From: David Storor [redacted]
Sent: Friday, October 4, 2024 11:41 AM
To: medboardconsultation
Subject: Consultation - Health Checks for Late Career doctors

Executive Officer,
Medical,
AHPRA

Dear Sir/Madam

I am providing the following submission in response to the request by AHPRA for feedback regarding its proposal for health checks on late career doctors.

I believe my experience and training enables me to provide appropriate feedback to the Medical Board regarding its proposed options as outlined in the consultation document provided.

I am a dual Fellow – RANZCP and RACP – with post graduate qualifications in Addiction Medicine and Psychiatry of Old Age. I have undertaken Health assessments of Health Practitioners for AHPRA and for its predecessors, the Medical Board and Nursing and Midwifery Council, and other professional boards for a period of some 15 years. I have assessed and treated impaired practitioners for over 30 years. I am well aware of the adverse effects of impairments on a health practitioners ability to practise their profession safely.

I trust the attached submission is of assistance to AHPRA and the Medical Board.

Yours sincerely,

Dr David Storor
Consultant Psychiatrist
FRANZCP; FAChAM (RACP); MB,BS

[redacted]

Dr David Storor

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[redacted]

Friday, October 4, 2024

Executive Officer, Medical
AHPRA

Dear Sir/Madam

RE: Consultation – Health Checks for Late Career Doctors

Please see my feedback submitted below:

Questions for consideration

The Board is considering three options to ensure doctors get the healthcare they need and are able to keep providing safe care to their patients.

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?**

A process in place to assess the health of late career doctors and their fitness to practise safely appears reasonable – on the basis of the material provided. Though without the time to properly analyze the studies quoted in the material, it unclear what the limitations of these studies are, or what caveats are discussed in their findings.

2. **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?**

No. Checks commencing at age 75 are more appropriate. The ageing Australian population enjoys better health overall compared to previous generations – for a number of reasons including awareness of preventative health measures and overall better access to health care. Mandatory health checks before 75 are likely to be low yield and be an unnecessary demand on the time of GPs and the doctors they are required to assess.

The figures provided certainly show an increase in complaints about late career doctors from 2015 to 2023. However, it cannot be argued that the general physical or cognitive health of late career doctors has deteriorated comparatively so much over that time period. I note the complaints against doctors under 70 have also risen over that time

frame – approximately 50%. It's likely other factors are contributing to the increase notifications – possibly a disconnect between the expectations of the modern health consumer compared to the professional standards held by the late career doctor.

There may also be issues around the current complaints process and its administration that explains the overall increase in complaints across all age groups. Younger practitioners with family responsibilities are more likely to oppose sanctions, compared to older practitioners who may decide it's time to retire - for reasons other than on health grounds

I note that the material provided shows that in the UK, older male non-UK graduates attract a higher number of complaints. Is there any information regards the proportion of complaints made against overseas trained doctors in Australia?

3. 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.

Option 3 is by far the most viable option, if legislation is to be changed.
Option 2 is an impractical drain on medical resources and would be a low benefit to cost outcome.
The evidence presented by the Board argues against option 1.

4.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?

No. Cognitive testing should be conducted if indicated, rather than routinely, on doctors under the age of 80. Undertaking the Addenbrooke's would likely be impractical for GPs.

Cognitive testing would likely be very low yield for doctors under 80, in the absence of any concerns identified by the GP on general examination.

5.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.

No. Any concerns that a doctor has a condition likely to impair their ability to practice safely should be notified to the Board under the existing notification provisions, either by the doctor themselves or their GP.

6.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?

No. Option 3 is sufficient, if implemented.

7. The Board has developed a draft *Registration standard: health checks for late career doctors* that would support option three.
7.1 Is the content and structure of the draft *Registration standard: health checks for late career doctors* helpful, clear, relevant, and workable?

It's helpful and clear. I have made comments about issues of relevance and practicality in answer to other questions.

7.2. Is there anything missing that needs to be added to the draft registration standard?
7.3. Do you have any other comments on the draft registration standard?
See my other comments
8. The Board has developed draft supporting documents and resources to support option three. 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.
8.1. Are the proposed supporting documents and resources (Appendix C-1 to C-5) clear and relevant?

The material is clear. Not all material is relevant. It is unclear what relevance many of the aspects of the history and examination required have to fitness to practice – except in the most broad and general of ways. See below (8.3 & 8.4).

8.2. What changes would improve them?

Modify and reduce the scope of questions and examinations.

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

No. With respect, this proforma appears to have been developed for a patient population usually over the age of 80 presenting to a tertiary university psychogeriatric/memory clinic. The extent of history required is likely unnecessary and intrusive and not directly relevant to fitness to practice. For example – "Do you have caring responsibilities for a family member or friend?"

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

Once again, the breadth of examination is more appropriate for a patient population over the age of 80 presenting to a tertiary university psychogeriatric/memory clinic. The cognitive testing should be undertaken as indicated, not routinely.

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

No further suggestions.

Yours sincerely

Dr David Storor
MB,BS; FRANZCP; FAChAM
[redacted]