Submission to MBA re External Funding of Doctors' Health programs

From: Doctors' Health SA

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Question 1:

The community invests significantly in the training of doctors and their expectations of the medical profession are high. Patients need to feel confident that when they attend a doctor, they will be treated by someone who is well.

Medical practitioners also have high expectations of themselves and their colleagues but the desire to achieve such high personal and professional standards can sometimes come at a cost.

Research indicates such a cost includes higher rates of depression, anxiety disorders, suicide and substance abuse, compounded by lower rates of attendance at a GP than the rest of the community. Significant barriers such as access, embarrassment and confidentiality are important reasons for this.

Doctors may not recognise when and why they are unwell and many feel unable to find a doctor with the time and willingness to offer them the formal medical care they require. Doctors may respond with significant and unacceptable levels of self-diagnosis and self-treatment of acute and chronic illness, including depression.

These unwell doctors are patients in every sense, but patients without a doctor.

Illness in the doctor has been linked to suboptimal patient care, poorer health outcomes and medico-legal complaints.

Conversely, healthy doctors practise better medicine and promote their healthy lifestyle choices to their patients.

Attempts to remedy this have so far been well-intentioned but ad hoc, fragmented and the literature continues to highlight how very few evaluated solutions there are in place.

In late 2007, the SA Government supported an extensive state-wide health survey of the profession (2500 respondents, 35% of the profession) which defined the extent of such self-treatment and identified those initiatives and strategies which the profession valued and supported. (see attached document)

These included a dedicated profession-driven and controlled health program offering voluntary preventive health check-ups delivered by trained doctors able to help connect doctors and medical students with formal health care delivered by a GP network in the community.

The profession supported its independence from both government and the Medical Board.

The program has therefore emerged after an unprecedented level of consultation with the profession and other key stakeholders since 2006 and the support for this externally funded program has been very broad.

The value of this program lies in its preventive focus, whereby the barriers preventing doctors from attending another doctor are directly addressed and minimised. Doctors are encouraged to present earlier in their illness to a concerned doctor and collaborate with them to improve their physical and mental health and address misuse of substances.

The focus on medical students acknowledges the fact that troubled medical students become troubled doctors who often present more frequently to the Board.

The entrenched attitude towards acceptance of self-treatment is set in medical school and early hospital years and the value in directing an external preventive health program to this group is clear.

Question 2:

A national health program should seek to influence a culture change within the profession away from inappropriate self-treatment and diagnosis towards encouraging all doctors and medical students to seek formal preventive health checks and formal medical care much earlier in their illness.

A national program should seek to overcome the multiple barriers which many doctors face when accessing formal health care by offering a choice of trusted, confidential doctor-friendly ‘points of first contact’ with the health system.

Historically, each jurisdictional doctors' health program has offered a phone service as the preferred point of first contact. Our experience in SA is that the uptake of this is very low (25 per year) compared to the number of doctors who identify they are unwell and lack a personal doctor.

Whilst doctors can be triaged to other medical practitioners effectively in this setting, for the majority of doctors without a doctor (40% in SA), the common advice to simply access mainstream medical practice is difficult.

The South Australian rural experience (Dr DOC program) has indicated that the existence of a state-wide 'program' for rural doctors has been popular and empowering and has allowed doctors to be approached for a check-up in the interests of their own health. The consequence of this intervention has seen rural doctors more prepared to seek formal health care rather than informal pathways of care for themselves and their families.

The other highly-rated intervention from this rural SA program has been the use of 'retreats' where groups of doctors have attended facilitated weekends to discuss their work-life balance. The positive impact of this intervention on the retention of rural doctors has been published (Gardiner et al 2005).

A national program should therefore offer all doctors and students (and anyone concerned about a troubled colleague or their medical spouse) a choice of ways to seek help and multiple points of entry into the health system and in SA we have made real efforts to determine these.

They include a web-based platform for those who need timely information and a 24-hour phone service for those who require anonymity and discreet phone advice.

A national program should offer easier access to mainstream networks of GPs who are interested in the health of doctors and medical students and to whom additional training can be offered. The development of training resources and a common curriculum would assist doctors in all jurisdictions to improve their skills in this area.

The opportunity to have a comprehensive check-up is highly regarded by SA doctors as a means of improving their health and there is no reason to suspect this is not the case across Australia. (see survey attached)

It is an innovative, non-stigmatising way to encourage doctors without a doctor to seek formal health care for the first time.

It is very widely supported and should be considered in a national program model

We have responded to this need in SA by offering check-ups in a dedicated after-hours clinic located centrally in the city. The basis for this derives from having followed a marketing approach in collaboration with the Business School of the University of Adelaide to address the needs of the profession which were identified in the primary survey in 2007.

The remoteness of rural practitioners requires innovative solutions and the use of telehealth consultations offers another significant new point of contact.

A national program must also be able to deliver innovative and boutique solutions to special groups within the profession such as solo, IMG, rural doctors and members of the profession who are disadvantaged through their high profile. The example of a rural IMG doctor without access to Medicare presents a challenge.

In summary, a greater choice of ways to access help are needed as telephone services are important but not enough to meet the varying needs of medical practitioners.

A national program model should therefore be funded sufficiently well to provide:

1. telephone advisory services

2. web-based health and health-provider information

3. training for those mainstream medical and allied health practitioners to improve their skills in the care of medical colleagues

4. education of the profession about the existing formal health care pathways already available to them in the community

5. early emphasis on better self-care within medical school curricula and within tertiary hospitals

6. encouragement to access a preventative and thorough checkup as a first step for doctors and medical students without a doctor to acquire a personal doctor for their ongoing care

7. innovative solutions for those disadvantages groups within the profession who have particular difficulty accessing health care from other mainstream doctors

Significant benefits to the profession, public and government are expected from such a national program.

Question 3:

The attempts by the profession to address the health of its own members have so far relied on the goodwill of many volunteer doctors around Australia to deliver phone and collegiate support. Some jurisdictions have driven new initiatives and different models whilst other jurisdictions only have very limited services.

A national registration scheme which seeks to protect the public must acknowledge and recognise the link between the health of the unwell doctor and the ability practise safely on the public.

If healthy doctors practise better medicine, the Medical Board of Australia has a legitimate mandate to act to mitigate public risk from unwell doctors by supporting a profession-wide health program for all doctors and medical students.

The profession does have solutions but lacks funding to offer core services in all jurisdictions and lacks the resources to trial newer models of service delivery which have the potential to reduce illness and notifications by patients.

It is our experience in SA that attempts to do more than offer a phone service to the profession receives strong and constant feedback from all sectors of the profession. The likelihood of funds appearing equitably from the many medical groups is unlikely to be achieved.

The logical funder is the Medical Board whose aims align with such a program and who has jurisdiction over both doctor and medical student beneficiaries of such a program.

Of interest is our own local survey in SA in 2008 (1200 responses) where we found that there is some support for a levy to fund a broader program. In response to the question as to whether the profession was prepared to support a state-wide health program for doctors through a levy on their medical registration;

Q1. SUPPORT FOR A LEVY? Yes 57% No 43%

Q2. HOW MUCH? $10-49 = 50 % $50-99 = 40 % $100+ = 10%

If the average $ for EACH range is $30, $75 and $100 respectively and the majority of 57% indicate a willingness to pay for a Program , a weighted averaging of the survey responses suggests :

Average = [(50 x $30) + (40 x $75) + (10 x $100)] / 100 = $55

could be consistent with the wishes of the majority of the profession.

The health of doctors would be complemented by a national, locally driven 'corporate' approach which complements the personal self-care and formal health care that doctors need to live and work well.

The role of the Board in funding this is clearly pivotal and needs to allow motivated practitioners to deliver it effectively at a local level with the capacity to be innovative and respond to those within the profession with special needs.

The key to the success of a national program is to allow the profession to find the solutions and to control it at a distance from the Board and government .The association between any such program and the Board risks deterring wary and potential participants.

The need for mandatory reporting exists in law and the requirement for monitoring should rest with the Medical Board. It can act as a strong motivator for non-compliant doctors to abide by the independent and professional formal medical advisor.

Finally, it would be expected that notifications to the Board will reduce as a result of a national approach to doctor health which emphasizes early detection and prevention of mental illness in particular.

It is very likely to be in the Board's own interests to make this happen.

Question 4:

What services should be provided by doctors' health programs – click on as many options as you want. In addition to the ones you have selected, what other services (if any) should be provided by doctors' health programs?

- ✓ Telephone advice during office hours
- ✓ Telephone advice available 24/7
- ✓ Referral to expert practitioners for assessment and management
- ✓ Develop and maintain a list of practitioners who are willing to treat colleagues
- ✓ Education services for medical practitioners and medical students to raise awareness of health issues for the medical profession and to encourage practitioners and students to have a general practitioner
- ✓ Programs to enhance the skills of medical practitioners who assess and manage the health of doctors
- × Case management and monitoring (including workplace monitoring) the progress of those who voluntarily enter into Case Management agreements (or similar) with the service
- ✓ Follow up of all participants contacting or attending the service
- ✓ Assistance in finding support for re-entry to work and rehabilitation
- ✓ Research on doctors' health issues
- ✓ Publication of resources – maintaining a website, newsletters, journal articles
- ✓ Other services (please list):

1. In SA our market research tells us that check-ups are important.
2. Special solutions for doctors in need include tele-health,
3. A robust training curriculum for those doctors who need further training in treating colleagues,
4. A profession-only clinic has been identified by a majority of SA doctors as important.

Question 5;

$25-40

Question 6;

The SA survey results from 2002007 SA DOCTORS' HEALTH SURVEY:

SUMMARY of RESULTS

The survey drew 2,586 responses representing 35.4% of all registered doctors in South Australia. This was a representative response rate (Baruch, 1999).

HEALTH-CARE ATTITUDES & BEHAVIOURS

1. Having a GP

a. 61% of doctors reported having a GP.... cf 86% of Australians (AMA survey)

b. Retired doctors were more likely to have their own GP (81%)

c. Self-employed doctors in private practice were least likely to have a GP (49%).

2. Physical & Mental Health

a. 76% rated their health as good, - highest in private practice specialists

b. 23% of doctors rated their physical health as fair or poor.

c. 24% rated their mental health as fair or poor - retired doctors had best mental health.

d. 40% of all doctors with fair/poor physical or mental health did not have a GP.

3. Check-ups

a. 25% of doctors had not had a check-up in the last 5 years (lowest for young doctors, as expected ?)

b. Attitudes to check-ups were very positive

c. 77% of doctors thought check-ups were desirable or useful

d. 69% believed an annual check-up was an important way of improving the health of the profession.

e. Check-up rates were much higher in doctors with a GP.

4. Barriers to Seeking Help

a. 71% of doctors listed at least one barrier to seeing a doctor

b. Confidentiality 29%, access 28%, embarrassment 28%, medical skill 24%, trust 20%, negative past experiences 7%.

c. Poor access to health care was rated by junior doctors (45%), and rural doctors (37%).

d. Confidentiality was also rated higher by these 2 groups 33% and 37% respectively.

5. Self Treatment

a. 44% of doctors indicated they had self-treated for conditions such as depression, hypertension, diabetes or infection in the past 12 months

b. The highest rate of self-treatment was amongst self-employed doctors working in private practice (58%) while the lowest rate was for retired doctors (20%).

c. 47% indicated they were likely to self-treat for these conditions in the future.

d. 12% (292) of doctors reported treating themselves for depression (this is higher than recent studies in Victoria and the UK).

6. Preparedness for Illness

a. Only 50% of doctors had income protection insurance including

b. 35% of self-employed doctors and

c. 28% of specialists

7. Treating Other Doctors

a. 43% of doctors had treated other doctors,

b. 89% felt confident to do it and yet

c. 60% would be prepared to undertake further training in this practice!!

NEW HEALTH-CARE INITIATIVES

8. Dedicated Doctors' Health Clinic

a. 48% of doctors said they would access help through a doctors' health clinic.

b. Highest interest was in young doctors (72%) and IMGs.

c. 58.6% of those with poor physical health and 63.2% of those with poor mental health believed access to a clinic would help.

9. A Doctors' Health Website

a. 58% of doctors would access a doctors' health website

b. younger doctors (76%) and rural doctors were the keenest.

This summary has been adapted from the Survey Executive Summary of Maria Gardiner (BA Hons, MPsych, Clinical) Adjunct Research Associate, School of Psychology, Flinders University who undertook the survey analysis on behalf of the Doctors' Health Working Group in 2008.

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