TOWARDS BETTER HEALTHCARE FOR DOCTORS

OPTIONS AND STRATEGIES TO IMPROVE POLICY DEVELOPMENT FOR DOCTORS' HEALTHCARE

AMA (Federal) and AMA Queensland

November 2001

Project Officer

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SUMMARY OF RECOMMENDATIONS

1. A consultative process regarding doctors' health issues should be initiated to collate and share information, review research, and establish priorities in order to advise the profession and Government.

   Such a consultative process must involve key people and organisations active in the field of doctors' health matters such as:
   - Doctors' Health Advisory Services
   - Medical Practitioner Boards
   - CPMC and Colleges
   - CPMEC
   - Council for Safety and Quality in Medicine
   - Australian Divisions of General Practice
   - Other existing doctors' health working groups.

   There will be a need to explore with these stakeholders their attitudes towards participation in such a body, should it be formed.

2. The concept of a Strategic Planning Group for Doctors' Health (SPGDH), as recommended by stakeholders attending the *2nd National Doctors' Health Conference* in Brisbane in November 2001, needs to be further explored.

3. The Federal AMA should consider hosting an interim secretariat to facilitate a Strategic Planning Group for Doctors' Health.

4. The interim SPGDH secretariat should explore ongoing funding options with key stakeholders.

5. The interim SPGDH secretariat should explore inclusion and funding options with other potential alliance partners such as dentists, veterinarians and pharmacists.

6. The interim SPGDH should convene a conference every two years, with working groups operating outside this time.

7. The AMA should convene an advisory Committee on Doctors' Health to advise the Public Health Committee and have input into the SPGDH.

RESPONDENTS

Discussions have taken place with, or information has been received from, the following people, to whom my sincere thanks are expressed.

Dr Bob Adler	Medical Practitioners Board of Victoria
Ms Christine Brill	Executive Director – AMA ACT
Dr Michel Claxton	AMA Federal Councillor
Dr Ray Cook	AMA Federal Councillor
Prof Geoff Dahlenberg	Chair – Confederation of Postgraduate Medical Education Councils (CPMEC)
Dr Garry Galambos	
Ms Grace Groom	National Primary Mental Health Co-ordinator – Australian Divisions of General Practice (ADGP)
Dr Phil Harrington	AMAQ Doctors' Health working group
Dr Bronwyn Hartwig	AMAQ Doctors' Health working group
Dr Craig Hassed	Senior Lecturer – Monash University Department of General Practice
Ms Jackie Holt	PHD candidate, and doctors stress management provider
Dr Jo Katsoris,	Registration Co-ordinator – Medical Practitioners Board of Victoria
Dr Di Khursandi,	Chairperson - Welfare of Anaesthetists Group
Dr John Mathew	Doctors Health Advisory Service - Victoria
Dr Frank New	AMAQ Doctors' Health working group
NSW Doctors' Mental Health Implementation Committee	
Mr Craig Patterson,	Executive Director – RANZCP
Dr Jonathan Phillips	Chairperson - Committee of Presidents of Medical Colleges (CPMC)
Dr Bill Pring	AMA Federal Councillor
Dr Don Reid	Doctors Health Advisory Service – Western Australia
Dr Val Summers	AMAQ Doctors' Health working group
Dr Philip Thomson	Doctors Health Advisory Service – Tasmania
Dr Jillann Farmer	Medical Investigator/Assessor
Dr Jack Warhaft	Victorian Doctors Health Program
Prof Doris Young	Professor – University of Melbourne Department of General Practice

BACKGROUND

At the 1998 AMA National Conference a Policy Discussion Group was convened to address the issue of the Health of Medical Practitioners. This resulted in the AMA's Ethics and Public Health Committee developing a Position Statement on this issue. It also led to the Doctors' Health Working Party subcommittee of AMAQ organising the 1st National Conference on Doctors' Health, which was held in 1999. This was followed, by a 2nd conference in November 2001. A central outcome of both these conferences was the perceived need for a national facilitating body to address the health needs of medical practitioners.

Both conferences have highlighted the vast amount of work that has been done in different parts of the country, however those interested in the field have not necessarily been aware of what others are doing, with the attendant risk of duplication of effort.

There are a large number of practitioners and organisations interested in doctors' health issues, and a large amount of material is available as individual papers, some planning material and materials in draft form. However, it is fragmented and dispersed in a variety of locations.

The difficulties encountered in compiling this report are testament to

- the fragmented nature of efforts in the field of doctors' health,
- the part-time and often voluntary nature of work of those involved,
- the lack of any central source of information

PROJECT DESCRIPTION

This project has been essentially a scoping exercise. The focus necessarily changed during this brief project to focus on process issues and policy options, rather than a complete compilation of a list of doctors' health services, which has been partially done and will be completed later.

The approach taken in this project has been to:

⇒ consult with key stakeholders in the field

⇒ focus on key process issues in regards to consultation and policy formulation

⇒ generate some policy options for consideration, and

⇒ begin collation of a database of services and individuals active in the field.

Within the available time limits it has not been possible to create a comprehensive database, or a full academic review into the extent of Doctors' health problems. However the report of The GP Wellbeing Project (available from the Department of Health and Ageing) contains a significant literature review of the area, as well as an extensive bibliography of reference material.

NATURE AND EXTENT OF THE PROBLEM

The AMA website includes a recent policy statement, which begins:

> *Medical practitioners have an above average health status that is similar to others in advantaged socio-economic groups. Some issues of concern, however, include higher than average rates of suicide, stress-related problems and substance abuse. The health of some sub-groups of medical practitioners may also be more at risk because of their professional circumstances. These include rural practitioners working in areas with scarce resources, some groups in training in hospitals with excessive work hours, female practitioners trying to balance competing professional and other obligations, practitioners from a non-English speaking background and Indigenous practitioners."*

There is widespread concern about factors contributing to doctors' poor health such as inadequate stress management, alcohol and substance abuse, as well as other manifestations of both mental and physical of ill health.

Respondents from AMA, GP groups, DHAS, Committee of Presidents of Medical Colleges (CPMC), and medical Boards all expressed concern about doctors' health issues and about the fragmentation of current approaches to this matter.

The GP Well-Being Project has recently been undertaken through a consortium based in the Departments of General Practice at Melbourne and Monash Universities. The terms of reference set out by the Commonwealth Department of Health and Ageing required the consultant of this report to:

⇒ Provide a clear statement of the problems affecting GP health and well-being.
⇒ Identify which segments of the general practice profession are most adversely affected by the problems.
⇒ Identify specific factors affecting the well-being of various segments of the profession, and;
⇒ Provide recommendations for action research for prevention and intervention strategies.

The study defines well-being as "the presence of physical, mental, spiritual, and social health" and considers 'Impairment' as "being ill". The main forms of doctor impairment are psychiatric illnesses and substance abuse.

The well-being of GPs is a major concern for the individual doctor, the profession, funders and consumers alike. Reduced well-being may lead to health problems for GPs, difficulties in coping at work and a reduction in quality of care to patients.

The *GP Well-Being Project* notes that "while doctors are physically healthier than the general population, intrinsic personality characteristics in an individual doctor can increase their susceptibility to burn out and impairment. Also their various coping styles in the face of stressors, and ability to change, may be determinants of well–being or ill health. In addition, there appears to be common characteristics across the medical profession that make doctors less than ideal patients. These include high rates of self-prescribing and self self-diagnosis; late presentations to other doctors; wide spread use of informal consultations; and denial and working through illness. In addition a number of doctors

experience difficulties in providing care to other doctors, which has implications for the quality and continuity of care received."

There are two key problems that need to be highlighted in relation to Doctors health:

A. Process issues relating to concerns about how doctors' health issues are considered and progressed in Australia.

B. Issues regarding priority areas of concern about doctors' health, as well as what interventions can be recommended to organisations, governments and doctors themselves to address these issues.

Problem A - Process Issues

It is evident that there is limited opportunity at present for interested stakeholders to conduct an overview, analyse research, or review the most effective means of improving Doctors' Health. The AMA has held two worthwhile conferences however these have not included a think-tank format, nor had action components or much follow through capacity.

Successful incremental improvements in doctors' health are not just a matter of new education programs. It will involve the establishment of a comprehensive process enabling careful consideration of the nature of doctors' health problems, their priority, review of research and coordinated implementation.

Change requires hard work, and will involve focussed interventions that have been carefully thought through by the key stakeholders in the field. These people should ideally be involved in a think-tank process to produce effective policy.

Implementation of recommendations will involve a co-ordinated process involving negotiation and lobbying. Invariably this will require national cohesion to be successful.

Problem B – Identification of priorities

It is difficult to state what are the key elements and priorities of concern about doctors' health. Equally it is difficult to recommended strategies that could be implemented to address these concerns. This is in part because there is no easily accessible summary of the literature. The author's attempts at various database searches have resulted in either a vast collection of poorly related articles, or nothing - depending on the search wording. There is a need for a searchable topic of 'doctors' health ' in medical library databases.

As a consequence it is impossible to extrapolate any recommendations about effective interventions at this stage, as there is much material to be reviewed, sifted through and organised before an intervention can be recommended.

KEY ISSUES

Problem A - Process Issues

There is at present no system in place to foster development of an integrated approach to Doctors' health issues in Australia. However a huge number of disparate groups have worked thoughtfully on various aspects of Doctors' health. They include:

- *AMAQ* has developed a multi-representative Working Party;
- The *Welfare of Anaesthetists Special Interest Group* has developed a comprehensive series of documents on issues, problems and solutions.
- The *New South Wales Doctors Mental Health Program* has also developed detailed policies and strategies for area health services, medical schools, College and Divisions of General Practice.
- The *GP Wellbeing Project* has recently been completed.
- The *Doctors Health Advisory Services* have laboured away locally in each state with variable levels of funding, and variable numbers of volunteers staffing their rotating panels (in one case a panel of 2).
- The *Victorian Doctors' Health Program* has recently commenced its service. As the only body of its type in Australia, it will be able to provide useful information about processes and policies in due course, particularly about rehabilitation.
- The *RANZCP Victorian Branch* has formed a Colleague Support Panel, as has the *RACS*.
- GP stress management programs operating as *You and Your Practice* (Developed by Jackie Holt) that are run by the *Australian Divisions of General Practice* around the country.
- *Committee of Presidents of Medical Colleges (CPMC)* and *the Chairs of Postgraduate Medical Education Committees (CPMEC)* have discussed the issue and are looking for co-ordinated approaches that address their concerns.

There is a need to identify both key stakeholders and the current activities in the doctors' health field. At present there is no comprehensive collection of information about who or what is currently being done in this area. The listings obtained from various sources for this report were notable for their inaccuracy in many cases, providing testament to the need for a good database to be centrally kept. Unfortunately there are limited systems in place to facilitate the development and review of best practice guidelines for the management of doctors health.

RECOMMENDATION 1:

- A consultative process regarding doctors' health issues should be initiated to collate and share information, review research, and establish priorities in order to advise the profession and Government.

- Such a consultative process must involve key people and organisations active in the field of doctors' health matters such as:
  - Doctors' Health Advisory Services
  - Medical Practitioner Boards
  - CPMC and Colleges
  - CPMEC
  - Council for Safety and Quality in Medicine
  - Australian Divisions of General Practice
  - Other existing doctors' health working groups.
- There will be a need to explore with these stakeholders their attitudes towards participation in such a body, should it be formed.

Problem B – Identification of priorities

Current AMA policy includes a statement of key issues:

> *Key issues include the importance of:*
> - *medical practitioners and their families having their own general practitioner and managing their own health within the usual professional context of a doctor/patient relationship; and*
> - *medical students having access to confidential medical and other health services so that they are confident that seeking help will not damage their career progression.*
>
> *Medical Practitioners are encouraged to:*
> *(a) take responsibility for their own physical and psychological health;*
> *(b) establish a continuing relationship with their own general practitioner;*
> *(c) recognise there are dangers to others associated with a reluctance to admit illness or failing competence;*
> *(d) recognise that there are personal dangers associated with continued self-medication and prescribing;*
> *(e) seek early expert attention for any work-related stress;*
> *(f) incorporate regular leave, good nutrition, exercise, leisure and family time into a regular healthy lifestyle wherever possible; and*
> *(g) be especially sensitive to the problems involved in the transition from colleague to patient, when assuming the role of the treating medical practitioner to colleagues, and provide treatment in keeping with the accepted rules of the doctor-patient relationship with particular reference to confidentiality.*

Priorities mentioned by other respondents are as follows (in no particular order):

- *The empowerment of doctors.*

  Doctors live and work in a culture where there is a pervasive expectation from colleagues, teachers, and patients that they be constantly 'on duty'. Doctors-in-training have been enculturated that their medical work should take priority over self and family. Individuals expressed concern about the belief of some doctors that they are 'weak' if they have time off, and the guilt that is often felt if they do. Most doctors work in an atmosphere of constant pressure to perform at a very high level.

- *The need for culture change towards encouraging appropriate self-care among medical practitioners and students.*

  There is a need to normalise help-seeking behaviour by medical students and practitioners. The use of simple strategies by pressured doctors can empower and encourage them to further look after themselves. Several respondents spoke of frustration in working in this area, and of the denial by many medical practitioners of their own health and family issues. Such denial can be addressed via repeated awareness and education programs. The course initiated by Jackie Holt – You and Your Practice (YYP) works along these lines by encouraging simple modifications of practice style to allow elements of self-care. Similarly, those run by Craig Hassed and others for the Divisions, RACGP etc were mentioned.

- *Early Prevention via education of medical students and young graduates to promote culture change for future practitioners.*

  A change of emphasis in the doctors' health field from impairment, to preventive interventions, was commented upon. Many respondents identified the need for education of students and young doctors in the health risks of medical practice, and the need for self-care in the interests of healthy survival. In Victoria and NSW, medical students are now registered (at no cost) to enable the Board to deal with health issues. This could provide an avenue to input into beliefs about stress management and self-care.

- *DHAS co-ordination and funding.*

  It was not possible to speak to all DHAS coordinators and presidents. Those I did speak with indicated that funding of DHAS is an important issue, which needs to be addressed, since some (most?) operate on a shoestring budget. Some indicated that getting enough volunteer panel members is a problem due to the 'on call' nature of the service. The complementary roles of DHAS and other doctors' health programs seemed to be an issue for further discussion. It was mentioned that the DHAS might move to a central contact number, although there are mixed views about this. Some, but not all, DHAS have a manual of procedures and referral contacts - There is probably scope for sharing of manuals (excluding local contacts) between DHAS in each state.

- *The role of Divisions, which now have an increasing profile (and funding) for doctors' health initiatives.*

  Some Divisions are now running stress management courses, and may have better access to funding than other bodies. Their future role and the possible use of standard modules need exploration.

- *The need for involvement of key overarching bodies*

  In Australia there is a need for a key overarching body to co-ordinate the development of an effective series of initiatives. Such bodies should include the Committee of Presidents of Medical Colleges (CPMC) and the Colleges, Medical Boards, Council of Postgraduate Medical Education Committees (CPMEC), AMA, and Council for Safety and Quality in Medicine.

- *Greater Recognition of systemic stressors.*

  Medical practitioners need to recognise systemic issues that generate work stress, and be able to review their practice structures, routines, appointment processes and billing practices.

- *Attention to the needs of older practitioners.*

  Attention needs to be paid to the needs of older practitioners who may be vulnerable on the verge of retirement to 'burn-out' and significant health issues. Several respondents mentioned the need for middle-aged practitioners to receive retirement planning assistance. There is often a need for career counselling for older practitioners, who may still have something important to contribute but can no longer practice clinical medicine.

- *Development of research database.*

  There is a general lack of evidence about what works. A key issue for an ongoing working group is the development of a database containing relevant research findings.

- *Improved clinical support of GP's.*

  Several GP representatives spoke of the need for peer support groups especially for those doing a lot of primary care psychiatry. This could take the form of general peer review groups, specific cognitive behavioural therapy, or psychiatry review groups with a general psychiatrist. Better peer support would provide better patient care by reducing GP's stress.

Key elements of interventions promoting doctors' health.

Awareness, early detection, treatment and rehabilitation are useful ways of segmenting an approach to doctors' health issues generally. The fields of prevention, facilitation of access to treatment, and monitoring can also be added, although monitoring is relevant mainly to drug abuse.

Awareness and Prevention
Any series of interventions about doctors' health will have to incorporate awareness as a key element. It is clear that the denial by an individual doctor about his or her health problems is a key issue in help-seeking behaviour.

Several respondents emphasised the need to pay attention to the early formation of attitudes about the health needs of the doctor. This will involve input at medical student level with repeated emphasis at various stages of the professional life of a doctor. There is a need to consider carefully what preventive approaches can be taken, both for medical students and younger practitioners. Some GP Divisions and RACGP branches are running stress management programs. However research about their effectiveness is limited.

Early detection of impairment.
The Medical Boards in Australia do not have a uniform definition of "incompetence" and "impairment". Similarly the various Boards function under slightly different Medical Practice Acts and slightly different definitions in each State.

Facilitation of access to treatment.
In order for doctors to access treatment effectively when concerned about illness, the means of access will need to be well publicised and reliably effective. Issues of confidentiality are relevant to the prospective doctor-patient. It is likely that insufficient attention to matters of confidentiality will reduce the likelihood of distressed doctors seeking treatment. The NSW DHAS has funding from the NSW Board, and according to respondents is able to keep at 'arm's length' and provide confidentiality.

Rehabilitation and monitoring of impaired doctors.
The VDHP is the first such body in the country. It is modelled on North American programs, and focuses on rehabilitation and monitoring of impaired doctors. Such a body implicitly has two groups of doctor-patients: those with established impairment undergoing rehabilitation and those just seeking a referral such as from the local DHAS.

One population is that of doctors required to attend doctors' health service for rehabilitation because of recognised health problems or poor performance. The other is a group of doctors with no established impairment (at that point) contacting a service for help to access an appropriate treating doctor. Their needs and circumstances are obviously different. A new body, such as the VDHP will need to consider: its need for information from treating doctors to whom it may refer, whether the above two groups are handled differently, and how sensitive information may be held. Boundaries between services may need clarification.

Once a process of collaborative consideration of doctors' health issues is established, there is a need for:

- ongoing review of research as to the nature of the problems in the doctors' health field, and what interventions are effective ;
- establishment of priorities for intervention;
- generation of proposals for effective intervention and negotiation with relevent parties for implementation.

POLICY OBJECTIVES AND STRATEGIES

GOAL A.
ESTABLISHMENT OF PROCESS AND STRUCTURE FOR PLANNING, NETWORKING AND COMMUNICATION.

It is clear that some coordination and liaison is needed. It has been observed that trying to organise doctors is like trying to herd cats. In this, as in any project involving multiple doctors, there will be many opinions and different views.

Objective A1: Reach agreement between stakeholders about need for, and style of an overarching body.

⇒ *Strategy Option 1: Conduct a needs analysis.*

A formal needs analysis could be conducted by questionnaire to all interested parties This would be somewhat tedious and cause a delay before any action ensues. However, if some sort of consultation is not conducted, there is a risk of various bodies regarding the AMA as going off at a tangent and attempting to 'take over' the field.

⇒ *Strategy Option 2: Accept that there is a need for a body to undertake the roles of facilitation, consideration of research, and formulation of intervention proposals to be taken if the area of doctors' health is to progress.*

From informal consultation in the preparation of this report, there appears to be a variety of needs with which such a body could assist:

- ongoing review of research in the doctors' health field, including review of international research and programs, in order to establish 'what works';
- facilitation of information sharing and a think-tank function;
- National coordination of Doctors' Health Advisory Services;
- the development and costing of specific proposals, in order to recommend action;
- To provide for networking among those involved in the field eg via a bi-annual conference.

⇒ *Strategy Option 3: Propose formation immediately of a national facilitating body.*

A Guiding Model could be the concept and style of the Strategic Planning Group for Private Psychiatric Services (SPGPPS). The Strategic Planning Group acts as a think-tank group in calling together the key stakeholders in the field, in order to facilitate networking, consideration of the overview issues, and coordinated policy proposals. The SPGPPS is resourced by the AMA for secretarial support, as well as for part of a Project Officer who organises annual meetings.

Federal AMA could play a facilitating role to institute a national think-tank which could be a Strategic Planning Group for Doctors' Health (SPGDH). It should be understood that such a proposal would not involve the AMA 'taking over' anything, just

administrative co-ordination of services. Such a body could have a secretariat at AMA Federal office with support similar to the SPGPPS.

There are other ways of forming a national review group, but the AMAQ and Federal AMA clearly have the motivation to further the issues of doctors' health. Colleges and ADGP are obviously specific to their own groups. The Boards are state-based organisation, whereas the AMA and Colleges have a national focus. The AMA is the only overarching medical organisation for all medical groups. Some liaison with New Zealand groups of a similar nature may also be useful.

The role of a Strategic Planning Group for Doctors' Health (SPGDH) could include the following elements:

- Facilitation of an information sharing and clearing house process for initiatives
- Facilitation of a national think-tank function to foster incremental improvements in doctors' health initiatives;
- Organisation of an annual doctors' health conference: central organization of the conference would provide retention of some corporate memory which can easily be lost with rotating conference committees. Rotation of a conference between States and Territories would require interested individuals to be prepared to take on the responsibility, which has been a difficulty.
- Review co-ordination issues for existing doctors' health services.
- Ongoing review of research in the doctors' health field, including review of international research and programs, in order to establish best practice guidelines.
- Development and costing of specific proposals, in order to recommend action to Government, Colleges, Boards, practitioners, medical schools etc.
- Liaison and inclusion of interested groups and organisations in an ongoing consultative process. Such bodies should include the learned Colleges, Medical Practitioner Boards, ADGP, and representatives of medical schools and other student teaching bodies, such as Doctors-in-training.
- The body could have a role as being a lobbyist to government.
- Such a body could have a role in informing the AMA, Colleges and others, and acting as an educational force to the profession.
- The formation of an AMA Committee on Doctors' Health (subset of the Federal AMA Public Health Committee) could have input into the SPGDH group.
- SPGDH could seek alliances with other bodies (model approach from Pharmacy Boards and Pharmaceutical Society of Australia as in Tasmania). It may be that other similar health professionals, eg dentists and others, may join with medical practitioners in such enterprises for health professionals, and by such means both be more effective and widen the sources of funding.
- SPGDH could work largely via email with the establishment of several ongoing working groups, meeting annually at a conference. Each working group would need a coordinating chairperson used to working with email groups. A convenient separation of working groups could be:

  - *Awareness and prevention research review working group.*
    Activity Focus: To investigate what works.
    Membership: Medical educators, stress management providers, DITs.

- *Local state-by-state co-ordination working groups (partly exist via DHAS)*
  Activity Focus: To streamline local access and co-ordination
  Membership: DHAS, VDHP, AMA branches

- *Implementation recommendations working group*
  Activity Focus: To set priorities, to make recommendations regarding lobbying.
  Membership: AMA (Fed), CPMC and Colleges, CPMEC , Council on Safety and Quality in Medicine.

- *Rehabilitation and monitoring working group*
  Activity Focus: To refine process of rehabilitation
  Membership: VDHP, Boards rep.

The above groupings are just a draft proposal. They would need modification according to the interested personnel.

RECOMMENDATION 2:

- The concept of a Strategic Planning Group for Doctors' Health (SPGDH), as recommended by stakeholders attending the *2nd National Doctors' Health Conference* in Brisbane in November 2001, needs to be further explored.

Objective A2: Explore possible funding options for a strategic planning group for doctors' health.

⇒ *Strategy Option 1: Explore funding of a SPGDH with AMA Federal initially.*

The Federal AMA may be willing to contribute to the establishment of a Strategic Planning Group for Doctors' Health. The financial commitment in establishing a SPGDH secretariat would be approx. $20,000 (assuming no significant infrastructure costs):

0.2 secretarial support	approx. $ 6,000
0.2 project officer	approx. $13,000
Conference expenses	approx. $ 2,000
Total initially:	approx. $22,000

⇒ *Strategy Option 2: Explore funding with Boards, Council for Safety and Quality in Medicine, and other interested groups.*

The Medical Practitioners' Boards have a clear stake in promoting prevention of illness in doctors, and could be approached for some financial commitment, given that an improvement in doctors' health is of material benefit to them and could potentially reduce expenses incurred by those organisations. There are indications that the Council for Safety and Quality in Medicine could be approached in relation to funding of the SPG envisaged.

⇒ *Strategy Option 3. Explore inclusion and funding options with other potential alliance groups.*

If the SPGDH made alliances with other health professionals (eg: dentists, veterinarians, pharmacists) it may be that the initiative would both be more effective and have greater financial viability.

RECOMMENDATION 3:

- The Federal AMA should consider hosting an interim secretariat to facilitate a Strategic Planning Group for Doctors' Health.

RECOMMENDATION 4:

- The interim SPGDH secretariat should explore ongoing funding options with key stakeholders.

RECOMMENDATION 5:

- The interim SPGDH secretariat should explore inclusion and funding options with other potential alliance groups, such as dentists, veterinarians and pharmacists.

GOAL B.
POLICY OPTIONS TO FACILITATE AWARENESS, PREVENTION OF ILLNESS, HELP-SEEKING TREATMENT AND REHABILITATION

Breen and Court identified prevention, early detection, treatment and rehabilitation as useful ways of segmenting an approach to doctors' health issues. In a more general sense, awareness perhaps should precede all of these as it is necessary for consciousness raising. Similarly help seeking is identified as a key matter, with its subset of factors obstructing doctors getting help for health issues. The segments of rehabilitation and monitoring are particularly relevant to drug abuse problems.

Objective B1: Awareness and Prevention.

⇒ *Strategy Option 1: Written Policy Statements*

Some guiding models in this area are:

Canadian Medical Association Policy Statement: Physician Health and Wellbeing, 1998.
There is a need to benefit from international experience in relation to doctors' health initiatives, and a more detailed inquiry could be made, particularly of North American initiatives.

Doctors' Mental Health Working Group, Report and Recommendations, Centre for Mental Health, NSW Health Department, and NSW Branch AMA, 1997.
http://www.dmh.org.au
NSW doctors mental health program has formulated strategies for area health services, medical schools, branches of medical colleges, rural divisions of general practice. Adoption, with permission, of some or all of these strategies will save a lot of policy development resources and allow focus to move to implementation.

⇒ *Strategy Option 2: National questionnaires to raise awareness*

This questionnaire may be similar to a survey used in Finland - *Self-reported Health, Illness, and Self-care among Finnish Physicians.*

⇒ *Strategy Option 3: Stress Management programs*

There is a need to provide an opportunity for medical practitioners to reflect on their lifestyles and practice processes. The divisions are increasingly running such programs and may have some revenue to run these from federal CME funds. On the whole such groups are sporadic and poorly co-ordinated. Once a format which works well has been established (eg Jackie Holt's work, Greg Hassed's psychiatry courses) there is a great saving of effort in not duplicating such a program. These programs could be suitable models however further evaluation of these program is probably prudent.

⇒ *Strategy Option 4: Education in health risks and self-care for students and young practitioners.*

There is a need to focus on medical students and young doctors. Initiatives may include:

- stress management courses for students and younger doctors
- inclusion in the examinable curricula of psychiatry courses material about health risks for medical practitioners and self-care strategies.
- inclusion in the examinable curricula of all Colleges material about health risks for medical practitioners and self-care strategies.

⇒ *Strategy Option 5: Education in health risks and self-care for established practitioners.*

A review of self-care issues could be part of College Maintenance of Practice Standards (MOPS) programs, especially Practice Visits. Also of merit is inclusion in College MOPS programs an element to do with monitoring of practitioners' self-care

⇒ *Strategy Option 6: Mentorship.*

This was mentioned by one DHAS president however there does not appear to be any guiding models in the medical field.

⇒ *Strategy Option 7: GP peer support and review groups.*

Review groups, while focussing on clinical management, are experienced by GP's as highly supportive and of personal value.

Objective B2: Early Detection of illness.

⇒ *Strategy: Regular Health review*

The 'Docs for docs' program (run in both QLD and SA) are ideal models of programs to encourage doctors to have their own GP. The SPGDH could faciliate the expansion of these programs nationally.

Objective B3: Facilitation of access to treatment and encouragement of help seeking for episodes of illness.

⇒ *Strategy 1. Simplify access to help*

The BMA has a central number for the country http://www.helpdoctor.co.uk/sick_doctors.htm and the Canadian Medical Association uses provincial numbers http://www.cma.ca/inside/policybase/2000/health-brochure.htm. It is worth debating the merits of a national contact numbers for the Doctors Health Advisory Service. An argument for this approach include ease of advertising of the number across all medical groups nationally, whilst arguments against it include the fact that calls still have to go to each State to a co-ordinator and that local knowledge is imperative to successful referrals.

⇒ *Strategy 2. Advertise regularly to raise awareness.*

This may involve circulation of business cards regularly to students and medical practices, as the ACT DHAS and AMA currently do.

⇒ *Strategy 3: Support the existing DHAS to get adequate funding, support and panel members.*

Existing DHAS funding arrangements are different across the country with some receiving money from the local Board, and some from the local AMA Branch. An SPGDH when formed can probably lobby more effectively for a more systematic and equitable funding arrangement for the DHAS's.

⇒ *Strategy 4. Combine DHAS with support services for other health professionals groups eg dentists, veterinarians and pharmacists.*

In Tasmania, the DHAS has been approached by the local branches of the Pharmaceutical Society of Australia and the Pharmacy Board to join forces. This seems both a useful efficiency of resources, and also a way of potentially increasing the funding pool. In the ACT, the AMA and DHAS have recently extended their service to cover veterinary surgeons.

⇒ *Strategy 5: Provide College-based Colleague Support Panels*

The impression is that it is a useful low level measure but needs further investigation before recommendations be made to each College about the merits of this approach.

Objective B4: Rehabilitation and monitoring of impaired doctors.

The VDHP is the only organisation of its type in Australia and after further evaluation may prove to be a useful model for other states. Canada has a model of coordinated rehabilitation in which the central body communicates with treating doctors, and gets reports from them. North American data suggests that high levels of successful rehabilitation can be achieved. The Welfare of Anaesthetists SIG has done a great deal of work on various protocols - eg protocol for substance abuse intervention. Such protocols could be adapted with permission and applied to other groups of practitioners.

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- Chairman, Victorian Branch, RANZCP 1999-2001
- Federal Councillor, RANZCP 1995-2001
- Chair, Victorian Branch RANZCP GP Liaison S/C
- Member Victorian DHS Advisory committee Primary Care Mental Health
- Member Medical Profession Advisory Group to Medical Practitioners' Board of Victoria

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- Member AMAVic Council 1999-2001, representing Vic Branch RANZCP
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