Funding external doctors' health programs

Submission of Professor Greg Whelan and Dr Kerry Breen

General comments

Leadership

This topic is one that calls out for leadership of the medical profession. With the change to a national medical board, the Medical Board of Australia (MBA) is now placed in a position comparable to that of the UK General Medical Council and is thus well placed to take a leadership position in regard to how doctors look after their own health. Indeed, the MBA has already done so in Chapter 9 (entitled "Ensuring Doctors Health") of Good Medical Practice: A Code of Conduct for Doctors in Australia. Leadership sometimes involves taking decisions that are not automatically popular. In this instance, the notion of funding well resourced advisory services for doctors may be unwelcome for the following reasons:

- The well documented tendency for doctors to deny their own health needs.
- The existing voluntary Doctors Health Advisory Services (DHASs) may feel threatened by change.
- There may be concerns that by accepting funding, a DHAS will compromise its independence.
- The modest increase in registration fees (at around 55 cents a week) coming on top of what many perceive as an unwarranted increase in the cost of annual registration is easily opposed – unless via leadership, the long term benefits of health programs to the profession and to our workforce needs are appropriately recognised and promoted.

Some issues for the MBA to consider

We ask that the Board members turn their minds to the following issues:

1. The reasoning behind the establishment of the Victorian program, driven primarily by the experiences of the Health Committee of the Medical Practitioners Board of Victoria (MPBV) during the 1990s (see attachment A). Although never discussed to our knowledge, it is difficult to believe that the experience of health committees of the other state medical boards was not similar to that in Victoria.
2. The different but complementary roles of Medical Board mandated "health committees" (called "health programs" in some jurisdictions) and voluntary health advisory services (also called "health programs" in some jurisdictions). The former, dealing primarily with doctors who are impaired or allegedly impaired, are essential for the protection of the public; the latter play a large role in maintaining the health of the medical workforce and intervening before impairment becomes an issue.
3. The existence, almost universally, of similar programs throughout the states and provinces of the USA and Canada, many dating back forty years, and recently reinforced by the American Medical Association (see attachment B for links to the US and Canadian programs and to the 2008 AMA statement).
4. The assuredness that voluntary services will still be able to find enthusiastic volunteers in the years ahead. Indeed why should such a valuable service be voluntary?

5. Without some extra funding, how can existing DHASs undertake the additional desirable, indeed essential, roles that are taken on by the programs in South Australia and Victoria?
6. The fact that alternate sources of funding such as via MDOs still involve the medical profession directly funding the services.
7. If the MBA won't lead on doctors health, who will?

Responses to the questions posed in the consultation paper:

Q 1: Is there a need for health programs?

The existence of DHASs in almost every jurisdiction seems to us to answer this question. Whether in the form of voluntary advisory services or funded and staffed programs, they perform a different but complementary role to the "health programs" or "health committees" of each state committee of the MBA. Both are essential, the former to the well-being of the medical profession and the latter to the role of the MBA in protecting the community.

Q2: Preferred model for external health programs

We do not support the notion of one preferred model. Clearly we are familiar with the Victorian program but we believe that there are differences (in population, geography, history, medical culture, size of the profession, and strength of the existing DHASs) that mean that it would be wiser to encourage each jurisdiction to develop its own preferred model to be funded. This could involve the MBA spelling out minimal criteria to be met and only approving the funding of those programs that meet the criteria (allowing considerable flexibility initially to allow services to develop progressively).

Q3: The role of the Board in funding external health programs

The VDHP was developed jointly by the then MPBV and AMA Victoria (see attachment A). The service has been well used and is well respected and at no stage in its ten years of existence has there been any objection to it being funded out of the general revenue of the MPBV. With strong leadership by MBA, hopefully in concert with a fully briefed Federal AMA, there is no reason why funding should not come from the entire medical profession via the MBA.

Q4: Range of services provided by doctors' health programs

In order of priority, our experience leads us to suggest the following services:

1. An independent, confidential advice service, contactable by phone (preferably with 24 hour contact via a pager service), with the option of face to face contact
2. Triage and referral to appropriate care, including assisting participants to have their own GP (this assumes maintaining a list of appropriate and willing specialists and GPs, including rural GPs)
3. Assistance in rehabilitation and re-entry to the work place
4. Education of medical students and the profession at large (about their own health issues and about the skills needed to treat colleagues)
5. Rural outreach services
6. Research (ie analysis of experience); this assumes adequate follow up.

7. Support and monitoring of at- risk participants, (CAMP) working closely with the treating doctor(s) and other health professionals, and agreed work place supervisors (this is also a form of support for treating doctors)

It is assumed that there will be a physical office with secretarial support, maintenance of a website and provision of e- newsletters.

Q5: Funding

As the VDHP has cost approximately $28 per annum per registrant in Victoria, somewhere in this ball park should be appropriate. Smaller jurisdictions might be more costly (per registrant) to fund. This problem could be circumvented by having regional programs (eg combining Victoria and Tasmania, and the Northern Territory with South Australia). This might also overcome an additional issue in the smaller jurisdictions of protecting confidentiality.

Q6: Other comments

One of the developments that was not anticipated by the VDHP was the growth in the use of its services by medical students (most often referred by the clinical deans in the medical schools) and the numbers of younger doctors in training seeking assistance (see attachment A). The growth has possibly been aided by the appointment of a medical director with a background in general practice, psychiatry and support for junior doctors. This growth is clearly also related to the fact that VDHP is independent of the universities, the training hospitals and the medical board. While it might be argued that the medical schools and employers should contribute to funding a service, we would argue against that for three reasons. First, medical students after they graduate will pay for the service while they remain registered. Second, we see it as symbolically important that the profession is seen to be taking responsibility (collectively) for its own health and not relying on others; student access to programs funded by the profession will enhance this. Third, it is consistent with the absence of any fee for the compulsory registration of medical students under the national legislation.

In Victoria, the nursing profession established a Nurses Health Program modelled to a large extent on the VDHP. We understand that the nursing profession across the nation support the adoption of this type of program for all nurses, funded via registration fees. It will be a pity if the nursing profession achieves this and the medical profession does not.

Finally but possibly most importantly we make the following positive suggestions. Given the existence of some very active DHASs in various jurisdictions as well as other barriers to change, we feel that any move to improve the services to unwell medical students and doctors should be developed slowly and in consultation with stakeholders. In Victoria, the change from a voluntary DHAS to a funded VDHP took almost five years of consultation, discussion and planning (between 1996 and 2001). A key step in the process was a workshop (arranged jointly by the Medical Practitioners Board and the Victorian Branch of the AMA) attended by nearly all the key stakeholders to discuss what the issues were, to exchange views and ideas, and to come to an agreed position. That workshop benefitted from being addressed by an invited medical director of a large US doctors health program. MBA might wish to consider the same approach but on a national scale. If this is to be done, we also suggest that at least one well-informed person be invited from both the USA and Canada to participate in a national forum. Funding support for such a large initiative could be sought from government.

If it is accepted that moving forward slowly is the preferred way to approach change, we would also suggest that (a) MBA agrees on an interim basis to fund existing programs at their current levels and (b) MBA encourages each DHAS, in collaboration with the State Medical Board (Committee of the MBA) and the State Branch of the AMA, to develop proposals for a service that meets minimum criteria set by the MBA. This approach would give existing DHASs more control over their own future and would avoid the appearance of forcing the VDHP model on other states. Plans developed in each jurisdiction would be informed in part via stakeholders participation in a national workshop.

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Declaration of interests:

* Professor Whelan served as Acting CEO/Medical Director of VDHP during 2007-2009 and has had a long experience in assessing and managing doctors with health issues related to addiction (many referred from VDHP or MPBV).

* Dr Breen was involved in the establishment of VDHP while serving as President of the MPBV. He subsequently chaired the Board of Directors of VDHP from 2005-2009.

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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).