

OMA Physician Health Program garners praise within Australian medical community

by Michael Kaufmann, MD
OMA Physician Health Program

The OMA Physician Health Program (PHP) continues to garner national and international recognition for its success in treating the addicted physician. Recently, PHP founder and program director Dr. Michael Kaufmann accepted an invitation from the Rural Doctors Association of Queensland, Australia, to deliver a keynote address on the topic of physician health, held during the association's June 2001 annual meeting in Brisbane.

The association's original invitation quickly expanded into a multi-lecture proposition, co-sponsored by various Australian medical organizations, which saw Dr. Kaufmann travel to a handful of cities across the continent, providing medical professionals with important information on the topic of physician health.

Following is a first-person account of Dr. Kaufmann's three-week visit to Australia, and his perceptions on the issue of health and addiction as it relates to Australia's medical professionals.

June 1: Brisbane

Upon arrival in Brisbane, after 30 hours of continuous travel, the first thing I did was to head to my hotel room and take a hot bath.

Not a nap, for despite my fatigue (I can't sleep on planes), I was determined to remain awake until bedtime and adjust quickly to the 14-hour

time difference between eastern Australia and Toronto.

The first order of business on the itinerary involved the Rural Doctors Association of Queensland, which had requested that I address its annual meeting on the subject of doctors' health, from a rural GP's perspective.

The Medical Board of Queensland wondered if I would visit its Health Assessment and Monitoring program, and perhaps prepare a lecture for its clinical consultants on the challenges of assessing and treating doctors.

The Australian Medical Association became involved in a sponsorship package, as did the Queensland Rural Medical Support Agency and the Southern Queensland Rural Division of General Practice, resulting in a packed agenda for my first week in Oz.

So much seemed reversed. Day was night and summer was winter —

although the temperature was in the mid-twenties in Brisbane, and the weather was "mostly fine," as they say in Australian lingo.

Thinking myself refreshed, I jumped in a cab and joined my colleague, Dr. Jillann Farmer, for my first afternoon on the job in Australia.

Dr. Farmer is director of the Health Assessment and Monitoring program of the Queensland Medical Board. It is her responsibility, on behalf of the regulatory authorities in that state, to arrange assessment of doctors that come to her attention who may be impaired.

Dr. Farmer's program also monitors addicted doctors afterward, mostly using a sophisticated urine monitoring protocol. Theirs is a function of the regulatory board, not the medical association, as in the case of the OMA Physician Health Program — but one of several differences I was to discover.

We spent the afternoon in discussion, much poorly recalled by me due to the impact of the jet lag which I denied feeling.

June 4: Brisbane/Stanthorpe

This was the first full day of work in Australia, beginning with medical rounds at the Royal Brisbane Hospital.

The title of my presentation was "Recognition and Management of Doctors in Distress." There were about 150 trainees and staff doctors seated above and in front of me in an old-style lecture theatre. The presentation was also telecast live to smaller hospitals in Toowoomba and Rockhampton.

I was pleased by the number of questions asked — more than I normally experience from audiences in Canada. To this point, the day was very much like any on the job in Ontario. But there was little about the remainder of the day that was typical.

From the lecture theatre we went to Brisbane airport and drove around the main terminal to a smaller one behind. A pilot was standing on the tarmac beside a four-seat, twin-engine plane chartered to transport me to Stanthorpe, a town of about 3,000, situated on the western slope of the Great Dividing Range, about three-hours drive away, but only 40 minutes by air.

I knew that the Southern Queensland Rural Division of General Practice wanted me to visit a small town, but I didn't know who was to meet me, where I was to go, who I'd be meeting with, or if I was expected to do a presentation. I decided to relax and go with the experience.

Fruit and wine production have replaced tin mining as the main industry of the Stanthorpe area and it was easy to see the many vineyards surrounding the town as we approached the landing strip.

There was no airport in the usual sense, just an abandoned shack beside the landing area. A car was waiting to take me to the office of Dr. Tim Wellingham, with whom I spent the afternoon touring the area

and local hospital.

He described his general practice and explained how, under the Australian system of private practice, he was able to bill his patients directly. He could also choose to "bulk bill" Queensland Health, the state government scheme, in selected cases.

Two-tiered medicine is a fact in Australia, and apparently well accepted — at least by doctors and government.

That evening, I joined a gathering of GPs and their spouses from Stanthorpe and neighbouring Warwick. We talked about rural practice from the family perspective, physician risk and distress — topics all too familiar to me as a former rural family doctor and current practitioner of physician health.

Afterwards, I was returned to the airstrip with the pilot for our return to Brisbane.

June 5: Brisbane

The following evening, I addressed members of the College of Psychiatrists and the Medical Board of Queensland. My topic was "The Challenges of Assessing and Treating Impaired Doctors."

The audience consisted mostly of senior psychiatrists, clinicians usually called upon to assess and treat doctors for the Medical Board.

Supper was first, followed by my presentation. The room was packed, and the audience seemed attentive.

At one point, I explained how Canadian doctors in recovery from chemical dependency are expected to abstain from all mood-altering substances. One of the psychiatrists asked about the use of cannabis: surely a little social marijuana was acceptable. His query seemed odd to me, but I just re-emphasized that marijuana was a mood-altering drug, therefore not advised.

It was my first exposure to attitudes borne of different cultural perspectives.

June 6

Wednesday morning we produced an educational videotape. I joined Dr. Farmer, Dr. Frank New, a Bris-

bane psychiatrist, and Dr. Emily Garde, a rural GP, on a panel moderated by Dr. David Rimmer, the Medical Advisor of the Queensland Rural Medical Support Agency (QRMSA) — an agency that works to promote the recruitment and retention of GPs in rural and remote Queensland, the vast, tropical state in Australia's northeast.

My topic was preventive measures for personal health, culture shock, and the doctor's place in the rural environment. The discussion is to be telecast later this year to isolated physicians practising in the Australian outback.

I wondered if my own transition to life in rural Ontario compared in any way to that of my future audience. But I expect the themes of new places, new people and new attitudes are universal.

After the taping, I accompanied Dr. Rimmer to the QRMSA offices. Poring over a map of the district with members of the staff, it was explained to me that there are many tiny towns and villages scattered throughout the region, often isolated from one another not only by distance, but also by unpaved roads that become impassable during the tropical rainy season.

Unique strategies are required to serve the mostly aboriginal populations of these towns, and preserve the well-being of the doctors and their families devoted to them.

Dr. Rimmer's personal circumstances are an example. He and his wife spend every other month in a village called Kowanyama, on the western side of the Cape York Peninsula, where he functions as the local GP. Then he returns to Brisbane to continue his duties with the QRMSA.

I was also introduced to the staff of a sister agency, the Queensland Rural Medical Family Network (QRMFN). This agency facilitates communication between family members — spouses of GPs mostly, throughout the rural and remote country.

I was impressed by the thoughtfulness of a program that considers the

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impact of isolation and cultural dislocation upon the doctor's family members, and facilitates their adjustment to these challenging circumstances.

That evening, I was privileged to address the Doctors Health Subcommittee of the Australian Medical Association, Queensland. The committee, chaired by Dr. New, whom I had met at the taping that morning, is the arm of the medical association that considers doctors' health initiatives.

I was pleased to be able to describe the OMA Physician Health Program, and feel proud about our accomplishments to date, achieved in a short period of time.

There is, as yet, no program in Queensland to match the PHP in scope or sophistication.

June 7-8: The Rural Doctors Association of Queensland Annual Conference, Brisbane

Welcome to the 12th Annual Conference of the Rural Doctor's Association of Queensland, in conjunction with:

Australian College of Rural and Remote Medicine; Queensland Rural Medical Support Agency; Queensland Rural Medical Family Network.

Keynote Speakers:

Dr. Michael Kaufmann (eminent

Canadian doctor, writer, and lecturer) will discuss doctors' health, vulnerability and impairment.

RDAQ is flying this world expert out for the conference because of his unique

communication that are critical to the health and well-being of all families.

This was the front page of the conference program. When I first read it, I was impressed and flattered. Then, I panicked.

My presentation was to lead off the conference, and even from the program description, I didn't think I'd fare well compared to Reverend Hyman, billed as "Australia's funniest serious speaker."

As it turned out, I had reason to be challenged. Rev. Hyman's presentation was witty, stimulating and motivating. It was moving and, at times, quite personal. In fact, it was quite complimentary to my own, more scientific presentation about doctors' health and impairment risk.

After our opening presentations, I listened to a panel consisting of a rural doctor, a rural doctor's wife, and the teen-aged son of another outback GP. They talked about the challenges of living in a remote area from their

personal perspectives.

The doctor raised an issue that caught my attention: he listed some guidelines for doctors to consider when treating their own families. These remarks provoked discussion

understanding of rural doctor health issues.

Rev. Graham Hyman (Australia's funniest serious speaker) provides insight and understanding on the issues of adolescence, relationships and effective com-

from many of those attending the plenary session, but not the kind of discussion I anticipated.

No one suggested that this practice was unethical. Even if there are other doctors in the community, or nearby, GPs attending to the medical needs of their family members is commonplace, and quite acceptable in rural Australia.

I commented on the practice of treating one's own family as being discouraged in Canada (when other choices exist), prompting the wife of the doctor on the panel to vigorously defend her right to choose any doctor she preferred, even if it was her husband. This turned out to be another cultural point of departure, and quite a hornet's nest.

The next day, I conducted two workshops based on the "12-Steps for Doctors Seeking Re-Humanization." (This series of articles, previously published in the *Ontario Medical Review*, is posted on OMA WebLink at: www.oma.org/php/12steps.htm).

The workshops were, to my surprise, well-attended and well-received.

I am learning that people are interested in matters of the spirit, and doctors are no exception. It seems that the practice of medicine can challenge our humanity — whether in downtown Toronto or outback Australia.

Friday evening, I attended a working group of the Brisbane North Division of General Practice. Convened to take advantage of my being in the city, the objective of the participants was to design a "Doctors for Doctors" program.

This initiative impressed me. It was their intention to promote the need for doctors to have, and use, GPs of their own, and to train family doctors in the particular skills required to attend to a colleague and his or her family. We shared our experience in this area, giving me much to consider for the Physician Health Program.

Thus ended a very busy first week in Australia.

June 9: Melbourne

I travelled to Melbourne on Saturday, the day after my participation at the RDAQ conference ended.

Melbourne is a city with a population of around three million. It is located in the state of Victoria in the southeast tip of the continent.

As Australian states go, only Tasmania, immediately to the south, is smaller. But as cities go, only Sydney is larger. The usual skyscrapers are there, but so too are lovely Victorian homes, old-style green trams, large municipal gardens and multicultural neighbourhoods.

June 11

My host in Melbourne was Dr. Jack Warhaft, the recently hired director of the Victorian Doctors Health Program (VDHP), a new program patterned after North American physician health programs such as the OMA's, and the first of its kind outside North America.

I had the opportunity to spend a few days with Dr. Warhaft to discuss his start-up details, and share my experience of beginning a new service for the medical profession in Ontario.

On this particular morning, I also had the opportunity to share my views about physician health with members of the public.

Dr. Warhaft had alerted the press to my visit and the opening of his program for Victorian doctors, resulting in a live interview on the Australian Broadcasting Corporation's (ABC) morning radio show in Melbourne.

June 12

On Tuesday, Dr. Warhaft and I met with senior staff representatives of the Australian Medical Association, Victoria. We explained our respective programs, and I noted that Dr. Warhaft's is not a medical association program.

The VDHP is an independent program, governed by a board of management and funded primarily by the Medical Practitioners Board of Victoria, the regulatory body.

In the evening, I addressed his management board, describing the history, philosophy, management and service of the OMA Physician Health Program.

I was questioned at some length regarding a number of practices considered to be routine by our program, including total abstinence-based recovery and residential treatment for chemically dependent doctors.

There was some difficulty accepting the need for abstinence from substances not the doctor's drug of choice, and also exposing the doctor to the personal and financial hardship of time away from family and practice for treatment.

I discovered that, for many in Australia, addiction is not seen as a disease but rather a behaviour that may be unlearned.

June 13

The following morning entailed additional media sessions. Dr. Warhaft and I were interviewed at some length about impairment in doctors by *The Age*, a respected Melbourne daily newspaper. The article, which appeared in the Sunday edition, was accurate and fair.

That afternoon, I addressed the Turning Point Journal Club about the PHP and the services we offer. Turning Point is a major addiction research and treatment facility in Melbourne, comparable to the Addiction Research Foundation of the Centre for Addiction and Mental Health in Toronto.

Present at the Journal Club were a variety of addiction practitioners who listened with interest, although many subscribed to the same beliefs about addiction I was finding familiar in the Australian clinician, and unusual in a North American addiction medicine doctor.

June 14

On this day, I was able to meet with members of the Health Committee of the Medical Practitioners Board of Victoria. This is the committee of the regulatory board that reviews cases of impaired doctors.

Again, I met with the now-familiar differences of perspective. One member of the committee, a psychiatrist, repeatedly questioned me about the need for a drug-dependent doctor to abstain from other mood-altering substances, such as cannabis and codeine, if not the doctor's drug of choice.

And there was no question in the psychiatrist's mind about the use of alcohol in such a case — moderate drinking is quite acceptable.

Knowing how unacceptable this would be in Ontario, or anywhere in North America, I had difficulty hiding my horror at such an approach.

But, by now, I was accustomed to this point of view, so I simply reiterated the OMA program philosophy and approach, and backed it up with the excellent outcomes our doctors in recovery enjoy — results the Australians so far can't match.

Still, I felt challenged to research these questions and practices in more detail to assure their support in science.

That evening, I returned to Brisbane on my way to Fraser Island to address another conference of rural general practitioners.

June 15: Fraser Island

The journey to Fraser Island passes through the town of Hervey (pronounced Harvey) Bay, a coastal tourist and agricultural town. My host there was Dr. Kathy Diminic, a local general practitioner.

Dr. Diminic took time from her practice to show me the sights of the town and surrounding area. The economy is dominated by sugar cane production and tourism geared to the beach and Fraser Island, a short distance by ferry off the coast, where the Southern Queensland Rural Division of General Practice was holding its annual postgraduate weekend for doctors of the area, along with their spouses and families.

June 16-17

I opened the plenary session of the weekend retreat with the same topic offered to the RDAQ conference two weeks earlier: "The Recognition and Management of Distress and Impairment in Doctors."

Saturday evening was the conference banquet, where I delivered a presentation entitled "The Top Ten Ways You Know You're a Rural GP,"

based on my personal experiences being a country doctor in Ontario.

Sunday morning, I presented the "12-Step" workshop to another interested audience, then departed Fraser Island for Sydney.

June 18-20: Sydney

While in Sydney, I was the guest of Dr. Stephen Jurd and his wife, Libby. Dr. Jurd is a psychiatrist and addiction medicine practitioner, whom I had met before in Toronto. He took a few days off work in order to spend time with me, and show me "his Sydney."

One afternoon was set aside for work, however. I was invited to share lunch with Dr. Alison Reid, and some of her colleagues at the Medical Board of New South Wales, prior to sitting in on a meeting of the Doctors Health Committee.

Over lunch, Dr. Reid shared with me that the Medical Board dealt with many cases of doctors with drug or psychiatric problems, but few due to alcohol problems. This surprised me, as the majority of chemically dependent doctors helped by the PHP claim alcohol as their drug of choice.

I listened to the case histories under discussion and realized that, once again, Canadian physicians were much like their Australian counterparts with respect to impairment issues. It was the culture of failing to view alcohol use as problematic that was different.

Many of the cases characterized as drug problems, or depression, were replete with examples of alcohol abuse, even when “in recovery.”

I was graciously invited to share my opinion regarding these cases, and I did, feeling well-received by the committee members.

June 21: Home

I departed for home on the morning of June 21, the shortest day of the year in Australia, but the longest day of the year at home — and for me.

Travelling east around the globe, we kept gaining time, arriving at home in the mid-afternoon of the same calendar day, despite nearly 24 hours in transit!

It took several days to overcome jet lag after the return trip, but it's taking much longer for the vivid memories to settle.

For three weeks in June, it seemed to me that everyone was interested in doctors' health. Gone are the days when doctors afflicted with drug or alcohol problems, serious psychiatric problems, or even moderate personal distress, are ignored to suffer in secret.

Perhaps it's taking a scant few years longer for the Australians to develop the capacity to respond as we are learning to do in North America, but in the long-run, this

discrepancy is infinitesimal.

And for me, it has been an honour beyond words to have made a small contribution to the physician health initiative in Australia, based on our experience thus far in Ontario. OMR

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Dr. Kaufmann, CCFP, FCFP, a former family practitioner, is medical director of the OMA Physician Health Program. Dr. Kaufmann is certified in addiction medicine by the American Society of Addiction Medicine.