Health impairment allegations against doctors

Qualitative analysis and insights for Australian general practitioners

Owen Bradfield, Matthew Spittal, Marie Bismark

Background
General practitioners (GPs) are pivotal in supporting and treating unwell doctor-patients. However, little is known about the precursors or associations of medical regulatory processes against allegedly impaired doctors.

Methods
A thematic analysis was conducted of semistructured interviews with 21 doctor-patients and four doctors' health experts.

Results
Doctor-patient participants had experienced a past or family psychiatric history, personal loss or trauma, access to drugs at work, workplace stress or recent patient death or suicide. Many avoided seeking care and were significantly unwell when notified to medical regulators. Regulatory processes caused distress, symptom relapse, suicidality, financial pressures and work difficulties. Doctor-patient participants sought assistance from GPs, doctors' health services, medical defence organisations, recovery groups and benevolent associations.

Discussion
When treating doctor-patients, GPs can consider targeted mental health screening, openly discussing mandatory reporting obligations and accessing advice from their medical defence organisation or local doctors' health service. Trust and clear communication benefits doctor-patients and the wider communities they serve.

As doctors, we live in a fantasy that ill-health only happens to other people. [TP1]

Doctors experience higher rates of depression, anxiety and substance abuse than the general population.[1] Known risk factors include work stress, excessive work hours, exposure to workplace trauma, unsupportive workplace cultures and easy access to prescription medicines.[2] Many doctors neglect their health, work when sick and self-medicate,[3] predisposing to substance dependence.[4] General practitioners (GPs) consult with a wide spectrum of patients and will often encounter other doctors as patients (hereafter 'doctor-patients') during their career. GPs can play a crucial role in the recognition, early intervention and treatment of doctor-patients.[5] They are able to support doctor-patients' wellbeing by establishing a therapeutic alliance and encouraging regular preventive and mental health screening. This can assist doctor-patients to overcome many of the barriers that doctors generally face when trying to access healthcare, which include stigma and fear.[6] Being doctors themselves, GPs are uniquely placed to understand some of the challenges faced by unwell doctors who work within a system that expects resilience and stoicism.[7]

Section 5 of the *Health Practitioner Regulation National Law Act 2009* (Qld) ('the National Law') defines 'impairment' as 'a physical or mental impairment, disability, condition, or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect his or her capacity to practise the profession'. Sections 140 and 141 of the National Law require treating practitioners to notify the Australian Health Practitioner Regulation Agency [AHPRA], the Medical Board of Australia, the Queensland Health Ombudsman, the Health Care Complaints Commission and the Medical Council of New South Wales (NSW) (hereafter, collectively referred to as 'regulators'), if they 'form a reasonable belief' that a colleague or doctor-patient is placing the

public at 'substantial risk of harm' by practicing while intoxicated or impaired. These 'mandatory reporting laws' apply in all Australian jurisdictions except for Western Australia. Similar mandatory reporting obligations exist in New Zealand, where Section 45 of the *Health Practitioners Competency Assurance Act 2003* (NZ) requires practitioners to notify the Medical Council of New Zealand if a doctor is unable to perform the functions required for the practice of their profession because of some mental or physical condition.

Mandatory reporting laws are controversial, with critics arguing that they deter help seeking;[8] however, proponents assert that disclosure of an impairment causing public risk is necessary to protect patients.[9] Nevertheless, prior research indicates that the subjective elements of mandatory reporting laws (ie 'substantial harm' and 'reasonable belief') have created confusion for treating practitioners,[10] many of whom are unaware of, or misinformed about, the function and scope of mandatory reporting.[11] This makes mandatory reporting challenging for GPs, who walk a fine line when seeking to advance the interests of their doctor-patients while also discharging their legal responsibilities.

Although doctors' health and its impact on patient care has been studied extensively,[12] there is no prior Australian research specifically examining the effects of disciplinary or regulatory notifications, investigations, hearings or sanctions (hereafter 'regulatory processes') on allegedly impaired doctors. This research is important because if regulatory processes worsen health outcomes for these doctors, the regulatory aim of public protection may not be achieved. Therefore, we conducted qualitative interviews with 21 doctor-patient participants who were the subject of regulatory processes and four experts in doctors' health. Doctor-patients are a hard-to-reach group, and understanding their experiences is vital to improving available health services within a complex regulatory environment.

The aims of this study were to explore: (1) the events that led to regulatory intervention among doctors with health concerns; (2) the impact of regulatory processes on unwell doctors; and (3) the ways in which treating practitioners (especially GPs) can recognise, support and assist doctors with mental health or substance use challenges who are facing regulatory processes. We used a qualitative study design due to the limited existing evidence base, the wide range of unanswered questions about the impacts of regulatory processes and the exploratory nature of our inquiry. We used semistructured in-depth interviews to provide a safe space for nuanced conversation around sensitive topics.

Methods

Recruitment

Using purposive and snowball sampling, we recruited 21 doctor-patient participants (DP1–21) and four treating practitioner participants (TP1–4). To facilitate recruitment of doctor-patient participants, three Australian medical indemnity insurers (MIPS, Avant and MDA National) shared a notice and a plain language statement about the study on their websites and/or communication bulletins. Additional doctor-patient participants were recruited in response to information posted on Facebook, and through peers who had already completed interviews in this research project. Treating practitioner participants were recruited from the researchers' own professional networks.

Participants

Doctor-patient participants were eligible for inclusion in the study if they had physical health, mental health or substance use challenges and had been the subject of regulatory processes relating to their illness. They included doctors suspended or disqualified from practice. We excluded doctors who had been the subject of regulatory processes unrelated to their health or those who were acutely distressed or suicidal. Although there were no formal inclusion criteria, we recruited treating practitioner participants with experience working with Australian doctors' health services.

Consent

All participants received written and verbal information about the study, including the voluntary nature of the research. All participants were assessed as capable of consenting to participate, and all provided written consent.

Data collection

Information was collected from participants through in-depth semistructured interviews conducted via Zoom between September 2020 and February 2022. A preprepared interview guide was used. Although not formally piloted, minor modifications were made as interviews progressed to improve the clarity of the questions and participants' understanding. The substance of the questions was not modified. A trauma-informed approach was adopted.[13] The lead researcher (OB) is a doctor and drew upon his own experiences of the challenges of clinical medicine to establish rapport with participants. Doctor-patient participants were asked to describe: their motivation for participation; their medical history and diagnoses; perceived barriers to accessing treatment; the type of regulatory processes they faced and their outcomes; their experience of and reaction to the regulatory process; the most stressful aspects of the process; their advice to other doctors subject to regulatory processes; recommendations for reform; and their reaction to the interview. Participants were not compensated for their participation in the study. Interviews were audio recorded and saved onto a password-protected encrypted hard drive. Audio recordings were de-identified, transcribed verbatim, and uploaded into NVivo™ (2020; QSR International, Denver, CO, USA). Names were not used during interviews to preserve anonymity.

Data analysis

An inductive approach to thematic analysis was used,[14] providing flexibility and a richly detailed account of data themes. The researchers immersed themselves in the data, systematically reviewed and analysed transcripts and identified and labelled important sections of text. Ideas

arising from the data were identified and organised into codes using NVivo™. Codes were iteratively reviewed for interconnectedness to see where themes should be merged or split. The final coding framework was decided by consensus. Participant recruitment and interviews continued until no significant new themes emerged. The research team also reflected on the experiences of two researchers (MB, OB) as practicing clinicians and former medicolegal advisors to impaired doctors, and the potential influence of these experiences on their interpretation of the interviews.

Table 1. Participant characteristics

	Doctor-patients (n=21)	Treating practitioners (n=4)
Sex		
Female	10	3
Male	11	1
Jurisdiction[A]		
New South Wales	8	1
Victoria	6	2
New Zealand	3	0
Queensland	2	1
Western Australia	2	0
Other	2	0
Speciality		
General practice	6	2
Doctor-in-training	6	0
Surgeon	2	0
Psychiatrist	2	2
Other	5	0
Nature of illness[B]		
Depression	8	N/A
Alcohol abuse	4	N/A
Other substance abuse	8	N/A
Psychosis	2	N/A
Personality disorder	2	N/A
Physical health condition	1	N/A

[A] Totals do not sum to 21 because some doctors faced regulatory processes in more than one jurisdiction.
[B] Only reported for doctor-patients, some of whom had more than one illness type, so totals do not sum to 21.
N/A, not applicable.

Data security and privacy

All files and documents (other than the consent form) were deidentified and securely stored electronically. No information about who participated was shared with insurers. We used a professional transcription company with a confidentiality agreement. Participants were advised that the researchers may be obliged to disclose criminal conduct or new 'notifiable conduct' identified during interviews to police, emergency services or medical regulators. This advice was necessary because, as registered medical practitioners, the researchers (OB, MB) were subject to 'mandatory reporting laws' if 'notifiable conduct' was disclosed during interviews that required mandatory reporting. No notifiable matters were raised. Support services were available if any participants became distressed during the interview. These were not required.

Ethics approval

All procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008. Written consent was obtained from all participants. All procedures involving human participants were approved by The University of Melbourne Medicine and Dentistry Human Research Ethics Committee (Approval no. 2056342).

Results

Descriptive analysis

The characteristics of the 21 doctor-patients and four treating practitioners interviewed in this study are summarised in Table 1. Participants ranged from 10 to 50 years postgraduation, with a median of 21 years. The duration of the interviews

ranged from 44 to 128 minutes, with a median of 98 minutes.

Doctor-patients were notified to regulators by colleagues, employers, police, ambulance, treating practitioners or self-notified. Most had become significantly unwell with inadequate treatment (due to an unwillingness or inability to access effective treatment) before a specific incident involving a substantial risk of harm prompted a mandatory notification:

> *Sadly, I have seen doctors impaired by psychosis, advanced dementia, intoxication, or anaesthetic agents like propofol or fentanyl. When they can no longer practise medicine safely, this warrants mandatory notification.* [TP4]

> *I had a history of poor clinical performance, and my colleagues reported me because I was using stimulants.* [DP8]

> *I became depressed, I thought life was not worth living and began using substances. Then there was a boundary violation.* [DP12]

> *I was drinking in the carpark at 9 am and was intoxicated by 11 am.* [DP18]

Most doctor-patients required medication (antidepressants, mood stabilisers, antipsychotics or opiate substitution therapy). Some were admitted to inpatient psychiatric or residential drug rehabilitation facilities. Others required extended courses of inpatient electroconvulsive therapy.

Most notifications resulted in regulatory restrictions relating to doctor-patients' health or work. Regulatory restrictions relating to doctor-patients' health included treatment from a GP, psychologist, psychiatrist or addiction medicine specialist; or attendance at a support group (eg Alcoholics Anonymous, Narcotics Anonymous, or a Doctors-in-Recovery Group). Other conditions included urine or hair drug monitoring or neuropsychiatric testing. Regulatory restrictions relating to doctor-patients' work included restrictions on work hours or location, or requirements for supervision, mentoring or case auditing.

In addition to health impairment allegations, 10 doctor-patients faced associated professional misconduct allegations (eg self-prescribing opiates or benzodiazepines, theft of medication from their place of employment, forging colleagues' signatures on prescription pads or positive urine or hair drug testing results).

Precursors to regulatory processes

As outlined in Table 2, doctor-patients described various themes associated with their emotional wellbeing and response to regulatory processes. Using the 4Ps framework,[15] we separated these into predisposing, precipitating, perpetuating and protective factors.

Effects of notifications on unwell doctors

The psychological and non-psychological implications of being unwell and receiving a notification are summarised in Tables 3 and 4. Doctor-patients found regulatory processes to be psychologically distressing, and attributed regulatory processes to suicidal ideation and the relapse of symptoms of pre-existing mental health and substance use challenges. For example:

> *I received the notification and ... everything came crashing down.* [DP4]

Despite these adverse psychological effects, doctor-patient participants accepted that some regulatory processes were necessary to protect themselves and their patients:

> *I realised that I was protecting my patients by not working.* [DP21]

> *I would be categorical that my mental health has been worsened by the prolonged nature of this investigation.* [DP9]

Doctor-patients also described the financial, vocational and privacy impacts of regulatory processes. Many described being professionally isolated, experiencing delayed progress through speciality training, being unable to practice medicine, considering early retirement from medicine or engaging in defensive practice. For example:

> *I'm completely bankrupt ... not working ... I'm currently homeless ... and on Centrelink.* [DP16]

> *Even though I was cleared, I left general practice because I lost all my confidence.* [DP11]

Support services accessed

As outlined in Table 5, doctor-patients accessed a range of support services after they were notified to medical regulators and while negotiating regulatory processes. Despite privacy concerns with disclosing mental health or substance use challenges to treating GPs, those who did disclose their challenges found GPs to be one of the most helpful sources of support. Other important supports included doctors' health advisory services (and the recovery groups they facilitate), medical defence organisations and medical benevolence associations.

Discussion

Summary of findings

There are three key findings of the present study. First, most doctor-patients were notified to medical regulators through mandatory reporting. We found that almost all doctor-patients in this study were significantly impacted by mental health or substance use challenges, with evidence of risk to themselves or others, when they were reported to medical regulators. Many had trouble engaging with, accessing or adhering to voluntary treatment. Some were admitted to residential drug rehabilitation facilities, whereas others required inpatient psychiatric admissions, sometimes for extended courses of electroconvulsive therapy. Moreover, and consistent with prior research,[16] we found that doctor-patients feared that disclosing health concerns to treating practitioners may result in mandatory reporting and subsequent regulatory processes. This is concerning because fear undermines the trust within the therapeutic alliance that is necessary for optimum health outcomes.[17]

Table 2. Factors associated with regulatory processes and poor health

Description	Illustrative quotes
Predisposing	Past psychiatric history: *I've had depression since my late teens*. [DP10] Childhood trauma: *I was physically and sexually abused and raped as a child*. [DP2] Family psychiatric history: *My father and grandfather had schizophrenia*. [DP9] Personality factors: *Obsessional doctors are too thorough and often get burnt out*. [TP1] Low self-esteem: *I never thought I deserved to be a doctor*. [DP19] Self-treatment for chronic headaches and back pain: *I took Endone for back pain and then got withdrawal symptoms*. [DP17] Teenage recreational teenage drug use: *Marijuana* [DP2, DP7]; *MDMA and cocaine* [DP5]; *heroin* [DP6]; *alcohol* [DP7] Access to drugs: *I had access to very strong medications at work*. [DP4]
Precipitating	Relationship breakdown: *My wife left me, so I took an overdose*. [DP13] Personal tragedy: *My father died, and my mum was diagnosed with cancer*. [DP17] Vicarious trauma: *I was seeing a lot of traumatic things and reading a lot of sad stories in* [the intensive care unit]. *There was no regard for my psychological welfare – no one at work ever asked me 'Are you OK with what you just saw?' I developed anxiety and depression*. [DP7] Working excessive hours: *Instead of recognising I had a problem, I would work more, which became a vicious cycle*. [DP8] Patient suicide: *I had three patient suicides and developed an acute stress reaction and had to take time off work*. [DP2] Training stressors: *I attempted the written exam while pregnant and moving to a new training centre and became burnt out and depressed*. [DP19]
Perpetuating	Stigma*: People are open about depression. But it's still not accepted that doctors might be alcoholics or heroin addicts*. [DP6] Fear: *I was so scared that if I told my GP anything, I would get suspended. I hid my drug use until it was too late and then everything unravelled anyway*. [DP6]
Perpetuating (Cont'd)	Denial: *Doctors often respond to stress by working harder and longer. It's like going downhill on a bicycle, instead of putting on the brakes, they pedal faster to get control of the bike, so they often accelerate their trouble towards impairment by not seeking help early*. [TP1] Lack of insight: *I tell my patients to see a psychologist, but I didn't tell anyone about my problem. I just tried to keep busy, but I couldn't block it out at 3 am*. [DP3] *When you first attend AA, you think everyone else is worse than you are, and that you can still drink, which is ridiculous*. [DP17] Lack of peer support: *We're a very conservative profession. It's a bit like throwing a rock into a pond. You hope it will send ripples right across the profession, but the medical profession is like quicksand. You throw a rock in and it makes a plop and then nothing happens.* [TP1]
Protective	Support networks • Friends and family *Having family and close friends helps, being honest and having a chat to them.* [DP8] *I needed to be near my family.* [DP9] *I had lots of support from family, friends, and colleagues*. [DP11] • Colleagues *Supervisors* [DP6] *Mentors* [DP19] *Senior colleagues you can trust.* [DP5] *Most colleagues who know my story have been overwhelmingly supportive and understanding.* [DP17] Hobbies *Swimming and jogging* [DP4] *Kung Fu* [DP8] *Cross fit* [DP10] *Gym and meditation* [DP12] *Golf* [DP13] *Cycling* [DP20] *Music and theatre* [DP7] Spirituality, including *Buddhism* [DP12] and the *church* [DP15] Access to services (see Table 5)

GP, general practitioner.

Second, participant interviews revealed that regulatory processes and poor health do not occur in a vacuum. Rather, we observed recurring patterns of predisposing, precipitating, perpetuating and protective factors within doctor-patients' personal and professional lives. Personal factors included a past or family psychiatric history, past drug use or a recent personal loss or trauma. Vocational precursors included long working hours, access to drugs at work, working with trauma victims, geographical relocation for work or training or recent patient death or suicide. This suggests that doctors experience similar personal risks for mental illness or substance use disorders as does the general population, but that unique work situations can exacerbate those risks.

Third, we found that regulatory processes resulted in a range of psychological reactions, including acute distress, suicidal ideation, relapse of mental health symptoms, anger, projection and, for some, acceptance and gratitude. Regulatory processes also caused financial stress, professional isolation, delayed progress through speciality training, early retirement from medicine and defensive practices. To survive regulatory processes, most doctor-patients received medical, legal, financial and peer support from GPs and other treating practitioners, doctors' health advisory services, medical defence organisations, facilitated doctors' recovery groups and medical benevolent associations.

Strengths and limitations

This is the first Australian study to recruit unwell doctor-patients who have been subject to regulatory processes relating to their health. It revealed novel findings of relevance to doctor-patients, GPs, medical regulators and policy makers. We recruited doctor-patients from a range of specialities, practice locations and age categories, allowing for diverse viewpoints. We supplemented this with the perspectives of senior clinicians with expertise treating significantly unwell doctors. Moreover, the semistructured and in-depth nature of our interviews facilitated unanticipated findings to emerge. However, the small and qualitative nature of the study and our focus on Australia make it difficult to generalise our findings to other jurisdictions with different regulatory frameworks.

Table 3. Psychological impacts

Reaction	Illustrative quotes
Acute distress	[When doctors receive a notification]*, they are in crisis – absolute distress. The risks are very high.* [TP1] *I received the notification…and everything came crashing down.* [DP4]
Illness relapse	*I would be categorical that my mental health has been worsened by the prolonged nature of this investigation.* [DP9] *The regulator cherry-picked the most stigmatising aspects of my entire life story and then included them in a report about me that was communicated to my employers. This has left me perpetually re-traumatised.* [DP15]
Suicidal ideation	*I almost ended up driving my car into a pylon with the kids, because of the regulatory process … I was so close to ending it.* [DP2]
Anger–revenge	Five doctor-patients started or completed law degrees *I'm going to take them on.* [TP4]
Blame	Externalisation: *My psychiatrist was a wanker.* [DP4]
Acceptance–insight	*I am remorseful. I'm not embarrassed. I want to own what I've done.* [DP4] *Eventually, I realised that I had to want to get better and that AHPRA didn't care.* [DP5] *I realised that I was protecting my patients by not working.* [DP21]

AHPRA, Australian Health Practitioner Regulation Agency.

Implications for general practice

Our findings underscore the importance of every doctor having their own GP.[18] Even eminent and experienced doctors who care deeply about their patients can become unwell. As colleagues and peers, GPs are ideally placed to understand the unique pressures, challenges and working environments that predispose some doctors to poor mental health and emotional wellbeing. Many doctors struggle to transition from the role of doctor to patient.[19] Through open dialogue and engagement, GPs can help overcome the stigma, shame and embarrassment that often prevents doctor-patients with mental illness or substance use challenges from accessing healthcare. As stewards and gatekeepers of the healthcare system, GPs can play a central coordinating role in the assessment, early intervention and management of doctor-patients with complex and severe conditions who require assessment and management from, and referral to, psychiatrists, psychologists, addiction specialists or doctors' health services.

Despite this, our study also shows that doctors who are significantly impacted by symptoms of mental illness or substance use may be reluctant to access treatment for fear of being reported to medical regulators. It is therefore crucial that GPs are alert to early warning signs or precursors of distress and impairment. They may consider targeted mental health screening of at-risk doctor-patients, especially those with the predisposing or precipitating factors identified in this study; for example, those with a history of mental illness, those working long hours or currently studying for examination, and those exposed to high levels of vicarious

Table 4. Non-psychological impacts

Impact	Illustrative quotes
Financial	*If I can't use my medical knowledge at all, then there's nothing I'm qualified to do except a minimum wage job. I can't even get a job as a drug rep, a waiter or as a barista.* [DP4].
	I'm completely bankrupt … not working … I'm currently homeless … and on Centrelink. [DP16]
Work	Professional isolation, delayed progress through speciality training, inability to practice medicine, early retirement from medicine, defensive practice.
	For six months, I received regular correspondence from AHPRA saying I was a danger to public health and safety. Even though I was cleared, I left general practice because I lost all my confidence. [DP11]
Privacy	*If I relapse, I will try to get treatment anonymously because mandatory reporting made my problems exponentially worse. I can't tell my GP anything because AHPRA will obtain my records and know everything about me.* [DP7]
	I would stop working, go overseas, get myself sorted and come back. I wouldn't tell anyone here. [DP16]

AHPRA, Australian Health Practitioner Regulation Agency; GP, general practitioner.

trauma. For unwell doctors who are significantly affected by mental health or substance use challenges and who continue to practise medicine, GPs may need to assess their memory, attention, concentration, judgment and decision making, or refer them for an occupational assessment, to determine whether they are safe to continue practising medicine.[20]

It is also critical that GPs and their doctor-patients correctly understand their mandatory reporting obligations under Sections 140 and 141 of the National Law, to encourage help seeking and minimise unnecessary breaches of patient confidentiality. Importantly, the high reporting threshold of 'substantial harm' to the public is unlikely to be triggered by common mental health conditions such as anxiety or mild to moderate depression. As this study reinforces, most doctor-patients reported significant illness when they were notified to regulators. In addition,

Table 5. Services accessed by unwell doctors facing regulatory processes

Description	Illustrative quotes
Treating practitioner(s) Doctor-patients spoke of the importance of having a good GP and psychiatrist or psychologist to support their recovery and prevent relapse; however, privacy was a concern, as outlined in Table 4	*Get a good GP whom you trust and who will advocate for you.* [DP2] *My mental wellbeing is the best it's ever been because I've had my anxiety treated by my current psychiatrist.* [DP14]
Doctors' health advisory services These provide independent and confidential advice, support and (in some jurisdictions) case management and supported recovery groups for unwell doctors	*Our mission is to improve the health of the profession for the good of the community.* [TP1] *I rang them when I was close to suiciding. They were very helpful and supportive.* [DP2] *They have a great recovery group.* [DP5]
Recovery groups Doctor-patients with substance use disorders preferred to access facilitated recovery groups specifically targeted to doctors (eg Caduceus and Australian Doctors in Recovery) rather than general groups like Alcoholics Anonymous or Narcotics Anonymous	*I'm blessed with the Doctors in Recovery group.* [DP14] [Australian Doctors in Recovery] *is incredibly supportive.* [DP17] [These groups can be] *hard to access … secretive* [in order to protect doctors' privacy]. [DP15]
Medical defence organisations These provide legal assistance and advice to eligible member doctors. Doctor-patients who accessed support and advice overwhelmingly described positive experiences	*Really supportive … huge relief, huge help. Without my MDO, I don't know what I would have done. They helped me psychologically to understand the legal terminology … My MDO helped my health.* [DP5]
Medical benevolent associations These are registered charities that provide short-term financial assistance for doctors in financial need	*They helped me financially … I wouldn't have survived otherwise.* [DP2] *They were really compassionate.* [DP15]

GP, general practitioner; MDO, medical defence organisation.

a past risk is not reportable if the risk has since been mitigated by treatment. Similarly, if the doctor-patient is no longer working, and does not intend to return to work until it is safe to do so, then there is no risk to the public and notification is not required. We recommend that GPs consider explicitly discussing their reporting obligations early in the treating relationship with unwell doctor-patients to reassure them that reporting is not required in situations where they are receiving care, accessing support and taking leave as needed to avoid risks to patient safety. Moreover, we note that treating practitioners in Western Australia do not have a legal obligation to notify medical regulators about impaired or intoxicated doctor-patients, but may retain an ethical obligation to voluntarily report them.

Finally, GPs should be aware of the many resources available to unwell doctor-patients who are experiencing financial or legal problems. AHPRA publishes guidelines that provide detailed information on reporting obligations.[21] In addition, treating GPs and their doctor-patients can seek advice from their medical defence organisation or can anonymously contact their state or territory doctors' health service for further information about local resources for doctor-patients. A new Drs4Drs website (www.drs4drs.com.au/) provides information, advice and a 24/7 telephone support service staffed by experienced GPs and counsellors trained in doctors' health. Similarly, Hand-n-Hand can provide confidential peer support for healthcare workers needing emotional and wellbeing assistance (www.handnhand.org.au/).

Conclusion

GPs will encounter doctors as patients throughout their career. Supporting doctor-patients to stay healthy not only benefits the doctor-patient, but also the doctor-patient's own patients. Whole communities therefore stand to benefit indirectly from the care and support provided by GPs to a single doctor-patient. Although this study is early work and qualitative in nature, the themes explored reinforce the need for transparency and safety in the treating practitioner–doctor-patient relationship. In addition, given that regulatory reporting of health impairment by treating practitioners is not mandatory in Western Australia, further research to compare experiences and outcomes across jurisdictions is also urgently needed to enlighten public policy debate. This would inform efforts to reduce stigmatisation of impairment and the late presentation of those who are significantly impacted by mental health or substance use challenges.

Authors

Owen Bradfield MBBS(Hons), BMedSc(Hons), LLB, MBA, FRACGP, Law and Public Health Unit, Centre for Health Policy, Melbourne School of Population and Global Health, The University of Melbourne, Melbourne, Vic

Matthew Spittal PhD, MBioStat, Professor, Centre for Mental Health, Melbourne School of Population and Global Health, The University of Melbourne, Melbourne, Vic

Marie Bismark MBChB (Otago), LLB, MBHL, MPH, MPsych, FAFPHM, Professor and Head of the Law and Public Health Unit, Centre for Health Policy, Melbourne School of Population and Global Health, The University of Melbourne, Melbourne, Vic

Competing interests: None.

Funding: OB was funded by the Australian Government on a 2020 Melbourne Research Scholarship, a 2020 Fulbright Future Scholarship and a 2021 Avant Foundation Grant. MS was funded by the Australian Government on an Australian Research Council Future Fellowship (FT180100075). MB was funded by the Australian Government on a National Health and Medical Research Council Investigator Grant (APP1195984).

Provenance and peer review: Not commissioned, externally peer reviewed.

Correspondence to:
owenmb@student.unimelb.edu.au

Acknowledgements

The authors sincerely thank the Medical Indemnity Protection Society, Avant Insurance, MDA National and Australian Doctors in Recovery for their assistance recruiting doctors into this study. The authors also gratefully acknowledge those who participated in this study. Without their generosity, input and candour, this project would not have been possible.

References

1. Beyond Blue. National mental health survey of doctors and medical students. Melbourne: Beyond Blue, 2019. Available at https://medicine.uq.edu.au/files/42088/Beyondblue%20Doctors%20Mental%20health.pdf [Accessed 28 March 2022].
2. Bradfield OM, Bismark M, Scott A, Spittal M. Vocational and psychosocial predictors of medical negligence claims among Australian doctors: A prospective cohort analysis of the MABEL survey. BMJ Open 2022;12(6):e055432. doi: 10.1136/bmjopen-2021-055432.
3. Galbraith N, Boyda D, McFeeters D, Hassan T. The mental health of doctors during the COVID-19 pandemic. BJPsych Bull 2021;45(2):93–97. doi: 10.1192/bjb.2020.44.
4. Merlo LJ, Singhakant S, Cummings SM, Cottler LB. Reasons for misuse of prescription medication among physicians undergoing monitoring by a physician health program. J Addict Med 2013;7(5):349–53. doi: 10.1097/ADM.0b013e31829da074.
5. Dunkley K. Every doctor needs their own GP. Melbourne: AMA Victoria, 2021. Available at https://amavic.com.au/news---resources/stethoscope/-369-every-doctor-needs-their-own-gp [Accessed 6 August 2022].
6. Vayr F, Herin F, Jullian B, Soulat JM, Franchitto N. Barriers to seeking help for physicians with substance use disorder: A review. Drug Alcohol Depend 2019;199:116–21. doi: 10.1016/j.drugalcdep.2019.04.004.
7. Wallace JE. Mental health and stigma in the medical profession. Health (London) 2012;16(1):3–18. doi: 10.1177/1363459310371080.
8. Goiran HN, Kay M, Nash L, Haysom G. Mandatory reporting of health professionals: The case for a Western Australian style exemption for all Australian practitioners. J Law Med 2014;22(1):209–20.
9. Bismark MM, Morris JM, Clarke C. Mandatory reporting of impaired medical practitioners: Protecting patients, supporting practitioners. Intern Med J 2014;44(12a):1165–69. doi: 10.1111/imj.12613.
10. Bismark MM, Mathews B, Morris JM, Thomas LA, Studdert DM. Views on mandatory reporting of impaired health practitioners by their treating practitioners: A qualitative study from Australia. BMJ Open 2016;6(12):e011988. doi: 10.1136/bmjopen-2016-011988.
11. Health Care Complaints Commission v Orr [2015] NSWCATOD 124. Available at https://www.jade.io/article/416489 [Accessed 14 March 2023].
12. Pitkanen M, Hurn J, Kopelman MD. Doctors' health and fitness to practise: Performance problems in doctors and cognitive impairments. Occup Med (Lond) 2008;58(5):328–33. doi: 10.1093/occmed/kqn080.
13. Isobel S. Trauma-informed qualitative research: Some methodological and practical considerations. Int J Ment Health Nurs 2021;30(Suppl 1):1456–69. doi: 10.1111/inm.12914.
14. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol 2006;3(2), 77–101.
15. Alyami H, Sundram F, Hill AG, Alyami M, Cheung G. Visualizing psychiatric formulation. Australas Psychiatry 2015;23(5):575–80. doi: 10.1177/1039856215593024.
16. Kay M, Mitchell G, Clavarino A, Frank E. Developing a framework for understanding doctors' health access: A qualitative study of Australian GPs. Aust J Prim Health 2012;18(2):158–65. doi: 10.1071/PY11003.
17. Muran JC. The alliance construct in psychotherapies: From evolution to revolution in theory and research. World Psychiatry 2022;21(2):308–9. doi: 10.1002/wps.20973.
18. Johnson N. A GP for every doctor. newsGP, 12 September 2019. Available at www1.racgp.org.au/newsgp/professional/a-gp-for-every-doctor [Accessed 1 August 2022].
19. Kay M, Mitchell G, Clavarino A, Doust J. Doctors as patients: A systematic review of doctors' health access and the barriers they experience. Br J Gen Pract 2008;58(552):501–8. doi: 10.3399/bjgp08X319486.

20. Candilis PJ, Kim DT, Sulmasy LS; ACP Ethics, Professionalism and Human Rights Committee. Physician impairment and rehabilitation: Reintegration into medical practice while ensuring patient safety: A position paper from the American College of Physicians. Ann Intern Med 2019;170(12):871–79. doi: 10.7326/M18-3605.
21. Australian Health Practitioner Regulation Agency (AHPRA). Guidelines for mandatory notifications. Melbourne: AHPRA, 2020. Available at: www.medicalboard.gov.au/Codes-Guidelines-Policies/Guidelines-for-mandatory-notifications.aspx [Accessed 28 July 2022].

correspondence **ajgp@racgp.org.au**