template. The MAs also had member communications (n=52) and annual reports (n=17) but had more website pages (n=40).

Finally, the content extraction templates were analyzed to determine which of the identified components (e.g., Overall Mission, Aims or Philosophy, Oversight and Governance, Intake Processes, etc.) were referenced or not referenced by each organization. These results are summarized across Figure 3, Table 4 and Table 5. The number of documents did not necessarily correspond to the number of components referenced. For example, the AMA had few documents comparatively but touched on most components within these documents. Contrastingly, MSPEI had several publicly available documents but did not touch on as wide a variety of components. Most MRAs and all MAs referenced overall mission, aims or philosophy (n=8 MRAs and n=9 MAs) and most organizations referenced oversight and governance (n=10 MRAs and 8 MAs).

All or most MRAs referenced reporting (n=11), specific illnesses (n=10), and monitoring (n=10) whereas they largely did not reference funding (n=2) or wellness offerings (n=4). Contrastingly, nearly all MAs referenced funding (n=8) and wellness services (n=8), the only exceptions being NBMS which detailed its services behind a members-only portion of their website. Fewer MAs touched on reporting or other duties (n=1) and monitoring (n=3) in comparison to the MRAs, but most also had references to specific illnesses (n=8).

Table 2 *Summary of Documents by Medical Regulatory Authority (MRA) or Medical Association (MA)*

Province	MRA or MA	Acronym	Total Documents
British Columbia	College of Physicians and Surgeons of British Columbia	CPSBC	17
	Doctors BC	DBC	15
Alberta	College of Physicians and Surgeons of Alberta	CPSA	18
	Alberta Medical Association	AMA	5
Saskatchewan	College of Physicians and Surgeons of Saskatchewan	CPSS	8
	Saskatchewan Medical Association	SMA	9
Manitoba	College of Physicians and Surgeons of Manitoba	CPSM	25
	Doctors Manitoba	DMB	14
Ontario	College of Physicians and Surgeons of Ontario	CPSO	13
	Ontario Medical Association	OMA	8
Quebec	Collège des Médecins du Québec	CMQ	2
New Brunswick	College of Physicians and Surgeons of New Brunswick	CPSNB	8
	New Brunswick Medical Society	NBMS	1
Prince Edward Island	College of Physicians and Surgeons of PEI	CPSPEI	24
	Medical Society of PEI	MSPEI	5
Nova Scotia	College of Physicians and Surgeons of Nova Scotia	CPSNS	7
Nova Scotia	Doctors Nova Scotia	DNS	34

Province	MRA or MA	Acronym	Total Documents
Newfoundland and Labrador	College of Physicians and Surgeons of Newfoundland and Labrador	CPSNL	10
	Newfoundland and Labrador Medical Society	NLMA	31
Yukon	Yukon Medical Council	YMC	4
	Yukon Medical Association	YMA	-
Nunavut	Health Professions, Government of Nunavut	HPN	-
Northwest Territories	Professional Licensing, Government of the Northwest Territories	PLNWT	-
	Northwest Territories Medical Association	NWTMA	-
Total Documents			**258**

Table 3 *Summary of Documents Extracted, Medical Regulatory Authority (MRA) or Medical Association (MA) and Document Type*

		MRA										
Document Type	**Total**	CPSBC	CPSA	CPSS	CPSM	CPSO	CMQ	CPSNB	CPSPEI	CPSNS	CPSNL	YMC
Policy document[a]	**37**	3	14	1	3	5	2	-	2	1	2	4
Annual Report	**33**	3	1	1	12	5	-	-	-	5	6	-
Website Page	**14**	9	3	1	1	-	-	-	-	-	-	-
Member/Registrant Communication	**50**	2	-	5	9	2	-	7	22	1	2	-
Strategic Plan	**-**	-	-	-	-	-	-	-	-	-	-	-
Other[b]	**2**	-	-	-	-	1	-	1	-	-	-	-
Total Documents	**136**	**17**	**18**	**8**	**25**	**13**	**2**	**8**	**24**	**7**	**10**	**4**

		MA								
Document Type	**Total**	DBC	AMA	SMA	DMB	OMA	NBMS	MSPEI	DNS	NLMA
Policy document[a]	**3**	-	-	1	1	1	-	-	-	-
Annual Report	**17**	5	1	-	-	-	-	2	1	8
Website Page	**40**	9	4	2	8	7	-	1	5	4
Member/Registrant Communication	**52**	-	-	6	4	-	-	-	25	17
Strategic Plan	**7**	1	-	-	1	-	-	2	2	1
Other[b]	**3**	-	-	-	-	-	1	-	1	1
Total Documents	**122**	**15**	**5**	**9**	**14**	**8**	**1**	**5**	**34**	**31**

[a]Policy documents include Terms of Reference, Standards of Practice, and Guidelines.

[b]Other documents include research or surveys undertaken by the organization, special projects or statements, or a website not directly related to physician health.

Figure 3 *Summary of Components Referenced or Not Referenced in Documents with Total Documents per Organization*

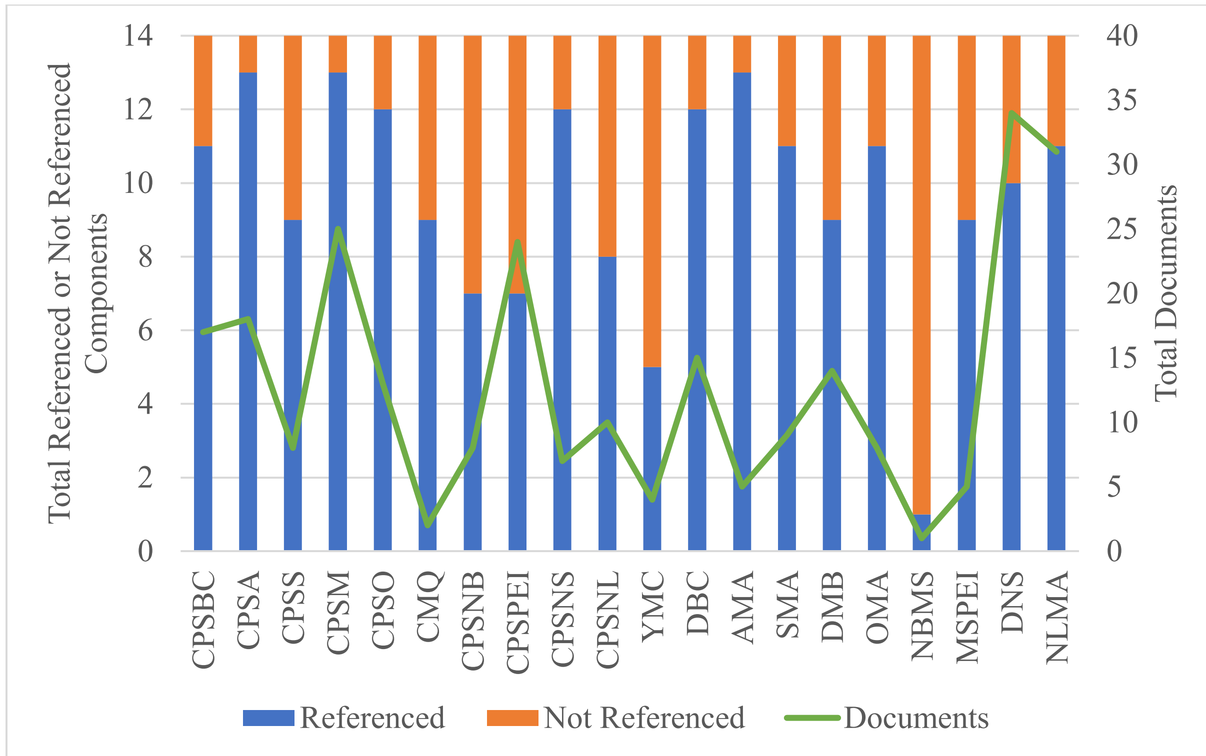


Table 4 *Summary of Components Referenced (R) or Not Referenced (NR) by Medical Regulatory Authority (MRA)*

	MRAs										
Component	**CPSBC**	**CPSA**	**CPSS**	**CPSM**	**CPSO**	**CMQ**	**CPSNB**	**CPSPEI**	**CPSNS**	**CPSNL**	**YMC**
Overall Mission, Aims or Philosophy	R	R	R	R	R	R	NR	NR	R	R	NR
Oversight and Governance	R	R	R	R	R	R	R	NR	R	R	R
Intake Processes	R	R	NR	R	NR	NR	R	NR	R	R	NR
Quality Assurance Mechanisms	R	R	R	R	R	R	NR	R	R	R	R
Confidentiality & Privacy	R	R	R	R	R	R	NR	R	R	NR	NR
Funding	R	R	NR	NR	NR	NR	NR	NR	NR	NR	NR
Reporting, Duties to Report or other ethical duties	R	R	R	R	R	R	R	R	R	R	R
Health Assessment or Fitness to practise Processes	R	R	NR	R	R	NR	R	NR	R	NR	NR
Referral to Treatment	NR	R	R	R	R	R	NR	R	R	NR	NR
Wellness, Prevention, Advocacy. Education and Support	NR	NR	NR	R	R	R	NR	NR	R	NR	NR
Monitoring Services	R	R	R	R	R	R	R	R	NR	R	R
References to Specific Illnesses	R	R	R	R	R	R	R	R	R	NR	R
Reference to Partners/Partnerships	R	R	R	R	R	NR	NR	R	R	R	NR
Outcomes	NR	R	NR	R	R	NR	R	NR	R	R	NR

Note. The language "Referenced" and "Not Referenced" was chosen to capture the possibility the service or component is offered by the organization but is not listed in any publicly available document. Outcomes refers to results, participants in program, participants in practice, etc.

Table 5 *Summary of Components Referenced (R) or Not Referenced (NR) by Medical Association (MA)*

	MAs								
Component	**DBC**	**AMA**	**SMA**	**DMB**	**OMA**	**NBMS**	**MSPEI**	**DNS**	**NLMA**
Overall Mission, Aims or Philosophy	R	R	R	R	R	R	R	R	R
Oversight and Governance	R	R	R	R	R	NR	R	R	R
Intake Processes	R	R	R	R	R	NR	R	R	R
Quality Assurance Mechanisms	R	R	NR	NR	R	NR	R	NR	NR
Confidentiality & Privacy	R	R	NR	NR	R	NR	NR	R	R
Funding	R	R	R	R	NR	NR	R	R	R
Reporting, Duties to Report or Ether Ethical Duties	NR	R	NR	NR	NR	NR	NR	NR	NR
Health Assessment or Fitness to practise Processes	R	R	R	R	R	NR	NR	R	NR
Referral to Treatment	R	R	R	R	R	NR	NR	R	R
Wellness, Prevention, Advocacy. Education and Support	R	R	R	R	R	NR	R	R	R
Monitoring Services	NR	NR	R	NR	R	NR	NR	NR	R
References to Specific Illnesses	R	R	R	R	R	NR	R	R	R
Reference to Partners/Partnerships	R	R	R	R	R	NR	R	R	R
Outcomes	R	R	R	NR	NR	NR	R	NR	R

Note. The language "Referenced" and "Not Referenced" was chosen to capture the possibility the service or component exists but is not listed in any publicly available document. Outcomes refers to results, participants in program, participants in practice, etc.

4.2 Physician Health Approaches and Perspectives

The extracted documents were analyzed to understand current dominant approaches to and perspectives on physician health in Canada as implemented by Canadian MRAs and MAs. An initial set of approx. 30 codes were identified in an inductive manner following data immersion. Coding in content analysis enables the organizing of content into succinct categories. The codes were further analyzed and revised until the codes which were used most frequently by organizations remained. These codes were then categorized into overarching classifications based on whether they described how they approached physician health or described a perspective on physician health. This section first presents the codes and content identified in relation to the MRA's or MA's approach. The comparative findings for each component will then be summarized, expanding on these codes within the context of the component where relevant. Not all components elicited meaning in the form of a descriptive or perspective code. Most meaning came from the content describing the overall approach, however in some cases this meaning was threaded through components. Two components spoke to codes that were categorized as perspectives and will be flagged as such and elaborated on in the section 4.2.2. For ease of reporting results, components have been grouped into Overall Approach, Administrative Components, Operational Components, Reference to Partners and Partnerships, and Outcomes (such as results, participants in program, participants in practice, etc.) as seen in Table 6. The chapter will then conclude with the codes and exemplary quotes relating to the perspectives of the MRA or MA on physician health. Knowing I would have the opportunity to meet with decision makers representing MRAs and MAs and discuss their perspectives in Phase II, the emphasis in Phase I was placed more on understanding the established approaches as described in their publicly available textual representations. Nonetheless, there were a number of

important and foundational themes both implicitly and explicitly extracted from the content extracted in Phase I, including the impact of physician health, how health was framed, and the relation of physician health to risk.

Table 6 *The Organization of Components for the Reporting of Results*

Grouping	Components Included
Overall Approach	Overall Mission, Aims or Philosophy
Administrative Components	Oversight and Governance
	Intake Processes
	Quality Assurance Mechanisms
	Confidentiality & Privacy
	Funding
	Reporting, Duties to Report or other ethical duties
Operational Components	Health Assessment or Fitness to practise Processes
	Referral to Treatment
	Wellness, Prevention, Advocacy. Education and Support
	Monitoring Services
	References to Specific Illnesses
Partners and Partnerships	Reference to partners / partnership programs
Outcomes	Outcomes

4.2.1 Descriptions of Physician Health Approaches

The descriptive codes and their operational definitions relating to physician health approaches are listed in Table 7. To get an understanding of how the use of these codes differed across organizations, NVivo 12 for Mac was used to examine the use of the main codes by organization, as seen in Table 8. The content was reviewed manually to ensure the use of the word was reflective of the code. The most frequently used description of physician health programs across all documents was confidential, which was used by 9 MRAs and 8 MAs in

reference to their approach. Only CPSNL, CPSNB, and NBMS did not describe their approach as confidential in publicly available documents. Supportive and preventive approaches were the next most frequently cited. Supportive approaches were described by 8 MRAs and 8 MAs, and this code included references to approaches being compassionate, helpful, accessible, and respectful. Preventative approaches were described by 9 MRAs and 7 MAs and this code included references to early identification. Notably, for MRAs, prevention was often in reference to preventing transmission of bloodborne viruses (BBVs), whereas for MA's prevention was in relation to preventing a health outcome like burnout. The reference to mandates or duties was a frequent reference by MRAs and included references to their respective legislation. The only omission was CPSNB which does not have a formal approach to physician health. NLMA was the only MA to reference mandate, citing supporting physician health as within their organizational mandate. Similarly, specific to MRAs was the description of being balanced or fair in the approach, which was referenced by 7 MRAs. No MA described their program as such. Collaborative also emerged as a code in reference to working with system partners or to working with the physicians themselves and used by 11 of the 20 organizations. Finally, some MAs used the language of interventive to describe their approach to physician health, but very few MRAs did so. Examples of these descriptions follow in the section on Overall Approach.

Table 7 *Codes and their Operational Definition Identified in Physician Health Approaches*

Codes	Operational Definition
Confidential	Approaches that are described as confidential, private or discrete.
Supportive	Approaches that are described as being supportive to the physician, including approaches described as being compassionate, helpful, accessible, sensitive or respectful.
Preventative	Approaches that strive to be preventative, including the early identification of physician illness.

Codes	Operational Definition
Mandated or Duty	Approaches that derive from the MRA's legislated mandate or from the physician's duty.
Balanced or Fair	Approaches that aim to be balanced, fair, or judicious in their approach.
Collaborative	Approaches that are collaborative with the physician or other system partners.
Interventive	Approaches that are interventive or intervene in the health of physicians.

Table 8 *Main Codes Identified on Physician Health Approaches and their Usage by Medical Regulatory Authorities (MRAs) and Medical Associations (MAs)*

Codes	Use by Organization		Total
	MRA (n = 11)	**MA (n = 9)**	**(n=20)**
Approaches to Physician Health			
Confidential	9	8	17
Supportive	8	8	16
Preventative	9	7	16
Mandated or Duty	10	-	10
Balanced or Fair	7	-	7
Collaborative	5	6	11
Interventive	2	7	9

Note. Frequencies were determined using stemmed analysis (e.g., "balance" and "balanced") in NVivo 12 for Mac, which were manually reviewed to ensure accuracy.

Overall Approach. References to the overall mission, aims and philosophy of PHAs were extracted in order to determine how the MRA or MA generally approached physician health. All 9 MAs and 8 MRAs reported an overall aim, mission or philosophy towards physician health. The fundamental codes describing the PHAs emerged in the overall approach and were often embedded throughout the remaining components. PHAs were commonly described as “confidential”, “supportive”, “preventative”, “collaborative” or “interventive”. As aforementioned, specific to MRAs was the reference to their approach resulting from the MRA’s

mandate or the physician's duty, as well as the description of the approach being "fair" or "balanced". Exemplary quotes for each code across MRAs and MAs are shown in Table 9.

Table 9 *Examples of Codes Used to Describe Physician Health Approaches*

Code	Exemplary Quotes	Organization
Confidential	"The [OMA] Physician Health Program (PHP) provides **confidential** support for individuals who are struggling with substance use and mental health concerns, as well as with other behaviours that have a personal and professional impact."	OMA
Supportive	"The College's health monitoring department is confidential and **supportive."**	CPSBC
Preventative	"Given growing concerns with physician burnout and disengagement, supporting physician health and wellness is a priority for Doctors Nova Scotia (DNS). This means investing in efforts to support physicians **before they become burnt out and unwell,** as well as providing services to physicians who need personal and professional support."	DNS
Legislative	"The College's **mandate** is one of public safety. As such, the College strives to ensure that patients receive care that is safe and not compromised by the health of the physician."	CPSNS
Balanced or Fair	"CPSM will be **judicious** and **balanced** in responding to any health information disclosed under the reporting requirements. As a primary function, the CPSM [Physician Health Program] **balances** the regulatory mandate to protect the public with supporting and empowering members experiencing both acute and chronic health concerns to optimize their wellness."	CPSM
Interventive	"Supporting the development of effective personal wellness strategies and early **intervention."**	AMA
Collaborative	"A confidential and **collaborative** approach to maintaining your health condition and its impact on your practice, outside of CPSA's complaints process."	CPSA

Note. Emphasis added.

Administrative Components. The administrative components captured the oversight and governance of the program, as well as the intake processes, quality assurance, confidentiality, funding, and reporting or legal/ethical duties set out for the physician.

***Oversight and Governance*.** References to oversight and governance, including references to organizational strategies related to physician health, were reported by 10 MRAs and 8 MAs. Most references to oversight and governance cited by MAs and MRAs were committee structures overseeing physician health, although these ranged in terms of function and legislative mandate, respectively. For MAs, the committees may be advisory in nature (DMB and NLMA) or provide both oversight and services to physicians in the program (SMA). In some provinces the MA's committee featured representation from provincial stakeholders, such as the Ministry of Health (DBC) or the relevant MRA (OMA and AMA). For other MAs, the references to oversight and governance were limited to the presence of a physician health strategy (MSPEI and DNS). For MRAs, oversight was often referenced under the purview of a legislated committee (CPSBC, CPSA, CPSO, CPSNB, CPSNL) and/or had powers delegated from the registrar (CPSA, CPSM). For CMQ and CPSS reference was limited to oversight of physicians with BBVs. For CPSPEI reference was limited to regulations stemming from the Medical Act. CPSNS stated that "Wherever legally possible, complaints that connect to the health of the physician will be examined through the lens of physician wellness rather than through the disciplinary lens". Given the mechanical nature of this component, few descriptors or codes were elicited in the review of this component.

***Intake*.** Intake, including processes for how the program accepts individuals, applies the policy to individuals, or defines eligibility, was referenced by 6 MRAs and 8 MAs. Most MRA references to intake were focused on the mechanics of referring and/or the various modes of

making a referral (CPSBC, CPSNB, CPSNS, and CPSNL) such as via a self-report on Annual Renewal or under a Duty to Report. However, CPSM included themes like support and confidentiality (“Every referral we receive to the PHP is handled with **compassion**, **discretion**, and a personal connection” [emphasis added]) and CPSA included prevention (emphasis added) in their references:

> We encourage all physicians, residents and medical students who presently have a health condition (including physical and mental health conditions, and substance use disorders) to seek medical attention **early** for their own health and to minimize the impact on their practice.

Like CPSA and CPSM, MAs often highlighted the supportive approach to intake adopted by the organization, as exemplified in the following (emphasis added): “If you are concerned about another physician, resident or medical student… We will plan and coordinate with you a series of confidential steps to ensure your colleague receives any **help** they might need” (DBC); “If you, a loved one, or a colleague are experiencing difficulties, we can **help**” (OMA); and “**Support** is available to physicians throughout the spectrum of their careers, from medical school and residency, through active practice and into retirement (SMA)”. As well, DBC, AMA and DNS emphasized accessibility, highlighting the 24/7 nature of their intake. Finally, some MAs support other professions in the province (OMA and DNS) as well as the family members and dependents of physicians (AMA, DBC, DMB, OMA, and MSPEI) and therefore would outline this eligibility in their intake references.

Quality Assurance Mechanisms. Quality assurance references spoke to how the organization reviewed and managed outcomes of their approaches, including any references to how the MRA or MA assures safety and makes decisions. This column also included any references specifically to the adherence to routine practices for BBVs. 10 MRAs but only 4 MAs made references to quality assurance mechanisms.

Except for CPSNB, all MRAs referenced quality assurance mechanisms. However, these references were limited to guidance around the adherence to routine practices for BBVs in CPSBC, CPSS, CPSO, CMQ, CPSPEI and YMC. CPSNS only stated "Working with physicians, their caregivers, and their legal counsel, the College will identify the appropriate scope and the appropriate safeguards to support safe medical practice". CPSA, CPSM and CPSNL included the reference to routine practices for BBVs, but also additional quality assurance mechanisms. CPSA and CPSM detailed the process of determining an agreement between the MRA and the physician. In this policy both CPSA and CPSM emphasized working collaboratively with the physician, for example as stated by CPSM (emphasis added):

> Through **collaboration** with the member's treating providers we work to ensure the necessary medical or mental health care is in place to support the member's continued safety to practice.

Similarly, CPSNL also highlighted the potential results of their review process, such as "the application of terms, conditions, or restrictions of practice, in the interest of protecting the public and ensuring quality medical care".

Quality assurance references were more limited for MAs. DBC referenced a past pilot project which was undertaken to review and validate their approach to complex cases. They also have a published logic model with key outcome indicators. MSPEI similarly has an evaluation framework included in their wellness strategy. OMA has as part of their objectives "To complete a comprehensive program evaluation every five years in order to improve program service and performance". AMA simply stated, "Working with the AMA Physician and Family Support Program is one way to ensure that difficulties can be identified and mitigated before a crisis or concern about patient safety arises".

Confidentiality. The confidentiality component captured extracts related to how the organization managed confidentiality and privacy. Almost all programs described their services

as confidential, however this component specifically aimed to capture policies and processes supporting confidentiality, not excerpts which only referenced the approach being confidential. In sum, 8 MRAs and 5 MAs referenced confidentiality processes in their publicly available approach descriptions.

In addition to outlining confidentiality processes, MRAs often included a supportive tone, such as "Registrants can be assured we will be **compassionate and sensitive** when discussing confidential health issues" (CPSBC, emphasis added); "The College **respects** the confidentiality and privacy of all information it receives or creates in the course of fulfilling its regulatory functions" (CPSS, emphasis added); and "Irrespective of how the College becomes involved, our focus is to **sensitively** approach the matter with utmost emphasis on physician confidentiality and patient safety" (CPSNS, emphasis added). Processes referenced by MRAs ranged from assurances that their health information is not shared publicly (CPSNS, CPSBC and CPSO) to more detailed statements (CPSM) and policies (CPSA, CPSS, CPSPEI, CMQ). Notably, CPSS, CPSPEI and CMQs policies related to BBVs and not physician health as a whole.

MAs made less reference to explicit policies and processes. DBC, AMA, DNS, OMA and NLMA outlined the conditions under which privacy is maintained, such as "Calls… and referrals to our therapists are not documented in the provincial electronic health record" (AMA) and "Monitored Health Professionals who are non-compliant with the relevant monitoring policy, or the [Physician Health Program's] Work Interruption and Return to Work Policy or Premature Termination Policy may be reported directly to the appropriate regulatory authority" (OMA).

Funding. The funding component captured references to how the association, authority, or participants fund or pay for the approach. This included any reference to overall program costs

in an annual report as well the costs to individual physicians. Only 2 MRAs referenced funding whereas 7 MAs provided a reference.

CPSBC and CPSA both referenced funding at the individual level, with CPSBC stating monitored registrants generally pay for the cost of independent assessments. While CPSA did not state explicitly the costs for monitored registrants, "Alumni" of the program with substance use conditions can elect to continue in their monitoring at no cost. MAs on the other hand referenced both individual costs and program costs. DNS highlighted program costs, whereas DBC, AMA, MSPEI and the NLMA all explicitly reference funding from the provincial government. As well, reference was made by SMA, DMB and NLMA to additional affinity funding awarded by the CMA's Affinity Fund to support physician health and wellness. Notably, support in the way of access was emphasized by some MAs. For example, SMA stated that their Medical Benevolent Society provides funding for physicians who cannot access treatment because "Financial ability should never be a **barrier** for people to get the help that they need to be happy and healthy" (emphasis added).

Reporting**.** Reporting, including Duties to Report or other ethical duties, aimed to capture the reporting requirements the organization referenced or anything that the physician "must" do. A Duty to Report is a Standard of Practice MRAs implement which registrants are required to adhere to. Invariably, every MRA referenced reporting. Comparably, only 1 MA referenced a reporting requirement.

Reporting references by MRAs ranged from statements repeated on websites to dedicated policies. In some instances, the references referred to legislated Duties to Report or Medical Acts (CPSBC, CPSM, CPSPEI, CPSNS, and CPSNL). The Duty to Report was often cited as both a legal, professional an ethical one: "College registrants have an ethical and legal responsibility to

notify the College if they or a colleague have a health issue that impairs their fitness to practise" (CPSBC); "Members who may have a diminished ability to provide safe and competent medical care have an ethical responsibility to report to CPSM and restrict or withdraw from practice" (CPSM); and "All members of our profession share a responsibility to the patients of unwell physicians. Physicians are obliged to report to the College when they have reasonable grounds to believe a colleague's health is placing patients at risk" (CPSNS). CPSO and CPSNB did not reference a dedicated Duty to Report, but both jurisdictions have their own Code of Ethics which highlights the responsibility to be aware of their health and seek help when needed. Other jurisdictions subscribed to the Code of Ethics and Professionalism established by the Canadian Medical Association. For CPSS, CMQ and YMC, the reference to reporting was limited to instances of BBVs, which often have their own distinct policy relating to reporting and monitoring. AMA was the only MA to refer to a reporting requirement, stating:

> All physicians in Alberta are bound by the CPSA's Standards of Practice, which stipulate the reporting requirements regarding physicians' medical conditions. When appropriate, [Physician and Family Support Program] will encourage the physician to self-report to the CPSA's [Physician Health Monitoring Program]. In the rare instance where the physician does not self-report to CPSA's [Physician Health Monitoring Program] and there may be serious harm to patients or others, the [Physician and Family Support Program] is obligated to do so. However, prior to taking that action the matter would be fully discussed with the physician.

Operational Components. The operational components included the aspects of the programs that related to the actual delivery of services, including health assessments, referrals, wellness offerings, and monitoring services. As well, any references or processes relating to specific illnesses were captured here. Both the assessment and monitoring components captured meaning in the form of perspectives on physician health, which will be further discussed in section 4.2.2.

Assessments and Fitness to Practise. Assessments and determination of fitness to practise aimed to capture how the organizations determine health or fitness to practise medicine. 5 MRAs and 6 MAs referred to these processes in their publicly available descriptions. For CPSBC and CPSA, the assessment highlighted a key perspective and was framed by the risk; for example, "The health monitoring department will assess the level of **risk** a registrant's health issue poses to the public in the context of their scope of practice" (CPSBC, emphasis added). CPSBC, CPSA, CPSM, and CPSNS all reference using reports from treating physicians or independent assessors. CPSO and CPSNB referred to Committees who review Fitness to practise. DBC, SMA, DMB and OMA reference conducting assessments for physicians, however DNS and AMA coordinate assessments for physicians.

Referral to Treatment. Referral to treatment aimed to capture how the MRA or MA managed referrals to treatment. 7 MRAs and 7 MAs referred to this service. Some MRA references to referral to treatment were limited to the case of BBVs, requiring or suggesting a seropositive physician be under the care of a treating physician (CPSS, CPSO, CMQ, and CPSPEI). CPSA, CPSNS and CPSM instead referenced connecting a physician with treatment, with emphasis on support: "Although our program does not provide any form of direct treatment, we do offer **support** and guidance to help you manage your health condition and minimize the impact on your practice" (CPSA, emphasis added); "Every situation regarding physician health is unique. Although our program does not provide direct treatment, we can **connect** physicians to available resources" (CPSNS, emphasis added). MAs comparatively either offered treatment (SMA) or would support the physician in accessing or treatment (DBC, AMA, DMB, OMA, DNS and NLMA).

Wellness. Wellness was a broad component that highlighted the wellness offerings of the MRA or MA, ranging from wellness itself to prevention, advocacy, education and more general support. Only 3 MRAs referenced services related to wellness, whereas 8 MAs referenced wellness. The only MA that did not had their services behind a members-only wall (NBMS). MA wellness offerings ranged from support with family relationships (DBC, DMB), case coordination for complex health issues (AMA), counselling and crisis counselling (DBC, AMA, DMB, DNS) prevention and educational services (DBC, AMA, SMA, OMA) stress management (SMA), conflict resolution (DBC), career transitions (DBC), Balint groups (DNS), financial and legal support (DBC, SMA), coaching (MSPEI), leadership development (MSPEI, DNS), "Docs for Docs" programs (DBC, NLMA), system level advocacy (DBC), peer support (DBC, AMA, DNS), equity, diversity and inclusion (MSPEI, SMA) and research and special projects into physician health and wellness (DMB, OMA, NLMA). Wellness offerings were positioned as preventative ("We know that comprehensive physician health programming needs to encompass prevention and reducing stigma for help seeking behaviours…" [DMB]) or in relation to the risk factors for physicians ("Need for control, Perfectionism, Dedication and devotion to work to the exclusion of pleasure and interpersonal relationships, Emotional remoteness, Chronic self-doubt…" [SMA]) or in relation to the healthcare system (as by DNS, emphasis added):

> An element of burnout is related to the level of disrespect physicians feel is directed **toward their profession**…Administrative hassles such as excessive paperwork and meetings…Financial concerns re: uncompensated time for the paperwork and meetings and financial demands related to student debt, maintaining a practice and retirement planning.

MRA references to wellness were limited, in one case to a recurring banner in registrant communications: "Please look after your own health & well-being. Healthy & happy physicians look after their patients competently and with compassion" (CPSPEI). CPSM and CPSO both had more elaborate references to physician wellness, stating they will provide registrants with

assistance in "setting boundaries within the practice environment to support optimal well-being" (CPSM) to creating a dedicated space on their website (CPSO).

Monitoring. Monitoring components captured references related to how the MRA or MA stated it monitors physicians under a PHA construct. This component also captured testing regimes and the requirement to be under the care of a treating physician for seropositive physicians. 10 MRAs referenced monitoring, but only 3 MAs referred to monitoring services. CPSBC, CPSA and CPSM outlined the nature or monitoring (e.g., reporting from treating physicians, colleagues, participation in community supports) as well as duration of monitoring. Monitoring also referenced key perspectives on physician health as it was often positioned in relation to patient safety (emphasis added): "A monitoring plan may or may not be required and each member's situation is reviewed individually and tailored to optimize outcomes for both **patient safety** and the member" (CPSM).

CPSS, CMQ, CPSO, CPSPEI, and YMC references were limited to the testing regimes for seropositive physicians and physicians performing EPPs, for example (as stated by CPSO):

> Physicians who want to perform or assist in performing exposure prone procedures in Ontario must be tested for HCV, HIV and HBV, if they have not been confirmed immune to HBV, before they commence performing or assisting in performing exposure prone procedures in Ontario.

CPSNL included both the nature of monitoring agreements and monitoring for seropositive physicians. Given the nature of the programs in their province, SMA and OMA both provide monitoring, and NLMA is under agreement with CPSNL to provide monitoring for physicians suffering from substance use disorders.

Processes for Specific Illnesses. A component to capture processes for specific illnesses was included to account for the nuance of specific BBV policies, which this paper considered under the umbrella of physician health, as well other references to specific conditions like

substance use disorders which has received a lot of attention in the literature. 10 MRAs and 8 MAs references to specific illnesses. For MRAs, references to specific illnesses ranged from simply listing conditions that qualified for intake ("What is a health concern? A health concern is a physical, cognitive or mental health condition which can include: a condition affecting manual dexterity, a condition affecting visual acuity, cognitive impairment, mental health diagnosis, substance-use disorder, blood-borne pathogens…" [CPSBC]) to policies requiring or encouraging HBV vaccination (CPSM, CPSBC, CPSO, CPSPEI, and CPSNL). There was also an emphasis on mental health and substance use conditions in MRAs, and for example, CPSA has a suite of policies related to SUDs. However, CPSM challenged the perception that mental health and substance use conditions are the dominant concern:

> It is a common misconception that reporting is only required for mental health conditions. A surgeon with Parkinson's disease, a psychiatrist undergoing chemotherapy for breast cancer, a family doctor with substance abuse disorder, and an internist who has had a stroke are all examples of members whose illness could impair their ability to perform safely and are therefore important conditions to disclose to CPSM's Physician Health Program. Where there is confusion about whether a condition is reportable members should contact the Physician Health Program for more information.

References to specific illnesses by MAs also included simple lists detailing the range of conditions supported ("The Physician Health Program provides assistance to colleagues, physicians in training and their families who may be struggling with a variety of issues, including mental health, relationship issues (professional and personal), substance abuse/addiction, physical health…" [SMA]) however there were also some specialized processes provided by the DMB, AMA and NLMA. The DMB had specialized groups for physicians "struggling with social, relationship, financial, behavioural, or substance use issues", the AMA has dedicated resources for SUDs, and the NLMA provides a monitoring program only for SUDs.

Partners and Partnerships. The partnership component was added over the course of the template pilot in order to account for the systems-level collaboration often occurring in these programs. 8 MRAs and 8 MAs referred to system partners. Most MRAs referred to their MA counterpart in their publicly available documents and advising physicians to seek support from their services ("The College wants to encourage the membership to seek help with any health problems… The MSPEI Physician Health Program is truly a welcomed program for physicians in our province (CPSPEI)."; and "Dealing with a regulatory body such as CPSA can be stressful, so we encourage physicians to contact all available resources, including AMA's Physician and Family Support Program (PFSP)" (CPSA). MAs on the other hand more often referenced other provincial or even national partners like health authorities and the CMA. For example, DMB stated: "Doctors Manitoba's is working with three regional health authorities as part of the Physician Health and Wellness Community of Practice Project to improve organizational and system level responses to physician health and wellness" (DMB). As well, DNS including the following in reference to a strategic framework:

> Doctors Nova Scotia has approved the "Restoring the Joy in the Practice of Medicine" framework, which outlines the future of comprehensive family medicine in Nova Scotia. With physician wellness at its core, the plan aims to help physicians strengthen their individual resilience and wellness, connect with colleagues and organizations, and engage with system partners – all meant to help physicians become more effective leaders in the health-care system.

Outcomes. The outcomes component aimed to capture quantitative references to results or outcomes from the PHAs. 6 MRAs and 5 MAs referred to outcomes. MRAs often reported outcomes in Annual Reports, reporting the number of physicians currently in practice ("More than 80% of physicians involved in PHMP are currently in practice" [CPSA]) or the number of referrals in a year ("Since May 1, 2019 the Physician Health Program (PHP) reports the

following activities: New Referrals: 41…" [CPSM]). MAs like DBC and AMA provided more detailed reporting on the nature and frequency:

> PFSP statistics for the period of January to July 2020 showed 1399 total callers to the 24-hour Assistance Line. Of this number, 478 were new callers (down 2% overall from this same period last year) and 921 were callers who had previously accessed this service (up 19.3% overall in this same period from 2019). Total callers for the year was up by 11% overall. Case Coordination services have experienced a 32% increase compared to this same period last year. (AMA)

4.2.2 Perspectives on Physician Health

In addition to the previously reported descriptive codes which captured salient approaches to supporting, regulating or managing physician health, codes were developed that spoke to key perspectives, attitudes or opinions on physician health. These codes were further divided into three categories. The first included the impact of physician health on patient care or quality of care, patient safety, and the healthcare system. The second captured how the organization framed health, including negatively as an issue or challenge, neutrally as simply a health condition, or more broadly in terms of wellness. Finally, the third group measured how often physician health was referenced in relation to risk. These codes and their usage across MRAs and MAs are detailed in Table 10.

Table 10 *Codes Identified on Physician Health Perspectives and their Usage by Medical Regulatory Authority (MRA) and Medical Association (MA)*

Codes	**Use by Organization**		**Total**
	MRA (n = 11)	**MA (n = 9)**	**(n=20)**
Perspectives on Physician Health			
Impact to:			
Patient Care or Quality of Care	7	5	12
Patient or Public Safety	7	1	8
Healthcare System	3	6	9

Codes	Use by Organization		Total
	MRA (n = 11)	**MA (n = 9)**	**(n=20)**
Understanding of health:			
As Issue or Challenge	8	6	14
As Condition	6	-	6
As Wellness	11	9	20
In relation to:			
Risk	10	6	16

Note. Frequencies were determined using stemmed analysis (e.g., "risk" and "risky") in NVivo 12 for Mac, which were manually reviewed to ensure accuracy.

With respect to the impact of physician health, for MRAs physician health was often explicitly positioned in comparison to the implications to patient care (CPSS: “This is a very important issue because there is growing evidence that physicians give **inferior care** when symptoms of burnout are present” [emphasis added]; CPSM: “A physician’s health and well-being impact the **quality of care** they provide to their patients” [emphasis added]), patient safety (CPSBC: “The College’s health monitoring department…ensures **public safety** by monitoring registrants who transition from sickness to health” [emphasis added]) or the healthcare system (CPSNS: “There is much to be gained from examining issues that surround physician wellness from all angles. After all, **our system** and our patients depend on healthy physicians” [emphasis added]). Notably, patient safety implications were also raised in the monitoring component, as discussed above. For MAs, physician health was framed through the impact on the healthcare system and the wider profession (DBC: “Our vision is a healthy, connected, and resilient physician community”) although there were also references to patient care (NLMA: “All NLMA members are strongly encouraged to avail of the program because by taking care of yourself, you will offer even better care to your patients”; AMA: “Mission: Support physicians, their immediate families and enhance the quality of patient care and public safety”).

The understanding and use of language to describe health by the two organizations was also notable. From the implicitly negative lens, both MRAs and MAs referred to health as an issue or challenge. For example, “The Program’s objectives include the early identification and monitoring of a member who has a health **issue** which has the potential to adversely impact the member’s ability to practice medicine safely” (CPSM, emphasis added) and “The Physician Health Program provides assistance to colleagues, students, residents and their families who may be struggling with a variety of **issues** including mental health…” (SMA, emphasis added). However, only MRAs referred to health as a condition, such as “A confidential and collaborative approach to maintaining your health **condition** and its impact on your practice” (CPSA, emphasis added). Moreover, all organizations referred to health through the lens of overall wellness, (CPSNS: “Wherever legally possible, complaints that connect to the health of the physician will be examined through the lens of physician wellness rather than through the disciplinary lens”; SMA: Physician wellness - or looking after physicians so that they can look after their patients – is a central theme as physician leaders from across Saskatchewan gather this week”) producing a variety of descriptions and indicative of the broad interpretation of health by both organizations.

Finally, the language of risk was prevalent throughout many approaches. As aforementioned, risk was referenced in the assessment and wellness components. References to risk also included the risk to patients (CPSBC: “The health monitoring department will assess the level of **risk** a registrant’s health issue poses to the public in the context of their scope of practice” [emphasis added]; CPSM: “As a physician community we have many members who are able to contribute substantially despite personal medical problems... The College has an important role to play in ensuring that this happens in a way that does not pose a **risk** to the

safety of the public" [emphasis added])" and the personal risk of the physician (SMA: "Physicians are at very high **risk** of addiction, and very unlikely to seek the necessary help" [emphasis added]; CPSA: "In the rare occasion that a physician's own health… is at **risk**, we ask them to limit their practice or to withdraw completely" [emphasis added]). Risk was also referenced in relation to the discourse around BBVs and mental health, including addictions. Managing the risk of transmission of BBVs underpinned many of the policies and approaches: "This Standard of Practice is intended to **minimize the risk** of exposure to bloodborne viruses for both patients and physicians during the provision of medical care" (CPSNL, emphasis added); and "The College's Blood Borne Viruses policy sets expectations for: **reducing the risk** of acquiring or transmitting a blood borne virus…" (CPSO, emphasis added). The risk associated with mental health and addictions was highlighted at the programming level in the overarching naming of programs, such as DMB's Physicians at Risk program targeting SUDs and other mental health concerns, or CPSA's and AMA's joint Strategic Framework to Reduce the Risks of Substance Use Disorder in Anesthesiologists. The risk of SUDs was also embedded in some of the approaches overarching aims, such as OMA's "The Physician Health Program of the Ontario Medical Association will serve the needs of physicians at risk of, or suffering from substance use disorders, and/or psychiatric disorders through prompt intervention, referral to treatment, monitoring and advocacy". There appears to be an implicit assumption that these conditions carry more risk than others given they warrant explicit risk considerations.

4.3 Summary of Phase I Findings

The objective of Phase I was to comparatively describe the stated services of physician health approaches (PHAs) and perspectives on physician health in Canada. Quantitatively, there was a high volume of documents addressing physician health identified across the country

(n=258), however no province or territory completely referenced every component as identified in the North American guides as services provided by PHAs (Bailey and Jefferies, 2012; Federation of State Physician Health Programs, 2019). Qualitatively, both MRAs and MAs shared the same descriptors to describe their overall approaches: "confidential", "supportive", "preventative", "collaborative" or "interventive". Additionally, specific to MRAs was the use of "mandated" and "balanced" to describe their approaches, reflective of their legislated duties to protect the public while also balancing the needs of their registrants.

Administrative components often only outlined the mechanisms related to their approaches' oversight, intake, quality assurance, confidentiality, funding, and reporting requirements. Most MRA and MA approaches adopted committee-based structures to their oversight and governance. MRAs highlighted the role of reporting at intake, whereas MAs emphasized accessibility and support. Most quality assurance mechanisms for MRAs related to bloodborne viruses (BBVs) and no other health condition, however two MRAs used collaboration to describe how they approach one aspect of their quality assurance mechanisms (the definition of monitoring agreements). Few MAs referenced quality assurance. Despite describing their program as confidential, not all programs outlined their policy or process to assuring confidentiality. Supportive tones were used however by those that did. Funding was only referenced by 2 MRAs, while most MAs provided a reference, and was described as supportive (e.g., removing barriers for physicians to get help). The legal, ethical and professional duty to report a health condition was referenced by every MRA but only 1 MA.

Operational components covered health assessments, referrals, wellness offerings, and monitoring services. Despite the essentialism of determining health and fitness to practise, only 5 MRAs and 6 MAs referenced these processes. Notably, assessments flagged the first reference to

a perspective on physician health: the importance of and relation to risk. Some references to referrals to treatment for MRAs were limited to BBVs, others referenced supporting physicians to identify a treating physician. 1 MA facilitated access to treatment while most, like MRAs, supported accessing treatment. Only 3 MRAs referenced wellness, whereas most MAs had several offerings related to wellness, such as counselling, education, supporting with relationships, leadership, peer support, and more. These were often described as preventative and like assessments were also positioned in relation to risk. Monitoring components were mostly referenced by MRAs, and only few MAs. Again, most MRA references were limited to monitoring for BBVs. Specific references were made to BBVs by 5 MRAs, others listed out conditions that qualified for intake like physical, cognitive or mental health conditions. There was also some emphasis on SUDs.

Partnerships were spoken of collaboratively by the majority of MRAs and MAs, however MRAs often referred to the MA while the MA referred more often to other provincial or national partners. Just over half of the organizations quantified their outcomes. MRAs often reported the number of physicians current in practice in their program, while MAs provided more detailed statistics related to the cases received.

The content analysis also revealed some perspectives on physician health. Physician health was often positioned in relation to patient care, patient safety, or the impact to the healthcare system. Notably, there were three varying interpretations of health as a concept: a negative “issue” or “challenge” used by most MAs and MRAs, a neutral “condition” that was only used by MRAs, and the broad construct of wellness, which was used by all. Risk was also embedded in much of the content from MRAs and MAs. In conclusion, using both quantitative and qualitative content analysis, I achieved a foundational understanding of the diverse

approaches adopted by MRAs and MAs in Canada and gained insight into their perspectives on physician health. This awareness lays the foundation for the research conducted in Phase II, wherein, the research dives deeper into stakeholder approaches to and perspectives on physician health cross-nationally.

CHAPTER 5: PHASE II RESULTS

This chapter reports the results from the Phase II thematic analysis of semi-structured interviews with Medical Regulatory Authorities (MRAs) and Medical Association (MAs) from across Canada. The objective of Phase II was to further understand the approaches and perspectives of these two key stakeholders on the topic of physician health, and how these perspectives have informed development and management of their established physician health approaches (PHAs). Though data collected from MRAs and MAs were coded separately, themes were identified with shared meaning across both sets of stakeholder data. Following an overview of the participating organizations and participant characteristics, this chapter will report the results from the reflexive thematic analysis and shared meanings identified in the two groups.

5.1 Phase II Participants

Interview invites were sent in five waves to 24 organizations. Overall, 14 organizations responded and agreed to participate (7 MRAs and 7 MAs) for a participation rate of 58%. There was strong representation from coast-to-coast, however there was no representation from either the MRA or MA in Ontario, Quebec, and the three territories. Of those organizations who did participate, some interviews featured multiple representatives from the organization, resulting in a total of 23 individuals who participated across the 14 interviews. The participating organizations are listed in Table 11 along with the participants per organization. The characteristics of the participants are listed in Table 12. There was strong senior representation, with nearly half of the participants holding leadership positions. The remainder of the participants were either senior managers or directors working directly in physician health.

Table 11 *Participating Medical Regulatory Authorities (MRAs) or Medical Associations (MAs) in Phase II*

MRA or MA	Acronym	Number of Participants (n=23)
College of Physicians and Surgeons of British Columbia	CPSBC	1
Doctors of BC	DBC	1
College of Physicians and Surgeons of Alberta	CPSA	1
Alberta Medical Association	AMA	2
College of Physicians and Surgeons of Saskatchewan	CPSS	1
Saskatchewan Medical Association	SMA	3
College of Physicians and Surgeons of Manitoba	CPSM	2
Doctors Manitoba	DMB	3
College of Physicians and Surgeons of New Brunswick	CPSNB	1
New Brunswick Medical Society	NBMS	2
Medical Society of Prince Edward Island	MSPEI	1
College of Physicians and Surgeons of Nova Scotia	CPSNS	1
Doctors Nova Scotia	DNS	3
College of Physicians and Surgeons of Newfoundland and Labrador	CPSNL	1

Table 12 *Characteristics of Participants in Phase II*

Characteristics	Number of Participants (n = 23)
Seniority	
Senior Leadership	10
Director or Management	13

Note. Senior leadership included Chief Executive Officers, Registrars, and Assistant Registrars.

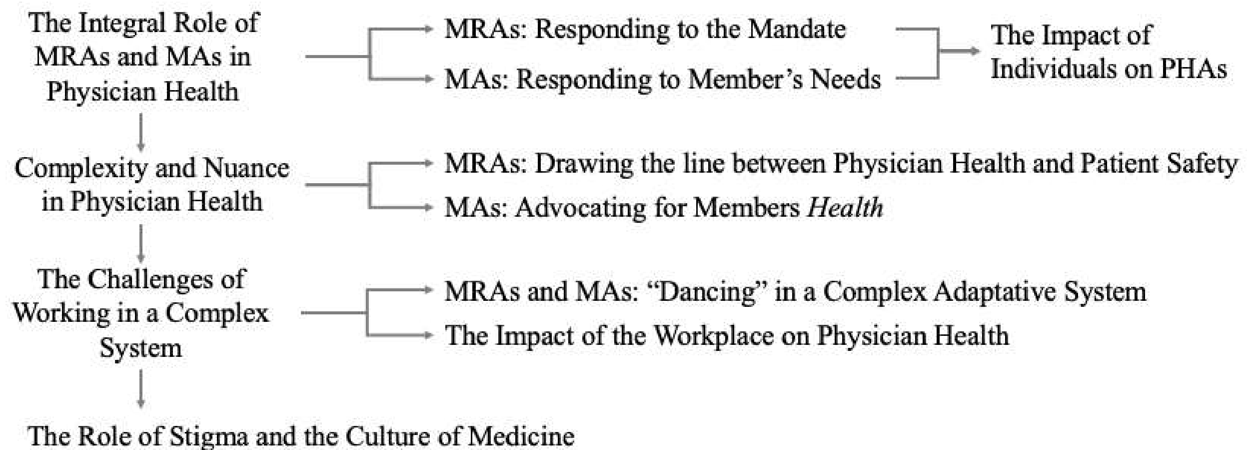
5.2 Thematic Analysis Results

Thematic analysis was conducted using the tenants of reflexive thematic analysis as outlined by Braun and Clarke (2022), a recursive process with emphasis on shared meaning in the transcripts. To ensure thematic details were not lost in the amalgamation of the groups, the transcripts were divided into MRA or MA for the initial coding and theme development. At the point when themes were further developed and refined, the codes and themes across MRAs and MAs were considered as a whole, with emphasis on identifying shared meaning between the two groups. Both groups generated a similar thematic arc: regulating, managing or supporting physician health is required of them as either the regulator of or advocate for physicians, however, there is an intrinsic complexity to this that demands nuance in their approaches. Moreover, both organizations must confront the challenges presented by the healthcare system, the culture of medicine, and stigma when working in physician health. The themes and their subthemes are diagrammed in Figure 4. With this thematic backbone, this section will now detail these and related themes in the approaches to and perspectives on physician health in Canada.

5.2.1. The Integral Role of MRAs and MAs in Physician Health

Both the MRA and MA participants made it clear in their interviews that interacting with physician health was required of them as an organization. For MRA participants, this requirement derived from their mandate or legislative duties. For MA participants, this requirement came from their members themselves. Whether this obligation came top-down or bottom-up, both MRAs and MAs are implicated in the topic of physician health. Moreover, embedded in both groups was the role of key individuals who either initially brought physician health to the table or who have informed the lens adopted by the organization to physician health.

Figure 4 *Themes and Sub-Themes Generated from Medical Regulatory Authority (MRA) and Medical Association (MA) Interviews*



MRAs: Responding to the Mandate. For participants from MRAs, the role of the mandate was foundational to their work in physician health. For example, in response to asking how the College first became engaged with the topic of physician health, two participants responded accordingly:

> **We recognize that health is an important component of competence**… But essentially, we feel that the health is and should be more within the general bracket of competency rather than a professionalism issue… so essentially its under Part 3 of the Health Professions Act, rather than Part 4 which is the Professional Conduct part. (CPSA, emphasis added)
>
> **We view physician health and fitness to practise as essential, and a small but crucial part of our overall mandate at the College to ensure patient and public safety** …We don't really engage with some of the core regulatory functions like registration, and complaints, accreditation, quality assurance... We're not those things, and yet, we play a supportive role. (CPSBC, emphasis added)

In both cases, participants reported physician health formed an "important" or "essential" part of their mandate and was clearly differentiated or positioned in the context of the other regulatory functions. In other jurisdictions, the role of the mandate and their legislative duties were more

subtle, like in Manitoba where the role of protecting the public was an undercurrent in their approach to physician health:

> We focus on supporting our members in being healthy and promote reporting when they're not well so we can ensure that we are doing our **duty to protect the public** and also make sure our physicians are safe. (CPSM, emphasis added)

In Saskatchewan, the participant reported protecting the public from risk was one of the lenses adopted when assessing complaints related to health:

> If we have a complaint, we are legally bound to investigate each of those complaints. And so, if I have something that's raised to me in a formal matter, that there's potential harm to allowing that physician to continue to practice, then I have to decide what I'm going to do. And so oftentimes that's kind of the question I have to ask myself, do I have enough information? Is the physician likely impaired? **Is there a risk of harm to the public?** If there is, then I make a formal referral. (CPSS, emphasis added)

For other MRA participants, the mandate was also raised in response to the question of coercion in PHAs, one of the key issues identified in the literature:

> …But that's why you never have to forget your primary mandate is to protect the public. (CPSNL)

> …It's a very delicate balance between the employer's obligation to support an employee**,** the College's obligation to protect the public**,** and the ultimate goal to keep the physician healthy. (CPSNB)

In response to the question of coercion, The College in Nova Scotia also emphasised that supporting the physician may be outside their mandate as a regulator:

> …I dislike the wording of that question which seems to imply that a regulators appetite to look at this makes the matter worse. The regulators have a responsibility here, which is to public safety, and this is a threat to public safety. There are other players in this space that can participate to support the physician. (CPSNS)

Notably, in many provinces, working in physician health was not a recent development but one which has evolved over many years, if not decades:

> I've been in and working with the College for over 20 years, but we've always had sort of a… some sort of a physician health focus. (CPSS)

> It's difficult to give a precise date, but the physician health monitoring program is in its thirtieth year this year. (CPSA)
>
> So, we've always been involved and there has always been a department to address issues... So, how many years ago in the 155-year history of the College? We've always had a department that has taken a lively interest in the fitness of physicians to practice. (CPSBC)
>
> I think over 10 years ago… as it was emerging across Canada there was a need for regulators or some other authority to support practicing physicians and members. (CPSM)

In sum, for MRA's, participants felt work in physician health was a part of their regulatory purview, albeit one that was distinct from their other regulatory functions and was also an aspect many MRAs have been regulating for some time.

MAs: Responding to Member's Needs. While MRA participants may be responding to their legislative duties, it was clear from those speaking from the point of view of MAs that their work in physician health has evolved in response to the needs of their members. Moreover, similarly to MRAs, most MAs have been supporting physician health for several years. For example, DMB and NBMS participants reported decades of work in this space:

> **Doctors Manitoba has for thirty-ish years supported individual physicians who were working in the area of physician health**, whether it be psychiatric treatment, addictions treatment, peer support … **it was really responding to a request by physicians who were doing the work.**.. (DMB, emphasis added)
>
> **Well, we have been in this space for a couple of decades at least,** providing support in a variety of means. Early on there was a focus on alcohol addiction, there was some support groups, and there was also some financial support in the early days… And then we built up a counseling service of sorts, that was a lighter touch from probably the mid 2000s until about 2015 or so. And now we have a much more robust, full-service program… **We were hearing from doctors that stress and burnout were big drivers for them, and we needed to deliver**. (NBMS, emphasis added)

Responding to members has also informed how MA approaches to physician health have evolved. Member needs, coupled with the evidence in the research, were the driver behind one MA's approach, per the participant's report:

> To go back to your original question [on how and why the approach evolved], when it was this more relaxed, interventionist approach and transitioned on to something more fulsome, **is I think it came it down to demand… I think we became aware, and the research showed that, you need a more comprehensive larger scale approach to tackle the physician** (DBC, emphasis added)

Instead of relying on academic research, other MA participants surveyed members regularly to understand their needs:

> **We do a lot of surveying to make sure our work is aligned with what members needs are priorities are**. So, all of those [approaches] that I spoke of were in response to what they told us as a collective in both quantitative and qualitative surveys. (MSPEI, emphasis added)

Another MA participant also reported evolving particularly in response to COVID-19 and the need for support in the healthcare system:

> We try to be fairly topical in terms of what's going on in the community, so a lot of our recent presentations and collaborations have been around COVID related matters –I'm sure that doesn't surprise you… It was last year we were responding to the murder of a physician who was murdered in his clinic and the repercussions that the community felt around that about safety in the workplace and things like that. So, it's constantly evolving, and **we try to keep with the present needs in the physician community in terms of whatever we're offering**. (AMA, emphasis added)

An additional aspect of enabling the MAs to support physician health that was shared amongst interviewees was the role funding played in their ability to respond. In some provinces, this funding came from the government:

> [*On the role of an individual supporting the development of physician wellness offerings*] And through her work, **she raised the advocacy with the medical association that this was an area that needed our involvement…and needed to be funded through the contract of the master agreement we have with government**… And we got it in the first agreement that I was responsible for negotiating… (MSPEI, emphasis added).
>
> … In the early 90s, if I'm not mistaken, is when the AMA negotiated with the government to get the **funding for a 24/7 support line**. So that's been going for quite some time. (AMA, emphasis added)

And in other provinces, the funding was put in place by the organization itself:

> ... We're very lucky here in that I don't have to go to my board every year to plead my case to get funding. **Funding is in place all the time, we look for other avenues to add**

> **some funding, but this program is never in jeopardy in terms of providing support**. (SMA, emphasis added)

Or through the CMA:

> I was just going to say, **one of the caveats to all of the new programming is largely a consequence of funding we've received from the Canadian Medical Association**. So, every Provincial Medical Association has received a commitment of $1,000,000 from the CMA over four years… We also have some funding in our physician services fee agreement with the government that also augments that money.... (NBMS, emphasis added)

> [*On what drove the changes in their program*] And then on top of that, CMA started giving some financial support, and particularly in the area of physician wellness. And so, for us I think it was the stars kind of aligned, with us having an inkling that there is something going on in this physician community… and then actually had or **was able to get some grant money through CMA to support some of those ideas we had in the Restoring the Joy**. (DNS, emphasis added).

In one province, funding has also informed how the program has evolved:

> **[A] really great question is… "Who is funding you?" [because it] is going to drive these changes.** And so, our program is funded by the Ministry of health… But the decisions that have ebbed and flowed over time is [because of], "Who is funding us?" (DBC, emphasis added)

Thus, for MAs, their own mandate being a member's association and needing to respond to member's needs, enabled by funding, is what led them to becoming involved with physician health.

The Impact of Individuals on PHAs. A sub-theme in the role of MRAs and MAs in physician health that emerged from the transcripts was the role of individuals. For the MRA participants, the clinical background of the individual working in physician health appeared to shape the approach adopted at the MRA. In Manitoba, the background of being family physicians meant they found the relationship with the physician important and considered the "whole person":

> [*On the process of determining fitness to practise*] And the medical director… and I will sit after the meeting and look at all the information in front of us. And we do find the interview so valuable to really put everything **together because we're both family**

> **doctors, relationships are important, and we do see the whole person and really kind of try and understand how they ended up here and what's going on.** (CPSM, emphasis added)

Contrastingly, in Newfoundland, the occupational medicine background of the MRA participant informed their approach to physician health and views on the issue of illness versus impairment:

> [*In response to a question about distinguishing illness and impairment*]: **I told you my background is occupational medicine,** so I have very strong views about that…I was at an international conference in Chicago, and we had a forensic psychiatrist presenting to us. And he made a statement. He said, "Diagnosis does not equal disability". And I have never forgotten that… But the diagnosis alone and in fact here at the College, I've regularly said even in complaints or whatever, "Don't go on the diagnosis". Because there's so much nuance to a diagnosis. (CPSNL, emphasis added)

For the MA participants, the narrative around the role of individuals differed slightly. Instead of the individual's clinical background informing their approach, it was the more general experience of individuals, either as a sick physician themself, experience supporting sick physicians, or a passion for physician health, that shaped the approach. In Saskatchewan, these were individuals with lived experience:

> Back in the 70s, the issue... around physician impairment from the use of drugs or alcohol became an issue. And there were physicians who were in recovery themselves who as part of their recovery and their benevolence said, "**You know what, we should also be reaching out to help our colleagues who may have this same issue**". And so, they decided to form a group that could provide recovery to other physicians, so in the 70s that's how it started. **It was a small group of well-intentioned recovering physicians who wished to help their fellow colleagues**. (SMA, emphasis added)

In Nova Scotia, it was a single physician who noticed a colleague in trouble:

> So, the [Professional Support Program] … **It was actually in the 1980s** that it was started, and it was one of the first in Canada. **It stemmed from simply a physician who was noticing another physician struggling with alcoholism**, it was starting to impact their work and patient safety, so they picked up the phone and reached out to ask if they were OK and if they needed support… (DNS, emphasis added)

And in both PEI and Manitoba, it was an individual or a pair of individuals, respectively, with a particular passion for physician health that put physician health on the MA's agenda:

> Well, it predates me, so I've been at the medical society for eight years, and when I arrived**, we had a physician leader who informally took it upon herself to be the go-to person for any of her colleagues who were suffering health issues.** (MSPEI, emphasis added)
>
> [*When asked how physician health has evolved at the MA*] **First was the committee that was created in 2012, 2013, which was driven by [an individual] who wanted there to be a physician health committee that was really focused on prevention and wellness** …. So, [they] chaired that committee for a couple years and then the next to take over was [another physician]… She had a passion for this work and that's when it expanded into having the Physician and Family Support Program like that EAP type service which is modeled after other PTMA's… (DMB, emphasis added)

Moreover, in the case of Saskatchewan, the individuals at the MRA and MA were so important that it led to the formalizing of their ways of working to provide assurance that the current approach would continue:

> …I have been in my role for or in this particular role for 10 years. And I was in the deputy role for 10 years before that, and I was on contract for two years before that. So, it's been pretty consistently me dealing with this. And [my counterpart at the MA] has been upstairs for probably the same length of time**. So, what we were concerned about is this working really well because of the two individuals, as much as anything else?** What I was fearful of is if I left or she left, would it change? **So, we sat down, and we did a series of guiding principles and kind of a memorandum of understanding as to how the program would work.** And that hopefully will stay in place for a while and allow people a sense of how we do these things. (CPSS, emphasis added)

Therefore, for MRAs and MAs, physician health is squarely within their purview, either because of the top-down mandate or the bottom-up needs of members. In both groups, there is a history of working in physician health and a sub-theme of key individuals who have informed and shaped their approach to physician health. MAs benefitted from funding, made available either through the government, their own organization or national member associations. MRA participants both implicitly and explicitly highlighted the role their legislated duties play in informing their work. However, for both organizations, despite these clear roles to work in physician health, how best to conduct this work was not as clear.

5.2.2 Complexity and Nuance in Physician Health

Complexity and nuance underpinned the narratives of MRA and MA participants. While both MRAs and MAs are clearly implicated in the oversight or support of physician health, there was an intrinsic tension in the operations for both stakeholders. For MRAs, given their role as regulator and their wider mandate (such as discipline), participants felt they needed to be judicious in their approach. Participants from MRAs also perceived themselves to be limited in their ability in some respects, particularly around communications, prevention and the concept of success. MA participants on the other hand benefited from being more freely able to support along the continuum of health, but their role was still nuanced. MAs often employed physicians who supported ill physicians as system navigators and not as a physician. Moreover, their role as advocates for physicians was qualified by the need to also look out for patients. Thus, while both stakeholders are implicated, neither could offer a singularly comprehensive solution to this complex problem alone.

MRAs: Drawing the Line between Physician Health and Patient Safety. While it was clear in the interviews that the connection between the MRA's mandate and physician health existed, "drawing the line" between physician health and patient safety was often not a straight one. The theme of complexity and nuance manifested in a few ways within the narrative of MRA participants. Sometimes complexity arose from simply the physician health file itself:

> …The problem is that you have such variability both in health conditions and in the tasks that somebody has to undertake that it's very difficult to find one assessment fit for all. (CPSA)
>
> … And we've been able to get them out of practice for a while until they deal with their personal problems. Because these are never just straightforward cases. (CPSS)

Complexity also arose in individual cases because of need to identify whether a particular physician's health 'qualified' for regulation. As discussed in the literature review, regulators

have jurisdiction where there is a risk to patient safety. In the spectrum of health, not every illness results in an impairment that impacts patient care, requiring MRAs to evaluate each file in turn. As a result, they often rely on treating physicians or external experts for an understanding of the clinical condition. But the regulatory decision lies with them. As stated by the participant from the MRA in Alberta:

> [*On determining the fitness to practise of registrants*] There is a spectrum. Typically, if there is not a great deal of urgency, what will happen is that the program would get information from an individual's treating physician, usually… We do rely very heavily on treating physicians but will on occasions get an independent exam... **But ultimately the decision has to be made by us based on the best information available**. (CPSA, emphasis added)

The participant from Nova Scotia highlighted how this decision-making ability is fundamental to their role as a regulator:

> [*On how decisions are made in their PHA*] At the front end, when you seek an undertaking that you will refrain from practice until we have a better understanding of what is going on, that is a severe thing. And that's done at a time when you don't have a lot of evidence. So typically, those decisions are made based on what's the least we can do to assure public safety right now. **What's the most minimally intrusive thing without departing from our mandate of public safety?** … But after that stage, how are decisions made? They are usually made in consideration of all the evidence. And what evidence will we get? Well it depends… **And one of the things I think we're reasonably good at the College, because it's what we have to do, is make decisions… we are trained to know what's adequate and appropriate evidence. And that's what we do.** (CPSNS, emphasis added)

And the participant from Newfoundland summarized why this judiciousness in a case-by-case basis is so important, given the fear of the MRA:

> The College is different. The College holds the license. And the College's ability to put limitations or restrictions on a physician is pretty absolute. **So, you have to be very careful what you do and be on solid ground**… So, physicians are afraid to come to us with a health issue, for fear of what we might do to their ability to earn an income and their reputation... There's a responsibility in the College… **In the end, our job is to protect the public.** (CPSNL, emphasis added)

Given this case-level complexity, MRA participants often spoke of their overall balanced approach, a theme for MRAs found in Phase I:

> [*On the use of an independent contractor to vet decision-making*]. We try to be **fair to the doctors** while at the same time **upholding the mandate of protecting the public.** (CPSM, emphasis added)

However, participants had varying perspectives on the ability to find this balance in MRA approaches, from if balance had been achieved, to questioning how to achieve balance and whether balance was achievable at all. The participant from CPSBC felt that their approach may have "nailed it":

> … I'm happy with the number of registrants that we have in our program. I'm aware that we have percentagewise more than many of the other regulatory authorities... **That tells me that we're doing something right. Maybe we've nailed it in terms of that sweet spot of where we ought to be.**

When pressed further on how they achieved this right balance, the participant responded:

> I think it's a bunch of things**. I think it's how we structured our Health Professions Act that takes a lively interest in health and the fitness of physicians**... I think it also comes down to good leadership within our organization. My department is well situated and well-funded and well respected within the group, and so we got the resources to look at and develop good policies and procedures to really look into inquiries on physician health. **And also, that balance. We've got good relationships with the other stakeholders. I've described the health monitoring department as one stakeholder or one party to a dance...** And I think in this province we developed…we really worked hard at identifying and creating that collaborative relationship, building bridges and building fences. And making sure we are all doing our part. So, there's a number of factors that goes into that right touch... But I think we kind of nailed it in our province.

Evidently, in British Columbia, achieving the right nuance is dependent on a clear mandate, strong individuals, funding, and relationships with other stakeholders in the health system. Alternatively, three other MRA participants explicitly highlighted how this balance is sometimes a struggle to find:

> [*On how they manage confidentiality]* We certainly do not report, as a result of a physician's health, if there are conditions and restrictions applied so their license or their scope is limited… the reasons for that are not in the public domain…**We are mindful of the fact that the public's right to know does not overwhelm the physicians right to privacy. And it can be tricky.** The addicted physician in many cases will be restricted from prescribing opioids. And the public has a right to know that the physician cannot prescribe opioids, the public doesn't have a right to know why, but they might infer it. (CPSNS, emphasis added)

> [*On the options available when a physician is not collaborative*] The only other option we have though is to take it to tribunal, which is the legal route, where the tribunal can take their license. It doesn't seem fair or right to take a physician who has a serious health issue, that particularly affects their ability to problem solve and to have insight, to a legal environment, right? **So, that part is a struggle.** (CPSNL, emphasis added)

> [*In response to the question of coercion in physician health programs*] Yes, that's the worst part of my job. Because in my core I am a clinician. So, my DNA is about wanting to help, wanting to support, rather than taking away privilege. So, it is very conflicting. And sometimes very painful when we know someone is struggling and knowing the impact this is going to have long term and short term on that person once you apply a suspension or a limitation on someone's license... **So, it's a very delicate balance that I always struggle with and that I always find difficult. And I know it's going to be part of my job and my biggest challenge is to try to harmonize those things that at the end of the day, the public comes first in this role**. (CPSNB, emphasis added)

And one MRA participant reported the means of "striking the right balance" was a source of "endless debate":

> [*In response to the question of coercion in physician health programs*] … I think you're correct on all those things. You can inhibit physicians from self-disclosing and from seeking care. But I don't see any easy way around it…**It's striking the right balance between their responsibilities to patients and the physician's right to privacy and to have their illness in peace. How we go about that is a source of endless debate, really**. (CPSA, emphasis added)

Thus, there was no consensus among MRAs on how best to find balance in their approach, let alone if balance was even achievable. One MRA acknowledged the part of this difficulty may result from the nature of regulating and the "bluntness" of their tools:

> [*In response to the question of coercion in physician health approaches*] Well, I wouldn't call it coercion. Physicians get to make the decisions they make. I suppose some people might say well your choice of a suspension hearing or voluntarily withdrawing is that coercion? I hope they don't see it like that. It's just the choices I have. **And I tell them my tools are pretty blunt,** if you voluntarily withdraw, we can work with that. If they don't voluntarily withdraw, I don't have a lot left. (CPSS, emphasis added)

Another way complexity manifested in MRA approaches was in the more administrative side of the program. For example, Phase I found many MRAs described their approach as supportive. However, one participant in Phase II used this description in a "subtle" but distinct way:

> The other thing is that we're a supportive program. We don't really engage with some of the core regulatory functions like registration, and complaints, accreditation, quality assurance... **We're not those things… we play a supportive role**…When I first started in this job I used to say we are a supportive arm of the College but I was actually afraid that registrants would start to get confused about that. We don't actually support the registrants. I care as a person, I care as a physician, as a former colleague, and I care as a regulator about the registrants, but our job is not to advocate for or support the registrants. Our job is to support the public. **So, when I say supportive it really is supportive in the sense that we support the other regulatory functions. Subtle but important**. (CPSBC, emphasis added)

This further illustrates the nuance in the language surrounding MRA approaches.

In addition, when considering how to develop and expand their approach, the participant from CPSM highlighted the difficulty in "drawing" the line between physician health and public safety and the need to stay in their "lane":

> So, I think we'll be looking to do more promotional stuff which is not we've done much of nor would we do it well, because it's hard in our position. **We're all about the public, but at the same time drawing that connection for the public between a healthy provider and good care is helpful**… **it's just a matter of how do we do that and how do we keep within our lane.** (CPSM, emphasis added)

The difficulty in expanding their approach without leaving their lane was raised by another MRA contemplating how they might approach prevention at the physician-population level:

> And I think questions remain as to what extent we should be looking to be proactive, and maybe start working at a population level as well… So, if we can improve the health of all physicians by doing something, maybe we say every physician should have two days off every two weeks…But I think part of the problem is that regulators, the Colleges, have sort of been a little bit fearful of going down that sort of approach because the profession is to a large extent self-employed contractors. **And so, there's a reluctance to be prescriptive for some things that will be good for health.** (CPSA, emphasis added)

And finally, there is complexity and nuance present in defining success for PHAs, as seen in the following exchange:

> [*I asked, "How does your college define success for your program?" They first responded, "*I don't know" *and I prompted them with the quote from their website, "Keeping physicians in practice"?*] **It's keeping physicians in practice appropriately. That's what we'd like to think. But success is also detecting doctors with disease, and I'm not sure we do a very good job about that, for example**. There's probably a

> lot of barriers to self-reporting, still. So, I think it's really defining success goes right through, it's a multi-dimensional thing. Identifying the physicians, assessing them properly, putting in place appropriate accommodations or limitations, and only excluding those who should be excluded, and also intervening at some stage with those salient problems that at population [level]. For example, COVID-19 may be contributing to the violence and aggression in the workplace, what's the College doing about that? What's the College doing about undue fatigue at work? All these things that probably we've been relatively silent on over many years. (CPSA, emphasis added)

Similarly, in another jurisdiction, the participant felt their program could only be criticized for failing to manage the complexity:

> I think we manage the cases that we have well, but I think there's probably a failure in the sense that that in most cases, we're trying to support physicians in practice so they can continue to contribute if they can do so safely and effectively, but we've mismanaged that. **I think the profession (and the College shares some of the blame) has failed to shed adequate light on the harms and dangers of working while unfit to practice.** And I think that impedes reporting. When you think about it, it's silly that I am reluctant to report you when I have reasonable grounds to think your practice is unsafe because of the hassle, because the perception of the College is no good, when I should be thinking about the 2000 patients you're caring for**. There is a dynamic there, there is a psychology there, that we have failed to manage well. Because you asked me how I thought about the performance of the program, but the reality is you can only criticize it because it is massively under subscribed.** (CPSNS, emphasis added)

Ultimately, only one participant really had clarity on how to persist despite such complexity:

> [*In response to the question of coercion in physician health approaches*] I'll address it head on. Yes, it does. Is it going to drive the problem underground? Is it going to scare the physicians when the regulators involved? Yes…[But] I'm going to do my job… There is a limit to autonomy, and professional autonomy, and respect owed to autonomy. And it ends. Like the harm principle – your right to swing your arm ends where my nose beings and doctor, if you are creating a problem, I don't care, I will go after it 100%. Is it going to make it difficult for you? Yes. Is it going to cause you to run away from the problem? But I'm going to go after it. You get support from your legal counsel. You get support from the PHP, but I have got the cape for the public. **So, I would confront those issues head on and say they definitely exist, but we just carry on.** (CPSBC, emphasis added)

More often, the need to be nuanced was recognised, in recognition of the mandate to serve the public interest:

> **You know it's trying to put a dose of humanity there but recognizing that your principal role is to protect the public**. And so, you always got to have that out in front: you have to protect the public. But you have to do that still recognizing that physicians

> are human beings and they do have rights as well. So, let's try to do it in the least invasive way we possibly can. (CPSNL, emphasis added)

Additionally, the participant from Saskatchewan, who works with the SMA's PHP wondered how MRAs might manage the movement of a physician health file between departments if the PHP is not arm's length, when contemplating the potential for conflicts of interest in programs:

> I can see that within the Colleges that have their own physician health programs, and they are under the same roof as the College…I don't think I'm in a conflict very many times, if at all. Because that wall is there and what I do is I do my piece, and then wait for them to do their piece. But I can well understand that if you are the physician health person within the College staff, your check is coming from the College, and you're having to put that wall up and keep everything secure, at some point that information can become part of a disciplinary process… It isn't used to... it will be referenced, because it is part and parcel of understanding why someone might not have been in the right frame of mind and got themselves in trouble. So, it's not like the information isn't used. **But it has to be used properly let's put it that way. So, I only have information that gets sent to me, I don't have access to the full file, neither do I want access to the full file. So that is a good question to ask the other regulators that have in-house programs, how do they manage that? What of the health file is shared if there is charge of unprofessional conduct?** (CPSS, emphasis added)

In sum, MRA participants reported complexity at multiple levels: from individual cases to overall approaches. The need to be balanced in the approach was emphasized given the powers of the MRA and the reality of their blunt regulatory tools. Most notable in this theme was the lack of consensus on the ability and manner to achieve balance in their approach, and the single example of a province who had. Most participants reported struggling with the complexity or feeling restricted in how they could improve their approaches by the need to stay in their regulatory lane. The differing use of fundamental approach descriptors found in Phase I was also highlighted. Except for one participant, there was no clear understanding on how best to navigate the complexity faced by MRAs. Finally, there may be additional complexity in programs or approaches that are not arm's length.

MAs: Advocating for Members *Health*. Complexity and nuance were also evident in the participant interviews with MA participants. One way complexity presented was with respect

to their interpretation of health and resulting approaches across the spectrum of health. Participants representing MAs often adopted a broad stance towards physician health and viewed physician and wellness as integrated with other aspects of their work, in contrast to MRAs who had to distinguish their physician health work from other regulatory functions. For example, in Nova Scotia, physician health is embedded in their approach to policy and overall strategy:

> **We kind of view wellness as really integrated into the work that we do in the policy space**... Essentially, we were hearing a lot of stories about physicians who were becoming unwell or poor behavior in the system from physicians, and rather than looking at creating additional resources in a reactive way, like the professional support, **we decided to look at what are sort of the things that need to happen within the physician community to be able to change the culture amongst physicians.** So, Restoring the Joy [*their new strategic framework]* was born out of that. (DNS, emphasis added)

In Saskatchewan, physician health is a lens they apply to all their work:

> **You know when you think about almost everything that we do in terms of the programs and services we offer physicians has a physician wellness construct to it.** When you're advocating or advancing the fee for service compensation, will there's a physician health and wellness construct within that payment modality. So, even the EMR program, what does the literature say? The EMR is one of the main sources of physician burnout. So, I think we are becoming much more deliberate and thoughtful such that whenever we are thinking about what we're doing we have to put that (physician health and wellness) lens up there. (SMA, emphasis added)

As a result, MA participants reported offering a suite of services and strategies to support physician health:

> The other comment I would make if your question is meant to be broader on physician wellness, is the medical association also has a healthy working environment advisory committee and we have a framework that we work within where we've identified three main factors that we feel that advancements in would help to support healthy working environments and those are psychosocial safety, physician leadership, and equity diversity and inclusion**. And so, we have a number of different strategies underway in each of those domains or factors that we think then lead to healthy working environments, support wellness, and support the quadruple aim**. (AMA, emphasis added)

However, while MA participants may have taken a more comprehensive approach along the spectrum of health, they also recognised their own responsibility to patient safety:

> [*In response to a question on how they would describe their role as an advocate*] **I'm going to say advocacy for the client's health**. We would never advocate for the client if they wanted something that was not in the interest of their health. But we also would not take on the role of advocating for anything that might be risky for patient care. So yes, we will advocate but it's more around their health and you know, the best outcome. (AMA, emphasis added)

> [*In response to a question on how they would describe their role as an advocate*] **But it's not what we call blind advocacy. I also have an ethical responsibility to keep patients safe.** So, if physicians are not compliant, we certainly have the ability to refer them, to alert the College around that. (SMA, emphasis added)

As a result, there is a boundary with respect to how most MAs conduct their programs:

> Because our wellness program we want it to be a safe place for physicians to feel like they're not going to get sent off to the College because they are having a tough time, **but there is a line there around patient safety and protection of course as well.** (NBMS, emphasis added)

There is some nuance in the role of MAs, too. Moreover, there was some implicit nuance in the approaches and supports offered by MAs. For example, in Saskatchewan, their program's physicians act as both a governing body and as treating physicians:

> Our committee has two roles. **Number one they are tasked with oversight of the work that we do with the establishment of our philosophy, our processes, those kind of things. But they're also a treating group**. So, part of my job is to look at the expertise that's on the committee and when someone comes in to be able to match them with someone who they might fit with. So, we have an addictions medicine specialist, we have psychiatrists, we have a recovering physician in the committee. (SMA, emphasis added)

Alternatively, other MA's employed physicians who explicitly did not provide treatment, as evidenced in the following exchanges:

> [Me]: And so, sorry, just to double check there. The assessment physician, are they in some senses taking on some sort of treating physician role? AMA: **No, we don't do treatment. We refer to people who do treatment,** and that can include family doctors, psychiatrists, and some things like that. But our role is more support and navigation and helping them find their way through the system to get the best help for them. (AMA, emphasis added)

> [Me]: Yes, so, there is a comprehensive psychiatric piece but also group support, also family physicians for physicians specifically with addictions. And MDCare is more broadly psychiatry support, is that right? DMB: **Right, so, PAR isn't psychiatry. I happen to be a psychiatrist, but I'm not practicing in any way as a psychiatrist when I do that work. It's just peer to peer.** The peer support is not clinical support, if

> that makes sense. Whereas the treatment aspect of it by the psych nurse and the medical doctor with addictions training, that part is clinical. (DMB, emphasis added)

This nuance of using physicians more as peers, alongside some with some health support, was also evidenced in British Columbia and Nova Scotia, where physicians are referred to as "program physicians" or "navigators", respectively:

> So, we call them program physicians… **Every physician client or patient has the opportunity to have a conversation with one of our program physicians. So, they're not a [most responsible physician], they're not diagnosing, not prescribing medication, but because they're physicians, they do need a very detailed health needs assessment around what could benefit them, around what's the level of medical support you need right now, what's the level of functioning, do we need to triage things more urgently**. So, our physicians are there to provide a detailed medical needs assessment, and within that, going back to something I said earlier, that conversation also functions as peer support. Physicians really love talking to other physicians about their struggle. (DBC, emphasis added)

> **I refer to the PSP counselors as navigators.** So, they have that first conversation with the client, like "Hey, what's going on in your life, what are the issues you're facing?". And they can refer them, but sometimes it's just touching base and keeping in touch with that PSP counselor… But they find out like do they need help with finances? Do they need couples counseling? If it's something like they need some leadership training, and they connect with resources within DNS and those outside of the community. So, it's not just psychologist, **the PSP counselor is a navigator for all the resources that are available depending on what the issue is.** (DNS, emphasis added)

Moreover, in British Columbia, the PHP is licensed as a medical clinic, despite not offering direct treatment to physician-patients:

> So, we are licensed as a medical practice. The PHP is licensed as a medical practice.... But since were licensed as a medical practice, every single interaction with a client has to be documented and charted. (DBC)

As a result, one MA took the following approach to communicating about their program:

> We did a lot of branding, we just had a lot of collateral with their name and phone number, and that's **all we're trying to push out is whatever you need call [name] and they'll figure it out from there, instead of trying to get everybody to understand what we do and how we do it.** (NBMS, emphasis added)

Finally, like MRAs, MAs also often had a nuanced approach to outcomes of their approach, and in particular how success is understood and measured. One participant offered an alternative proxy measure for success in their eyes:

> I mean of course, we've always struggled with how you measure success with an abstract concept like wellness**.** I mean some of the ways that we have measured success is the number of self-referrals. People on their own initiative reaching out and asking for help. The fact that, anecdotally one of the things I see, and it speaks to whether your physician health program is recognized as a reputable to access for help**… Anecdotally what do I see as success? When physicians my age are reaching out to the program, because they don't do that**. (SMA, emphasis added)

And like for the MRA participants, success in this space is difficult to capture for MA participants too. A participant from DNS summarized how success measures may not actually be reflective of the change needed to achieve success in the overall approach:

> We have put metrics in place that are very minute in a lot of ways because we want to be able to demonstrate the value of the investment that is being made by DNS and CMA. But I think it's important not to lose like that strategic high-level oversight of what is it that we actually think we're able to accomplish in this system by doing this work.… **So even though we have these metrics put in place, I don't think they'll ever have significant change if it's not really connected to that strategic partnership component of doing that work... So, we have some really tiny things to measure, but at the end of the day that's not really why we're in it** (DNS, emphasis added)

Moreover, in one jurisdiction, the level of complexity was something their approach measured in and of itself, in order to assess their PHA:

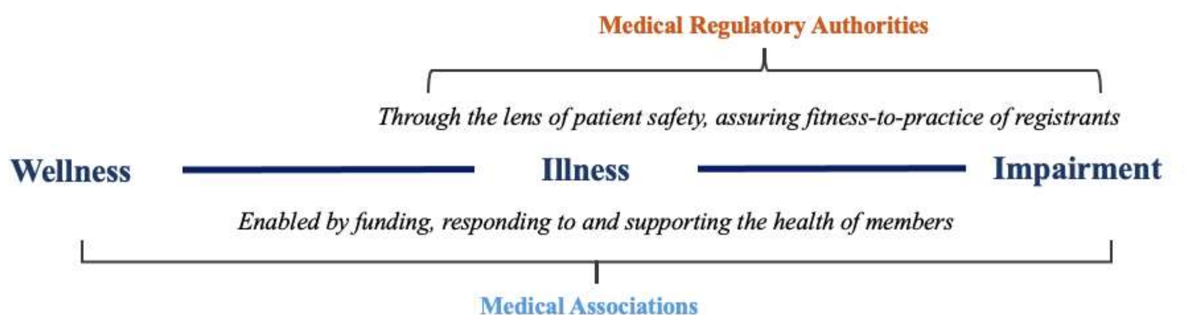
> We also collect a lot of data around complexity. So, it isn't a measure of success, but we do use a lot of measures to think about**, because what makes it tricky in the physician health world is you wouldn't want to say a measure of success is like "we closed a case in two months" because that person might have need two years of support. So, we have developed some sophisticated metrics around how we capture complexity.** And then we come up with some data analysis as a result. So, we measure things such as case duration, activities on the file. We also gather tons and tons of data that we can extract from our [electronic medical record] that measure complexity. (DBC, emphasis added)

In sum, while MAs do not face complexity in the same way as MRAs, their chief role as advocators is moderated by their ethical responsibility to patients. MAs also struggled with

defining success. Instead of feeling confined by distinct lanes, MA participants reported adopting physician health lens to all their work, enabling MAs to adopt comprehensive offerings to address physician-member needs. However, there were still limits, as except for one province, most approaches used physicians in a limited capacity or as navigators for those using their services, not as physicians themselves, which introduces an implicit level of nuance to their approach. Complexity and nuance were common threads throughout both the MRA and MA interviews.

How their Mandates Inform their Interactions with the Spectrum of Physician Health. As a result of their respective mandates, both organizations are implicated in physician health. As summarized in Figure 5, this results in two different approaches along the spectrum of health. MRAs, given their duties to interact with only part of the health spectrum, tend to be implicated more on the illness to impairment end of the spectrum. Conversely, MAs support along the continuum of health, as enabled by funding. MRAs and MAs therefore have overlapping mandates, whether legislatively or as requested by their members, along the spectrum of physician health.

Figure 5 *Medical Regulatory Authorities and Medical Associations Interactions with the Spectrum of Physician Health*



5.2.3 The Challenges of Working in a Complex System

Healthcare is a complex adaptive system. It has several intelligent actors who respond in "nonlinear" ways and often work independently towards their own respective goals, with "no single point of control" (Rouse, 2008, p. 18). This dynamic of healthcare systems is evident in physician health approaches. As outlined above, both MRAs and MAs have a clear role in the support, management, and regulation of physician health. If physicians are to receive support along the length of the physician health spectrum, MRAs and MAs often must collaborate, adding a system-level layer of complexity to their work. However, they are not the only players interfacing with physicians; workplaces and health authorities also emerged as key actor's impacting physician health.

MRAs and MAs: "Dancing" in a Complex Adaptive System. In both the MRA and MA participant interviews, the added complexity of needing to collaborate emerged as an essential theme to their respective organization's work in physician health. As aforementioned, one MRA participant described this collaboration as a dance:

> **I've described the health monitoring department as one stakeholder or one party to a dance.** There's the regulator, there's the health authority which employs or contracts physicians, and there's the [BC] PHP which advocates for physicians. The health authority is in charge of making sure healthcare happens on time, on budget, efficient, they've got the right people, so on, so that involves health issues when they arise. The PHP advocates for physicians. They've got to make sure physicians are healthy, they're the doctors for doctors, they don't call them registrants, they call them patients or clients, meaning they advocate for them. And then there's us that has to assure public safety. **We all have a part.** (CPSBC, emphasis added)

Other MRA participants highlighted the distinct lanes of MRAs and MAs, and the need for clarity between the organization's work together:

> [*When asked how the MRA's approach has evolved*] So now, really the College is about fitness to practise and making sure patients are adequately protected if a physician does have a health problem. That's clearly what the College's role is. Whereas the Association's is more around helping the physician. Now, the two are very closely linked

> obviously. Because helping the physician, generally, not always but generally, will help the patients, because a healthy physician makes for good treatment. **So, you can see the interests are very closely aligned, it's just the roles have become more distinctly defined.** (CPSA, emphasis added)

One MRA participant highlighted how an understanding of their respective roles led to an evolution of their approach:

> [*When asked how the MRA became involved in physician health*] We used to have a committee that was called… the SPARC committee, and basically what it was a committee that would assist physicians with substance abuse, and the College was part of that committee. In fact, in those days, both CEOs from both organisations sat on the committee. Which of course when you think about that... It wasn't the best setup to ensure that people self-reported.… So, that committee is now referenced as the Saskatchewan Physician Health Program. **And we work collaboratively with them, but we're arm's length from them.** (CPSS, emphasis added)

Moreover, while one MRA participant found collaboration and unity would benefit both organizations, other participants highlighted the tension collaborating on physician health may introduce:

> [*On how the approach has evolved*] And we've also done a really nice job of working with the association, so I have gone and given presentations with the head of their physician health committee. **Even though we are often at odds, because the association and the College are not always on the same page about things, with health we have really tried to be.** They are actually promoting our work and we're promoting their work as well, so, we're really **creating a sense of unity in programming,** and I think that is a success too. Because we have others speaking about our program, promoting it, and also trying to help with referrals. (CPSM, emphasis added)
>
> [*On collaboration with the MA, who provides assessments for the College in this case*] That's interesting, because you know we have had public people who said to us "**Well that's like the fox and the hen house".** But there was a formal agreement, a legal agreement, between the NLMA and the College here for substance abuse issues and it worked fairly well… **Now I do believe they are struggling to find their way. So, on one hand, they are the advocacy group, the union for doctors, representing their membership. And here they are now telling the regulatory body that they're not fit to practice, right? So, that's a bit of a struggle to find your way with that**. (CPSNL, emphasis added)

When responding to the issue of coercion in PHAs, three MA participants highlighted the theme of boundaries and needing distinct "lanes" in their approach given the challenge of physicians reporting to an MRA:

> I think it's often a challenge for people to come forward to someone who can discipline or impact their licensure. So, I think that decision that happened before my time to separate the two entities was a good decision. **That doesn't mean you don't work collaboratively at times, but people need a safe place to come to**... It's not OK to support physicians who are not well to continue either putting their colleagues or their patients at risk. **But yes, I believe it's best to have separation.** (SMA, emphasis added)

> Well, I think there has to be some separation you know, I don't envision us locking arms and going around the province promoting our program with the College in tow, per se. Because a lot of the time there doesn't need to be any involvement when physicians are having an issue whether it be a mental health issue or worried about potential addictions or whatever the case may be. **You know a physician's biggest fear is they're going to get a complaint from the College, so I think there's that side of the coin. We don't work a lot with the College**. (NBMS, emphasis added)

> I just want to say**... if the physician health program is completely intersected with the regulator, physicians are not going to phone, or not going to access care**. And it just creates interesting tension over what the mandate is for the physician health program. Is it truly to promote and protect the health of physicians, or is it to protect the general public? **And I think when it is intertwined it is very questionable.** And there is a lot of fear and uncertainty that a physician health program can be supportive. (DBC, emphasis added)

However, like with some participants representing MRAs, some MA participants found a meeting point where both organizations could work collaboratively despite these differing objectives:

> **They are the regulatory body, and we're a support body, and there seemed to be the thought that the two were separate entities pulling opposite directions.** And at this point we look at the two bodies as having different priorities. For us, the priority is support of the physician. While also needing to understand that they need to be providing safe care to patients. Whereas the College is kind of the opposite, like their priority is patient safety, but also understanding that the physicians involved need support. **And so, at this point, we work together much more closely for physicians who do have those kinds of issues where patient safety might be a concern. And both entities work to support the physician and come to some kind of plan that will be supportive for the physician while ensuring patient safety.** (AMA, emphasis added)

> So, we're trying to work with that collaboratively understanding we have separate and distinct lanes. And if Doctors Manitoba is perceived to be too cozy with the College,

> that's not going to work well for some of our members. **So, we have different mandates, but we need to find this space where we can work together to get the best outcomes for our shared population, which are physicians and medical learners**. So, that's how we work with the College. (DMB, emphasis added)

In one province, this collaboration is resulting in the documentation of the MRA's impact on the health of the MA's PHP participant for the purposes of improving the processes at the MRA:

> So now, with every single file… we actually collect pretty detailed information on their involvement with the College and the impact this has on their health, with the intention of sharing this with the regulatory College to inform their own policy work because there's a lot of opportunities there but there's never been a systematic way that physician health programs have collected data. **What they normally say is "it's stressful" but they don't have numbers or data to support it. So that is a data gathering piece that we collect, that the College knows were collecting this, that we intend to carry forward so they can change their own policies. Because there is a lot of work to be done around when a physician is disciplined or on a health leave, how they can be supported while also maintaining the interests of the general public.** (DBC, emphasis added)

It appears important therefore for both sets of participants to work collaboratively but with clearly defined roles and boundaries. In one jurisdiction, this may even result in the MA informing the MRA on how to improve their own PHA. Given their overlapping mandates, physician health may be a sufficiently common ground for both organizations.

The Impact of the Workplace on Physician Health. In addition to working collaboratively together, both MRAs and MAs highlighted an additional stakeholder implicated in the dance around physician health: the workplace. A physician's workplace, and the resulting role health authorities in Canada play in the workplace, emerged from both sets of interviews as an important consideration for both stakeholders:

> **It really is important to give at least some consideration to the health authorities, they can drive a lot of the frustration and concerns physicians have**. Whether it's how the system is performing overall, the relationship with senior management in the health authority, and then there are disciplinary matters relating to the physicians privileging, that can certainly be a stressful time for any doctor... (CPSNB, emphasis added)

Participant representing MRAs emphasized that they were dependent on health authorities for getting a physician back into practice, and for two MRAs this was described as a significant barrier. As the MRA participant from Saskatchewan stated:

> We have not had a person that's been impaired in this province, that has never gone back to work. We've been able to monitor them, we've been able to get whatever treatment support they need to put them back in and support them but oftentimes, what they say is look, **"you may have burned a lot of bridges in your work environment with bad behavior over who knows how many years before you finally got caught doing something".** So, the reason I sit with them, and if it's also somebody who works within the regional health structure, I also have the region come and join us. And so, they will have an undertaking with health program to sign, they'll have one with me to sign, and they'll have one with the region. But we all sit down and say is this going to work? **Because sometimes the environment is toxic, and they burned their bridges and even if they are fit to practice and we pop them back into that same practice, they will fail, because they will not get that support**. (CPSS, emphasis added)

This same sentiment was echoed in New Brunswick:

> So, one of the challenges is the relationship with the [regional health authorities] … So the biggest challenge is when you provided all those resources, and the physician has completed successfully the treatment plan, and we assess their fitness to return to work, **from the employer's perspective there's a bit of resistance, right? Because that relationship of trust has been broken. They had an employee who was supposed to be fit to be at work, and then for some reason had developed this diagnosis. So that relationship is broken, and it's about educating the employer about how to rebuild that relationship so they can welcome back this employee that they need in a safe way.**.. But that's probably one of the biggest challenges for the physicians who are ready to come back and the resistance from the employer… (CPSNB, emphasis added)

One MRA acknowledged that like the College, the health authority had their own jurisdiction and was empowered to exercise that right:

> And we draw fences. I can't ask them to do my job. I can't ask them to pressure the doctor to inactive their license, as an example. Similarly, I tell the health authority "I'll look into health, not going to tell you anything specific about that doctor, and when we determine that this doctor is healthy, we're going to certify that the doctor is healthy and then it's over to you. **But just because we give them a license doesn't mean you need to give them a job. You've got your power, you've got your jurisdiction, you've got your authority. You guys run with that**". (CPSBC, emphasis added)

Another MRA has found a different approach to addressing system level issues arising from the health authorities' scope of power:

> [*On collaboration with other stakeholders than the MA*] Now there's informal conversations that go on between the College and the regional health authorities about various issues, so often in the course of dealing with either a quality assurance issue or a complaint issue there are systems problems that contributed to that. For example, the quality issue. You might have a physician with burnout, but when we look at the workload that that physician had in their regional health authority and the amount of time they were on call and supports that were available, we recognize there's a huge system issue here. What we've recently started to do with that is when we identify a systems issue, we ask the chair of the council to take it to council, and we have the council discuss. And then the chair writes a letter to the regional health authority saying we have identified a systems issue here that we think you might want to consider… **we were going to put full weight of the whole council, which is public and private members behind it, and so that's really how we handle that now on the system side.** (CPSNL, emphasis added)

While MRAs highlighted the role of workplaces in influencing individual physician health files, MAs more often cited the system-level impacts of workplaces on all physicians. For some MAs, occupational issues were among the top reasons physicians needed support:

> …The struggle with the PSP which has been the flagship position health program for such a long time is it focuses on the individual. And we track what people are calling in for and the vast majority **I believe it's over 60% is occupational. And it's conflict with other professions, some physicians with physicians, some physicians other health care workers, but if you dig down deep into what people are saying, a lot of it is just the burnout, the tiredness from the system**. (DNS, emphasis added)

For many MAs, this is what lead them to developing leadership supports for their physicians to begin effecting the healthcare system. As requested by the physicians in PEI:

> What our members were telling us was "**Help us to understand how to advocate for our patients, and for ourselves more effectively within the health system…** because we have so many irritants in our day-to-day workplace and so many barriers to being able to do what's right for our patients that we need to find a better way of doing things". (MSPEI, emphasis added)

Finally, another concern highlighted by participants representing MAs with respect to the workplace was the need for equity, diversity and inclusion (EDI) support in approaches to PHA. As one participant stated:

> [*On what success looks like for the MA*] In my mind success will be when [physician wellness is] seen holistically as something that serves the system when we all do this work, and we integrate it into our business plans in our strategic plans in a very

> intentional way… And then EDI also becoming... you know this work that we're doing adding this EDI lens as well to everything we're doing, and that work is never done. And we know in Nova Scotia with the number of international medical graduates who come here every year, that's a particular area of focus where the system needs to support those physicians better on wellness. **Racism is alive and well, and that's a cause of burnout and disengagement and unwellness. So, it all fits together, right?** (DNS, emphasis added)

As a result, in response to their member's needs, most MAs have developed plans or found avenues to respond and improve workplaces, particularly with request to equity, diversity and inclusion (EDI):

> The systemic issues that are making physicians unwell, the rules, the policies. **We're now integrating some recent work around EDI, because the link between equity and discrimination and physician health is very significant**. Half of our physicians in this province are racialized. They are international medical graduates, and they are racialized components of our membership. (SMA, emphasis added)

In sum, given their essential but distinct roles in physician health, MAs and MRAs often work together. Having clear boundaries and scopes of work was reported as an enabler of effective relationships. The role of the health authorities and the workplace also emerged as a critical enabler or hinderance for physician health. Moreover, as highlighted in the following, there are additional stakeholders like the Canadian Medical Protective Agency (CMPA), physicians conducting assessments for the program, and even the physician themself, that are also implicated in physician health work and may present challenges:

> **Most often, the most important collaborator is the physician.** So, the physician, if there's a complaint against the physician and we want to pursue it through the lens of physician health, that requires the consent of the physician. That's an important piece. Assuming we get the matter under the umbrella of physician health, I'm very mindful of the College being the regulator, the big bad wolf. And the apprehension or the distrust the physician may have of us. So, we always do our best to connect the physician with Doctors Nova Scotia which has a Physician Support Program. Similarly, if we are regularly encouraging the physician to get the support of the CMPA, because that will help as well. And then oftentimes we have to reach out to members of the profession to provide assessments, evaluations, right? They are under no obligation to do so…**And sometimes insight gets in the way…** [*I asked, did they meant insight on behalf of the physician?*] **Yes, the dementing physician may not know they're dementing, the alcoholic physician may not have come to terms with that.** (CPSNS, emphasis added)

Working in a complex adaptive system evidently adds additional complexity to the nuance of working in physician health.

5.2.4. The Role of Stigma and the Culture of Medicine

A final theme shared between both participants representing MRAs and MAs was the role of stigma in the context of medicine. For both groups of participants, stigma included both societal stigma and the internal stigma from individual physicians and was intertwined with the culture of medicine:

> Stigma is very difficult to manage because **often it's the stigma you have within yourself that is really the most too difficult to deal with**. Societal stigma in some ways is just teaching people to ignore it. But physicians really come with a pre-baked need to be tough and healthy, and not be weak. And changing that mindset is incredibly difficult. **And so, if they do develop a health problem, that they often themselves feel considerable shame around it somehow, they're not worthy to be physicians anymore.** (CPSA, emphasis added)

In addition to being "pre-baked" with the "need to be tough and healthy", as found in the literature, the training for medicine also teaches physicians this internal stigma:

> **It's pretty enculturated in the training for medicine that no one under any circumstances puts up their hands and says they're not OK.** So, we have been teaching people from an early stage of training that this is just not something that doctors do. You help everyone else you don't help yourself. (CPSM, emphasis added)

This stigma and culture directly impacts PHAs. As two participants highlighted, the impact of stigma on mental health conditions like addictions is a barrier to the successful implementation of the PHAs and a perpetuator of physician unwellness:

> [*In response to "what's next" for your approach*] … I do hope, and this has been my goal for the past 32 years so not very original, but to educate more people about the disease. It's not a choice, people don't want to have this diagnosis, and we need to get the employer to be more acceptive and supportive**. Because if you're diagnosed with cancer, you will get a lasagna at your front step every day of the week. If you're diagnosed with substance use disorder, you won't even get a card.** No one is supporting you. Because it is seen as a shameful disease, so I guess my goal is to continue to create awareness for those responsible and for those stakeholders that are very important. (CPSNB, emphasis added)

> It is about challenging some of those things about stigma. No one hesitates to go to the hospital if they're having chest pain, but heaven forbid you should go there if you have a mental health issue. **Or when someone has a physical health issue, we send flowers, we send cards, we welcome them back with cake and a party when they come back to work**. **But for mental health they slink back into work, and no one says boo because somehow, we're going to embarrass them because they don't know they have a mental health issue.** We are beginning to make some changes in that but it's twofold it's the external stigma and it's the internal stigma and those are difficult things to address. (SMA, emphasis added)

This culture can have staggering impacts, as one MA participant shared in the following anecdote from their work that highlighted the impact of collectively denying physicians the opportunity to be human:

> I know I've said it before… but one of the poignant things that happened is when a physician was brought to us because of an alcohol addiction, and the first time I met with them the first thing they said to me was **"What took everybody so long to care about me?"** So, this is somebody who had been drunk for the last five years at work... Everyone knew and no one said anything, because they didn't think it was their business. So, they let this person struggle and **that's part of that whole stigma that we don't allow physicians to be human and to have those struggles and to have to support them**. (SMA, emphasis added)

This culture among physicians to turn a blind eye to another physician's struggle, despite their responsibilities to each other as colleagues, was highlighted by most MRAs.

> [*On how they support physicians back into practice*] And then once you're ready to come back to work, then we sit down, and we decide how are they going to be monitored or monitored in the workplace. Because you'll find as you talk to physicians across the country if they do this work**, physicians are not very kind to each other. They look the other way**. (CPSS, emphasis added)
>
> And [another person] said it well earlier this week. They have seen colleagues struggling and didn't know what to do. So, that's kind of what I'm trying to say, is that not saying anything is the worst, not only for the person who is suffering in silence but also for yourself because they feel the guilt for years to come; "I should have done something, and I didn't". So not only are you helping someone who's in need of help, but you don't want to carry that guilt for the rest of your life…. **Sometimes the physician feels that "I'm not going to get involved it's too complicated and I don't want to be seen as a rat", there's all kind of reasons why there's barriers to address those difficult conversations, but at the end of the day it's in your oath and we have to apply this to the colleagues next to us**. (CPSNB, emphasis added)

Alternatively, the culture in medicine may also contribute to a conflict of interest, or bias, against regulators that impedes their ability to support physicians, as highlighted by one MRA participant:

> A conflict of interest arises when a party has a reasonable apprehension of bias. That's what a conflict of interest is. And there is a broadly held apprehension of bias across the medical profession that the regulator is out to get them. **So, the central conflict of interest is they think we're out to get them, and really won't believe me when I say "No, we want to help you".** So, if you really want to talk about conflict, that's the true conflict… (CPSNS, emphasis added)

In response, some participants reported having developed communication styles to address concerns at the individual and physician population level. For the MRA participant in Manitoba, addressing stigma in medicine has become part of their program's mandate:

> Well, I think in terms of the elements of stigma and shame, we work harder now to acknowledge that... **I think it's been part of the mandate of the program to raise awareness and to recognize that health issues can be dealt with in a compassionate, respectful, dignified way that still enables individuals to practice to the best of their abilities and can give them space to focus on their own healing**. (CPSM, emphasis added)

This was similarly important for the MRA participant in Nova Scotia:

> You shouldn't be disciplined for being sick. **But building a culture within our program and a style of communication that the physician knows that this is not about discipline, that's something we have to do on a regular basis.** Because people come to the program with the perception that we are only in the business of discipline. So, you're not completely wrong to use the word stigma because **the physician in the culture of medicine conflates illness with malfeasance, so that's fair**. (CPSNS, emphasis added)

However, for other MRA participants, the impact of the culture of medicine was not exclusively negative. For two MRAs, the culture of medicine could also facilitate success in their approaches and meant physicians willingly worked "really hard" to "do the right thing":

> Very, very, very few doctors pull on their socks in the morning and say, "I'm going to go out there and… hurt people or I'm going to go out here and be a menace". They don't. They really do care. And when you tell them, "Look, you really do have a substance use disorder, and you really were impaired that day you showed up the OR". Or "you know, your chemotherapy is giving you brain fog to the point where your heads not in the

> game”, and they get it. **And so, doctors really do strive to do the right thing. And they tell me I want to work with you, because I want to show the whole world that I am doing my utmost and I never want to put patients at risk…So, I’m happy to work with your program because it’s a testament that I can work safely.** (CPSBC, emphasis added)
>
> [*On first engaging with a physician*] But once they understand this is the way to get back to their passion, physician who love their job will do everything they need to get better so that is why we have 100% success. Because we can assist them with their ultimate goal… **That's probably why I have good statistics so far because we have physicians who are working really hard. And when you give homework the physicians, they really try, they want to be the best, so they do well**. (CPSNB, emphasis added)

Similarly, for the participant from CPSM, appealing to a physician’s desire to do the right thing was important to their approach:

> We had one last week that was, suddenly just said “I can't do this anymore and I've known for months now that I've on been on the edge, and I'm done”, and just saying you know it's OK to not be OK and you're doing the right thing. Reinforcing the self-regulation component, I think that's a big way that we get around this. It's part of your professional duty, you are doing the right thing, this is absolutely the right thing that was supposed to happen. **Doctors like to be told they are good, so I think connecting the dots about you have actually, even though you feel terrible and otherwise because you feel awful and you're not functional, you did the right thing, or this is the right thing, this is how it's supposed to work, this is a requirement…** (CPSM, emphasis added)

Conversely, where MRA participants reported ways to use the culture to their advantage, MA participants focused on normalizing help seeking behaviour using profession-wide communications or outcome measures:

> [*On the different ways their program will evolve*] The other level is people who may have an awareness but maybe don't even having awareness about their own health, and how that's impacting them. I mean physicians are notoriously late to seeking care for their own health, **and we want to normalize help seeking behavior and try and start to address that fear of reprisal, whether it be from your attendings if you're a resident, or from the medical school if you're a student, or from the College. So, how can people seek care and not be ostracized by their peers, not have their license taken away from the College etc.… It's not like one poster campaign will solve this issue, but that relentless constant pressure slowly overtime might make change.** (DMB, emphasis added)
>
> And sometimes you hear well wouldn't your ultimate outcome want to be a reduction in these services? And it's almost like patient safety, you want to see more patient safety issues illuminated because of again it's normalizing that it's OK to have unsafe practices

> and to address then to bring them to light. It's the same thing so, again [name] is incredibly diligent at tracking the utilization and referrals and where they're coming from. **So the referrals piece and I think it's a really good outcome that says we're starting to normalize or destigmatize, help seeking behavior**. But again, they (outcomes) are not always easy. And their proxies. **But ultimately that's kind of what you want to see. You want to see behaviors from physicians that are signaling that these programs are doing what we want them to do.** (SMA, emphasis added)

Ultimately, the convergence of stigma and the culture of medicine was neatly summed up in the following:

> Well, I think we are often challenged sometimes by stigma on two fronts. **Stigma from the external worlds around a mental health and addiction issue, but also the self-stigma physicians have about having these issues, because part of their training, there is no permission to have these issues**. I think there is a fallacy out there, and all the resiliency in the world doesn't protect you from mental health or addictions issues. And physicians often think that they can simply outsmart these things. That somehow recovery is a cognitive exercise. **And so yes, we do need to work on that, and part of that is pushing against those old myths, and that old culture of medicine messages.** (SMA, emphasis added)

Stigma and the culture of medicine directly impact PHAs. Participants reported physicians taking years to get help and confirmed the culture of gaze aversion among colleagues. Where the two groups diverged was with respect to how to deal with this culture. Some MRA participants reported using a physician’s desire to do the right thing and work hard to their benefit, whereas MA participants attempted to normalize help seeking behaviour. Nonetheless, both sets of participants agreed the stigma and culture of medicine is a significant barrier for their approaches, and one that is deeply entrenched in the profession.

5.3 Summary of Phase II Findings

Participant interviews shared the same thematic arc: working in physician health was required of both MRAs and MAs but presented significant complexities on multiple levels. Most of the MRAs and MAs interviewed referenced the decades their organization has worked in physician health. For MRAs, this work derived from their legislated duties to protect the public.

For MAs, they were responding to member's needs and driven by the availability of funding. Explicit in some of the MRA and MA transcripts was the impact of the individual on the how and when the organization approached physician health. For some MRAs, they approached physician health through the lens of their clinical background. For most MAs, it was an individual or group of physicians who brought or helped the MA's approach evolve.

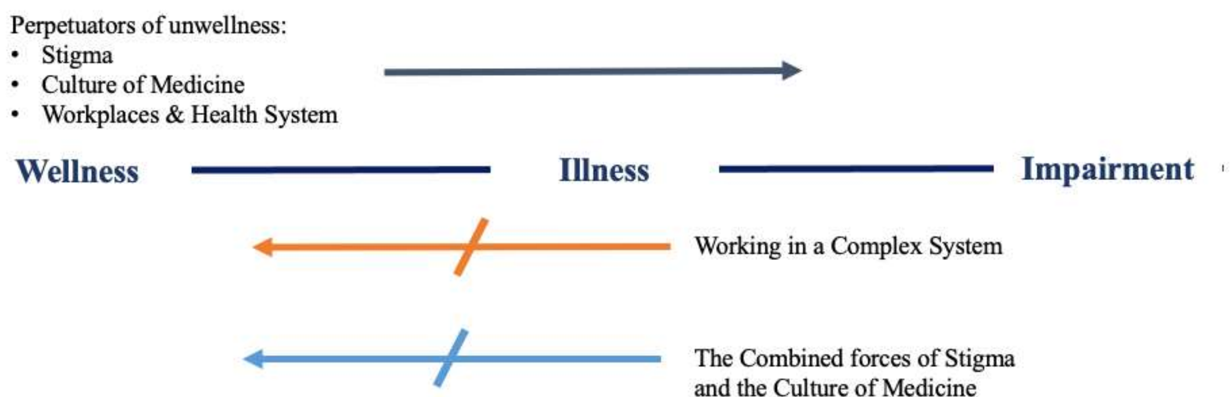
However, despite the clarity in mandate for MRAs and MAs, both organizations struggled with complexity in delivering their PHAs. For MRAs, connecting physician health and patient safety required them to be judicious and balanced, a code identified in Phase I. Only one MRA felt they had "nailed" this balance, while most struggled or were challenged by the nuance demanded in PHAs. Complexity also impacted how some MRAs communicated about their program, how others contemplated approaching physician-population interventions, and how most conceptualized success. MA approaches featured similar levels of nuance. While MAs had more freedom to support physician health along the spectrum, they also were qualified in their approach by their own responsibility to patient safety, and their operations often featured some nuance given their role as a member association. Only one MA delivered treatment under their construct of PHAs, the remainder used physicians as peers or navigators for those physicians they were supporting. Some MAs also struggled with measuring success, given the abstract concept of wellness and the inability to directly measure the indicators that matter most, such as changes in the culture of medicine towards physician illness.

Added to this complexity is the difficulty of the context of medicine, including the challenge of working in a complex adaptive system, the context of stigma and the culture of medicine. MRAs and MAs must often collaborate and do so with the benefit of boundaries and defined "lanes" within their work, and a clear point of shared meaning. However, MRAs and

MAs are not the only organizations that impact physician health. Both organizations highlighted the impact of workplaces, under the authority of health authorities in Canada, on physician health. Workplaces were a barrier to physicians returning to work, and as two MAs cited, were among the top reasons physicians needed support. Thus, most MAs had developed approaches to improve working environments, including with respect to equity, diversity and inclusion.

A final theme shared between MRAs and MAs was the role of stigma and the culture of medicine. These forces were intertwined. MRAs and MAs both reported physicians experience both societal and internal stigma, and the culture of medicine which MRAs and MAs reported denies physicians the opportunity to be human. One MRA highlighted the bias of physicians against MRAs. In effort to combat these forces, MRAs emphasized support in their communications to individuals or used the culture of medicine to their benefit. MAs emphasized profession-wide communications. Ultimately however, in addition to the challenges of working in a complex adaptive system, the culture of medicine contributes to the level of stigma, which keep physicians in a state of unwellness.

Figure 6 *The System Level Perpetuators and Limiting Factors to Supporting Physician Health*



CHAPTER 6: DISCUSSION AND CONCLUSION

This chapter concludes the thesis by first summarizing the main findings in Phase I and II, placing these findings in the context of existing literature, evaluating the limitations of the study, and finally, highlighting the implications for PHAs in Canada going forward.

6.1 Summary of Main Findings

This thesis explored PHAs in Canada in effort to describe the diverse approaches to physician health, the perspectives on the issues related to physician health, and the outcomes of these approaches. Phase I offered a foundational summary of the current approaches provided by MRAs and MAs in Canada and alluded to some perspectives on physician health. Phase II further explored the approaches of MRAs and MAs in semi-structured interviews, illuminating more clearly their perspectives on physician health.

6.1.1 Phase I

The objective of Phase I was to comparatively describe the stated services of PHAs and perspectives on physician health in Canada using quantitative and qualitative content analysis. An analysis of the publicly available content on MRA and MA websites across Canada was conducted. Content was identified and extracted into a template based on the PHA components identified in the literature, such as oversight, confidentiality processes, and monitoring regimes (Bailey and Jefferies, 2012; Federation of State Physician Health Programs, 2019). A total of 258 documents were identified and their relevant content extracted into the corresponding components for 20 organizations, 11 MRAs and 9 MAs. No content was available for the MA in the Yukon, the MRA in Nunavut and both the MRA and MA in the Northwest Territories. The quantitative content analysis revealed that despite the number of documents referencing

physician health across these organizations, no approach comprehensively referenced every component identified in the literature.

The qualitative content analysis was categorized into two sets of codes: codes describing the approach and codes speaking to a perspective on physician health. MRAs and MAs shared five main codes when describing their approaches: confidential (used by n=17 total, 9 MRAs and 8 MAs), supportive (used by n=16 total, 8 MRAs and 8 MAs), preventative (used by n=16 total, 9 MRA and 7 MAs), collaborative (used by n=11 total, 5 MRAs and 6 MAs), and interventive (n=9 total, 2 MRAs and 7 MAs). In addition, specific to MRAs was the use of mandate or Duty (n=10) and the related code of being balanced or fair in their approach (n=7) as a result of their mandate. These codes mainly derived from the content related to the overall approach but were also embedded in their descriptions of their approach components. Administrative components were often described as supportive, and some operational components framed approaches in relation to risk and patient safety. Partnerships were spoken of collaboratively, whether between MRA and MA or the MA and other stakeholders at the provincial and national level. Outcomes were reported by 11 organizations in total, with emphasis on number of physicians kept in practice or more detailed statistics, depending on the provider.

Phase I also highlighted some emergent perspectives of MRAs and MAs on physician health. Physician health was often positioned with its impact on patient care (used by n=12 organizations total, 7 MRAs and 5 MAs), on patient safety (used by n=8 total, 7 MRAs and 1 MA) or to the health care system (used by n=9, 3 MRAs and 6 MAs). There were different conceptualizations of health across the content. Most referred to health as an issue or challenge (n=14, 8 MRAs and 6 MAs), while only MRAs referred to health as a neutral condition (n=6). Contrastingly, all organizations referred to physician health under the umbrella of wellness.

Finally, there were some discourses on risk in the content (used by n=16 total, 10 MRAs and 6 MAs. Risk was embedded in some operational components (monitoring, assessments and wellness) but was also used in relation to patients, the physician themselves, and certain conditions. BBVs and substance use disorders were characterized as risky conditions, either framed by risk or described as such. In sum, Phase I provided comprehensive foundation of the approaches adopted by MRAs and MAs to physician health and highlighted some initial themes in how physician health is perceived by MRAs and MAs in Canada.

6.1.2 Phase II

The objective of Phase II was to further understand the approaches and perspectives of these two key stakeholders on the topic of physician health, and how these perspectives have informed their approach to and the outcomes of their PHAs. Semi-structured interviews were conducted with the 14 organizations (7 MRAs and 7 MAs) that responded to the invitation. Some interviews were held with multiple participants, for a total of 23 participants, with 10 senior leaders represented (Chief Executive Officers, Registrars or Assistant Registrants) and 13 Directors or Managers. The interviews were transcribed and analyzed using the tenants of reflexive thematic analysis, with emphasis on shared meaning. MRAs and MAs were coded separately, and then themes were generated and refined based on the themes shared between the two groups.

There are layers of complexity in physician health. Both MRAs and MAs are both implicated in physician health. For MRAs, this derives from their legislated mandate, and for MAs this comes from their need to respond to their members. However, their respective mandates and roles in physician health result in nuanced approaches. MRA described their approach as judicious and emphasized the need to balance their overall regulatory objectives.

This need to be balanced also impacted how MRAs felt they could communicate about their program, work to prevent poor physician health, and define success in their approaches. Contrastingly, while MAs were free to support along the continuum of health, they were still moderated by their professional responsibility to patient safety. Moreover, given treatment was outside their scope as an organization, there was nuance in MAs approaches too, as they employed physicians to serve as peers or system navigators and not treating physicians. Like MRAs, MAs also struggled to define and measure success.

Moreover, MRAs and MAs are working in a complex adaptive system. Stigma, the culture of medicine, as well as workplaces and the health system as a whole all contribute to physician unwellness and keep physicians in a state of poor health. However, MRAs are limited in their response to these factors given the fear of discipline and their need to protect the public. MAs are better positioned to support along the health continuum; however, they are limited by the entrenched culture of medicine, the stigma, and the limits of their own sphere of influence. Thus, while there is clarity in the role MRAs and MAs must play in supporting physician health, there is a distinct lack of clarity on how best to approach physician health in Canada.

6.2 Findings in the Context of Existing Literature

This section considers the findings of Phase I and II in the context of the literature on physician health, from how physician health was described, to the actual approaches adopted by PHAs in Canada, and finally the issues identified related to PHAs.

6.2.1 Discourses on Physician Health

The literature review highlighted two divergent narratives in physician health. For most physician health concerns, a physician who is unwell or ill is somehow lesser than other

physicians, unable to overcome the illnesses that normally afflict their patients. The ideal physician is one who places their work over their own wellbeing. Conversely, bloodborne viruses (BBVs) introduced risk and moral dissonance to physician health, given the association of BBVs with behaviours society deems ‘deviant’. A risk reflects both a statistical probability and the moral or symbolic implications of the act (Webber, 2016). Phase I and II touched on both of these discourses, with Phase I highlighting the discourses on BBVs and both Phase I and Phase II reinforcing the complexity associated with being an ill physician.

In Phase I, the role of risk and particularly the emphasis of risk in BBVs was evident. Dedicated BBV policies persisted across the country, and in the case of the oversight, quality assurance, confidentiality, reporting, and referral to treatment, the content from some jurisdictions was solely related to BBVs. The components identified for Phase I represented what the literature considered best practice (Bailey and Jefferies, 2012); Federation of State Physician Health Programs, 2019). Therefore, one interpretation of these findings is that BBVs enjoy best practice approaches to physician health. However, in the context of the risk-laden perspectives associated with BBVs in the second part of Phase I, a more likely conclusion it the heightened rigour is in response to the perceived risk associated with these conditions, as opposed to a desire to treat these conditions ‘best’. As stated in Chapter 2, only 5 transmission events have occurred globally since 2010 (Henderson et al., 2020).

Both Phase I and II addressed the concept of the ill physician. In Phase I, most organizations (n=14) referred to health as an issue or a challenge. Only MRAs used neutral language like “condition”. All organizations used the broad concept of wellness. These varied frames for physician health present a conflicting picture of how health is conceived for a physician by MRAs and MAs. Health and poor health were more likely to be referred to as a

negative or a positive, than simply neutrally (i.e. just a facet of life). In Phase II, reflective of the discourses in the literature were the MRAs and MAs descriptions of the internal stigma in physicians. The tension identified was neatly summarized in the quote from CPSA:

> But physicians really come with a pre-baked need to be tough and healthy, and not be weak…And so, if they do develop a health problem, that they often themselves feel considerable shame around it somehow, they're not worthy to be physicians anymore.

That sick physicians feel unworthy of their role is striking. Evidently the timeless themes in the discourses on physician health persist today, despite both MRAs and MAs working in Canada to support ill physician. And in some provinces, for decades.

6.2.2 Physician Health Approaches in Canada

The literature review highlighted three models for approaching physician health: one driven by the MRA with some collaboration with the MA, one provided solely by the MA, and one provided by a third party through contract with the MRA and/or MA. Notably, no third-party model exists at present in the current approaches to physician health in Canada. Instead, most provinces adopted the second model, where both the MRA and MA deliver physician health services. Ontario and Saskatchewan appeared to be the only province adopting the first model, with a primary MA-led PHA. In the remainder of the provinces, collaboration varied across provinces, with some less than others. In the absence of comprehensive outcome data from Phase I or Phase II, it is difficult to determine which approach is most effective. Thus, within the Canadian context, PHA models largely lie on a spectrum ranging from collaborative to more independent approaches, with some provinces providing PHAs exclusively through the MA.

6.2.3 Issues in Physician Health Approaches and the Context of Medicine

Within the literature, four key issues were identified in the topic of physician health. Firstly, PHAs may be coercive given the pressure applied to physicians to participate,

particularly from MRAs. Secondly. PHAs may be stigmatizing either by conflating illness and impairment, or in their approach to certain illnesses. A third set of related issues stem from the lack of due process, oversight and the potential for conflicts of interest. Finally, the inter-related role of self-regulation and the culture of medicine as a barrier for PHAs was a key issue identified in the literature. The findings in Phase I and II in relation to these issues follows.

Coercion was examined in this thesis in Phase II. The interviews offered no great insight into the issue of coercion in MRA approaches to physician health. The constant response to the question of coercion from MRAs was that although it likely was true, they had to do this work even if it was a barrier to these programs being successful and if it infringed on the physician. The primary mandate to protect the public, the need to find a balance between the duty to the public and the rights of physicians, were all echoed in the interviews. One MRA neatly summarized it by describing the tools of the regulator as blunt, which limits their ability to cut through the issue with nuance. For some MRAs, it was personally conflicting for them, but was justified through their mandate. For others, it was simply the reality of the job and nonetheless their responsibility. MAs acknowledged that the fear resulting from needing to report was a barrier, and further reinforced the need for MRAs to be judicious in their approach to physician health. One MA is going so far as to document the negative impact of the MRA on the health of their PHP participants, for the purposes of informing the MRA on how to improve their processes.

Phase I and Phase II touched on the two aforementioned aspects of stigma. Beginning with the issue of illness versus impairment, in Phase I, the determination of fitness to practise by MRAs was underpinned by the risk to patients. When asked directly about this in interviews, some MRAs called upon their clinical background and their commitment to distinguishing

disability and diagnosis. Others re-emphasized the importance of using experts to distinguish where along the health continuum the physician lay. Both MRAs and MAs highlighted the role internal stigma plays in the experience of whether a physician feels stigma, and how societal stigma and the culture of medicine compound these effects. However, absent from the study was the voice of the physicians themselves.

With respect to the stigma towards certain illnesses, in Phase I both SUDs and BBVs were framed in relation to risk in the content from MRA and MA. Risk in the context of BBVs was discussed above, however risk in the context of SUDs was not identified in the literature, although an apparent concern for MRAs and MAs. In Phase II, references to BBVs were limited. Responses to the question of stigma towards certain conditions detailed the role stigma plays in PHAs in general: at the societal and individual level, perpetuated by the culture of medicine. Specific references were more often made to substance use disorders. Substance use disorders where the reason one MA became involved in physician health, were a point of collaboration in another, and the specific manifestation of stigma towards substance use disorders: physicians “slink back into work” with no support from their physician colleagues. It appears whether by omission or distinction, there is a persistent stigma towards these two conditions in PHAs.

Both Phase I and II spoke to specifically the aspect of fairness within their processes, and Phase II addressed the issue of conflicts of interest. In Phase I, while most MRAs and MAs had oversight by committee, only some MRAs or MAs touched on components like quality assurance (outside of references to BBVs), had detailed confidentiality processes, and outlined their approach to determining assessments or monitoring agreements. While these processes may exist but were simply not referenced online, there is a lack of transparency and accountability when these processes are not in the public domain. Moreover, given the need to balance the

considerations of the physician and the fear they face when reporting or seeking help, more information available to them about how a MRA approaches physician health would likely be of benefit. In Phase II, the detailed accounts of their processes alluded to more due process than is evident in the content online. Moreover, Phase II participants also addressed the issue of conflicts of interest or bias in PHAs. One MRA participant highlighted that it may be difficult for MRAs with in-house approaches to keep the boundaries of health and discipline, but another emphasized that the more relevant bias in PHAs may be held by the physicians against the MRAs, as opposed to within the MRAs against physicians.

The Phase II findings and the complex relationship between medicine and stigma further entangles these topics. The interviews repeated the findings that medicine encourages stoicism and restricts a physician's ability to succumb to the illnesses of their patients. It appears medicine further perpetuates societal stigma such that physicians embody the stigma themselves. The narratives of physician-patients highlighted in the literature may be a proxy of this internal stigma pervading medicine, as they attempt to reconcile or communicate their unique experience of being an ill physician. Fear is also raised in the context of medicine and stigma. Evidently, the experience of physicians in PHAs is fearsome, considering both the societal fear and shame related to illness, as well as the fear of reporting to their MRA and losing their license and livelihood. The voice of the physician is missing from this thesis and should be considered in future studies.

6.3 Challenges and Limitations in the Study and Implications for Future Studies

This section highlights the challenges and limitations in this thesis. As stated in Chapter 3, I undertook this academic research upon request from the College of Physicians and Surgeons of Nova Scotia (CPSNS) as part of a wider contract looking at physician health. Although I was

granted freedom in this work and was not knowingly influenced by the opinions of CPSNS, approaching this project the perspective of needing to apply the research back to my work presented three challenges. Future research should consider these challenges and address the gaps left behind.

I pursued the research of both MAs and MRAs after my initial literature review revealed the importance of both stakeholders. However, my dual role with CPSNS meant I came to every interview having previously stated my relationship to a MRA. With MRAs, this served to as a catalyst to rapport. With MAs, more time was needed in the outset to explain why I was interviewing MAs. Moreover, it became clear in Phase I and was reinforced in Phase II that MRAs and MAs should be considered distinct. Aspects of their approach specific to MRAs or MAs were not explored in depth, such as an analysis of the content within each duty to report in every province and territory for MRAs, or a comprehensive evaluation of the suite of wellness offerings provided by each MA. Future research should consider MRA and MA approaches distinctly in order to better understand these gaps and further analyze their outcomes.

There was also a persistent tension in my attempt to treat of BBVs as a physician health condition. My intention to include BBVs on the physician health spectrum and un-do the othering these viruses have been subject to was rendered moot in many respects. In my Phase I pilot, I needed a dedicated catchall for references to specific illnesses to capture nuanced policies relating only to BBVs. The distinction made for these viruses by the organizations I was studying limited my ability to consider the content related to BBVs alongside the other physician health content. Moreover, given my active role in the field, I felt unable to effectively challenge my peers on their basis for continuing with such differential treatment. Future research may therefore consider analyzing the approach to BBVs in Canada separately and compare these processes

against the broader approaches detailed in this thesis. This will serve to further understand how this physician health issue is treated and highlight the differential treatment seropositive individuals and physicians are subject to.

Finally, the need to apply this work back to CPSNS meant I was limited by the perspectives I could explore. It was evident in Phase II that MAs and MRAs work in a complex adaptative system. Workplaces and health authorities also have a critical role to play when it comes to physician health. Other third parties, like the Canadian Medical Protective Association (CMPA) also have a critical function in this space. Future research should explore the interface between PHAs, workplaces and the CMPA and elaborate on how these environments contribute to poor physician health or limit the PHAs of MRAs and MA. This study was also unable to consider the experience of physicians in PHAs themselves. Given they are the ones the literature says experience coercion, stigma and unjust practices, a qualitative inquiry into their experience is warranted to better understand how these impact physician participants of PHAs.

6.4 Implications for Physician Health Approaches in Canada

PHAs in Canada face significant complexity. MRAs and MAs are implicated in this work, but in a complex adaptative system neither can serve as a complete solution to the issue of physician unwellness, illness and impairment. No clear best practice model emerged from either Phase I or Phase II. Moreover, in Phase II, only one MRA felt they had found the right balance in their approach. The absence of outcome data, whether in their publicly available documents or in their interviews contributed to this conclusion and meant one of the aims of the thesis was not met. Nonetheless, in the absence of best, there were some key takeaways in the approaches, in particular the impact of individuals, collaboration and communication. There are also some important implications around funding and outcomes that MRAs and MAs may consider in their

future approaches in order to address the complexity and improve their approaches, for the benefit of both the provider and physicians.

6.4.1 The Impact of Individuals

Phase II highlighted the importance key individuals play amongst MRAs and MAs. In both MRA and MA interviews, participants either explicitly or implicitly highlighted the role individuals have to play in shaping the approach adopted by the organization. Beginning with MRAs, the role of individuals was indirectly highlighted as program leaders discussed how their clinical backgrounds informed their approach to physicians entering their programs. Those with a background in family medicine relied on relationships and considered the "whole person" in their evaluations. Those with a background in occupational medicine approached physician health through a functionality lens, neatly divorcing diagnosis from disability. While in the absence of outcome data there is no way to know whether one background or another is preferred, MRAs should consider the impact of the background of those working directly in their program.

In MA interviews, overwhelmingly the direct actions taken by an individual physician or a group of physicians was the catalyst for MAs beginning to work in physician health. This was true of Saskatchewan, Nova Scotia, PEI and Manitoba. However, in some provinces, it was apparent that key individuals were still in place, generating a key dependency. MAs should be aware of this dependency on key individuals, and ensure, as done in Saskatchewan, a memorandum of understanding, the use of regulations under legislation, or other formal document is in place that ensures lasting approaches, and not one dependent on certain individuals. Given the need to effect change, and the likelihood it will take time to being seeing this change, having lasting approaches to physician health is needed.

6.4.2 Collaboration

Collaboration also emerged in Phase II as an important aspect of approaches. In the sole interview where the participant felt they had “nailed it”, collaboration was listed as one of the essential ingredients to achieving their desired balance. However, collaboration between these two stakeholders was reported by some as difficult. MAs and MRAs as organizations are often at odds, and MAs being too close to MRAs may give the appearance of a “fox in the hen house” as one participant said. As a result, the majority of the participants reported a need for strong boundaries and clearly defined lanes. In some cases, this was formalized in a memorandum of understanding. In other provinces, they depended on the strong working relationships developed over time. Ultimately, provinces looking to improve collaboration should consider further defining the boundaries of their roles, and may even consider formalizing the relationship, in order to better serve their members and registrants. However, there are limits to collaboration. As highlighted in Phase II, as even a perceived “fox in the hen house” will serve neither the MRA or the MA. MRA’s in Canada are also legally responsible to meet their legislated duty to the public first, with other actions subject to (or second to) this mandate. Collaboration may also be complicated by the role of the CMPA. As a result, collaboration in physician health may be nuanced, for example a MA supporting a physician seeking an IME at the request of a MRA, or a MRA referring their participants to additional wellness supports offered by the MA.

6.4.3 Communication

The language MRAs and MAs use to describe their programs is important. While the effectiveness of organizational communications is beyond the scope of this thesis, it was notable to observe the differences in communication styles in both online content analyzed in Phase I and interviews in Phase II. Both MRAs and MAs used registrant or member communications,

but MAs more often used their websites to reference their PHAs. MRAs may consider hosting dedicated or lasting references for physicians to navigate to in times of need. In addition, the use of supportive tones in some components and the references to risk in others all contribute to the perception of the PHA. Moreover, it was notable that for one MRA, the use of supportive language was *not* in reference to the program supporting the physician, but the program supporting the other regulatory functions of the College. Such language should be revised in order to more clearly capture the intent of the organization. Moreover, clearly outlined approaches, success measures, and performance against those measures would improve accountability for PHAs.

Finally, Phase II also highlighted the importance of communications with physicians, whether to reassure that the physician had "done the right thing" or to normalize help-seeking behaviours. Given the barriers unwell physicians face, clear communications which outline their approach and perspective may support the early identification of physicians who need support. As one MA participant said, "this is not something that will change overnight, but the consistent and relentless messages from these two key stakeholders may help shift stigma and the culture of medicine towards more supportive approaches".

6.4.4 Outcomes and Evaluation

Phase I found the definition and reporting of outcomes and success measures is limited. Phase II highlighted this may be due in part to the complexity of defining success in approaches, like the improvement in wellness, and the difficulty or inability to evaluate the ideal measures like changes in the health system, stigma, and culture. Nevertheless, PHAs must be evaluated by some metric in order to inform decision making. Given the layers of complexity in physician health, MRAs and MAs may consider adopting a systems-thinking, pragmatic approach to

complex program evaluation, akin to that seen in Crane et al. (2018). Like this thesis, pragmatic approaches use the most appropriate evaluation method for the research question and use multiple data sources from multiple perspectives for a “richer collection of knowledge” (Crane et al., 2018, p. 424). Moreover, the Phase I content analysis and Phase II participants identified different considerations at the macro-level (healthcare system and medical profession), meso-level (PHA, MRA, and MA), and micro-level (physicians) that should be evaluated. These have been summarized in Table 13 as proposed measures alongside potential qualitative or quantitative evaluation questions to facilitate evaluation as suggested by Crane et al. (2018). The complexity inherent to PHAs revealed there is no one measure that accurately or comprehensively captures the success of PHAs in Canada. While a single stakeholder may not evaluate their approach by every measure listed in Table 13, due to the complexity and systems-level dependencies, MRAs and MAs should be flexible and use a variety of measures across different levels and adopt different methods of evaluation in order to obtain a better understanding of their approaches. A pragmatic and multi-level approach to complex program evaluation provides a framework that should facilitate systematic analysis and further understanding and better inform decision making around PHAs in Canada.

Table 13 *Physician Health Approaches Evaluation Measures at the Macro, Meso and Micro Level Identified in Phase I and II*

System Level	Measure	Evaluation Question(s)	Potential Evaluation
Macro – Healthcare System	Collaboration	How do organizations collaborate with system partners? How are system roles and boundaries defined, either formally (e.g., MOU) or informally?	Qualitative – Interviews with stakeholders

System Level	Measure	Evaluation Question(s)	Potential Evaluation
Macro – Medical Profession	Stigma	How has stigma been reduced within the medical profession?	Qualitative – Interviews with provincial and national stakeholders as well as physicians
Meso – Physician Health Approach	Referrals and Referral Types	How many members/registrants does the approach or program support? How and from where does the approach or program receive referrals?	Quantitative – Approach data
Meso – Physician Health Approach	Maintenance in the Workforce	How many members/registrants are able to continue practice?	Quantitative – Approach data
Meso – Medical Regulatory Authority (MRA)	Nature of Referral	For what health conditions do physicians need monitoring/regulation?	Quantitative – Approach data
	Balance	How does the MRA manage the balance between the duty to the public and rights/needs of the physician?	Qualitative – Interviews with MRA employees and participants in MRA's PHA
Meso – Medical Association (MA)	Nature of Referral	For what concerns do physicians seek support?	Quantitative – approach data
	Responsive-ness	How does the MA collect information on member needs? How effective is the MA at responding to the needs of members?	Qualitative – Interviews of MA members
Micro – Physician	Experience in PHAs and Reporting to PHAs	How do physicians experience PHAs in Canada? How do physicians in Canada feel about reporting a colleague/physician to a PHA?	Quantitative – Survey of physicians Qualitative – Focus groups or interviews with physicians

6.4.5 Funding

Funding has implications at both the program and individual level in PHAs. At the program level, as reported by the Phase II participants, funding was essential for the MAs to work in physician health. Most MAs in Phase I also referenced funding from the provincial government or the CMA. The importance of funding was also highlighted by one MRA as key factor enabling them to perfect their approach. While MRAs and MAs likely do not need reminding of the importance of funds to support physician health, given its importance to both organizations, provinces and territories may consider how the resources of both organizations could be pooled to either secure additional funding from system partners or from national partners to further support their respective approaches.

On the individual level, absent from most funding references in Phase I and II was the role of funding. In particular, with the exception of some MAs, there was a lack of published information relating to how the individual may have to pay for programming. While physicians are more often middle class and with means, a characteristic noted in the literature when examining the success of PHAs on recovery from substance use disorders, it is notable that a physician is required to report without the transparent knowledge of the cost of participation. This is especially notable given the physician may lose their livelihood as a result. If PHAs, and particularly MRA approaches, aim to reduce the barriers for physicians seeking help, upfront communications about the cost of the program may support this. Moreover, MRAs and MAs should work together to ensure cost is never a barrier for physicians, whether through a joint fund or additional government funding.

6.5 Conclusion

The overarching aim of this thesis was to explore PHAs in Canada, in effort to describe the (1) diverse approaches to physician health, (2) perspectives on physician health, and (3) how MRAs and MAs view the outcomes of these approaches. This thesis used a sequential multi-method design approach to provide a basis of understanding of these key programs in Canada. Using quantitative and qualitative content analysis, Phase I systematically reviewed and synthesized the PHAs as provided by MRAs and MAs across the country, revealing the key descriptors and initial perspectives on physician health. Phase II interviewed and thematically analyzed interviews with MRAs and MAs across Canada, highlighting the complexity embedded throughout both MRA and MA approaches. Future work is needed to understand the impact of workplaces on physician health, as well as the experience of physicians in PHAs themselves. Studies should also consider the distinctive nature of BBVs, which persist as a separate physician health condition despite advances in modern medicine. MRAs and MAs should consider their communication approaches to their work in physician health, and consider the language used and funding related to their program to enhance transparency and reduce barriers for physicians in seeking support. MRAs and MAs may also consider using complex program evaluation matrices across macro, meso and micro-levels to comprehensively evaluate their approaches on different measures.

Ultimately, there is no clear best practice approach to physician health in Canada. MRAs and MAs navigate significant and layered complexity to achieve their legislative aims and meet their member’s needs. More formal or informal collaboration is likely needed between these two stakeholders, as well as other stakeholders at the provincial and national level to comprehensively address the spectrum of physician health. Sustained communications and

consistent approaches, evaluated using multi-level and wide-ranging evaluation measures, are also needed to begin eroding the compounding forces of stigma in the culture of medicine and to effect systems-level change.

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Appendix 1: Phase II Email Invitation

Subject: Invitation for Research Participation | Interview on Physician Health

Dear [Title. Name]

I hope this finds you well and safe. I am reaching out to invite you to participate in a study on physician health. The goal of this study is to better understand the perspectives on and approaches to physician health programs in Canada.

I am conducting 60-minute interviews online via MS Teams. During the interview, you will be asked questions on your approach to physician health, and perspective on issues identified in the literature. Attached is more information on the study and what your participation would look like.

Participation in this study is voluntary with no impact on your professional standing.

As the [insert role of recipient here], if there are 1-2 others in your organization/authority who also supports or manages physician health, please share the details of the study directly with them and if they are interested, they may reach out to me to schedule a time to connect.

I would also appreciate the opportunity to supplement the publicly available information on your physician health program with any documents, policies, etc., that relate to or describe your program. Information shared will be attributed to your province and/or organization and may be included as part of my academic thesis and peer-reviewed publications.

I am also a Consultant for the Physician Health Program at the College of Physicians and Surgeons of Nova Scotia. This research is being conducted as part of my Master's in Health Administration. The outcome of my research may inform part of my work. If you have any questions or concerns about your participation, you may contact my supervisor Jeanna Parsons

Leigh at j.parsonsleigh@dal.ca or 902 494-8881. This study has been approved by the Research Ethics Boards at Dalhousie University (#2021-5654).

I greatly appreciate your consideration. Please let me know if you have any questions or concerns.

[Consent form to be attached]

Appendix 2: Interview Guide for MRAs

Do you have any questions about the study details I just described?

I will now turn on the audio recorder and ask you a few questions to formally record your consent.

Have you heard all of the study details?

Have all of your questions been adequately answered?

Do you agree to be interviewed for research purposes?

Do you have any questions or concerns about the process? If not, let's begin….

Questions

1. How did the College first engage with the topic of physician health?
2. Can you describe your current approach to physician health?
    a. PROMPTS: This may include, determining fitness to practise, monitoring, duties to report, and determining licensing conditions or undertakings?
3. How has the College's approach to physician health evolved?
    a. What drove these changes?
4. How does your program define success?
    a. Are periodic reviews built into your program and based on what criteria?
    b. Do you seek stakeholder / participant feedback?
    c. Are you happy with the rate of participation?
    d. What do you think are the biggest barriers to physicians accessing your program?
5. How does your program make decisions?

6. What collaboration does your program with other provincial/territorial stakeholders, like the medical association?
    a. PROMPTS: This may include outreach, education, etc.
7. How does your program approach confidentiality?
    a. For example, implying a physician's health via license conditions?
    b. What or how much information do you share with stakeholders (like workplaces/health authorities)?
8. What's next – real or theoretical – for your physician health program?
9. How has the COVID-19 pandemic affected your physician health program and/or your approach to physician health?

My next questions relate to issues raised in the literature. Some may be relevant to your program, and others may not. You may skip any question.

10. Some of the literature states that regulatory involvement in the topic of physician health leads to coercion, or at minimum, undermines the voluntariness of these programs and is a barrier for physicians to receive care. What is the College's view on this issue?
11. Another issue noted in the literature on physician health programs relates to the issue of illness versus impairment, meaning a diagnosis of a condition (illness) may not actually impact their competence or conduct (impairment). How does your program approach and manage any perceived or experienced stigma with respect to the conduct of your program? How does your program approach this issue?
12. A final issue relates to conflicts of interest. For example, commentaries in the United States have argued treatment centers accepting referrals sponsor some physician health

programs generates a conflict, or assessments conducted internally. How does your association manage perceived or real conflicts of interest?

I will share an interview transcript with you after which you may edit to ensure your comfort with the official record.

Thank you for sharing your insights with me. If you have no further insights to share, I will now turn off the recorder and ask you some questions about your jurisdiction.

Appendix 3: Interview Guide for MAs

Do you have any questions about the study details I just described?

I will now turn on the audio recorder and ask you a few questions to formally record your consent.

Have you heard all of the study details?

Have all of your questions been adequately answered?

Do you agree to be interviewed for research purposes?

Do you have any questions or concerns about the process? If not, let's begin….

Questions

1. How did the Association first engage with the topic of physician health?
2. Can you describe your current approach to physician health?
    a. PROMPTS: This may include, determining fitness to practise, monitoring, duties to report, and determining licensing conditions or undertakings?
3. How has the Association's approach to physician health evolved?
    a. What drove these changes?
4. How does your program define success?
    a. Are periodic reviews built into your program and based on what criteria?
    b. Do you seek stakeholder / participant feedback?
    c. Are you happy with the rate of participation?
    d. What do you think are the biggest barriers to physicians accessing your program?
5. How does your program make decisions?

6. What collaboration does your program with other provincial/territorial stakeholders, like the medical association?
    a. PROMPTS: This may include outreach, education, etc.
7. How does your program approach confidentiality?
    a. For example, implying a physician's health via license conditions?
    b. What or how much information do you share with stakeholders (like workplaces/health authorities)?
8. What's next – real or theoretical – for your physician health program?
9. How has the COVID-19 pandemic affected your physician health program and/or your approach to physician health?

My next questions relate to issues raised in the literature. Some may be relevant to your program, and others may not. You may skip any question.

10. Some of the literature states that regulatory involvement in the topic of physician health leads to coercion, or at minimum, undermines the voluntariness of these programs and is a barrier for physicians to receive care. What is your Association's views on this issue?
11. Another issue noted in the literature on physician health programs relates to the issue of illness versus impairment, meaning a diagnosis of a condition (illness) may not actually impact their competence or conduct (impairment). How does your program approach and manage any perceived or experienced stigma with respect to the conduct of your program? How does your program approach this issue?
12. A final issue relates to conflicts of interest. For example, commentaries in the United States have argued treatment centers accepting referrals sponsor some physician health

programs generates a conflict, or assessments conducted internally. How does your association manage perceived or real conflicts of interest?

I will share an interview transcript with you after which you may edit to ensure your comfort with the official record.

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