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CARING FOR THE CARERS, HELPING DOCTORS IN TIMES OF CRISIS.

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INTRODUCTION

In April and May of 2004 I was fortunate enough to travel to Europe as a Churchill Fellow. My project was entitled “Caring for Carers, Helping Doctors in Times of Crisis”. This involved visiting a number of organisations in Europe that are recognised as world leaders in supporting doctors and their families who, through illness or misadventure are in crisis. I spent eight weeks meeting with representatives from these organisations in an effort to understand the way in which they were structured, and their relative strengths and weaknesses. From this I was able to glean a number of ideas that I feel will enable doctors in Australia to be looked after in a more supportive and professional manner.

I would like to thank the numerous people I visited in Europe for their time, assistance and support. In particular I acknowledge the role of Mrs Stephanie Winson of the Royal Medical Benevolent Fund. I would also like to thank my referees, Dr Andrew Ellis, OAM, orthopaedic surgeon at Royal North Shore Hospital, Dr Richard Hurley, president, Medical Benevolent Association of NSW and Mrs Mary Doherty, AM, Social Worker, Medical Benevolent Association of NSW for their ongoing assistance.
EXECUTIVE SUMMARY

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CARING FOR THE CARERS, HELPING DOCTORS IN TIMES OF CRISIS

A Churchill Fellowship to improve the services available to Australian doctors in times of need.

Fellowship Highlights

1. Royal Medical Benevolent Society of Ireland
2. Sick Doctors Trust, UK.
4. Royal Medical Benevolent Fund, UK.
5. General Medical Council, UK.
6. Medical Protection Society, UK.
7. Doctors’ Health Programme at 13th World Congress of Anaesthesiologists, France
8. Baby Jesus Hospital for Sick Children, Italy

Like the rest of the population, doctors are susceptible to all types of illness. In fact, doctors are recognised to have a higher rate of sickness, particularly mental illness. It has been reported that 10% - 12% of doctors at some time in their professional careers are affected by either mental illness or addiction. The suicide rate for medical professionals is far higher than for the general population. In order to help these doctors, and in particular to protect their patients from harm, there is a need for readily available and professional assistance. It is important to avoid duplication of any such services and to minimise the administrative costs associated with the provision of these services. It is vital that any service that aims to serve doctors and their patients is run efficiently and employs experts and professionals. There is a need for the awareness of services such as the Medical Benevolent Association of NSW to be increased so that it may be more effective in assisting doctors in times of crisis. This should be disseminated and implemented by increasing doctors’ awareness of the availability of services through increased publicity, and through increased cooperation with the Royal Colleges, professional medical organisation and medical defence organisations. It is vital that effective fund raising methods are employed and that there is ongoing lobbying of professional organisations and government for support. There needs to be an effective allocation of resources so that any doctor and their family who, through illness or misadventure, are in crisis receive the best possible care.
Programme


Organisations and People Visited.

1. Royal Medical Benevolent Society of Ireland (Dr R. Brown)
2. Sick Doctors Trust, UK. (Dr J. Oxley)
3. Doctor’s Support Line/Doctors Support Network, UK. (Dr L. Fagan)
4. Royal Medical Benevolent Fund, UK. (Mrs S. Winson, Mr M. Baber)
5. General Medical Council, UK. (Ms S. McNamara)
6. Medical Protection Society, UK. (Dr S. Brown)
7. Doctors’ Health Programme at 13th World Congress of Anaesthesiologists, France
8. Baby Jesus Hospital for Sick Children, Rome
1. The Royal Medical Benevolent Fund Society of Ireland
The Royal Medical Benevolent Fund Society of Ireland was founded by “medical gentleman” in Dublin in 1839 and is now administered by a central committee of physicians, surgeons and general practitioners who pay a small stipend to a part time secretary/treasurer. The annual income from donations and investments is €150,000 with grants to beneficiaries in excess of €100,000. Administrative costs run at less than 5%. Financial assistance is awarded to needy doctors and their families by the central committee at their second monthly board meeting. Applications are not considered by the committee unless they have been recommended by two previous donors to the organisation.

This is the only organisation offering assistance to medical practitioners in Ireland. Its existence is well known amongst doctors in Ireland and it has a very strong a regular donor support group. The disadvantage of this organisation is that it does not employ a professional social worker or counsellor and this type of work is left to the part time secretary/treasurer who currently is a retired general practitioner. I also feel that it is a disadvantage that applications need to be recommended by two previous donors as this may impinge on a recipient remaining anonymous to anyone but the central committee members.

2. The Sick Doctors’ Trust
The Sick Doctors’ Trust was established in 1995 and provides early intervention and treatment for doctors suffering from addiction to alcohol or other drugs, thus protecting patients while offering hope, recovery and rehabilitation to “impaired colleagues”. It assists the recovery of the addicted doctor in formulating a lifestyle conducive to a continuing and uninterrupted recovery. It is an organisation largely based on the 12 step philosophy of Alcoholics Anonymous. It provides counselling and support to addicted doctors and their families and offers a 24 hour telephone help line. It does not offer financial assistance. Over the last five years the Sick Doctor’s Trust has been involved in the treatment of 225 doctors. They feel that 86% of treated doctors remain sober after two years and that 96% are able to return to medical employment.

The Sick Doctor’s Trust provides an expert service and means of support to doctors with an alcohol or other drug addiction, though on occasions the support for family members is not as strong. The major downside of an organisation such as the Sick Doctor’s Trust is that it only looks at one particular issue and in the case of the addicted doctor, this may not address the entirety of the problem.

3. National Counselling Services for Sick Doctors
National Counselling Services for Sick Doctors was established in 1985. It provides a dedicated doctor to doctor telephone counselling service. A caller rings a 24 hour recorded message and is given the telephone number of the appropriate adviser on call at that time. This service is completely confidential and an onward referral is given if indicated. This is a volunteer service run by doctors for doctors.

This service has excellent availability. However it does have the problem that the initial contact is with an answering service. In fact only 40% of initial callers go onto contact the appropriate advisers. It also has the disadvantage that it is an entirely voluntary organisation although professional assistance is available on referral.
4. **Doctor’s Support Line/Doctor’s Support Network.**
The Doctor’s Support Line is another telephone counselling service available to doctors in the UK. It describes itself as a “warm, friendly, self help group for doctors with mental health problems”. This service is available for 36 hours per week, mostly in the evenings. It is an independent and supportive service staffed by volunteer doctors. The Doctor’s Support Network is an extension of the Doctors Support Line where doctors with mental health problems are able to meet in small non threatening self help groups.

These organisations offer a more holistic support service for doctors with mental health problems. Again it faces the problems of lack of professional services being available and is essentially run by doctors with a past history of mental health difficulties.

5. **The Royal Medical Benevolent Fund**
The Royal Medical Benevolent Fund is a huge organisation. It employs a full time chief executive officer and five social workers. Its main aim is to help doctors who are in financial need as well as assisting their families if required. Its beneficiaries receive in excess of £800,000 annually. It has a number of smaller committees in various areas of the United Kingdom and the central office in London is run in an extremely efficient manner, in a not dissimilar way to a successful small business.

In many ways the Royal Medical Benevolent Fund is the benchmark of organisations to help doctors. Of course it has considerable financial reserves that enable it to be run in the manner in which it is. Recently it has commenced a programme of support to its beneficiaries that entail quite comprehensive financial advice as well as financial assistance which it has found to be an important addition to their services.

6. **The General Medical Council of the United Kingdom**
The General Medical Council of the United Kingdom is the statutory body responsible for the registration and administration of all doctors in England, Scotland, Wales and Northern Ireland. It runs a number of programmes to educate doctors in appropriate medical practice and also for impaired physicians. It is also responsible for disciplinary action against doctors.

The General Medical Council is seen by many English doctors to be the instigator of deregulation proceedings against them, therefore it is not seen by many to be at all supportive of impaired doctors and particularly those with any mental illness.

7. **The Medical Protection Society**
The Medical Protection Society insures doctors against malpractice allegations. Interestingly, a considerable proportion of the doctors that they are required to defend have a variation of some type of personality disorder. This often takes the form of the disruptive physician who has lack of insight and disproportionate self confidence as well as the type of personality that has resulted in professional isolation.

There is no doubt that the whole process of a medico-legal case is extraordinarily stressful for the doctor being sued. It was disappointing to see that there was not a clear line of communication between the Medical Protection Society and support services available for doctors. It would be very useful if all medical defence organisations in Australia were made more aware of services available to doctors during times of stress such as that resulting from medico-legal proceedings.
Doctor’s Health Programme at the 13th World Congress of Anaesthesiologists.

I attended a number of lectures and discussion groups headed by European and American physicians involved in the care of impaired doctors. This included lectures on the epidemiology of addiction, the mortality rate of addicted physicians, the recognition and management of addiction, and burnout in medicine. These talks highlighted the high rate of stress, dissatisfaction, mental illness and alcohol and drug addiction amongst doctors. It is now recognised that addicted anaesthetists have up to 20% mortality rate in five years. Nevertheless there are now a number of programmes around the world aimed at treating doctors with mental illness and addiction problems. Many of these programmes have very successful outcomes.

My attendance at this conference made me aware of the high rate of problems amongst doctors, however it was worthwhile to see the development of a number of new programmes for impaired doctors resulting in their eventual successful rehabilitation, protection of patients and ultimate return to the medical register.
CONCLUSIONS AND RECOMMENDATIONS

My Churchill Fellowship has taught me a great deal. There is no doubt that doctors are a high risk group for mental illness, addiction and suicide. However through the provision of appropriate services many of these problems can be addressed and successfully managed. Organisations such as the Medical Benevolent Association of NSW have a vital role to play in the care of doctors and their families during times of crisis.

Important lessons to be learnt include:

1. The need to improve awareness of services available to impaired doctors.

2. The need to employ professionals, both in the direct care of impaired doctors and also in the day to day running of organisations such as the Medical Benevolent Association of NSW. While it is important that doctors care groups are run by doctors for doctors, it is just as important to seek expert advice when necessary.

3. Ensure independence of such organisations.

4. Ensure efficient and appropriate allocation of resources and minimisation of running costs.

5. Lobby government, Royal Colleges and other medical organisations to ensure their support both financially and logistically.

6. Avoid duplication of services.

7. Ensure direct lines of communication between Medical Boards, Medical Defence organisations and organisations such as the Medical Benevolent Association of NSW so that doctors, in times of crisis, can be identified early and receive the appropriate support.