PHYSICIAN HEALTH, WELLBEING AND BURNOUT

Dr. Maria Patriquin MD CCFP FCFP
Founder of Living Well Integrative Health Center
and the Humanizing Health Care Collective

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DR. MARIA J. PATRIQUIN DISCLOSURES & BIAS

- **Living Well Integrative Health Center**, founder of not for profit PMH www.livingwellihc.ca
- Physician Lead: **Group Medical Visits** CHTeams/NSHA, **Group psychoeducation** & **group therapy** in family medicine
- **Collaborative Care consultant** & key informant for formation of Collaborative care toolkit, Doctors NS. (honorarium received)
- **Mental Health Committee** Atlantic Canada Representative, CFPC
- Patient Medical Home 60/20 **Care and Compassion Grant** recipient 2016, CFPC (grant for project costs)
- **Assistant professor** Dalhousie University Department of Family Medicine
- **Collaborative Working Group** on Shared Metal Health Care, CPA/CFPC
- **Editorial Advisory Board**, Canadian Family Physician
- Canadian Pediatric Society **Strategic Mental Health Task Force** CPS/CFPC
- Host and Co-chair 2020 **Canadian Collaborative Mental Health Care Conference** www.shared-care.ca
- Self diagnosed "Pathological Optimist"

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OBJECTIVES & AGENDA

- Identify motivation to address the **health, wellbeing and burnout** in family physicians
- Describe factors that **prevent, protect and are proven** to work to attain and maintain health
- **Consider the human drivers and barriers to** implementing change
- Recognize the **individual, organizational and systemic changes** that warrant implementation
- Describe how **embracing shared human values** and **collaborative care** will ultimately **transform the culture of medicine**

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MEDICAL PRACTICE WILL ALWAYS BE STRESSFUL

- We treat people in their most vulnerable of states. They are sick, dying, struggling and scared along with their families
- And we are human we feel along with our patients this is what makes us good at or jobs and can cause us suffering too
- High Responsibility + Low Control = STRESS
- Our work requires self-sacrifice, performance under pressure
- Under strain, feeling a lack of cognitive flexibility, under resourced and unsupported, the same qualities that we hold as strengths engender stress: hard working, perfectionistic, competitiveness, performance driven, independant, self-directed, motivated and value driven.

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WHAT DOES IT MEAN TO BE HEALTHY AND WELL?

1984 WHO World Health Organization revised the definition of health defined it as "the extent to which an individual or group is able to realize aspirations and **satisfy needs and to change or cope** with the environment. Health is a resource for everyday life, not the objective of living; it is a **positive concept, emphasizing social and personal resources, as well as physical capacities**".

Mental, intellectual, emotional and social health referred to a person's ability to handle stress, to acquire skills, to maintain relationships, all of which form **resources for resiliency** and living.

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A CULTURE OF STRESS

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What are the sources of stress in our work lives?

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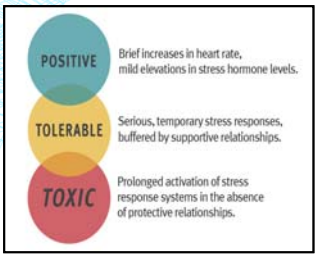
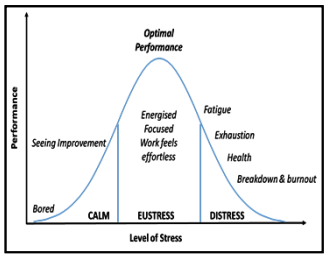
STRESS: THE GOOD, BAD AND UGLY

Long-term exposure to high work stress can result in burnout





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TERMINOLOGY

Stress is an adaptive response to external stimuli and situations and they result in physical, cognitive and emotional changes. Stress requires a change or deviation from what would be ones normal way of functioning or typical response.

Burnout has 3 dimensions as measured by the Maslach Burnout Inventory: **1) feelings of energy depletion or exhaustion; increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and 3) reduced professional efficacy/ reduced feelings of work-related personal accomplishment.**

Depression persistently diminished mood, loss of motivation, feelings of guilt or worthlessness, social2) i isolation, changes in relationships, Life interfering anxiety symptoms, Use of alcohol, non-prescribed medications, illicit substances, Sustained decline in function, Changes in eating patterns or weight loss/gain, SI or self-har

Compassion fatigue State of exhaustion and dysfunction (biologically, psychologically, and socially) as a result of prolonged exposure to secondary trauma or a single intensive event Helplessness Feeling incapable of effecting successful patient outcomes Confusion Isolation Exhaustion Feeling of being overwhelmed by work

Empathic Distress A strong averseive self-oriented response to others suffering accompanied by the desite to withdraw to protect ineself from intense negative feelings

Secondary vicarious trauma Guilt Loss of confidence Trouble sleeping Difficulty enjoying leisure activities and daily life Depression Worry about reputation ~**PTSD Shame Feelings of inadequacy** Difficulty concentrating Declining clinical judgment Avoidance of some procedures *Helo S & Moulton CE, Transl Androl Urol, 2017*

PTSD: ***Hyperarousal****:* disturbed sleep, irritability, outbursts of anger, hypervigilance ***Avoidance****:* avoid thoughts, places, people, feelings, and conversations ***Reexperiencing:*** intrusive thoughts, dreams, psychological or physiological

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FREUDENBERGER'S 12 PHASES OF BURNOUT

1. **The prove yourself compulsion**
2. **Working harder**
3. **Neglecting one's needs**
4. **Displacement of conflict**
5. **Revision of values**
6. **Denial of emerging problems**
7. **Withdrawal**
8. **Obvious behavioral changes**
9. **Depersonalization**
10. **Inner emptiness**
11. **Depression**
12. **Burnout Syndrome**

How can you recognize when you are burning out?
When our energy accounts drop into negative balance, most physicians react by going into "survival mode" at work. Instead of finding adventure, challenge, and enjoyment in your practice, you find yourself putting your head down and simply churning through the patients and paperwork, focused on simply making it through the day and getting back home. A common thought at this point is, "I am not sure how much longer I can go on like this." Survival mode and this voice in your head are signs that you are well into burnout's downward spiral. It is time to take different actions to lower stress and get some meaningful energy deposits ASAP.
Dr. Drummond "The Happy MD"

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THRIVING VERSUS SURVIVING

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CFPC BURNOUT E-PANEL 01/2019

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"THE PROBLEM GOES BEYOND ANY INDIVIDUAL'S ABILITY TO COPE"

CMA 2018 SURVEY

- 1/3 to ½ of Canadian physicians experience burnout regardless of location or specialty
- one in three experience symptoms of burnout on a weekly bo is characheized and measured by so and so 1st described masclach WEST ET AL
- nearly 1 in 10 have thought about suicide in the past year
- Of the 2547 physicians and 400 medical residents surveyed, 30% reported high levels of burnout,
- 44% of physicians who were experiencing burnout intended to discontinue their practice within 4 years
- Thirty-four percent met criteria for depression

http://www.cmaj.ca/content/188/17-18/1213 https://cmajnews.com/2018/10/11/even-resilient-doctors-report-high-levels-of-burnout-finds-cma-survey-cmaj-109-5674/
WEST ET AL

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Burnout is…
A normal response to abnormal amounts of stress

Burnout is not: a flaw, weakness, character or skill deficit or fault of an individual

read that again please

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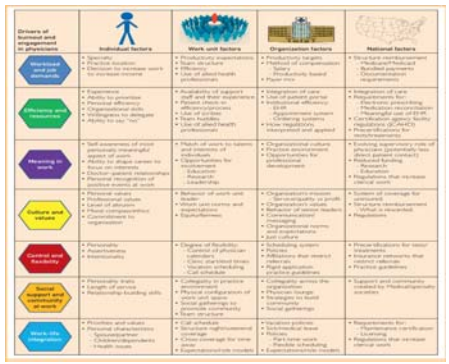

HTTPS://WWW.MAYOCLINICPROCEEDINGS.ORG/ARTICLE/S0025-6196(16)30625-5/PDF

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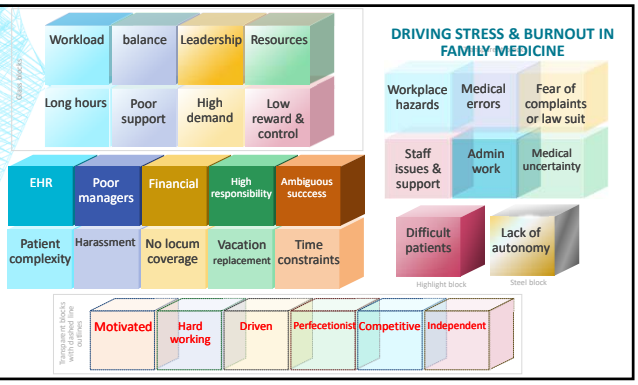

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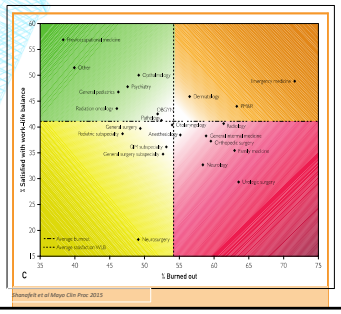
BURNOUT KNOWS NO BOUNDARIES *NO ONE IS IMMUNE*



Shanafelt et al Mayo Clin Proc 2015

Predisposing factors:

- Sleep deprivation
- High level of work/life conflict
- Work interrupted by personal concerns
- High level of anger, loneliness, or anxiety
- Stress of work relationships
- Anxiety about competency
- Difficulty "unplugging" after work
- Regular use of alcohol and other drugs

Sargent MC, et al. J Bone Joint Surg Am 2009

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BURNOUT IS BAD FOR LEARNING AND FOR STUDENTS

Care
Character
Conscience
Communication
Courage
Competency
Contribution
Collaboration
Conscience
Compassion .....

In residents, studies show burnout rates of 41-90%

Levels rise quickly within the first few months of residency

ACGME work hour changes do not appear to have improved sleep, burnout, depression symptoms or errors

Resident distress (e.g. burnout and depression) associated with perceived medical errors and poorer patient care

West, CP et al, JAMA 2006; Desai et al, JAMA 2013; Sen S. JAMA Intern Med 2013

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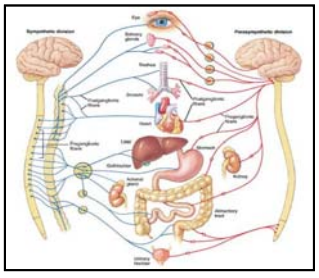
BURNOUT IS BAD FOR THE BODY



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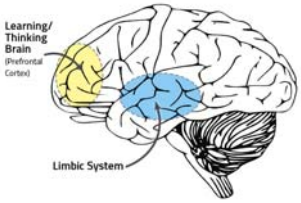
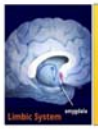
BURNOUT IS BAD FOR THE BRAIN

Survival Mode: Flight/Fight/Freeze

Frontal lobe (Prefrontal cortex) goes offline
Limbic system / mind and lower brain functions take over



Emotional Midbrain



- When traumatized or when we
- Hit cumulative stress overwhelm
- The midbrain (amygdala) is imprinted
- With threatening and benign data
- The alarm is then set and
- Triggered by any trauma remainder
- Causing a fight, flight or freeze reflex

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BURNOUT CAN BE FATAL

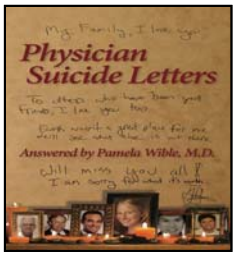
HTTPS://CMAJNEWS.COM/2018/09/28/HAS-SUICIDE-BECOME-AN-OCCUPATIONAL-HAZARD-OF-PRACTICING-MEDICINE-CMAJ-109-5614/

Why Do Doctors Commit Suicide?

By PRANAY SINHA SEPT. 4, 2014

NEW HAVEN — TWO weeks ago, two medical residents, in their second month of residency training in different programs, jumped to their deaths in separate incidents in New York City. I did not know them, and cannot presume to speak for them or their circumstances. But I imagine that they had celebrated their medical school graduation this spring just as my friends and I did. I imagine they began their residencies with the same enthusiasm for healing as we did. And I imagine that they experienced fatigue, emotional exhaustion and crippling self-doubt at the beginning of those residencies — I know I did.

Anna Parini



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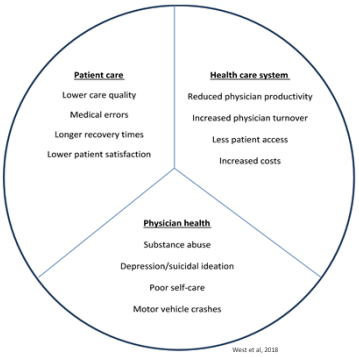
THE EFFECTS OF BURNOUT



West et al, 2018

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BURNOUT IS BAD FOR PATIENTS

Poor patient care
More medical errors
Increased lengths of hospital stay
Alterations in utilization of primary health care services
Readmissions
Medication errors
Lower satisfaction with quality of care
Mistrust, poor therapeutic alliance

Patel et al, 2018 West et al, 2018

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BURNOUT IS BAD FOR THE SYSTEM & PRACTICE

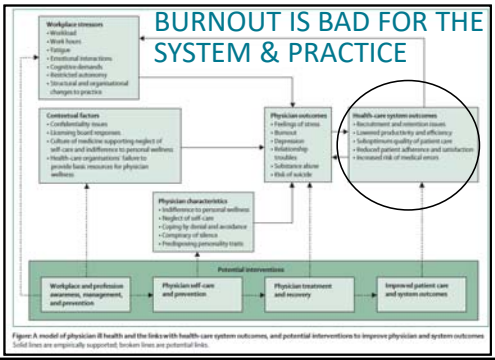

Figure: A model of physician ill health and the links with health-care system outcomes, and potential interventions to improve physician and system outcomes
Solid lines are empirically supported; broken lines are potential links.

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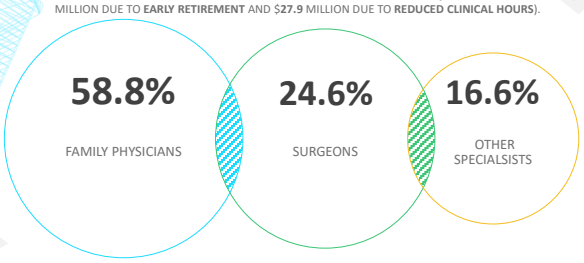
BURNOUT COSTS:

THE TOTAL ESTIMATED **COST** OF BURNOUT IN CANADA = **$213.1 MILLION** ($185.2 MILLION DUE TO **EARLY RETIREMENT** AND $**27.9** MILLION DUE TO **REDUCED CLINICAL HOURS**).



Dewa et al. BMC Health Services Research 2014, 14:254
http://www.biomedcentral.com/1472-6963/14/254

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WHAT COSTS ARE WE NOT CONSIDERING… THE HARM WE DON'T INTEND

- Unpaid work of kind, committed people
- Unpaid work of family/friend caregivers
- Low paid work of 1st responders, group home workers and PCW's.
- The individual & system costs of more medical errors
- The cost of ignoring conflict management
- The cost of ignoring hc provider health & burnout
- The cost of compromising the therapeutic relationship by replacing FDr. with tech ?
- The cost of not providing easy access to episodic care for unattached patients & those with access issues
- The cost of mistrust. Patients thus seek more care (office, ER & walk-in visits)
- Medical errors, loss of QOL & lives lost

- The cost of attrition of providers
- The cost of replacing providers that leave
- The cost of placing providers in positions where lack of resources require them to practice beyond their scope
- The cost of having specialists patching through family medical care for those without
- The cost to family doctors as they carry more burden of administration due to systemic restraints and policies
- The cost of denying a crisis that everyone knows is here
- The cost of neglecting consideration for vulnerable groups that have no say in the evolution of collaboration
- The cost to our families, community, society
- Cost to future generations

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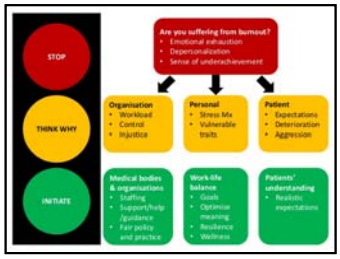
BURNOUT IS A REVERSIBLE CONDITION

READ THAT AGAIN



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INTERVENTIONS THAT HAVE SHOWN EFFICACY FOR INDIVIDUAL LEVEL CHANGE

- Self care
- Mindfulness
- Building resilience
- Creative Art therapy
- CBT
- Team based interventions
- Counselling
- Mindful communication
- Relaxation techniques
- Boundary setting
- Managing conflict training

- Stress reduction training
- Breathing and relaxation techniques
- Exercise programs
- Reduced work load
- Control over schedule
- Practice management training
- Interpersonal skills training to increase social support
- Physician patient communication
- Clinical meaningful work
- Mindful Mediation therapy
- Psychotherapy
- Psychoeducation

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WELLBEING INTERVENTIONS: AN EVIDENCE-BASED FRAMEWORK

1. **Educate and Increase Awareness**
   - Using these slides!
   - Create a Speaker's Bureau
2. **Designate Time for Reflection**
   - Groups, debrief protocols
3. **Teach Practical Skills**
   - Mindfulness, CBT, exercise
4. **Build Community**
   - Diversity
   - Mentoring and coaching programs
   - Opportunities to socialize at work
5. **Ensure Access to Care**
   - Confidential, easy to access, available both during and after work hours
   - 24-hour emergency phone line
   - Online resources with screening tools for burnout, depression and suicide
6. **Improve Workplace Environment**
   - Review workloads and schedules with physician input, autonomy, flexibility
   - Adequate staffing to reduce admin/clerical tasks for physicians
   - Personnel optimized to work at top of licenses in most meaningful work
7. **Transform Institutional Culture**

Developed by ML Goldman, CA Bernstein, LS Mayer

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FRAMEWORK OF INTERVENTIONS & WELL-BEING INITIATIVES

Key components of Well-Being Initiatives	Stage of Intervention: Preliminary	Intermediate	Advanced
1. Educate and Increase Awareness	Presentations at employee orientation and regularly planned didactics and workshops	Institutional website that includes online modules and links to well-being resources	Established Speaker's Bureau and curriculum including interdepartmental Grand Rounds
2. Designate Time for Reflection	Voluntary groups led by peers as needed (e.g. debrief protocols for seminal events)	Structured, regularly scheduled groups with consistent membership and expert facilitation	Policies for flexible work scheduling and regularly planned days off for wellbeing
3. Teach Practical Skills	Health-oriented classes available in the community (e.g. yoga, gym, etc.)	Facilitated evidence-based workshop to teach mindfulness and CBT skills	Designated time and specified availability for skills groups and physical exercise classes
4. Build Community	Recurring social events and shared community resources (e.g. childcare)	Structured mentorship and professional development programs (e.g. peer-to-peer coaching)	Department led team-building activities and funded annual retreats
5. Ensure Access to Care	Employee health insurance that appropriately covers mental health benefits	Internal mental health service that provides referrals to the community	In-house, fully staffed mental health services, including short-term free services and 24/7 crisis support
6. Improve Workplace Environment	Health information technology updated to improve user experience, with regular feedback	Physical infrastructure with shared spaces conducive to collaboration and team building	Personnel optimized to work at top of licenses in most meaningful work (e.g. task shifting)
7. Transform Institutional Culture	Institutional wellbeing committee established with broad member input	Department chairs and executive leadership engaged in culture of wellbeing	Innovative policies to maintain wellbeing (e.g. sick coverage, parental leave)

Developed by ML Goldman, CA Bernstein, LS Mayer

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KEY FOR THE INDIVIDUAL LIES IN LEVERAGING THE SCIENCE BEHIND RESILIENCE, OPTIMISM, RELATIONHSIP AND NEUROPLASTICITY…

http://livingwellbc.ca/entries/general/the-science-of-habits-dr-maria-patriquin-

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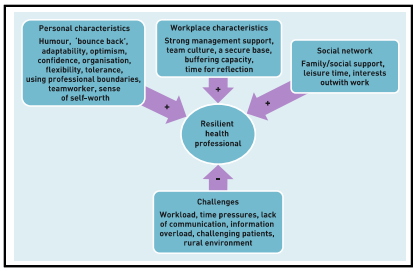
THE RESILIENT DOCTOR



Br J Gen Pract. 2016 Jul;66(648):e507-15

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WHAT IS RESILIENCE ?

re·sil·ience *noun* \ri-ˈzil-yən(t)s\

: the ability to become strong, healthy, or successful again after something bad happens

: the ability of something to return to its original shape after it has been pulled, stretched, pressed, bent, etc.

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WHAT FOSTERS RESILIENCE?

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HOW DO WE BUILD RESILIENCE ?

- Hobbies outside medicine
- Humor
- Realistic recognition (Overcoming denial/culture)
- Exercise, sleep, nutrition
- Supportive professional relationships
- Boundaries
- Time away from work
- Passion for one's work
- Supportive personal relationships
- Practicing mindfulness
- Focusing on positive emotions like gratitude and optimism

Swetz, J et al, 2009

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RESILIENCE THROUGH THERAPY

Psychodynamic Therapy

- Less intensive version of psychoanalysis
  - Fewer sessions per week and fewer years
  - Less theory about sex, id, and superego
- The focus is on improved self-awareness and insight into unconscious thoughts and feelings which may be rooted in past relationships.
- In addition to insight, therapists suggest changes in patterns of thinking and relating to others.

Interpersonal Therapy

- A further extension of psychoanalysis
- The goal is less focused on insight, and more on relational behavior change and symptom relief
- The focus is less on the past, and more on current feelings and relationships including the interaction with the therapist.

Roke et al, 2008 Italia et al, 2008 Patel et al, 2019 Panagioti et al, 2017 Clough et al, 2017

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RESILIENCE THROUGH SELF CARE

Physicians who self-care are healthier, are more "well", make patients more satisfied with care and do a better job of caring including make less errors. Shanafelt TD et al. JAMA Int Med. 2017

Family time, friends, eating well Lee 2008

Exercise Weight et al

Work life balance Shanaflet et al 2015

self management, prioritizing needs, attending to self care McCue et al

Art & Play tx Italia et al 2008

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RESILIENCE THROUGH MINDFULNESS

From Mindfulness: Attitudinal Factors that promote healing and wellbeing:

Non-judging: being an impartial witness to your own experience. Things just are. They are neither good nor bad.

Patience: for the wisdom as all things unfold with time.

Beginner's Mind: As if seeing it for the first time

Trust: in the inner wisdom of our feelings and body.

Non-striving: Grasping, wanting, goal directed e.g.. "fix-it"

Acceptance: Not fighting but allowing things to be as they are so we can choose what's healthiest

Letting go: Changing our attachment to things having to be a certain way, usually ideal or perfect.

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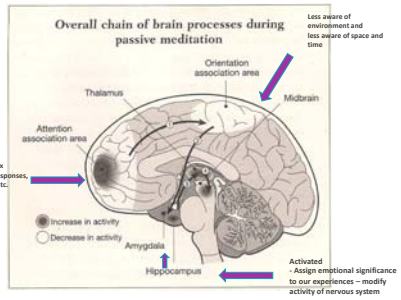
RESILIENCE THROUGH MEDITATION

The Mindful Brain – Physiology



Changes in limbic system leads to modified activity of the autonomic nervous system PAVR (2016)

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BENEFITS OF MEDITATION

Decreases anxiety and increases empathy Barbosa et al, 2013

Improves self-regulation, reduces stress, burnout symptoms, improves emotional wellbeing, patient care skills and productivity Luberto et al, 2017 Verweij etal

Feasible, fewer burnout symptoms, increased work engagement and well-being, increased compassion towards self, other and patients Verweij et al, 2016 *

Decreased stress and burnout symptoms Fortney, 2013 * Krasner et al, 2009*

Decreased Stress and increased mindfulness skills Pflugeisen et al

Reduces stress and promote self care behaviors Kabat Zinn, 2009, 1982, 1992

Enhanced self care, integrated pause mindful moments into work day, decreased rumination, reduced stress in patient interactions, enhanced communications skills, improved team communication Orellana-Rios et al 2018

Decreased emotional exhaustion Ospina et al

Improves efficacy in counselling skills Frank 2000

Patel et al , 2019 West et al, 2016 West et al, 2018 Panagioti et al, 2016 Rosenzweig et al, 2008 Mason 2007, Frank 2000

A way of being and it can also be taught as skillful means to center

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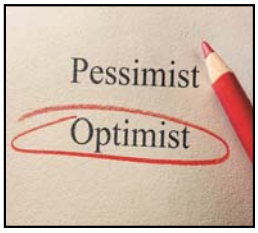
RESILIENCE THROUGH OPTIMISM



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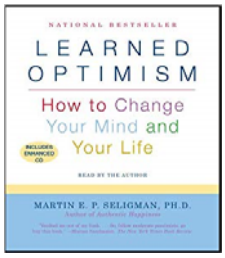
RESILIENCE THROUGH LEARNED OPTIMISM



"Life inflicts the same setbacks and tragedies on the optimist as on the pessimist, but the optimist weathers them better." (Seligman, 2006: 312)

Seligman & Garber, 1980; Maier & Seligman, 2016) According to Seligman's explanatory style definition, "***The basis of optimism does not lie in positive phrases or images of victory, but in the way you think about causes***" (Seligman, 2007: 52) optimist people self care better According to Seligman's explanatory style definition, Optimistic individuals also tend to be more aware of their health status and how to stay that way.

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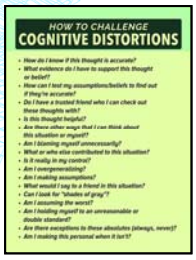
OPTIMISM & RESILIENCE THROUGH GRATITUDE & APPRECIATION, KIND DEEDS & CHALLENGING BELIEFS



OPTIMISM HAS BEEN LINKED TO subjective career success, with higher career adaptability and with better coping skills and team work

Wetzel et al Spurk et al., 2015 (Tolentino et al., 2014)

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OPTIMISM FOR LEADERS & MANAGERS

"At work, optimism has been linked to intrinsic motivation to work harder, endure during stressful circumstances, and show more goal-focused behavior" (Luthans, 2003).

Optimism is an important contributor to employees' well-being, it has been linked to improved overall happiness in the workplace, task-orientation, solution-focused approaches, perseverance, and decision-making efficacy (Strutton & Lumpkin, 1992; Normal et al., 1995; Podsakoff & MacKenzie, 1997; Choik Foong Loke, 2001; Harter et al., 2003; Gavin & Mason, 2004).

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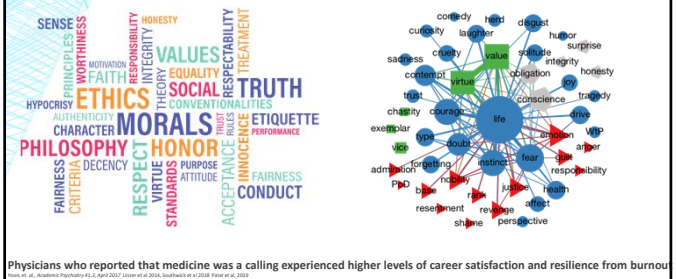
RESILIENCE THROUGH VALUE, MEANING AND PURPOSE



Physicians who reported that medicine was a calling experienced higher levels of career satisfaction and resilience from burnout

Yoon, et. al., Academic Psychiatry 41.3, April 2017 Linzer et al 2014, Southwick et al 2018 Patel et al, 2019

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NEWSLETTERS

46

Publications

47

RESILIENCE & MEANING THROUGH COMPASSION

From latin "co-suffering"
Awareness and understanding of the suffering of another accompanied by the desire to help

- Increases wellbeing
- Increases adherence to treatment
- Lower rate of burnout in physicians
- More meaning in work
- Decreases negative emotions
- Decreased anxiety and stress
- Better HbAIC levels
- Lowered LDL levels
- Better follow through and adherence to treatment plans
- Better follow up of chronic disease

48

THE VALUE OF EMPATHY

Positive emotions
Increased awareness
Greater sense of social support
More purpose
Greater life satisfaction
Fewer illness and depression symptoms

ACCELERATED HEALING
ENHANCED IMMUNE FUNCTION
DECREASED INFLAMMATORY MARKERS

THE COST OF HEALTH

Office Visit .....$ 31.46
Flu vaccine.....$ 14.52
Tray fee .....$ 3.63
Geriatric Office Visit..$ 39.93
Pap Smear .....$ 21.00
Counseling 30 min.....$ 25.4MSU

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THE BENEFITS OF COMPASSION: ENABLING & ENGAGING PATIENTS PHYSICIANS

- Greater sense of social support
- Greater life satisfaction
- Fewer symptoms
- Positive emotions
- Increased awareness
- Greater sense of social support
- More purpose
- Greater life satisfaction
- Fewer illness and depression symptoms

Lower rate of burnout in physicians
More meaning in work
Decreases negative emotions
Decreased anxiety and stress
Increased resilience
Decrease vicarious traumatization

Compassion Satisfaction:
Positive sentiment the provider experiences when able to empathetically connect and feel a sense of achievement in the care-providing process
Positive reinforcement with patient's improve and belief that provider has made a positive impact
Emotionally fulfilled by one's work in the "human service fields"

50

SELF-COMPASSION IS CRITICAL TO OUR CARE:

Self- compassion is when we notice our own suffering and respond to it with kindness and care. At this time of reform this is more relevant than ever.

It is critical to living and **working healthy** as physicians. **Doctors suffer as humans** and also experience vicarious trauma when caring for patients.

Critical to being able to have **clarity** and see patients for who they are otherwise we run the risk of projecting, stereotyping, making mistakes, crossing boundaries which are neither healthy for ourselves or patients.

Holding others pain is a **privilege** and its important to show up for that experience having cared for ourselves this **enables** us to be more compassionate of others.

Understanding and sharing life's joys, sorrows, failures, imperfections and suffering connects us. **Holding our shared sense of humanity is healing.**

51

"COMPASSION IS THE CORNERSTONE OF THE THERAPEUTIC RELATIONSHIP AND THE ANTIDOTE TO BURNOUT"

HTTPS://WWW.CFP.CA/CONTENT/63/4/306.FULL

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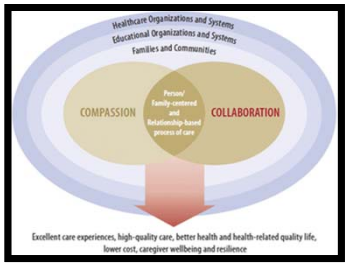
RESILIENCE IS STRENGTHENED THROUGH COMPASSION AND COLLABORATION



53

"THROUGH A COMPASSIONATE LENS, CIRCUMSTANCES, ILLNESS, BEHAVIORS AND PEOPLE ARE NOT WHAT THEY ONCE SEEMED. THEY BECOME HUMANS STRUGGLING TO COMMUNICATE THEIR NEEDS."

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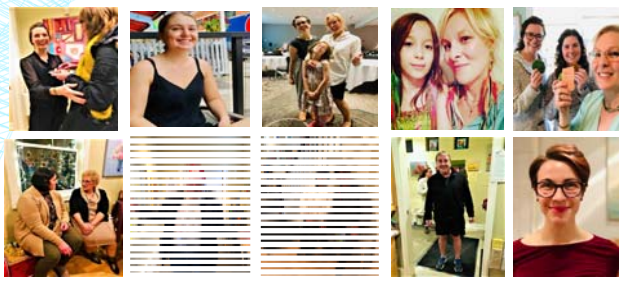
RESILIENCE THROUGH COMMUNITY & CONNECTION



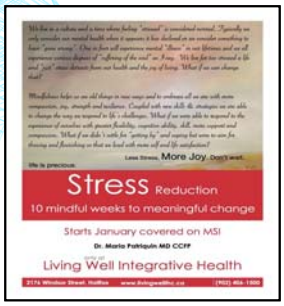
55

RESILIENCE THROUGH LEARNING, TRAINING & SKILLS

LeBlanc et al, 2007 McCue et al, 1991 Burgard et al West et al Patelet al

56

DR. MARIA PATRIQUIN STRESS REDUCTION CLASS



Combination of didactic & experiential learning

Strengths & Skills based

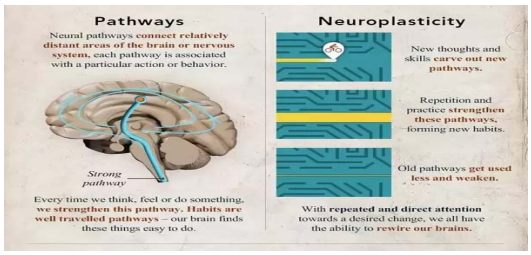
Harnessing optimism resilience neuroplasticity and compassion

A unique and innovative program encompassing techniques, strategies & framework formed from:

Positive Psychiatry, Mindfulness Based Stress Reduction (**MBSR**), **CBT**, Acceptance and Commitment Therapy (**ACT**), Emotion Focused Therapy (**EFT**), Psychodynamic (**ISTDP**), Non-Violent Communication (**NVC**), Trauma Informed Care & Trauma Focused Therapy (**TIC/TFC**)

57

MESS WITH YOUR MIND RATHER THAN IT MESS WITH YOU LEVERAGE OUR ABILITY TO LEARN NEW



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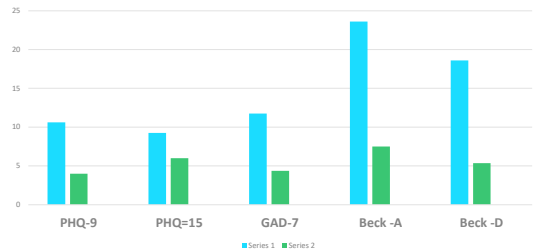
SMALL THINGS THAT MAKE A BIG DIFFERENCE

59

QUESTIONNAIRES PRE AND POST



60

POSITIVE OUTCOMES

- Reduced overall perceived stress
- Anxiety, depressive & somatising symptoms improved
- Self awareness & Self management ability increased
- Acquired valuable coping Skills & tools
- Improved communication at work and home
- Improved ability to retain self-care practices
- Emotional regulation
- Clearer boundaries
- Better work habits
- Increased distress tolerance
- More creative expression
- Improvement in managing stress
- Feeling of belonging and community
- Improved sense of self worth
- Better quality of life & subjective happiness
- Feel like I can be me (strengthened personal values like authenticity, integrity, openness)
- People describe feeling whole again
- People describe feeling deeply connected to people they barely know and are filled with a sense of belonging

61

THESE HAVE BEEN REPLICABLE & ENDURING EFFECTS OF OTHER GROUPS AND PROGRAMS

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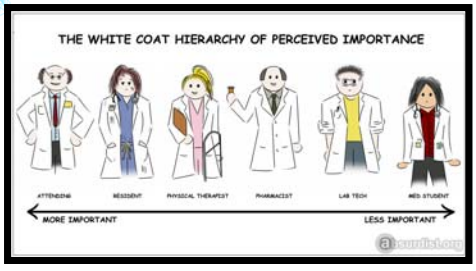
RESILIENCE THRIVES IN ALLIANCE



Allied health may be defined as those health professions that are distinct from medicine and nursing. http://www.asahp.org/what-is/

63

COLLABORATIVE CARE CAN HELP US ADDRESS THE BURNOUT CRISIS: THE CASE FOR THE PMH

The World Health Organization defines collaborative practice in health-care as occurring "when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, careers and communities to deliver the highest quality of care across settings," and inter professional education as occurring "when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes."

64

"WITH A FULL COLLABORATIVE CONSTITUTION OF HEALTH CARE PROVIDERS WE CAN DRAW UPON A HUGE SOURCE OF WISDOM AND EXPERTISE. THIS STANDS TO SERVE PATIENTS, PROVIDERS, SYSTEMS AND INSTITUTIONS. THIS COULD HELP SOLVE BURNOUT & OUR CARE CRISIS"

65

RESILIENCE & COLLABORATION THROUGH TEAM BUILDING

- Person Centered Care
- Role Clarification
- Team Functioning
- Collaborative Leadership
- Interprofessional Communication
- Interprofessional Conflict Resolution
- National Interprofessional Competency Framework.

Canadian Interprofessional Health Collaborative (CIHC) Feb. 2010

66

VERBAL

Language, Meaning & Tone (Attitude)

Consider labels…

- The "Frequent flyer"
- The "difficult" patient (15-30% of interactions)
- The "Borderline"
- The "Sensitive patient"
- The "Personality"
- The "Non-compliant"
- The "Self-sabotage"
- The "Hysterical"
- The "Medically Unexplained symptoms/syndromes"

COMMUNICATION

Boundaries
Space
Posture /Pose
Eye contact
Touch /Not touching

NON-VERBAL

Body Language, Environment

- Wait area. Seating, space, entrance/exits, privacy. Is there enough? Are there safe spaces?
- Posters, literature and self- help resources. Informative? Provides opportunity to open safe conversations
- Magazines and other typical waiting room reading.
- Radio, news, or soothing music?
- Support staff, flow, accessibility.
- Communication with other providers staff, providers (SBAR, NVC). Define clear roles etc. in circle of care. Krasner 2009 Patel et al, 2009 Moss et al, 2016

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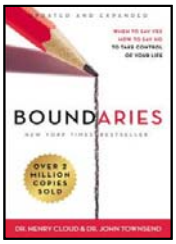
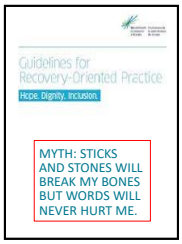
RESILIENCE THROUGH HEALTHY COMMUNICATION

CLEAR COMMUNICATION, INTENTIONAL, KIND, THOUGHTFUL, HELPFUL, NECESSARY, RECIPROCAL, COMPASSIONATE, BOUNDARIES …





MYTH: STICKS AND STONES WILL BREAK MY BONES BUT WORDS WILL NEVER HURT ME.

Consider… Words, Tone, Boundaries, Space, Posture /Pose, Eye contact, Touch /Not touching, Supports, Resources

Language frames our thoughts and thoughts frame our language

68

ORGANIZATION BASED INTERVENTIONS

- Team building
- Scheduling
- Protected time off
- Adequate coverage for time off
- Readily available support programs
- Debriefing
- Advocacy & Funding
- Safe spaces
- Restricting excessive work hours
- Training programs for knowledge, skills and coping
- Expression of value alignment
- Training programs patient skills complex patients, communicating with patients
- Support & debriefing plan for medical errors
- Restricting resident on call hours
- Mentors to connect peer support
- Good HR practices and supports
- More usable HER systems
- Small group programs that foster community

69

MAKE THE CASE TO EXECUTIVE LEADERSHIP:

- Improve the patient experience and reduce medical errors
- Improve retention of valued members of the medical staff and prevent resource-intensive adverse outcomes among physicians (e.g. leave of absence, attrition, suicide)
- Enhance creativity and flexibility in responding to the challenges of the changing health care system
- Establish your institution as a leader on an issue of national importance
- *Shanafelt TD, Noseworthy JH. Mayo Clin Proc. 2017 leaders affect burnout and job satisfaction Drummond*

70

NINE ORGANIZATIONAL STRATEGIES

DR. TAIT SHANAFELT (CHIEF WELLNESS OFFICER, STANFORD MEDICINE, STANFORD, CA) AND DR. JOHN NOSEWORTHY (CHIEF EXECUTIVE OFFICER, MAYO CLINIC, ROCHESTER, MN) RECENTLY PROPOSED NINE STRATEGIES AS A PATH TOWARD REDUCING PHYSICIAN BURNOUT THAT CAN BE ADAPTED FOR SPECIFIC ORGANIZATIONS.

FIGURE 5. Organizational strategies to reduce burnout and promote physician engagement. [a]Often will focus on improving efficiency and reducing clerical burden but should focus on whichever driver dimension (Figure 1) deemed most important by members of the work unit (Figure 3).

71

ORGANIZATION-DIRECTED INTERVENTIONS ARE MORE LIKELY TO LEAD TO REDUCTIONS IN BURNOUT THAN PHYSICIAN-DIRECTED INTERVENTIONS

- 20 independent comparisons from 19 studies (1550 physicians)
- Used the emotional exhaustion domain of the Maslach
- **Organization-directed interventions are more likely to lead to reductions in burnout than physician-directed interventions**
  - Structural changes
  - Fostering communication between members of the health care team
  - Cultivating teamwork
- Interventions targeting experienced physicians showed greater evidence of effectiveness

- 2617 articles including 15 randomized trials of 716 physicians and 37 cohort studies of 2914 physicians
- 230 articles met criteria for full review
- Most studies reported on changes in burnout domain score
- Both individually-focused and organizational interventions can reduce burnout
- **Both individual and organizational strategies are probably necessary, but there are no studies to date which include both.**

Panagioti, et.al., JAMA Internal Medicine, December, 2016 controlled interventions to reduce bo West, et.al., Lancet, November,

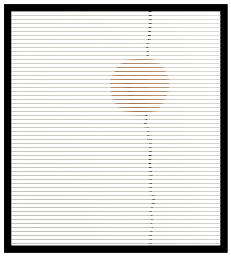
72

LEAD WITH OPTIMISM, COMPASSION AND RESILIENCE WITH A STRONG MORAL COMPASS, CULTIVATE A SENSE OF BELONGING "BE WITH US NOT FOR US"




73

QUICK FIXES WON'T HOLD…

And have significant long term consequences

74

CHANGE IS HARD: JUST ONE OF INDIVIDUAL & INSTITUTIONAL BARRIERS TO IMPLEMENTATION

You can't change what you refuse to confront.

75

CHANGE IS A COMPLEX ADAPTIVE PROCESS

Complexity…

helps us understand change. The study of it as an emerging science which analyzes organizations from many dimensions not just from a reductionist, mechanistic perspectives.

Complex systems are living, unpredictable, creative, innovative, adaptive and flexible, embrace complexity, challenge and continuously evolve.

Complexity… Global, cultural and societal shifts affect access and provision of care and receptiveness to change …

Traditional systems are machines, predictable and inflexible and rigid. They are self preserving and take comfort in controlling behavior. They recycle, revisit, tend not to change.

A HUMAN IS A COMPLEX ADAPTIVE SYSTEM

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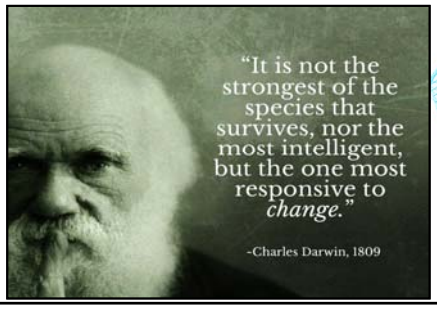
"Change is harder when it is posed as a threat. People and systems do not function well under threat"



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A DISEASE BASED MODEL IS A DETERRENT TO SEEKING CARE. A WELLNESS-BASED MODEL IS STRENGTHS BASED AND CONSIDERS THE WHOLE PERSON

- prevention
- some medicines
- non-medicinal approaches
- diet
- Exercise
- Socializing & social support
- one's environment, faith, culture
- sense of purpose, meaning, value
- positive role of counseling & psychotherapy
- educate
- build skills & capacity
- foster resilience
- protective and therapeutic

An illness based model is not person centered

78

10 COMMANDMENTS OF PHYSICIAN WELLNESS FEELS CONDEMNING

I. Thou shall not expect someone else to reduce your stress.
II. Though shall not resist change.
III. Thou shall not take thyself in vain.
IV. Remember what is holy to thee.
V. Honor thy limits.
VI. Thou shall not work alone.
VII. Thou shall not kill or take it out on others.
VIII. Thou shall not work harder. Thou shall work smarter.
IX. Seek to find joy and mastery in thy work.
X. Thou shall continue to learn.

(Krall 2014)

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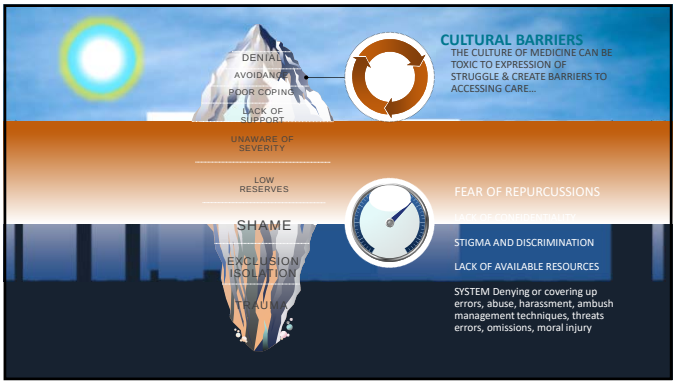

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STIGMA & DISCRIMINATION WORSEN BURNOUT

THE EFFECTS OF STIGMA AND DISCRIMINATION CAN BE SEEN IN THE CHRONIC UNDERFUNDING OF THE MENTAL HEALTH SYSTEM

Negatively impact all area of life and is frequently more **harmful** than the illness itself.

Negative attitudes, lack of respect or pessimism regarding recovery, steps to remove control over decision-making **interfere with recovery**.

Fear being labelled or judged is high

Family caregivers report experiencing **isolation** & loss of support due to shame and blame contamination

Health care providers experience lack of respect and **inadequate support** and accommodations when seeking care

81

MYTH: STICKS AND STONES WILL BREAK MY BONES BUT WORDS WILL NEVER HURT ME. SHAME

- People shrink
- shame can masquerade
- shame and guilt
- recoil from others
- feel badly about themselves
- scrutiny of the entire self
- feel worthless and powerless
- exposed

- Too busy
- Lack of self awareness
- Not knowing how & procedures
- Shame
- Lack of supervisory alliance
- Fear of rejection
- Fear of punitive actions
- Fear of judgement (weak, less than, meme here purple,
- Seen it gone bad for others don't want similar consequences
- Fear of unknown and unexpected
- Lack of support Nedrow A, Steckler N & Hardman J. Physician Resilience & Burnout. Fam Pract Mgmt Jan-Feb 2013

82

NOT ENGAGING PHYSICIANS AS PARTNERS WHEN THEY ARE PATIENTS CREATES A BARRIER TO CARE

HTTPS://BMCMEDEDUC.BIOMEDCENTRAL.COM/ARTICLES/10.1186/S12909-018-1277-0

- **The impact of patient feedback on the medical performance of qualified doctors: a systematic review**
- Patient feedback is considered integral to quality improvement and professional development. However, while popular across the educational continuum, evidence to support its efficacy in facilitating positive behavior change in a postgraduate setting remains unclear. This review therefore aims to explore the evidence that supports, or refutes, the impact of patient feedback on the medical performance of qualified doctors.
- **Methods**Electronic databases PubMed, EMBASE, Medline and PsycINFO were systematically searched for studies assessing the impact of patient feedback on medical performance published in the English language between 2006-2016. Impact was defined as a measured change in behaviour using Barr's (2000) adaptation of Kirkpatrick's four level evaluation model. Papers were quality appraised, thematically analysed and synthesised using a narrative approach.
- **Results**From 1,269 initial studies, 20 articles were included (qualitative (*n*=8); observational (*n*=6); systematic review (*n*=3); mixed methodology (*n*=1); randomised control trial (*n*=1); and longitudinal (*n*=1) design). One article identified change at an organisational level (Kirkpatrick level 4); six reported a measured change in behaviour (Kirkpatrick level 3b); 12 identified self-reported change or intention to change (Kirkpatrick level 3a), and one identified knowledge or skill acquisition (Kirkpatrick level 2). No study identified a change at the highest level, an improvement in the health and wellbeing of patients. The main factors found to influence the impact of patient feedback were: specificity; perceived credibility; congruence with physician self-perceptions and performance expectations; presence of facilitation and reflection; and inclusion of narrative comments. The quality of feedback facilitation and local professional cultures also appeared integral to positive behaviour change.
- **Conclusion**Patient feedback can have an impact on medical performance. However, actionable change is influenced by several contextual factors and cannot simply be guaranteed. Patient feedback is likely to be more influential if it is specific, collected through credible methods and contains narrative information. Data obtained should be fed back in a way that facilitates reflective discussion and encourages the formulation of actionable behaviour change. A supportive cultural understanding of patient feedback and its intended purpose is also essential for its effective use.

Nothing for us without us

http://cargocollective.com/gfiorentino

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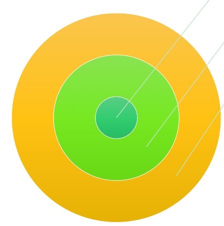
CONSIDER WHAT THE INDIVIDUAL NEEDS TO RETURN TO WORKING WELL

- **First**: understand, assess, plan & communicate, support
- **Second**: treatment, recovery & rehabilitate, strengthen supports. Institute changes to workplace
- **Third**: Return to work with ongoing supports, therapy, accomodations & reinforcement of skills. Regular evaluations and feedback, ongoing dynamic adaptations. Debrief after difficult & errors. Brainstorm and collaborate. Communicate well. Cultivate healthy community, peer support & an atmosphere of kind, compassionate and embraced shared humanity



Return to work
- Self care & self management
- Regular therapy and support.
- Ongoing skill building

Rehabilitation
- Work hardening focus on skill building
- Graduated exposure

Off work: assessment, treatment and recovery
- Assess and plan
- Secure resources & start treatment plan

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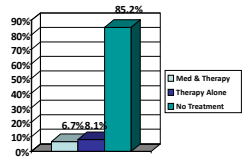
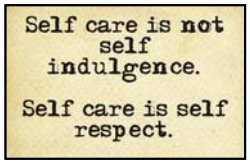
WHAT IS ELSE IS CREATING BARRIERS TO IMPLEMENTATION ?

Utilization of Mental Health Services Among Depressed Medical Interns



Guille, C. et al. J Grad Med Educ. 2010 Jun; 2(2): 210–214.



"Through a supervisory lens subject to the inner critic that judges our success by how well we think our students are performing, expectations and stress grow."

85

RESIDENTS AND STUDENTS UNIQUE STRESSORS

- Devalued
- Lack of protected time for necessities
- And self care
- Taking care of basic needs seen as
- Weakness Intolerance Barriers to disclosure & accessing care
- Lack of education, prepared
- Lack of supervisory alliance
- Skills deficits and lack of support to deal with difficult encounters
- Medical errors secondary traumatic stress Lack of education, prepared
- Lack of supervisory alliance

- Stigma
- Judgement
- Ostracism
- Isolation
- Criticism
- High expectations
- Lack of social support
- Prolonged on call hours
- Excessive work week schedule
- Lack of respect by superiors
- and supervisor

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REMIND OURSELVES & OUR STUDENTS THAT WE GROW FROM MISTAKES

"Shortcomings are not failures but opportunities to learn, adapt, change and evolve. This is the basis of the scientific method after all…
we are just human we err!"

87

WE GROW FROM ADVERSITY POST TRAUMATIC GROWTH

Post traumatic growth is reflected in emotional growth through self awareness and wisdom, a sense of connection, belonging and strengthening of relationships. People experience more awareness of personal strengths and how to harness them. From a growth mindset, one experiences new possibilities and a deeper sense of appreciation for life. Resilient survivors continue to grow, and even thrive, in spite of, and quite often because of, their histories. (Armour, 2007)

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WE CAN GROW WITH COMPASSION

FRAMEWORK FOR LINKING CULTURAL NORMS IN MEDICINE WITH BURNOUT FACTORS AND POTENTIAL INTERVENTIONS

Positive value	Negative potential	Burnout factor(s)	Potential mental training interventions
Service	Deprivation	Compassion fatigue Entitlement	Reframing Appreciation and gratitude
Excellence	Invincibility	Emotional exhaustion	Mindful self-compassion Inner critic awareness
Curative competence	Omnipotence	Ineffectiveness Cynicism	Self-awareness Generous listening
Compassion	Isolation	Depersonalization	Connection and community Silence as energizing

(Nedrow 2012)

89

90

WHAT IS OATH WHAT IS MORAL IMPERATIVE ?

WHAT DO YOU VALUE? WHO DO YOU, WE WANT TO BE IN THE FACE OF CHALLENGE, CHANGE AND A CRISIS IN CARE?

91

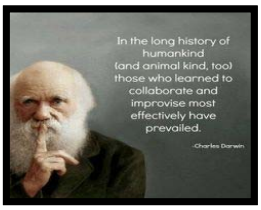
SHARED HUMANITY

"Holding others pain is a privilege. Holding our own, makes us healthier care givers. Understanding and sharing life's joys, sorrows, failures, imperfections, and suffering connects us. Holding our shared sense of humanity is healing." *Dr. Maria Patriquin*

Humanizing health

92

DARWIN ACTUALLY SPOKE TO THE STRENGTH OF SOCIAL AND MATERNAL BONDS…
"***COMMUNITIES***, WHICH INCLUDED THE GREATEST NUMBER OF ***SYMPATHETIC*** MEMBERS, ***WOULD FLOURISH BEST***…"



93

*"**COMPASSION** IS THE CURRENCY OF RELATIONSHIPS. WE ARE SOCIAL BEINGS AND OUR **BRAINS ARE SOCIAL ORGANS**…*

*We have the capacity to **learn, change and grow** together.*

*Because of our social nature, our interactions hold the potential and capacity to harm or to heal. Our success as physicians and as sentient beings will be defined by our ability to **honor the role of relationships** and the importance of regard for our deep seated need to **belong and connect**.*

*By virtue of these qualities and values, our care holds the potential of being able to establish the healthiest forms of working relationships if the **process is…***

compassionate, collaborative and considers our humanity".

Thank you Dr. Maria Patriquin MD CCFP FCFP

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Thank you

PMH IN NOVA SCOTIA

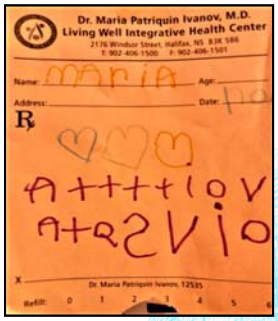
Successful examples of practices operating as a PMH in the province

www.livingwellihc.ca

May we work together for meaningful change

95

THANK YOU TO MY FAMILY



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RESOURCE SLIDES AND HELPFUL LINKS

- http://livingwellihc.ca/entries/general/important-concepts-in-collaborative-transformation- Important conceptualizations in transformation to a collaborative model of primary HC provision.
- https://www.flipsnack.com/doctorsnovascotia/doctorsns-oct2017/full-view.html?p=1 page 24 Group Medical Visits
- https://www.flipsnack.com/doctorsnovascotia/doctorsns-sept2017/full-view.html?p=1 The Road to MD; How to survive and thrive in medical school
- http://livingwellihc.ca/files/documents/LivingWellWinter2016NL_1.pdf Love Begins With the Letter "C" https://www.cfp.ca/content/63/4/306.full
- http://livingwellihc.ca/entries/general/the-science-of-habits-dr-maria-patriquin- The Science of Habits
- Systemic Issues in Mental Health Care Provision , The Coast, Chronicle Herald & Dal News http://livingwellihc.ca/entries/general/systemic-issues-in-mental-health-care-provision-published-as-mind-and-body-june-2017-the-coast-letters-
- https://www.yourdoctors.ca/blog/health-care/an-investment-that-pays-off-building-mental-wealth An investment that pays off. Building Mental Wealth
- Supporting Primary Care Transformation Tool Kit for Doctors NS https://doctorsns.com/sites/default/files/2019-01/next-steps/Collaborative-Practice-Tool-Kit2019.pdf

Please contact me visit www.livingwellihc.ca or email me at kindonpurpose@gmail.com

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THE FOLLOWING SLIDES ARE RESOURCES THAT I AM HAPPY TO SHARE

- The following 8 slides are derived from my work on collaborative care and are short form notes for small changes you can make in your practices to move towards a collaborative practice. The 1st are recommendations for leaders and organizations regarding adoption of the PMH and collaborative care in addressing the crisis in family medicine.
  For more information please visit www.livingwellihc.ca or email me at kindonpurpose@gmail.com
- I hope that you will join us for this conference…

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RECOMMENDATIONS FOR LEADERS AND ORGANIZATIONS REGARDING ADOPTION OF THE PMH AND COLLABORATIVE CARE AND ADDRESSING THE CRISIS IN FAMILY MEDICINE
DR. MARIA PATRIQUIN

- *1. **"Collaboration/integration is a process NOT an endpoint".** It is a way of being, working and functioning that necessitates working together. Another way of saying this is "collaboration **is a verb not a noun".** The Webster dictionary defines it "as a purposeful relationship in which all party strategically choose to cooperate in order to achieve shared or overlapping objectives". In this circumstance there are many shared objectives of which the most important is better patient care. Collaboration as a process is constantly changing, evolving and is responsive to various changing factors in the healthcare landscape.*
- ***2. Collaboration is conciliation i.e. "the unity of knowledge". Where is the unity and where are the sources of knowledge derived? "The process by which we derive information and knowledge for the transformation must be a culmination of multidisciplinary and interdisciplinary research".***
- ***3. "Collaboration requires engagement on every level". Global, government, policy, practice, organizations, institutions, administrations, researchers, teachers, providers, patients, and communities, etc.***
- ***4. "Learning to transition to collaborative care is an adaptive process that has both technical and adaptive challenges. A technical approach to an adaptive process doesn't work. The approach itself must be integrative" (in this sense integrating adaptive as well as technical solutions).***
- ***5. "Collaborative practices must be patient-centred AND population centered. Collaboration requires continual adaptation and change to varying individual as well as community and population variables. This, to some extent, this reflects how patient centered care is envisioned and supported in the community (beyond the walls of a practice) and how communities can foster healthy practices in individuals belonging to larger groups."***

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- ***6. "Patients must be consulted in the process of formation of collaborative care otherwise the process itself is not patient centered and risks falling short of needs. Collaboration grows collaboration. Including patient voice in the process of transformation demonstrates authenticity, consistency and continuity in considering what is truly conducive to patient centered care. There are no existing patient interest groups for primary care provision".***
- ***7. "Collaborative care exists within a larger landscape and must also consider global trends and economies, agencies, organizational and institutional interests, government and policy formation, societal pressures, cultural shifts, technological advances and innovation, financial and fiscal restraints, availability of professional resources and the environment".***
- ***8. "Collaborative practice is dynamic and should be intelligent, informed, proactive, purposeful, innovative, flexible, optimistic, responsive, responsible, stable and resilient." The word conciliation refers to the coming together of meaning and derives from the Latin word COM meaning "together" and Sileans meaning "jumping" or "resilient. Success is not possible without failure. With resilience, we grow from failure. It acts as a built in mechanism to provide information about what works and what doesn't work. Resilience is necessary.***
- ***9. "Stronger collaborative practices are formed when the providers involved are respected for having knowledge, expertise, and experience, and opportunities are made to give voice to their vision. The 'lived work experience' holds some validity and credibility. Providers need to be permitted some degree of autonomy and choice over what they experientially know is a good fit for them. 'Prescribing' partners and practices don't work".***
- ***10. "Collaborative relationships are highly reliant on communication and inherently require some form of leadership. In a strong collaborative practice there needs to be some agreement upon the style of leadership that is conducive to the provider-centered components of care as well as the overall collaborative structure and set up". Transitioning to collaboration and integration requires leaders, champions, trailblazers and risk takers. Tasks and roles should be defined by skills and not by disciplines.***

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- *11. Primary care embraces the value of providing continuous care throughout the lifespan. Although this is ideally a component of the training and subspecializing is discouraged, not one provider can be all to everyone at all stages of life. This is why "a collaborative model suits lifespan care. Multiple providers with varying expertise collectively meet needs through shared roles and responsibilities. This type of set up honors intellectual liberty and engenders enriched care by nurturing and investing in the interests and aptitudes of the providers". One wouldn't want a family physician with expertise in geriatrics providing ongoing prenatal care. "Tasks and roles should be defined by skills and not by discipline".*
- *12. Collaboration requires structure to ensure efficiency, effective use of resources, to encourage innovative ways to deliver care and in an effort to ensure patient care is enhanced. "Structure is a value adding component to collaborative care". This includes (not exclusively) EMR, administration and access, assessment, evaluation and feedback, programming and training. This speaks to the necessity for collaboration to include some formal processes and procedures.*
- *13. Communication is the foundational practice necessary for a seamless transition to collaboration and integration. It is it is also the foundation of ongoing practice. "Communication is the language of collaboration". There should be opportunity for both formal and informal communication in a collaborative model of care. Formal communication occurs through shared charting or EMR, assessments and regular meetings. There are well established tools to assist in the process. Informal communication promotes strong interpersonal relationships and recognizes limitations inherent in formal communication practices. Informal communication includes practices such as brainstorming, problem solving as well as the "Warm" handover. "Both formal and informal communication serves to enhance patient care and working relationships in a collaborative practice".*
- *14. "Collaborative care is best envisioned as holistic and integrative. Integrative care fits into a 'wellness' model of health. Health is not merely defined as the absence of illness and disease but also by the subjective experience of being and living well. A wellness model fosters healthy practices that both prevent disease and promote wellness in addition to treating illness. Holistic care is a value adding practice and considers the whole person, their families, relationships, work, culture, community and traditions. It necessitates patient engagement and further strengthens relationships between patients and providers by positioning them as the center of the collaboration. A wellness model of care is truly a patient-centered care. No person wants to be defined or remembered for what ailed them". A wellness-based model is one that considers the whole person. It is a strengths-based model that embraces the bio –psychosocial approach to care and places value and credibility on prevention, some medicines, as well as non-medicinal approaches to care including diet, exercise, socializing, social support, one's environment, faith, culture, sense of purpose, meaning, and value, and emphasizes the positive role of active care. It seeks to educate, build skills, capacity and foster resilience, which is both protective and therapeutic. It places the patient at the center of their care emphasizing choice and aligning with being patient-centered, an important pillar of the collaborative care model.*
- *The reality is that our system is not well, nor is it serving the needs of patients or providers. This creates barriers to accessing and providing care. An over-reliance on evidence based medicine has replaced common sense and has discouraged and creates artificial divisions where there should be integration and interdisciplinary collaboration. It has also contributed to a culture where there is more emphasis on numbers and outcomes rather than the whole person. There is lack of consideration for the qualitative experience of what is supposed to be a healing interaction and relationship between provider and patient. There is a growing body of evidence that demonstrates empathetic exchange or compassionate care has significant positive health outcomes and this is not factored into the existing model.*
- *15. A collaborative care model is only as healthy, functional and happy as the people that work and function within it. This speaks to the importance of physicians and health care provider's health. This must consider their needs and the importance of a work-life balance as well as the need to be engaged in healthy practices themselves. Providers must be heavily encouraged to self-care, be mindful and responsive to their changing needs, to establish a sense of safety, security and stability as well to ensure that they are deriving from their work role a sense of meaning, purpose and mastery. Providers need care and need to take care.*
- *16. "Collaboration is reliant on healthy relationships. Compassion is the currency of relationships. We are social beings and our brains are social organs. We have the capacity to learn and grow together. Because of our social nature, our success will be defined by our ability to honor the role of relationships and the importance of regard for our deep seated need to connect and belong. By virtue of these qualities and values, the collaborative model of care holds the potential and promise of being able to establish the healthiest forms of working relationships if the process of forming them is itself compassionate and considers our humanity".*

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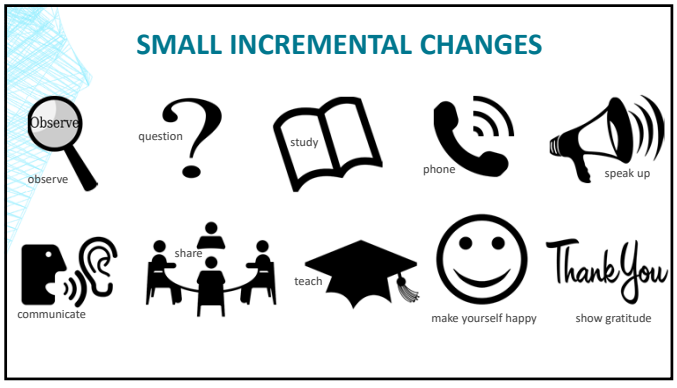

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SMALL BUT MIGHTY MOVES…

November 2, 2017

Barna

I just wanted to take the time to let you know that you are such a pleasure to have as a consultant. You are meticulous, make yourself very available and are so incredibly communicative. This particular communication touched me as it also shows how very compassionate and caring you are. I had thought for a long time to write to you showing gratitude as none of this is an easy task especially during a time of healthcare reform and high stress, but the thought alone does not count unless you know I've had it often.

Yours sincerely, Maria Patriquin, MD, CCFP

2017/03/23: Nexium Dose/Unit:40mg Sig:once daily Doses:30 Refills:0 *DISCONTINUED DUE TO RENAL FUNCTION (last prescribed, faxed: 2017/03/23)*

2017/02/28: n/a Dose/Unit:ATTENTION Sig:e GFR is 19!!!! please put alert on chart *(last prescribed, faxed: 2017/02/28)*

2017/02/17: Fucidin Dose/Unit:ointment Sig:apply to affected area bid nose Doses:30gm *(last prescribed, faxed: 2017/02/17)*

2017/02/17: Zyprexa Dose/Unit:20mg Sig:bid D/C Doses:3months Refills:4 *(last prescribed, faxed: 2016/03/27)*

2017/02/17: n/a Dose/Unit:D/C pariet valsartan Sig:nifedipine inc to 60XL od 3/12 *(last prescribed, faxed: 2017/02/17)*

2017/02/03: esomeprazole Dose/Unit:40 mg od Doses:3/12 Refills:1 *(last prescribed, faxed: 2017/02/03)*

2017/02/03: Risperdal Dose/Unit:10mg Sig:od Doses:180 Refills:1 *(last prescribed, faxed: 2017/02/03)*

2017/02/03: budesonide Dose/Unit:64MCG Sig:NASAL USE 2 bid Doses:1 bottles Refills:5 *(last prescribed, faxed: 2017/02/03)*

2017/02/03: Pariet Dose/Unit:20mg Sig:bid Doses:12 months *(last prescribed, faxed: 2017/02/03)*

2017/02/03: Zyprexa Dose/Unit:60mg Sig:once daily dose inc Doses:3months *(last prescribed, faxed: 2017/02/03)*

2017/02/03: n/a Dose/Unit:1% hc cream Sig:bid 60 gms *(last prescribed, faxed: 2017/02/03)*

2017/02/03: n/a Dose/Unit:eGFR is 35 Sig:please advise if need dec meds due to dec renal function *(last prescribed, faxed: 2017/02/03)*

REFLECTIVE EXERCISE

Name one positive thing/event/moment about the week that past:

Did you have any questions/challenges/observations about the lesson: _____ ?

Name a moment/circumstance that you either used or reflected on the skill taught last week: _____

Other comments/suggestions/feedback:

_____BP: ____weight: __Height:_WC__ *Dr. Maria Patriquin Inc. ©*

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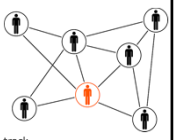
SMALL BUT MIGHTY VALUE ADDING COLLABORATIVE MOVES…

Ask patients to bring family or friends who can have input and provide support



Request a medication review for chronic disease management

Use tools to engage and facilitate care and behavioral change. Set goals, track progress, suggest follow up etc. e.g. SMART goals, PHQ's, FOH

Write a letter to connect care providers within a patient's circle of care
Use your EMR to distribute.

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USEFUL LINKS TO COLLABORATIVE RESOURCES & TOOLS

"A National Interprofessional Competency Framework." *CIHC*, CIHC, Feb. 2010, www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf.

- "ACHIEVING PATIENT-CENTRED COLLABORATIVE CARE." *CMA*, Association library/document/en/PD08-02-e.pdf.
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