## Your details

**Name:** [redacted]

**Organisation (if applicable):**

**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- ☐ No, do not publish my submission

# 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?**

Answer

I oppose the introduction of options 2 and 3.

Registered late career doctors should **not** be required to have health checks including tests for cognitive impairment as outlined in options 2 and 3 of the Consultation Regulation Impact Statement (CRIS). I oppose these options in their current form but I am open to an alternative option namely that late career doctors as well as other doctor groups should be required to have alternative regular GP health checks by their GP, another GP or appropriate specialist but without mandatory tests for cognitive impairment ( details to be provided later in section 3).

Lack of Evidence from CRIS for options 2 and 3

1. Table 1 of the CRIS indicates that Health Impairment was the 5th most common cause for notification for over 70's doctors in 2023. The most common cause was Clinical Care followed by Pharmacy/Medication, Communication and Documentation in that order and then Health Impairment. The implication is that health (and cognitive) impairment is the common denominator for notifications and complaints but CRIS has failed to connect the dots and provide robust evidence to support that.
   While the Board/Ahpra's workload has increased the CRIS document has not convincingly established that health and cognitive impairment in the over 70's doctors is the underlying cause in an evidence based peer reviewed study which the Board should commission. Therefore mandatory health checks and cognitive testing for older doctors cannot be justified

2. The Board / Ahpra have made reference to their unpublished data (their reference # 47 ) in the CRIS document. Figures 7 and 8 of CRIS have provided incomplete data. There is no information provided for the

pre pandemic years of 2016, 2017, 2018 and the COVID years of 2020, 2021 and 2022. We do not know if the spike in the over 70 yr old doctor notifications in 2023 is an aberration / outlier result or part of a longer term trend. We don't know what influence COVID itself had on the data disclosed or undisclosed given the difficulties patients had getting health care and doctors providing health care during those dark years and noting the fact that over 70's doctors were at greater risk from COVID with respect to morbidity and mortality.

3. We do not know what proportion of cases led to a successful or unsuccessful medical negligence claim and a successful claim might indicate a more serious offence. CRIS has not provided this data. It is also noted that medical defence insurance premiums do not generally increase with age and are based on billings, the scope of the individuals practice, the general risk profile of the type of practice and perhaps the number of claims against an individual.

4. I also have some concern regarding the arbitrary data analysis into under 70's and over 70's groups and that this might be introducing a level of bias. The GMC article (CRIS reference 82) on page 87 states *"Doctors under 30 years old, most of whom are in training, and doctors not on the GP or Specialist Register aged 30–50 years had a relatively low probability of being complained about…….. This is possibly because they work under more supervision. However, a greater proportion of the complaints about these doctors led to a sanction or a warning than for complaints about GPs and specialists."*
The CRIS data could be collated in multiple age groups so as to eliminate such potential bias particularly given the many years it takes to undergo prevocational as well as vocational specialist training in Australia often followed by overseas fellowships when younger doctors are being supervised. Many of these doctors while overseas will maintain their registration in Australia. During these training periods greater responsibility for clinical care is born by the supervising doctors. If a notification is made against an Australian doctor while overseas in a different jurisdiction it is unlikely that the same notification would be made in an Australian jurisdiction. Ahpra's data could also be collocated under other categories adopted by the GMC model. The Board could commission such a study.

Evidence from CRIS supporting status quo option 1

5. Interestingly table 1 of the CRIS document shows that between 2019 and 2023 there was an increase of
45.7 % for health impairment notifications and a decrease of 22.8 % for clinical care notifications for over 70's doctors. Does that mean in 2023 over 70's doctors were sicker but provided better clinical care? If the health

impairment notifications rate was the canary in the coalmine it could be assumed and not unreasonably so that as health impairment notification rates increase so should clinical care notification rates increase and this was clearly not the case for over 70's doctors between 2019 and 2023 as noted above.

6. The CRIS document shows (figure 8) that there was a substantial increase in the number of notifications received per 1000 doctors between 2015 and 2019. This increase was not disproportional between the under 70's and over 70's groups (70% vs 73%). We do not know whether all doctors' performance was generally worse between 2015 and 2019 or whether there were other factors such as health consumers having greater advocacy for or greater access to making complaints facilitated by such measures as the introduction of health ombudsmen in some states, greater public awareness and electronic notification procedures. We just don't know what caused this spike in both groups during those pre-pandemic years. In any event after 2019 to 2023 the rate of notifications remained relatively stable and not significantly disproportional between the 2 groups with the under 70's group declining by 3.8% and the over 70's group increasing modestly by 10%.

   This pattern was also seen in the area of clinical care notifications regarded as the most important class of notification from a patient clinical outcomes perspective (table1). Between 2015 and 2019 the rate of notifications for clinical care increased by 191% for the under 70's group compared to 221% for the over 70's group while between 2019 and 2023 the notification rate in this category declined by 28% for the under 70's and 22.8% for the over 70's. We don't know why the notification rates for clinical care levelled off during the pandemic years. In any event we need all the pandemic years data and as well 2024 and possibly 2025 data before we can make a more informed assessment as to whether the major spike in the rate of notifications between 2015 and 2019 is a one-off event or a sustained trend. If it is a sustained trend but not disproportional between the under 70's and over 70's groups, a reasonable person might regard the proposed targeted approach to the over 70's doctors as unjustified and discriminatory.

7. Again the evidence for maintaining the status quo is found in Ahpra's own data. Figure 10 indicates that in 2022-2023 there were NO cases that required a doctor fine, a reprimand or registration suspension (presumably for more serious matters) in the over 70's group but that was not the case in the under 70's group. It is most likely the case that there were no notifications of drug or substance abuse in the over 70's group as opposed to the under 70's group. This suggests that younger doctors are a greater risk to patients than older doctors. We also know from figure 10 and by deduction that overall, no regulatory action was taken against the doctor in 76.8% of notifications in the over 70's group. This suggests that most notifications were trivial or had no basis. On the other hand, the regulatory action taken in 2022-2023 under the "impose conditions "category (presumably for less serious offences) according to figure 10 was twice as

high in the over 70's group compared to the under 70's group (14.99% vs 7.17%). We do not know the types (graded by severity) of imposed conditions and the absolute numbers / relative incidence of each type of imposed condition. It would be helpful to have more information about those data subsets. It would also be helpful to know what regulatory actions were taken for each of the notification/complaint types. In other words does the punishment fit the crime?

8. The CRIS document on page 30 with citation #82 states *"In 2014, the GMC* (sic the General Medical Council of the UK) *reported that the relative proportions of doctors at higher risk of being complained about, being investigated or receiving a sanction or a warning showed that the highest risks arose for:*

   * male doctors overall

   * male doctors over 50 years old who are non-UK graduates and

   * male GP's aged 30-50 years who are non UK graduates."

Pages 87 and 88 of the CRIS citation #82 (i.e. GMC article same as my reference 1) makes for disturbing reading. I am not quite sure why this citation was included in the CRIS document but the GMC has raised a sensitive and difficult matter. The citation raises issues pertinent to Australia's medical workforce. Has the Medical Board of Australia investigated whether foreign trained male doctors whose primary medical qualifications are from non-English speaking countries as being at a higher risk of receiving a sanction or warning? Clearly targeting doctors in this demographic would be viewed by a not unreasonable person as discriminatory on the basis of sex, race and age profiling. In my view there is a parallel here with respect to health checks for older doctors.

Reference 1: General Medical Council. Developing our understanding of risk: The state of medical education and practice in the UK report [Internet]. London: GMC; 2014 [cited 2021 Apr 16]. Available from https://www.gmc-uk.org/-/media/documents/somep-2014-final_pdf-58751753.pdf

Evidence from other sources supporting option 1.

9. A research paper into serious misconduct tribunal cases between 2010 and 2017 of Australian doctors failed to establish a link between impairment and most categories of misconduct. (reference 2). It states

*"The most common type of misconduct was inappropriate clinical care (25.7%), followed by sexual misconduct and the illegal or unethical prescription or provision of drugs, which were equal in number, each amounting to 20% of matters. Impairment was the least likely to feature as the main head of complaint, appearing in only 4.8% of matters (although it was frequently a secondary complaint in prescription matters). The 'Other' head of misconduct was substantial, comprising 29.7% of cases in which the subtypes of matter were diverse and not readily categorized."*

Reference 2

Jenni Millbank PhD, LLM, LLB(Hons), BA, Distinguished Professor. Serious misconduct of health professionals in disciplinary tribunals under the National Law 2010–17. Australian Health Review, 2020, 44, 190–199

This raises an interesting question. Were the complaints made against older doctors in CRIS for health impairment made as a primary complaint or a secondary complaint or both? For example, if a complaint was made against a particular doctor under pharmacy/medication for a dosage error and concern was also raised about the doctor having a health or cognitive impairment issue would that be logged once under pharmacy/medication or twice under pharmacy/medication and health impairment? If 2 notifications are made but only one notification is recorded who makes the call about which is the primary and the secondary notification? And why?

**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?**

We all know that prevention is better than cure and that early intervention is better than late intervention or no intervention at all. Page 4 of the CRIS document states……*"Early intervention is a key element of good healthcare. By identifying and addressing problems early, we aim to avoid more serious impacts later. This principle underpins the Medical Board of Australia's (the board) approach to doctor's health. The Boards code of conduct (Code) requires all doctors to have their own general practitioner (GP), to help them take care of their health and*

*wellbeing throughout their working lives. Healthy doctors are the corner stone of Australia's healthcare "*

The recent AHPRA August 2024 newsletter also states … "*The Board's goal is to safely extend the careers of late-career doctors by preventing avoidable risk to patients. Information gained in the health checks would enable doctors to address any emerging health issues and continue to practise safely, controlling the later stages of their careers"*

Given the inevitable scenario of the Board / AHPRA implementing option 3 i.e. mandatory GP health checks for late career doctors I propose that the age be reduced from 70 to **60 or 50 years** as initiating intervention in the 70's in many cases is too late to turn one's health fortunes around. There is also an argument that health checks should be mandatory **for all doctors** irrespective of their age thereby negating any potential accusation that the Board is acting in a discriminatory manner by age profiling. This accords with the Boards code of conduct that all doctors should have a GP and accords with the Geneva Declaration.

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**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 1

As noted I support option 1 ie the status quo .

A reasonable person would regard this a nondiscriminatory option.

With respect I believe that Ahpra should just get on with the job under the current status quo and forcefully and fully investigate and prosecute complaints with all appropriate regulatory actions as they are currently empowered to do under all relevant sections of the National Law including appropriately directed health checks and tests of cognitive impairment as well as drug and substance screening where indicated and as they have been for many years and weed out those doctors who should not be practicing , ( such as recidivists, multiple offenders and those who clearly do not meet acceptable standards of clinical care ) and impose heavier fines and sanctions to act as a deterrent and assist those doctors who may need help.

A review of serious misconduct tribunal cases in Australia between 2010 and 2017 states that less severe regulatory actions were taken against doctors than against nurses, midwives, psychologists, pharmacists and dentists for the same malfeasance. (reference 3). This implies that the Board/Ahpra could take more severe disciplinary measures against offenders especially in matters of sexual misconduct and substance abuse. This approach would be more in line with the values of the broader community and many sporting codes in Australia.

> Reference 3: Jenni Millbank PhD, LLM, LLB(Hons), BA, Distinguished Professor. Serious misconduct of health professionals in disciplinary tribunals under the National Law 2010–17. Australian Health Review, 2020, 44, 190–199

In rugby league a recent veiled allegation and publicised photo of “white powder” use resulted in a fine to the player in the tens of thousands of dollars.

Option 2

I do not support this option. The cost is prohibitive and relies on specialist and environmental physicians, who I imagine would find difficulty in meeting the increased demand and at the expense of current and future patients. There are direct and oblique references to this in the CRIS document.

Option 3

I do not support this option in its present form for all the reasons including evidence given in sections 1,2 and 4 of this response.

While I do not support option 3 in its current form may I with respect suggest an **alternative GP health check scheme**. Let’s call this **STATUS QUO 2.0**. This would entail an older doctor if not all doctors having to see a GP say once a year (or other time interval as determined appropriate by the Board) as one hopes most doctors do. There would be no prescriptive guidelines including for cognitive tests. The GP would be able to suggest cognitive tests where appropriately indicated. The provision of a certificate of attendance would be mandatory. At the time of registration renewal there would be 3 questions

1. Do you have a regular GP?
2. Have you seen your GP for a routine health check in the last 12 months? (or other time interval to be determined)
3. Do you have a certificate of attendance?

There are provisions in clauses 11.2 and 11.3 in the Boards code of conduct which require treating doctors to report doctors who are ill and impaired and who the treating doctor believes the subject doctor is putting patients at risk of **substantial**

**harm**. The topic of “mandatory reporting” of doctors could be incorporated into medical defence insurance risk management activities as part of a wider educational campaign.

**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.

Late career doctors should not have cognitive function screening that establishes a baseline for ongoing cognitive assessment. This view is supported by the following 2 references.

Reference 4
Devi G et al. Cognitive Impairment in Aging Physicians: Current Challenges and Possible Solutions. Neurol Clin Pract 2021 Apr; 11(2): 167–174. (**especially the section on The problem with Age-Based Cognitive Testing on page 172**.)

This states
*“Age-based mandatory cognitive testing has met with understandable physician-led resistance, with the Stanford medical faculty successfully protesting such requirements. Reflecting this mindset, the American Medical Association recanted its suggestion for testing physicians aged 70 years and older,11 stating instead that “the effect of age on any individual physician’s competence can be highly variable. While age is one factor in predicting potential competence, other factors such as practice setting, clinical volume, specialty, and stress also can contribute”(AMA, personal communication, March 23, 2018).*
*This opposition springs from important limitations associated with testing. Screening tests are imperfect tools that can have untoward consequences. False-positive results would require competent physicians to undergo time-consuming, anxiety-provoking evaluations, and false-negative results may lead to erroneous assumptions about clinical competence. In addition, performance on more*

*extensive cognitive testing does not necessarily reflect clinical competence. Good performance does not guarantee acceptable functioning as a physician nor does poor performance make for an unsafe physician. Experience may be as or more relevant than test scores. Other factors, including age-related declines in physical dexterity, are specialty specific, affecting surgeons more than psychiatrists."*

These views are also reflected in the following article opinion piece (reference 5) by Dr Phillip Norris.(Southport ,Queensland ), a psychiatrist in the area of Psychiatry of Old Age.

*"I also have concerns about the cognitive tests proposed by the board, such as the Montreal Cognitive Assessment (MoCA) and the Addenbrooke's Cognitive Examination. These tests have not been validated specifically for assessing the capacity of physicians.*

*The lack of norms and the potential for test familiarity among doctors undermine the reliability and relevance of these tests in determining a doctor's professional competency.*

*Moreover, cognitive tests often fail to capture the full range of skills required in medical practice, such as interpersonal communication, practical problem-solving, and emotional intelligence.*

*They also tend to overlook the context in which a doctor works, which is crucial for a comprehensive evaluation of their capabilities.*

*The current proposal also does not address the variability in individual health and performance among doctors of all ages.*

*Without clear evidence linking age directly to increased risk, enforcing blanket medical examinations and cognitive tests on older doctors appears to lack justification"*

Reference 5

https://www.ausdoc.com.au/opinion/assuming-older-doctors-are-a-threat-to-patients-is-age-discrimination-i-have-a-safer-solution/

The CRIS document also acknowledges on page 20/21 that …. "*It is difficult to relate the precise degree of neurocognitive loss to doctors' competence because the actual levels of cognitive impairment that preclude safe practice have not been determined. There are no agreed guidelines to help medical boards decide what level of cognitive impairment in a doctor may put the public at risk."*

There are also a number of different cognitive impairment tests and it is not known which one is most fit for purpose.

Some doctors will feel intimidated and threatened by the cognitive testing. There is a difference in having a cognitive test as part of an ACAT assessment to

determine eligibility for support services and having one to determine if you are fit to continue in your professional career.

Many over 70's doctors have told me that they will not re- register if they must undergo cognitive testing. This may result in a significant reduction of the medical workforce requiring an increased intake of medical students into Australian universities and the recruitment of overseas trained doctors often from countries with poor health systems. From a global health perspective the latter option raises an ethical dilemma.

If option 3 is implemented screening cognitive function tests should not be included in the mandatory GP health check as the screening tools advised in C-3 of the CRIS document are not fit for purpose for doctors as noted above.

**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.**

YES

| 6. Do you think the Board should have a more active role in the health checks/fitness to practice assessments?<br><br>If yes, what should that role be? |
| --- |
| NO |

# 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?**

YES

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

NO

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

The direction under TRANSITION is ambiguous. . I think it would read better as

"During the first year of the operation of this standard, health checks will occur for doctors who are 70 ,73, 76 ,79 or 80 years in any part of that first year of the scheme to be able to register the following year."

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# 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?**

C1 to C5 are clear but not necessarily relevant. They are however just guidelines.

**8.2. What changes would improve them?**

See response to question 8.4

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

Yes.

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

NO.

My initial response to the CRIS document was that the proposed guidelines for patient questionnaire and examination were too intrusive and overstepped the mark in some areas such as the examination of a doctors genitalia ( ref. CRIS C-2. page 84 ) and testing for cognitive impairment. The clinical examination of genitalia can be an embarrassing and humiliating experience and, in some cases, culturally inappropriate or even taboo for example for individuals of Islamic faith. I imagine LGBTIQA+ doctors might feel particularly vulnerable if not threatened. I have canvassed opinions from several health care practitioners approaching or over 70 years regarding this issue of genital examination and their responses have all been similar such as: “not in the scope” and “humiliating “and “unnecessary” and “an overreach”.

However, on a more forensic reading of CRIS page 39 states…

“*The Board is not prescribing how the general health check should be undertaken*.”

And the opening sentence of CRIS C-2 page 83 also states ….

*“The assessing/treating doctor should use their clinical judgement to determine which examinations and investigations are required for each late career doctor”.*

With respect to the issue of genital examination I believe the inclusion in the examination guidelines was just that **a guideline** and not a mandatory aspect of the examination. However it is also noted that “genital examination “is the only examination guideline item which is followed by the words “and follow up as directed” This is intriguing. I believe this issue requires further clarification. My personal view is this item should be deleted from the guidelines.

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

NO

LASTLY…….

In the event of the Board /Ahpra after consultation with all stakeholders being **absolutely resolute** about implementing mandatory GP health checks for late career doctors under its preferred option 3 I respectfully make the following recommendations and suggestions to the Board/AHPRA

1. to reconfirm that mandatory health checks may be performed by the doctors own GP, another GP or a specialist physician to avoid any doubt as to who can perform the check and provide some “flexibility “in this matter.
2. to release data for 2016, 2017, 2018, as well as 2020, 2021 and 2022 years relating to figures 7,8 9 and 10 to allow public analysis and scrutiny.
3. to delay the implementation of mandatory GP checks by one year or two years to allow data for 2024 plus or minus 2025 to be collected, reviewed and made available for public scrutiny and comment
4. to provide data in multiple age groupings and other groupings as per the GMC model.
5. to provide more details regarding the categories of complaint notifications made against doctors and with examples for each complaint category.
6. to provide examples of health impairment complaints and absolute numbers and relative incidence.
7. to provide the percentage of complaints leading to medicolegal claims, either successful or otherwise if that is known.
8. to provide more details about the type and number and incidence of the “impose conditions” regulatory actions taken.
9. to lower the age for mandatory GP health checks from 70 years to 60 or even 50 years thereby acknowledging that earlier intervention and treatment will successfully achieve the Board/Ahpra’s stated aims of promoting doctor health and therefore patient safety.
10. to instead consider mandatory health checks **for all doctors** irrespective of their age thereby negating any potential accusation that the Board is acting in a discriminatory manner by age profiling
11. **to make cognitive testing optional and not routine or compulsory**. The GP would have the discretion to advise cognitive testing, where clinically indicated.
12. to encourage if not mandate all Medical Board /Ahpra executive team and Board members to undergo the same GP health checks as doctors.
13. to consider mandatory drug testing (urine sampling and/ or hair analysis ) for under 50 year old male doctors given that the Board /Ahpra has probably identified this age and gender group as at risk of

drug and substance abuse. And to consider spot alcohol breathalyser testing during work hours for all doctor groups.

14. to consider **an alternative GP health check scheme** such as noted above …STATUS QUO 2.0

Signed

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