TO: All Residents and Fellows

FROM: Paul Bragg, MD, FRCPC
Assistant Dean
Postgraduate Medical Education

SUBJECT: Well-being Program for Physicians In-Training

You will find enclosed a document that describes the Well-being Program for Physicians In-Training. Please read it carefully and familiarize yourself with its contents. This program is designed to assist you as a resident or fellow in preventing and managing personal, medical or academic problems if and when they may arise.

I cannot stress to you the importance of reading through this document in detail at this time; issues such as needle stick procedures and management of emotional difficulties are best understood well in advance of any potential event.

Please do not hesitate to contact me at 562-5413 if you encounter any academic difficulties or with your well-being in general.

Enclosure

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Well-being Program for Physicians In-Training

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I. PREAMBLE

Many students, residents, fellows and staff members within the Faculty of Medicine suffer from physical, emotional or spiritual health problems. These problems often go unnoticed and lead to serious disability. The size and importance of this problem is unknown as there is no existing system to identify and manage these difficulties. What we do know is that there have been prominent difficulties within all programs at the postgraduate level which have led program directors, PAIRO, the certifying colleges and the licensing authorities to become alarmed at the magnitude of this problem.

There are several possible reasons why physicians and physicians-in-training experience these difficulties:

- The Faculty of Medicine comprises approximately 800 physicians-in-training, many of whom are poor at self-care.
- Many individuals have a sense of invincibility despite all of the evidence to the contrary.
- There is still a stigma associated with the recognition of emotional difficulties and a sense of denial.
- Many members of the university community are new to Ottawa, lack support and feel isolated.
- University programs lack strong mentor relationships.
- Insecurity, anxiety and fear are common in many educational and practice environments.
- Individuals are often unwilling to self-identify a problem as they fear that these may adversely affect career advancement.
- In some circumstances, program intimidation and harassment may contribute to these problems.

To address some of these issues, independent groups at other levels of the faculty have been developed to deal with issues of physical and emotional health.

A formalized program known as the Well-being Program for Physicians In-Training is provided to deal with these important issues with our Postgraduate colleagues.
The principles of this program are:

- That physical as well as emotional health concerns should be recognized and addressed.
- That prevention, as well as management, are equally important.
- That while the program and health promotion activities will be widely advertised, the actual care delivered will be low profile and confidential.
- That multiple points of entry into the core programs for individuals in difficulty will be encouraged.
- That participation in part or all of these programs is voluntary.

II. GENERAL OBJECTIVES

The Well-being Program for Physicians In-Training will meet the physical, emotional, personal and academic/career needs of residents and fellows, within the Faculty of Medicine. This will be accomplished in a supportive, confidential and non-judgmental environment at arms length from the Postgraduate Dean’s office. Confidentiality and discretion is guaranteed.

Ms. Monique Beaulne at 613-737-8473 (Manager, Medical Education, Ottawa Hospital) has been appointed as the Director of this program. Appendix II and III also provide other contacts which may be useful.

The Faculty Wellness Program Director, Dr. Derek Puddester can also be contacted at 613-562-5800 x8507.
III. PROGRAM DESCRIPTION AND SPECIFIC OBJECTIVES

The three components of the program deal with physical, emotional and academic well-being. Each of these in turn have an aspect of health promotion as well as, the management of difficulties when they may arise. These are described as follows:

1. **Physical Well-being:**

   **Disease Prevention.** There are two important aspects to this: immunization and needlesticks. All Residents and Fellows must maintain their immunization status appropriate to their clinical discipline. Health care workers should be immunized for Hepatitis B, DTP, influenza and MMR as appropriate. To assist in this initiative, the Postgraduate Education office will survey all Residents and Fellows, and make available opportunities for immunization through the Faculty of Medicine, the University's Health Services and Employee Health Services at the appropriate hospitals. Residents and Fellows can also access their personal physicians with this regard. It is the expectation of the Faculty that all Residents and Fellows will be appropriately immunized. Regular TB surveillance is also mandatory. Yearly TB skin testing will be provided through the Faculty of Medicine in the spring of each year, and trainees will be notified of this. Once again, the Faculty recommends this on a regular basis, but believes that it is the responsibility of the trainee to maintain their health. The immunization forms and services can be found in your admission kit and can also be accessed via the postgraduate website at [www.medicine.uottawa.ca/postgraduate](http://www.medicine.uottawa.ca/postgraduate).

   **Needlestick protocol.** From time to time, trainees may come in contact with potentially infected substances via needlestick injuries, etc. There is increasing evidence that immediate action is necessary to reduce the risk of infection and needlestick protocols have been developed (Appendix I) Residents and fellows must familiarize themselves with these policies at the onset of their training. Any Resident or Fellow who has been potentially exposed must follow these recommendations in an effort to protect their health and well-being. Included in this appendix are the names of contact individuals who can be approached anonymously to ensure optimal therapy and the appropriate counselling.

2. **Emotional Well-being:**

   **Promotion of good emotional well-being.** The Faculty feels that this is an essential part of a Postgraduate program. It is the responsibility of every Resident and Fellow to maintain an appropriate balance in their work and social lives. It is also the responsibility of Residents and
Well-being Program for Physicians In-Training
Page 4

Fellows to look out for their colleagues, and to provide assistance whenever this balance is lost leading to emotional difficulties. Throughout the period of training there will be regular workshops and large group sessions addressing this topic, as stress in the work place is an increasing cause of disability. If concerns are identified by Residents or Fellows that will influence training, these should be brought to the attention of the Program Director and/or the Associate Dean, Postgraduate Medical Education.

The consequences of poor emotional well-being are acute or chronic emotional disorders such as anxiety, depression and suicide. In addition alcohol and chemical dependency, as well as eating disorders can be a manifestation of this problem. Stress also has its effect on marital and personal relationships and may be directly or indirectly related to issues of abuse and harassment. If difficulties arise and acute or chronic emotional disorders present themselves, trainees can pursue health counselling through any of the identified routes in a confidential manner. The identified contact individuals, the hospital education offices, the Postgraduate Education office, Health Services or personal physicians, can all provide the necessary counselling.

Alcohol and chemical dependencies are conditions that are under-identified amongst our colleagues in medicine. There is always a fear that the notification of this problem will adversely affect one's training and career opportunities. The Faculty of Medicine has taken a formative or corrective approach rather than a punitive one. There are several hotlines that deal with just this specific issue, and these numbers are provided in Appendix III.

Should difficulties arise pertaining to marital and personal relationships, the contact individuals identified can be of assistance. In addition personal mentors, colleagues and Faculty members are always available if called upon. In the event of financial difficulty, Trainee Assistance Awards are available with demonstration of need. Contact individuals are listed in Appendix III.

The University has a zero tolerance policy for issues of abuse and harassment. The principles and policies can be found under Appendix IV.

3. Academic/Career Well-being:

The academic development of a Resident or Fellow is the responsibility of the individual and his/her program. However, the Faculty coordinates many centrally administered programs. These often deal with the general skills and competencies required of all physicians and will be given predominantly in the first year of training, but also in the individual core programs. In addition to this, the Faculty recognizes the need for career counselling in terms of future training and practice opportunities. The Faculty will also be as flexible as possible to permit Residents to transfer from one program to another recognizing the difficulties caused by early career selection. While many inquiries pertaining to training and practice opportunities should be directed via the Program Director, the Faculty maintains an open-door policy should questions remain. If there is a disruption in training for academic or health related reasons there are definite policies that guide the Faculty in assisting our Residents and these are included on our website at
www.medicine.uottawa.ca/postgraduate/.

SUMMARY

A trainee's well-being is an essential part of our postgraduate training programs. While programs and the Faculty are dedicated to promoting good health and addressing problems, if and when they arise, there is an assumption that the trainee and his or her colleagues also bear responsibility to address this problem with the highest priority. Recognizing all of the potential challenges to maintaining one's emotional and physical well-being, there is a greater onus upon us to work towards our own health as we would do for our patients.

The preceding sets out a series of policies and procedures as they pertain to the maintenance and management of well-being in our postgraduate trainees, yet should there be additional questions or concerns, Residents and Fellows are always encouraged to be in touch with the Well-being Program Director (Ms. Monique Beaulne), the Faculty Wellness office or the Postgraduate Education office.
Appendix I

HOSPITALS’ NEEDLESTICK POLICIES

Teaching Hospital Setting:
The careful handling of any potentially infective material and the strict adherence to the policy of universal precautions are extremely important and mandatory. Postgraduate trainees are encouraged to familiarize themselves with each hospital policy at all times. Individual hospital policies are available through Hospital Employee Health Services or from the office of the Director of the Physicians In-Training Well-being Program (Monique Beaulne). Contact persons listed below can be reached anytime during the day.

Immediate Care is required. Do not delay. Initial management involves cleaning the site, the identification of risk and possible early therapeutic intervention. Proceed to the Emergency Department of the hospital and identify yourself as a member of the House-staff. Indicate the type of injury sustained (i.e. needle stick). The Infectious Diseases consultant on call may be notified and will either see you in the E.R. or speak to you by telephone to address your immediate questions and concerns. If required, you will receive a 2 or 3 day PEP pack to initiate therapy until you can fill a prescription at the Pharmacy.

Documentation and notification are essential. Call the Director of the University Well-being Program for Physicians in training, Ms. Monique Beaulne, at 613-737-8473 during office hours, who will help you to ensure that you have taken the necessary steps and precautions. You must also contact the appropriate person (listed below) of the hospital where the injury was sustained.

Community Setting:
If you are in a community setting, present yourself to the closest hospital Emergency Department for immediate care and management. Again, contact Monique Beaulne immediately to ensure that the intervention meets the existing guidelines.

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<tr>
<th>HOSPITAL</th>
<th>CONTACT</th>
<th>TELEPHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Ottawa Hospital – General Campus</td>
<td>Occupational Health &amp; Safety</td>
<td>613-737-8391</td>
</tr>
<tr>
<td>The Ottawa Hospital – Civic Campus</td>
<td>Occupational Health &amp; Safety</td>
<td>613-761-5555 ext.14161</td>
</tr>
<tr>
<td>The Ottawa Hospital – Riverside Campus</td>
<td>Occupational Health &amp; Safety</td>
<td>613-738-8400 ext 88250</td>
</tr>
<tr>
<td>Children’s Hospital of Eastern Ontario</td>
<td>Occupational Health &amp; Safety</td>
<td>613-737-7600 ext 2278</td>
</tr>
<tr>
<td>Royal Ottawa Hospital</td>
<td>Occupational Health &amp; Safety</td>
<td>613-722-6521 ext 6491</td>
</tr>
<tr>
<td>Rehabilitation Centre</td>
<td>See The Ottawa Hospital-General Campus</td>
<td>613-737-8391</td>
</tr>
<tr>
<td>Hôpital Montfort</td>
<td>Occupational Health &amp; Safety</td>
<td>613-746-4621 ext 2211</td>
</tr>
<tr>
<td>Elizabeth Bruyère Health Centre</td>
<td>Occupational Health &amp; Safety</td>
<td>613-562-6262 ext 4037</td>
</tr>
<tr>
<td>St-Louis Residence</td>
<td>Occupational Health &amp; Safety</td>
<td>613-562-4262 ext 3333</td>
</tr>
<tr>
<td>St. Vincent Hospital</td>
<td>Occupational Health &amp; Safety</td>
<td>613-562-4262 ext 3333</td>
</tr>
</tbody>
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CRISIS INTERVENTION PROGRAM

Residents or Fellows may be reluctant to seek help with the faculty due to privacy concerns.

At each site on the medical campus there is a contact person whose role is to get sufficient information so as to facilitate the connection to a community or institutionally based specialist as needed, (eg. Psychiatrist, marriage counsellor, family therapist, etc.) The role of the contact person is not to provide assessment and treatment, however the specialist will manage problems immediately and as necessary in a confidential fashion.

All inquiries are confidential and will be handled discreetly and as quickly as possible. If necessary, no name needs to be revealed.

If a trainee finds herself/himself under inordinate stress, even if it is felt to be short lived, he or she should first contact Monique Beaulne (737-8473) with the recognition that a brief period of time off (1-2 day-s) may be all that is necessary away from work to recover. More prolonged leaves may require a medical certificate.

The Faculty of Medicine also has a Faculty Wellness Program, which can provide you with assistance in finding immediate care. If you prefer, you can communicate with the Director of the Wellness program, Dr. Derek Puddester at 562-5800 X 8507.

The University of Ottawa offers Student Health Services and postgraduate trainees also have access to this service. Feel free to call the Health Services to arrange for a medical appointment with Dr. Don Kilby (or other physician on site) at 564-7826.
INTRODUCTION

The Faculty of Medicine is committed to a policy of zero tolerance of sexual harassment in all its forms. As members of the University, the Faculty adheres to policy #67 dealing with sexual harassment.

Policy 67 adopted by the University provides that:

"Whereas the University of Ottawa Act, 1965, provides that one of the University of Ottawa's objectives is "to promote the advancement of learning and the dissemination of knowledge";

And whereas the Human Rights Code, (1981) provides inter alia that "every person who is an employee has a right to freedom from harassment in the work place because of sex";

And whereas, in recognition of its responsibility to have an appropriate environment for the discovery and sharing of knowledge, the University has made a commitment to create an atmosphere of reciprocal respect amongst all members of the University community;

And whereas the University recognizes as well that all members of the University community are entitled to a working and learning environment which is pleasant, professional, and promotes due respect and regard for the rights and feelings of all;

And whereas romantic or sexual relationships between faculty members and students or between supervisors and employees or students are ones in which a power differential may exist;

And whereas an abuse of that power differential creates a negative environment for work and study and casts doubt on the validity of the consent to such relationships;

The University therefore strongly disapproves of romantic or sexual relationships between faculty
members and students or between supervisors and employees or students, and expects members of its community to refrain from engaging in them;

The University therefore affirms that sexual harassment is a negation of such reciprocal respect in addition to being a violation of the fundamental rights, dignity and integrity of the person and that it undermines the environment required for the advancement of learning and the dissemination of knowledge."

**Definition**

Sexual harassment is defined in Policy 67 as follows:

a) unwanted sexual attention from a person who knows or ought reasonably to know that such attention is unwanted; or

b) implied or expressed promise of reward for complying with a sexually oriented request; or

c) implied or expressed threat of reprisal or actual reprisal for refusal to comply with the sexually oriented request; or

d) a sexual relationship which constitutes an abuse of power in a relationship of trust; or

e) Sexually oriented remarks or behaviour which may reasonably be perceived to create a negative psychological and emotional environment for work or study".

As the practice of medicine requires a high order of trust between physician and patient, the highest standards of ethical behaviour and integrity are mandated by the Faculty in order to provide an exemplary environment for the training of new physicians.

For these reasons, the Faculty affirms its commitment to a policy of zero tolerance for sexual harassment and to apply Policy 67 of the University of Ottawa to all students and trainees including undergraduate, graduate and postgraduate students and residents, fellows and other trainees, support staff and faculty, regardless of whether such individuals are on the University payroll, it being understood that, for APUO members, Section 39.5 of the Collective Agreement also applies.

The faculty has established a conflict resolution policy to provide a readily accessible process within the Faculty to help resolve conflicts, including those involving sexual harassment. This policy provides a voluntary informal resolution of such complaints for students, trainees, faculty and support staff of the Faculty of Medicine. The process described by the conflict resolution policy was designed to be consistent with, and does not replace or over-ride existing University and APUO policies. At all times, the member has the option to lodge a complaint in accordance with these policies.

**Procedures**

Policy 67 provides for the establishment of a Committee on Sexual Harassment, a process for
dealing with complaints, the appointment of a University Sexual Harassment Officer, a process for appeals and disciplinary action, requirements for confidentiality and a statement of the rights of the complainant and respondent. Certain parallel procedures are described in Section 39.5 of the APUO Collective Agreement and apply to APUO members.

Complaints are to be made to the Sexual Harassment Officer as soon as possible and apart from exceptional circumstances, "a complaint shall not be considered if it is made more than six (6) months after the alleged incident(s)".

"A complaint may be made by either an individual or individuals who have been directly affected by the alleged sexual harassment, or by any person who has actual knowledge that sexual harassment has taken place."

Policy 67 further provides for the handling of the complaint by the Sexual Harassment Officer and for the possible eventuality of a hearing before a Complaint Panel which may be established under the authority of the chairman of the committee on sexual harassment who is the Secretary of the University. The Complaint Panel shall determine and shall file a report setting out:

a) "A summary of the relevant facts;
b) A determination as to whether the acts complained of constitute sexual harassment as defined in Policy 67;
c) Recommendations as to appropriate disciplinary action and other measures which in its opinion are necessary in the circumstances."

This report is then forwarded to the Administrative Committee and to the Dean of the Faculty for action. Certain parallel procedures are described in Section 39.5 of the Collective Agreement and apply to APUO members.

**Disciplinary Action**

"Disciplinary action includes but is not limited to an apology, reprimand, transfer, suspension, expulsion, or dismissal, depending on the seriousness of the conduct, the respondent's connection to the University, the respondent's prior record and any mitigating factors, it being understood that any disciplinary action shall be undertaken in conformity with procedures set out in the relevant Collective Agreement or University policy."

**Grievance**

For purposes of grievance, procedures are set out in the Collective Agreement for APUO members. All trainees, support staff and members of the Faculty but not members of the APUO, are governed by Policy 32 which describes the appropriate grievance process.

It should be noted that where there is evidence of sexual harassment committed by a member of the Faculty, either admitted by the member or established by the investigative process provided for in the policy, such evidence may be considered in the evaluation of a faculty member's performance in respect to promotion and tenure where such conduct is relevant to performance.
In the case of trainees and faculty members engaged in the practice of medicine, such behaviour will be reported to the College of Physicians and Surgeons of Ontario in accordance with the regulations of the College.

Approved by
Faculty Council September 28, 1993
University Administrative Committee in October 1993 (Motion 1249.3)
Revised and approved June 1999
Appendix IV

Office of Gender and Equity Issues
Conflict Resolution Policy

Please refer to University of Ottawa Web site:
http://www.med.uottawa.ca/GenderEquity/eng/conflict_resolution.html

Students, trainees, faculty and support staff of the Faculty of Medicine require a well-advertised readily accessible process within the Faculty to help resolve conflicts. Such a mechanism would deal with conflicts in the areas of sexual harassment, non-sexual harassment or intimidation and scientific misconduct or misappropriation of intellectual property. Recently, the College of Family Physicians of Canada Working Group on Intimidation in Postgraduate Medical Education has outlined the problem of intimidation for residents and the Provincial Association of Interns and Residents of Ontario have suggested an internal Faculty process to deal with cases of intimidation and harassment. The process outlined here was designed to accommodate suggestions made in these reports. This policy applies to all students and trainees which includes undergraduate, graduate and postgraduate students and residents, fellows and other trainees, support staff and faculty, it being understood that APUO members are covered by their Collective Agreement. In addition, all members of the faculty must be aware of existing University policies which apply in these cases, and the process outlined below was designed to be consistent with these existing policies. The Office of Gender and Equity Issues is available for consultation and clarification of procedures to be followed.

Outline of University of Ottawa Policies and the Context of Conflict Resolution Policy:

1) As members of the University, the Faculty adheres to Policy no. 67 dealing with sexual harassment, and has a Faculty Policy on Sexual Harassment (October 1993). APUO members are covered by the provisions of the Collective Agreement. These policies cover the definition of sexual harassment and all formal procedures to deal with complaints. In cases of sexual harassment complaints the Faculty Conflict Resolution Policy is intended to provide a voluntary informal resolution of such complaints. Complainants will be informed of the University Sexual Harassment Policy and may choose to address their complaints directly to and consult and work with the University of Ottawa Sexual Harassment Officer who does provide use of both informal and formal complaint resolution procedures. Should the Faculty's informal conflict resolution process fail to address the complaint to the satisfaction of those involved, the complainant may proceed to lodge a complaint to the University Sexual Harassment Officer in accordance with Policy no. 67 and the Collective Agreement, the latter applying when the complaint is against an APUO member.

2) For purposes of complaints in the case of non-sexual harassment or intimidation, scientific fraud or misconduct, procedures are set out in the Collective Agreement for APUO members. Support staff are governed by Policy no. 32 which describes the grievance process. Policy no. 32 does not define harassment or intimidation. Policy no. 32 provides for an informal settlement step followed by 4 levels of decision. Graduate students are governed by Policy no. 110 _Policy on Treatment of
Graduate Students on Non-academic Matters, which describes discrimination, employment, treatment of graduate students on non-academic matters and the grievance procedure. In cases not covered by the above policies, grievances can be filed with the Dean. None of these policies provide a defined process for local informal resolution of complaints. The Faculty Conflict Resolution policy is intended to provide a defined process for this informal settlement.

**Definitions:**

Harassment involves engaging in vexatious comment or conduct that is known or ought to be known to be unwelcome. Intimidation occurs when words or actions disparage or humiliate another individual and cause the individual to undertake a course of action against their will, or refrain from undertaking an activity that, except for harassment, would be undertaken.

There are numerous types of unacceptable harassing or intimidating behaviours including, but not limited to (adapted from the Professional Association of Interns and Residents of Ontario (PAIRO) April 1997):

1) Verbal intimidation/harassment, e.g. shouting, swearing, belittling, disparaging remarks of a racial, sexist, religious, homophobic, or otherwise discriminatory nature.

2) Physical intimidation/harassment, e.g. pushing, punching, slapping, threatening gestures, or throwing objects at an individual.

3) Education/service imbalance, particularly for postgraduate medical trainees, e.g. contractual infractions, inadequate supervision, excessive service load or service assignment without educational merit.

4) Reprisal or threat of reprisal for negative feedback of staff, program or service, including the lodging of a complaint or grievance.

Harassment and intimidation create a hostile and stressful environment that interferes with academic and work performance. The Faculty is committed to a policy of zero tolerance for any form of harassment or intimidation, and is committed to providing an exemplary working and learning environment for all members of the Faculty community.

Scientific fraud or misconduct is described in the Academic Regulations of the Faculty of Medicine and in the Collective Agreement and includes, but is not limited to: misrepresentation or falsification of data; lack of honesty in the collection and interpretation of data; assisting or colluding with colleagues in committing scientific misconduct; conducting clinical trials and evaluation of drugs, medical devices or other diagnostic and therapeutic modalities where the investigator has a real or perceived conflict of interest, or takes undue financial or other advantage from or by reporting on such studies.
It is recognized that students and trainees in particular may hesitate to report these behaviours and may tolerate and acquiesce to these behaviours for various reasons, including fears of loss of present and future opportunity, fear of poor evaluation or grades, and/or fear of increase in the intimidation or harassment.

**Informal Conflict Resolution Process:**

Preamble: All participants in the conflict resolution process are to maintain strict confidentiality except where disclosure, with the permission of the complainant, may be required to discreetly gather information to support a complainant or respondent, to implement the resolution of a complaint or to monitor terms of resolution. At any stage of the process, the complainant, respondent, or other participants may consult with the University of Ottawa Sexual Harassment Officer and/or the Faculty Office of Gender and Equity Issues, as necessary, for advice and assistance in these matters. The process described here is intended to resolve the matter informally.

Step One: Initiation of Complaint. Support staff, students, trainees and Faculty members are encouraged to deal with conflicts by reporting and discussing the issue with someone at the next highest level, e.g. division head, department head, graduate or postgraduate supervisor, residency program director, mentor or designated divisional or departmental ombudsman. The individual approached would speak with the complainant, and to those involved in the incident(s) and seek a resolution with them. When step one is not feasible (in cases where there may be conflict of interest or in which the most appropriate individual to approach is the alleged perpetrator), or after such discussion(s) does not lead to satisfactory resolution, the complainant may proceed to step two of informal resolution.

At step one, the complainant should record the details of circumstance(s) of the intimidation or harassment and of the attempts to resolve the issue. A limit of 14 days is placed on resolution of the conflict at step one.

Step two: Informal Resolution. This step will involve one or more of 4 individuals identified by the Faculty as having recognized conciliation and dispute resolution skills, representing different sectors of the Faculty; i.e. a basic scientist, a clinician-educator, a clinician-scientist and an administrator or member of the support staff. These 4 individuals (hereafter referred to as the Complaints Officers) will be permanently appointed. Complainants will have the opportunity to seek advice from any one of the Complaints Officers and to initiate the informal resolution process. The Complaints Officer approached will seek out the facts of the complaint and with the permission of the Complainant, will involve expert assistance as necessary. A limit of 1 month is placed on resolution of the conflict at this step.

Should the informal resolution process fail to address the complaint to the satisfaction of any of the parties involved, the following applies:
1) In the case of a complaint of sexual harassment, the complainant may proceed to the Sexual Harrassment Officer;

2) In the case of non-sexual harassment or intimidation or scientific fraud or misconduct the complainant may proceed to file an official grievance in accordance with the Collective Agreement (APUO members) or University policies. If the situation is not covered under these policies, the complaint may be filed with the Dean.

In summary, this policy provides for a voluntary informal internal conflict resolution process to deal rapidly and sensitively with complaints of sexual harassment, other forms of harassment and intimidation and complaints of scientific misconduct which may arise within the Faculty of Medicine. The policy is consistent with existing formal University of Ottawa and APUO policies pertaining to these complaints. Moreover, complainants are free to address their complaints directly to the University Sexual Harassment Office, or to avail themselves immediately of the grievance procedures provided for in the applicable University policies or the Collective Agreement.
RESIDENT WELL BEING

POSITION PAPER

June 1998
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Part One: Behind the White Coat... Our Feelings about Ourselves

Canada has a system of medical training that is the envy of the world. Our undergraduate programs are charged with the responsibility of selecting the men and women who will enter a respected and honoured profession. However, there are far more applicants than positions for training and selection is competitive. Applicants must not only be well above average academically, but must also demonstrate an understanding of communities, families, individuals, and themselves.

Many applicants have spent the bulk of their late adolescence and early adulthood focused on maximising their admission potential and, as a result, have developed a sense of competitiveness, self-discipline, and achievement. Pressured by the competition inherent in admission to medical school, many applicants take on extra academic or co-curricular activities to obtain additional experience that might enhance their attractiveness to admission committees.

Once admitted to medical school, the demands placed on the individual continue. Throughout their undergraduate training, medical students must understand vast amounts of scientific and psychosocial material, and learn to apply it to clinical situations. Medical students are pressured to select a postgraduate stream of study early in their training, and often feel the need to obtain additional experience that might enhance their attractiveness to an entirely new set of admission committees for residency training. In addition, medical students are confronted with financial pressures related to escalating educational expenses such as tuition fees, and often need to negotiate significant debt loads.

In residency, the demands are more focused but tend to escalate. Physicians continue to work diligently, and assume more responsibility for teaching and patient care. The pressures mount as residents prepare for their final examinations and entry into independent practice.

Such competitiveness fosters an environment in which high and often unreasonable expectations are placed on residents such that nothing but excellence can be expected or displayed. This can result in excessive demands on residents, and high levels of insecurity, inadequacy, and fear of incompetence may develop. Finally, a culture of denial pervades medical training and residents are taught to deny that they are feeling overwhelmed, stressed, fatigued, or uninformed. Consequently, the CAIR Well Being Committee recommends that:

- Residency training programs encourage the use of program and stage specific training objectives, and ensure that these objectives are developed in a collaborative process with residents and are realistic, reasonable, and reflective of core learning needs.

- Residency training programs train residents to have self-appraisal skills.

- Residency training programs develop mentoring programs that form part of the learning milieu.
Residency training programs foster an environment in which residents are respected as colleagues.

Residency training programs ensure that residents are provided with comprehensive feedback that includes the identification of both strengths and weaknesses. Appropriate levels of confidence should be fostered and encouraged.

Residency training programs should include sessions on goal setting, substance use, personal and team management, and work addiction in their professional development curriculum.

PHOs consider creating an award for both residents and supervisors, where modeling the role of the physician as a balanced person and professional is recognized.

CAIR continue to encourage the development of evaluation systems that ensure residents can openly discuss their academic and personal concerns without fear of reprisal.

CAIR work with the Canadian Federation of Medical Students to lobby for an undergraduate evaluation system that discourages evaluation tools that foster undue competition.

CAIR continue to encourage the development of evaluation systems that include self-assessment.

CAIR lead a discussion with PHOs on the integration of recreation and professional life.

CAIR consider the establishment of a national resident's week.
Part Two: Working Beyond Service - Residents and Workload Issues

The term Housestaff originated when residents lived in the hospital for the duration of their training. In exchange for their ongoing service (twenty-four hours a day, seven days a week, three hundred and sixty-five days a year) residents were given modest accommodations, meals, and an education. The latter half of this century saw the rise of "Provincial Housestaff Organizations" or PHOs and witnessed the birth of collective agreements between residents and their employers. While there have been many improvements to the Canadian training system as a result of the collective bargaining process, there remain a number of critical areas that continue to affect the well-being of Canada's new physicians.

A. Clinical Demands

Canadians expect that hospitals will provide expert care twenty-four hours a day and expect that a physician will be part of their care team during that time period. Residents staff many hospitals between five pm and eight am and do so after working a regular day. In many cases, residents are expected to work in excess of twenty-four to thirty-six hours, and this can occur without sleep, rest breaks, or proper nutrition.

Many PHOs have negotiated collective agreements that limit their call frequency to one period of call every three days, or "one in three" call, and some have successfully negotiated call frequencies of no greater than one in four. In addition, several PHOs have ensured an absolute maximum working period for some specialties of twenty-four hours, with all specialties limited to a twenty-eight hour shift. Unfortunately, even this seemingly excessive maximum consecutive hours of work for the average Canadian worker is ignored by some programs and some residents are expected to work up to and sometimes beyond thirty-six hours in a row.

CAIR is committed to contributing to an environment in which Canadians are provided with the best possible care. To maximize the care provided by new physicians, the CAIR Well Being Committee recommends that:

- PHOs continue to bargain for reasonable workload limits, which could, among other things, include a maximum of one in four call or a maximum duty period of twenty-four hours.

- CAIR investigate the impact of sleep deprivation on the care of Canadians and the health of residents.

- CAIR facilitate a dialogue for PHOs on the role of clinical associates in teaching hospitals, and their potential role in reducing the call frequency and workload experienced by residents working in understaffed hospitals.
B. **Non-clinical Demands**

1. **Non-clinical Academics**

   Both the Royal College of Physicians and Surgeons of Canada (RCPSC) and the
   College of Family Physicians of Canada (CFPC) define the curriculum for training
   programs they accredit. Generally speaking, these curricula have focused on the
   clinical areas residents need to master. However, aspects of training such as ethics,
   medical law, and principles of medical organization are often neglected during
   residency. Consequently, the CAIR Well Being Committee recommends that:

   CAIR lobby both the RCPSC and CFPC to ensure that adequate curricular time for
   instruction in these areas is protected by their training programs, and that such
   instruction be in place prior to the introduction of the CLEO examination.

   CAIR develop an annual forum for PHOs to identify "Neglected Themes in
   Postgraduate Medical Education."

   CAIR encourage both the RCPSC and the CFPC to have, as a central part of their
   accreditation process, a review of compliance of working conditions as set forth by
   the appropriate collective agreement.

2. **Teaching**

   Residents are not only expected to participate in the direct clinical care of Canadians,
   but they are also expected to participate in the academic activities of their
   universities. Often, this includes direct teaching and supervision of medical students
   or other residents. As with all educators, residents must dedicate a great deal of time
   to the development of educational materials, and must develop skills to meet their
   goals as adult educators. However, unlike most educators, residents receive no formal
   training in the principles of adult education. In addition, residents receive no
   remuneration for time committed to the education of the university's undergraduate or
   postgraduate students. Traditionally, residents have donated this service as part of
   their commitment to excellence within the profession, and as part of the profession's
   historical commitment to mentorship.

   In recent years, universities have considered charging residents a significant tuition
   fee. While many residents pay a fee to the university for administrative expenses,
   CAIR stands opposed to any system that unilaterally imposes fees upon residents
   while ignoring the unique roles of residents in the health care system and the role of
   the PHO to participate in the negotiation of such fees. Consequently, the CAR Well
   Being Committee recommends that:
CAIR facilitate a discussion amongst PHOs on the theme of tuition fees in postgraduate medical education.

CAIR continue to be an active participant in both the RCPSC and CFPC's National Conference on Postgraduate Medical Education.

CAIR recognize postgraduate programs, residents, and faculty who foster excellence in both medical education and the training of medical educators.

CAIR encourage the RCPSC and the CFPC to facilitate the development of residents' teaching skills.

CAIR investigate the possibility of hosting an annual training seminar in medical education for senior or chief residents, with a view to such a seminar being recognized as an essential part of postgraduate medical education.

iii. Service to the Profession

Residents feel a strong desire to participate in the various systems that influence how medical care is delivered to Canadians. Organized medicine has many complex levels in Canada and many residents are aware of opportunities to participate in their PHOs, provincial or national medical associations, and CAIR. Efforts within these organizations provide a unique training experience whereby residents gain a set of skills that will be of great use to the public. These skills include, but are not limited to, health policy, health economics, governmental relations, public advocacy, media training, and organizational management.

Clearly, not all residents can easily integrate such additional demands into their already busy training schedule. To facilitate such integration, the CAIR Well Being Committee recommends that:

PHOs consider negotiating time for PHO/CAIR activities into their collective agreements as guaranteed time off service.

CAIR develop a position advocating that participation in medical organizations (e.g. provincial housestaff organizations) can be recognized as an academic rotation.

CAIR develop a joint award with the RCPSC and the CFPC that recognizes resident leadership.

CAIR and the PHOs consider alternate methods of encouraging leadership (e.g. presidents could be part-time residents, and the PHO or CAIR could contribute to the remainder of their salary).

iv. Research
The development of physician-researchers is important for the Canadian public. However, many residents find programs have difficulty designing training programs that meet their needs. Rather than integrating research training into their clinical experience, many programs simply add the research training onto residents' heavy clinical duties. In such programs, residents are particularly vulnerable to high levels of stress. Consequently, the CAIR Well Being Committee recommends that:

Research streams be designed such that there is protected time for residents' research.

Both the RCPSC and CFPC ensure that such streams are accredited according to established standards.

Research training should not extend the duration of the program as specified by its accrediting college.

CAIR consider the establishment of an award for resident research in the basic and clinical sciences, and health policy and promotion.
Part Three: Forced Martyrdom - Residents and Family Life

Canadian medical residents enjoy some of the best training conditions in the world as compared to trainees in other countries, thanks to collective agreements that have been negotiated by their provincial housestaff organisations (PHOs). However, the hours associated with the training of a specialist or a family physician continue to be far in excess of those of the average Canadian; for example, surgical residents usually start work at 6:30 am and end at 6:00 pm. This includes time spent "rounding" on pre- or post-operative cases, in the operating room, teaching and completing administrative work. Residents also spend many hours studying around their cases, preparing teaching rounds, reviewing administrative information and completing research projects which are often mandatory and without protected preparation time. Add to this schedule working every third or fourth night in the hospital and the work commitment easily totals one hundred hours per week.

CAIR's research indicated that residents identify their family and social lives as the most significant areas adversely affected by long working hours. Residents say they feel more prone to separation, divorce, or a prolonged single life because of their working hours. Residents who are also parents say they have great difficulty balancing their roles as clinicians and parents, and often experience guilt and regret over the loss of time spent with their children.

In addition, programs that require training outside large centres (such as rural family practice), may isolate residents from social and family ties. While one objective of this training is learning how to adjust to such isolation, the learning process can be quite difficult, painful and damaging to residents' and their families.

This is not a simple debate as many residents believe their working hours represent significant and necessary clinical experience in their profession - experience that some believe is the minimum required in preparation for independent practice. Others argue that this is a distortion propagated by residents prone to over-achievement and competition, and a system dependent on the cheaper labour of residents. In any case, the hours residents must dedicate to their education and work are substantial.

The impact of such a commitment on the resident's family is extensive. This poses significant concern given the prominence of families in resident's support networks, and the responsibilities that residents have to their families. Given that it is of importance to society that our families be given the time and respect to stay healthy and productive, the CAIR Well Being Committee first recommends that:

Respect be given to all families, regardless of their structure or content, and appropriate provisions should be made to identify their role in the training of Canadian physicians. Specifically, no family should be discriminated based on grounds as age, gender composition, marital status, physical or mental disability, medical condition, national or ethnic origin, political affiliation, race, religion, sexual orientation, or socio-economic status.

In addition, the CAIR Well Being Committee recommends that:
Each residency training program should develop a formal orientation for all new residents, and include sessions for the family members of the resident. Family members should also be encouraged to attend social events and retreats where appropriate.

Residency training programs must ensure that parental leave is respected and encouraged.

Each program investigate local daycare resources and arrange for access for residents, preferably on the same site as the resident’s rotation. Daycare after regular working hours should be subsidised for the children of residents when that resident is on call.

Each program respect the choice of residents to complete their training on a part-time basis and provide appropriate training options.

Rural residency training programs incorporate, into their core curriculum, sessions on coping with isolation. In addition, funding pool should be developed to facilitate visits between residents and their families as well as for long distance telephone/electronic communication.

Residency training programs requiring rural rotations should maintain sufficient flexibility to take into account resident’s family demands.

Chief residents receive, as part of their training in administration and management, orientation sessions on the role of families in resident well being.

Residency training programs have, as part of their core curriculum, sessions on balancing and integrating professional and family life. In addition, such sessions should be integrated into the undergraduate medical school curriculum.

Residency training programs develop and distribute a list of resources for residents facing family difficulties, such as individual, couple, or family therapy. Access must be confidential and without excessive expense.

PHOs have a responsibility to their membership to advocate for contracts that contain useful, equitable, and enforceable provisions that pertain to the workplace. While contractual issues are negotiated between PHOs and their employers, and are not unilaterally determined by PHOs, PHOs should endeavour to obtain such provisions in their contracts. Given the impact the workplace has on the family life of residents, the CAIR Well Being Committee suggests that:

Call systems should be designed to avoid unsafe workloads, preserve educational value, and minimise loss of personal or family time.

PHOs have some form of parental leave written into their contract, with equitable access given to both men and women, and with equal access for adopted children.
Residents should also be informed of parental leave standards legislated by the Canadian Labour Code.

If PHOs hold retreats, social events, or planning activities, they should then strive to incorporate the families of their members.

PHOs lobby for subsidised provision of daycare for the children of residents on call after regular working hours.

CAIR use its liaison positions, where-ever appropriate, to inform other national medical organisations of the importance residents place on families.

CAIR consider developing a centralised database of literature and evidence on the impact of medical training and practice on families of physicians.

CAIR work with the PHOs to investigate the impact training has on residents and their families as well as possible strategies to minimise negative impact.
Part Four: Taking Care of Ourselves during Residency Training

It is understood that residency training is a particularly stressful time in the life of any physician. While the majority of residents are able to mobilise effective ways to manage stress, others may be more sensitive to the impact of such significant stressors.

The profession as a whole has become more aware of the incidence of impaired physicians over the last fifteen to twenty years. Some physicians attempt to treat their own illnesses, particularly those which carry negative stereotypes, such as psychiatric illness. Many professional organisations have developed programs to recognise and treat substance use disorders, mood disorders, anxiety disorders, and personality disorders. In addition, the literature is beginning to witness a more formal approach to the study of illnesses in physicians and regulatory agencies and medical associations are beginning to invest resources in the prevention of such serious disabilities.

Many residents report experiencing significant distress when confronted with difficult patient issues and tragedy in the course of clinical duties. In addition to the stressors particular to residency, residents confront many of the same stressors as other Canadians. Quite often, residents silently cope with the dissolution of their relationships, wrestle with debt load, or struggle with the challenges of raising children or caring for elderly members of their families.

Finally, there continues to be little education in the Canadian medical training system about such impairment, and even less training in how to care for wounded healers. Consequently, the CAIR Well Being Committee recommends that:

- Residency training programs and PHOs strongly encourage residents to obtain the services of a family physician.

- Residency training programs and PHOs develop a confidential database of private, nonacademic physicians who have expertise in the care of medical professionals and are open to new patients.

- Each PHO consider developing a core program of resources for residents, such as a telephone hot line, list of confidential and non-academic psychiatric services, identified inpatient resources, list of detoxification centres and follow up programs for recovery from substance use, and list of expert speakers who can address programs on the issue of physician health.

- Residency training programs develop policies that clearly prohibit residents from taking pharmaceutical samples off site to avoid physician self-medication.

- CAIR endorse the CMA position statement on "Physician Health and Well-Being."

- Residency training programs and PHOs ensure resident education on mandatory reporting of impaired physicians where such reporting systems exist.
CAIR develop an extensive resource library on physician health, including electronic media, and develop a borrowing system with the PHOs.

CAIR consider seeking funding to develop an initiative to generate research in the area of resident physician health.

CAIR consider sponsoring an annual symposium on resident health, or consider doing so as part of a joint conference with another group involved with physician health.

Residency training programs develop critical incident debriefing teams to reduce the impact of traumatic events on caregivers.

Residency training programs encourage multiple methods of reducing stress, such as advocating for access to recreational and athletic equipment and offering seminars in time management, relaxation therapy, and financial planning.

CAIR review and consider endorsement of the Canadian Psychiatric Association's position statement on the "Treatment of the Mentally Ill Physician."
Part Five: Training Canada's New Physician Workforce - Residents and Career Issues

Canada is respected around the world for its excellent medical education system. Canadians continue to benefit from some of the world's most highly skilled clinicians, but many Canadians are unaware of the dramatic changes that have occurred in the system over the past decade. In the early 1990s almost every major stakeholder in the training system introduced significant changes to the training and licensure systems. The ultimate effect of these changes on the delivery of health care to the Canadian public is yet to be assessed; however, the short-term effects have been most detrimental to Canada's resident physicians.

Physicians can no longer become general practitioners or GPs after one year of training; rather, they must complete a two-year program to become family physicians or a four to seven year program to become a specialist. Entry spots into these two training streams are quite competitive; in some provices, there is no guarantee that every medical student will be "matched" to a postgraduate training position. This has resulted in medical students feeling that they are forced to decide on their ultimate career very early in their medical training and prior to their exposure to some medical disciplines.

To complicate matters, there are few opportunities for residents to alter their choice of postgraduate training. For example, medical students focusing on gaining admission to a surgical training program throughout medical school are likely to "match" to a surgical residency. However, should they realise after one year of residency that they would prefer to train in paediatrics they are likely to discover that, in many cases, there is no opportunity to switch training streams. Consequently, residents must remain in the training stream initially chosen. Residents can no longer opt to become a general practitioner and are left with the choice of staying and being unhappy in their profession, or leaving medicine for other pursuits. Either choice reflects a huge loss for residents, the profession, and the Canadian public. Based on these concerns, the CAIR Well Being Committee recommends that:

CAIR review the "Guidelines on Career Flexibility" developed with other stakeholders in 1997 and consider endorsement and advocacy.

CAIR develop a position statement and publicise an implementation strategy for the - concept of a first year of postgraduate training with common content and flexibility. This strategy should not result in any extension of the current duration of postgraduate training.

CAIR investigate the notion of returning to a two-stage matching system, by which medical students are matched to a common first year and PGY-2 residents are then matched to a specialist/family practitioner stream. Such a system should not extend the overall duration of training programs.

CAIR work with the CFMS on a joint task force on career flexibility to develop an overall strategy in this area.

CAIR investigate the degree of flexibility reported to exist in the current system, with
consideration of the funding of a formal study on flexibility.

In addition, the CAIR Well Being Committee reaffirms CAIR's four principles on physician resources:

Graduates of Canadian medical schools must be assured access to the system.

Coercive measures must not be used to force new doctors to specific geographic locations or domains of practice.

Changes to the health care system which affect physicians must be applied to the profession as a whole and must not be targeted against any one group within the profession.

Doctors in training and in practice in Canada are a national resource and, therefore, interprovincial mobility must be maintained.
Part Six: Feeling Safe - Residents and Fears of Harm

In the duty of providing medical care, residents are occasionally exposed to dangerous, or potentially dangerous agents or situations. All physicians are exposed to aggressive or violent behaviour at some point in their training, and have a high risk of being injured if they lack the basic skills to manage such behaviour.

To reduce the risk of harm to Canadian residents by violence or aggression, the CAIR Well Being Committee recommends that:

- All residency training programs, particularly psychiatry, family practice, and emergency medicine, develop curricula that teach principles of non-violent crisis intervention.
- All residency training programs consider an annual "safety assessment" where programs and representatives from the PHO complete a safety assessment of the working environment.
- All residency training programs should develop curricula that review the creation of a safe clinical setting.
- CAIR and the PHOs investigate the incidence of episodes of assault and/or battery against residents and advocate for strategies to decrease the overall incidence.
- Also in the duty of providing medical care, residents are occasionally exposed to infectious diseases that may place their own health at risk. In this regard, the CAIR Well Being Committee reaffirms CAIR's "Position Paper on Infectious Disease."
Part Seven: Crossing Boundaries - When Training is Tainted by Maltreatment

Medical culture has changed dramatically over the past half-century. Supervisors and residents have been forced to change their communication and behavioral styles and their roles in the family systems of medical education. Traditionally, the medical team has operated as a strict hierarchy, with a paternalistic approach to knowledge acquisition and development of professional identity. In recent decades, this traditional approach has been challenged by an influx of diverse learners and faculty members as well as an integration of principles of adult education into the medical training system.

Consequently, residents in the current training system enjoy a work environment where the issues of intimidation and harassment are being addressed more openly compared to the past. However, medical culture continues to tolerate and propagate attitudes and behaviors that can be labeled in no other way than resident maltreatment.

Residents can also be the source of intimidation and harassment directed towards medical students, other residents, paramedical staff, patients, and supervisors. The cause of such behavior can be complicated as the behavior may reflect excessive amounts of stress, an illness that causes irritability, such as manic-depressive illness, or the way in which the medical culture influenced the professional identity of the resident. Regardless of the cause, such behavior is unacceptable and needs to be identified early and managed appropriately.

CAIR has developed a "Position Paper on Intimidation and Harassment." In addition, many PHOs have developed their own policies reflective of these principles, and many universities have designed systems to address allegations of maltreatment. The CAIR Well Being Committee applauds these efforts, and recommends that:

PHOs review, on an annual basis, the incidence of reports of maltreatment of residents within their programs.

PHOs consider adding to their collective agreement sections that specifically address intimidation and harassment, including systematic methods of investigating all allegations.

PHOs work with residency training programs to ensure that opportunities exist for residents to seek confidential counseling regarding issues of maltreatment.

CAIR consider formally evaluating the incidence of resident maltreatment and how it is affected by current or proposed methods of investigation.

CAIR continue to work with other stakeholders in the training system on these critical issues.
CAIR consider entering into a dialogue with members of other health care professionals, particularly nursing, to review aspects of professional conduct between established professionals and residents.

CAIR consider developing a rational resident advocacy award to recognize and celebrate those who have shown initiative in developing a safe and respectful working environment for residents.