INAUGURAL WORKSHOP OF THE

EUROPEAN ASSOCIATION FOR PHYSICIAN HEALTH

OSLO, 28-29 OCTOBER, 2009.

Attendees from: Austria, Belgium, Finland, Germany, Hungary, Ireland, Norway, Poland, Spain, Sweden, Switzerland and United Kingdom

The European Association for Physician Health (EAPH) brings together researchers, caregivers and regulators from a number of disciplines interested in the area of physician health. Their interest includes a consideration of effective interventions for those doctors who suffer physical or mental health problems as well as those with behavioural issues that threaten their careers. In this way the work of EAPH recognises the impact that sick and disruptive doctors can have on the quality of patient care, and so includes in its remit the links that exist between physician health and patient safety, with an aim to improve both areas.

The workshop was conducted using brief plenary presentations and film followed by generous time for group discussions. This paper outlines the principal themes that emerged from the group work.

1. Recognition of problems. The early recognition of problems is very important, both in terms of preventive healthcare and to enable greater success in secondary interventions. Doctors of all ages often find it difficult to admit to their own health issues and also to acknowledge problems suffered by their colleagues. Discussion focussed on two main areas; first, concerning how to get doctors to recognize their own health issues and, second, how to recognize a doctor in difficulty and enable him or her to get appropriate help.

Educating doctors to recognise their own mental and physical health problems should ideally begin in medical school, particularly for those problems concerning alcohol and drug abuse which often starts during undergraduate years. Although it is sometimes difficult to get space in the curriculum for this topic, it can usually be fitted into an appropriate area such as communication or ethics. Senior doctors' role modelling self-care and being frank about their own difficulties are useful means of developing openness in others. In addition, most attendees spoke of concerns that few young practitioners had their own doctor and that this should be encouraged across Europe.

Recognising and addressing the health problems of colleagues may create difficulties for a number of reasons: because people find it hard to raise issues that seem personal; because they fear the consequences for the colleague involved; and because they may have resource issues that they consider would worsen without that doctor.[1] Providing the means for them to discuss this dilemma confidentially has proved useful; for example, by using the advice and support provided by the National Clinical Advisory Service in the UK.[2] Educating doctors to help them to feel more confident about judging the ill-health of a colleague is important[3], including helping them to take a complete career history and to spot "red flags" that might indicate a longer term problem. A fair and open organisational culture will make this an easier process.[1]

2. How to assess difficulties. Participants use a number of ways to assess difficulties; different methods undertaken by different organisational roles happen across Europe, some formal, but most informal. Working towards the use of shared assessment methods and intake-outcome measures for specific problems could be a useful long-term goal for the Association. In the United Kingdom, but rarely elsewhere, the GMC insists that, in cases of addiction, the treating doctor should be separate from the assessor, and this may also be considered important in other aspects of mental health.

3. Managing a doctor in difficulty. Doctors often find it very difficult to treat other doctors, whether for mental health problems or physical ones.[3] Courses, such as those run by PAIMM in Barcelona[4], are important in helping the treating doctors to understand ways to discuss difficulties, create boundaries, recognise pitfalls and the follow the necessary process of treatments. In addition, they may need occasional support along the way since both they and the doctor-patient may slip off the process to the detriment of the latter.

The management process will usually be different depending on whether the doctor has come voluntarily into treatment or has been referred, perhaps by a disciplinary body or an employer. Not surprisingly, most participants who provide treatment found that doctors are much easier to treat when they come voluntarily. It was pointed out that shame was frequently an aspect of the doctor-patient's emotional state, and it was important to acknowledge and work with that shame and resistance, whatever type of intervention is used.

It was clear from the presentations that different countries, or regions within a country, have developed very different ways to offer assistance for mental health problems in doctors, and use a variety of treatment models. Where they have been evaluated it has been found that doctors do well in treatment, usually better than the general population.[5,6]

4. Managing the organisation. Organisations can certainly damage individual staff[7] and participants voiced their concerns about the fact that most of them had no means of influencing organisations to improve their environment or specific relationships within it, even when it appeared clear that these were pathogens in a doctor's health, sometimes with more than one doctor suffering as a result of some aspect of the same organisation. However, this is much less true if the doctor is referred rather than coming voluntarily. In this case, there should be ways to feed back into the organisation. Methods to evaluate organisations and their effects on staff stress and burn-out have been developed[8], and ways to change them for the benefit of both staff and patients have been described[9]. However, there remains little research in this important area.

5. Political aspects including funding. Background political and sociological aspects of the work that surrounds physician health were discussed in some groups. For example, one participant questioned why doctors (any more than teachers) should have *a duty* to be healthy. It was agreed that they did have such a duty and this then adds to the reasons for providing specialised fast-track services.

Models of funding for these services naturally varied widely for different countries. Participants expressed the view that the cost of interventions was extremely small given their frequent success,[5,6] and compared with the enormous cost of sickness absence, early retirement and litigation. A health economics analysis of the area would be extremely useful, as is the clear message that physician health is a patient safety issue.[7]

6. Regulation. The health of doctors and their fitness to practise has always been an important issue within the regulation of the profession and it was decided that membership of the Association should be open to those in regulatory bodies across Europe. It was clear from the discussions that the power and actions of these organisations differ hugely in the various countries: while in some countries there is almost no chance of a doctor being referred, by contrast, the UK's General Medical Council now has relatively strong powers and clear processes. Whether the differing powers of these bodies actually affects how or whether doctors seek help for problems is not known.

The formation of the European Association for Physician Health. At the end of the workshop a draft constitution was presented to members and accepted. It allowed a committee of eight officers and these were duly elected. Their initial principal duty will be to develop the programme for the EAPH conference to be held in Barcelona in 2010.

References

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