Under the new Act, the SA Medical Board will require much more information on the health of individual doctors and students, particularly in relation to infectious diseases. While transmission rates of bloodborne viruses from health-care professionals to patients are low, such transmissions do occur, with potentially serious consequences for patients.

As part of the Board's role of public protection, it is appropriate that the Board is made aware of practitioners who are infected with bloodborne viruses so that appropriate protective steps can be put in place. It should be emphasised that these steps would not necessarily or routinely mean denying the right to practise medicine.

There is already a requirement in the current Act for a treating doctor to report to the Board, in writing, the details of patients who are medical practitioners, and are suffering from a condition which impairs or may impair their ability to practise medicine safely. The new reporting requirements now place a responsibility on the patient who is a doctor to also report his or her own health status to the Board.

Overall, the SA Medical Board will maintain a careful balance of confidentiality, support for the medical profession, including medical students, while looking after the best interests of the general public. ❑

Return to work for junior doctors after ill-health

Jillann F Farmer

THE MEDICAL BOARD OF QUEENSLAND, through its Health Assessment and Monitoring Program, provides active support to the medical profession, particularly to doctors recovering from impairment (ie, illness which has been serious enough to affect their capacity to practise). There are about 50 new referrals to the program each year — 37% have a psychiatric illness, 45% involve drug misuse (other than alcohol), and 7% alcohol misuse. At least 60% of practitioners who come to the Board's attention have a dual diagnosis (eg, depression and drug misuse).

Board databases do not specifically collect information on the stage that the doctor has reached in his or her career at the time of illness. However, approximations can be made through manual collation of recent data, with the rough figures on diagnoses in junior doctors being 17% alcohol misuse, 17% other drug misuse, 25% depression, 8% post-traumatic stress disorder, and 17% bipolar affective disorders.

Case histories

The following case histories illustrate the work of the program with doctors recovering from drug misuse and/or mental illness.

Identifying details have been altered in the interests of practitioner confidentiality. However, details pertaining to significant events, milestones, Board intervention and outcomes have been reported as accurately as is compatible with maintaining confidentiality.

Case 1

This young doctor (less than two years after graduation) was rostered to cover ICU alone, with a consultant on remote call. In an endeavour to control stress-related symptoms, he treated himself with benzodiazepines. Their use escalated, as did his symptoms of poor sleep, poor appetite, weight loss and social withdrawal. Recognising that his symptoms were worsening, he sought relief in S8 drugs, which he obtained from the operating theatres (adjacent to ICU). His drug misuse continued (varying in severity) over several years. He was eventually found unconscious in the theatre change rooms.

The Board was notified. His primary and most urgent need was for detoxification because of long-term misuse of benzodiazepines and opiates. Once this had been undertaken, an assessment of his fitness to practise was arranged by the Board.

A minimum of three months off work was needed, but he had no income protection. Showing considerable initiative (particularly given the severity of his illness), he started a dog-grooming business, and managed to support himself through a lengthy period of time out of the medical workforce.

When his medical condition had stabilised, he secured a new medical post with Board support. He was required to fully disclose his medical history to his supervisor, to undergo random urine drug screening (up to 16 tests per month), and was subject to monthly workplace reports from his supervisor to the Board. With the passage of time, reporting and testing requirements have been gradually reduced. He is progressing very well, and there has been no relapse.

Challenges

- He needed time off without income protection.
- He needed to overcome the label of "impaired doctor".
- Once he had left the hospital he had been working in, there was no sense of duty of care elsewhere.
- His vulnerable position with his employer necessitated intervention and advocacy even after he was employed.

Lessons

- There is a need for education of peers to monitor junior doctors and, if necessary, initiate early intervention. If this

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doctor's drug misuse had been detected earlier, the escalation in drug taking would probably never have occurred.

- Income protection is essential for *all* medical practitioners, and should be taken out as early as possible in a career. Insurers are increasingly stringent in refusing insurance or insisting on exclusion clauses for those with a history of mental illness.
- There is nothing wrong with doing non-medical work for a while, and it can even assist in the recovery process.
- Long-term stability in the profession can be achieved after an apparent disaster.

Case 2

This intern developed bipolar illness in the intern year. She was absent from work for three months, and then attempted re-entry. She relapsed and, on medical advice, abandoned her internship.

When referred to the Board, she was working in an unskilled, casual position in the hospitality industry. Five years had elapsed and she had been stable for three of those five years.

The Board organised a three-month placement for a training clerkship. The hospital was so impressed they offered her a job. She is now in her Senior House Officer year, and has been receiving excellent reports — *"She is the best resident I have ever had"*. As with most practitioners with bipolar affective disorder managed by the Board, it has been necessary to have a long-term prohibition on night duty.

After so long "in the wilderness", this young woman has so much to contribute. There have been intermittent relapses, but she has the insight to manage these, and appropriately withdraws herself from the workforce.

Challenges

- Deskilling — she was away from medicine for five years.
- She didn't fit in anywhere — she was not a student, but, as she had not completed her internship, she was not really a doctor.
- There was no apparent benefit to the hospital in taking her on, so organising the initial clerkship took a lot of advocacy.
- Special rostering needs have remained a long-term issue — she can not do night duty.

Lessons

- Sometimes it is just too much to become a doctor and deal with illness at the same time — time out is OK. Even a protracted period away from clinical work does not mean the end of a career and may in fact save it.
- Sometimes an illness helps doctors bring special empathy to their work. Having been a patient and in hospital can add an extra dimension to doctoring.

Case 3

This student developed a psychotic illness in sixth year. He took antipsychotic medications for four months and then withdrew at the beginning of his intern year. He then had a relapse and took nine months off. The hospital was very supportive, but when he started his internship again he received very negative reports.

He tried a new placement with a different employer so he could get a more objective assessment, but the negative reports continued. After six months, he had a meeting with the Director of Clinical Training, the Medical Education Officer and the Consultant. He decided to abandon internship, disclosing a dulling of cognition when taking antipsychotics.

Three weeks later he phoned, relieved and grateful to be off the treadmill. He planned to resume his previous passions for mathematics and languages.

His family needed debriefing, which, although outside the Board's brief, was provided with the doctor's consent. They experienced great difficulty coming to terms with what had happened to their wonderful, talented son.

The Board staff continued to provide support for job seeking (ie, they continued to engage in advocacy with prospective employers and to help him with his curriculum vitae). He found part-time work in a field in which his excellent interpersonal skills were an asset, and is now studying for an alternative career.

Challenges

- Ultimately, this doctor was just too sick with a chronic illness to embrace the challenges of internship.
- A small community can be supportive, but can also result in labelling, whether real or perceived.
- A doctor who is perceived to have "failed" may not be particularly "saleable" to other prospective employers.
- His family had an enormous emotional investment and no appropriate support or forum.

Lessons

- Sometimes it is not worth the personal and institutional cost of continuing to juggle a medical career with serious illness.
- Sometimes a "good outcome" is the appropriate redesign of career goals.
- Families of young doctors need support when the goals they have all worked towards are not achievable because of an illness that may not be externally visible.
- It is not inappropriate to hope that new medications and/or remission of illness may make it possible to revive a stalled medical career.
- Even when a junior doctor must abandon the profession, the profession should not abandon him or her.
- The following cases illustrate the need to provide support to an individual to withstand family pressures or pressures from employers, and the damage that can come from breaching confidentiality.

Case 4

This intern developed a psychotic illness during internship. She presented as very well after the episode, but subjectively felt very fragile, and was certain she was vulnerable to relapse should she return to work.

Her family, noting the absence of symptoms, and probably fooled by the coping mechanisms adopted by this very

able young woman, became quite impatient after she had taken a month away from work, and started demanding that she return. Likewise, her employer, facing staffing problems, was in regular contact, wanting to know when she would be able to resume work.

When she came to the Board's attention, the acute episode had resolved, but she continued to feel vulnerable to relapse. She had not re-established a normal sleep pattern, and continued to feel somewhat dysphoric.

At an initial meeting with Board staff, she outlined a timeline for return to work that she felt she could cope with. Board processes were timetabled to coincide with her timeline, allowing her to refer employer and family to the Board in the event of further disagreement about a return to work.

The timeline proceeded uneventfully and on schedule. No relapses have occurred to date, and she has become a very valued member of the hospital staff. Assessments are consistently in the range "very high" to "excellent".

Challenges

- Maintaining a good rapport with hospital administrations, while not necessarily delivering what they need or want, can be very difficult!
- Dealing with families raises complex issues of confidentiality, boundaries and professional identity. For example, consider the implications of a doctor's mother ringing the Board to argue the case in favour of a return to work!

Lessons

- In the absence of significant secondary gain associated with prolonging work absence, a doctor who insists that he or she is not fit to return to work should be deemed not fit to return, unless assessment unequivocally refutes that assertion.
- Empowering a vulnerable return-to-work candidate to control his or her own timetable (with appropriate input from treating health professionals) maximises the chance of a successful return.
- The normal boundary which would apply to family issues (of not needing to deal with these or become involved) may not be appropriate when dealing with very young doctors still tightly enmeshed in their family of origin.

Case 5

This intern experienced a single episode of psychosis against a background of depression after using cannabis. She voluntarily withdrew herself from the workforce, and resigned from her intern position. When she was again well enough to return to work, she approached the hospital from which she had resigned (Hospital A), but was told that they had a full staff complement.

Another hospital (Hospital B) was approached, and was interested in offering a trial clerkship. This was suddenly cancelled at short notice.

Some weeks later, the Medical Superintendent of Hospital B disclosed that the Medical Superintendent of Hospital A had approached him, and had made several statements about the intern's suitability, which resulted in the withdrawal. By this time, the Medical Superintendent of Hospital A had had no association with the intern for over five months. He was not in possession of any current medical reports and, by any description, the statements he made were inaccurate and frankly defamatory.

A period of protracted unemployment followed. Eventually, a third hospital was persuaded to offer a trial clerkship. They were very impressed, but unable to offer employment on the basis that they had a full staff complement, and no reserve funding. However, because of the positive reports from the placement, the intern successfully competed for a position in a subsequent open-selection process. Reports have been extremely positive, and there has been no recurrence of either depression or psychosis.

Challenges

- Once this intern resigned, nobody felt she was their responsibility.
- Significant deskilling had occurred, making her even less attractive to prospective employers.
- A single ill-informed breach of confidentiality had catastrophic consequences for this young doctor, resulting in long-term unemployment and deskilling.

Lessons

- Some senior colleagues still don't understand confidentiality.
- A breach of confidentiality, even made in good faith, can have unintended implications.
- A person should not make a comment if he or she is not prepared to put it in writing!
- Encourage tenacity and self-belief, even in the face of disheartening failures. It pays off in the long run. ❑