Australia needs to implement a national health strategy for doctors

Coordinated systemic change and enhanced access to care are needed to improve doctors' wellbeing

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Over the past decade, there has been growing recognition of the prevalence of psychological distress across the medical profession and that practitioner wellbeing has significant implications for patient safety. The fact that burnout, anxiety, depression, suicidal ideation, and completed suicide are higher in doctors than in the general population[1,2] is a problem requiring urgent and novel interventions.

To date, the approach to managing this problem has prioritised educative approaches promoting individual resilience, self-care and self-awareness over tangible systemic and cultural change that enhances wellbeing and supports health access. At the organisation level, individual colleges and employers have endorsed disparate and uncoordinated initiatives, ranging from altruistic grassroots interventions to reactive administrative responses. Uncoordinated initiatives with unknown outcomes have been the resulting legacy.

In October 2020, the federal Minister for Health launched the *Every Doctor, Every Setting* (EDES) document, a (draft) national framework to guide "coordinated action on the mental health of doctors and medical students".[3] Even though this document has the potential to inform substantial action, it has yet to be formally implemented and is at risk of becoming a lost opportunity. Moreover, the coronavirus disease 2019 (COVID-19) pandemic has continued to accentuate the growing challenges of providing health care, as well as the psychological burdens borne by doctors.

Even though the overarching strategic approach taken by the EDES document to enhance the health of the profession is commendable, any national strategy must do more than build upon existing resources. The available evidence base is limited as, to our knowledge, there is no other country with a national doctors' health plan that focuses on prevention. For instance, the model of care in the United Kingdom[4] focuses on the unwell doctor rather than on prevention. Furthermore, a Canadian approach for support has been province-specific, rather than national, at this stage (eg, https://php.oma.org/). An Australian plan should deal with the issues outlined below.

A well resourced and well governed national response is required (Box). The response should support the health and wellbeing of the medical professionals in all workplace settings, private and public practice, hospital, and community care. For many years, the Australasian Doctors' Health Network (http://www.adhn.org.au/) of doctors' health services has provided

confidential helplines for medical practitioners. These existing doctors' health services have the Medical Board of Australia as the main funder, with funds disbursed via the Australian Medical Association's (AMA) Doctors' Health Services.

A more comprehensive and sustainable national health strategy should be sourced more broadly from all key stakeholder organisations, including colleges, universities, and professional and regulatory bodies. Individual state and territory doctors' health service hubs are necessary to ensure their sensitivity to the needs of the local medical community. Hubs could be integrated with health centres in rural and regional areas and provide joined-up care for medical students and doctors through spokes to connect with telehealth (eg, for specialised care not available locally) and psychosocial support services (eg, domestic violence). Each hub could incorporate research, knowledge translation, and education, with supported capacity to collaborate nationally.

There should be independent governance of the doctors' health services, separated from the funders, to ensure effective delivery of, and collaboration between, these services. Although annual reporting for doctors' health services will facilitate evaluation of outcomes, this needs to be de-identified and disaggregated to ensure anonymity.

The development of a detailed national curriculum for students' and doctors' health is essential to ensure consistency in teaching at medical schools and beyond. Doctors' health should be incorporated across professional education, including pre-vocational and college training and subsequent continuing professional development programs for all specialties.

Even though the priority would be the delivery of individual and organisational interventions to reduce psychological distress, doctors' health should not be conflated with basic mental health and wellbeing. Physical, mental and cognitive health all need to be specifically considered.

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A proposed national health strategy for doctors

Purpose of the strategy:

- Promote concrete interventions to improve the health of medical students and doctors that focus on organisational/cultural change, as well as those that support individual resilience and wellbeing
- Reduce the barriers that doctors experience when accessing health care for themselves across all regions for all doctors and across the career cycle
- Improve treatment provided to doctors for their physical and mental health care
- Enhance access to doctor-peer support for doctors
- Ensure investment in evaluation of specific interventions to ensure a wellbeing focus informs future initiatives, including new workplace technologies
- Endorse the inclusion of medical students' and doctors' health in the design of all future changes within health services, educational institutions, and other organisations where doctors work and learn
- Ensure independent governance, separate from funders

Strategic approach and development:

- Involve all major stakeholders, such as the Australasian Doctors' Health Network together with the local state and territory doctors' health services, the Medical Board of Australia, medical defence organisations, the Australian Medical Council, medical schools, medical colleges, Australian medical associations, rural doctors' associations, junior doctor organisations, medical student organisations, and state and territory health services
- There must be a national professionalism curriculum as part of a broader career lifespan approach, inclusive of all doctors and medical students at all career stages, in public and private practice, in all work settings
- There should be foundational support for the health of the medical profession as a whole rather than focus solely on the individual
- The strategy should guide future investment in doctors' health across the many and varied medical institutions and organisations where doctors work, train and interact

Operational characteristics of the strategy:

- National curriculum for medical students' and doctors' health — improved education will include self-care, wellbeing initiatives, supporting colleagues, health access including an understanding of the potential barriers to care, delivery of care to doctor-patients, and the intersection of leadership and doctors' health in enabling safe care
- Prevention and wellbeing — recognising the role of health organisations and individual doctors in prevention, including self-care
- Doctors' health access — enhancing health access, including reducing stigma, increasing skills in help seeking, and delivering care to other doctors
- Research agenda — the development of outcome-focused rather than descriptive research into the health issues that doctors experience (physical and mental), their health access, and evaluation of interventions designed to deal with systemic/cultural issues and to support the multiple dimensions of doctors' health
- Legislative review to reduce the impact (perceived and actual) of regulatory barriers on doctors' access to care

Whole of career and profession approach

Doctors' health initiatives currently emphasise the health of younger members of the profession, the group that experiences the most psychological distress.[1] However, a national strategy must encompass the entire career cycle, from medical students to doctors transitioning to retirement. This strategy must be formulated in a consultative and inclusive manner, ensuring diversity of age, career stage, specialty, gender, ethnicity, and sexual orientation in policymakers.

That rates of depressive symptoms and suicidal ideation are higher in medical students than in the rest of the community[1,5] highlights the necessity to engage with doctors' health at the earliest opportunity. Medical schools have taken disparate approaches to health and wellbeing. Existing student welfare programs and their outcomes should be evaluated in the context of increasingly dense curricula with conditions of high cognitive load and stress. It is necessary to develop a broadly standardised framework of teaching, based on a national curriculum, delivered by faculty members from multiple specialties, and provided throughout the course.

Most universities lack a clear treatment pathway for medical students requiring mental health care. Generic student counselling services are unable to provide specialised care to this vulnerable group, and financial stress confounds the ability of students to access psychology and psychiatry services. Funding for a national health strategy should allow medical students to access financial support for this purpose.

Similarly, little attention has been paid to later career practitioners. Although this group has reported the lowest levels of psychological distress,[1] there has been no meaningful attention paid to how to support practitioners transitioning to retirement or thereafter.

Other practitioners whose welfare should be prioritised include those in rural and regional Australia, international medical graduates, general practitioners, and other specialists working in private practice. Current programs that promote improved gender diversity should be extended.[6]

Promoting organisational change

Most existing programs to reduce psychological distress in doctors have focused on improving individual resilience. Yet a meta-analysis showed that small significant reductions in burnout were greater in organisation-directed than physician-directed interventions.[7] This highlights the need for, and effectiveness of, systemic organisational changes to education systems and workplaces to reduce distress.

For instance, prevailing paradigms view work–life conflict as resulting from an individual's sense of responsibility[8] and pressure from societal gender roles.[9] Instead, work–non-work balance must be considered from a broader, non-dichotomous

perspective, to promote improved working conditions for all doctors.

A reset from a simplistic focus on rostered work hours and towards a broader focus on ensuring positive work environments that support wellbeing is needed. It is also necessary to evaluate how new technologies affect practitioners' cognitive and administrative load, often outside of stipulated working hours.[10]

Promoting structural change requires coordinated, nationwide advocacy from doctors, and for medical colleges, medico-professional organisations, such as the AMA, and trade unions, such as the Australian Salaried Medical Officers' Federation (ASMOF), to negotiate with employers. Practitioner safety, staff recruitment and retention, developing workforce flexibility and sustainability, ensuring adequate leave coverage, and professional development opportunities should be prioritised.

Reducing barriers to help seeking

Positive role-modelling from all doctors, in all specialties, can support doctors' access to health care. Improving access will reduce doctors' self-treatment and use of informal ("corridor consultation") options. Proactive strategies to recruit and train a pool of general practitioners, clinical psychologists and psychiatrists willing to care for doctors will build a valuable resource for the profession.

Several main barriers to help seeking that have been identified by doctors, namely confidentiality, concerns about career progression, impact on registration, time and stigma,[1] require action. Medical students and doctors often hold stigmatising attitudes towards other doctors experiencing mental illness.[11] Stigma is a barrier to receiving care because it reduces a doctor's capacity to recognise their health needs in a timely manner, and it discourages engagement with colleagues about mental health in a supportive manner. To date, stigma has not been effectively addressed by the profession. Enabling systemic change requires more than education and publicity about stigma. It requires interventions at multiple levels, overtly championed across the profession, to enable the necessary cultural change to prevent illness being equated with personal failing.

Narratives are powerful, so mental health ambassadors willing to publicly discuss their own illness experiences are important. Enhancing the capacity of doctor-peer support groups such as Hand-n-Hand peer support network[12] would ensure better access to regular peer support within a structure that maintains a necessarily safe space. Another possible strategy is the use of self-directed peer review groups, which psychiatrists report as supporting learning and wellbeing by providing a collegial space for processing emotional aspects of their practice.[13]

An electronic hub (eg, The Essential Network[14]) containing health information, screening tools, evidence-based treatment guidelines, and self-administered structured psychological treatments may address time and confidentiality barriers for doctors. Such initiatives need to be effectively integrated with local doctors' health services providing individualised, person-centred care.

Even though regulation is essential to support impaired practitioners who refuse care, the requirement for treating practitioners (except in Western Australia) to make a mandatory notification to the medical regulator if their doctor-patient is thought to be practising with an impairment[15] remains a significant potential barrier to health access.[1,11] These concerns led to the threshold for making a mandatory notification by a treating practitioner being raised to that of "a substantial risk of harm to the public" or sexual misconduct in connection with practice.[15]

However, these 2020 legislative changes have failed to reassure the profession.[16] Doctors need better education about the *Health Practitioner Regulation National Law*,[17] concurrent with legislative reform to standardise the WA amendment. Therefore, reducing the perception (and potential reality) that help seeking is a threat to career progression or registration is essential. Doctors' health care matters and requires an independent, comprehensive, well connected, well resourced and well governed national response.

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1 Beyond Blue. National Mental Health Survey of Doctors and Medical Students, 2013. https://www.beyondblue.org.au/about-us/our-work-in-improving-workplace-mental-health/health-services-program/national-mental-health-survey-of-doctors-and-medical-students (viewed Jan 2022).

2 Milner AJ, Maheen H, Bismark MM, Spittal MA. Suicide by health professionals: a retrospective mortality study in Australia, 2001–2012. *Med J Aust* 2016; 205: 260-265. https://www.mja.com.au/journal/2016/205/6/suicide-health-professionals-retrospective-mortality-study-australia-2001-2012

3 Everymind. Every Doctor, Every Setting: a national framework to guide coordinated action on the mental health of doctors and medical students, 2019 [website]. https://lifeinmind.org.au/every-doctor-every-setting (viewed Feb 2022).

4 NHS England. NHS Practitioner Health [website]. https://www.england.nhs.uk/gp/the-best-place-to-work/retaining-the-current-medical-workforce/health-service/ (viewed Aug 2022).

5 Rotenstein LS, Ramos MA, Torre M, et al. Prevalence of depression, depressive symptoms, and suicidal ideation among medical students: a systematic review and meta-analysis. *JAMA* 2016; 316: 2214-2236.

6 Royal Australian and New Zealand College of Psychiatrists. Discussion paper: gender equity and the College: why does it matter? RANZCP, 2022. https://www.ranzcp.org/files/membership/wellbeing/ranzcp-discussion-paper-gender-equity.aspx (viewed Feb 2022).

7 Panagioti M, Panagopoulou E, Bower P et al. Controlled interventions to reduce burnout in physicians: a systematic review and meta-analysis. *JAMA Int Med* 2017; 177: 195-205.

8 Guille C, Frank, E, Zhao Z, et al. Work–family conflict and the sex difference in depression among training physicians. *JAMA Intern Med* 2017; 177: 1766-1772.

9 Milner A, Witt K, Spittal MJ, et al. The relationship between working conditions and self-rated health among medical doctors: evidence from seven waves of the Medicine in Australia Balancing Employment and Life (Mabel) survey. *BMC Health Serv Res* 2017; 17: 609.

10 Arnold MH. Teasing out artificial intelligence in medicine: an ethical critique of artificial intelligence and machine learning in medicine. *J Bioeth Inq* 2021; 18: 121-139.

11 Wijeratne C, Johnco C, Draper B, Earl J. Doctors' reporting of mental health stigma and barriers to help-seeking. *Occupat Med* 2021; 71: 366-374.

12 Bridson TL, Jenkins K, Allen KG, McDermott BM. PPE for your mind: a peer support initiative for health care workers. *Med J Aust* 2021; 214: 8-11. https://www.mja.com.au/journal/2021/214/1/ppe-your-mind-peer-support-initiative-health-care-workers

13 Nash L, Karageorge A, Lancaster, Prager S. How peer review groups support learning and wellbeing in psychiatrists. *Australas Psychiatry* 2022; 30: 556-563.

14 Black Dog Institute. TEN: The Essential Network for health professionals [website]. https://www.blackdoginstitute.org.au/the-essential-network (viewed Feb 2022).

15 AHPRA and Medical Board. Guidelines: mandatory notifications about registered health practitioners, March 2020. https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Guidelines-for-mandatory-notifications.aspx (viewed May 2022).

16 Seselja E. Mandatory reporting discourages doctors from seeking help, puts patients in harm's way, GP body says. *ABC News* 2020; 15 Dec. https://www.abc.net.au/news/2020-12-15/mandatory-reporting-laws-discourage-doctors-from-seeking-help/12982380 (viewed Jan 2022).

17 *Health Practitioner Regulation National Law*. https://www.ahpra.gov.au/About-Ahpra/What-We-Do/Legislation.aspx (viewed Aug 2022). ■

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