Your details
Name: [redacted]
Organisation (if applicable):
Are you making a submission as? ☐ An individual medical practitioner
Do you give permission to publish your submission? ☐ Yes, without my name

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. 70 is not “old” any more. Doctors have a wealth of experience they can share, and only some will be falling ill. Doctors of any age may be falling ill or be risky practitioners. This is too narrow-minded and is low-hanging fruit. This will turn off some of our most revered doctors from contributing to the workforce. And what sort of a metric is patient complaints? Patients don't always know when they've had good or bad care, guideline-based or people-pleasing care, or always know what's best for them. Patients have many tactics for gaining power over their doctor, from passive aggressive behaviour to outright disrespect, to making complaints. What other people groups have been identified as being risky for a complaint? I fear the damage may already have been done, and the near-70 year-olds among us have already heard that those younger than them trust complaining patients more than them.

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?
N/A

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.

1. I've already seen this play out successfully. If a doctor in the practice has a near miss or starts practicing in a different or odd way, they're tapped on the shoulder, brought to the near miss meeting or call themselves out. And some of them are older. Younger doctors, with their own demographic-based risks, also call themselves out. And every doctor makes an AHPRA health declaration yearly, takes out their insurance, and naturally practices in a way which attracts or deters certain patients.

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 age discrimination, and is at best low hanging fruit.
Why don't we cognitive test all 70yo workers in Australia in jobs with an element of risk? Because we have data on "patient complaints"?
Why don't we drug test all doctors? And then study their patient outcomes?
Why don't we screen X, Y and Z demographic with the highest suicide rate in case they're making unreasonable decisions?

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.

N/A

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?

If any form of fitness to practice test is mandated for any demographic, then there should be remuneration across the board for the profession. It will automatically raise the risk of the job, from its already high level. It would signal to the public that only a subset of doctors are likely to be up to the standard. So with a higher standard, Medicare rebates would need to come up, and the private sector would likely increase their fees to cover for this increase in expectation and loss of staff.

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?

It may be well-intentioned, but I believe the metric of patient complaints speaks equal volumes about the populace as the practitioners. But nobody in public policy or media ever wants to call out the consumer. You could equally draw a conclusion that the public has a problem with older doctors, therefore we should start an education campaign for the public so that they're aware that a treasure trove of knowledge lies in these venerated mentors.

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

N/A

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

We can all imagine risky demographics of practitioners. How can we study them all? 70 is an easy and blunt tool. The MBA should publish a list of the demographics they've studied, and seek community consultation on high risk demographics they might have missed.

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?

N/A

8.2. What changes would improve them?

I think I've made it clear that my opinion is that it shouldn't go ahead, it's a hurtful interpretation and application of the data, and that there are other demographics of doctor who could be equally looked into and then disrespected publicly.

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

N/A

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

N/A

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

There would be an abundance of stats available to tell us which health maladies a doctor is most likely to experience. Age-related cognitive disorders, mental illness, and drug and alcohol misuse could all be prevalent, and there are likely some surprising finds too. Perhaps sleep deprivation, poor posture and metabolic syndrome are more common. These stats could be informative and helpful, whereas targetting older doctors based on patient complaints is like barking up the wrong tree then cutting it down for progress.