Your details

Name: Belinda Sasse

Organisation (if applicable): Monash Health

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- ☐ No, do not publish my submission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?

No.

Why should only a 'no' response require evidence, and not a 'yes' response? Shouldn't the case for change be the case that requires evidence?

Why this is poor policy:
Doctors practice in concert with others – nursing staff, other doctors, support staff etc. These colleagues have mandatory reporting requirements to report impairment.
This policy would place an unfair financial and administrative burden on older doctors
Implementing a recurring age-based financially burdensome requirement is discriminatory.
This policy would encourage late-career doctors on low hours to retire and leave communities with reduced or no healthcare access.
Older doctors already have to pay AHPRA fees, College fees, and insurance while working reduced hours; this would be the nail in the coffin for many.

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?

There should be no such check.

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

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.

Again – why does only the case for maintaining the status quo require evidence? Should not the case for change be more in need of supporting evidence?

Why this is poor policy:
Doctors practice in concert with others – nursing staff, other doctors, support staff etc. These colleagues have mandatory reporting requirements to report impairment.
This policy would place an unfair financial and administrative burden on older doctors
Implementing a recurring age-based financially burdensome requirement is discriminatory.
This policy would encourage late-career doctors on low hours to retire and leave communities with reduced or no healthcare access.
Older doctors already have to pay AHPRA fees, College fees, and insurance while working reduced hours; this would be the nail in the coffin for many.

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.

There should be no such check.

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.

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?

No.

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

This policy should be discontinued.

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

I note your draft would stop older doctors who do not pay for these assessments from teaching for free. Is that truly what you want?

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?

No. They are clear but not relevant as there should be no such check.

8.2. What changes would improve them?

There should be no such check

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

No.

Social history:
Of what relevance to the regulator are questions such as ‘who lives in your household’ and ‘are you satisfied with your social engagement’? Why should such information be shared with the regulator? Do you think any doctor will answer ‘no, I am not satisfied with my social engagement’ on a form being sent to the regulator?

Medical history questions are invasive and detailed.

Past history:
Doctors will be concerned they may lose their right to practice if they take more than 2 weeks off due to an illness leading it to be declarable on this form
Family history in a 70+ year old is seldom relevant.

The regulator should not care about family history that has not led to development of an illness in the individual

Medication, allergies, and vaccinations
Presence of allergies or sensitivities is not of relevance to fitness to practice

Investigations
Requirement to disclose recent investigation results is a disincentive for older doctors to undergo such investigations

Alcohol and substance
Requiring answers to these questions in only persons aged over 70 is discriminatory, particularly as they are less likely to engage in substance abuse
Tobacco use does not affect fitness to practice where it has not led to an illness

Lifestyle
The regulator does not need to know if a doctor exercises for over 150 minutes per week

The questionnaire is exhaustive and invasive.

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

Height and weight are invasive questions.
What does ‘appearance’ purport to add?

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

There should be no such check.