PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	DOCTORS ADMITTED TO A PHYSICIANS' HEALTH PROGRAM: A COMPARISON OF SELF-REFERRALS VS. DIRECTED REFERRALS
AUTHORS	Braquehais, María Dolores; Valero, Sergi; Bel, Miquel Jordi; Navarro, María Cecilia; Matalí, Josep Lluís; Nasillo, Viviana; Padrós, Jaume; Arteman, Antoni; Bruguera, Eugeni; Casas, Miquel

VERSION 1 - REVIEW

REVIEWER	Robert L. DuPont, M.D. Institute for Behavior and Health, Inc., United States
REVIEW RETURNED	23-Apr-2014

GENERAL COMMENTS	The goal of the study was to identify demographic and other differences between physicians who were voluntary and involuntary admissions. The findings – for example that the involuntary patients were older, more likely to be male and more likely to be substance abusers – are hard to see as meaningful. My experience is that the distinction of voluntary and involuntary in PHP cases is somewhat arbitrary because virtually all of the "voluntary" admissions to PHPs have someone with a proverbial gun at their heads. I am thrilled to see a PHP study from Spain but I am hard pressed to see this as a meaningful contribution to the PHP literature, other than that it exists at all.

REVIEWER	Debbie Cohen Cardiff University, Wales, UK
REVIEW RETURNED	27-Apr-2014

GENERAL COMMENTS	Abstract The abstract is clear and concise but English language needs to be addressed in places. Strengths and limitations The language here will need to be reviewed. However the authors do not discuss that limitations may also relate to the way the service is presented to users, which is an important consideration. Introduction The introduction is clear but there are some factual errors that relate

	to the PHP services cited. This should be corrected as services in the UK provide treatment as well as basic preventative and counselling services. I am not sure whether line 27 is a language error or not however the authors talk of compulsory actions in all 'countries' but I think they may be referring to the different Colegios de Medicos in the differing Spanish regions – this needs clarification. Methods and results The methods are clearly written and explain the methodology well. The results would benefit from further review of the language to increase the clarity of the difference between being admitted to the programme and in patient admissions. Discussion The discussion again requires attention to English language. The first paragraph talks about compulsory treatments in other countries. If indeed they mean other European countries then this is inaccurate and needs addressing. If they are referring to counties or areas in Spain then it seems this is an accurate reflection from their introduction. The discussion outlines the limitations of the study well as these are an important factor when interpreting this study. However the results do reflect what is known in other studies, particularly about disclosure. It would add to the paper if the authors were able to reflect on this in the discussion, and reference papers on this topic as it is an area at present not remarked on or considered by the authors.

REVIEWER	Joan M Brewster, PhD Dalla Lana School of Public Health University of Toronto Toronto, Canada
REVIEW RETURNED	27-Apr-2014

GENERAL COMMENTS	The issue of encouraging physicians to voluntarily use Physician Health Programs (PHPs) is an important one. Nevertheless, this paper does not examine the issue in enough depth to answer the question. Characteristics of voluntary and non-voluntary referrals to the Spanish PHP are compared via chart review. It is not surprising that voluntary referrals are less likely to have substance use diagnoses (SUD), as resistance to treatment is characteristic of this disorder. The found characteristics of non-voluntary referrals (older, male, SUD) are not specific enough to guide targeting of programs to encourage use of PHPs. Non-voluntary referrals are also more likely to have longer treatment, and more frequent treatment in follow-up. This suggests that physicians who refer voluntarily have less severe problems than those who enter the program non-voluntarily. The unanswered question is why physicians self-refer, and how to encourage more self-referral. Programmatic changes, rather than targeting individuals with specific characteristics, might be a reasonable focus for this question. The authors are aware of the limitation of a chart review study with minimal information. Specific points: • Page 4, line 54: Here, and elsewhere in the paper, the authors refer to "malpractice." In North America, this term refers to specific legal actions. Physicians who are referred to PHPs by their licensing bodies can have a variety of practice difficulties, but not necessarily "malpractice."

	• Page 5, line 30: Should “identified” be “distinguished?” • Page 5, line 34: PHPs usually have a multi-faceted monitoring program, which consists of more than remaining abstinent. • Page 5, bottom paragraph: A clear rationale for the study was not provided. What led the authors to examine this question, and what might be the implications of results? • Page 6, line 13ff: The authors need to give more information about “induced referrals” and how they are distinguished from voluntary referrals. Are induced referrals where a colleague or relative contacted the PHP, or where they encouraged the physician to contact the PHP? Many “voluntary” referrals have been encouraged by colleagues or relatives to seek help. • Page 6, line 42: Provide a reference for the Helsinki declaration. • Page 7, line 30: The proportion of voluntary admissions is very high, especially compared to North American programs. The authors note at the beginning of the discussion that “Most PHPs in other countries are mainly devoted to provide compulsory treatment” (page 8, line 16-18). Despite these findings, the authors look at individual characteristics for reasons for voluntary referral, instead of looking at aspects of the PHP that might encourage voluntary referral.

VERSION 1 – AUTHOR RESPONSE

In answer to Dr. DuPont’s comments:

1) “The findings – for example that the involuntary patients were older, more likely to be male and more likely to be substance abusers – are hard to see as meaningful” and “I am thrilled to see a PHP study from Spain but I am hard pressed to see this as a meaningful contribution to the PHP literature, other than that it exists at all”

Although we recognize the limitations of our study:

- “The main limitations of this study are: a) it is a retrospective chart review; b) there was only one main diagnosis for each patient not obtained after a semi-structured interview; c) the lack of personal and ecological variables from the users, as no data was available in terms of personality traits and/or other psychosocial aspects possibly related to the type of referral to our program” (see Discussion, page 9, lines 7-13).

We have added the following sentences to justify the implications of our work:

- “To the best of the authors’ knowledge, this is the first study that analyzes the traits and clinical needs of those who have entered a PHP. This could help identify which doctors may present greater difficulties in asking for help and should be taken into account when designing preventive and treatment strategies for them” (see Introduction, page 5, lines 8-11).

- “Cross-country comparisons between PHPs are difficult. Data about other PHPs in the US [12] and Canada [13] mainly provide information about non-voluntarily referred sick doctors as a result of substance use disorders. In the UK, the Practitioner Health Program treated 554 practitioners and 20 other professionals during the 2008-2011 period, 85% for mental disorders, 28% for substance use disorders, and 17% for physical problems. Regretfully, no information was available regarding the ways of access to this program. However 29% of patients needed an intervention from the Regulatory Body.[14] In Switzerland [8], during a three-year period, 80 patients were treated at the ReMed program mainly for burn-out and depression (43%) followed by practice and everyday life problems (32%) and only 13% for addictive behaviours. In Norway [7], after analyzing the data of 227 doctors

who had come for counselling to a specific program designed for them, 73% were in need of treatment for anxiety and depression. When analyzing the ways of accessing the program, only 45% were self-referred. No information for cases needing mandatory treatment is available from Switzerland and Norway PHPs". (see Discussion, page 7 lines 20-25 and page 8 lines 1-9).

- "Results from this study should be interpreted cautiously, especially when trying to generalize our findings to other settings. The specific philosophy of our PHP is one aspect to be considered. However, some features of sick doctors with difficulties in seeking help may be similar to those observed in other PHPs. Therefore, preventive and treatment strategies for sick doctors in all countries may benefit from taking into account these findings" (see Discussion, page 9 lines 22-25 and page 10 lines 1-2).

2) "My experience is that the distinction of voluntary and involuntary in PHP cases is somewhat arbitrary because virtually all of the "voluntary" admissions to PHPs have someone with a proverbial gun at their heads".

We agree with this comment. In order to clarify the type of referral we have specified that self-referral to our program is different than other types of referrals (induced by colleagues, working institutions, relatives, etc. or forced by the "Colegio de Médicos"):

- "We classified the types of referrals into two groups: voluntary vs. non-voluntary. We distinguished:
1) Voluntary referrals: patients self-referred to the program.
2) Non-voluntary referrals:
2.1) Induced referral by managers, colleagues or relatives.
2.2) Confidential information about practice problems received by their "Colegio de Médicos".
2.3) Formal complaint to the "Colegio de Médicos" due to practice difficulties". (See Methods, page 5, lines 15-22).

In response to Ms. Cohen's comments:

1) "Abstract: The abstract is clear and concise but English language needs to be addressed in places".

We have revised it (as well as the whole manuscript) with the help of two native English speakers (see Abstract, page 2).

2) "Strengths and limitations: the language here will need to be reviewed. However the authors do not discuss that limitations may also relate to the way the service is presented to users, which is an important consideration"

We have reviewed the language (see Strengths and limitations, page 3, lines 2-12) and we have included that important consideration in several places along the new version of the manuscript:

- "Conclusions: Type of referral to a PHP may be influenced not only by sick doctors' personal traits but also by each program's design and how it is perceived by service users" (see Abstract, page 2, lines 18-20).

- "Type of referral may be influenced by sick doctors' personal traits as well as by the specific nature of PHP programs and how they are presented to users" (see Strengths and limitations, page 3, lines 11-12)

- "However, the specific nature of our PHP should be taken into account when interpreting our results.

Patients may feel encouraged to seek help in our program where voluntary referrals are promoted and mandatory actions are only applied to cases at risk or in evidence of practice problems. Therefore, type of referral may be influenced not only by the sick doctors' problems but also by each PHP's design including how it is presented to service users". (see Discussion, page 8, lines 17-22).

3) "Introduction:
3.1) "The introduction is clear but there are some factual errors that relate to the PHP services cited. This should be corrected as services in the UK provide treatment as well as basic preventative and counselling services"

We have left the sentences about PHPs as follows:
- "The first specific programs for physicians (Physicians' Health Programs, PHPs) suffering from mental disorders (i.e. sick doctors) were developed in USA since the late 1970s with the main aim of preventing malpractice behaviors, mainly related to drug and alcohol misuse.[1-3] Programs with intensive preventive and treatment interventions were developed later on in Canada,[4] Australia,[5] and the UK[6]. Norway[7] and Switzerland[8] mainly offer preventive and counselling services for doctors. Some French regions are currently working to implement similar programs for their practising physicians". (see Introduction, page 4, lines 2-9).

And we have added a description of the services provided by the UK PHP in the Discussion section:

- "In the UK, the Practitioner Health Program treated 554 practitioners and 20 other professionals during the 2008-2011 period, 85% for mental disorders, 28% for substance use disorders, and 17% for physical problems. Regretfully, no information was available regarding the ways of access to this program. However 29% of patients needed an intervention from the Regulatory Body". (see Discussion, page 8, lines 22-25 and page 9, lines 1-2).

3.2) "I am not sure whether line 27 is a language error or not however the authors talk of compulsory actions in all 'countries' but I think they may be referring to the different Colegios de Medicos in the differing Spanish regions – this needs clarification".

We have clarified:

"The Spanish PHP promotes voluntary treatment as well as enrollment for preventive interventions. Treatment becomes obligatory only when risk or evidence of practice difficulties are identified. Mandatory actions can oblige sick doctors to undergo psychiatric treatment; if they suffer from an addictive disorder this includes proving abstinence once treatment has been completed. The final objective of all these interventions is to help sick doctors recover their personal wellbeing and help them go back safely to their professional practice" (see Introduction, page 4, lines 19-25).

4) "Methods and results: The methods are clearly written and explain the methodology well. The results would benefit from further review of the language to increase the clarity of the difference between being admitted to the programme and inpatient admissions".

We have revised the language and we have added the following statement to clarify the types of treatment patients receive once they are admitted to the Programme:

- "If, after a clinical evaluation, a mental disorder is identified, the sick doctor is offered outpatient or inpatient treatment depending on the severity of each case". (see Methods, page 5, lines 23-24).

5) "Discussion: the discussion again requires attention to English language. The first paragraph talks about compulsory treatments in other countries. If indeed they mean other European countries then

this is inaccurate and needs addressing. If they are referring to counties or areas in Spain then it seems this is an accurate reflection from their introduction. The discussion outlines the limitations of the study well as these are an important factor when interpreting this study. However the results do reflect what is known in other studies, particularly about disclosure. It would add to the paper if the authors were able to reflect on this in the discussion, and reference papers on this topic as it is an area at present not remarked on or considered by the authors".

In the discussion, we have focused on the type of referral and in the difficulties in generalizing our findings to other settings due to the specific nature of our PHP. Cross-country comparisons are difficult as, for instance, Regulatory Bodies are not separated institutions in some countries (e.g. Spain, France, etc.). Nevertheless, we have completed our discussion with the following sentences:

- "Cross-country comparisons between PHPs are difficult. Data about other PHPs in the US [12] and Canada [13] mainly provide information about non-voluntarily referred sick doctors as a result of substance use disorders. In the UK, the Practitioner Health Program [14] treated 554 practitioners and 20 other professionals during the 2008-2011 period, 85% for mental disorders, 28% for substance use disorders, and 17% for physical problems. Regretfully, no information was available regarding the ways of access to this program. However 29% of patients needed an intervention from the Regulatory Body.[14] In Switzerland [8], during a three-year period, 80 patients were treated at the ReMed program mainly for burn-out and depression (43%) followed by practice and everyday life problems (32%) and only 13% for addictive behaviours. In Norway [7], after analyzing the data of 227 doctors who had come for counselling to a specific program designed for them, 73% were in need of treatment for anxiety and depression. When analyzing the ways of accessing the program, only 45% were self-referred. No information for cases needing mandatory treatment is available from Switzerland and Norway PHPs [7-8]". (see Discussion, page 8, lines 20-25, and page 9, lines 1-9).

- "Despite the differences between PHPs, mandatory actions in different countries have in common that once malpractice problems are identified, sick doctors are obliged to undergo psychiatric treatment and if they suffer from an addictive disorder they have to remain abstinent. Otherwise, their license to practice will temporarily or definitively be suspended [12-14]". (see Discussion, page 8, lines 10-14).

In response to Dr. Brewster's comments:

1) "The issue of encouraging physicians to voluntarily use Physician Health Programs (PHPs) is an important one. Nevertheless, this paper does not examine the issue in enough depth to answer the question. Characteristics of voluntary and non-voluntary referrals to the Spanish PHP are compared via chart review. It is not surprising that voluntary referrals are less likely to have substance use diagnoses (SUD), as resistance to treatment is characteristic of this disorder. The found characteristics of non-voluntary referrals (older, male, SUD) are not specific enough to guide targeting of programs to encourage use of PHPs. Non-voluntary referrals are also more likely to have longer treatment, and more frequent treatment in follow-up. This suggests that physicians who refer voluntarily have less severe problems than those who enter the program non-voluntarily. The unanswered question is why physicians self-refer, and how to encourage more self-referral. Programmatic changes, rather than targeting individuals with specific characteristics, might be a reasonable focus for this question. The authors are aware of the limitation of a chart review study with minimal information".

We have carefully considered these reflections and included some sentences in the text in line with Dr. Brewster's concerns:

- "To the best of the authors' knowledge, this is the first study that analyzes the traits and clinical

needs of those who have entered a PHP. This could help identify which doctors may present greater difficulties in asking for help and should be taken into account when designing preventive and treatment strategies for them (see Introduction, page 5, lines 8-11)".

- "In our PHP, we have observed that doctors are more likely to voluntarily ask for help when they are women and suffer from non-substance use disorders. Those self-referred are also younger when comparing to those whose way of access has been non-voluntary. These results suggest that doctors with addiction problems tend to delay seeking help, maybe because they fear the consequences of their demand [15]. In line with other studies, women physicians are more likely to ask for help when they suffer from mental distress than their male counterparts.[16]
However, the specific nature of our PHP should be taken into account when interpreting our results. Patients may feel encouraged to seek help in our program where voluntary referrals are promoted and mandatory actions are only applied to cases at risk or in evidence of practice problems. Therefore, type of referral may be influenced not only by the sick doctors' problems but also by each PHP's design including how it is presented to service users". (see Discussion, page 8, lines 15-25 and page 9, lines 1-2).

- "Our group has recently suggested that a non-punitive philosophy for sick doctors may encourage help seeking amongst them. Since it was created in 1998, self-referrals to the Barcelona PHP have grown from 81.3% during the first years to 91.5% in the last period.[17]" (see Discussion, page 9, lines 3-6).

- "Results from this study should be interpreted cautiously, especially when trying to generalize our findings to other settings. The specific philosophy of our PHP is one aspect to be considered. However, some features of sick doctors with difficulties in seeking help may be similar to those observed in other PHPs. Therefore, preventive and treatment strategies for sick doctors in all countries may benefit from taking into account these findings" (see Discussion, page 9 lines 22-25 and page 10 lines 1-2).

2) "Page 4, line 54: Here, and elsewhere in the paper, the authors refer to "malpractice." In North America, this term refers to specific legal actions. Physicians who are referred to PHPs by their licensing bodies can have a variety of practice difficulties, but not necessarily "malpractice."

We have generally used the terms "practice difficulties" or "practice problems" instead of "malpractice" along the new version of the manuscript.

3) "Page 5, line 30: Should "identified" be "distinguished?"

We have rewritten that sentence as follows:

- "We classified the types of referrals into two groups: voluntary vs. non-voluntary. We distinguished (…)". (see Methods, page 5, lines 15-16).

4) "Page 5, line 34: PHPs usually have a multi-faceted monitoring program, which consists of more than remaining abstinent".

We have completed the previous statements with that broader view of our PHP's interventions.

- "The Spanish PHP promotes voluntary treatment as well as enrollment for preventive interventions. Treatment becomes obligatory only when risk or evidence of practice difficulties are identified. Mandatory actions can oblige sick doctors to undergo psychiatric treatment; if they suffer from an

addictive disorder this includes proving abstinence once treatment has been completed. The final objective of all these interventions is to help sick doctors recover their personal wellbeing and help them go back safely to their professional practice". (see Introduction, page 4, lines 23-25).

5) "Page 5, bottom paragraph: A clear rationale for the study was not provided. What led the authors to examine this question, and what might be the implications of results?"

We have added the following sentences to the Introduction section:

- "To the best of the authors' knowledge, this is the first study that analyzes the traits and clinical needs of those who have entered a PHP. This could help identify which doctors may present greater difficulties in asking for help and should be taken into account when designing preventive and treatment strategies for them (see Introduction, page 5, lines 8-11)".

6) "Page 6, line 13ff: The authors need to give more information about "induced referrals" and how they are distinguished from voluntary referrals. Are induced referrals where a colleague or relative contacted the PHP, or where they encouraged the physician to contact the PHP? Many "voluntary" referrals have been encouraged by colleagues or relatives to seek help".
We have clarified the different types of referrals as follows:

- "We classified the types of referrals into two groups: voluntary vs. non-voluntary. We distinguished:
1) Voluntary referrals: patients self-referred to the program.
2) Non-voluntary referrals:
2.1) Induced referral by managers, colleagues or relatives.
2.2) Confidential information about practice problems received by their "Colegio de Médicos".
2.3) Formal complaint to the "Colegio de Médicos" due to practice difficulties". (See Methods, page 5, lines 15-22).

7) "Page 6, line 42: Provide a reference for the Helsinki declaration"

We have included it (see reference no. 10).

8) "Page 7, line 30: The proportion of voluntary admissions is very high, especially compared to North American programs. The authors note at the beginning of the discussion that "Most PHPs in other countries are mainly devoted to provide compulsory treatment" (page 8, line 16-18). Despite these findings, the authors look at individual characteristics for reasons for voluntary referral, instead of looking at aspects of the PHP that might encourage voluntary referral."

We have considered this reflection and have included it in several places:

- "Conclusions: Type of referral to a PHP may be influenced not only by sick doctors' personal traits but also by each program's design and how it is perceived by service users" (see Abstract, page 2, lines 18-20).

- "Type of referral may be influenced by sick doctors' personal traits as well as by the specific nature of PHP programs and how they are presented to users" (see Strengths and limitations, page 3, lines 11-12)

- "However, the specific nature of our PHP should be taken into account when interpreting our results. Patients may feel encouraged to seek help in our program where voluntary referrals are promoted and mandatory actions are only applied to cases at risk or in evidence of practice problems. Therefore, type of referral may be influenced not only by the sick doctors' problems but also by each

PHP's design including how it is presented to service users". (see Discussion, page 8, lines 17-22).

- "Results from this study should be interpreted cautiously, especially when trying to generalize our findings to other settings. The specific philosophy of our PHP is one aspect to be considered. However, some features of sick doctors with difficulties in seeking help may be similar to those observed in other PHPs. Therefore, preventive and treatment strategies for sick doctors in all countries may benefit from taking into account these findings" (see Discussion, page 9 lines 22-25 and page 10 lines 1-2).

VERSION 2 – REVIEW

REVIEWER	Joan M Brewster University of Toronto Toronto, Canada
REVIEW RETURNED	11-Jun-2014

GENERAL COMMENTS	Most of the concerns from the first review have been addressed. Specific comments: Page 6: Are "induced referrals" by colleagues, relatives, etc., or are these "voluntary" but encouraged by colleagues or relatives? This needs to be clarified. Page 9, line 25: "malpractice" should be "practice." Page 10: lines 27-28: What does it mean that diagnoses were "not" obtained after a semi-structured interview?

VERSION 2 – AUTHOR RESPONSE

We want to thank the reviewer, Dr. Brewster, who has added new comments to improve the quality of our work.
We have revised the content of the manuscript according to his recommendations. All changes are highlighted in yellow in the new version of our manuscript.

In response to his comments:

- Page 6. Are "induced referrals" by colleagues, relatives, etc., or are these "voluntary" but encouraged by colleagues or relatives? This needs to be clarified"

We have clarified the type of referral from the title page to the abstract and have changed the distinction between "voluntary vs. non-voluntary referrals". Instead, we have decided to differentiate between "self-referrals" and "directed referrals" or "non-self-referrals" (see all changes highlighted in yellow along the text). Besides," induced referrals" are better defined at the Methods section (they can be either induced or encouraged by colleagues, relatives or managers). We believe this new denomination is more accurate and we are grateful to the reviewer for his thoughtful observation in this sense.

- Page 9, line 25: "malpractice" should be "practice".
We have changed it.

- Page 10: lines 27-28: What does it mean that diagnoses were "not"obtained after a semi-structured interview?"
We have clarified that diagnoses were not obtained after a "structured" (not semi-structured) interview

such as the SCID (and added its reference-see reference no. 18).

We have also corrected the title of Table 1 and have written “type of referral” instead of “type of admission”.