Submission to AHPRA
On behalf of the Australasian Doctors Health Network

Doctors' health: An opportunity to improve the health of the medical profession and benefit the Australian community.

Professional discussion and debate about doctors' health should be informed by both the evidence within the medical literature and by the clinical experience of doctors working in this area. With the release of the consultation paper by the Medical Board of Australia, it is an appropriate time for the medical profession to take a greater role in enhancing the health of our profession. It is clearly desirable and equitable to have similar core systems of support to meet doctors' health needs, regardless of where they are practising. The national registration process, with the newly established Medical Board of Australia, offers an opportunity to reconsider these doctors' health issues from a national perspective.

IMPAIRMENT

The focus of the consultation paper is on doctors' health programs funded by the profession by means of a levy dedicated specifically to this purpose. Such a service is relevant to all doctors, not only impaired doctors. The serious doctors' health issues that may result in a doctor being reported to the regulatory authorities are not the issues that most Australian doctors' health services regularly see. In the past, serious issues of impairment have been generally managed by the state and territory medical boards, with the support of medical specialists in the community. In NSW the Medical Council's Impaired Registrants' Health Program offers support to maintain impaired doctors in practice when it is safe to do so, monitoring health conditions as required with drug testing, regular reviews and assessments. The Victorian Doctors' Health Program is the only Australian program to offer case management (but not treatment) for doctors with serious health issues who are willing to contract with the Program and comply with treatment. Case management includes help with occupational and social problems.

The medical profession as a whole is becoming increasingly engaged in discussions about the health of doctors, as evidenced by national and international conferences. Research into this area is broadening. The focus has shifted to some extent from the historical emphasis on mortality, suicide

and impairment. Discussions now focus on the broader preventive, physical and mental health issues and the emphasis on maintaining the well-being of doctors.(1) The Canadian Medical Association has shown leadership in this area and has released a series of policy documents around doctors' health.(2) In 2011, the Australian Medical Association released its position statement *"Health and wellbeing of doctors and medical students"* which positions health access as central to the improvement of the health of doctors.(3)

Much of the published literature has focused on the mental health of doctors. The term "sick" doctor" has been adopted as a convenient euphemism to refer to a doctor who has a serious mental health issue.(4) The "sick" doctor is regularly presented as a doctor with a substance use problem associated with unprofessional behaviour and impairment of practice.(5) Doctors with cognitive disorders, addiction problems and more serious mental health conditions deserve and require support from their peers – and not just the doctors treating them. It is in this group where impairment is more likely to occur; impairment which may adversely affect patient care. Programs like that of the VDHP and the Medical Council of NSW, which provide or oversee case management, can provide a management pathway separate from the MBA in collaboration with their treating general practitioners and other specialists. Treating practitioners can also provide vocational advocacy and support for the individual doctors and his or her family.

The international literature provides detailed descriptions of programs for seriously impaired doctors and these are similar to the current health monitoring programs for doctors with serious health issues who have been notified to the Board in Australia, or are similar to the VDHP model.

We note that there is a lack of any profession–wide approach to the health of doctors. Doctors are expected to keep themselves well and perform at executive level, often without the sort of system support that others receive, particularly in tertiary hospitals. The model of waiting for the impaired doctor to err and then be reported is unacceptable. The profession is best equipped to developing efficient and workable programs. There is a cohort of motivated but under-resourced doctors already working in this area, and national support would be a very efficient way to enhance this existing network.

WHAT KIND OF SUPPORT IS NEEDED FOR THE NON-IMPAIRED DOCTOR?

Recent studies confirm that doctors are relatively healthy compared to the general population.(8) Doctors suffer with the same range of health issues as the general community.(9) A careful review of the data reveals that the rates of mental illness are also very similar to those of the general community.(10)This is not surprising because higher education and social status is generally

associated with better health. Over 90% of doctors rate their health as good or excellent. However many could still improve their preventive health activity.

Although the suicide rate is higher in doctors, this may be partly related to higher completion rates.(10) Some studies report very high levels of stress and burnout in the medical community but it is still difficult to correlate these findings with rates of diagnosed illness.

A major issue of concern that is central to the role and future of doctors' health services is to ensure that there are no impediments to doctors accessing health care appropriate to their needs.

Healthy doctors = healthy patients

There is increasing evidence that a doctor with a healthy lifestyle tends to have a positive influence on their patients' health behaviours.(15) This finding also supports arguments for programs that enable doctors to proactively address their health – and that of their patients.

Barriers to doctors' health access

Enhancing health access has the potential to improve the preventive, physical and mental health of doctors, but doctors have difficulty accessing high quality confidential independent health care.(11). While failure to access health care is often painted as the problem of an individual doctor whose bravado or lack of judgement prevents him or her from accessing care, the reality is far more complex.(12) Multiple barriers include the individual doctor's behaviour in accessing or not accessing care; but there are also barriers associated with the treating-doctor and with being a doctor (system issues). These system issues include being time poor because of long working hours, but more commonly relate directly to the culture of medicine that rewards the doctor who never takes a sick day and who never gets stressed. Adverse cultural factors for health self care often commence in medical schools, a key area of intervention.

Doctors can have difficulty accessing high quality health care for both mental and physical health problems. Professor Chris Silagy's publication of his personal difficulties in accessing quality care for his lymphoma(14) is one of many narratives published within the medical literature that challenge the profession to be more aware of health access issues and the importance of an established therapeutic relationship.

The solution is not simply the approach in which doctors are educated that they need to have their own GP. Specific steps to improve access include programs run by a number of Australian DHAS to provide opportunities for doctors who treat doctors to share their (de-identified) experiences and to

gain further expertise from their peers. Programs also provide training for doctors who wish to treat doctors, but who feel they need further specific guidance.

Current doctors' health services

Over the past 40 years, state-based services have been established to address a need for anonymous confidential phone support and advice. These services usually provide a point of contact for colleagues in distress, having difficulty accessing care or needing advice about how they can support colleagues. Many services are provided to doctors who are not impaired but need support in their decision to access healthcare. For many years, these organisations have collaborated, most recently through the Australasian Doctors' Health Network (ADHN). This collaboration has enabled information sharing between these services and consolidation of collective knowledge. It has also enabled support for the biennial doctors' health conferences, held in Australia and New Zealand since 1999. Despite this activity, there are few publications that report on the activities of Australian doctors' health advisory services, in their current form.

The funding and the types of services offered vary but all of these services rely heavily on volunteer support from doctors. Back up for the doctors providing the front line call service varies significantly. Neither Tasmania nor the Northern Territory has a service at the present time, but each is supported by other states.

The Doctors' Health Advisory Service (NSW) hosts a website on behalf of the doctors' health services in Australia and this provides a number of links to relevant information.(16) The new South Australian doctors' health program has an information based website offering information and online appointments at their doctors' health clinic. The Victorian Doctors' Health Program runs a website and has published papers about their service.(17, 18) Like other services, the VDHP has seen changes over recent years, with a growing emphasis on prevention and education and on the needs of medical students and young doctors (who are contacting more often). Understanding how these services have changed over time, in response to their interaction with doctors requiring assistance, offers some insights into the design of a doctors' health program that will be perceived as relevant by the majority of members of the profession.

While current services offer advice and support, there is little to be found in the literature to describe or evaluate, any doctors' health programs designed to offer a health service to the wider medical profession that includes both physical and mental health.

Together, clinical experience and the literature on doctors' health support calls for the profession to proactively assist doctors to access services, to maintain their health, and to assist impaired or potentially impaired doctors to access treatment and care. Just before the change to the national registration process, the South Australian Medical Board undertook a survey of their registrants that revealed that the majority of registrants in South Australia were willing to consider contributing at least $50 towards such a service.

Question 1: Is there a need for Health Programs?

Yes there is a clear need for Doctors' Health Programs. Early intervention may help to prevent impairment. If this impairment is not recognised it can have significant adverse consequences for both the doctor and his or her patients. The key areas where non-recognition of impairment due to a health condition might arise include drug addiction, cognitive impairments, and some psychiatric and physical conditions.

Doctors often put off seeking help for a health problem until the condition is more severe. Doctors often self-medicate for a health problem based on their own self-diagnosis, and without adequate input from a more objective health professional, delaying proper treatment. Self-medication may by itself cause further problems and possible impairments.

When a doctor does seek help, the reaction from their peer treating doctor is not always as appropriate and supportive as one would expect.

One of the most valuable services DHAS provide is ready linkage of doctors seeking help, with doctors who feel comfortable and competent treating their peers.

Doctors are in the best position to recognise that the work of a health professional is stressful in a number of ways. One must often sacrifice one's own feelings and priorities in order to adequately look after patients at critical times in their lives. Doctors deal with the problems of death and dying but may not have opportunities for debriefing in order to deal with such challenges on an emotional level.

Despite the fact that there have been many advances in health care over recent years, we still get significant reports of unhealthy work environments. There can be enormous time pressures which prevent doctors and other health professionals from eating properly, taking sufficient rest and having sufficient sleep, and these may prevent doctors from looking after themselves more appropriately. Doctors' health advisory services conduct seminars with medical education institutions and health employers, to seek advice, and open better communications with those

organisations.

We recommend a profession-wide, proactive and preventative approach to dealing with doctors in the early stage of an illness that can lead to suboptimal care and potentially to impairment. It is desirable for busy doctors to have a number of choices for accessing health care, including phone, face to face, and internet contact. The long term aim of DHAS is to encourage doctors to increasingly access appropriate mainstream health services, and use them wisely.

Question 2: Preferred model for external health programs

In order to try to address the needs of doctors' health, most states and territories in Australia have developed advisory services under a number of different models of service delivery. At a recent meeting of Australasian DHAS in New Zealand, four major principles of importance were identified, to be incorporated in a DHAS. These principles were seen as core features of DHAS service, but do not rule out other additional service components, based on sound concepts.

The first principle is to have a **preventative approach** in the advisory service. Doctors should be encouraged to manage their own health in a better way. DHAS will encourage more appropriate help-seeking behaviour through education and interventions within organisations and with individuals and therefore help prevent progression to impairment. The aim is to prevent impairment which could affect patient care adversely.

The second principle is to provide **a contact service for doctors** in each of the States and Territories where these services function. Doctors are on-call and available for various levels of time coverage, to answer calls from doctors that are concerned by health conditions. The DHAS ensure that the doctors answering such queries are well-trained in the sort of problems that are likely to arise when a doctor suffers a health condition, and particularly where that health condition may cause impairment and affect patient care.

The third major principle is the development of **a network of practitioners** who feel comfortable dealing with their colleagues, and who are willing to look after doctors on an ongoing basis. Most of the DHAS already have such a network of general practitioners available for referrals from the service. Usually the DHAS holds meetings or educational sessions to help to further improve the skills of such general practitioners in dealing with their colleagues. It is important to have a general practitioner network that is available and well enough trained, that those general practitioners in the network feel confidence in coping with their colleagues. Contact with an expert organisation that is familiar in dealing with different health situations that the general practitioner may not have

previously encountered themselves, is an important function of the DHAS.

Education is the fourth major principle of the functioning of the DHAS. There are two main streams of education that are important. The first stream is education of the profession as a whole, as part of that preventative approach to developing better self-care behaviour in doctors, and the prevention of delay in seeking help for conditions that may cause impairment. The other major stream of education is for the general practitioner network, and some significant other practitioner groups who deal with doctors as patients, especially psychiatrists and specialists in addiction medicine. The issues associated with psychiatry and addiction medicine, where a doctor is involved as patient, can include significant medico-legal issues that must be adequately addressed by the professional. The support of the advisory service, through education and also for direct expert advice, is a further critical aspect of DHAS provision for these other practitioner groups.

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

The ADHN believes that funding through the collection of a levy from doctors' registration fees is the most appropriate way to fund doctors' health services. This will provide security of funding and stability of services, with less exposure to political or other pressures. Such funding should support DHAS programs that incorporate the four core features identified by the ADHN, and discussed under Question 2. The ADHN has the capacity to nationally link all programs within each jurisdiction to share ideas, resources, and to assist smaller jurisdictions establish viable locally-based models of care.

Funding should ensure that each state/territory has the capacity to deliver a doctors' health service that is responsive to the local needs. Funding may also be used to help set up other appropriate local needs-driven services.

The Doctors' Health Service must be operationally independent of the Medical Board of Australia and AHPRA if it is to successfully deliver these services. We support the creation of a Memorandum of Understanding between the MBA and the State and Territory DHAS, to establish and implement this range of services, whilst preserving confidentiality of doctors, with the expectation that impaired and non-compliant doctors presenting a serious risk to patient care through impairment, would be reported to the Board as required by law. The requirement for full financial accountability would be met through an annual report to the State and territory Boards of the MBA, which would include statistical de-identified data.

Fees should be collected on an equitable basis, ie. the same levy for all registrants in Australia. This levy should be clearly marked as such on the registration form so that it is seen as a distinct contribution by the members of the profession. This money should be distributed on a per capita

basis. However, it is acknowledged that States or Territories with lower numbers of registered practitioners may have difficulty achieving the core features of a DHAS, unless they receive base funding, and/or support from a neighbouring region.

State and Territory based doctors' health services should be free to seek additional funding at a State or Territory level or from other organisations.

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

The range of services provided has been identified under Question 2:

1. Prevention, through communication with the medical community about the services that are available
2. A contact service/helpline
3. A network of practitioners available for referral
4. Education of the profession as a whole and education of doctors to provide better care for colleagues

Follow up is part of the VDHP model but other states do not include follow up as part of their service. This is partly due to resource constraints but also due to a philosophical position in relation to (a) preserving anonymity and confidentiality and (b) encouraging doctors to use mainstream services responsibly.

In Victoria, the VDHP refers doctors seeking help to existing health services, but also follows up selectively for case management, based on the principles of preventing impairment in doctors, preventing harm to patients, and providing assistance to doctors treating potentially impaired doctors. In NSW, case management for impaired doctors is overseen by the NSW Medical Council.

Funding for future initiatives such as work assistance or research should also be sought by doctors' health services at a State or Territory level.

Question 5: Funding

We suggest funding in the range $25 to $40 to be appropriate.

We recommend a model in which funding is provided to a trust that is financially accountable to the Board. If the MBA agrees to funding of doctors health services as a levy associated with registration fees, the ADHN would seek to engage in discussions with the MBA concerning the financial structure of a trust to administer the funds, and its governance.

Question 6: Other comments

A secure funding base for doctors health services will enable the profession to meet the obligation to look after its own members, while safeguarding patient care Services provided by doctors' health services must at all times maintain confidentiality, with the obvious exception of circumstances that meet requirements for mandatory reporting.

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