The Royal Australian College of General Practitioners

RACGP Submission to the Medical Board of Australia

Funding of external doctors' health programs

Introduction

This submission

The Royal Australian College of General Practitioners (RACGP) makes this submission to the Medical Board of Australia on behalf of its members.

The RACGP seeks the Medical Board's consideration of the feedback provided in this submission which is intended to ensure that the health and wellbeing of medical students, trainees and practitioners is protected and promoted at all stages of their professional lives.

The RACGP is committed to working with all relevant stakeholders to achieve better health outcomes for medical professionals, their families who support them, and the patients to whom they dedicate their professional lives.

About the RACGP

The RACGP is the specialty medical college for general practice in Australia, responsible for defining the nature of the discipline, setting the standards and curriculum for education and training, maintaining the standards for quality clinical practice, and supporting general practitioners in their pursuit of excellence in patient care and community service.

1. Doctors' health

Most medical students/trainees/practitioners' physical health status is similar to that of people in advantaged socio-economic groups. Some studies also suggest that they are less likely than the general population to suffer lifestyle-related illnesses.

However, there is evidence that, when compared with the general population and other professions, medical practitioners are at greater risk of stress-related problems including burn-out[1] (16%-36%), anxiety disorders (18%-55%), depression (14%-60%), substance use[2,3] and are more susceptible to suicide.[4,5,6]

Overall, medical practitioners tend to:

- persist despite difficulties experienced – that is, overwork, continue working while ill, and deny or minimise the symptoms and consequences of their illness[7]
- self diagnose – between one quarter and almost all doctors surveyed by various researchers reported "self-treatment"
- self-medicate – in the past, some studies have shown that approximately 10% of medical practitioners self-prescribe[8,9,10,11,12,13] particularly among doctors with moderate to severe depression who are more likely to prescribe their own anti-depressants (30%) compared to doctors with minimal to mild depression (9%).[14]

There is a need to improve the way medical students/trainees and practitioners' mental health and overall wellbeing is promoted at each stage of their professional lives. Hence, the RACGP strongly believes that there is a need to support the continuation of Australian doctors' health programs.

Helping medical students/trainees and practitioners cope with the challenges they face is the collective responsibility of all stakeholders involved in their personal and professional development. This includes medical professionals themselves, social networks, education and training institutions, professional associations, employers, and all other government and non-government organisations that influence health care service delivery in various ways.

Doctors' health programs are an important part of such a collective effort. To succeed they must provide non-punitive and confidential services, tailored to the needs of the individuals seeking assistance.

That is, doctors' health programs must not become in any way extension of the national Medical Board's roles and responsibilities. To do so would only exacerbate the profession's existing fear that seeking help will lead to adverse personal and professional consequences.

2. Preferred model for doctors' health programs

2.1 Retention of state-based doctors' health programs

The RACGP does not support the introduction of a singular national doctors' health program, modelled on a single state program. Feedback received from the profession indicates that each existing program has its own merits and has been developed in accordance with local needs.

Therefore, the RACGP is of the view that:

1. The individual state-based doctors' health programs should continue to exist.

2. The state based doctors health programs should continue to operate independently, free of the MBA's influence and the requirement to disclose the identity of doctors accessing treatment and advice, or the nature of the support services provided to individuals.

3. There should be national consistency in the basic service options and conditions of service usage including:
    a. provision of telephone advice 24/7
    b. referral to medical practitioners who are experienced and willing to treat medical students/trainees/practitioners
    c. exemption from mandatory reporting by treating practitioners.

4. Accessing doctors' health programs should not pose any risk of personal or professional sanctions to the service recipient, as fear of such consequences is the most obstructive barrier to professionals seeking help.

2.2 Reducing barriers for doctors seeking healthcare

To facilitate access to healthcare for medical practitioners, both perceived and actual barriers must be addressed.

Doctors have difficulty accessing healthcare for many reasons. Choosing a health service provider is a complex process, often fraught with a range of personal and professional risks for medical students/trainees and practitioners.

Concern about confidentiality is frequently cited as key factors contributing to a medical practitioners' reluctance to seek assistance. [15,16,17,18,19,20,21,22,23]

That is because it is often feared that a breach in confidentiality may compromise:

- others perception of their competence and signify personal weakness[24,25]
- their professional integrity and stigmatize them[26,27]
- their career development – anecdotal evidence suggests that employers are less likely to appoint medical practitioners with a history of depression[28,29,30]
- their professional registration/insurance/private practice/earning capacity.[31]

As such, the legislative provisions requiring mandatory notification of possibly impaired doctors, under sections 140 and 141 of the Health Practitioner Regulation National Law are currently the most obstructive barrier preventing medical students/ trainees and practitioners from seeking help when they need it.

The new legislation places the reporting onus on all health practitioners involved in another health practitioners care, and is worded in the past tense so that no exception can be made for an impaired medical practitioner who seeks help and voluntarily ceases or modifies their practice while receiving care.

Medical practitioners have indicated that these new provisions will deter them from seeking help and place any existing or future doctors' health program at risk of abandonment by the profession if mandatory notification by a treating doctor continues to be required by law.

The guidelines for mandatory notification recently issued by the Medical Board of Australia do little to allay doctors concerns of personal and professional consequences for those undergoing assessment or treatment.

Steps taken by the Western Australian Parliament to introduce local amendments to the Health Practitioner Regulation National Law, which exempts treating doctors from mandatory reporting, is a step in the right direction.

The remaining states and territory should adopt similar legislative changes to help restore medical practitioners' faith in the system and encourage them to seek help when they need it without fear of personal or professional sanctions for doing so.

2.3 Cost and source of funding

The College does not support an increase in registration fees for the continuance of existing or future doctors' health programs.

Medical practitioners have already experienced a significant increase in the cost of medical registration upon transfer to the national registration scheme without seeing any clear cost-benefits.

Through a national registration system, cost savings (from the restructure and any operational efficiency gains) should have been achieved, and should be re-directed to fund supporting services for medical practitioners - including doctors' health programs.

2.4 Stakeholder support and collaboration

The RACGP and other professional and non-government organisations currently involved in the delivery of state and territory doctors' health programs, are committed to continuing their support for each of the existing programs.

The RACGP, for example, has a range of educational and peer support resources to offer the profession. The RACGP Curriculum includes core units on the topic of doctors' health which focus on:

- raising awareness of the factors that influence doctors health
- emphasising the importance of maintaining their own physical and emotional wellbeing and its impact on their provision of health care
- achieving compliance with personal occupational health and safety requirements (eg. vaccination requirements, managing needle-stick injuries and complying with requirements if they have an infectious disease including chronic blood-borne viruses)
- developing the skills to recognise and manage stress from both work and outside of work
- encouraging doctors to develop and seek appropriate personal and professional networks to facilitate communication about stressful situations to ensure appropriate support
- encouraging doctors to develop a relationship with an independent general practitioner that can provide health care with appropriate confidentiality

- understanding the implications of self management of illness, including self prescribing and the risks associated with this behaviour

Conversely, the RACGP curriculum also focuses on doctors treating other doctors, in which case they need to:

- demonstrate compassion toward their colleagues, supporting them through the various crises that occur in life, being aware that the isolation and stigma that colleagues experience often contributes to the problems they face
- have a clear understanding of the need to have well defined personal and professional boundaries when dealing with a distressed colleague
- be aware that treating a sick doctor can be professionally challenging, which may impact upon the ability to care effectively for sick doctors, and ensure that they maintain appropriate confidentiality
- provide a safe environment for the doctor-patient to raise all relevant health concerns
- know the relevant medical board and medical indemnity requirements regarding impaired colleagues
- be aware of backup resources for support of both treating doctor and doctor-patient
- approach the care of such doctors with the same high standards of care that is delivered to all patients.

Other resources provided by the RACGP include self help literature and a GP Support Program (est. 2008). Through the GP Support Program, RACGP Members can access professional advice to help cope with life's stressors which may include personal and work related issues that can impact on their wellbeing, work performance, safety, workplace morale and mental health.

3. Closing comments

The RACGP does not support the establishment of a national doctors' health program as a preferred model, particularly if the health program is an extension of the national Medical Board's activities.

Rather, the College advocates for:

1. The continuation of individual state based doctors health programs

2. Their operation as independent entities with expertise in doctors health matters

3. National consistency in the basic service options and conditions of service usage, including telephone support, and referral to a treating medical practitioner

4. Removal of all perceived and actual barriers which deter medical students/trainees and practitioners from seeking help when they need it, including exemption from mandatory reporting

5. Commitment by all relevant stakeholders to promote on-going development and provide on-going support for each of the state-based doctors health programs

6. No further rise in registration fees to pay for doctors' health programs. Future funding should be derived from operational efficiencies that were expected to derive form the transition to a single national medical board.

The RACGP cautions that direct or indirect integration of health management and disciplinary matters will only compound medical practitioners existing fears about approaching doctors health programs for assistance.

Therefore, legislative provisions requiring mandatory notification of possibly impaired doctors, under sections 140 and 141 of the Health Practitioner Regulation National Law should be reviewed, and changes made in accordance with the arrangement in Western Australia.

References

[1] Jenkins D. Burnout in rural general practice. New Zealand Medical Journal 1998; 111(28) :328

[2] Hughes PH, Conard SE, Baldwin J, Storr CL, Sheehan DV. Resident physician substance use in the United States. J Am Med Assoc 1991; 265(16):2069-2073.

[3] Hughes PH, Brandenburg N, Baldwin J, Storr CL, Williams KM, Anthony JC et al. Prevalence of substance use among US physicians. J Am Med Assoc 1992; 267(17):2333-2339.

[4] Lindeman S, Laara E, Hakko H, Lonnqvist J. A systematic review on gender-specific suicide mortality in medical doctors. Br J Psychiatry 1996; 168(MAR.):274-279.

[5] Schernhammer ES, Colditz GA. Suicide rates among physicians: A quantitative and gender assessment (meta-analysis). Am J Psychiatry 2004; 161(12):2295-2302.

[6] Swanson SP, Roberts LJ, Chapman MD. Are anaesthetists prone to suicide? A review of rates and risk factors. Anaesth Intensive Care 2003; 31(4):434-445.

[7] Frank E, Segura C. Health Practices of Canadian Physicians. Canadian Family Physician 2009; 55: 810-817.

[8] Hughes PH, Conard SE, Baldwin J, Storr CL, Sheehan DV. Resident physician substance use in the United States. J Am Med Assoc 1991; 265(16):2069-2073.

[9] Hughes PH, Baldwin J, Sheehan DV, Conard S, Storr CL. Resident physician substance use, by specialty. Am J Psychiatry 1992; 149(10):1348-1354.

[10] Schwenk TL, Gorenflo DW, Leja LM. A survey on the impact of being depressed on the professional status and mental health care of physicians. J Clin Psychiatry 2008; 69(4):617-620.

[11] Van der Bijl H, Oosthuizen P. Anxiety, depression, health attitudes and coping strategies in doctors and teachers in a Cape Town setting. S Afr J Psychiatry 2007; 13(2):46-51.

[12] Chambers R. Health and lifestyle of general practitioners and teachers. Occup Med 1992; 42(2):69-78.

[13] Chambers R, Belcher J. Comparison of the health and lifestyle of general practitioners and teachers. Br J Gen Pract 1993; 43(374):378-382.

[14] Schwenk TL, Gorenflo DW, Leja LM. A survey on the impact of being depressed on the professional status and mental health care of physicians. J Clin Psychiatry 2008; 69(4):617-620.

[15] Schwenk TL, Gorenflo DW, Leja LM. A survey on the impact of being depressed on the professional status and mental health care of physicians. J Clin Psychiatry 2008; 69(4):617-620.

[16] Thompson WT, Cupples ME, Sibbett CH, Skan DI, Bradley T. Challenge of culture, conscience, and contract to general practitioners' care of their own health: Qualitative study. Br Med J 2001; 323(7315):728-731.

[17] Kahn KL,Goldberg RJ,De Cosimo D,Dalen J.Healthmaintenance activities of physicians and nonphysicians. *Arch InternMed* 1988; 148(11): 2433–2436.

[18] Davidson S, Schattner P.Doctors' health-seeking behaviour: a questionnaire survey.*Med J Aust* 2003; 179(6): 302–305.

[19] McKevitt C,MorganM.Anomalous patients: the experiences of doctors with an illness. *Sociol Health Illn* 1997; 19(5): 644–667.

[20] Richards C. *The health of doctors. Physician heal thyself—but how?* London: King's Fund Publishing Office, 1989.

[21] Campbell S,Delva D. Physician do not heal thyself. Survey of personal health practices amongmedical residents. *Can Fam Physician* 2003; 49: 1121–1127.

[22] Gross CP,Mead LA, Ford DE, KlagMJ. Physician, heal thyself? Regular source of care and use of preventive health services among physicians. Arch InternMed 2000; 160(21): 3209–3214.

[23] Allibone A,Oakes D, Shannon HS. The health and health care of doctors. J R Coll Gen Pract 1981; 31(233): 728–734.

[24] Adams EF, Lee AJ, Pritchard CW, White RJ. What stops us from healing the healers: A survey of help-seeking behaviour, stigmatisation and depression within the medical profession. Int J Soc Psychiatry 2009.

[25] Thompson WT, Cupples ME, Sibbett CH, Skan DI, Bradley T. Challenge of culture, conscience, and contract to general practitioners' care of their own health: Qualitative study. Br Med J 2001; 323(7315):728-731.

[26] Schwenk TL, Gorenflo DW, Leja LM. A survey on the impact of being depressed on the professional status and mental health care of physicians. J Clin Psychiatry 2008; 69(4):617-620.
[27] White A, Shiralkar P, Hassan T, Galbraith N, Callaghan R. Barriers to mental healthcare for psychiatrists. Psychiatr Bull 2006; 30(10):382-384.
[28] Adams EF, Lee AJ, Pritchard CW, White RJ. What stops us from healing the healers: A survey of help-seeking behaviour, stigmatisation and depression within the medical profession. Int J Soc Psychiatry 2009.
[29] White A, Shiralkar P, Hassan T, Galbraith N, Callaghan R. Barriers to mental healthcare for psychiatrists. Psychiatr Bull 2006; 30(10):382-384.
[30] Hassan TM, Ahmed SO, White AC, Galbraith N. A postal survey of doctors' attitudes to becoming mentally ill. Clin Med 2009; 9(4):327-332.
[31] Schwenk TL, Gorenflo DW, Leja LM. A survey on the impact of being depressed on the professional status and mental health care of physicians. J Clin Psychiatry 2008; 69(4):617-620.