Doctors' health and wellbeing: taking up the challenge in Australia

Promoting psychological wellness in doctors requires tailored interventions

Doctors' health and wellbeing seems to be attracting increasing international attention by the medical profession.[1,2] Is this because doctors' health is worse than it used to be? Is medicine becoming too overwhelming for its practitioners? Does health promotion targeted at the profession work? And what is the profession doing about the health of its members?

Doctors are physically healthier than the average person in the community,[3] even though they do not always follow their own healthcare advice (see Kay et al, *page 368*).[4-7] At the same time, they have significant psychological vulnerabilities,[8] and are more likely than the average person to suffer from one or more of "the three D's" — drugs, drink and depression (including suicide). Whether this is predominantly due to the stress of the job or to pre-existing personality traits has long been debated (see Riley, *page 350*).[9]

The relatively small proportion of doctors who experience mental illness or substance misuse are described as being *impaired*. Many of them ultimately come to the attention of state medical boards, usually through referral by concerned colleagues. The New South Wales Medical Board has established an Impaired Registrants Panel, whose members work with impaired doctors and medical students to decide on how they can continue to work or study while the public interest is being protected (see Wilhelm and Reid, *page 372*).

> **Unhealthy doctors cannot be expected to deliver high-quality healthcare**

Troubled doctors are a larger group who are significantly affected by stress, although their disability may not be such that they cannot practise. Screening Australian doctors for anxiety and depression using the General Health Questionnaire has revealed a high level of stress among general practitioners;[10] similarly, in New Zealand, severe stress symptoms are much higher among GPs than in the general population.[11] This *troubled* group is at risk of becoming *impaired* in due course.

The most visible group are the *dissatisfied* doctors. They complain about "the system" and its demands, and contemplate leaving the profession.[12] Nevertheless, they are able to function quite well and do not have a "health problem" in the strictly medical sense. Whether they can be said to have "hypo-wellbeingness" is an interesting philosophical question. Whatever one's viewpoint, these doctors may be at risk of "burnout".

Strategies aimed at promoting health and wellbeing among doctors must firstly consider which of these three groups is being addressed, and then tailor the intervention accordingly. The *impaired* doctor needs an early intervention and rehabilitation program; the *troubled* doctor needs a preventive approach to stress, plus an easily accessible referral pathway;[13] and the *dissatisfied* doctor needs social support together with reform of "the system" so that known deficiencies (eg, workforce shortages, excessive paperwork, low remuneration levels) are adequately addressed.

What has been done in Australia to reach these groups of doctors? Most states have the equivalent of a doctors' health advisory service (DHAS), which often has little funding and depends on considerable goodwill by a panel of treating doctors. However, in May 2004, the DHAS network formed an Australasian doctors' health planning and reference group, which may help to coordinate and refocus efforts in this area. Since 1999, there have also been national doctors' health conferences every 2 years.

To try to provide a more sustainable service in Victoria, the Australian Medical Association (Victoria) and the Medical Practitioners Board set up the Victorian Doctors' Health Program in 2001. The aim of the Program is to provide confidential medical services to doctors, as well as referrals to specialists, such as psychiatrists, if required (see Warhaft, *page 376*). However, Australia is some way short of the US model of Physician Recovery Networks, which, although having no statutory role, intervene in situations where doctors are considered at risk (see Brown and Schneidman, *page 390*).

Several specialist colleges have established their own support services for members who are experiencing difficulties. For example, the Australian and New Zealand College of Anaesthetists has been particularly active in supporting colleagues, especially in the area of substance misuse. Similarly, the Royal Australian and New Zealand College of Psychiatrists has assisted its impaired practitioners to obtain help through colleague support panels.

Divisions of General Practice have taken up various wellbeing programs covering areas such as stress management techniques, improving skills in the business aspects of running a medical practice, and providing opportunities for social support through peer networking.[14] Unfortunately, the causal links between the *impaired*, the *troubled* and the *dissatisfied* are not very clear, and this has implications for the type of preventive programs being pursued. For example, do the various "docs-4-docs" programs run by Divisions of General Practice (with the aim of supporting GPs to better withstand the stresses of their profession) do anything to prevent impairment?[15] This seems unlikely, as doctors with psychological problems are less likely to engage in the relatively open forums that the Divisions organise.

The challenge has also been taken up by several Australian universities, which have developed "personal and professional development" programs to deal with self-care for health professionals.[16] An innovative way of promoting psychological health has been introduced at Monash University, where first-year medical students undertake a single-semester subject that teaches "mindfulness"-based stress management techniques that they can practise on themselves.[17] Similar courses are also being offered at postgraduate level.

We need a better understanding of which programs work best for which groups of doctors. In the meanwhile, we can use liberal doses of common sense to guide us on what is worthwhile. Useful approaches are likely to include the provision of well advertised

but confidential referral pathways for medical students and doctors who need help, the enhancement of a "no blame" culture that accepts and supports those who are starting to falter (see Hayhow, *page 365*), and attention to solving defects within the healthcare system. Unhealthy doctors cannot be expected to deliver high-quality healthcare. The increased attention to this issue in recent years is timely for doctors, their families and their patients.

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