Your details

Name:

This submission has been developed by a working group of members of the Australian and New Zealand Society of Occupational Medicine (ANZSOM), including:

[redacted]

Organisation (if applicable):

Australian and New Zealand Society of Occupational Medicine

The Australian and New Zealand Society of Occupational Medicine (ANZSOM) is the peak body for medical practitioners and other health professionals who practice in occupational medicine, environmental medicine and workplace health more generally. Our members include specialist occupational and environmental physicians, general practitioners, occupational health nurses and allied health professionals, who work in various industries and settings to help manage workplace risks and protect and manage workers' health.

Our members consider medical issues within the wider context of their psychosocial, industrial, and motivational frameworks, and have a key role in communicating with employers, business and government. They focus on the health effects of the relationship between workers and their work lives, at both an individual and an organisational level. This includes considering the needs of culturally and linguistically diverse workers.

Are you making a submission as?

- ☒ An organisation
- ☐ An individual medical practitioner
- ☐ Other registered health practitioner, please specify:
- ☐ Consumer/patient
- ☐ Other, please specify:
- ☐ Prefer not to say

Do you give permission to publish your submission?

- ☐ Yes, with my name
- ☐ Yes, without my name
- ☐ No, do not publish my submission

YES, with the name of the organisation

Feedback on the Consultation regulation impact statement

The Medical Board of Australia is consulting on three options to ensure late career doctors are able to keep providing safe care to their patients.

The details of the options for consideration are contained in the consultation regulation impact statement.

1. Should all registered late career doctors (except those with non-practising registration) be required to have either a health check or fitness to practice assessment?

If not, on what evidence do you base your views?

Summary

The Australian and New Zealand Society of Occupational Medicine (ANZSOM) welcomes the opportunity to comment on the Australian Health Practitioner Regulation Agency (AHPRA) Consultation document. Members of ANZSOM have extensive experience and expertise regarding medical examinations for safety critical workers regarding their fitness to work.

ANZSOM is opposed to the proposal to require medical examinations or health checks of practising doctors aged 70 and over. It is considered the problem has not been adequately defined and there is insufficient evidence that the proposed solution will address AHPRA's concerns by reducing notifications or improving patient safety. Additionally, the proposed assessment structure does not have a strong evidence base, is unlikely to be cost-effective *and will create a moral hazard for examining doctors.*

ANZSOM contends that there may be more appropriate and cost-effective ways to achieve the desired outcome and has *included suggestions* in this response.

1. Introduction

APHRA has identified that older doctors (70+ years) have a higher rate of notifications than younger doctors (<70 years) and a recent rapid rise in notifications regarding doctors over 70 years old. It attributes this pattern to an increase in physical and cognitive issues with age and proposes a medical solution in the form of health checks and cognitive assessments. However, the rationale for linking the rise in notifications to the proposed solution of medical examinations is lacking. This is partly because the problem has not been adequately analysed and defined and partly because the proposed solution is problematic in itself. These two deficiencies are discussed in detail in this submission.

2. Deficiencies in analysing and defining the problem

The deficiencies include a failure to adequately analyse the problem and to show that the rise in notifications is due to health problems, as well as a failure to consider alternative explanations for the rise.

2.1 Analysis and definition of the problem by APHRA

AHPRA Is concerned about the rapid rise in notifications. Analysis of this phenomena first requires an understanding of what makes a notification. A notification represents a person's perception that the service provided was sub-optimal and then a decision to report it. This is a blunt instrument with which to measure doctors' performance. Notifications for doctors 70 years and older have nearly doubled (1.9) between 2015 (36.2/1000) and 2023 (69.5/1000). It is unlikely that the health of doctors has deteriorated so much over eight years, that this could explain this increase. Therefore, changes in notification numbers may reflect social factors (such as ageism or a perceived sense of entitlement) leading to reporting as much as they do changes in actual performance. Ill health may be one reason for poor service but by no means the only one (refer to Section 2.3).

APHRA has broadly grouped notifications into 17 categories. The most common were notifications regarding clinical care, communication and pharmacological/medication (table 1, p24). It is not clear whether these notifications have been validated and proven or, equally importantly, how many notifications were made but were not upheld. Until the data is presented in more refined detail, it is difficult to see where a medical solution would be appropriate.

Clinical care issues and prescribing errors are noted in the APHRA consultation paper, and there appears to be an assumption that these are due to cognitive decline. It should be noted that alternative explanations are possible, such as failure to keep abreast of recent advances in diagnosis and treatment and lack of IT skills to access information regarding possible adverse drug interactions or current management of unusual conditions. These latter deficiencies in practice will not be addressed by medical examinations but by improved continuing professional development (refer to Section 4. A better approach).

A major failing of the justification for medical assessment of older doctors proposed by AHPRA is that although there is some evidence that there is a decline in performance and patient outcomes with increasing practitioner age, no evidence is presented that medical examinations would be able to identify the practitioners at risk or prevent notifications. It is hard to justify a complex system of medical assessments if they may not address the problem.

2.2 Attribution of notifications to health problems

The paper by Thomas *et al*. is a key paper on which AHPRA bases its concerns and solutions, being the only paper which analyses the notifications of Australian doctors over the time period 2011-2014. (Note, the analysis by Thomas *et al*. covers a different time period from the period of rapid rise in notifications, 2015 – 2023, that concerns APHRA, so its findings may not be applicable).

The paper by Thomas *et al*. has several shortcomings. Firstly, the analysis of data is misleading in places. The authors state, "The vast majority [of senior doctors] (86.8%) did not receive a notification". Later in the paper, they state, "Nonetheless, as a group, the older doctors had a higher overall notification rate than the younger colleagues" (page 5). However, elsewhere (page 3), they state that the number of younger doctors who had no notification is 84.2%, which is a direct contradiction to their latter statement.

Secondly, the paper overrepresents the role of cognitive decline in the number of notifications. Thomas *et al*. calculate a Standardised Incidence Ratio of 15.54 on comparison of older and younger doctors regarding cognitive decline. They show this dramatic relative statistic in the summary of the paper. However, from Table 2 we can see that the absolute number of notifications due to cognitive decline in older doctors is only 72; i.e. 4.3% of 1607 notifications. This puts a very different perspective on the size of the problem of cognitive decline in older doctors.

Finally, the Thomas paper does not offer a clear rationale for why medical examinations are the solution to the rise in notifications similar to AHPRA (see above). This would require evidence that notifications in older doctors relate to cognitive or physical health issues and that there has been resulting harm which could have been prevented by a health assessment. The paper by Thomas *et al*. shows that 95% of notifications were for "performance concerns" (e.g. prescribing errors) or "conduct concerns" (e.g. inadequate record-keeping); it is by no means clear how medical examinations would help reduce these notifications.

Thomas et al. Health, performance and conduct concerned among older doctors. Journal of Patient Safety and Risk Management. 2018. 1-9

2.3 Alternative explanations for increased notifications

While it is important to identify relevant health issues, it is also important to consider other explanations for the rise in notifications of late-career doctors.

For example, some late-career doctors may opt out of the strenuous demands of regular practice but still wish to contribute their extensive knowledge and experience to the community. Medico-legal practice offers an attractive alternative, and there are numerous organisations that seek to engage the services of such doctors. Writing reports that are adverse to claimants is anecdotally known to attract complaints with a view to discrediting the doctor and, hence, the report.

It is important in analysing the rise of notification of late-career doctors that the proportion arising from medico-legal work (and other alternatives and alternative explanations) is assessed. This may reflect a shift from regular practice into an area prone to complaints and does not necessarily show cognitive decline or other problems in practice by late-career doctors.

The possibility that difficulties with IT skills in older doctors may underlie some prescribing errors should be more fully considered particularly as it was also pointed out by Thomas *et al*. Rectifying this problem would require a very different solution from medical examinations.

Across this whole topic is the question of ageism. People of different ages are stereotyped, and there are cognitive biases with every age group. Ageism is common in Australia. The Australian Human Rights Commission has reported that ageism affects every aspect of life. It is the most pervasive form of prejudice and is often embedded in humour making it more socially acceptable.

Australian Human Rights Commission 2021. What's age got to do with it? A snapshot of ageism across the Australian lifespan, September 2021 ISBN 978-1-925917-55-0

3. Deficiencies in the proposed solution of medical examinations/health check

3.1 Defining physical and cognitive requirements (i.e. the inherent requirements) for safe medical practice

To assess an individual's fitness for a particular role, the inherent requirements of the job and the physical and cognitive requirements to perform it must be defined and standards set. This allows the health practitioner to fairly assess the worker with reference to clear standards. Examples of this are the Australian national vehicle driver medical standards *Assessing Fitness to Drive* and the *National Standard for Health Assessment of Rail Safety Workers*. These evidence-based documents have been created through many years of research and consultation. (Members of ANZSOM have been central to development of these documents). This process has yet to be carried out for doctors whilst recognising the great diversity of practices, yet it would be necessary to support the proposed health checks.

Guidance for General Practitioners is available in the form of recommendations for health screening activities at different life stages for general health but not for employment. These do not offer guidelines applicable to fitness for medical practice.

For example, whilst it is necessary to enquire about genitourinary function as an assessment of general health it is an irrelevant question regarding ability to perform medical practice.

3.2 Sensitivity and specificity of examination for cognitive function

Assessment of cognitive function is central to this proposal for health checks but, as correctly identified in the discussion paper and the paper by Thomas *et al*., there is no agreement on which, if any, tests have adequate sensitivity and specificity relevant to medical practice.

Tests for cognitive decline (such as the MoCA) are designed for use in a clinical situation and not for screening. In a clinical situation, the doctor is assessing a clinical concern or symptom, and the probability that the patient has cognitive decline (i.e. the pre-test probability) is reasonably high. Therefore, if the test is positive, the doctor can be reasonably confident that the patient has cognitive decline. In other words, the positive predictive value (PPV) will be high, and the number of false positives will be low. If, however, the test is used in a screening situation the pre-test probability for cognitive decline will be low. The same test will then have a low positive predictive value, and the number of false positives will be high.

The MoCA has been reported to have a sensitivity of 90% and a specificity of 87% using a cutoff of 26 points. (Ziad *et al* 2005). The AIHW reports the prevalence of dementia in Australia for the 70 to 74 age group as 41/1000. Using the published sensitivity and sensitivity for MoCA given above, we can calculate that the Positive Predictive Value for the MoCA to detect cognitive decline (at cut point 26) for this age group is 22.84%. That is, for 100 people who test positive with this test 77% will falsely test positive. That is, they will be falsely accused of suffering cognitive decline.

A false positive diagnosis of cognitive decline would be devastating for a doctor and would end their career as easily as would a true diagnosis by raising doubt for the doctor as well as their patients, family and medicolegal organisations including AHPRA.

The use of any clinical test in a screening situation is inadvisable, and screening for cognitive impairment is likely to have consequences for some innocent people.

Ziad S et al The Montreal Cognitive Assessment, MoCA: A Brief Screening Tool For Mild Cognitive Impairment J Am Geriatrics S: 2005; 53(4), 695-699 https://doi.org/10.1111/j.1532-5415.2005.53221.x

AIHW Dementia in Australia. https://www.aihw.gov.au/reports/dementia/dementia-in-aus/contents/population-health-impacts-of-dementia/prevalence-of-dementia#

3.3 Moral hazard to general practitioners

It is unclear whether the purpose of this assessment is a true Fitness for (safety-critical) Work Assessment (which should be carried out by an Occupational and Environmental Medicine (OEM) Specialist or otherwise specifically trained and accredited doctor) or a general health check. It is financially and logistically unfeasible for all the assessments to be carried out by OEM Specialists, and therefore the doctor's

general practitioner (GP) would be carrying out either a fitness for work assessment or a general health assessment.

If the former, then the doctor's GP would be placed in a difficult medicolegal situation, where they are being asked to conduct an assessment without having any clear standards to refer to or any defined workplace requirements. As the doctor's usual treating doctor this would cause a conflict of interest and place the doctor-patient relationship at risk. This potential conflict of interest has been studiously avoided in other safety critical work standards (e.g. Health assessment of rail workers) and would be in direct contrast with the intent of AHPRA and all medical colleges that every doctor should have their own GP.

If the intent is the latter, a general health check, then there is no need for a new structured assessment, and doctors could be required simply to attend for the existing 75-year-old health check and attend their GP regularly.

Either way the proposal suggests that the results will not be sent to AHPRA, even if there are issues detected and even if there is a subsequent related AHPRA notification. The GP is not required to report their colleague unless they are concerned about significant risk, but there is no guidance on what would constitute a risk level requiring a mandatory report.

However, we would assume that in the case of a significant adverse event and legal proceedings, the GP records would be subpoenaed, and this places the GP in an unclear situation medicolegally, where they are being asked to conduct an assessment without enough clarity to ensure they are qualified to conduct it.

The purpose for which personal information is being collected must be clearly stated or it violates Privacy legislation. This is important for both the doctor/GP collecting the information and the patient/older doctor giving the information. This is relevant to the design of the forms C1 and C2.

3.4 Lack of evidence for the benefits of age-based fitness for work screening

There is little evidence that arbitrary age-based examinations for safety critical work are useful.

For example, several state/territory driver licensing authorities require age-based fitness-to-drive assessments (ACT (75 years), NSW (75 years), QLD (75 years), SA (70 years) and WA (80 years). Victoria and the Northern Territory do not have such testing requirements. A careful examination of driving accident rates in NSW and Victoria by Monash University Accident Research Centre found no difference between the two states (Langford *et al*. 2008).

Many other safety critical workers, for example rail workers, require periodic examinations throughout their working lifetime and increased frequency of examination in older workers. This is quite different from imposing an arbitrary examination at a certain age.

The discussion paper cites various countries which require examination of doctors over certain ages but gives no evidence that these examinations are beneficial. Similarly, the discussion paper cites other professions which require compulsory retirement at various ages but does not cite evidence that shows these compulsory retirements to be beneficial.

The discussion paper lacks an evidence base that shows medical examinations of late career doctors would lead to better outcomes for patients.

Langford J, Bohensky M, Koppel S, Newstead S. Do age-based mandatory assessments reduce older drivers' risk to other road users? Accid Anal Prev. 2008 Nov;40(6):1913-8

3.5 Cost-benefit concerns

3.5.1 Will Medicare rebates be available for health assessments?

AHPRA and the Dept of Health and Aged Care would need to clarify whether and which Medicare item numbers can be accessed for these assessments. Usually, examinations conducted for occupational or employment purposes are non-rebatable, and the added cost of this for older doctors may deter them from continuing to work, leading to workforce shortages

AHPRA suggests in the consultation paper that GPs could use Medicare item number 707, which is available annually from the age of 75. This does not cover 70- to 75-year-olds, and the guidelines for the item number would need to be adjusted to cover the required assessment.

3.5.2 Are mandatory nonspecific medical examinations cost-effective?

Any new initiative, whether funded by the taxpayer or privately, should be rational and effective and offer value for money. Once introduced it would be difficult to alter the screening program again, so it is important to ensure that a cost/benefit analysis supports this proposal.

The paper by Thomas *et al*. gives information regarding the number of older doctors required to be examined to identify one doctor with a medical condition likely to lead to a notification. Table 3 shows that 100 of the 1607 notifications older doctors were for “all health concerns”, and by similar calculation, 72 were for “physical illness/cognitive decline”. There were 7627 registered older doctors in the three-year survey. Therefore, assuming using excellent screening tools (which we have already demonstrated are not available in the case of cognitive decline) the NNT to detect one case of “all health concerns” is 76 and for “Physical illness/cognitive decline”, 106. These figures would be higher if examinations were required annually. It is highly debatable that this is an economically sound practice, particularly when based on only 3 years of data.

4. A better approach to managing concerns about medical practitioner performance

ANZSOM contends there is a better approach to achieving AHPRA's objective of improving practices associated with notifications utilising a combination of strategies outlined below.

1. ***The current practice of requiring doctors to self-declare to AHPRA at the time of annual reregistration that they are in good health with regard to their ability to practice safely should remain.***

Plus

2. ***Doctors for whom a notification is made, and a medical factor is discerned to be important should be referred, on a case-by-case basis, for an appropriate medical examination.***

Plus

3. ***Continuing Professional Development (CPD)***

   Given that there has been a large amount of work in recent years to develop CPD as a means of ensuring good practice this would be a logical base on which to build improved practices in general to avoid notifications.

   The Royal Australasian College of Physicians (RACP) CPD program requires that every physician has an annual conversation with a colleague. The template for this includes aspects of health and encourages the doctor to reflect on their own health with a trusted colleague. This is very similar to the idea of every doctor having a health assessment.

   On 12 September 2024, the RACP advised all Fellows of "Important updates to the 2025 CPD Framework", which stated that "Beyond the existing focus on embedding cultural safety, for 2025 Fellows will need to embed ethics and professional behaviour in their CPD activities. You will be required to undertake and record a minimum of two activities that relate to ethics and professional behaviour and two activities focusing on cultural safety, including addressing health inequities". This provides an opportunity for AHPRA to work with others to improve medical practices that may contribute to increased notifications.

   This professional lifetime activity to improve practice broadly from the ethical and behavioural point of view would benefit doctors of all ages and help to develop a culture of self-reflection and self-care. This approach would empower doctors to take responsibility for their own health and avoid the concern regarding ageism in the proposal for compulsory medical examinations for doctors aged 70 and over.

Conclusion

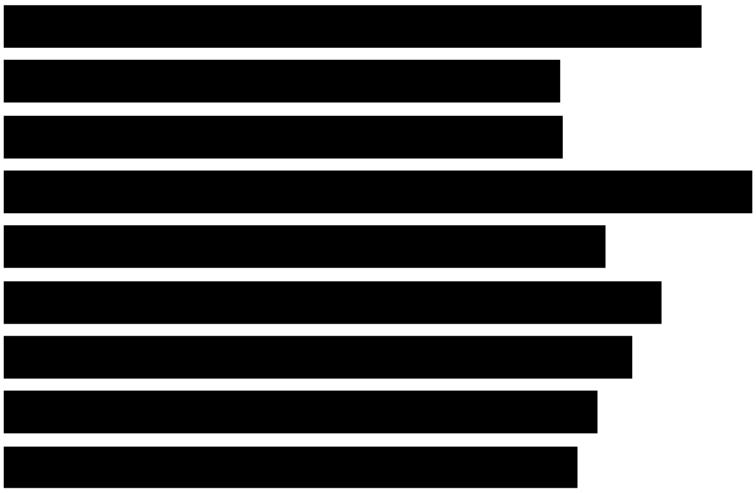
In conclusion, we have shown above that there are significant flaws in the current AHPRA proposal.

The problem has not been adequately defined and there is insufficient evidence that the proposed solution of medical examinations will reduce notifications or improve patient safety. The proposed assessment structure does not have a strong evidence base, is unlikely to be cost-effective and will create a moral hazard for examining doctors.

We do, however, welcome the conversation prompted by the paper, which is a timely opportunity to improve the experience of both patients and doctors by introducing a robust and evidence-based structure for doctors' professional and personal development.

ANZSOM would welcome the opportunity to discuss this submission further and to advise regarding implementation of initiatives proposed by AHPRA.

This submission has been compiled by an ANZSOM Working Group convened by the ANZSOM General Council, comprising:



It has been endorsed by the ANZSOM General Council

5. If a health check or fitness to practise assessment is introduced for late career doctors, should the check commence at 70 years of age or another age?

See response to Question 1. ANZSOM does not support routine health checks for late career doctors as a strategy for reducing notifications.

6. Which of the following options do you agree will provide the best model? Which part of each model do you agree/not agree with and on what evidence do you base your views?

Option 1 **Rely on existing guidance, including Good medical practice: a code of conduct for doctors in Australia (Status quo).**

Option 2 **Require a detailed health assessment of the 'fitness to practise' of doctors aged 70 years and older every three years for doctors from the age of 70 and annually for doctors from the age of 80.**

These health assessments are undertaken by a specialist occupational and environmental physician and include an independent clinical assessment of the current and future capacity of the doctor to practise in their particular area of medicine.

Option 3 **Require general health checks for late career doctors aged 70 years and older every three years for doctors from the age of 70 and annually for doctors from the age of 80.**

The health check would be conducted by the late career doctor's regular GP, or other registered doctor when this is more appropriate, with some elements of the check able to be conducted by other health practitioners with relevant skills, e.g., hearing, vision, height, weight, blood pressure, etc.

ANZSOM supports Option 1 in relation to health assessments.

As described in Question 1, there is insufficient evidence to support the other options.

Also as described in our response to Question 1, there are other options that should be explored to address the issue.

7. Should all registered late career doctors (except those with non-practising registration) have a cognitive function screening that establishes a baseline for ongoing cognitive assessment?

If not, why not? On what evidence do you base your views?

ANZSOM does not support this proposal.

Assessment of cognitive function is central to this proposal for health checks but, as correctly identified in the discussion paper and the paper by Thomas *et al*., there is no agreement on which, if any, tests have adequate sensitivity and specificity relevant to medical practice.

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8. Should health checks/fitness to practice assessments be confidential between the late career doctor and their assessing/treating doctor/s and not shared with the Board?

Note: A late career doctor would need to declare in their annual registration renewal that they have completed the appropriate health check/fitness to practice assessment and, as they do now, declare whether they have an impairment that may detrimentally affect their ability to practise medicine safely.

ANZSOM does not support the proposed health checks as detailed in our response to Question 1.

9. Do you think the Board should have a more active role in the health checks/fitness to practice assessments?

If yes, what should that role be?

ANZSOM does not support the proposed health checks as detailed in our response to Question 1.

Feedback on draft Registration standard: Health checks for late career doctors

This section asks for feedback on the Board's proposed registration standard: Health checks for late career doctors.

The Board has developed a draft Registration standard: health checks for late career doctors that would support option three. The draft registration standard is on page 68 of the CRIS.

7.1 Is the content and structure of the draft Registration standard: health checks for late career doctors helpful, clear, relevant, and workable?

ANZSOM does not support the proposed health checks as detailed in our response to Question 1. Refer response to Question 1.

7.2 Is there anything missing that needs to be added to the draft registration standard?

ANZSOM does not support the proposed health checks as detailed in our response to Question 1. Refer response to Question 1.

7.3 Do you have any other comments on the draft registration standard?

ANZSOM does not support the proposed health checks as detailed in our response to Question 1. Refer response to Question 1.

Draft supporting documents and resources

This section asks for feedback on the draft documents and resources developed to support Option three - the health check model.

8. The Board has developed draft supporting documents and resources (page 72 or the CRIS). The materials are:

   C-1 Pre-consultation questionnaire that late career doctors would complete before their health check

   C-2 Health check examination guide – to be used by the examining/assessing/treating doctors during the health check

   C-3 Guidance for screening of cognitive function in late career doctors

   C-4 Health check confirmation certificate

   C-5 Flowchart identifying the stages of the health check.

   The materials are on page 72 of the CRIS.

8.1 Are the proposed supporting documents and resources (Appendix C-1 to C-5) clear and relevant?

ANZSOM does not support the proposed health checks as detailed in our response to Question 1. Refer response to Question 1.

8.2 What changes would improve them?

ANZSOM does not support the proposed health checks as detailed in our response to Question 1. Refer response to Question 1.

8.3 Is the information required in the medical history (C-1) appropriate?

ANZSOM does not support the proposed health checks as detailed in our response to Question 1. Refer response to Question 1.

8.4 Are the proposed examinations and tools listed in the examination guide (C-2) appropriate?

ANZSOM does not support the proposed health checks as detailed in our response to Question 1. Refer response to Question 1.

8.5 Are there other resources needed to support the health checks?

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ANZSOM submission to AHPRA regarding Consultation Regulation Impact Statement: "Health checks for late-career doctors" (August 2024)

Summary

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Thomas et al. Health, performance and conduct concerned among older doctors. Journal of Patient Safety and Risk Management. 2018. 1-9

2.3 Alternative explanations for increased notifications

While it is important to identify relevant health issues, it is also important to consider other explanations for the rise in notifications of late-career doctors.

For example, some late-career doctors may opt out of the strenuous demands of regular practice but still wish to contribute their extensive knowledge and experience to the community. Medico-legal practice offers an attractive alternative, and there are

numerous organisations that seek to engage the services of such doctors. Writing reports that are adverse to claimants is anecdotally known to attract complaints with a view to discrediting the doctor and, hence, the report.

It is important in analysing the rise of notification of late-career doctors that the proportion arising from medico-legal work (and other alternatives and alternative explanations) is assessed. This may reflect a shift from regular practice into an area prone to complaints and does not necessarily show cognitive decline or other problems in practice by late-career doctors.

The possibility that difficulties with IT skills in older doctors may underlie some prescribing errors should be more fully considered particularly as it was also pointed out by Thomas *et al*. Rectifying this problem would require a very different solution from medical examinations.

Across this whole topic is the question of ageism. People of different ages are stereotyped, and there are cognitive biases with every age group. Ageism is common in Australia. The Australian Human Rights Commission has reported that ageism affects every aspect of life. It is the most pervasive form of prejudice and is often embedded in humour making it more socially acceptable.

Australian Human Rights Commission 2021. What's age got to do with it? A snapshot of ageism across the Australian lifespan, September 2021 ISBN 978-1-925917-55-0

3. Deficiencies in the proposed solution of medical examinations/health check

3.1 Defining physical and cognitive requirements (i.e. the inherent requirements) for safe medical practice

To assess an individual's fitness for a particular role, the inherent requirements of the job and the physical and cognitive requirements to perform it must be defined and standards set. This allows the health practitioner to fairly assess the worker with reference to clear standards. Examples of this are the Australian national vehicle driver medical standards *Assessing Fitness to Drive* and the *National Standard for Health Assessment of Rail Safety Workers*. These evidence-based documents have been created through many years of research and consultation. (Members of ANZSOM have been central to development of these documents). This process has yet to be carried out for doctors whilst recognising the great diversity of practices, yet it would be necessary to support the proposed health checks.

Guidance for General Practitioners is available in the form of recommendations for health screening activities at different life stages for general health but not for employment. These do not offer guidelines applicable to fitness for medical practice.

For example, whilst it is necessary to enquire about genitourinary function as an assessment of general health it is an irrelevant question regarding ability to perform medical practice.

3.2 Sensitivity and specificity of examination for cognitive function

Assessment of cognitive function is central to this proposal for health checks but, as correctly identified in the discussion paper and the paper by Thomas *et al*., there is no agreement on which, if any, tests have adequate sensitivity and specificity relevant to medical practice.

Tests for cognitive decline (such as the MoCA) are designed for use in a clinical situation and not for screening. In a clinical situation, the doctor is assessing a clinical concern or symptom, and the probability that the patient has cognitive decline (i.e. the pre-test probability) is reasonably high. Therefore, if the test is positive, the doctor can be reasonably confident that the patient has cognitive decline. In other words, the positive predictive value (PPV) will be high, and the number of false positives will be low. If, however, the test is used in a screening situation the pre-test probability for cognitive decline will be low. The same test will then have a low positive predictive value, and the number of false positives will be high.

The MoCA has been reported to have a sensitivity of 90% and a specificity of 87% using a cutoff of 26 points. (Ziad *et al* 2005). The AIHW reports the prevalence of dementia in Australia for the 70 to 74 age group as 41/1000. Using the published sensitivity and sensitivity for MoCA given above, we can calculate that the Positive Predictive Value for the MoCA to detect cognitive decline (at cut point 26) for this age group is 22.84%. That is, for 100 people who test positive with this test 77% will falsely test positive. That is, they will be falsely accused of suffering cognitive decline.

A false positive diagnosis of cognitive decline would be devastating for a doctor and would end their career as easily as would a true diagnosis by raising doubt for the doctor as well as their patients, family and medicolegal organisations including AHPRA.

The use of any clinical test in a screening situation is inadvisable, and screening for cognitive impairment is likely to have consequences for some innocent people.

Ziad S et al The Montreal Cognitive Assessment, MoCA: A Brief Screening Tool For Mild Cognitive Impairment J Am Geriatrics S: 2005; 53(4), 695-699 https://doi.org/10.1111/j.1532-5415.2005.53221.x

AIHW Dementia in Australia. https://www.aihw.gov.au/reports/dementia/dementia-in-aus/contents/population-health-impacts-of-dementia/prevalence-of-dementia#

3.3 Moral hazard to general practitioners

It is unclear whether the purpose of this assessment is a true Fitness for (safety-critical) Work Assessment (which should be carried out by an Occupational and Environmental Medicine (OEM) Specialist or otherwise specifically trained and accredited doctor) or a general health check. It is financially and logistically unfeasible for all the assessments to be carried out by OEM Specialists, and therefore the doctor's general practitioner (GP) would be carrying out either a fitness for work assessment or a general health assessment.

If the former, then the doctor's GP would be placed in a difficult medicolegal situation, where they are being asked to conduct an assessment without having any clear standards to refer to or any defined workplace requirements. As the doctor's usual treating doctor this would cause a conflict of interest and place the doctor-patient relationship at risk. This potential conflict of interest has been studiously avoided in other safety critical work standards (e.g. Health assessment of rail workers) and would be in direct contrast with the intent of AHPRA and all medical colleges that every doctor should have their own GP.

If the intent is the latter, a general health check, then there is no need for a new structured assessment, and doctors could be required simply to attend for the existing 75-year-old health check and attend their GP regularly.

Either way the proposal suggests that the results will not be sent to AHPRA, even if there are issues detected and even if there is a subsequent related AHPRA notification. The GP is not required to report their colleague unless they are concerned about significant risk, but there is no guidance on what would constitute a risk level requiring a mandatory report.

However, we would assume that in the case of a significant adverse event and legal proceedings, the GP records would be subpoenaed, and this places the GP in an unclear situation medicolegally, where they are being asked to conduct an assessment without enough clarity to ensure they are qualified to conduct it.

The purpose for which personal information is being collected must be clearly stated or it violates Privacy legislation. This is important for both the doctor/GP collecting the information and the patient/older doctor giving the information. This is relevant to the design of the forms C1 and C2.

3.4 Lack of evidence for the benefits of age-based fitness for work screening

There is little evidence that arbitrary age-based examinations for safety critical work are useful.

For example, several state/territory driver licensing authorities require age-based fitness-to-drive assessments (ACT (75 years), NSW (75 years), QLD (75 years), SA (70 years) and WA (80 years). Victoria and the Northern Territory do not have such testing requirements. A careful examination of driving accident rates in NSW and Victoria by Monash University Accident Research Centre found no difference between the two states (Langford *et al*. 2008).

Many other safety critical workers, for example rail workers, require periodic examinations throughout their working lifetime and increased frequency of examination in older workers. This is quite different from imposing an arbitrary examination at a certain age.

The discussion paper cites various countries which require examination of doctors over certain ages but gives no evidence that these examinations are beneficial. Similarly, the discussion paper cites other professions which require compulsory retirement at various

ages but does not cite evidence that shows these compulsory retirements to be beneficial.

The discussion paper lacks an evidence base that shows medical examinations of late career doctors would lead to better outcomes for patients.

Langford J, Bohensky M, Koppel S, Newstead S. Do age-based mandatory assessments reduce older drivers' risk to other road users? Accid Anal Prev. 2008 Nov;40(6):1913-8

3.5 Cost-benefit concerns

3.5.1 Will Medicare rebates be available for health assessments?

AHPRA and the Dept of Health and Aged Care would need to clarify whether and which Medicare item numbers can be accessed for these assessments. Usually, examinations conducted for occupational or employment purposes are non-rebatable, and the added cost of this for older doctors may deter them from continuing to work, leading to workforce shortages

AHPRA suggests in the consultation paper that GPs could use Medicare item number 707, which is available annually from the age of 75. This does not cover 70- to 75-year-olds, and the guidelines for the item number would need to be adjusted to cover the required assessment.

3.5.2 Are mandatory nonspecific medical examinations cost-effective?

Any new initiative, whether funded by the taxpayer or privately, should be rational and effective and offer value for money. Once introduced it would be difficult to alter the screening program again, so it is important to ensure that a cost/benefit analysis supports this proposal.

The paper by Thomas *et al*. gives information regarding the number of older doctors required to be examined to identify one doctor with a medical condition likely to lead to a notification. Table 3 shows that 100 of the 1607 notifications older doctors were for "all health concerns", and by similar calculation, 72 were for "physical illness/cognitive decline". There were 7627 registered older doctors in the three-year survey. Therefore, assuming using excellent screening tools (which we have already demonstrated are not available in the case of cognitive decline) the NNT to detect one case of "all health concerns" is 76 and for "Physical illness/cognitive decline", 106. These figures would be higher if examinations were required annually. It is highly debatable that this is an economically sound practice, particularly when based on only 3 years of data.

4. A better approach to managing concerns about medical practitioner performance

ANZSOM contends there is a better approach to achieving AHPRA's objective of improving practices associated with notifications utilising a combination of strategies outlined below.

1. ***The current practice of requiring doctors to self-declare to AHPRA at the time of annual reregistration that they are in good health with regard to their ability to practice safely should remain.***

Plus

2. ***Doctors for whom a notification is made, and a medical factor is discerned to be important should be referred, on a case-by-case basis, for an appropriate medical examination.***

Plus

3. ***Continuing Professional Development (CPD)***

   Given that there has been a large amount of work in recent years to develop CPD as a means of ensuring good practice this would be a logical base on which to build improved practices in general to avoid notifications.

   The Royal Australasian College of Physicians (RACP) CPD program requires that every physician has an annual conversation with a colleague. The template for this includes aspects of health and encourages the doctor to reflect on their own health with a trusted colleague. This is very similar to the idea of every doctor having a health assessment.

   On 12 September 2024, the RACP advised all Fellows of "Important updates to the 2025 CPD Framework", which stated that "Beyond the existing focus on embedding cultural safety, for 2025 Fellows will need to embed ethics and professional behaviour in their CPD activities. You will be required to undertake and record a minimum of two activities that relate to ethics and professional behaviour and two activities focusing on cultural safety, including addressing health inequities". This provides an opportunity for AHPRA to work with others to improve medical practices that may contribute to increased notifications.

   This professional lifetime activity to improve practice broadly from the ethical and behavioural point of view would benefit doctors of all ages and help to develop a culture of self-reflection and self-care. This approach would empower doctors to take responsibility for their own health and avoid the concern regarding ageism in the proposal for compulsory medical examinations for doctors aged 70 and over.

Conclusion

In conclusion, we have shown above that there are significant flaws in the current AHPRA proposal.

The problem has not been adequately defined and there is insufficient evidence that the proposed solution of medical examinations will reduce notifications or improve patient safety. The proposed assessment structure does not have a strong evidence base, is unlikely to be cost-effective and will create a moral hazard for examining doctors.

We do, however, welcome the conversation prompted by the paper, which is a timely opportunity to improve the experience of both patients and doctors by introducing a

robust and evidence-based structure for doctors' professional and personal development.

ANZSOM would welcome the opportunity to discuss this submission further and to advise regarding implementation of initiatives proposed by AHPRA.

This submission has been compiled by an ANZSOM Working Group convened by the ANZSOM General Council, comprising:

[redacted]

It has been endorsed by the ANZSOM General Council

2nd October 2024

[redacted]

Dr Dominic Yong

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