Your details

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Organisation (if applicable): Centre for Healthy Brain Ageing (CHeBA), UNSW

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- ☐ No, do not publish my submission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?

If it can be shown to be practicable, reliable and valid. My accompanying letter about challenges with cognitive assessments cast doubts about this.

Does the field of practice matter? For example, doctors purely working in medico-legal work where incompetencies will soon emerge as reports are challenged.

There will be even greater difficulties for doctors in rural and remote settings being able to access health checks.

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?

Re evidence.
AHPRA has cited statistics but there may be confounding factors. Would repeat subjects of complaint may be a more reliable benchmark than age?
If allowance is made for repeat 'complainees' what are statistics regarding age?

Suggest commencing at age 75 would be more practicable as it can be incorporated into the 75+ health assessment.

Others argue that 70 is too late. From the cognitive viewpoint, I disagree. The prevalence oof dementia is very low in those 60-64 (perhaps 1%), low in 65-69 (perhaps 2%), and doubling every 5 years thereafter.

Rates of MCI converting to dementia are based on clinic populations. Findings from screening in general population is much lower, 4.8% in our study of 70-90 year olds (Brodaty et al, 2013 **DOI:** 10.3233/JAD-2012-120169 or https://content.iospress.com/articles/journal-of-alzheimers-disease/jad120169)

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 2 may not be practicable as per workforce availability, cost for doctors.

Option 3 – why is weight, blood pressure included? Will you ask about cigarettes, alcohol, falls? What will be thresholds for concern?

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?

Pls see attached letter.

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
Confidential unless urgent need to let Board know if there is imminent safety risk.
There will need to be indemnification for examining doctor.

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?

Consider less intrusive options:

1. Self assessment of knowledge arranged by Dr's professional body e.g. appropriate College. with results kept confidential to the doctor as long as s/he completes self-improvement module related to any deficiency detected and returns for re-assessment in say 6 or 12 months. This would be different to CPD in that Dr will complete an exam online and receive results confidentially. A flag will be recorded by the College or professional body requiring action for Dr to remedy and reassess.

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?

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?

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?

I like that C1 remains confidential between the doctor and the health checking doctor. This also be stated as applying to C2 and C3.

8.2. What changes would improve them?

Confidentiality should explicitly state that it applies to C1,2 & 3

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

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

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

[redacted]

To the Medical Board of Australia

Australian Health Practitioner Regulation Agency
G.P.O. Box 9958
Melbourne VIC 3001

[redacted] **Provision of clinical advice on health checks for doctors aged 70 years and older**

[redacted]

We note the following:

1. There are a number of models overseas for providing physical and cognitive health checks for doctors (see the very comprehensive Californian Public Protection and Physician Health Guidelines Assessing Late Career Practitioners: Policies and Procedures for Age-based Screening https://www.cppph.org);
2. Consideration of candidate tools for cognitive screening is complex due to: -
   (i) The practice effects of tools such as the Mini Mental State Examination (MMSE) or the Montreal Cognitive Examination Assessment (MOCA) used routinely in many health environments, and with which most clinicians are familiar;
   (ii) ceiling effects of the above tools in highly intelligent individuals;
   (iii) the failure of such tools such as the MMSE to test frontal systems;
   (iv) normative scores for physicians are only available for a limited number of tools;
   (v) the Addenbrooke tools (e.g. ACE-111 and ACE-R) may be possible suitable candidates, and there has been one study using the ACE-R although the ACE-R is beset with a number of copyright issues due to the MMSE embedded within it;
   (vi) inevitably several tools will be required due to the foreseeable practice effects after one round of screening;
   (vii) default options (e.g. NUCOG) will be particularly required for neurologists, old age psychiatrists and geriatricians who will be familiar with many of the extended cognitive screening tools such as the Addenbrooke tools;
   (viii) "cut offs" for significance and triggers for referral for further screening are unknown in doctors;
   (ix) prevalence of significant cognitive impairment – i.e. that which would preclude practice – is unknown in doctors which makes scoping difficult. We note that, for some, even Mild Cognitive Impairment will often be a significant constraint to practice, or require significant changes to practice. Data from amyloid-PET studies (e.g. AIBL) indicates 35% of "healthy" 70 year and above persons have excess amyloid in their brains, with a group reduction in memory scores of 0.5 SD below those without amyloid. The significance of this to doctors is unknown but very clearly points to the complexity of what "healthy and safe for practice" actually means, in particular the Board's intent to "identify those at risk";
   (x) Distant online completion of tools cannot guarantee that the identified doctor has actually completed the tool.

3. Consideration of appropriate assessors is complex because:
    a. The most feasible screening would be a 'one stop' physical and cognitive health check;
    b. Overseas models use trained accredited providers;
    c. Use of the doctor's own GP may be problematic for a number of reasons, including:
        i. Evidence suggests that many GPs are not skilled in cognitive screening and detection of dementia;
        ii. Evidence suggests that GPs themselves are considered one of the high-risk groups for impairment and failure to recognise the need for retirement;
        iii. By definition, a doctor's GP will have a Conflict of Interest by virtue of being an advocate for their patient, and often having a long-term relationship with them. It is well-recognised that even for experienced GP assessors, it is difficult to maintain detachment, and to give constructive feedback in relation to fairly senior colleagues who are not doing particularly well;
        iv. "Collusive collegiality" is a commonly encountered problem in a profession that has not shifted to systemic acknowledgement of ageing as an important issue. The literature has shown that not all doctors believe that impaired or incompetent colleagues should be reported to regulatory authorities, and amongst those who identify impairment or incompetence in colleagues, 33-45% of doctors do not act on this.
    d. Robust training of assessors is required in:
        (i) cognitive screening and the use of whatever tool is chosen;
        (ii) sensitive disclosure in light of the risks associated with first diagnosis of dementia in a population who have not invited assessment;
        (iii) lifestyle toolkits for ageing and retirement advice;
4. There is a complexity in the choice of physical screens; despite myriad overseas models, some more complex than others. Perhaps physical screening should be restricted to minimal health status for practice and based on a general frailty assessment model. Further complexity is rendered by the variation required to meet different specialty task demands;
5. A two-tiered approach of a pool of trained GP assessors as initial screeners with referral to a pool of appropriate specialists (or perhaps Dr-specialist of choice) with some oversight or regulation of compliance with follow-up would be important;
6. A clinical pathway model is useful with integration within current legislative frameworks and impairment pathways;
7. Priming of the target audience is considered important to engage an otherwise resistive profession. In doing so it would be useful to acknowledge and engage the extensive and ground-breaking work already undertaken by several of the Australian medical colleges such as the Colleges of Surgeons and Anaesthetists;
8. Infrastructure with resources is considered useful;
9. As proposed by the Board, assessors would need legislative protection and clear training around their responsibilities under the legislation, not unlike work we have been involved in with the Victorian VAD legislation – where doctors providing services under that legislation will receive training (embedded within the legislation).

Signed

[redacted]