MEDICAL COUNCIL of NEW ZEALAND

MEDICAL COUNCIL NEWS

Protecting the public, promoting good medical practice
Te tiaki i te iwi whānui me te whakatairanga pai i te mahi e pā ana ki te taha rongoā

How are you, Doctor?

Dr Kate O'Connor MB ChB, FRANZCR

Deputy chairperson of the Medical Council of New Zealand and chairperson of the Council's Health Committee

"As doctors we are constantly exposed to stresses and hazards that can impair our relationships and ourselves…"

In this issue of ***Medical Council News*** we've broken from our usual format and invited a number of doctors who are involved in looking after doctors' health to write about their experiences and the challenges they face. Their stories make for reflective reading.

Other people's health is something we all think about every day as doctors, but what about taking care of our own health?

As doctors we are constantly exposed to stresses and hazards that can impair our relationships and ourselves: working long hours, fatigue, sleep deprivation, patient demands, secondary traumatic stress[1], consequences of mistakes, debt, demands of external bodies (including the Council and colleges), fear of complaints and litigation, and infectious diseases. In addition we are, of course, vulnerable to the same illnesses as the rest of the population.

Anecdotal comments suggest there is reluctance by many doctors to notify health concerns about colleagues or themselves to the Council because of the possible impact on a doctor's career and ability to practise.

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Studies from countries similar to ours suggest that 1–2 percent of a population's practising doctors may be performing poorly due to illness – that is 118–237 doctors in New Zealand. The Medical Council's Health Committee currently monitors only 172 doctors (as at 30 June 2008), that suggests we are no different to other parts of the world although under–reporting is always a concern.

Patient safety – the reason for mandatory notification

The Health Practitioners Competence Assurance Act 2003 (HPCAA) provides for notification of any mental or physical condition affecting the fitness of a doctor to practise medicine. Health practitioners, their employers, medical officers of health, and persons in charge of a hospital or other organisation that provides health services must notify the Council of any doctor they consider may be unable to practise safely because of illness.

Deans of medical schools, are required to advise the Council if students completing a course may be unable to practise safely as a doctor because of illness.

If we want to retain the public's trust in medical regulation, we need to act professionally, which includes referring doctors when health concerns exist.

When is a doctor "unfit"?

Under the Council's definition:

A doctor is not fit to practise if, because of a mental or physical condition, he or she is not able to perform the functions required for the practice of medicine. Those functions would include:

- the ability to make safe judgements
- the ability to demonstrate the level of skill and knowledge required for safe practice
- behaving appropriately
- not risking infecting patients with whom he or she comes in contact
- not acting in ways that impact adversely on patients.

The Council has an important role in assessing and supporting the treatment of doctors with health problems affecting their practice, through the work of its Health Committee. The committee's key objective is to ensure public health and safety. We believe that with appropriate treatment, management and monitoring, doctors who have health problems can often continue to practise medicine safely. We see ourselves as having a role in promoting the rehabilitation of doctors back into the workforce.

Telling patients about a doctor's health issues

It is a matter of public record if, for public health and safety, the Council must alter a doctor's registration status, for example, by suspending or placing mandatory conditions on a doctor's practice, or by asking the Minister of Health to prohibit a doctor's prescribing of certain drugs.

However, if patient safety is not at risk, the Council believes a doctor is entitled to privacy about an illness, so long as the doctor agrees to monitoring and any other requirements. It is a complex issue, but simply enforcing a patient's "right to know" (breaching privacy) runs the risk that doctors will be even more reluctant to reveal their own or a colleague's problem.

Although the Council has been the subject of media criticism, it has a long–standing policy of not discussing individual doctors or cases publicly, when it is confident that patient health and safety is not being compromised.

Getting help

Some Colleges, for example, the Royal New Zealand College of General Practitioners, have their own early warning systems and programmes. Support is also available from indemnity organisations and groups such as the Association of Salaried Medical Specialists and the New Zealand Resident Doctors' Association.

Elsewhere in this issue of *Medical Council News* you will find information about best practice for keeping yourself well and managing stress. Council strongly recommends that doctors should have their own general practitioner for objective assessment of health needs and support in times of stress.

This issue also contains information about the process of notification to the Health Committee and what ensues, should you have concerns about yourself or a colleague. Finally, a healthy work/life balance is to be encouraged. Your good health is your most valuable asset and it deserves the same care and attention you give to your patients.

Dr Kate O'Connor MB ChB, FRANZCR

[1] Richards JG. The health and health practices of

The Council would like to thank all the doctors who contributed articles for this issue of *Medical Council News*.
We hope that their contributions will make a difference to the health and well–being of all those in the profession.

If you would like to discuss or raise a health issue or matter arising from this newsletter, please email the Council's health manager, Lynne Urquhart, at lurquhart@mcnz.org.nz or phone 0800 286 801 extn 774 during business hours

Impressions of the Health Committee – by Dr Joanna MacDonald

I was a member of the Health Committee (the committee) for the eight years that I served on the Medical Council, and chairperson of the committee for six of those years. In reflecting on that experience, I am left with three key impressions. The first is the complexity of the situation that arises when a doctor has an illness; the second, the dilemmas that such situations present for all those involved; and the third, the dedication to the public of all those involved.

First, the complexity. It may be necessary initially to explain the workings of the committee and its role in the Medical Council. The committee of the Council is made up of four Council members, one of whom is a public member of the Council and another who is always the psychiatric member of the Council. This is because the majority doctors who are involved with the committee have psychiatric or substance dependence problems. The committee meets approximately every two months to discuss all doctors who have been referred, and to regularly review the progress of those under its supervision. While the committee has the statutory responsibility, delegated by Council, to ensure that public health and safety are not compromised by the practices of unwell doctors, it is the Council staff, particularly its health team, who work behind the scenes, liaising with the doctors, organising their assessments, and ensuring that their treatment packages are coordinated.

Doctors who have an illness come to the attention of the committee by a number of avenues. Many refer themselves on recognising that their illness has the potential to impact on their practice. In other cases the committee is notified by concerned colleagues (mostly, but not exclusively, medical), employers, supervisors or family members. When the committee shares the concern that the doctor's illness may impact on their practice, it arranges for an assessment by an independent practitioner in a specialty relevant to the illness of concern. This independent doctor is nominated by the committee but agreed to by the referred doctor.

The unwell doctor may also already have their treating doctor; a general practitioner (if they are not the treating doctor); and involvement of one or more counsellors (for example, for substance dependence issues and psychological therapy). Often the employer or a workplace contact (again with the doctor's agreement) and usually a family are also involved (with the doctor's agreement) in due course. On occasion occupational health staff, other workplace colleagues, and supervisors or directors of training may also be involved.

As can be seen, this makes for a complex system, which is coordinated by the health team and, specifically, each doctor's case administrator. These staff have the complex and demanding task of ensuring that all those who need to be are involved; that information is shared as necessary, but equally that the doctor's confidentiality is protected. In addition, they are responsible for ensuring that random urine tests for drug monitoring occur in a timely fashion (which may require early morning phone calls to doctors). They must also ensure that other routine monitoring (such as blood tests) is occurring as specified; arrange for follow–up appointments with the independent assessor if necessary, and respond to any concerns or crises regarding the doctor. As can be seen, supporting and assisting an unwell doctor is not a straightforward matter.

Dilemmas arise for all of those involved in this system. For the doctor who is unwell, there is the initial dilemma of deciding whether the illness "warrants" self–reporting to the committee. This decision is sometimes removed from the doctor by circumstances (for example, if colleagues report that the doctor is unwell, or they are admitted to hospital). Otherwise the decision as to whether they are putting patients at more risk by working than by not working is extraordinarily difficult. This because,

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universally in my experience, doctors are driven by a very powerful sense of loyalty to their patients and work colleagues. This inevitably means that they are unable to make an objective judgement of the degree to which they may be impaired by their illness.

The intense sense of shame that doctors tend to feel at suffering from an illness further complicates the situation. Similarly, colleagues who are aware that a doctor is unwell have an uncomfortable dilemma between confronting the doctor, ignoring the situation, or reporting to the committee with the attendant fear that they will lose a trusting and collegial relationship. In reality, it is very rare for an unwell doctor to resent those who "reported" once they have recovered.

Treating doctors face a conflict between their duty to the doctor who is their patient, and to the wider community of patients who may be at risk if the doctor is practising while unwell. Treating doctors are usually expected to inform the committee if they have concerns that the treated doctor may not be fit to practise, but understandably this raises a dilemma as to when the risk to the public is sufficient to risk losing their patient's trust and therapeutic relationship by notifying the committee.

> "When the committee shares the concern that the doctor's illness may impact on their practice, it arranges for an assessment by an independent practitioner…

Similar, but perhaps less personal, dilemmas are faced by the committee's independent assessors, who have to decide "how sick is too sick" to work, a decision that is usually far from straightforward. There are few "rules". Most illnesses will be more or less impairing, depending on the severity of the illness, the demands on the doctor, the supports they have available, and their insight and cooperation with treatment. The assessor is required to balance all of these factors in making a recommendation to the committee.

The committee and its staff also face these dilemmas. They establish trusting relationships with the unwell doctors and are aware of their individual circumstances and of the challenges that arise for doctors from caring about and feeling loyal to their patients. They understand the consequences – financial and personal – for doctors who are asked to withdraw from work or reduce their working hours. Equally, they understand the concerns of employers, and the public, to have doctors who are fit enough to work, and the concerns of the treating doctors not to betray their patient–doctor. They must weigh these concerns, with the report of the assessors, to decide how best to protect the public and help the doctor to recover and be able to return to work. Such decisions are never taken lightly.

An additional complication for the committee, staff and assessors can arise when it is apparent that a doctor is making choices that seem to be unhelpful (like refusing to engage in treatment), but are not positively necessary to protect the public. Here, the committee has to be careful that it is primarily the protection of the public that is guiding its decisions, not primarily concern for the doctor. Thus, focusing on public protection has to be the committee's lodestone, even when the doctor may feel that their situation is made worse by the committee's actions, for example, by being made to withdraw from work temporarily.

This leads me to the issue of the dedication of all concerned. As mentioned above, without fail the most powerful motivation for doctors to keep working despite illness is their loyalty and duty to their patients and colleagues. Paradoxically, of course, this dedication and hard work are often aetiological factors in the illness, particularly in psychiatric and addictive illnesses, setting up a treadmill that the doctor can escape only with assistance from the committee. The assessing and treating doctors, committee staff and members are also dedicated to trying to protect the public; to enable the doctor's recovery by ensuring that the doctor is fit to work and to facilitate any help that is required to restore fitness.

The reward in all of this is that most of the doctors who come to the committee are helped to continue working or to return to work in some capacity, by being helped to manage their illness in a way that allows them to practise safely. This obviously benefits the public and the doctors. Few doctors would remain under its supervision for longer than five years, and most for less than that length of time. Despite their initial reactions to involvement with the committee, which are often of fear or anger, many doctors express gratitude for the help they have received when they reach the point of no longer being under its supervision. And some choose to stay under its supervision, albeit at arm's length, as a form of "safety net".

I have felt privileged and humbled to work with the unwell doctors, those involved in their treatment and the committee, its staff and assessing doctors during the past eight years.

Dr Joanna MacDonald
MB ChB, FRANZCP

Doctors' health and fitness to practise – by Dr Edwin Whiteside

An international conference on doctors' health will be held at BMA House in London on 17–19 November 2008. This will be a joint meeting sponsored by the British Medical Association (BMA), together with the American and Canadian Medical Associations, with the theme "Doctors' health matters – finding the balance". Several New Zealanders will attend this meeting, which will provide ongoing support and information for continuing efforts in New Zealand to improve the health of our profession.

The impact of litigation and increasing demands from the public, as well as health legislation in New Zealand, are placing great pressure on doctors. Job satisfaction is affected, and doctors are increasingly vulnerable to pressure, which may lead to mental and physical ill health. However, doctors in general tend to minimise their own health problems, not take sick leave from work, and to self–diagnose.

In a recent publication in the United Kingdom, "*Good Doctors, Safer Patients,*" the chief medical adviser, Sir Liam Donaldson, proposed a new focus on the assessment, rehabilitation and supervision of doctors with performance problems. This included a proposal that doctors approaching retirement could be invited to a review to assess whether a further 5–year period of re–licensing was appropriate. In an attempt to clarify causes for performance problems, interest has emerged in assessing doctors' cognitive performance as part of "fitness to practise" proceedings and safety measures. An Australian study has found that such impairment is responsible for 63 percent of all adverse medical events, and that most of these were preventable through educational programmes and appropriate professional support.

In addition to cognitive difficulties, depression appears to be a common problem, particularly affecting female doctors, with identified risk factors including sleep deprivation, alcohol excess and poor job satisfaction. Recent studies have established an association between depression and deficits in episodic memory, as well as limited attention span, mood changes, poor decision making, and interpersonal difficulties. Other studies including those from New Zealand have emphasised the adverse effect of post–traumatic stress disorder, especially for resident medical officers and emergency physicians as well as for doctors whose work routinely deals with death.

While in the past concerns about doctors' health have tended to focus on mental ill health and substance abuse, the broader definition of "impaired physician" implies the inability to fulfil professional responsibilities due to any physical, mental or behavioural disorder. Doctors can be challenging as patients and there are many reasons for this. Many doctors believe they will never become ill and should not "over–dramatise" personal illness. As well, they may have concerns about other people discovering they are ill as this may

demean them in the eyes of patients or colleagues. It is also apparent that the medical profession does not always deal well with disability among its own members. The importance of competent assessment of doctors' fitness to work, therefore, cannot be overstated and is fundamental to occupational health practice.

A recent document, *Good Medical Practice,* highlights the importance of non–clinical attributes such as teamwork, leadership and communication in determining a doctor's "fitness for work", which is not simply a matter of technical or clinical competence, skills or knowledge. The major reasons for early retirement for doctors in the National Health Service in the United Kingdom were found to be psychiatric (33 percent), musculoskeletal (27 percent) and cardiovascular illness (17 percent).

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The major findings of ill health related to psychological disturbances and unhealthy lifestyles reinforce the impression that psychiatric illness is the main affliction of doctors.

Based on studies of suicide in physicians, it appears there is an increased suicide rate-twice that of the general population. Some studies emphasised an increased risk in female physicians that were found to be four times greater than for women in the general population. In general the presence of a mood disorder, a history of alcohol or drug abuse, and the association of an ongoing physical illness as well as self–critical personality features were all found to be predictive of suicide in physicians. It is incumbent on the profession to ensure that methods of assessment of doctors' "fitness to work" are consistent with best practice, and that both experienced occupational physicians and mental health professionals are involved in carrying out the assessments.

Addiction problems, of course, have always been recognised as being an important cause of impairment among doctors, although the prevalence of alcohol problems in doctors may be no higher in the population as a whole, and rates of illicit drug use may be less. However, it appears there are high rates of prescription drug use, mainly opiates and benzodiazepines in the context of self–medicating for stress. This practice of self–treatment with controlled drugs is a unique concern for doctors.

Addiction problems can extend across all specialties at all levels of seniority, although anaesthetists and GPs working in isolation may be at greater risk. Despite this fact, results from impaired physician programmes in North America, Australia and Spain are encouraging with up to 75 percent of treated doctors being drug–free and practising for follow–up periods of between 2 and 8 years. Such programmes facilitate access to help and treatment while emphasising the need for confidentiality, long–term supervision and monitoring, as well as membership of self–help groups.

> "The evidence indicates that doctors respond well to specialist treatment, so the sooner they are referred on to such services the better…

The development of substance misuse in doctors cannot be reduced to a single factor, and the relationship between perceived stress at work and substance misuse in doctors appears to be mediated by individual vulnerability. The need to maintain an image of competence often leads to isolation, with long hours of work and breakdown in family relationships as further risk factors. The occupational hazard of the ability to self–prescribe is under–recognised and under–diagnosed, and even the most astute clinician may fail to take a urine sample when faced with a secretly addicted doctor presenting in crisis. Early diagnosis is critical but sometimes many years can elapse before doctors seek help. However, doctors sometimes access treatment in a crisis, which offers an excellent opportunity for treatment interventions and referral to specialist treatment as required.

While doctors often find it difficult to be patients, it is important they access experienced psychiatrists, addiction medicine specialists and occupational physicians to provide effective intervention and ongoing support. The evidence indicates that doctors respond well to specialist treatment, so the sooner they are referred on to such services the better. Return–to–work programmes need to have a joint approach involving workplace supervisors and colleagues, but sometimes this is undermined by the employer organisation trying to get rid of the patient–doctor or not having formal support and procedures in place for rehabilitation. Occupational health services are well placed to support the employer, particularly where the work is highly stressful and where emotional demands and pressures by both management and patients exist.

The need for individually tailored return–to–work programmes requires coordination and monitoring, but can be successfully achieved through the right system of support.

It is hoped that in the future in New Zealand, greater efforts, concern and appropriate funding will be provided for more preventative programmes, especially for younger doctors, as well as effective intervention for those with established illness causing personal distress or performance problems at work.

Dr Edwin Whiteside
Director, Doctors' Health Advisory Service
Occupational medicine

For more information about the DHAS or assistance please phone 0800 471 2654. Additional information about doctors' health can also be found on the DHAS Australasian Network Website: **www.dhas.org.au**

Doctors' poor health – still an issue?
by Dr Geoffrey Robinson

Last week I attended an end–of–year social function for fourth–year medical students, and wondered if they will still be afflicted by the doctors' health issues of the past. These particular issues are what I have termed the "Four Ds" – depression, drugs (including alcohol), dimming (burn–out), and disruptive behaviour (personality problems like narcissism).

Well, it seems not too much has changed, other than a predominance of woman students, who were drinking wine, despite my tutorials. These students will have the same industrious, obsessive–compulsive, altruistic, ambitious and self–critical traits that may predispose them to psychological problems, particularly depression, that one study showed to affect as many as one in three medical students.

Perhaps these traits are compounded by a medical school culture that used to imbue students with elitism and individualism, prioritising strength and being in control, including over emotions. There was an expectation of coping, which carried over to the junior doctor years – the "baptism of fire", a fire doused by the then–normalised culture of heavy alcohol use by males, now probably by women as well.

This background of what I see as vulnerability needs to be acknowledged, as does the stress of the junior doctor years. This stress includes fatigue; professional isolation, such as night duties; limited control over work; postgraduate examinations; geographical relocation during training; intrusion of work on young families and relationships; routine interaction with fear, illnesses, uncertainty and death; and varying supervisor support.

> "So our health may improve, and indeed I am impressed that many older doctors in both hospital practice and general practice are seemingly achieving better work–life balance…

These factors have also contributed to high rates of depression, suicide and substance abuse in junior doctors; although I am pleased to say that I do not hear nowadays of suicide by junior doctors, which was once a common tragedy in New Zealand.

Perhaps it is timely to acknowledge the Resident Doctors Association and its world–leading initiatives to reduce hours and improve conditions. Indeed, what will be different about the medical students of this generation is their clear desire and ability to put boundaries around the job, even medicine. So our health may improve, and indeed I am impressed that many older doctors in both hospital practice and general practice are seemingly achieving better work–life balance, heeding the advice of many bodies including the Medical Council, Colleges (particularly the RNZCGP) and the Doctors' Health Advisory Service (DHAS). In fact, a high point in medical preventive health was a 1997 publication, *In Sickness and in Health*, edited by John O'Hagan and John Richards. At the time, no other country had such a manual that covered a comprehensive range of issues affecting the health of doctors and other health professionals. It would be timely also to acknowledge Dr Edwin Whiteside, who has chaired the DHAS over two decades.

So we can be encouraged; and indeed, if we can get past the "Four Ds", doctors' general health and life expectancy is better than most occupational groups. The high rates of cirrhosis in the profession reported in United Kingdom studies of 30 years ago have much

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> "There are risks, as addiction and psychological disorders have a propensity to relapse; and this risk must be successfully balanced against the predictable intolerance of some of the public and media…

improved in recent years. A spectrum of psychological illness will continue to beset us as a profession, but we should be better armed to detect warning signs in ourselves and our colleagues.
It is not difficult to answer: "Are we our brothers' keepers?" There have been too many tragedies when colleagues have clearly shown major changes in behaviour and no one has taken action. Most doctors now have their own GPs, and risky "corridor consultations" are seemingly less prevalent and acceptable.

Nevertheless, there is an ongoing number of doctors with illnesses at the more severe end of the spectrum who regularly come to the attention of the Medical Council of New Zealand (Health Committee). These illnesses include depression, bipolar disorder, alcoholism and opiate dependency, complicated at times by personality disorders.

The Medical Council is commended on its recent guidelines on how to help deal with the "disruptive doctor".

I note the wording in the Health Practitioners Competence Assurance Act 2003, which carries a legal requirement to notify a health practitioner to the Medical Council of New Zealand (Health Committee) if they are "unable to perform" because of some mental or physical condition. This sets the bar high, and the former phrase of "may be/is impaired" should be reconsidered in the Act revision. As an assessor of the Medical Council of New Zealand (Health Committee) for nearly 30 years, I am pleased to report that this committee has operated consistently in an exemplary way to assist the profession and its more profoundly ill. Manager Lynne Urquhart and recent chairs Dr Kate O'Connor and Dr Joanna MacDonald have been fastidious in developing management plans and monitoring health–impaired doctors over many years. They have fostered a culture of rehabilitation in getting these doctors back into the workforce (usually with "conditions") as soon as practicable.

There are risks, as addiction and psychological disorders have a propensity to relapse; and this risk must be successfully balanced against the predictable intolerance of some of the public and media. Interestingly, a recent United States anaesthesiology editorial promoted a "one strike and you're out" default position for opiate–dependent anaesthetists. The writers suggested such doctors should be elsewhere in medicine because of the risk of relapse (drug "availability"), and risk of fatal doctor overdose upon relapse (9 to 31 percent). I doubt this view will prevail, but anaesthetists are the medical subgroup most recognised as being at risk of drug abuse and in need of special consideration. This is an example of the difficult issues the Medical Council of New Zealand (Health Committee) encounters.

Dr Geoffrey Robinson
MB ChB, FRACP
Physician, addiction medicine

Doctors' health statistics

Doctors, like the general population, can suffer from various afflictions including drug and alcohol dependence, psychiatric problems and a wide range of physical disorders, all of which can affect their performance.

The Health Committee received 66 new referrals of doctors during the last financial year. Of these, 11 doctors were involved in a high–level monitoring programme and 36 needed a lower level of monitoring. Another 16 cases were closed.

In addition, the Council continued to monitor 196 doctors from the previous year. Of these, 59 were in a high–level monitoring programme, 72 were monitored at a lower level and 71 files were closed. A high–level monitoring programme involves regular review and follow–up of a doctor's health by the Health Committee. A low–level programme involves periodic monitoring of a doctor's health, often through progress reports from the doctor's treatment team.

The total number of doctors monitored for the year was 172. See Table 1 for a summary of health statistics for doctors.

Table 1: Doctors' health statistics

1 July 2007–30 June 2008

New referrals received	66
High–level monitoring	11
Low–level monitoring	36
In abeyance	3
Closed	16

Monitoring continued from previous year	196
High–level monitoring	59
Low–level monitoring	72
Closed	71
Total doctors monitored at 30 June 2007	**172**

New referrals – source of referral	
Self	37
Employer	9
Council	7
Treating doctor	5
Media	2
Other	6

New referrals – suspected condition	
Drug abuse	2
Alcohol abuse	16
Psychiatric	34
Physical – includes cognitive, transmissible major viral infections	14

"Treating Very Important Patients with Very Important Principles" – training doctors to treat other doctors – by Dr Hilton Koppe

"A doctor who treats herself or himself has a fool for a doctor and an idiot for a patient." Despite the wisdom within these words and the recommendations from most learned medical organisations that doctors should not treat themselves, there is ample evidence that doctors have a poor track record on seeking assistance with their own health care.[1] There is also a common belief within the medical community that it can be challenging to treat colleagues when they do present for medical care.

When I began working in the field of doctors' health in 1996, I became concerned about this conundrum. On the one hand, doctors were less likely than the general population to seek appropriate health care for themselves, and then when they did seek health care, the doctors who treated them found it very challenging.

I was keen to do something about this, so I searched the literature for information on training programmes designed to help provide skills and support for those doctors who do treat other doctors. Much to my horror, I could find no such information in the medical literature.

As a result, our GP Wellbeing programme, which we ran through North Coast GP Network, developed a training programme to meet this need. After a series of focus groups to identify issues facing doctors who treat other doctors, we developed a workshop called "Treating Very Important Patients with Very Important Principles". This workshop has since been delivered throughout Australia and New Zealand.

This article briefly outlines how these workshops are delivered, as well as the rationale underpinning the activities.

Workshop principles and design

The workshops are designed on the assumption that participants will have had some experience in treating other doctors, or are planning to do so in the near future. The goal of the workshop is for participants to reflect on their lived experience, and to hear how other colleagues have managed similar situations to those that they have faced or may face in the future.

Cases are used early in the workshop to identify potential barriers to a good outcome for a doctor requiring medical care. Participants are asked to identify potential barriers both from the point of view of the patient–doctor as well as from the point of view of the treating doctor.

Common barriers are summarised in Table 1.

Table 1: Barriers to a good outcome when the patient is a doctor

Barrier	Patient–doctor	Treating doctor
Time	• Hard for busy doctors to find time to see another doctor • Awareness that other doctors are busy and don't want to burden them with extra work	Awareness that treating other doctors can be complex and time–consuming
Confidentiality	Doctors fear who will have access to their medical information (a major barrier to doctors seeking appropriate medical care)	Pressure may be put on treating doctor not to record all or part of the consultation
Embarrassment	• May appear to have lack of knowledge • May present late, having missed or ignored early signs of important diagnosis • May present early, be worried about something that ends up being trivial • Condition may be of a personal nature	• May appear to have lack of knowledge in front of a colleague • Worry about missing a diagnosis • Concern that management plan may be inadequate
Role definition	• Unwilling to take on "patient" role • Seeking treatment in inappropriate location, eg, corridor • Seeking treatment at inappropriate time, eg, without appointment with practice colleague	Unwilling to take on their "normal doctor" role Temptation to collude with inappropriate requests from patient–doctor
Boundary issues	Seeking treatment from partner or supervisor	Difficulty in separating therapeutic relationship from other relationships
Money	Desire to pay for treatment so as not to be seen as a burden for treating doctor, knowing the treating doctor may not want to charge a colleague OR Expectation that will not be charged	Desire not to charge a colleague, while at the same time wanting to make the therapeutic relationship as normal as possible
Legal issues	Doctors are aware that any diagnoses or treatments recorded in medical record will be passed on to insurance companies if asked for when insurance is applied for	Concern about managing a patient–doctor who is not fit to practise

Once the barriers have been identified, the next step in the workshop is to develop strategies to help overcome these barriers. To assist in the process, a model for a consultation is used to break down the complexity of a challenging consultation into smaller, more manageable parts.

This model and common strategies are summarised in Table 2.

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Table 2: Strategies used to overcome barriers when the patient is a doctor

Stage of consultation	Strategies
Connection /reconnection This is the part of the consultation that goes on before the nitty–gritty of the consult starts. It can include the time taken in walking from the waiting room to the consultation room. When the patient is a doctor, it may also include a pre–consultation phone call or conversation when the prospective patient–doctor asks the treating doctor if they would be willing to take them on as a patient.	• Think about timing of the consult – start of day? – end of the day? • Where does the patient–doctor sit? – in the waiting room? – in the tea room? • Need to clarify: – role of each party – confidentiality and records – *"I've got time for you."* • Respect for what patient–doctor is doing • Attitude of partnership, eg, *"I'm sure you have thought a lot about the issues that brought you here. I would like to work with you to sort them out."*
Information gathering This includes the history and examination parts of the consultation.	• Start with an open–ended question and be prepared to listen without interrupting for a while • Don't assume they have told you everything • Be prepared to ask questions of a personal nature, eg, substance abuse, sexuality (see Table 3) • Be meticulous and disciplined, especially with examination
Exploring thoughts and feelings This involves further exploration of the thoughts and feelings which the patient–doctor may have about being a patient or about being unwell. It will be unfamiliar territory for most doctors.	• Acknowledge that both treating doctor and patient–doctor may have uncomfortable feelings • Ask patient–doctor what they think the problem is • Be aware that it may be difficult for the patient–doctor to let their barriers down and be cared for
Patient education This involves coming to a shared understanding of what is going on, and negotiating an appropriate management plan.	• Team approach to management plan, but starting with *"what I normally do in this situation is…"* • Balance between acknowledging their professional knowledge base but not making assumptions they know it all • Resisting the temptation to collude with inappropriate management plan suggested by patient–doctor
Safety netting What to do with results, when to make another appointment and what to do if things do not go as planned all need to be discussed.	• Formalise "contract" by arranging appropriate follow–up and future consults • Be clear on access to and interpretation of results • Treat as a patient in special circumstances when arranging follow–up or in a crisis situation
Closing the consultation Just as important as starting the consult, but often ignored when thinking about effective consultation strategies.	• Reinforce your commitment to them • Agree on payment • Agree on how to book next appointment (will almost always need a second appointment)

To assist treating doctors in ensuring important but difficult issues are discussed when the patient is a doctor, the workshop also includes a psychosocial screening tool that has been adapted from the HEADSS screen (see Table 3) developed for use in consulting with young people.[2] Participants have the opportunity to practise asking role–playing patient–doctors about more personal aspects of their life that may relate to their health.

This "Two HEADSS are better than one" model is shown in Table 3. Comments in *italics* are examples of possible questions which can be used during a consultation.

Table 3: Two HEADSS are better than one

Young people (and doctors)	Doctors
Home *"Who is living at home with you?"* *"How are things going at home?"*	**Health (general)** *"What concerns do you have about your health in general?"*
Education *"How are you managing with your ongoing professional education?"*	**Enjoyment / Engagement** *"What sort of things do you do for fun?"* *"What do you do to unwind at the end of the day?"* (Many doctors tell me that at the end of the day they tend to come home and "withdraw" from things, rather than "engage" with something else. For example, they may be more likely to withdraw into the news on TV or into a glass of wine than to engage with their family members. While this is understandable at the end of a long day, it may not be the most effective way to get a clear head!)
Activities *"What sort of activities do you have outside medicine?"*	**Alcohol** *"It is well known that many doctors can run into problems with alcohol. What is your current alcohol consumption on average?"*
Drugs *"It is not uncommon for doctors to use prescription or illicit drugs as a way of coping with some of the stressors of the job. Have you ever been tempted to use any drugs in this way?"*	**Depression** *"Doctors are known to have higher levels of depression than the general population. This can be quite difficult to detect at times. I would like to ask you some questions to assess your mood. Would that be all right with you?"*
Suicide *"Studies show that male doctors have double the suicide risk compared to the general population, and that female doctors' risk is increased six times. Have things ever got so hard for you that you have considered hurting yourself in any way?"*	**Support** *"Many doctors can feel quite isolated and alone at times. From whom do you get personal support when you need it? How effective do you find this support?"*
Sexuality *"Are you engaging in any sexual activities that may put your health at risk?"*	**Safety** The treating doctor needs to make an assessment that the patient–doctor is safe, both from the point of view of self–harm and from the perspective of being safe to practise medicine. When in doubt about either issue, it is recommended that the treating doctor seeks assistance from the appropriate bodies, eg. Medical Council, Doctors' Health Advisory Service.

Conclusion

It is not enough for medical organisations to recommend that doctors seek appropriate medical care for themselves. That is only half of the issue. Treating other doctors has its unique challenges.

Organisations which make such recommendations need to give some thought to providing appropriate training and support for those doctors who are taking on this challenging role of offering care to their colleagues. Experience has shown that the provision of workshops like the one outlined in this article helps to better equip doctors with the skills needed to treat other doctors. The workshops also provide much needed collegiate support.

Dr Hilton Koppe
MBBS
Australian health education consultant and general practitioner

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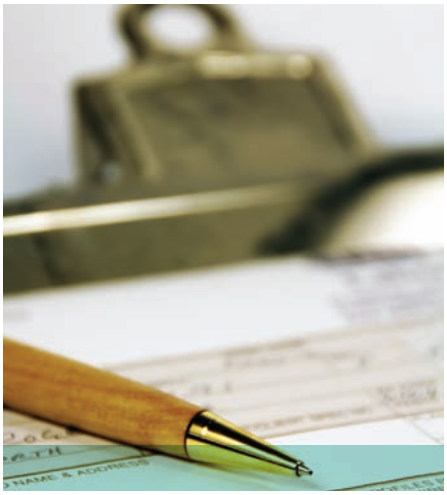


Being a doctor's doctor – by Dr Janet Frater

We often hear the comment that when doctors have surgery they are much more likely to have complications than the average patient. Fortunately I am not a surgeon! Nevertheless, when I reflect on being a GP to quite a number of colleagues over the years, I realise they often bring more complex problems than my other patients. Their problems also seem to take more time to sort out. The illness experience of doctors is complicated.

Doctors are often reluctant to admit to illness and think of it as a weakness. They present late when they have exhausted all simple options. They have often self–medicated inappropriately, for example, grabbed the Augmentin from the cupboard!

They have no documentation for themselves or their families. They tend to think of the worst diagnostic possibility and have researched it thoroughly before they present for a 15–minute consultation. This can make you feel anxious when you bring them into your room and you wonder if your competence is being assessed.

They may try to be a good patient but find it difficult to relinquish control.

As a profession we have higher levels of depression and substance abuse than the general population. This can complicate the doctor/doctor consultation, with the issues of fitness to work and notification to the Medical Council. There are also issues of privacy and confidentiality, eg sitting in a waiting room where the doctor may be recognised.

An understanding of role ambiguity is essential for being a doctor's doctor. The clear boundaries that exist with our usual patients, who have less medical knowledge and skill than us, are blurred when we consult with our colleagues. The patient–doctor has difficulty in surrendering control and may find themselves going behind their GP's back and reverting to self–referral and self–management rather than openly questioning their opinion.

I have learned that it is best to acknowledge the difficulties in the roles and raise these issues when I first see the doctor as a patient. Good communication skills are essential to encourage open discussion.

- Acknowledge the difficulty in switching roles of doctor and patient. "In general I will treat you as my other patients in this consultation, but we obviously have shared knowledge and collegiality and this can make it more difficult for us both."
- Encourage open discussion of fears and concerns, however unrealistic these may be. A helpful statement could be "Of course as doctors we always think of the worst. What have you been thinking this could be?"
- Acknowledge that we may disagree on investigation or treatment options. I could say, "We all tend to have our own ideas on what should be done. What are your ideas on this management plan?"
- Encourage honesty by letting them know your feelings. For example, "I sometimes find myself over–investigating colleagues, and they often find it awkward to tell me when they have not done what I suggested. I hope we can be honest with each other."
- Don't assume the same level of medical knowledge, particularly when a colleague is from another specialty. I might say, "I usually give the same detailed level of explanation that I would give to my other patients, so please let me know if this is pitched at the wrong level for you."

> "As a profession we have higher levels of depression and substance abuse than the general population…

One of the more sensitive areas for

discussion is the fee. Traditionally doctors did not charge colleagues. If doctors are to get good medical care, paying a standard fee is important as it creates a clear role definition between doctors. It also avoids the embarrassment of imposing on a busy colleague, the dilemma of finding an appropriate thank you gift, and the tendency to corridor consultations. I always try and discuss this issue with the patient–doctor and point out the importance of maintaining good professional boundaries with colleagues. There is usually relief at being able to discuss this openly.

Many colleagues get medical insurance and I would encourage this. It is especially useful for visits to specialists where costs are a lot higher than going to the GP. I think as a profession we need to be more open in this area. However, for older colleagues it is still difficult to accept the change in thinking and it is harder to raise the issue with them.

Another issue for GPs who see doctors is the time involved for a consultation. As the consultation is likely to be more complex, I encourage colleagues to consider booking a double appointment rather than putting the GP under the time pressure of dealing with everything in 15 minutes. It is also helpful for all doctors to see their GP on a regular basis before a problem arises (have an annual check–up). This helps to develop a relationship, and basic screening can be addressed.

Of course we all need to practise what we preach. It's good for us when we go to our colleagues to try and learn to be in a patient role as it gives us valuable insight. It is often hard to find the right GP, especially in rural areas and smaller centres. Ideally we need someone we don't know well because of confidentiality and boundary issues. We never know when we may have stress and mental health problems. We also need someone whom we know to be competent. They should preferably have enough experience so that we won't be so tempted to tell them what to do! It is a good idea to discuss appropriate doctors with our colleagues if we are having difficulty finding the right person.

In conclusion, if we are a doctor's doctor we need to remind ourselves that it is a privilege to be of service to our colleagues. I have certainly appreciated the care and wisdom of my GP over the years. We also need to acknowledge the ambiguity of roles and be explicit about our expectations when we start the consultation. We need to encourage each other to be honest and keep appropriate boundaries including payment for services. Putting our performance anxiety aside may be something we have to work on!

Many of us will need to treat colleagues in our medical careers. It is good if we can discuss the issues as a profession and all work at becoming better at being both doctor and patient.

Dr Janet Frater
MB ChB, Dip Obst, FRNZCGP

"Of course we all need to practise what we preach. It's good for us when we go to our colleagues to try and learn to be in a patient role as it gives us valuable insight…

The doctor's doctor – by Dr Sara Weeks

I think the only thing harder than seeing a colleague as a patient is seeing a colleague as a patient!

Since I became a consultant I have had the privilege of treating a number of colleagues who have trusted me enough to share their problems, uncertainty, confusion and shame with me. It must be harder for colleagues to consult me, as a psychiatrist, than it has been for me to see obstetricians, gynaecologists, GPs and cardiologists. However, I remember the professionalism, expertise and compassion shown by those I have consulted myself, and I would like to thank them all. I have tried to emulate those qualities when treating others.

This article is about being the doctor of a doctor, but the issues apply both ways.

Doctors tend to present quite late with psychiatric symptoms – we are all trained to ignore symptoms of stress such as fatigue, sleep disturbance, worrying, difficulty concentrating, and feeling overwhelmed. Often it is the other things in life that suffer as more and more of the waning supplies of energy and motivation are poured into work. Often it is not until we become concerned about our work functioning that we do anything about it.

When a doctor comes to see me, sometimes referred by their GP (very occasionally, in fact!) but more usually self–referred, they have generally already worked out what is going on, and have often tried an SSRI or two (all too often self–prescribed). I usually spend some time talking about "being in the other chair" but then get on with treating them as I would any other patient. I can usually give more "technical" explanations of causality and how we think medications work, and sometimes the questions are quite curly!

It is really important not to assume that just because someone has undergone medical training they will know about their condition and its treatment. Sometimes patient–doctors are unwilling to reveal that they do not know much about a particular area, and making assumptions about their knowledge (for example, that citalopram can interact with migraine treatments) can be dangerous. The maxim that the "special patient" often gets poorly treated remains true.

Sometimes, the patient–doctor has an unspoken fear about fitness to practise, which could theoretically get in the way of honesty during a consultation.

> "Often it is not until we become concerned about our work functioning that we do anything about it…"

I generally make this overt, and indeed it has rarely been the case with doctors who refer themselves. Often I advise a reduction in work hours, or some time off, and it can sometimes be challenging to get the patient to agree to this – finding locums, "coming out" about having difficulties, and activating income protection insurance (if they have any) are all stressful and can seem too much for a depressed person – it can seem easier to just keep going.

If I consider a patient–doctor is not fit to practise, and cannot wait the several weeks needed to arrange cover, I attempt to persuade them of this rather than become directive. However, I have needed to "get bossy" on occasion, and indeed it can be a relief for someone else to tell you that you have to stop or reduce work for a while, as it goes against the grain to admit this yourself! Often so much energy and focus have been put into continuing working that it can feel like the only thing that is keeping you going, and the fear of stopping this anchoring and containing activity is that you will fall apart completely!

Sometimes the trigger for a consultation can be a complaint to the HDC – a hugely stressful process. The actual complaint may be unrelated to the depression, but the ensuing process is so stressful that the doctor becomes symptomatic. Feeling under the microscope, questioning one's own practice, and the shame of being found wanting by those we serve, all while attempting to continue practising, can be entirely overwhelming.

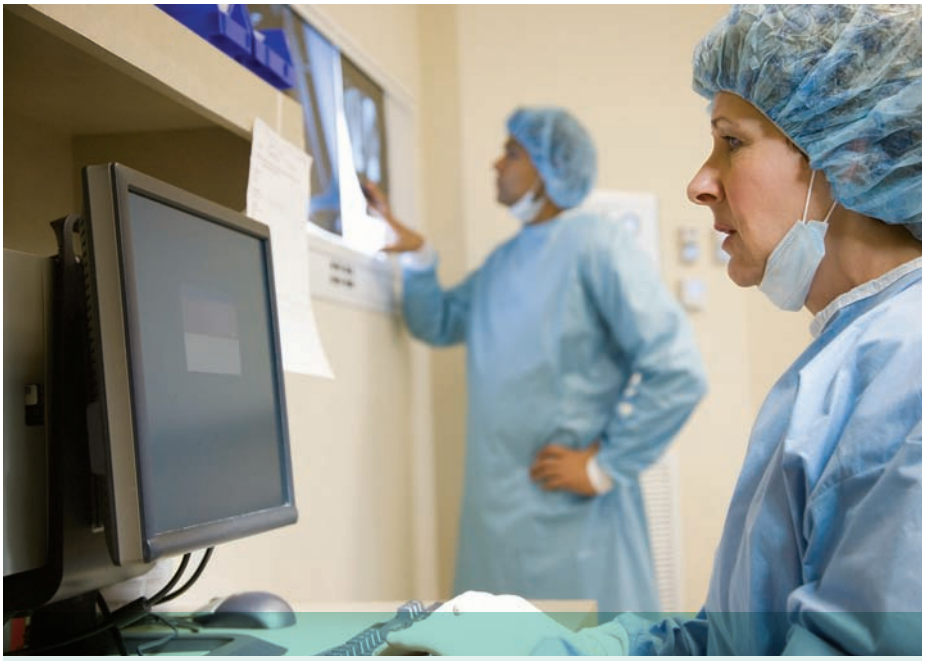
One special consideration for me when seeing a colleague as a patient is managing the waiting room – ensuring that none of that doctor's patients are booked in before or after, or with any of the other practitioners in the practice, which can be a tad challenging at times.

Often a colleague has made their own diagnosis, with rationale attached, and challenging this can be difficult, particularly if they are very attached to the diagnosis. I find that the best way to do this is to listen carefully and respectfully, and then go through one's own rationale and management.

Seeing senior colleagues, particularly when you have previously worked with them, can be particularly difficult. In "the old days", if a colleague was not insured, one would see them gratis. Even when insured, there would be a "collegial" direct–billing arrangement – and in today's insurance situation this does not begin to cover the standard fee (in psychiatry anyway!). This financial disparity contributes towards the "special patient" situation, and one's own ingrained respect for (and occasionally house–surgeonly fear of) the colleague can impact uncomfortably on the situation.

It is absolutely necessary to consider these factors before embarking on the consultation. If you find them impossible to overcome, you should consider whether you are the right doctor to assess and treat the particular patient. You should also "get over" the fact that you have been "chosen" and the "honour" attached, as this can also impact on the quality of the interaction.

Transparency in interaction is vital, particularly when there is Medical Council or employer reporting involved. The situation is clear when the patient–doctor has been referred for assessment by the Medical Council, though of course the limits of confidentiality should be explained at the outset of the interview. It can be murky when the doctor has chosen to consult you themselves, and unfortunately reporting requirements can impact adversely on the therapeutic relationship. You may have a real drive to protect your colleague; you may make assumptions about the degree of impairment, and identify with their predicament ("There but for the grace of God go I."). Advocacy is, I believe, part of the role of the treating doctor, but not at the expense of common sense or safety. Looking at the bigger picture is necessary.



"I have found the best way to manage this is to give them parameters within which they may adjust…"

Hypomania is particularly difficult to manage, as often the patient–doctor does not realise they are impaired, can be very convincing, and under the current legislation cannot be compelled to accept treatment. Doctors treating doctors seem to have a real reluctance to use the Mental Health (Compulsory Assessment and Treatment) Act 1992, and particularly to subject a colleague to the exposure involved in admission to hospital. However, the destruction of relationships and reputation, even if they are not involved in patient care, can be devastating. Advance directives in the case of a recurrent condition can be useful, if not legally binding.

Ongoing interaction, when the crisis has passed, is particularly useful – even just to check in, review stress levels, and have a forum to discuss issues. It also provides an opportunity to get to know and develop a relationship with the well person, rather than seeing them only when unwell. Doctors tend to have a large coping capacity, and may be a lot more impaired in comparison to their usual level of functioning.

Compliance, adherence and concordance do seem to be particularly challenging with medical patients (including nurses!) and there is a tendency for them to adjust medication dosage without consultation. I have found the best way to manage this is to give them parameters within which they may adjust the medication, with clear instructions on when to contact the treating doctor.

There are many complicated issues involved in treating a colleague, both for you and them, but above all we owe a duty of care, which transcends the collegial relationship.

Dr Sara Weeks
MB ChB, FRANZCP

Patient safety – the reason for notifying the Council about a colleague

Many doctors are reluctant to raise concerns they may have about a colleague with either the colleague or the Council. Despite the statutory obligation, no one likes to initiate a review of a colleague. However, it is far better to act than let a crisis develop. As long as the condition is reversible or can be managed, a doctor can often continue to practise while receiving treatment.

If you are unsure whether a colleague is unwell, you are entitled to seek medical advice to help form your opinion. You are legally protected, provided you have acted in good faith and with reasonable care.

How to notify the Medical Council

The notification or concerns should be put in writing to the registrar of the Council. You should include details of any medical advice obtained. The registrar will then pass the information to the Council's Health Committee to consider as quickly as possible.

If you are wanting more specific information on how to make a notification you should consider either calling the Council's health manager, Lynne Urquhart (0800 286 801 extn 774) or get in touch with the Medical Protection Society on 0800 225 5677.

The health of rural doctors – by Dr Pat Farry

Landscapes can be deceptive. Sometimes a landscape seems to be less a setting for the life of its inhabitants than a curtain behind which their struggles, achievements and accidents take place. For those of us who, with the inhabitants, are behind the curtain, landmarks are no longer geographic but also biographical and personal.

So begins the book *A Fortunate Man* by John Berger – the story of a country doctor.

These sentiments ring true for any doctor who has lived and provided patient care in the same rural area for a number of years. Many of the geographic features and buildings are associated with vivid memories of patients and their families, and outcomes good and bad.

When you live within, and you are part of, a small community, the "successes" and "failures" of your care of patients are known and judged not only by the patient and their family but by the whole community.

You may well ask if I am an appropriate person to be writing about the health of rural doctors in New Zealand. I wondered about that myself when I received the request.

I have provided rural health services in general practice, hospital and maternity for up to 38 years, and have been involved in rural medical education for 36 years. I have had to overcome a major addiction from which I remain in recovery today. I have been Director of Rural Health at a time when it was considered by many that we were approaching a crisis point in rural health in New Zealand. I found this difficult to influence and I came to realise that in the rural environment we are always "the loss of one GP" away from a crisis.

I don't know how many times I have been witness to the sudden development of serious ill health in a rural GP colleague, resulting in the already worried and stressed spouse having to frantically start searching for locums to take over duties at the practice. The smaller and more isolated the practice, the more urgent the need for a locum. It should not be the responsibility of a worried or even grieving spouse to be searching for locums at a time like this.

Over the past 38 years of being committed to rural health I have interacted with many rural communities, their health trusts and companies, their hospital boards, and more recently their district health boards (DHBs) and primary health organisations (PHOs).

All of these communities and their health–based organisations are unique; most are extremely supportive of their rural workforce, but, unfortunately, some are not.

Some community health trusts have no direct contact with their health professionals – even in an advisory capacity. Members of such trusts have often asked me why I think they have so much trouble retaining their workforce. At the same time the departing GP is telling me that for many years their requests have fallen on deaf ears. Likewise DHBs often cannot understand why their rural hospital generalists have a high turnover and low morale. One important reason for this is the lack of clinical governance at most of these hospitals. As well, for many years hospital boards and DHBs did nothing to ensure that the generalist doctors servicing their rural hospitals had a training pathway and vocational registration. These doctors were classified by their pay scale, Medical Officer Special Scale (MOSS), which did not in any way recognise the special generalist skills these doctors bring to rural patients. Thankfully this situation has been corrected with the establishment of the Division of Rural Hospital Medicine of the RNZCGP.

I can hear you saying that these things are more to do with the provision of rural services than the health of the rural doctor. This is not the case in my experience. The anger, disappointment and frustration impacts negatively, not only on rural GPs and their families, but unfortunately sometimes on the patient.

Then there is the issue of providing 24/7 care for the community. Again, the smaller the community, the more stressful the roster. In a two–doctor practice each will be on call every second weekend – say from 6pm on Friday until 9am on Monday. If that doctor sees twelve patients over the weekend, they will earn somewhere between $9 and $12 an hour.

If we are to continue to provide such essential services, doctors must be appropriately remunerated. Otherwise more rural doctors will move to cities, where after–hours services are managed with 8–hour shifts.

Indeed our junior doctors are mostly only expected to work shifts. House surgeons' quarters have disappeared because RMOs are not expected to have to sleep while on call. This will inevitably change the expectations of our future rural workforce and will alter the willingness of our GP registrars to work in rural New Zealand, where you are expected to leave your bed to see acutely ill patients in the middle of the night.

A research project is being undertaken at present to study the effects of this type of work on the health of rural GPs in New Zealand.

I believe that being adequately remunerated is only part of the solution to 24/7 rural medical care. Adequate time off is also essential and this cannot happen until the workforce issues in rural general practice are corrected. Rural selection of medical students and rural medical immersion programmes give some hope, as does the PGY2 rural experience programme. The RNZCGP, however, still does not consider that a specific rural general practice training programme is required, even though in a survey of the 2000 and 2001 GP registrars, 40 percent considered their training did not prepare them adequately for rural practice.[1] I hope that the newly formed Rural Faculty of the RNZCGP will be involved in the development of a specific curriculum for rural GP vocational training in the future.

It's probably now time to discuss more directly the factors involved in the health of rural GPs and their families. One important issue is who provides GP care for the rural GP and their family. This is not so much of a problem in bigger towns where there may be a choice of doctors or even practices, but in small towns there may be no choice.

If the doctor's family members have issues that are private, they may not wish to discuss them with a GP who is a practice partner of their spouse or parent. This makes it very important that a continuing, trusting relationship develops over a number of years. Such a relationship should develop through the patient seeing the same doctor for all routine consultations in the hope that, when something serious occurs, the doctor–patient relationship is solid and trusting so that even the most private issues can be dealt with. Living in a small town I have had to be GP to many friends as well as colleagues and their families. One such colleague has been my family's GP for 26 years.

> "If we are to continue to provide such essential services, doctors must be appropriately remunerated…"

Even the simplest therapeutic interventions for self or family can be a "slippery slope" for a rural GP. There is a great risk that we will "over–read" or "under–read" the evidence in dealing with medical problems for ourselves or our family members.

I believe that the pharmaceutical limit for family members should be "over the

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counter" items only, while diagnostic input should be limited to "I think you should see the doctor!".

Some sole rural GPs will be saying, "That's all very well, but I have, on occasions, had to give my spouse or my children antibiotics." I agree it is unrealistic to consider this might not happen in an urgent situation. So what's the bottom line? My belief is that absolutely no mind–altering medications should ever be prescribed for self, spouse or family without at least a second opinion, by phone if necessary, from the family's GP and then only in an emergency. It is interesting to note that the Medical Council has recently given national recommendations about medical care of family members.

Finally I would like to acknowledge the excellent work done by the Health Committee of the Medical Council. I can say from personal experience that this committee serves the safety of the New Zealand public, but also has the best interests of the doctor at heart. Committee members act with professionalism, care and confidentiality at a high level.

Dr Pat Farry
MB ChB, FRNZCGP

Reference:
[1] Hill D, Martin I, Farry P.
What would attract general practice trainees into rural practice in New Zealand?
NZ Med J; 5(1161).

Retirement from medical practice: a surgeon's view – by Dr Pat Alley

Retirement is an inevitability of any working life, but is a particular challenge to the medical community for several reasons:

- Since the nature of the work is as much vocational as occupational, multiple or even parallel careers that an individual can fall back on are not common.
- The training is long, and getting longer for specialists, and the sense of "owing the community" tends to keep people working, sometimes longer than they should.
- There are increasingly potent fiscal pressures – student debt is but one of many – that keep people in employment for longer.
- Medical practice is by and large fulfilling and interesting work – why would you want to stop doing it?
- There is a widespread fear that if work stops there will not be enough money to live on.

However, none of us can work forever (although there is on record a surgeon in Yugoslavia still operating at the age of 101!). In Australia and New Zealand there is no mandatory age of retirement for anybody. The trick is to get the right answer to the question, "When should I retire?" The simple answer is, "When I am ready, happy to do so and can afford to." Commonly, however, it is not the case that doctors retire willingly and happily, and I now want to explore some of the issues around that.

In surgery it is preferable to have a planned elective operation with all the relevant facts about the patient to hand. Acute unplanned procedures, even if very necessary, are more risky. So it is with retirement. A "good" retirement is usually one that is planned for years, even decades. "Bad" retirements are often acute retirements, which are to be avoided if at all possible. The worst–case scenario for a doctor is being forced to retire because of failing competence or health or both. They have not planned for this eventuality at all. They leave their work unhappily under a cloud of variable darkness. Physical and mental health issues are common consequences of such departures from practice.

While there is no mandatory age of retirement for any employment group, doctors do represent a special case, simply because their work affects the lives of others in tangible and potent ways. For this reason they should have closer attention paid to them by regulatory authorities. The relationship between competence, health and practice has been exhaustively written about, but all doctors need to be reminded that minor changes in cognitive, clinical and communication ability may well pass unnoticed by the individual. I have heard surgeons say, "I'll retire when I slow up and can't cope with the workload." Sadly, when such an individual makes that judgement then it is usually well past the time they should retire. They should not rely on close third parties, such as a life partner or an anaesthetist (in the case of a surgeon) in making such judgments, because of the reluctance to cause offence by saying, "I'm sorry, you're past doing this job and you should stop now."

Actuarial data in New Zealand indicate that we can expect to live till our early 80s if we are female and our late 70s if we are male. That means that from a "normal" retirement age there will be up to 15 years, or maybe more, to

fill before we shuffle off this mortal coil. Standardised mortality rates for cardiovascular disease in particular are substantially lower for doctors than the general population.

Doctors are well used to planning their employment and education. The undergraduate career is long. The intern and trainee period may be up to 8 years or more, and there are more years spent in postgraduate and specialist educational environments preparing for one employment destination. So it is curious to hear a doctor say in November, "Oh – I think I'll retire at the end of this year. Spend a bit more time with the wife and grandchildren and get my golf game sorted out."

Such short–term planning for retirement is bound to fail. And, as an aside, do not even consider using your leisure pursuits as replacement activity for retirement. There is only so much golf you can play in a week and after three months you will begin to hate the game you once loved. The same goes for occasional recreational pursuits.

So the main message is that retirement has to be planned well in advance.[1]

15–20 years before retirement

Regular health checks with your GP should be well established by now. You should be adhering to a regular (at least three times a week) one hour exercise regime with a view to maintaining cardio–respiratory fitness, reasonable upper and lower body strength, and, importantly, as near to ideal body weight as possible. Have your eyesight checked regularly from now on.

You should be developing a range of interests and activities outside your working environment, including your own continuing education. If you might be considering a parallel career such as counselling or teaching, now is the time to find out what extra qualifications you may need.

> "When retirement occurs, adjustments are necessary about such apparently mundane things…

In respect of your financial circumstances, now is the time to seek advice on strategies to close the gap between your desired retirement income and your actual likely income. Consider retirement investment options along with superannuation options and tax plans. A financial adviser can also indicate the best time, based on your economic profile, for you to retire.

A related matter is where you intend to live in retirement. If you wish to stay in your locality, is the present house you are living in going to suit a smaller household? Consider the size of your garden – will it be too large for you in retirement?

5–10 years before retirement

Continue to follow the advice above, with the further consideration of how your current skill set might be adapted for a transitional employment role, if that is what you are considering. The availability of employment parallel to medicine is worth investigating at this time. For example, the clinical departments of medical schools are often seeking good clinical teachers.

This is the time to discuss retirement with your life partner. They very much need to be part of the decision. Medical life by its nature often invades family time and time with one's spouse.

When retirement occurs, adjustments are necessary about such apparently mundane things as whether the recently retired will be in for lunch or not. As the sage wife of a recently retired specialist commented to me, "Retirement is more husband and less money!".

Consultation with your practice partners should occur at this stage as well.

Up to 2 years before retirement

You should undertake a careful review of your financial plans at this stage. If you are considering ceasing practice totally, take legal advice on the retention or disposal of the medical records of your patients. Your professional indemnity situation should be discussed with the provider who covers you. Review your will.

Travel is often an important theme of retirement – interestingly, most retiring doctors travel extensively, and to unusual places. However, this travel bug seems to depart after about 5 years, and closer destinations – the east coast of Australia and the Pacific – are favoured by those over 75. So with the expensive travel often done in the early retirement years, some time spent planning travel activity is worthwhile at this stage.

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There are several retirement strategies for the general population, which are appropriate for doctors as well. The "crisp method" is a clean break from work with no return to anything remotely related to it. The "blurred method" is a stop–start approach where intermittent return to work occurs; this is not recommended for any employment group, let alone doctors. By far the commonest is the "bridging method" where there is a gradual, staged withdrawal from work.

Whatever method you choose, it is appropriate to recall the "Rs" of retirement: [2]

- Retire the word "retirement"
- Retain the competencies you need
- Restructure your priorities
- Renew your zest for education
- Respond to new opportunities
- Recharge your body by getting and keeping physically fit
- Revisit your childhood dreams
- Remember that your wisdom stays with you.

Dr Pat Alley
MB ChB FRACS Dip Prof Ethics

[1] Royal Australasian College of Surgeons; Planning Life After Surgery. Discussion document. RACS; 2008 October.

[2] Clunie G cited in Waxman B. Winding down from surgical practice. Aust N Z J Surg. 2008

Free counselling service for doctors proving its worth

Towards the end of 2005 the Medical Assurance Society (MAS) and the Medical Protection Society (MPS) jointly set up and funded a free counselling service available to any doctor in New Zealand.

> "Some of the results have been unexpected. For example, it had been initially assumed that the service would be mostly accessed by doctors who had received complaints…"

A number of factors led to the establishment of this service.

- In 2004 Dr Wayne Cunningham published data on the impact on doctors who had received complaints against them, which showed a variety of significant adverse outcomes for those doctors.
- MPS is at the front line of the immediate emotional impact of complaints – the doctors who answer the phones are dealing every day with worried, anxious and upset doctors, many of whom are receiving a complaint for the first time, and who are rightly concerned about the possible long–term outcomes.
- The barristers who assist these doctors through the process are also well aware of the difficulties doctors face in dealing with complaints, and were keen to be able to offer practical support to those who seemed to be struggling.
- MAS, particularly through its income support policies, is aware of the impact of stress generally on a doctor's ability to work.

The two organisations reasoned that a counselling service would be useful to their members and the wider medical community.

Access to counselling is easy and confidential – all a doctor needs to do is to ring the MPS freephone number (0800 225 5677) and they will be advised by the medico–legal consultant on duty how to arrange counselling. The name of the doctor is not recorded, so MPS and MAS are not aware of who is actually using the service. The doctor can see a psychiatrist or clinical psychologist of their own choice or one recommended by MPS/MAS. At this stage there is no limit on the number of sessions available.

MPS has now conducted a review of the service, with the full results to be submitted this year for publication in the *New Zealand Medical Journal*. The review consisted of a questionnaire for the providers of the therapy, another questionnaire sent on to the doctors by the therapists, and a third allied questionnaire for doctors who had received a complaint through the office of the Health and Disability Commissioner.

Some of the results have been unexpected. For example, it had been

> "Although a different need is being met than that which was originally envisaged, the benefits are clearly there…

initially assumed that the service would be mostly accessed by doctors who had received complaints.

In fact fewer than 30 percent had this as a precipitating reason for attending.

Work stress, including high workload and reduced staff numbers, interpersonal difficulties and bullying, featured strongly. Personal difficulties relating to family, relationships and cultural adjustments made up the bulk of the remainder.

A few doctors who presented had more significant psychopathology, including depression, bipolar disorder and sexual abuse. Most of these had not been previously treated. The reviewers considered that even if the service had achieved no more than assisting these doctors it still would be regarded as being very successful.

Fortunately it was also shown that both the providers and the doctors generally regarded the intervention as being very useful, with a significant number of doctors reporting an improved ability to either continue at work or to return to work earlier. The first doctor questionnaire opened by the reviewers had the comment, "Thank you very much for providing this assistance – it has been so useful to me."

The total number of doctors accessing the service over 2½ years is just over 80, and most needed only a few sessions to address their issues.

The service is clearly only scratching the surface of need as most of the psychiatrists and psychologists reported seeing more doctors who funded themselves than doctors who were funded by MPS/MAS. There was a strong feeling that better publicity for the service would be helpful. This was confirmed in the survey of doctors who had received complaints, with most not aware that free counselling was available. However, only a few felt they would have actually needed to access it.

Both MPS and MAS are committed to continuing the service, and expect it to be used more with increased publicity. Although a different need is being met than that which was originally envisaged, the benefits are clearly there, and both organisations see this as an important contribution to the health of New Zealand's medical community.

The counselling service is contactable 24 hours a day, 7 days a week on 0800 225 5677. Calls are totally confidential and no details about the doctor are recorded by MPS or MAS.

Tim Cookson
MB ChB
Medico–legal consultant to MPS

Resources for help

Cole's Medical practice in New Zealand, editor Ian St George (2009 edition), Medical Council of New Zealand.

Available free of charge to all practising doctors in hard copy or online at **www.mcnz.org.nz>>Publications>>Good medical practice**

In Sickness and in Health, editors John O'Hagan and John Richards, DHAS, Wellington (1997). A handbook for doctors, other health professionals, their partners and families.

Ethics 101 – encouraging dialogue on ethical issues

Do you know when it's inappropriate to accept a gift from a patient? What do you do if you hear that one of your colleagues is limiting patients to one medical complaint per visit? Can you refuse to accept a new patient if their medical history is complex?

When faced with these types of dilemmas, doctors often contact the Council for guidance. Unfortunately, the response isn't always black and white. The details of each individual situation tend to be quite unique and the advice to one doctor may not be the same as to another doctor in a similar situation.

To encourage dialogue on these issues, the Council has introduced the Ethics 101 column – inspired by a column published by the College of Physicians and Surgeons of Alberta. In each newsletter this column will outline an ethical situation, and we'll ask for opinions from the profession. We'll publish a selection of responses giving various viewpoints in the following issue and on our website.

There will be no "right" or "wrong" answers – rather we aim to hold a thoughtful discussion about the pros and cons of various approaches. This approach will allow doctors to benefit from the wisdom of their colleagues, and will also create interest among the profession about practical responses to ethical issues.

What would you do?

In your role, you often see patients who are unable to work and want you to sign a form that will allow them to receive a sickness benefit. One such patient suffers from gout, but he won't comply with treatment that could help to control his symptoms, and is unwilling to change unhealthy aspects of his lifestyle. If this patient followed your recommendations, he could almost certainly improve his health and be able to return to work.

Would you complete this patient's sickness benefit form? If so, what would you write on it? What else would you do?

This question was suggested by Dr Jenny Pearson, GP. Email your answers to Michael Thorn, Senior Policy Analyst, at **mthorn@mcnz.org.nz** (use the subject line "Ethics 101"). If you have ideas for topics for future columns, please feel free to send them to us as well.

Responses to our previous column

Our last column asked what you would do in the following situation.

"You have enjoyed working in general practice for 10 years but have recently received an offer to join a new cosmetic practice.

The hours, pay and working conditions would be much better than you currently enjoy, but you are acutely aware that there is a shortage of general practitioners in the area. Furthermore, you know your patients will have difficulty finding a new doctor.

Do you have an obligation to the community to continue providing care? Or should you accept the offer, which will allow you to work less for significantly more income?"

Dr Anton Wiles, an Auckland GP, stated, "In the end one's responsibility is to oneself, to balance work, family, leisure, lifestyle and income… [however] there is a responsibility to exit practice in a way that allows patients time to seek an alternative health provider."

Dr Kirsty Laws, a GP in Warkworth, stated, "Is it unethical for a doctor in a shortage specialty or district to seek better paid or less demanding employment? If the answer is yes, then I am denied the most basic right of any worker."

Dr Laws also expressed a concern that health bureaucrats might use responses to this question to try to solve workforce problems of their own making, and that the Council is in

danger of confusing professional ethics with moral virtue.

Editorial note: We would like to make clear that it is not our intention that this column be used to guide policy or set new ethical standards. Instead we simply hope the answers doctors provide might be of help to their colleagues!

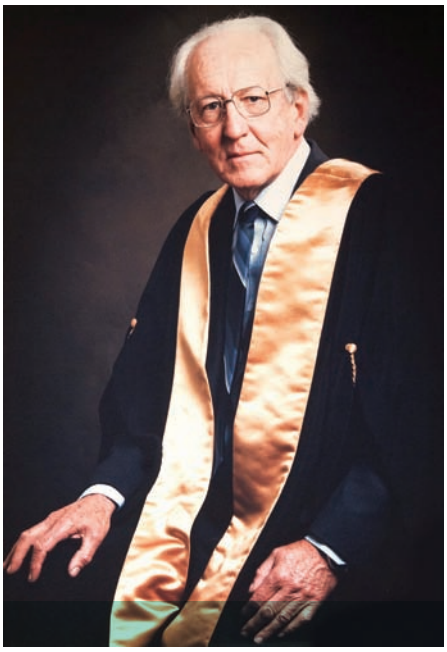
Dr Joanne MacGregor, GP, stated that the doctor's decision should be looked at in a wider context. "He also has a wife and family. He is part of a wider community. He is part of a wider medical system … Government and statutory bodies also have a responsibility to this doctor. It cannot be left to the goodwill and self–sacrificing ideals of an individual doctor to prop up a whole system that is not working … Perhaps we should be looking at what we can do as a profession and as a society to make general practice as attractive as cosmetic medicine."

Dr Greig Russell, GP and a student of ethics, looked at the question from a number of different perspectives. He concluded that the community, doctors and regulators might all benefit if all doctors sought "to expand the depth and breadth of medical practice available to a population". In this case, the doctor would benefit both personally and professionally from moving into a cosmetic practice. And by helping to find a replacement who would not end up feeling entrapped and embittered, she would also ensure that the community would benefit.

Full responses to this question can be found on our website, www.mcnz.org.nz, under the heading "News / Ethics 101". All these responses are well worth reading, and we are very grateful to the doctors who provided them.

Obituary: *Professor David Cole*

David Cole died on 8 September 2008. He was a giant – a gentle, humble, persuasive, logical, humorous, sensible, sensitive, intellectual man with a broad and optimistic view of the world. He was a Medical Councillor from 1972 until 1988,and in the last five years a member of its Education, Specialist Registration and Preliminary Proceedings Committees. His contributions in those roles were considerable. I have no doubt he would have chaired the Council, but he saw a conflict of interest between his role as a medical school dean and that position.

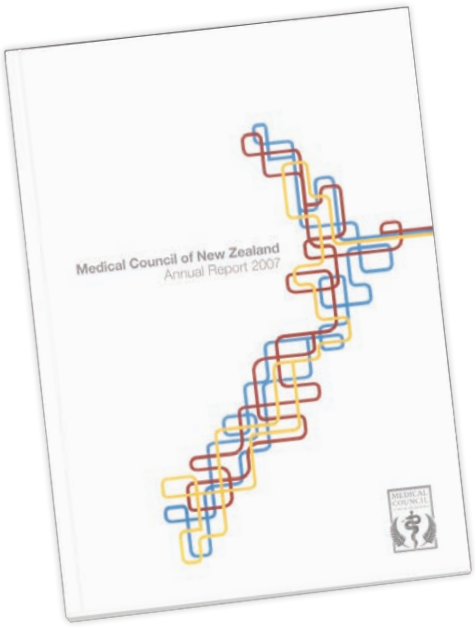


Professor David Cole
Photo: Courtesy of the Faculty of Medical & Health Sciences, The University of Auckland

I think his greatest contribution to the Council's work is his book. It was first published in 1984 by the Medical Protection Society as *Medical Practice and Professional Conduct*. David was Chair of the Preliminary Proceedings Committee – the prosecuting body for the Medical Council in the days before disciplinary matters were separated from the Council with the creation of the Health and Disability Commission and the Medical (later Health) Practitioners Disciplinary Tribunal. The book gave commentary on a series of illustrative medical disciplinary cases. A second edition appeared in 1995, published by the Medical Council of New Zealand as *Medical Practice in New Zealand: A guide to doctors entering practice*. This retained some of the disciplinary flavour, but included new material, and was directed more clearly to new registrants, especially international graduates. By 1999 David had left the Council, and stocks of his book were empty.

My first edition was in 2001, and, in the tradition of other medical texts, I wanted to recognise the first author: I think David was flattered, if a little embarrassed, but a new edition has appeared every year since then as *Cole's Medical practice in New Zealand*. It is now the work of an editorial board and thirty authors. That says something about David Cole.

Dr Ian St George
MB ChB, DObstRCOG, FRACP, FRNZCGP, DipEd MD
Council member and editor of *Cole's Medical practice in New Zealand*.



Medical Council of New Zealand 2007 annual report

The Council's 2007 annual report can be either read or downloaded online at **www.mcnz.org.nz>>Publications»MCNZ annual reports, highlights and strategic plan** or you can request a copy by emailing **info@mcnz.org.nz**

Lost doctors

In this issue of *Medical Council News*, we list several "lost" doctors whom we cannot trace because they have failed to let us know their new addresses. (See opposite page.)

If you change your address, you must let us know your new address within one month. You can change your address online at **www.mcnz.org.nz Registration>>Currently registered doctors>>Change your personal details.**

New Council members appointed

The Minister of Health appointed three new Council members in September. They are:

- Dr John Adams, the dean of the Otago Medical School
- Dr Allen Fraser, an Auckland psychiatrist
- Ms Judith Fyfe, a lawyer, businesswoman and former journalist.

Four existing members of Council were reappointed by the Minister. They are:

- Professor John Campbell, current chair of the Council and professor of geriatric medicine at the University of Otago
- Jean Hera, community health worker and manager at the Palmerston North Women's Health Collective
- Liz Hird, barrister and national legal adviser to HealthCare Aotearoa (Inc)
- Heather Thomson, who has been a lay member on many boards including the Cartwright Committee, the Public Health Commission, the Maori Health Commission and the Bay of Plenty District Health Board.

Drs Joanna MacDonald and Deborah Read have stood down from Council.

Order your free folder

In recent years, the Council has produced over 30 statements on topics such as:

- Informed consent
- The responsibilities of doctors in management positions
- Keeping patient records.

You can order a free hardcover folder to store these statements.

We encourage you to order a folder for yourself or your practice.

As new statements are produced, or others are updated, we will send them to you automatically with the Council newsletter. You can then file them in the folder for quick reference.

You can place your order at **folder@mcnz.org.nz** or phone 0800 286 801 extn 793.

The statements are also on our website at **www.mcnz.org.nz>>Publications & guidance>>Statements.**

Cole's Medical practice in New Zealand

A new edition of *Cole's Medical practice in New Zealand* is available either online at **www.mcnz.org.nz>> Publications>>Good medical practice** or you can request copies by **emailing info@mcnz.org.nz**.

Edited by Ian St George, a Council member, the book's main purpose is to introduce for new entrants to medical practice in New Zealand the main legislation, ethical standards and guidelines. *Cole's*, however, is a valuable resource for all in the profession.

A guide to cosmetic procedures for patients

The Council has produced a plain English guide for patients called *What to expect from your doctor when you have a cosmetic procedure*. It outlines issues patients should be aware of and questions they should ask their doctor before undergoing a cosmetic procedure.

Copies of the guide are available from our website, **www.mcnz.org.nz** or you can request copies by emailing **info@mcnz.org.nz**

Seeking Wellington-based doctors

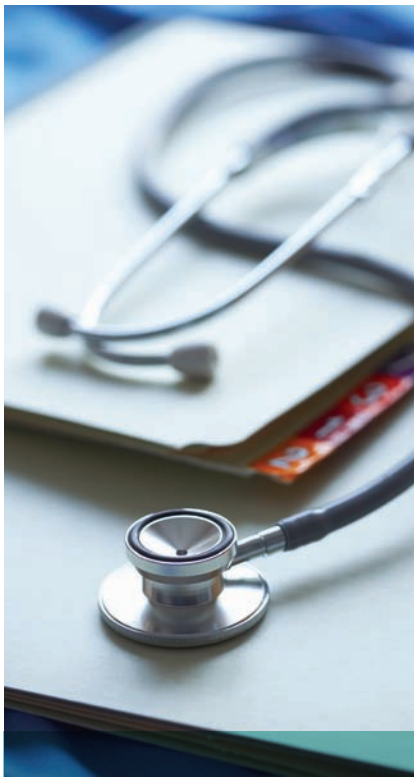
NZREX is the entry examination for some international medical graduates who want to practise in New Zealand. The Council is seeking doctors from the Wellington region to help add to the bank of questions used in the NZREX.

Please contact Megan Purves **(mpurves@mcnz.org.nz)** if you are interested and familiar with the standard of practice expected of new graduates in the New Zealand system.

"Lost" doctors

The following doctors will be removed from the medical register unless we receive their new addresses. If you know how to contact these doctors, please email **apc@mcnz.org.nz** or phone 0800 286 801 extn 785.

- Dr Nadeem Andrew Ansari
- Dr Alan John Farrell
- Dr Michael James Kimber
- Dr Vincent Sze Sern King
- Dr Hani Taysir Suleiman Mustafa
- Dr Timothy Martin Platt
- Dr Adam Michael Roberts
- Dr Leigh Sindelman
- Dr Andrew Logan Stuckey
- Dr Colleen Reindina Frederika Van Laar



Annual practising certificate fee increase

The Council has, after considerable debate, decided to increase the cost of your annual practising certificate (APC) from $540 to $640 (GST inclusive). The intended increase will take effect from 1 July 2009. There has been only one increase in the APC fee since 1997/98 and this was from $485 to the current fee of $540 in 2005/06.

The increase of $100.00 (GST inclusive) in the APC fee will provide additional annual revenue of around $1.03m for the Council.

The Council's APC fee accounts for 80 percent of Council's total revenue. Significant increases in Council's costs have led to the increase in the APC fee. The Council is accountable to the profession for the efficient and effective use of your funds and we aim to manage our budget and costs conservatively. However, there have been several cost increases to the Council resulting in a substantial reduction in our reserves.

Increased costs for the Council

The main increase in costs arises from:

- Council's increased workload. There have been substantial increases in the costs of Professional Conduct Committees (PCC), the Health Practitioners Disciplinary Tribunal (HPDT) and Performance Assessment Committees (PAC).

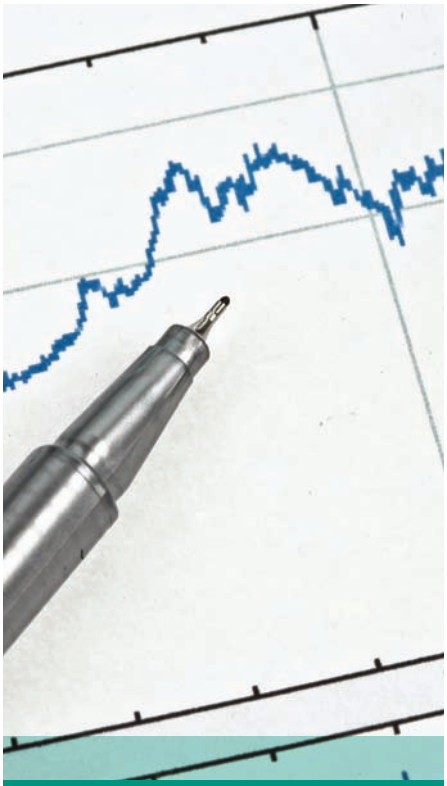
  PCCs have increased in number from six in 2005/2006 to eighteen in 2007/08, and HPDT hearing days have increased by a similar amount. PACs have increased from 19 to 42 in the same period. The costs of litigation are significant, with one particular PCC case alone costing the Council around $0.71m to date. Council has very little control over these costs.
- The costs associated with the development of the Council's new information and technology systems will be around $3.0m. There have been no major investments in IT development in the last 10–15 years. These costs are funded from reserves. In one year's time we anticipate that doctors will be able to access their own full record on–line, organise their APC, and carry out several other common functions electronically. The system has a planned lifespan of at least 10 years.
- The costs required to develop and implement initiatives within the Council's four strategic directions
  - — Fitness to practise.
  - — Medical migration.
  - — Medical education.
  - — Accountability to the public and to stakeholders.
- The general cost increases for certain administrative services over the past two years, for example, telephone, tolls and internet, audit fees.

Cost savings

Council members and staff have this year cut $160,000 from our budget with savings in areas such as travel and accommodation, staff salaries, international liaison expenditure and fees, and printing of publications.

Annual practising fees, income and expenditure for comparable professions

The intended increase to $640 on 1 July 2009 will still retain the Council's APC fee at a significantly lower level than many comparable professions.



STOP PRESS

The new Minister of Health, Tony Ryall has given the profession a commitment that the Medical Council election will be binding.

Speaking to the Association of Salaried Medical Specialists in late November Mr Ryall indicated that the four top polling doctors chosen by the profession would serve on Council.

Nominations for Council must be received by noon on Friday, 23 January 2009.

Annual practising certificate (APC) incomplete applications

The Council – would like to advise all doctors applying to renew their APC, that any incomplete APC applications received in the Council office will be returned unreceipted for completion before any processing begins.