Doctors' health: can we do better under national registration?

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ABSTRACT

- The move to national registration of doctors presents both threats and opportunities for the manner in which doctors seek health care and for providing assistance to doctors who may be impaired by illness.
- The most striking threat is the regressive nature of the provisions for mandatory reporting of ill doctors.
- The new system should be grasped as an opportunity to achieve national agreement on resourcing adequate services to help distressed doctors and to foster education and research into the health of doctors and medical students.
- The new system also provides opportunities to explore ways of encouraging doctors to improve their poor record of not attending to their own health, such as denying Medicare rebates for most doctors who self-refer.

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Doctors have a poor record of attending to their own health. Treatable conditions such as hypertension go unrecognised, health screening is avoided, most doctors do not have a general practitioner, and many doctors self-refer for investigations or to specialists and self-prescribe medications.[1-4] Doctors' families are often exposed to similar approaches. It has been repeatedly estimated that between 10% and 15% of doctors at some point in their careers become ill in ways that lead to impairment, usually via mental illness, drug misuse and dependence, or physical illness affecting performance.[2] When this happens, many doctors are reluctant to seek help and, as a consequence, medical boards see such doctors quite late in the course of illness.

The Australian Medical Council code of conduct for Australian doctors,[5] recently endorsed by the Medical Board of Australia (MBA), expects all doctors to have their own GP. But will doctors follow the new code? If not, why? These questions have been the subject of little research, but evidence and anecdotes suggest a number of barriers, including practicality of access, personal ego, lack of confidence in other doctors, and concerns about embarrassment and maintenance of confidentiality.[2,3,6] These barriers may be reinforced by anticipation or experience of consulting a GP who seems ill equipped to cope with another doctor as a patient.[7] So long as it remains acceptable for doctors to self-refer, many will continue to do so, arguing that this enables them to rapidly access the best care. Many doctors are unwilling to recognise the disadvantages of not having a GP, including lack of central coordination and record keeping, absence of objectivity, and failure to consider and address psychosocial, family, work and lifestyle issues.[6]

Recognition of doctors' lack of early access to high-quality care and late referrals to medical boards were key factors behind the development, commencing over 40 years ago, of state- and province-based doctors' health services in the United States[8] and Canada[9] that are independent of medical boards. In the US, the American Medical Association promoted this approach and continues to provide support and leadership for these services.[10] The services generally provide early intervention, triage to appropriate care and, where appropriate, monitoring, rehabilitation and support to re-enter the workforce. With the exception of Victoria, this model has not been adopted in Australia. Instead, other jurisdictions rely on the very generous voluntary work of doctors' health advisory services which, through lack of resources, focus primarily on doctor-to-doctor advice by telephone. In Victoria, the primary factor which led the Victorian branch of the Australian Medical Association and the Medical Practitioners Board of Victoria (MPBV) to jointly establish the Victorian Doctors' Health Program (VDHP) in 2000 was the recognition by the MPBV that, despite significant changes to legislation in 1991 and 1994 designed to encourage possibly impaired doctors to come forward, nothing had changed. Impaired doctors were still referred late in their illness. In addition, the MPBV had no powers to guide impaired doctors to the best available help, and programs for rehabilitation and re-entry to the workforce did not exist. The VDHP has been described in detail elsewhere[11,12] but its key features include an independent honorary board of directors, funding from annual fees for renewal of registration, salaried expert medical staff who undertake assessment and provide triage to appropriate care (but do not become involved in treatment), after-hours access, confidentiality, accessibility for doctors and medical students, support for rehabilitation and re-entry, and roles in education and research. VDHP participants are expected and assisted to find a GP.

The move to a single national system of medical registration should be grasped as an opportunity to do better in this area, but this is by no means assured. Instead, the necessary and appropriate focus of the MBA on protecting the public makes it possible that we will go backward unless those concerned about the health of their colleagues are prepared to look at the issues squarely. Why should one predict a negative outcome? The greatest concern lies with the highly regressive provisions in regard to mandatory notification of possibly impaired doctors under sections 140 and 141 of the *Health Practitioner Regulation National Law Act 2009* (Qld). The new legislation bundles mandatory notification of health matters with notification of alleged misconduct. Previous state legislation (eg, the *Medical Practice Act 1994* [Vic] and its successor, the *Health Professions Registration Act 2005* [Vic]) placed the reporting onus on treating doctors and required reporting only where an impaired doctor continued to practise against advice. The national legislation places the reporting onus on all health practitioners and is worded in the past tense so that no exception can be made for an impaired doctor who seeks help and voluntarily ceases to practise while receiving care. These new provisions are likely to deter doctors from seeking help and, if strictly interpreted, could lead to closure of the VDHP and threaten the confidential telephone services provided in other jurisdictions. The guidelines for mandatory notification recently issued by the MBA provide little reassurance in regard to health notifications.[13] This is not surprising given the regressive nature of the legislation. On a more positive note, the Western Australian legislature has recently passed a local amendment that exempts treating doctors from the mandatory reporting provisions of the legislation.[14]

In addition to the likely negative impact of the Health Practitioner Regulation National Law Act, what other barriers are there to the wider introduction of the types of health programs that are in place in North America and Victoria? In summary, barriers include issues of cost, accountability and parochialism. In regard to cost, it is estimated that the VDHP costs each doctor in Victoria about 55 cents per week, a very small investment considering that the program prevents the loss of medical students and doctors from the profession. Those 55 cents also help provide education about doctors' health to medical students and the profession and help foster research. This cost represents 0.03% of the new annual renewal of registration fee. In regard to accountability, undoubtedly there are potential tensions between the need for the confidentiality of VDHP-type programs and the medical board's focus on protecting the community. However, balancing individual needs with the rights of the community to be protected is a theme common to all legislation that regulates professional conduct. It needs to be acknowledged and handled appropriately. Most physician health programs in the US have formal contractual or legislated agreements with the relevant state medical board to deal with these issues.[8] In Victoria, a memorandum of understanding between the MPBV and the VDHP made it clear that clients of the VDHP must be reported to the MPBV if they do not follow advice and treatment and are deemed to be placing the community at risk.

In regard to parochialism, there has been a healthy sense of competition between the states and territories in Australia in many fields, including medical regulation, sometimes fostering improvement and sometimes causing resistance to change. The various doctors' health advisory services in Australia (and New Zealand) now come together regularly to discuss issues in common under the banner of the Australasian Doctors' Health Network. These discussions should focus on what will be best for the medical profession (including medical students) in the future and should examine a range of models. Given the differences of size and population of the Australian states, it may be appropriate to fund more than one model. As reaching consensus is likely to be difficult, a strong case can be mounted for a national workshop to be convened for this purpose, hopefully supported by the federal Department of Health, the Australian Health Practitioner Regulatory Agency, the MBA, the Australian Medical Association, and the medical schools and medical professional colleges. Inviting speakers from existing services in Canada and the US to participate would enhance the discussion. Ideally, such a workshop should include delegates from all the registered health professions, as there is also a need for a national debate as to whether these services should be doctor specific or accessible by all health professionals and students.

What about the future? The VDHP experience of seeing increasing numbers of younger doctors in distress suggests that education and awareness of the service is leading to earlier intervention and preventing more serious problems[12] — an encouraging trend. It is also very encouraging that Victoria's medical schools see the value of referring distressed students to an independent program.[12] Apart from encouraging and adequately funding doctors' health services so that early intervention, education and prevention become a strong focus nationally, can anything else be done to change doctors' attitudes to their own health? To foster the practice of all doctors having their own GP, one simple measure that could be examined would be to deny Medicare rebates for doctors who self-refer for investigations or to specialists, with exemption for doctors who are geographically isolated. This would not prohibit self-referral but would provide a financial incentive for doctors to comply with the Australian code of conduct.[5]

Competing interests

I was deeply involved in the work that led to the establishment of the VDHP from 1998 to 2000 and chaired the Board of Directors of the VDHP from late 2005 until late 2009.

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