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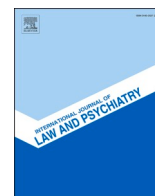
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Australian and New Zealand doctors' experiences of disciplinary notifications, investigations, proceedings and interventions relating to alleged mental health impairment: a qualitative analysis of interviews

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ABSTRACT

When poor mental health impairs a doctor's ability to safely practise medicine, poor patient outcomes can result. Medical regulators play a critical role in protecting the public from impaired doctors, by requiring monitoring and treatment. However, regulatory processes may paradoxically harm doctors, with potential adverse implications for the community. There is little prior research examining the experiences of doctors with prior mental health or substance use challenges who are subject to regulatory notifications and processes relating to their health. Therefore, we explored this issue through the thematic analysis of semi-structured qualitative interviews. Participants reported that mandated treatment improved aspects of their health, but that fear of regulatory processes delayed them seeking treatment. Participants recognised being significantly unwell at the time of regulatory notification. Participants told us that regulatory processes triggered psychological distress, symptom relapse, and adverse financial and vocational implications. They also told us that these processes eroded their trust in regulators and regulatory processes. To improve health outcomes for unwell doctors and to create safer healthcare for the community, we propose: 1) greater awareness and education of the medical profession about the thresholds and requirements for mandatory reporting of health impairment; 2) better integrating specialised doctors' health services into existing regulatory pathways; and 3) adoption of a more therapeutic approach to regulation by medical regulators.

1. Introduction

The mental health and wellbeing of registered medical practitioners (hereafter "doctors") is a health policy priority (Horton, 2019), because poor doctor health has been linked to poor patient outcomes (West, Dyrbye, Erwin, & Shanafelt, 2016). Doctors experience high rates of depression, anxiety, and substance abuse (Beyond Blue, 2019). Risk factors include long working hours, stressful working environments, exposure to potentially traumatic experiences, poor work-life balance, and easy access to prescription medications (Bradfield, Bismark, Scott, & Spittal, 2022b). Doctors frequently work when sick; avoid or delay

seeking medical treatment; and self-diagnose and self-medicate (Galbraith, Boyda, McFeeters, & Hassan, 2021), predisposing to substance misuse (Merlo, Singhakant, Cummings, & Cottler, 2013). When poor health potentially impairs a doctor's clinical performance, decision-making and ability to safely practise medicine, they may come to the attention of medical regulators.

In Australia, doctors are regulated under a National Scheme that governs 16 health professions. The Australian Health Practitioner Regulation Agency (Ahpra) maintains the national medical register, and investigates complaints about doctors' health, conduct, or performance (Bennett et al., 2018). It can refer complaints to the Medical Board of

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Australia, the Queensland Health Ombudsman, the Health Care Complaints Commission, and the Medical Council of NSW¹ (hereafter “medical regulators”) to take regulatory action under the *Health Practitioner Regulation National Law Act 2009 (Qld)*. Anyone can formally complain to Ahpra about a doctor. However, health practitioners and employers are mandated to report “notifiable conduct” that includes placing the public at risk of substantial harm by practising while impaired or intoxicated with alcohol or drugs (hereafter “mandatory reporting”) (*Health Practitioner Regulation National Law Act 2009 (Qld)*, s140–141). The Medical Council of New Zealand operates within a similar multi-profession scheme under the *Health Practitioner Competence Assurance Act 2003 (NZ)*, where health practitioners and employers are also mandated to report doctors “unable to perform the required functions” for the practice of medicine “due to a mental or physical condition” (*Health Practitioner Competence Assurance Act 2003 (NZ)*, s 45).

Under the *Health Practitioner Regulation National Law Act 2009 (Qld)* (s 5), a doctor is impaired if they have “a physical or mental impairment, disability, condition, or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect his or her capacity to practise the profession”. Therefore, a distinction needs to be made between “impairment” and “illness”, because a doctor may be unwell but still able to deliver safe medical care. Australian medical regulators can restrict the practice of impaired doctors by: refusing to grant registration; imposing conditions on, or suspending their registration; directing them to undergo a health assessment; referring them to a Health Panel; or taking immediate action in urgent situations (*Health Practitioner Regulation National Law Act 2009 (Qld)*, ss 55, 60, 178, 80, 169, 181 and 156, respectively). Similar powers are vested in the Medical Council of New Zealand (*Health Practitioner Competence Assurance Act 2003 (NZ)*, ss 16, 27, 50(4), 50(3), 49 and 47, respectively). In exercising these powers, medical regulators must balance public protection against the rights and interests of doctors. The public expects medical regulators to protect it from unsafe doctors, and this can be achieved by requiring impaired doctors to be assessed and treated. However, regulatory processes can also cause emotional distress (Bradfield, Bismark, Scott, & Spittal, 2022a). A recent survey of nearly 8000 UK doctors found that doctors with a recent or current complaint are twice as likely to experience depression, anxiety, or suicidal thoughts compared to doctors with no prior complaint (Bourne et al., 2015).

In this study, we examine the impact of regulatory complaints, investigations, hearings and interventions relating to alleged mental health impairment (hereafter “regulatory processes”) on the health and wellbeing of doctors with a history of mental health or substance use challenges (hereafter “unwell doctors”). While research has previously examined the impact of regulatory processes on doctors generally, their impact on allegedly impaired doctors specifically (and their willingness to access healthcare) is understudied. Unwell doctors are a hard-to-reach cohort. Yet, their views and lived experiences are critical to understanding and improving how medical regulatory processes respond to allegations of impairment. Therefore, this study aimed to explore: 1) how unwell doctors experience regulatory processes; 2) the impacts of regulatory processes on unwell doctors’ health; and 3) the ways in which regulatory processes support or hinder doctors’ health. A qualitative study design was selected, owing to the limited existing evidence, the wide range of unanswered questions about the impacts of regulatory processes, and the exploratory nature of our inquiry. We used semi-structured in-depth interviews to provide a safe environment for

nuanced conversation around sensitive topics that would not be uncovered using structured surveys alone.

2. Materials and methods

2.1. Participants and recruitment

Using purposive and snowball sampling, we recruited 21 unwell doctors (“participants”). Participants were eligible to participate if they: 1) had a current or past mental illness or a substance use disorder; and 2) are currently, or had been, the subject of regulatory processes relating to their illness. Participants included doctors suspended or disqualified from practice. We excluded doctors who: 1) had been the subject of regulatory processes unrelated to their health; 2) were incapable of consenting to participate; or 3) were acutely distressed or suicidal. To facilitate participant recruitment, three Australian medical indemnity insurers (MIPS, Avant, and MDA National) shared a notice and a plain language statement about the study on their website and/or communication bulletins. Eleven participants were recruited through insurers. Seven were recruited through snowball sampling after learning about this study from existing participants. We also posted information about our study on two doctors’ Facebook groups, to which three doctors responded. No participants were known personally or professionally to the researchers.

We also recruited four doctors with experience working for doctors’ health services (“treating practitioners”). They were recruited to supplement a broader perspective on the issues of interest. Convenience sampling was used to recruit them from the researchers’ professional networks.

2.2. Consent

All participants received written and verbal information about the study, including the voluntary nature of the research. All participants were assessed as capable of consenting to participate, and all provided written consent.

2.3. Data collection

In-depth semi-structured interviews were conducted with participants over Zoom between September 2020 and February 2022. An interview schedule was prepared by OB and MB, based on their knowledge of the *Health Practitioner Regulation National Law Act 2009 (Qld)* and experience working with unwell doctors. Although not formally piloted, it was modified as interviews progressed, to improve the clarity of questions. A copy of the interview schedule is included as a Supplemental File. OB conducted all interviews in a confidential setting. A trauma-informed approach was adopted (Isobel, 2021). OB is a doctor and health lawyer with experience supporting unwell doctors. OB did not require formal training prior to conducting interviews and drew upon his experience and knowledge to establish rapport with participants, when probing for further information, and when monitoring for signs of distress. Participants were asked to describe: their motivation for participation; their medical history and diagnoses; perceived barriers to accessing treatment; the type of regulatory processes they faced and their outcomes; their experience of, and reaction, to the regulatory process; the most stressful aspects of the process; their advice to other doctors subject to regulatory processes; recommendations for reform; and their reaction to the interview. Participants were not compensated for their participation. Interviews were audio-recorded and saved onto a password-protected encrypted hard drive. Audio recordings were de-identified, transcribed verbatim, and uploaded into NVivo™ (Version 1.6.1, QSR International, 2020). Names were not used during interviews to preserve anonymity.

¹ In Queensland, notifications are investigated in conjunction with the Office of the Health Ombudsman pursuant to the *Health Ombudsman Act 2013 (Qld)*. In NSW, notifications are received and investigated by the Medical Council of NSW in conjunction with the Health Care Complaints Commission, pursuant to the *Health Practitioner Regulation National Law Act 2009 (NSW)* and the *Health Care Complaints Act 1993 (NSW)*.

2.4. Data analysis

The six steps to inductive thematic analysis, as outlined by Braun and Clarke (2006), were employed in this study. We familiarised ourselves with the data to identify patterns that arose within the data without pre-conceptions about themes. This provided flexibility and rich detail. OB and MB immersed themselves in the data, systematically reviewed and analysed transcripts, and identified and labelled important sections of text. We identified components or fragments of ideas arising from the data and organised them into codes using NVivo™. Codes were iteratively reviewed for interconnectedness to see where themes should be merged or split. The researchers agreed upon the final coding framework by consensus. Participant recruitment and interviews continued until no significant new themes were emerging. OB also regularly reflected and debriefed with the research team to ensure that he remained critical and objective when interpreting and analysing interviews, in view of his prior experience working closely with unwell doctors.

2.5. Data security and privacy

All files and documents (other than the consent form) were de-identified and securely electronically stored. No information about who participated was shared with insurers. We used a professional transcription company with a confidentiality agreement.

2.6. Risk management

We prepared an adverse event protocol to mitigate and manage potential harms. Participants were directly asked if they were experiencing any psychological distress before, during and after interviews. If participants experienced distress, interviews would be stopped, and participants referred to support services (such as their treating doctor, Lifeline, Beyond Blue or ambulance as appropriate). No participants required this. Participants were advised that researchers might be legally required to disclose information obtained during interviews to police, emergency services, or medical regulators – for example, if criminal conduct or new notifiable conduct was raised. No notifiable matters were raised during any interviews.

2.7. Ethics approval

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008. Written consent was obtained from all participants. All procedures involving human participants were approved by the University of Melbourne Human Research Ethics Committee (approval number 2056342).

3. Results

3.1. Demographics

The characteristics of the 21 unwell doctors and four treating practitioners are summarised in Table 1. They ranged from 10 to 50 years post-graduation, with a median of 21 years. Interviews ranged from 44 min to 128 min, with a median of 98 min.

Most participants reported being subject to registration conditions at the time of interview. These included mandated treatment from a general practitioner, psychologist, psychiatrist, addiction medicine specialist, doctors' health program, Alcoholics Anonymous, Narcotics Anonymous, or a doctors-in-recovery group. Other conditions restricted work hours and work location, or required supervision, mentoring, case auditing, drug monitoring, or neuropsychological testing. Five participants reported being suspended. Half were subject to immediate action, of whom some were still awaiting a final regulatory outcome at the time

Table 1
Characteristics of interviewees.

Characteristics	Participants (n = 21)	Treating practitioners (n = 4)
Sex		
Female	10	3
Male	11	1
Jurisdiction*		
NSW	8	1
Victoria	6	2
New Zealand	3	0
Queensland	2	1
Western Australia	2	0
Other	2	0
Specialty		
General Practice	6	2
Doctor-in-training	6	0
Surgeon	2	0
Psychiatrist	2	2
Other	5	0
Nature of illness**		
Depression	8	N/A
Alcohol abuse	4	N/A
Other substance abuse	8	N/A
Psychosis	2	N/A
Personality disorder	2	N/A
Physical health condition	1	N/A

* Totals exceed 21 because some doctors had regulatory processes in multiple jurisdiction.

** Participants, but not treating practitioners, were asked about the nature of their illness. Totals exceed 21 because some participants had more than one illness type.

of interview.

3.2. Illness severity at the time of regulatory notification

Most study participants reported being significantly impacted by poor mental health when they were notified to regulators. Some reported requiring inpatient psychiatric treatment or residential drug rehabilitation. Many reported taking medication (anti-depressants, mood stabilisers, anti-psychotics, or opiate substitution therapy) or requiring extended courses of inpatient electroconvulsive therapy

Table 2
Illness severity at the time of regulatory notification.

Diagnosis	Illustrative quotes
Psychosis	<i>I was psychotic and found wandering the streets... and was admitted under the Mental Health Act. Ahpra was notified (P2).</i>
Substance use disorder	<i>I used heroin since I was a teenager. It got worse due to stress at work. I accidentally overdosed and passed out while driving. The police reported me to Ahpra. I am now on Suboxone (P6). I started using drugs recreationally as a teenager. When I ended a toxic relationship, I started using methamphetamine again. I started missing work because I would just sleep through. My colleagues reported me to the Medical Board (P5). I was exposed to trauma in ICU. I didn't look after my health properly and I started using propofol. One day, I was found unconscious in bed after I had used (P7).</i>
Alcohol use disorder	<i>My colleagues reported me for drinking too much. I used to drink up to 14 standard drinks a day. I got better but then, one night, I relapsed and got drunk again. I drove home, had a motor vehicle collision and was reported again (P14). I'm an alcoholic. I drank for 30 years, but the problem got worse and I started drinking at work...My colleagues reported me to the Medical Board (P18).</i>
Mood disorder	<i>I have a family history of depression and bipolar. I got severely depressed and ended up in a psychiatric inpatient unit. I was admitted for two months and had 18 ECTs (P10). My marriage ended, so I took an overdose of sleeping tablets and woke up in hospital. That's how I was referred to the Medical Board (P13).</i>

(ECT). Table 2 provides illustrative examples of participants' reported health challenges.

3.3. Participants avoided, delayed, or struggled to access support

Many participants believed that their involvement in regulatory processes could have been avoided if they had accessed help for their declining mental health earlier. However, as outlined in Table 3, they reported evading or deferring treatment due to shame, a lack of insight, financial concerns, or fear of regulatory repercussions. One notable and traumatic problem was the difficulties faced by unwell doctors in accessing healthcare when treatment was provided by their own employing health service. In participants' views, these factors contributed to worsening health.

Participants regretted not looking after themselves and not responding sooner to warning signs that their mental health was deteriorating. They wished they had "owned" their illness earlier and had been more "honest" to themselves about their difficulties and had sought

Table 3
Reasons why participants avoided or deferred early treatment.

Factor & description	Illustrative quotes
Stigma: Participants were "embarrassed" and "ashamed" to tell others about their illness and feared being "judged".	<i>People are a bit more open about depression. But it's still not accepted that doctors might be alcoholics or heroin addicts (P6). I was so deeply ashamed. When I finally told my GP, it was a relief because I got some help (P17).</i>
Regulatory concerns: Participants feared being reported to regulators by treating doctors. To prevent this, participants avoided treatment or treated themselves.	<i>I was so scared that if I told my GP anything, I would get everything taken away from me. I hid my drug use for fear of being suspended, until it was too late and then everything unravelled anyway (P6). There's still lots of uncertainty about the [mandatory] notification process. I've known doctors tell their colleagues they feel burnt out, only to find that they've been reported to the Medical Board (treating practitioner, female). I stopped [seeing my psychiatrist] after 12 months...I had almost no time to fit them in. To take a session off work was costly (P13). I'm a single mum. My children rely on me working. They're in a private school now and I have a mortgage. I was afraid I was going to lose my job. Do I destroy my kids' lives by speaking up, or do I just try and get through and not say anything? (P2). I was severely unwell and shouldn't have been working for some weeks before I admitted it (P21). I didn't see my self-prescribing [of opiates and benzodiazepines] as harming anybody and I didn't think I was impaired at work. But it got out of hand (P4). Even taking two weeks off work is a big deal, even though you're not really working at your capacity anyway (P6).</i>
Financial concerns: Concern that taking time off work for assessment, treatment, or recovery might result in loss of income. Concern that loss of registration might result in loss of career.	
Denial or lack of insight: Some participants did not recognise, at the time, how unwell they had become and continued to work. They realised afterwards that this put patients at risk.	
Patient care concerns: Participants who wanted to take time off work were reluctant to ask their employers because this would: require disclosure of health information to employers; leave rosters unfilled; add to colleagues' workloads; and adversely impact patient care.	
Difficulty accessing care: Some health services were reluctant to treat participants whom they also employed. This resulted in delayed or fragmented care.	<i>Despite being a really high suicide risk, I was shunted between mental health services. One service couldn't treat me because I worked there, but the other service didn't want me either. I got no follow up on discharge because I lived out of area (P2). The service struggled with the fact that they were having to treat me, particularly because I held senior roles there. Unfortunately, it took over a year before I was transferred to another service (P21).</i>

timely support and advice from trusted health practitioners, family, friends, or peers. Some wished they had felt more comfortable requesting time off work when they first became unwell and wished that workplaces had been more encouraging of them taking leave.

I wish someone had said to me that I can still be a good surgeon and not work every day (P8).

3.4. Positive impacts of regulatory processes

Treating practitioners reported that regulatory processes were sometimes necessary to ensure unwell doctors received the help they needed, especially when their mental health was adversely impacting patient care. Likewise, almost all participants reported that mandatory assessment, treatment, and monitoring improved aspects of their health. Key quotes relating to this theme are summarised in Table 4.

We noted that participants who remained abstinent from substances often reflected positively on their regulatory experience, using words such as "life-changing" (P18), "empowering and validating" (P20) and "supportive" (P21). Similarly, we also noticed that participants from New Zealand spoke positively about their regulatory experiences in ways that many participants from Australian jurisdictions did not. Participants who relapsed often reflected on some of the negative aspects of the regulatory process, as outlined below. However, it was difficult to draw comparisons between these groups, due to the qualitative nature of this study.

Table 4
Positive impacts of regulatory intervention.

Factor & description	Illustrative quotes
Suicide prevention. Treating practitioners recognised the important role of regulators in keeping doctors alive as a last resort.	<i>Notification is often a lifesaving thing. Doctors who are very unwell with mental instability or alcoholism are right on the edge and, unless you involve the regulator, they could suicide. The mission is to improve the health of the practitioner and the profession for the good of the community (treating practitioner, male). It is challenging trying to develop a therapeutic relationship with a doctor who doesn't accept they have a problem and does not realise how their substance use or mental illness is impacting their practice (treating practitioner, female). My patients are my priority, so I value the conditions they have put on my registration as a means of keeping my patients safe (P2). The silver lining is that I finally got my problem diagnosed and I've been focusing on staying healthy. I would have struggled to do that myself (P16).</i>
Patient safety. Both treating practitioners and unwell doctors recognised that regulatory sanctions were ultimately designed to keep patients safe.	
Obtaining a diagnosis. Many participants said that regulatory processes resulted in mandatory treatment conditions that directly improved aspects of their health.	
Maintenance of abstinence. Participants who were subject to drug monitoring conditions said that regulatory processes helped them to successfully maintain abstinence.	<i>I'm in a better place now because of the drug testing. I needed a little bit of a carrot and stick when I was first coming out of addiction because I wasn't making good decisions...I had friends who used drugs who were not doctors and they are all still using. I am lucky because the monitoring keeps me abstinent (P6). Yes, it's onerous, but the drug monitoring helps me stay clean, and helps me continue to work in a manageable way. They protect me and my patients. I would be happy to do three-times weekly urine screening for the rest of my career because it is a protective mechanism. Overall, it is positive for my health (P17).</i>

3.5. Perceived problems with the current system

Despite these positive impacts on health, participants reported that some aspects of regulatory processes were distressing and detrimental to their mental health and emotional wellbeing. These are summarised in Table 5.

3.6. Psychological sequelae of poor regulatory processes

Many participants reported that the stress of regulatory processes triggered a relapse of their pre-existing mental health conditions, resulting in hospitalisation for depression or bipolar disorder in the weeks following the notification of a regulatory complaint. Others reportedly stopped exercising, stopped eating properly, gained weight, developed insomnia, lost confidence and self-esteem, “lost interest in [their] recovery” (P17) from substance misuse, or “spiralled out of control” (P15). This was often compounded by competing stressors, such as family commitments or studying for specialist exams.

Regulatory processes were reportedly the most psychologically distressing life experience for most participants, even when compared to the death of a parent, past sexual and physical abuse, domestic violence, and the birth of a critically unwell premature baby. Participants expressed feelings of helplessness, fear of the unknown, loss of control, and suicidal ideation. Some participants told us that the stress of regulatory processes led to relationship difficulties with partners or family, including “strain”, “arguments”, separation, and divorce. Others said they became more socially reclusive and lost trust in lawyers, patients, medical regulators, and people in general. Several participants felt so traumatised by their experiences of regulatory processes that they would not reveal symptoms of relapse to the regulator or their treating practitioners if their symptoms relapsed in future. Others said that they would travel overseas or attempt to seek support and treatment on an anonymous basis. These themes are captured in Table 6.

3.7. Non-psychological sequelae of poor regulatory processes

In addition to the psychological impacts, participants also reported vocational, financial, professional, clinical, and reputational implications of regulatory processes, as outlined in Table 7.

4. Discussion

This qualitative study of unwell doctors and treating practitioners revealed positive and negative experiences of regulatory processes. Unwell doctors and treating practitioners all reported that mandated treatment improved aspects of participants’ health, but that fear of regulatory processes impeded healthcare access, leading to worse health, psychological distress, and symptom relapse. These findings are important because they call into question the effectiveness of some aspects of regulatory systems that are designed to protect the public from potential harm associated with impaired doctors.

4.1. Overcoming the fear of regulatory processes

Participants described multiple barriers to health access which, consistent with existing literature (Vayr, Herin, Jullian, Soulat, & Franchitto, 2019), included stigma, denial, lack of insight, and lack of access to services. However, fear of regulatory processes (especially mandatory reporting) was the most common response. Participants felt uncomfortable talking candidly with treating doctors about their mental health for fear that information would be disclosed to regulators, which might suspend or restrict their registration. Participants felt that these concerns contributed to delayed diagnosis and treatment, worse health outcomes, and harsher regulatory sanctions. Fear of mandatory reporting undermined mutual trust between treating practitioners and unwell doctor-patients. This is concerning because studies show that mutual

Table 5
Perceived problems with the current system.

Factor & description	Illustrative quote
Delays by regulators were described as “devastating” and impacted “immensely” on some participants’ employment and mental health. Participants perceived a lack of awareness, empathy, or communication from regulators about delays.	<i>I would be categorical that my mental health has been worsened by the prolonged nature of this investigation. (P9).</i> <i>Every month, Ahpra would tell me that the Board didn’t get a chance to look at my matter. The decision took 18 months, which is an inordinately cruel amount of time (P7).</i> <i>Not knowing when the investigation is going to conclude or what they’re going to do plays on my mind. I’ve had sleepless nights for two years. I just want this to be wrapped up. If they’re going to suspend my registration or reprimand me, I want them to do it now so that I can just get it over and done with, and can get on with my life (P8).</i> <i>They hear nothing for months...deathly silence (treating practitioner, female).</i> <i>Nobody gave me any information about what to expect when I appeared before the Medical Council. I truly thought that was it, goodbye, done and dusted, finished you’re gone (P14).</i> <i>The Ahpra investigator rang me while I was in hospital and in pain the day after surgery. They wrote everything down and used it against me (P10).</i> <i>I received a call from Ahpra when I was at home alone the day after ECT. I didn’t understand why they were calling me. I don’t remember much about the conversation (P11).</i>
Communication from regulators was sometimes perceived by participants as inadequate, legalistic, formulaic, or inopportune.	<i>I knew there was something wrong because I wasn’t using drugs and yet I was testing positive. I asked Ahpra to speak to the lab, and they didn’t. Instead, they deregistered me. I was doing all the right things, jumping through all the hoops they required of me. Urine testing is a big deal. It’s three times a week, it takes a long time. Every time you do this test, you are exposing your genitals... so for them to not even interpret the results properly is just disgraceful (P4).</i> <i>I had been abstinent for over seven years, with over 900 clear urine tests, and they are making a big deal about results that two eminent toxicology professors say are false positives. Making those sorts of mistakes is expensive, frustrating, and costly (P12).</i>
Lack of expertise or accountability: Participants thought that case managers lacked understanding of mental illness, substance use disorders, or doctors’ health. They also felt that relapse was treated as a professional misconduct issue, rather than a health issue. Some drug test results were interpreted without expert advice.	<i>I wasn’t treated like a person, they just treated me like a junkie (P16).</i> <i>The HCCC is full of ex-policeman and ex-detectives. They need people with compassion, or get some doctors or psychologists in there who have a bit more of an understanding of mental health (P17).</i>
Participants commonly perceived a lack of empathy or support from regulatory staff, whom they described as “confrontational”, “hostile”, “heartless”, “legalistic”, and “uncaring”.	<i>There was no excuse for missing a test, even if the collection centre was closed... Compliance officers were not medically trained, and didn’t know that Paracetamol and Panadol were the same, so some of them would ask me, “Why are you not disclosing this drug?”...They lost sight of the fact that I wasn’t using drugs and that the reason you’re doing the test is to prevent harm to the public. Instead, it became all about the process (P6).</i> <i>My compliance officer showed no flexibility, empathy, or support.</i>
Participants described regulatory compliance officers as inflexible . Participants said they were afforded little or no input into their treatment, but were reluctant to challenge this for fear of being labelled “insightless”.	

(continued on next page)

Table 5 (continued)

Factor & description	Illustrative quote
	<i>Submitting forms a couple of days late was a non-compliance and she was very condescending, "Well doctor, until you can prove otherwise, this is going to be marked as a noncompliance, and the Board will consider this as you not engaging with their conditions." This added to my stress (P2).</i>
Judgmental: Some participants felt judged by Medical Board members, and independent medical examiners.	<i>I sat in front of the Medical Board and they're all shaking their heads, making judgmental comments. They perceive you as a sinner (P14).</i>
Many participants who were subject to drug monitoring conditions felt that the process was stigmatising and humiliating .	<i>I walked in [for my independent psychiatric assessment]. He looked at me and said, "Oh, you're that G boy" (P16). Pathology staff must watch you urinate to preserve the chain of custody. Sometimes when you pee, you need to poo as well. It's just humiliating and makes you feel like a criminal. One of them made jokes about my genitals. That's not good for anyone's mental health (P16). The other day, one of the collectors yelled out my name and said, "You've been a naughty boy again" (P5).</i>

Table 6
Psychological impacts of regulatory processes.

Factor	Illustrative quote
Acute stress reaction	<i>Doctors take a very catastrophic view of the notification. They are in crisis – absolute distress. The risks are very high (treating practitioner, male).</i>
Illness relapse/ aggravation	<i>My whole health condition became public knowledge. There were media articles written about my case. That was incredibly harmful to my mental health, and the mental health of my family. The subsequent media attention made my recovery really difficult, and subsequently has led to a relapse (P17).</i>
Anxiety	<i>Every time I see my lawyer's name pop up in my inbox, every time I get a call from the lawyer, every time I even open my emails, before I even see what's in it, I get palpitations...I cry a lot more easily than I did before (P10).</i>
Suicidal ideation	<i>It pushed me to a very, very terrible spot, the worst place I've ever been to in my life. They've pushed a lot of other doctors even further, to the point to where they have suicided (P4). It was a really dark period, that was the closest I've ever been to killing myself ... I had it all planned out which is really sad (P16).</i>
Loss of motivation	<i>I was always good at sport and I was a good looking guy, I was a doctor, I was successful. And after this, I was a big fat de-registered loser. I was overweight and had lost all my confidence and wasn't competent to do anything else (P4).</i>
Loss of trust in treating practitioners	<i>If I relapse, I will try to get treatment anonymously because mandatory reporting made my problems exponentially worse. I can't tell my GP anything because Ahpra will obtain my records and know everything about me (P7). I would stop working, go overseas, get myself sorted and come back. I wouldn't tell anyone here (P16). I would err on the side of under-reporting, rather than over-reporting. If they think you drink a whole bottle of wine each night, they don't need to know that you actually drink three bottles (P18).</i>

trust in the therapeutic alliance is necessary for optimal health outcomes (Muran, 2022). Our findings illuminate the importance of unwell doctors having access to confidential mental health care.

Most participants agreed that restrictions on their practice were sometimes necessary to ensure they received treatment. Those who received mandated treatment agreed that their mental health improved,

Table 7

Non-psychological impacts of regulatory processes on unwell doctors.

Factor & description	Illustrative quote
Vocational: Participants whose registration was suspended said that they struggled to find alternative employment, due to a lack of transferrable skills, and restrictions on using medical knowledge in non-clinical (medical advisory or medical administration) roles. ^a	<i>If I can't use my medical knowledge at all, then there's nothing I'm qualified to do except a minimum wage job. I couldn't even get a job as a drug rep, a waiter or as a barista (P4).</i>
Financial: Legal fees and drug monitoring expenses were associated with financial hardship for some participants.	<i>I am trying to support a child on my own. I am not working and on the dole (P6). I'm completely bankrupt. It was costing me \$12,000 per year in drug testing, which is hard when you are not working...I'm currently homeless...and on Centrelink. I got my first payment last week, which was quite humiliating. I couldn't afford legal representation (P16). More than half my salary goes on drug testing and legal costs...I've spent over \$100,000... I've known of doctors that have had to give up because they haven't got the resources to stick up for themselves (P12).</i>
Professional: Restrictions on work hours or duties reportedly caused professional isolation, and delays in completing specialty training. Participants believed that prospective employers were sometimes reluctant to employ participants who required supervision. Some participants were unable to find a supervisor and could not return to work. Participants were concerned that regular drug testing prevented them from arriving at work on time, which impacted on colleagues and patient care, and limited the types of careers they could pursue.	<i>My conditions required a mentor, two work supervisors, an addiction specialist, a GP, and three-times weekly urine testing. Because of the number of appointments, I was often late for work and handover, which impacted colleagues and patients. I'd be apologising to people who didn't know why I was late. I was never that chaotic when I was a drug addict, and it gave the appearance that I had some sort of problem. This was stressful and I didn't progress at work because I was missing teaching on the only day I had free. Trying to be on an 8:00 am to 6:00 pm roster just didn't work. I don't think Ahpra understands the impact of this on your work and on patients. It's not the testing, just the way they regiment it (P6). With random drug testing, you must ring up everyday to find out if you need monitoring, but you can only call after midnight. It's just barbaric. You can stay up until midnight and then be tired the next morning, or you can ring first thing in the morning and then try to fit the monitoring into a busy day. The Medical Board has little understanding of the practicalities of the conditions they impose. (P18). For six months, I received regular correspondence from Ahpra saying I was a danger to public health and safety. Even though I was cleared, I left General Practice because I lost all my confidence (P11). This whole Ahpra process has turned me off medicine. I could walk out tomorrow and not miss it (P8).</i>
Clinical: Participants believed that their clinical skills declined because of time off work or conditions limiting the hours, location, or nature of their work. Others lost confidence in their abilities, lost interest in medicine, or practised more defensively by referring more patients to specialists, ordering more tests, recommending less surgery, second-guessing clinical decisions, and documenting more thoroughly. Some retired prematurely from medicine.	
Reputational: Many participants felt "angry" and "violated" that regulators "destroyed" their reputation by accessing and sharing sensitive health information with employers and supervisors during regulatory processes. Some participants' personal information was published by Tribunals and newspapers.	<i>They dug up everything I told my GP over the last 10 years and it's now all public information. Why would you feel safe talking to your GP? (P10). Even in the psych ward, I didn't feel like my treating consultants were there to support me, but were happy to hand over my 50-page psych history to the Medical Board (P15).</i>

^a The Medical Board of Australia has published a working definition of "practice" on its website. It includes any role in which the person uses their medical skills and knowledge in management, administration, education,

research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of medical services. It is not restricted to the provision of direct clinical care. See: <https://www.medicalboard.gov.au/registration/types/non-practising-registration.aspx> (accessed 14 December 2022).

and that earlier treatment might have avoided further deterioration of their health and might have reduced the severity of regulatory outcomes. Nevertheless, even when participants were treated and recovered their health, many said they would prefer to seek future treatment overseas or anonymously to avoid being the subject of further mandatory reporting. Therefore, it seems that prior experiences of regulatory processes reinforced (rather than reduced) participants' trepidation and mistrust of treating practitioners, medical regulators, and regulatory processes. If unwell doctors are not divulging information about their health to their treating practitioners or the regulator, this can adversely impact their health and, ultimately, their care of patients. This finding calls into question the effectiveness of some regulatory processes aimed at public protection, particularly mandatory reporting. This is particularly troubling because participants in our study avoided or delayed seeking help, even when they had insight into their illness and its severity.

Notably, participants' fears were not only about mandatory reporting *per se*, but also about treating practitioners not understanding or correctly discharging their mandatory reporting obligations. While Ahpra has attempted to clarify the requirements for mandatory reporting (Ahpra., 2020), we believe that more work is needed to educate the medical profession about the scope of its mandatory reporting duties (Bismark, Mathews, Morris, Thomas, & Studdert, 2016). In particular, it is important for treating practitioners to understand the difference between illness and impairment. Australian case law is clear that an illness can only attract regulatory sanctions if it detrimentally affects, or is likely to detrimentally affect, the doctor's capacity to practise medicine (*Health Care Complaints Commission v Liprini* [2020] NSWCATOD 94). New Zealand case law similarly requires the illness to adversely impact on the practice of medicine (*Medical Council of New Zealand v T* [2020] NZHPT 1097). In light of the findings from this study, this distinction is critical because reporting unwell doctors who are not impaired unnecessarily exposes them to potentially harmful and lengthy regulatory processes that can reinforce stigma and lead to avoidance of help-seeking. This can have wider adverse implications for patients and the public. It can also erode the trust that practitioners and the profession place in regulators and regulatory processes.

4.2. Making regulatory processes more therapeutic

Participants told us that regulatory processes not only create a barrier to health access, but they can also trigger emotional distress. Consistent with previous research (Charles, Warnecke, Nelson, & Pyskoty, 1988), participants reported that regulatory processes were their most stressful life experience. However, participants reported that regulators did not recognise this. Participants described their psychological distress in terms of anxiety, illness relapse, and suicidal ideation, and many attributed this to delays, errors and perceived unsympathetic or inappropriate interactions with staff who lacked mental health training. Participants told us they wanted to feel respected, supported, informed, and heard when dealing with medical regulators. They also wanted to interact with people who understood doctors' health, mental illness, and substance use disorders.

In the UK, a 2013 report found that the stress of UK regulatory processes contributed to the suicide of 28 doctors. It concluded that the UK medical regulator had a positive obligation to ensure that regulatory processes do not damage the mental health of doctors (Horsfall, 2014). By adopting attitudes, processes, and communication methods that are trauma-informed, non-judgmental, compassionate, and empathic, medical regulators can play an important role in generating a positive psychological impact on unwell doctors that can facilitate doctors'

recovery and rehabilitation. This approach, termed "therapeutic jurisprudence" (Wexler & Winick, 1996), has been successfully applied in other court and tribunal settings involving people with lived experience of mental illness, including mental health tribunals (Diesfeld & McKenna, 2007) and victims of crime compensation tribunals (Bennett Cattaneo & Goodman, 2010). We believe there is merit in applying this approach to regulatory processes involving doctors with alleged health impairment.

We also found that regulatory delays were of significant concern to unwell doctors and treating practitioner participants in this study, who believed they contributed to adverse psychological outcomes. This is consistent with prior research that suggests that engagement with, and passage through, legal and administrative processes may worsen the long-term prognosis of personal injury claimants (Grant & Studdert, 2009). In recent years, Ahpra has undertaken extensive work to expedite its response to notifications (Scholefield, 2022), by establishing a triage committee comprising doctors and investigators to resolve low-risk notifications within six weeks. Ahpra has also recently established a dedicated team to manage health notifications (Biggar, Fletcher, Van Der Gaag, & Austin, 2022). We commend this work that seeks to make regulatory pathways kinder and more therapeutic for unwell doctors. We also recommend that regulators: establish regular, accessible, and personal communication with unwell doctors about the progress of the regulatory process; improve staff communication skills; and develop staff knowledge and understanding of mental health and substance use challenges.

Another important way in which regulators could make their processes more therapeutic is to delegate the management and monitoring of unwell doctors to independent doctors' health services. For example, each Canadian province currently has its own Physician Health Program (PHP) (Canadian Medical Association, 2022), which receives referrals from regulators, but operates independently. PHPs provide holistic and confidential early intervention, treatment, rehabilitation, residential therapy, return-to-work support, and relapse contingency planning. Recovering doctors are placed on a mandatory treatment and monitoring contract for five years under the case-managed care of a multi-disciplinary team of social workers, nurses, and doctors with expertise in mental illness and addiction, who understand regulatory reporting requirements. Transient relapses are managed by PHPs and only reported to regulators if the doctor places the public at risk by not adhering to treatment or withdrawing from the program (Brewster, Kaufmann, Hutchison, & MacWilliam, 2008). In this way, relapses are treated as a health problem rather than a professional misconduct issue. Canadian PHPs effectively divert impaired doctors away from regulatory sanctions towards therapeutic support (Monahan & Bonnie, 2004).

Moreover, there is evidence that the North American model of PHPs work and we believe there is merit in adopting a similar model in Australia. The prognosis for impaired doctors managed by PHPs is better than for patients managed by non-physician programs (Morse, Martin, Swenson, & Niven, 1984). In addition, doctors who successfully complete a PHP treatment program are at lower risk of subsequent legal claims compared to a matched cohort (Brooks et al., 2013). This suggests that they may also protect patients and the public. On the contrary, regulatory bureaucracies are inherently slow and inflexible, and this makes them ill-suited to responding quickly to the sometimes rapidly changing nature of medical illnesses. Doctors may become seriously unwell before regulators act, thus putting the public at risk, while suspended doctors may have to wait many months after they have recovered before being allowed to re-enter the workforce. A case-managed approach through a PHP may be more agile to the changing needs of the doctor's illness, without compromising the paramountcy of patient safety. As one treating practitioner participant who works with a PHP told us, the ultimate mission of PHPs is "to improve the health of the profession for the good of the community".

4.3. Strengths and limitations

Our study has limitations. Participants self-selected and doctors with a difficult experience of regulatory processes may have been more motivated to participate to improve the system for others. This study was also limited to doctors in Australia and NZ. Doctors in other jurisdictions may have different experiences of regulatory processes. However, the aim of qualitative research is not to achieve a sample size large enough to make statistical comparisons or for findings to be generalised. Instead, the aim is to focus on depth of relatively small samples to understand the contexts, meanings, interpretations, and subjective experiences of individuals and how individuals 'make sense of their place in the world' in their own words (Liamputtong, 2013, pp. 18–19). We also recognise that some of the closed questions and prompts used in our interview schedule may have influenced if or how participants responded, and this may have tacitly influenced our analysis of key themes. Finally, the number of participants from New Zealand and the number of treating practitioner participants was small, compared to unwell doctor participants from Australia. This made it difficult to assess differences between these groups.

Our study has several strengths. The semi-structured and in-depth nature of our interviews facilitated unanticipated findings to emerge. Participants included unwell doctors with experiences of regulatory processes and practitioners who treat unwell doctors, allowing for broad and balanced viewpoints. This is the first study to focus specifically on the experiences of allegedly impaired doctors and has revealed novel findings of relevance to unwell doctors, treating practitioners, medical defence insurers, medical regulators, and policy makers. We believe that these findings will inform and augment growing calls for co-ordinated systemic change and enhanced care to improve doctors' wellbeing (Wijeratne, Kay, Arnold, & Looi, 2022).

5. Conclusions

In this novel study, we interviewed doctors with mental health or substance use challenges who were subject to regulatory processes relating to their health. Their stories were supplemented with accounts from practitioners with expertise treating unwell doctors, to give a broad perspective. Unwell doctors reported that fear of regulatory processes was a barrier for them accessing healthcare, that this contributed to delayed diagnosis and treatment, and that this may have exacerbated adverse health outcomes. Concerningly, they also reported that these fears were reinforced by subsequent negative experiences of regulatory processes, even when they finally received treatment that improved aspects of their health. As a result, many said they would avoid future treatment if they relapsed, suggesting a level of suspicion and mistrust amongst unwell doctors towards medical regulators and their own treating practitioners. To overcome this, we argue for: 1) greater awareness and education of the medical profession about the thresholds and requirements for mandatory reporting of health impairment; 2) better integration of specialised doctors' health services into existing regulatory pathways; and 3) continued work to embed a more therapeutic approach to regulatory processes. We hope this translates into better health outcomes for doctors, and safer healthcare for the community.

Contributions

OB and MB developed the initial idea and methodology for the study. OB sought ethical approval and conducted the interviews. OB and MB conducted the thematic analysis. They are also jointly responsible for the overall data as guarantors. OB drafted the manuscript. MB, KJ and MS assisted with the interpretation of results and revised the draft manuscript critically for important intellectual content. All authors have given final approval for the article to be published.

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Declaration of Competing Interest

OB was previously employed by Avant Insurance and is currently employed by the MIPS. While MIPS, Avant and MDA National were involved in facilitating the recruitment of potential participants, they did not have access to study data and had no input into the analysis or interpretation of results.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.ijlp.2022.101857>.

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