Response to

Questions for consideration - AHPRA Health Checks for Late Career Doctors

The Board is considering three options to assure doctors get the healthcare they need and are able to keep providing safe care to their patients.

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?

Response:

The answer is no for the following reasons:

- Older doctors vs younger doctors

The reference article used as a basis of this assertion (Thomas et al - 2018) analysed notifications in the 3 years 2011-2014 in younger doctors (36-60 years) and older doctors (age over 65 years). Overall, 84.2% of younger doctors and 86.8% of older doctors did **not** receive a notification over the 3-year period. Under the study category "All health concerns" older doctors had a 1.5 times relative risk, however the absolute risk (6.2% for older doctors and 4.0% for younger doctors) was low. Older doctors were associated with more physical illness and cognitive decline however younger doctors had more mental illness and substance abuse.

As far as "Performance concerns", younger doctors had **higher** notifications (61.6%) then older doctors (54.4%) with respect to inadequate investigations, poor assessments and diagnosis, poor communication and problem with procedures. Older doctors however had more notifications about inappropriate prescribing (6.4% to 4%). Despite the relative rate of notifications for prescribing being 1.6 times, the absolute rate in older doctors was low (i.e. 93.8% of older doctors with no physical or cognitive problem)

As far as "Conduct concerns", older doctors (39.4%) received more notifications on record keeping, reports and certificates, unlawful use and supply of medications, disruptive behaviour and breach of boundaries. Younger doctors (34.4%) notifications were slightly lower and there was however more fraud and overcharging concerns in this group.

In summary, older doctors were at higher **relative** risk of notifications relating to physical or cognitive impairment, but this category only amounts to 6.2% of all complaints about older doctors, and the absolute risk is low (93.8% with no physical/cognitive issues). Older doctors received less notifications in areas related to performance and more notifications in areas related to conduct (which is not assesses in a physical examination).

Four limitations of the Thomas study were outlined

- Notifications being an imperfect marker of quality of care
- Medical regulators coded the reason for notification on information know at notification and not on subsequent assessment and adjudication
- A lack of information as to the context (practice setting, group, solo, circumstances)
- No comparative data as to the work performed by older and younger doctors

Bismark et al in an article "Identification of doctors at risk of recurrent complaints: A national study of healthcare complaints in Australia" in 2013 reported that *"A small group of doctors accounts for half of all patient complaints lodged with Australian Commissions. It is feasible to predict which doctors are at high risk of incurring more complaints in the near future. Widespread use of this approach to identify high-risk doctors and target quality improvement efforts coupled with effective interventions, could help reduce adverse events and patient dissatisfaction in health systems"* . The authors then went on to say that 3% of Australia's medical workforce accounted for 49% of complaints and 1% accounted for 25% of complaints.

To assess all doctors based on physical and cognitive performance based on 6.2% of the notifications and the fact that the older doctor group is not homogeneous in nature seems a misguided decision.

- **Notifications (complaints) as an indicator of competence.**

  The authors of the Thomas et al article (2013) noted that "N*otifications are an imperfect marker of quality of care with previous research suggesting most instances of poor performance, impairment or unethical conduct do not result in a formal notification of concern.*"

AVANT medical defence reports that over a lifetime of practice the average medical practitioner will receive 5 notifications. In the Bismark et al (2013) article of the notifications received only 8.5% resulted in regulatory action. The total number of complaints is not evenly spread across the profession and approximately 3% of practicing doctors accounted for half of all complaints. The number of prior complaints doctors had experienced was a particularly strong predictor of their short-term risk of further complaints.

One of the critical issues that needs to be addressed up front is the indicator used by AHPRA to indicate clinical risk. According to the most recent AHPRA annual report (2023) on medical practitioners, 5.7% of doctors are subject to a notification (complaint). Of those complaints, 60% result on no further regulatory action, 11.2% result in regulatory action and a smaller percentage 7% had condition imposed or had their registration cancelled/suspended.

Based on the rise in notifications from 2015 to 2023, in older and younger doctors, without any evidence of a "physical/cognitive competency pandemic" in doctors there are obviously confounding factors related to increased notifications other than age. Also, in the 2023 data (fig 9, p23), the number of notifications for the 75-79 and 80+ year groups was lower than the 70-74 year age group which goes against the notion that notifications rise with age. In 2019, 80 year old doctors received less notifications than those under 70 years. There are odd data discrepancies comparing the 2015, 2019 and 2023 notification results which question age as a significant factor.

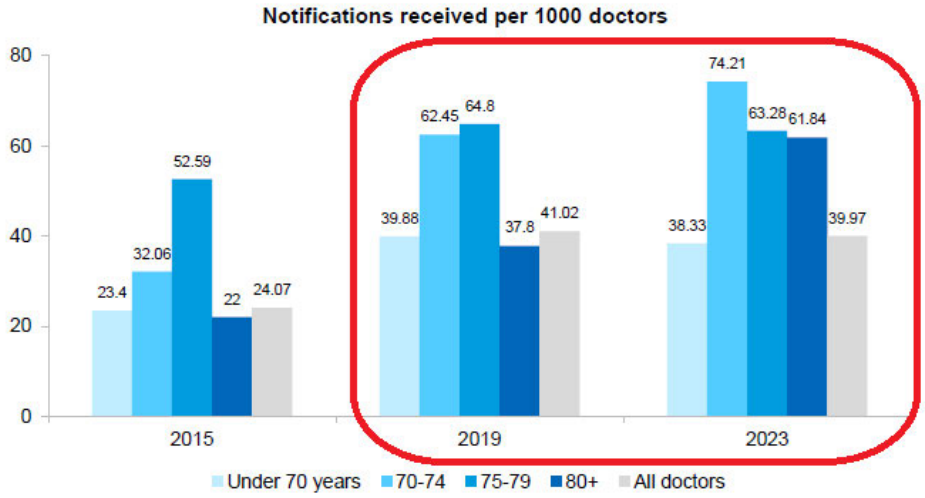

Figure 9: Notifications received per 1000 doctors (excluding doctors holding non-practising registration)

- **Evidence related to a fitness to practice and health assessment effectiveness/risk reduction.**

There is an assumption, but no real evidence provided, that the two measures (Options 2 and 3) outlined in the consultation document will provide a reduction in notifications (the basis used for calculating risk) for late career doctors. Mention is made to overseas interventions such as mandatory screening of performance, most commonly initially through multi-source feedback and/or a peer review process, however **no evidence** is provided on the effectiveness of physical and cognitive health assessments as a screening measure for risk (as based on notification data).

To screen all doctors at 70 years and 3 yearly until 80 years and then then annually based on a "fitness to practice" or "health assessment" to detect physical and cognitive impairment is an inefficient screening test (based on the evidence from the Thomas and Bismark papers). The fact that factors other than physical cognitive impairment in the older doctor group (small percentage of older doctors) are related to notifications is critical to any consideration in this matter.

A good screening test is based on the likelihood of the condition, accuracy in diagnosis, reliability, the impact of the condition and the likelihood of detecting a problem in the early stages and remediation (not removal from profession) and acceptability. A more targeted approach based on risk rather than age is recommended and a better indicator of risk is essential.

Relating to the "Choosing Wisely Australia" program any screening or intervention needs to consider the risk of harm over benefit.

The "fitness to practice" or "health assessment" do not address many of the competency criteria e.g. cultural aspects of care provision which are covered in the AHPRA documents "Good Medical Practice – A code of Conduct" or "Shared Code of Conduct".

- **Workforce capacity issues**

The other significant factor that needs to be considered is the signal that this proposal sends to late career doctors (70 years plus) and the increased likelihood of premature retirement of this group from the workforce. This proposal also sends a signal to a large number of doctors in the 65-69 year age group regarding imminent additional regulatory demands and costs on the profession. This is especially so for rural doctors.

Recent workforce data published by the DOHA (GP Supply and Demand Study (health.gov.au)) has highlighted the precarious situation faced by Australian general practice and the reliance on a significant number of late career doctors in working beyond 70 years of age in supporting health care provision, teaching and training.

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?

Response:

Primary Health Networks, RACGP and AMA organisations recommend that all doctors should be encouraged to have their own general practitioner and be seen for checkups on a regular basis based on their level of health risk and exposure the health system environment at any age. These organisations also encourage GPs to be engaged in preventive health measures and to monitor their physical and psychological health, engage with there colleagues in a supportive clinical environment, and when indicated seek care from their regular GP, specialist or the Doctors Health Advisory Service (DHQ).

Understandably APHRA is frustrated that more doctors do not follow this advice, however nonparticipation in health promotion and prevention (secondary or tertiary) is a population wide phenomenon and not confined just to the medical profession.

There are environmental pressures impacting the health profession with an increased level of workplace stressors in general practice due to increasing consumer demand, more burdensome reporting, regulation and decreased workforce reserve. From a 2023 PHN needs assessments there is an increasing difficulty of health consumers in accessing health care, equity and related social and financial issues. The above factors can affect health professional performance and are unrelated to physical or cognitive performance issues.

There is also a concern that the regulatory role placed on a doctor's regular GP to police capacity to work will affect the existing doctor patient relationship. A reasonable option would be for medical professionals and staff to flag concerns about declining performance (not adverse events or mandatory notifications) to the Doctors Health Advisory bodies. This would encourage more assessments and counselling in a non-regulatory environment.

With an aging population, a significant number of patients prefer to visit a doctor in their age group and disadvantaging late career doctors would affect this older patient group.

Based on the rising number of notifications in doctors from 2015 (a couple of years after the Thomas and Bismark studies were published) without any evidence of a significant decline in doctor physical or cognitive decline, factors other than aging workforce need to be explored.

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).

Response:

It is recommended that this option retained given the lack of evidence that the implementation of Options 2&3 will result in reduced risk to health consumers (as indicated by a reduction in notifications received). Several presumptions are made based on age and the number of notifications (complaints) however there is a question over notifications (complaints) as a marker of risk. As mentioned previously the AHPRA Annual Report 2023 indicates that 60% of complaints did not result in any regulatory action. Over the period 2015 to 2023 (Fig 8, p22) the number of complaints against under 70-year-old doctors and doctors over 70 years increased (1.9 times), and if age alone was the only factor, then the under 70 year age group notification rate (1.6 times) would not have increased. In Fig 9, p23, the number of complaints against 75 plus year doctors were lower than the notifications in 70-74 year old doctors, which does not support the higher risk in increasing age argument. In Fig 9 in the 2019 data notifications were less in the 80 plus age group than the under 70 year age group. This raises confounding factors other than age as the cause of rising notification rates. The low number of notifications related to health issues as outlined in Table 1 on page 24 also raises concerns over the assessment measures outlined in Options 2&3.

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.

Response:

This option is incredibly expensive and no evidence has been provided as to risk reduction benefit based on clinical competency. This option does provide a more extensive physical and cognitive testing but is light on detail on specific clinical skills testing (higher executive functions). This assessment does not cover the areas listed in the "Good medical practice – A Code of Conduct" document (i.e. only a fraction of the areas related to notifications). This option would be a major barrier to remaining in the profession for most doctors.

Importantly a doctor with a physical disability can deliver competent health care in a supportive work environment. A doctor with a physical or mild cognitive impairment can still work in a supportive and specifically work task suited role. Physical health related complaints form a very small proportion of notifications.

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.

Response:

Based on the level of risk, this is not a targeted approach to the problem or an efficient way of addressing this problem. This assessment could detect a major physical or mild cognitive impairment, but not higher-level executive functions (related mostly to clinical competency) or the behavioural factors contained in the "Good medical practice – a code of conduct" document. Physical health related complaints form a very small proportion of notifications. As said previously, a doctor with a physical disability can deliver competent health care in a supportive work environment.

No significant evidence is provided as to risk reduction benefit (i.e. executive function, behavioural concerns). This option has the risk of affecting the doctor's relationship with their regular GP and non-disclosure of specific information.

A more suitable (targeted and efficient) option would be to encourage referral based on concerns of physical/cognitive capacity to Doctors Health Advisory services, which would remove barriers currently faced with a regulatory approach (excluding mandatory notifications).

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?

Response:

A cognitive function test is best used to assess doctors with indicators of clinical risk rather than age alone.

Cognitive screening tests have limitations as outlined on pages 87-88 and a mild cognitive impairment (e.g. speed in decision making) may not be associated with clinical risk. Older age is associated with cognitive decline but does not affect people uniformly (p 87) and cognitive impairment is not inevitable.

A better approach which removes the concerns related to a regulatory approach is to encourage participation in preventive health care and also referral to doctors' health services. This would assist reporting by concerned practice staff and provide a less confrontational approach.

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.

Response:

A better option is to focus on risk rather than age and to support GPs engaging with a primary care doctors. (refer to above comments). Referral to Doctors Health Advisory services is another useful option for AHPRA to consider for an assessment and counselling approach, rather than a regulatory approach which may be counterproductive (excluding mandatory notifications).

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?

Response:

Apart from encouraging doctor participation in doctors' health services, the answer is no.

The consultation document compared doctors with airline pilots. Conducting a health assessment and cognitive test without assessing the pilot's competency to handle an emergency in flight (though check captains and flight simulation exercises) is like the APHRA proposal Options 2&3.

The medical assessment for a pilot relates to defining the risk of "sudden incapacitation" either mentally or physically. A medical check was never meant to check the proficiency of the pilot to perform their duties.

There is no evidence base for a medical or occupational assessment that determines fitness to perform the duties of a medical officer. There also does not appear to be justification of age alone being the indicator for such a concern. Instead, all categories of doctors that have increased rates of reporting should be equally considered by AHPRA.

7. The Board has developed a draft *Registration standard: health checks for late career doctors* that would support option three.

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?

Response:

The Board have not demonstrated to any level of satisfaction that a health assessment for late career doctors would reduce the number of notifications (complaints) the indicator used by the Board to reflect competency to practice and as a basis to evaluate the intervention. Notifications are also a

poor indicator of competency, in a work environment with many confounding factors related to notifications.

If the Board is serious about Option 3, then a randomised controlled trial of using a better measure than the number of notifications as a surrogate for the level of clinical competence is needed before wider implementation.

8. The Board has developed draft supporting documents and resources to support option three. 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.

8.1. 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?

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?

Response:

See response to Question 7.

Dr Peter Adkins

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11th September 2024