A Descriptive Framework for Physician Health Services in Canada

Prepared by the Tricoastal Consortium for the Canadian Medical Foundation

May 2016

This report was created by the Tricoastal Consortium[1] under the Canadian Physician Health Institute. The Canadian Physician Health Institute is dedicated to improving the health of Canadian physicians, and is the result of co-operative participation between the Canadian Medical Association and the Canadian Medical Foundation.

[1] For details of the Consortium's membership please see page 14.

Executive Summary

The work of physicians is both stressful and safety-sensitive. Each province and territory in Canada has evolved unique approaches to providing services that not only mitigate the risks of medical practice on the health of physicians, but also reduce the impact of doctors' health on their ability to practice safely.

Our country is large and diverse, and the services required to mitigate these risks (referred to in this document as physician health services) are sometimes complex. As a result, their independent evolution in multiple locations to suit local needs has presented challenges to those seeking to share, cooperate and collaborate on a national scale. Service providers in different locations may use identical terms to mean completely different things, or they may use entirely different terms to mean the same thing. This project is an attempt to address this challenge by creating a common language for the description of physician health services in Canada.

Most jurisdictions in Canada have chosen to bring a number of physician health services together under the banner of a Physician Health Program, or PHP. These PHPs have a great deal of diversity in their organizational structure, the range of services they provide, their mechanisms of accountability to their stakeholders, and the manner in which they pursue activities such as scholarship and outreach (which some do not see as central to their primary missions).

Although PHPs are not the only providers of physician health services in Canada, they are certainly important in this capacity. Their coming together, and realizing that they lacked precise definitions of their core services, led to the conception of this project.

The Canadian Medical Foundation took the initiative to fund an *ad hoc* working group (The Tricoastal Consortium) to lead the necessary work, and with the support of the Canadian Medical Association, and the active collaboration of the Forum of Canadian Physician Health Programs, the project was completed – this ***Descriptive Framework*** was born. It defines of 17 core physician health services (and modes of activity within each service).

Application of the framework makes it possible to generate an integrated overview of Canada's PHPs, including their organizational structures, accountability mechanisms, and some of the related non-core activities in which they engage.[2]

This project is an important achievement in its own right, but it is also starting point for many other activities that might build on the framework's foundation. By putting a definitional "outer boundary" on the diversity in local solutions to common national problems, this project has set the stage for further collaboration on a national and even international scale. In response to this opportunity, one aspect of the project was to ascertain and summarize the ways in which participants envision using the final product. Those potential uses are summarized in a companion report.[3]

[2] Such an overview will be presented in a separate document, to be delivered to the CMF and to participating service provider organizations in June 2016.

[3] ***From Development to Use***, © CMF May 2016.

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Project Background

The Forum of Canadian Physician Health Programs (FCPHP) consists of representatives from each of Canada's existing PHPs. With the support of the Canadian Medical Association, Forum members have been gathering once or twice each year in Ottawa for more than a decade to share practices and encourage the widespread provision of physician health services to Canadian doctors.

Some Canadian PHPs have been in existence for many years, have well developed services and stable funding. Others are much earlier in their development, and/or have less certain financial support. The political geography of Canada creates economies of scale for certain provinces that others do not enjoy. These realities, plus factors such as local topography and population density, all work together to produce a situation whereby physicians in some parts of the country have much better access to physician health services than others.

FCPHP members have been trying for some time to collaborate to make the distribution and availability of services more equitable. However, their efforts to collaborate to improve access were often hindered by uncertainty about the basic nature of core services provided.

For example, in one province the term "monitoring" might be used to describe a core service; in another the term might be also be in common use, but imply quite a different range of services. In a third jurisdiction, a completely different term might be used to represent the same essential set of activities. The FCPHP realized that for the dream of equitable access to become reality, sharing and collaboration were necessary. However, they acknowledged that building a common vocabulary must precede large scale success in sharing and collaboration.

In November 2014, the FCPHP decided to focus its efforts for the upcoming year on building such a common vocabulary. Its nascent plan was to meet in the spring of 2015 to create a proposal for the project, and then to seek funding to do the required work at its fall meeting. Two events subsequently altered this plan:

1) The CMA announced a restructuring, resulting in the cancellation of the FCPHP meeting which would normally have taken place in the spring of 2015; and
2) The Canadian Medical Foundation (CMF) issued in December 2014 a request for proposals to develop "Standards of Service and access for Canadian Physician Health Programs."

Although the CMF's goals were not identical to the FCPHP's, they were similar enough to inspire three FCPHP members (NS, ON and BC) to form a consortium (The Tricoastal Consortium, or TCC) with the assistance of an experienced consulting team, to respond to the request for proposals. After selection and negotiation processes were concluded, a contract was signed in June 2015 between the TCC and the CMF to undertake the current project.

As described later in this report, the work proceeded through a collaborative and iterative process of successive inquiries. One of the findings that emerged from the process was that while FCPHP members supported the goal of equitable access to services for Canadian physicians, they were not yet ready to embrace the development of normative standards for these services. This finding led to an agreement between the TCC and the CMF to refocus and rename the project's final deliverable as a ***Descriptive Framework for Physician Health Services in Canada***.

Iterative Development

In keeping with the spirit of its origins, the ***Descriptive Framework*** project was characterized by a collaborative approach to tool development. The TCC believes this co-creative approach has been essential to the quality and relevance of the resulting tool.

Multiple opportunities were provided to participating PHPs to review drafts, provide feedback, and shape future directions. Table 1 below summarizes the key activities and participants in this process.[4]

Date		Project Phase	Activity	Participating Provinces
2015	June	Preliminary framework development	Draft framework "A"	TCC (BC, ON, NB)
	July		Interview data collection	TCC
	August		Draft framework "B"	TCC
	September		Interview data collection via telephone	BC, AB, SK, MB, ON, QC, PEI, NB, NS, NL
	October	First round data gathering and reporting	Draft framework "C"	TCC
	November		In-person consultation Ottawa	BC, AB, SK, MB, ON, NS, NL
2016	January	Second round data gathering and reporting	Draft framework "D"	TCC, based on consultation input
	February		Online data collection	BC, AB, SK, MB, ON, NB, NS, NL
	March		In-person consultation Vancouver	BC, AB, SK, MB, ON, NS, NL
	April	Reporting and uptake recommendations	"Final" ***Descriptive Framework*** and uptake documents produced	TCC, based on consultation input
	May	Third (final) round data gathering and reporting	Online data collection using "final" ***Descriptive Framework***	BC, AB, SK, MB, ON, NB, NS, NL

Table 1: Project timeline and participants

Initial Descriptions

The project commenced in June 2015 with the efforts of representatives from three provincial PHPs (from British Columbia, Ontario and Nova Scotia) serving as members of the Tricoastal Consortium. These three programs are very different in their scope of service and approach to their work, despite many commonalities. Their representatives suggested that both the commonalities and differences

[4] At the present time, physicians working in Canada's Territories are served by a PHP in one of the southern provinces, under contract to a Territorial regulator or Medical Association; there are no distinct Territorial PHPs.

would be an asset in developing tools that were relevant across programs and service delivery models nationally.

The non-physician members of the TCC team developed the first iteration of the tool (draft framework "A"). They next conducted interviews and gathered data from the three TCC programs based on that framework.

The strengths and limitations of this tool quickly became apparent, and in particular, the issue of definitions emerged almost immediately as a central concern. Words that had been assumed to refer to the same activities (e.g. "intake"; "clinical"; and "intervention") were found to have different meanings to different users. At this point the TCC recognized that an essential component of the project would be the development of a glossary and shared definitions.

Learning from this experience, a second iteration of the tool (draft framework "B") was developed. It was used as the basis for follow-up interviews with the TCC team and, soon thereafter, with their PHP colleagues in seven other provinces. The result of this data collection was collated and reviewed by the TCC, leading to the creation of the third iteration of the tool (draft framework "C").

Information provided by each province was then organized according to this third draft framework, and a set of national comparisons was prepared. These summaries reflected how delivery of each service by a given province's PHP compared to the mode of service delivery in other jurisdictions. The national comparisons were circulated to each participating PHP in blinded form, highlighting their data but with all other provinces de-identified.

Through this approach, the TCC sought to work collaboratively with the country's PHPs to define a standard scheme for comparison using a graphic display. The aim was to develop a tool that would allow each program (including entities who do not consider themselves PHPs in the strictest sense) to create a program-specific graphic display, showing which services they provide, and the level of development of each service. In addition, programs were offered a common set of "levels", which facilitated comparing degrees of maturity and complexity across jurisdictions and organizations (using a graphic display).

A sample of this display is presented in Figure 1, showing reported levels for four of the fifteen services described in draft framework "B". In this image, the four proposed levels of service maturity/complexity are indicated on the y axis, with vertical bars illustrating the levels of service delivery reported by each of the nine participating provinces for each service. Provinces are de-identified and randomized, with the goal of the graph being to illustrate the range and variation of services available across the country.

Throughout the project, the TCC reiterated its commitment to maintaining the confidentiality of program data, recognizing the sensitivity of program comparisons across jurisdictions. It is important to note that comparison or sharing of identified program data was to be undertaken only on a "willing disclosure" basis. This potential to share assumed that participants might see value in the comparison for purposes of quality improvement, through learning how their programs differ or reflect common characteristics.

Feedback and Refinement

In November 2015 the members of the Forum of Canadian Physician Health Programs (FCPHP) gathered to review the draft framework, and to provide feedback and suggestions for its improvement. At that meeting, the TCC acknowledged that concerns had been raised during the project's interview process regarding the description "standards" for the project's ultimate deliverable.

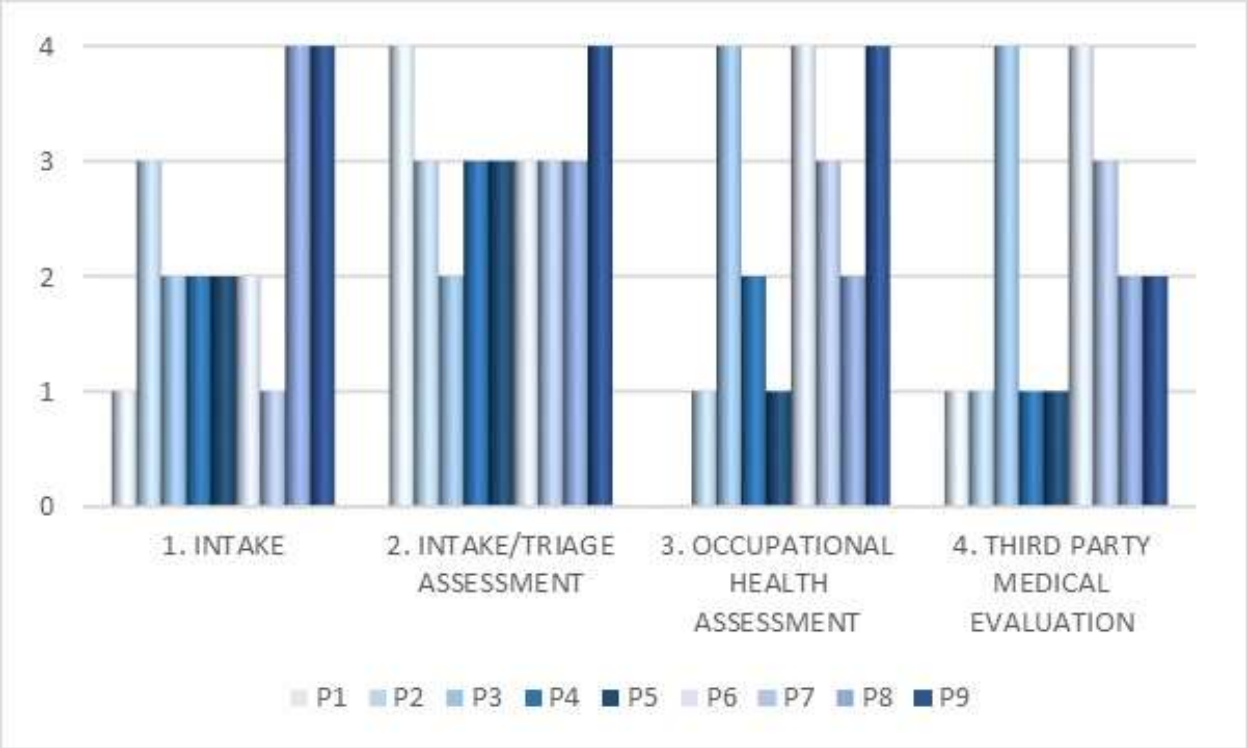

Figure 1: Sample graphic display, Draft framework "C"

While this had been the terminology used in the RFP and the contract for the project, some FCPHP members suggested that establishing standards had not been the intention of the initiative they discussed at the project's genesis. Many stressed the importance of viewing the initiative as an invaluable opportunity for quality improvement within and across programs, and noted concern about the barrier to this opportunity that might be represented by use of the term "standards". To them, the presence of an authority imposing or requiring compliance was implicit in such a term, and as such adoption of standards was a step which the programs were not yet ready to invite.

Concern was also stated regarding use of the term "implementation" of anticipated "standards". For some this term reinforced the assumption of an intention to impose standards. Of particular concern was the fact that most programs were not likely to have the resources to meet externally imposed benchmarks, with the result that they could be judged as inadequate (not "up to minimum standards").

By contrast, they had anticipated a process whereby each program will determine the best way to engage with funders and stakeholders regarding the optimal use of the framework and provincial program data in their respective jurisdictions.

TCC members reiterated that their working philosophy stressed the co-creative, collaborative nature of definitional development, recognizing that stakeholders across varied jurisdictions have very different program resource realities.

FCPHP members requested that the TCC communicate their concerns to the project funder and request a change to the terms and conditions for the TCC's engagement. Specifically, they requested that references to "development of standards" be amended to define the project as "development of a descriptive framework for quality improvement"; and references to "implementation" would be amended to refer to uptake and adoption, to emphasize individual organizations' choice in how the tool

is used. These requests were duly communicated by the TCC. Soon after, the CMF readily agreed to changes to the project terms, and noted its intention to facilitate whatever process would contribute to optimal utility of the resulting tool.

The strengths and weaknesses of the graphic display format used for reporting comparative data were also explored by FCPHP members at the November meeting. They acknowledged the benefit of a display which allows the user to view comparisons (e.g.) across all services and activities of a given PHP, or across multiple programs for a given service.

At the same time, specific features of the display were identified as problematic. PHP leaders agreed that the use of the term "Levels" was problematic for describing a progression along the y axis in the display. Concern was expressed about assuming that the relationship amongst the levels was one of "increasing maturity", when differences might in fact reflect (e.g.) the choice of a mature program to limit service delivery in one area in order to allocate resources to another priority.

Further discussions resulted in suggestions for numerous additional improvements to the framework, including identification of preferred terminology for the tool's glossary.

FCPHP members also encouraged the TCC to continue to explore how provincial data summaries might reflect the availability of all health services available for physicians in their respective jurisdictions, including those which are not provided by a PHP (e.g. through the provincial College, universities or physician employer institutions). Such a display would reflect the physician's view of existing services, regardless of provider (rather than presenting a display that would suggest a given service is unavailable in that jurisdiction).

At the conclusion of the meeting, FCPHP members agreed to participate in another round of data collection, based on a new and revised Framework, early in 2016.

Moving Online

Based on the input from PHP colleagues, TCC members developed the next version of the tool (draft framework "D"). Efforts were made to standardize terminology even further, and to replace the term "level" with the label "mode".

The new draft ***Descriptive Framework*** was then transformed into an online survey format. This approach to data collection reduced the workload generated for both the TCC and the participating PHPs, and at the same time provided a way to test the new standardized terminology.

Online surveys were completed by participating PHPs during February 2016, and based on the data submitted the TCC team prepared individual reports for each program/province. The reports presented definitions of service areas and delivery modes, along with a single graphic image for each of the services explored.

An example is presented in Figure 2. In this new graphic display, the y axis represents the total number of programs surveyed, with a stacked bar chart illustrating by colour how many programs had indicated their mode of delivery for the service was (a), (b), (c) or (d). A solid line indicated the median response for the total number of participating programs. These components were common to all snapshot reports – however for each individual province, a red arrow was added to indicate the response from the province for which the report was prepared. Again, no identifying information was provided for any other province.

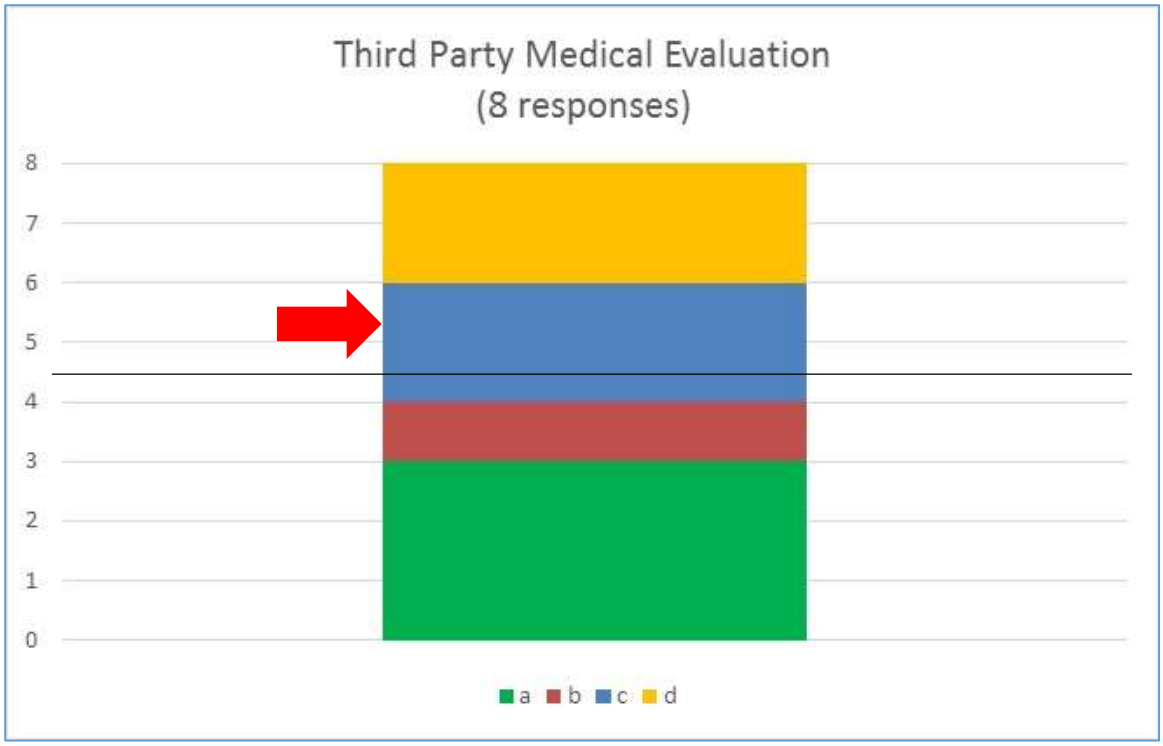

Figure 2: Sample graphic display, draft framework "D"

For some sections of the ***Descriptive Framework*** relating to scholarship, outreach and wellness activities, data collected through the survey revealed challenges in developing discrete, relevant modes of delivery. Repeated analysis of the responses to these questions resulted in a failure to identify four distinct modes of delivery for all questions.

Although there were clear differences between and across programs, there were no common subsets. For example, with respect to educational activities, no more than two programs were found to share the same mix of activities. As an alternative to graphs, the resulting information was presented in a more detailed, descriptive form, as shown in Table 2.

Activities	Program Count
a) We do not offer learning opportunities ourselves, but we offer advice on where to find education resources from other providers.	0
b) We offer static resources such as documents, videos, books either for download or to borrow.	5
c) Our staff prepare and facilitate formal learning events (lectures, grand rounds, small group learning, etc.).	7
d) We develop customized learning opportunities, in response to requests from physician-serving organizations.	7
e) We host conferences or other larger scale learning opportunities.	4

Table 2: Education data sample (no relevant modal framework identified)

Engagement and Fine-tuning

PHP representatives came together in March 2016 for a second in-person consultation. All those who took part in this meeting had participated in the survey based on draft "D" of the ***Descriptive Framework***, and had received provincial reports that addressed many of the concerns raised during the 2015 meetings.

Further advice was provided regarding terminology and formatting. It was suggested that, to increase clarity, going forward each section of the online survey should include a descriptive paragraph. The TCC was encouraged to continue to refine the mode descriptions to articulate clearer differences between modes, including the progression from no/limited service to comprehensive offerings, and to clarify the relationships between delivery modes (i.e., in most cases, mode "c" would include the activities described in modes "a" and "b").

PHP representatives also considered two particular issues raised by the TCC. The first of these was the question of eligibility for service. To this point in the tool development process, the TCC had asked a posed of questions about service eligibility as a separate section of the Framework. However data analysis revealed that for many participating programs, eligibility varied by service, and no single set of responses applied to a given program's entire suite of offerings.

It was agreed to alter the Framework to explore service eligibility separately for each offering. In future surveys, programs would be asked to indicate conditions of eligibility for each service in relation to three factors: Physician Career Stage, Client Relationship to Physician, and Presenting Problem.[5]

The other issue was the challenge of how provincial data summaries might reflect the availability of all health services available for physicians in their respective jurisdictions including those which are not provided by a PHP (e.g. through the provincial College, universities or physician employer institutions). As previously noted, such a display would reflect the client physician's view of services available, regardless of provider (rather than presenting a display that would suggest the service is lacking in a given province).

The TCC reported on efforts to explore this challenge, and advised that the scope of data collection required for comprehensive provincial summaries was beyond the capacity of the current project. None the less, they had briefly explored the potential for a future phase of development for the ***Descriptive Framework***.

As with the collection of data on service eligibility in the proposed Draft framework "E" (as detailed later in this report), the TCC proposed data analysis that would integrate service offerings from multiple providers in any given jurisdiction. By capturing and integrating who serves which groups of clients, this analysis would be able to report on availability of all health services available for physicians in their respective jurisdictions – including those services not provided by a PHP.

The resulting display could reflect the client's view of service availability in their province/territory, regardless of the organization(s) providing services. A preliminary conceptual approach was shared (Table 3).

[5] These factors are described in greater detail in the Framework Summary, beginning on page 10.

Jurisdiction	Domain/Activity	Mode	Who Provides Service	Who is Served
Prov/Terr 1	1	c)	PHP	Practicing MDs
Prov/Terr 2	1	d)	PHP	All MDs including retired
Prov/Terr 2	2	b)	Regulatory Body	Practicing MDs
Prov/Terr 3	1	c)	PHP	Practicing MDs
Prov/Terr 3	2	b)	Health Authority EAP	Physician family members
Prov/Terr 4	1	c)	PHP	Practicing MDs
Prov/Terr 5	1	d)	PHP	Practicing MDs
Prov/Terr 5	2	b)	University Student Health Service	Learners

Table 3: Conceptual approach for future data collection

Towards the end of the March 2016 meeting, participants expressed a desire to undertake one more round of data collection using the anticipated draft framework "E", based on the refinements proposed during the consultation. This request, and the overall positive tone of the meeting, reflected the trust developed through the project's co-creative process.

Participants had engaged as partners who shared the goal of refining and improving a draft tool. Moreover, they indicated that they looked forward to their programs and services using the tool for program development, quality improvement, quality assurance and to advocate with their governing bodies for required resources. They suggested that the Canadian jurisdictions without existing PHPs should consider the utility of the framework as a tool for development of program options and advocacy for resources to implement programs.

PHP leaders also encouraged the TCC to engage in scholarly and peer dissemination of the descriptive framework, nationally and internationally. They applauded the CMF's agreement to publication of the ***Descriptive Framework*** in this document under a Creative Commons Attribution-NonCommercial-ShareAlike license. The terms of this license facilitate future distribution, use and adaptation of the initial framework by others with an interest in physician health. By granting this license, the CMF (funders) and the TCC (authors) seek to facilitate dissemination and adaptation of the framework across Canada and beyond, and Canadian PHP users strongly support this intention.

At the same time, they stressed the importance of future releases being created through consultation with users in any jurisdiction, ideally leading to consensus on changes to content.

Looking Ahead

Following the Vancouver meeting, members of the TCC integrated their colleagues' feedback into the final draft of the ***Descriptive Framework*** – at least, final for this phase of the tool's development. This version is presented starting on page 10, including the glossary that is considered integral to the tool. The framework now describes a total of 17 services.

As requested by Canadian PHPs in at the March consultation, this "final" draft will be the basis for one more cycle of surveying, analysis and reporting, to be conducted in May 2016. Although such activity

was not contemplated in the original project agreement, once again the CMF agreed to vary the terms of the TCC's engagement to accommodate the request of stakeholder programs. This activity cycle will continue to focus on the PHPs (i.e., programs that have participated to date), and data collection will not be extended to other organizations providing physician health services.

Under the terms of the CMF grant, and based on the Consortium's proposed approach to the work, this report is one of two final deliverables. The companion report, ***From Development to Use***, provides recommendations for encouraging uptake and adoption of the framework as a neutral tool to be used at the discretion of the country's PHPs. The report recommends dynamic, collaborative stewardship of the framework, so that it can be updated and revised as Canadian PHPs evolve and develop. Like this report, it will be delivered to the CMF in May 2016, and concurrently released on the CMF's website under the terms of the Creative Commons license.

In June 2016, representatives of the TCC will attend a meeting of the Board of the CMF, to share the results and learning arising from this project. The presentation will include a review of options for the future development of the ***Descriptive Framework*** in Canada, focusing on documenting services provided to Canadian physicians by other (non-PHP) organizations. The goal of such development would be to more completely document the full range of services available to physician-clients in each jurisdiction from the perspective of the service consumer.

The Descriptive Framework in Summary

The details provided in this report reflect the ***Descriptive Framework*** as of May 2016. A high level summary of the four sections of the framework is provided below, followed by specific details of the mode descriptions for services and activities in sections 2, 3 and 4.

Section 1: Organization Description

This section of the framework summarizes data provided by participating programs on the following characteristics of their organization:

- Program name
- Province
- Other jurisdictions for which the program provides services
- Governing body
- Organizational structure (e.g., program within a larger organization; independent non-profit organization; other)
- Source of funding for the organization's operations?
- Number of physicians served (including residents, fellows and retired physicians)
- Numbers (in FTEs) and types of personnel who interact with and/or provide services to physician clients, and the nature of their affiliation (employees, volunteers or contracted service providers)
- How is the organization accountable for its collective work: to whom, using what structures and mechanisms?

Section 2: Services Offered

For each of the fifteen services described, participating programs are asked to choose from multiple mode descriptions provided; in most cases each successive activity mode includes the service options described in the previous modes. The services described are:

2.1 Intake
2.2 Triage (Intake assessment)
2.3 Occupational health assessment
2.4 Assessment requested by Third Party
2.5 Refer to family doctor
2.6 Link to other medical treatment (not including family doctors)
2.7 Link to residential treatment
2.8 Certified clinical counselling service
2.9 Link to non-clinical advisory resources
2.10 Intervention/approach to physician at risk
2.11 Return to work
2.12 Accommodation
2.13 Contractual monitoring
2.14 Case management
2.15 Peer support
2.16 Workplace behaviour improvement
2.17 Work group relationship improvement

For each service, programs are also asked to indicate conditions of eligibility for that option in relation to three factors: Physician Career Stage, Client Relationship to Physician, and Presenting Problem.

Section 3: Accountability

For each of the activity areas described, a range of mode descriptions is provided; in most cases each successive activity mode includes options described in the previous modes.

3.1 Program and service planning
3.2 Service quantity measurement
3.3 Service quality improvement

Section 4: Scholarship, Outreach and Wellness

To data, data collection with Canadian PHPs has not revealed any appropriate options for modal progressions in the ***Descriptive Framework*** for the activities in this section. As a consequence, for these areas a check-box of possible options is presented, followed by an "other" option where respondents can indicate any items not offered as a checkbox selection.

4.1 Education
4.2 Health and wellness promotion
4.3 Scholarship
4.4 System level advocacy

The Descriptive Framework in Detail

In this document, the ***Descriptive Framework*** is presented in its online survey format, including narrative examples and mode descriptions. A preamble explains the survey's structure with respect to service eligibility. Throughout the framework, blue highlighting references defined terms that are included in the Glossary section.

PREAMBLE

The framework development process has defined 17 services relevant to physician health. All organizations invited to participate in this survey restrict eligibility for each service in some way to the population of physicians and trainees (and their dependents) in each province.

Three criteria seem to be relevant to determining eligibility for a particular service: career stage, relationship to eligible party, and presenting problem. This section defines a set of categories for each of these criteria. For further clarity, the Glossary section provides definitions for additional terms used in throughout the framework including in these criteria.

CAREER STAGE

Physicians progress through a number of stages in their careers, and some organizations provide certain services only to those at select career stages. The career stages of interest are (in chronological order): medical student, resident, fellow, Practicing physician, semi-retired, and retired. For the purposes of this survey, semi-retired indicates that a physician has reduced or stopped his or her practice, but either remains licensed to practice, and/or retains membership in the local provincial/territorial medical association. Retired indicates that the physician has given up his/her license, and no longer is a member of the local provincial/territorial medical association. Also, for simplicity, we are grouping residents and fellows together as postgraduate trainees. For each service your organization provides, you will be asked to indicate the career stages of clients to whom that service is available.

- ☐ Medical students
- ☐ Residents and fellows
- ☐ Practicing physicians
- ☐ Semi-retired physicians
- ☐ Retired physicians

RELATIONSHIP TO ELIGIBLE PERSON

The range of services that some organizations provide includes some that are available not only to the physician (or trainee) himself/herself, and others that are also available to other people who are related in some way to the physician. For the purposes of this survey, the physician (at whatever career stage) is considered the "eligible person". For each service that your organization provides, you will be asked to indicate a category or service mode that describes the breadth of relationship that affords eligibility to receive the service.

The service modes identify the individuals and groups that are eligible to receive services. Mode a) includes physicians at any stage of their career from medical school through to retirement. Modes b) and c) include spouses and specific family members. Mode d) includes all physicians and family members regardless of their relationship to the physician. This would include the physician's family.

a) Physicians and Learners (medical students/residents/fellows)
b) Physicians, Learners and their spouses/partners (as locally defined)
c) Physicians, Learners, their spouses/partners (as locally defined) and their eligible dependents (as locally defined)
d) Physicians, Learners and any of their family members (no restrictive definition)

PRESENTING PROBLEM

Some organizations provide services to clients who present with certain categories of problem, but not others. For example, an organization may provide contractual monitoring to persons with substance use or mental health issues, but not to others with physical health issues such as blood-borne pathogens or neurodegenerative diseases. For each service your organization provides, you will be asked to indicate whether you limit the provision of the service to certain categories of presenting problem.

This question describes the eligibility of a range of client problems for physician health services. Mode a) indicates that services are restricted to those clients presenting with substance use issues (e.g., alcohol use, stimulant use, abuse and dependence). Mode b) indicates that services will be provided for mental health issues (e.g., burnout, depression, anxiety, marital discord, stress) in additional to substance use issues. Mode c) indicates that a broader but well-defined range of problems are eligible for service (e.g., head injury, neurodegenerative disorders, chronic pain), while d) is indicated when all client problems are eligible for physician health services, without limitation. Please note that each of the modes includes those Presenting problems in the previous mode, e.g., b) includes a); d) includes a), b) and c).

a) Substance use, abuse and dependence issues
b) Mental health and psychiatric issues
c) Other defined physical and mental health problems that impact the eligible person's health and function
d) All Presenting problems without limitation.

About the survey structure

When answering the survey, please note that many of the questions offer as a first option *a) We do not offer this service (skip to the next question)*. If you choose this option, you will not be offered further questions about eligibility to receive that service. Please choose carefully in case the next option on the list may apply (often, it notes that clients are redirected as appropriate, and this is a considered a minimal level of service).

Section 1: Organizational Description

The organizational data collected in this section of the survey will be limited to organization name and jurisdictions served. Based on interviews conducted in earlier phases of the project, a draft organizational description has been prepared by the TCC team and provided separately to each participating service provider for their review and improvement. The content for these descriptions will include the following information:

1. Organizational structure (e.g., program within a larger organization; independent non-profit organization; other)
2. Numbers (in FTEs) and types of personnel who interact with and/or provide services to physician clients, and the nature of their affiliation (employees, volunteers or contracted service providers)
3. How is the organization accountable for its collective work: to whom, using what structures and mechanisms?
4. What is the source of funding for the organization's operations?)

Survey questions:

1.1 Please indicate the province in which your program, service or organization primarily provides physician health services.

(Drop down menu, single answer only, all ten provinces offered).

1.2 Please indicate whether or not your program, service or organization is also responsible to provide health services for physicians in one of Canada's territories:

(Tick box list, multiple answers accepted (Yukon, NWT, Nunavut) and "none of the above")

1.3 Please indicate the name of the program, service or organization for which you are completing this survey. If your responses summarize services provided by multiple entities, please name them all.

Text box:

Section 2: Services

The first two questions in this section of the survey describe a range of opportunities for clients to first access physician health services, also capturing a sense of how the response is provided and by whom.

2.1 How does your organization make itself available to interact with potential clients requesting services?

The a) mode, the least extensive, captures a variety of non-interactive (in real time) methods of accessing services, including (e.g.) leaving voice messages, making contact via e-mail or other, similar means such as online connection via a website. These contacts are then answered as soon as possible by any appropriate staff member. The b) mode describe how a call is answered by a staff member, during business hours only. The c) mode indicates that in addition to a) and b), anyone calling the organization will be able to speak directly to a clinician during business hours, and the d) mode suggests that the caller can also access a clinician by telephone anytime. When selecting your response for this section you may wish to refer to the Descriptive Framework Glossary, specifically the definition of clinician.

a) We prompt the caller to leave a message on telephone intake line, or via e-mail, and we return the contact as soon as possible.
b) We provide a telephone response or in-person intake during business hours.
c) We make a clinician available for telephone response or in-person consultation during business hours.
d) We make a clinician available to callers 24/7.

2.2 Which mode of activity best describes how your organization determines the services that would be most useful for a client?

This question asks how appropriate services are determined and accessed through your organization. Again, when selecting your response for this section you may wish to refer to the Descriptive Framework Glossary, specifically the proposed definition of clinician.

In mode a), a client has access to information outlining the services you offer. This could be available through written information distributed through your office, through professional associations, universities, etc. or on the program website. In modes a) and b), service selection is determined by the client or with the assistance of your non-clinical personnel. In modes c) and d), the client is assisted by your program's clinicians to access services that best meet their needs based on an assessment of their Presenting problem. Please note that each of the modes includes those presenting problems in the previous mode, e.g., b) includes a); d) includes a), b) and c).

a) The client requests a specific service from our organization.
b) Our non-clinicians (e.g. administrative assistant) assist with problem definition and service selection.
c) Our non-physician clinician staff (e.g. regulated health professionals such as Social Workers or Counsellor) assist with problem definition and service selection.
d) Our physician staff assist with problem definition and service selection.

2.3 Which mode of activity best describes how your organization responds to clients who present with health concerns that might impair *their own* potential safety to continue in practice?

This question asks you to select the mode which best describes how your organization would respond when clients present with health concerns which they recognize might impair *their own* potential skill and safety to continue in practice. This could include a range of physical or mental health problems, as further listed under "presenting problem".

Please select the mode that best describes your organization's response.

a) We do not offer this service (skip to Q2.4).
b) We assist the client in finding an appropriate provider of occupational health assessment services after helping them better define the problem.
c) We prepare a detailed referral package including obtaining collateral information, and assist the client with interpretation and implementation of the assessment's recommendations.
d) We conduct the entire occupational health assessment ourselves in some, but not necessarily all, cases.

Please also describe eligibility to receive this kind of service from your organization:

Career Stage (select all that apply)	*Relationship to Eligible Person (select one)*	*Presenting Problem (select one)*
☐ Medical students ☐ Residents and fellows ☐ Practicing physicians ☐ Semi-retired physicians ☐ Retired physicians	a) Physicians and Learners (medical students/residents/fellows) b) Physicians, Learners and their spouses/partners (as locally defined) c) Physicians, Learners, their spouses/partners (as locally defined) and their eligible dependents (as locally defined) d) Physicians, Learners and any of their family members (no restrictive definition of family members)	a) Substance use, abuse and dependence issues b) Mental health and psychiatric issues c) Other defined physical and mental health problems that impact the eligible person's health and function d) All Presenting problems without limitation.

2.4 Which mode of activity best describes how your organization responds to *third party* requests for physician health and/or behavioural evaluations?

Third parties, such as health authorities, hospitals, universities and regulatory colleges will, at times, require health and/or behavioural evaluations to determine a physician's fitness for work, or to assess progress with respect to a disorder or condition that affects the ability of that physician to work safely.

This question asks you to select the mode which best describes how your organization would respond when clients present with concerns about *someone else's* potential skill and safety to continue in practice. This could include a range of physical or mental health problems, as further listed under "presenting problem".

Please select the mode description that best describes your organization's response:

a) We do not offer this service (skip to Q2.5).
b) We assist the client (third party) in finding an appropriate provider of occupational health assessment services after helping them better define the problem.
c) We prepare a detailed referral package including obtaining collateral information, and assist the client (third party) with interpretation and implementation of the assessment's recommendations.
d) We conduct a comprehensive occupational health assessment ourselves in some, but not all, cases.

Please report on clients' eligibility to receive this kind of service from your organization:

Career Stage (select all that apply)	*Relationship to Eligible Person (select one)*	*Presenting Problem (select one)*
☐ Medical students ☐ Residents and fellows ☐ Practicing physicians ☐ Semi-retired physicians ☐ Retired physicians	a) Physicians and Learners (medical students/residents/fellows) b) Physicians, Learners and their spouses/partners (as locally defined) c) Physicians, Learners, their spouses/partners (as locally defined) and their eligible dependents (as locally defined) d) Physicians, Learners and any of their family members (no restrictive definition of family members)	a) Substance use, abuse and dependence issues b) Mental health and psychiatric issues c) Other defined physical and mental health problems that impact the eligible person's health and function d) All Presenting problems without limitation.

2.5 Which mode of activity best describes how your organization responds to clients with identified need for a family physician?

This question asks how your organization responds to a client with an identified need for a family physician. Mode a) indicates that you do not provide this service. Mode b) indicates that you will make an ad-hoc attempt to identify a possible family physician in the client's area. Mode c) indicates that you maintain a list of family physicians who are accepting new patients, and communicate part or all of this list to the client. Mode d) indicates that you gather relevant information from the client (e.g., language preference, gender preference, geographical preference) and match them to a specific family physician from your database.

Please select the mode description that best describes your organization's responses, remembering that starting with mode b), each successive activity mode includes the service options described in the previous modes.

a) We do not offer this service (skip to Q2.6).
b) We make ad-hoc attempts to find a family doctor for a client.
c) We provide a list of family doctors accepting new patients.
d) We assess the client's needs and match to an appropriate family physician.

Please describe eligibility to receive this kind of service from your organization:

Career Stage (select all that apply)	*Relationship to Eligible Person (select one)*	*Presenting Problem (select one)*
☐ Medical students ☐ Residents and fellows ☐ Practicing physicians ☐ Semi-retired physicians ☐ Retired physicians	a) Physicians and Learners (medical students/residents/fellows) b) Physicians, Learners and their spouses/partners (as locally defined) c) Physicians, Learners, their spouses/partners (as locally defined) and their eligible dependents (as locally defined) d) Physicians, Learners and any of their family members (no restrictive definition of family members)	a) Substance use, abuse and dependence issues b) Mental health and psychiatric issues c) Other defined physical and mental health problems that impact the eligible person's health and function d) All presenting problems without limitation.

2.6 Which mode of activity best describes how your organization responds to clients with identified need for more specialized medical treatment?

Please note that this question *does not* relate to provision of Residential Treatment, which is discussed separately in the following question.

For the purposes of this question, specialized medical treatment could include community programs, psychiatrists or other medical specialists for substance use and/or psychiatric disorders. In modes b), c) and d), a client may require referral from their family physician (or other physician) in order to access these services. In mode e), your organization is actively involved in facilitating access to treatment and providing a detailed referral package and collateral information to the treatment provider. In some cases, this includes assisting and providing advocacy for the client applying for third party coverage for treatment and disability insurance issues. Generally, each successive activity mode includes the service options described in the previous modes.

Please select the mode description that best describes your organization's responses:

a) We do not offer this service (skip to Q2.7).
b) We offer an un-vetted list of treatment providers to clients.
c) We offer a vetted list of treatment providers to clients.
d) We collaborate with the client to define the problem(s) and then recommend or refer clients to treatment providers.
e) We provide a referral package and collaborate actively with an external treatment provider on behalf of the client.

Please describe eligibility to receive this kind of service from your organization:

Career Stage (select all that apply)	*Relationship to Eligible Person (select one)*	*Presenting Problem (select one)*
☐ Medical students ☐ Residents and fellows ☐ Practicing physicians ☐ Semi-retired physicians ☐ Retired physicians	a) Physicians and Learners (medical students/residents/fellows) b) Physicians, Learners and their spouses/partners (as locally defined) c) Physicians, Learners, their spouses/partners (as locally defined) and their eligible dependents (as locally defined) d) Physicians, Learners and any of their family members (no restrictive definition of family members)	a) Substance use, abuse and dependence issues b) Mental health and psychiatric issues c) Other defined physical and mental health problems that impact the eligible person's health and function d) All presenting problems without limitation.

2.7 Which mode of activity best describes how your organization responds to clients with identified need for residential treatment?

This question refers *only to residential treatment* (e.g., not to other specialized medical treatment such as community programs, psychiatrists or other medical specialists for substance use and/or psychiatric disorders – those services were addressed in the previous question).

Some clients requesting services require residential treatment for substance use and/or psychiatric disorders. In modes b) and c), you provide a list of providers to the client so that they may self-refer or have their family physician (or other attending physician e.g. psychiatrist) refer them for residential treatment. This does not preclude access to other services offered by the organization.

In mode d), you assess the client to determine the most appropriate treatment provider based on the client's problem(s). The client is either referred by you, by their attending physician, or they may self-refer.

In mode e), your organization is actively involved in facilitating access to treatment and providing a detailed referral package and collateral information to the treatment provider. In some cases, this includes assisting and providing advocacy for the client applying for third party coverage for treatment and disability insurance issues. Generally, each successive activity mode includes the service options described in the previous modes.

Please select the mode description that best describes your organization's responses:

a) We do not offer this service (skip to Q2.8).
b) We offer an un-vetted list of treatment providers to clients.
c) We offer a vetted list of treatment providers to clients.
d) We collaborate with the client to define the problem(s) and then recommend or refer clients to treatment providers.
e) We prepare a referral package and collaborate actively with an external treatment provider on behalf of the client.

Please describe eligibility to receive this kind of service from your organization:

Career Stage (select all that apply)	*Relationship to Eligible Person (select one)*	*Presenting Problem (select one)*
☐ Medical students ☐ Residents and fellows ☐ Practicing physicians ☐ Semi-retired physicians ☐ Retired physicians	a) Physicians and Learners (medical students/residents/fellows) b) Physicians, Learners and their spouses/partners (as locally defined) c) Physicians, Learners, their spouses/partners (as locally defined) and their eligible dependents (as locally defined) d) Physicians, Learners and any of their family members (no restrictive definition of family members)	a) Substance use, abuse and dependence issues b) Mental health and psychiatric issues c) Other defined physical and mental health problems that impact the eligible person's health and function d) All presenting problems without limitation.

2.8 Which mode of activity best describes how your organization responds to clients who identify a need for counselling or psychotherapy services?

This question asks you to select the mode which best describes how your organization would respond to a client with an identified need for counselling or psychotherapy services. Mode a) indicates you do not offer this service; for mode b), you redirect the client to a website such as the Canadian Counselling and Psychotherapy Association or a similar resource that helps people find supportive counselling. For mode c) you give the client a list of names of counsellors whom your organization recommends as having worked with physicians, and being sensitive to their needs. The client forms an individual business relationship with one of these counsellors.

In mode d), you offer the client counselling through a network of credentialed counsellors with whom your organization has a business relationship. Although the client may be aware that they are seeing counsellors who do not work for your organization, the client does not have to form a business relationship with the individual counsellor in order to obtain services. And in mode e), you offer the client counselling with counsellors who work directly for your organization, or are contracted seamlessly to your organization, so that the client is not necessarily aware that they are engaging with a separate entity.

Please select the mode description that best describes your organization's response:

a) We do not offer this service (skip to Q2.9).
b) We redirect the client to another organization or provider.
c) We offer the client a vetted list of service providers after detailed problem definition is completed.
d) We link the client to a vetted provider network that delivers services under contract with our organization.
e) We offer the client an appointment with a staff counsellor.

Please describe eligibility to receive this kind of service from your organization:

Career Stage (select all that apply)	*Relationship to Eligible Person (select one)*	*Presenting Problem (select one)*
☐ Medical students ☐ Residents and fellows ☐ Practicing physicians ☐ Semi-retired physicians ☐ Retired physicians	a) Physicians and Learners (medical students/residents/fellows) b) Physicians, Learners and their spouses/partners (as locally defined) c) Physicians, Learners, their spouses/partners (as locally defined) and their eligible dependents (as locally defined) d) Physicians, Learners and any of their family members (no restrictive definition of family members)	a) Substance use, abuse and dependence issues b) Mental health and psychiatric issues c) Other defined physical and mental health problems that impact the eligible person's health and function d) All presenting problems without limitation.

2.9 Which mode of activity best describes how your organization responds to clients who identify a need for other, non-clinical services (e.g. family lawyers, credit counsellors)?

Clients will call the organization seeking a range of services that may not be directly related to health and therefore they might be most appropriately served by a non-clinical resource such as credit counselling, family legal advice, and others. In this domain, mode a) indicates that this is a service which you not offer. The continuum then moves through ad hoc support in mode b), to the development and maintenance of un-vetted lists in mode c) and of vetted lists in mode d). For mode e), you actively match and refer the client to an appropriate provider of the non-clinical resource or service.

Please select the mode description that best describes your organization's responses, remembering that starting with mode b), each successive activity mode includes the service options described in the previous modes.

a) We do not offer this service (skip to Q2.10).
b) We make ad hoc attempts to find service for the client.
c) We provide an un-vetted list of services to the client.
d) We provide a vetted list of services to the client.
e) We assess the client's needs and match to an appropriate service from our list of vetted providers.

Please describe eligibility to receive this kind of service from your organization:

Career Stage (select all that apply)	*Relationship to Eligible Person (select one)*	*Presenting Problem (select one)*
☐ Medical students ☐ Residents and fellows ☐ Practicing physicians ☐ Semi-retired physicians ☐ Retired physicians	a) Physicians and Learners (medical students/ residents/ fellows) b) Physicians, Learners and their spouses/partners (as locally defined) c) Physicians, Learners, their spouses/partners (as locally defined) and their eligible dependents (as locally defined) d) Physicians, Learners and any of their family members (no restrictive definition of family members)	a) Substance use, abuse and dependence issues b) Mental health and psychiatric issues c) Other defined physical and mental health problems that impact the eligible person's health and function d) All presenting problems without limitation.

2.10 Which mode of activity best describes how your organization responds to clients with an identified concern about the behaviour, health and safety of another physician (i.e., not about themselves)?

This question asks about responses to a client's concern about the behaviour, health and safety of another physician. Examples of concern may cross multiple topics such as substance use (e.g., concerns about a colleague appearing intoxicated in the workplace), signs of mental health problems (e.g., concerns about a colleague appearing depressed, suicidal, or anxious), or behavioural problems (e.g., disruptive or unprofessional conduct).

Mode a) indicates that you do not offer this service, while mode b) reflects that you redirect the client to another organization, such as a clinical service or regulatory body. Mode c) indicates that you provide general advice to the client (e.g., consult hospital policy, consider additional resources such as CMPA or www.ePhysicianHealth.com , or suggest Human Resources be consulted). Mode d) indicates that you collect detailed information from the client and design/deliver specific advice on how to approach the situation (for example, you might guide a client's planned meeting with a colleague who presents as depressed including agenda planning, invitees, documentation, and follow-up). Mode e) indicates that you are prepared to collaborate with the client in their direct intervention with the other physician (e.g., join a Chief of Staff and assist in an intervention with a physician with a substance use disorder). Generally, each successive activity mode includes the service options described in the previous modes.

Please select the mode description that best describes your organization's responses:

a) We do not offer this service (skip to Q2.11)
b) We redirect the client to others who provide this service.
c) We provide general advice about how to approach situations like this.
d) We provide specific advice about how to approach the client's particular situation, including scripting suggestions.
e) We offer to be immediately available by telephone and/or offer to accompany the client to the meeting with the physician of concern.

Please describe eligibility to receive this kind of service from your organization:

Career Stage (select all that apply)	*Relationship to Eligible Person (select one)*	*Presenting Problem (select one)*
☐ Medical students ☐ Residents and fellows ☐ Practicing physicians ☐ Semi-retired physicians ☐ Retired physicians	a) Physicians and Learners (medical students/ residents/ fellows) b) Physicians, Learners and their spouses/partners (as locally defined) c) Physicians, Learners, their spouses/partners (as locally defined) and their eligible dependents (as locally defined) d) Physicians, Learners and any of their family members (no restrictive definition of family members)	a) Substance use, abuse and dependence issues b) Mental health and psychiatric issues c) Other defined physical and mental health problems that impact the eligible person's health and function d) All presenting problems without limitation.

2.11 Which mode of activity best describes how your organization responds to clients with an identified need for return to work coordination?

A client who has been absent from work due to a health-related concern may require assistance to safely return to work. Return to work coordination includes:

- Planning for accommodations such as graduated return to work, work hours, scope of practice and/or practice supports;
- Implementation of the return to work plan; and
- Assessment and evaluation of the accommodation; and follow up.

Sometimes these services involve referral to another resource such as a family physician, occupational physician or occupational therapist with knowledge of accommodation and return to work for physicians.

For a client with psychiatric or mental health concerns or substance use disorders, the return to work plan may also include contractual monitoring (see 2.13).

Generally, each successive activity mode includes the service options described in the previous modes. Please select the mode description that best describes your organization's responses:

a) We do not offer this service (skip to Q2.12).
b) We give general advice and redirect to others who provide this service.
c) We give specific advice and refer the client to others who provide this service.
d) We provide return to work coordination services.

Please describe eligibility to receive this kind of service from your organization:

Career Stage (select all that apply)	*Relationship to Eligible Person (select one)*	*Presenting Problem (select one)*
☐ Medical students ☐ Residents and fellows ☐ Practicing physicians ☐ Semi-retired physicians ☐ Retired physicians	a) Physicians and Learners (medical students/residents/fellows) b) Physicians, Learners and their spouses/partners (as locally defined) c) Physicians, Learners, their spouses/partners (as locally defined) and their eligible dependents (as locally defined) d) Physicians, Learners and any of their family members (no restrictive definition of family members)	a) Substance use, abuse and dependence issues b) Mental health and psychiatric issues c) Other defined physical and mental health problems that impact the eligible person's health and function d) All presenting problems without limitation.

2.12 Which mode of activity best describes how your organization responds to clients with an identified need for assistance with workplace accommodation of a disability?

A client with a disability, including a stable disorder in remission, may require assistance with their working conditions, including:

- Planning for accommodations such as working conditions, work hours, scope of practice and/or practice supports;
- Implementation of the accommodation plan; and
- Assessment and evaluation of the accommodation; and follow up.

Sometimes these services involve referral to another resource, such as a family physician, occupational physician or occupational therapist with knowledge of workplace accommodation for physicians.

For a client with a disability relating to psychiatric or mental health concerns or substance use disorders, the accommodation plan may also include contractual monitoring (see 2.13).

Generally, each successive activity mode includes the service options described in the previous modes. Please select the mode description that best describes your organization's responses:

a) We do not offer this service (skip to Q2.13).
b) We give general advice and redirect to others who provide this service.
c) We give specific advice and refer the client to others who provide this service.
d) We provide workplace accommodation services.

Please describe eligibility to receive this kind of service from your organization:

Career Stage (select all that apply)	*Relationship to Eligible Person (select one)*	*Presenting Problem (select one)*
☐ Medical students ☐ Residents and fellows ☐ Practicing physicians ☐ Semi-retired physicians ☐ Retired physicians	a) Physicians and Learners (medical students/residents/fellows) b) Physicians, Learners and their spouses/partners (as locally defined) c) Physicians, Learners, their spouses/partners (as locally defined) and their eligible dependents (as locally defined) d) Physicians, Learners and any of their family members (no restrictive definition of family members)	a) Substance use, abuse and dependence issues b) Mental health and psychiatric issues c) Other defined physical and mental health problems that impact the eligible person's health and function d) All presenting problems without limitation.

2.13 Which mode of activity best describes how your organization provides to clients with an identified need for Contractual Monitoring?

This activity relates to a client with a health problem that creates a need for behavioral, biological and/or workplace monitoring. A client may call because they have a need for contractual monitoring. It may be related to health or behavioral concerns. They may seek formal contractual monitoring on their own behalf, or because they have been directed to do so by a third party (e.g. regulatory body or workplace). Contractual monitoring involves a formal agreement for provision of a range of activities that may include:

- Treatment compliance monitoring
- Workplace monitoring
- Behavioural monitoring
- Biological monitoring
- Symptom stability
- Case management (see 2.14)
- Relapse response and reporting contingencies

Mode a) should be selected if you not offer this service. For mode b), you redirect the client to a family doctor, or to a list of providers, such as the directory of local Certificants of the Canadian Society of Addiction Medicine.

Mode c) indicates you would arrange an interview with one of your staff, to collaborate with the client to define the problem(s), then make a referral to an external provider who can enter into a contractual monitoring relationship with the client. By contrast, in addition to the services provided under mode c), mode d) indicates that you can enter into a formal contract to provide contractual monitoring services.

Please select the mode description that best describes your organization's responses, remembering that each successive activity mode may include the service options described in the previous modes.

a) We do not offer this service (skip to Q2.14).
b) We redirect to another provider or organization.
c) We collaborate with the client to define the problem(s) and then refer the client to others who provide this service.
d) We provide contractual monitoring directly to the client.

Please describe eligibility to receive this kind of service from your organization:

Career Stage (select all that apply)	*Relationship to Eligible Person (select one)*	*Presenting Problem (select one)*
☐ Medical students ☐ Residents and fellows ☐ Practicing physicians ☐ Semi-retired physicians ☐ Retired physicians	a) Physicians and Learners (medical students/residents/fellows) b) Physicians, Learners and their spouses/partners (as locally defined) c) Physicians, Learners, their spouses/partners (as locally defined) and their eligible dependents (as locally defined) d) Physicians, Learners and any of their family members (no restrictive definition of family members)	a) Substance use, abuse and dependence issues b) Mental health and psychiatric issues c) Other defined physical and mental health problems that impact the eligible person's health and function d) All presenting problems without limitation.

2.14 Which mode of activity best describes how your organization responds to clients with an identified need for non-contractual case management, defined as the need for follow-up or coordination of care without a formal agreement?

Clients contacting an organization will sometimes require case management: a collaborative, client-driven process for the provision of quality health and support services through the effective and efficient use of resources. Case Management supports the clients' achievement of safe, realistic, and reasonable goals within a complex health, social, and fiscal environment. The term "case coordination" is sometimes used synonymously.

This array of support services is offered to a client without utilizing the more formal approach captured in a contractual agreement entered into between the client and the provider organization (as described in the previous question).

Mode a) indicates that this is a service that you do not offer, while in mode b), you redirect the client elsewhere. In mode c), you undertake an assessment of the client's needs prior to referring the client elsewhere for ongoing case management. Mode d) indicates that you have a well-defined approach to follow a client's progress towards specific, pre-determined goals over a limited time frame, or, you provide support through a process that is more flexible and not necessarily time-limited.

Please select the mode description that best describes your organization's responses, remembering that each successive activity mode may include the service options described in the previous modes.

a) We do not offer this service (skip to Q2.15)
b) We redirect the client to others who provide these services.
c) We collaborate with the client to define the problem(s) and then recommend or refer the client to others who provide this service.
d) We provide case management services.

Please describe eligibility to receive this kind of service from your organization:

Career Stage (select all that apply)	*Relationship to Eligible Person (select one)*	*Presenting Problem (select one)*
☐ Medical students ☐ Residents and fellows ☐ Practicing physicians ☐ Semi-retired physicians ☐ Retired physicians	a) Physicians and Learners (medical students/residents/fellows) b) Physicians, Learners and their spouses/partners (as locally defined) c) Physicians, Learners, their spouses/partners (as locally defined) and their eligible dependents (as locally defined) d) Physicians, Learners and any of their family members (no restrictive definition of family members)	a) Substance use, abuse and dependence issues b) Mental health and psychiatric issues c) Other defined physical and mental health problems that impact the eligible person's health and function d) All presenting problems without limitation.

2.15 Which mode of activity best describes how your organization responds to clients with an identified need for informal support from peers with similar experiences?

Peer support is defined as a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. This is not viewed as a clinical service, nor as a patient/physician relationship. Rather, it reflects a relationship amongst colleagues who identify a shared experience (e.g., survivorship of cancer, recovery from substance use, or the lived experience of litigation/complaint). This shared experience can create a shared understanding of each other and a capacity to provide accountability and support in their ongoing recovery processes.

Please note that this service area does *not* include the peer support that your staff provide by being a physician colleague on the other end of the phone.

Mode a) indicates that you do not provide this service; mode b) suggests you may provide this service on an ad-hoc basis (e.g., suggest a client in recovery reach out to a colleague who has indicated a willingness to provide peer support). Mode c) indicates that you create and maintain a list of known individuals and groups and provide relevant information to the client (e.g., provide client with the name of a Caduceus group leader, or refer the client to a peer support program for physicians facing a disciplinary process). Mode d) indicates that you provide services in modes b) and c), and that you may also actively facilitate peer support networks (e.g., train peer support volunteers and host meetings, and/or host Caduceus groups in procured space). Please select the mode description that best describes your organization's responses:

a) We do not offer this service (skip to Q2.16).
b) We make a best effort to connect the client to a suitable peer if we know of one.
c) We redirect the client to individuals and groups that offer peer support of various kinds.
d) We facilitate peer support for clients by recruiting and/or training peer supporters (individual or groups).

Please describe eligibility to receive this kind of service from your organization:

Career Stage (select all that apply)	*Relationship to Eligible Person (select one)*	*Presenting Problem (select one)*
☐ Medical students ☐ Residents and fellows ☐ Practicing physicians ☐ Semi-retired physicians ☐ Retired physicians	a) Physicians and Learners (medical students/residents/fellows) b) Physicians, Learners and their spouses/partners (as locally defined) c) Physicians, Learners, their spouses/partners (as locally defined) and their eligible dependents (as locally defined) d) Physicians, Learners and any of their family members (no restrictive definition of family members)	a) Substance use, abuse and dependence issues b) Mental health and psychiatric issues c) Other defined physical and mental health problems that impact the eligible person's health and function d) All presenting problems without limitation.

2.16 Which mode of activity best describes how your organization responds to individual clients with an identified need for help with problematic workplace behaviour?

A client may request services when concerns have been raised regarding their workplace behaviour. These issues could have been labelled as (e.g.) discrimination, incivility, unprofessional conduct, bullying, harassment, or disruptive behaviour. In some cases, a client may be required by their organization to involve an external service provider for issues that have not been managed and resolved within that organization. Services provided may include collaborative problem definition; provision of third party assessment(s); educational intervention(s); and other program services such as (e.g.) return to work coordination or contractual monitoring.

Please select the mode description that best describes your organization's responses, remembering that each successive activity mode includes the service options described in the previous modes.

a) We do not offer this service (skip to Q2.17).
b) We offer general advice and redirect to others who provide this service.
c) We collaborate with the client to define the problem(s) and then refer clients to others who provide this service.
d) We provide a comprehensive array of services for concerns relating to problematic workplace behaviour.

Please describe eligibility to receive this kind of service from your organization:

Career Stage (select all that apply)
☐ Medical students
☐ Residents and fellows
☐ Practicing physicians
☐ Semi-retired physicians
☐ Retired physicians

2.17 Which mode of activity best describes how your organization responds to a work groups with an identified need to improve interpersonal relationships?

A client may request services as a representative of a work group (e.g. team, department, family practice group) when concerns have been raised regarding the interpersonal relationships and functioning of the group as a whole. Services provided may include (e.g.) collaborative problem definition; provision of third party assessment(s); and educational intervention(s).

Please select the mode description that best describes your organization's responses, remembering that each successive activity mode includes the service options described in the previous modes.

a) We do not offer this service (skip to Q3.1)
b) We offer general advice and redirect to others who provide this service.
c) We collaborate with the client group to define the problem(s) and then refer them to others who provide this service.
d) We provide a comprehensive array of services relating to improving interpersonal relationships among the members of a work group.

Please describe eligibility to receive this kind of service from your organization:

Career Stage (select all that apply)
☐ Medical students
☐ Residents and fellows
☐ Practicing physicians
☐ Semi-retired physicians
☐ Retired physicians

Section 3: Scope and Quality of Services

3.1 Which mode of activity best describes how your organization decides what services it will or should provide?

Once an organization has been formed to support its clients, it uses a variety of strategies to guide decisions regarding which services to develop and provide, and which services to scale down. Four of these strategic are described below: mode a) indicates that no such process exists as yet. Mode b) allows for a more ad hoc and practical, budget-driven approach to deciding on which services to provide.

Mode c) indicates that you employ tools such as client surveys, stakeholder interviews and other ways to seek information about client satisfaction and future needs. Mode d) suggests that a periodic, formal, structured, collaborative and multi-layered strategy is employed to obtain service planning information from clients and other stakeholders.

Please select the mode description that best describes your organization's processes, remembering that starting with mode b) each successive activity mode includes the activities described in the previous modes.

a) We have no formal process for such decisions.
b) Our decisions are based upon budget and ad hoc assessment of clients' needs.
c) Our decisions are based on occasional or regular surveys of clients' satisfaction and needs.
d) We include formal, cyclic strategic planning in collaboration with stakeholders.

3.2 Which mode of activity best describes how your organization collects data on the quantity of the services it provides?

Organizations providing physician health services may collect data on the quantity of services provided for various reasons including internal accountability, program evaluation, quality assurance, and research. In the descriptions offered below, mode a) indicates that no data is collected regarding quantity of service. Mode b) suggests that data is collected to simply count the number of service requests for a given range of criteria (e.g., how many clients called per month, case counts by service type). Mode c) assumes that service activity data is collected for weighted measures, e.g. effort metrics such as interactions per client; or hours or money spent per case.

Please select the mode description that best describes your organization's activities:

a) We do not collect quantitative data.
b) We collect simple quantitative data.
c) We collect weighted quantitative data (effort metrics).

3.3 Which mode of activity best describes how your organization evaluates the quality of the services it delivers?

This question asks about your organization's practices for evaluating and improving the quality of services you deliver. Through such practices, service providers ask the questions, "Are the services we're providing good?" and "How could they be better?" This may involve the collection of clinical and administrative data. Four modes of activity are described, and starting with b) it is assumed that each successive mode may include the previous ones. For mode c), internal data collection and analysis may include internal audits and client satisfaction surveys; for mode d), processes based on external standards may include audits or organizational reviews.

Please select the mode description that best describes your organization's activities:

a) We have no formal process.
b) We utilize an informal process based upon ad hoc client and stakeholder feedback.
c) We engage in formal, regular internal data collection and analysis.
d) We compare internal data against external benchmarks or standards.

Section 4: Scholarship, Outreach, Advocacy

4.1 What educational activities are you involved in?

Educational activities are defined as structured activities with learning objectives, including but not limited to accredited activities. These include lectures, hospital rounds, workshops, webinars, and other activities than can be incorporated into the educational agendas of stakeholders and their organizations. These activities will be provided directly by your organization or via the organization which locates and designates appropriate instructors/facilitators. In some instances, your organization will organize and conduct educational conferences and events entirely under its own aegis or in collaboration with another organization, such as the Canadian Medical Association.

Please check all those activities below that apply to your organization; if an educational activity is not listed, please add it in the text box provided.

- ☐ We do not offer learning opportunities ourselves, but we offer advice on where to find education resources from other providers.
- ☐ We offer static resources such as documents, videos, books either for download or to borrow.
- ☐ Our staff prepare and facilitate formal learning events (lectures, grand rounds, small group learning, webinars, etc.).
- ☐ We develop customized learning opportunities, in response to requests from physician-serving organizations.
- ☐ We host conferences or other larger scale learning opportunities.
- ☐ We also undertake the following educational activities not listed above:

(Text box)

4.2 What health and wellness promotional activities are you involved in?

We define health and wellness promotional activities as preventive activities that are not included in the previous question about more structured educational activities. Health and wellness promotion might include referring clients to activities created by other organizations (e.g., testicular cancer awareness programs, Health Canada's Low Risk Drinking Guidelines, etc.); creating and distributing publications to raise awareness and promote health and wellness on one or more topics (e.g., article in in-house Journal, blog posting, fact sheet); or undertaking specific campaigns generated by your organization on one or more topics involving more than publications (e.g., wellness fairs, lecture series on burnout prevention, course on Promoting Civility in the Medical Workplace, etc.). Please check all those activities below that apply to your organization. If a relevant activity that you engage in is not listed, please add it in the text box provided.

- ☐ We do not engage in health and wellness promotion activities, but supply links and referrals to other organizations who do so.
- ☐ We develop and distribute fact sheets, brochures and links to other resources either in print or online.
- ☐ We engage in social marketing or other campaigns to raise awareness and promote health and wellness for physicians.
- ☐ Our staff contribute blogs, articles and other non-scholarly content to print and on-line publications on physician health and wellness.
- ☐ We also undertake the following health and wellness promotional activities not listed above:

(Text box)

4.3 How does your organization participate in scholarly activities related to physician health and wellness?

Examples of scholarly activities include research, presentations and participation in conferences or meetings with a focus on physician health and wellness. It could also include publication of original research or review articles in (peer-reviewed) journals or chapters in textbooks; and/or participation in local, regional or national committees on physician health and wellness. In some cases, scholarly activities may also include providing grants or other funding support to staff or outside contractors/grantees.

Please check all those activities below that apply to your organization. If a relevant activity that you engage in is not listed, please add it in the text box provided.

- ☐ We are not formally involved in scholarly activities, although our members may be in other capacities.
- ☐ We financially support time for staff engagement in research related to physician health and wellness.
- ☐ We financially support time for staff engagement in peer-reviewed research activities related to physician health and wellness.
- ☐ We fund non-staff members (through grants or other mechanisms) in their scholarly work on physician health and wellness.
- ☐ We also undertake the following scholarly activities not listed above:

(Text box)

4.4 How does your organization work toward system-level change to support the collective health of physicians?

This question refers to the organization's participation in system level initiatives that seek to have a positive impact upon the collective health and wellbeing of physicians. Examples include the development of strategies to deal with "disruptive behaviour" in the workplace or to examine the needs of aging physicians. These initiatives are usually designed to develop and influence policy that guides regulators, health authorities, universities and other stakeholders, and will thereby have a direct impact upon physicians working in these environments.

Examples of this form of activity include (e.g.) organizational participation as consultants; in working groups; or in the development of relevant campaigns that will impact physicians and key policy influencers. The activity may focus at a provincial, national and/or international level (e.g., the creation of this descriptive framework).

Please check all those items below that apply to your organization; if a system-level change activity that you engage in is not listed, please add it in the text box provided.

- ☐ We are not involved in system-level advocacy as an organization, although our staff members may be involved individually.
- ☐ We have organizational support for staff to participate in external task forces, working groups and/or committees.
- ☐ We create and fund working groups or committees to develop or change policy on physician health issues.
- ☐ We financially support staff to develop and maintain relationships with key influencers of policy that affect physician health and wellness.
- ☐ We originate and manage campaigns to develop or influence policy related to physician health and wellness.
- ☐ We also undertake the following system-level change activities not listed above:

(Text box)

Glossary

Throughout this reference, defined terms are listed with a notation of the numbered section of the Descriptive Framework where they are cited. For example,

Accredited activities**: Authorized or approved activities that recognize or conform to a standard **4.1

signifies that the term "Accredited activities" is used in the Descriptive Framework domain 4.1.

Throughout the Framework, such items are highlighted in blue to signal that they are defined terms that are further described here.

Bracketed numbers following a definition, e.g. (1), refer to the Reference list provided later in this document.

A

Access: Ability to use services provided by physician health programs through different means which may include: telephone or internet consultation, in-person consultation, access to in-person or online resources. **2.1, 2.2**

Accommodation: Identification and change of rules, working conditions or procedures to enable a physician with a disability who is otherwise qualified, to maintain an acceptable level of performance in the workplace. **2.11, 2.12**

Accountability: An obligation or willingness for an individual or organization to accept responsibility or to account for its actions. **2.15, 3.2**

Accredited activities: Authorized or approved activities that recognize or conform to a standard. **4.1**

Ad hoc: An action taken for the particular end or case at hand without consideration of wider application. **2.9, 3.1, 3.3**

Advocacy: Activities contributing to physician health service expertise and influence in working with physician populations to improve health. Speaking on behalf of others when required and supporting the mobilization of resources to effect change. **2.6, 2.7, 4.4**

Assessment: The act of making a judgment about something: the act of assessing something. **2.2, 2.3, 2.4, 2.11, 2.12, 2.14, 2.16. 2.17**

Assessment requested by third party: Any Occupational Health Assessment, or related medical evaluation, requested by a **third party** (e.g. workplace, regulatory College, University or other source) and not strictly and solely being requested by the client being evaluated. **2.4**

Audit: A formal examination and evaluation of an organization's processes, practices and activities, either undertaken by the organization (internal audit) or by an outside group (external audit). **3.3**

B

(No terms defined)

C

Career Stage: Eligibility to receive service from the organization based upon the current point in the physician's career. (**Section Two**)

Case: An individual client of the organization and the records associated with his/her documented problem. **3.2**

Case Management: A collaborative, client-driven process for the provision of quality health and support services through the effective and efficient use of resources. The term "case coordination" is sometimes used synonymously. Case Management supports the clients' achievement of safe, realistic, and reasonable goals within a complex health, social, and fiscal environment. **2.13, 2.14**

Certified Clinical Counselling Services: Psychotherapy or other clinical advice / guidance, offered by suitably trained and credentialed non-medical therapists. Examples include, but are not limited to, clinical psychologists, social workers, psychiatric nurses, etc. **2.8**

Client: Individual who seeks assistance from the organization and/or makes use of the organization's services. (**Section 1, 2 and 3 throughout**)

Clinical: Relating to the observation and treatment of patients. May include discussions and/or treatment by physicians, psychologists, nurses, counselors. Antonym is **non-clinical**. **2.4, 2.10, 2.15, 3.3**

Clinician: A physician or other qualified person who is involved in the treatment and observation of living patients, as distinguished from one engaged in research. **2.1, 2.2**

Collateral information: Information about a client that the organization obtains from any source other than the client who is the subject of the information. **2.3, 2.4, 2.6, 2.7**

Contractual monitoring: An agreement between a client with a health or behavioural problem and an organization to engage in a relationship whereby the organization monitors and documents the client's compliance with treatment and other activities that support recovery, e.g. behavioral and/or biological and/or workplace monitoring. **2.11, 2.12, 2.13, 2.16**

Counselling: A relationship in which a professional or trained individual attempts to help another, so as to understand and solve his or her difficulties in psychosocial adjustment; counsellors may also advise, opine and instruct in order to direct another's judgement or conduct. (2) **2.8**

Credit counselling: A process where financial help is given to a client through education, budgeting, and the use of a variety of tools with the goal of reducing and eventually eliminating debt. **2.9**

D

Dependents: Family members who financially depend upon the physician. Defining criteria may vary by jurisdiction but typically includes children under xx years of age (as determined by jurisdiction) or yy years of age (as determined by jurisdiction) if enrolled in full-time study in higher education program, and adult children incapable of self-support because of mental or physical incapacity. **(Section Two)**

Disability: An umbrella term covering impairment, activity limitation, and participation restriction. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations. (3) **2.3, 2.7, 2.12**

Disruptive Behaviour: The use of inappropriate words, actions or inactions by a physician which interferes with his or her ability to function well with others to the extent that the behaviour interferes with, or is likely to interfere with, quality health care delivery. (4) **2.16, 4.4**

Domain: a topic or area of activity relevant to the delivery of physician health services as utilized in this framework. **2.9**

E

Effort Metrics: A quantitative measure that tracks resources invested for services delivered, including in this instance e.g. visits per case; time spent per visit; dollar cost per client, etc. **3.2**

F

Family doctor/physician: The physician acting as the primary care provider and coordinator of continuous medical care for a physician-client, family physicians manage the health, diagnose and treat the diseases, physiological disorders and injuries of their patients. Or a physician who specializes in family practice. **2.5, 2.6, 2.7, 2.11, 2.12, 2.13**

G

Governance and Administration: Leadership and oversight activities which focus primarily on the fiduciary responsibility and exercise of authority over the explicit trust that is understood to exist between the mission of an organization and those whom the organization serves. (**Section Three**)

H

Health and Wellness Promotion: Health promotion is the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions. (6) **4.2**

I

Intake: The act of initial contact and information gathering with a client requesting service. **2.1, 2.2**

Intervention: Activities or responses to a client who expresses concern about the health and safety of a physician. For the purposes of this framework, refers only to the process of approaching a physician at risk. **2.10**

J

(No terms defined)

K

(No terms defined)

L

Learner: Individual in training to become a physician. For the purposes of this framework, includes medical students, residents, and fellows. (**Section Two**)

Licensed: The documented authority to practice medicine within a certain locality. (**Career Stage**)

M

Mode: A manner, way, or method of doing something, used in this framework to describe how an organization delivers a given service or activity. (**Section Two**)

N

Non-clinical: Relating to professions, relationships or activities which do not involve the observation and treatment of patients. Antonym of clinical. **2.2, 2.9**

O

Occupational Health: The promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations by preventing departures from health, controlling risks and the adaptation of work to people, and people to their jobs. (7) **2.3, 2.4**

Occupational Health Assessment: A detailed clinical assessment designed to assess the extent to which clients' health poses a risk to their work, or which their work poses a risk to their health. The assessment informs recommendations for measures to mitigate either or both of these risks. **2.3, 2.4**

P

Peer: Two or more physicians who share common background, experiences or problems. **2.15**

Peer reviewed: A process where a scholarly work is evaluated by a group of experts in the same field to ensure that it meets necessary standards to be published or accepted. **4.3**

Peer support: A system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. (8) This is not viewed as a **clinical** service, nor as a patient/physician relationship. Rather, it reflects a relationship amongst colleagues who identify a shared experience (e.g., survivorship of cancer, recovery from substance use, or the lived experience of litigation/complaint. This shared experience can create a shared understanding of each other and a capacity to provide **accountability** and support in their ongoing recovery processes. **2.15**

Physician at risk: See **Intervention** **2.10**

Practicing physicians: Any category of physicians registered by a provincial college of physicians and surgeons working in any form of medical practice on a full or part time basis (including conditional licensure). For the purposes of this framework, does NOT include any registered learner, semi-retired or retired physician. (**Sections One and Two**)

Presenting problem: The limiting range of services provided by an organization, as divided by thematic subsets. **(Section Two)**

Program and Service Planning: Process undertaken by an organization to determine which services to provide, and to what extent they should be provided. **3.1**

Psychotherapy: To treat, through the use of a psychological methods, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning. (9) **2.8**

Q

Quality Improvement: Making changes that lead to better client outcomes (health), stronger system performance (care) and enhanced professional development. **3.3, 5.4**

R

Redirect: The primary action taken is to direct the client to independently contact and follow up with a service or resource outside the organization. **2.3, 2.4, 2.8, 2.10, 2.11, 2.12, 2.13, 2.14, 2.15, 2.16, 2.17**

Refer: The act of facilitating a connection of the client to another service, resource or organization; may include handover of specific case details in referral letter or referral package. **2.6, 2.7, 2.9, 2.11, 2.12, 2.13, 2.14, 2.15, 2.16, 2.17**

Referral package: A series of documents which may generally include referral letters, plus any required forms and documents as required by funding agencies (e.g., Provincial Health Ministries, insurance companies) for a specialized treatment or service, including residential treatment. **2.3, 2.4, 2.6, 2.7**

Relationship to eligible person: The relationship to the physician which determines eligibility to receive service. **(Section Two)**

Retired: Describes a physician who has given up his/her license, and no longer is a member of a provincial/territorial medical association**. (Section Two)**

Return to Work Coordination: Clients who have been absent from work due to a health related concern may require assistance to safely return to work. Return to work coordination includes: planning for accommodations such as graduated return to work, work hours, scope of practice and/or practice supports; implementation of the return to work plan; assessment and evaluation of the accommodation; and follow up. Sometimes these services involve referral to another resource (e.g., family physicians, occupational physician or occupational therapist with knowledge of accommodation and return to work for physicians). For clients with psychiatric or mental health concerns or substance use disorders, the return to work plan may also include contractual monitoring**. 2.11, 2.12, 2.16**

S

Semi-retired: Describes a physician who has reduced or stopped his or her practice, but either remains licensed to practice, and/or retains membership in the local provincial/territorial medical association. **(Section Two)**

Social marketing: An approach used to develop activities aimed at changing or maintaining people's behaviour for the benefit of individuals and society as a whole (e.g. Walk the Doc, or Buckle Up for Safety). **4.2**

Specialized medical treatment: Treatment which is not provided by a family physician, such as community programs, psychiatrists or other medical specialists for substance use and/or psychiatric disorders. Such medical treatment might be intensive or episodic and offered on either an inpatient (hospital) or outpatient basis. **2.6, 2.7.**

Spouses/partners: Partners (as locally defined) of physicians who may be eligible to receive service from the organization. **(Section Two)**

Static Resources: Pre-formulated instructional materials such as tip sheets, videos, books on topics related to physician health. **4.1**

System Level Advocacy: Work that addresses organizational, systemic and cultural change to support and improve the collective health of physicians. **4.4**

T

Third Party: Another individual or group who is not the client or the organization. **2.4, 2.6, 2.7, 2.13**

Third Party Assessment: See **Assessment requested by third party**

Triage (intake assessment): Preliminary exploration of client needs to determine appropriate service options (may not involve follow up). **2.2**

U

Unprofessional conduct: Conduct which is contrary to a commitment to the health and well-being of individual patients and society through ethical practice, high personal standards of behaviour, accountability to the profession and society, physician-led regulation, and maintenance of personal health. (10)

V

Vetted: Something that is approved or verified for use in a particular context or for a particular purpose. **2.6, 2.7**

W

Workplace Behaviour Improvement: A process by which efforts are made to improve the interpersonal and professional relationships and activities of a client when concerns have been raised regarding their workplace behaviour. These issues could have been labelled as (e.g.) discrimination, incivility, unprofessional conduct, bullying, harassment, or disruptive behaviour. In some cases, a client may be required by their organization to involve an external service provider for issues that have not been managed and resolved within that organization. Services provided may include collaborative problem definition; provision of third party assessment(s); educational interventions; and other program services such as (e.g.) return to work coordination or contractual. **2.16**

Work Group Relationship Improvement: A process by which efforts are made to improve the interpersonal and professional relationships and activities of a group of people sharing a common workplace. **2.17**

X

(No terms defined)

Y

(No terms defined)

Z

(No terms defined)

References

The following sources were consulted by the Tricoastal Consortium in the development of the ***Descriptive Framework***, and in many cases serve as the source of definitions in the Glossary:

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Programs Consulted

The following Canadian physician health services and programs participated in the development of the ***Descriptive Framework***.

Province	Program	Consulted by the Project
British Columbia	Physician Health Program of British Columbia	Andrew Clarke, MD, MEd, Executive Director, Physician Health Program, Doctors of BC
Alberta	Physician and Family Support Program	Terrie Brandon, MD, CCFP, Clinical Director, Physician and Family Support Program, Alberta Medical Association
Saskatchewan	Saskatchewan Physician Health Program	Peter Butt, MD, CCFP, CCFP (EM), FCFP University of Saskatchewan Brenda Senger, RPN, Director, Physician Support Programs, Saskatchewan Medical Association
Manitoba	Doctors Manitoba Health and Wellness Program	Rick Sawyer, Chief Administrative Officer, Doctors Manitoba Barry Hallman, Membership and Benefits Program Coordinator, Doctors Manitoba
	Physicians at Risk	Derek Fewer, MD, CM, FRCSC, University of Manitoba and Health Sciences Centre
	MD Care	Mark Prober, MD, BSc, FRCPC, University of Manitoba and Winnipeg Regional Health Authority Linda Mary, RPN, MFT (Cert.), Coordinator, MD Care / Faculty Counselling Service, University of Manitoba
Ontario	Physician Health Program	Michael Kaufmann, MD, CCFP, FCFP, diplomate American Board of Addiction Medicine, PHP Medical Director, Ontario Medical Association Derek Puddester, BA, BMedSc, MD, MEd, FRCPC, PCC, PHP Associate Medical Director, Ontario Medical Association Joy Albuquerque, MD, FRCP, PHP Associate Medical Director, Ontario Medical Association
New Brunswick	Physician Health Program	Chantal Cloutier, Director, Physician Health Program, New Brunswick Medical Society

Province	Program	Consulted by the Project
Nova Scotia	Professional Support Program	Coordinator, Professional Support Program, Doctors Nova Scotia
Prince Edward Island	Prince Edward Island Physician Support Program	Kathie McNally, MD, CCFP, FCFP, Physician Advisor and Advocate
Newfoundland and Labrador	Newfoundland and Labrador Physician Care Network	Susan King, MD, Medical Director, Physician Care Network, Newfoundland and Labrador Medical Association Tracey Bridger, MD, FRCPC, Chair, Newfoundland and Labrador Physician Wellness Advisory Committee Lynn Barter, ABC, Associate Executive Director, Newfoundland and Labrador Medical Association

The Quebec Physicians' Health Program (Programme D'Aide aux Médecins du Québec) was provided with project information and offered opportunities for input into the development of the ***Descriptive Framework***, but chose not to participate in the project.

About the Tricoastal Consortium

The Tricoastal Consortium is an ad-hoc working group convened by its members to respond to a December 2014 request for solutions for the development of standards of service and access for Canadian physician health programs. Members of The Tricoastal Consortium are:

- **Andrew Clarke, MD, MEd (Vancouver, BC)**
  Clinical Associate Professor, Department of Psychiatry, University of British Columbia, Faculty of Medicine and Executive Director, Physician Health Program, Doctors of BC.
- **Michael Kaufmann, MD, CCFP, FCFP, diplomate American Board of Addiction Medicine (Toronto, ON)**
  Current and founding (1995) Medical Director, Physician Health Program, Ontario Medical Association; Developer and Medical Director of Physician Workplace Support Program, Ontario Medical Association.
- **Derek Puddester, BA, BMedSc, MD, MEd, FRCPC, PCC (Ottawa, ON)**
  PHP Associate Medical Director, Ontario Medical Association; Special Project Lead, Innovation, Curriculum and Evaluation, Postgraduate Medical Education Program, Faculty of Medicine, University of Ottawa; and Medical Associate, Telepsychiatry Program, Department of Psychiatry, Children's Hospital of Eastern Ontario.
- **Carolyn Thomson, MD, CCFP, FCFP (Halifax, NS)**
  Coordinator, Professional Support Program, Doctors Nova Scotia, and Assistant Professor, Department of Family Medicine, Dalhousie University.
- **Patricia Evans, BA, MCE (Adult Learning) (Vancouver, BC)**
  Principal Consultant, Patricia Evans & Associates Inc., project manager. Specialist in consulting and research services to the health services, research and academic sectors.
- **Ms. Aynsley Meldrum, BA (Vancouver, BC)**
  Project Administrator, Patricia Evans & Associates Inc., project administrator and research associate.

About the Canadian Medical Foundation

The ***Descriptive Framework*** project was funded by the Canadian Medical Foundation, a national charitable organization focused solely on supporting Canada's physicians and health care system through three priority areas:

- Funding physician health and well-being initiatives;
- Funding bursaries for medical students; and
- Funding physicians' philanthropic, research and medical outreach priorities.

The Canadian Medical Foundation was founded in 1987 by the Canadian Medical Association. Thanks to the support of MD Financial Management and CMA Holdings Incorporated, the Canadian Medical Foundation is proud to direct 100 percent of all donations directly to charitable works.

For further information please see http://medicalfoundation.ca/en/