Wellness Package for NOSM Residents
Dear NOSM Residents,

This wellness package has been created with both NOSM-specific, provincial and national resources to provide you with options on how to stay well during residency here. This document has been modified from a Wellness Package created by Ottawa resident PARO members.

This package consists of three parts. The first part provides tips from fellow residents on how to enjoy your free time in Sudbury. Part two consists of fact sheets about wellbeing issues you may face during residency, and part three contains a list of wellbeing resources available to residents.

I hope you find this guide useful and I welcome any feedback that you may have.

Ashleigh Farrell
Wellness Package

DEAR NOSM RESIDENTS,

PART 1: WELLNESS IN SUDBURY – TIPS FROM FELLOW RESIDENTS

COFFEE SHOPS
GROUP SPORTS
SUDBURY FESTIVALS!
RELAXATION
WINTER ACTIVITIES
SUMMER ACTIVITIES
WALKING/RUNNING/HIKING/BIKING
YOGA
FOOD AND DRINKS

PART 2: CAIR WELLBEING RESOURCES

BURNOUT
SLEEP DEPRIVATION
PAGER MANAGEMENT
MULTIPLE ROLES
FEEDBACK
MENTORS
NEIGHBOURHOOD WATCH: PEER SUPPORT
EMOTION SHIFT
DEPRESSION
SUICIDE

PART 3: IMPORTANT RESOURCES AND CONTACTS:

CMA CENTRE FOR PHYSICIAN HEALTH AND WELLBEING
THE CANADIAN PHYSICIAN HEALTH NETWORK
EMPLOYEE ASSISTANCE PROGRAM
LEARNER AFFAIRS AT NOSM
PARO 24 HOUR HELPLINE
Part 1: Wellness in Sudbury – tips from fellow residents

Coffee Shops
(other than the usual Starbucks, Tim Hortons)
Old Rock – 212 Minto Street - http://oldrock.ca/

Group Sports and Other Activities
Sudbury Sport and Social Club - http://www.sudburyssc.com/
Goodlife – two locations in Sudbury, but can go to any Goodlife location if doing rotations in other cities (CMA has discounted memberships!)
Pickup Hockey in the winter with the docs in town (ask around!)
Cheer on our OHL Team (Sudbury Wolves) at the Sudbury Arena

Sudbury Festivals!
Northern Lights Festival Boreal (http://nlfbsudbury.com/news-and-events)
Summerfest (http://sudburysummerfest.vianet.ca)
Other summer festivals: Garlic Festival, Blueberry Festival, Greek Festival, Italian Festival (http://www.sudburytourism.ca for more details)
Cinefest – Usually in September, showcases Canadian films
Ribfest – Labour Day Weekend (http://downtownsudbury.com/downtown-events/ribfest)

Relaxation
Euroskincare – Massages and other spa treatments (http://www.euroskincareboutique.com)

Winter Activities
Lake Ramsey - skating
Queen’s Athletic Field
Cross country skiing – Laurentian, Walden Ski Club, Conservation Area
Snow shoeing – Conservation area
Ice Fishing

Summer Activities
Lake Ramsey for swimming (many beaches in town!)
Fishing (over 200 lakes in the area)
Walking/Running/Hiking/Biking
Laurentian University – track available nearby running/biking trails
Sudbury Cycling Club - http://sudburycc.ca
Lake Laurentian Conservation Area
Killarney Provincial Park – just over an hour away, great for hiking and camping
Onaping Falls – great for a day trip or camping
Manitoulin Island – Cup and Saucer is worth the trip!

Yoga
Myyoga – 2 locations in Sudbury

Food/Drinks
The Laughing Buddha – Laid back, great menu, nice patio.
The Fromagerie – Nice atmosphere, occasionally has local artists/musicians.
Tommy’s Not Here – Rated #1 in Sudbury
Ripe – Great Italian food.
Umai Sushi – Good a la carte sushi.
Respect is Burning – Although, ironically, it recently is closed after a fire.
Pat and Mario’s – Local owners, great food.

Burnout
Overview:
Burnout is a commonly used term that in general refers to the negative impact of continued stress of job/training demands upon the person. Maslach’s model (see: http://maslach.socialpsychology.org) includes three key components of burnout: emotional exhaustion; depersonalization; and, reduced personal accomplishment. Emotional exhaustion is often viewed as a key element and may be a precursor to worsening of the other 2 features. Emotional exhaustion is the result of working/training at an extremely demanding level resulting in becoming emotionally...
over-extended, depleted and fatigued. As Dr. Krall of the Marshfield Clinic’s Physician Health Committee describes, “It comes from the need to be continually present. A person has nothing left to give.” Depersonalization is the experience of becoming more negative, cynical, impersonal or cold in one’s interactions with family, patients, colleagues and staff. Dr. Krall notes, “Work has hardened the individual and he or she has lost their compassion. It may be a defence against further emotional exhaustion.” Patient dissatisfaction, complaints and medical errors emerge from this. Decreased personal accomplishment is the reduced sense of competence and efficacy often associated with an increasing negative view of one’s abilities. As Dr. Krall explains, “Not only has one lost his or her compassion, but one starts to doubt the worth of what he or she does. Does it really make any difference?” Questioning whether to drop out of training can emerge from this. Thomas’ (2004) review of the literature on burnout in residency concludes “burnout levels are high among residents and may be associated with depression and problematic patient care.” Burnout, if not addressed, may render a resident more vulnerable for the emergence of depression. This results in patient care risks as recent literature (Fahrenkopf et al 2008) identifies a 6-fold increase in medication errors by depressed residents.

**Wonder if you’re burning out? Here are some suggestions:**

- Do a self assessment via a link provided below.
- Talk with someone you trust about your concerns. Don’t wait, don’t just think you need to quietly tough it out to prove “I’ve got what it takes to be a physician.”
- Review ways to manage and reduce burnout. Links are provided below.
- Regain your balance. Burnout is often associated with a reduction in time spent in social activities, exercise, sleep, obtaining good nutrition. Make a deliberate effort to put more of these back into your life.
- Check out these websites for detailed suggestions on managing burnout and preventing burnout

**Additional Information:**

- Self-test: Try this link for a quick assessment for burnout and for detailed information on burnout and its management
- Ontario Medical Review’s series on physician burnout: Part 1, Part 2, and Part 3

**References:**

Sleep Deprivation

Overview:

**Prevalence.** “Faculty and residents must be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract its potential negative effects.” (ACGME Common Program Requirements VI.A.3). So much to learn. So much to do. As one resident explained, “It’s like trying to take a drink from a fire hydrant.” One could easily drown in all there is to do and learn. Sleep remains difficult to get enough of in residency. In a survey at a US medical centre in 2007, 21% of residents (n=43) reported getting 5 or fewer hours of sleep in the previous week and 62% reported getting 6 or fewer hours. This compares with surveys elsewhere indicating 20% of residents get 5 or less hours and 66% get 6 or less hours (Baldwin and Daughtery, 2004). Similar numbers were noted in a study in Japan (Nakamura, Kitahara and Nishiyama, 2005).

**Impact.** The L.I.F.E. Curriculum (Learning to Address Impairment and Fatigue To Enhance Patient Safety, www.lifecurriculum.info ) notes that “people on average require approximately 8 hours of sleep every 24 hours to satisfy their physiological needs. When people get less than 5 hours of sleep over a 24 hour period, their peak mental performance usually deteriorates.” (LIFE Teachers Guide, page 15). Numerous studies have revealed the impact of sleep deprivation on residents. These include: increased errors in simulated surgeries; increased errors in ECG
interpretation; increased time to complete a variety of medical procedures; less thorough examinations and documentation; increased risk of motor vehicle accidents and ‘near misses’ post call.

**Self-Assessment.** Beware! Two large obstacles exist to recognizing your own sleep deprivation. First, is the “I can handle it. I’m good on little sleep” myth. This myth is a common one among residents and is fuelled by an implicit physician’s code that a ‘real Doctor’ works through fatigue and doesn’t complain. Youthful sense of invincibility may intensify this. Second, the very nature of sleep deprivation makes it more difficult to notice when you are very sleepy.

**Warning signs for excessive sleepiness:**
1. Complete the Epworth Sleepiness Scale and see how you’re doing: Epworth Sleepiness Scale
2. Residency specific warning signs (adapted from LIFE)
   - Sedentary nodding off (e.g. during conferences) or driving
   - Micro-sleeps (5-10 seconds) that cause lapses in attention
   - Difficulty focusing on tasks
   - Repeatedly checking your work
   - Irritability
   - Decreased affective range, flattened affect
   - Difficulty with problem-solving
   - Reduced ability to multi-task
   - Increased forgetting

**Intervention:**
- Sleep. Make yourself sleep post call.
- Nap. A 15-20 minute nap in the afternoon or during a night shift. Sleep prophylactically before and after night shifts.
- Use caffeine carefully, prn related to alertness and not socially or for prolonged periods. Do not use caffeine before your shift ends.
- Make your sleeping space conducive to sleep. Reduce light, noise, air temperature.

**Additional Information:**
- Sleep Hygiene Tips

**References:**
- LIFE Curriculum
- Tips for Surviving Residency by PARO
Pager Management

Overview:
When you are handed your first pager, you are starting a long and perhaps quite ambivalent relationship with a device that is likely to be with you throughout your career- in various shapes and abilities. Simon Ahtaridis put it well in The New Physician, 2002 “Your first breath will begin when you join your team and receive a pager. A pager may seem exciting, but after two days, you’ll abhor it and develop odd beliefs and behaviours. If a pager goes off next to you, you’ll breathe a sigh of relief and say, “That was too close,” as you peek from behind a desk as if there was a page-operator sniper hiding behind a gurney, seeking out new targets.” As with any relationship, yours with the pager will grow, change, have ups and downs. Throughout your career your pager is likely to have a considerable place of power- instantly demanding your attention, often immediately requiring you to do something and almost certainly quickly causing a shift (often to the negative) in your emotions. Included on this page are suggestions for managing the pager in your practice.

Reactions to Being Paged
Residents at one US medical centre noted these common reactions:
• Early reactions to being paged: Nervous, pumped up, felt like I’d be making a contribution, “wow, someone wants to talk to me,” “I’m going to get to do
something!”, fear, excited, frustrated, tachycardia, tachypnea, “What should I do now?” “How do I call them?

- Thoughts that quickly run through your mind when paged: I hope it’s a mistake. I hope I don’t have to go in. Not again! Can I handle this? Why are they paging me? I wish it was someone else. Now what! Again! Give me a break! Somebody is dying. Am I on call? Please not the ER again. This better be important. I hope it’s not the trauma pager. What do they want no! Road trip, have to come in.
- What are some of the emotions that you experience when paged?: Fear, increased heart rate, chest tightness, frustration, aggravation, disbelief Anger (when it’s the ER number)

All of these reactions to being paged are normal, average, to be expected and you’re likely to have them, too. Much like Pavlov’s dogs, this classical conditioning over time becomes ingrained and more difficult to change. So as you start your relationship with your pager, now’s the time to set the terms. Let’s address pager management.

**Pager Management - Your Reactions**

- 1. Developing adaptive thoughts. What would be a healthy, less stressful thought to have when your pager goes off? Perhaps tell yourself “Take a deep breath, relax, you can handle it.” “It’s not the end of the world, I’ll get through this.” “I don’t need to be mad at the world because I was paged.” “I have back-up if I’m not sure what to do.” Decide what you’d like to think.
- 2. Develop adaptive feelings. What would be healthier, less stressful emotions to have when your pager goes off? Perhaps calm determination, confidence. Decide what you’d like to feel.
- 3. Develop adaptive behaviours. What would be healthier ways to respond physically and behaviourally when your pager goes off? Perhaps take a deep breath, hold it briefly and then exhale slowly to the count of 4. As you exhale let your shoulders drop down. Walk at normal speed to get to the phone, desk, etc. (unless it’s a STAT).
- 4. Decide how you would like to react.

Now rehearse these thoughts, emotions and behaviours. Imagine yourself being paged and as you imagine it, deliberately practice the thoughts, feelings and behaviours you chose above. Then page yourself and practice these thoughts, feelings and behaviours in response to the page. Really, do this and do it 10-20 times until you get the routine down with your adaptive thoughts, feelings and behaviours. If you already have developed the less adaptive emotions, thoughts or behaviours to your pager, then change the type of alert and practice the adaptive reactions. It may seem silly but something as simple as changing the alert and practicing a few times with your reactions can make a huge difference. You are now taking some control over your conditioned response to the pager. A step ahead of Pavlov’s dogs!

**Pager Management - Best Practices**

Residents at the 2008 workshop on pager management offered these based on what they’ve seen and learned:

- Respond promptly;
- Respond with a polite voice and with respect;
- When you’re on make sure the pager is on, when off, turn it off;
- If you page then wait for the response;
- Be succinct with text paging;
• Politely excuse self from conversation when paged.
• To reduce pages, check in with nurses before you leave and be clear with orders in check out.
Pager etiquette when with a patient:
• Apologize for the interruption before looking at your pager.
• Explain if you need to reply immediately and that you only interrupt patient contact if it's an urgent matter. Do not answer the page in the room with your patient
  
  Before you leave the exam room, write down where you left off with the patient.
• Before returning to your patient, stop, do an emotion check and make sure you are not bringing any negative emotion from the page contact back into the room with your patient. Do an emotion shift if you notice negative emotion. See Emotion Shift topic for details.
• Return to the patient, apologize for the disruption and state where you left off- do not ask the patient where you left off.

Additional Information:
• Smith, Fraser. Who invented that bleeping thing? British Medical Journal, 2003; 327; 719.
• Ahtaridis, S. An internal medicine survival guide. The New Physician, October 2002

Multiple Roles

Overview:
One of the most frequently identified concerns in physician well-being is the challenge of having a life outside one’s practice. Residents surveyed at a US medical center on well-being concerns ranked balancing multiple roles as their top concern. In a subsequent resident retreat, the break-out group on balancing multiple roles drew the largest number of residents. Discussion was very active, open and reflected the challenges residents have in managing their roles as resident, partner, parent, sibling, son/daughter and oh yes, human being.
Residency is a time of imposed change in the balance of these roles. Some of these impositions include:
• geographic move with likely separation from family, relatives, friends, home culture
• decreased leisure time with long weeks, exams to prepare for, papers to write, etc
• decreased flexibility with one’s schedule with mandatory training activities that as a result dictate when you are able to take time off

Much is available on this topic and will be linked to below, but here are a few practical steps to help you become mindful on how to address the challenges to balancing the multiple roles.
1. **Clarify your roles.** Consider all the different roles you do have in your life. Here’s a quick checklist to clarify your roles. This is a partial list and you may have more:
   - Do you have parents who are alive? If so, you have a role as son/daughter.
   - Do you have siblings? If so, you have a role as brother/sister.
   - Are you married or in a committed relationship? If so, you have a role as spouse/partner.
   - Do you have children? If so, you are a parent.
   - Do you have relatives? If so, you have a role(s) as grandchild, aunt/uncle, niece/nephew.
   - Do you participate in a religion? If so, you may have a role as elder, committee member, etc.
   - Do you take care of your home, laundry, budget, food? If so, you have a homemaker role.
   - And then there is your role as resident with its multiple sub-roles as patient care provider, student, researcher, etc.

2. **Clarify your time commitments in each role.** Assuming 7 hours of sleep per night you have 119 waking hours per 7 day week. If your duty hours range from 60-80, you have 39-59 hours left for all your other roles, including the resident roles of student and researcher. How much time per week would you like to give to each role? What’s ideal? It may be wise to ask the people involved in your life in each role for their input on this, but start by letting them know how much time is already needed for residency. Check this site for another way to check your time commitments: http://www.aafp.org/fpm/2001/0200/p66.html

3. **Reduce your time in the least important roles.** Can you hire a housekeeper 1-2 times a month to do the regular cleaning? Can you send out the laundry? Check your priorities using time management guidelines. A succinct guide to time management is found at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2608106/pdf/jnma00386-0057.pdf

4. **Be kind to yourself.** Your residency hours will vary from week to week and so will the time you have for your other roles. Use well-being strategies noted on this website and elsewhere to help you take care of yourself. Practice good sleep hygiene and nutrition. Use the survival tips for residency: http://www.pairo.org/Content/Default.aspx?pg=1231

5. **Seek the advice of others.** Ask your mentor, key faculty, other residents, program director or others for advice on how to seek balance in multiple roles. We are all confronted by this challenge and many may have learned ways that you might find helpful.

**Additional Information:**

- Advice on balancing family and career - http://www.annals.org
- Female Physicians and role balance - http://ap.psychiatryonline.org/cgi/content/full/28/4/331
Feedback

Overview:
Residency provides an intensive training experience in which feedback guides the development of the physician. The training program’s provision of feedback and the resident’s seeking and using the feedback foster the development of the physician. In fact it is viewed as critical. Clinical education is rooted in experiential learning. Duffy and Holmboe (2006) note “Physicians learn from their patients. Educational theory and empirical research demonstrate that clinicians develop competence in their work by learning from their mistakes in performance. Advancing to expert levels of competence will not happen by reviewing failures in secret and making personal corrections; it needs guided feedback from other experts. The feedback needs to be based on an accurate appraisal of performance that identifies areas for expanding knowledge or improving methods of work.” As noted at the International Physician Health Conference in 2006, feedback is considered one of the top ten conditions for a healthy residency and is provided in real time, has a constructive focus, is consistent between verbal and written input, and includes self-care items. Residents ask for real time feedback and participate in training on how to seek and receive
feedback.

**Additional Information:**

- Accepting Feedback
- Asking for and Receiving Feedback
- 7 Tips For Receiving Feedback Gracefully
- Physician Characteristics Associated with Proficiency in Feedback Skills

**References:**

- Assessment in Lifelong Learning and Improving Performance in Practice Physician Know Thyself 2006 Duffy FD, Holmboe ES, JAMA 296:1137-1139

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**Mentors**

**Overview:**

Mentoring has a long and highly regarded tradition in medicine. The Hippocratic Oath refers to it in description of the relationship with teacher, “...to regard my teacher in this art as equal to my parents; to make him partner in my livelihood...” (Setness, 1996). Ramanan (2006) notes “Mentoring during early stages of a career has been associated with high career satisfaction and may guide development of professional expertise.” Personally, each of us can think back to one or more teachers who were instrumental in the development of our careers and manner with patients. Their influence reflected how they were more than teachers, they were mentors. An important component of residency training is the development of a relationship with a mentor. In fact, at a presentation at the International Conference on Physician Health in 2006, involvement with mentoring was identified as one of the top ten strategies for a healthy residency. It was specifically advised that each program have a formal system in which each new resident is assigned to a mentor with specific expectations in the mentoring relationship. Informal mentoring is also encouraged. Mentors may be faculty or more senior residents. Residents utilize their mentors for consultation on professional and personal concerns.

A survey by Levy (2004) identified three things residents seek from mentors:1) career advice such as post residency choices, research options, exploration of 'the
big picture’; 2) support including confidential support, being open to any type of question and discussion of current stresses, listening to ideas, facilitate networking and providing a sounding board; 3) role modeling that offers encouragement and inspiration, advice on career-personal life balance, real-life perspective, demonstrating light at the end of the training tunnel, offering examples of successes and managing difficulties. In short, Levy noted effective mentoring involves “individual advocacy and attention to the career development of each house officer.”

Suggestions:
1. If shortly into your first year your program does not provide you with a mentor, ask your program director for one.
2. In your first meeting with your mentor talk about their and your prior mentoring relationships, what you valued and did not like and what you hope to develop in this new mentoring relationship. Plan to meet at least 3 times a year and prn.
3. Clarify with your mentor that discussions are kept confidential and are not included in the evaluation process.
4. If after a few meetings you do not find the mentoring contact supportive talk with your peers and consider requesting a different mentor. Mentoring involves a goodness of fit and it is ok to acknowledge and change a match that is not working well. It is not an indictment of you or the mentor to make a change.
5. Basic guidelines you should expect your mentor to follow (Levy, 2004)
   • provide a confidential relationship involving trust, openness, sincerity
   • ask you what you want in the mentoring
   • prioritize access to meet prn and as scheduled
   • encourage you to share your ideas, goals, dreams about your career
   • will be supportive, not judgmental as you explore training and career paths
   • will support and enjoy your achievements, not compete with you

Additional Information:
• Mentoring background information
• Online resources

References:


• Setness P. Mentoring: Leaving a legacy of opportunity and responsibility. Postgraduate Medicine online 1996; 100(4)
Neighbourhood Watch: Peer Support

Overview:
Residents over the years have repeatedly explained that a major way they adaptively manage the stresses of training is through the support of their family and their peers in residency. In particular, the other residents you train and work with are likely to be the first people who notice when stress is affecting you. A neighbourhood watch involves residents looking out for and supporting each other as they deal with the stresses of training. This includes bringing up to another resident concerns you notice followed by offering support and resources to turn to. A neighbourhood watch is based on the beliefs that: residency is a time of collaboration not competition; we are all in this together dealing with an acutely stressful time in our lives; and, each resident’s well-being and success supports other residents’ well-being and success. The concept of neighbourhood watch comes from the Ottawa 2006 conference on physician well-being presentation on The Top Ten Strategies for a Healthy Residency.

Steps to Building a Neighbourhood Watch
1. Identify your stress warning signs. How does stress begin to show up in you? What are its physical, cognitive, emotional and interpersonal manifestations? Write down the various ways stress shows up when it starts to take a toll on you. If you are unsure of your warning signs, ask those who you are the closest and most open with
to tell you how they see stress show up in you. But, first assure them that you will not react defensively to their comments.

2. **Consider who you would invite to be in your neighbourhood watch.** These are people you would trust to honestly and supportively give you feedback if they see the stress warning signs occurring for you. Pick at least 1 resident, 1 family member and perhaps a friend.

3. **Ask each person to be in your neighbourhood watch.** An example of how to ask is, “Residency is a pretty stressful time and I’d like to ask you to let me know if you ever see the stress starting to get to me. Some of the ways I know stress gets to me include (provide examples). If at any time you see me showing any of these things would you please take me to the side and tell me? I promise that if you give me feedback on any of the warning signs by saying ‘This is part of the neighbourhood watch you asked me to be in,’ that I’ll remember I asked you to do this and I will not become angry or defensive. Instead, I will listen and thank you for telling me.”

4. **Accept the request from another resident to be in their neighbourhood watch.** When you see a stress warning sign in that resident, consider these guidelines for addressing it:
   - _Select a private time_
   - _Start with a reminder of the neighbourhood watch agreement “You asked me to be part of your neighbourhood watch. I’m honouring that agreement now and have a concern to share with you. Is now an ok time?”_
   - _State your concern openly and supportively._
   - _Offer support and encourage the resident to consider resources to address the concern. These may include talking with their mentor, chief, program director or contacting RWBC_

**Resources**
If you notice another resident showing warning signs of stress and you are unsure of how to address it with them, contact your Resident Wellbeing Committee. Remember residents are all in this together and as a result you may be part of an early warning system that can help a peer address their stress before it becomes distress and possibly impairment.

A description of the Neighbourhood Watch Program for Medical faculty at the University of Ottawa: [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC80171/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC80171/)
Emotion Shift

Overview

Emotion shifts are the things we do to help us not get stuck in an upsetting thought or feeling. Emotion shifts are used to help us take a break from upsetting thoughts and feelings, but not to try and forget about them. The more confident we become in using emotion shifts, the less we will worry about having the upsetting thoughts and feelings and the more we can then feel safe in looking at and figuring out the things that cause us to become upset.

In medicine, emotion shifts are especially helpful for residents who are moving quickly from one activity to another or one patient to another. Using an emotion shift can help you avoid bringing a negative emotion (anger, frustration, impatience, anxiety) that emerged in a prior activity into your next activity. Imagine the clinic patient who sees you after you just found out you have 2 admits waiting. Doing an emotion shift will help you approach that clinic patient with attention and compassion rather than the emotions that might have popped up about the extra work.

Emotion shifts were introduced to us by Dr. Lee Lipsenthal. Information about his presentations, including emotion shifts is at http://www.findingbalanceproductions.com.

An adaptation of the emotion shift involves these steps:

- Become aware of the negative emotion or thought. Use your awareness of when you are angry, frustrated, impatient, anxious to prompt you to start an emotion shift.

- Pick an alternative emotion you would prefer to have in place of the negative one. For example you could substitute calm for impatient, relaxed for tense, accepting for
angry.

- Pick an image you naturally associate for the preferred emotion. For example, the image for calm could be standing in a park on a warm summer day feeling the sun’s rays.

- Then do the following:

1. Take a deep breath, hold it briefly and then slowly exhale, letting your shoulders drop as you exhale.
2. Take another deep breath, hold it briefly and then slowly exhale, close your eyes and picture the positive image.
3. Take another deep breath, hold it briefly and then slowly exhale, close your eyes, picture the positive image and then the preferred emotion you want to have.
4. Repeat #3
5. Return to your activity while thinking about the preferred emotion as you start in.

Depression

Overview

1. Depression happens.
A sadness that doesn’t go away. Activities devoid of pleasure. Persisting fatigue even when you get sleep. Thoughts that things are hopeless or that you’re helpless to deal with life. Starting to slip up on your work or turn in projects late. There are a few of the symptoms residents have described when they sought help for suspected depression. These residents were linked to confidential help and their depression improved. If you suspect you may have depression, you are not alone. Rates of depression are higher in medical students and residents than in the general population with upwards of 30% of residents reporting depression compared to 12-19% lifetime occurrence for the general population.

2. Depression is important to address.
Depression can interfere in your life in many ways, affecting your relationships with loved ones, impairing your training, impacting your manner with patients and misleading you into doubting your abilities and choice to be a physician. Left untreated, depression is more likely to recur, more likely to disrupt your career, more likely to affect how you counsel your patients on their own mood concerns and may lead to thoughts of suicide.

3. Depression self-tests.
Below are links to self-tests for depressive symptoms. These are meant to help you learn the manifestations of depression. These are not for diagnostic purposes. Please do not use these tools to treat yourself. Remember, self or peer prescribing is expressly prohibited and may lead to termination from training as well as legal repercussions. Please come talk with RWBC, a friend, your mentor or others and get
help, don’t treat yourself.

- Zung: http://www.afraidtoask.com/depression/depressionzung.htm?submit=Click here to Score It!

4. Ways to address depression. Here are some basic guidelines:
- Learn about depression. Check reputable links for information such as the Canadian Mental Health Association.
- Talk with trusted people about your concerns. Family, friends, your mentor, program director, your Resident Wellbeing Committee. No matter who you contact, just do it, don’t keep it secret.
- Have a primary care physician with whom you can share your concerns. This person will be an invaluable resource for you as you deal with your depression.
- Engage in self-care activities. Rest, exercise, get good nutrition, moderate caffeine and limited alcohol use. Check some of the suggestions found under Burnout on the CAIR website for additional suggestions.
- Seek consultation and treatment.

Depression can be effectively treated and does not need to interfere in your life and your success in residency. Please talk with someone about your concerns.

5. Suicide
Physicians are at higher risk for suicidal behaviour. On average, the United States loses the equivalent of at least one entire medical school class each year to suicide. If you are having such thoughts this is not because there is something wrong with you as a person. It is not because you don’t have what it takes to complete residency and be a good physician. Please read the information below and let someone know the distress and the thoughts you are having.

There are multiple pathways to thinking about suicide and one of the most frequent is correlated to depression. Unremitting depression is a major risk factor for developing suicidal thoughts and eventually acting on them. Many theories describe the emergence of suicidal thinking. According to one explanation, cognitive narrowing, a person becomes increasingly focused on the distressing situations, emotions and thoughts they are experiencing. The person begins to view “for now” situations, emotions and thoughts as “forever.” The person becomes unable to notice the positives in their life and the caring relationships in their support system. As a result, suicide creeps into the person’s thinking, appearing to be a logical choice for dealing with the person’s faulty assessment of their situation. Physicians as a group are at higher risk for suicide (see http://www.afsp.org/files/Misc_//JAMA.Physician_Suicide2003.pdf), and we speculate that this may be related to the confidence physicians develop in their own thinking and problem-solving through their training so that when they conclude, through distortions of cognitive narrowing, that suicide is a logical option they become more at risk for acting on it rather than asking for help.

**IF YOU ARE HAVING THOUGHTS OF SUICIDE**
**Tell someone now.**
Tell a friend, program director, program coordinator, call your clergy person, crisis line. Keep trying until to reach someone. Let others help you get to the help you
need to get through this safely.

**Be with others.**
Do not isolate at home. Seek others out and ask to spend time with them, spend the night at a friend’s home and explain why.

**Remove alcohol and medications.**
Alcohol use greatly increases the risk for suicidal thinking and behaviour. Remove it from your home for now. Ease of medication access greatly increases risk for suicidal behaviour. Give your supplies to a trusted person to hold for you.

**Additional Information and Links**
- Depression in Residents and its Effects on Patient Care
- MedlinePlus Depression Information
- National Institute of Mental Health - Depression information
- Physician Suicide website resource for issues specific to suicide and depression among physicians including issues with training, licensure

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**Suicide**

**Overview:**
Physicians are at higher risk for suicidal behaviour. On average, the United States loses the equivalent of at least one entire medical school class each year to suicide ([http://www.physiciansuicide.com/](http://www.physiciansuicide.com/)). If you are having such thoughts this is not because there is something wrong with you as a person. It is not because you don’t have what it takes to complete residency and be a good physician. Please read the information below and let someone know the distress and the thoughts you are having.

There are multiple pathways to thinking about suicide and one of the most frequent is correlated to depression. Unremitting depression is a major risk factor for developing suicidal thoughts and eventually acting on them. Many theories describe the emergence of suicidal thinking. According to one explanation, cognitive narrowing, a person becomes increasingly focused on the distressing situations, emotions and thoughts they are experiencing. The person begins to view “for now” situations, emotions and thoughts as “forever.” The person becomes unable to notice the positives in their life and the caring relationships in their support system. As a result, suicide creeps into the person’s thinking, appearing to be a logical choice for dealing with the person’s faulty assessment of their situation. Physicians as a group are at higher risk for suicide and we speculate that this may be related to the confidence physicians develop in their own thinking and problem-solving through their training so that when they conclude, through distortions of cognitive narrowing, that suicide is a logical option they become more at risk for acting on it rather than asking for help.

**IF YOU ARE HAVING THOUGHTS OF SUICIDE**

1. **Tell someone now.**
Tell a friend, program director, program coordinator. Call your clergy person, crisis line. Keep trying until to reach someone. Let others help you get to the help you
need to get through this safely.

2. **Be with others.**
Do not isolate at home. Seek others out and ask to spend time with them, spend the night at a friend’s home and explain why.

3. **Remove methods.**
Have a friend take your medications, firearms, sharp instruments (knives, razors, etc.) and keep them for you temporarily.

4. **Remove alcohol and medications.**
Alcohol use greatly increases the risk for suicidal thinking and behaviour. Remove it from your home for now. Ease of medication access greatly increases risk for suicidal behaviour. Give your supplies to a trusted person to hold for you.

**Additional Information and Links**
- Depression in Residents and its Effects on Patient Care
- MedlinePlus Depression Information
- National Institute of Mental Health- Depression information
- Physician Suicide website resource for issues specific to suicide and depression among physicians including issues with training, licensure

**References**
- Suicide rates among physicians
- Suicide in training
Part 3: Important resources and contacts:

CMA Centre for Physician Health and Wellbeing
http://www.cma.ca/index.php/ci_id/25541/la_id/1.htm

The Canadian Physician Health Network
http://www.cma.ca/index.php/ci_id/25567/la_id/1.htm

Employee Assistance Program
Confidential and voluntary support provided free of charge by HSN. Available 24/7/365.
Tel: 1-800-387-4765
Website: www.workhealthlife.com

ePhysicianHealth.com

Comprehensive and interactive online modules for physician health, written by leaders in each field. Provides evidence-based information and tools for self-help and collegial support. Note: you can also download a printable e-book for each module.

Learner Affairs Office at NOSM
In cooperation with counsellors at Lakehead University, Laurentian University, and our community partners, Learner Affairs takes a preventative and proactive approach in assessment and referral for personal issues. Through an effective system of culturally competent counselling by professionally trained counsellors and advisors, students may access services through Learner Affairs or, where appropriate, referrals may be suggested to external agencies or services.

They are located on the first floor of the Medical School Building in room HSERC100 at the East campus and on the second floor of the Medical School Building in MS2001 at the West campus. However, their service delivery extends to all communities residents are placed in.

Laurentian University (East Campus)
935 Ramsey Lake Rd
Tel: (705) 675-4883
http://www.nosm.ca/about_us/general.aspx?id=4022

OMA website for Ontario mental health care and addiction services:
http://php.oma.org/links.html
PARO 24 Hour Helpline

Available to residents, their partners and family members. Toll-free number 1-866-HELP-DOC (1-866-435-7362) is accessible anywhere in Ontario, 24 hours a day, 7 days a week. In addition to providing immediate assistance in emergency or urgent matters, the Helpline will provide referrals for such issues as but not limited to:

• Stress management
• Eating disorders
• Sexual, emotional or physical abuse
• Anxiety
• Anger management
• Depression
• Gender issues
• Intimidation or harassment
• Substance abuse
• Relationship counselling
• Career or work-related crisis
• Sexual issues