Medical Board of Australia consultation on the funding of external doctors' health programs

Submission received from: Dr Margaret Kay

Question 1: Is there a need for health programs?

Do you see any value in, or need for external health programs for medical students and/or doctors? Please explain your reasoning

Yes there is a need and there is value in an external health program for medical students and doctors.

A doctors' health program is necessary because doctors have serious difficulties accessing health care. Most doctors are healthy and it is difficult to sustain any argument that doctors should have a special doctors' health program simply because they suffer more health issues. It is well documented that many doctors delay their presentation for care when they are ill and may only access care when they are seriously ill and can no longer work, or become impaired and are required to stop work. This failure to access health care is complex. Doctors fail to access care for both physical and mental health issues. There are many barriers to health access identified within the literature. Some of these relate to the individual, others to the quality of care provided by their peers while many of the barriers are located within the medical profession's culture itself.

The very existence of the many doctors' health services that already exist in Australia attests to the need for a doctors' health program. These services emerged to respond to a need that was identified by members within the profession. Many doctors have benefited from these services. Until now, most services have been run by dedicated volunteers however the provision of such services is potentially unsustainable in their current form.

It is also relevant to acknowledge the evidence that shows that doctors who practice positive preventive health behaviours are better at enabling their patients to engage in positive health behaviours. Enabling doctors to prioritise their health has clear benefits for the public.

When doctors have serious difficulties accessing health care this potentially impacts upon the health of the doctor, the health system, the profession and the patients they care for.

Question 2: Preferred model for external health programs

Of the existing models in Australia as described above, is there a model that you would prefer to see adopted nationally? Is there an alternative model that you would like to see adopted nationally?

Proposed Model: A Pathway to Care

This proposed model for a doctors' health program is designed to offer some insights into the issues that need to be considered. It is consistent with the conceptualisation of doctors' health in a broader context and visualises the main purpose of a doctors' health program as providing doctors with a pathway to health care.

Ultimately, this proposed model is not designed to remove the personal and professional responsibility of the individual doctor to seek and access health care appropriately. However, this model recognises that access to health care is difficult for doctors and seeks to address this difficulty by providing a pathway to care. This model is designed to facilitate health access in multiple ways. The responsibility for health access is not only the responsibility of the individual doctor who is requires care. Neither is health access visualised as the sole responsibility of the profession as a whole (or a service facilitating this access). Barriers and facilitators to health access lie at every level of care. This model addresses the health access issues in multiple ways.

Structure of this model:

If a levy is raised then the money needs to be made directly available to a national body that is then responsible for delivering the doctors' health program. It would be ideal for the program to have a national body to assist with the coordination of the services while the services are actually delivered locally in each state and territory. Pragmatics would suggest that Tasmania may need to be supported by Victoria, Northern Territory by South Australia and Australian Capital Territory by New South Wales.

1. This national body will be an umbrella organisation that has a number of roles:

Receive the funds from the funding body

Distribute the funds to the state/territory services

Report to the funding body

Coordination of communication between state and territory services

Promote the doctors' health programs nationally

Facilitate liaison with key stakeholders by being a visible body with expertise in this area

Facilitate the organisation of biennial Doctors' Health Conferences

Hold national resources (including maintaining a website with dedicated online resources available to doctors and to the doctors' health programs in the states and territories)

Facilitate research into doctors' health issues / evaluation of services

This national body would consist of representatives of each state/territory service and would need some administrative support. This service would meet a number of times during the year via teleconference and at a face-to-face at least once per year.

2. The state/territory doctors' health programs

Each state/territory program would be responsible for enabling the delivery of the program so as to address the needs of their medical community in an equitable manner.

Essential elements of this model:

• *Confidentiality:*

All levels of the service need to provide confidential care.

• *Independent program:*

A service needs to be independent of the funding body. Funding needs to be transparent and reporting should be independent of the clinical care delivered by the board.

Although financial reporting to a funding body is essential for fiduciary reasons, there needs to be a legal agreement to ensure that the funding body cannot have access to any clinical information about the clients. This is particularly important for funds gathered by the Australian Health Practitioners Regulatory Authority. This agreement is necessary to remove any perception of conflict of interests between the duties of the Medical Board of Australia and the duties of the service enabling care. This independence will have advantages for both parties.

• *Accessible care*

Most doctors are located in cities but health care services are widely distributed throughout Australia and an effective model will ensure that rural and regional doctors have access to the program. Much of this access can be using telephone and online (including teleconferencing) technologies.

• *High quality care:*

The aim of this model is to enable more doctors to receive independent, confidential, high quality care. Most of the clinical care is provided to doctors through the usual Australian health care system. This is the most cost-effective and flexible way to deliver health services to doctors. The purpose of this model is to enhance the health access of doctors so that doctors can more readily engage with the healthcare system. Better engagement with the health system, as a patient, is likely to reduce inappropriate self-care.

This model is designed to address concerns raised in the literature regarding the quality of care that doctors receive. Better training and resourcing of treating-doctors will enable doctors to deliver high quality of care to their doctor patients.

• *Equitable service:*

Funding can only be justified if an adequate service can be delivered equitably. Funds raised from the profession as a whole need to be distributed equitably to benefit the profession as a whole. Funding needs to be adequate to deliver the services described.

Although services need to be equitable, this does not mean that they need to be the same in all jurisdictions. The specific services provided need to be responsive to, and tailored to, the local needs of different medical communities in different states and regions.

Four essential components of this model (red arrows):

There are four essential components to this model.

Each component is important in its own right in contributing to the health of doctors. Each of these components should be integrated to facilitate a pathway to care for doctors that will address the different needs of different doctors. These components may be delivered differently in different states and territories i.e. the service is flexible. The structure of the health system and the geography of the state/ territory will impact directly on determining the best ways to facilitate the access to health care.

1. Preventive Care

Aim to ensure all doctors have the knowledge and skills related to maintaining their own health during their career. Doctors are already health literate and the focus is on reflecting upon and recognising their personal health needs which will change over time. This component of the program is designed to increase doctors' understanding of how to access care and skills in supporting their peers to access care.

2. Point of First Contact

Doctors need to have access to confidential, independent care 24hrs a day. Having a helpline for doctors to ring at any time as a point of first contact is an essential component of the model. During office hours, it is reasonable for this call to be answered by a person trained in doctors' health issues so as to screen the calls that need clinical attention. Counselling for those who require care urgently needs to be available.

After hours services should be provided by doctors, preferably general practitioners who have a breadth of experience across all fields of health care and are experienced in providing on-call acute care.

This component is designed to enhance the health access of doctors. Many doctors simply need to talk through the issues in a confidential environment. Some need permission to access health care and others need resources so that they can effectively support their colleagues in their health seeking.

3. Network of Care

This 'first contact' service will only work well if there is adequate back up. There needs to be a way to help the doctor to identify a health care provider. Not all doctors need this assistance however having a list of experienced general practitioners can be helpful. A range of doctors in different regions of each state and territory who are willing to treat doctors is helpful. These doctors will benefit from access to training to enhance their skills to provide care for doctors.

There is also a need for a resource of doctors with specific skills in treating mental health issues and substance abuse in doctors to facilitate referral when a doctor is more seriously ill.

4. Case Coordination

Treatment in this model is visualised as being provided within the usual Australian health care system by providers who have the appropriate skills to care for the condition that the doctor has. This model works well when the doctor has a general practitioner (GP) who provides a link to other relevant specialist and allied health services depending upon their health issue. When the doctor does not have a GP, then the program has the capacity to direct a doctor towards an appropriate practitioner in their area. Sometimes this is necessary because the doctor has moved or the treating doctor has moved and the care pathway has been disconnected. This is a particularly common circumstance for doctors in training.

At times when the doctor is particularly unwell, this doctor may benefit from having their care coordinated by the doctors' health program. This service is most likely to be necessary when a doctor-patient has a complex health issue and does not have adequate social supports to enable them to connect with a health service effectively early in their care.

On occasions this health issue may be identified as one that is likely to impair their practice of medicine e.g. after a major accident or because of substance abuse or a episode of psychosis. This coordination of care will vary depending on the case, but can involve assistance in negotiating return to work in a protected or monitored environment, assistance in arranging assessments for competency to practice (e.g. dexterity to recommence operating after suffering an injury) or devising a contract of care between the health providers and the doctor-patient and acting as a third party in determining whether the terms of this contract has been fulfilled. When substance abuse is involved coordination can assist by ensuring that testing is facilitated and that there is compliance with the requirements.

Independent case coordination is not always needed. When it is needed, coordination of care by a third party with experience in this area can reduce the burden on the health provider. It can also provide the doctor-patient with a place of first call when they are dissatisfied (sometimes very appropriately) with the service they are receiving. Many issues can be resolved through coordinated communication between the parties involved with the expert input from the health service.

Case coordination may involve supportive treatment, even counselling, with the aim to assist the doctor to connect/remain connected with their health provider. The treatment, even for the most complex case, is seen to be provided by a health provider who is external to the service.

Other aspects of the model

Points of Engagement

This model enables a doctor to enter the pathway to care at multiple points and benefit from the various components as the need arises. Although the components of this model are integrated, an individual doctor can engage with any specific component depending on their need.

Many doctors will only engage with the preventive component. If a doctor effectively maintains their health and has access to care then the health program will have little to offer that doctor personally. However the program will also enable doctors deliver high quality care to their colleagues when they are ill and will provide support for that doctor if they have a close colleague confronting health issues.

This model is specifically designed to foster the individuals within the medical profession to accept responsibility for their own health and for the health of their colleagues. It provides a structure through which doctors can seek support for themselves and can actively contribute to provide support to others.

Most doctors will never need to engage with the case coordination component, however this provides an ideal safety net for both the clinician who is seriously unwell and for the doctors who may need support when providing complex care for their colleagues.

Education

This model is underpinned by the need to deliver quality education around the issues of doctors' health. This education recognises the existing health literacy of the members of the profession and recognises that most doctors already agree that having an independent general practitioner is a good idea. Education encourages and enables doctors to be reflective about their health needs, proactively maintain their health and seek care when necessary. Education includes training doctors to identify and address barriers experienced when seeking care. Education also enables doctors to deliver better care to their peers. Doctors have a wide range of health issues that may require the care of any specialty service so all doctors need the skills to deliver care to their colleagues.

Education needs to begin in medical school and continue through the pre-vocational, vocational and continuing medical education programs in all specialties. These programs can be supported through educational resources available from the doctors' health program. Ultimately the education of the profession will foster a positive culture towards seeking health care.

Research

This model is also underpinned by a recognition that research in the field of doctors' health is limited. Specifically, little is known about the delivery of doctors' health programs to the broader profession. Any doctors' health program should be established with the view to contributing to this knowledge.

Intended outcomes of the model:

This model is designed to address multiple levels of the health access issues that doctors face to enhance doctors' recognition of their need for care, their access to care and the quality of treatment that they receive.

The ultimate outcome is for healthy doctors who are better able to provide high quality care to their patients.

Individual doctor-patient:

Each doctor will be more proactive in their approach to their personal health care.

They will be more aware of their preventive health needs which will depend upon their personal health history, their family history and their age. Each doctor should actively reflect upon their personal health issues and ensure that they seek appropriate preventive health care (including immunisations), manage their health issues proactively and safely with the guidance of their doctor and engage with their doctor to ensure appropriate follow-up care. They should actively seek to improve their day-to-day personal health behaviours, being aware that there are positive benefits for themselves and their patients.

Doctors should have their own general practitioner (GP) who can assist them in managing their primary health care needs, including the coordination of their health care with other health providers. Finding a general practitioner involves

attending that GP and developing a trusting therapeutic relationship with that GP. Issues such as self-prescribing, self-investigation and other self-management health practices should be openly discussed with the treating doctor so that clear boundaries are overtly determined. This will avoid misunderstandings and facilitate the delivery of better care.

Doctors should be aware of the contact number for support so that they are never isolated and can access care when/if they need assistance e.g. at times of personal crisis and at times they need support providing care for their peers.

Each doctor should be mindful of the importance of role modeling and mentoring of students and junior doctors, and their peers. Actively fostering a healthy culture including a positive approach towards doctors' health care access will benefit individual doctors and the profession as a whole.

Doctors should be prepared to and know how to support colleagues who are struggling with significant health issues. Doctors should actively avoid contributing to the stigma that doctors sometimes experience when seeking care.

Treating doctor:

A treating doctor should ensure that they deliver high quality care to all their patients, including their doctor-patients. The treating-doctor should recognise the importance of the first consultation with a medical practitioner who is seeking health care and ensure that they validate this decision to access care.

A treating doctor should be aware that there are specific skills required to successfully deliver care to their peers. A doctor who accepts the responsibility of providing care to their peers should ensure that they maintain their skills in delivering high quality care to the doctor-patient and actively seek education in developing this expertise.

Colleagues require independent care and confidential care. If it is not possible to provide such care, then it is appropriate to arrange referral and to follow up after this referral to ensure that the doctor-patient has been successful in accessing care.

A treating doctor should identify opportunities for and proactively deliver preventive health care for their doctor-patients, including appropriate recalls for screening and follow up. The treating-doctor needs to be aware of their responsibilities to report impairment to AHPRA and be aware of the professional and legislative requirements and the relevant guidelines available.

Profession

The medical profession should foster a culture that actively encourages doctors, and their students, to seek appropriate health care. Medical training enhances health literacy but this not a substitute for health access. Fostering a positive approach to health access includes encouraging maintenance of preventive health behaviours and advocating for conditions in the medical workplace that facilitate health access and actively reducing the stigma associated with seeking care.

The medical profession needs to normalise the concept of health access for its members. This can be done by encouraging doctors' health to be approached in a holistic manner and positioning doctors' health as a mainstream part of medicine. All doctors should be encouraged to have their own GP but this in itself does not assure health access. When considering issues of professional education in medicine, the training of doctors in delivering high quality health care is paramount and the need to provide the same quality of care to medical peers needs to be overtly acknowledged. Mentoring and role modeling positive health behaviours should be established as a professional expectation.

The doctors' health programs need to work with the professional colleges and other professional organisations to ensure that it successfully delivers in its aim to enhance health access. The profession should engage with the program to actively promote and support the program.

I have attached an illustration of a potential model for an external health program.

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

Do you believe that it is the role of the Board to fund external health programs?

The Medical Board has a role in funding external health programs BUT this must be an INDEPENDENT program with only financial and de-identified statistical reporting. The money should be gathered with registration money but clearly labeled as money for the doctors' health program and all money needs to go to the doctors' health program. The money should be given to an independent body to then distribute to the states to be able to demonstrate that this in an independent process. The states/territories are then responsible for delivering the relevant program in their program as each state/territory has the necessary knowledge of the local environment.

Funding must be EQUITABLE per doctor and all doctors need to be able to access this service.

The national body may maintain responsibility for maintaining website etc.

It may be appropriate for SA to cover NT and Victoria to cover Tas - simply for logistical reasons.

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

What services should be provided by doctors' health programs. In addition to the ones you have selected, what other services (if any) should be provided by doctors' health programs?

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)

> *It may be that specific services in each state address these issues slightly differently because of the logistics of distance/centralisation etc in each area.*

Question 5: Funding

How much of an increase in registration fees is acceptable to you, to fund doctors' health services?

$25 - $40

Question 6: Other comments

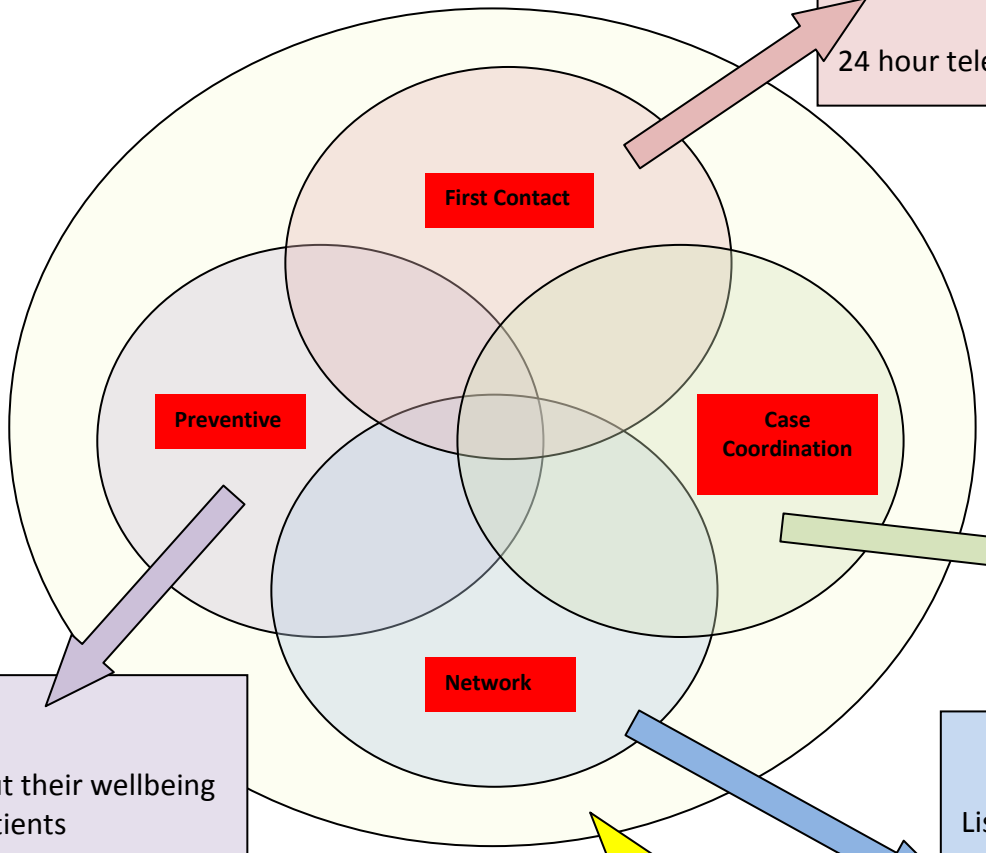
Do you have any other comments or feedback about external health programs?

It is essential that there is adequate funding available and this is the right time for the medical community to be discussing this. Any service will still rely on some volunteer work from the profession itself eg GPs may still need to volunteer to take the call but in a supported environment this is likely to work well.

A Doctors' Health Service: offering a Pathway to Health Care

Overarching principles
Confidential
Independent
Accessible
High quality
Equitable

This is **not** a treatment service:
Treatment is provided within the usual Australian Health Care System
- public or private



First Contact

24 hour telephone service

Case coordination

Assist doctor-patients and treating doctors with complex care
Assist in arranging rehabilitation/ return to work

Preventive

Education for students and doctors about their wellbeing
Education about how to treat doctor-patients

Network

List of GP and specialists with skills and interest in treating doctors

Embedded in Research

Four Points of Contact

Different contact will suit needs of different doctors
Multiple contact points may be needed for some doctors
Contact may be necessary for personal assistance
Contact may be necessary for advice to assist colleagues