

Distressed doctors: a hospital-based support program for poorly performing and “at-risk” junior medical staff

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At the age of 32, after completing 14 years of training, a surgical registrar at a major Melbourne hospital needed to pass only one more exam to become a surgeon. However, on a Saturday in March 2006, he went into the registrars' quarters at his hospital and took his own life.¹

The medical profession is one with a significant risk of stress,^{2,3} substance misuse and suicide,^{4,5} due to the nature of the work. This is combined with the committed, conscientious, obsessive personalities of our medical professionals.⁶ However, young doctors give their own health care a low priority, and feel great pressure not to miss shifts because of ill health.⁷

Despite a conference in 2001 focusing on the junior doctor in distress,⁸ and various programs^{9,10} to assist impaired doctors (including the Victorian Doctors Health Program¹¹ [VDHP]), a recent national survey of the health and wellbeing of junior doctors outlined existing areas of concern within hospitals. Fifty-four per cent of respondents reported excessive workloads, and 70% reported experiencing high levels of stress. Importantly, 46% believed that their hospital administration was not supportive.¹²

In response to the 2006 suicide, the Royal Melbourne Hospital (RMH) has developed a hospital-based support program for “at-risk” junior doctors. Here, we describe the program and report the key lessons we have learned through its implementation.

Program overview

RMH is the busiest hospital in Australia,¹³ providing a full range of adult medical specialties (excluding obstetrics and gynaecology), including acute and subacute care, community liaison and mental health facilities. The hospital employs over 500 junior medical staff in intern, hospital medical officer and registrar positions. It complies with safe-hours guidelines,¹⁴ accreditation of pre-vocational¹⁵ and vocational training positions,¹⁶ and incorporates best-practice recommendations from quality and safety inquiries.¹³

For the purposes of this article, “at-risk behaviour” is defined as any behaviour of a doctor which may indicate a risk of self-harm or harm to patients due to mental health issues impairing his or her clinical conduct. The intention of the RMH program is not to treat individuals who are at risk but, if such behaviour exists, to identify it early and seek prompt referral to appropriate specialists, such as the VDHP, for assessment and treatment.

Junior medical training is challenging, due to the nature of the work,⁶ pressures of exam preparation¹⁷ and maintaining a work-life balance. Significant responsibility is inherent in the work of caring for patients, particularly in life-or-death situations, resulting in significant stress and physical demands.¹⁸ The RMH program has targeted modifiable factors that impact on junior staff stress, such as rostering, supervision, and workplace culture. Drug and alcohol use and physical¹⁹ and mental illness will also impact on performance, and require prompt identification and referral for appropriate treatment.¹¹ We also acknowledge that some individuals will be more emotionally and physically resilient to the rigours of junior medical life (including the after-hours shifts, broken sleep and physical demands of being on one's feet for a full shift) than

ABSTRACT

- Despite “safe-hours” campaigns and doctors health programs, “at-risk” behaviour and suicides still occur in junior doctors.
- A recent national survey found that 46% of junior doctors believed that their hospital administration was not supportive.
- The Royal Melbourne Hospital has developed a comprehensive program for preventing and identifying at-risk behaviour and supporting junior doctors, tailored to the individual's needs.
- Patient and individual doctor safety is paramount, and confidential collaboration between medical workforce and medical education structures, clinical supervisors and the Victorian Doctors Health Program is required.
- The boundaries of the hospital's “duty of care” for those who do not want assistance is unclear, and balancing increased supervision within a limited workforce is challenging.

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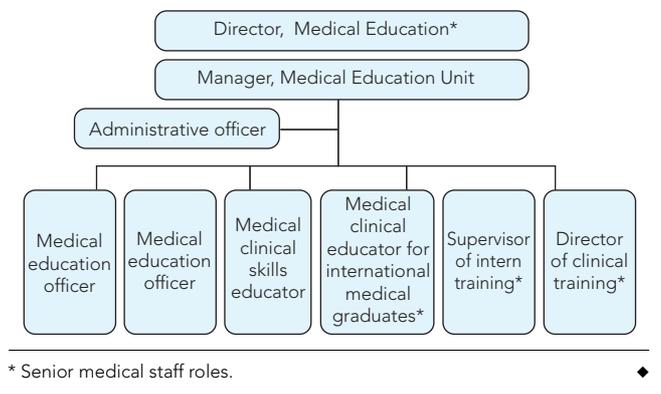
others. We further acknowledge that the most important support mechanisms are not from within the organisation, but involve family, friends and the individual's general practitioner or other health professional. Thus, an individually tailored program is important. Although the program focuses on junior staff, such principles are also applicable to senior staff.

A. Prevention

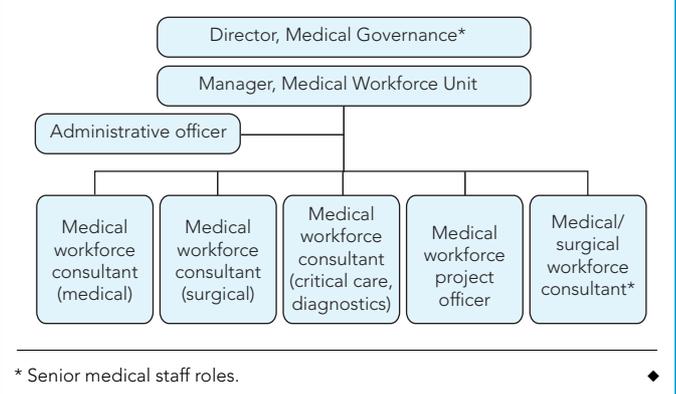
The program's preventive strategies generally expand on best-practice medical staff working conditions.^{14,15} Following the Melbourne registrar's suicide, awareness of working conditions for medical staff was heightened among RMH hospital board members and executive staff, and this reinforced leadership “buy-in” and accountability.

A focus on enhancing and ensuring adequate medical education for junior doctors led to additional staffing appointments in the RMH Medical Education Unit (MEU), the most important of which were the Director of Clinical Training (DCT) and an additional Medical Education Officer (MEO) for individual²⁰ and system-level²¹ support (Box 1). The program relies heavily on the skills, expertise and personalities of the MEOs, DCT and supervisor of training. The MEU monitors trends and numbers of doctors seeking assistance; assists with planning of preventive programs and resource allocation; and oversees the competency of junior medical staff in liaison with the medical colleges and the Postgraduate Medical Council of Victoria. The MEOs and medical clinical skills educator provide mentoring, pastoral care, clinical skills training and career advice, and assist with designing education programs for junior medical staff. The medical clinical educator for international medical graduates (originally an international graduate), supervisor of intern training and DCT are senior medical staff

1 Structure of the Medical Education Unit at Royal Melbourne Hospital



2 Structure of the Medical Workforce Unit at Royal Melbourne Hospital



who perform mentoring and educative roles for junior medical staff. MEU positions are mostly part-time appointments.

Hospital medical staff are also supported by a Medical Workforce Unit (MWU), with approachable, appropriately trained staff (Box 2). The MWU provides a single, on-site, open-door reference point for medical staff issues (recruitment and appointments, credentialling, safe rostering, and vacancy and leave management) and liaises with human resources personnel to facilitate employment of international medical graduates at RMH via a qualified migration agent. Human resources personnel are also involved in professional behaviour and disciplinary issues. The MWU manager provides peer support and support for industrial and professional issues. Medical workforce consultants and project officers provide a point of accountability and continuity over the junior medical training years and facilitate relationships with medical staff. They are responsible for recruitment, rostering and human resources support for junior and senior medical staff.

Most hospitals have systems for appointments, rostering and performance management, and these new RMH initiatives further support the welfare of young doctors. Safe-hours rostering protects work-life balance, minimises fatigue and decreases stress,²² and proactive leave replacement via a 24-hour on-call MWU prevents excessive overtime and prolonged shifts.⁵ Specific clinical competence and orientation programs target overseas-trained medical graduates.²³ Effective supervision by accountable senior medical staff is essential.²⁴ The hospital provides 24-hour resident quarters with computers and kitchen facilities for those in the hospital after hours.

Open, two-way communication with management and a supportive work culture are critical. In addition to meetings of formal committees, regular meetings between the Director of Medical Services and the President of the Hospital Medical Officer Society, and open-door policies within the MEU and MWU facilitate informal communication pathways.

Importantly, a hospital-wide 24-hour on-call peer support program with peers trained in counselling (including medical staff and MWU staff), and human resource policies on bullying, harassment and equal opportunity, facilitate culture change.

B. Identification

Ideally, poorly performing junior doctors self-present,²⁵ either directly or indirectly, by requesting roster modifications, career

advice or clinical skills training. Usually, however, issues of underperformance²⁰ are identified by a fellow resident, registrar or a consultant supervisor, either during rotations or as part of formal assessments.²⁶ Occasionally, they are identified through complaints from non-medical staff, patients or their families (particularly if there are issues regarding communication²⁷). Notification of professional or impaired-practitioner issues is sometimes made to the Medical Board of Australia (MBA) (formerly to the Medical Practitioners Board of Victoria).²⁸

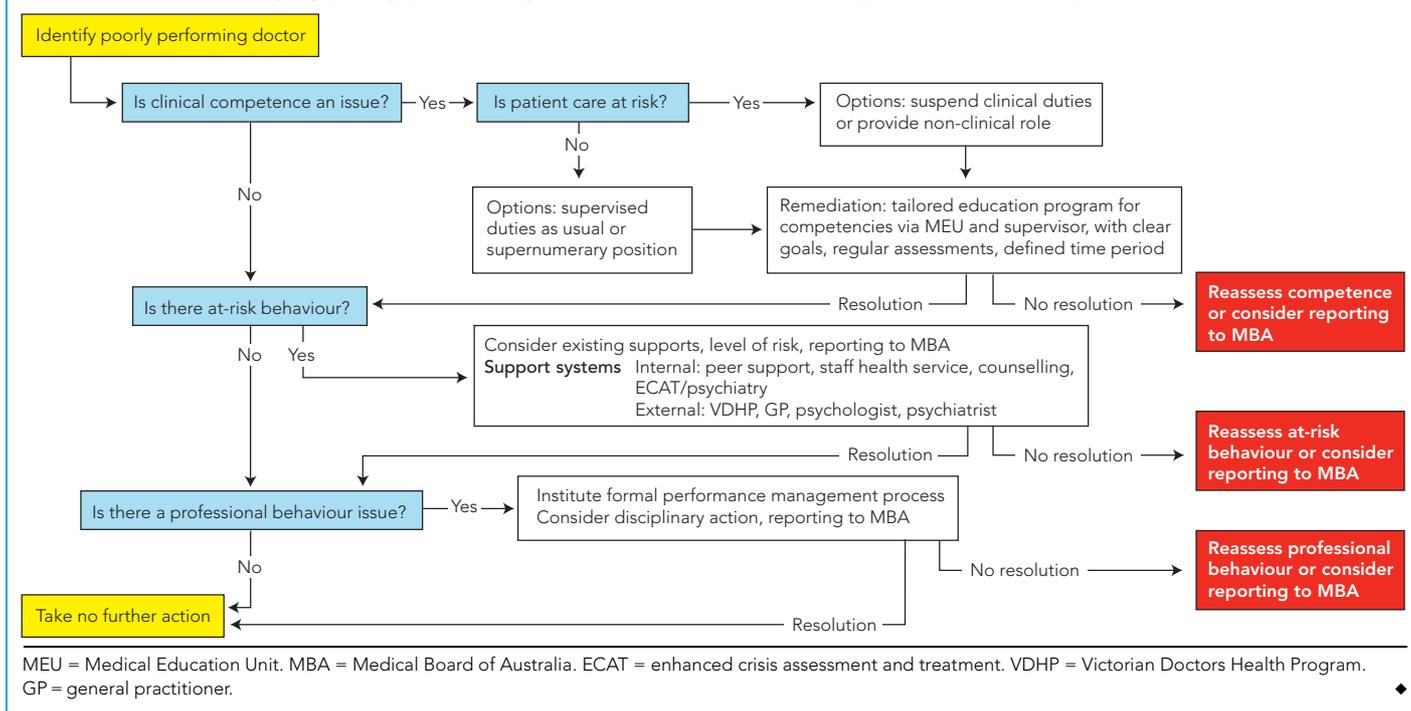
C. Management and personalised support

Preferably, junior doctors with performance issues or at-risk behaviour should actively seek assistance and collaborate with the organisation in their rehabilitation and remediation. To facilitate this, certain key questions need to be asked. These include questions about risks to patient safety and to the doctor concerned, and questions about issues of clinical competence and professional behaviour. Differing responses require different support pathways. Confidentiality is essential through all stages of management.^{29,30} A flowchart of the organisational approach is outlined in Box 3, but each case needs to be tailored to the individual's needs and may involve one or all of the issues.

1. Is the doctor a risk to patient safety?

While determining the most appropriate pathway for supporting and managing the young doctor, it is essential to determine whether patient safety is at risk. If patient care is not at risk, then the individual can maintain his or her usual role while management and support programs are instituted. If patient care is potentially at risk, then the individual needs strict clinical supervision, or to be removed from clinical duties altogether. This may include removing him or her from night duty or weekend duty when there is limited on-site supervision. Alternative non-clinical duties can be sought for the individual (eg, assisting with quality improvement and clinical risk management initiatives within medical administration). If time away is required, it is important that the doctor returns to work as soon as possible.³¹ It has been asserted that "there is nothing wrong with doing non-medical work for a while, and it can even assist in the recovery process".³²

3 Procedure for managing poorly performing or at-risk medical staff at Royal Melbourne Hospital



2. Is the doctor a risk to him- or herself?

Issues of practitioner mental health and impairment need to be identified. As noted above, this program is not intended to include treatment of impaired or at-risk medical staff, but is intended to identify and support the individual to seek appropriate management. Any imminent or semi-urgent risk to the doctor requires prompt referral to appropriate clinical care, either via the on-site staff clinic, the individual's GP or psychiatrist, or the VDHP. Ideally, the individual consents to such referral and has some insight into the problem. Confidentiality is paramount, and additional staff members (such as an MEO or DCT) are involved with obtaining the individual's consent. Documentation should be limited to only what is necessary in the individual's personnel file, in order to preserve confidentiality.

3. Are there clinical competence issues?

Clinical competence issues are coordinated confidentially by the relevant supervisor of training (to ensure appropriate clinical supervision), the MEO (for tailored clinical competence programs) and the MWU (to modify rosters and leave, if required). A clinical learning contract²¹ based on the Australian Curriculum Framework for Junior Doctors³³ is established, with opportunities for self-reflection and supervisor assessment. Individual clinical skills training may also be required. Monthly meetings between MWU and MEU team members track the progress of poorly performing junior medical staff to ensure that current support systems are optimal.

4. Are there professional behaviour issues?

These issues will require assistance from the human resources department for disciplinary action or referral to the MBA. Mandatory reporting of professional incompetence³⁴ is now required under the regulations of the MBA; however, referral to the MBA at any stage may be required for individual or patient safety.

Lessons learned and recommendations

The key lessons we learned from implementation of our support program for at-risk doctors include the following:

- Despite existing supports, junior staff are extremely reluctant to seek assistance for fear of harming future career prospects.³⁵
- If junior staff seek assistance, it is often sought privately.
- Confidentiality is essential.
- Some senior staff still foster an "in-my-day" attitude, which discourages doctors from seeking assistance.

Individual cases in which doctors have participated in the RMH support program have resulted in harm minimisation and successful remediation of individuals into the workforce, but the success of the program will be evaluated through analysis of key trends. An organisational checklist has been developed to assist hospitals to undertake self-evaluation against the key principles. It includes specific "yes/no" and "rate 1–5" questions about organisational attitudes, accountability, engagement, support systems, and prevention, identification and management issues in relation to poorly performing or at-risk junior medical staff.

One of the key challenges is to determine the extent of the hospital's duty of care to the young doctor. If the individual does not want assistance, and if there is no immediate risk that the individual will harm him- or herself or compromise patient care, then intervention cannot occur. The individual can only be encouraged to seek assistance.

Another major challenge is balancing the resource implications arising from such programs. Employing the doctor concerned in a supernumerary position or taking them off night shift for prolonged periods while undertaking educational programs creates additional financial cost, and is difficult with a limited workforce. However, it is difficult to measure the financial benefit of remediating such individuals within the workforce, versus the negative ramifications of not doing so.

Combining prevention, early identification and tailored education and management programs (with early referral to doctors health programs if required) provides a comprehensive hospital-based support program for young doctors, and would be adaptable to other health professional groups.

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Competing interests

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