check

Independent learning program for GPs

Unit 511 November 2014

GP health and wellbeing

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GP health and wellbeing

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The five domains of general practice

- Communication skills and the patient-doctor relationship
- Applied professional knowledge and skills
- Population health and the context of general practice
- Professional and ethical role
- Organisational and legal dimensions

RACGP

ABOUT THIS ACTIVITY

Doctors enjoy good general health[1] but are vulnerable to burnout[2] through their exposure to various stressors and pressures in their role as healthcare providers. This unit of *check* focuses on issues of general practitioner health and wellbeing, and provides education about the importance of seeking formal healthcare when necessary. It aims to foster a supportive, non-judgemental culture that instils confidence in their ability to access appropriate avenues of help.

LEARNING OUTCOMES

At the end of this activity participants will be able to:

- describe situations that require mandatory reporting of a doctor
- explain how a complaint may affect a doctor's health and wellbeing
- outline best practice management of a needlestick injury sustained by a doctor
- discuss potential problems that have been identified when doctors self-treat
- discuss strategies that may help doctors in practice to accommodate the process of ageing.

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GUIDE TO ABBREVIATIONS AND ACRONYMS IN THIS UNIT OF *CHECK*

AHPRA	Australian Health Practitioner Regulation Agency	HCV	hepatitis C virus
BSL	blood sugar level	HIV	human immunodeficiency virus
GPCOG	GP assessment of cognition	MDO	medical defence organisation
HBV	hepatitis B virus	PEP	post-exposure prophylaxis

CASE 1

DR ANN HAS A FEW DRINKS AT LUNCH

Dr Ann is a GP aged 40 years. Her colleagues are aware she is going through an acrimonious divorce and she has mentioned she is not sleeping or eating well. She has been drinking more alcohol than usual.

One day she has a few drinks at lunch before her afternoon session. The practice manager receives a complaint from the patient attending the first appointment after lunch. The patient reports she smelt alcohol on Dr Ann, who was also dishevelled, vague and distracted throughout the consultation. The patient says that she had previously respected Dr Ann but the practice must do something or she will complain to the Medical Board of Australia (the Board) if this happens again. The practice manager, a trained nurse, immediately talks to Dr Fred, the senior doctor in the practice.

QUESTION 1

What should Dr Fred do?

FURTHER INFORMATION

Dr Fred interrupts his afternoon session to go to Dr Ann's office and finds his colleague smells of alcohol and looks the worse for wear. Dr Ann admits she had a few glasses of wine at lunch and says she had forgotten she was working that afternoon. Dr Ann then becomes tearful and tells Dr Fred she thinks she is depressed and doesn't know what to do. Dr Fred advises Dr Ann to go home now. He asks her how she is feeling, and whether she will be ok at home, or if he should phone a friend for her. Dr Ann says she thinks she will be ok and her daughter will be home from university later that day. Dr Ann's appointments for that afternoon and the next day are cancelled, and her patients are advised that she is unwell.

The next day Fred meets with Ann to discuss the situation. He tells her he may need to inform the Board via the Australian Health Practitioner Regulation Agency (AHPRA) of what has happened.

QUESTION 2

What is the role of the Board? How does it relate to AHPRA?

QUESTION 3

Under what circumstances must Dr Fred make a report to AHPRA? Is the practice manager required to make a report to AHPRA?

QUESTION 4

If Dr Fred had not observed Dr Ann himself, can he rely on someone else's observations?

QUESTION 5

What are the exceptions to the requirements for making a mandatory notification?

QUESTION 6

Given the exceptions to mandatory reporting requirements, with whom can Fred discuss this situation? Are there any other options for Dr Fred and Dr Ann?

FURTHER INFORMATION

Dr Ann contacts her medical defence organisation (MDO) and with their assistance makes a self-notification to AHPRA, outlining her difficult circumstances, depression and alcohol abuse. Dr Ann decides to take a short break from work. She then consults her doctor, who confirms the diagnosis of depression and prescribes antidepressant treatment. Dr Ann decides to stop drinking alcohol.

QUESTION 7

What is 'impairment' under the Health Practitioner Regulation National Law (National Law)?

QUESTION 8

What is the likely outcome of a notification of an impaired medical practitioner to AHPRA?

QUESTION 9

What are the possible consequences if neither Dr Fred nor Dr Ann makes a notification to AHPRA? Is there any protection for people making a notification?

QUESTION 10

If Dr Ann saw her doctor about her depression and commenced treatment for it, is her treating doctor obliged to make a mandatory report about Dr Ann's impairment?

CASE 1 ANSWERS

ANSWER 1

This is a very difficult situation. It would be preferable for Dr Fred to:

- tell Dr Ann that a patient has made a complaint against her and provide details of the complaint
- give Dr Ann an opportunity to explain what happened at the consultation
- offer support for Dr Ann.

This course of action may be possible if they have a good relationship but under some circumstances it may be difficult.

ANSWER 2

The core role of the Board[1] and AHPRA[2] is to protect the public.

The Board is one of 14 national boards regulating registered health practitioners in Australia. As well as their core role to protect the public, national boards set the standards that practitioners must meet, and manage notifications (complaints) about the health, conduct or performance of health practitioners.

AHPRA works in partnership with the national boards to implement the National Registration and Accreditation Scheme under the Health Practitioner Regulation National Law (the National Law), which is in force in each state and territory.

ANSWER 3

According to AHPRA, 'All registered health practitioners have a professional and ethical obligation to protect and promote public health and safe healthcare. Under the National Law, health practitioners, employers and education providers have some mandatory reporting responsibilities.' The obligation is on any health practitioner or employer who forms a reasonable belief that another health practitioner has engaged in notifiable conduct to make a report to AHPRA as soon as practicable.[2]

Notifiable conduct is defined as:[3–5]

- practising while intoxicated by drugs or alcohol
- engaging in sexual misconduct
- placing the public at risk of substantial harm because of an impairment
- placing the public at risk because of a significant departure from accepted professional standards.

If Dr Fred considers that Dr Ann was intoxicated while at work, then that would be notifiable conduct and Fred has an obligation to inform AHPRA.

Mandatory reporting obligations apply to all registered health practitioners and not only to those in the same profession as the person making the report.[3,5] The National Law applies to various health professionals, including nurses (and midwives) and doctors.[4] Hence, if the practice nurse formed the view that Ann was intoxicated at work, then she would have an obligation to inform the Board. It is not necessary for both the practice nurse and Fred to make a mandatory notification, as an exception arises if someone else has already made a notification.

ANSWER 4

Making a notification to AHPRA about another health practitioner is a serious step to take. Fred must have formed a 'reasonable belief' that notifiable conduct occurred.[4–6] Speculation, rumours and gossip would not be enough to form a reasonable belief. A reasonable belief requires a stronger level of knowledge, such as direct knowledge or observation of the behaviour, or a report from a reliable source. If Fred had not observed Ann, he would need to consider whether his informant (in this case the practice manager) is reliable and, if so, that may be enough for him to form a belief that Ann has been seeing patients while intoxicated.

ANSWER 5

There are exceptions to the requirements to make a mandatory notification. Exceptions arise where the health practitioner who would be required to make the notification:[5]

- reasonably believes that someone else has already made a notification
- is employed or engaged by a professional indemnity insurer, and forms the belief because of a disclosure in the course of a legal proceeding or the provision of legal advice arising from the insurance policy
- forms the belief while providing advice about legal proceedings or the preparation of legal advice
- is exercising functions as a member of a quality assurance committee, council or other similar body approved or authorised under legislation which prohibits the disclosure of the information
- is a treating practitioner in Western Australia
- is a treating practitioner in Queensland, under some circumstances.

ANSWER 6

Fred can ring his MDO and discuss the situation with one of their staff. The discussion would be confidential and the doctor employed by the MDO will not be under any mandatory reporting obligation.

One of the exceptions is that if Fred believes that someone else has notified the relevant authorities about Ann's conduct, then he does not need to report her. Fred could give Ann the option to self-report and if she agrees, Fred would no longer have a mandatory obligation to report his colleague. He may want to document his discussion and this document should be stored securely.

ANSWER 7

Impairment is defined in the National Law to mean a person has a physical or mental impairment, disability, condition or a disorder (including substance abuse or dependence) that detrimentally affects, or is likely to detrimentally affect, the person's capacity to practise as a doctor.[4,7]

ANSWER 8

AHPRA and the Board take all notifications seriously. After undertaking a preliminary assessment of a notification, if the Board decides that a doctor may be impaired and further action is necessary, they may:[8]

- take immediate action, which may include suspending a doctor's registration, imposing conditions, accepting undertakings or accepting the surrender of registration
- require the doctor to undergo a health assessment
- refer the matter to a health panel.

The health assessment is conducted by an experienced and appropriately qualified, independent medical practitioner or psychologist. The Board pays for the assessment and the assessor writes a report for the Board.[8]

The doctor who was assessed is usually given a copy of the report, unless the Board believes it contains information that may be prejudicial to the doctor's health or wellbeing, in which case it is given to a doctor or psychologist nominated by the doctor. After receiving the report, the doctor who was assessed must discuss the report and ways of dealing with any adverse findings with a person nominated by the Board. The person nominated to discuss the report will be a registered medical practitioner.

If the Board believes that a practitioner's health is impaired, it can take one or more of the following courses of action:[8]

- caution the doctor
- accept an undertaking from them
- impose conditions on the practitioner's registration.

In Dr Ann's case, the Board may accept an undertaking from her. Such an undertaking would usually include Ann seeing her psychiatrist (if she is seeing one) and her GP regularly. Her treating doctor would provide the Board with reports. In some situations, the undertaking may be to undergo drug or alcohol testing.

ANSWER 9

Any practitioner who fails to make a mandatory notification when required may be subject to an investigation and possible action by their medical board. However, no penalties are prescribed under the National Law for a practitioner who fails to make a mandatory notification. However,[6] In Dr Ann's case, if the patient makes a complaint to AHPRA about Ann, then AHPRA may investigate.

The National Law protects doctors who make a notification in good faith, which means well-intentioned or without malice.[4,5] Doctors who make mandatory notifications in good faith are protected from civil, criminal and administrative liability, including defamation. The National Law clarifies that making a notification is not a breach of professional etiquette or ethics, or a departure from accepted standards of professional conduct. There is no provision for confidential reporting and the doctor is likely to be aware of who made the report. Note that legally mandated notification requirements override privacy laws. However, doctors who make notifications that are frivolous, vexatious or not in good faith may be subject to conduct action.[5]

ANSWER 10

To trigger a mandatory report regarding a doctor's impairment, the doctor must have placed the public at risk of substantial harm because of the impairment.[5,7] Impairment alone does not require a mandatory report. Therefore if Ann is able to practice safely then there is no need for a notification. If Ann is too unwell to work but she follows her doctor's advice, has some time off and returns to work when her treating doctor feels that she is well enough, then there is no need for a mandatory report.

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RESOURCES FOR DOCTORS

- The Medical Board of Australia website has information sheets on notifications, management of impaired practitioners and students, and panel hearings, www.medicalboard.gov.au
- Medical Board of Australia. Good Medical Practice: a Code of Conduct for Doctors in Australia, www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx
- National Board guidelines for registered health practitioners: guidelines for mandatory notifications, www.medicalboard.gov.au/Codes-Guidelines-Policies/Guidelines-for-mandatory-notifications.aspx

CASE 2

DR MARY RECEIVES A COMPLAINT

Dr Mary has received a letter of complaint from a long-term patient, Mrs Jones, who was diagnosed with breast cancer 1 month ago following a routine mammogram. The breast clinic informed Mrs Jones that the cancer had been detected 1 year ago when she had a mammogram that Dr Mary had ordered. Mrs Jones is angry because Dr Mary never informed her of the result. The cancer is now in an advanced stage, requiring surgery and chemotherapy, and has a poorer prognosis than if treatment had commenced earlier. In her letter, Mrs Jones says she will inform the Medical Board of Australia (the Board) and intends to sue Dr Mary for malpractice.

QUESTION 1

What impact can such a complaint have on a doctor?

QUESTION 2

How common is it to receive a complaint?

QUESTION 3

What should Dr Mary do? Should she respond to the letter?

FURTHER INFORMATION

Dr Mary and her practice manager look back through the records to find out what happened. They discovered they received the abnormal result and that Mrs Jones had made an appointment to see Dr Mary. The electronic records showed that Mrs Jones arrived at the practice for her appointment, but her medical records showed no clinical consultation took place. Dr Mary and the practice manager assumed Mrs Jones left before being seen. It was a particularly chaotic day and there were a number of emergencies. A follow-up appointment was not made.

QUESTION 4

What should be included in the letter to Mrs Jones?

QUESTION 5

What is the natural history of recovery for the 'second victim'?

QUESTION 6

What strategies might help Dr Mary to cope?

FURTHER INFORMATION

After the letter has been sent to Mrs Jones, Dr Mary and her practice manager organise a practice meeting with the staff to review how the practice handles abnormal results and follow-up appointments. They review all of their processes, consider what can go wrong, and put in place extra checks and a patient-recall system to circumvent future similar mishaps.

CASE 2 ANSWERS

ANSWER 1

Most doctors choose their profession because they want to improve the lives of others. Errors resulting in patient harm are distressing for the doctor concerned. Studies have reported on the emotional effect of adverse events on doctors. The term 'second victim' has been used to describe the healthcare professional, who may be traumatised by such events. The 'first victim' is always the patient.[1]

Commonly reported reactions among health professionals following adverse events are fear, guilt, shame, self-doubt, anger and disappointment.[2] Doctors with a current medico-legal matter have a higher prevalence of psychiatric morbidity, compared with those with no current matter. A study of 3171 physicians in internal medicine, paediatrics, family medicine and surgery in the USA and Canada reported that following errors, 61% of physicians described increased anxiety about future errors, 44% described loss of self-confidence, 42% experienced difficulty sleeping, 42% reported reduced job satisfaction and 13% reported harm to their reputation.[3]

Many doctors also experience periods of re-enactment of their errors, often with feelings of inadequacy, and of self-isolation and 'what if' questions.[4]

ANSWER 2

All medical practitioners can expect to receive at least one claim or complaint at some time in their professional career. In 2012–1013 the Australian Health Practitioner Regulation Agency (AHPRA) received notifications regarding 4.2% of medical practitioners.[5] The rate of claims against doctors in the private sector during that period was 3.4%.[6] It is hard to obtain data regarding direct patient complaints, and of course some of these complaints and claims may relate to the same doctors, but when considered over a 40-year career period, most doctors are going to receive at least one claim or complaint in their career. The threat of a medical negligence claim is commonly one of the most severe sources of stress in a doctor's working life.

In the 2012–2013 financial year, AHPRA reported that approximately 1 in 25 (4.2%) of Australia's 95,690 medical professionals received a notification of a complaint from the Board. The number of complaints is increasing and AHPRA reported a 14% increase in notifications across all professions over the 2012–2013 period.[5] Doctors received more complaints than other health professionals: doctors made up 16% of health practitioners in 2012–2013 but they received 54% of complaints.[5]

ANSWER 3

Dr Mary should immediately inform her medical defence organisation (MDO) that she has received this letter. Doctors should inform their MDO of all letters of complaint and seek the MDO's assistance in responding to them. Responses to letters of complaint should be thorough, considered and compassionate.

ANSWER 4

With the help of the claims manager at her MDO, Dr Mary drafts a letter to Mrs Jones. In the letter, Mary expresses sympathy with the diagnosis of breast cancer. She explains that Mrs Jones's follow-up appointment was marked in red for review of abnormal results and that her attendance at the practice was recorded. Unfortunately, it seems she did not wait to be seen and the practice did not have a system to flag that situation.

ANSWER 5

Most doctors who are the subject of a claim will have an emotional reaction. After the initial disbelief and denial, there may be anxiety and self-doubt. As the matter progresses, disbelief may be replaced with anger and resentment.[1,2] Of the doctors involved in claims for medical negligence, 16% may describe the onset or exacerbation of a previously diagnosed physical illness and 2% experience suicidal ideation.[7] Many doctors develop doubts about their clinical competence and lose confidence, so it may take them longer than usual to see patients and they find clinical practice more draining than previously.[8]

Although many doctors contemplate leaving medicine or changing the scope of their practice in response to a complaint, most are able to deal with these reactions and reach a resolution of symptoms within a reasonable time frame. For example, in a study of 21 health professionals, the majority described the impact of their error as long lasting, but the reported duration of impact ranged from a few months to 1 year or more.[2]

ANSWER 6

The following strategies might help Dr Mary to cope:

- **Emotional support**
  Most doctors in this situation value being able to talk about the complaint and the adverse event.[2] A trusted colleague, friend or partner may be able to listen with a sympathetic ear. The MDO may also provide support. A claim or complaint can have physical and emotional effects so it is important that the doctor maintain contact with their own GP. The doctor's GP will be a valuable source of support concerning the doctor's wellbeing and provide a referral if further formal counselling or psychiatric assessment is needed.
- **Surviving the legal/investigative process**
  The legal analysis of a medical complaint is not equivalent to a medical workup or the investigation of a patient. The processes are often unpredictable and it may take years to reach resolution. In this case, it is unclear whether this will be a medical board complaint or a claim or both. There can be a flurry of activity followed by months when nothing happens. These factors can cause feelings of powerlessness and frustration, and increase the difficulty in recovering from the adverse event and reaching closure.[2] The doctor's MDO should be a valuable source of information about the process, the likely course of the investigation and progress of the doctor's particular claim or complaint.
- **Making sense of the personal meaning of the claim or complaint**
  After an adverse event, doctors may feel insecure in their professional roles. They may have a sense of shame and a belief they are 'bad' or incompetent. Many doctors discover that these feelings affect their work to some extent and some find they take extra care in performing their work to avoid problems.[1,2] It can be helpful to reflect on complaints and determine if the adverse event could have been prevented in some way. It is always helpful to reflect on whether changes could be made to improve practice processes.

CONCLUSION

Even the most experienced and competent medical practitioner can become involved in medical negligence claims and complaints. They can occur at any time in a doctor's career. Systems failure (as in this case) and issues with communication can often be important contributing factors. Most published studies in this area highlight that collegial support is very helpful in assisting doctors to navigate this period in their lives.[2,4,9]

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CASE 3

A SLIP OF THE HAND

Andrew, aged 45 years, is a long-term patient at your practice. He presents with a hand injury, which he sustained when the kitchen knife slipped while Andrew was drying the dishes. The wound is clean and superficial, and requires suturing. There is no apparent injury to the tendons. You explain what will be involved in repairing the laceration and obtain Andrew's consent for the procedure. Unfortunately, as you insert the needle into Andrew's hand to inject the local anaesthetic, Andrew involuntarily jerks and you prick your hand with the needle.

QUESTION 1

What are the typical risks of infection and routine precautions that should be taken in the general practice setting that could have minimised exposure risk in this case?

QUESTION 2

How common are bloodborne viruses in Australia?

QUESTION 3

What should be done following a needlestick incident?

QUESTION 4

What questions do you need to ask Andrew?

FURTHER INFORMATION

Andrew looks a little awkward as he tells you that he is positive for human immunodeficiency virus (HIV). He had not wanted to disclose his status because of concerns about his privacy. Andrew asks you not to record his diagnosis in the practice notes. He declines testing for hepatitis B virus (HBV) and hepatitis C virus (HVC) as he had tests recently and they were negative. He says that his HIV is 'fully suppressed'.

QUESTION 5

What is post-exposure prophylaxis (PEP)? How can it be accessed?

FURTHER INFORMATION

You present to your nearest PEP provider and explain what happened. You tell them that you are immunised against HBV with demonstrated seroconversion. The PEP providers take a history

and baseline blood tests, provide you with a 28-day course of HIV PEP, advise that you do not need HBV PEP, and arrange follow-up over the next 3 months. They tell you that until follow-up serology is complete you must take precautions, including practising safe sex, and should not donate blood, sperm or organs. Apart from experiencing a 'hangover' for the first few days of treatment you manage well and feel ready to resume work.

QUESTION 6

Can you continue working as a GP while you wait for your final serology testing?

CASE 3 ANSWERS

ANSWER 1

General practice staff are at risk of infection through exposure to:[1]

- aerosols or respiratory droplets
- contaminated surfaces or materials
- mucous membranes, blood (eg through needlestick injury) or body fluids.

Preventive activities depend on the risk involved and are outlined in the Royal Australian College of General Practitioners' guidelines *Infection prevention and control standards*.[1]

All blood and body fluids should be considered potentially infectious. For minor surgical procedures the following precautions are recommended:[1]

- Use standard aseptic technique.
- Use personal protective equipment, including single-use gloves and goggles and, where appropriate, impermeable gowns and facemasks.
- Use a no-touch technique, which aims to avoid direct contact between the health professional's hands and the patient during the procedure by using forceps when applying dressings or using clean single-use gloves if a no touch technique is not possible (eg probing a penetrating wound).
- Ensure safe handling and disposal of sharps.
- Ensure safe processing, sterilisation and tracking of reusable equipment.
- Have a written practice policy on managing sharps and exposure to blood and body fluids.

ANSWER 2

Approximately 26,000 people were reported to be living with the HIV in Australia at the end of 2012. HIV rates were reported to be slightly lower in Australia, compared with the United Kingdom in 2011, and several fold lower than rates in the United States in 2009.[2]

Approximately 207,000 people were reported to be living with chronic HBV in Australia in 2012 (estimated prevalence 0.9%),[2] the majority of whom migrated to Australia from countries of high prevalence.[3] Chronic hepatitis C virus (HCV) affects an estimated 230,000 Australians and is usually acquired through injecting drug use.[2]

People at most risk of HIV are men who have sex with men, and people from high prevalence countries and their partners. HBV and HCV transmission, however, continue to occur predominantly among those with a recent history of injecting drug use.[2]

ANSWER 3

The needle is contaminated with your blood and Andrew's blood. You need to stop the procedure, acknowledge what has happened and dispose of the needle and syringe.

You also need to decontaminate the exposed area immediately. This is best achieved by washing your hands with soap or standard handwash and water, and managing your wound. Use of caustic agents such as bleach for skin washing is not recommended as these may compromise the integrity of the skin.[1] Injection of antiseptics and disinfectants into wounds is also not recommended.[4] Exposure to mucous membranes is treated by rinsing the contaminated areas with water or saline.[1]

It may be appropriate to ask a colleague to assist with caring for your patient while you clean up and decontaminate, particularly if the patient has a bleeding wound, or if you will not be able to complete the procedure.

ANSWER 4

You will need to ask Andrew a number of personal questions. First ask any other people present to leave the room. Then explain the risks of infection through exposure to blood and other body fluids and that you need to ask Andrew about his exposure to or presence of bloodborne viruses such as HIV and hepatitis, acknowledging that it can be difficult to disclose this information.

Say you would like to run through a list of risk factors for bloodborne viruses,[4–6] and ask Andrew to identify any that apply to him, such as:

- having lived in, or having had a sexual partner from, a country with a high prevalence of HIV or viral hepatitis
- male-to-male sexual activity
- blood transfusions, dental procedures or surgery performed overseas
- blood transfusions in Australia prior to May 1990
- past or current injecting drug use
- piercings or tattoos performed outside of Australia or in a non-professional setting
- known previous exposure to a bloodborne viruses or previous incarceration.

Ask Andrew directly if he has ever been diagnosed with HIV or hepatitis. If not, ask if he will agree to be tested today. You could ask if he had been tested before or given a blood donation in Australia and, if so, when this took place.

Guidelines for initial risk assessment are included in the RACGP's *Infection prevention and control standards*.[1] It should be emphasised that where the risk of infection is high, preventive activities may need to be started within 3 days[4,7] and advice should be sought as soon as possible from either a sexual health physician or infectious diseases physician. Seeking advice from specialists should not be delayed by waiting for laboratory results as needlestick/sharps injury with fresh blood poses a significant risk.

ANSWER 5

PEP stands for 'post-exposure prophylaxis' and is any preventive medical treatment started immediately after exposure to a pathogen. Its use is time-dependent.[4,7]

HIV PEP is a short course of HIV-antiretroviral therapy taken to reduce the risk of seroconversion. Where indicated, it should be started as soon as possible (ie do not delay use while establishing the source's HIV status), and within 72 hours of exposure.[4] PEP can be accessed from sexual health centres and hospital emergency departments. To find your nearest service you can call the PEP hotline for your state or territory on:

- NSW 1800 737 669
- VIC 1800 889 887
- SA 1800 022 226
- TAS 1800 005 900
- WA 1300 767 161
- QLD (healthline) 134 325 84.

Alternatively, check an online resource such as www.getpep.info/where.html.

HBV PEP is anti-HBV immunoglobulin and/or immunisation, depending on immunisation status and serological testing. People with documented positive HBV surface antibody do not require HBV PEP.[4,7]

There is no HCV PEP, so management consists of monitoring for seroconversion, with rapid referral if this occurs.[4,8] New oral antiviral therapies for HCV have prompted interest in these agents as PEP and clinical trials are ongoing.

In conclusion, the risk of bloodborne viruses depends on the nature of the exposure and the risk that the source person was infected and able to pass on their infection. Exposures need to be assessed on a case-by-case basis to determine an appropriate management plan, including use of PEP.[4] The estimated risk of HIV transmission/exposure with a known HIV-positive source in the setting of a needlestick injury or other sharps exposure is 1 in 440, based on prospective studies.[4]

ANSWER 6

National guidelines govern the activities of healthcare workers known to be infected with bloodborne viruses.[9] For healthcare workers who have potentially been exposed, modification of work practices (ie avoidance of exposure-prone procedures) is recommended only in the case of percutaneous exposures with BOTH exposure to a large volume of blood AND exposure to blood containing high titre of HIV, HCV or HBV.[1,10] Note, exposure-prone procedures are defined as procedures where there is a risk of injury to the healthcare worker resulting in exposure of the patient's open tissues to the blood of the worker (eg contact with sharp instruments, needle tips or sharp tissues).[9] Individual medical insurers may have specific requirements in order to maintain insurance cover. In this case, you can continue working and should not need to modify your work practices, but should call your insurer to clarify any requirements they may have.

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RESOURCES FOR PATIENTS AND DOCTORS

- The Australian Society for HIV Medicine provides information on their website for PEP, www.ashm.org.au/default2.asp?active_page_id=494
- Victorian Aids Council, www.getpep.info

CASE 4

DR GEORGE IS NOT WELL

Dr George, 48 years of age, is a busy GP who has worked in the same practice for many years. Lately he has not been feeling well. Since his wife left him 6 months ago he has not been sleeping or eating well, and is drinking more alcohol. He is unable to sleep unless he has drunk most of a bottle of wine and even then his sleep is disturbed. He awakes early and feels tired and lethargic during the day. He eats takeaway meals most evenings and has gained weight.

One day at work, Dr George does a fingerprick test and finds that his blood sugar level (BSL) is 12 mmol/L. Later that day in the staff room, he mentions his BSL to his friend and colleague Dr James and asks 'Do you think I should start myself on some metformin or have a formal blood test and check some other things? I've no idea what my cholesterol is. I have been feeling pretty ordinary lately and perhaps it's due to my blood sugar. What do you think?'

QUESTION 1

How should Dr James respond? What are some of the problems associated with providing medical advice in this setting?

FURTHER INFORMATION

Dr George does not look happy with Dr James's response. George mentions that he doesn't have a GP and doesn't think that he really has time for 'that sort of thing'.

QUESTION 2

What are some of the problems with self-treatment?

QUESTION 3

Are there any legal barriers to self-prescribing?

QUESTION 4

What are some of the barriers to doctors seeking medical help?

FURTHER INFORMATION

Dr James recommends a GP (Dr John) for Dr George, who is experienced in treating doctor-patients. He suggests that Dr George rings him now to make a long appointment to discuss his health. Dr George still looks uncomfortable, but he makes an appointment and presents to Dr John.

QUESTION 5

What are some of the challenges for Dr John when treating a doctor-patient?

QUESTION 6

What issues should Dr John consider when treating doctor-patient colleagues? Are there any things he might want to clarify with Dr George at the first appointment?

CASE 4 ANSWERS

ANSWER 1

George seems to be seeking advice from James without a formal clinical consultation occurring. This is known as a 'corridor' or 'curbside' consultation. Advice provided in this setting is often inaccurate or incomplete and rarely best practice.[1]

James has received a very incomplete history from George. James may feel embarrassed to seek further information and may feel he is intruding if he questions his colleague further. To ensure appropriate medical care, a doctor requires access to information of a sensitive nature, such as drug and alcohol consumption, and mental health issues. Knowledge of such issues may place James in an awkward situation if George discloses information that may affect George's ability to practice.

James has not performed a physical examination and may feel awkward about performing such an examination on a friend/colleague. A survey of 430 clinicians reported that 86% had refused to write a prescription for a friend or a family member; 65% of those not prescribing stated that the need for a physical examination strongly influenced their decision not to prescribe.[2]

Difficulties may also arise with documenting an informal consultation. There could be concerns regarding confidentiality within the practice where Dr George is working. Corridor consultations often result in inadequate documentation, poor or fragmented care, and lack of follow-up.[3]

James has noticed that George has not been himself lately and is worried about him. James replies, 'Your health is important. It sounds like you have diabetes and you need a thorough assessment. You should make an appointment to see your GP and discuss this properly'.

ANSWER 2

The medical profession expects patients to seek appropriate medical help when they encounter problems with their health. Yet doctors do not behave this when it comes to their own health. An Australian study found that 90% of 358 surveyed doctors felt it was acceptable to self-treat acute illnesses, and 25% felt it was acceptable to self-treat chronic illnesses.[4] Self-treatment by doctors, which includes diagnosing and treating as well as prescribing for oneself, is deeply ingrained in medical culture and can be acquired as early as when aspiring physicians are medical students.[5,6]

Self-treatment poses a number of potential risks. Avoidance of a medical consultation means a physical examination has not taken place, so the diagnosis and necessary follow-up care may not take place. There is also a risk of misdiagnosis. Doctors may neglect their health until their symptoms become serious[3] and often present late with serious problems.[7] For example, an average delay of 6 years between onset and consulting about drug and alcohol problems has been reported.[7] The practice of self-medication may also be a risk factor for later substance misuse.[8] When treating patients, doctors generally adhere to current guidelines and best practice. However, when treating themselves, doctors may not always accept appropriate treatments, particularly for medical problems with adverse social meanings such as mental illness.[9] Moreover, doctors who are treating themselves are less likely to sign themselves off work and may in fact be working when they should be on sick leave.[10] *Good Medical Practice: A Code of Conduct for Doctors in Australia* (the Code)[11] encourages doctors to have a GP and to seek independent, objective advice when medical care is needed and to be aware of the risks of self-diagnosis and self-treatment.

ANSWER 3

Self-prescribing is a complex area and there is significant variation in the relevant legislation between Australian states and territories. Doctors need to understand and comply with the laws regulating prescription medicines that apply in the area(s) where they practice. As a general rule, self-prescribing of Schedule 8 drugs (controlled drug) is not permitted except in a very limited set of emergency situations. No self-prescribing of Schedule 4 (prescription only medicine or prescription animal remedy) or Schedule 8 medications is permitted in Victoria under any circumstances and there are restrictions on the medications that can be self-prescribed in Western Australian and the Australian Capital Territory.[12] Lastly, all registered doctors in Australia are bound by the Code, which specifically cautions against prescribing for oneself, family, friends or 'those you work with'.[11]

ANSWER 4

Doctors often find it difficult to seek medical assistance for various reasons, which may be real or perceived. These reasons are often referred to as 'barriers' to seeking healthcare.[13] For example, doctors have difficulty adopting the sick role, may feel embarrassed about consulting a doctor and may not want to inconvenience colleagues. They may also feel guilty about consulting a doctor for a minor illness. There may be concerns about confidentiality or lack of time to see a doctor. The culture of medicine is one of working through illness; an image of invincibility is encouraged and vulnerability denied. Doctors with mental health issues may have concerns that seeking treatment may affect their registration and right to practice.[14]

Although the Code encourages doctors to have their own GP, a 2003 Australian study of doctors' health behaviour reported that only 55% of doctors had their own GP.[4] A similar study in 1995 reported that 42% of doctors had their own GP.[15]

ANSWER 5

The doctor-patient is entitled to the same high standard of treatment and respect as other patients; however, this group of patients has some unique challenges.[16] Possible pitfalls include treating the doctor-patient more as a colleague than a patient and having higher expectations for recovery and treatment compliance. Doctors treating doctor-patients should be as thorough in their assessment, examination, explanation and follow-up of results as they would be for other patients.[16]

Some doctor-patients may assume 'VIP status' and try to circumvent administrative and medical regimens. This can lead to confusion, poor medical care and poor outcomes.[16] There can also be problems with maintaining appropriate boundaries. The Code[11] advises that, whenever possible, doctors should avoid providing care to people with whom they have a close personal relationship, so caution should be exercised when treating doctor-patients who are also close friends and colleagues.

ANSWER 6

The following issues should be considered and/or clarified:[16]

- **Confidentiality** – Fear of breach of confidentiality can be a significant barrier to doctors seeking care and this concern could be weighing on Dr George's mind. Dr John should discuss patient confidentiality, assuring George that he will ensure confidentiality as much as possible. It is important to note that doctors' rights to confidentiality are not absolute and in some circumstances the medical board might need to be notified following a consultation with a doctor-patient.
- **History and examination** – Doctors treating doctor-patients should not avoid asking personal questions or taking a history of drug and alcohol use. The physical examination should be as thorough as for other patients and should be performed in the same clinical setting as for any other patient.
- **Prescribing, ordering and follow-up of test results** – Given the risks of self-prescribing, John assures George that he will provide all necessary prescriptions, and will order and review all of George's pathology tests. John advises George to make an appointment to see him to discuss the results of the pathology tests and at any other time if he has concerns, and not to feel in any way that he is 'wasting his time'.
- **Discuss the diagnostic and/or treatment plan in detail** – Do not assume the doctor-patient has a wealth of knowledge about their medical problem, especially if it is outside their practice area. Similarly, discuss medications in detail without assuming knowledge of doses, adverse events and related information.
- **Billing** – Some doctors may choose to bulk bill or waive their fees for doctor-patients, but this is a matter of etiquette rather than ethics. Some doctor-patients may feel more comfortable paying.

CONCLUSION

Dr John undertakes a thorough history and examination of Dr George, and orders appropriate further testing. John counsels George about his lifestyle in general and his escalating alcohol consumption in particular. George takes a short period of leave and continues to see John regularly. George manages to reduce his alcohol consumption and change his diet, which leads to a gradual weight loss and normalisation of his BSL. When he sees John again, George comments that he is a better doctor himself as a result of going through this experience.

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CASE 5

PAUL IS CONCERNED

Paul, a GP aged 67 years, presents for a check-up. You have not seen him before and he does not have a regular GP. He is a full-time procedural GP working in a small rural practice of three doctors who service the general practice clinic, a 12-bed hospital and emergency department. Paul's clinical load includes general practice, antenatal care and care of low-risk inpatients. Surgery and deliveries are no longer undertaken at the hospital. He shares in a one-in-three after-hours on call roster. He has some weekends off but rarely takes longer holidays. His wife works part-time as the practice manager.

Paul reports he is generally fit and well but often feels tired and is forgetful. He has concerns about his professional performance and is beginning to wonder how much longer he can maintain his current workload. A colleague who shares these concerns suggested he should have a full medical review. He has no localising symptoms and has undertaken a thorough batch of blood tests for himself, which he presents to you. The tests are all normal except for mildly elevated fasting lipids. He also participates in the bowel screening program and recent results were negative.

QUESTION 1

What are the possible causes of lethargy and forgetfulness in this case?

QUESTION 2

What are some of the barriers that prevent doctors seeking healthcare?

FURTHER INFORMATION

A full and accuate history is taken and does not show any concerning features. Physical examination is normal. There is no indication of current cardiovascular disease and his calculated absolute cardiovascular disease risk is 15% (moderate).[1] Use of the GP assessment of cognition (GPCOG) tool,[2] a screening tool for cognitive impairment designed for use in the primary care setting, indicates low risk of significant cognitive impairment. There is no history or symptoms of alcohol misuse, substance abuse or mood disorder. Liver function tests are normal. Paul's Kessler Psychological Distress Scale (K10)[3] score was 14 (low). Paul states he wishes to continue working but acknowledges it may be time to start planning a gradual reduction in his workload.

QUESTION 3

What are the effects of normal ageing that Paul should consider and plan for in relation to his professional duties?

QUESTION 4

How can doctors alter their work practices to accommodate the developmental process of ageing?

QUESTION 5

Is there a mandatory retirement age or other conditions on practice for doctors and other professionals?

QUESTION 6

Is there a role for formal cognitive testing in this case?

QUESTION 7

As the treating doctor, are you obliged to make a mandatory report to the Australian Health Practitioner Regulation Agency (AHPRA) about Paul's concerns about his professional practice?

CASE 5 ANSWERS

ANSWER 1

Possible causes of lethargy and forgetfulness include:

- normal ageing
- depression, anxiety, substance abuse
- mild cognitive impairment or early dementia
- organic illness and chronic diseases.

Note, doctors have a lower risk of lifestyle-related illnesses such as heart disease and smoking-related conditions[4,5] but are at a greater risk of psychological problems including mental illness and stress related problems, as well as substance abuse,[6,7] compared with the general population. A *beyondblue* survey reported higher rates of psychological distress and attempted suicide in doctors, compared with the general population and other health professionals. Very high levels of psychological distress were significantly higher in doctors, compared with the general population and other professionals (3.4% versus 2.6% versus 0.7%).[8] Certain subgroups of doctors may also be at increased risk of poor health because of their professional circumstances (eg doctors who work excessive hours and/or are unable to take sufficient leave, and doctors working in rural/remote areas with inadequate resources and professional support).[9]

ANSWER 2

There are many barriers,[9,10] both real and perceived, that prevent some doctors and medical students from seeking medical advice. These include:

- concerns about lack of confidentially
- embarrassment
- perceptions of weakness
- the stigma of ill health within the medical community
- perceived impact on career development
- perceived impact on colleagues and patients
- the expectation that doctors will work when unwell
- the implications of mandatory notification
- access to professional treatment (time, experienced personnel, geographic location).

ANSWER 3

Ageing doctors are at risk of chronic and degenerative diseases and malignancies, as well as a number of sensory and neurocognitive changes associated with normal ageing, including:[11]

- impaired hearing and sight
- reduced manual dexterity
- decline in processing speed and memory
- reduced problem solving and fluid intelligence
- reduced ability to multitask.

ANSWER 4

Examples of how doctors can alter their work practices to accommodate the ageing process include:[11,12]

- reducing hours on call
- reducing shift work
- a transition to part-time work
- ceasing or decreasing procedural work
- reducing exposure to situations requiring rapid decision-making and response (time-critical emergency situations)
- pursuing roles in chronic disease management
- increasing consulting time allocated per patient
- using memory aids such as prescribing software and practice guidelines
- seeking second opinions and advice from colleagues in difficult cases
- pursuing non-clinical duties such as teaching, medico-legal work and research.

ANSWER 5

There is no current mandated retirement age or requirement for mandatory performance assessment for older doctors in Australia.[12] All registered medical practitioners, regardless of age, need to 'recognise and work within the limits of their competence' as

specified in the Medical Board of Australia's *Code of Conduct*.[13] The Royal Australian College of Surgeons has a position statement for ageing surgeons in active practice, which recommends annual health and vision checks and performance reviews; however, this has not been mandated.[14]

Other professionals with high levels of responsibility, such as pilots, judges and directors of publically listed companies, have mandatory retirement ages. For example, commercial pilots must retire at 65 years and are required to have 6-monthly physical and mental examinations from age of 40 years. Judges and directors of publically listed companies must retire at age 72 years.[12]

ANSWER 6

There is no agreed method or standard of cognitive testing that reliably predicts clinical performance.[12] There may be some benefit in baseline testing and ongoing surveillance in selected individuals, particularly those continuing to work in higher-risk practices well into older age, but there is no firm evidence to support such testing.

ANSWER 7

As there is no evidence that Paul has any impairment or is placing the public at risk, there is no need to report him to AHPRA. On the contrary, he has good insight and has taken responsible steps to ensure his fitness to practice.

Notifiable conduct is defined in the Medical Board of Australia Guidelines for Mandatory Reporting. Section 140 of the Health Practitioner Regulation National Law defines 'notifiable conduct' as when a practitioner has:[15]

- practised while intoxicated by drugs or alcohol
- engaged in sexual misconduct
- placed the public at risk of substantial harm because of an impairment
- placed the public at risk because of a significant departure from accepted professional standards.

CONCLUSION

Paul returns 12 months later for his planned annual health check. He reports that he has ceased his weeknight on-call duties and that his practice is actively recruiting a new doctor and a GP registrar. Once a new doctor is appointed he plans to cease weekend calls and to reduce his consulting hours. He has already increased his appointment times from 15 to 20 minutes and reports that this has reduced his work stress and increased his enjoyment. He plans to take on some registrar supervision duties and has undertaken some 'train the trainer' education, as well as updating his clinical knowledge. The practice may also accommodate some medical students. He is excited about his changing role in the practice and the prospect of sharing his knowledge with the next generation of doctors.

Paul and his wife have sought financial advice and have begun planning for a gradual transition to comfortable retirement in the next 5 years.

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RESOURCES FOR DOCTORS

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GP health and wellbeing (Activity ID: 8567)

In order to qualify for 6 Category 2 points for the QI&CPD activity associated with this unit:

- **read and complete the unit of *check* in hard copy or online at the *gplearning* website at http://gplearning.racgp.org.au**
- **log into the *gplearning* website at http://gplearning.racgp.org.au and answer the following 10 multiple choice questions (MCQs) online**
- **complete the online evaluation.**

If you are not an RACGP member, please contact the *gplearning* helpdesk on 1800 284 789 to register in the first instance. You will be provided with a username and password that will enable you access to the test.

The expected time to complete this activity is 3 hours.

Do not send answers to the MCQs into the *check* office. This activity can only be completed online at http://gplearning.racgp.org.au

If you have any queries or technical issues accessing the test online, please contact the *gplearning* helpdesk on 1800 284 789.

FOR A FULL LIST OF ABBREVIATIONS AND ACRONYMS USED IN THESE QUESTIONS PLEASE GO TO PAGE 3.

FOR EACH QUESTION BELOW SELECT ONE OPTION ONLY.

DR JAMES

Dr James is a GP aged 68 years who works in a remote country practice. He shares the after-hours on-call roster with you, performs antenatal care and attends to low-risk inpatients at the closest hospital, which is 120 km from your practice. Dr James has been increasingly vague and anxious in the past year, and his overall condition has worsened since his wife's recent sudden death.

QUESTION 1

Which statement is correct with regards to the incidence of health problems in clinicians?

A. Doctors experience the same levels of lifestyle-related diseases as the general population.

B. Doctors experience fewer mental health problems than the general population.

C. Doctors are at lower risk of substance abuse than the general population.

D. Doctors have lower rates of attempted suicide than the general population.

E. Certain subgroups of doctors are at increased risk of health problems because of their professional circumstances.

QUESTION 2

Taking your advice, James sees a GP in the city, who reports that he is fit to continue practising and advises James to reduce his clinical load more manageable. Which statement is correct with regards to ageing doctors in practice?

A. Concern about lack of confidentially is not a barrier for ageing doctors seeking healthcare.

B. Pursuing roles in chronic disease management is not recommended as a way of accommodating the process of ageing.

C. A transitioning to part-time work is one way that doctors can alter their work practices to accommodate ageing.

D. Ageing GPs in active practice must have annual health and vision checks.

E. The mandatory retirement age for doctors is the same as for the general population.

SAM

Sam is a homeless man aged 22 years who presents with a hand injury requiring suturing. While you are stitching the wound, Sam sneezes violently and you stab your finger with the needle.

QUESTION 3

What should you do next?

A. Wash your wound with soap or standard handwash and water.

B. Finish stitching Sam's wound.

C. Wash your wound with bleach.

D. Inject antiseptic into your wound.

E. Call the post-exposure prophylaxis (PEP) hotline immediately to access PEP.

QUESTION 4

Sam reluctantly discloses he is an occasional injecting drug user and has no knowledge of his viral status. Which statement correctly describes the implications of Sam's disclosures for you?

A. You definitely require hepatitis B virus (HBV) PEP.

B. You should have hepatitis C virus (HCV) PEP.

C. Your decisions regarding use of PEP can be delayed until Sam's viral status is determined.

D. Should you require human immunodeficiency virus (HIV) PEP, timing is not an issue as its use is not time-dependent.

E. Your risk of HIV transmission with a known HIV-positive source in the setting of a needle stick injury is estimated to be 1 in 440.

DR JULIA

Dr Julia received an anonymous letter from a patient claiming to have been sexually involved with Dr James, her practice partner.

QUESTION 5

Which statement regarding notifiable conduct and mandatory reporting in general practice is correct?

A. Practicing while intoxicated by alcohol does not constitute notifiable conduct.

B. Engaging in sexual misconduct is defined as notifiable conduct.

C. A doctor must directly observe a notifiable behaviour to make a notification.

D. There are no exceptions to the requirements for mandatory reporting.

E. Mandatory reporting guidelines do not apply to practice nurses.

QUESTION 6

Dr Julia recalls that Dr James had a reputation for being a ladies' man at university and while training. What is the most advisable course of action for Dr Julia?

A. Report Dr James to AHPRA.

B. Report Dr James to the Medical Board of Australia.

C. Do nothing and store the letter in a confidential, secure place.

D. Destroy the letter.

E. Discuss the letter with the practice nurse.

DR JONAS

Dr Jonas received a letter of complaint from a patient, Mr Atkins, who has inoperable lung cancer and claims that Dr Jonas failed to diagnose this condition. Mr Atkins states that he has started proceedings to sue Dr Jonas.

QUESTION 7

Which action should be the immediate priority for Dr Jonas?

A. Telephone the patient.

B. Write to the patient.

C. Talk to a colleague.

D. Contact his medical defence organisation (MDO).

E. Dispose of the letter.

QUESTION 8

Which of the following statements is correct with regards to adverse events and medical negligence complaints?

A. Fear, guilt, shame, self-doubt, anger and disappointment are common reactions that health professionals experience following an adverse event.

B. Australian doctors receive the least complaints of all health professionals.

C. Of doctors involved in a claim for medical negligence, 20% experience suicidal ideation.

D. Dr Jonas is the first victim in this case.

E. Mr Atkins is the second victim.

DR SMITH

Dr Smith is a GP aged 48 years. His wife and only child died in a motor vehicle accident 3 months ago. Since returning to work, he has been noticeably subdued and melancholic. Dr Brown, a colleague and personal friend asks him how he is. Dr Smith reports that he is unable to sleep without medication. He thinks he is depressed and might start himself on antidepressants.

QUESTION 9

Which statement is correct with regards to doctor self-treatment?

A. No problems have been associated with clinician self-treatment.

B. Self-medication may be a risk factor for future substance abuse problems.

C. *Good Medical Practice: A Code of Conduct for Doctors in Australia* (the Code) encourages doctors to self-treat.

D. There are no legal barriers to doctors self-prescribing in Australia.

E. Australian doctors can self-prescribe schedule 8 drugs.

QUESTION 10

Dr Smith asks Dr John if he could see him as a patient or, alternatively, just give him a prescription for sleeping tablets and an antidepressant. Which of the following statements is the most correct regarding treatment of doctor-patients and/or friends?

A. There are no cautions against treating friends.

B. There are no pitfalls or potential problems with treating a doctor-patient.

C. The Code advises that doctors should avoid providing care to doctor-patients who are close friends and colleagues.

D. Doctors treating doctor-patients should avoid asking personal questions.

E. Doctors treating doctor-patients should always waive their fees.

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