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Asociación Colombiana de Psiquiatría ACP

Revista Colombiana de Psiquiatría

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Updated article

Design and implementation of the Professional Wellbeing Programme of the Medical Council of Uruguay

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ARTICLE INFO

Article history:
Received 11 November 2020
Accepted 4 February 2021
Available online 30 March 2023

Keywords:
Programme development
Sick doctor
Healthcare of doctors

ABSTRACT

Multiple studies have reported a high prevalence of mental health problems among male and female physicians. Although doctors are reluctant to seek professional help when suffering from a mental disorder, specialised services developed specifically to treat their mental health problems have reported promising results. The purpose of this article is to describe the design and implementation of the Professional Wellbeing Programme (*Programa de Bienestar Profesional*) of the Uruguayan Medical Council (*Colegio Médico del Uruguay*). The context, inputs, activities and some of the outputs are described according to a case study design. The main milestones in the implementation of the programme are also outlined, as well as the enabling elements, obstacles and main achievements. Emphasis will be placed on the importance of international collaboration to share experiences and models, how to design the care process to promote doctors' access to psychiatric and psychological care, the need for them to be flexible and dynamic in adapting to new and changing circumstances, such as the COVID-19 pandemic, and to work in parallel with the medical regulatory bodies. It is hoped that the experience described in this work may be of use to other Latin American institutions interested in developing mental health programmes for doctors.

DOI of original article: https://doi.org/10.1016/j.rcp.2021.02.005.
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Diseño e implementación del Programa de Bienestar Profesional del Colegio Médico del Uruguay

Palabras clave:
Desarrollo de programa
Médico enfermo
Cuidado de salud del médico

R E S U M E N

Son múltiples los estudios que informan de una alta prevalencia de problemas de salud mental en médicos y médicas. Aunque los médicos presentan resistencias a la hora de solicitar ayuda profesional cuando están aquejados de trastornos mentales, los servicios especializados desarrollados específicamente para tratar sus problemas de salud mental han reportado resultados prometedores. El propósito de este artículo es describir el diseño y la implementación del Programa de Bienestar Profesional del Colegio Médico del Uruguay. El contexto, los insumos, las actividades y algunos de los productos se describen de acuerdo con el diseño de un estudio de caso. También se señalan los principales hitos en la puesta en marcha del programa, así como los elementos facilitadores, los obstáculos y los principales logros. Se enfatizará la importancia de la colaboración internacional para compartir experiencias y modelos, cómo articular el proceso asistencial para fomentar el acceso de los médicos a la atención psiquiátrica y psicológica, la necesidad de que sean flexibles y dinámicos para adaptarse a circunstancias novedosas y cambiantes como la pandemia por COVID-19 y la necesidad de que vayan en paralelo con las exigencias de los organismos reguladores de la práctica médica. Se espera que la experiencia descrita en este trabajo pueda ser de utilidad a otros colectivos latinoamericanos interesados en desarrollar programas de salud mental para los médicos.

Introduction

There are multiple studies that discuss the high prevalence of mental health problems in physicians. Data from the UK *National Health Service Practitioner Health Programme*[1] reveal that, of the total number of physicians who consulted as patients in the period 2008–2017, 80% did so for mental health problems such as depression, anxiety and symptoms indistinguishable from post-traumatic stress disorder, and 15% for alcohol or drug abuse, mainly alcohol dependence. There were also consultations for personality disorder, bipolar disorder, physical health problems affecting mental health, and a small number for undiagnosed schizophrenia or psychosis. Very high rates of suicide, which exceed those of the general population, have been reported for physicians.[2–4]

In one review on the mental health of physicians,[5] it was concluded that even when reports on the prevalence of mental health problems are conflicting, there is a general consensus that physicians face a large number of risk factors, both occupational and individual, and that seeking help is challenging due to the complexities surrounding a physician-turned-patient. These factors are related to the clinical work itself, the systemic characteristics of the occupational environment, and the personal characteristics, personality traits, and psychological characteristics of the physician. As a consequence of the combination of these factors, the degree of job exhaustion due to stress or *burnout* is alarming both in the English-speaking world and in Latin America.[6–8] It is to be expected that physicians with a low perception of personal fulfilment are more exposed to developing *burnout* syndrome.

For their part, barriers have been described that prevent physicians from seeking professional help when they are afflicted with mental problems. The list is long and it includes denial and minimisation of the problem, the perfectionist and self-demanding traits of physicians, the ignorance and prejudices that physicians themselves have about mental illness, which is seen as a failure or weakness, the fear of stigma, of being discredited as professionals, the belief of physicians that their colleagues are difficult patients, which leads them to avoid getting involved in the care of other physicians, and the tendency towards "corridor consultations", self-diagnosis and self-medication, among others.[5]

On the other hand, specialised services developed specifically for interventions for physicians with mental health problems have reported promising results. The report by the *American Medical Association* (AMA) on the phenomenon of the sick physician was the starting point for all the physician health programs (PHP),[9] even though they were oriented towards regulating practice rather than building a physician support network. A review by Braquehais et al.,[10] shows that PHP developed progressively in the United States from the late 1970s and later in other countries such as Canada, Australia, the United Kingdom[11] and Spain.[12] In Latin America, there are only a few experiences of healthcare for the sick physician, in Buenos Aires and Rosario (Argentina) and a single report in Brazil.[13]

After the creation of a Physician's Well-being Commission in 2016, the Medical Council of Uruguay (Colegio Médico del Uruguay; CMU) recognised the importance of having a physician's health programme oriented, above all, to addressing mental health problems. The purpose of this article is to describe the design and implementation of such a programme.

A case study of the design and implementation process of the Professional Well-being Programme (Programa de Bienestar Profesional; BienPro) of the Medical Council Association

of Uruguay is presented, following the logical model for programme evaluation,[14] for which the context, inputs, activities and some of the products are reviewed.

Background information

Currently, there are no studies on the prevalence of mental health problems among physicians in Uruguay. There are indirect data available, such as those provided by a survey carried out by the CMU in which high percentages of low satisfaction with the accomplishments achieved in the profession and with job satisfaction were observed.[15] Forty-six percent of those surveyed thought that the medical profession affected their family life negatively or very negatively and 40% thought that working in the profession was worse or much worse than they had expected when they started studying. Nevertheless 80% thought that the medical profession was the best professional choice. Several studies reveal a high frequency of job burnout in residents of Internal Medicine[16] and Anaesthesiology[17] respectively: 33% and 42% with a high degree of emotional exhaustion; 50% and 39% with a high or moderate degree of hardening or interpersonal distancing, and 36% and 38% with a low degree of personal fulfilment. The frequency of severe job burnout in the personnel of intensive medicine units was 51% of physicians and 42% of nursing staff.[7]

The only study[18] available on alcohol and drug use among physicians in Uruguay showed that in the previous year 13% of anaesthesiologists and 7% of internists had problematic alcohol use; 47% and 45% used tranquilisers without a prescription; 9% and 5%, non-prescription opioids, and 6% and 3%, cocaine.

In the absence of more epidemiological data, there is a perception in the medical community that problems such as depression and suicide are common, and that little has been done to date to prevent them.

Contributions and inputs

In the last decade there has been a growing concern from academia regarding the improvement of physicians' well-being and the negative impact that the work of the sick or disabled physician has on professional behaviour, patient safety and the quality of medical care,[19] to the point that the inclusion of self-care as a subject in the undergraduate and residency curriculum has been proposed. In this sense, BienPro is also aligned with the 2020 National Health Objectives of the Ministry of Public Health, one of which was to "build an institutional culture of safety and quality of care".[20]

BienPro was developed with the international collaboration of leaders and members of programmes already in operation: the Physician's Health Programme of the Medical Society of the District of Columbia in the United States[21] and the Comprehensive Care Programme for Sick Physicians (Programa de Atención Integral al Médico Enfermo, PAIME) of the Spanish Medical Colleges Organisation (Organización Médica Colegial de España), originally developed by the Barcelona College of Physicians (Colegio de Médicos de Barcelona).[10,12,22,23] These advisory services included clinical-therapeutic, collegiate, deontological and legal matters.

Programme description

BienPro was developed within the framework of the CMU, created by law in 2009 "with the task of guaranteeing physicians and the community the exercise of the profession within the established deontological framework." It constitutes, therefore, the regulatory entity of professional practice by guaranteeing compliance with ethical and deontological standards, and is able to recommend sanctions in cases of non-compliance. At the same time, it aims to continuously improve quality in the professional practice of registered physicians, support the physician to practice his/her profession with dignity and independence and establish, based on the law of the Code of Medical Ethics, the obligation of the physician to meet the personal physical and mental requirements necessary for their professional conduct, with refusal to join a rehabilitation programme meriting additional disciplinary measures. Furthermore, membership in professional associations is mandatory in Uruguay, since one of the premises for professional practice is to have a university medical degree, to be authorised by the Ministry of Public Health and to be a member of the CMU as a professional association.

As a way of responding to the situation of physicians with mental health problems, in April 2016, the National Council of the CMU decided to create a Professional Well-being Commission whose mission "among others, will be to promote health as a whole, advising colleagues who need assistance on topics such as *burnout* or addictions; referring them on appropriately, with this entire process being managed with the utmost confidentiality."

The objectives and activities of the programme were defined as follows (Table 1).

A road-map was established that included the preparation of a draft of the project, discussion with CMU authorities, advice from the Medical Colleges Organisation (Dr. Serafín Romero Agüit) first by teleconference and then in person, the presentation of the project at the VII PAIME Congress in the Balearic Islands in 2017, exchange with members of the Galatea Foundation (Fundación Galatea) and the Galatea Clinic (Clínica Galatea) and in-country presentation to healthcare institutions, unions, civil liability insurance and physician healthcare insurance, in order to hear opinions and receive suggestions.

During this time, it was necessary to combine technical aspects and those of the healthcare process, legal aspects, regulatory aspects, logistics and infrastructure, and economic and financial aspects. The programme is free for CMU's nearly 15,000 active members. It is financed with the CMU's own resources from the membership fee. The physician member signs a programme entry agreement and agrees to accept the terms and conditions of the programme and adhere to the team's recommendations. For its part, BienPro undertakes to maintain confidentiality except in situations agreed upon with the physician member. BienPro may advocate in favour of the physician in institutional instances to the extent that the physician adheres to the recommendations.

Table 1 – Programme characteristics.

Objectives	Examples of activities	Examples of products
Develop mental health promotion and prevention programmes for physicians: a salutogenic approach.	Instances of ongoing professional training on work stress, job burnout and, more recently, on strategies to reduce the emotional impact of the COVID-19 pandemic.	International Panel in the first year of the programme.
		Series of conferences (between six and ten per year) on medical health issues. Dissemination through social networks and blog. Telecare and emotional support groups for physicians affected by COVID-19. Stress reduction workshops based on mindfulness.
Generate devices that contribute to optimising care for physicians with mental problems.	The BienPro clinical unit was created with the participation of psychiatrists, psychotherapists and a social worker to promote timely consultation for the affected physicians, ensure confidentiality throughout the process, optimise the psychiatric treatment provided by their healthcare provider, ensure follow-up, make recommendations on reintegration into work and provide support throughout the process.	Interdisciplinary care of physician-turned-patients in conjunction with the Integrated National Health System subsidiary institutions that provide healthcare.
	This clinical unit has three areas of intervention: mood disorders and psychosocial problems, addictive disorders and severe persistent psychiatric disorders. More recently it has also focused on physicians with personality disorders. BienPro has enabled the interrelationship of professionals who assist physicians (psychiatrist, psychologist, occupational health) through the organisation of clinical meetings.	Facilitation of access to psychiatric consultation, rapid coordination without bureaucratic requirements, coordination with mental health providers through periodic clinical meetings, offering follow-up. Support and endorsement in the face of authorities and employers.
Generate instances of remediation in situations of suicide, disruptive behaviour and transgression of sexual limits with patients.	Psycho-educational intervention and support in situations of suicide. This is a workshop aimed at caring for people in the work environment of a physician or health worker who committed suicide.	Workshops in the last two years regarding the suicide of two doctors, one nurse and two service workers.
	Ongoing training courses on inappropriate professional behaviour.	Workshops for the treatment of physicians with inappropriate conduct. Incorporation of psychotherapeutic interventions based on dialectical behaviour therapy for people with high-functioning borderline personality disorders.
	Emotional support groups for physicians affected by COVID-19.	

Throughout the process of linking the physician with BienPro, the responsibilities of both parties in relation to formal and regulatory aspects are accommodated. Upon admission to the programme, the physician member is required to sign a declaration of acceptance of entry to the programme in which the rights and obligations of both parties are established. The CMU undertakes to provide care for the physician in an absolutely confidential manner, free of charge, seeking the rapid connection of the physician with his or her healthcare provider, and he or she agrees to adhere to the therapeutic recommendations of the professionals of the technical group and the coordinator. This is basically an agreement between the physician and the treating team. In cases where these objectives are not met, this statement can be modified and a follow-up agreement can be made in which new guidelines and commitments are established. This statement makes it clear from the beginning of the care process that only in cases where the safety of patients and the physician is at risk will the CMU authorities be notified. The first step is the anonymous and confidential case study by the Complex Situations Group made up of the treating professionals and two clinical advisors from the National Council who establish the guidelines to follow in the relationship with the physician-turned-patient member.

After this long process, the programme was launched in March 2018 with a guide and an action manual based on the PAIME Procedures Manual adapted to the characteristics of the CMU.

Discussion

International experience demonstrates that colleges of physicians offer a supportive environment for the physician and his or her family, ensure confidentiality and respect, are a reference for health institutions and authorities, and have in place legal resources to take protective measures for the physician and for third parties.

Through this programme, the Medical Council Association of Uruguay does not seek to compete with or replace the mental healthcare that must be offered by the Integrated National Health System (Sistema Nacional Integrado de Salud) providers. Its fundamental role is to act as a coordinator and facilitator of the care process in order to improve the access of physicians to psychiatric and psychological care in a fast, simple and effective manner. The aim is to optimise access, treatment quality and follow-up that can be provided by the healthcare institution at which the physician is seen.

The improvement in the efficacy of the treatments is achieved through a greater adherence to the treatment and a better follow-up that arises from a better coordination between the mental health professionals who treat the physician-turned-patient. Hence, one of the fundamental tasks of BienPro is coordination between treating physicians through frequent clinical meetings. It also has a supporting role in the face of authorities and institutional heads.

The programme is conceived within a dynamic that allows us to react according to the emerging circumstances of the context, as is the case of psycho-educational interventions and support in situations of suicide. This has also been demonstrated in the rapid ability to react to the situation that COVID-19 has generated, by implementing measures such as the emotional support group for physicians affected by this disease and a joint conference with psychiatric societies shortly after the start of the pandemic in Uruguay. There is also the development of educational activities for physicians, through virtual conferences and contact with the media: written press, radio and television, with the aim of dissemination and as a communication strategy in times of lockdown.

The fact that the CMU is a regulatory body for professional practice represents a challenge, as is the case with PAIME, which as a professional association programme, promotes the rehabilitation of physicians suffering from mental or addictive disorders, whilst ensuring the safety of professional practice.[24] The main role of the regulatory bodies of the medical profession is to ensure that physicians are in good standing to practice. There are several different models for this depending on the legislation of each country. The first programmes of this type started in the United States in the 1970s and were intended to control malpractice conduct that could result from mental disorders in physicians, especially addictions. These programmes later gave rise to the creation of state programmes and, then in the 1990s, to the creation of the *Federation of State Physician Health Programs* in order to coordinate the actions of said programmes.

In other cases, professional well-being programmes are run by associations and organisations that function independently of the regulator even though they must respond to the regulatory body in case of risk to practice.

Although in the experience of regulatory entities, reactive strategies in the form of disciplinary measures prevail, sometimes in the case of substance abuse disorders and rehabilitation treatments, as well as in other serious mental disorders, on other occasions, it has been decided to resort to proactive and remediation strategies that facilitate access to health programmes over disciplinary measures with the endorsement of the regulatory entity.[25] These strategies are oriented towards the care of the mental health of physicians, aiming at the early detection and treatment of mental health problems instead of simply ensuring that conduct does not involve risks to practice.[26]

Offering a programme of care as a regulatory body can be perceived as a threat to physicians and it is difficult to balance trust in the institution with the responsibility of the association to self-regulate. It is important to note that developing the care programme must occur in parallel with the regulatory aspects of the professional association, a facet to which the governing boards contribute and not the clinical units. This shows the complexity of the balances when going from clinical discussion to that of the association and highlights the need to know how to settle on the best decision. Having the responsibility and duty of self-regulation of the profession is a privilege and a burden at the same time.[24] In the Spanish PAIME model, in serious cases or in cases of non-compliance, lack of adherence to treatment or risk to practice, the therapeutic contract modality is made use of. One of the clauses of said contract includes possible disqualification in case of non-compliance, which allows a rigorous control of the cases that involve a risk to safe clinical practice.[26] However, the main objective continues to be to help the physician achieve a state of health that allows him or her to continue performing professionally in accordance with the established standards.

Facilitating elements in this implementation process were the following: *a*) a commitment by CMU leaders, decision-makers and other stakeholders; *b*) international collaboration, especially with PAIME, but also with other programmes, and the contribution of external experts; *c*) the explicit interest of various groups of physicians (health services, professional associations, unions, healthcare and civil liability insurance), and finally, *d*) the commitment by the technical group that worked promptly and efficiently to comply with the road-map, as well as the clinical group that is carrying out the proposed activities.

Among the main obstacles that continue to persist today is the prevailing culture of medicine in Uruguay, due to which medical groups, healthcare institutions and trade union organisations, to a large extent, continue to avert their gaze when faced with mental health problems of physicians and a conspiracy of silence is opted for which only perpetuates and aggravates the situation. Despite the changes that are taking place, there is still no culture of transparency, responsibility and accountability for problems. While situations are still being "swept under the carpet", transparency is necessary for the proper functioning of the systems and to provide help to the professional with a mental disorder as soon as possible, whilst certainly maintaining absolute confidentiality.

The implementation process of a mental health programme for physicians in Uruguay has been described, reviewing the international background, the national inputs

received and those from international collaboration, the characteristics of the programme, examples of the activities carried out to date, and some products. Other results are still in the processing stage.

We hope this work can contribute to other Latin American groups interested in developing physician health programmes.

Conflicts of interest

The authors declare that they have no conflicts of interest.

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