Health of Doctors

Position Statement

May 2013

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Foreword

The Royal Australasian College of Physicians (RACP) believes that doctors have a responsibility to themselves, their families, their patients and the healthcare system to take care of their own health. However to quote Dr Herdley Paolini, Director of the largest Physician Support Service in the United States[1], this "has traditionally been seen as an individual problem, but in fact it is a workplace issue".

This position statement expresses the RACP's current understanding of and attitude to the health of doctors, and highlights aspects of medical practice that impact on how doctors care for their health and seek help when they are unwell. We encourage our members (Fellows and trainees) and all other doctors to attend their own general practitioner on a regular basis and to model healthy behaviours, for example by exercising regularly, maintaining a good diet and ensuring they get enough sleep. We also urge all doctors to monitor their own physical and emotional wellbeing, and to seek assistance early if they have any concerns or feel they are experiencing significant stress. It is important for doctors to adhere to the medical advice and management plans of doctors who treat them. Caring for other doctors requires sensitivity and we encourage doctors to provide support and assistance to colleagues in a confidential manner.

We commend this document to you and thank all those who have contributed to its development. The RACP is committed to fostering an understanding among its members of the importance of their own health, wellbeing and resilience, and to supporting Fellows and trainees who are experiencing difficulty.

This document aims to consolidate knowledge and inform the development of programs that improve the quality of healthcare available to medical practitioners, such as training for doctors in how to treat other doctors, which are important developments that the RACP hopes to encourage. We aim to highlight the importance of work in this area, to generate enthusiasm to pursue innovative approaches to support the health of doctors, and to raise awareness among our members as well as other doctors about the importance of safeguarding their own health and wellbeing.

Associate Professor Leslie E Bolitho AM

President
The Royal Australasian College of Physicians

Executive Summary

- Doctors, like anyone else, need to look after their own health.

- As an important component of maintaining their own health, doctors should have their own general practitioner and undertake regular health checks.

- While doctors as a group enjoy comparatively good physical health, certain characteristics of the medical profession predispose doctors to specific health risks.

- Historically, the medical professional culture has encouraged doctors to sacrifice their own health through accepted practices such as working long hours and taking work home. Increasingly efforts are being made to address counterproductive workplace behaviours, and workplace bullying is no longer tolerated.

- Medical training presents an opportunity to increase healthy practices, awareness of warning signs, and strategies to manage stress. These may translate into lifelong protective habits and promote resilience. Continuing professional development also provides an opportunity to engage with doctors around the issue of maintaining their own health.

- When health concerns arise for doctors, they may be reluctant to seek appropriate medical care. Doctors may feel uncomfortable assuming the role of patient, and may opt instead to treat themselves or seek informal care from a colleague.

- Regulatory frameworks are an important consideration, as mandatory reporting of impaired doctors can act as a deterrent to seeking help.

- Doctors are encouraged to seek independent medical consultations, and there is growing recognition that a particular skill set can be taught to help doctors treat other doctors more effectively.

- Doctors' health advisory and referral services are important avenues by which doctors can seek help, and these operate in all jurisdictions of Australia and New Zealand. We welcome the action that regulatory, accreditation and indemnity bodies are taking to support doctors' health.

- Medical colleges have an important role as they engage with doctors in the course of their training and continuing professional development. The RACP has a number of initiatives underway and in development to support Fellows and trainees with health concerns.

- Occupational and environmental medicine physicians and rehabilitation physicians have a key role to play in supporting impaired doctors to realise the health benefits of work.

Tips & Checklists for Doctors and Trainees

Key messages to doctors:

- Optimising your physical and mental health optimises your clinical efficacy, and also has benefits for your family.
- All doctors should have a general practitioner.
- Doctors should not self-treat or self-prescribe, nor treat or prescribe for family and friends.
- Be alert to the signs of stress and burnout, in yourself and in others.
- If you have a health concern, seek help.

The RACP encourages physicians and trainees to:

- ✓ Establish and maintain regular contact (healthcare) with a general practitioner (preferably outside of the family and practice setting).
- ✓ Adopt a balanced lifestyle – with time for self, family and friends, and for professional life (see below: *Ten ways to be a healthier physician*).
- ✓ Establish and/or participate in local professional support networks. These might include: professional supervision, mentor programs, peer support networks, or formal professional groups.
- ✓ Recognise that both personal life and professional life will be affected by work-related stress. Learn about the physical and emotional characteristics of excessive stress and burnout – in oneself, and in colleagues. Find out about action you can take if professional impairment is recognised in a colleague (e.g. role of local Medical Board).
- ✓ Incorporate health maintenance as part of professional life.
- ✓ Act now.

Ten ways to be a healthier physician

1. Have your own general practitioner.
2. Avoid taking work home.
3. Establish a buffer-zone (time out) between work and home.
4. Take control of your work hours. The following are a few examples:
   - Schedule breaks
   - Take days off
   - Strike a balance between the hours of paid work and the demands of your job
   - Put holidays in your diary months ahead and tell your family.
5. Manage your time by making realistic schedules and not over-committing yourself (at work or at home).
6. Manage your work environment. This may take time, new skills and lobbying for better work conditions.
7. Use your colleagues for support and maintain and work on relationships with your partner and friends.
8. Take time out for your own needs through such activities as relaxation, enjoying personal interests or pursuits and maybe spending time alone.
9. Do not feel guilty or "less of a doctor" for demanding a life balance.
10. Humour is therapeutic: surround yourself with fun and humour daily.

Signs of Burnout

Would you recognise these signs of burnout in yourself or a colleague?

1. Emotional exhaustion

2. Cynicism

3. Perceived clinical ineffectiveness

4. Sense of depersonalisation in relationships with co-workers, patients or both[2]

Consider how your health would be affected.

1   Introduction

Managing their own health is an integral part of professionalism for all doctors. For doctors to provide the best possible care to their patients they need to be functioning at their optimum physical and mental capacity. This means they have a responsibility to monitor their own wellbeing and take appropriate actions to maintain their health and address any issues when they arise. Like all people, doctors should have their own general practitioner and have regular medical assessments.

Doctors have a responsibility to themselves, their families, their patients and the broader health system to take care of their own health, yet there are barriers to doctors seeking appropriate healthcare. The medical profession has a long entrenched culture of denying their own health issues and "soldiering on" even when they are unwell.[3] As a group they have a poor record of following preventive health guidelines[4] and are reluctant to seek help if they have a health problem.[5] When they do seek medical care, the help they seek is often informal and can be sub-optimal.

There are also some specific occupational stressors facing doctors. There are emotional and physical demands of providing health care, particularly in some areas of practice. Doctors in certain work environments or practising in particular areas of medicine may experience unique pressures. Responses to the inevitable stress experienced by medical practitioners must include personal action and responsibility. However support is available from external agencies including specialist colleges, medical councils and boards, and employing authorities.

This statement on the *Health of Doctors* highlights the importance of promoting the health and well-being of practitioners, for the benefit of themselves, their families and ultimately their patients. It considers health broadly defined, so as to encompass physical, psychological, social and spiritual wellbeing.

Although RACP trains, educates and represents specialist physicians, issues of doctors' health apply equally to all doctors, so this statement will refer to the health of doctors more broadly. It has been developed under the leadership of the Australasian Faculty of Occupational and Environmental Medicine (AFOEM) of the RACP.

1.1   Health issues facing doctors and trainees

According to many measures, particularly of physical health, doctors are a comparatively healthy group of people. The Australian Medical Association[6] reported in 2011 that medical practitioners tend to be healthier than the average, as is expected of a comparatively advantaged socio-economic group. However there are certain characteristics of medical practice as a profession and the types of personalities it attracts that tends to predispose doctors to experience higher than average problems in certain areas. These include:

- Burnout
- Depression
- Anxiety
- Substance use problems
- Dysfunctional interpersonal relationships
- Physical hazards

The medical profession naturally attracts individuals who are hard-working and hold themselves to very high standards. A high proportion of doctors are inclined to aim for perfection, are self-sacrificing and can be self-critical. While these features may lead to professional success, they also predispose the doctor to stress related symptoms.[7]

Stress and Burnout[*]

Doctors as a group tend to experience stress-related health issues, suicide and problem substance use at a higher than average rate.[6] A UK analysis found that 28 per cent of doctors showed above-threshold symptoms for stress.[8] While doctors experience depression at approximately the same rates compared to the general population, estimated to be around six per cent (over a 12-month period),[9] however when they do it can have a significant impact on their ability to practice medicine safely.

Quantifying the exact proportion of doctors in Australia and New Zealand experiencing burnout is difficult, however research confirms that burnout is common among practising doctors.[10] At any given time it is likely that approximately one of every three doctors is experiencing some symptoms of burnout.[11] A recent analysis reports that levels of burnout range up to 60 per cent among practising doctors, 53 per cent among medical students and 61 per cent in medical trainees, with 74 per cent of a cohort of US paediatricians meeting the criteria for burnout.[12] Qualitative research conducted in 2012 assessing burnout amongst New Zealand surgeons revealed that key risk factors included being female, working in small hospitals and working more than 60 hours per week.[13]

The nature of medical practice is likely to predispose doctors to higher than average levels of occupational stress due to their self-imposed high standards, tendency to overwork and lack of tolerance for mistakes.[14] A recent study examining the impact of occupational stressors on physicians found that depression was more common among those who experienced a high "effort reward imbalance".[15] This used a model for evaluating occupational stress that incorporates rewards as well as of coping with various job demands.

Substance Use

Recent studies have shown that doctors have a lower incidence of high alcohol intake compared to other occupational groups or the general population.[16] Prescription drug use is of greater concern, as vulnerable doctors are more likely than the general population to use tranquillisers, sedatives and stimulants.[17] The use of pharmaceuticals for non-medical purposes was reported by the Australian Institute of Health and Welfare (AIHW)[18] as the largest growth area of illicit drug use between 2007 and 2010 (3.7 per cent to 4.2 per cent) in Australian society as a whole. This behaviour amongst doctors is facilitated by easy access to medications and the ability to self-prescribe.

Doctors have been found to self-prescribe medications for depression, to help stay awake or for other psychological problems.[19] It is worth noting however that most of the studies documenting doctors' substance use in Australia and New Zealand are now fairly dated. While anecdotal evidence suggests substance use is a problematic issue for many doctors, more research in this area is warranted to assess the scale of the problem and to assess the effectiveness of strategies to address it.

Occupational hazards facing doctors

Medical practitioners have a slightly elevated risk of death by injury, estimated at 180 per cent compared to the general population in the UK. Doctors, like all health care workers, are in the normal course of their work exposed to a wide range of infectious diseases. With this exposure comes increased awareness of procedures to minimise the risk of infection, but these cannot eliminate the risk entirely.[20] Doctors do risk contracting airborne diseases such as tuberculosis and influenza.[†] Accidental needle-stick injuries may also transmit blood-borne infections such as hepatitis B and C and HIV.[21]

In addition to infectious diseases, doctors may be exposed to unsafe levels of radiation or noxious chemicals.[22] Other physical hazards include burns from lasers or steam sterilising equipment, back injury, or other hazards associated with various chemicals used in hospital setting.

Working in various health care settings, particularly a large hospital, can pose significant psychosocial stressors for health care workers. Doctors often work shifts, which can be long and usually include

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[*] Burnout is defined as a "syndrome of emotional exhaustion, depersonalisation and a sense of low personal accomplishment that leads to decreased effectiveness at work", in Maslack C, Jackson SE & Leiter MP. *Maslack Burnout Inventory Manual, 3rd Edition*. 1996; Palo Alto, California: Consulting Psychologists Press.

[†] Although tuberculosis is not very prevalent among health care workers currently, a study of Auckland medical students found that of those who had not been immunised, 23 per cent tested positive for tuberculosis by their fifth year (Meech, op. cit.).

some night shifts. This kind of work can be physically and emotionally depleting over time and the associated health risks can affect both the quality of doctors' work and their health and safety outside work (for example, if driving while exhausted). In addition the workloads and demands placed on doctors – both by employers and self-imposed – can be very high. Hospitals are complex organisational systems, and doctors often lack a sense of certainty and control over their job design. They may feel that their job is at risk, which leads to stress. Often, too, doctors have little if any opportunity to provide input into the conditions of their work. This lack of autonomy and control, combined with extreme demands and expectations of excellence, contribute to outcomes such as stress and burnout in many doctors. Doctors working in social and professional isolation – for example in solo or small practices or in remote areas – are subject to different workplace stressors arising from the lack of peer interaction and support.

Additionally, many doctors are exposed to occupational hazards in the form of abuse and/or mistreatment from their patients. This is particularly pertinent for doctors working in emergency departments, who are dealing with an increasing number of alcohol-related presentations. Recent qualitative research that assessed the effect of intoxicated patients on emergency department staff concluded that such patients have a significant negative impact on the workload and safety of staff.[23]

Employers, under law, have a duty to provide a safe working environment. In New Zealand, under the Health and Safety in Employment Act (1992), employers have a duty to provide and maintain a safe working environment. This regulation identifies both the physical and non-physical work environment as issues for consideration including work arrangements, the effects of shift-work and overtime arrangements, and the psychological environment, including overcrowding, deadlines, and other stress factors. Employers, therefore have a statutory responsibility to minimise environmental stressors on doctors in the work place. In Australia the Work Health and Safety Act (2011) establishes the duty of employers to provide a safe workplace and safe systems of work. This Act also refers to protecting the health of workers which is defined explicitly to include both physical and psychological health.

1.2 Risk factors affecting specific groups of doctors

Certain subgroups of doctors and trainees are at greater risk of experiencing adverse health outcomes associated with their practice, due to particular stressors associated with their situation.

Medical Students and Trainees

Medical students and trainees are subject to many of the same health issues as fully qualified doctors. A recent study of the student body at a US medical school found that nearly 25 per cent of the student body was at least mildly depressed and "approximately 20 per cent of men and 40 per cent of women had clinically significant state anxiety and that 20 per cent to 25 per cent of men and 40 per cent to 46 per cent of women had clinically significant trait anxiety."[24] Patterns of overwork, neglecting one's own health and disengaging from social and family connections may be established during medical school and persist throughout doctors' careers.

Women Doctors

Balancing the demands of work and home effectively are a high priority for most female and male medical practitioners.[25] In Australia, women generally are participating in the workforce more than in earlier decades. The increase in paid work comes without reducing the number of hours worked at home, with women still doing two-thirds of household work.[26] Female medical practitioners are therefore at particular risk of work related stress as many retain the primary role for managing the household. While doctors in general experience higher rates of marital stress and divorce, this is even more pronounced for female doctors.[16]

Often the work environment offers few supports for women doctors and they are subject to more incivility [*] bullying or harassment at work. Women can experience inappropriate sexual comments and behaviour, which may not be overt or intentional, but which are still demeaning. Female doctors are

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[*] Incivility is a form of interpersonal mistreatment comprising rudeness, ambiguous comments, and violation of societal norms of respect or professional behaviour. Tolerating incivility within a workplace or industry breeds contempt, subverts standards of acceptable behaviour, angers bystanders and can lay the groundwork for more serious behaviours such as bullying to flourish. Incivility is discussed in greater detail in section 3.1.

vulnerable to high rates of verbal abuse and physical assault by male patients and other healthcare workers.[27]

More women are having children during their medical training.[28] This is because many students are entering medical school at an older age. There are now improved employee benefits, including parental leave and provision for part-time training. However those exercising these benefits may feel guilt associated with their colleagues having an increased workload while covering their absence (particularly as there are anecdotal reports of some hospitals not employing locums for parental leave). Furthermore, medical practitioners may experience criticism and disapproval from colleagues and their supervisors. The importance of life balance for women doctors is illustrated by recent qualitative research from New Zealand assessing factors influencing career decisions in internal medicine.[29] This study revealed that employment "flexibility" is more valued in female physicians than their male counterparts, and female physicians were more likely to be influenced by the option of part-time, flexible working hours and lack of on-call duties.

It is vital that doctors and trainees are able to provide quality parenting to their children through flexible workplace practices that support the family balance. The early years are recognised as being crucial to a child's development. This is not only important for the children of doctors but also ensures that they set a healthy example to the community.

Rural and Remote Doctors

Remote areas of Australia have fewer doctors per population, with proportions ranging from 97 general practitioners per 100,000 in major cities to 68.2 general practitioners per 100,000 in remote areas and 47.1 general practitioners per 100,000 for very remote populations.[30] This places considerable pressure on doctors to work extra hours and to work when unwell. Onerous on-call obligations, difficulties in maintaining support from colleagues, poor access to continuing professional development, and difficulty in getting locum relief make regional practice additionally demanding. Compounding these health impacts for doctors in regional practice are the limited opportunities for them to obtain medical care for themselves. These additional stressors may also operate in "high demand and underserviced" areas of metropolitan Australia and New Zealand.

Doctors who are either practising in remote locations or in professional isolation are unable to access the informal peer support and ongoing professional development opportunities that their colleagues in tertiary centres often have. It is recognised that "chance encounters" with colleagues in informal settings allow doctors to engage in informal peer review and to seek second opinions.[31] These mechanisms provide a valuable sounding board for complex cases, as well as ethical decisions or other concerns like medico-legal issues. Isolated doctors need to find other mechanisms by which to access this kind of support, for example through clinical networks, telemedicine, formal mentoring relationships, and regular visits or sabbaticals to tertiary centres to access ongoing professional development.

Rural practitioners may also feel unable to retire at their preferred age due to the lack of available replacements and a sense of obligation to the community. This is evidenced by the ageing rural workforce, with the average age of rural general practitioners found to be 49.[32] They may either delay retirement or feel unable to request a reduction in duties due to shortages of available replacements. This results in overwork and additional stress, which places them at risk of burnout.

Indigenous Doctors

Indigenous populations have, on average, poorer health than their non-Indigenous counterparts. The fact that there are so few Indigenous doctors compounds this problem, as Indigenous doctors are highly valued by their own communities. While Aboriginal and Torres Strait Islander peoples account for 2.3 per cent of the Australian population, they comprise only 1.6 per cent of the Australian health workforce.[33] There are various initiatives in place to increase the number of Indigenous doctors. In 2011 there were at least 160 Aboriginal and Torres Strait Islander doctors in Australia and 218 Aboriginal and Torres Strait Islander medical students,[34] although data collection issues make these statistics difficult to compile accurately. Increasing the number of Indigenous doctors in both Australia and New Zealand is seen as critical to improving the health of Indigenous populations. Addressing the particular health stressors of these doctors is essential.

Indigenous doctors are better placed to address the health of Indigenous people, as they are embedded in the culture and as such they themselves have an Indigenous concept of health. Indigenous doctors are highly valued within Indigenous communities because many Indigenous

people are more likely to seek help for health issues if there is a doctor of their own culture available in their community. The Indigenous model of health includes a greater awareness of the wellbeing and "health" of the community, and not only the absence of disease and wellbeing of the individual.

For Indigenous doctors working in rural and remote communities or metropolitan Indigenous communities, the demands placed on them are similar to those on rural and remote doctors discussed above, but are often more severe. Being so highly sought after places extra stressors on Indigenous doctors as they are relatively scarce, so there is often pressure to take on a very large clinical load. If located in an Indigenous community their work is also likely to include a broader community development mandate beyond their clinical load. These commitments compete with the doctors' own needs to spend time with their families, which may also be extensive.

Māori doctors face similar pressures to Australian Indigenous doctors in terms of cultural stressors, being highly sought after and having excessive demands placed on them. They can be reluctant to work primarily in large hospital settings due to the cultural insensitivities that may pervade such institutions. Māori are significantly underrepresented in the medical workforce. The latest available statistics reveal only 2.6 per cent of the New Zealand medical workforce identify as Māori,[35] yet Māori account for 15 percent of the New Zealand population.[36] Additionally the Māori population faces significant health disparities which results in increased demand for Māori doctors. This has significant implications not only for service provision, but also on the expectations of a finite number of Māori physicians. Māori doctors are in high demand to be cultural representatives on numerous committees and agencies, and face the additional pressures of an innate responsibility to their iwi (tribe) and local Māori community. As a result, Māori doctors may be hesitant when it comes to promoting their ethnicity, a postulation supported by the fact that only half of Māori doctors in New Zealand are registered with Te Ora (Te Ohu Rata O Aotearoa), the Māori Medical Practitioners Association.[37]

There are important issues around occupational stressors for Indigenous doctors working in mainstream metropolitan health settings, and for Indigenous medical students. Workplaces and educational institutions need to be aware of the cultural environment that they provide for students, trainees and doctors. Sensitivity to cultural issues affecting Indigenous students, trainees and doctors is crucial to ensure their retention within the profession.

The Māori Health Committee is developing a document that will address "what it means to be a Māori doctor" as there is a need to articulate how the Māori perspective influences health delivery in New Zealand. For example, Māori have their own understanding regarding the concept of health i.e. the Whare Tapa Wha and Te Wheke models, and involving the whanau (the extended family) in health decision-making is a key tenet. This document seeks to empower Māori doctors and acknowledge their unique perspective on healthcare in New Zealand.

Overseas Trained Doctors Seeking Local Registration

Anyone moving from one country to another will face significant psychosocial challenges. When doctors move from one country to another the process to transfer credentials to the new jurisdiction compounds this stress. Initially it can be difficult for international medical graduates (IMGs) to get reliable information about the process, as pathways to registration in Australia or New Zealand can vary significantly depending on their visa status. They may also be recruited into positions to fulfil a particular medical workforce need, which is inadequately matched to their clinical skills, previous experience or social supports. These situations can be a significant cause of stress, particularly when IMGs are often expected to meet heavy clinical demands while completing their local training and certification requirements.[38]

Undergoing training and registration in a new country can also be a very difficult situation.[39] Some IMGs may come from a healthcare system that operates very differently to the Australian or New Zealand systems. Subtle distinctions such as culturally based consulting styles and values can impact on their ability to practise confidently. In addition, language and communication often pose significant challenges. Even for IMGs from English speaking countries or with a very high level of education in English, the colloquialisms and local jargon used by patients may pose difficulties.

Research has found that overseas-trained doctors may experience discrimination and lack the inherent confidence and respect from patients, compared with their locally-trained colleagues who have comparable qualifications and experience.[40] This discrimination may be compounded by a change in status for IMGs during the time that they are seeking local registration.[41] The additional stressors faced by IMGs may manifest in service provision and patient interactions. Recent Australian research assessed the risk of complaints to medical boards against IMGs compared to Australian-

trained doctors.[42] IMGs were found to have 24% higher odds of receiving complaints to medical boards and 41% higher odds of adverse disciplinary findings than their Australian-trained counterparts.

These stressors, combined with the isolation from familiar communities and likely from extended family supports, can pose a significant health risk for overseas trained doctors. To support overseas trained physicians' transition into the New Zealand workforce the RACP's Adult Medicine Division in New Zealand is developing a series of resources highlighting key legislative, cultural, social and environmental elements of the health system in New Zealand. The aim is that these resources, when combined with peer support and other programs, will offer a contextual introduction to New Zealand and guide the overseas trained physicians to further information or supports as needed, easing their integration into the New Zealand setting and enhancing their cultural competence.

Doctors Involved in Medico-Legal Proceedings

If a doctor becomes the subject of a medico-legal complaint or lawsuit or is reported under mandatory reporting regulations pertaining to fitness to practise, these proceedings are invariably stressful and emotionally challenging. In Australia there is variable support available to help medical practitioners deal with the emotional aspects of such proceedings. The RACP has identified a need for a peer-to-peer support program for members undergoing a medico-legal complaint. The objective is to identify and implement early remedial measures for the medical aspect of the complaint, in order to offset future complaints. In addition, the support program aims to assist members in managing their natural emotions and to reduce feelings of isolation associated with the complaint. Such a program is likely also to identify medical practitioners who have reached or are close to burnout. Providing support at this stage offers the opportunity to address the challenges they face and facilitate their return to practice.

In New Zealand there is no tort-based malpractice system. The Accident Compensation Corporation (ACC) removes the ability for patients to sue a registered health practitioner. and medical injury is compensated through this tax-payer funded scheme. However ACC can report a doctor to the Medical Council if there is a perceived risk of harm to the public. Also health professionals must comply with the Code of Consumer Rights as enforced by the Health and Disability Commissioner, and may have a complaint lodged against them if a consumer feels they have breached the Code. In such circumstances, it is important that doctors have access to appropriate support to ensure they are properly prepared and do not suffer undue stress.[43]

The Medical Protection Society (MPS) and Medical Assurance Society (MAS) in New Zealand have partnered with the New Zealand College of Clinical Psychologists to offer a counselling service. This service provides confidential support to health professionals who are suffering stress associated with an adverse incident or a medico-legal matter. The MPS also offers other support services appropriate for such situations including medico-legal advice, legal representation, and media relations advice and support.[44]

1.3 Impact of doctors' health issues

Doctors, like anyone else, need to look after their own health. They have a responsibility to themselves, their families, their patients and their colleagues to take care of themselves and seek appropriate care when they need it. Evidence shows that doctors who comply with preventive healthcare practices are more likely to have patients who practice the same preventive measures.[45] Reduced health and wellbeing of medical practitioners is associated with reduced quality of patient care.[46] Patients are less likely to trust their doctor and adhere to recommended therapy when the doctor is showing signs of burnout.[47] Doctors who are anxious or depressed are less likely to show empathy for patients and their judgement around patients presenting with mood disorders is diminished.[48]

There is also a significant impact on doctors' families, specifically their spouses and children. A longitudinal study has reported that more physicians were divorced compared to a matched control group (20 per cent versus 14 per cent), and they also reported significantly higher rates of dissatisfaction with marriage (47 per cent versus 32 per cent).[49] The issue of doctors treating themselves and their own families also impacts on the health outcomes for their families. Physicians' children receive a poorer quality of healthcare relative to comparable children from non-physician families.[50] This finding may be related to the doctors themselves providing primary care to their own family members.

There is a growing awareness that medical practitioners and other healthcare professionals are at risk of burnout which threatens the sustainability of the healthcare enterprise. [51] When doctors experience burnout they are at risk of leaving the profession altogether, or making a mistake that harms a patient.[12] Studies have found that 53 per cent of dissatisfied general practitioners consider leaving the profession and 56 per cent of doctors feel that their occupation impacts adversely on their physical and mental health.[52] [53] A 2003 study found significant levels of job dissatisfaction, isolation and experiences of being bullied among doctors.[54] Such findings support the existence of an entrenched culture of incivility leading to burnout and bullying, which presents significant challenges for recruitment and retention within the profession.[55]

As well as adversely affecting doctors themselves, their families and their patients, these findings represent a missed opportunity to realise the health benefits of work for many doctors. A growing body of research supports the fact that work is generally good for health and wellbeing.[56] Central to this claim is the notion of "good work" – namely work that makes a positive contribution to the health and wellbeing of the worker.

The RACP through AFOEM is seeking to understand more precisely the concept of "good work" and identify how its characteristics can actively be propagated. While this analysis does not focus specifically on the medical profession, it will be worthwhile to assess how the findings can be applied in the healthcare industry. Initial findings presented in 2011[57] suggest there could be significant opportunities to improve in a systematic way the impact of work on the health of doctors.

2 Primary Prevention: Maximising Doctors' Health

2.1 Health Promotion

The health of doctors has been an increasing focus around the world particularly in the last two decades, with many professional medical associations collaborating internationally to share strategies and approaches for ensuring the wellbeing of doctors and the development of a range of doctors' health and wellbeing programs. Some services provide the possibility of seeking help anonymously, which goes some way to addressing doctors' concerns about confidentiality.

In Australia, programs addressing doctors' health consist primarily of advice, support and referral services, operating along various models. Appendix 1 lists the services currently available in Australia and New Zealand. They generally offer a minimum of telephone support, advisory and referral services that medical practitioners can call if they have health concerns. The Victorian Doctors' Health Program (VDHP) offers a broader range of service including rural outreach, education programs, return-to-work support, case management and ongoing monitoring. The Medical Board of Australia has recently announced that it will fund a health program (or health programs) for doctors across Australia,[58] building on the experience of the VDHP and other models.

beyondblue is a non-profit organisation that works to address issues associated with depression and anxiety in Australia. In 2009 *beyondblue* established the Doctors' Mental Health Program[59] to address the prevalence of depression and anxiety among Australian medical students and practitioners. As well as identifying risk factors for depression and anxiety, the program aims to increase awareness of the symptoms and promote help-seeking. As part of this program *beyondblue* has conducted a world-first survey of Australia's doctors and medical students in to get a clearer picture of their mental health and the support they may require, with the results due out in mid-2013.[60] In partnership with medical students' associations in Australia and New Zealand, the program also has developed a self-help guide to promote wellbeing among medical students.[61]

2.2 Engaging with Medical Students and Trainees

There is growing recognition that addressing wellness issues in the early stages of medical careers can have a beneficial effect. In the US physician wellness programs increasingly engage with medical students via medical schools, and training institutions offer various proactive initiatives addressing medical student wellness.[62] This approach is intended to raise issues of life balance, wellness, stress management and so on early in medical training so that doctors develop increased awareness of their importance and strategies for managing them. This trend is mirrored in Australia, seen in initiatives such as a health and wellbeing website for junior doctors,[*] *beyondblue*'s wellbeing guide for medical students, *Keeping Your Grass Greener*[†], and programmes run by the individual medical schools. These initiatives aim to maximise the opportunity to build resilience, awareness and positive health behaviours in doctors early in their careers, with a view to maximising their health and wellbeing for the duration.

Doctors in Australia and New Zealand are becoming increasingly aware that looking after themselves and building resilience helps them provide better care to their patients.[63] As the body that trains specialist physicians in Australia and New Zealand, the RACP is in a strong position to build on this trend and reinforce the health and wellbeing needs of the medical workforce in the early stages of medical careers. In New Zealand the RACP has published a resource entitled "How to Survive as a New Consultant" that contains advice for newly qualified specialist physicians. Topics covered include managing various professional relationships and roles, stressful situations that may arise, and dealing with patients and their families. It emphasises to new consultants the many pathways by which they can access support, and provides direction and encouragement to access supports when required. Another initiative of the RACP is to enhance our ability to identify and support trainees experiencing difficulty. The goal is to launch a formal early intervention program in 2014 to identify and support trainees in difficulty. This is intended as a mechanism to provide help before a trainee becomes subject to the formal Independent Review of Training consequent to unsatisfactory performance.

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[*] www.jmohealth.org.au

[†] www.amsa.org.au/keepingyourgrassgreener

2.3 Supporting Doctors' Lifelong Health

Various regulatory, accreditation and indemnity bodies have a role in supporting doctors' health throughout their lifetime. Medical colleges such as the RACP also engage with doctors in the course of their continuing professional development (CPD). This ongoing engagement provides opportunities to develop CPD modules specifically related to caring for one's own health and providing health services to other doctors. Medical colleges also have the opportunity to integrate and continually reinforce messages about the importance for doctors of attending to their own health, and develop strategies to support them to do so.

The Medical Council of New Zealand's seminal document covering practice standards – "Good Medical Practice"[64] – places significant emphasis on doctors' health as an area impacting on the quality of medical practice. This document states emphatically that all doctors should be registered with their own general practitioner and should not treat themselves. It also identifies several strategies doctors could follow to protect their own health and identify any issues they may face.

3   Secondary Prevention: Identifying Problems Early

3.1   Professional Culture & Workplace Bullying

The preventive health recommendations of having a general practitioner and going for regular health checks have not yet become integrated into the professional culture. Various deeply ingrained cultural features of the medical system contribute to the stress that doctors often experience. The medical care system encourages self-sacrifice and "driving yourself into the ground", and discourages time for reflection and self-care.[65] There is still a widespread belief that being a committed doctor means working long hours and taking work home, despite increasing evidence that longer work hours do not equate to improved efficiency and can lead to decreased productivity. Work overload, excessive on-call and high demand areas (e.g. regional practice, neonatology, emergency and intensive care) place individual practitioners at higher risk of burnout and thus contribute to the economic effects of a "burnt out workforce".

These dynamics typically originate during medical training. Although there have been efforts to make the hours of work and other demands imposed on medical students and trainees more reasonable, there is a tension between these efforts and the need to expose trainees to adequate caseloads in support of the training experience, which can be a stressor in itself. Medical training remains a process that places a great deal of pressure on individuals. As well as the high level of academic demands on students, there is often a lack of emphasis on the importance of peer support among medical trainees.[16]

Workplace bullying is an unacceptable feature of any industry and the health industry in particular, as we know the significance of its consequences. The cultural context of incivility and other counterproductive workplace behaviours within medical professions often reinforces unhealthy practices such as overworking, working while unwell, self-treatment and avoiding seeking help. Medical trainees can be made to feel that they must conform to these behavioural norms in order to ensure their success, or may feel that failure to adhere to such an unspoken code of conduct will harm their career. It has often been argued[66] that bullying and harassment is a form of "initiation rite" into medicine, with many studies finding that more than half of medical students and trainees reported mistreatment. A recent study in Australia found that 21 per cent of general practitioners felt they had been bullied,[67] and that one in four doctors in a recent study had experienced persistent negative behaviours from a colleague or senior that had undermined their professional confidence or self-esteem.

A report from the Association of Salaried Medical Specialists (ASMS) in New Zealand[68] records a recent increase in the number of complaints from members about bullying or harassment. Although this appears to reflect an increase in the incidence of bullying amongst the medical workforce, it hopefully represents a heightened awareness, and/or reduced tolerance to workplace bullying. The ASMS advises its members on appropriate steps to take if they believe they have experienced a form of workplace bullying, which may include making a formal complaint to their employer and entering a dispute resolution process. In April 2013, a media report revealed a high prevalence of workplace bullying occurring in one New Zealand District Health Board.[69] This would indicate that urgent action is required to improve systematic processes to address bullying within the health workforce in New Zealand.

Counterproductive workplace behaviours and bullying can be perpetrated by doctors in a pecking order of seniority, although other health professionals such as nurses may also be sources of negative behaviour, particularly towards junior doctors.[70] Doctors who are subject to incivility or even bullied may be unsure how to seek help, and fearful of the consequences of reporting bullying, particularly if the perpetrator is their senior. [71] Working in such a context contributes to the health effects outlined above, particularly stress and burnout. The RACP encourages doctors who experience incivility or bullying to make use of their employer organisation's policies and procedures around such behaviours. Many employers now have both formal and informal avenues for seeking support and advice. Where such supports are unavailable, a confidential discussion with a peer or colleague who is not involved in the situation may also be helpful.

3.2 Access barriers & self-treatment

There exists a "culture of denial" [72] around doctors' own health and medical issues which makes them reluctant to seek care for their own health. They have a strong inclination both to overwork themselves and to work when they are unwell, rather than seeking appropriate medical care. Although findings are more pronounced for general practitioners and other doctors who work in private practice compared to salaried hospital doctors, the majority of doctors are reluctant to take any sick leave at all.[73] [74] Working while unwell tends to be a characteristic of self-employed people, however it seems to be even more prevalent in doctors.

The reluctance of doctors to seek help is evidenced in the fact that only a minority of doctors (31 per cent) have their own general practitioner,[75] compared to nearly 9 out of 10 among the general population.[76] Doctors have difficulty not only in adopting the patient role but in treating other doctors as patients. This results in many doctors self-treating and self-prescribing when facing their own health problems, as an alternative to seeking an independent medical consultation.[77]

A recent review of studies over the past two decades found that typically more than half of doctors reported self-treatment, and only one in two had a general practitioner.[78] In cases where self-treatment is clearly ill advised it is fairly common for doctors to seek informal care, such as that of a practice colleague or friend. Despite the practice being officially discouraged for several decades, many doctors appear to consider it acceptable and appropriate to diagnose and treat themselves for a range of acute and chronic conditions.[77] [78] The Medical Council of New Zealand (MCNZ) has advised it is updating their statement on "*Doctors who provide care to themselves or those close to them*". As part of the feedback to the MCNZ on this statement, the RACP noted that while self-treatment, self-prescribing and treating family or friends cannot be eliminated entirely, it is best practice not to prescribe for or treat those close to you unless it is an emergency situation.

When doctors do seek medical care, they are likely to receive a lower quality of care than to the general population, and have greater concerns about confidentiality.[79] Confidentiality concerns are thought to be a contributor to doctors' reluctance to seek help for their own health and medical issues. In one study, 26 per cent of doctors acknowledged having a condition warranting a medical consultation but felt inhibited about consulting a doctor. [80] The research shows that quality of care is related to the way they seek help, which is often informal and may involve self-care or self-assessment.

Patterns of inappropriate health care behaviour develop very early in physicians' careers: trainee and young physicians give their own health a low priority.[81] Practices that are deeply ingrained within medical culture are often initiated as early as medical school, when students often begin self-diagnosis and treatment.[78]

A study based on a focus group of general practitioners in Ireland summarised doctors' attitudes to their own health reflected in a dysfunctional "informal shadow contract"[82] which echoes the unspoken agreement by which many doctors feel bound:

> "*I undertake to protect my partners from the consequences of my being ill. These include having to cover for me and paying locums. I will protect my partners by working through any illness up to the point where I am unable to walk. If I have to take time off, I will return at the earliest possible opportunity. I expect my partners to do the same and reserve the right to make them feel uncomfortable if they violate this contract.*

> "*In order to keep to the contract I will act on the assumption that all my partners are healthy enough to work at all times. This may mean that from time to time it is appropriate to ignore evidence of their physical and mental distress and to disregard threats to their wellbeing. I will also expect my partners not to remind me of my own distress when I am working while sick.*"

This statement sarcastically condenses several of the cultural barriers and attitudes that inhibit doctors from seeking appropriate medical help and adhering to medical advice.

3.3 Doctors treating Doctors

Just like all people, doctors need to have regular contact with a general practitioner and will require the care of various specialist doctors and other health professionals over the course of their lifetime. When doctors are patients, there are certain features that often characterise consultations. In particular doctors may come to a medical consultation with preconceptions about their diagnosis and preferred treatment options. The treating doctor may not provide as much information to a patient who

is a doctor, assuming that they have the knowledge – even if they have a different specialty. These consultations may also be characterised by a lack of clarity about boundaries, particularly if the treating doctor and the patient doctor have a friendship or other professional association. A recent Australian study identified several ways of strengthening the doctor-patient relationship, and found in particular that empathy was especially important.[83]

There is increasing recognition that doctors who treat other doctors require specialised skills and training. Doctors' Health South Australia (SA) is a non-profit organisation that was formed to improve the health of doctors through clinical services as well as an accredited training program to enhance the skills of general practitioners who have other doctors as patients. It links doctors and medical students with general practitioners in their GP Network. These general practitioners have a self-identified interest in or willingness to treat doctors and undergo accredited training in doctors' health. Doctors' Health SA runs a "Doctors for Doctors" seminar that is accredited by the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine.

In NSW the Doctors' Health Advisory Service (DHAS) NSW has partnered with the NSW branch of the Australian Medical Association (AMA) to run a seminar called "Caring for Colleagues". This has been developed in recognition that many doctors do not access adequate independent health care and that this can impact on their health and therefore their practice. The course covers topics including doctors' health behaviours and barriers to seeking health care, and general practitioners who complete both seminars and a homestudy exercise can claim CPD points from the Royal Australian College of General Practitioners (RACGP).

In addition to the training offered, Doctors' Health SA operates a dedicated profession-only general practitioner clinic in the Adelaide CBD on weeknights and weekends. This allows doctors to access health services where they know that the general practitioner has been trained to treat medical professionals. The clinic has an online booking service, and for doctors who are not located nearby there is also a listing of general practitioners in the network who have received training in treating other doctors. These clinical and referral services are backed up by a 24 hour phone service is also available to support doctors (as in most other jurisdictions).[84]

Doctors who wish to locate a doctor who is trained in treating other doctors should contact their local Doctors' Health Advisory Service. See **Appendix 1: Support for Doctors** for further details.

3.4   Low Threshold Support Services

In order to support doctors' health effectively, the importance of support services that have a low threshold for entry, namely that allow doctors to access help before their problem escalates and they become severely impaired, is well recognised. All states in Australia as well as New Zealand have doctors' health advisory programs. These typically consist of at least a helpline (usually 24 hours) that provides confidential advice and referral. Some include phone counselling and they all provide links to appropriate clinical services. These services provide an essential support for doctors who may be experiencing health problems or are at risk of getting into difficulty. Anonymity and confidential service provision are important features of low threshold services, many of which are provided on a peer support model. However many doctors fear disciplinary action within the regulatory framework, so services are more effective if they are supportive rather than punitive.

The New Zealand Continuing Professional Development (CPD) Committee of the RACP is currently developing a Regular Practice Review (RPR) Framework. One of the proposed requirements of a RPR is that an external assessment is made of the doctor's holistic practice including their personal wellbeing, allowing the reviewed doctor to improve the quality of care he/she delivers to all patients. It is anticipated that RPRs will serve to identify any issues before there is a significant risk of harm. The RPR process also seeks information on the doctor's satisfaction level with his/her role to identify any potential barriers or issues that may arise.

The RACP is considering how best to support its Fellows who are experiencing difficulty. These physicians are not impaired in terms of fitness to practise, but are at increased risk of impairment if they are unable to resolve or manage the issues they face. Options under consideration include developing a Continuing Professional Development (CPD) module that addresses self-care for physicians. The RACP recognises that having an avenue by which physicians in difficulty can access support without fear of disciplinary action is an important measure to protect the health of its Fellows. A working group is identifying mechanisms and pathways to provide non-punitive support for Fellows in difficulty before it impacts on their clinical practice.

4 Tertiary Prevention: Mitigating Potential for Damage

4.1 Regulatory framework and mandatory reporting

Both Australia and New Zealand have regulatory frameworks that include mandatory reporting in certain instances when doctors' health is impaired. Both the Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Council of New Zealand (MCNZ) have criteria for doctors' fitness to practise that relate to conduct, competence (MCNZ) or performance (AHPRA) and health.

In New Zealand under the Health Practitioners Competence Assurance Act 2003, it is mandatory to report a health practitioner when he/she "is unable to perform the functions required for the practice of his or her profession because of some mental or physical condition"[85]. If the health practitioner may pose "a risk of harm to the public by practising below the required standard of competence" they must be reported to the responsible authority who in turn must report the circumstances to a range of organisations.

In terms of health, AHPRA defines impairment as "a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence), that detrimentally affects or is likely to detrimentally affect a registered health practitioner's capacity to safely practise the profession [or a] student's capacity to undertake clinical training."[86] The Medical Council of New Zealand (MCNZ) defines the competencies required by a practising doctor as comprising the ability to:

- make safe judgments
- demonstrate the level of skill and knowledge required for safe practice
- behave appropriately
- not risk infecting patients
- not act in ways that adversely impact on patient safety.[87]

Once the relevant body is notified of a health practitioner or student with impairment or competence concerns then conditions may be imposed upon their registration or annual practising certificate. For example, a doctor may be placed under supervision to ensure he/she is competent to practise medicine. Other measures may involve limiting practice in certain ways, mandating treatment or suspending registration.

Members of the public can notify the regulatory or responsible body if they have concerns relating to doctors' impairment or competence. In addition doctors' employers, other health practitioners or service providers, health service organisations, and education providers are legislatively required to make a notification if they are aware of a doctor's impairment. Mandatory reporting is important to ensure that all practising doctors are fit and competent to practise and do not pose a risk of harm to their patients. Problems arise from the uncertainty surrounding the clinical interpretation of these concepts and the onerous reporting obligations on a doctor who assesses a doctor. Various attempts have been made by differing regulatory authorities to qualify these statements.

Mandatory reporting, while an important mechanism to protect patient safety, can also act as a deterrent to help-seeking. A doctor experiencing a health problem that could compromise their ability to practise safely may avoid approaching a colleague or supervisor for advice or support for fear of having a notification made against them to the relevant regulatory body.

4.2 Returning to Medical Practice after Injury or Illness

The evidence is clear that wherever possible a vocational rehabilitation approach should be used to support the optimal outcomes for people with an injury illness or disease. Doctors are no different though the studies describing this specific sub-population are sparse.

Doctors' health can have a significant impact on their ability to work. Occupational medicine physicians and rehabilitation physicians have an important role at the intersection of health issues, disability and workplace, and can facilitate return to work by understanding the context of the work and its impact on health. They can work with both doctors and their managers to facilitate programs and maximise the likelihood of good health and productivity outcomes.

Doctors who have experienced an episode of illness or injury and may be ready to return to work can benefit from negotiated adjustments to their usual conditions of work. Those doctors whose illness or

injury has resulted in a temporary or permanent disability will require the intervention of an occupational physician, a rehabilitation physician and/or a general practitioner to assist in their return to work, and may require additional management from a specialist such as a cardiologist, neurologist, oncologist or psychiatrist. This may involve temporary or permanent changes to hours worked, duties performed or people with whom the doctor interacts. In some cases doctors will need to rearrange their working patterns and to take on different tasks that are more suited to their current health status.

A study of the Victorian Doctors Health Program (VDHP) has found that case management is an effective model to protect the health of doctors.[88] Most of the program participants who underwent case management had some involvement with the local regulatory board, and 78 per cent reported problem substance use with the remainder having a mental illness. After case management 84 per cent of participants were in medical work.

There should be – wherever possible – a vocational rehabilitation approach, so that injured or ill doctors are able to have a structured, phased re-entry to practice appropriate to their situation. The nature of the adjustments to working conditions, their duration, and the timetable and process for their review need to be facilitated by an occupational physician or a rehabilitation physician in consultation with other treating specialists to ensure that the doctor's reputation, general health and medical indemnity issues are addressed. This discussion presents a unique opportunity to ensure that the conditions of the doctor's work are enhancing, rather than detracting, from their overall health and wellbeing and productivity.

When returning to work it is important that the process be managed appropriately. Occupational and rehabilitation physicians play a crucial role in brokering arrangements for the mutual benefit of both the doctor and the employer. Occupational physicians and/or rehabilitation physicians have the specialised training to negotiate with management the graduated return to work of doctors. They are able to assess competencies, review work task complexity and broker supervision if required. The occupational physician and/or rehabilitation physician will support, consult and advise the treating general practitioner or treating specialist as he/she facilitates a safe and effective return to work. This includes discussing communication strategies necessary to deal with any stigma or innuendo within the medical workforce which may impact negatively on the doctor and return to work process.

Currently, processes related to medical practitioners utilise appropriately trained occupational physicians or rehabilitation physicians in an ad hoc manner. Such specialists can ensure measures of fitness for work, monitor progress and develop contingency plans to facilitate optimal outcomes. This area of specialised practice would benefit from the development of standards. For injuries or illnesses not directly related to work and thereby financial support of the various worker's compensation schemes, impairments associated with malignancy or illnesses associated with ageing (e.g. stroke, heart disease, arthritis) mean that managers often lack the insight or understanding to adhere to graduated return to work plans and may be unable to offer supervision or work if required. This is particularly seen in the private sector where health service organisations tend to be smaller and lack the resources to provide work-based rehabilitation.

Appendix 1: Support for Doctors[89]

Are you OK? A website to promote the Health and Wellbeing of Junior Doctors
A website dedicated to the health and wellbeing of junior medical officers (JMOs) where JMOs can access vignettes, self-assessment tools and brief, specific advice on common problems.

Australian Medical Association Peer Support Service (VIC and TAS)
A free and confidential telephone support line (1300 853 338) provided for medical practitioners by medical practitioners. Any medical practitioner or medical student who lives, works or studies in Victoria and Tasmania can use the AMA Victoria Peer Support Service. The service is open to both members and non-members of AMA Victoria.

CRANAplus Bush Support Services
A 24-hour telephone support and debriefing service for multi-disciplinary remote and rural health practitioners and their families.

Doctors' Health Advisory Service
Confidential and compassionate services for medical practitioners and students in all states, territories and New Zealand.

Dr DOC Program (SA)
DR DOC is an initiative of the Rural Doctors Workforce Agency. It is committed to providing a range of services to assist South Australian rural medical practitioners and their families to maintain optimum health and wellbeing.

RACGP General Practitioner Support Program
Support for RACGP members with a range of issues. Face-to-face and telephone counselling service available.

Rural Doctors' Association of Australia
A national body representing the interests of rural medical practitioners across Australia.

Rural Health Workforce Australia
The peak body for the rural health workforce agencies which recruit and support local and remote health professionals in each state and the Northern Territory.

Rural Medical Families Support (NSW)
A support network for medical families in rural and remote medical practice. Initiatives include creating a 'friendship network' to minimise feelings of loneliness and isolation experienced by some rural families; providing comprehensive 'family programs' at continuing professional development weekends and medical conferences; facilitating medical student holiday placements with rural general practitioners for students interested in experiencing rural practice and life; and providing crisis assistance for rural medical practitioners and their families who are stressed or ill.

Te ORA

The Māori Medical Practitioners' Association represents Māori medical students, doctors and medical practitioners working as clinicians, specialists, researchers and teachers. Te ORA aims to advance Māori health by increasing Māori medical workforce and providing a supportive network for our members. This includes dedicated peer support in times of stress (Te Ngākau).

The Victorian Doctors Health Program
The Victorian Doctors Health Program (VDHP) is a confidential service for doctors and medical students who have health concerns such as stress, mental health problems, substance use problems, or any other health issues. Services include advice and information, assessment and referral, case management, advocacy and assistance returning to work. There is also a support group for doctors with substance use disorders and a Rural Outreach Program for rural doctors. The VDHP services can be accessed, in the first instance, by telephone (03 9495 6011); however, most participants are seen face-to-face either in the VDHP office in Melbourne or another convenient venue. VDHP also has an important role in education about doctors' health issues, offering a variety of talks and workshops tailored to the needs of attendees.

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