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

Submission received from: Management Committee, Doctors' Health Advisory Service Queensland

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

Doctors get ill. Some doctors are predisposed to greater difficulty by pre-existing and associated problems, medical, personal and social. Illness can impair doctors. Healthy doctors are more likely to have a style of practise, and to provide a more convincing model for patients to develop good health and well being.

Doctors who are ill may not think, and behave, appropriately. One manifestation of inappropriate behaviour is not seeking professional help when indicated. This occurs for many reasons, including the several conflicts of interest that must be managed when a doctor is required to become a patient. Such difficulties can be accentuated by the responses of those they encounter, socially and professionally, when they become unwell. Unfortunately this too often includes the treating doctor eg 'doctors do not get sick', 'corridor consultations', 'You can write your own prescription for post – op analgesia. You are a doctor.'

At a time when a doctor is ill and not thinking well (high level reasoning is affected as a nonspecific effect of illness, and of its treatment), it is often the case that a person close to and familiar with the doctor will notice the change, with concern. Those in contact with the sick doctor (colleagues, friends, family) are not "trained" in the management of the sick doctor. How to handle people, especially colleagues, with an impairment does not come automatically. It may come with experience but the actual outcome is not assured. A desirable knowledge base and set of skills is more likely if developed with experienced colleagues, such as those within a DHAS. There is available an abundance of anecdotal information, research based-knowledge, recommendations, and warnings, but the learning, which requires the incentives of need and purpose, often does not eventuate before the attending practitioner is confronted with the circumstances for the first time.

Highly intelligent, well qualified, experienced and well regarded practitioners often do amazingly poorly when required to respond to the discovery of a sick doctor who is not their patient.

It is notable that the Doctors' Health Services have developed independently in many jurisdictions in response to this need. These developments were not the result of a direction from professional organizations, universities, government or regulatory authorities, but as responses to a need perceived and acted on by a few individuals.

A notable feature of each of these services is that they have each developed separately and by the volunteer effort of interested practitioners, who in providing advisory services have developed their knowledge and skills by their own experiences. Costs (minimal because of the volunteer nature of the organizations) were funded by donations. Services were provided at no cost to those who sought assistance.

High professional standards, confidentiality, anonymity and independence are fundamental values in these services.

Doctors' Health Services provide for a need that is not adequately met by other established medical services. They provide the knowledge and skills to recognise a doctor in difficulty, and how to refer that person to the appropriate treatment. The Medical Board is not in a position to offer such early intervention, as these situations are only brought to the attention of the Board late in their evolution.

The experience over time of those involved with Doctors' Health Services has encouraged the development of services beyond the initial 'Point of first contact' and emergency intervention service, towards preventing such situations arising, by education, research, and more sophistication organized efforts including seminars, conferences etc.

Before these services were established, and in far too many instances at the current time, doctors having difficulties do not make use of "mainstream" medical services, and continue to practice with inappropriate risk to the community, and to themselves. In part this is the result of a "culture" that exists within the medical profession which quite correctly emphasizes the priority of patient care, but which unfortunately does little to encourage a balanced approach, emphasizing the responsibility of practitioners to develop and maintain their own well-being.

disorders, as well is untreated major medical disorders.

Precedents of these problems can be seen in the development of unhealthy lifestyles such as the failure to take meal breaks, constipation, excessive work hours, poor nutrition and a lack of balance of general life activities. These were highlighted in a presentation by Doctor Jane le Maire, of the Ward of the 21st century, of Calgary Hospital, Canada at the

recent International Doctors Health Conference in Auckland, New Zealand 2011. She described research which involved studying the effects of feeding junior doctors healthy balanced meals at lunchtime! She described several notable outcomes, most significantly improved health and well-being of the patients that doctors were treating, supporting the notion that "healthy doctors make healthy patients."

The medical profession, and the services they provide for general health care, have not been sufficient to adequately deal with the problems presented by our colleague who are having difficulties.

The experience of well-established models of service in other jurisdictions (Canada, USA) demonstrates a substantial benefit of better developed services. A hallmark of the success of these services is a markedly improved rate of self reporting of practitioners with difficulties to the services to make use of the assistance offered. The services offer far more sophisticated rehabilitation programs, educational programs, research, and general support, including arranging funding for practitioners to make use of the services. Practitioners become involved as they accept that they are much more likely to be able to stay in practice by regaining their health and well-being, and overall be in a better financial situation, than if they continued untreated.

A major advantage of a service established on more professional lines would be to develop professionals with a greater level of expertise, the means to pass on accumulated knowledge and developed skills, closer, expert supervision of services provided, continuing education, and research pertaining to the causes, effects, extensive need, outcomes and development of initiatives. The Doctors' Health Services in Australia and New Zealand have provided training for the practitioners who receive calls from distressed doctors and their associates, as well as for those who are providing treatment and support.

It has been particularly impressive to note the extent to which the knowledge and skills required to provide this service rely upon developed experience. An important feature of the Doctors' Health Services is that it provides a readily identifiable source of reference, a second opinion, expertise and support for practitioners who wish to continue to provide services to colleagues. Education is also provided to undergraduates, but this is limited because the resources, and by the increase in the number of medical schools. Currently an annual lecture is provided to the medical students of one university of the four in Queensland

The former Medical Board of Queensland had at times provided a sophisticated service which facilitated the re-employment of practitioners, successfully. It is understood that the lack of resources of the Medical Board led to the discontinuation of this service

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?

The Victorian Doctors Health Program was modelled on the successful experience of the international services. While it has not been able to provide the same extent of services, it has been able to provide much more and better quality services than those available in other jurisdictions which have not been funded in the same manner.

It is notable that the Victorian Doctors Health Program operated after the development of a Memorandum of Understanding with the Victorian Medical Board (after having provided sufficient grounds for the Medical Board to trust the organization), that recognized the responsibility to protect the public from the risks of impaired doctors continuing in practice.

DHAS Q prefers the VDHP model.

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?

It is important that the funding of the doctors, health services be reliable and secure.

Any source of funding will have with it a conflict of interest which needs to be recognized and managed appropriately.

It is important for a Doctors' Health Services to be able to continue its operations at "arms length" from any regulatory authority such as the Medical Board, as the perception of confidentiality and anonymity is fundamental to providing confidence for practitioners, and those associated with them, when considering the very difficult decision to make the first contact. It is recognized that financial accountability must be satisfied by providing appropriate details of the use of funds. It is essential to its viability that any Doctors' Health Services continues to preserve the anonymity of those contacting its service.

There has been demonstrated, in several jurisdictions, that very satisfactory working arrangements can be made between the Doctors' Health Services and the regulatory authority.

It is also the case that there are significant cost savings for a regulatory authority such as the Medical Board by having fewer impaired registrants reported for the very complex and expensive assessments which subsequently need to be undertaken by having the less severe and urgent circumstances being safely and effectively managed in a clinical setting, with their care overseen by a "case management" role of an independent Doctors' Health Services.

There would be a substantial amount of work to be done to provide mutual reassurance between the Medical Board and the Doctors' Health Services, for the appropriate procedures to be developed, agreed and maintained in the continuing operations. This is feasible and has been done successfully before.

Members of the profession and their professional organizations have been very sensitive to increased registration fees. However it is also notable that members of the profession and their professional organizations have been very supportive of the notion and the services provided by Doctors' Health Services.

If the funds to be allocated to the Doctors' Health Services – a levy – were clearly identified as being for this purpose, and not included as an increase of general registration fees, there is likely to be significant support amongst the profession. Anecdotally, my own experience has been surprising and very agreeable support for such a fee, often spontaneously attracting a comment to the effect "That is not much at all."

It is recognized that for the Medical Board to collect these fees and to pass these on would be an imposition on the Medical Board. However, it is considered that the advantages to the Medical Board, to the profession and to the community at large would justify this. It would however be necessary that the full amount of the levy be passed on to the Doctors' Health Services without a proportion being withdrawn, for example for administrative costs

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)

> *All the services described (except those limited to office hours) are worthy of inclusion as responsibilities of the Doctors' Health Services.*
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> *In addition to the ones you have selected, what other services (if any) should be provided by doctors' health programs?*
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> *While it is not envisage that Doctors' Health Services would provide treatment, but have an emphasis on being the point of first contact, emergency intervention, case management and education, encouragement of clinically appropriate services and managements would be an important role. Practitioners would continue to be referred to existing services for specific treatment. It has been the pattern that those doctors who have volunteered for the DHAS On Call have also been those who have developed the extra skills that are an advantage when treating colleagues.*

The DHAS services have already accepted that they have a responsibility to provide services to medical students. The DHAS Q has also made available services for pharmacists and dentists.

Future considerations would include providing information and skills to other related organiations, working closely with Medical Defence Organizations, health administrations, universities, insurance and legal services.

In future it is reasonable to consider services to other Health Practitioners. The model developed by the Doctors' Health Services would also be applicable in other professions.

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?

DHAS (Q) has a very few firm view that the services should be funded by the profession, accepting that the Medical Board of Australia, via its role in administering registration and the associated fees, would be the most appropriate agency to assist with this.

The Medical Board should provide the funding which would allow the establishment of professionally organized External Doctors' Health Services. Other interested stakeholders should be approached to assist with funding these external services

Matters relating to the relationship of the external body to the Medical Board of Australia, as well as oversight and supervision will need to be decided.