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Submission to: Consultation on Board funding external doctors' health programs - from Victorian Doctors' Health Program

MBA leadership in Doctors' Health

The current consultation on funding of external doctors health programs provides an ideal opportunity for the Medical Board of Australia (MBA) to foster and support doctors health advisory services (DHAS) throughout Australia, leading to a strong ongoing commitment to the health of doctors. This is the opportunity to establish doctors health advisory services with stable funding, achieved through the introduction of a nationwide levy associated with doctors' registration fees.

The opportunity presents to build on the expertise already in place within the doctors health programs functioning throughout Australia, and to harness the very significant altruistic energy developed by the doctors and other health professionals working through these programs. At this time, there are a number of different models used by these programs, and it is considered by many of those running the services that such different models are required in different regions because of differing needs. The establishment of stable funding would enable the different models to continue, but would also allow for the further development of these services over time.

Leadership by the MBA, fostering the development of such services with stable funding, can make a greater impact on patient safety throughout Australia. Strong and efficient doctors' health programs are also a foundation stone for the development of broader health and well-being for all health professionals, (see below).

The Victorian Doctors' Health Program (VDHP) is the most comprehensive doctors' health program in Australia. Our service is based on service models in North America and Canada, and has features similar to a more recent model in the United Kingdom (1). The VDHP model may well be the type of service that could in time, be emulated throughout Australia, with variations to accommodate local needs.

The Value of Triage AND Case Management

All All of Australia's Doctors' Health Advisory Services (DHAS) support the need for better access for doctors to healthcare. This is based on the understanding that there can be barriers within doctors themselves, but also barriers from the reactions of their colleagues when approached for care or treatment. These access problems are outlined below, and have been studied in some detail. Most of Australia's DHAS organisations provide a triage approach to doctors that contact them, referring them to other treating practitioners as required. Those DHAS organisations usually rely on local medical board health program structures for dealing with practitioners who are impaired and require close monitoring when returning to work.

It is only the VDHP which provides voluntary case management agreements to doctors who approach the

organisation and who are at risk of impairment unless their illness is properly treated and managed. This service is provided in recognition that it is useful for doctors who may be suffering from conditions that could impair them in terms of their patient care, to be able to approach a peer organisation for support and case management, rather than having to necessarily be reported to the Medical Board. This is seen as an exercise of a collective responsibility to peers who are not bad - just ill. It also protects patients. Such case management by the VDHP is always conducted in conjunction with active treatment from a relevant treating doctor(s). In this way, case management also supports the treating doctors, and is welcomed by them. VDHP does not provide direct medical care or treatment to program participants. Some other Australian DHAS organisations have difficulty with the concept of case management and generally have not had extensive experience in this area. Those organisations are therefore cautious about the inclusion of such functions as part of their own services.

The VDHP model indicates that an adequately staffed and funded doctors' health program can provide voluntary case management agreements for doctors, alongside Medical Board Health Programs, providing another avenue to assist the doctor at risk of impairment (thus increasing access to care for more doctors). The VDHP model of care shows that it is possible to integrate the preventive and access-enhancing approach for the majority of contacting doctors, together with the case management model for physicians at risk of suffering impairment.

Agreement amongst DHAS.

The Australasian Doctors Health Network (ADHN) has been meeting for many years now, and brings the Australian State and Territory, plus New Zealand DHAS together. ADHN has recently turned its attention to the commonalities amongst different DHAS throughout Australia. In a meeting in November last year, and through recent discussion, a number of common core services have been identified by the DHAS on this network. The core services identified are ***not*** designed to be a description of the ***only*** services that should be run by DHAS. It is recognised that different services in different jurisdictions may have the need to provide other types of services in addition to the core services.

The four core services that have been identified include the following. The ADHN believes that a **preventive approach** is important with education campaigns directed towards individuals and organisations. There should also be a **contact service for doctors** which is available on a ready basis, and where enquiries can be dealt with by a knowledgeable doctor. There should be a **network of general practitioners** who feel comfortable dealing with their colleagues and who can be accessed by the DHAS. The final principle is that there should be an **educational program** which includes education to the profession as part of the preventive approach, but also includes education of the general practitioner network, and other doctors who may commonly deal with doctors health problems. Such areas of medicine include general practice, addiction medicine and psychiatry.

The ADHN also recently achieved agreement in believing that the continuation of the work of the DHAS services is vitally important for doctors health and patient safety in the community. ADHN also believes that funding through a levy, included in registration fee collection from doctors by the MBA, is likely to lead to the most stable type of funding.

The VDHP provides the four core services. In addition, we provide case management for potentially impaired doctors, vocational advocacy and rehabilitation support, and family support interventions.

The Rationale for the Establishment of VDHP Model

VDHP was established jointly by the Medical Practitioners Board of Victoria (MPBV) and the Australian Medical Association Victorian Branch (AMAVic) in 2000 in response primarily to the observations of MPBV that doctors coming to the attention of the MPBV with health problems including drug or alcohol dependence were often referred late in the evolution of those problems. Anecdotal evidence indicates that reasons for this

late referral included the perceived stigma of Medical Board involvement and the reluctance of colleagues and supervisors to “dob people in” Changes brought about by the new Victorian Medical Practice Act in 1994, intended to make it less threatening for possibly impaired doctors to approach the MPBV but had not improved this situation. Furthermore the MPBV had no means of ensuring that these doctors accessed the best available care, rehabilitation, and support to re-enter the workforce. VDHP commenced operation in 2001.

Scientific Evidence for Doctors' Health Services.

Unfortunately the scientific evidence base concerning doctors' health is not complete. There are similar barriers in collecting adequate evidence about doctors' health as there are in doctors actually accessing adequate health care. Despite these difficulties, a large amount of information has accumulated over the last 20 years. In general, doctors have quite good physical health status compared to the rest of the population, and this is understandable in terms of their tertiary education and knowledge of healthcare (2,3).

Key health problems of doctors.

Current evidence indicates that there are higher rates of depression and anxiety in health professionals including doctors. Such symptoms do not necessarily correlate with diagnosable mental illnesses, and are often referred to as problems of stress (4-13). We are not sure how much these stress-related problems are associated with current workplace issues, and how many maybe associated with the role of the healthcare professional.

There appears to be a greater suicide rate amongst doctors, and especially in women doctors. The estimate of this rate varies from 1.5 times, up to a four to six times increase in rates of suicide (14-17).

There would appear to be a greater than usual incidence of substance use disorders including use of prescription medications and alcohol (18-20). Published studies indicate that about 1% of doctors become dependent on narcotics, about 10% misuse psychotropic medication, and between 6 and 10% have alcohol dependence or abuse problems.

Evidence from overseas in United Kingdom and Spain indicates a prevalence of impaired practitioners of around 0.5% to 1% of the practitioner population (1). In Victoria this would lead to a prevalence estimate of between 85 and 170 practitioners being impaired or potentially impaired at any one time in our community.

Issues of access to care for doctors.

A number of studies have looked at the need for a preventive approach. Entrenched attitudes often exist in doctors, of denial of illness; or cultural attitudes shared in the medical workplace which are counter-productive to accessing adequate medical care. Such studies include research by Australian researchers, including Dr Margaret Kay (21-24). Cultural problems associated with accessing medical care have been shown to be likely to start in medical students and doctors in training. Other studies have shown different patterns of use of medical care in the families of doctors.

Other studies have shown more subtle difficulties for doctors in accessing care, including barriers that arise due to the treating doctors they may approach. There seems to be some stigma in the profession concerning issues of mental illness or substance use disorders.

Some studies have focused on personality issues possibly associated with attitudes towards seeking medical care. A personal contribution from an Australian doctor has highlighted the vital impact of an adequate therapeutic relationship for a doctor to feel comfortable in accessing care (25,26).

The impaired, or potentially impaired doctor.

A number of studies now show that doctors who suffer from substance use disorders can, through a case management program conducted by a doctors health service achieve five-year long successful outcomes at a

level of around 80% (27-29). This compares to a 40 to 60% one year success rate with substance use disorders managed in the community. The VDHP has been able to achieve a five-year 83% success rate for doctors in its programme being case managed for substance use disorders.

Unfortunately the evidence for suicide prevention is scant at this stage. Programs to help prevent suicide in doctors are only in their infancy. Key components of a suicide prevention strategy include the preventive health strategies generally undertaken by doctors' health advisory services. However, strategies that include early identification of seriously ill doctors, and rapid access to high-quality treatment are also required.

Doctors present with cognitive difficulties which may be due to short-term or long-term health conditions. The identification and adequate delineation of the impairments that may be present is vital in determining whether those doctors can practice adequately. Occasionally, other physical conditions can cause impairment sufficient to prevent adequate practice in some specialties. A doctor's health service which deals with such issues needs expertise in understanding such impairments and their impact on adequate practice.

Cost effectiveness of doctors health services.

There is barely any literature discussing cost effectiveness of the activities of doctors health services. This is a gap that must be bridged by adequate research in the future. There is strong anecdotal evidence that there is a significant cost saving effect from DHAS activity.

The only good recent information about cost effectiveness comes from the London based practitioner health programme which has recently completed 3 years of a pilot phase, and has been approved for ongoing work. In their annual report for 2011, they list costs associated with doctors being suspended or ill. They then discuss issues of sick leave costs and extra treatment costs. One can only speculate on costs in terms of inadequate treatment of patients. Their program costs around £1 million per year for a program which services a registered doctor base of twice the size of Victoria. Conservative estimates indicate that at least £1.5 million is saved by the activities of their service. The VDHP would suggest that early intervention with medical students and doctors in training is likely to have an important preventive effect, leading to longer term cost savings.

Implications for treatment of other health practitioners.

In Victoria, the previous Nurses Board established a funded Victorian Nurses Health Program modelled in part on VDHP. VDHP understands that the nursing profession wishes to see a similar service funded on a national level. We would support them in that, but believe that it is important that doctors should have similarly robust doctors health services.

Any of the healthcare professions can at any one time have members of their profession who are suffering from impairment that may affect patient care adversely. When the health condition concerned is identified as a serious one, those health practitioners are likely to be referred to a doctor with experience in managing healthcare practitioners who suffer impairment. Typically such doctors are psychiatrists and addiction medicine specialists. It is vitally important that such doctors have adequate support and training opportunities provided by a robust doctor's health advisory service.

We would note that it is only through programs like that run by VDHP, where case management is an integral part, that the knowledge base develops for giving adequate assistance and training to doctor's managing impaired health practitioners. We consider the case management function is a vital part of our service which helps to equip the doctors who treat impaired health practitioners: be they doctors, or other health practitioners.

International doctors health service experience.

The VDHP model of doctors health service was developed as an Australian-based emulation of the strengths of a North American model of doctors' health service. Whilst there are a number of different models of health

service in Canada and the USA, there is a common and more highly developed model which includes the telephone triage service as well as case management of impaired or potentially impaired physicians.

In the last three years, a similarly highly developed model of doctors health service has been developed in the London region of the United Kingdom. The major difference with the UK model is that an active treatment approach is also taken with physicians who contact that service. So the UK service treats not just impaired physicians, but also other physicians suffering from stress or mental illness. This type of model is consistent with the United Kingdom health system as a whole, which has only a small private element to its structure.

The the VDHP compares very favourably in terms of the cost of providing similar services to those provided in London and North America. The VDHP has similar levels of funding and appears to treat and deal with a similar number of doctors presenting. We have been able to achieve equal levels of success for doctors suffering from substance use disorders. (See also Attachment B)

VDHP: a successful comprehensive programme.

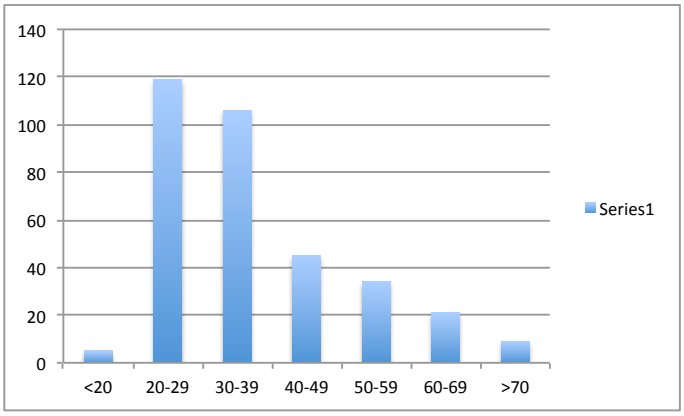
The Victorian Doctors Health Program (VDHP) was established jointly by the Medical Practitioners Board of Victoria (MPBV) and the Australian Medical Association Victorian Branch (AMAV) in 2000 in response primarily to the observations of MPBV that doctors coming to the attention of the MPBV with health problems including drug or alcohol dependence were often referred late in the evolution of those problems and that MPBV had no means of ensuring that these doctors accessed the best available care, rehabilitation, and support to re-enter the workforce. Changes brought about by the new Victorian Medical Practice Act in 1994, intended to make it less threatening for possibly impaired doctors to approach the MPBV, had not improved this situation. VDHP commenced operation in 2001. Since then the value of these services has been recognised and commended by the previous Medical Practitioners Board of Victoria (MPBV) including favourable mention in both their 2003 and 2009 Annual Reports. (See also Attachment A)

The VDHP employs a multidisciplinary team committed to, and highly experienced in the health of doctors. Our team includes a psychologist, social worker and a number of doctors with specific skill areas. Our medical director, Dr Kym Jenkins, is a psychiatrist, with a background as a general practitioner, and experience in supporting medical students and young doctors. We believe the skill set of our employees is well-suited to the comprehensive nature of the service we provide.

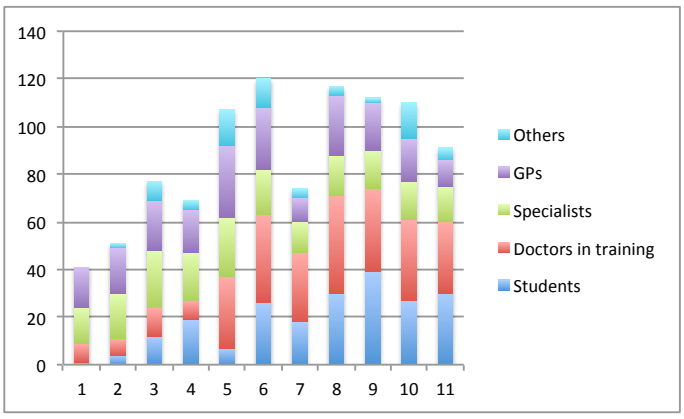
The Board of the VDHP consists of doctors with a number of specific interest and skill areas, and appointed by the Victorian AMA and the Australian Health Regulation Agency (AHPRA) in conjunction with the Victorian Medical Board. The VDHP Board includes doctors with experience as general practitioners, academia, psychiatry, administrative skills and includes representation of younger medical graduates. AHPRA appointees cannot be sitting MBA members.

The VDHP continues to upgrade its ability to provide statistical information about the services that we provide. Of first contact doctors, approximately 48% are male, making an approximately even ratio of gender. In the first contact doctor group 86% come from metropolitan areas, and 14% from rural areas. Amongst medical students, 17 .5% of enquiries are from international students.

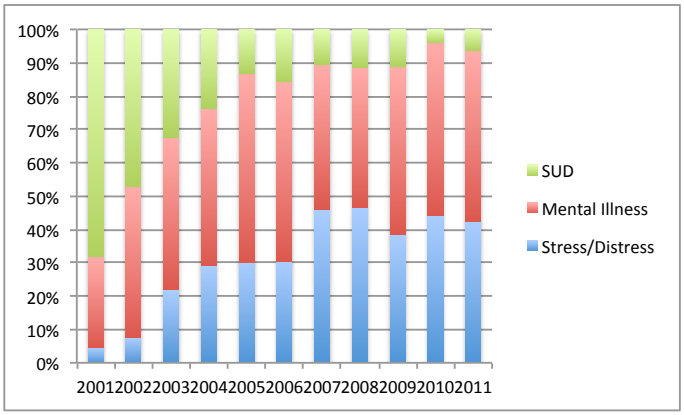
The table below indicates the age distribution of doctors assisted by the VDHP over the last 10 years. The age distribution indicates the strong representation of younger doctors or medical students in presentations, but this has been more pronounced in recent years. The higher representation of the younger age group seems slightly different to the presentations of the younger age group in the North American programs and in the London program.



The next graph indicates the different practice groups of doctors presenting to our program. There has been a gradual increase in enquiries to our program over the period of time the program has run, with a probable plateau situation occurring in the last five years. The lowermost blue and pink bars indicate students and doctors in training, showing that the proportion of the younger age group of practitioners has increased significantly over the time of operation of our program. The figures for specialists and general practitioners have remained relatively constant. Programs in North America and London that provide significant statistics have indicated a greater incidence of requests for assistance from younger practitioners, but probably not to the same extent that the VDHP have experienced in Victoria.



The graph below shows the types of problems presenting to this service over the period of our operations. At the start of the Victorian program we received a large number of presentations for problems with substance use. Over time that proportion has quite significantly decreased. The program's substance use voluntary case management program has a success rate at five years of around 83%, and the proportion of doctors suffering substance use problems and attending the program has decreased with the success of our program. It is also apparent that there is a much greater presentation to our program from doctors suffering stress and distress issues, but not suffering diagnosable more serious mental illness. This pattern appears to be consistent with patterns observed in North America and in London. There has probably been a slight increase in the number of presentations of doctors suffering more severe diagnosable mental illnesses.



The graphs demonstrate the range of doctors that have been assisted by the Victorian program, with a broad age range, but a more recent increase in contacts from medical students and younger medical graduates. Our program to assist doctors suffering from substance use disorders through a case management approach, has achieved the type of success that has been reported by the North American programs and the London program.

Question 1: Is there a need for Health Programs?

There is significant agreement within the profession that health programs established specifically for doctors are extremely valuable and can contribute to greater patient safety and improved patient care. This is certainly the view strongly held by those involved in the provision of these programs in Australia. The introductory comments in this submission clearly indicate the reasons why such doctors' health programs are needed. The VDHP believes that a comprehensive program such as that provided in Victoria adds not only directly to the health of the profession but also provides a foundation stone for continuing skill development for those doctors providing health services to impaired or potentially impaired health professionals of all disciplines.

Question 2: Preferred model for external health programs

The VDHP supports the recommendations of the Australasian Doctors Health Network (ADHN) that four core components of a doctors' health program should be present in any program provided in Australia. We understand also that the ADHN does not wish to limit doctors' health services to ***only*** these four core services.

The four core services include a preventive approach, a contact service for doctors, a general practitioner network, and an educational approach. Through education and awareness campaigns the preventive approach encourages doctors to look after their health in a better way. The contact service staffed by experienced clinicians provides a first contact phone service, or a face to face assessment, for doctors concerned about their health.. The network of general practitioners comprises those identified as being comfortable and competent in the provision of health services to their colleagues. The educational approach has two streams, one providing substance to the preventive approach, and the other providing educational opportunities for members of the general practitioner network and other practitioner groups significantly involved in doctors' health.

In addition to these four core services the VDHP strongly advocates for the need for a more comprehensive program which includes voluntary case management services similar to the program that is currently provided in Victoria. The provision of these voluntary case management contracts increases the likelihood that colleagues, family and medical administrators will effectively encourage doctors to approach the VDHP before they become impaired to the point where patients are at risk and mandatory reporting is required. A small

number of VDHP participants do meet the requirements for mandatory notification to MBA and any comprehensive doctors' health program would obviously need to fully comprehend and adhere to their obligations in this regard. Furthermore some participants are referred to the VDHP by the Victorian Medical Board. Mutual respect and confidence in the relationship between the relevant medical board and the doctors' health program is crucial to the effectiveness of these programs and is dependent upon good communication supplemented by a robust Memorandum of Understanding (MoU) between the two parties. Such an MoU would, among other detailed obligations and responsibilities, confirm the confidentiality of participant identification, subject to legal requirements

The experience gained from case management within the VDHP also provides much greater knowledge and expertise about the management of the potentially impaired doctor. This knowledge (de-identified) then informs the material incorporated into educational programs for doctors who are involved in the care of impaired or potentially impaired doctors. Such treating practitioners, supported by the VDHP, thereby also gain the necessary knowledge and expertise to care more competently for other health professionals.

Question 3: The role of the Board in funding external health programs.

Current health practitioner legislation specifically provides for Boards, at their discretion to "*provide financial or other support for health programs for registered health practitioners and students" Health Practitioner Regulation National Law Act 2009*, Section 35 (1) (n). (subsequently included in each Sate/Territory legislation through the "applied law" model). This clearly suggests that at the time of the introduction of this legislation Health Ministers of all jurisdictions were aware of the potential value of such programs and envisaged the future need to facilitate the provision of financial support.

VDHP supports the position that funding through the collection of a levy from doctors' registration fees is an appropriate role for the MBA. This would provide security of funding and thereby stability of such services. Such fees should be collected on an equitable basis, i.e. the same levy for all registrants in Australia. The VDHP suggests that medical students should not be required to pay a levy, but should be eligible to receive services from funded doctors' heath programs.

Allocation of these funds would support the operational costs of doctors' health programs available to each state and territory, potentially based on different models of operation in different jurisdictions, but all incorporating as a basic requirement, the four core features identified by the ADHN. Additional funding supplements should be considered in certain circumstances including the following:

- Where States or Territories with lower numbers of registered practitioners have difficulty achieving the core features of a doctors' health program unless they receive some additional funding or support from a neighbouring region.
- Additional seed funding for the establishment of a new program in those states/territories where no or a very basic program currently exists
- Additional services over and above the 4 core services – where the service, business plan and costing is approved by the MBA (e.g. the voluntary case management service currently offered by VDHP). Ultimately research findings may assist in the identification of value adding services worthy of receipt of additional funding
- Research activities particularly where these focus on statistical analysis to assess the value of the various services – again subject to specific MBA approval

A Memorandum of Understanding should be established between the MBA and each State and Territory doctors' health program specifying, for instance, the reporting requirements of the health program in regard to activity data (de-identified) and financial information (budget and financial performance data), agreement regarding the preservation of confidentiality and documentation of the health program's commitment to compliance with mandatory reporting requirements,

Question 4: Range of services provided by doctors' health programs

The first five items listed under this question, and the last item (publication of resources) all would seem to fit within the four core services identified under question 2 by the ADHN, and supported by the VDHP as a basic group of services.

Only the item suggesting follow up of ALL contacting participants would appear to be outside of the models of all the current doctors' health programs. Doctors seeking help are referred to treating doctors known to be competent to treat their peers. Selective follow up by the program is required initially to confirm attendance with the treating doctor and thereafter for occupational support, rehabilitation support, and case management monitoring.

The other three items (case management, work assistance and research) would be appropriate additional services to fund subject to program approval by the MBA.

Question 5: Funding

The VDHP suggests that funding in the range of $25 to $40 per registered doctor would be appropriate, with the lower level of $25 supporting the 4 core services. More comprehensive programs which include supplementary services such as the voluntary case management service of VDHP will require funding around $30-40 per registrant.

Question 6: Other comments

The decisions made by the Medical Board of Australia following this consultation process will have long lasting consequences for the adequate provision of doctors' health services, for the health of Australia's health practitioners and ultimately for the health of Australian patients. Funding that merely provides support for the four core services identified by the Australasian Doctors Health Network would provide only a very basic service to doctors in Australia. VDHP strongly believes that a responsible MBA leadership position would involve the collection of a levy from medical registrants to support a more comprehensive doctors' health service similar to those provided in North America, the United Kingdom and in Victoria. A comprehensive doctors' health service includes the provision of case management for impaired or potentially impaired doctors. attracting early referral and intervention and thus preventing impairment causing patient harm and mandatory referral to the MBA. The experience gained through case management also allows doctors' health services such as the VDHP to provide extremely valuable evidence based educational facilitation to those doctors involved in the management of impairment of health practitioners.

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Attachment A: Extracted from the 2009 Annual Report of the VDHP

About the Victorian Doctors Health Program

Our history

The Victorian Doctors Health Program (VDHP) was established jointly by the Medical Practitioners Board of Victoria (MPBV) and the Australian Medical Association Victorian Branch (AMAV) in 2000 in response primarily to the observations of MPBV that doctors coming to the attention of the MPBV with health problems including drug or alcohol dependence were often referred late in the evolution of those problems and that MPBV had no means of ensuring that these doctors accessed the best available care, rehabilitation, and support to re-enter the workforce. Changes brought about by the new Victorian Medical Practice Act in 1994, intended to make it less threatening for possibly impaired doctors to approach the MPBV, had not improved this situation. VDHP commenced operation in 2001.

Our charter

The constitution of VDHP lays down five objectives directed towards the wellbeing of medical practitioners and medical students. They are to (a)encourage the development of, and facilitate access to, optimal services for education and prevention, early intervention, treatment and rehabilitation, (b) encourage and support research into the prevention and management of illness, (c) facilitate early identification and intervention for those who are ill and at risk of becoming impaired, (d) act as a referral and co-ordination service to enable access to appropriate support for participants and their families and (e) ensure access to high quality rehabilitation and encourage re-training and re-entry to the workforce. The model chosen for VDHP was partly based on similar organisations already established in most US states and Canadian provinces. Although still unique in Australia, services similar to VDHP have long been established in those two countries.

Our governance and funding of VDHP

VDHP is an incorporated not for profit public company registered with the Australian

Securities and Investment Commission. The shareholders in the company are MPBV and AMAV. VDHP has an independent and honorary Board of Directors composed of seven medical practitioners and a chartered accountant. Half the directors are nominated by AMAV and half by MPBV. Serving members of MPBV are ineligible for appointment. The chairperson of the Board is nominated by agreement between AMAV and MPBV. VDHP is funded entirely by MPBV according to a budget which is negotiated annually. Annual running costs of VDHP represent a contribution of approximately $28 per registered doctor in Victoria. A detailed statement regarding corporate governance is available on the VDHP web site (www.vdhp.org.au).

The VDHP meets with the owners of the company (AMAV and MPBV) twice per year to keep those organisations informed of VDHP activities. Under company law, VDHP is externally audited and holds an annual general meeting. There is in place a memorandum of understanding (MoU) between MPBV and VDHP which details the obligations of VDHP to MPBV. The MoU specifically addresses the obligations of treating doctors to comply with Section 36 of the *Health Professions Registration Act(Vic) 2005*; ie the reporting to MPBV of any doctor whose illness has seriously impaired the doctor's capacity to practise and is putting the public at risk. In addition, the VDHP constitution establishes a broad based consultative council which is convened at least once per year, bringing together nominees of the medical colleges, medical schools, medical defence organisations, medical student societies, and agencies that support doctors and students with health problems.

The VDHP Board supports and monitors the work of its clinical staff via two Board subcommittees, one for financial matters (Finance and Audit Subcommittee) and the other for clinical audit (Quality and Case Review subcommittee). Board members have no access to the clinical records or identifying information of any participants in the Program but problematic cases are discussed anonymously at meetings of the Quality and Case Review subcommittee.

Our staff and what they do

VDHP is staffed by two part time senior clinicians (one a psychiatrist, who is also the Medical Director of the Program, and the other an addiction medicine specialist), a psychologist and a full time office manager. The work of the clinical staff includes the assessment of new participants and referral to appropriate care, monitoring the progress of those who enter into voluntary agreements, education of medical students and doctors, and research. The work also includes giving advice and/or preliminary counselling by telephone. Some contacts result in the caller being able to access appropriate assistance directly without the potential participant attending VDHP for assessment. Telephone advice is also given to concerned colleagues, employers, or clients' families. After hours telephone cover is provided.

VDHP clinical staff do not provide direct treatment of participants but instead provide triage to ensure that health needs are met promptly and with the best available and appropriate resources. Participants who do not have their own general practitioner are expected and assisted to find one. Over time, the VDHP has built up a network of general practitioners and relevant medical specialists and clinical psychologists to whom participants can be referred. In addition, an agreement has been signed with a large private psychiatric hospital to facilitate referral and where necessary admission of participants whose needs are urgent. It has also built up a strong referral base in that the advice and services of VDHP are increasingly relied upon by medical administrators in public and private hospitals and by medical school staff who have concerns about the wellbeing of students.

Our achievements

Work load and changing patterns of referrals

The workload of VDHP over the years 2001 – 2008 is depicted in Table 1 and the nature of the primary presenting health issue is depicted in Table 2. These statistics refer only to those doctors and medical students attending VDHP for their initial assessment and do not cover any clients assisted towards help by telephone.

Table 1: Initial assessments at VDHP; 2001-2008*

Year	Medical Students	Doctors in training	Specialists	General Practitioners	Others	Total
2001	1	8	15	17	0	41
2002	4	7	19	19	2	51
2003	12	12	24	21	8	77
2004	19	8	20	18	4	69
2005	7	30	25	30	15	107
2006	26	37	19	26	12	120
2007	18	29	13	10	4	74
2008	30	41	17	25	4	117

Table 2: Primary presenting problem to VDHP; 2001-2008

Year	Stress/distress No (%)	Mental Illness No (%)	Substance use disorder No (%)
2001	2 (5%)	12 (27%)	30 (68%)
2002	4 (8%)	24 (45%)	25 (47%)
2003	17 (22%)	35 (45%)	25 (32%)
2004	21 (29%)	34 (47%)	17 (24%)
2005	32 (30%)	60 (57%)	14 (13%)
2006	37 (30%)	66 (54%)	19 (16%)
2007	35 (46%)	33 (43%)	8 (11%)
2008	53 (47%)	48 (42%)	13 (11%)

**Footnote: The total number of participants in Table 1 differs from Table 2 because approximately 4% of new participants have been categorised with more than one 'primary' problem and because Table 2 omits the small number of doctors with physical health problems.*

The workload has grown progressively since the first published report of our work [See *Warhaft N. The Victorian Doctors Health Program: the first three years. Med J Aust 2004; 181: 376-379*]. Particularly striking has been the increase in the number of medical students and doctors in training seeking help from VDHP and the increasing proportion of participants seeking help with stress related problems. It is possible that these changes represent earlier identification of potentially more serious health issues and reflect the impact of VDHP education programs on the attitude of medical students and younger doctors to managing their well being. It is also possible that these changes reflect increasing stressors in the health care system for young doctors. Whatever the cause, the importance of the work of VDHP towards the welfare and protection of the community, by preventing ill health and impairment in doctors should not be underestimated.

Amongst doctors in training, more female doctors seek help from VDHP than their male colleagues. For doctors over 50 years of age, more males are seen, but this may reflect the gender distribution of that part of the medical workforce age spectrum.

Another trend observed is a fall in the numbers of doctors attending with substance use issues. Over the same period, the numbers of doctors being referred to MPBV with this problem has not increased so it is possible that this represents a real decrease in Victoria. If so, the reason for this is uncertain, although removal of pethidine from the Pharmaceutical Benefits Scheme Doctor's Bag in 2005 may be one factor.

A proportion of participants (those with substance dependency issues or serious mental ill-health) are asked to sign comprehensive care and monitoring agreements (including breath, urine and hair testing as appropriate), and are then followed closely by VDHP staff in collaboration with treating doctors and other nominated monitors such as workplace supervisors. The success of this aspect of the program in keeping doctors well and in the work force is reflected in the following statistics. Over the years 2001-2008, 85 doctors and 5 medical students with substance abuse problems signed such agreements. At the time of entry, over half of these participants (50 or 56%) were not working or studying, were suspended from work or were on sick leave, but within six months, 30 of this 50 were back at work or study. Of the participants who have now been followed up for five years or more by VDHP, 86% (32 out of 37) remain well and in the workforce. For the remaining five, two are on sick leave, one's registration is suspended by MPBV and one has retired.

How we meet our charter

In addition to the clinical assessment and triage work of the Program as described above, the VDHP charter calls for VDHP to seek to educate medical students and doctors about their own health; to take steps to prevent, or detect at an early stage, health issues leading to impairment; to foster rehabilitation and re-entry programs; and to foster research into such health problems.

Education of the medical profession about health issues and about VDHP has been tackled on several fronts. A regular newsletter is sent to all registered doctors and medical students (courtesy of MPBV mail outs). A website has been established: newsletters and other material are posted there (www.vdhp.org.au) . Clinical staff regularly give presentations on doctors health matters and on the services of VDHP to medical students, doctors in training, divisions of general practice, medical colleges and hospital grand rounds. In 2008, 33 such

presentations were given.

VDHP holds a workshop each year to address significant health issues for the profession. The initial workshop in 2007 was on the topic of stress and distress in doctors in training. The theme for 2008 was on assisting doctors to become better equipped and more confident when asked to become a treating doctor for another doctor and in 2009 the theme will be prevention of violence in the medical workplace.

Rehabilitation programs are delivered via other agencies as identified by VDHP. Re-entry to the workplace is facilitated by VDHP negotiating with workplaces on behalf of participants to ensure graduated re-entry and adequate support and oversight. Research to date has focused on analysis of the VDHP client data base and has led to presentations of this data to a number of national conferences. By agreement, all research proposals are submitted to the human research ethics committee of a major public hospital.

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Attachment B: Websites for information about the health programs in USA and Canada, and for an updated statement from the American Medical Association in 2008

1. Federation of State Physician Health Programs. Available at http://www.fsphp.org/ (accessed February 2012).
2. Canadian Physician Health Network. Available at http://www.cma.ca/index.cfm/ci_id/25567/la_id/1.htm (accessed February 2012).
3. American Medical Association. Physician Health and Wellness 2008 Available at http://www.fsphp.org/Resolution_609.pdf (accessed February 2010).