AHPRA, Mistrust, and Medical Culture in Australia

Dr David Arroyo
MD (University of Queensland
David Arroyo is a recent medical school graduate from the University of Queensland.
He was born in the United States where he earned a Master of Biomedical Science and worked as an Emergency Medical Technician for six years which included four years as a supervisor. He continues to perform research across a number of fields. This article is a brief excerpt from an essay which won the Catherine Thorp-Cramb Prize in Doctors' Mental Health.

Abstract
From nearly the moment that medical students take their oaths, the assault on one's mental health begins. Students understand that they will make sacrifices to study medicine, but the understanding that the medical field may take a significant mental health toll is generally overlooked and underappreciated. Many factors leading to this demise have been well-described in the literature, yet, a doctor's mental health is often not discussed, silenced by both professional and societal stigma. This is a worldwide issue with some disastrous consequences. For example, in the United States alone, an estimated 300-400 doctors commit suicide each year, more than doubling the rate of the general population. This is equivalent to an entire cohort of medical students, making the profession among the most dangerous in the country. In Australia, doctors experience significantly high levels of psychiatric morbidity, which typically manifest as depression, anxiety, burnout, and suicidal ideation, eroding both their personal and professional lives. Many doctors do not seek help for mental health conditions, largely due to stigma as well as an unfounded fear of a notification to the Australian Health Practitioner Regulation Agency (AHPRA). This essay will outline issues surrounding concerns that doctors with mental health issues may have regarding AHPRA and discuss the mistrust that persists in contemporary medical culture in Australia.

Introduction
The notion that all individuals are predisposed to mental illness was well chronicled by the philosopher Plato in Timaeus, where he became among the first of his colleagues to demonstrate a primitive, yet pragmatic, understanding of the complex dynamics of mental health resulting in a modern truth: we are all susceptible. While contemporary conceptualisations of mental illness have evolved considerably from the times of unbalanced humours, diseases of the psychē (soul), and "cold bile" as underlying aetiologies, there still persists a fundamental, yet pervasively false impression (or perhaps belief) that, as modern-day healers, doctors are somehow exempt from the stressors that lead to mental health deterioration. Doctors are subject to a multitude of biological, psychological, and social stressors which is capable of destabilising one's mental health. Indeed, the medical field is distinct from other professions, unapologetically offering an overwhelming workload, immense pressure, unrelenting competitiveness, and unrealistic expectations. These factors significantly increase the risk of depression, anxiety, stress, emotional exhaustion, depersonalisation, and suicide [1-4], and are significant contributors to the extraordinarily high incidence of burnout that has plagued doctors across continents and cultures for decades [5,6]. This essay will outline issues surrounding concerns of an AHPRA notification and discuss the mistrust among colleagues that persists in contemporary Australian medical culture.

The AHPRA myth: A justified fear?

There is a pervasive concern culminating in a harmful, yet widespread myth that must be addressed: the fear of a report to Australian Health Practitioner Regulation Agency (AHPRA). The prevailing belief is that doctors cannot disclose mental illness to another healthcare professional without risking punishments such as significant practice restrictions, public shaming, and even loss of registration. Are any of these assumptions accurate? The practical answer is, in short, no.

Prior to debunking this myth, one must first acknowledge the shortcomings of AHPRA and Australian law. The mission of AHPRA is to support the health practitioner boards including the Medical Board of Australia to protect the public through the regulation of health practitioners to ensure safe healthcare throughout Australia [7]. AHPRA investigates formal complaints and addresses concerns over the impairment of doctors following reports by other healthcare practitioners or organisations. Recently, the Queensland parliament passed a new law titled, Health Practitioner Regulation National Law and Other Legislation Amendment Act 2018 which, in addition to increasing penalties for offences under Australian law, intends to "support registered practitioners to seek help for a health issue (including mental health issues)" [8]. The legislation is designed to provide treating doctors guidance when making the determination of impairment [9]. However, a number of medical organisations representing over 53,000 Australian practitioners opposed the bill arguing that it is ambiguous and discourages doctors from seeking help for a mental health condition (Table 1) [10].

Table 1. Australian medical organisations opposing Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2018 in its current form[49]

Australian Medical Association (AMA) Queensland
The Royal Australian and New Zealand and College of Psychiatrists, Queensland Branch (RANZCP QLD Branch)
The Royal Australian College of General Practitioners (RACGP)
Australian College of Rural and Remote Medicine (ACRRM)
Australasian College for Emergency Medicine (ACEM)

Proposed amendments to the law advocated by these organisations were denied [9]. The new law is applicable to every state but Western Australia which over a decade ago had implemented laws reflective of the proposed amendments. This indeed has the potential of eroding a trust that doctors give to their patients yet feel that they are not entitled to receiving themselves. With this in mind, feelings that AHPRA has created a structural stigma is not unjustified. Under the pretext of patient safety, doctors may understandably feel that they are being unfairly, and perhaps unethically, targeted for seeking help for a mental health issue.

Additionally, the AHPRA investigation process may in itself raise concerns. In 2017-18, 35.5% of notifications took more than six months to resolve [11], and the potential for a prolonged fight over a doctor's profession may trigger or worsen issues such as depression and anxiety. For the doctor who is already suffering from a mental health issue, this process is detrimental and may feel like a punishment for experiencing something that is commonly found in the general population. As a result, it is not uncommon to find that doctors seek treatment far away, use pseudonyms, and pay cash for mental health services (See Appendix 1 for alternatives).

Importantly, under the AHPRA investigation process, practitioners are considered competent until proven otherwise. The myth that APHRA is a reasonable threat to medical practitioners will be dispelled here. Under mandatory reporting laws to AHPRA, there is a significantly high threshold for the mandatory reporting of a healthcare provider for mental impairment that detrimentally impacts their ability to practice. The practitioner making the report must first have a reasonable belief that the treating doctor is a threat to patient safety, based on specific events, and ideally, the decision to report should be free of bias. Action taken against a practitioner for mental health impairment is exceedingly rare. For example, in 2017-18, of the 63 mandatory notifications made against doctors throughout all of Australia for impairment, only 13 had resulted in a suspended or cancelled registration [11]. Of relevance, a 2013 study showed that the distribution of all complaints filed against doctors over the previous 11 years was significantly skewed [12].

The study showed that 3% of Australian practitioners accounted for 49% of total complaints with 1% accounting for 25% [12]. This indicates that those cases where sanctions were imposed were exceedingly rare outliers and these practitioners likely posed a realistic danger to the public. The specific circumstances of these cases were unknown and may have overlapped with other APHRA-related issues of misconduct. Significantly, a doctor who has sought help voluntarily for a mental health condition is highly unlikely to go through the process of an AHPRA investigation, let alone experience any consequences; with the vast majority of those forced to undergo any investigation absolved. Additionally, in 2020, mandatory notification requirements will change from a practitioner being "at risk of harm" to the public to "substantial risk of harm" to the public which is designed to support practitioners in seeking help [13]. The evidence demonstrates that despite flaws, AHPRA is not the enemy of medical practitioners. Given the low probability of sanction, why do doctors often feel AHPRA is a realistic threat?

Doctors do not trust their own

Perceived social condemnation among both the public and peers may be the most important driving factor behind the fear of an AHPRA notification. There are several important factors behind a doctor's reasons for not seeking treatment, supported by an abundance of high-quality evidence. The fear of stigmatisation is the most commonly cited reason doctors refuse professional help, both in Australia and worldwide [1,14,-17]. This is evidenced by a shocking finding from Beyond Blue's 2013 National Mental Health Survey regarding how doctors feel about their depressed colleagues. An astounding 31% of female doctors and 45% of male doctors in Australia did not believe that doctors with a mental health history would be as reliable as the 'average' doctor [1]. This sentiment has already been passed to the next generation as evidenced by an Australian study of younger, mostly depressed, physician trainees who did not seek help. The vast majority (88%) believed that doctors should portray an image of good health [18]. A recent meta-analysis found that depressive symptoms in doctors was associated with medical errors [19]. Despite these sentiments, there is no evidence to suggest that a doctor that has been treated for a mental health condition is at an increased risk to their patients. Surprisingly, stigmatisation among doctors in Australia might very well be worse than the general Australian population [20]. Other factors for not seeking help include embarrassment (59%), lack of confidentiality (52.2%), and the impact on their right to practice (34.3%) [1]. Doctors fear a report might increase the risk for lawsuits, affect employment, and salary negotiations, all representing a threat to one's finances and personal life. Not unlike the Australian general population [21], there was also a generalised preference to self-manage (30.5%) [1], which may be seen as a reportable violation depending on the choice of self-management. Those who voluntarily seek treatment despite these concerns, are likely to keep their condition a secret which can lead to feelings of isolation and loneliness, exacerbating mental health decline.

Where does the mistrust begin?

Perhaps the most influential experiences arise during the medical school years. A 2015 study found that students were negatively judged by supervisors for seeking help for burnout and that their colleagues openly revealed mental health problems of other colleagues [22]. Witnessing this behaviour at an early level may lead to the fear of stigma ultimately resulting silence and prevent doctors from seeking help. These factors are among the reasons that only a third seek help for their own mental health conditions [21], and these types of experiences are likely reasons that doctors reaching even the highest level of their training do not seek help. It is well-established that students become more empathetic after completing rotations in psychiatry [23-25]. Since these studies are performed on a student population that have completed their psychiatry rotations in recent years, perhaps doctors need regular mental health education to help prevent empathy dissipation. Education about how to appropriately address a colleague in distress, coupled with available support is key.

The first encounter

Despite the issue of doctor's mental health being a current concern, with an evidence-base that has never been better, both doctors and medical students fail to support each other. Doctors tend to internalise the perceived negative views of their colleagues resulting in an unhealthy refusal to seek treatment for issues that are unlikely to fade over time. They must also be aware that a colleague who discloses a mental health issue could be doing so for the first time. The first experience of disclosing a mental health condition has the power to alter how one will approach any future issues. A negative experience could mean that they never seek help again. Therefore, it is the responsibility of all doctors to demonstrate a supportive response and handle mental health disclosures appropriately. The principles of beneficence and non-maleficence (expected for any patient) must be consciously applied to fellow doctors without judgement, in the forms of dignity and empathy, and arguably most important of all, with complete confidentiality. The importance of appropriate handling cannot be understated, and these personal and professional responsibilities cannot be abdicated. Doctors fear stigma. It is not surprising the current environment leads to a reluctance to seek help and a tendency to leave mental health issues unaddressed. It is a brave decision when a doctor does disclose a mental health issue. Should it have to be a brave decision? Or, can it be the norm? The prevalence of mental health conditions, affecting those who take on the task of healing others, means disclosure to colleagues and seeking professional help should not seem difficult. Nor should it come with any fear of sanction. The unfortunate reality is the medical field has not come close to reaching this point. The pace of change is slow, meaning it is possible it will take many more generations of doctors who will who suffer, learn, witness, and speak out in order to create a culture that is mentally healthy for doctors. Through promotion, education, and open discussion, both medical students and doctors can change attitudes and nurture a new culture. The idea that a doctor is susceptible to suffering and still be competent is one that needs to be made commonplace. This sentiment must become the norm from the first day of medical school, especially since this is when the stigma and silence begin. This will help create a much needed change in culture.

Conclusion

Medicine is among the most challenging fields in existence, psychiatric morbidity is endemic and suicide an occupational hazard. Evidence continues to demonstrate the magnitude of the problem. The medical field has historically overlooked the mental health and wellbeing of its own. This is beginning to change. It is important that doctors with a mental health condition seek treatment without fear of APHRA. The privilege to practice medicine must not be jeopardised unnecessarily. Changes needed in the culture of medicine are long overdue. This must begin from day one of medical school. It may prove to be challenging or meet with resistance, but it is time for a significant change. This is not simply a human resources issue, but is indeed a human rights issue.

Acknowledgements

The author would like to thank Jessica Arentz, Kate Holzlein, and Thomas Rowe for their comments on this piece as well as Lars Eriksson for assistance with the search strategy. The author also wishes to thank author and physician, Dr Pamela Wible, MD who has dedicated much of her career towards helping doctors in distress and has helped shed a light on an important issue of much relevance to the author. She was a great inspiration throughout the development of this paper.

Correspondence
Dr David Arroyo
david.arroyo@uq.net.au

Appendix 1

Resources for help
If you or someone you know is in crisis, there is help. Please contact any of the following:
Beyond Blue Lifeline: 13 11 14
Beyond Blue Suicide Call Back Service 1300 659 467
https://www.beyondblue.org.au/get-support/get-immediate-support

For confidential support for issues affecting doctors such as work-related stress, bullying, harassment, discrimination, sexual harassment, substance use, personal stress, mental health, trauma counselling, self-harm, suicide, violence, grief and bereavement:

RACP Support Program:
24/7 Support
1300 687 327 (Australia)
0800 666 367 (New Zealand)
https://www.racp.edu.au/fellows/physician-health-and-wellbeing/i-need-support/racp-support-program

Queensland Doctors' Health Programme
24/7 Support
07 3833 4352
https://dhasq.org.au/

References

[1] Beyond Blue. National mental health survey of doctors and medical students. Melbourne, Australia; 2013.

[2] Rotenstein LS, Ramos MA, Torre M, et al. Prevalence of depression, depressive symptoms, and suicidal ideation among medical students: a systematic review and meta-analysis. JAMA. 2016;316(21):2214-36.

[3] Andrew LB. Physician suicide. In: Brenner BE, editor. Medscape. [Internet]. WebMD; 2018. [updated 2018 Aug 1; cited 2019 June 30]. Available from: https://emedicine.medscape.com/article/806779-overview#a1

[4] American Foundation for Suicide Prevention. Healthcare professional burnout, depression and suicide prevention. [Internet]. 2019. [updated 2019; cited 2019 June 30]. Available from: https://afsp.org/our-work/education/healthcare-professional-burnout-depression-suicide-prevention/

[5] Kumar S. Burnout and doctors: prevalence, prevention and intervention. Healthcare. 2016;4(3):37.

[6] Rotenstein LS, Torre M, Ramos MA, Rosales RC, Guille C, Sen S, et al. Prevalence of burnout among physicians: a systematic review. JAMA. 2018;320(11):1131-50.

[7] Australian Health Practitioner Regulation Agency. National Registration and Accreditation Scheme Strategy 2015-2020. [Internet]. 2017 [updated 2017 October 17; cited 2019 June 30]. Available from: https://www.ahpra.gov.au/documents/default.aspx?record=WD15%2f18461&dbid=AP&chksum=Y%2f9CwoiBP-MuzHa1dje1DLw%3d%3d

[8] Australian Health Practitioner Regulation Agency. Legislative amendments on mandatory reporting and fake practitioners. [Internet]. 2019 [updated 2019 February 26; cited 2019 June 30]. Available from: https://www.ahpra.gov.au/News/2019-02-26-legislative-amendments-on-mandatory-reporting-and-fake-practitioners.aspx

[9] Hayes P. Mandatory reporting laws pass without profession-recommended changes RACGP. newsGP [Internet]. 2019 Feb 27 [cited 30 June 2019]. Available from: https://www1.racgp.org.au/newsgp/professional/mandatory-reporting-laws-pass-without-profession-r

[10] Royal Australian College of General Practitioners. Queensland doctors call on state government to save lives. [Internet]. 2018 [updated 2018 December; cited 2010 June 30]. Available from: https://www.racgp.org.au/gp-news/media-releases/2018-media-releases/december-2018/queensland-doctors-call-on-state-government-to-sav

[11] Australian Health Practitioner Regulation Agency. Annual Report 2017/18. 2018 [cited 2019 June 30]. Available from: https://www.ahpra.gov.au/annualreport/2018/notifications.html

[12] Bismark MM, Spittal MJ, Gurrin LC, Ward M, Studdert DM. Identification of doctors at risk of recurrent complaints: a national study of healthcare complaints in Australia. BMJ Qual Saf. 2013;22(7):532-40.

[13] Australian Health Practitioner Regulation Agency. Mandatory notifications: What you need to know. [Internet]. 2019 [updated 2019 December 3; cited 2019 December 9]. Available from: https://www.ahpra.gov.au/Notifications/mandatorynotifications.aspx

[14] Lyons Z, Laugharne J, Laugharne R, Appiah-Poku J. Stigma towards mental illness among medical students in Australia and Ghana. Acad Psychiatry. 2015;39(3):305-8.

[15] Adams EF, Lee AJ, Pritchard CW, White RJ. What stops us from healing the healers: a survey of help-seeking behaviour, stigmatisation and depression within the medical profession. Int J Soc Psychiatry. 2010;56(4):359-70.

[16] Hassan TM, Ahmed SO, White AC, Galbraith N. A postal survey of doctors' attitudes to becoming mentally ill. Clin Med. 2009;9(4):327-32.

[17] Gold KJ, Andrew LB, Goldman EB, Schwenk TL. "I would never want to have a mental health diagnosis on my record": A survey of female physicians on mental health diagnosis, treatment, and reporting. Gen Hosp Psychiatry. 2016;43:51-7.

[18] Axisa C, Nash L, Kelly P, Willcock S. Psychiatric morbidity, burnout and distress in Australian physician trainees. Aust Health Rev. 2020;44(1):31-8.

[19] Pereira-Lima K, Mata DA, Loureiro SR, Crippa JA, Bolsoni LM, Sen A. Association between physician depressive symptoms and medical errors: a systematic review and meta-analysis. 2019;2(11):e1916097.

[20] beyondblue information paper: stigma and discrimination associated with depression and anxiety. [Internet]. 2015 [updated 2015 August; cited 2019 June 30]. Available from: https://www.beyondblue.org.au/docs/default-source/policy-submissions/stigma-and-discrimination-associated-with-depression-and-anxiety.pdf?sfvrsn=0

[21] Brijnath B, Antoniades J. "I'm running my depression:" Self-management of depression in neoliberal Australia. Soc Sci Med. 2016;152:1-8.

[22] Dyrbye LN, Eacker A, Durning SJ, Brazeau C, Moutier C, Massie FS, et al. The impact of stigma and personal experiences on the help-seeking behaviors of medical students with burnout. Acad med. 2015;90(7):961-9.

[23] Janoušková M, Weissová A, Formánek T, Pasz J, Bankovská Motlová L. Mental illness stigma among medical students and teachers. Int J Soc Psychiatry. 2017;63(8):744-51.

[24] Pascucci M, Ventriglio A, Stella E, Di Sabatino D, La Montagna M, Nicastro R, et al. Empathy and attitudes towards mental illness among Italian medical students. Int J Cult Ment Health. 2017;10(2):174-84.

[25] Lyons Z, Janca A. Impact of a psychiatry clerkship on stigma, attitudes towards psychiatry, and psychiatry as a career choice. BMC Med Educ. 2015;15(1):34.