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- ☐ No, do not publish my submission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?

No.

I recommend that the medical profession be presented with;
1) higher quality evidence that this intervention will substantially achieve the stated goal of the Board; and;
2) a vote of medical practitioner's be taken prior to introduction of mandatory health checks for late career doctors.

It is regulatory overreach to coerce medical practitioners, with risk to their livelihoods, to have costly health checks (oftentimes meaning overservicing of healthy practitioners) to overcome the Boards' perceptions (based on poor quality evidence of harms ensuing) that doctors are reluctant patients.

The right to work is a fundamental human right. To make this right contingent or to infringe this right there needs to be unequivocal proof that the infringement is necessary, reasonable, proportionate and that less onerous options have been pursued.

I contest that the Boards position (of adopting option 3) will not achieve the goal of detecting medical impairment in late career doctors that will cause harm because GP's are not skilled in the assessment or evaluation of complex, dynamic, neuropsychological deterioration in 'medical patients'. This might only be achieved by Option 2; but then it is still unlikely. As such, the cost of infringing the right to work outweighs any benefit; with any benefit being relatively small when considered in the context of the whole medical workforce.

1. Insufficient data to justify introduction

The statistics on late career doctors provided by the CRIS to justify introduction of health checks failed to provide insufficient detail of the nature of the notifications, types of doctors involved, the gravity of the notifications or the outcomes of the notifications.
In fact, the outcomes (indicative of the gravity of the notifications) led to no fines, reprimands or suspensions of registration suggesting less severe issues compared to doctors aged under 70.

Further, late career doctors had fewer notification in some of the categories listed. Unless the specialties, types of complaint etc are provided, it is wrong to use this data to justify such a huge regulatory and costly change. If a proportion of notifications came from older doctors writing medicolegal reports, it is commonplace that more complaints would be made as this is the nature of that area of practice.

Further, during the pandemic, the Board encouraged retired doctors to re-enter the medical workforce. Why was this permitted if the Board held such grave concerns regarding the risk of older doctors at the time? What impact has it had on reports and complaints?

It is thus impossible to use the data supplied in the CRIS to justify introduction of health checks without further detail on which to justify the plan.

I was unhappy with the 'Consultation Regulation Impact Statement: Health checks for late career doctors' document, as it is alarmist.

For instance, the quote found on page 21, *"Shojania et al. suggest 'that tens of thousands of citizens are injured, or die, due to medical errors'"* is from the USA (where the population is multitudes higher than Australia) and referred to doctors, nurses and pharmacist of any age (not just older doctors) causing avoidable harm (and some of these harms were minor in the scheme of things).

The comparison of compulsory retirement of Judges and mandatory annual comprehensive medical examination of pilots, whilst informative, is not comparable with the need for doctors to undergo medical examinations.
An arbitrary age for Judges to retire was set decades ago, when medical science and life expectancy were different. Compulsory retirement of Judges it is a contentious issue, with many believing this unnecessarily robs society of a fit and willing Judges with decades of experience.

With pilots, multitudes of people literally have their life in the pilots' hands, with no choice of pilot. It is thus reasonable that pilots are screened for likely causes of sudden incapacity (epilepsy, diabetes, arrythmia). This is not the case with doctors. Patients have a choice who they have as a doctor and can seek second opinions.

2. <u>Current regulatory requirements suffice</u>
Registered medical practitioners are currently required by the Medical Board to have a GP and maintain their health as part of annual medical registration obligations.

Currently, all registered medical practitioners are obliged to engage many hours of peer review annually. This process (especially when viewed on a temporal, annual continuum), together with mandatory reporting (and less formal professional/clinical avenues) provided real-world, real-time avenues of detecting evolution of impaired medical professionals.

Further, mandatory reporting of colleagues believed to pose a danger to the public is operative. I believe this, together with the professionalism of medical practitioners, does not justify mandatory health check for late career doctors. If the Medical Board has a notification regarding a doctor, the Board has powers to ensure appropriate medical / cognitive assessments are undertaken.

3. <u>Unnecessary early retirements</u>
Introduction of another layer of complex regulatory bureaucracy risks precipitating a mass exodus of disgruntled, but highly experienced and skilled late career doctors from the medical workforce rather than comply with a costly (in time and money) nuisance, ageist agenda of dubious utility. This itself would pose a serious risk to public health, and the wealth of benefit currently supplied by this highly valued and respected cohort. Further, as always, the cost will be disproportionately borne by part time practitioners who are predominantly female. I, for one, balk at the prospect.
The cost of the assessments is significant, especially if Option 2 is adopted. The cost of being a specialist medical practitioner is prohibitive, especially for part time practitioners. College fees are in the thousands of dollars, indemnity fees are in the many thousands of dollars, AHPRA registration is over a thousand, the cost of CPD is huge, then this is a further cost for doctors.

4. <u>Waste of specialist resources</u>
Delivery and interpretation of cognitive assessment that is sufficiently comprehensive and sensitive to, 1) have validity when tested in a medicolegal context, such as disbarring a medical practitioner from practice; and 2) utility for the purpose of detecting mild cognitive impairment or early dementia is a highly specialised undertaking.
General practitioners do not have skills nor scope of practice to undertake and definitively interpret such cognitive assessments.
I am not of the opinion that a three yearly less skilled cognitive evaluation in a 'health check' would fulfill the aim of the Board if mandated.
Thus, all doctors aged 70 would be exposed to a futile exercise. Argument can be made that it is worthy that doctors get health checks. I agree, but to mandate this is overreach and infringes the freedoms, needs and autonomy of doctors.

There will be unknows that the Board has not predicted. Further there is no evidence to support your proposal. There needs to be at least robust pilot study, documenting evidence that the plan actually works, (and to look for unforeseen consequences). These consequences maybe lead to loss of rural and remote doctors, or other doctors leaving due to regulatory overreach.

Given the high cognitive reserve of older medical practitioners it is unlikely that a non-specialist evaluation of cognition will have any meaningful utility for the purpose the Medical Board proposes. It would be unwise for all medical practitioners to be subject to such an experiment. The societal cost of burdensome medical examinations of predominantly fit medical practitioners would not be cost effective, noting the over stretched health resources and medical workforce. If the Medical Board is serious regarding introduction of these mandatory health checks, a quality randomized control study ought to be undertaken of medical practitioners undertaking these health checks, the rates of failure and the rates of notification change.

5. <u>Ageism</u>

I am concerned about the Medical Boards lack of sensitivity regarding 'Agism'. Firstly, 70 is now considered a healthy age to be in the workforce. The suggestion that a 70-year-old doctor can only work if they pass a test is offensive. If cognitive decline from age 70 is considered by the Medical Board to be such a risk, why then are you not proposing assessments for all health practitioners (such as nurses, pharmacists who also can cause significant harm to patients with errors). The plan is discriminatory against older people.

I opt for no change to the status quo

If this is overridden by the Board my recommendation is that, if the reason for introduction is 'to prevent avoidable harm', then the only option with any potential to approach this goal would be introduce an extensive and detailed 'fitness to practice' assessment for all doctors aged 70 and older, to be conducted by Neurologist or psychiatrist with specialised skills in neuropsychological testing. The cost needs to be borne by the public (i.e. the tax payer) if this is what they believe will protect them.

The draft plan undermines the professionalism of the medical profession and devalues late career doctors who have a vast amount of knowledge, skill and wisdom to share with the public and their juniors.

If the board is serious about averting 'preventable harm' you would be introducing mandatory health checks for all doctors. The actual number of impaired doctors (through mental illness and substance abuse) is far higher, proportionally, in the younger cohorts of doctors.

Doctors' health remains their responsibility, even as we age. Doctors, with their medical knowledge and experience, are in general, very well place to actively care for their own health and age well; often without the need for medical assessments or interventions.

The annual registration process and code of conduct requires that doctors care for their health and have a GP; it is discriminatory to subject older doctors to scrutiny that undermines their integrity merely because a tiny fraction have impairment.

It is not helpful to public confidence in the medical profession to imply late career doctors are a danger (when shear numbers of suspensions and reprimands occur amongst younger doctors).

Further, the public has the option of seeing a younger doctor if they are ageist or concerned a doctor may be impaired. It also demonstrates that the notification system works - if the public report valid concerns and colleagues/health practitioners have mandatory obligations to report.

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?
80

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.

I do not support mandatory health checks (see answer to question 1 above).
I support option 1.

A routine health check by a GP is very unlikely to reliably diagnose Mild Cognitive impairment in doctors. Only specialist assessment can reliably diagnose MCI or dementia.

However, if a mandatory check is introduced by the Board, I recommend Option 2.

My reasoning for option 2 is that (if the aim of the health check is to detect impairing health condition that would place the public at risk) the complexity of the assessment and life altering implication of a finding of impairment sufficient to impact the late career doctor's practice – only a specialist has skills to perform with validity such an assessment and for this to have medicolegal validity.

Further, there is serious risk (noting the profound implications) that GP's undertaking Option 3 would '**over report**' possible impairment (by practicing defensive medicine when complex cognitive assessment and interpretation of results is outside of their scope of practice). There is medicolegal risk for the GP should they 'miss' an impairment.

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. This is meaningless and burdensome.
In law, there is a 'presumption of capacity'.

Further, only a highly sophisticated neuropsychological battery (that take hours to undertake) would provide any meaningful baseline for highly intelligent doctors with high cognitive reserves that readily mask minor (and functionally insignificant) deficits.

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.

Medical confidentiality requires protection.
Any health / medical information should not be shared with the Board.
Assessing medical practitioners have mandatory responsibility to report impaired doctors.

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, it is not workable.
The cost benefit analysis is wrong

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

In the Pre-consultation questionnaire - mental health assessment –
There is no assessment for hypomania or mania
There is no assessment of psychosis
There is no assessment of suicidality
There is no assessment of grief

- All of which can contribute to serious risk to self or others, especially in older populations

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. Is the guidance in the draft Advertising Guidelines appropriate? Are the proposed supporting documents and resources (Appendix C-1 to C-5) clear and relevant?

8.2. What changes would improve them?

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

No

8.4. Are the proposed examinations and tools listed in the examination guide (C-2) appropriate?
No

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