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I: So now that I’ve just read the consent form, I just wanted to go over a couple of main points to make sure you understand what's involved. You understand that this will be audio recorded for about 60 to 90 minutes.

R: Yes.

I: The following risks are involved. Although unlikely, you may find the interview upsetting or distressing. You may not like all of the questions that you will be asked. You can refuse to answer any questions. As with all research, there is a chance that confidentiality can be compromised. However, we're taking all precautions to minimize this risk by securely storing all information you provide us. You don't have to agree to take part in the study. And you can ask me any questions you want before, throughout and after the interview. You can also withdraw at any stage of the interview without giving a reason. If you choose to withdraw, all your information, including the audio recording and transcription of the interview, will be destroyed. However, please note that it will not be possible to withdraw your information once the results have been published or aggregated with the data poll. I won't keep any of your personal information any longer than necessary. And I won't use your name next to the data you provide. Your transcript of the interview won't include any personal information either. You are aware that the study's findings will be published in manuscripts, presentations and policy reports.

R: Yes.

I: Are you still willing to take part?

R: Yes.

I: And do you have any questions for me before we begin?

R: No.

I: Great. So quickly I'm just going to go over the main purpose of the study. So this study aims to help understand practice choices among psychiatrists. And we're interested in learning about your preferences for specific aspects of clinical work, the values that guide your practice more generally, and practical considerations that shape your choices. We are also interested in how your intentions changed throughout the training and years of practice, and what your plans are moving forward. We know that a lot has changed during the pandemic for healthcare providers. So while we're hoping to learn about that, we're more interested in more general your experience. And then I'll ask more specific questions around the context of COVID-19. So our first question is, I was wondering if you can tell us a little bit about how your career unfolded.

R: So I'm currently working in Toronto. I'm doing a fellowship at the St. Michael Hospital in an inner city community. Which I will be done soon, and then I will have an academic position, working in inpatient and ACT team and doing some teaching.

I: So are you currently doing inpatient and ACT team, or is that something you will begin once you start your academic position?

R: Oh, sorry, I will begin in September in inpatient. And the ACT team, I'm currently only doing the ACT team.

I: Okay, I see. And can you maybe walk me through why you chose psychiatry, what led you to choosing psychiatry?

R: Yeah. I remember I really loved the rotation in psychiatry. Like the contact with the patient, the time to talk with them, how everyone is very different. And, yeah, the human contact, and how we can make a huge difference for them by taking the time to know them, explore what their struggles are, what are the symptoms, how we can support them. So I was finding that really interesting. And for me, I loved that more than other specialty where it was more like, oh, you need to see the patient, you need to be very quick. Or it’s medication, and you don't have the time to talk about the other struggles and like the non-pharmacological thing. So it was just like something that seemed more according to my personality, and the kind of practice I want to do. I want also to do some teaching. So I thought it was great with the patient, but also have time to do some teaching with residents. So I just really loved the contact. And then I did a couple of rotations in psychiatry, emerg psychiatry, child, and other things just to be sure I love it. And yeah, I just find that I had the time to talk wit the patient, the connection to make a difference. To work with a team also is something very important for me. And not just, yeah, be in a hurry to see everyone. And that's why. And I really love like never knowing what my day will look. With psychiatry, like it's never a dull moment. Especially my area is psychotic patients with an ACT team. So I mean we have guidelines, but most of the time they don't apply to my patients. Like not exactly. So you need to be more original, really work as a team to support the patient. And I just find it was really interesting and always a challenge to help the patient. And that was what I want to do. And it also like keeps me on edge because I don't know what will happen during my day.

I: So it sounds like it’s exciting, like just not knowing what the day's going to bring.

R: Yeah. And I mean they are bit agitated sometime. So they keep me busy during the day.

I: I can imagine, yes. Can you tell me currently a little bit about your practice? You mentioned that you're doing the ACT team. Is that the only… So you're just doing outreach, I assume. Or are you doing other stuff, too? If you don’t mind helping me understand how your practice is organized.

R: At the moment, I'm only doing ACT team full time. So I'm mostly doing outreach with the team. The community, I go to a shelter a lot also. I have a lot of patients homeless or with substance use disorder. So that's a lot of my practice. Some of them are well enough to come to the office. So I have more regular appointments at the office. I have a few of them that are BPD patients. So I also follow them. And we do have some residents from time to time where I work. So I try to do some teaching also. But that's most of my practice right now.

I: Can you just clarify what you mean by BPD, if I heard that correctly?

R: Borderline personality disorder.

I: Oh, okay, BPD. Gotcha. Okay.

R: Sorry, French is my first language. So sometimes the acronym are in French.

I: No, I gotcha. And so can you maybe… So obviously you work in a team. Do you mind maybe helping me understand who you work with in terms of like the other healthcare providers that work with you?

R: So the team is with St. Michael Hospital. Usually there is four psychiatrists that all do part time. So they are there one and a half days, I will say. I'm there full time. We have like one team. There is a team lead, and we have like a couple of nurse, case managers, social worker, OT, some residents, some social worker students. So it's a mix of everyone. And everyone works with everyone. There is no like a couple of team that's one team working with all the psychiatrists. So yeah, mostly it’s that. And we do work a lot with other housing workers that are at the hospital for inpatient team. The ER also. When our patients are there, usually they know they work with us. They reach out to have a background. We can go to them to the ER. Or when they are at the hospital also, the intervention team to do some follow-up. So we work a bit with everyone. But we're mainly a team of around 10 to 15 case manager and nurse and things like that, plus four physicians.

I: Oh, that’s nice. And so it sounds like there’s collaboration also with the hospital and the emergency and inpatient there. So you know the people there, and you exchange information as needed for your patients.

R: Yeah. Oh, and we do have peer support also - which is very great.

I: It is great. So who do you report to?

R: Because of my fellowship, I have like two psychiatrists I will say I report that are my main supervisors. But I will say that, yes, they are my supervisors, but they are not always there. Sometimes I report everything I do every day. But when there's something, they are available, and they are the ones that I reach out.

I: And so, you know, you do outreach treatment. But what kind of services do you provide? Do you do therapy, pharmacotherapy?

R: Our team or me, just to be sure?

I: Pardon me?

R: More me what I do, or the team.

I: No, just you. Sorry.

R: Okay, just me. So I do follow… So I have a roster of patients that I just take care of them. I do follow-up with them. So like any outpatient follow-up. But I do also outreach to see them, if need. So that's mostly follow-up. I have some patients that I don't do formal psychotherapy, but I do still use some element of psychotherapy with my borderline patients. Just because there's \_\_\_ , [00:11:21] and I see them regularly, always at the same time, and things like that. But it's not formal because I don't have the time to do a full psychotherapy. I do that. And I will also help my colleague when there's anything acute. They’re not at the office, and someone needs to be seen for something specific, or need to be formed or assessed, I will also do it. Because of circumstance with our team, I'm also doing injection for the long acting injection right now with…

I: Opiate agonist therapy, you mean?

R: No, I just do the injection as… Like the nurse, we do the injection for the medication. So because we have not enough nurses at some point, I started also doing some of the injection for the patients from our team.

I: Okay.

R: I'm still doing it for the moment. But yeah.

I: I read that on your survey. I think you said you also provide substance use treatment. So I was just curious if that involves opioid agonist therapy or anything like that. I'm just curious.

R: We do have patients on that. Most of the time I don't start them. I mostly continue them, and work with sometime some substance use team, just coordinating. Just because our team is not officially substance use.

I: I see. Okay, gotcha. And what does your work week look like? If you don't mind going through your schedule. I know you work full time with the ACT team.

R: The work schedule is very different from one week to another. I will say usually we have a morning meeting where we talk about all the patients, what’s acute in the last day. So that's one hour every morning. And then some of my day, like let's say today, I'm mostly at the office, unless there's any urgents. So all my patients that are more stable or able to come to the office are scheduled for Monday. That's easier for me. Usually, let's say Tuesday, it's more a day I do outreach. We have patients out of our catchment area sometimes. So Tuesday is often a day, if I need to go let's say to Scarborough, and we are downtown Toronto, that's the day I will go with the team. Because it takes most of my day to go that far. And then the rest of the week are mix, depending of my week if I have more office time or outreach time. That's a mix. Because the other person on the team works four days a week, but 10 hour days. Usually I start at the same time… Well, a bit later than them for the morning meeting at 8:30. And I finish between 4:00 to 6:30, 7:00, depending on the day. Because some of the patients are in the evenings. So I just go in the evening. But the mix of clinic and outreach, I will say that some, they are just meeting and talking about some case, and just what we need to do with the other staff or housing worker or the family doctor. And some, they are mostly just outreach and see the patient after, and then come back to the office. I will see between… Let's say, some day I'm not able to find anyone. So sometimes I see zero patients in a day, to maybe 15 patients a day. It's very different from one day to another.

I: Yeah, I can imagine, especially with this patient population. And just out of curiosity, when you're not doing outreach and you're not face-to-face with patients, other than meetings with your colleagues, do you also… I imagine you have to do paperwork.

R: Yes. So paperwork, charting, emails with other physicians. I try to take time with the resident to do some teaching also. At some period, also I was having an online course. Like how to prescribe let’s say clozapine or something like that – for my own interest. So sometime I was like taking two hours in a week that I'm just doing an online course also.

I: Awesome. Thank you for walking me through your work week. And I was curious if you can maybe tell me a little bit about the split between new patients and recurrent patients, on average. I can imagine it's changing a lot. But on average, how many new patients would think you guys take?

R: It depends if we’re at full capacity or not. If I remember correctly, for psychiatrists being part time, and the number of workers we have, we're supposed to be around 210 patient max. So around 50 each person. I currently have around 40 patients that are like mostly my patients. But I see a lot of other psychiatrists’ patients because I'm always at the office. So more recently, I had a couple of admissions. Let’s say one a month. Because I also discharge other patients. And there's a rotation just… Like if a psychiatrist have a new admission, then the next one goes to another one. And so it will go back. Because we don't have the full staff. The nurse is orienting like that for the moment. I think we're not taking any new admission just because we have more patients than we have staff. But yeah, maybe at the end, having one every month or so. But I also ask to have more admissions because I have the capacity.

I: And it sounds like there's nurse shortages in your workplace right now.

R: Yes. I think that's the case a bit everywhere in health care.

I: Yes.

R: I mean we were full for time sometime. And then I think we're missing one nurse. They're looking for, but so far no one applied. So one nurse, and maybe one to three case managers. And we just… Someone retired as a peer support. So we also need another peer support. Yeah, a couple.

I: So it sounds like you have to kind of take over some of the roles in the absence of it.

R: Yeah.

I: Do you mind maybe describing your sources of income? Just like what's the funding model for the work you do?

R: I know most of the ACT… Well, the other ACT team mostly have a salary. The one I’m working in, it's not the case. So it's fee-for-service for all the psychiatrists. And so yeah, depending of if we see a patient or not. I know the other psychiatrists have a stipend. They have a certain amount of money which I don't. I do have a grant to do my fellowship, in addition to… They let me bill my own patients. Like all the inpatients I'm seeing, I bill for them. And then there's a certain percentage of what I'm billing that the association took. And I don't know exactly where it goes, but they take a certain percentage of what I'm billing.

I: Oh, okay.

R: And I forgot to say we have a nurse practitioner also with our team. Sorry, it's new since… We also have that.

I: But for you, it's fee-for-service, and then you have some funding for your fellowship through the grant.

R: Yeah.

I: But it’s all fee-for-service. And it's interesting because, yeah, I've heard that from other ACT providers in Ontario that it's salaried. But it sounds like yours is fee-for-service. Okay.

R: Yeah.

I: So I'm going to change gears a little bit. How do you think psychiatry is understood by the rest of the medical community?

R: I think it's better than it used to be. I mean there's more campaign during med school and everything. We talk a bit more about mental health issues and things like that. So people are more aware it exists than I thought than before. I still feel it's very taboo, and people don't want to acknowledge they have mental illness, or that it's possible to have depression, burnout, or thing like that. It’s still something that won't happen to us, but to someone else, I think it's the perception people have. Like healthcare providers, but also society in general. I will say that during my training, less now, but at the beginning of my residency and things like that, when I was doing rotation to other specialty, I still had comments like, “Why did you choose psychiatry? You could have done something else. Oh, you're good. Like you could have a chose.” Like I mean I don't think they want to be mean, but that's not a nice comment to do. Like I chose psychiatry because I love that, not because I cannot do anything else.

I: Yeah.

R: And I talked with some new resident or some clerk, and they also have kind of some comment when they were saying, “Oh, yeah, I'm interested in psychiatry, and people were just like, Yeah, but you could do something else. Like you're good. Why did you choose psychiatry?” So I think it's still not recognized.

I: As valuable as it should be.

R: Yeah.

I: I’m sorry you had to experience that. And it sounds like almost…pretty much every psychiatrist I've interviewed has shared your experience in terms of being questioned for choosing this field. And it sounds like even in this day and age, not everyone in the medical community is recognizing the value. And I apologize you had to experience that.

R: Well, I think it's still better than before. But there's still that conception that you go to psychiatry because you don't have any other option, or you're not like a real doctor. Also, often I will say that if someone just feels a bit sad, or have anxiety, or are a bit agitated, like they are very prompt to ask like psychiatry to deal with that. Even when sometimes just asking a couple of questions, say, “Hey, that's maybe normal to be a bit sad if you have a cancer and you think you will die,” like thing like that. I just feel like people don't want to deal with that. As soon as, “Yeah, I want to die,” or…they ask psychiatry to find a solution for that. I mean when I was at McGill, I had a lot of consults that I didn't find very pertinent. Like, Oh, yeah, he wants to kill himself. And when you talk to the patient, like well, he doesn't want to kill himself, but he's very psychotic. Like he jumped off the balcony because a demon was saying to jump. But nobody asked him. So I still feel it's something that people are not at ease to deal with. And so they ask us like very quickly. It's not bad, it’s just they don't necessarily take the time. Or that, or make no sense. I had a lot of consultation in the past where, “Okay, where's the patient?” “ICU.” “Okay. Is he intubated?” “Yeah.” “Okay, how I'm supposed to do a consultation if the patient is not able to speak or unconscious?” Like I wish like it's not real, but I had so many consultation like that where like, “Can you wait that he's able to talk?” And like they're asking for that. Like so I will say there's still misunderstanding about psychiatry, and just letting go thing. I mean I did my residency recently. So that's the thing that happened. And when I talk with some residents, they still have consultations like that.

I: Wow. It sounds like they don't want to deal with anything that has to do with emotions, it sounds like. And as soon as there's any sign of it, they ask for a psychiatrist to do a consultation. And it sounds like a lot of time it's maybe unnecessary if it's very minor, and it's kind of a normal reaction to what's going on with them physically.

R: Yeah. So yeah, I feel that. But I still feel that people are a bit more open to talk about mental illness, burnout, or things like that. Especially with the pandemic. Or substance use and \_\_\_ abuse and \_\_\_ , [00:25:57] I think people are a bit more willing. More with very ill patients and psychotic ones with ACT teams. So I'm not saying like the first line, really. But I know from colleagues, they have more consultations for that.

I: Interesting. What are the expectations from patients, and how do they differ in your experience?

R: Expectation for patients are that sometimes when they are referred to our team, like they don't know our team at all. They were just referred, saying, “Hey, it's an ACT team,” or it’s a psychiatrist. Like, “They will deal with all your problems. They will know what to do.” Like as if magically I have a solution. I wish. But I will say that what I do right now, if you refer them to my team, usually it's because it's a level of care that is higher than what you can provide. It can be like daily med observation, form, content like that. And it's also because you tried a couple of things, and it didn't work. So it's like chronic or very difficult patients. I mean, yes, we can help them, of course. But I don't have a magical solution that will resolve everything. And sometimes some of our patients, I think they have the expectation of that when they are referred to the team. Or some of them and their family that work with the team and know that it's very high intensity, that we're very flexible and available, have the impression…they just take for granted that, hey, if they call us, we shall answer right away, we should provide something. I had a family member of my patient that called and expected to be seen like the same day. And when we offered something, like they're like, “No, that's not good enough. Like that's too late. That's another good hour. I don't want… Like you need to come instead.” So I will say I have some patients like that. Or just like, “Okay, like why the prescription is not done?” “Well, I talked to you an hour ago.” But the prescription is not done just because we're so quick to see them and answer. So their expectations are just way too high. And I have other patients that are just very, very happy to work with the team because they feel lonely. It’s the only connection they have with other people. Or only moment in the week they will talk with someone. They are so happy to that. So it's a mix. I mean some patients doesn't want at all to work with us because they don't see the point, they don't think they are sick, they don't think we will help them. Some want to be seen every day, and have the team. And others, their expectation doesn't make any sense at all. So it’s a mix. I think it's the same for everyone.

I: And here it sounds like also the families get involved because it is more of a, you know, challenging or complex case. So sometimes families are also involved. And they have expectation. So you have to navigate through all of that.

R: Family or other worker that sometimes will have a solution. But we don't always have something. Sometimes I will say because we work doing outreach, and we have colleagues that work inpatient or in the ER that see like a lot of our patients, sometimes we need to talk like with each other. Because there's misunderstanding about what are you doing. Where the patient is so often at the ER, like are you doing something in the community? Or if we are unhappy with some discharge that could happen, like we find that patient’s unwell So that's not the patient, but like other workarounds. So sometimes we have to just talk and see what are our struggle, but also for the ER or the inpatient team, what are their struggles for their team also? And work together.

I: I see. And how do you see your role in the context of the broader healthcare system?

R: I will say my role is more to support the team and the patient. I think… I love working with a team, but you need a good team. That they are able to think by themselves, have autonomy to have judgment about what they're doing. Like they can’t reach out to me every time they're seeing someone, asking, “Oh, well, I wasn't sure.” But also I want them to know that they can reach out to me if there's any question or they need me to ask someone. So I think it's a balance between saying, Hey, I'm there to help you if there's any question about some medication. Because you're in the community, what you're doing is more acute, and like you don't have as much support as if you are in the hospital. Like he's at the hospital. There’s security. You can have the inpatient team and things like that. In the community, if the patient is unwell, you need to deal with that, and assess, okay, is it safe to let him go home or he needs to go to the hospital? And I think like psychiatrists work as part of the team, and take decision with the team because they see the patient very often. So they need to know that we're here to help them and support whenever it's possible, and brainstorm with them. But also at the end, make a decision if there's something. Like okay, he's okay to stay at home, or you need to go to hospital, we're doing this or that. So that kind of leadership also at the end to take the final decision. And have also the responsibility and the ability if anything happened. So a lot of leadership, team work with the team, and support them, and teaching a bit why we're doing something. Because we don't have the same background, sometimes not understand something. Or with the other worker, like let's say housing worker, things like that, they don't always understand why we let people in the community, even if they are very unwell. So it's more support. And the goal of the ACT team is mostly like having a good relationship…well, having a relationship with the patient, and helping with housing and quality of life. It doesn't mean they won't have any symptom or won't go to the hospital. That will still happen. But at least they know like they can come to see us and talk and discuss, even if they're using drugs or not taking the medication. That we’ll still be there. And then helping the family also. Because sometimes they are very struggling, they don't know what to do anymore with the patient. So mostly support, to try to improve quality of life of the patient.

I: Thank you for walking me through that. And so like supporting in every aspect, it sounds. From the healthcare providers, to the patient, their families, wherever you can, it sounds like.

R: That’s my way of doing it. I just find the team is very important. Like having a good team makes a huge difference. Also when you know you can trust them, and they can trust you and that you will answer.

I: Absolutely. You know, every workplace has its frustrations. What are some frustrations top of your mind?

R: I will say for Toronto, it's such a big city with many hospitals. We don't work in the same place. Let's say my place, it's three hospitals. But we have other hospitals with ER that are not affiliated with us. So we don't have the same system. So we're not able to see each other’s note. And when they go to the ER, sometime they don't know they are our patient. They don't communicate with us. We don't know what happened. And sometimes I will appreciate that they just reach out so we can have a common care plan. That will be very appreciated for that. And also just because some of my patients are a lot to follow up sometimes, and then they pop up at another hospital on the other side of the city, and then nobody lets us know. And we're like, But we want to see him. Like I'm searching for him for moms.

I: Oh, wow.

R: Or they ask are they… Sometimes also not understanding what we are doing I have some… Sometimes they’re calling, like, “We have your patient. He’s due for his injection. Why you didn't give it to him? What are you doing? Like you're not supposed to do it?” I'm like, “Yeah, we tried. We searched for him like every week. But he burned his apartment and the apartment around. He was in jail. And then he was released without us knowing it. And he has no cell phone, no place to live. So how I'm supposed to find him?” Like it's not that I don't want, just we try, we're not able. There's way too many people in Toronto to just be able to find all of them. So that thing - not understanding exactly the reality of everyone, is one of the things. And also I just find that if we could work better with the police, that will be like amazing. I had a patient that I had to do a form because they were very, very unwell, and at risk to just do something to other people, and things like that. I did inform the police. And the patient assaulted the police officer. So because of that, instead of bringing him to the hospital for what was the goal initially, they just brought him to jail. And when we tried to say, Okay, we understand for you jail is more important than going to the hospital because he assaulted someone. We’re like, “But can you still bring him to the hospital after, please? At the beginning, that's the reason why we sent you, and that's why he's so unwell.” And then they just release him without sending him to the hospital, and we just lost him.

I: Oh my gosh.

R: So it's happened a couple of time. Or a patient, “I just want to know what's happening,” and they won't let us know. Like communication is very bad. Or we’re trying to find some patient. We do form. And then they're like, “Yeah, we didn't find him.” I’m like, “Yeah, but that's been three months that we do form regularly, and you're not able to find him. Like then how are we supposed to find him?” So that's communication difficulty with the police officer. Because our patients are so involved with them, like substance use abuse, or like homeless, the police will see them. I just wish it’s better - the communication.

I: And cooperation also, it sounds like. It sounds like they're not listening to you when you're like, “Please let us know.” They just release them.

R: Yeah.

I: And when you follow up with these patients after, it's very difficult, I can imagine.

R: I'm going to say that because I'm working on another setting where there was a specific team with the police with…they have additional training for mental health. And they were the one like working with our patients, or answering our call when they need to be brought to the hospital, or anything like that. And although it was a smaller place than Toronto, but like I knew them. They had my number. I had their number. And we were just like reaching out. Or saying like, “Hey, I need to see this patient. He’s very agitated. I have some safety concern. Can you come with us, please?” And they will come with us. So that was just amazing. And I don't have that at all here.

I: That's unfortunate. And just to clarify then, with your ACT team you don't have a police officer working within the ACT team.

R: We don’t.

I: Okay. Do other ACT teams in Toronto, do you know if they have police working with them? Or I don't know if that's something specific to British Columbia. Because over here, that's sort of how the teams are based. But I was just curious.

R: Not that I'm aware in Toronto. Like there's a lot of police divisions. Depending on where we work, there's different police divisions that we work with them. But no one is specifically attached to an ACT team. Or we don't have a specific number to call to reach out. You have that in British Columbia?

I: Yeah. We have a police officer who, you know, received more training, or so I've heard. So they work with the nurses and the psychiatrists within the ACT team. So…

R: Okay. I know in Quebec at some place, they have that. But as far as I know, not in Toronto. They have some crisis intervention team, which is a nurse and a police officer. But they don't work directly with the ACT team. They just work in general with mental health.

I: I see. Okay. And what would you say you like most about your work?

R: Sorry?

I: What would you say you like most about your work?

R: The teamwork, I really… Like for me, I need to work with a team. I don't like to be alone in the office. I really love just being a part of the team, having meetings, talking to someone that can just stop at my door and ask questions whenever they want. That. And when I have patients that are very unwell, and they are able to be better, it's very satisfying to see that. And some of them like let us know that we make a difference for them. So that's the part I really love about what I'm doing.

I: It’s very rewarding, it sounds like.

R: Yeah. So that's the main part. Like I love that. And I also want an academic position because I want to do some teaching. So when I work with any medical resident or whatever. I also love to take some time for teaching. They need more time than seeing the patient alone. But I just find it's very rewarding because we don't have that… Well, we have teaching. But sometimes we're so busy to see patients or doing whatever paperwork or other things that we don't take as much time that I think we should. Which residents are the people that are still a learner. They have a lot of autonomy. But I still think that taking some time, and just, “Hey, do you have any questions? Do you want to talk about this case,” or whatever. So I try to do it. So far I have more time than the staff. So I take the time when I have a resident to do that. And so far they let me know that it's very appreciated to have that time. So that's another thing I really love - the teaching

I: That’s great. So I'm going to ask more COVID-19 specific questions now. So can you share anything about how your practice has changed during the COVID 19 pandemic?

R: It was a bit weird during the pandemic. I think it was a general feeling. Because we're not supposed to be too close to each other. At some point it was working remotely. Which make no sense for an ACT team because you're everyone working together, having meeting. Like if you're alone at home, how are you supposed to engage with patients? They don’t have a place to live, they don't have internet, they don't have a cell phone most of the time. So you're not able to see them. You need to go in the community. So remotely was not an option that worked very well for our population. And trying to have like informal discussion about the patient, or someone asking you a question, if you're not physically with them, it's also harder because you need to either send an email or call. You don't know if like it's a good time or not. So for working as a team, that was very difficult. Also the team works very well if they know each other, and if they are going to friends, I will say, and they know that, hey, if there's anything, they can ask someone else. And because there's such a huge turnover in the ACT team, if you start working during the pandemic and everyone is working remotely, you don't have the chance to bond with the other person, and to know what's happening also. So it was very harder for the team as a person as well, but also with the patient, to do follow-up, to be sure to engage. We lost some people to follow-up because we're not able to see them in person, they were not able to come to the office as much. The group was difficult to have. It was only like through Zoom. But most of our patients doesn't have Zoom. So they were not able to participate. They were more alone. I think some of my patients were using more also because they were more alone, having anxiety and things like that. They asked us to minimize the in-person contact. Also doing med observation and things like that were harder. So globally for our kind of work, it was more difficult.

I: I can imagine.

R: With everyone. It didn’t sense with an ACT team.

I: And just so I understand. So during, you know, the restrictions, were you still able to see some patients in person, or was a completely restricted to virtual contacts? Because I can imagine, I'm sure you lost a lot of patients who didn't have access to…

R: Well, we were still doing in person.

I: But it was limited.

R: Well, it was more limited. It's also… Like in the community, it’s not too bad because let's say you meet outside, like you can have distance. But if I need someone to come to the office, and I want to meet him with the case manager, and things like that, like you need to have this distance between you and the patient. And you need to ask them to wear a mask. Also, for me working with a new patient, they are already very ill and psychotic. And then I'm like, Hey, I'm your new psychiatrist. You only see my eyes. Like I have the mask. Sometimes I have like all the equipment, and like I'm just yellow. And then the mask, that was like very, very weird for a new patient that doesn't know us, to meet some of them. Or haven't seen me without the mask, also, because we still wear them. And I say hello to one of them without my mask because we were outside, and he didn't recognize me at all. So yeah, I mean it's a different challenge. And because we don’t look kind of the same with the mask, some of the patients were just unsure who we are. So sometimes one of my colleague, “I'm [colleague].” “I'm [colleague].” And they’re like just, “Oh, yeah, you’re [colleague].” And I'm like, “No, I'm your psychiatrist.”   
“Oh, you’re [colleague].” “No.” Like that’s kind of… It's funny, but I imagine it's harder for them to just know who we are exactly. So some patients, even after a year, they still think sometimes I’m the nurse coming.

I: Wow.

R: I’m like, “Yeah, why not? Just answer my questions.” [laughs]

I: And do you think that the changes experienced during the pandemic influence your practice going forward?

R: I will say that the good thing was that now we're more able to use Zoom or phone call to do follow-up. So for some patients that are let's say well enough to have at least a phone, and are hard to find or out of our catchment area, that's kind of nice. Because I'm still going to do some kind of follow-up with them without having to travel for like an hour to maybe see them, if they are not a home. So for that, for the flexibility, it was really great. So I'm doing more some quick follow-up on phone when it's possible. So that's helpful for that. Especially like let's say I had COVID at some point, and I was still able to work a little bit from home. So that was very helpful for that - by phone. I realized that I really love to work with a team, and not alone at a desk. That's able to see people. So for me, it's really crystallized that I want to work with the ACT team. I wasn't sure. Yeah, it made me realize I really hate to work alone in the office and just see patients. So I'm really glad that now we're more back to normal for that. That's my main thing, yeah.

I: So it sounds like, you know, you found a place of work that you seem to be really happy with. It's team-based. You get to go out there. And every day is different. I know you can’t predict it. But wondering if you have any other particular clinical interests that you have as a psychiatrist.

R: I will say like the teaching that I will do with the academic position. And in general, psychotic patients more are my main interest. So while most of my patients right now are like psychotic, schizophrenia, schizoaffective disorder, I still have personality disorder and bipolar disorder. But mostly it's schizoaffective and schizophrenia now. But also I will have a more acute case when I will do inpatient. But there will be some of them less ill. Also more like new onset and things like that. So right now I'm not able to have that. There are just the chronically ill. But with the inpatient, I will be able to do that. So I'm pretty happy with what I'm doing after. Like it's exactly what I asked. Like inpatient, to have some follow-up, also ACT team, to do the outreach, work more with the team. I will do both also, which will give me the opportunity to be able to understand both sides. Because I will hospitalize my own patient. I'm supposed to do on call at the ER also. Which I think is interesting. Like you see other patients. It's always more acute. For the moment, I still love that. I will still later when I'm older. But for the moment I just love the inpatients and the ER. And working there just gives you the opportunity to work with a team. And the ER, they know you a little bit better. So it's easier when you have your own patient there. They can reach you easier, and you can talk with them. And I will have also the teaching part. So I was really lucky that exactly what I want, that’s what I got.

I: I’m so happy for you. And just so then to clarify, if you were to think about your ideal psychiatric practice, how would it differ from what you're about to begin in September, right? So is there anything that’s different?

R: I mean in my practice, I think…I hope will be what I want. I hope practice will be that we have more resources to help support like in the community, at the hospital, and things like that. But that's outside of what I can provide. I will say that I will still want some time for teaching. So that's a small thing I will have to discuss when I start - how I can integrate to be sure to have residents and time to do some teaching also. But other than that, that's what I want like for the moment.

I: That’s great. I know that you're about to, you know, in September, you're going to start…you're going to get this new thing you've been wanting to do. And I’m really happy for you. Do you mind maybe just… I know you explained quite a bit, but I'm just curious if we can go back to you mentioning, you know, more supports. You know, in an ideal practice, you wish there were more supports in the community. If you wouldn't mind maybe breaking that down just so we have it on record. And it doesn't have to be something you're responsible for but just health system overall.

R: I will say if we can have like another nurse caseworker and like social worker and everything, that will be a first step. That will be amazing. Because now everyone’s caseload is very heavy. So they don't have as much time to do some follow-up for some of the things. So that's one of the first things. I don't have peer support where I will work. I hope it will be the case in the next few years just because it's amazing. I've worked this year with one that was very good. And they can just reach out to someone and share an experience that I will never be able to do with the patient. So I hope I will have one. If we can have like physio or more OT to help like with the living space, and how we can help them achieve goals. And sometime go back to work or studying for some of them, that will be also really great. I think if we have more funding also to help. Sometimes it’s just like the token to take public transport. We don't have that on our team. Another team have but we don't. And sometimes it's what makes it difficult with the patient to come to our office for an appointment. So I know the case managers sometimes pay out of their pockets. Which is not supposed to be the case but they do it. So having like more funding for that. Or to help the patient a little bit for a meal or anything like that sometimes. I know it’s not the goal but just it's kind of helpful. That would be amazing. Or having… Like Toronto is so big. Have people everywhere. We only have a car for the team. If we have more than one, that would be amazing also, because it's so far away sometimes. If we can have more housing. There's a crisis in Toronto. I suppose it’s the same in BC. Like affordable housing would be amazing, because that's one of the first problems we have. I mean there's a lot of things that could be better to support. But if we have those housing, that will be amazing also. Things like that. So it's a mix of everything that are not like my practice or anything like that. It's more like having funding and things in place also that make things easier.

I: For sure. Thank you for going over those details. They're very important to note.

R: At the same time, if we can have new medication with less side effects, or more injection also, that would be amazing.

I: I agree. So when you started your career, what were your goals and aspirations?

R: I don't want to do a burnout when I start. I love… Like I'm a bit of a workaholic. Like I know, my friends know also. And they're just like, You will burn out if you work as much as you're working right now, or you say yes to everything. So that's something I need to keep in mind. My goal? I think I just want to still like what I'm doing let's say at 10 or 20 years. I like the team I'm working with right now, what kind of work I'm doing. Not every day but most of the days. So I want to do that, and still enjoy what I'm doing in the future. So I think I will mix and switch a little bit as well. So I'm doing inpatient, ACT team, teaching, just to be sure I'm not bored and have different things. I want to still appreciate that, and do more teaching in the future. Maybe I'm in administrative role also. Not right now, but if it's in 10 or more years, I want to touch that also.

I: So I'm going to ask more personal questions now. And so feel free to skip if you don't want to answer them. But I was curious, would you say that you have any personal priorities or goals that influenced your career?

R: I will say I'm happy right now with what my career looks like or will look like. My more personal goal will be like to have… Because of the pandemic, it was kind of difficult and things like that. Just I want a family and children in the future. So yeah, it was kind of difficult with the pandemic with everyone being kind of at home, not meeting new people. And also for me to have to move cities, that's making it harder. So hopefully when I start as a staff and I won't move again, that will be a bit easier to have that time. I will see.

I: And plan for that. So would you say that your plans to start a family has influenced your career in any way?

R: I mean I did choose something that I want to appreciate when I go to work. Because if I hate what I'm doing then it will influence my personal life from when I go home. And the kind of work I will do also is something which I find flexibility for my schedule more than others. So yeah, it kind of helps that I have this flexibility to have a family and things like that. I will be able to change a bit my schedule also. So it did influence a bit for that.

I: For sure. And have financial considerations influenced your career choices?

R: A bit. Well, yeah, okay, I love community work. But I think that's one of the things that pays less, unfortunately. And it's also very high demanding. So I will still do it, but that's also why I will do other things like inpatient. I mean I know my patient will be there. I won't have to search all around the place to find them. So I'm sure to be able to bill something. So that's why I will do both. And also to compensate. Because teaching, it can take more time. So yeah, I did influence a bit what I'm doing, and just doing outreach all the time.

I: And I wanted to ask you, do you think there's anything that your patients may perceive about you that has affected your practice? So this can be anything from your ethnicity, your gender, languages spoken.

R: I will say definitely ethnicity and gender. I think it's less the case in a big city like Toronto where there's a lot of Asian woman, Asian in general. But I still have patients that are racist. So it doesn't work well. I’ve had comments. In general, it's okay. But still, like for some patients, they didn't appreciate that. I will say more being a woman than being Asian. And I had patients that absolutely wanted a woman so they were happy. But others want men. Or I've looked too young for them. I had a comment, like often, like, “Oh, you look too young to be the doctor. Where the doctor is?” Or if I have a male with me, automatically she's the doctor and the one in charge, and not me. I’m sad it still happens in 2023.

I: Yeah.

R: But that's the reality. I will say because of the team where I am, and the patient now are used, that's better. But if I go and meet with new people, for some of them I look too young. And if I work at the ER also. Like because it's always new patients, like some of them are like, “Okay, when do I see the real doctor,” and not want to see you because you won’t take the decision or anything like that. Like I had that. Or others that say, “Hey, I absolutely want someone that is a male and is speaking English like without any accent,” because it's not my first language. So I understand I still have an accent when I talk. So yeah, it's happened from time to time. Not most of the time. But being a woman and looking young, it’s definitely what I’ve had the most comments from the patient and the family, but also from other worker at some place when they don't know me. Like, “Oh, you're not supposed to…” Like I love when the patients are a bit agitated and things like that, like \_\_ on that. [01:03:55] And in the past, I've worked at a place, and they were like, “Oh, well, I don't think it's a good idea you see the patient. You’re like colleague. Your senior will see this patient. He’s a bit agitated.” And it was like my senior? He's my junior, and he's afraid of the patient. So I don't think that's a good match. I will go see him. But I’ve had comments like that by people.

I: So even from the medical, like your colleagues seem to have these prejudices against…

R: Yeah.

I:. Preconceptions. I'm sorry you're still experiencing that in this day and age. I'm curious about, you know, you mentioned earlier that your rotation was mainly positive in psychiatry. Are there any key people that influenced your plans?

R: Not necessarily one. I think… Like I've worked with different ones that were good for something, and other things were less my type of work. So I think it's just a mix of them, and having different style of way to work with a patient. I don't have one person in mind that I say, oh, it's because of him that I chose psychiatry, or anything like that. I think it’s just a combination of everything together, having experience and exposure to that.

I: Any positive or negative experiences?

R: During rotation or…

I: Or residency.

R: Like psychiatry or overall, like other…

I: Overall, or psychiatry that, you know, kind of influenced your plans or kind of solidified your decision to go into psychiatry.

R: I think psychiatry, I had like a lot of autonomy to see the patient, have the time to discuss and things like that. Which I love. Because I had other rotations as a clerk where like let’s say pediatrics, people tend to micro manage a little bit more everything you're doing. So psychiatry, where you can talk with them, and just your own patient, was really nice. That's one of the things I really love and make me say, hey, I want to go there. Also, I find it's a stereotype, but when I did some surgical rotation, I will say that some were very nice, and some were more rude. Like just say more, “Oh, you need to be very efficient. You need to do that. You need to love like surgery.” Which I understand you do, but it's not what I love. And I think it's fine. I still did my rotation, and everything was fine. I didn't have a problem. But I just feel like it's like too much pressure that you're supposed to love what you're doing, and have more enthusiasm, even if I told you that's not what I want to do. I mean I also love the schedule. I'm not a morning person. So I hate when I did surgery and I’d have to be 5 am at the hospital. Like I did psychiatry, and I was starting at 9:00. So that's quality of life for me.

I: That’s nice.

R: Yeah. So that’s a mix of things. Yeah, good rotation, good supervisor. Yeah.

I: Thank you for sharing that. In what ways does the policy environment or practice opportunities influence your career?

R: I will say that when I applied for residency… I did my residency in Quebec. And there was like, I don't know, like a mindset that people didn't want to be a family doctor at that point because of all the policy and like, oh, you need to do this, this and this, and follow that rule. Like it wasn't attractive to be a family doctor. So that's one of the reasons also I didn't want to do that. And of all the specialties, psychiatry was the one that I found the more for me. I did want to do that more than family doctor. But because of the policies was also something that let me say, hey, I don't want to do that. I don't want someone dictating me all the rules, and how many patients I'm supposed to see, and what I'm supposed to do, and things like that. So that's one of the things for when I chose residency. And also I know other people were not too keen in Quebec about that. So they didn't want to be a family doctor, and they chose a specialty instead. And then I was lucky when I applied for a position, there's kind of a shortage of psychiatrists right now. I mean that's kind of a good time to apply to a place because everyone needs a psychiatrist. So we have a lot of choices. Just say, “Hey, I have this interest. I would like to do this. Is there any possibility,” and just talk about that. So I think I was just lucky at the time that there's a position available right now, they need. And for me, what I have interest was where I will work needs. But I also like talked to another place, and that’s also what they need. So I think it was lucky.

I: Um-hum. I'm sure, you know, you’re great at what you do as well. But no, it sounds like, okay, so these events kind of helped you kind of solidify your decision to psychiatry. And just to clarify, did you do residency in Quebec?

R: Yes.

I: Okay, thank you. If you were to make any changes to the payment system, what would you change?

R: I will say because I do outpatient and things like that, I feel that if we're allowed to kind of bill for meetings we do, and case management with either the family doctor, the team, things like that, that would be amazing. Because I talk a lot with the team, the family doctor and other thing, and it's not something I can really bill. I mean I have a case conference four times a year for one patient. If it's a scheduled meeting of three and more people, things like that. But I spend way more time than that talking with the team or with a family doctor, and things like that. So I just wish we can have compensation for that. Or at least a certain amount for that. Or either if the patient is missing his appointment, and we do outreach, let's say I spend like an hour, two hours trying to go, he's not there, I’m trying to find him, and things like that. If it happens too often, that's kind of hard to bill at the end of the day. Maybe being salaried explains why the other ACT team are doing that. You're sure to have something at the end of the day. But if you're not salaried. I think that could be great. And I think talking with the family in general. So be more recognized.

I: There’s no billing to bill for time spent talking to family members either?

R: If they are the shared decision-maker, there's something. I learned like two months ago that there's something. But other than that, if I just talked to the family without the patient being there. And it's happened sometime, they have concerns or they are very, very involved. That's not something I call bill. And all the paperwork, like all the forms I need to do also. I think it's particular to us being an ACT team. And so they don't necessarily have a family doctor, or isn’t easy to find, and just give \_\_. [01:13:17] So I do them. It’s all like paperwork. Once or twice is not…that's okay. But when it's like every day, it’s a lot. Yeah, that could be a thing. I mean the billing is different everywhere. So it's a bit tricky for me to answer that. Because here, it's like a different billing than what I learned when I was in Quebec. Like it's unit-based here, and not by visit. Yeah, so it's a bit different.

I: Yeah. For sure, yes, it's different. But the fee-for-service, it doesn't cover the time you spend in paperwork or meetings or communicating with other healthcare providers or families. I'm just curious, do you have a bill for the time you're commuting, for instance, to go see a patient when you do outreach work?

R: In Ontario, billing work is…so it's unit-based. Which means what we're doing, like one unit is 20 minutes, two units is 46 minutes, and then like 76 minutes, and go on. So it's a bit weird for me in community. Because let's say I see the patient. They're not always willing to sit down or talk to me for like exactly 20 minutes with me. And if it's under that, it's not a visit.

I: Yeah.

R: Sometimes there are some others that they’re not able to talk 20 minutes with us. So I wish they kind of find something for that, especially in the community. If you're at the office, that's easy to do. But in the community, that's harder. We have some premium. So let's say I'm travelling, I can bill travel twice a day if I go to different locations. And I can bill for a patient up to 10 times a day if I go to a different location. So if they all live in like in the same boarding house or shelter or anything like that, I'm not allowed. But I move like organization, I can bill that travel for patient travel. Just, well, I do a lot of outreach. So to travel for me, it's not a lot. I'm doing more. But I suppose that usually people don't do a lot of travel. So it doesn’t work for them. But it doesn't count like how long it takes you to go to the place. Whether it’s a five minute distance or a one hour…

I: You get paid the same.

R: It’s the same.

I: I see.

R: And the patient needs to be there.

I: Okay. Wow. Thank you for clarifying that. What would you say needs to happen to improve patient access to psychiatric care?

R: What could be improved? I think for the patient there's a lot of difficulty to find where they need to go to have follow-up and care, especially if they are very unwell. Let's say a psychotic patient, they are not enough organized to go through all the steps for that. Often they don't have a family doctor to reference them. So they need to go to the ER. Sometimes I find they are very unwell maybe after a hospitalization, then someone will refer them. So it takes a lot of time. And waiting time is… I'm trying to transfer someone to another ACT team because it's out of our catchment area. And they're seeing that the waiting list, it's like more than one year.

I: Wow.

R: So definitely it could be improved. Like easier access, faster access for that. I suppose also something… Like we have CTO – community treatment order. I don't know if it's exactly the same in BC because it's not the same in Quebec. But if they are under that, they should have like faster intake for the team, or things like that. Or at least we should be able to…the treatment order easier. But sometimes because we don't have a team or thing like that, it's hard. But that's one of the things also. Not necessarily to answer that question but could be improved a lot – the treatment order - that need to be like unwell or at the hospital to see them. Like clearly it's different in this province and in Quebec. And it's every six months that we need to renew them. So if we have difficulty seeing the patient, they will just lapse. I'm used to in Quebec, I can ask 1, 2, 3 and sometimes up to 4 or 5 years at the time.

I: So it's like it can be five years, whereas in Ontario it's every six months.

R: Yes.

I: It’s a huge difference.

R: Yeah.

I: Wow. Do you feel like the model in Quebec in that sense works better for patient access?

R: I will say some other thing in Quebec I prefer, like the treatment order, I need to see the patient but I don't need to reassess every six months. I can ask longer, and it makes more sense for me. Also, I don't need to worry that he's so unwell that he's at the hospital or meeting criteria for a form. I can just show the judge that, “Hey, I have this past history. He’s unwell. Not taking medication. That this and this happened.” So I find that easier because you can bring them like to the hospital, you can see them way easier than if you need to renew every six months. And usually if someone do the treatment order, you follow them also. And it’s not only an ACT team. Like regular outpatient psychiatrists also do the follow-up. So that's one thing that I prefer. But I will say Ontario, the form are more useful. Because if I see someone, I have up to seven days to do a form 1 to bring them to the hospital and be sure someone is seeing him. And like the residents will do it on their own, also. In Quebec, I don't have the same thing to do. They need to be on the hospital ground, and they need to have acute danger for themselves or someone else, and then I can take them in the hospital. But not in the community. So I will say for that, it's helpful in Ontario because we can act faster to bring them to the hospital and see them and provide the care. But a treatment order like makes no sense for me to renew every six months.

I: Yeah. Yeah, that's a good point. I'm just cognizant of the time here. So I wanted to ask you, if you were to mentor a psychiatric resident, what advice would you give them about planning their career in psychiatry?

R: Finding something they like. Like we spend too much time at work for you to just go because you need to go to work. And it's very hard, like at some time very demanding, mentally exhausting. So to have like a good quality of life balance. I love work. But I think taking time outside of work is also important. Trying to like have a very good relationship with a team you're working. That makes a huge difference, if they like you or not. So try that they like you. And work with them as a team, and not just taking the decision without consulting them. That would be one. Yeah, it would be the advice I will say. And that it's okay also if you don't know what to do with the patient. That's okay, that will happen. And at some time, you will feel like you really want to try to help the patient, and there's nothing you can do. You feel very helpless for that. That will happen. It's not you, it's not the team. That's the system that have flaw. Like it could happen, but it's not on you. And just try to find something outside of the box sometimes. Still be careful what the guidelines are, but just adapt. Because the guidelines are not perfect for the kind of patient we have sometimes. And just, yeah, find something that whatever you do, at the end of the day you're okay with what you have done. Like if something happened, are you able to explain what you've done, and why you didn't do some other thing? I think as long as you’re able to do that, whatever happened… Because something can happen - suicide or I guess all the thing like that. If you’re at peace with what you’ve done, I think that's what is important.

I: Um-hum. No, that's great advice. Is there anything else you think is important for me to know before we end the interview that is pertaining to the aim of the study?

R: I don't know if it’s in the scope of the study, but I will say I think because of the pandemic, doing psychiatry was less fun. Like you didn't have like the relationship with the patient, with the team, and everything which makes psychiatry really great. So I have the impression they have less interest in psychiatry during the pandemic. This wasn't a normal one. And maybe… Yeah, maybe less clerks being interested in applying to psychiatry because it was so weird and like not warm to have like online Zoom or thing like that to do the assessment.

I: Yeah, it sounds like especially psychiatry, this is something you need to have, is to be able to be closer to the patient physically, and be able to do this work. So I can really understand it could dissuade some residents to applying. That’s a good point.

R: Yeah. I think if we’re able to have more contact with peer support at the beginning of our training, that could be very helpful to see like differently the patient and what they're living with, what they struggle. Not all the peer support are good. I worked with some that I don't find the best. But I've worked with a very awesome one. And that makes a huge difference, talking with them and understanding their side.

I: That's a very good point. That's a very important insight. Thank you. Thank you so much for sharing your experience. So I'm just going to stop this recording.

[end = 85 minutes]