DOCTORS TREATING DOCTORS

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DOCTORS TREATING DOCTORS

OUTLINE

Introduction

Literature Evidence

Personal Experience

Requirements of professional bodies

Doctors have high rates of mental health issues, including anxiety, depression, substance dependence and suicide

Multiple factors as to why doctors fail to seek appropriate and timely treatment

Brooks S, Gerada C, Chalder T. Review of literature on the mental health of doctors: are specialist services needed? J Mental Health 2011;1:1-11.

Standards of preventive care and medical treatment utilised by doctors for patients are not always applied to themselves

Decision-making not always based on medical knowledge and is modified by social context

Byner B. Doctors as patients: A study of the medical care of physicians and their families. Medical Care Mar-Apr 1968; 6(2): 157-167.

LITERATURE EVIDENCE

Only approximately 50% of doctors have their own independent GP

Of those, only a very small number regularly visit for preventive care

Doctors have similar rates of chronic illness and have the same preventive health needs as the general population

Richards JG. The health and health practices of doctors and their families. NZ Med J 1999; 112:96-9.

Kay MP, Mitchell GK, Del Mar CB. Doctors do not adequately look after their own physical health. MJA 4 Oct 2004;181(7):368-370

LITERATURE EVIDENCE

‘Doctors are often said to be healthier than the general population because their standard mortality ratio is lower

However, doctors have similar rates of chronic illness and have the same preventive health needs as the general community’

Kay M, Mitchell G, Clavarino A, Doust J. Doctors as patients: a systematic review of doctors’ health access and the barriers they experience. BJGP July 2008;58:501-508.

LITERATURE EVIDENCE

‘Most doctors who have their own GP still self-treat and access informal health care

This is not surprising when we acknowledge that self-treatment and informal care have always been a normal part of the pathway to formal health care for all’

Kay M, Mitchell G, Clavarino A, Doust J. Doctors as patients: a systematic review of doctors’ health access and the barriers they experience. BJGP July 2008;58:501-508.

LITERATURE EVIDENCE

Barriers to effective health care for doctors;

- similar to those experienced by general population, including with respect to the known social determinants of health (financial, physical/ geographical, cultural and educational)
- lack of time
- work commitments
- cost factors

LITERATURE EVIDENCE

Barriers to effective health care for doctors;

- embarrassment
- wish to not impose upon a colleague
- Potentially trivial problem
- potential exposure of errors in self-diagnosis and self-management
- personality issues; locus of control
- confidentiality
- societal/medical culture
- systemic/structural factors

‘BURNOUT’

‘A syndrome of emotional exhaustion, depersonalisation and a sense of low personal accomplishment that leads to decreased effectiveness at work’

‘Burnout may result from chronic work stress’

‘Stress is both a physical and emotional syndrome’

‘BURNOUT’

‘It occurs when the demands on someone are greater than their capacity to respond and is mediated by both factors in the external work environment and internal qualities in the person’

Paterson R. Adams J. Professional burnout – a regulatory perspective. NZMJ April 2011;124(1333)

Chambers C. Tired, worn-out and uncertain; burnout in the New Zealand public hospital senior medical workforce. ASMS Health Dialogue Aug 2016; 12.

PERSONAL EXPERIENCE

Providing support and advice on both health and work issues to doctors

Can include advice on stress/'burnout' issues, but also on other physical and mental health problems

Conducting assessments around medical fitness for work and around work injuries and/or musculo-skeletal problems

PERSONAL EXPERIENCE

If no primary or specialist practitioner involved, doctors use a combination of;

- no care (including failing to investigate sx)
- self-care/treatment
- arranging own blood and imaging
- seeking advice/treatment from workplace clinical colleagues (including through ‘corridor consultations’)

Dealing with such doctor-patients as for any other patient in terms of;

- confidentiality/ethics issues/discussion
- appropriate history, examination and investigations
- not necessarily assuming that medical training obviates the need for explanation and discussion

STRATEGIES

Provide appropriate explanation of specific role and responsibility in each consultation

Role as OP may variously include being;

- treating doctor
- non-treating/assessing specialist
- advisor to workplace management, and/or
- independent advisor to third parties (such as MCNZ, insurance company, ACC, NZTA, etc)

STRATEGIES

Necessary to recognise that in dealing with a doctor (or other senior health professional) as a patient;

- their intelligence, training, and understanding of the health and disability sector should be considered
- listen seriously to their concerns and suggestions

STRATEGIES

Essential to provide clear, logical and preferably evidence-based advice and plan for any investigations and treatment

Recognise that your advice will not always concur with the beliefs of your doctor-patient.

Just because patient is a ‘doctor’;

- the specific problem/issue may be outside their area of expertise/interest
- they may not know the system or procedures for accessing care/funding
- they may prefer an external clinician to take some control and/or to provide objectivity

STRATEGIES

Many doctors will ‘surrender’ responsibility for their specific problem to a clinician who will investigate/treat the condition appropriately

Many doctors also find it useful for a specialist advisor (e.g. OP) to be the person making recommendations to workplace management around any necessary modification to working hours and/or responsibilities

PRIVACY ISSUES

Often a concern when dealing with colleagues in same organisation

Concerns should be discussed openly and reassurance provided as appropriate

Concerns around;

- venue for the clinical assessment
- any discussion with and/or correspondence to workplace management
- imaging or blood tests (locations and results)

Sometimes useful or necessary to refer the patient-doctor to services within another DHB or external health organisation

MEDICAL FITNESS FOR PRACTICE/WORK

A practising doctor needs to be able 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

MEDICAL COUNCIL OF NEW ZEALAND

MEDICAL FITNESS FOR PRACTICE/WORK

MCNZ expects doctors to have their own general practitioner

'MCNZ expects that you will not provide care to yourself or those close to you in the vast majority of clinical situations.'

MCNZ - Statement on providing care to yourself and those close to you (Nov 2016)

MEDICAL CARE - MCNZ

Care includes ‘anything that is done for a diagnostic, preventive, palliative, cosmetic, therapeutic or other health-related purpose, including but not limited to;

(1) prescribing medication and other substances
(2) ordering and performing tests
(3) conducting physical examinations and
(4) providing a course of treatment.

Reporting by doctor him/herself, a clinician colleague or Clinical Director/CMO to Medical Council of New Zealand

Health Practitioner Competence Assurance Act 2003

DISCUSSION/QUESTIONS?

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Please contact for any literature references or copies of relevant articles

Thank you