The Impaired Physician

by

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The Chairman of the meeting was Mr. David Brownbill.

There are a number of issues in identifying impaired physicians and this isn't a topic that was of my choosing. It's really something that came upon me and I didn't have any choice but to take an interest. You will all understand that it's a fairly chilling subject at times and it's an appropriate topic for a gathering such as this, because in dealing with impaired physicians there are serious medical and legal and ethical issues.

Perhaps the most important and difficult task is identification of the sick doctor and I'm going to be as broad as I can possibly be in speaking of impairment. It's not easy to think of oneself as impaired or to think of one's colleagues as impaired and it's also not easy to see it.

Intervention is something I'm going to talk about because that's a very challenging task. When you reach the stage where you know that someone is sick and is not seeking appropriate care it's time to do something. The mechanics of how you actually organise it and get that person to appropriate health is a challenge in itself.

Treatment is something I'm going to say nothing about. One of the lessons in dealing with impaired physicians is that the last thing you need is someone with amateur status trying to go beyond their capabilities. That's something for the experts. I am however going to speak a little about return to work because that's an area where there are several dilemmas and very difficult issues.

As I look around, I suspect physicians don't have a monopoly on impairment. We all deteriorate in various aspects with age and there are natural changes that occur. Not all of the changes with age could be regarded as impairment, though one does notice that the dinner suit tends to shrink a little. Physical illness can impair our capacity to practise in quite subtle ways and sometimes in more obvious ways: the surgeon with the big tremor is certainly at a disadvantage.

Psychiatric illness and drugs and alcohol are more difficult to talk about. It's not quite as acceptable to be an alcoholic and be not working because of that or to have a psychiatric illness. It's the difference between having your coronary artery grafts or having your anal warts fixed; people tend more to talk about the former. There is fatigue and other impairments, other stresses that occur in people's lives that impair their capacity to work.

We've got rid of any idea of a compulsory retiring age and I think that was seen by some as a great positive. The disadvantage with that, or the problem posed by it is that we then have to find some other method of determining when someone should cease to practise. And

if there's going to be a serious assessment to decide when it's time to stop, that's going to mean that some of us will stop in our 40s and 50s and some will go on working into their 80s or 90s or beyond because we don't all age at the same rate. We don't have a way of deciding the appropriate retiring age.

It gets difficult for some people to think about it, but it's important to recognise how common psychiatric illness is in the community. A very large study in the United States of the lifetime prevalence of major depressive episode in the community showed that 17 per cent over a lifetime and in the previous 12 months 10.3 per cent of the community had a major depressive episode as defined by standard international definitions. I think most of us would not like to see depressive illness as that common in the community and we'd certainly hope that we're not one of the 10 per cent who had it this last 12 months or one of the 17 per cent who've had it at some stage during our lifetime.

The good news for half of us is that we don't have any of these problems. The bad news is that 14 per cent of people will have the vast majority of the problems and I think most of us have felt a little melancholy at some time. I certainly hope we know what it feels like. It's important to know it and to be able to share that feeling and understand others when they feel like that.

According to Beck, the persistent score on the Inventory of Depression of 17 or above indicates borderline depression and you may need professional treatment. I suspect quite a few people here will have scored in the big league at some stage and one of the difficulties is that professionals - and this comes down to what we mean by "impairment" - can be very sick with a level of illness that would be absolutely debilitating to many other people and yet they go on being able to work reasonably well, perhaps not working at their very best but still working well and at a standard that's seen as generally acceptable.

The medical literature has a fair bit of evidence of sick doctors. Now I'm biased because being an anaesthetist my interests were particularly focused in the welfare of anaesthetists. A study on drug abuse by anaesthesia personnel highlights that seven of 44 identified drug or alcohol users, i.e. abusers, died. I'm not able to say how many committed suicide and how many died secondary to accidental overdose or drug related disease. But the picture becomes clearer with time.

My interest in this was sparked when one my registrars committed suicide. He became a pethidine addict. We recognised the problem.

He went away and had treatment and came back to work, was noted to relapse, went back to treatment and then suicided. I had the opportunity to explain much of this to the coroner because some members of this person's family were concerned as to how could we possibly let this person come back to work, surely we had some responsibility to keep them away from work. And I must say I was greatly impressed at the commonsense of the coroner as this case was investigated and the integrity of the sergeant who assisted the coroner in unravelling the very difficult issues with great balance and sensitivity. I must say I also learned a bit about the ability of barristers to convey argument about which they knew very little.

It really looks pretty bad for anaesthetists. A study published in 1968, "Causes of Death", was done by people from the American Society of Anaesthesiologists using the so-called "death records" of the American Medical Association. They decided that the death rate from suicide amongst anaesthesiologists appears more than twice that of a comparable population. A follow-up study had suicide accounting for nine per cent of all deaths of anaesthetists. Compare that with the general community where suicide runs somewhere between one and two per cent.

The reason these studies were done was not thinking about impaired physicians but people looking for cancer, particularly leukaemias that may have been caused from exposure to concentrations of anaesthetic agents. The thing that stuck out each time people looked at the health of anaesthetists was the suicide rate. It was only in fact some years after these studies that the problems of substance abuse came to light. People sort of knew about it but the magnitude of the problem wasn't recognised. Suicide was the only major health problem amongst American anaesthesiologists.

I think there is no doubt that we as anaesthetists have a unique ability to obtain drugs with which we can do ourselves damage, but we don't have a monopoly on drug abuse. I've always enjoyed reading this study which was done by an American who was doing sabbatical leave in Brisbane where he looked at the drug use patterns of students in the helping profession. This was a very generous study where they included in helping profession students not only doctors but also lawyers, teachers, social workers and policemen, so it was "helping profession" in the broadest sense.

But it seemed to me that a surprising number of people used non-prescription drugs - so, the antihistamines, marijuana, sedatives,

tranquillisers, hallucinogens, stimulants, cocaine and opiates were self-obtained, not obtained by prescription. And so there's pretty good evidence that people going through tertiary studies have reasonable enthusiasm for sampling drugs. And I must say the extent to which we live in a drug use society was brought home to me at a conference of the Australian Society of Anaesthetists that preceded the Adelaide Grand Prix one year where the conference bag was a cooler bag for carrying two bottles of wine and it contained one bottle of red and a box of Panadol. I was actually going to speak on the problem of substance abuse at that meeting.

It is not restricted to anaesthetists though and it's not new and in the 1890s the habit of using morphine was particular prevalent among women and physicians who used the hypodermic syringe. It's not restricted to the United States either. Nathan Serry published "The Problem of Substance Abuse" from the records of the Medical Practitioners Board of Victoria. I want to emphasise the last line, "prevention and early intervention are crucial" and I want to emphasise one of the points I made before, that people who are very severely ill can manage to go on working and in fact, sadly, the work is often the last thing that suffers.

So how do we identify people who are in trouble? People who are developing problems, be it depression or other psychiatric illness, albeit a drug or alcohol problem, or who are simply stressed beyond their ability to cope, have all sorts of changes in their life. They will commonly withdraw from family activities, and keep much more to themselves, marital breakdown is pretty common, their children tend to behave in unreasonable ways, they might have drink-driving charges, they might be noticed to behave in strange ways socially, they might go on spending sprees and have some fun with the money while they're earning it. They can withdraw from church or from leisure groups and their hobbies and the things from which they gain pleasure in their life tend to fall away. There might be change in weight. Often people get a bit skinny as they get sick. They can look tired, develop a tremor or they might just have more days off from work, seem to have a bit more sickness. Professionals are terrible at taking the sick leave they really should take. We all tend to turn up for work regardless of how we feel.

It's not easy sometimes to get inside people. You can work with them for a long time and just not notice some subtle changes. We tend not to ask the right questions. But work performance is difficult because it's difficult to measure. It's very difficult to pick when people's work

patterns change. There are some people - and I'm sure this applies to all professions, who are really, really, really good and there are some people who are just good. And it's hard to tell when a really good person is having an off day; whether they're falling below the standard you'd accept from other people. We've got different expectations of what people will do. If a good person doesn't seem to be performing quite as well, the very capable, normally high performing isn't performing quite as well, they might have a serious problem that they're having trouble dealing with.

In medicine many of us deal with pieces of equipment and it's easy to make excuses or to say that there is a problem with technology. In the last few years I've had the experience of giving an anaesthetic for someone having coronary artery grafts and while they're on bypass the electricity failed in the operating theatre, so we had a darkened operating theatre and someone depending on the pump. You can sit there and pedal for a while but you hope the lights come on while you're manually winding the pump. There are technical failures. There are equipment failures that can be used as an excuse, and that can hide the physician's impaired performance.

The other thing we have is consumerism in medicine. When my car breaks down I take it to the mechanic and say, "Please fix" or if my computer doesn't work I used to take it to the technician and now I ask my son to do it. But when people go to the doctor they like to tell us how to practise medicine and it's not always such a good idea. Now I don't have any problem with involving patients in decisions where they have a legitimate choice to make, but sometimes people want to make choices that are contrary to what we believe to be the proper practice. That imposes additional stresses and sometimes you don't know whether the patient pushed someone into doing something silly or they did it of their own accord.

I have mentioned a number of things that relate to natural changes in practice. There's the isolation of practice. Many people work alone. It's not as though we're all in a factory and one of the process lines goes a bit slow. There's variability in human performance and variability in the protoplasm we work with and so there will be different outcomes. It's very hard to know how to compare practices and even if we could compare there's often isolation that prevents appropriate comparisons being made.

I don't know how many of you remember "A Few Good Men", one of my favourite movies for a few reasons. The marines' code is "Unit,

Corps, God, Country" and I think we're not very good at recognising and ratting on our friends when they're not performing up to standard. Physicians aren't alone in that. I think all professions tend to stick together. So you mightn't see them because it's isolated. You can't measure it, so it's only subjective opinion, and even if you did have serious doubts it's very difficult and uncomfortable because of the unwritten, unspoken code. The other thing is that, leaving all those aside, some people just start off better than others anyway.

I want to turn it around and look at it from the sick doctor's point of view. We get used to sitting on one side of the table. It's an unfamiliar role for us to be sick. We don't like to think of ourselves as sick, we don't like to have days off and you put yourself in a dependent position going and telling someone about your health. I guess lawyers find it hard to go and talk to other lawyers about their own legal problems. And the professions aren't that big, so it's very hard to go to someone who you know is good who doesn't know you or know anything about you or know a whole lot of people that you work with, so you really put confidentiality on the line when you go and talk to another doctor about serious problems.

There is stigma associated with some forms of illness and I've mentioned that. Some doctors have the idea that "because I understand what I'm doing I can control it, so it might be all right for me to inject a narcotic analgesic when I've got a headache because I know the pharmacology of the drug and I won't use it again and I won't let it do me any harm." It doesn't work like that.

If you develop an illness that might impair you from performing your professional function, by the time a medical specialist invests 12, 13, 14, 15 years of their life in becoming a specialist it's not easy to go and talk to someone about an illness that might take that away from you. It's easy to see yourself firstly as a professional and all the other things come behind it. And so to seek help really puts all those things that you value on the line.

The other thing is, we're just blind. It's very hard to see that you're sick. Lots of accountants manage to go bankrupt. I've got a great engineer friend who knows all about materials and is in charge of maintenance for a huge organisation and he's got a thing that's called Atkinson's folly. He went to buy a boogie board and he thought, "This is ridiculous, I'm not going to pay $300 for a piece of foam like this, I can make one in foam and fibreglass, I'll make it myself." Well, it cost him $450 and it doesn't really work, but he got an awful long way

along the construction of this thing before he realised it was dumb and he should've just bought one in the first place. We can get a long way along a sickness before we actually realise that there's a problem. So we go along paddling our own canoe not realising that there's actually a better way to cross the river.

I mentioned a whole lot of things that people might recognise in seeing that one of their friends is sick. Why don't we just pick them up and take them to the doctor quickly? Why can't we talk to them about it and get them to get the proper help at the right time? I think one of the things here is we're not sure enough. Although we can work with people a lot we often don't know them really well and it's not always comfortable to talk about how you're really feeling about things, it's something that gets trained out of you. We don't get really sure. We're not sure enough to act. We have suspicions but not enough to act. It's sometimes risky to bowl up to someone and suggest that "Maybe you're an alcoholic and it's time you went to inpatient care and let's go and talk to someone about it." You might lose a friend doing that. It would be a bad thing if you got it wrong.

The other thing is how many people have driven past a car accident. It's often more comfortable not to get involved. It would be nice to think that one of your other friends will recognise the problem and deal with it. So it takes a fair bit of guts to get out there and recognise a problem. You need the sensitivity to pick the problem and the guts to go in there and do something about it and eventually something happens and you just can't avoid it. Either the person gets so sick that they do something really catastrophic where they fall into trouble or their friends recognise them as being so sick that they can't avoid it any more and so, despite the fact that they might lose a friend and they don't want to get involved, they just have to.

Intervention is a serious business. You actually take someone who is really at the limits of their capacity to survive in their environment, someone very severely stressed by an illness of any kind. To interrupt their life and their professional function and their family function and threaten so many of those things to get them into health again is pretty tough and it needs to be done in a way that will manage the denial.

Now drug addicts are the greatest deniers of all things. They're fantastic liars and will make up incredible stories that you just can't help but believe. They are so persuasive. I think narcotic addicts are probably better than alcoholics but they're both pretty good. And you can't take someone on in a one-to-one situation because his or her

denial will beat you any time. Someone who is really wound up just won't be told and I suspect on the inside they're desperate to be found out and get help but they just can't face it at the time. So you need helpers.

This brings in a dilemma that it's nice to have a team approach. The trouble is, if you've got six people in the room to have the interview that's five more threats to the confidentiality than you would otherwise have. But you can't do it alone. Someone who has been through the illness that you're pretty sure this person has got is an enormous asset. The people from Narcotics Anonymous and Alcoholics Anonymous are fantastic at dealing with denial of alcoholics and drug addicts. And when the interview is planned there's no turning back. You can't have a seven-person argument and have the sixth person walk out of there alone going to do what they have been doing. It has to be structured in such a way that that person will end up in treatment.

So, sitting round the table you need to have someone who has absolutely incontrovertible evidence that there's a problem. You need someone to manage the discussion. It's nice to have the spouse, partner or very close friend along as support because very often they will have been caught knowing that their partner was sick and feeling absolutely trapped and unable to do anything about it. It's fantastic to have someone from Narcotics Anonymous or someone who's got that illness there. And I'm going to put in a plug for Narcotics Anonymous and Alcoholics Anonymous and other peer support groups. They are absolutely priceless.

Not so long ago I was involved in an intervention with someone who was using narcotics, I was able to have two people from Narcotics Anonymous ring that person that night, meet with them for breakfast the next day and talk about their problems. I really think that some people in life need a gold star. It's tough for those who do get addicted to any substance but those who become active recruiters for these organizations do a fantastic job for the community.

The aim, of course, is to get someone healthy and back to work and that's not always easy and it's not always appropriate, but I think it's an important option to have available at the time of that intervention. The intervention is a tense sort of an interview and it really involves turning someone's whole life around. If at the end of that the only outcome can be "Yes, you know you're sick and your career has ended" then it's very likely that people will suicide. But if there's a possibility of going to work again, that person will cling to it and that gives them some hope

that they can get back to work and continue on with their life.

I think very often when people are restored to health it's fantastic if they make a decision to change their career because often it has been the pattern of their whole life that's got them into an illness, particularly drugs, alcohol and psychiatric illness. But the time of the intervention isn't the time to talk about that. It has to be a time of hope and often people will think that if they can't work then the financial problems will be beyond their capacity to cope.

People can go back to work and do some really strange things unless they're adequately supervised. So return to work having been impaired needs to be a very carefully organised event and it needs to involve a mechanism which can assess that person's performance. They can be doing dumb things and not be recognised as being in trouble. There need to be the structures in place where if that person is relapsing in their illness and becoming impaired again it will be recognised before they get into serious trouble. There are times where I seriously have to question the appropriateness of return to work.

I think the question of advocacy for sick doctors is central to any prospect of them returning to work and I think here in Victoria the Medical Practitioners Board is in a difficult spot, as are all medical practitioners boards. They have a duty to protect the community from doctors who aren't adequately trained, or who aren't for some other reason able to work. And yet the fact that they are in that position of protecting the community puts a barrier between their relationship with the doctor. They can't have a primary role of protecting the community and a primary role of protecting the doctor.

So there has to be some sort of a balance and there are various programs in the United States - I think with 50-something states they've probably got 50 different models of care - where there is a sick doctor program. I've had the position as head of department having employees wanting to come back to work and I need a way of knowing that they are continuing to be well and I think the Medical Board needs a way of knowing that they are continuing to be well.

I can understand medical administration wanting to be able to reassure the hospital's insurers that their staff members are not working with known health problems that could impair their capacity, but who can do it? The treating doctor certainly can't. The treating doctor has to have a relationship with the patient that isn't intruded on by the need to say, "You're being good. You're being bad. You're being sick. You can go to work" or making that judgment whether or not they're well

enough to go to work. I think the treating doctor needs to be the treating doctor and he needs to be an independent assessor not related to the Medical Board, not related to the employer and who is able to be the advocate for the patient. It has to be a two-way advocacy role saying, "Yes, if I say they're okay, they're okay and if I say they're not okay, they're not okay." It takes a long time and a lot of money for an organisation to be able to develop the credibility so that everyone will accept their decision. It's something we don't have in Australia. I'm not being in any way critical of the Medical Board because I think many of the things the Medical Board has done have been very good and as good as can be done within the legislation under which it operates, but I think there's room for improvement.

I think at times there have to be serious questions about whether or not people should return to work at all. A study done by Emile Minck who surveyed training programs in anaesthesia in the United States, looked at return to work of parenteral - as in injecting, opioid abusers. The anaesthesia residents were in their first three years of training when they returned to work. One third had a successful re-entry to training, that is, they completed their training without having relapsed. Two-thirds relapsed and of the two-thirds that relapsed 25 per cent of them, i.e. a quarter of 66 per cent, so 16 per cent, one-sixth of the overall group who went back to work presented with death as their initial symptom of relapse.

For someone in that situation to go back to work, you're offering them Russian roulette and I think in that circumstance one has to give pretty hard advice that coming back to work is not a good idea. But there's a problem in that. I can recommend to someone they don't come back to work but I have a belief that drug addiction is an illness and it's probably one of the more malignant forms of illness in the anaesthetic community. If that person's well, if they don't relapse, then they should be allowed to work and they can work perfectly well and the patients are perfectly safe in their hands. Now the good news is that there have been no reports of patients coming to harm in the hands of an anaesthetist who is a narcotic addict whereas there have been many reports of anaesthetists coming to harm at their own hands.

But if you don't let someone come back to work you're discriminating against his or her illness. You can liken it to other forms of illness for example, a diabetic. If they're unstable and have a hypoglycaemic attack they're just as impaired during that hypoglycaemia but people would never say the diabetic mustn't do any work in medicine. There

are lots of diabetics around and diabetics expect to be able to drive cars and do all sorts of things. So if I say they can't come back to work, I'm discriminating against the sick and if I say they can come back to work I'm offering them Russian roulette and I don't think either of those are very comfortable options.

The other challenge in getting someone back to work is their confidentiality and the dilemma of confidentiality versus support. If someone's sick and they're coming back to work it's a great thing if their friends that they work with know that they've had a problem and are in a position to be supportive and understanding. They might help stop them from getting sick again or recognise it if they are becoming ill again so that they have early intervention and early treatment rather than waiting for another major event like the conversion of St Paul. It's better to intervene at an early stage where someone's just showing some signs of trouble rather than where they're seriously ill. But to do that you have to breach their confidentiality. To get the support someone has to go wide open and say, "This is the problem and this is how it's affected me." That's not an easy thing for people to do.

I think we have to think of health as our personal responsibility, looking after ourselves and having our lives in balance. We've got a responsibility to our peers and our loved ones to look after ourselves in our work and to understand that our work depends on us being healthy. Health doesn't depend on going to work. So we should be running away from work to seek health not running away from sickness to work and, hopefully, by doing that we'll avoid crises.

QUESTION: Years ago one of my colleagues, an anaesthetist, decided that one of our senior surgical colleagues was slipping in what he was doing. He was worried about it and he wanted to tell his senior surgical colleague that perhaps he really was reaching the stage where he ought to give up practice. He didn't know what to do about it so he asked one of the guy's partners who was slightly younger for advice and the advice he was given was "If you do that all you'll do is lose a friend. The senior surgeon is not remotely interested in hearing your comments and I would suggest you don't even contemplate doing it." What would you tell him to do?

DR WEEKS. I don't have an answer to that. There isn't any easy slick answer for it. I think that the only easy solution is when we have sufficient quality management in the way we deliver health care so that it's not someone thinking the surgeon's slipping, it's someone being able to say "Come and have a look at these figures, things don't seem to

be going quite so well." I think when we develop as part of our practice - and I hope we do head in that direction - much better measurements of performance and outcome then that will provide the mechanism for dealing with this problem. I think the practical solution for now, because what I'd like is still some years away, is that the surgeon has a wife who might actually agree and I think if people really are friends they can have that conversation. If that costs the friendship the friendship probably wasn't worth having.

QUESTION: MS SKENE. Loane Skene, Melbourne University Law School. I also teach a compulsory segment for fifth year medical students on the impaired doctor, so today's medical students are in fact getting a dose of the sorts of things that you've been talking about tonight before they even graduate. May I make a couple of comments? First of all, I think that there is less flexibility for the doctor in deciding whether to report than might appear from what you've been saying. Under the new changed legislation under the Medical Practitioners Act, there is a section that requires doctors who see registered health professionals, which includes both doctors and also other registered health professionals, to report to the relevant registration body if they believe that the health professional who is impaired and presents a risk to the community. So although there is still some discretion for them in deciding whether this person is a risk to the community, once they form that view then they're required to make that report.

DR WEEKS. Absolutely true. The difficulty is in actually making the decision that the person is impaired and that's the tough call to make. I think the other thing is that if someone genuinely believes that a person does have a health problem, yes, it's a good idea to report it to the Medical Board but the question is whether it's better for the sick doctor for an intervention to take place and that person be directed to proper medical care first and say as part of that that you are continuing to have treatment. To say, "Yes, we do have to report this to the Medical Board, but it is much better that you report it to the Medical Board first from treatment than me to do it outside dobbing you in without taking any of the responsibility for trying to get you help."

MS SKENE. I thought that the view that you gave of the compassionate involvement, particularly of getting somebody from a narcotics or alcohol group and the family involved was particularly helpful. One aspect of impairment that you didn't mention, and the one that is most easily diagnosed, is when the health professional has an infectious disease and, obviously, there's a higher rate of

infection, perhaps not so much amongst anaesthetists but certainly among surgeons, for example, than in the community as a whole. So, this might be one case where you can form a view more readily that the person is first of all impaired and then, secondly, a risk to other members of the community.

DR WEEKS. I don't know that there's good evidence that any of the infections actually are a risk to the community.

MS SKENE. It depends what it is. I was thinking of HIV and hepatitis.

DR WEEKS. They're at no more a risk to the community from surgical practice than having dinner together. I think it's very comfortable for the community to say "My doctor should never have hepatitis or be HIV positive" but the community also expects everyone to treat those people the same because there is not a risk from social contact.

MS SKENE. The Medical Practitioners Board has issued guidelines to doctors saying that if they are intending to do surgery and they're HIV positive they should tell the patient and let the patient make the decision whether they want that surgeon to operate upon them.

DR WEEKS. I think it tells them if they were going to do something that they believe would put the patient at risk. That's not the same as doing surgery. I'm not sure of the wording on it.

MS SKENE. I just wanted to make one final point. In relation to medical students who come into university, the student profile of a typical medical student is one who is perhaps more likely to develop psychiatric illness or drug abuse, first of all because the type of student they are when they enter the university and then, secondly, because they're cut off, they work very hard, they're very highly motivated, they have the access to drugs that other students don't have. And often I believe that students who are at risk of subsequently developing impairment are people who might be discovered during the time that they're at the university. In fact, a number of students I've heard about at Melbourne University are not just in medicine but also in other faculties. One of the problems with the medical degree at Melbourne University is that it's a six-year degree and if the student has progressed some years through the degree and the abnormality is then discovered, if they're not allowed to finish the degree they have nothing. I wondered what your view would be on giving, say, a Bachelor of Medical Science or some other qualification during the six-year period so that a student who is found during the six-year under-graduate period not to be a suitable person to be a doctor could come out with something.

DR WEEKS. I'd question a decision being made during training that someone's not a suitable person to be a doctor on health grounds. I don't think that's an appropriate decision to be made. I think someone should be allowed to complete their medical degree regardless of their health. Whether or not they go on to practise medicine I think is another issue.

QUESTION: I teach fourth and fifth year students, fourth year both at Monash and at Melbourne. I teach fourth year Monash students community medicine, the fourth year students I teach at Melbourne are doing psychiatry in the introductory period. I think one of the big problems we face with this is that we're taught to be different from the patients, so it's "us" and "them" and I think this is a major hangover that persists throughout our whole career so when we notice symptoms we ignore them. In 1980 in Victoria we set up the Doctors' Health Advisory Service, which I'm sure you're aware of, and one of your colleagues is on the Executive Committee. This was not to do with narcotics, but it was recognising that doctors get sick too and was giving them permission to get help for illnesses of all shapes and sizes, not just drugs or any other narcotic. A lot of doctors get depressed and don't get proper treatment. They don't get proper treatment for reasons; they don't realise they're depressed, they get stuck into alcohol, or they have a three-day course of antidepressants and it doesn't work so they stop them. Now the Medical Practitioners Board is much more responsive to doctors' illnesses than the Medical Board used to be. It's a different game altogether - although some people on the board were on the previous board. Last year we had a seminar dealing with the impaired doctor, as you're probably aware of, and I think things are moving slowly. In 1980 we began the Doctors Health Advisory Service in Victoria. New South Wales followed about 12 months later, Tasmania followed about five years later, Western Australia set up the system. Doctors are now being accepted as being okay to be sick. Now major problems are, first of all, getting recognition of the fact they're ill, getting adequate treatment from somebody whom they can accept full treatment from. Often doctors who go to other doctors don't get decent treatment. They get "You know as much as I do, take these pills if you think it's all right or go on to something else." This is not decent treatment and not proper. They ought to be treated like any other ordinary patient and they're not and this is because doctors are embarrassed by having doctors who come to them as patients and I think we ought not to allow this to happen. We ought to accept the fact that we are ordinary patients when we go to see a doctor and we ought

to try and encourage the doctor who's treating us if we're sick to treat us as an ordinary patient. Once we become patients we get second-class treatment.

DR WEEKS. Could I just pick up on a point? The question of the Doctors Health Advisory Service I think is an interesting one in that I think it does some great work. On the other hand I'm concerned that it actually sends the wrong message and I wonder if doctors think "Well, if I get something wrong I'll go to the DHAS and they'll point me in the right direction." Wouldn't it be better for us all to have our own general practitioner?

QUESTION: I want to carry that further. Paul Nisselle some time ago wrote an article, on how we medicos need a GP and I thought there's a lot of sense in this. I actually said, "How do we appoint a GP? I know all the GPs in this area and how do I decide on someone who is suitable?" I thought a friend around the corner would be suitable and I thought, "How am I going to find out if this bloke is all right?" The answer was "Go and ask the local chemist." And I said, "Who would you go to in this area?" He said, "Joe Blow" and I said, "Just where I was going to go, thanks very much." And he is the old school family general practitioner, he's older than me and he sat me down, took a history from my birth to the present, and he said, "This isn't good enough. That isn't good enough. I'm going to do all these things again." He took control and he sent me off to his specialist, not to my friends, and he made me report back and he rang me back and it has taken a load off my mind. After all, I'm getting towards late 50s now and bits and pieces are falling off and it is a great comfort to know that it's someone who's conscientious, competent, concerned and will bully me, if necessary, and I strongly advise all our colleagues, medical and legal to do the same. A GP is really the key to the whole problem.

QUESTION: Could I just ask if you've got any information or any comments on gender differences in the impaired physician, given that 50 per cent of medical graduates now are women and there are statistics that say the suicide rate in female doctors is a lot higher than in male doctors and I think especially in female anaesthetists.

DR WEEKS. It actually used to be mainly males but it's pretty even now.

QUESTION: JUDGE STRONG. Michael Strong, County Court Judge. So far as solicitors are concerned we often don't know which of them are impaired but they're not going to kill you. So far as barristers and judges are concerned, generally we know which of them

are drunks or drug addicts and so on and the difficulties they cause can be addressed in the Court of Appeal. We have a solution that perhaps you don't have.