

# SUBMISSION

Friday, 4 October 2024

## **AMA submission to the Medical Board of Australia consultation on health checks for late career doctors**

### **Introduction**

The Australian Medical Association (AMA) supports doctors to continue practising medicine and to remain actively engaged with the profession beyond the age of 70. The introduction of mandatory health checks for late career doctors has the potential to become a major disincentive for doctors to remain engaged in the workforce, denying patients access to a doctor and younger doctors' access to an educator or mentor.

The AMA has been engaged in these major policy reforms for more than a decade now. Throughout extensive consultations with the Medical Board of Australia and engagement with the Expert Advisory Group (EAG) in 2017, the AMA championed a process that is reasonable and respectful of the contributions of late career doctors. The AMA strongly opposes any moves towards UK-style revalidation — something that was ultimately rejected by the EAG and the Board.

The Board's preferred model, as outlined in the consultation paper, most closely fits with the past 10 years of AMA advocacy, the AMA support doctors who want to continue practising medicine to remain in the workforce. This must also be the Board's objective in implementing these health checks. To achieve this, there will need to be significant engagement with the profession and an increase in education and resources.

Doctors who continue to practise beyond the age of 70, in most circumstances, do so with sound skill and judgment, adapting their scope of practice, workload, and procedures to mitigate risks and ensure patient safety. It is crucial to recognise their autonomy and the value of their extensive experience, while also safeguarding patient wellbeing. Striking this

balance is vital, as it addresses both the rights of practitioners and the imperative of maintaining high standards of patient care.

The AMA advocates for regular health checks for all doctors and supports initiatives such as the [Every Doctor, Every Setting: National Framework](#), the [I have a GP](#) project, and [AMA Queensland's Every Dr needs a GP](#) campaign. These programs emphasise the importance of every doctor having access to their own healthcare provider, underscoring the AMA's support to the health and wellbeing of doctors at every stage of their careers. Throughout this consultation, the Board must place practitioner wellbeing at the forefront of the decision-making process.

The AMA has received significant feedback from members on the proposal. In responding to this consultation, we have sought to balance the continued concerns some members have expressed, while recognising the extensive efforts and consultation undertaken by the Board over many years to arrive at a position that has addressed many of the representations made by the AMA over several years. The concerns of members are legitimate concerns the Board must address in the ongoing consultation and eventual implementation. Many of these concerns are included in this submission, along with recommendations to address them. Any introduction of mandatory health checks must be structured in a way that supports the continued, safe engagement in the workforce of all doctors who want to continue practising. The Board's preferred option in this consultation is too complicated for late career doctors and treating practitioners. The Board should refine its preferred model of health checks for late career doctors so it is just a health check with one's usual general practitioner (GP). This would demonstrate the purpose of the health check is to support the health and wellbeing of the doctor, not to penalise the doctor for their age.

Noting much of the work leading into this consultation comes from the EAG in 2017 and the initial consultation in 2021, the Board should consider holding another round of consultation with a more recent evidence base on a health check designed around supporting the health and wellbeing of doctors.

## **Feedback on the consultation regulation impact statement**

### **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?**

There is a strong body of evidence demonstrating the benefit of having a regular GP. Health assessments provide an opportunity to identify and address any emerging health concerns, ensuring physicians remain actively engaged with their own health management. Any health check for late career doctors should be just that — a regular health check with a usual GP or

other doctor, with the outcomes not reported to the Board. The purpose must be to enable doctors to maintain their wellbeing throughout the later stages of their careers.

Older and more experienced medical practitioners are valued by their peers as mentors and sources of guidance. They fulfill important roles in leadership and training and provide health services where appropriate. The AMA supports the Board's aim not to undermine the important service late career doctors provide to the medical community and their patients. A responsive approach to health checks for late career doctors must take the least intrusive course of action while protecting the public.

The AMA absolutely rejects any models of revalidation.

Doctors recognise age-related changes, such as decline in sensory and neurocognitive functions, can impact older individuals. These changes may include reduced processing speed and problem-solving abilities, impaired hearing and vision, and decreased manual dexterity. In the context of late career doctors, these factors can potentially affect patient care, depending on the severity of the changes, and the nature of the clinical role being undertaken.<sup>i</sup> While the AMA agrees that supporting the profession in addressing this issue is important, the introduction of health checks must also make the community feel safer. The AMA is concerned this process has reduced the public's trust in late career doctors and we would expect the Board and Ahpra to make additional efforts to reassure the public about the safety of the profession. The AMA has more general concerns about notifications which are addressed later in the submission.

The AMA notes regular health checks are designed to assess a broad spectrum of age-related changes, identifying subtle shifts in health status, and encouraging doctors to engage consistently with their own GP's, as recommended by the Board's [Code of Conduct](#). This is a difficult task, particularly in the early stages of cognitive and functional decline. Cognitive decline is also harder to identify in higher-functioning individuals, like doctors. While we agree cognitive assessment is an important factor to consider, there will need to be additional consultation with the profession on how this is to be achieved.

[The AMA did not support the introduction of mandatory reporting](#), preferring the Western Australian model. The primary reason for our objection was it would discourage doctors from seeking medical treatment, particularly for mental health issues. The Board made efforts to educate the profession about the requirements of mandatory reporting and reinforce the message doctors should seek medical care when they need it. Despite this, we know mandatory reporting still causes a high degree of anxiety among the profession when seeking care, and when providing care to colleagues.

The AMA would like the Board to pursue a similar education campaign after the introduction of the health check requirements. The health checks put the treating doctor in a challenging position, so the Board must ensure there are resources and supports available for GPs to help manage their patients. Guidelines and education material must be clear and explicit in what is expected of GPs and other doctors performing the health checks.

If the treating doctor identifies there may be an issue that could impact the patient's ability to practise medicine, there should be a range of appropriate responses to manage this. The AMA would expect a notification would be used only in extreme circumstances where the treating doctor has imminent concerns about public safety. The Board must make this clear and explicit in their communications to medical practitioners.

**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?**

Most doctors begin retiring or reducing their scope of practice between the age of 65 and 70. They naturally make adaptations to suit their lifestyle as well as health status. Some doctors also choose to retire in this age bracket, but where able, doctors should be encouraged to remain in the workforce as long as possible.

There is always going to be an argument about the age at which these checks should begin. Some states and territories in Australia have introduced mandatory annual fitness to drive checks from the age of 75. Federal judges have a mandatory retirement age of 70. The AMA does not propose an alternative. However, we reject any suggestions the age should be lowered.

The Board will need to craft communication regarding the age at which health checks must be applied in a way that is evidence-based, transparent and fair.

Many AMA members have expressed concerns the introduction of mandatory health checks is a form of age discrimination. The AMA encouraged the Board to seek legal advice on the introduction of mandatory health checks during earlier consultations. We again strongly suggest the Board seek and publish legal advice on whether mandatory health checks for doctors over a certain age to qualify for registration contravenes the Age Discrimination Act 2004. We would also like advice on whether Section 38 of the National Law permits the Board to set a registration standard for a subset of the profession based on a shared characteristic (age) separate from the profession or specific individuals.

## **Which option 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?**

The AMA cannot support reforms that are burdensome, onerous, resemble revalidation, and force doctors into earlier retirement. The AMA rejects any proposals including a fitness-to-practice assessment. The costs outlined are also unreasonable for the late career doctor to incur at regular three-yearly and yearly intervals.

The AMA does not support retaining the status quo. While there are some outstanding concerns regarding the data informing the reforms, the medical workforce is ageing along with the rest of the population. There is likely to be greater scrutiny on late career doctors in the years to come. Having a process in place that the public is aware of should increase the public's confidence in the profession. However, the process must not place undue burden on clinicians and force them out of the workforce. Retaining the status quo is the AMA's second least preferred option.

A simplified version of the third option, which involves conducting regular health checks with a usual doctor is preferred. We do not support the requirement for cognitive testing and would prefer the health assessment was of a general nature, or with much refined guidelines. This must be accompanied by education and support for all doctors. The AMA notes the Board's current proposal is a significant improvement from the original proposal for revalidation. The AMA actively engaged with the work of the EAG on revalidation and was pleased with the final report, which supported improvements to CPD and measures to support at-risk doctors.

Most late career medical practitioners continue to practise safely, providing much-needed services, supporting their local communities, and mentoring younger doctors and other health practitioners. We believe this is especially important for rural and regional areas, which are undersupplied and have a higher ageing medical practitioner population.

The Board must tread carefully in its communication with the medical community. There is a delicate balance between enforcing compliance and inadvertently driving experienced physicians towards premature retirement. For some late career doctors, the health checks may be perceived as a coercive imposition. To mitigate this, the Board must clearly convey the health checks are designed to be minimally invasive, representing the least disruptive approach possible. It is crucial to emphasise that only health concerns meeting mandatory reporting criteria will be disclosed, ensuring the process remains supportive, rather than burdensome.

Support and education must be made available to treating doctors and doctors attending a health check to ensure it does not undermine the existing therapeutic relationship. Ensuring

both participants understand how they should discuss changes in physical health or cognitive ability, and appropriate changes to practise or scope as a result, will limit notifications and ensure doctors continue to practise safely.

The AMA recognises there are times when seeing a medical practitioner other than one's usual GP is appropriate. Therefore, we support the flexibility in the proposed health check, which allows for some elements of the check to be conducted by other health practitioners. For example, an optometrist completing a vision test or cardiologist completing a regular heart health check. Tailoring to a telehealth approach is also a sensible option, particularly where access is difficult in regional and rural areas, where a higher percentage of late career doctors practise and reside.

### **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?**

The AMA does not support explicitly including cognitive function screening in the health assessment. There is mixed evidence on the value of cognitive testing for screening. However, if the Board decides to implement cognitive screening tests, these tests must demonstrate adequate reliability, sensitivity and specificity to meet the specific needs of this population. The Board has not provided sufficient evidence to show this will improve safety, particularly given the imposition this will have on the doctors performing the tests and those undergoing them.

It is important to note late career doctors come from highly educated backgrounds, which impacts on the benefit of cognitive screening. For example, the Mini-Mental State Examination (MMSE) is neither highly sensitive nor specific. It may not detect cognitive changes in such an intellectually advanced group. The MMSE's scores can be influenced by educational and sociocultural factors, which may introduce biases and lead to misclassification. Educated individuals with early-stage dementia might score well, potentially masking underlying issues. Moreover, familiarity with the test can further compromise its accuracy.<sup>ii</sup>

The time required to administer more sensitive screening tools (MoCA, ACE-III) would add significant time and cost burden to the late career doctor. Not all GPs will be familiar with these tests or have subscriptions to them, which places a financial imposition on GPs. This could force a doctor over the age of 70 to find a new GP, or seek additional, subspecialist assessment, undermining the objective of ensuring continuity of care.

A better model would not include specific cognitive function screening in the health check, but it would make it clear in resources for GPs that they should consider cognition, and use

their clinical judgement regarding screening, and/or write a referral for formal assessment if required.

### **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?**

Health checks must remain confidential between the late career doctor and their treating doctor. The late career doctor has a right to privacy on matters pertaining to their health where it does not compromise or impact patient safety and where the threshold is not met for mandatory reporting. It will also encourage doctors to participate in health checks knowing their right to privacy is respected and they can have a confidential conversation about any adjustments they may need to make to ensure they can continue to practise safely.

Supporting materials and educational resources for late career doctors and their treating physician should make it clear that if practise modifications can be reasonably made for them to continue to practise safely, a notification to the Board is not required.

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

The AMA does not see any evidence to support a more active role for the Board in health checks at the present time, beyond education and communication.

The current proposal should be allowed to run for at least three years and then be subject to an appropriate evaluation to determine whether a more interventionist approach should be considered. The National Health Practitioner Ombudsmen reviewed the vexatious notifications framework after its introduction and should do likewise with this reform.

### **Feedback on draft registration standard: health checks for late career doctors**

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

The AMA believes the content of the draft registration standard is clear, relevant and workable.

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

On page 69, in the section, 'Are there exemptions to this standard?', there should be a consistent mention of exemptions. On page 38, it specifies: "A doctor who has previously had

a health assessment as part of their general health care would not need to undertake a further general health check purely to meet this requirement.” This statement is understood as an exemption, and therefore, should be included in the draft registration standard. This is so the late career doctor avoids enduring extra costs in completing any assessments or health checks.

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

The AMA appreciates the Board’s engagement throughout the consultation. However, there is refinement required prior to the introduction of the proposed mandatory health checks as detailed in this submission. There will need to be a major education campaign which the AMA is happy to assist with. A further round of consultation should be considered. Beyond this reform, the AMA wants to see a broader conversation within the profession on ageing. On page 70, under *‘What happens if I don’t meet this standard?’*, the Board has specified possible consequences. However, detailing the circumstances and scenarios when consequences will apply, will be useful for late career doctors.

### **Draft supporting documents and resources**

#### **Are the proposed supporting documents and resources (Attachments C-1 to C-5) clear and relevant?**

As stated earlier, the AMA prefers a much simpler process. While the documents read in isolation are clear, it is unclear how they are intended to be used together. Specifically, it is unclear whether these documents are an expectation or a mandatory requirement, and whether all aspects of the assessment included in these must be completed at each health assessment. The forms proposed are lengthy and potentially onerous to complete. Completing the forms prior to the appointment would speed things up, however, some sections do not make much sense. For example, in form C1, under health support, it requires the practitioner to write in their current GP. If the practitioner has the check with their current GP, this information is an unnecessary duplication.

The AMA strongly supports digital operability of forms. Forms must be integrated into software and able to be completed ahead of time.

Additionally, the late career doctor should not have to fill in information that does not frequently change, i.e. allergies, blood test results, or medications. The treating doctor should also have such information on file. The AMA would like the Board to outline the pertinent information required for the health check so late career doctors and treating practitioners are not wasting time duplicating information.

It should be clear in the standard that GPs must only complete what would be reasonably expected by a peer/RACGP/ACRRM, and not an MBA-mandated, specific fitness-for-work medical assessment.

AMA members and GPs are concerned about the time it will take to complete the history and examination as spelled out in the resources. It would probably take an hour of nurse time (if conducting blood pressure checks, weight, height etc) and an hour of the treating practitioner's time.

In attachment C3, the principles of cognitive screening and screening of cognitive function sub-sections are useful and provide good guidance for doctors. The same principle should be followed for developing useful guidance tools for the physical health check section. However, there must be a balance by not being too prescriptive in the information provided. The Board must remember to remain fluid and flexible in its approach on instructing how the health check is completed. It needs to be made clear whether the templates proposed by the Board are an example only, and not a mandatory requirement, or whether the Board wishes to introduce a mandatory health assessment form.

The flow chart, C5, is unclear. It reads: "Does the late career doctor have any health issues?" A late career doctor may have minor health issues, so they answer yes. The lead-on box then reads: "Does the late career doctor have health issues that detrimentally affects or is likely to detrimentally affect their capacity to practise medicine?" Both only allow for a yes option. A late career doctor with minor health issues should be answering no to this part of the flow chart. Minor health issues do not detrimentally affect the doctor's capacity to practise medicine.

### **What changes would improve them?**

The AMA suggests separate FAQs be provided for the late career doctor and treating practitioner to inform all involved in the process.

Themes to consider in the FAQ for the late career doctor include:

- Follow up processes after a health check is completed, if concerns are flagged.
- What to expect during the health check to allay concerns.

Themes to consider in the FAQ for the treating practitioner include:

- The scope of responsibility of the treating practitioner once the health check is signed and completed. This is to provide reassurance to the practitioner. Treating practitioners need to be provided with information on whether completing health

checks and signing the certificates would increase their liability should a late career doctor later be determined to be unfit. The messaging must be clear in this regard.

- What are the key medical issues a treating doctor needs to look out for and what conditions/issues are negligible/not an issue.
- The level of follow up required if health issues are found.
- Options available to the treating practitioner if they feel the late career doctor is not approaching the health check in good faith.

### **Is the information required in the medical history (C1) appropriate?**

The explicit note at the top of the pre-consultation questionnaire, stating the details obtained will be confidential and not shared with the Board will help reassure late career doctors. The questions are appropriate and seek information about all facets of health, which provides a broad overview of the late career doctor's health to the treating practitioner.

Some of the demographic information is likely to be unnecessary if the late career doctor has a regular GP who is already aware of this information.

The AMA recommends digital enablement options are explored, to minimise the burden on both the treating physician and the late career doctor.

While the information included is a comprehensive example of a health assessment, members have expressed concerns about a mandated specific form. We again reiterate the need for clarity from the Board as to whether it requires a general health check or a specific health assessment – we would support the former.

### **Are the proposed examinations and tools listed in the examination guide (C2) appropriate?**

The Board has noted the treating doctor should use clinical judgement to determine which examinations are required with parallels with the Board's flexible approach to the health check. The AMA has concerns about the appropriateness and relevance of a genital exam to practising medicine (p84). This is an invasive procedure and may dissuade late career doctors from engaging in the health checks for the fear of being invasively examined. This is an example of the challenges treating doctors will face in determining what is a general health check, and how much is related to the mandated Board check. Additionally, the question regarding manual dexterity is vague and provides no insight into the late career doctor's skills. We question whether the examination technique of mock "piano playing" is valid. Manual dexterity is a crucial element of practising medicine, especially for surgeons, thus careful thought and consultation must be undertaken to ensure this element is assessed appropriately.

The AMA would prefer a model where practitioners use their clinical judgement in accordance with their training to carry out a history and examination of the late career doctor.

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

The AMA would like a commitment from the Board and Ahpra for a significant education campaign. This should also focus on mandatory reporting to ensure the profession is clear on expectations.

The AMA suggests the following additions to improve clarity and support the doctor and practitioners in engaging with the health check:

- Listing the conditions that warrant further investigation.
- Including links to Ahpra's guidelines for mandatory notifications would be beneficial. A flowchart or diagram, illustrating the threshold at which the treating doctor might need to consider mandatory notification, would be essential.
- More guidance to treating doctors about what to do if the screening assessment indicates possible cognitive decline or impairment. There needs to be clear process to follow, escalation points, and support for treating doctors in this regard.
- The Board could create resources for treating practitioners conducting the health checks. These resources could include case studies to highlight different scenarios in which treating doctors could find themselves and provide considerations for specific cases. For example, the late career doctor who does not have a regular GP and is seeing the treating doctor for the first time, or the late career doctor who is showing signs of declining cognitive ability. These should be developed in conjunction with clinicians who have significant experience in doctor's health.
- Greater support should be afforded to doctors undergoing these health checks. Implementing a confidential support service would enable treating doctors to consult with colleagues about challenging cases without the concern of mandatory reporting or revealing personal details. A precedent for this approach exists with Ahpra's confidential consultations on mandatory notifications. Extending such a service to address concerns arising from health checks could offer valuable reassurance and facilitate more effective, unobtrusive support for practitioners.

- The Board should consider supports for late career doctors if they decide to transition into retirement, or reduces their working capacity because of the health checks. Comprehensive resources, educational programs, and support systems to assist with retirement planning and timing should be available for late career doctors in the event of eventual retirement.

Retirement can be an emotionally charged transition, particularly for those whose medical careers have been marked by considerable sacrifice and dedication. It is crucial to support late career doctors through a thoughtful transition process, ensuring they have ample time and guidance to plan effectively. The goal is to facilitate a positive and fulfilling end to their distinguished careers, preventing any sense of dissatisfaction or regret. The AMA is committed to ensuring late career doctors conclude their service on a high note, with the respect and support they deserve. <sup>iii</sup>

## Other comments

### Fiscal impact and Medicare rebate

The AMA is concerned about the financial implications of regular health checks. For practitioners, the costs associated with these checks — required every three years and annually after age 80 — add to an already burdensome list of expenses, including Ahpra registration, indemnity insurance, and professional development, to name a few. This financial strain is particularly acute for those working part time or in isolated settings, such as rural or remote practices. While the number of doctors in these areas may be small, the economic impact on late career doctors across Australia must be acknowledged.

The AMA understands the Board has discussed the introduction of an MBS item for these assessments. The AMA would support this and would also support a clear direction from Medicare of other MBS items that would be appropriate to bill.

### Data

Should the Board enact its proposal, it must add rigour to this process and provide medical practitioners and medical organisations with reliable, accurate and useable data moving forward. Transparency is essential.

Data the AMA would like to see reported on a yearly basis includes:

- Rate of notifications against doctors over the age of 70 who are completing health checks.
- Number of practitioners over the age of 70 opting into non-practicing registration.

- Number of practitioners opting to retire instead.
- Continuing reporting on reasons for notifications in the over 70 age group.
- Ongoing comparators with other cohorts.

## Medical college guidelines on health checks and maintaining good health

It is important to recognise the medical colleges views on doctors' health checks. Within specialties, guidelines underpin best practise for maintaining good health. The Royal Australian College of Surgeons (RACS) has published the Surgical Competence and Performance Framework, which states surgeons must demonstrate awareness and insight and reflect on their own surgical practice. RACS also stipulates surgeons should maintain their own personal health and wellbeing and optimise performance during surgical practise for the benefit of colleagues and patients. They list examples of what members can do, such as regularly and appropriately attending check-ups with a personal GP, or seeking psychological or psychiatric assistance for the onset of early mental health symptoms or concerns. <sup>iv</sup>

Other colleges such as the Royal Australian and New Zealand College of Psychiatrists and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists have developed wellbeing documents relevant to their profession which stipulate the importance of maintaining good health and seeking medical care with a regular practitioner when required.

## Notifications

The AMA is concerned by the universal trend of increasing notifications, up 15 per cent in the past 12 months. Most notifications continue to result in no conditions applied to a doctor's registration, however the notification process remains a stressful and sometimes harmful experience. The AMA acknowledges improvements Ahpra has made to the process in recent years, such as the introduction of the vexatious notifications framework, and the streaming of notifications. The problem of unnecessary, or inappropriate, notifications being made remains.

Notifications should primarily be made where an individual feels the practitioner is a risk to public safety. There are too many notifications made frivolously or unnecessarily. At a certain point this will become unsustainable with Ahpra staff diverted from cases requiring genuine assessment, not to mention the undue stress it causes health professionals. The AMA would like Ahpra to consider how to address this problem.

The AMA would also like further discussions regarding how the Board plans to manage the increased workload stemming from these proposed health checks. As a self-funded scheme, practitioners deserve transparency regarding the fiscal implication of new programs.

We recommend further consultation on this important work and look forward to continuing discussions.

## Contact

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<sup>i</sup> Skowronski, G. A., & Peisah, C. (2012). [The greying intensivist: ageing and medical practice - everyone's problem.](#) *The Medical journal of Australia*, 196(8), 505–507.

<sup>ii</sup> Tombaugh TN, McIntyre NJ. (Sept 1992). [The mini-mental state examination: a comprehensive review.](#) *J Am Geriatr Soc.* 40(9), 922-35.

<sup>iii</sup> Draper, B. M. (2017). [Older doctors and retirement.](#) *Med J Aust*, 206(5), 202-203.

<sup>iv</sup> Royal Australasian College of Surgeons. (2020). [Surgical Competence and Performance.](#)