Submission to the Queensland Parliament Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee inquiry into the Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2018.

From Dr Kerry J Breen AM, MD, FRACP **November 19, 2018**

This submission is restricted to the matter of the mandatory reporting by treating doctors of any health professional who is thought to be impaired. My views are informed by two decades of service as a member, Deputy President and President of the Medical Practitioners Board of Victoria and five years as Chairman of the Board of Directors of the Victorian Doctors Health Program. I have studied the international handling of this issue, written extensively on this and related subjects and have personally observed the confusion and distress caused by the current National Law as it applies to the mandatory reporting of impairment by treating doctors (at the end of my submission, some relevant published papers, reports and books are attached or identified) .

The proposed amendments do take two steps in the right direction. It is pleasing to see the change of language from the past tense to the present tense (a change that I called for in 2011) and also pleasing to see that sexual misconduct will now have its own section. Unfortunately the opportunity to create a standalone section for impairment has been missed and as a result doctors who are unwell through no fault of their own will still be stigmatised through being dealt with in the same language and same section of the legislation as are those accused of unprofessional conduct.

My deepest concern however is that via these proposed changes, the Health Ministers of Australia have refused to listen to the many experts and others who have urged that the legal duty to report must be removed from the shoulders of treating doctors. No matter how much effort is put into qualifying that duty, the effect will remain the same: sick doctors will delay or avoid seeking help for fear of being reported. Thus the national law will continue to have the perverse effect of increasing the risk to the community that an impaired doctor will continue to practise when it may be unsafe to do so. The Health Ministers also have ignored the fact that in the absence of a legal duty, every treating doctor will still have an ethical duty to notify any situation where an impaired doctor continues to practise. Treating doctors are well aware of and accept this ethical responsibility and indeed will at times use that obligation to coerce doctors into accepting treatment of an illness and stopping clinical practice until they are recovered.

As I wrote several years ago, this aspect of the National Law has set back the care of ill doctors and will continue to do so. The deaths of doctors, including some tragically by suicide, can be partially blamed on Health Ministers who refuse to take professional advice and seem driven by populist pressures.

Hopefully your Committee and the Queensland Parliament will reject this aspect of the amendments and insist on the Western Australia modification on mandatory reporting by treating doctors as was recommended by Mr Kim Snowball when, in 2014, he reviewed the National Law at the request of the Health Ministers.

Attachments

Contact information and abbreviated CV.

K J Breen. National registration legislative proposals nee. more work and more time. *Medical Journal of Australia* 2009, vol 191, no 8, pp 464-5.

K J Breen. Doctor's health: can we do better under national registration? *Medical Journal of Australia* 2011, vol 194, no 4, pp 191-2.

Relevant background reading

Council of Australian Governments: The independent review of the national registration and accreditation scheme for health professionals (the Snowball report). Available at https://www.aasw.asn.au/document/item/7785

Physicians with Health Conditions: Law and Policy Reform to Protect the Public and Physician-Patients. (May 2012). Report commissioned for the College of Physicians and Surgeons of Alberta and the Alberta Medical Association. (See also *Health Law Review* Alberta *Volume* 21, Number 1, 2013.)

K J Breen. Physician health and impairment in Australia: unsettled times. *Health Law Review* (Alberta) 2013:21; 23-28.

K J Breen. National registration scheme at five years: not what it promised. *Australian Health Review* 2016; 40(6):674-678.

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K J Breen. *Memoir of an accidental ethicist. On medical ethics, medical misconduct and challenges for the medical profession*. Australian Scholarly Publishing 2018. (Chapters 6 and 14.)

K J Breen, S M Cordner and CH Thomson. *Good Medical Practice: Professionalism, Ethics and Law* (4thed). Australian Medical Council, Canberra, 2016. (Chapters 10 and 13.)

Abbreviated CV 2018

Dr Kerry John Breen, AM, MBBS, MD, FRACP

Dr Breen served as President of the Medical Practitioners Board of Victoria (1994-2000) and as President of the Australian Medical Council (1997-2000). He served as Chair of the Australian Health Ethics Committee of the National Health and Medical Research Council (2000-2006) and NHMRC Commissioner of Complaints (2007-2013). He served as Chairman of the Board of the Victorian Doctors Health Program (2005-2009). From 2006-2014, he was a part-time member of the Federal Administrative Appeals Tribunal. He is currently a member of the Australian Research Integrity Committee of the NHMRC and ARC and holds an appointment as an Adjunct Professor in the Department of Forensic Medicine at Monash University.

He has published over 120 peer reviewed academic papers as well as several opinion pieces for the print media and internet publications. He is the lead author of *Good Medical Practice: Professionalism Ethics and Law* (4th ed), published in 2016 by the Australian Medical Council and the sole author of *So You Want to be a Doctor: A Guide for Prospective Medical Students in Australia* published by the Australian Council for Educational Research in 2012.

VIEWPOINT

National registration legislative proposals need more work and more time

Kerry J Breen

ABSTRACT

- The release for public consultation of the draft *Health Practitioner Regulation National Law 2009* represents a once-in-a-generation opportunity to ensure best practice in medical regulation.
- The draft law fails to build on the best aspects of existing state and territory legislation, particularly in regard to how allegations of misconduct, poor performance or impairment are to be handled.
- If adopted, this legislation has the potential to set back important improvements to professional regulation that have been implemented in Australia in the past 20 years.
- There are also legitimate concerns about mandatory reporting provisions and the likely increased cost of regulation.
- More time and more work are needed to get this new scheme right.

MJA 2009; 191: 464–465

eMJA Rapid Online Publication 21 September 2009

It is now 3 years since the Council of Australian Governments (COAG) decided to act on some of the recommendations of the Productivity Commission's health workforce report,[1] and 18 months since COAG announced that national registration for health professionals would begin on 1 July 2010.[2] Public debate has focused on the lack of evidence base for the Productivity Commission proposals,[3] whether national boards should be profession-specific,[4] and the independence of the associated accreditation system. However, none of these issues relate directly to the central role of registration, which is to protect the community.

The release of the exposure draft of the *Health Practitioner Regulation National Law 2009* (known as Bill B) for public consultation now brings this issue into focus.[5] Despite the original stated intention of the National Registration and Accreditation Implementation Project (NRAIP) that the legislation be framed in a way that "builds on the best aspects of [existing] State and Territory schemes",[6] and the extensive consultations the NRAIP has conducted, there is deep concern that the proposed legislation does not meet this intention and fails to reproduce existing, effective medical regulation legislation. As this is a once-in-a-generation opportunity to ensure best practice, I argue here that more work needs to be done and more time should be provided to allow the NRAIP to get this right.

These fundamental concerns are clearly articulated in the submission to the NRAIP from the Joint Medical Boards Advisory Committee of the Australian Medical Council and the individual submissions of the existing state and territory medical boards (all submissions are available at http://www.nhwt.gov.au/natregbillbsubs.asp). These bodies, which, without question, have the most extensive experience in the complexities of health professional regulation, have accepted that national registration must proceed, and have engaged positively to seek good outcomes for the community and those they regulate. However, in their submissions, they have identified that the provisions of Bill B relating to alleged unprofessional conduct, substandard performance and impairment of practitioners will not be workable as presently drafted. The Bill takes a complaints-focused approach, inappropriately regarding substandard performance and impairment as less serious categories of misconduct. This "one size fits all" draft legislation has the potential to wind back important improvements to professional regulation implemented in Australia in the past 20 years.

The legislation must clearly differentiate between matters of conduct, performance and impairment to allow the Medical Board of Australia to make an early assessment about which pathway is to be followed in relation to a particular notification (which might, or might not, arise out of a complaint), and give the flexibility to reassess and reassign a matter to a different pathway as it unfolds. Bill B, as drafted, requires a complaint to initiate an investigation and, after an initial assessment, provides little flexibility for reconsideration until the selected pathway is exhausted. In addition, Part 8, Division 7 of the draft legislation lacks important details, without which the performance processes are likely to be legally contestable and hence often unworkable.

From the viewpoint of the individual practitioner, most doctors have not opposed the proposed national registration system. Their reactions may have been different if the proposal had raised the likelihood (as the draft Bill B now does) of:

- a regressive change in how ill and possibly impaired doctors are managed;
- a mandatory reporting regime that threatens to make neighbour suspicious of neighbour;
- a significant increase in registration fees; and
- the addition of another layer of accountability.

In regard to impairment, the draft legislation will set back improvements made in recent years that have resulted in earlier presentation of sick doctors and improved access to the best available help. It goes far beyond the modern legislation in most Australian jurisdictions in at least three ways: it extends the statutory reporting obligation to all doctors and not just treating doctors; it fails to separate illness from possible impairment; and it fails to identify that any possibly impaired doctor who agrees voluntarily to suspend practice is no longer a risk to the public and should not be reported to a medical board. If an existing template has been used for this legislation, the obvious source is the 2008 mandatory reporting amendments to the New South Wales *Medical Practice Act 1992*. However, those amendments only extend to doctors who may be practising while intoxicated, leaving more general notification of alleged impairment as an ethical and professional obligation.

The approach to mandatory reporting of possible unprofessional conduct now proposed in sections 155 and 156 of Bill B, in combination with its definition of reportable conduct, is likely to create problems without any benefits. In their breadth, lack of specificity and bluntness of instrument, these sections are contrary to most of the current state and territory legislation (much of which is recent, introduced after wide consultation and parliamentary

debate). An exception, as far as mandatory reporting is concerned, is the amended NSW Medical Practice Act, but Bill B creates far broader reporting requirements than even that legislation. The NSW legislation places the onus on doctors to notify possible "flagrant departure" from professional standards, whereas the exposure draft of Bill B asks the reporting health care professional (ie, not just doctors) to make a much more difficult judgement about conduct that poses a "risk of substantial harm" to the public.

If the primary intention of this aspect of the mandatory reporting provisions is to assist in identifying "problem doctors" in hospitals, the reporting obligation should be restricted to medically qualified hospital managers, as they have governance responsibility for the medical staff they employ and are best placed to have all or most of the necessary information on which to base a decision to report. Such obligations are more likely to be fulfilled where institutions succeed in developing a strong culture of clinical responsibility. The United Kingdom health care system, which has also had its share of problem doctors, has chosen to use education and promotion of a culture of professional responsibility rather than to legislate mandatory reporting. The proposed Australian approach of expecting any health practitioner to report another health practitioner will create problems, especially for junior doctors who may have reasons for concern but will not usually have all the necessary evidence, nor the experience, wisdom or confidence, to make such a judgement. Even well justified reporting by a junior doctor is likely to have ramifications for that doctor's professional career, as the history of "whistleblowing" here and elsewhere amply demonstrates.

A steep rise in annual registration fees seems an unavoidable conclusion, based on the costs involved in adding layers of national committees (including the Australian Health Practitioner Regulation Agency [AHPRA] and its Management Committee, and the Medical Board of Australia) and their associated staff, the requirement for criminal checks of all new registrants, the proposed new position of "Public Interest Assessor", and the decision that existing state and territory medical boards and disciplinary tribunals will be maintained very much in their current roles. Recent advice from the AHPRA Management Committee that national agency staff will be limited to 35, down from initial estimates of nearly double that number, does not alter this conclusion.[7]

The proposed addition of another layer of accountability in the form of the Public Interest Assessor — being a person who is charged with assessing complaints and, in combination with the relevant national board, deciding what action is to be taken — comes as a surprise. In the absence of any explanation, this proposal undermines the valuable role played by community (ie, public) members of medical boards and hearing panels, and can be interpreted as indicating a lack of trust in the existing health complaints agencies and regulatory boards that strive to do their best at all times. Consistent with a previous Medicare agreement, all jurisdictions now have health complaints agencies, and most of these agencies already perform, in part, the role proposed for the Public Interest Assessor. A more cost-effective way of addressing the concerns implied by this new proposal would be to push for uniformity of this role for health complaints commissions in all jurisdictions — a suggestion that the Australian Health Workforce Ministerial Council has recently indicated it will accept.[8]

By not adopting existing effective legislation, the NRAIP also brings attention to a serious flaw in the approach that COAG has chosen to bring about national registration; namely, that legislation will be prepared at the direction of the NRAIP, agreed to by health ministers (but not debated in public) and put before the Queensland Parliament. Doctors in all jurisdictions other than Queensland are clearly not represented in that parliament, yet COAG has agreed that other jurisdictions will use their best endeavours to adopt this legislation as their template.[2] The greater the departure of the draft Bill from the best of existing legislation, the more serious this flaw becomes.

Some public submissions to the NRAIP have questioned the insistence on the tight timeline of mid 2010 for a process that represents a crucial opportunity to develop best-practice regulation for protecting the community and guiding health professionals. COAG set this timeline 18 months ago, before the complexity of the task was fully appreciated. COAG and the health ministers would be wise to recognise that to "hasten slowly" is now appropriate. The existing regulatory system, although somewhat inefficient in terms of interstate mobility, will nevertheless continue to adequately protect the community.

Competing interests

I have made personal submissions to the initial consultation on the content of Bill B and to the draft legislation. I have also contributed to a submission from the Victorian Doctors Health Program on the draft Bill B.

At the time this article was finalised, public consultation on Bill B had closed, but a revised version of the proposed legislation had not been released.

Author details

Kerry J Breen, AM, MB BS, MD, FRACP, Chairman, Board of Directors (also Past President, Medical Practitioners Board of Victoria, and Past President, Australian Medical Council)

Victorian Doctors Health Program, Melbourne, VIC.

Correspondence: kerry.breen@bigpond.com

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(Received 4 Aug 2009, accepted 31 Aug 2009)

VIEWPOINT

Doctors' health: can we do better under national registration?

Kerry J Breen

ABSTRACT

- The move to national registration of doctors presents both threats and opportunities for the manner in which doctors seek health care and for providing assistance to doctors who may be impaired by illness.
- The most striking threat is the regressive nature of the provisions for mandatory reporting of ill doctors.
- The new system should be grasped as an opportunity to achieve national agreement on resourcing adequate services to help distressed doctors and to foster education and research into the health of doctors and medical students.
- The new system also provides opportunities to explore ways of encouraging doctors to improve their poor record of not attending to their own health, such as denying Medicare rebates for most doctors who self-refer.

MJA 2011; 194: 191–192

Doctors have a poor record of attending to their own health. Treatable conditions such as hypertension go unrecognised, health screening is avoided, most doctors do not have a general practitioner, and many doctors self-refer for investigations or to specialists and self-prescribe medications.[1-4] Doctors' families are often exposed to similar approaches. It has been repeatedly estimated that between 10% and 15% of doctors at some point in their careers become ill in ways that lead to impairment, usually via mental illness, drug misuse and dependence, or physical illness affecting performance.[2] When this happens, many doctors are reluctant to seek help and, as a consequence, medical boards see such doctors quite late in the course of illness.

The Australian Medical Council code of conduct for Australian doctors,[5] recently endorsed by the Medical Board of Australia (MBA), expects all doctors to have their own GP. But will doctors follow the new code? If not, why? These questions have been the subject of little research, but evidence and anecdotes suggest a number of barriers, including practicality of access, personal ego, lack of confidence in other doctors, and concerns about embarrassment and maintenance of confidentiality.[2,3,6] These barriers may be reinforced by anticipation or experience of consulting a GP who seems ill equipped to cope with another doctor as a patient.[7] So long as it remains acceptable for doctors to self-refer, many will continue to do so, arguing that this enables them to rapidly access the best care. Many doctors are unwilling to recognise the disadvantages of not having a GP, including lack of central coordination and record keeping, absence of objectivity, and failure to consider and address psychosocial, family, work and lifestyle issues.[6]

Recognition of doctors' lack of early access to high-quality care and late referrals to medical boards were key factors behind the development, commencing over 40 years ago, of state- and province-based doctors' health services in the United States[8] and Canada[9] that are independent of medical boards. In the US, the American Medical Association promoted this approach and continues to provide support and leadership for these services.[10] The services generally provide early intervention, triage to appropriate care and, where appropriate, monitoring, rehabilitation and support to re-enter the workforce. With the exception of Victoria, this model has not been adopted in Australia. Instead, other jurisdictions rely on the very generous voluntary work of doctors' health advisory services which, through lack of resources, focus primarily on doctor-to-doctor advice by telephone. In Victoria, the primary factor which led the Victorian branch of the Australian Medical Association and the Medical Practitioners Board of Victoria (MPBV) to jointly establish the Victorian Doctors' Health Program (VDHP) in 2000 was the recognition by the MPBV that, despite significant changes to legislation in 1991 and 1994 designed to encourage possibly impaired doctors to come forward, nothing had changed. Impaired doctors were still referred late in their illness. In addition, the MPBV had no powers to guide impaired doctors to the best available help, and programs for rehabilitation and re-entry to the workforce did not exist. The VDHP has been described in detail elsewhere[11,12] but its key features include an independent honorary board of directors, funding from annual fees for renewal of registration, salaried expert medical staff who undertake assessment and provide triage to appropriate care (but do not become involved in treatment), after-hours access, confidentiality, accessibility for doctors and medical students, support for rehabilitation and re-entry, and roles in education and research. VDHP participants are expected and assisted to find a GP.

The move to a single national system of medical registration should be grasped as an opportunity to do better in this area, but this is by no means assured. Instead, the necessary and appropriate focus of the MBA on protecting the public makes it possible that we will go backward unless those concerned about the health of their colleagues are prepared to look at the issues squarely. Why should one predict a negative outcome? The greatest concern lies with the highly regressive provisions in regard to mandatory notification of possibly impaired doctors under sections 140 and 141 of the *Health Practitioner Regulation National Law Act 2009* (Qld). The new legislation bundles mandatory notification of health matters with notification of alleged misconduct. Previous state legislation (eg, the *Medical Practice Act 1994* [Vic] and its successor, the *Health Professions Registration Act 2005* [Vic]) placed the reporting onus on treating doctors and required reporting only where an impaired doctor continued to practise against advice. The national legislation places the reporting onus on all health practitioners and is worded in the past tense so that no exception can be made for an impaired doctor who seeks help and voluntarily ceases to practise while receiving care. These new provisions are likely to deter doctors from seeking help and, if strictly interpreted, could lead to closure of the VDHP and threaten the confidential telephone services provided in other jurisdictions. The guidelines for mandatory notification recently issued by the MBA provide little reassurance in regard to health notifications.[13] This is not surprising given the regressive nature of the legislation. On a more positive note, the Western Australian legislature has recently passed a local amendment that exempts treating doctors from the mandatory reporting provisions of the legislation.[14]

In addition to the likely negative impact of the Health Practitioner Regulation National Law Act, what other barriers are there to the wider introduction of the types of health programs that are in place in North America and Victoria? In summary, barriers include issues of cost, accountability and parochialism. In regard to cost, it is estimated that the VDHP costs each doctor in Victoria about 55 cents per week, a very small investment considering that the program prevents the loss of medical students and doctors from the profession. Those 55 cents also help provide education about doctors' health to medical students and the profession and help foster research. This cost represents 0.03% of the new annual renewal of registration fee. In regard to accountability, undoubtedly there are potential tensions between the need for the confidentiality of VDHP-type programs and the medical board's focus on protecting the community. However, balancing individual needs with the rights of the community to be protected is a theme common to all legislation that regulates professional conduct. It needs to be acknowledged and handled appropriately. Most physician health programs in the US have formal contractual or legislated agreements with the relevant state medical board to deal with these issues.[8] In Victoria, a memorandum of understanding between the MPBV and the VDHP made it clear that clients of the VDHP must be reported to the MPBV if they do not follow advice and treatment and are deemed to be placing the community at risk.

In regard to parochialism, there has been a healthy sense of competition between the states and territories in Australia in many fields, including medical regulation, sometimes fostering improvement and sometimes causing resistance to change. The various doctors' health advisory services in Australia (and New Zealand) now come together regularly to discuss issues in common under the banner of the Australasian Doctors' Health Network. These discussions should focus on what will be best for the medical profession (including medical students) in the future and should examine a range of models. Given the differences of size and population of the Australian states, it may be appropriate to fund more than one model. As reaching consensus is likely to be difficult, a strong case can be mounted for a national workshop to be convened for this purpose, hopefully supported by the federal Department of Health, the Australian Health Practitioner Regulatory Agency, the MBA, the Australian Medical Association, and the medical schools and medical professional colleges. Inviting speakers from existing services in Canada and the US to participate would enhance the discussion. Ideally, such a workshop should include delegates from all the registered health professions, as there is also a need for a national debate as to whether these services should be doctor specific or accessible by all health professionals and students.

What about the future? The VDHP experience of seeing increasing numbers of younger doctors in distress suggests that education and awareness of the service is leading to earlier intervention and preventing more serious problems[12] — an encouraging trend. It is also very encouraging that Victoria's medical schools see the value of referring distressed students to an independent program.[12] Apart from encouraging and adequately funding doctors' health services so that early intervention, education and prevention become a strong focus nationally, can anything else be done to change doctors' attitudes to their own health? To foster the practice of all doctors having their own GP, one simple measure that could be examined would be to deny Medicare rebates for doctors who self-refer for investigations or to specialists, with exemption for doctors who are geographically isolated. This would not prohibit self-referral but would provide a financial incentive for doctors to comply with the Australian code of conduct.[5]

Competing interests

I was deeply involved in the work that led to the establishment of the VDHP from 1998 to 2000 and chaired the Board of Directors of the VDHP from late 2005 until late 2009.

Author details

Kerry J Breen, MB BS, MD, FRACP, Retired Gastroenterologist
Melbourne, VIC.
Correspondence: kerry.breen@bigpond.com

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(Received 2 Sep 2010, accepted 7 Nov 2010)