From: Robert Clancy [redacted]
Sent: Thursday, August 22, 2024 11:32 AM
To: medboardconsultation <medboardconsultation@ahpra.gov.au>
Cc: philip Morris [redacted]
Subject: COMMUNICATION WITH HEALTH PROFESSIONALS: COGNITIVE ASSESSMENT OVER 70

Dear Board,

I am a senior physician in Australia who with two others developed the specialty of Clinical Immunology. I admit the appearance of bias, being over 70. I am also the most experienced medical-scientist in mucosal immunology and its relationship with disease, vaccination and related matters.

My purpose in writing is to support the submission (attached) by my colleague, [redacted]: support widely discussed and agreed across our profession. [redacted] articulates very clearly the factual basis to concerns re targeting an age group based on (presumed) perceptions of risk, a view not substantiated by evidence and an issue that can be adequately handled by existing regulations.

Could I add to this excellent summary, the following:

1. Following extensive discussion with colleagues (most less than 70), there is the appearance of a growing gap between a Board out of touch with the reality of medical practise. The untested idea of cognitive testing everyone over 70 is an unnecessary time and money wasting exercise - there are better ways to provide safety oversight (which of course, is supported by me and essentially every medical practitioner). [redacted] drew attention to the opportunity to get data that would be meaningful, giving the Board an objective base on which to make policy.

2. The Board and the medical profession has a long and valuable history. Covid to an extent tarnished this relationship with decisions that defied science and countered the revered doctor patient relationship. It refused to be inclusive of experience and knowledge (as an example, I sent two offers of help given I could, without the courtesy of reply). The current idea of global cognitive testing over an arbitrarily selected age, without wider discussion and provision of evidence for such an intrusive decision, risks widening a gap no one wants. There could be valuable initiatives taken to ensure that once again the health professions and their Board sing from the same sheet, and are firmly mutually supportive.

3. Having been a clinician for 50 years, I have noted both the massive changes in how medicine is practised, and the way in which so much of medicine has become a technology-based business. Young doctors (in my case gastroenterologists and clinical immunologists) respect and profit from contact with older physicians with vastly different experiences. Reducing the small pool that exists through policy unsubstantiated by evidence, with its added bureaucratic layers to navigate, would threaten the balance of medical practise. Just this week, one of Australia's most experienced and respected physicians "retired" prematurely rather than face the embarrassment and stress of answering the most ridiculous "complaint" I have witnessed in my career. Rather the Board could maximise benefits experience brings, by supporting, encouraging and promoting mentorship by facilitating opportunities.

4. To an individual, my older colleagues have been sensitive to the physical and mental requirements of medical practise, retiring appropriately, or adjusting to maximise their experience and skills as they became older, shifting their practise to best fit circumstances. This regulatory servo system, is usually (and fiercely) reinforced by their family, friends and colleagues.

I do hope these comments are helpful. We all want the best medicine there can be, provided by a fit medical force committed to providing quality medicine. We want a board that is in touch with us, sharing our goals. Mandatory untested cognitive assessment based on an arbitrary age, imposed on my profession does nothing to achieve these ends: rather it widens a gap that no one wants.

With best wishes,

Robert Clancy

Mandatory Medical Examinations of Doctors Aged 70: Unjust Discrimination or Necessary Safeguard?

[redacted]

In the realm of medical ethics and professional practice, the proposal to subject doctors aged 70 and older to medical examinations and cognitive testing raises crucial questions regarding discrimination, public safety, and the preservation of invaluable experience.

Profiling of a community group based on *stereotypical assumptions* based on a particular characteristic of a group such as race, age, ethnicity, religion, disability, marital status, or sex is a form of discrimination that is outlawed in most countries. The Medical Board of Australia proposes to mandate medical examinations and cognitive testing on doctors aged 70 and over on a negative stereotypical assumption that all these doctors are a risk to patient welfare [1].

While not wanting the public to be at risk from impaired doctors, either younger or older, this proposal raises the question of whether the Medical Board of Australia is age profiling older doctors. And a reasonable person could ask whether the Board is discriminating against these doctors based on age.

The Board claims that current regulatory measures are failing to detect some practitioners with health issues, and this therefore increases the risk to patients. The Board provides no robust evidence that supports this claim. The Board already has extensive and legitimate powers to assess younger and older doctors who have medical conditions that might affect their cognitive performance and clinical practice without the need to specifically target older doctors.

One way the Board can identify doctors of concern is to ask doctors with two or more complaints made against them in a defined period, or who have been reported for significant lapses in standard of care, to undergo a health check. The Board has this capacity, and this should be the norm regardless of age. By implementing a strategy of proactively identifying doctors of concern, no matter what age, the Board would be able to achieve its aim of reducing risk to the public without discriminating against older doctors.

The Board notes there has been an increased number of notifications and an increased rate of notifications (per 1000 doctors) from 2015 to 2023. Using the Board's own data [1] it is clear the rate of notifications increased substantially from 2015 to 2019. But his rate of increase was the same for doctors below 70 as it was for doctors 70 and over; 70% and 73%, respectively. From 2019 to 2023 the rate of increase in notifications plateaued; for doctors below 70 there was a decline of 3% and there was only a modest increase of 9% for doctors 70 and over.

This pattern was also seen in the type of notifications per 1000 doctors. For one of the most crucial notifications – Clinical care - the rate of notifications increased 190% from 2015 to 2019 among doctors below 70 and increased 222% for doctors 70 and over. But, from 2019 to 2023 the rate of notification in this category declined by 3% among doctors below 70 and declined by 22% for doctors 70 and over.

Furthermore, the nature of regulatory action taken by the Board in 2022-23 was much more severe for doctors below 70 (requiring suspension, fines and reprimands) than doctors 70 and over (needing none of these sanctions), suggesting that the younger doctors presented a greater risk to the community.

There is no evidence in these data that there is an 'explosion' of notifications among older doctors that is different to that of doctors below 70. The rate of notifications increased about 70% in both groups between 2015 to 2019 and then flattened out to 2023. The explanation for this pattern is not clear, but given it was observed in both groups and of the same magnitude, it is likely that for the period 2015 to 2019 it related to changes in reporting such as the start of health ombudsmen offices in states, encouraging the public to consider making complaints to health regulators, as well as making notifications easier via electronic means. The data do not support the notion that the rate of notifications for doctors 70 and over are continuing to increase or rise disproportionally.

The Board does not provide information about the specific nature of notifications made within the notification categories and whether the notifications or complaints were upheld. Without this information it is premature to conclude that doctors 70 and over are more of a risk to the public than younger doctors.

If the Board wanted to provide more convincing evidence to justify its proposal to mandate medical examinations and cognitive testing for older doctors, the Board should commission a properly designed study or survey of doctors across different age cohorts examining their physical health, mental and cognitive status, substance use, and their capacity to examine and treat patients. Only after a study like this was done which identified problematic performance of older doctors could the Board legitimately argue for mandatory medical examinations and cognitive testing of these doctors.

Medical indemnity insurers in Australia do not increase their premiums based on the older age of doctors. Their policies are based on two primary characteristics. The first is the nature and risk profile of the practice and, second, the number of cases that practitioners look after at times in their career (for example, as reflected in practice income). The actuaries that advise the medical indemnity insurers do not counsel that older age is an additional risk factor that would justify additional premiums.

Health committees of medical boards across Australia are generally aware of those doctors who have impairments based on underlying medical conditions. A report from an Australian medical board noted that there is no significant difference in the proportion of doctors over the age of sixty compared to other doctors known to these committees [2]

In view of all this evidence, it is my opinion that so far there is no substantial indication that healthy older doctors pose a risk to the public. The Medical Board of Australia has not provided sufficient grounds to mandate physical examinations and cognitive testing for doctors 70 and older.

The Board might wish to target other doctor groups because of certain characteristics. For example, male doctors from around the late 30s to early 40s are more likely to have alcohol and substance use problems than older doctors [3, 4, 5]. Presumably a drug or alcohol affected doctor would pose a risk to the public. The Board could mandate regular breathalyser tests, urine drug screens and hair analyses for this group of doctors before they are allowed to see patients, but it does not. Instead, it relies on notifications of problematic behaviour or drug use to identify and mitigate the risk from these doctors, rather than target a whole a whole category of male physicians of a certain age. The Board should use the same approach for older doctors.

The Board also proposes to force doctors aged 70 and older to undergo regular cognitive tests. This is despite any robust evidence that healthy aging among older doctors is associated with any significant cognitive impairment that would affect patient care. We need to distinguish healthy aging from the development of medical conditions that become more common as individuals age. Medical boards already have the capacity to intervene to protect the public in situations where older doctors develop illnesses (for example Alzheimer's disease) that affect cognitive capacity.

Healthy aging is associated with subtle changes in cognition. There are gradual changes that occur in fluid intelligence and crystallised intelligence [6]. Fluid intelligence involves cognitive characteristics like processing speed, problem solving, and reasoning, learning new information, short-term memory, executive functions and psychomotor ability. Fluid intelligence peaks in early adulthood and then declines slowly. These changes are small and gradual. The changes in fluid intelligence are counter-balanced by age-related improvements in crystallised intelligence. Crystallised intelligence involves cognitive characteristics like vocabulary, general knowledge, medical knowledge, experience and pattern recognition, and 'wisdom'. In healthy aging, these changes complement each other resulting in the individual not significantly changing in cognitive capacity over time.

These changes of healthy aging have not been linked to problems in clinical practice that would lead to concerns for public safety. Studies of physician age and in-hospital mortality of the patients these doctors care for have generally shown no association with age when controlled for procedural volumes [7] and no

association between physician age and patient readmission [7]. The reasons behind associations between age and specific clinical outcomes are complex and are not likely to just relate to age of physician [8].

It is important to note that individual variation is substantial in all doctors who age. There is no consensus or agreed guidelines that help medical authorities decide what level of age-related cognitive changes may put the public at risk. The Board acknowledges this significant limitation:
It is difficult to relate the precise degree of neurocognitive loss to doctors' competence because the actual levels of cognitive impairment that preclude safe practice have not been determined. There are no agreed guidelines to help medical boards decide what level of cognitive impairment in a doctor may put the public at risk. [1, page 20].
Prospective studies have not been done addressing this issue [2]. The American Medical Association in 2015 noted:
the effect of age on any individual physician's competence can be highly variable [9],
and in 2018 it withdrew its support for testing physicians cognitively at 70 years of age [10].
The Board recommends that screening cognitive tests be used for regular testing of older doctors [1]. The tests mentioned include the Montreal Cognitive Assessment (MoCA), the Addenbrooke's Cognitive Examination (ACE-III), the Mini Mental State Examination (MMSE), and the Clock Drawing Test (CDT).

What the Board fails to mention is that there are no norms for the cognitive screening tests they propose (MoCA, ACE-III, MMME, or Clock Drawing Test) for medical practitioners. So, using these tests to determine cognitive impairment for physicians is meaningless and the test results are uninterpretable. None of these screening instruments have been evaluated in order to determine what scores would determine the doctor's capacity to take a history, do a focused physical exam, or to plan management of patients.

Furthermore, you cannot meaningfully test physicians on these screening tests if they are familiar with them and practiced on them (as all physicians will be when they find out what cognitive screening tests they will face).

Relying solely on cognitive testing to predict functional vocational capacity poses several dangers. They have limited scope and do not capture the range of abilities necessary for the work environment. They do not consider the context in which the doctor will be working. They are static and do not assess changes over time in response to experience, training or therapeutic interventions. They have inherent cultural biases which disadvantage individuals from diverse backgrounds. An individual's emotional state can significantly affect test performance, skewing results to underestimate the doctor's vocational capacity. These tests emphasise quantitative data and overlook aspects like motivation, interpersonal skills, creativity, and practical problem-solving abilities, which are crucial in physician work. These tests can create a false sense of precision and certainty. Undue confidence can be placed in test results. Intelligent and well-educated doctors may score highly on the screening tests, but these results may not reflect the performance of the physician in the workplace. Finally, there are ethical concerns regarding the use of cognitive tests, especially if the tests are used without appropriate consent, interpretation, and support from qualified professionals.
It follows from the evidence above that the Board should not require older doctors to have regular cognitive tests with screening examinations that so severely lack validity and reliability.

The targeting of doctors aged 70 and older for forced medical examinations and cognitive testing by the Board will discourage older doctors from contributing to the profession. Older doctors have a lot to offer the medical profession. Their experience, mentoring skills, continuity of care, patient advocacy, and research contributions are invaluable. By continuing to practice, older doctors can help to improve patient care and contribute to the advancement of medical knowledge. The loss of senior doctors will be a major disadvantage the community at this time of physician shortage.

In my opinion mandatory cognitive testing of all doctors aged 70 and above is inappropriate and raises the question that it is a form of age discrimination. There is insufficient evidence to support the notion that healthy aging doctors pose a significant risk to patient care. Age profiling undermines the principles of fairness, equality, and individual assessment.

Instead, the Board should focus on targeted assessments based on reasonable suspicion, such as evaluating doctors with multiple complaints or significant lapses in the standard of care. By adopting fair and evidence-based approaches, the Board can ensure patient safety without resorting to age targetting in the medical profession.

Alternatively, if the Board believes it is a good idea for older doctors to have health checks from their general practitioners to benefit the doctor's health and to reduce the risk to the public, then this should be mandatory for all doctors regardless of age, given that younger physicians are just as valuable individuals as older doctors and the risk of unwell (or drug affected) doctors of any age on the public is just as important. The absolute risk to the public based on notifications to the Board is nine times higher for doctors aged under 70 than doctors aged 70 and older. The Board would be well advised to ask all doctors to have a regular medical check-up with their general practitioner and enforce its code of conduct:

The Board's code of conduct (Code) requires all doctors to have their own general practitioner (GP) to help them take care of their health and wellbeing throughout their working lives. Healthy doctors are the cornerstone of Australia's healthcare system [1, page 5].

This approach would reassure the medical community that the Board was not trying to unfairly target older doctors.

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