Mandatory reporting, doctors' health and ethical obligations

Malcolm H Parker

To the Editor: Before and since 1 July 2010, when the National Registration and Accreditation Scheme for health practitioners commenced, the claim that mandatory reporting laws will deter impaired doctors from seeking help has frequently been made. It was on the basis of this claim that Western Australia legislated to exempt health professionals from reporting impaired practitioners they are treating. At a recent conference of the Royal Australian College of General Practitioners, a representative of a medical indemnity organisation labelled the mandatory reporting laws a disgrace because the health of impaired doctors who are deterred from seeking help for this reason would be put at risk. However, she also indicated that the problem was more one of perception than reality because doctors feared triggering a mandatory report automatically if they sought help from another doctor for a perceived impairment.[1] It is a problem of perception because, under the laws, only doctors whose impairment places the public at risk of "substantial" harm are required to be reported.[2]

If doctors have an unreasonable fear of mandatory reporting, we can infer that many are unaware of the details of the laws, in particular the reporting thresholds. Yet an argument against introducing the laws was that doctors were already under an ethical obligation to report, to the relevant authority, unprofessional conduct, impairment or performance that would put patients at risk.[3] For this argument to be valid, doctors would need to be aware of the details of mandatory reporting because the Medical Board of Australia's code of conduct for doctors states, in its list of ethical obligations, that doctors should be aware of their reporting obligations.[4] So this particular argument does not appear to be valid.

Because medical professionalism puts the wellbeing of the patient first; because psychological or physical health status may affect professional performance; and because the Board, like the state boards that preceded it, has a primary duty to the safety of the public — any doctor whose impairment poses a substantial risk or, in the absence of that doctor's insight, any treating doctor who considers that a substantial risk exists should surely feel ethically compelled to report the matter to the Board. No doctor whose impairment does not pose a substantial risk should feel deterred from seeking medical help.

The consequences for impaired doctors who are reported under the new legislation are no different from those of reporting a doctor when it was "merely" an ethical requirement — being placed on an impaired practitioners' register and supported, managed and monitored, while, in most cases, continuing to practise. If impaired doctors and their treating doctors feel deterred by mandatory reporting laws, we are entitled to conclude that there was, and continues to be, significant non-compliance with the ethical obligations that arguments against mandatory reporting depend on.

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1 East M. Doctors' health at risk with new laws. *Australian Doctor* 2010; 22 Oct: 4.
2 *Health Practitioner Regulation National Law Act 2009* (Qld) s. 140(c). http://www.legislation.qld.gov.au/LEGISLTN/ACTS/2009/09AC045.pdf (accessed Jan 2011).
3 Brand D. Working towards an outcome for your profession. *Doctor Q* 2008; Dec: 7.
4 Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia. http://www.medicalboard.gov.au/Codes-and-Guidelines.aspx (accessed Jan 2011). ❑

Occult lead poisoning from Ayurvedic medicine produced, prescribed and purchased in India

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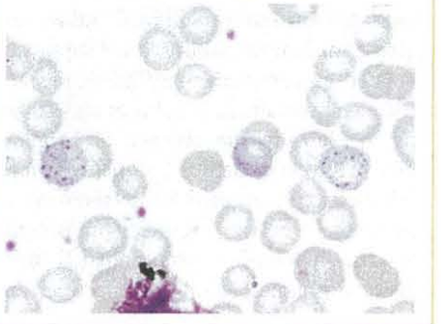
To the Editor: A 28-year-old man presented to his general practitioner with a history of epigastric pain and constipation over 1 month. In addition, he had a history of chronic low back pain. Findings on physical examination were unremarkable. Laboratory investigations showed normochromic, normocytic anaemia with basophilic stippling (Box 1). His whole-blood lead level was subsequently estimated to be 4.12 μmol/L (level recommended by the National Health and Medical Research Centre for all Australians, < 0.48 μmol/L). The patient was referred for toxicological review. Further questioning revealed he had used three Ayurvedic medicines (Vatyog [Arya Aushadhi Pharmaceutical Works, Indore, India], Sahacharadi [Arya Vaidya Nilayam, Madurai, India] and Gandharvahastadi [Arya Vaidya Nilayam, Madurai, India]) for back pain, dispensed to him 3 months earlier during a trip to India. He ceased taking the medications, and a 19-day course of oral chelation with succimer was administered. His blood lead concentration fell rapidly, with a moderate rebound 6 weeks after the completion of chelation therapy. A negative blood lead result for the patient's pregnant partner excluded environmental exposure in the patient's home.

1 Blood film from the patient showing coarse basophilic stippling



Vatyog and Sahacharadi were analysed for heavy metals (Gandharvahastadi was not available for analysis). Sahacharadi was lead-free, but the Vatyog tablet tested contained 448 μg of lead. The patient had potentially ingested 896 μg of lead daily for 3 months. World Health Organization guidelines recommend daily lead intake should not exceed 3.5 μg/kg/day.[1] Dietary intake of lead in developed nations has been reported to be about 0.1–0.7 μg/kg/day.[1]

Ayurvedic medicine originated in India more than 2000 years ago and relies heavily on herbal products.[2] Many people take Ayurvedic medicine without any problems. In some traditional remedies, salts of heavy metals are included as active ingredients.[3] A study in the United States found that one-fifth of Ayurvedic herbal products manufactured in

2 Packaging from the lead-containing Ayurvedic medicine