C O R R E C T E D V E R S I O N

STANDING COMMITTEE ON LEGAL AND SOCIAL ISSUES

LEGISLATION COMMITTEE

Inquiry into the performance of the Australian Health Practitioner Regulation Agency

Melbourne — 4 September 2013

Members

Ms G. Crozier	Mrs A. Millar
Mr N. Elasmar	Mr D. O'Brien
Ms C. Hartland	Mrs I. Peulich
Ms J. Mikakos	Mr M. Viney

Participating member

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Secretary: Mr R. Willis

Witness

Dr K. Jenkins, medical director, Victorian Doctors Health Program.

The CHAIR — I declare open the Legal and Social Issues Legislation Committee public hearing. Tonight's hearing is in relation to the inquiry into the performance of the Australian Health Practitioner Regulation Agency. I welcome Dr Kym Jenkins, medical director, Victorian Doctors Health Program. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Legislative Council standing orders.

All evidence is being recorded. You will be provided with a proof version of the transcript within the next week. Transcripts will ultimately be made public and posted on the committee's website. I now invite you to proceed with a brief presentation to the committee, after which I will allow members to ask questions of you. Again, thank you very much for being with us this evening, Dr Jenkins.

Dr JENKINS — Thank you. On behalf of VDHP we put this submission together because we are obviously concerned about the future of our organisation and the services that we provide. Just to recap, VDHP was set up in 2001 as a joint initiative of the AMAV, which is the medical association of Victoria and the then medical practitioners board. It was there to fill an obvious gap in looking after doctors and doctors' health. It was modelled on similar programs in North America and Canada, and it was set up at a time when there was increasing recognition, as there has been throughout the 13 years since, of the specific health needs of doctors and how doctors are not good at looking after themselves. The old adage that doctors make the worst patients is unfortunately true for a whole load of reasons that I will not have time to go into here.

We actually see a really wide range of health problems in the doctors we look after. In the early years I think it was perceived that we were there to look after doctors who had serious mental health problems or had substance use issues. Even though we still do those things, because our volume of work has increased over the years the doctors with substance use issues now constitutes probably about 10 per cent of our new referrals per annum. We run a whole range of services covering all aspects of doctors' health. We try to work very closely with general practitioners and external practitioners because we are not funded to provide ongoing treatment within the doctors' health program. We see ourselves predominantly as a triage and advice and support organisation.

The numbers of doctors attending our service over the years have steadily increased. We would see around 110 face-to-face new consultations each year, and we would get well over 200 phone calls for advice. Some of the phone calls that we get can be solved quite easily over the phone; it may just be advice about who would be an appropriate practitioner for that doctor to go and see. Other times it may be third parties ringing us up and wanting advice about how to handle a doctor who is not travelling too well, and that may be employers, families, friends or universities who do not know what to do within their own organisations about the health of a colleague.

We do a lot of external work by secondary consult and with external organisations, as well as the face-to-face work that we do. Of the people that actually come in to see us, the majority would have problems that really falling into 'stress' and 'distress' rather than actually the serious mental health end of the spectrum, although we do cross the whole spectrum. We see people with physical health problems as well, where their physical health problems are impacting upon their career choices or their capacity to practice medicine. I am a psychiatrist and I believe you cannot separate physical and mental health anyway, so we try to take a very holistic view of the practitioner's health.

We do a lot of direct clinical work, a lot of indirect clinical work. Some people may only come and see us once or twice, and once we ensure that they are linked in with appropriate ongoing health practitioners, we can bow out of their care. Other people have got much more complex problems and require ongoing case management. The case management program that we use may involve liaising between ourselves and three or four other clinicians, the person's employer, their medical insurance agencies and people like the medical benevolent fund if there are financial concerns as well. It really is a whole-of-person case management program. That is one of the things that is very unique in Australia with regard to the Victorian situation and one of the aspects of our program that we are really most concerned about into the future.

At the moment we have got 45 doctors that we are case managing, and the majority of those would not actually be working if they were not in a case management program with us. We also run a support group for doctors who have had substance use disorders, and that meets weekly. Those doctors value that very highly as a way of staying well, and it is one of the supports that they feel is essential for them continuing practising medicine at a high and appropriate level.

We are very aware all the time that, as well as having a duty of care to the doctors who come to see us, those doctors have a duty of care to their patients as well and that we are often walking a sort of tightrope between caring for the individual practitioner and them caring for their patients. Consequently it is essential for us to have a very good working relationship with AHPRA or the medical practitioners board.

The way into the future for doctors' health if you look at the literature worldwide is for more organisations like ours being set up. Ours is the only one that follows this model in Australia. We are very worried, as we go into the future, with funding cutbacks and the fact that we have no guarantee of funding into the future, that we cannot continue to offer the level of services that we currently offer. I think in my submission I used the term 'lowest common denominator' for want of a better term. We know that the medical board at the moment is looking into funding doctors' health services into the future, but it is highly unlikely that there will be enough funds to fund the services that we have got.

Over the past three years, from the time of national registration, we did have some money guaranteed by Daniel Andrews when he was health minister, which gave us three years funding, but that was three years funding at the level of 2009 into 2010, so without any CPI we have already had considerable belt tightening and limitations on the services that we can provide, and we are just in holding mode at the moment. This year we have had some funding from the medical board and we have managed to top up our funds with grants and bequests from various other medical organisations, but it has been a real struggle trying to scrape together enough funds to keep the organisation running.

One of my main concerns in this is obviously for the future of the VDHP which, obviously, being the medical director, I feel passionate about because it is the organisation that I run. I could be doing a million and one other things as a psychiatrist, but I feel it is really important to keep the practitioners who are doing the work out there as healthy as we possibly can. We do know that if you do not have an adequate doctors' health program, doctors do not get help, and that is well recorded in the literature. We ask every doctor who comes to us whether they have got a GP, and if they have got a GP, whether they have told their GP the problems they have come to see us about. About 60 per cent of the people we see have not let their GP know that they have a problem. Doctors are not very good at using mainstream medical health services for a whole variety of reasons, including shame and stigma and everything. We think it is just really important to look after the people who are looking after others.

I have alluded to the fact that we need to have a very good working relationship with the Medical Board of Australia. Our role is a non-regulatory role but it is sort of complementary to the role of the medical board as well. Liaison between the various committees of the board is important on many levels, not least of which is that when doctors are actually being investigated by the medical board or AHPRA it is an incredibly stressful time for those doctors. We can be around to help them through that stressful time.

One of the things that doctors find most stressful under the current system is probably the enormity of AHPRA and the generic level of investigations and notifications when notification has been made. Doctors come in to see me and tell me that they do not know who to go to to find out where their investigation has got to and where it is up to, and their careers are on hold, or they feel as though they are on hold and in limbo, until it is all sorted out.

The CHAIR — Dr Jenkins, could I — —

Dr JENKINS — Sorry, I could talk forever.

The CHAIR — Yes, and I am sure you have very much more to say, but I would like to move to members questions, if that is all right, unless you have any concluding remarks that you would like to make to the committee.

Dr JENKINS — I think probably the only other aspect of our work that I have not touched on at all in this, having focused on the clinical work, is the vast amount of educational work that we do and our links with the universities and the various learned colleges, very much in promotion and prevention in relation to doctors' health, thinking that prevention is better than cure, and advocacy and liaison with external organisations. I had better take some questions.

The CHAIR — Thank you very much. There may be some questions in relation to that element, anyway. I would like to go to the point that you raised and obviously the very good work that the program does in supporting doctors who have been either self-referred or referred to your program. You mentioned the funding under the former agreement that was put in place and that has now ceased. It is my understanding that part of the funding for the program comes out of registration fees; is that correct? Could you just clarify where the additional funding has come from to keep the program operating?

Dr JENKINS — The funding for this year has been from some funds that the Medical Board of Australia has found for us. That was $350 000-plus, with GST as well. On the rest, we have some money from the Victorian Medical Benevolent Association and the three universities in Victoria have found us various sums as well. So it is a hotchpotch of $10 000 from this organisation and $20 000 from that organisation from people who wanted to support the work that we are doing.

The CHAIR — Could you confirm to the committee when that funding runs out?

Dr JENKINS — We have no guarantee beyond the middle of next year.

The CHAIR — So 1 July next year?

Dr JENKINS — Yes, the end of this financial year.

Ms MIKAKOS — Further on the issue of funding, as I understood it, you were saying before that previously there was Victorian government funding for a three-year period?

Dr JENKINS — Yes.

Ms MIKAKOS — Have I understood correctly that you were saying that there is no Victorian government funding at the moment and from when that three-year funding expired?

Dr JENKINS — That money came from AHPRA and I think it was money that was left over from the liability that the Medical Practitioners Board of Victoria had when everything was changed over to national registration, but that funding was guaranteed for only three years. I cannot tell you the exact specifics of whose pocket that money came out of.

The CHAIR — Just on that point, as you said, when the transition from the old medical boards to AHPRA happened, AHPRA was administering the money to support the program?

Dr JENKINS — Yes. We have a specific memorandum of understanding.

Mr O'BRIEN — Thank you for coming tonight to give your evidence. Just going back one step further, it is our understanding that prior to the introduction of the national scheme, you effectively were funded by a $25 levy through the MBA; is that correct?

Dr JENKINS — Yes, it was through the MPBV — the Medical Practitioners Board of Victoria, as it was at that stage. The $25 levy was registration, paid towards us.

Mr O'BRIEN — In a sense that scheme would enable it to be funded into the future. It was quite stable, in the sense that you had a number of practitioners and then you would have that levy each year?

Dr JENKINS — Yes. I do not think practitioners were aware at that stage that it actually was a levy.

Mr O'BRIEN — Then you have written in your concern on page 2 that despite medical registration fees going from $350 to $670 and doctors perceiving fewer services, one of the services that is no longer being included in the registration fees is the VDHP.

Dr JENKINS — Yes. I have been corrected on the amounts I have quoted, in that the $350 was $450.

Mr O'BRIEN — But your point is that there was an amount taken out. Has AHPRA given you any reason why a similar levy of $25, or whatever sum was appropriate, has not been maintained in the national scheme?

Dr JENKINS — I am not sure that this is information that has come directly from AHPRA, but now there are 14 professions and AHPRA is the national organisation. We are looking after just the medical profession and we are just in Victoria.

Mr O'BRIEN — Sure, but if you were pre-existing, one would think, especially if the fees have gone up, that there ought to be enough money to at least keep what was already there and then look at increased fees for expanded services. Have you sought a written reason from them as to that, or are you not able to feel comfortable doing that? Where are things at?

Dr JENKINS — We have not sourced a written reason, no.

Mr O'BRIEN — Just one other aspect that intrigued me was the sort of stigma or confidentiality aspect. Obviously the service you perform is very important. There would also be issues with investigations. How do you manage those protocols of notification et cetera, particularly the duty of a doctor and nurse?

Dr JENKINS — We are bound by the same mandatory reporting regulations as any other health professional. We were very concerned about that when the national scheme came about, that the mandatory reporting would deter people who really needed help from seeking help. I have looked closely at our figures over the past three years and that does not appear to be the case. Since reporting has been mandatory, the number of people I have reported to the medical board has not increased, because with or without mandatory reporting one still has an ethical obligation to report if you felt somebody was going to harm their patients.

The whole issue of confidentiality is quite contentious. We want our organisation to be as confidential as possible but, as I said earlier, we are constantly aware of that tightrope we are walking, of looking after the practitioners but also our duty to look after, to make sure that the community and the populations the doctors look after are well looked after as well. There are times when actually reporting somebody to the medical board may be the sort of step you need to take in order to get that doctor to get help. In the long run that is more helpful than less helpful.

The CHAIR — Just on that point, are you saying that therefore the program prevents the public from potentially becoming at risk, by supporting them?

Dr JENKINS — Sorry, can you rephrase that question?

The CHAIR — You said you walked a tightrope, I think was the phrase that you used, in supporting the doctors and protecting the community.

Dr JENKINS — You are balancing risk versus confidentiality the whole time.

Mr ELSBURY — You would have been communicating with other bodies in other states that offer similar sorts of services. Have you tried to approach AHPRA as an organisation and say, 'Look, these services are not being delivered, and we already have the bodies established in each state, so why can't we work together on this?'.

Dr JENKINS — We have an organisation that is called the Australasian Doctors Health Network. It is a loose network of doctors health programs. In other states there are a whole variety of different organisations. None has the model that we have, and none has the level of services across education, assessment, ongoing case management and the other extra services that we provide. In some places it is a telephone answering service only; in other places it may be a preventive health check-up with no ongoing services and a limited role in education. It is very different across the country, but we do meet regularly, and we have met representatives from the Medical Practitioners Board of Australia with whom we discuss ongoing funding into the future.

Mr ELSBURY — Going back again to the metaphorical tightrope that you talk about, under the old system you could direct the attention of the Victorian board to a doctor who is possibly having some issues. Would you feel comfortable under the current regime of actually reporting someone to AHPRA?

Dr JENKINS — I have done so, but I feel more anxious about the process.

Mr ELSBURY — Why is that?

Dr JENKINS — Because I feel that the trauma that the doctor goes through once they have been reported is far greater. It is tough enough to be reported to your own professional regulatory body anyway. The reports I get from the doctors going through that process are that they are a lot more traumatised by the process than they used to be.

Mrs MILLAR — I am interested in what your staffing structure is, and are any of the services provided on a pro bono basis?

Dr JENKINS — Our staffing structure is very small. There is myself; I am currently employed 16 hours a week. We have two other psychiatrists, who are also senior clinicians. They assess people, and they work on a sessional basis — maybe one or two sessions a week. We have a full-time case manager, a part-time case manager and a full-time office manager. We pay the facilitators of the support group that we run on a sessional basis. We provide an after-hours service, which is done pro bono by myself and the other senior clinicians. I do not think we actually employ anyone else. We have a counsellor at the moment who does not charge her fees, and we rely on a lot of goodwill. Obviously, with our limited budget, the major cost is salaries, but nobody who works for us gets full award wages.

Ms MIKAKOS — You cited earlier the number of face-to-face consultations and phone calls your organisation conducts per annum. I would be hazarding a guess in suggesting that the vast majority of medical practitioners would be going elsewhere, because I imagine there would be a large number who would be facing stresses or anxieties or other medical issues. Why would they be opting not to use your service, is essentially my question?

Dr JENKINS — I cannot really answer that, because I only know about the people whom we see. I know from when we are seeing people and ask them why they have not gone to their GP, the answer may be, 'I cannot go to my GP. He has known me since I was this high — since I was five years old — he knows my whole family. It is too shameful to speak to a GP'. They perceive that by going to an organisation that is specifically for doctors they will get the hearing that they need, or they may perceive that we have specific expertise in looking after other doctors.

One of the roles that we have is running education programs for other doctors to help them look after other doctors. It requires an additional skill set to look after other medical practitioners, because, as I said right at the beginning, doctors make bad patients. They know how to selectively disclose what is wrong with them in order to be told what they think is already there. You have to have an extra skill set in order to deal with highly intelligent people who are frightened and who have a lot of stigma and shame about their problems, in order to get beyond their defences.

Ms MIKAKOS — But the figures would suggest that the vast majority of practitioners would feel comfortable to use their GP or other medical services?

Dr JENKINS — We do not have any figures that say that, and there is literature worldwide that suggests that people do not like going to services that are not specifically for doctors. I am not saying that that is a good idea, and into the future we ought to have a medical workforce that is capable and competent of looking after everybody, irrespective of their professions, and looking after their own, but at the moment we do not have that, so we do need doctors health programs that are specifically for doctors. If you have a generic health program, people do not use it. You just have to look at things like the employee assistance programs in hospitals and things. The number of doctors who go to those is really very small proportionately compared to the number of doctors who work in the hospitals.

A lot of doctors' problems — rather than actually going to other practitioners in outside health services — are unmet needs. There are problems that if only people sought help when the problems were small, or felt comfortable to seek help when the problems were small, they could get help, but some of the big problems that we used to see were because people were too afraid to get help.

There are specific groups that are at risk of this, particularly the international medical graduates, who may have visa problems or registration issues and who are afraid that if they were to go to another agency and say, 'I'm depressed; I'm not coping', they may no longer be able to work in Australia. Because of the education programs that we do with international medical graduates they know about us, and they feel safe coming to us.

Ms MIKAKOS — As a follow-up question, do you believe you offer a particular expertise in relation to particular issues? You mentioned the cohort of international students, but do you believe that you have particular expertise, for example, when it comes to substance abuse issues?

Dr JENKINS — Yes, very much so.

Ms MIKAKOS — So your expectation would be that those practitioners would tend to come to your service rather than use the mainstream medical services?

Dr JENKINS — As I said, we only see who we see. We may just be seeing the tip of the iceberg. But often if you are a medical practitioner, firstly, you do not know where to go to get help for yourself, and, secondly, you are afraid to go to mainstream services because you might end up waiting in the waiting room with a load of your own patients and cannot face the shame and the stigma of doing that.

Often there are complicating factors like if people have issues with the medical board or issues with their employers. We get involved because we are good at negotiating with the workplace and running return-to-work programs for people who have been out of the workforce for a while. We are liaising with employers and saying, 'Hang on, this is the situation for this person at this moment. They cannot do the full quota of their work, but with a breathalyser each morning or with regular hair testing to make sure that they are not using substances, they will be okay to work. But we want reports on that at regular intervals to make sure that it is the case, or this becomes a case for the medical board'.

In giving that example I am not including people who have already gone to work in an impaired state because they will be before the medical board already. I am talking about people who are not travelling well and are at risk of getting that far down the line. We can catch them before they put patients at risk.

Mrs PEULICH — I have three questions. First of all, can you confirm whether you are of the view that the health program providers for the medical profession should be a separate body to that responsible for registration and disciplinary matters?

Dr JENKINS — Very much so.

Mrs PEULICH — Secondly, your case management, just to confirm yet again, would liaise with other service providers and customise a program?

Dr JENKINS — Absolutely. Out of the 45 people we are case managing at the moment, each one has an individual case management program.

Mrs PEULICH — Last question: what should therefore be contained in a national health program? Given your earlier comments about whether it is customised or particularly relevant to a particular professional group, should there be customisation or a generic program for the various professions within the medical fraternity? What should really be in a national health program? Can you give us some dot points?

Dr JENKINS — For doctors? Because I think if it is for all health practitioners, it will not be fully utilised.

Mrs PEULICH — So you are saying a generic program will not be as effective, so it needs to be customised to a profession?

Dr JENKINS — No, because the needs are different in each profession. The medical profession is the only one where we can prescribe and we can treat. Out of all the health professions we are the only ones that can do all those things, so the risks are greater.

Mrs PEULICH — What do you want in there?

Dr JENKINS — What do I want on my wish list for a doctors health program?

Mrs PEULICH — What is essential?

Dr JENKINS — Essential is ready access to services in hours and after hours, and a communication of that, and the capacity to be reactive to the problems and to have a proactive role as well in education and prevention.

One area I have not touched on is the amount of work we do with the universities in timetabled slots for medical students and the risks they are going to face in the professions as they go through the profession. I think that education role is imperative. We need to be reactive clinically. I personally see the case management role as incredibly important as well. It is probably the role in our organisation that is most under threat at the moment, but that is the role where we have an occupational health-type role in getting doctors back to work, running graduated return-to-work programs and things, and keeping people well — rather than just getting them well, keeping them well and maintaining that — as well as relapse prevention.

Mrs PEULICH — So your concerns about being subsumed into a national program are exactly what?

Dr JENKINS — That if there is only going to be limited funding, which we anticipate will be a lot less than the funding we are used to getting now, the services that we could provide may be reduced to the level of being a telephone answering service.

The CHAIR — On behalf of the committee I thank you very much for both the submission you have provided to the inquiry and the evidence you have given this evening. It has been most helpful.

Witness withdrew.