The Victorian Doctors Health Program: the first 3 years

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ABSTRACT

- The Victorian Doctors Health Program (VDHP) was established in November 2000 to provide a confidential and compassionate service for doctors and medical students with health concerns, including alcohol, other drug and mental health problems.
- Although funded by the Medical Practitioners Board of Victoria, the VDHP is completely independent of the Board.
- Its staff include a director with experience of North American Physician Health Programs and a case manager/psychologist.
- In its first 3 years of operation, the VDHP had 438 contacts: 218 requests for advice and information, and 220 contacts resulting in provision of services (to 92 doctors and students with alcohol or other drug problems, 82 with psychiatric problems, and 40 with stress-related or emotional problems).
- 99 participants received standard care (assessment, referral and up to two consultations with the program) and 56 extended care (three or more consultations with the program).
- 65 participants (most with substance use disorder) entered the more intensive Case Management, Aftercare and Monitoring Program (CAMP); 57 of these have had outcomes considered satisfactory, with 50 returned to work.

MJA 2004; 181: 376–379

Doctors are thought to be usually reluctant to report their own illness or impairment, or that of their peers, to medical registration boards, because of fear of loss of registration and livelihood. The unfortunate consequence is that some doctors may not access treatment until their condition can no longer be concealed from or tolerated by medical and other colleagues or affects patient care.

To encourage earlier presentation and provide easy access to appropriate management and specialised resources, the Medical Practitioners Board of Victoria and the Australian Medical Association Victoria recently established a specialised health program for doctors and medical students — the Victorian Doctors Health Program (VDHP).

The VDHP joins earlier and continuing contributors to the field of doctors' health, such as the Doctors' Health Advisory Service and the Box Hill Hospital re-entry program for impaired anaesthetists, which successfully returned five specialists to practice after treatment for opiate dependency.[1]

Here, I describe the principles of the VDHP and its activities and participants in its first 3 years of operation. I do not assess the overall impact or efficacy of the program.

Development of the Doctors' Health Program

The VDHP was established in November 2000, and began full-time clinical service in May 2001. Its mission statement is "to provide a confidential and compassionate service for doctors and medical students with health concerns, including alcohol, other drug and mental health problems". This service is provided free. The program is fully funded by the Medical Practitioners Board of Victoria, but its operation is totally independent of the Board. It serves about 18 000 registered medical practitioners and 2500 medical students in Victoria. It is also available to deregistered medical practitioners and overseas medical graduates.

The aims in developing the program were threefold:

- To draw on the considerable North American experience of Physician Health Programs.[2-7]
- To incorporate the 1994 recommendations of the US Federation of State Medical Boards Ad Hoc Committee on Physician Impairment.[8] These include the elements of a model program, such as assessment, relapse management and confidentiality, a two-pathway system of referral (voluntary or mandated), and the principle of a contract for case management).
- To develop a program specifically suited to Australia. For example, the North American culture for managing substance use disorders is largely abstinence-based, and there is much medical and community support for abstinence from all drugs, including alcohol, and for self-help group programs such as Alcoholics Anonymous and Narcotics Anonymous. This is not generally the case in Australia.

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The VDHP has a five-person board of management appointed by the Medical Practitioners Board of Victoria and the Australian Medical Association Victoria, but independent of both bodies (ie, no member of the Medical Practitioners Board can be a member of the VDHP board). The management board has appointed three staff members to deliver the program: a medical director with expertise in managing drug and alcohol problems and experience of North American physicians' health programs (0.8 full-time-equivalent), an office administrator (full-time) and a case worker/psychologist (full-time). The services provided by the VDHP are shown in Box 1.

Program activities and participants

Between its inception on 19 May 2001 and 30 June 2004, the VDHP had 438 contacts: 218 were requests for advice and information, many of which were anonymous, while the remaining 220 contacts resulted in the use of one or more of the program's services.

Primary reasons for the 220 contacts that resulted in program participation are shown in Box 2. Most involved alcohol or other drug problems (92), followed by psychiatric problems (82) and stress-related or emotional problems (40). Of the 92 doctors with an alcohol or other drug problem, 23 had a comorbid mental health disorder. Some of the 17 doctors with a personality difficulty or disorder had been referred by their employers as "disruptive". Five of the doctors who sought psychiatric assistance had violated sexual boundaries.

1 Services offered by the Victorian Doctors Health Program

Initial intervention: contacting the person who has made the referral (such as doctor's spouse or employer) for further information and engaging the participant in assessment.

Preliminary assessment: conducted by the VDHP.

Referral: for specialist assessment and treatment.

Case management: may include ongoing monitoring, advocacy and assistance with return to work, as necessary.

Monitoring: chemical, behavioural and workplace.

Advocacy: this includes, when appropriate, supporting doctors and medical students in various settings, including workplace and courts.

Family support: through counselling, including group therapy.

Assistance with return to workplace: through workplace conferencing and development of a structured re-entry program.

Follow-up: periodic contact to determine compliance with and efficacy of therapy.

2 Primary reasons for contact among 220 participants in the Victorian Doctors Health Program

Reason for contact	No. of contacts
Alcohol or other drug problem	**92**
Alcohol	41
Other drugs	51
Psychiatric problem	**82**
Depression	50
Personality difficulty or disorder	17
Bipolar mood disorder	7
Sexual boundary violation	5
Psychosis	3
Stress-related or emotional problem	**40**
Physical condition	**6**

All doctors with alcohol or other drug problems were referred to appropriate outpatient or inpatient treatment facilities and, after primary treatment, returned to the VDHP for case management and relapse prevention. All those with psychiatric disorders were referred to an appropriate psychiatrist, with the VDHP monitoring progress by maintaining contact with both the participant and the treating doctor. Many of the 40 cases of stress-related or emotional problems were related to "doctor burnout" and were managed with counselling by a psychologist or psychiatrist.

Six contacts were doctors seeking management for a physical condition. For example, one doctor sought referral to a specialist for management of previously self-managed diabetes and hypertension; another doctor was moving from a rural to an urban area and was looking for a personal general practitioner. Doctors with a physical illness were referred to an appropriate general practitioner or specialist for treatment, with subsequent follow-up by the VDHP.

The VDHP provided care at three levels:

- ***Standard care:*** preliminary assessment and referral, and up to two consultations with the VDHP (99 cases);
- ***Extended care:*** three or more consultations with the VDHP (56 cases); and
- ***Intensive involvement:*** entry into the Case Management, After-care and Monitoring Program (CAMP) (65 cases).

In standard and extended care, participants were followed up by the VDHP until it was mutually agreed that the program could be of no further assistance or, in six cases, until repeated attempts at follow-up were unsuccessful. Those receiving standard or extended care included 34 doctors who had early symptoms of alcohol misuse or were in long-term recovery from substance use disorders. The other 58 doctors with substance use disorders entered CAMP, along with seven doctors with mental health disorders requiring intensive after-care and monitoring (eg, psychosis).

The "CAMP" program

Participants in CAMP are required to enter into a written agreement with the VDHP tailored to their individual needs (Box 3). For example, all participants are required to attend a general practitioner, while all with a substance use disorder are required to attend an addiction medicine specialist, and some a psychiatrist.

Of the 58 CAMP participants with a substance use disorder, 50 were men, and 15 were diagnosed with a comorbid mental health disorder. Their drugs of choice were alcohol (21), pethidine (18), heroin (7), codeine (3), benzodiazepines (3), amphetamines (2), cocaine (2), nitrous oxide (1) and ketamine (1). They belonged to a broad range of disciplines: general practitioners (20), anaesthetists (6), hospital medical officers (6), surgeons (4), pathologists (3), radiologists (3), registrars (3), interns (2), physicians (2), researchers/academics (2), overseas graduates (2), and an obstetrician/gynaecologist, an occupational medicine specialist, a paediatrician, a psychiatrist and a medical student.

Group meetings are an important part of the CAMP program for almost all participants. The Caduceus Group (named after similar mutual support groups for health professionals in the United States) meets weekly and is facilitated by professional alcohol and other drug counsellors. Mutual self-help groups, such as Alcoholics Anonymous and Narcotics Anonymous, are considered crucial components of many CAMP agreements. Self-medication is prohibited for all participants, and monitoring for drug use is required.

The optimal outcome for CAMP participants is considered to be stable recovery, abstinence, resumption of work (or the capacity for this) and good quality of life. However, abstinence, even without return to work, or sufficient reduction in drug use to allow return to work, are also seen as satisfactory outcomes. It is also acknowledged that substance use disorders are chronic relapsing diseases. As relapses may occur at any time in the course of life, contact should preferably be maintained indefinitely.

The progress of participants has varied, with most having outcomes considered satisfactory (Box 4). This includes 52 of the 58 with a substance use disorder; 46 are abstinent, 39 of whom are working (see Box 5A and Box 5B). Of the six with unsatisfactory outcomes, three have died. One of these had his CAMP agreement terminated because of non-compliance 3 months before his death. He had not worked as a doctor for over 10 years and was a "street-drug user", dying of a heroin overdose. Another deceased participant had his CAMP agreement terminated by mutual consent, had been deregistered by the Victorian Medical Board and had moved

3 Case Management, Aftercare and Monitoring Program (CAMP): schedule of undertakings

Participants in CAMP must sign a contract agreeing to some or all of the following:

Abstinence from all mind/mood-altering drugs (unless prescribed).

Treatment by:

- Addiction medicine specialist (all SUDs)
- General practitioner (all participants)
- Psychiatrist (all mental health disorders and some SUDs) or
- Alcohol and drug counsellor (all SUDs).

Attendance at:

- Caduceus Group (therapeutic/monitoring support group) and/or
- Mutual help group (eg, Alcoholics Anonymous or Narcotics Anonymous).

Prohibition on self-medication and self-prescribing (including over-the-counter preparations containing codeine and pseudoephedrine).

Urine drug screening and/or breath testing (typically 3 times weekly at first for SUDs, with diminishing frequency over time).

Other undertakings (eg, specialist counselling).

Return-to-work conditions:

- return to work only with approval of, and under conditions laid down by, treating doctor and VDHP.
- no prescribing or administration of S8 drugs until provision revoked in writing by the VDHP medical director.
- appointment of a workplace monitor who reports 3-monthly to the VDHP.

SUD = substance use disorder.

4 Progress of participants in CAMP (Case Management, Aftercare and Monitoring Program)

Disorder and outcome	No. of participants
Substance use disorder	**58**
Satisfactory outcomes	
Abstinent, working	39
Abstinent, not working	7
Improved,* working	6
Unsatisfactory outcomes	
Deceased	3
Deteriorated or unchanged	2
Relapse	1
Mental health disorder	**7**
Satisfactory outcomes	
Improved,* working	5
Recovered, not working	1
Unsatisfactory outcome	
Left program	1

* Improved = participants whose substance use or mental health disorder is no longer problematic, and who are not impaired.

interstate 6 months before his death, which was drug-related. However, the third participant who died had been active in CAMP and, according to a coroner, died of physical causes, with drugs not implicated. Another of the participants considered to have an unsatisfactory outcome relapsed after more than 2 years' abstinence and is currently being re-treated.

Of the seven CAMP participants with a mental health disorder but no concurrent substance use disorder, the condition of five has improved, and they are working (see Box 5C). Another also shows improvement but chose to defer his employment for 12 months. The other (with a personality disorder) left the program; although neither his current health nor employment status is known to VDHP, his capacity to practise was never considered impaired, and there was no known or perceived risk to patients under his care.

Relationship with the medical registration board

The VDHP maintains a confidential program independent of the Medical Practitioners Board of Victoria. It is required to notify the Board only of participants who breach the Medical Practice Act 1994 — that is, registered health practitioners with an illness or condition that has seriously impaired, or may seriously impair, their ability to practise *and* (my italics) may result in the public being put at risk.[9] To date, no Board notifications have been necessary, as impaired participants who enter the program are asked to cease practice until they have achieved stable recovery and can safely return to work; all those considered impaired have either complied with this or had already been suspended from practice.

Of the 65 CAMP participants, 36 are known to the Board. Some participants were referred by the Board to the VDHP, while others were reported to the Board either before they sought VDHP assistance or independently of seeking assistance.

Conclusion

The VDHP provides a structured, confidential way of coordinating and delivering the appropriate management for a range of health problems experienced by an important community resource — medical professionals. The current case profile of the VDHP shows a predominance of substance use and mental health disorders requiring attention, but also a considerable number of doctors seeking help for stress or emotional problems. The VDHP upholds the interests of both the profession and the community. It will maintain its links with the North American Physician Health Programs and will review the recently updated guidelines of the US Programs,[10] which provide a new "gold standard" for delivering health services to the medical profession.

Acknowledgements

The Medical Practitioners Board of Victoria and the Australian Medical Association Victoria developed and have provided ongoing support for the VDHP. We thank Mr Gordon Storey (Self Help Addiction Resource Centre [SHARC], Melbourne) for valuable advice and assistance with program development and operation, and the many medical directors of North American Physician Health Programs who have provided support and training, particularly Dr Greg Skipper (Alabama), Dr Lynn Hankes (Washington) and Dr Mike Kaufman (Ontario).

5 Some participants in the CAMP program

A. Elizabeth (polydrug user)

Elizabeth, a senior hospital medical officer aged in her early 30s, was suspended from practice by the Medical Practitioners Board of Victoria (MPBV) for opiate dependency. Subsequently, she attended an addiction medicine specialist who referred her to the Victorian Doctors Health Program (VDHP).

Elizabeth had been a bright, popular medical student who enjoyed partying and some recreational drug use. A few years after graduating, she experienced some personal difficulties, including difficulties with her partner, and became a heavy polydrug user (heroin, amphetamines, benzodiazepines and alcohol).

For 3 months after her initial contact with the VDHP, Elizabeth's condition deteriorated, until she finally agreed to undergo inpatient treatment. After discharge, she entered into a formal agreement with CAMP (Case Management, Aftercare and Monitoring Program) and has been abstinent for 2 years. She has been accepted into a specialist training program and is delighted with her "new life". The MPBV have replaced all previous conditions on her medical registration with a sole condition — that she continue to attend the VDHP. Elizabeth will continue to be monitored for an indefinite period.

B. Walter (alcoholic)

Walter, a mid-career physician, presented to the VDHP with an alcohol problem. He had asked his treating doctor to refer him to the program after reading about it in a daily newspaper.

Walter was drinking compulsively and daily. He was forced to make up multiple excuses for his failure to attend his practice, which was closed for days at a time. His family life was in chaos, and his marriage was imperilled. His financial state was desperate. But he was completely resistant to the idea of "treatment".

For nearly 6 months after the initial contact, the VDHP monitored Walter's progress. After a major relapse on alcohol, he was persuaded (albeit with great difficulty) to undergo inpatient treatment. After 28 days, he was discharged and entered into a CAMP agreement with the VDHP.

Water recently celebrated his second "sobriety" birthday. Now in good health and with a satisfying professional life, he is enjoying family life and is resolving his financial problems. He continues to be an enthusiastic participant in the VDHP program, attending Alcoholics Anonymous three times a week and assisting "newcomers" in their recovery.

C. Ken (stressed, depressed and suicidal)

Ken, a radiologist, had recently relocated from interstate. He contacted the VDHP one afternoon requesting an urgent appointment. On presentation, he commented, "I want to kill myself".

Ken was obviously highly intelligent. He had a history of mild depression over several years, but no previous episode had remotely resembled the current crisis. He had a very supportive family, but, although he liked his job, he found it stressful. He was in good physical condition, playing competitive sport.

The VDHP arranged for immediate admission to an inpatient treatment facility. During the 3 weeks of his admission, arrangements were made to commence family support.

On discharge, Ken declared himself a "new man". He entered into a CAMP agreement with the VDHP, which worked with his employer to facilitate a smooth re-entry into the workplace and to negotiate working conditions that would enhance his recovery. Over the next 6 months, Ken experienced occasional lapses, with one episode of depression requiring a brief readmission to hospital. His overall progress has been excellent, and he is now content with his work, family and social life.

The VDHP will continue to monitor Ken for the present, with a view to transferring him to "follow-up" when appropriate.

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(Received 2 Jul 2004, accepted 24 Aug 2004) ❑